

General practitioners' knowledge of when to refer deaths to a coroner

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SUMMARY

Background. In 1992 about 179 000 deaths were reported to coroners in England and Wales and these represented 32% of the total number of registered deaths. Many of these cases were referred to coroners by general practitioners who certify the vast majority of deaths which occur outside hospitals. The safeguards to society which are provided by the coroner system in England and Wales are undermined if doctors fail to recognize those deaths which should be reported for further investigation.

Aim. A study was undertaken to assess the ability of general practitioners to recognize deaths which require referral to a coroner.

Method. A postal questionnaire consisting of 12 fictitious case histories was sent to all 323 general practitioners in Sheffield and the senior staff of the local coroner's office (two coroner's officers and two deputy coroners). Ten of the case histories contained a clear indication for referral to the coroner.

Results. A total of 196 general practitioners (61%) and all the coroner's office staff returned the questionnaire. General practitioners correctly identified whether or not referral was indicated, with reasons, in a mean of 8.5 cases (range 4–12). Only six general practitioners (3%) were correct in all 12 cases. All of the coroner's staff were correct in all cases.

Conclusion. General practitioners may be failing to bring certain categories of cases to the attention of coroners because of misconceptions or ignorance of their medico-legal responsibilities. General practitioner education in this area, and a closer working relationship between general practitioners and coroners may improve the situation.

Keywords: cause of death; referral of patients; doctors' knowledge; autopsies.

Introduction

THE legal requirements for the investigation and certification of death in England and Wales are generally regarded as among the most thorough in the world. All citizens including

doctors have a duty under common law to report deaths in some circumstances to the coroner. Few people, apart from registrars of births, deaths and marriages, have a specific statutory obligation to report cases and so in practice most deaths are reported by doctors and the police. In 1992 about 179 000 deaths were reported to coroners and this represented 32% of the total number of registered deaths.¹ Many of these cases are referred by general practitioners who certify the vast majority of deaths which occur outside hospitals. The safeguards to society which are provided by the coroner system in England and Wales are undermined if doctors fail to recognize those deaths that should be reported for further investigation.

In a previous study, the inability of hospital clinicians to recognize some categories of reportable deaths was highlighted.² It was decided to undertake a similar study to assess the ability of general practitioners to recognize cases which should be reported to the coroner. All of the local senior coroner's staff were included, to provide a standard against which general practitioners' performance could be measured.

Method

In 1993, all 323 general practitioners listed by Sheffield Family Health Services Authority and the four senior staff at the local coroner's office (two coroner's officers and two deputy coroners) were sent a postal questionnaire consisting of 12 fictitious case histories. The questionnaires were accompanied by a letter from the Department of General Practice, Sheffield University, signed by R S and T U. One reminder letter, enclosing a questionnaire, was sent to non-respondents.

Ten case histories contained a clear indication for referral to the coroner. The design of the study was similar to the previous study² in the use of fictitious case histories which allow demonstration of knowledge in the context in which that knowledge is required.^{3,4} Case histories were carefully based on specific situations which may occur in general practice. Two of the case histories, and their correct answers, are shown in Appendix 1. After each case history the clinicians were asked if they would report the death to the coroner and to state the reasons for their decision. The decision to report cases was at the sole discretion of the respondents. One mark was awarded for a correct answer with no marks for an incorrect answer. A correct answer was defined as an appropriate response together with clear identification of the indication for referral. The maximum recognition score possible was 12.

A preliminary section of the questionnaire asked for information relating to years of service in general practice, possession of the MRCGP, a medicolegal qualification, or other postgraduate qualifications and any participation in specific postgraduate medicolegal education.

Results

A total of 196 general practitioners (60.7%) returned the questionnaire, as did all four of the coroner's staff. Three incomplete questionnaires were excluded from the study, thus results are based on 193 general practitioners. No general practitioner had specific medicolegal qualifications.

The number of questions answered correctly by general practitioners is shown in Table 1. The mean recognition score of the

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Table 1. Number of questions answered correctly by general practitioners.

No. of questions answered correctly	No. of GPs
4	2
5	12
6	16
7	31
8	31
9	40
10	31
11	24
12	6

general practitioners was 8.5 (range 4–12) and six general practitioners achieved a maximum score of 12. Thirty general practitioners (15.5%) recognized half or fewer of the cases requiring referral or otherwise to a coroner. All four of the coroner's staff achieved maximum scores of 12.

