BRITISH JOURNAL OF HOSPITAL MEDICINE

MMC
Modernising Medical Careers

MODERNISING MEDICAL CAREERS

Legal aspects of death and the coronial system: responsibilities of the foundation year doctor M2
Carol Seymour

The clinical anatomy of the great veins of the neck M5
Harold Ellis

Prescribing analgesia for the surgical patient M7
Maya Nagaratnam, Hannah Sutton, Robert Stephens

Part 2: how to critique a manuscript M11
Rebecca Leon, Ardeshir Bayat

Principles of plaster application M13
Claire F Young, Fares Haddad

So you want to be ... an obstetrician M15
Daghni Rajasingam

IN NEXT MONTH'S MMC SUPPLEMENT

Applied anatomy of abdominal incisions

Critical appraisal: medical literature and impact factors

Oesophageal rupture

In association with

WESLEYAN
MEDICAL SICKNESS

Legal aspects of death and the coronial system: responsibilities of the foundation year doctor

Introduction

It is timely for the foundation year doctor to be aware of the law and procedure relating to coroners and inquests, which is changing fast. Following the Shipman inquiry, and the Bristol and Alder Hay cases, the system for death certification, the coronial procedure and disposal and handling of the human body and body parts have come under close public scrutiny. This has resulted in proposed reform of the coronial system, tightening up of death certification and the cremation process, and regulation of what happens to body parts under the Human Tissue Act 2004. These are very sensitive matters for both the bereaved and for the foundation year doctor.

What is a doctor's responsibility after death?

Complaints about the way a patient's death has been managed are a frequent cause of inquiry to the medical protection organizations and the British Medical Association.

The ethical principles underlying good medical practice are the same as the management of the patient when alive. Additionally, there is a responsibility to respect the family, and to provide clear, effective, empathetic communication about the cause(s) of death, and procedures which follow the death. It is important to remember that the doctor still has a duty of confidentiality to the deceased, as outlined in the Access to Health Records Act 1990.

Communicating with the bereaved

Breaking bad news can be daunting for the foundation year doctor, and a real test of communication skills. The public expect the doctor to be accustomed to dealing with death, and also expect sensitivity, compassion, respect and a caring attitude to assist the bereaved in registration of the death. The doctor must be adequately prepared, having studied the clinical record, and be able to answer the family's questions (within the bounds of the deceased patient's confidentiality). This might require some training or at least prior discussion with a consultant, educational supervisor or trainer as appropriate.

Professor Carol Seymour *is Medicolegal Adviser at the Medical Protection Society, 33 Cavendish Square, London W1G 0PS*

Consent for a post mortem examination

Although in the past this is a role which has been delegated to junior doctors, the Department of Health (2003) code of practice states that consent for a hospital post mortem, which is not a coroner's post mortem, should be undertaken by someone senior enough to answer the bereaved's questions, and who has experience in post mortem examinations. You should therefore ensure that you have had some training or at least have had a discussion with your consultant, educational supervisor or trainer before undertaking this role.

Who should certify death?

This is a statutory duty, under the Births, Deaths and Registration Act 1953, of the doctor attending the patient in the last illness, who is likely to be aware of the patient's past medical and family history, diagnosis, investigation and treatment. This doctor must have access to the clinical records and not rely on his/her memory. Furthermore, this is not a duty that can be delegated to non-medical staff, although the patient information officer or bereavement counsellor of the trust may provide assistance. It is important to be aware that certification of death is not an NHS responsibility. Completion of the medical certificate of cause of death (MCCD) is an activity where accountability would be to the General Medical Council (GMC).

Purpose of the medical certificate of cause of death

The main purposes for death certification and registration are to allow the family to

register the death and arrange the funeral, provide an accurate and permanent record of the death, and how and why the deceased died, and to allow the family to settle the estate.

Secondary purposes are that death certification provides information about the contribution of different diseases to mortality, and permits statistical analysis which may assist in monitoring health and planning health services for the population. It also safeguards against concealment of homicide or neglect leading to death.

Medical certificate of cause of death form

Certification of death must be done promptly and accurately, as it is legal evidence of the fact and cause of death. Errors not only delay the funeral, but also risk further distress to the bereaved, and problems for the doctor, if it was found that a cause of death was assigned which was known to be untrue.

