These letters are selected from rapid responses posted on bmj.com. Selection is usually made 12 days after print publication of the article to which they respond.

bmj.com To submit a rapid response go to any article on bmj.com and click "respond to this article"

LETTERS

HOSPITAL MORTALITY RATIOS

A plea for reason

Many of the arguments in the article by Lilford and Pronovost and the editorial by Black add nothing new to the debate on monitoring the quality of care.[1-4] We recommend section G and appendix 9 from the Francis inquiry report on Mid Staffordshire for an independent review of these issues.[5]

The Healthcare Commission's investigation into Mid Staffordshire[6] preceded the Department of Health's inquiry,[5] as did reports by George Alberti and David Colin-Thomé. These were not public inquiries that "take on a life of [their] own"[1] but serious investigations of what were found to be very poor standards of hospital care. Sometimes inspections by the Care Quality Commission, the Healthcare Commission's successor, find problems and at other times they do not: finding problems is not a "self fulfilling prophecy."[1]

Without the Healthcare Commission's investigation,[6] prompted by mortality alerts, it is likely that the unacceptable situation in Mid Staffordshire would have continued unchecked and unrecognised by the commission's self assessment system based mainly on process measures.[7] Under this system, two thirds of the standards of compliance were subsequently discovered to be wrong for hospitals considered to be at risk by the Healthcare Commission.[8] We believe that an intelligent approach to monitoring quality of care is called for, making use of both outcome (including mortality indicators) and process information to ensure such tragedies do not occur again.

Brian Jarman emeritus professor **b.jarman@imperial.ac.uk**
Paul Aylin clinical reader in epidemiology and public health
Alex Bottle lecturer in medical statistics, Dr Foster Unit at Imperial, Department of Primary Care and Public Health, School of Public Health, Imperial College, Jarvis House, London EC1A 9LA

Competing interests: The authors are employed in the Dr Foster Unit at Imperial. The Dr Foster Unit at Imperial College London is funded by a grant from Dr Foster Intelligence (an independent health service research organisation).

1 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)
2 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066.
3 Aylin P, Bottle A, Jarman B. Monitoring mortality. *BMJ* 2009;338:b1745.
4 Aylin P, Bottle A, Jarman B. Monitoring hospital mortality, A response to the University of Birmingham report on HSMRs. Available at: http://bit.ly/W6S7f.
5 Department of Health. Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf.
6 Healthcare Commission. Investigation into Mid Staffordshire NHS Foundation Trust. 2009. Available at: www.cqc.org.uk/_db/_documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf.
7 Health Committee. Sixth report—patient safety.18 June 2009 (para 235). Available at: www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/15112.htm#a40.
8 Joint Commission International. Quality oversight in England—findings, observations, and recommendations for a new model. Submitted to Department of Health, 30 January 2008. Available at: www.policyexchange.org.uk/assets/JCI_report.pdf.

Cite this as: *BMJ* 2010;340:c2744

Good national data needed

The Care Quality Commission takes an interest in the debate on the use of hospital mortality ratios to judge hospital performance.[1 2] However, neither the Care Quality Commission nor its predecessor, the Healthcare Commission, has ever launched a formal investigation of an organisation solely on the basis of overall mortality statistics, nor is it likely to happen in the future.

We welcome good national audit data. Currently they are not widely available, do not cover all areas of care, and are not always timely. Data would always be subject to the general problems of completeness, accuracy, and interpretation. Administrative data are by no means perfect, but their continued use has helped to improve quality measurably. Ironically, since everyone understands the nuances and pitfalls we are well placed to undertake a meaningful dialogue with organisations.

Chris Sherlaw-Johnson surveillance manager
chris.sherlaw-johnson@cqc.org.uk
Nick Bishop senior medical adviser
Heather Wood investigations manager, Care Quality Commission, London EC1Y 8TG

Competing interests: None declared.

1 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
2 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)

Cite this as: *BMJ* 2010;340:c2777

Death is final: getting the balance right

The articles by Lilford and Pronovost and Hawkes and the accompanying editorial by Black are critical of hospital standardised mortality ratios.[1-3] They contain a number of misrepresentations. Hospital standardised mortality ratios are not, as Lilford and Pronovost claim,[1] a signal about preventable deaths. They simply measure how much a hospital's overall death rate varies from that of a "standard hospital" after taking the characteristics of the patients treated into account.[4]

Hospital standardised mortality ratios do not correlate well with some process measures. But is the gold standard for the quality of health care mortality or adherence to process measures? This is a matter of opinion rather than fact, and possibly a decision for patients rather than healthcare providers to make.

