

Speaking for the dead to protect the living: the role of the coroner and the Shipman Inquiry

THE Shipman Inquiry (<http://www.the-shipman-inquiry.org.uk/>) was established with the primary goal of learning lessons to protect patients in future from the actions of a homicidal doctor. In order to accomplish this purpose, the Inquiry could have focused on a narrow set of solutions centred on the process of death certification and registration, or it could have taken a broader approach to revamping the death investigation system. In my view, the Inquiry correctly chose the latter approach.

Dr Harold Shipman, as the Inquiry reported, killed 215 of his patients between 1975 and 1998. At first glance, it would seem that a structured system of certification and registration could correct this problem, but with careful study and discussion with other jurisdictions, it became obvious to Dame Janet Smith, Chairman of the Inquiry, that the solution would not be either simple or necessarily fully reliable. There are recommendations from the Inquiry about a death certification system to go along with a strengthened death registration system. The Inquiry Report also encourages dialogue between coroners, treating physicians, and families. These recommendations are very much in line with practices in other jurisdictions and will certainly strengthen the death investigation system, provide better information to families, and go a long way towards preventing another Dr Shipman.

The approach of the Inquiry went beyond addressing these issues. The Inquiry also looked at restructuring the coroner's system. This was the advice given to the Inquiry by representatives of different countries. The systems studied were those used in Victoria, Australia; Maryland, United States; Finland; Scotland; and my own office, the Office of the Chief Coroner for Ontario, Canada. While there are differences between these various systems, there are common features, especially shared by the Maryland, Ontario, and Victoria systems, which broaden the role of the coroner.

The primary focus of the British coroner's system is to investigate cases with the goal of answering who, how, when, where and by what means someone died. Inquests are frequent and cursory, and their main purpose is not preventative. It is my impression that the public is relatively unaware of the role of the coroner and would view it as primarily administrative. This system does not actively promote the coroner as an independent investigator of potential healthcare issues. Families did not approach coroners with concerns about Dr Shipman and I believe it would be beneficial to promote such dialogue in future.

A dynamic death investigation system not only accurately determines who, how, when, where the deceased died, and the manner of death, but performs other valuable functions as well. Data from coroners' investigations can be used to help determine health policy. Coroner's conclusions are

important for criminal trials, and other medicolegal purposes. Families also gain necessary information and solace from accurate and timely investigations. In the Province of Ontario, the Office of the Chief Coroner has taken the inquest system and refined it so that the series of in-depth inquests each year produce detailed recommendations to prevent future deaths in similar circumstances. Some of the inquests are mandatory, such as for deaths in custody and in mining and construction sites. The other inquests are discretionary and the issues explored vary year-to-year and are dependent upon events that have received a lot of public attention and issues that have been debated frequently. These can involve deaths related to transportation, the healthcare system or justice matters. For example, there were a series of deaths of young children who were being followed by Children's Aid Societies. These children had been left in their homes despite concerns about potential abuse because the law at the time put greater emphasis on maintaining family structure than personal safety. The inquests resulted in a new law, which reversed priorities. They also resulted in recommendations for better assessment tools and computer-tracking systems for Children's Aid Societies in the province.

Other inquests studied deaths involving young drivers and recommended a graduated licensing system for inexperienced drivers. These inquests were actually held in the schools where the students were from, and highlighted issues such as speed, alcohol consumption, differing weather conditions and inexperience. An inquest into a subway crash resulted in 100 recommendations that not only fixed the root mechanical cause of the accident, but changed training and the culture within the system to make safety the main goal.

The coroner's system, through detailed investigations, expert reviews, and inquests, has become a major 'watch-dog' monitoring the safety and efficiency of the healthcare system. These inquests and investigations not only produce valuable recommendations, they also raise the profile of the Office of the Chief Coroner. In Ontario, the public understands that if there are questions about a death, the coroner should be contacted and told the concerns. I believe that this high public profile would have resulted in Dr Shipman being caught sooner in our jurisdiction.

