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,[1] 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.[2] 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.

BMJ 1999;318:1503–4

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 misuers 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 liase 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.[3] 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,[4,5] 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

essential if drug misuse treatment is to be brought into the mainstream. The guidelines represent a consensus framework for good clinical practice,[6] and clinicians can expect to be judged against this reference point. If we deviate from the guidelines we should defend such deviation because they provide protection for the public against practice which is deficient.

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Minimising the impact of visual impairment

Low vision aids are a simple way of alleviating impairment

Visual impairment is responsible for much individual suffering and economic hardship. Magnifying devices and other types of low vision aid can significantly reduce the degree of handicap associated with impaired vision. Two thirds of the people who would benefit from a low vision aid (about 600 000 people in the United Kingdom), however, do not possess one.[1] What are the reasons for this disturbing situation?

Currently about 316 000 people are registered as blind or partially sighted. However, the registers underestimate the number of people with low vision by a factor of three,[2] so almost 1 000 000 people in the United Kingdom have untreatable low vision. Community based surveys support this estimate and have shown that around 20% of those aged 75 and over have visual acuity less than 6/12.[3] With the advent of annual screening for patients over 75 and the high prevalence of visual impairment, general practitioners are becoming increasingly familiar with low vision and its associated problems such as depression and falls.[4 5]

Demographic trends indicate that the situation is likely to get worse because the causes of low vision are predominantly age related. Unfortunately, medical intervention is unlikely to offer much help. No treatment currently exists for age related maculopathy, the primary cause of visual impairment in the United Kingdom. Furthermore, although continuing advances in the management of conditions such as glaucoma and diabetes are likely to reduce the degree of visual impairment associated with these conditions, the overall number of people with impaired sight may not diminish because the benefits of improved management are likely to be offset by the general trend toward increased life expectancy.

In the absence of a cure for blindness, rehabilitation is of paramount importance. The most effective way to reduce the degree of handicap associated with visual impairment is by providing low vision aids as part of a comprehensive low vision service.[1] When dispensed appropriately these simple magnifying devices enhance residual vision and often permit people with impaired sight to perform daily tasks such as reading. Regrettably, evidence based on observational studies and expert opinion collated by the Partially Sighted Society suggests that many people are not benefiting from this simple form of management.[1] The greatest consequence of this failure is that many old people require residential care because they can no longer live alone.[1] So why are low vision aids underused?

One reason might be that the benefits to be gained from the use of low vision aids are not widely recognised in the community. Yet the ability of these devices to alleviate the problems associated with visual impairment is well established,[1 6-8] and has been highlighed at Cardiff University's low vision clinic, which provides low vision services for the people of south Wales. Data collected over six months from 168 new referrals showed that, although only about 20% of those referred could read normal print when they first came to the clinic, this figure rose to almost 90% after provision of a suitable low vision aid and some training (unpublished data). Rarely can medical intervention be so effective. The improvement in reading performance addresses the primary complaint of people with age related maculopathy, and it is perhaps for this reason that more than 80% of people report a benefit from attending low vision clinics.[6] Other reasons why people with impaired vision do not benefit from a low vision assessment include the fact that some may fail to recognise their degree of visual impairment or fear treatment, the stigma of blindness, and differences in ophthalmological referral criteria.

Nevertheless, low vision aids provide a simple and effective means of alleviating the problems associated with visual impairment. Greater provision of these inexpensive devices would greatly reduce both the social and economic impact of low vision.

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BMJ 1999;318:1504