The basic issue is whether variations in hospital mortality are a screening or a diagnostic tool.[4] Screening tools are fallible and need to be followed by specific diagnostic tests. It is a concern if a public inquiry is the sole diagnostic response to an isolated hospital standardised mortality ratio. A systematic, well structured, institutionally based response to the hospital standardised mortality ratio as a screening tool[5] is required.

But an eagerness to advocate for process or audit measures cannot make an important issue go away. Hospitals are in the life and death business. They cannot simply be given licence to avoid the court of public opinion. Over time, institutional reputations can recover. Sanctions can be lifted. Penalties can be reversed. But death is final. Getting the balance right between patients and institutions will always be difficult.

David I Ben-Tovim director, clinical epidemiology and redesigning care units, Flinders Medical Centre, Bedford Park, SA 5042, Australia **david.ben-tovim@health.sa.gov.au**

Competing interests: DIB-T has been supported to analyse Australian hospital mortality by grants from the Australian Commission on Safety and Quality in Health Care, and the Australian Health Insurance Association.

1 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)
2 Hawkes N. Patient coding and the ratings game. *BMJ* 2010;340:c2153. (23 April.)
3 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
4 Ben-Tovim D, Woodman R, Harrison JE, Pointer S, Hakendorf P, Henley G. *Measuring and Reporting mortality in hospital patients. Cat no HSE 69.* Canberra: Australian Institute of Health and Welfare, 2009.

5 Jarman B, Bottle A, Aylin P, Browne M. Monitoring changes in hospital standardised mortality ratios. *BMJ* 2005;330;329.

Cite this as: *BMJ* 2010;340:c2741

What about community standardised mortality ratios?

The hospital standardised mortality ratio may not be a good measure of a hospital's quality,[1] but it focuses attention on the quality of a hospital's performance.

Clinical coding has undoubted problems,[2] despite its central importance. It is improving but still inadequate. In a system where hospitals are required to assess themselves, clinical coders risk being put under undue pressure to adopt practices that may show their trust in a favourable light. Until clear standards are introduced with external, mandatory, and robust review of practice, heavy reliance on secondary diagnoses to assess the quality of care must be questioned.

Ascribing the hospital as the sole cause of death seems perverse when the patient's journey may have involved many healthcare practitioners and health professionals not associated with the hospital. As a hospital practitioner, I have often questioned why someone near death has been admitted when a more dignified death at home might have been preferable: a medical assessment unit is no place to die.

I have also often wondered why it has taken so long for a patient to come to our attention, and felt angry and helpless. Mortality ratios inherently assume that death can always be prevented by medicine, and they cannot always distinguish the preventable from the unavoidable.

A better measure might focus on deaths in a community rather than a hospital. That might reflect the overall care available and the whole patient journey, rather than apportion the blame solely to the hospital. I suspect that hospitals fortunate to find themselves among supportive general practitioners with generous palliative care and community care services will seem to do well, regardless of their quality, until such changes are introduced.

Mark J Dayer consultant, Taunton and Somerset NHS Trust, Taunton TA1 5DA **markdayer@nhs.net**

Competing interests: None declared.

1 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
2 Hawkes N. Patient coding and the ratings game. *BMJ* 2010;340:c2153. (23 April.)

Cite this as: *BMJ* 2010;340:c2749

Hospitals fit for purpose

The three related articles on hospital mortality ratios are brave and stand firm for honesty in the face of primitive witch-hunting, directing us to think more clearly about the appropriate roles of and expectations for our hospitals.[1-3]

We are not in the business of maintaining life without end. Belatedly attention has turned to the proper task of helping people who are dying,[4] usually after 80 or more years of life. Death often comes with an accumulation of diseases spanning the range of physical and mental health, often including a degree of dementia.[5] People are perhaps unreasonably encouraged to hold on to a view that they will die at home in the comfort of their own bed. More may be enabled to do this. Yet when the chips are down individuals and families seek the safety of a professional institution to help them at this difficult time. For a few (10%) this may be a hospice, most of which depend on charitable donations to function. Many more of us will die, as reflected in these articles,[1-3] in our local hospital.

