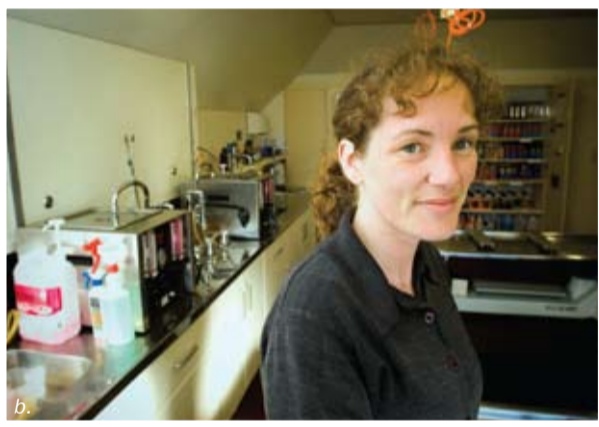


DEAD CERTAIN

What to do when a patient dies

PHOTOGRAPHS J DOROV



Patient death is a fact of general practice but what happens afterwards can be stressful and complicated for the family and the GP. Reporter Lucy Ratcliffe follows the steps that need to be taken after death comes knocking

When west Auckland GP Peter Woolford gets a call to say one of his patients has died, he generally drops everything and dashes off to be with those left behind.

"It's like babies," Dr Woolford explains. One just goes, even if it's in the middle of the night. In fact, it suits him better to do it in the middle of the night. His wife doesn't agree, but he thinks it's better because it doesn't affect his other patients.

If he does get a call during the day, however, he'll go immediately if the death was unexpected leaving his practice partners to see his other patients. Otherwise, he'll pop out on his first break. "Everybody understands," he says.

He'll even cut short a fishing trip if he's needed.

As a GP with a passion for palliative care, Dr Woolford deals with dying and death more frequently than others and feels privileged to do so.

It's a privilege, however, other GPs may not experience so often, given most will only see about two or three terminally ill patients a year.

Be prepared

One of the best ways a GP can prepare for a patient's death, to make it easier for everyone, is to have some kind of system in place for when the inevitable happens, Dr Woolford says. A good system is one where the patient's family can easily get hold of the GP of the deceased, and, if the GP is unavailable for whatever reason, there is a plan in place for patient records to be available for other medical colleagues to access, he says.

By law, a person's cause of death must be certified by a doctor and if that can't happen the death is automatically referred to the coroner. Dr Woolford says there's nothing worse for a distraught family than to have the police turn up and for the death to become a coroner's case initially when it doesn't need to.

"I believe as GPs we have a responsibility to have something in place...I really feel strongly about that."

It's something acting chief coroner Wallace Bain also feels very strongly about. So much so, he met with the RNZCGP earlier this month to express its importance.

Dr Bain cites a worst case scenario: a Maori male dies of a suspected heart attack in the middle of a sports match during the weekend in a small rural town. The deceased's GP is away for the weekend and practice staff cannot access medical records to see whether the man had a history of heart problems. Practice staff can't contact the GP and the coroner is left to deal with a distressed family that wants the body released as soon as possible for the tangi. A locum could sign the death certificate but they may not feel comfortable doing so unless they can talk with the patient's GP or see the notes.

With no notes available and no doctor able to certify the death, the coroner is faced with ordering a postmortem, which the family is likely to object to on cultural grounds – which they can now do under new coronial law. In Dr Bain's view, the deceased's GP is breaching the law and would probably be summonsed to an inquest to explain why he or she had no system in place for when a patient dies.

While a coroner can override a family's objection to a postmortem, if needed, the situation can be avoided altogether, Dr Bain says. One way to avoid this is for GPs to provide contact details to the coronial service, he says.

"We're not going to abuse it. Believe me the last thing they want is to get into the court process...All we want to do is minimise the stress," he says.

While Dr Bain doesn't expect GPs to be on call 24/7 or to go without holidays, he believes they need a system in place for everything to run smoothly. Making arrangements directly with families is also another way to minimise stress, says Dr Woolford, who happily gives out his contact details to patients, local police and ambulance staff.

"It very rarely gets abused," he says. "People phone me less when they have got my phone number."

But GPs may not always hear about their patient's death from the family or emergency services. On one such occasion, an

elderly patient missed an appointment with Dr Woolford. Knowing she lived alone because he'd treated her late husband and that it was unusual for her to be unreliable, Dr Woolford went to check on her. He found the house locked up and he suspected she was dead inside.

Dr Woolford phoned local police, told them the story and asked them to come and help him break in. His suspicions were correct and, although he was fairly certain she'd died of a heart attack, he wanted to refer it to the coroner so the police could track down any remaining relatives because he didn't know of any other family.

