CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Coping with sudden death

SIR,—I was visiting my son one evening when the doorbell rang. An elderly neighbour wanted his help to put her invalid, 85 year old husband to bed. He had fallen, she said, some 20 minutes earlier, and she could not move him. We found him, clearly dead, stretched out across the floor of their tiny living room. She accepted my opinion but wanted her own doctor to come and confirm his death. We managed to contact him immediately at 10 15 pm, and he told my son that he would come himself in 15 minutes. At 10 50 pm we rang again and this time were told that an emergency doctor was on his way.

At 10 55 pm a knock at the door announced the arrival of two large policemen, who had been summoned by the emergency medical service. They squeezed into the room, stepping carefully over the corpse, and sat down, notebooks at the ready and their portable radio squawking. On discovering that the deceased had not been seen by a doctor in the past fortnight, they called the coroner's officer and proceeded to question, albeit kindly, the widow about such details as her husband's date and place of birth, full name, occupation, and marital status, which confused the poor lady completely. They also explained that they would have to stay until the coroner's officer arrived.

An hour and a half after our first call to the doctor an emergency service doctor arrived, shoehorned himself into the room, in which there was by now standing room only, pushed aside the cat, placed a stethoscope carefully over the deceased's vest, and pronounced him dead, testifying to this in writing on a scrap of notepaper that he handed to the policemen before leaving. He did not look at or speak to the widow. Our next visitor, half an hour later, was the coroner's officer, a dour but gentle man, who disposed of the doctor's note with contempt and explained that he would have to have the body removed immediately and a necropsy performed as soon as possible. The undertakers arrived within the hour, and three hours after his death the corpse was removed, leaving the widow stunned and speechless, clutching her cat for comfort.

I was left profoundly disturbed about the handling of the whole affair, not least by the behaviour of my medical colleagues. The policemen and coroner's officer were unsurprised by this. It was not unusual, they said; last week it had taken them two and a half hours to get a doctor to attend in similar circumstances, and they were scathing about some doctors' lack of knowledge of the procedures to be followed in the case of sudden death.

Is there not a need for a review of such procedures in the case of a death that is not unexpected, even if sudden? In this case, the death of an elderly man housebound by emphysema for many years, the prolonged presence of two policemen and the appearance of the coroner's officer seemed totally inappropriate. It also seemed sad that the body had to be removed in such haste, before the shocked widow had had time to accept the fact of her husband's death. Surely we could devise a better way of dealing with events such as this, more consonant with our current thinking on bereavement, and ensure that doctors, particularly those working for deputising services, are adequately trained for such emergencies.

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Explanation and management of neurological disability

SIR,—Drs E M R Critchley and J D Mitchell (9 May, p 1203) outline many of the failings of neurologists in the follow up of chronic neurological disease and many of the requirements for continuing care. I am surprised, however, that they do not mention younger disabled units, of which there is a nationwide network more extensive by far than that of neuroscience units. Such units often pick up the pieces of a life shattered by the revelation of incurable disease and provide respite, rehabilitation, support to carers, and organisation of home services.

We have been looking at the future provision of services based on our younger disabled unit and have already put forward proposals for the establishment of an aids library and an outreach service, which will train and maintain community nurses and paramedical staff. We already provide a comprehensive advice service and accept referrals informally from non-medical sources, although we always seek general practitioners' consent before seeing such patients. While I would not be averse to the development of disabled living centres near neuroscience outpatient departments (if only because they may encourage more neurologists to become interested in rehabilitation), the network of younger disabled units would provide a less remote base. Not all neuroscience patients attend