

with her strong need to express love—two very different things.

Among all deaths the sudden traumatic death of a young person tends to have the greatest impact on the bereaved, who therefore need particularly careful handling. Bereaved people should always be offered the chance to see the body, and generally this should be encouraged. It is an important part of accepting the reality and often helps to dispel the imagined disfigurement. Fact is generally preferable to fantasy, and what right have we to protect bereaved people? The deceased is their relative, and their feelings will tell them what they need to do. We are perhaps just protecting ourselves and hindering them in the process.

Seeing the body is also a chance for the people to inspect, touch, hold, kiss, or say goodbye to their loved one. Staff should give permission for these free expressions, as well as allow the chance for bereaved people to be left alone with the body.² Some may need several visits. Sheila Awooner-Renner was unnecessarily (and cruelly) kept waiting, and when she eventually got to her son she felt inhibited and was watched. There was no need to wait for the coroner's officer.

How are we to avoid this well meaning but inappropriate handling of distressed relatives? The hospice movement has led the way, but the acute sector needs a system for coping 24 hours a day. Accident and emergency departments are increasingly recognising the needs of bereaved people, regarding them as unofficial patients (often led by nurses). As well as the senior accident and emergency staff hospital chaplains, social workers, and sometimes bereavement counsellors are available.³ Staff in other emergency specialties, such as intensive and coronary care and neurosurgery, should also have some training and awareness of these matters and be able to integrate their services with those of the hospital and community.

Unresolved grief reactions may linger and might be reduced by good, early handling, which should include encouraging the bereaved to express their feelings as they say goodbye to their loved one.

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Ultrasonography and perinatal mortality rates

SIR,—Though variations in perinatal mortality rates among health authorities do occur,¹ and it is right to seek improvement in the services provided,² caution must be exercised in planning any such improvement.

Dr Isabel M Shirley and Ms Fiona Bottomley outline the programme of fetal surveillance that, they suggest, is responsible for a reduction in perinatal mortality rates in their unit.³ Their claim for an improvement in perinatal mortality rates is at best only in the uncorrected rate, whereas most units quote perinatal mortality rates corrected for fetal anomaly. A single screening test at 19 weeks such as they suggest will identify major congenital anomalies. This does not, however, allow much time for counselling and treatment if termination is considered.

The results of other studies of the efficacy of ultrasonography in pregnancy have not been encouraging. Such screening has not been shown to have any benefit either as a single or as a two stage procedure,^{4,5} apart from reducing the number of patients induced for incorrectly diagnosed post-

maturity.⁶ The study by Dr Shirley and Ms Bottomley is awaited with interest as the predicted numbers required in such a study to produce valid results range from 12 000 to 46 000.^{7,8}

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Junior doctors' years

SIR,—Dr John Roberts suggests that American doctors in training are able to concentrate on learning rather than on patient care because they "have the help of attending (senior) physicians at all times."¹

Having worked within both systems, I have observed that this is not true. In surgery, obstetrics, and anaesthetics supervision by senior staff is at about the same level in America as it is in Britain. At my present hospital residents often complete whole operating lists without the attending (senior) surgeon ever appearing. How many registrar lists in Britain are completed without the consultant taking a close interest?

Dr Roberts states that junior doctors depend on one consultant for a recommendation to the next job. This is also not true. References are not even requested until a candidate has been shortlisted (on the basis of his or her curriculum vitae). The performance of the candidate at interview is clearly the main determinant of whether he or she gets the job. References may not even be examined until after the committee has reached a tentative agreement. Though I have not sat on an interview committee myself, I am told by those who have that examination of the references only rarely results in that decision being changed.

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- 1 Roberts J. Junior doctors' years: training, not education. *BMJ* 1991;302:225-8. (26 January.)

Need for liver biopsy in alcoholic liver disease

SIR,—In the recent retrospective study concerning the need for liver biopsy in patients with suspected alcoholic liver disease in whom there is raised serum γ -glutamyltransferase activity but otherwise normal serum transaminase activity, Dr A Ireland and colleagues found only reversible histological changes (steatosis and Mallory bodies), although fibrosis or cirrhosis was a common finding in patients with additional abnormalities of serum liver biochemistry.¹ The authors offered no comment on whether histological examination was indicated in patients with raised activity of γ -glutamyltransferase only, although they imply that there is no need for a liver biopsy.

