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LETTERS

CORONERS

Role of the coroner's office



I believe that the coroner's jurisdiction in which I work has an exemplary model of dealing with bereaved relatives.¹ All bereaved relatives are given a half hour appointment with a coroner's officer the day before the postmortem examination. This is to discuss tissue and organ retention; particularly the fate of any retained tissues once the examination has been completed, in line with the Human Tissue Act 2004. Moreover, this provides an opportunity for relatives to raise any concerns about the care of their loved one and ask any questions. After the postmortem examination, the relatives are contacted by telephone to explain the results and what happens next. Once the autopsy report is completed, the relatives can request a copy. This level of interaction between the coroner's office and relatives is not uniform around the country, a failing that will hopefully be redressed by the Coroners and Justice Act 2009.

I take pride in communicating with relatives and feel that being able to give closure and provide answers to grieving relatives is one of the most satisfying parts of my job.

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Competing interests: None declared.

1 Autopsies—why families count too. *BMJ* 2010;340:c902. (24 February.)

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Leadership is needed

I was saddened by the personal view¹ but glad to see Delamothe's article publicising the coronial system.² After all, the UK's best kept medical secret is that 22% of all deaths involve a postmortem examination under a coroner or procurator fiscal. And the same applies in Ireland.

A lot of local authority money is sloshing around there, lots of NHS consultant time shifting, quite a few zero governed independent pathologists,

lots of underused teaching opportunities, and an unacceptable amount of poor autopsy practice.³

The coronial system for England, Wales, and Northern Ireland will be revised under the new Coroners and Justice Act 2009. But there are two crucial issues. Firstly, what is the purpose of the coronial autopsy? This is not well defined anywhere, and one view quite consistent with the current law is that it (merely) provides coroners with information that enables them to dispense with an inquest. Secondly, the separation of the coronial system, and its output, from the NHS, where most of its subjects come from. There is no indication that this will change.

Perhaps the *BMJ* could help improve autopsy quality, and its usefulness for the nation, by actively supporting better leadership in this important, but almost deliberately neglected, part of medicine.

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Competing interests: None declared.

- 1 Autopsies—why families count too. *BMJ* 2010;340:c902. (24 February.)
- 2 Delamothe T. Good and bad coroner stories. *BMJ* 2010;340:c1064. (24 February.)
- 3 National Confidential Enquiry into Patient Outcome and Death. The coroner's autopsy: do we deserve better? 2006. www.ncepod.org.uk/2006.htm.

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We can communicate better thanks to the new act

The recent article describes a disastrous communication breakdown—as usual, at a point of transfer between two systems.¹ In this case, from health care to law.

With this transfer, secrecy descends to protect the purity of any evidence that might subsequently be presented in court. The NHS has no option here; helping the relatives is not the primary purpose of the Ministry of Justice.

But the anonymous author had difficulty getting information from the coroner even after a natural cause of death had been identified. Under the Coroners and Justice Act 2009, the new medical examiners will examine all non-coronial deaths and will advise whether or not cases need referral to the coroner in the first place. Coroners will be able to refer deaths of obviously natural cause back to the medical examiner system for certification. The new chief coroner should be able to insist on improved communication by coroners. Pilots of the new system have already shown

that coronial referrals, and hence unconsented postmortem examinations, will be reduced.

Medical examiners will also improve communication with the bereaved. They will be obliged to offer an interview with every bereaved family, unless the coroner is investigating. This should provide an independent explanation of why their relative died. But the medical examiner should also get the family's perceptions of defects in care and will have a duty to inform NHS clinical governance systems.

If the medical examiner system had been in place in Mid Staffordshire, recent events there might have been very different.

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Competing interests: PNF is president of the Royal College of Pathologists, which will be lead college for medical examiners of the cause of death. He chaired the intercollegiate working group that defined the curriculum for training medical examiners and has been involved in developing and piloting the new system.

1 Autopsies—why families count too. *BMJ* 2010;340:c902. (24 February.)

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PRIORITY TREATMENT FOR VETERANS

Lest we forget

The article about the ethics of priority treatment for veterans and its suggestion that the moral question should be passed to parliament is intriguing.^{1 2} Britain currently has five million veterans, who until 2008 were entitled to priority treatment only for the condition(s) for which they receive a war pension. Since the 2008 guidance, all are entitled to priority treatment from the NHS for conditions that are likely to be related to their service. About 140 000 armed forces personnel are serving in the UK, and 18 000 leave each year. Many will have served in combat zones. Physical wounds may be obvious, but symptoms of post-traumatic stress disorder may show themselves long after the event. Future veterans will probably have higher rates of mental health problems, suicide, homelessness, illicit drug use, and alcoholism than their peers.

