To some, the role of medical examiner (ME) evokes memories of the TV character Quincy ME from the US series of the same name. The ME role introduced by the Coroners and Justice Act 2009 (Bit.ly/CoronerAct2009) in England and Wales is certainly less dramatic. The role comes into non-statutory force in hospitals in April 2019 (Department of Health and Social Care, 2018), after having been piloted in seven sites since 2008. Sheffield was the first pilot site and, since its start in March 2008, the ME has reviewed more than 25,000 cases (NHS Improvement, 2017).

The ME system is intended to help bring “a robust, transparent system of independent scrutiny to the process of death certification” and “effective medical scrutiny applicable to all non-coronial deaths” (Department of Health and Social Care, 2018a). However, the chief coroner (2018) has questioned whether MEs can be truly independent because they are employed by the NHS. This varies from the Coroners and Justice Act 2009, which stated that local authorities should appoint people into these roles.

Doctors appointed to the role must have appropriate experience; many will be consultants or GPs. MEs will need to maintain their competence and will report through a national system.

Medical examiner: friend or foe?

The role of medical examiner comes into non-statutory force in England and Wales in April 2019. The role involves ensuring accurate medical certification of the cause of a patient’s death. Medical examiners will report problems in the treatment or care of the deceased to the clinical governance team or coroner. They will also listen to relatives’ concerns and explain to them the cause of death. Examiners may need to speak with staff and/or check patient records and care plans.

Why do we need MEs?

There have been numerous high-profile care failings in the last 30 years, such as those involving Harold Shipman, Mid Staffordshire Foundation Trust, Morecombe Bay Foundation Trust and Gosport War Memorial Hospital. In the third of her six reports, Dame Janet Smith (2003), who led the Shipman Inquiry, recommended better control of death certification and better analysis of deaths, stating that if an ME process had been in place, problems would have detected much earlier. Affected relatives wanted and needed an independent process to voice their concerns and for action to be taken. The powerful evidence heard in the public inquiries warranted the bereaved to have this when deaths may not have benefited from the services of a coroner.

After a person’s death, relatives want to know with a degree of certainty exactly what caused their loved one to die. The current system rarely provides an adequate explanation by a doctor when a family receives a death certificate. Studies have shown death certification to be poor, with a third of scrutinised certificates needing major change, 8% showing failure to understand the indications for referral to a coroner, and 12% leading to wrong International Classification of Diseases coding (Furness et al, 2016).
Clinical Practice

Discussion

Box 1. What a medical examiner can do: examples

Case 1
A family wanted clarification on whether nurses had correctly assessed and treated their dying mother for pain. The medical examiner looked at the nursing records, spoke to the attending doctor and established that there had been individualised care plan and that pain had been managed properly, but that agitation from delirium had been difficult to control. The family accepted this explanation but said they would have appreciated it being given at the time that it occurred.

Case 2
Relatives expressed concerns that the administration of critical drugs to their father, who had Parkinson’s disease, had been missed or delayed. A review of the nursing plans and medicines administration records showed that this had been the case. This seemed unlikely to have led or contributed to his death, but the medical examiner referred the case to the trust’s clinical governance team for investigation. Meanwhile the family received support from the patient experience team.

What is the role of MEs?
Medical examiners work in collaboration with coroners. Coroners still determine the identity of the deceased as well as how, when and where they died. When the death is thought to have been sudden with unknown cause, violent or unnatural, coroners still decide whether to hold a post-mortem examination and, if necessary, an inquest.

MEs have three main aims:
- To ensure there is accurate medical certification of the cause of death;
- To detect whether there were significant problems in the treatment or care of the deceased, and ensure they are reported and reviewed by clinical governance systems or a coroner;
- To increase transparency for the bereaved, listen to their concerns and explain the cause of death to them.

In addition MEs are responsible for detecting problems in treatment and care, but they do not investigate them. As soon as they detect a significant problem, they must refer the case to either the coroner or the clinical governance system. Box 1 features two examples of ME scrutiny.

MEs have the responsibility of asking questions and/or seeking clarifications. Beyond looking at patient notes, they might speak to staff and check records of patient safety incidents, complaints and safeguarding concerns. Staff may find this difficult, as they may feel challenged in their practice and/or professionalism.

MEs need to be particularly sensitive to problems that affect frail or vulnerable people, be they young or old (for example, those with physical or learning disabilities) because these groups are consistently the most affected by failures of care. MEs may need to liaise with the coroner and registrar to allow swift death certification, registration and release of the body for burial or transportation, which might be important to the family for cultural or religious reasons. Other aims of the role include:
- Providing information on public health surveillance;
- Improving data-collection systems, especially the Learning From Deaths programme, which gathers data on avoidable deaths (Bit.ly/LearningFromDeaths).

What are the benefits?
Some professionals reading this article may feel concerned about the introduction of this role but one of the ME pilot sites has attracted extremely positive feedback from staff and relatives. The pilots have demonstrated that the ME system can be efficient and effective without causing undue delays (Royal College of Pathologists, 2018).

Junior doctors have taken the opportunity of the pilot to ask for advice and support in dealing with deaths, deciding which ones to report to the coroner and framing their reports. They have consistently said they lack training to fulfil these tasks, often delegated to them by consultants without adequate instructions. As an ME, I have seen first-hand how my early advice to junior doctors has led to dramatic increases in the accuracy of death certification and provided valuable learning.

The benefits for the bereaved are likely to be the most dramatic. In current practice, relatives of deceased patients rarely see a doctor; they usually see a nurse and bereavement care staff. In the new system, relatives are given a chance to ask a doctor questions. Often, they want to hear – in simple terms – what really happened. In my experience, some relatives only feel able to express concerns they may have had after a death. Although MEs have limited time with relatives, they can:
- Bring clarity;
- Dissipate doubts;
- Address negative thoughts such as: “Could I have done anything to spot the problem earlier?”.

Implications for nurses
Medical examiners will look at the quality of many aspects of clinical management, especially treatment and care delivered by any registered staff member. They may look at patient records, observations, care plans and care evaluations. Concerns expressed by relatives may lead MEs to focus on certain aspects of care, such as drug administration, personal hygiene or nutrition. Although employers will continue investigating poor professional standards using the regulatory frameworks of bodies such as the Nursing and Midwifery Council, all health professionals must recognise the legal role of MEs and support their work.

In conclusion, MEs will be neither friends nor foes. In trusts with good governance, MEs will not expect to uncover new problems at such a late stage. Although they may acknowledge good work and provide positive feedback to staff, nurses must be aware that MEs will also report problems. If necessary, they may also stop the death certification and release of a body, and report a death to the coroner, who may follow up with an inquest. NT

References