It should be pointed out, however, that although histological changes of steatosis and Mallory

bodies such as were found in their patients are often reversible with abstinence from alcohol, it has been shown in several studies that these histological features in drinkers are independently predictive of cirrhosis. Indeed, in one long term prospective study 28% of patients with severe steatosis alone and without histological features of alcoholic hepatitis developed cirrhosis over a period of 10-13 years. The authors concluded that steatosis was a risk factor for the subsequent development of cirrhosis—despite its reversibility.² In our view, a liver biopsy should be carried out if raised γ -glutamyltransferase activity persists after abstinence for three to six months, allowing early reversible changes to clear—usually by the time referral to hospital and further assessment have been arranged.

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- 1 Ireland A, Hartley L, Ryley N, McGee JO'D, Trowell JM, Chapman WR. Raised γ -glutamyltransferase activity and the need for liver biopsy. *BMJ* 1991;302:388-9. (16 February.)
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Doctors, the onus is on you

SIR,—Ms Caroline White reports that patients appreciate facts about their illnesses and the opportunity to ask questions at consultation.¹ One easy way to give information is to supply patients with copies of their clinic correspondence.

We are currently analysing data derived from our questionnaire survey of patients' clinic letters. Each patient received a copy of a letter from an outpatient consultation, together with a short questionnaire. The letters mentioned recent clinical details, treatment, and outlook. Of 202 patients surveyed over 12 months, 91% requested copies of further letters. Supplying such information must assist in patients' understanding of their conditions and compliance with their treatment.

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- 1 White C. Doctors, the onus is on you. *BMJ* 1991;302:369. (16 February.)

BMA's guidelines on advertising

SIR,—The principles governing the General Medical Council's guidance on advertising concern the maintenance of good relationships between doctors and the protection of patients "from unscrupulous claims which could be contained in promotional material."¹ The unfortunate result has been that until recently patients were denied written information on matters such as the facilities in general practice: information they want,² need,³ and benefit from.³ The medical profession responded to the changing public mood late, somewhat unwillingly and patchily. Now a contractual obligation for NHS doctors to provide practice information leaflets is included in the 1989 terms of service.

Dr A W Macara's assertion⁴ that the BMA and the General Medical Council have publicised the need for information to patients for some years is undeniable, but the external pressure from patients,⁵ consumers' organisations, the Monopolies and Mergers Commission,⁶ and the new contract for general practice has given

momentum such that the change has been faster and gone further than the medical profession wished.

Since an early enthusiastic endorsement of patient information leaflets⁷ the *BMJ*'s reports on developments have highlighted the anxieties of medicopoliticians.⁸ The most recent guidelines on advertising are welcome but still emphasise what doctors should not do.⁹ Leavey and colleagues' paper on consumerism and general practice exemplifies the medical profession's satisfaction with the status quo and the scepticism about consumerism in medical care.⁹

The benefits of written information for patients are self evident and documented.^{3,10} The all important message for doctors, not yet endorsed by the *BMJ*, is that they should meet their contractual obligations to provide information with care and flair so that their patients—and prospective patients—become fully aware of the range and value of the services they provide. Doctors cannot assume that registered patients are already knowledgeable or using services effectively.^{4,5} The medical press has been too concerned with what should be avoided in written information, and it is time to reorient the discussion to what information is desirable and how it should be presented.

The restrictions that we are now struggling to guard in the name of patient benefit—for example, the advertising of special skills by either doctors practising "alternative" medicine or specialists^{1,2}—may be swept away by policy makers as those concerning practice leaflets have been. It behoves a proud and self governing profession to review its self imposed restrictions on a regular basis and with a critical eye, retaining only those regulations that are pertinent to the times. Change agreed by professional consensus is preferable to that imposed from outside, but the latter is the inevitable consequence of inertia.

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Abuse of student electives

SIR,—The chairman of the Medical Academic Staff Committee seems to suggest that British medical schools and hospitals are in danger of being overwhelmed by a flood of foreign students who, unable to obtain sufficient education in their own country, use electives in the United Kingdom as a cheap alternative.¹ In the context of the undoubtedly high number of medical graduates in some European countries, the logical conclusion must be to shut the doors of hospitals and medical schools of this country against the foreign invasion or, failing that, at least let them pay dearly.

If this represents the view of the committee he chairs, let alone that of the chief medical officer, the situation is very serious indeed. Over the years

thousands of foreign students have had the opportunity to spend time in British hospitals, improve their clinical as well as language skills, learn about medical education in another country, see the advantages and problems of a different health service, and generally broaden their horizons. I myself had the privilege of spending a year of my medical training in Glasgow University (paying for my fees as well as accommodation) as part of a programme organised by my home medical school in Hanover, Germany, and the German Academic Foreign Exchange Service. It certainly was one of the most fascinating experiences of my medical training, and I like to think that I was able to give something in return—if only by being a constant source of amusement because of my efforts to combine a German accent with the local variety.