Sheather states that parliament should adjudicate on the issue of priority treatment. But as a result of the new guidance, “parliament” has already decided, and veterans should be given priority. Robust policies are needed—for the guidance to work, the whole of our health organisation needs clarity of purpose. Primary care doctors need clearer guidance of conditions

deemed related to service, and secondary care needs clear referral pathways and relevant commissioning mechanisms in place to streamline veterans' care. It is our responsibility to avoid the follies of the past and prepare for our veterans' future health and social needs.

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Competing interests: None declared.

- 1 Godlee F. Lessons and legacies of war [Editor's Choice]. *BMJ* 2010;340:c1119. (25 February.)
- 2 Sheather J. Risk and equality. *BMJ* 2010;340:c642. (18 February.)

Cite this as: *BMJ* 2010;340:c1474

MORAL OBLIGATIONS

What about abuse other than torture?

Although clarifying ethical responsibilities relating to the abuse and torture of prisoners is a positive development,¹ most doctors will have no exposure to such situations during their working lives. It might be helpful to consider also the moral agency of doctors and other health workers who witness, or are complicit in, forms of abuse that fall short of torture.² Defining a broader spectrum of complicity would allow doctors to develop an ethical sensibility that this is a wider professional problem, and not just restricted to extreme cases.

Of particular relevance is the role of doctors, nurses, and therapists who witness institutional abuse of older people in healthcare settings, such as nursing homes and hospitals. Institutional abuse can be characterised by poor care standards, lack of a positive response to complex needs, rigid routines, inadequate staffing, and an insufficient knowledge base within the service.³

Throughout the developed world there have been numerous scandals relating to nursing homes,⁴ and it is a striking feature how many doctors and nurses have been tolerant of endemic poor care up to the point of the scandal breaking. Joint working is required between gerontologists, ethicists, family doctors (who provide much of the care in nursing homes in the developed world), and nurses to break the cycle of complicity in such abuse and develop a more effective sense of moral agency and appropriate action in such situations.

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Competing interests: None declared.

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AGE RELATED MACULAR DEGENERATION

Is associated with Charles Bonnet syndrome



PAUL PARKERS/SPIL

Chakravarthy and colleagues missed an opportunity to draw attention to the high rates of Charles Bonnet syndrome (up to 40%) that are found in age related macular degeneration that seriously impairs visual acuity.^{1,2} Charles Bonnet syndrome is the occurrence of complex visual hallucinations, with full or partially preserved insight, in the absence of delusions or hallucinations in other modalities.

The syndrome can be associated with high levels of distress, with some patients reporting anger, anxiety, and even terror.³ Moreover, although its association with cognitive impairment is unclear, dementia has later emerged in some cases.⁴

Patients rarely volunteer symptoms of this syndrome unless prompted, because they fear that they will be thought to have a psychiatric illness.⁵ Practitioners dealing with patients in high risk groups must therefore maintain a high level of awareness of this condition. A tactful inquiry as to the presence of visual hallucinations should form part of the routine assessment of patients with age related macular degeneration, especially in the late stage.

Reassurance that these symptoms are generally not an indication of mental health problems is often highly effective at reducing distress.³ However, if evidence of cognitive impairment is found, or insight into the unreal nature of the experiences reduces over time, the patient should be referred to psychiatry services to assess for the onset of a dementia.

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Competing interests: None declared.

- 1 Chakravarthy U, Evans J, Rosenfeld P. Age related macular degeneration. *BMJ* 2010;340:c981. (26 February.)
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Cite this as: *BMJ* 2010;340:c1611

ASSISTED SUICIDE

A step backwards?

Keir Starmer has coped well with a difficult task, but medically the position has become more complex.¹ An honest discussion with terminally ill patients about prognosis could be seen in retrospect as having helped the patient decide on an assisted death. Patients may wish to air anxieties about this option but need to be given "permission to speak," if only to dispel those anxieties. A similar problem already worries some doctors when giving strong analgesia to people who are dying. The options for suicide for a dying patient are limited, but one is the refusal of treatment: will palliation of any resulting symptoms be seen as "assistance"? Perhaps more useful advice from the Medical Defence Union would have been to emphasise that any discussions with patients that might be misinterpreted should be witnessed or recorded.

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Competing interests: SK is a member of Dignity in Dying.

- 1 Dyer C. Doctors face greater risk of prosecution than the public for assisting suicide. *BMJ* 2010;340:c1167. (26 February.)

Cite this as: *BMJ* 2010;340:c1609

A LIFE FREE OF DRUG REPS

Come into obstetrics

If O'Hanlon is serious in his desire to lead a life free of drug reps,¹ he should consider a career in obstetrics. We use about five drugs, all of which have been around for ages and are now out of patent. As far I am aware, there are no new drugs under development in our specialty. This is a concern. I have never seen a syntocinon rep. Do they even exist? Quite apart from a lack of free lunches we have to buy our own pens.

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Competing interests: None declared.

- 1 O'Hanlon S. My year without drug reps. *BMJ* 2010;340:c1102. (3 March.)

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