Many medical professionals might be concerned that involving the coroner in quality of care issues would promote more lawsuits and difficulties for medical professionals. There are occasions when family complaints turn out to indicate potential negligence. However, most of these families would proceed with legal action even if the coroner's investigation did not occur. In the vast majority of cases, the

coroner is able, in an unbiased way, to investigate, explain what happened, and very commonly bridge existing communications gaps. Many of these investigations result in positive recommendations that institutions and individuals agree to implement. Many relatives express the view that all they are looking for are answers, and that lessons are learned from a death. In order to accurately review these cases, we use expert panels of reviewers who often meet and review the case with those involved. This type of review is less structured and a form of informal mediation. Because all at the meeting understand the same technical language, and the meeting is an informed non-structured discussion, it is often very candid. Individuals and institutions will often agree to implement recommendations and a lengthy structured hearing, in the form of an inquest, is avoided. Recommendations might include increasing safeguards to avoid drug errors, changing procedures in the operating room to avoid anaesthetic deaths, or increasing staffing in long-term institutions.

In order to be viable, the coroner's system needs to be independent, well managed, with central policy making and direction. The system needs adequate financing, and ongoing training for coroners and pathologists is essential. The coroner's office should also provide public education. The system proposed by the Shipman Inquiry addresses all these issues and borrows some of the best ideas from the jurisdictions that were studied.

The United Kingdom and Canada have a long tradition of

using commissions or inquiries to study issues when things go wrong. For example, following a series of gruesome sexual murders in Ontario committed by a husband and wife, the province needed a better police model for handling such cases. We adopted the approach developed after the 'Modern Ripper' murders (committed by Peter Sutcliffe).

I am also aware of the second report on the coroner's system authored by Tom Luce. The recommendations in this report are slightly different, but in my view attempt to move the coroner's system in the same positive directions.

Also, the Office of the Chief Coroner in Ontario grew out of the British coroner's model. It is very satisfying to think we might be able to give back some ideas to build a more viable and relevant system for Britain in the future.

If the proposed model to modernise the coroner's system is adopted, the Inquiry will achieve the greater role of improving public safety through recommendations, improving the quality and confidence in the medical system by acting as a watchdog and providing valuable information to families. In my view the Inquiry has 'got it right'.

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Normalisation: horrible word, useful idea

DOCTORS cannot always explain their patients' symptoms. This is especially true in primary care. Almost any symptom can herald a serious condition, yet the same symptom can have a benign, trivial or even no explanation. Examples familiar to every general practitioner (GP) include headache, abdominal pain and fatigue. One of the GP's skills is to identify which patients harbour a significant illness — the 'sorting the wheat from the chaff'.¹ However, the 'chaff' is not insignificant: it still has some meaning for the patient, even if it does not fit neatly into a pattern of disease. Doctors may be satisfied by excluding important illnesses, but patients sometimes want to know more than what isn't wrong with them — they want to know what is wrong with them. Patients may expect more certainty than doctors can provide, particularly as both doctors and patients regard a diagnosis as a statement of certainty rather than one of probability. GPs and their patients would welcome a method that helps them with this common problem. Two papers in this month's *Journal* provide some illumination.

Dowrick *et al*² have used a qualitative analysis of consultations to categorise GPs' explanations to patients who presented with medically unexplained symptoms. They base their categories on the concept of 'normalisation'. This term is relatively unfamiliar, but it describes an important process. We are comfortable with the idea that some patients 'soma-tise' their symptoms; somatisation ranges from an under-

standable concern about underlying physical disease to 'somatoform disorder', which can be extremely disabling. Somatising explanations are usually contrasted with psychologising explanations; 'my headache is caused by a brain tumour' versus 'my headache is a result of stress'. Patients hold on to these explanations, or attributions, with varying intensity. The impact of these beliefs on the presentation and diagnosis of depression is well known.³ Normalisation is different. It is the recognition that symptoms are part of the normal human experience, and do not necessarily represent 'illness'. All of us — doctors as well as patients — have a symptom every day of our lives: yet we are not 'ill'.⁴ Indeed it is possible that some of the functional somatic syndromes, such as chronic fatigue syndrome, represent the end result of a breakdown in the normalisation process. This would explain the increased symptom reporting, across a broad spectrum of complaints, seen many years before the onset of the fatigue syndrome.⁵