"If there's any doubt at all I just give the coroner a ring...I try to sign the death certificate if possible because it's much less intrusive."

Dr Bain agrees: "I think doctors can be more proactive in writing certificates. It's what they think is the probable cause. It's not an exact science.

"There's no legal definition of what a cause of death has to be."

GPs are welcome to ring coroners to discuss deaths if they're unsure, Dr Bain says. Although he'd prefer if they phoned at 7.30am rather than 3.30am, he adds.

When the coroner needs to be involved

Of the 25,000 deaths in New Zealand each year only about a quarter goes to the coroner. Deaths that must be referred to the coroner are: suicides, homicides or those that occur in other unnatural or violent circumstances; where a doctor cannot give a certificate as to the cause of death; those occurring during, or as a result of, a medical, surgical or dental procedure; those occurring during, or as a result of, birth; or those occurring while the deceased was in official custody or care.

If there's any doubt at all I just give the coroner a ring...I try to sign the death certificate if possible because it's much less intrusive

In other words, if a GP learns of a death or stumbles across some circumstances where foul play is evident, they shouldn't move the body. Phone the police and they'll do the rest, including contacting the coroner, Dr Bain advises.

The coroner's key tasks are to ensure the identity of the deceased and cause of death are known, to establish when and where a person died, to understand the causes and circumstances of death, and ultimately to prevent further deaths in the same manner.

"What we're all about is prevention, prevention, prevention," Dr Bain says.

To help the coroner's cause, the coronial system has been overhauled with the introduction of the Coroners Act 2006. Dr Bain says it's the best system he's ever worked under. Previously 55 mostly part time coroners were working throughout the country and often were lawyers who subsidised the public service through their own firms. Now there are 14 full time coroners and a new role of chief coroner has been created with a coronial services unit established in Wellington. The system is now well resourced and on call 24/7, he says.

The changes were very much driven by cultural needs and the new act allows families to object to postmortems on cultural grounds or opt for an external postmortem only.

A coroner can override a family's wishes if it objects to a postmortem and the coroner has a feeling there's been foul play, Dr Bain says.

"The act is very culturally sensitive...It works very well," he says.

Top to bottom:

a. The longer the embalmer has to wait for the body, the more difficult the task

b. "Embalming is like a little operation" – Auckland embalmer Anthea Baxter

c. A rainbow of embalming chemicals

d. "Auckland is a multicultural city... and they all have different ways of saying goodbye" – Managing director of Auckland's Davis Funerals, Bob Russell

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The coronial process

Generally, if the death meets the aforementioned criteria, the body goes to the coroner and a preliminary investigation will take place. If the coroner can't establish the cause of death, or feels any questions are left unanswered, he or she may open an inquiry, which may include a postmortem.

"If the coroner has accepted jurisdiction, that's when I come in," says Auckland forensic pathologist Simon Stables. "My report will decide whether there needs to be an inquest. Most don't."

If a postmortem is required, it's vital the pathologist has a medical history for the deceased and that's where the GP's cooperation is needed again. Dr Bain says the coronial service will even pay GPs for the time they spend getting medical records together if needed.

What some people forget is the GP is bereaved as well. I think they need a chance to grieve too

"It's a lot easier to do a postmortem when you have got some background information," Dr Stables says. "If you know someone has got a history of asthma, you'll look a bit more carefully at the lungs...that history is extremely important," he says.

Once the postmortem is completed, the pathologist releases a report and the body. The coroner then decides whether an inquest goes ahead or not.

Not all coroners release the postmortem report to GPs, but it's something Dr Bain likes to do and would like to see others do as well.

"We like to involve the GP...It's not compulsory but we like to do that."

GPs are in a very good position to feed the postmortem results back to the family, Dr Stables says. He will go through the report with families himself, if required, but it depends on the family. "Some just aren't interested. They just don't want to know."

If a family does want the GP to go over the results, he warns the report is very detailed and, to keep explanations in simple language. Families often want to know if there's anything they could have done to save their loved one, and Dr Stables says quite often there isn't anything that could have been done.

"Just be honest with them. That's all they want at the end of the day."

Funeral arrangements

Once the coronial process is over, or the death certificate has been signed, funeral preparations can begin, which, as the funeral director at Auckland funeral home "Sibuns", John Drake, says, is now quite a complex business. "We see ourselves more as event planners to be honest," Mr Drake says. Funeral directors tend to be organising funerals, sometimes with as many as 700 mourners expected to attend, in a variety of venues.

