Medical Coroners

SIR,—The Departmental Committee appointed by the Home Office to inquire into Coroners Law has recommended that in future the appointments to the office of coroner should be confined to solicitors and barristers. This is but one of many ill-advised and retrogressive alterations in the existing law suggested by this committee which I hope sincerely will not be given statutory authority, for it would definitely exclude medical men from becoming coroners.

The great bulk of cases dealt with by coroners involve questions of a medical nature, and very few call for any legal knowledge at all. Among the proposals made by the committee is one to confine coroners' inquests to the discovery of the cause of death, and to exclude from the scope of the inquiry all questions of civil or criminal liability. This proposal, therefore, will render the possession of legal training by the coroner even less desirable than it is at present, and will tend to accentuate the importance and value of medical knowledge in the holder of the office. As a matter of fact the actual cause of death in cases of death from violence is already known before any inquest is held. In all fatal accidents in factories, building operations, and in all railway and street fatalities, and so forth, the cause of death is always simply "injuries." It seems fatuous in these circumstances to limit the functions of the coroner's jury to the discovery of what is already perfectly well known, and at the same time to deprive them of their age-old duty of deciding to whose fault, if any, the deaths were attributable.

If, however, this question of legal responsibility for fatalities is no longer to be inquired into by a coroner, why on earth should it be insisted upon that he should be a lawyer? Questions of law seldom arise at present in the coroner's court, and when they do they are of the simplest character, and can quite easily be dealt with by a medical coroner. In the future, if this recommendation be adopted, such legal matters will never occur at all. But medical questions of great complexity arise almost daily in our courts, and in my view these are best handled by medical men, who can, by virtue of their training, easily understand them, whereas a lawyer cannot. Out of 67,000 cases that came before coroners in 1934 only 140 were of murder and manslaughter, and it is chiefly in this class of case that legal questions arise. In street and other fatalities due to violence questions of negligence do arise, but these are relatively few, and, if this proposal of the committee becomes law, even these will disappear, and the jury will, as I have said, sit to decide merely the cause of death, which is already known.

Like my friend Mr. Purchase (September 12th, p. 560) I have had working practical experience for many years of the professions of both medicine and law, and while I am prepared to admit that my practice at the Bar has proved most useful to me in my work as a coroner, I must say, without any hesitation whatsoever, that I have found my medical training and education and knowledge of far greater assistance than my legal practice and experience. The ideal to strive for is a coroner with medical knowledge and also with some legal attainments.

A medical man who has read for and been called to the Bar but who has not actually practised law will be excluded from the office of coroner if this unwise proposal is carried out. In my view the rejection of such candidates for the office of coroner will be a profound mistake, and will be directly opposed to public interest and public safety.—I am, etc.,

London, W.2, Sept. 20th. S. INGLEBY ODDIE.

SIR,—When the Departmental Committee on Coroners issued its report I was permitted to offer criticism of some of its recommendations in your columns. In the *Journal* of September 12th (p. 560) I was happy to find support for my views in the letter of Mr. Purchase, who pronounces on the subject with the authority of a dual qualification.

While, however, he would stress the desirability of selecting for the position of coroners men who have had practical experience of medicine and law, it will be difficult to fulfil this requirement. Few who have been called to the Bar after being engaged in the practice of medicine are willing to renounce one vocation and adopt the other in the remote expectation of securing a coronership. He confirms my opinion that, as regards the relative importance of the "medical" qualification as opposed to the "legal," the former preponderates. Yet, where actual experience of both has not been possible to attain, the practising doctor who is a theoretical lawyer is still admirably suited for this office.

In his lucid observations on the state of conditions now obtaining in the selection of coroners he has perhaps unwittingly referred to a problem which has hitherto been ignored. Section 10 of the Coroners (Amendment) Act, 1926, among other things states: "The Coroners Act, 1892 (which relates to the appointment and powers of deputy coroners), shall apply. . . ." Reference to this Act of 1892 reveals the fact that the appointment of deputy coroners rests with the existing coroner, who, providing the choice conforms to the simple stipulation of "a fit person," can select a person irrespective of capacity or of the minimal professional standard. The sole arbiter is the chairman of a county or borough council or the mayor. This reposes undemocratic power in the hands of officials and civic dignitaries whose favour may be dictated by considerations which are more political and personal than professional.

The evil of this system lies in the fact that it is recommended that the ranks of coroners be recruited from their deputies. While there is no restriction on the free choice of a deputy by a coroner, any suggestions to better existing conditions are negatived by this circumstance.

There have been some instances of appointments of deputies to coronerships apparently made on the slender claim of this previous office, while the superior and double qualifications of other candidates have gone without recognition.—I am, etc.,

Dublin, Sept. 13th. JOHN SHIEL, L.R.C.P., L.R.C.S., Ph.C., Barrister-at-Law.

Health of African Natives

SIR,—The eloquent appeal of Sir Ernest Graham-Little on behalf of the natives in East (not South) Africa, supported by the well-known research work of Drs. Gordon and Vint, induces me to plead for another inquiry, which, to my mind, is equally important. In doing so I do not wish to minimize the importance of the work carried on in their particular field of endeavour, but I would like to lay stress on the fact that where natives are well fed and housed, with the subsequent diminution of parasitic and other diseases, their intelligence and physical fitness show a remarkable improvement, and can be favourably compared with the lower-grade manual workers, even in England, with its ancient civilization.

