services. Horst Seehofer, the minister of health, has already announced that statutory health insurance is in his sights. Redefining its scope is promised within the decade.

DOMINIK VON STILLFRIED
Health economist
Institute for Health Care Systems Research, MICHAEL ARNOLD
University of Tübingen, D-7400 Tübingen, Germany Head

1 Arnold M. *Health care in the Federal Republic of Germany.* Cologne: Deutscher Arzteverlag, 1991.
2 Leber W-D. *Risikostrukturausgleich in der gesetzlichen Krankenversicherung.* Baden-Baden: Nomos Verlagsgesellschaft, 1991:85-9.
3 Frevert U. *Krankheit als politisches Problem 1770-1880.* Göttingen: Vandenhoeck & Ruprecht, 1984.
4 Gesetzentwurf der Bundesregierung. *Entwurf eines Gesetzes zur Sicherung und Strukturverbesserung der gesetzlichen Krankenversicherung (Gesundheits-Strukturgesetz 1993).* Bonn: House of Parliament, 1992. (Working paper 12/3209.)

Reporting deaths to coroners

All the legal aspects of dying need re-examining

Start and colleagues confirm the long held suspicion that knowledge of which deaths should be reported to the coroner is no better among senior doctors than it is among their juniors (p 1038).[1] Embarrassingly, doctors in this analysis of fictitious case histories performed "only about half" as well as "experienced local coroners' staff." The fact that these lay officers rely on information supplied by doctors—whose awareness of what may be of medicolegal importance seems questionable—is entirely congruent with other anomalies inherent in the law concerning the disposal of the dead.[2]

Even with a knowledge of the law greater than that offered to the average medical student,[3] the precise legal duty placed on any doctor to report any death remains obscure. There is no statutory duty, and the common law duty referred to by Start and colleagues is that "of every person to give information which may lead to the coroner having notice of circumstances requiring the holding of an inquest."[4] The foundations of this common law duty are difficult to define: the case cited most often dates from 1702 and seems more concerned with the nature of the evidence required for a verdict of suicide.[5] As noted by Polson and Marshall, the duty cannot be enforced unless the failure to report obstructs the coroner,[6] and for such a charge to be proved it is necessary to prove intent to obstruct.[7] It can hardly be argued that lack of knowledge constitutes intent; it might be argued that the common law duty is so nebulous as to be meaningless.

The "local rules" cited by Start and colleagues,[1] having no statutory force, may represent a coroner acting in excess of his jurisdiction. We would not consider that the death in their case 1 would need to be reported, despite the short period of admission, so long as the attending doctor felt able to state the cause of death "to the best of his knowledge and belief."[8] We realise that this may run counter to the conclusion of Brodrick that a primary function of the coroner "is to help to establish the cause of death"[9] but, where the death is not both sudden and of unknown cause, we believe that the proper means of confirming a clinical diagnosis is a hospital postmortem examination.

What is less defensible—whether the clinical opinion of the cause of death is confirmed by a hospital postmortem examination or not—is the apparent inability of doctors to complete a death certificate accurately. In his recent analysis of 500 causes of death Slater found one or more inaccuracies in 29% of certificates,[10] in line with previous findings.[11] Comparison of these two papers is difficult: Slater views "a mode of dying" as unacceptable for inclusion in the cause of death, incorrectly citing recent guidance on completing death certificates published by the Office of Population Censuses and Surveys which, in fact, suggests only that a statement of mode of dying may be unacceptable if it is used alone on a medical certificate.[12] Removing "mode of dying (qualified)" from Slater's analysis almost halves the proportion of inaccuracies to 14·4%—appreciably less than Leadbeatter's estimate that 27·5% of 2085 causes of death were inaccurate.[11] That study also showed that it might be unwise to rely on such inaccuracies being corrected by what Slater refers to as "expert intervention by the Registrar of Births and Deaths."

What can be done? A short term solution that we have adopted, arising from regular audits of deaths in hospital, is for one of us to scrutinise the case notes of all patients who die after admission to medical wards. This is then followed by discussion with junior doctors of the certification or reporting of those deaths. Although time consuming, this appears to help and is similar to practice in Finland, where all death certificates are scrutinised by the provincial forensic pathologist, who requests revision of unsatisfactory entries before the documents are forwarded to the registrar general. Cooperation between committed pathology and clinical staff may also influence the hospital necropsy rate.[13]

A national long term solution, however, requires both debate and reworking of all legislation concerning the dead. A coherent legislative framework is needed to address all activities relating to death. These include the definition, diagnosis, and certification of death; transplantation; the need for hospital postmortem examinations as a part of audit; the role of the present coroner system versus a "medical examiner" system; and the retention of postmortem material for research. Even were parliamentary time and will sufficient to allow such legislative change it would remain necessary to ensure that doctors received education—if not examination—in their medicolegal responsibilities.

STEPHEN LEADBEATTER
Senior lecturer in forensic pathology
BERNARD KNIGHT
Professor of forensic pathology
Wales Institute of Forensic Medicine,
University of Wales College of Medicine,
Royal Infirmary,
Cardiff CF2 1SZ

1 Start RD, Delargy-Aziz Y, Dorries CP, Silcocks PB, Cotton BWK. Clinicians and the coronial system: an assessment of the ability of clinicians to recognise reportable deaths. *BMJ* 1993;**306**:1038-41.
2 Leadbeatter S, Knight B. Anomalies and ambiguities in the disposal of the dead. *J R Coll Physicians Lond* 1986;**20**:273-5.
3 Knight B, McKim Thompson I. The teaching of legal medicine in British medical schools. *J Med Education* 1986;**20**:246-58.
4 Knapman PA, Powers MJ. *The law and practice on coroners.* Chichester: Barry Rose, 1985.
5 R *v* Clerk '702 1 Salk 377.
6 Polson CJ, Marshall TK. *The disposal of the dead.* 3rd ed. London: English Universities Press, 1975.
7 R *v* Purcy and Others [1933]. All E R 630.
8 *Births and Deaths Registration Act 1953.* London: HMSO, 1953:s 22 (1).
9 Committee on Death Certification and Coroners. *Report.* London: HMSO, 1971. (Cmnd No 4810.)
10 Slater DN. Certifying the cause of death: an audit of wording inaccuracies. *J Clin Pathol* 1993;**46**:232-4.
11 Leadbeatter S. Semantics of death certification. *J R Coll Physicians Lond* 1986;**20**:129-32.
12 Ashley JSA. *Completion of medical certificates of cause of death.* London: Office of Population Censuses and Surveys, 1990.
13 Champ C, Tyler X, Andrews PS, Coghill SB. Improve your hospital autopsy rate to 40-50 per cent, a tale of two towns. *J Pathol* 1992;**166**:405-7.