

formal contractual relations with pathologists. The inquiry suggests that a special health authority could provide pathology services, including both forensic pathologists and histopathologists doing coronial work. Postmortem examinations should meet approved standards, with greater use of toxicology. The review calls for audit of coronial pathology and for the work to form part of a pathologist's appraisal.

The inquiry supports the proposals made by the Home Office's review of forensic pathology services for regional centres of excellence.³ It also supports the close association of forensic medicine and the coroner's service as exists in Victoria, Australia, a situation that has existed in Sheffield for three decades but which has not been replicated elsewhere in the United Kingdom. The Victorian Institute of Forensic Medicine (www.vifm.org) also coordinates the Australian National Coroner's information system, an internet based data system detailing coronial findings, which will be a major resource in injury prevention. Such information sharing should be a feature of any new system.

The review proposes that the new service should be based in the Lord Chancellor's Department. Dame Janet, who reported after the proposed abolition of the office of lord chancellor, proposes that the new service should be a body working at "arm's length" from the government, associated with both the new Department of Constitutional Affairs and the Department of

Health. This would provide independence, but the service would still be accountable to parliament.

Of the two proposals, it seems to us that Dame Janet's provides the most comprehensive system. Her proposal would provide for greater integration of the services required in death investigation, with medical issues left to those with appropriate medical training; such posts are likely to attract more experienced and motivated staff. The new system will require funding, but the status quo is not acceptable. Proper death investigation protects the public. It cannot be neglected any longer.

Christopher M Milroy *professor of forensic pathology*

(c.m.milroy@sheffield.ac.uk)

Helen L Whitwell *professor of forensic pathology*

Medico-Legal Centre, University of Sheffield, Sheffield S3 7ES

Competing interests: Both CMM and HLW do postmortem examinations at the request of various coroners. The department of forensic pathology is funded partly from coronial income and had dealings with both the coroner's review and the Shipman inquiry. Sheffield is a pilot centre for the Home Office's review of forensic pathology services.

1 Death certification and investigation in England, Wales and Northern Ireland. The report of a fundamental review. Stationery Office 2003. <http://www.official-documents.co.uk/document/cm58/5831/5831.htm> (accessed 19 July 2003).

2 The Shipman Inquiry. Third Report. Death and cremation certification. www.the-shipman-inquiry.org.uk (accessed 17 July 2003).

3 Review of Forensic Pathology Services in England and Wales. www.homeoffice.gov.uk/docs/forensic_pathology_report.pdf (accessed 17 July 2003).

Palliative care needs of minorities

Understanding their needs is the key

The opportunity to die with dignity is recognised by health professionals the world over as one of the most fundamental of all human rights. What is often forgotten is that notions of a good death vary considerably between cultures (and individuals within a culture), raising the risk of misunderstanding and cultural insensitivity.¹ This need not be the case, as our experiences show. Even in ethnically and religiously diverse modern Britain, receiving high quality care at the end of life is possible and may, we hope, soon be probable for all.^{2,3} Realising this aspiration will need fundamental changes on at least three fronts: tackling institutional discrimination in the provision of palliative care, progress in incorporating transcultural medicine into medical and nursing curriculums, and a greater willingness on the part of healthcare providers to embrace complexity and in so doing develop a richer appreciation of the challenges facing people from minority communities in achieving a good end.⁴

The introduction of palliative care into health care is a relatively recent phenomenon, and even now these services are mainly focused on the needs of elderly people dying from cancer. However, migrant communities in Britain are typically younger and have proportionately higher death rates from diseases not related

to cancer.⁵ Other factors may contribute to the difficulties in accessing appropriate terminal care. These include the belief among some that hospices, with their Christian roots, cater only for white Christian communities and that hospitals have "unreasonable" restrictions on visiting times and numbers of visitors for dying patients.⁶

No effective national provisions are in place for training of healthcare professionals in transcultural medicine, and few professionals will therefore have had any real opportunity to learn about death rites in different cultures. Why is it that a middle aged Muslim daughter insists on maintaining a day and night hospital vigil of her dying mother?⁷ Or why is it that Hindu parents wish their terminally ill child to die as close to the floor as possible?⁸ The importance of these and other rites of passage need to be understood by caregivers.

How do we move forward? The continuing evolution of palliative care services is crucial to ensuring that minority communities have access to high quality terminal care. Important developments have taken place in community palliative care, with the widespread introduction of Macmillan nurses and children's hospices. Priorities must now include services that embrace people with a much broader range of ter-

minimal conditions; these include end stage renal and cardiac failure, which are important causes of death within ethnic communities.

We need proactive strategies to recruit staff from a diversity of backgrounds.¹¹ Our experiences show that multifaith hospital “chaplains” and ethnic outreach workers represent a particularly valuable resource in helping overcome language barriers, develop services, and promote partnership with local communities.