This is not wrong: it has long been an honourable and appropriate role of hospitals and is the more so given current and future demography. What is wrong is that the education of staff, organisation of services, and the use of measures deemed to reflect quality have hitherto conspired to sustain a belief that survival is everything. These articles may prove to be the watershed in bringing sense, sensitivity, and economic reality to our hospitals.

David J Jolley honorary reader and consultant psychiatrist, Personal Social Services Research Unit, Manchester University, Manchester M13 9PL **david.jolley@manchester.ac.uk**

Competing interests: None declared.

1 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
2 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)
3 Hawkes N. Patient coding and the ratings game. *BMJ* 2010;340:c2153. (23 April.)
4 Department of Health. *End of life strategy—promoting high quality care for all adults at the end of life*. London: DH, 2008.
5 Hughes J, Lloyd-Williams M, Sachs G. *Supportive care for the person with dementia*. Oxford: Oxford University Press, 2010.

Cite this as: BMJ 2010;340:c2751

What about older people?

Factors such as frailty and comorbidities are particularly relevant to the care of older people but were not highlighted in the articles on assessing the quality of hospitals.[1-3]

The Dr Foster calculations do not seem to include factors representing functional status or (except in some conditions) disease severity.[4] A hospital standardised mortality ratio that does not take account of these factors (and perhaps also multiple comorbidity) may provide a limited representation of the quality of care of frail older people.

Helen Gaskell associate specialist in clinical geratology and honorary research associate in pain research
helen.gaskell@pru.ox.ac.uk
Hywel W Jones consultant geriatrician, John Radcliffe Hospital, Oxford OX3 9DU

Competing interests: None declared.

1 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
2 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)
3 Hawkes N. Patient coding and the ratings game. *BMJ* 2010;340:c2153. (23 April.)
4 Dr Foster Intelligence. Aylin P, Bottle A, Jen MH, Middleton S. HSMR mortality indicators. Available from: www.drfosterintelligence.co.uk/newsPublications/HSMRMethodology.asp.

Cite this as: *BMJ* 2010;340:c2768

Possible misuse of "palliative care" coding

Many of the criticisms of hospital standardised mortality ratios[1 2] relate in practice to the failure of trusts to code in depth, and to variations in results depending on which hospital standardised mortality ratio was used. That different techniques give different results should of course surprise no one.

Hawkes examines a still more serious concern: that hospital standardised mortality ratios can be and are being "gamed" by labelling high proportions of admissions (over 80% in one district general hospital) as needing palliative care.[3] Apart from the sheer improbability of such high proportions of unselected "takes" constituting such cases, this approach could conceal seriously deficient practice. Relevant to these concerns are the arguably lax entry criteria for the Liverpool care pathway,[4] and the poorly explained but significantly higher death rates for a range of common conditions in the United Kingdom compared with other developed countries. That these deaths are expected queries the definition of expected and whether the variation between individual clinicians in what constitutes an expected death is unacceptably wide. The weakness of UK survival data across a range of conditions might suggest that patients who would survive, for example, their cardiac disease or cancer or cerebrovascular accident if managed elsewhere in the developed world may be being prematurely written off in the UK. The "palliative care" option in the guise of the Liverpool care pathway[5] may make this kind of non-care or option for death easy and all but impossible to prevent. This whole rather murky area needs urgent examination.

Ronald J Clearkin physician, Market Harborough, Leicestershire LE16 8EL **rjemc@lineone.net**

Competing interests: None declared.

1 Black N. Assessing the quality of hospitals. *BMJ* 2010;340:c2066. (20 April.)
2 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:c2016. (20 April.)
3 Hawkes N. Patient coding and the ratings game. *BMJ* 2010;340:c2153. (23 April.)
4 Treloar A. Dutch research reflects problems with the Liverpool care pathway. *BMJ* 2008;336:905. doi:10.1136/bmj.39556.400370.80
5 Devlin K. Sentenced to death on the NHS. *Daily Telegraph* 2009 Sept 2. www.telegraph.co.uk/health/healthnews/6127514/Sentenced-to-death-on-the-NHS.html.

Cite this as: *BMJ* 2010;340:c2753

CARDIOVASCULAR PREVENTION

How Scotland targets

Targeted case finding is more manageable and may be more effective than untargeted screening in cardiovascular primary prevention.[1] Indeed, although national guidelines in Scotland and England have for many years recommended screening every five years for all those aged 40-74, uptake has been variable in primary care, and many people at high risk still do not have their risk stratified and appropriately managed.

By interrogating general practice patient systems with appropriate software, cohorts of high risk patients can be identified and targeted first.