The MCCD form is supplied in a book similar to a chequebook. There are three sections – a counterfoil remaining with the book, a certificate which is given in a sealed envelope together with a third section 'notice to informant' confirming that the certificate is issued to the bereaved or other authorized person.

Completion of medical certificate of cause of death

You should be aware of guidance at the beginning of the MCCD book and from the Office of National Statistics (2005) on completing the certificate. Only complete the MCCD if you have been involved in the care of the patient for the last 14 days before death and know the cause of death. Again, assistance from the patient information officer or bereavement counsellor can be helpful. Briefly after completing the patient demographics, your name and address, there are two key parts, part I and part II.

Part I is divided into three sections, I(a), I(b) and I(c), and you should indicate the major cause of death with any directly contributory causes in: I(a), I(b) and I(c) respectively, thus recording a sequence of linked events. For example (a) gastrointestinal bleed, (b) liver metastases, (c) carcinoma colon.

Part II refers to any contributing, but not directly linked causes of death. It is not a list of the past medical history. For example, it might include ischaemic heart disease and diabetes. If uncertain, discuss this with your consultant, educational supervisor or trainer as appropriate. It is not acceptable to give a mode of death as a cause, for example, heart failure. Doctors are also required to indicate if the certification of death takes account of information from a post mortem or that such information will be forthcoming or not, and also to indicate by ringing the appropriate statement, whether or not the doctor has seen the patient after death and if not, who saw the patient. The doctor is then required to sign and state the medical qualifications on a declaration of truth in relation to the MCCD, which has legal standing.

The cremation form

The cremation certification system has also come under scrutiny following the Shipman inquiry, and reform has been proposed. It is likely that the cremation forms will be regularly audited.

The purpose of the cremation form is to reduce the likelihood of destroying evidence of murder.

The form has eight parts, but the foundation doctor need only be aware of the first three.

Form A is the application for the cremation by a relative or authorized person.

Form B should be completed by the attending doctor who has issued the MCCD. The doctor must have seen the patient or body after death and will be paid a fee for completing the form.

Form C is completed by a second independent doctor, who is of more than 5 years standing after medical qualification and who also must see the body after death and question the doctor who completed form B.

Once completed, the medical referee of the crematorium considers the form and authorises cremation, unless there are concerns when he/she may question the doctor who signed form B. The Department for Constitutional Affairs has published a useful guide for doctors filling in cremation forms (http://www.dca.gov.uk/corbur/cremation_forms_guidance.pdf).

It is important to be aware, when completing form B, that there is a legal obligation to provide accurate information about the presence of a pacemaker or other implants that may represent a health hazard. Pacemaker explosions cause considerable and costly damage to the crematorium and can also injure staff. Omission of this important information could lead to a claim for compensation. There is a tick box on the form for documenting this.

The coronial system

Coroners, medically and legally, or legally qualified, are responsible to the Lord Chancellor for investigation of all unnatural deaths occurring within the jurisdictional district.

You have a professional duty to report to the coroner when the cause of death is violent, unknown or unnatural. If in doubt, you must discuss this with your consultant, educational supervisor or trainer and the coroner. If a case is referred to the coroner, this will need careful explanation to the family of the deceased.

The coroner will decide whether or not a post mortem or inquest should take place, and can authorize the foundation doctor to issue the MCCD. If the coroner decides on an inquest, he/she may ask you for a medical report.

Coroner's jurisdiction

The Coroner's code of practice is regulated by the Coroner's Rules 1984, Coroner's Act 1988 and the Amendment Rules 2004/05, although these are currently under review. Key amendments aim to improve the service for the bereaved and avoid unnecessary inquests. Importantly the term 'relative' will in future also include 'partner', who will soon be able to question witnesses of fact at the inquest.

When is an inquest necessary?

Under section 8 of the Coroner's Act 1988, the coroner must conduct an inquest if there is reasonable cause to suspect that the death was either a violent or unnatural one, or where the death was sudden and the cause is unknown. Inquests are also held if the death occurred in prison or such a place as to require inquest under any other Act. An inquest is also held where the death occurred within 24 hours of admission to hospital for a surgical or anaesthetic procedure.

What is an inquest?