Health professionals are increasingly encouraged to focus on the idea of a good death. However, definitions have tended to emphasise physical and psychological support rather than religious perspectives. These often include control of symptoms and help with resolving unfinished business. Training in issues to do with faith—a subject so important to so many people during their last days—need to be incorporated into professional training. An estimated 65 medical schools in the United States now offer modules on spirituality and health, and these examples of good practice need to be emulated in Britain.¹²

But even the best training cannot cover all aspects of care nor deal with the myriad of ways in which values and norms interact and adapt before finally being enacted in the hospital, surgery, or home. We

have, however, a relatively untapped potential for penetrating insights into how to shape the future agenda for the provision of palliative care: the doctors, nurses, and allied health professionals who, with their broad range of ethnic, religious, and cultural backgrounds, represent a most valuable learning resource. Understanding each other’s narratives of what constitutes a good death offers us the possibility of improving the quality of care we deliver. The added benefit is that this helps us as individuals make better sense of questions we will encounter at some stage in our lives: How do I want to die?

A Rashid Gatrad *consultant paediatrician*

Manor Hospital, Walsall WS2 9PS
(steadmana@walsallhospitals.nhs.uk)

Erica Brown *head of research and development*
Hardev Notta *Asian liaison officer*

Acorns Children Hospice Trust, Birmingham B13 9EZ

Aziz Sheikh *NHS/PPP national primary care post doctoral fellow*

St George’s Hospital Medical School, London SW17 0RE

Competing interests: AS chairs the research and documentation committee of the Muslim Council of Britain.

- 1 Helman C. *Culture, health and illness*. Oxford: Butterworth-Heinemann, 1998:224-45.
- 2 Department of Health. *The NHS Plan*. London: Stationery Office, 2000.
- 3 Hill D, Penso D. *Opening doors: improving access to hospice and specialist palliative care services by members of black and ethnic minority communities*. London: National Council for Hospice and Specialist Palliative Care Services, 1995.
- 4 Hendry J. *An introduction to social anthropology. Other people’s worlds*. London: Macmillan, 1999:17-33.
- 5 Firth S. *Wider horizons*. London: National Council for Hospice and Specialist Palliative Care Services, 2001:21.
- 6 Gatrad A R, Sheikh A. Palliative care for Muslims and issues before death. *Int J Pall Nurs* 2002;8:526-31.
- 7 Sheikh A, Gatrad AR. Death and bereavement: an exploration and a

meditation. In: Sheikh A, Gatrad AR, eds. *Caring for Muslim patients*. Oxford: Radcliffe, 2000:97-107.

- 8 Firth S. *Dying, death and bereavement in a British Hindu community*. Leuven: Peeters, 1997:53-68.
- 9 Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients’ perspectives. *JAMA* 1999;281:163-8.
- 10 Galanti GA. *Caring for patients from different cultures*. Philadelphia: University of Pennsylvania Press, 1997:107-14.
- 11 Alexander Z. *The Department of Health study of black, Asian and ethnic minority issues*. www.doh.gov.uk/race_equality/ziggistudy.pdf (accessed 8 Jul 2003).
- 12 Koenig HG, McCullough ME, Larson DB. *Handbook of religion and health*. Oxford: Oxford University Press, 2001:437-39.

Helping people bereaved by suicide

Their needs may require special attention

For every suicide it is claimed that on average six people suffer intense grief.¹ With around 5000 suicides per year in England and Wales and at least 800 000 worldwide, the burden of suicide is immense. Those affected include parents, partners, children, siblings, friends, colleagues at work, and clinicians. The need for provision of care for this population is emphasised in the *National Suicide Prevention Strategy for England*.² This issue has also been highlighted by the recent publication of the *European Directory of Suicide Survivor Services* by the International Association for Suicide Prevention, which lists support services for people bereaved by suicide.³ Here we review the specific issues faced by people who have lost someone through suicide, the nature of available help, and future needs in this area.

Does bereavement by suicide differ from the impact of other sudden death? Initial uncontrolled studies implied a particularly difficult grief process. More recent studies controlling for effects of loss in

general have shown that bereavement after suicide is not necessarily more severe than other types of bereavement but that certain features or themes may be more prominent.⁴⁻⁷ These factors may make coping with the loss particularly difficult.

Specific experiences that seem to be more common in people bereaved by suicide include stigmatisation, shame and guilt, and a sense of rejection.^{1 6 7} Feelings of guilt and blame may be linked to a quest to understand why the suicide occurred. Bereaved people may blame themselves for contributing to the death. Failure to recognise mental illness or its severity may be an added factor. Guilt and shame are, understandably, likely to be particularly prominent where the suicide of a son or daughter has occurred.⁵ Awareness of the generally negative reaction of the community to suicide compared with other types of death⁸ may compound the sense of stigma. This is likely to undermine social support, increase the isolation of the bereaved person,⁵ and make seeking