In Scotland the ASSIGN risk calculator is recommended for calculating risk by Quality Improvement Scotland. Actual data are used, but when data are missing, they can be "assigned" to individual people using the Scottish default value. The calculator also includes the Scottish index of multiple deprivation (by linking patient address postcode), which helps identify those most at risk, as well as tackling health inequalities.

Patients can then be invited to primary care centres for screening, to capture and record any missing data, to calculate individual risk more accurately, and to be offered lifestyle advice and drug treatment when appropriate.

People who default screening appointments can be "flagged up" with their ASSIGN risk score in the general practice patient system, which allows opportunistic screening when they attend primary care for other reasons.

Targeted case finding should allow best use of limited resources in primary care, help the people most at risk, and most effectively prevent or postpone cardiovascular events in patients entering the more expensive secondary care sector.

John C Stout GP lead, managed clinical network cardiology, Grampian, Peterhead Health Centre, Peterhead AB42 2XA
john.stout@nhs.net

Competing interests: JCS is leading the GRANITE primary prevention pilot in conjunction with Astra-Zeneca.

1 Marshall T. Targeted case finding for cardiovascular prevention. *BMJ* 2010;340:c1376. (23 April.)

Cite this as: *BMJ* 2010;340:c2764

BABIES BRINGING UP FEEDS

What about breastfed babies?

In their Practice article on what to do when a baby keeps bringing up his or her feeds, Banerjee and colleagues make disappointing assumptions about how babies are fed.[1] A 6 week old baby presenting with this problem is assumed to be being bottle fed artificial formula milk. This is clear from statements such as: "Type of feed—ask about volume and frequency. Knowing the different types of formula available and their indications is important." Breast feeding is not mentioned at all.

Although the rates of breast feeding in the UK are not as high as is desirable, the most up to date data indicate that about 48% of babies are breast fed at 6 weeks.[2] Breast feeding therefore needs to be taken into account in any assessment by any doctor. The authors may have assumed that babies bottle fed artificial formula milks are more prone to bringing them up, but the evidence is equivocal. Although gastro-oesophageal reflux may resolve more rapidly in breastfed infants,[3] the prevalence of regurgitation in the early weeks is similar across feeding methods.[4]

This article may reveal the cultural acceptance of bottle feeding with artificial formula milks as a norm. The way healthcare professionals question and approach parents and their children may reinforce this norm. Healthcare professionals should be mindful of modelling health promoting behaviour in all their encounters with others, including in work disseminated to the wide audience of the *BMJ*.

Catherine E Walshe research fellow, University of Manchester, Manchester M13 9PL **walshefamily@googlemail.com**

Competing interests: CEW is a breastfeeding counsellor with the National Childbirth Trust.

1 Banerjee J, Roy MM, Bhojani S, Emcy N. "My baby keeps bringing up his feeds!" *BMJ* 2010;340:c2189. (30 April.)
2 Bolling K, Grant C, Hamlyn B, Thornton A. *Infant feeding survey 2005*. London: The Information Centre, 2005.
3 Campanozzi A, Boccia G, Pensabene L, Marseglia A, Strisciuglio P, et al. Prevalence and natural history of gastroesophageal reflux: paediatric prospective survey. *Pediatrics* 2009;123:779-83.
4 Barak M, Lahav S, Mimouni FB, Dollberg S. The prevalence of regurgitations in the first 2 days of life in human milk and formula fed term infants. *Breastfeeding Medicine* 2006;1:168-71.

Cite this as: *BMJ* 2010;340:c2759

Dietary and nutritional advice

Banerjee and colleagues' article does not deal adequately with the nutritional management of a vomiting infant.[1]

Conditions such as cow's milk protein intolerance, lactose intolerance, and gastro-oesophageal reflux occur in breastfed infants and can be managed without the use of infant formulas.[2]

Table 1 is misleading. Firstly, partly hydrolysed protein formulas are not recommended in cow's milk protein intolerance, but extensively hydrolysed and free (not "basic") amino acid infant formulas are effective.[2]

Secondly, in lactose intolerance, soy formulas are not recommended for any child under 6 months because of concerns about phytoestrogen content.[3] Nutritionally adequate rice or oat milks are not available for children under 1 year, and rice milk should also not be used as a drink by children aged 1-4.5 years because of concerns about exposure to arsenic.[4] Lactose-free infant formulas are available (though not mentioned), so

JOHN HOWARD/SPL

a soy formula should not be considered firstline treatment for lactose intolerance.

