1st July 2011

Cate Honore Brett
Review of the Burial and Cremation Act 1964 Project
Law Commission

Submission on the ‘Final Words-Death and Cremation Certification in New Zealand. Issues Paper’

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide a submission to the Law Commission’s review ‘Final Words’.

2. The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards. Please refer to Appendix 1 for more information on ARPHS.

3. ARPHS understands that all submissions will be available under the Official Information Act 1982, except if grounds set out under the Act apply.

4. ARPHS would not like to be heard at any submissions hearing.

5. The primary contact point for this submission is:

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EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

6. ARPHS agrees with the importance of the issues identified by the Law Commission’s review ‘Final Words’ and is very supportive of a review of the Burial and Cremation Act 1964 and its associated regulations to improve the death certification system in New Zealand.

7. ARPHS suggests that a major step in improving the effectiveness of the death and cremation certification system in New Zealand is the improvement of the accuracy of, and access to, death certification data. This will require at least that:

   - Doctors certifying death are not placed in an untenable position due to a lack of independence or as a result of conflicts of interest.

   - The standard of death certification for the elderly needs to be at least as stringent as that applied to all other patient groups.

8. ARPHS suggests that a possible solution towards improving the accuracy of death certifications might be to have a medical speciality that deals with the dead, much in the way there are other medical and surgical specialities. ARPHS acknowledges that this might represent only one answer and would require further investigation.

9. ARPHS supports other potential solutions mentioned in the report that address the issues of independence for doctors certifying death and improving death certification for the elderly.

10. The extension of the role of the medical referee to that of death certification auditor and point of contact for Medical Officers of Health (MOsH) requiring death certification data could also be useful approaches provided that the two aforementioned barriers were addressed (independence of certifying doctors and death certification for the elderly).
11. The Auckland Regional Public Health Service (ARPHS), as an agent of the three Auckland DHBs, has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region.

12. MOsH and health protection officers (HPO) are employed by the public health units to act on behalf of the Ministry of Health to ensure compliance with the Burial and Cremations regulations and to reduce exposure to high risk cadavers.

13. The MOsH’ functions, relevant to this submission are to:

- Investigate and approve medical referee appointments.

- Provide advice to ensure that bodies with an infectious disease are treated in a manner that minimises the risk of spread of disease. The latter may include providing a letter to accompany the export of human remains that states the cause of death based on the medical certificate or the coroner’s report and the presence or absence of infectious disease. In 2010 ARPHS issued 101 letters for transportation of bodies overseas and for the year 2011, so far, 52 export certificates have been issued.

14. Of less relevance, MOsH may circumvent the requirements of legislation and order the cremation or burial of bodies in the event of a civil defence emergency. The Ministry of Health and public health service also have a significant role in using mortality surveillance data to direct their efforts and resource in improving population health.

15. Given the above stated roles, ARPHS has an interest in ensuring that certification of cause of death is accurate. Without accurate information we are unable to perform our function of protecting the public (both in New Zealand and internationally) from disease resulting from contact with dead bodies, and ensuring that medical referees are acting on the best possible information.
SPECIFIC COMMENTS ON ‘FINAL WORDS’ ISSUES PAPER.

16. It is important to note that the reliability of death certification in New Zealand has been questioned. For example, studies have consistently showed the underreporting of diabetes in death certificates and coroner’s reports.1,2,3

17. With regard to the accuracy of Medical Certificates of Cause of Death (MCCD), ARPHS would like to comment on the issues impacting on the accuracy of certification of death in New Zealand and suggest a way forward that is cognisant of these concerns, for further consideration.

*Independence of certifying doctors*

18. ARPHS agrees with the Commission’s report on the issue of lack of independence of doctors certifying death. Hospital doctors face several pressures that limit their independence in certifying death – they are answerable to senior doctors in their specialty teams, to their employer, and to the family of patients who have died, as well as having a professional responsibility to their dead patients. In addition, as they are almost always the doctor who last attended the patient, any further investigation of the cause of death could put their care of the patient under the spotlight.

19. Furthermore, there is a lack of information that would allow us to determine to what extent these pressures are impacting on the stated cause of death. However, even in the absence of such information, it seems clear that a system that is subject to such pressures and conflicts of interest casts doubt on the veracity of the MCCD, and needs to be changed.

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Certification of death in the elderly

20. ARPHS is concerned, as per the Law Commission’s report that accidental injury deaths in those aged over 70 years are not required to be reported to the coroner in the event that there are no unusual or suspicious circumstances surrounding the death.

21. ARPHS believes that the elderly actually require more, rather than fewer, safeguards against wrongful certification of cause of death, for the following reasons:

- Iatrogenic deaths (via act or omission) are far more likely to occur in the elderly population than in any other patient group because the majority of patients are elderly and (as stated in the report) the elderly are physiologically less resilient and more likely to die from sub-optimal treatment and treatment errors as they often have co-morbidities, are taking multiple drugs and present subtly or atypically.

- Elderly patients have been the recipients of discriminatory care in our healthcare systems where the value of the life of an elderly person, by virtue of age and co-morbidities, may be discounted relative to the life of a young person.