An inquest is a fact-finding exercise conducted by the coroner with or without a jury. The purpose is to determine who died, when and where, and how and in what circumstances. Evidence is given by witnesses of fact under oath. This means you must be clear and accurate in any witness statement you submit or any evidence you give in the coroners' court.

It is not a function of the coroner to apportion blame. Nevertheless, witnesses do have the right to representation. This should be discussed with the legal services department of the trust and/or your medical protection organization. You cannot be obliged to give evidence which is self incriminating.

An inquest with a jury is usually required for death in custody, industrial accidents, poisoning or as a result of alleged injury by police officers, and where death occurs in circumstances that, if repeated, could prove prejudicial to the public safety, for example, train and barge crashes.

KEY POINTS

- Respect the relatives of the deceased, make sure you communicate with them in a clear, effective and empathetic way and give explanations as appropriate.
- Balance this with your duty of confidentiality to the deceased.
- Legally to complete the medical certificate of cause of death you must be a registered practitioner and must have seen the deceased after death or within 14 days before death.
- Be clear as to the cause of death – if in doubt, consult a senior colleague, educational supervisor or the coroner.
- Consider post mortem or referral to the coroner where appropriate.
- Answer all questions in full, avoid using abbreviations. Only fill in cremation form B if you certified the death.
- Hand sign the form (do not use a stamp or just your initials).

Verdicts

The number of verdicts which the coroner can bring, include natural causes, accident or misadventure, suicide, unlawful killing, neglect, miscellaneous (covering drug dependence and industrial accidents), and a narrative verdict. An open verdict is when there is insufficient evidence to decide on the cause of death; the inquest can be reopened if further evidence materializes later. In most circumstances, the standard of proof is on the balance of probabilities. Verdicts of suicide or unlawful killing must be proved to the criminal standard, beyond all reasonable doubt. Verdicts such as self-neglect or lack of care may have implications for the healthcare professional involved and could result in a referral to the GMC.

Conclusions

There are many areas relating to your legal responsibilities after death, which may not have been covered in detail during clinical training. It is essential to be clear about your limitations and have a low threshold for seeking help from your consultant, educational supervisor or trainer. Medical protection organizations are there to help as well as the legal department of the trust. BJHM

Conflict of interest: none.

Department of Health (2003) *Families and Postmortems: A Code of Practice*. Department of Health, London

Office of National Statistics (2005) *Medical certificate of cause of death. Guidance for completion.* Office for National Statistics' Death Certification Advisory Group. General Register Office, London

RSM STUDENT MEMBERS' GROUP RESEARCH PRESENTATION

Pre- and mid-cycle chemotherapy FDG-PET scans to predict patient outcome in non-Hodgkin's lymphoma

The* British Journal of Hospital Medicine *is pleased to be publishing some abstracts from the Royal Society of Medicine's Student Members' Group Research Presentation. This is the winning oral presentation. For information about entering this year's prize, please contact young.fellows@rsm.ac.uk

Abstract

Introduction

Positron emission tomography (PET) has had an enormous impact on the management of non-Hodgkin's lymphoma (NHL). Qualitative studies have suggested that PET may be useful in predicting patient relapse. This study used a semi-quantitative analysis to investigate whether PET scans can be used to predict patient outcome in NHL.

Method

Pre- and mid-treatment PET scans were obtained for 50 NHL patients. These were analysed by extrapolating standardized uptake values (SUVs) for each lesion in the patient. Various variables, mainly SUVmean, SUVmax and tumour volume, were compared to try to predict relapse. T tests, ROC (receiver operating characteristics) curves and Kaplan–Meier survival analysis with log rank test were performed.

Results

Of 50 patients, 10 had relapses. Overall, the percentage difference in SUVmax was most useful. There was a significant difference in the means of patients who relapsed compared to those in remission ($P<0.01$). Using ROC curves, a threshold of 70% difference in SUVmax between pre- and mid-treatment scans was suggested to predict relapse (positive predictive value=0.75, negative predictive value=0.80, $P<0.01$).

Conclusions

A 70% cut off could fairly accurately predict whether a patient would relapse or remain in remission ($P=0.008$). BJHM

Mr Gamunu Ratnayake *is a medical student at Guy's, King's and St Thomas' School of Medicine, London SE1 9RT*