Medical Examiners and Coroners

As a medical-legal officer, the coroner or medical examiner is responsible for investigating and certifying specific types of death, and the records produced by these investigations can provide valuable data. Although which deaths are investigated is governed by state law, the types of deaths usually included are:[1]

- Deaths as a result of an accident, suicide, or homicide
- Deaths with unusual or suspicious circumstances
- Deaths from disease when "the death occurred suddenly and without warning, the decedent was not being treated by a physician, or the death was unattended"[2]

Information is collected in different ways in each state, depending on the system in place. For example, a state may have a medical examiner system, a coroner system, or a mixed system. The system may be centralized (controlled by one state office) or decentralized (controlled by county or regional offices).

The difference between coroner and medical examiner systems varies by jurisdiction. In addition, the qualifications, skills, and activities of personnel cannot necessarily be determined from the title of the office.

However, some differences between coroners and medical examiners may be generalized:

- Coroners are usually elected and are not required to be physicians. If an autopsy is needed, a coroner will frequently consult with a pathologist or forensic pathologist.
- Medical examiners, in most cases, are appointed and must be physicians. However, they may not be required to have special training in pathology or forensic pathology.

Coroner and medical examiner records generally include:

- Cause and manner of death
- Results of autopsies and laboratory tests for the presence of alcohol or drugs
- Circumstances leading to death

However, the information collected on suicides and other deaths varies by jurisdiction. For example, some coroners and medical examiners collect very detailed information on a suicide decedent's life circumstances, mental health history, treatment status, etc., while others do not. Some, but not all, coroners and medical examiners request that a psychological autopsy be conducted to determine if a death was a suicide.

Reports written are frequently narratives and have not been abstracted or computerized and are therefore difficult to aggregate or analyze. Reports are usually not published by coroner or medical examiner offices, although some offices do maintain electronic databases and will fill data requests. Some counties require a court order before this data can be released.

Additional Resources

Hanzlick, R. (2006). Medical examiners, coroners, and public health: A review and update. *Archives of Pathology & Laboratory Medicine, 130*, 1274–1282.

[1] National Center for Health Statistics. (2003). *Medical examiners' and coroner's handbook on death registration and fetal death reporting*. Hyattsville, Maryland: Centers for Disease Control and Prevention, National Center for Health Statistics.

[2] Ibid., p.1.

National Research Council of the National Academies. (2009). Chapter 9 Medical examiner and coroner systems: Current and future needs. In *Strengthening forensic science in the United States: A path forward*. Washington, DC: The National Academies Press. Retrieved from http://www.nap.edu/openbook.php?record_id=12589&page=241

U.S. Department of Justice, Office of Justice Programs. (2007, June). *Bureau of Justice Statistics special report: Medical examiners and coroners' offices, 2004.* Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/meco04.pdf