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.

CHRIS A J McLAUCHLAN

Derriford Hospital,
Plymouth PL6 3DH

- 1 Awooner-Renner S. I desperately needed to see my son. *BMJ* 1991;302:356. (9 February.)
- 2 McLauchlan CAJ. Handling distressed relatives and breaking bad news. *BMJ* 1990;301:1145-7. (17 November.)
- 3 Yates DW, Ellison G, McGuinness S. Care of the suddenly bereaved. *BMJ* 1990;301:29-31. (7 July.)

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}

DAVID J CAHILL

Bristol Maternity Hospital,
Bristol BS2 8EG

- 1 Warden J. Maternity services could do better. *BMJ* 1990;300:833.
- 2 Warden J. A friend at the top. *BMJ* 1990;301:1297. (18 December.)
- 3 Shirley IM, Bottomley F. Ultrasonography and perinatal mortality rates. *BMJ* 1991;302:408. (16 February.)
- 4 Bennett MJ, Little G, Dewhurst J, et al. Predictive value of ultrasound measurement in early pregnancy: a randomized controlled trial. *Br J Obstet Gynaecol* 1982;89:338-41.
- 5 Neilson JP, Whitfield CR, Aitchison TC. Screening for the small for dates fetus: a two stage ultrasound examination schedule. *BMJ* 1984;000:1203-6.
- 6 Waldenström U, Axelsson O, Nilsson S, et al. Effects of routine one-stage ultrasound screening in pregnancy: a randomised controlled trial. *Lancet* 1988;ii:585-8.
- 7 Thacker SB. Quality of controlled clinical trials. The case of imaging ultrasound in obstetrics: a review. *Br J Obstet Gynaecol* 1985;92:437-44.
- 8 Lilford RJ, Chard T. The routine use of ultrasound. *Br J Obstet Gynaecol* 1985;92:434-6.

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.

PETER C STRIDE

John Sealy Hospital,
Galveston, Texas 77550,
United States

- 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.

GEORGE BIRD
ROGER WILLIAMS

Institute of Liver Studies,
King's College School of
Medicine and Dentistry,
London SE5 9PJ

- 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.)
- 2 Sorensen TIA, Orholm M, Bentsen KD, Hoybye G, Eghoe K, Christoffersen P. Prospective evaluation of alcohol abuse and alcoholic liver injury in men as predictors of development of cirrhosis. *Lancet* 1984;ii:241-4.

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.

WENDY RUTHERFORD
ROGER GABRIEL

St Mary's Hospital,
London W2 1NY

- 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