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ACUTE PERSPECTIVE

David Oliver: The medical examiner role could transform our approach to handling death

David Oliver

In April 2019 NHS Improvement announced a national programme to introduce a new medical examiner role at all acute hospital trusts in England, to provide independent scrutiny of all deaths.[1 2] Wales is adopting a similar approach.[3] I can see potential for this initiative to transform the way doctors and hospitals handle and learn from death and to drive improvements in care and the experiences of bereaved people.

The current pandemic has brought temporary modifications under the emergency Coronavirus Act and covid-19 specific guidance regarding certification and notification of deaths.[4] Covid-19 has highlighted the vital importance of accurate, scrutinised death certification.[5]

Under the new initiative, each acute trust should establish an office of medical examiners of the cause of death. They will have administration support and be staffed by a team of medical examiners who are generally senior doctors, usually employed by the trust in a principal clinical role but with some sessions as a medical examiner built into their job plan.[6]

The stated purposes of the new national system are: to ensure greater scrutiny of all deaths not reported to the coroner (and hence better safeguards to the public) and appropriate direction of deaths to the coroner; to provide a better service to bereaved people and an opportunity for them to raise concerns with doctors not directly involved in their loved one's care; and to improve the quality and consistency of death certification and, in turn, the mortality data.

My own experience of working with medical examiners has been very positive. It has focused consultants' minds on discussing certification within the ward team before doctors go to the medical examiners' office to complete the certificate. We now have formal, protected times for those discussions, rather than junior doctors being phoned repeatedly while stuck on the wards or on call.

It's reassuring to know that deaths of patients under my care are scrutinised and discussed in more detail with their families. This can provide a useful heads-up about potential complaints and a chance to offer personal discussions. It may also prevent accidental worsening of grief by helping understanding, and I can see the potential to improve our data accuracy.

An unexpected early benefit has been the learning. I've already had several pieces of very positive feedback about care and communication from medical examiners, but also some useful observations about aspects of care and communication during a patient's final admission. Junior doctors gain learning opportunities from the discussions. This is one national initiative I welcome, so long as we collect meaningful data on its impacts, costs, and downsides and are prepared to learn and adapt as we go.

I do, however, have some reservations. Firstly, we need to ensure that we don't just pay lip service to working closely with families to co-design the approach, keeping them informed and involved. Previous poor experiences were a big driver behind the initiative.

Secondly, we must avoid creating additional complexity, duplication, and additional work for clinical staff who are also carrying out labour intensive, structured mortality reviews on selected cases, coroners' reports, incident reports and investigations, complaint responses, and clinical audits, often on the same cases.

Finally, we need to use the independent review of deaths for learning, education, and improvement—not blame.[7] The medical examiner role offers great potential to get this right.

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