Thirdly, the supporting evidence is poor for casein based formulas for "hungrier babies" and partially hydrolysed milks ("easy digest") for colic or constipation. Casein based milks are not recommended for young babies.[5] These descriptions, promoted extensively by milk manufacturers, help to perpetuate the idea that these infant milks are effective in their claims.

Finally, in the text of the article, the authors suggest that vomiting babies, not thriving babies, may be cow's milk protein intolerant, which may lead to lactose intolerance, but this is not supported by the reference they cite.

June T McMahon children's community dietitian, Children's Integrated Clinic, Seacroft Hospital, Leeds LS14 6UH
june.mcmahon@nhs.net

Competing interests: None declared.

1 Banerjee J, Roy MM, Bhojani S, Emcy N. "My baby keeps bringing up his feeds!" *BMJ* 2010;340:c2189. (30 April.)
2 Vandenplas Y, Koletzko S, Isolauri E, Hill D, Oranje AP, Brueton M, et al. Guidelines for the diagnosis and management of cow's milk protein allergy in infants. *Arch Dis Child* 2007;92:902-8.
3 Committee on Toxicity. Report on phytoestrogens and health (2003). Available at: http://cot.food.gov.uk/cotreports/cotwgreports/phytoestrogensandhealthcot.
4 Food Standards Agency. Arsenic in rice research published. Available at: www.food.gov.uk/news/newsarchive/2009/may/arsenicinriceresearch.
5 The health professional's guide to: "A guide to infant formula for parents who are bottle feeding" 2010. Available at: www.babyfriendly.org.uk/pdfs/health_professionals_guide_infant_formula.pdf.

Cite this as: *BMJ* 2010;340:c2762

MODERN GENETICS

No blind alleys in the clinic

In discussing the practical benefits of modern genetics, Le Fanu states that the prevention of monogenic disorders through antenatal screening is limited to thalassaemias and Tay-Sachs disease.[1] In fact, when any causative genetic mutation is known in a family, routine antenatal testing through amniocentesis or chorionic villus makes it possible to look for the same mutation in a fetus. In most cases it is therefore technically possible, though of course not always appropriate, to diagnose prenatally any monogenic disorder for which there is a known mutation.

Furthermore, Le Fanu did not discuss the impact of clinical genetics on patients and their families. Thanks to increasing genetic understanding and the availability of ever improving diagnostic techniques, clinical geneticists can now offer more effective genetic counselling based on better information. This allows patients and their families a more informed choice in how to manage their genetic conditions, whether in the form of prenatal testing in pregnancy or predictive testing for an adult onset disorder such as Huntington's disease or breast cancer associated with BRCA genes.

Andrew G L Douglas academic clinical fellow in clinical genetics, Wessex Clinical Genetics Service, Princess Anne Hospital, Southampton SO15 6YA **andrew.douglas@suht.swest.nhs.uk**

Competing interests: None declared.

1 Le Fanu J. Is modern genetics a blind alley? Yes. *BMJ* 2010;340:c1156. (30 March.)

Cite this as: *BMJ* 2010;340:c2754

INTELLIGENCE AND MORTALITY

Only ignorance stops progress

In their editorial Batty and colleagues discussed our work on intelligence and mortality, concluding that "efforts to reduce inequalities should continue to be broadly based, including educational opportunities and interventions initiated in early life."[1 2] We fully agree, but we wonder whether this conclusion is consistent with their reasoning, particularly their defence of four ideas (A-D) about intelligence and health that we questioned in our paper:

- A That intelligence is the fundamental cause of socioeconomic differences in health
- B That the importance of intelligence for mortality is the same for men and women
- C That early intelligence follows on from good health rather than the other way around
- D That intelligence might be a non-malleable trait as efforts to improve it "so far have yielded disappointing results."[1]

Don't these propositions suggest that the possibility of reducing inequalities is fairly small? Luckily, empirical findings paint a picture that is more promising for future public health measures.

Firstly, although propositions A and C may have some truth to them, they do not seem to suffice as explanations.

Secondly, we believe (in contrast with proposition D) not only that intelligence can be promoted but that this is already happening, as demonstrated by the secular trend in intelligence, the so called Flynn effect.[3] Intelligence is the result of interaction between genetics and the environment, including the social environment. Thus, it is only our own ignorance that stops us from formulating successful policies in this field.

