

appropriate decisions by empirical study,<sup>15</sup> not merely by asking clinicians to indicate a preference, since preferences can mislead.<sup>6</sup> Marshall McLuhan perhaps overstated his point when he claimed that the medium is the message, but the results of Elting et al show that we must not only make the content of clinical documents evidence based, but also develop formats appropriate to electronic and paper media, and test the effects of these formats on clinical decisions. A recent series explored these issues in depth.<sup>16</sup>

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## The coroner service

### *A relic in need of reform*

A Home Office research study on the coroner service in England and Wales<sup>1</sup> puts the spotlight on some important public policy issues, most of which need to be reviewed in light of the forthcoming Human Rights Act. Every coroner's investigation is an enforceable intrusion by the state into what would otherwise be a private family matter—the death of a loved one. Striking the correct balance between the reasonable needs of the state to investigate and the rights of the next of kin to privacy and religious ritual is not easy, and present evidence suggests that it is not done well in England and Wales.

A new factor in the equation will be the Human Rights Act, which gives domestic effect to those rights set out in the European Convention on Human Rights. This will need to come into effect in Scotland before the Scottish Parliament in 1999 and is expected to come into effect in England and Wales after the year 2000. Among the rights in the European convention are the right to respect for privacy and family life (article 8), and freedom of thought, conscience, and religion (article 9). The new act provides in clause 6(1) that "it is unlawful for a public authority to act in a way which is incompatible with a convention right." This provides a starting point for questioning some current practices in the coroner service.

According to the Home Office survey, 190 000 deaths, representing a third of all deaths in England and Wales, were reported to the coroner in 1996. In 1970 the number was 130 000—20% of all deaths. The increase is largely accounted for by natural deaths voluntarily referred by a doctor. Referrals by doctors now represent 60% of the coroner's caseload.<sup>2</sup> To direct such a large number of natural deaths into the medico-legal investigative system is both intrusive, for the families concerned, and costly. The extra 60 000 cases referred in 1996 compared with 1970 were associated with an increase of only 12 000 necropsies. So it seems that the great majority of these new referrals could be

certified on the previously known facts, bringing into question the rationale behind referring them to the coroner for investigation.

Of the 190 000 deaths reported, 68% were subject to necropsy under the legal authority of the coroner. However, among the 148 coroner districts the percentage dissected varied from 43% to 100%. On these figures, not all coroner districts can be striking an appropriate balance between the needs of the state and the rights of the next of kin. The prevalence of these legally enforced necropsies is of legitimate concern to everyone<sup>3 4</sup> but of particular concern to religious and ethnic minorities that do not approve of postmortem dissections.<sup>5</sup> It seems difficult to justify the current numbers of these necropsies, which are performed without the consent of the next of kin. They occur in more than one in five of all deaths in England and Wales. There are financial implications also. The two main costs within the £46.8m budget for the coroner service are mortuary services (£11.6m) and fees to pathologists (£11.9m). Reducing the necropsy rate could offer substantial savings.

The public inquest is another area of longstanding concern for it necessarily conflicts with the right to privacy. Currently an average of 12% of reported deaths come to inquest, but the figure varies from 5% to 25% across the 148 coroner districts. There were 22 000 inquests in 1996, with witness and juror expenses amounting to more than £2m. Many are unnecessary, and serve only to increase the distress caused to the family, particularly when the death is by suicide. Mandatory inquests should be abolished, except for deaths in custody or accidents at work, and greater discretion given to coroners. This legislative change would create a practice similar to that in Scotland.<sup>6</sup>

The variation in necropsy and inquest rates between coroner districts reflects the fact that the coroner service is not a single entity, but rather a set of local services. It is currently part of local government but

might be better placed within the Home Office. This would facilitate the development of a national service with uniform practices reflecting a more considered balance between the public interest and private rights. Currently 80% of coroners are part time, and a similar number work out of their home or the premises of their professional practice. Less than half the coroner districts are computerised. A national database of investigated deaths, as is proposed for Australia, would significantly improve access to the wealth of useful information generated by coroners.

