NZMA
New Zealand Medical Association

23 June 2011

Death and Cremation Certification
Law Commission
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Final words – Death and Cremation Certification in New Zealand

Thank you for the opportunity to comment on this matter.

The NZMA is New Zealand's largest medical organisation and has a pan professional membership. We have around 4500 members who come from all areas of medicine.

The NZMA aims to provide leadership of the medical profession, and promote:

- professional unity and values, and
- the health of all New Zealanders.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the Code of Ethics for the profession
- publish the New Zealand Medical Journal.

We are impressed with the quality and depth of the work the Law Commission has put into this consultation and consider it timely to look into this issue further.

From a medical perspective we believe there is a need for a system that is safe, in terms of making sure that suspicious deaths are properly investigated and that the statistics the Medical Certificate of Cause of Death (MCCD) provides are as accurate as possible, but also are not unduly onerous for doctors and appropriately reimburses doctors for the work undertaken.

Our answers to the specific questions raised are set out below:

Q1 Should a statutory body have the responsibility for the monitoring and oversight of death and cremation certification in New Zealand? Is there a case for that responsibility to lie with the Ministry of Justice, which also has responsibility for the coronial system?

We consider that a statutory body should have this responsibility and that the most appropriate body is the Ministry of Justice although the function could also be undertaken by the Ministry of Health if this was desired.

Q2 Should random and targeted auditing of death and cremation certificates be undertaken by the body with statutory responsibility for certification?

Yes, it should.

Q3 Should a single doctor continue to be permitted to complete the MCCD without any independent scrutiny or review?

No. While this works in most cases it places a heavy responsibility on the doctor who sometimes feels pressured by a range of people including the family, colleagues, funeral directors the police and coroner at times. Having a second line of review would make standing up to this pressure much easier.

Q4 Or should all deaths be subjected to some form of independent review before final disposition, irrespective of whether the deceased is to be cremated or buried?

Yes – as above. We consider that maintaining a degree of oversight will lead to greater accuracy in the MCCD and better health statistics.

Q5 Should a doctor be required to physically examine the body of every deceased person before completing the MCCD, irrespective of whether the deceased is to be buried or cremated?

We think they should. In most cases the doctor who examines the body should be the patient's usual doctor or one who contributed to their care in the hospital although that person may not necessarily be the same doctor who completes the MCCD. The same can be said for the signing of the cremation certificate

Q6 If not, should there be a temporal restriction on a doctor signing the certificate of a patient who has died and who has not been examined after death – e.g. the doctor must have seen the patient within 14 days of the death? (this provision would only apply when the doctor certifying had been treating the person during their last illness)

No. If the treating doctor is not available then another doctor should be able to do this. We do not think that that doctor need necessarily have seen the patient in the 14 days prior to their death. However, the doctor must be able to satisfy him or herself from a viewing of the body and a perusal of the patient's notes, of the cause of death.

Q7 Should all public hospitals be required to carry out regular internal audits of all Records of Death and MCCDs completed by their doctors to ensure deaths which should be referred to the coroner are referred and to improve the accuracy of death certification?

Yes.

Q8 Should all doctors who are required to complete MCCDs have access to independent expert advice?

If they consider they need it, then yes.

Q9 Should the Ministry of Health Guide to Certifying Deaths be updated and expanded to include a guide to reportable deaths?

There is a need for increased training in this area, particularly if there are to be changes to the certification process. Depending on what those changes are they may need to be reflected in an amended guide. If the changes are significant then we consider that a number of seminars or meetings held round the country will be necessary in order to update doctors.

Q10 Do the circumstances in which doctors are required to report deaths which are "without known cause" or deaths which occur "during medical, surgical, or dental operation, treatment, etc." to a coroner need to be better defined in the Coroners Act 2006?

We believe they do. Further, the matter should be covered fully in the guidelines and training.

Q11 Are there grounds for extending the coroners' jurisdiction to a broader category of deaths? If so which deaths? Where there are unresolved concerns about a death by family members or care givers should it be mandatory for these deaths to be discussed with the coroner?

We do not believe this will be necessary provided that doctors have access to independent advice.

Q12 Should S14 of the Coroners Act be amended to explicitly permit funeral directors, health care workers, relatives of the deceased or any other person with relevant information to report deaths directly to the coroner?

It could be allowed provided that the role of the medical practitioner is not excluded from the process.

Q13 Is there a case for making the Coroner's Record of Death certificate a statutory declaration used for all deaths (rather than hospital deaths only)?

We think that this idea has merit – provided it is part of the MCCD process.

Q14 Is there a case for introducing a second-tier of "reviewable" deaths, such as deaths arising from accidents in the elderly, which do not involve a full coronial inquiry but may involve a preliminary examination and possible referral to another authority such as the Health and Disability Commissioner?