Anton Lager PhD student, Centre for Health Equity Studies (CHESS), Stockholm University/Karolinska Institute, 106 91 Stockholm, Sweden
anton.lager@chess.su.se

Sven Bremberg associate professor, Department for Public Health Sciences, Karolinska Institute, 171 77 Stockholm
Denny Vågerö professor, Centre for Health Equity Studies (CHESS), Stockholm University/Karolinska Institute, 106 91 Stockholm, Sweden

Competing interests: None declared.

1 Batty GD, Kivimaki M, Deary IJ. Intelligence, education, and mortality. *BMJ* 2010;340:c563. (27 April.)
2 Lager A, Bremberg S, Vågerö D. The association of early IQ and education with mortality: 65 year longitudinal study in Malmö, Sweden. *BMJ* 2009;339:b5282. (11 December.)
3 Flynn JR. Massive IQ gains in 14 nations: what IQ tests really measure. *Psychol Bull* 1987;101:171-91.

Cite this as: *BMJ* 2010;340:c2765

ASSESSING PATIENT CAPACITY

CURB BADLIP in the UK

Minerva reported a bioethics memory aid to help doctors in the United States assess a patient's capacity during an emergency.[1]

In the United Kingdom, however, the law on making decisions about a person's capacity is different from that in the US. We therefore developed a bioethics memory aid, CURB BADLIP, for all healthcare professionals in England, Scotland, and Wales for use in patients aged 18 or over in an emergency; in Northern Ireland there is no legal provision to make a consent decision on behalf of someone else:

- C—communicate. Can the person communicate his or her decision?
- U—understand. Can the person understand the information being given?
- R—retain. Can the person retain the information given?
- B—balance. Can the person balance, or use, the information?
- B—best interest. If there is no capacity can you make a best interest decision?
- AD—advanced decision. Is there an advanced decision to refuse treatment?
- L—lasting power of attorney. Has lasting power of attorney been appointed?
- I—independent mental capacity advocate. Is the person without anyone who can be consulted about best interest? In an emergency involve an independent mental capacity advocate
- P—proxy. Are there unresolved conflicts? Consider involving the local ethics committee or the court of protection appointed deputy.

CURB BADLIP should be helpful for all healthcare staff when flow charts for making best interest decisions in adults with serious medical conditions are not immediately available.[2]

Matthew Hoghton general practitioner, Clevedon Riverside Group, Clevedon BS21 6DG
Stephanie Chadwick general practitioner, Bristol BS10 6SP

Competing interests: None declared.

1 Minerva. *BMJ* 2010;340:c1285. (9 March.)
2 Regnard C, Dean M. *A guide to symptom relief in palliative care*. 6th ed. Oxford: Radcliffe Publishing, 2009.

Cite this as: *BMJ* 2010;340:c2767

AFTER TRAUMATIC DEATH

Benefits of viewing the body

MICHELLE DEL GUERCIO/SPL

The results of Chapple and Ziebland's qualitative study on viewing the body after bereavement due to a traumatic death[1] are hugely welcomed by Disaster Action—a charity founded in 1991 by survivors and bereaved people from UK and overseas disasters.

We have personal experience of over 20 disasters, including rail, air, and maritime disasters and terrorist attacks. For many of us seeing the person who had died as soon as possible was very important, and the obstacles put in the way, sometimes by well meaning professionals, inevitably led to enormous distress.

We advocate that those close to the dead person must be given the opportunity to be part of the process as soon as possible after the death, which includes viewing the body. We are particularly concerned that police and coroners regard visual identification of disaster victims as unreliable. This may be right, but as a consequence official procedures now give little or no opportunity for family members to become involved or view the body early.

DNA identification, although useful when the body is badly damaged, can take many days to complete. Thus relatives are currently routinely kept away from the dead person for a long time. They are then told they can come and "view" the body if they wish, or open the coffin when it is released to a funeral director. For many, this is too late. It feels wrong and morbid, and they decline—much to their later regret.

We hope that this research will help agencies in future disasters to understand the importance of giving family members the chance to spend time with the dead person as soon as possible after the death.

Sophie Tarassenko co-chair and trustee, Disaster Action, London W1H 7DB **s.tarassenko@herts.ac.uk**

Competing interests: None declared.

1 Chapple A, Ziebland S. Viewing the body after bereavement due to a traumatic death: qualitative study in the UK. *BMJ* 2010;340:c2032. (30 April.)

Cite this as: *BMJ* 2010;340:c2757