The one fact that has always saddened me is the curious lack of British students using the same opportunities in return. Our programme in Hanover was supposed to be an exchange programme—but there were no applicants from the United Kingdom. Which hospital in Germany has had a British student for an elective? I am sure that the overwhelming majority would be only too happy to offer their facilities—if there was the demand. The main reason usually given by my fellow students in Glasgow was the language barrier. While I continue to be amazed by the lack of decent language education in this country, even this problem can be overcome as most German doctors and nurses speak enough English to make an elective worth the student's while. I still fail to understand why British medical schools do not encourage their students to go abroad. Is it simply narrow mindedness? The belief that British is the best and does not need any comparison? A tight curriculum that does not leave room for personal initiative? Or can they just not be bothered? I do not know the answer, but I feel sorry for the students who miss out on the opportunity of a lifetime and for the medical schools, which would get so much in return.

To try to prevent more foreign students from doing electives in Britain because of the potential of the system to be abused would lead to further deterioration of a situation that is already bad enough. Would it not be infinitely more rewarding for the Medical Academic Staff Committee and its chairman to explore ways of encouraging more British students to go abroad in order to strike a better balance? I am sure that there would be enough partners in Europe more than willing to help in this undertaking.

One final word: hardly a week goes by without advertisements by British health authorities in the German counterpart of the *BMJ* (*Deutsches Ärzteblatt*), looking for junior doctors. Could it be that they are looking in Germany because they are confident about the standard of medical education in Germany—and maybe also because they know that most applicants will have had some experience of the NHS during their studies?

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- 1 Anonymous. Abuse of student electives. *BMJ* 1991;302:241. (26 January.)

GPs' and patients' sexual orientation

SIR,—It has long been difficult for lesbian and gay people to find a general practitioner with whom they could feel relaxed in disclosing their sexual orientation (although for some reason this concern is usually expressed by gay men), but in the past it has been difficult to help more than a very few because of the restrictions on what might be seen as advertising. Encouraged by the recent changes in

this, the Lesbian and Gay Medical Association has consulted one of the large defence societies, which in turn consulted the General Medical Council, and was reassured that so long as a list of doctors is not published and that any callers are told that the information given is not exhaustive then there should no longer be any objection to collecting the names of sympathetic practitioners in order to help individual inquirers.

The association has been asked for help in this by London Lesbian and Gay Switchboard, a registered charity that has maintained with trained volunteers alone for 16 years what is now a 24 hours a day, 365 days a year personal telephone answering service. This is a remarkable achievement in itself but also one that makes this organisation one of the leading health education and advice resources in this country, not least in relation to HIV (and not only to lesbians and gay men). It deals with inquiries and anxieties from all over the world as well as in the United Kingdom.

Because Switchboard is frequently asked for advice on how to find a sympathetic general practitioner its staff are well aware that this is a real and unmet concern of our patients (whether or not it is justified or realistic). They have until now been unable to do much to help because of the doctrine that all general practitioners are equally able and willing to cope with all patients and all problems. Yet it is probable that some are more likely to welcome such patients than others, and the listing of special interests in the new directory of general practitioner services acknowledges such a possibility. It would be a great source of comfort to some of this group of patients to know that they would most likely be welcome before facing their new general practitioner.

I should be grateful if general practitioners who would like their practice to be included in Switchboard's computerised list (and of course there is no implication that such a practice includes a lesbian or gay practitioner) would write to Switchboard for a very brief questionnaire (about half a side) on which to fill in minimal information for a prospective patient to make initial contact. The address is BM Switchboard, London WC1N 3XX.

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Organising a reunion

SIR,—Dr Colin Kenny suggests that general practitioners are most likely to help by raising funds for a reunion of undergraduate classmates from pharmaceutical companies.¹ Such sponsorship may have been acceptable in the past, but times change. It would now be contrary to the guidelines of the Association of the British Pharmaceutical Industry and, indeed, could involve the pharmaceutical companies concerned in breaches of the code of practice for the pharmaceutical industry.

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- 1 Kenny C. How to organise a reunion of your undergraduate classmates. *BMJ* 1991;302:282-3. (2 February.)

Correction

Child health computing

Two authors' errors occurred in this letter by Ms Sally Jefferies and others (16 February, p 410). In the second sentence of the second paragraph, the third group identified consisted of 220 children and 241 items of information (not 240 items as published). The first sentence of paragraph three should read, "Of the 241 discrepant items of information, 179 were verified" (not 221 items as published).