- Given the slim margin for treatment error, the difficulty in determining cause of death in some elderly, and the potential for discriminatory care of the elderly, this is the group of patients from whom cause of death data gives our hospitals and our healthcare system some of the very best information on quality of care.

22. Improving the quality of death certification for the elderly will provide a rich source of data to help the health sector inform and improve the quality of our healthcare for all New Zealanders.
Medical referees

23. ARPHS believes that the role of medical referees should not be extended beyond this to a certification audit function in the absence of further resources and a proper process that would deal with the shortcomings in the death certification process.

24. The barriers facing medical referees in carrying out an audit of the certification of death include a lack of independence from their funeral industry employer; lack of information or knowledge of the circumstance, and sometimes cause, of death; lack of training, guidance and oversight; lack of audit of their practise etc.

25. In addition, the current medical referee system, which is intended to prevent cremation of bodies where referees are not satisfied that the cause of death has been determined and where there are no circumstances that may require further examination of the body, is hampered by the same constraints.

Medical Officers of Health

26. Medical Officers of Health act on behalf of the Director General of Health to appoint medical referees who are suitable for the task of approving cremation, with the primary aim of ensuring that cremation is not used to conceal a crime and that the body is suitable for cremation. The Medical Officer of Health checks the qualifications of the applicant and must also check that the applicant is not the subject of any other matter that might prejudice their appointment. This latter requirement is fulfilled by checking the Medical Council of NZ website to ensure that they are registered doctors acting within their scope of practice. Whether or not this check is adequate to the task of ensuring they are not the subject of a matter that might prejudice their employment, is a question that should be asked - certainly a higher standard may be required, particularly if medical referees were to take on an audit function with respect to the certification of cause of death.
27. In ARPHS experience, the role of the MOsH in ensuring that dead bodies do not spread disease, is hampered on two fronts: we are not always provided with adequate certification of the cause of death either because:

- The cause has not been determined as in the case of some coroners’ inquiries, so no Medical Certificate of Cause of Death (MCCD) is available, or no MCCD has been provided to the Medical Officer of Health, or

- The MCCD often lists an infectious disease as a contributory cause but we are unable to determine to what extent it had been treated or may be communicable to others at the time of death.

28. In order to determine the infectious nature of the body, we either need to speak to the doctor who looked after the patient at the time of death or receive a statement that explains whether the body was still suffering from an infectious disease at the time of death and if so, other relevant information such as the location of such an infection. Obtaining the relevant information from the right person is time-consuming and largely occurs in a time-pressured context such as that of a body awaiting exportation overseas or family and funeral directors wanting to proceed with funeral arrangements.

**Potential Solutions**

29. Given the shortcomings of the current death certification system described above, ARPHS is very supportive of the review of the current system.

30. ARPHS is concerned about the ability of medical referees and MOsH to be able to perform their intended functions at least adequately, and believes a major step in achieving this goal is improving the accuracy of, and access to, death certification data.

31. An improvement in the accuracy of death certification data will require that doctors certifying death are not placed in an untenable position due to a lack of independence or as a result of conflicts of interest.
32. In addition, the standard of death certification for the elderly needs to be at least as stringent as that applied to all other patient groups, but most likely should be more stringent, in order to improve quality of care through the identification of causes of death, particularly iatrogenic deaths.

33. ARPHS suggests that a possible solution towards obtaining these outcomes might be to have a medical speciality that deals with the dead, much in the way there are other medical and surgical specialities, such that doctors may be trained and specialise in this area.

34. Whatever changes to the current system are implemented ARPHS believes that the independence of those certifying death and involved as medical referees needs to be protected, hence ARPHS’ suggestions of a separate medical speciality. One of the factors to be considered as a way of protecting the independence of those undertaking this work should be their employment status. Having those involved as part of a national body with national functions of overseeing, surveillance and auditing death certification processes and data may be desirable. Locally such doctors could work within DHBs to certify deaths with access to all available data, and data could be fed into an internal quality control system for the DHB’s action to improve care. Such doctors could also provide the point of contact for coroners, funeral services, medical referees, and medical officers of health.

35. ARPHS acknowledges that while this might represent an ideal solution with respect to the problems of greatest relevance to our service, it may not be the only answer and would require further investigation.

36. Further, ARPHS supports other potential solutions mentioned in the report that address the issues of independence for doctors certifying death and improving death certification for the elderly. Similarly, extension of the role of the medical referee to that of death certification auditor and point of contact for MOsH requiring death certification data could be useful, provided that the aforementioned barriers were addressed.
37. ARPHS is very supportive of the review of death certification process in New Zealand. ARPHS acknowledges the need to balance public policy interests in ensuring that accurate certification of death occurs and cultural beliefs around how the deceased body should be treated. The Commission’s staged approach to its review of the Burials and Cremations Act will help resolve these issues. ARPHS hopes its comments and suggestions will help the Commission’s deliberations.

Yours sincerely

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APPENDIX 1 - AUCKLAND REGIONAL PUBLIC HEALTH SERVICE

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board.

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS’ primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, outstanding infrastructure needs, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.