There were no significant differences in scores when length of service, possession of the MRCGP or other postgraduate qualifications were taken into account (multiple regression analysis). Twenty one general practitioners (10.9%) reported participation in specific postgraduate medicolegal education but the scores of these respondents were not significantly different from those of the remainder.

The proportion of general practitioners correctly identifying the cases which should be reported to the coroner are shown in Table 2. A high percentage of doctors recognized the need to refer cases of possible suicide, industrial lung disease and possible drug interaction. Two general practitioners indicated that in the case of possible suicide, it would be preferable to record a natural cause of death, in order to avoid possible financial loss to the family. Deaths which resulted from industrial accidents and domestic accidents in which elderly people had fallen were often not recognized as cases that should be referred to the coroner, particularly if a long time had elapsed between the accident and the death. Those general practitioners who referred the latter case often did so for the wrong reasons, citing a history of surgery within one year of death.

The two cases which would not need to be reported to the coroner, involving chronic alcohol abuse and motor neurone disease, were correctly identified by 111 (57.5%) and 182 (94.3%) general practitioners, respectively.

Table 2. Proportion of general practitioners correctly identifying the 10 cases which should be reported to the coroner.

Indication for referral to coroner	% of 193 GPs responding correctly
Possible suicide	89.1
Industrial lung disease	88.6
Death related to drug interaction	88.1
Patient seen by practice nurse but not by certifying doctor in previous 14 days	85.5
Death in police custody	81.9
Self neglect	70.0
Patient seen by GP partner but not by certifying doctor in previous 14 days	57.5
Death related to minor medical procedure	50.3
Industrial accident	46.1
Domestic accident	39.4

Discussion

Most general practitioners are introduced to the medicolegal aspects of medicine during the final stages of the undergraduate medical curriculum. Although some practical experience is gained during hospital and general practitioner trainee posts, many general practitioners appear to acquire much of their knowledge of the coroner system through liaison with the local coroner's office and from colleagues in the practice. The ability of the coroner's staff to recognize all of the reportable cases in this study is indicative of the high standard of advice available to doctors uncertain of their responsibilities. General practitioners should remember that such advice can only be correct if the referring doctor is able to recognize and disclose all of the relevant information. The finding that length of service in general practice did not influence the ability of general practitioners to recognize reportable cases is important and younger partners seeking advice should be aware that senior colleagues may have no better understanding of the coroner system.

All doctors in England and Wales should know the circumstances set out under regulation 51 of the registration of births, deaths and marriages regulations 1968 which require a registrar to refuse to register a death until such time as a coroner has completed appropriate enquiries. Both Northern Ireland and Scotland have separate legislation which can cause confusion when doctors move between areas, and similar problems are encountered with the minor local variations in coroner practice which occur within England and Wales. All general practitioners should be familiar with the particular requirements in their own area. It is unfair to bereaved relatives to send them to the registrar with a death certificate, believing that they can register the death and finally conclude matters, only to be referred to the coroner's office by the registrar who has to refuse to accept the certificate. This avoidable sequence of events, which appears to occur regularly (C D, personal observation), causes unnecessary distress for relatives and diminishes the family's respect for the doctors involved.

Most general practitioners recognized the need to refer to the coroner those cases which involved death in police custody, industrial disease and possible suicide. Two respondents indicated that recording a natural cause of death would be preferable to recording possible suicide in order to avoid possible financial loss to the family. Such action cannot be justified in law. It appears that some general practitioners believe that they have discretion over whether deaths should be referred to the coroner. This confirms a previous suggestion that some general practitioners and hospital doctors frequently modify cause of death statements in order to avoid the involvement of the coroner or 'to avoid further distress to relatives'.⁵ If a death occurs in circumstances which ultimately require referral to the coroner then there is a clear duty for the general practitioner to report the case without delay. Decisions not to refer cases because of potential distress to relatives, embarrassment to colleagues or a failure to see any consequence by referral are misguided. Failure to report cases can have a wide range of outcomes: from serious crime going undetected to loss of industrial pension or other appropriate compensation for relatives. General practitioners are advised to report all deaths about which they are uncertain, remembering that the referral of a case does not automatically result in an autopsy or an inquest. In 1992, autopsy examinations were not held in 29% of cases referred to coroners in England and Wales.¹

Deaths from industrial or domestic accidents were recognized as cases requiring referral to the coroner by fewer than half of general practitioners. Those who did refer the domestic accident case often cited a history of surgery within one year of death which is irrelevant unless the surgery contributed to the death.