No. Cases are either reportable or they are not. In any event we note that relatives of the deceased – or indeed anyone at all – can raise a concern about the standard of care provided with the Health and Disability Commissioner.

Q15 Is there merit in reviewing the interface between the Coroner's Office and the various bodies charged with reviewing deaths and improving standards of health care?

Yes.

Q16 Should consideration be given to appointing medical advisors to the Coronial Services Unit to ensure coroners have access to expert medical advice in making assessments as to whether to accept jurisdiction of "unknown cause" and deaths in health care?

Yes. Anything that can assist the coroner in making appropriate recommendations and judgements in a timely fashion should be encouraged. We note that this is currently being trialled in Auckland.

Q17 In its current form is the medical referee system providing sufficient safeguards as to justify its continued existence?

As the consultation document points out, there are many inconsistencies in the process currently. In our view the inconsistencies need to be addressed and the system enhanced.

Q18 Is there a case for strengthening the medical referee system and extending it to all deaths?

Yes – see Q17. Having a second line of review in all deaths is appropriate (see our answers to Q3 and Q4).

Q19 Would the medical referee system be strengthened by ensuring referees have access to patient notes and to the person completing the MCCD?

While this would certainly strengthen the system it will add a level of complexity and potential accountability to the role which will also need to be reflected in the system. Having said that, we believe that the referee should have access to the notes if they consider they need to.

Q20 Is there a case for exempting coronial cases from the medical referee system?

We think there is. At present there appears to be an element of double handling in those cases the coroner has had full involvement (rather than just giving advice or guidance).

Q21 Is there a case for exempting hospital deaths from the medical referee system?

No. In hospital cases the medical referee can be part of the internal audit process but should be a senior clinician(s) with specific responsibility as described in the paper and appendix 1.

Q22 Could the role of medical referee be extended to include an advisory function for coroners and doctors in relation to death certification?

Yes. See Q16.

Q23 Should the regulation requiring medical referees to "definitely" establish the cause of death before authorising cremation be amended to reflect the actual level of certainty attainable without autopsy?

Yes but it also should be extended to the MCCD. The cause of death is often based on the balance of probabilities and these needs to be documented.

Q24 Should medical referees receive standardised training, payment and monitoring under a centralised administration? If so should that be the Coroner's Office?

Yes. We believe the coroner's office is likely to be the most appropriate body.

Q25 Is there a case for replacing the MCCD, as the document which allows the removal of the body, with a new Record of Death Notification to be completed by a doctor authorised under the Burial and Cremation Act or a nurse practitioner or nurse manager. (The Record of Death would include verification of identity of deceased, verification of life extinct, and preliminary assessment of whether the death is reportable or requires further investigation. The person completing this form would be obliged to undertake a physical examination of the body.) Doctors would remain under a statutory obligation to complete the MCCD within a prescribed period.

Determining the cause of death is a medical function and is one that should only be determined by a registered medical practitioner. A certificate of life extinct however, could be undertaken by an appropriately trained nurse – probably a Nurse Practitioner in the scope of primary care or geriatrics. This should not extend to a Nurse Manager of a facility as this could be a significant conflict of interest if there is any suggestion of inferior care, accident or medical misadventure.

An appropriately trained nurse as noted above could also provide a preliminary assessment as to whether the death should be reportable.

Q26 Should the authority to complete MCCDs be extended to nurse practitioners in circumstances where they have been the deceased's lead carer?

Accurate determination of cause of death can require the highest level of diagnostic abilities. If permission was extended beyond medical practitioners a high level of training with revised specific scopes of practice would be required in order to maintain current diagnostic accuracy .

Q27 Does the MCCD require simplification?

We think the certificate could be clarified, in particular the form should state that the cause of death is determined on the balance of probabilities.

Q28 Does the doctors' medical certificate for cremation require simplification and modernisation?

Yes.

Q29 Should these two certificates be amalgamated – e.g. a perforated portion at the base of the MCCD that can be provided to the funeral director or crematorium?

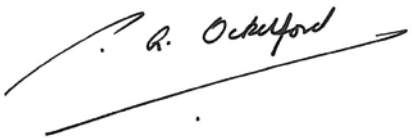
We think this idea has merit. The information for both should not necessarily be any different, apart possibly from the presence of a pacemaker. Further examination of a body after burial is possible but the process of exhumation (which would be required) is extremely difficult and bureaucratic so the level of confidence that further examination of the body is not required should be the same.

Q30 Who should bear the cost of death certification?

We offer no comment on this other than to note that the process of death certification can be time consuming and has significant medico-legal implications. Accordingly the medical practitioner needs to be appropriately reimbursed for the work.

The current situation of uncertainty about whether there will be some payment and who will be making that payment is likely to be one of the reasons why the current system is not working better than it is.

Yours sincerely



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