Patients and doctors also normalise symptoms; they minimise or externalise them: 'I have a headache because it's stuffy in here and I'm working too hard'. Different cultures have their own explanations for similar problems. Of course, the idea that patients with medically unexplained symptoms are committed to somatic explanations is something of a myth. Kirmayer *et al*⁶ have described a hierarchy of somatising explanations that included a sub-group of 'facultative

somatisers'; patients who presented with somatic symptoms but were prepared to accept psychological explanations when offered by the doctor. Perhaps a somatic symptom is seen by many patients as a way of legitimising their approach to the medical profession. Normalising and psychologising explanations are offered tentatively, if at all, because patients are not only uncertain of the meaning of their symptoms, but they are not confident of the doctor's interest in such explanations or his ability to help. For example, Pill *et al*⁶ found that many patients were reluctant to present psychological symptoms to their GP. This was not so much because of the stigmatising nature of psychological disorder but because they were often sceptical about the GP's ability to offer help other than medication, which was seen as palliative. The responsibility for the failure of doctors and patients to explore the psychological dimension of common somatic symptoms does not lie with doctors alone.

Dowrick *et al* argue that the GP's aim in normalising symptoms is to reassure the patient.² They describe three categories of normalising reassurance. The first is 'rudimentary reassurance without explanation' but perhaps accompanied by the 'authority of a negative test result'. The apparent reassurance of a negative test result may be as much for the doctor, who feels on safer ground in providing a normalising explanation once serious illness has been excluded. The danger is that investigation may reinforce the notion that the doctor is unsure in ruling out serious illness.⁷ There is a balance in such consultations between under-investigation, so the normalising explanation is strengthened, and over-investigation, so no disease is missed. The fulcrum of this balance represents as much the doctor's tolerance of uncertainty as the patient's.

The second type of normalising reassurance includes an explanation that is ineffective because it does not address the patient's concerns. Dowrick *et al*'s third category provides 'tangible mechanisms that address the patients' concerns, often linking physical and psychological factors' and 'have the potential to reduce the need for symptomatic investigation and treatment'.² This last part, which is impossible to prove in the sort of study under discussion, is the holy grail of modern psychosomatic medicine. In their second paper,⁸ the authors challenge the received wisdom that a patient who presents a somatic symptom is resistant to the idea of a psychological dimension to that symptom. They found that nearly all of the patients studied offered 'psychological opportunities' in the consultation. These were psychological explanations for their symptoms, although they were often tentative or oblique. GPs only picked up a few cues, although how much this was a failure to spot them or a conscious decision to let them pass unremarked is unknown. Dowrick *et al* comment 'our doctors may have disregarded opportunities because they had no effective response'.² They suggest an effective response is a constructive engagement with the patient's concerns, leading to an explanation linking psychological and physical factors. We have already pointed out that we do not know whether this process improves patient outcomes, either by reducing the need for investigation or giving rise to symptomatic improvement. This needs to be tested.

One technique that may be of use in this area is

'retribution'. This was first described in detail by Goldberg and Bridges.⁹ It is designed to help patients who make persistent somatising attributions in primary care move towards broader, more psychologically minded, explanations for their symptoms. It is a three-stage process, beginning with ensuring the patient feels understood, then broadening the agenda to include non-somatic explanations, and, finally, making the link between physical symptoms and psychological issues. The 'normalisation with effective explanation' described by Dowrick *et al*,² is probably an informal description of retribution. Many GPs will recognise it as a part of their therapeutic armoury. Similar packages have been shown to be successful in the UK.¹⁰ One big disadvantage of the technique is the investment of time teaching GPs how to use it, which is likely to reduce its applicability. Although a formal training in retribution may be beyond the aspirations of many GPs, we have the beginning of an evidence base for an effective response in a complex, but potentially rewarding area.

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