By focusing more narrowly on deaths of legitimate medicolegal interest, a national coroner service could improve the quality of investigations and data

collection, reflect a greater sensitivity to the rights of next of kin, and give better value for money.

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## Managing drug misuse in general practice

*New Department of Health guidelines provide a benchmark for good practice*

Guidelines on the clinical management of drug misuse were first issued by the Department of Health in 1991. The latest version, issued last month,<sup>1</sup> has been long awaited and has already sparked controversy. The new guidelines focus more on the role of the generalist than on that of the specialist in drug misuse, so they are particularly relevant to general practitioners.

The differences between the new and the old guidelines reflect changes over the decade both in our knowledge of drug misuse and in service delivery. Firstly, the new guidelines emphasise the developing evidence base, particularly the strong evidence for the effectiveness of methadone maintenance treatment.<sup>2</sup> Secondly, they recognise the importance of the structure of service delivery and the key role of shared care within this. The new guidelines place responsibilities not just on doctors but also on commissioning bodies to deliver a service and to support doctors. Thirdly, there is a new emphasis on the rights of drug misusing patients to access good quality services, and the responsibilities of all doctors to manage drug related problems. Running alongside this, however, is a strong emphasis on avoiding the "maverick" approach to replacement prescribing, on safety for patients and the public, and on the importance of local protocols to maintain standards.

So what do the new guidelines mean in practice? They spell out the rights of drug users to the same NHS entitlements as other patients and state that all doctors should be equipped to deal with drug related issues. This means that all general practitioners would be expected to offer basic harm minimisation advice, including offering vaccination against hepatitis B, as well as providing general medical services for drug misusers. This does not, however, mean that all general practitioners would be expected to prescribe replacement medication. Indeed, the guidelines make it very clear that doctors should not be pressured into accepting responsibilities beyond their level of skill, and a framework is provided for the involvement of doctors in the treatment of drug problems beyond the basic level which all doctors must attain. Doctors providing services more specialised than this basic level are divided into three groups: the generalist, specialised

generalist, and specialist, and recommended levels of activities and training are set out for each group.

The underlying principles for treatment show once again the attempt to broaden the base of drug misuse treatment while building in safeguards against poor practice. A multidisciplinary approach is emphasised throughout, with medication as just one strand of treatment, and harm-minimisation approaches are recommended because of the evidence to support their effectiveness. Nevertheless, the guidelines make clear that when doctors prescribe methadone they are responsible for ensuring that the patient receives the correct dose and that the drugs are not diverted to other drug misusers or sold. This translates into recommendations that: new prescriptions should usually be dispensed for supervised consumption over the first three months; substitute drugs should be dispensed on a daily basis until stability is achieved; doses should not be given to take home when there is any doubt about instability or diversion; and prescribers should liaise closely with pharmacists. The prescribing of tablets and injectable formulations is strongly discouraged, as is the prescribing of any preparations outside the licensed indications, except in exceptional circumstances or specialist settings.

Not all practitioners will endorse every recommendation in the guidelines. Some of the more specific recommendations, such as that regarding supervised consumption, are only very loosely evidence-based. The paragraph on diamorphine prescribing, which states that there is very little clinical indication for prescribed diamorphine, appears to fly in the face of some of the evidence available.<sup>3</sup> The guidelines only hint at the possibility of accreditation being introduced, with no specifics. There is also a degree of political evasiveness. When the effectiveness of a relatively inexpensive treatment such as methadone maintenance in reducing mortality and morbidity is now so well established,<sup>4,5</sup> for how long can it be considered ethical for some general practitioners to refuse to prescribe it within a shared care framework?

Nevertheless, the new guidelines represent a serious attempt to bring the evidence base into practice and to standardise treatment for drug misuse. This is