I plead for an inquiry into the effect of the equatorial climate on the physical and mental well-being of the European in Kenya. After twenty-one years' residence in that country, from which I have recently retired, I could quote many instances in my own practice, whose history after years of persistent struggle against adversity

has ended tragically, and could, in my opinion, be only attributed to the effects of the climate on the nervous system—effects which are insidious and progressive in their nature. After all, the natives of Africa are endowed by nature with a certain degree of protection against the deleterious influences of the sun's rays, but no such protection is inherent in the European, and when to this is added the susceptibility to diseases peculiar to a tropical climate, and the struggle for existence in a country in which by nature he is not fitted, it is not surprising that a nervous breakdown is a common occurrence.

To my mind the problem of native backwardness is more or less solved by improved hygienic measures, diet, and education, but the question of European fitness for residence in a tropical climate like East Africa goes deeper, and, I submit, is equally worthy of inquiry.—I am, etc.,

M. MACKINNON, M.D., D.P.H.

Twickenham, Middlesex, Sept. 15th.

SIR,—Will you allow me to correct the heading you have given to my letter in the *Journal* of September 12th (p. 560). My letter, as the text amply demonstrates, was concerned entirely with communities outside the Union of South Africa, which would be primarily responsible for the welfare of South African natives, and your addition of the word "South" to my title "African Natives" conveys a wrong impression, which I am anxious to avoid.—I am, etc.,

London, W.1, Sept. 15th. E. GRAHAM-LITTLE.

Anaemia and Toxaemia of Pregnancy

SIR,—The paper by Drs. Jocelyn Moore and E. M. Pillman-Williams on anaemia and toxaemia of pregnancy, which appears in the *Journal* of September 12th (p. 528), concludes with the sentence: "In other words, when the haemoglobin value is kept up in the region of 90 per cent. the incidence of toxaemia is lowered." In view of the importance of a careful and orderly approach to the difficult problem of the causation of the toxaemias of pregnancy, it appears to us to be profoundly unsatisfactory that such an emphatic statement should be published in a journal of the standing of the *British Medical Journal*, when examination of the data proves it to be entirely baseless.

Neglecting altogether to take into account the authors' curiously broad interpretation of toxaemia—which appears to include headache, nausea, vomiting, heartburn, and cramps at any stage of pregnancy—the evidence appears to be that one out of thirty-five iron-treated patients showed toxaemic symptoms, whereas six out of thirty-four patients not treated with iron showed such symptoms. As the authors provide data to the effect that of approximately 1,100 patients delivered in the institution in which they work 5.8 per cent. exhibited toxaemic symptoms, it is simple to calculate that the most probable number of toxaemic cases to be found in any group of thirty-four to thirty-five is two. It follows that the "control" group of thirty-four cases, in which six toxaemic patients were found, was quite unrepresentative of the population from which it was drawn. This is not very surprising in view of the small size of the group. On the other hand, the one toxaemic patient in the iron-treated group of thirty-five conforms much more closely to expectation, and it would obviously have been impossible, even if no toxaemic cases had occurred in this group, to draw any valid conclusions concerning the effect of iron. If the control group can deviate by four cases from expectation no significance can be attached to a deviation of two cases in the treated group. The only conclusion that can be drawn with propriety from these figures is, therefore, that the data are inadequate for the provision of any information on the relation between anaemia and toxaemia of pregnancy.

The authors of this paper also include a table in which the frequency of incidence of toxaemia in patients having different haemoglobin concentrations is shown. They make no comment on this table, but it seems to be the only possible source of the figure of 90 per cent. quoted at the beginning of this letter. The table is reproduced below.

Haemoglobin Content:	50–59%	60–69%	70–79%	80–89%	90%+	Total
Cases of toxaemia	1	3	12	9	2	27
Cases of toxaemia and chronic nephritis	1	—	—	—	1	2
Total	2	3	12	9	3	29

It means nothing unless we know what proportion of all cases would fall into each of the above groups. Fig. 1 of the paper by Fullerton (p. 523), which immediately precedes the paper which we are considering, indicates that in all probability the proportion of toxaemic cases to the total number of cases in an adequate series would be very similar in all the haemoglobin groups. But Fullerton's patients do not form adequate controls to the patients under consideration, so that here again no useful conclusion can be drawn. In other words, there is certainly no evidence here available from which one may conclude that the incidence of toxaemia is lessened when the haemoglobin is kept up in the region of 90 per cent.—We are, etc.,

MARY FISHER, M.R.C.S., L.R.C.P.,
Public Health Department, City of Oxford.
R. B. FISHER, Ph.D.,
Department of Biochemistry, University of Oxford.

September 14th.

National Maternity Service

SIR,—Dr. C. L. Somerville's solution of our midwifery problems (*Journal*, September 12th, p. 561) seems a simple one: there are certain difficulties in midwifery conducted in the patient's own home, therefore patients should go to a maternity hospital, where they will be delivered by "general practitioner specialists" (capable of doing Caesarean sections and operations for ectopic pregnancies), and it follows that the B.M.A. policy is all wrong.

But how far is this proposal based on facts or practical considerations? There will always be the doctor who cannot do any work unless he has much apparatus and many helpers, and he will naturally prefer to work where these facilities can be obtained—that is, in hospital. There will always be, we hope, the other type of doctor, who appreciates the importance of the essential parts of his technique as distinct from the outward forms and observances, and he will be found in general practice, conducting confinements with (we have it on good authority) results which are not inferior to those obtained in hospitals.

There are several reasons for his success. He has lost that childlike faith in asepsis with which we all leave our training schools, realizing that the towels and other contents of the drum are seldom sterile for long once