The failure to report these types of cases was also observed in the previous hospital-based study and may indicate that many certifying doctors consider only the eventual cause of death rather than the sequence of events leading to death.² In both the previous and present studies, many doctors appeared unaware that deaths resulting from chronic (as opposed to acute) alcohol abuse are no longer reportable unless there is another indication for referral. Cases involving self neglect or neglect by others are often complicated and all doctors would be advised to seek guidance about specific cases in these categories.

The majority of cases referred by general practitioners to the coroner are reported because the general practitioner is unable to give an accurate cause of death. The death may have been sudden, unexpected or the general practitioner may not have attended the patient within the previous 14 days. Many general practitioners considered that attendances within the 14 days prior to death by non-medical practice staff or an absent general practitioner partner were sufficient to allow the general practitioner to complete the death certificate. In both situations, the general practitioner cannot be considered to have attended the patient in person and such cases will have to be reported. Some registrars will not accept an examination of the body as an alternative to attendance during the previous 14 days despite the fact that this possibility is enshrined within current legislation. The coroner can and often will make the decision to allow the general practitioner to issue a death certificate if appropriate.

Although most respondents correctly identified a case involving a drug interaction as one that should be referred to a coroner, a number of general practitioners displayed a reluctance to refer deaths associated with medical treatment, particularly minor surgical procedures. Inappropriate reasons given for non-referral included the avoidance of embarrassment for hospital colleagues and that only a major surgical operation was relevant. There also appeared to be considerable confusion regarding the temporal relationship between a treatment and death. Several general practitioners stated that medical treatment was only relevant if death followed within one year. There is no legal basis for such opinion and all cases in which medical treatment may have contributed to death should be reported to the coroner. This group is not limited to anaesthetics and major surgery but covers the complete range of possible treatments and investigations including the effects of drugs, therapeutic or otherwise.

In addition to identifying some disturbing misconceptions held by respondents in relation to the coroner system in general, this study has identified several categories of reportable cases which may often not be referred by general practitioners. Some general practitioners were unable to identify half of the cases in the study which should be reported to the coroner. There is no reason to suppose that these observations apply only to Sheffield general practitioners.

The following recommendations are put forward: coroners should provide hospital doctors and general practitioners with a regularly updated guide to indications for referral, including information about local variations; general practitioners should seek advice from the coroner, coroner's officer or a senior pathologist regarding all cases about which they are uncertain; vocational training and continuing medical education should regularly address medicolegal subjects, with the participation of pathologists and coroners; postgraduate examinations should assess core knowledge of relevant medicolegal subjects, including the coroner system and death certification; and public awareness of the role of the coroner could be increased through the distribution of a simple explanatory leaflet which is available free from the Home Office.⁶ This leaflet could be given to relatives by general practitioners in cases which are to be

reported to the coroner.

Appendix 1. Examples of two case histories.

Case A

A 51-year-old man suffered severe brain damage and paralysis of his lower limbs after being crushed by a fork-lift truck in a car assembly plant 12 years ago. Since then he has been a long-term resident of a local nursing home and has had frequent problems with pressure sores and lower respiratory tract infections. His general condition has deteriorated gradually over the last year and recently he developed a further chest infection with signs of basal consolidation. The general practitioner initiated treatment but the patient died two days later.

Correct answer: this case should be reported as the death appears to be related to injuries sustained in an accident. The length of time since the accident is immaterial.

Case B

An 81-year-old woman fell down a short flight of stairs in the home for blind people in which she was a resident. She was admitted to hospital and underwent successful surgical fixation of a fractured neck of femur. Despite intensive physiotherapy, she mobilized poorly and was eventually discharged back to the nursing wing of the home. Her condition gradually deteriorated and six weeks after the operation she died after developing a chest infection which failed to respond to treatment.

Correct answer: this case must be reported as there is a strong causal link between the accidental fall and death. There is no distinction between deaths resulting from domestic or industrial accidents.

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Food for thought...

'The weighting of [cardiovascular] risk factors differs between the objective data of epidemiologists and the perceptions of the lay public... These discrepant weightings may represent a [patient's] tendency to weight visible risk factors, such as family history or weight, as opposed to such 'hidden' ones as cholesterol or blood pressure'.

Marteau TM, Kinmonth A-L, Pyke S, *et al.* Readiness for lifestyle advice: self-assessments of coronary risk prior to screening in the British family heart study.

January Journal, p. 5.
