THE LEGAL DUTY OF MEDICAL PRACTITIONERS IN THE CERTIFICATION OF DEATH*

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As a preliminary it may be convenient to consider shortly the law relating to the actual certification. In the case of the death of a person who has been attended during his last illness by a registered medical practitioner such practitioner must sign and issue a certificate stating, to the best of his knowledge and belief, the cause of death (Births and Deaths Registration Act, 1874, s. 20(2)).

The doctor's duty does not, however, end there. He shares, with others about the deceased at the time of death, the common law duty to inform the coroner of any circumstances which he has reason to believe would render an inquest necessary. In criminal cases this duty is stronger than some practitioners may readily admit—"in such a case, the desire to preserve the confidential relationship which exists between the medical man and his patient must be subordinated to the duty which is cast on every good citizen to assist in the investigation of serious crime" (Avory, J. (1914) 49, *Law Journal*, 713). Let me now consider and outline the class of case in which the coroner is put upon inquiry. He is concerned with the death of a person "if there is reasonable cause to suspect that such person has died either a violent or unnatural death or a death the cause of which is unknown" (Coroners Act, 1887, s. 3); he need not hold an inquest in cases of death from natural causes.

It may be of interest to analyse further the cases of violent or unnatural death and to see how some of them crop up in everyday practice and may present to the practitioner the temptation to issue a certificate which just avoids the coroner being put upon inquiry. I may say that I feel very strongly that the person to decide, in a case of any doubt, is the coroner—many cases are referred to him in this manner, and he is able to allow the practitioner to issue the certificate in the way proposed or desired.

TYPES OF VIOLENT OR UNNATURAL DEATH

These may be due to any of the following circumstances: accident or injury; operative shock and/or anaesthetics; want, exposure, or neglect by others or self-neglect; alcoholism, acute or chronic; drugs and drug addiction; industrial disease. I do not suggest that this list is exhaustive, but it may suffice.

Accident and injury cases include septicaemia following stings or injuries, and osteomyelitis following falls, etc. They also include cases of abortion. In the latter cases I always make some inquiry, and I hold an inquest unless I am abundantly satisfied that the case must be natural. It may be of interest to note that in a fairly short experience I have known of one conviction for procuring abortion in a case which was considered during life to be entirely natural, and another in which the dead woman had made a dying declaration in which she described how she had syringed herself. I always regard this sort of story with suspicion, since it may well originate with the abortionist, as is exemplified in the second case, in which, after I had adjourned my inquest, I received information which led to the arrest and conviction of the abortionist. Indeed, I tend to believe that deaths from natural abortion are very rare. When there is a streptococcal infection, abortion seems likely to be unnatural, and all such cases deserve the most critical investigation.

Operation and Anaesthetic Deaths.—In requesting that deaths after operation and/or anaesthetics (say with-

in twenty-four hours) should be reported to me so that I should at least know of them, I felt that I was on controversial ground in my own district of London. Some may think that coroners are tiresome people whose knowledge may not be up to date and who do more harm than good by holding inquests in, for example, anaesthetic cases, but the coroner and the doctor both have to abide by the law. How can a death which has been brought about, at the time when it occurred, by something external (operation or anaesthetic) be *natural*? It may be not *unexpected*, but that is not the same thing. Nevertheless, cases after operation and those after anaesthetics do not stand quite on the same footing, and I think it is pretty generally allowed that if a person who is already gravely ill dies after an operation (as distinct from dying during an operation or from the anaesthetic), he may die really mainly from his disease. In such cases one may regard the operation and its attendant shock as part of the disease. But cases where the death is due to the anaesthetic are different. There is a modern method of increasing popularity, I think, which deserves mention. I refer to "premedication"—that is, the administration of some drug like paraldehyde, or one of the barbitone group such as nembutal, to produce a drowsy state. The actual operation may be performed under the influence of an anaesthetic of transitory power, such as gas and oxygen. Now some of the drugs used in this way have delayed effects comparable to what used to be called delayed chloroform poisoning. Death may occur long after the patient has come round from the operation, and still be really due to the premedication drug. I think such cases do offer to the practitioner a tempting choice. Should he issue a certificate and give as the cause of death the condition which led to the operation, or should he boldly inform the coroner? It must not be forgotten that new anaesthetics tend to be used in cases where, say, ether or chloroform is contraindicated, and thus they may be on trial in cases where the mortality is already likely to be high. It seems to me that these cases will become more important as the method comes more into vogue.

Cases of neglect, want, etc., do not call for much comment from the point of view of certification except in so far as the Registrar-General requires them for the purposes of statistics. They should, of course, be reported, even though they are not entirely natural. Alcoholism and drugs, on the other hand, do provide medical practitioners with problems from time to time. What is a doctor to do who knows that one of his patients has died of delirium tremens, or of chronic alcoholism, or veronal poisoning, or the like? It is no real way out of the difficulty to issue a certificate for, say, hypostatic pneumonia—the terminal event. The latter is not, to the best of the doctor's knowledge and belief, the real cause of death at all, but if he opens the matter up fully he is not likely to be thanked by the patient's relatives. I think the doctor should issue a truthful certificate, and impress upon the family that he is obeying the law, and that if he evaded it the facts might come to light in a less desirable (or perhaps scandalous) manner.

Cases of industrial disease in which perhaps the widow of a workman is convinced that her husband's death and ill-health are due to his work form the last subject for discussion. Some occupations are admittedly dangerous in producing disease, and it seems that the proper course is for the doctor to give what certificate he can and to report the case to the coroner. It is much better in these cases, as in all the others, that the eventual responsibility for the course adopted should rest upon the shoulders of the coroner, for he is the person who can deal with the matter in any event, and he is now able (since 1927) to do so in cases of natural death, as I have already pointed out, without holding an inquest at all.

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