With more cultures residing in New Zealand, funeral directors find themselves dealing with a range of needs too, says the managing director of Auckland's Davis Funerals, Bob Russell. "Auckland is a multicultural city...and they all have different ways of saying goodbye," Mr Russell says. For example, Maori and Pacific Island families tend to want the body to stay at home or at a marae whereas Hindu and Jewish faiths require the body to be buried or cremated within 24 hours of death. Those needing to be buried or cremated quickly aren't usually embalmed.

Mr Russell estimates about 85 per cent of deaths in New Zealand are embalmed. With Maori families wanting the body as soon as possible, there's a lot of pressure on embalmers to perform the embalming process quickly.

This can be difficult, especially when embalming isn't always successful, Auckland embalmer Anthea Baxter says.

But knowing the cause of death and any other conditions the deceased may have had enables the process to be more successful, Miss Baxter says. If

a patient had jaundice, for example, the embalmers can use chemicals to correct the patient's skin tone.

One of the biggest changes in embalming over the years has been the use of more concentrated chemicals, she says. People are living longer and when they turn up in the mortuary they aren't in as good a condition as they used to be, Miss Baxter explains. The longer the embalmer has to wait for the body, the more difficult the task will be when it arrives, she says.

"Embalming is like a little operation. It's not just washing the person and doing their hair."

Cremation or burial?

By now the patient's family will have decided whether the deceased will be cremated or buried. Mr Drake says around 75 per cent of people are cremated these days, mainly due to its lower cost (around \$350) compared with being buried (plots cost up to \$5000).

The wishes of the family, or those of the deceased, dictate the GP's further involvement. If the patient is to be buried, the GP doesn't have to be involved any more essentially, but, if the patient is to be cremated, a cremation certificate needs to be filled out then sent to a medical referee.

The cremation certificate has to be filled in by the patient's GP or another doctor who has seen the patient before and after death, says medical referee Garry Clearwater, a former Auckland GP turned emergency medicine specialist. The purpose of the certificate is to confirm the cause of death has been established and to verify the correct person is being cremated, simply because the process is irreversible, Dr Clearwater says.

"Doctors don't realise they're filling out quite an important legal document," he says. "That shows up in the forms with important details being left out...They most often miss out the pacemaker question."

The pacemaker question is one of the most important because, if a patient has one, it needs to be removed before cremation because the batteries inside will explode when exposed to extreme heat. Says Mr Russell: "It can put a crematorium out of action." Understandably, Dr Clearwater says, many funeral homes are nervous that, one day, a pacemaker will slip through the system.

When the form has been filled in, Dr Clearwater has to check it thoroughly and, once he's given the nod, cremation can go ahead.

Time to say goodbye

With all the paperwork out of the way, GPs need to decide whether they're going to go to the funeral and what involvement they're going to have with the family.

Families have been delighted when the patient's GP turns up at the funeral service, Mr Russell says. That sentiment is echoed by the overwhelmingly positive responses Auckland University's head of general practice and primary healthcare Bruce Arroll and academic registrar Karen Falloon received after posing the funeral attendance question to doctors everywhere through an article in the *BMJ* (2007;334:1322, [22 June]) last year.

Dr Woolford tries to go to all his patients' funerals "because it's closure for me as well," he says. Attending the funeral service shows respect to the patient and their family, and generally there's no need to attend the wake so it's not a big burden, he adds.

After the funeral, it's important for GPs to phone the family or drop in to see how they're doing, says Hibiscus Coast Hospice medical director and former GP Rod MacLeod. "That means a lot. But I think what some people forget is the GP is bereaved as well. I think they need a chance to grieve too."

Professor MacLeod is a fan of, what he calls, a "death review", where the GP sits down with colleagues and talks about the patient's death. "It's important to remember [GPs] are people too and they feel losses as well."

Dr Woolford agrees: "You get attached to people...It's a natural part of life, and being there with somebody is a real privilege at the end of their life."

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For whom the bell tolls...

- There were 28,520 deaths registered in New Zealand during the year to December 2007 compared to 28,240 in the year to December 2006.
- Of the 2007 deaths, 14,280 were male and 14,250 were female.
- The median age of death during 2007, was 76.5 years for males and 82.5 years for females, compared with 71.5 for males and 77.1 for females in 1987.
- Only 5.6 per cent of the deceased were aged less than 40 years in 2007, compared with 8.9 per cent in 1987.
- Auckland had the most deaths in 2007, followed by Canterbury with 4107, then Wellington with 2886. The region with the lowest number of deaths was the West Coast with 255.

Source: Statistics New Zealand