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Negotiating the Unusual, Classifying the Unnatural
The Reporting and Investigation of Medical-related Deaths in England and Japan

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Abstract This chapter compares the Japanese system of reporting and investigating medical related deaths with the coronial system as practiced in England and Wales, focusing on the categorisation of deaths as 'unnatural' or 'unusual' – terms which have become increasingly problematic, ambiguous, and difficult to apply in a context of rapidly changing medical technologies. The chapter examines the legislation and institutionalised frameworks for investigation of medical related deaths in Japan and in England and Wales, and uses this material to cast light on broader issues. Some key questions here are definitions of 'natural' and 'unnatural' and the ways in which the idea of 'culture' may be deployed in debates over the classification and appropriate investigation of medical related death. The chapter also considers variations in notions of personhood and agency, and understandings of the body, and the ways in which globalised systems of knowledge, in this case medical and legal understandings of the body, and of death, may be refracted and negotiated in particular local settings.

Keywords Death. Personhood. Body. Natural. Unnatural. Coroners. Autopsy. England. Japan.

In comparing the Japanese system of reporting and investigating medical-related deaths with the coronial system as practiced in England and Wales, the similarities in the dilemmas faced are striking.[1] In both

1 The present work refers to death investigation systems in place in England and Japan as of July 2016. As this is a rapidly changing field, further changes in the formal frameworks of these systems will undoubtedly have taken place between the time of writing and publi-

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cases, advances in medical technology have led to a situation where existing categories of 'unnatural' or 'unusual' become increasingly problematic, ambiguous, and difficult to apply. At the same time, the growing complexity of medical care, and the number of different individuals, systems and procedures involved in the processes of testing, diagnosis, and medical treatment, have probably led to an increased potential for (possibly fatal) errors. Legislation and institutionalised frameworks for investigation of medical-related deaths in both countries struggle to keep pace with these changes. And questions of bioethics, notions of personhood, the role of the bereaved family, and beliefs concerning the body and the process of death are also important concerns in both Japan and the UK.

In this article, I compare the two systems in order to address two main objectives. Firstly, I seek to examine and compare the differing ways in which these common problems are addressed in these two settings, exploring the contrasts and similarities between them in terms of institutional and legal frameworks, as well as in the broader socio-cultural context. Secondly, I seek to use this material to cast light on broader theoretical issues: some key questions here are definitions of 'natural' and 'unnatural' and the ways in which the idea of 'culture' may be deployed in debates over the classification and appropriate investigation of medical-related death, as well as variations in notions of personhood and agency, and understandings of the body. More broadly, I explore the ways in which globalised systems of knowledge, in this case medical and legal understandings of the body, and of death, may be refracted and negotiated in particular local settings.

The issues raised here echo broader concerns of medical anthropology, more specifically those foregrounded in some other recent anthropological work focusing on rapidly changing medical technologies which span both medical and legal domains. Some key works here are Strathern (1992), Edwards et al. (1999), Franklin (1997, 2003), and Franklin and Roberts (2006) on new reproductive technologies and kinship; Franklin and Lock (2003) on the "remaking of life and death" in the context of an anthropological examination of the biosciences; and Franklin, Lury, and Stacey (2000) on globalisation and understandings of nature and culture. Margaret Lock's work (1997, 2001, 2002, 2005) has been very influential not only in the anthropology of Japan, but also in medical anthropology more generally.

Lock's work on organ transplantation and the contested notion of brain death is of particular relevance to this paper. Lock highlights the diversity of opinion within Japan and North America on these issues, and also takes a critical look at the assertion within Japan by one particularly vocal strand of opinion that Japanese aversion to organ transplantation can be

cation. However, as argued below, the underlying issues identified here are long standing ones, and the debates explored are likely to remain of relevance to researchers on this topic.

explained in terms of 'tradition', or culturally specific beliefs concerning the body. This is contrasted by these same commentators with "the perceived cultural vacuum of America […] this dearth of 'culture', in their opinion, facilitates the implementation of medical technology without regard to ethical and moral implications" (Lock 2002, 5). In fact, Lock demonstrates convincingly that the situation is far more complex than this opposition suggests, and that the history and practice of organ transplantation in North America, as in Japan, has been influenced by a range of factors, therefore certainly does not proceed in a cultural vacuum.

Similarly, in my discussions with medico-legal specialists in Japan, I often encountered the assertion that the Japanese have a particular resistance to autopsy because of their beliefs concerning the body. This was coupled with the assumption that no such resistance would exist in England, which tended to be perceived in a rather similar way to Lock's remarks on (some) Japanese perceptions of America, as an implicitly 'culture-free' zone, where medical investigations could proceed unimpeded by such considerations. The material presented below echoes Lock's findings for attitudes to organ transplantation, in that it seems that attitudes in both England and Japan regarding autopsy are more complicated than this imagined opposition of the two would suggest. The appeal to cultural difference as a means of resistance to autopsy can be found in England as well as Japan, in part reflecting the cultural diversity of contemporary British society. And in Japan (as in England) opinions on autopsy are divided, and it is by no means clear that all opposition to autopsy in Japan is based on culturally specific beliefs concerning the body.

Another important aspect of Lock's work which relates to the material presented in this paper is the question of what is 'natural' where death is concerned. As Lock (1997, 2002) points out, the idea of a 'natural death' is far from self-evident; this point has become particularly problematic with the introduction in recent decades of the category of brain death in the context of organ donation. More broadly, although the dominant view of 'nature', particularly in the context of modern scientific and biomedical discourses, has become that of something objective and independent of culture, in fact our perception and understanding of what is natural is always filtered and influenced by a range of factors which can be viewed as cultural (we might include here language and education, for example, as well as broader socially accepted regimes of knowledge).

Our understanding of what is natural therefore varies, depending in part on both historical and socio-cultural context.[2] Franklin, Lury and Stacey (2000, 1), in a volume on globalisation and shifting notions of nature

2 There is an extensive literature on this topic. On the concept of nature in the English language see for example Williams 1976, 1980; on varying notions of 'nature' in the context of the environment see Ellen and Fukui 1996, Weller 2006; on historical shifts in European

and culture discuss "the power of nature, not as a static concept or even as a flexible sign, but rather as a shifting classificatory process", while Lock (2002, 51) argues for 'empirical investigation' of the ways in which boundaries between the natural and cultural are constituted "in specific historical and geographical locations", while also underlining the fluidity of these boundaries in the light of technological transformations.

It is useful to bear these comments in mind when examining the ways in which medical-related death is classified and investigated in England and Japan. The debate over the definition of 'natural' is not simply of theoretical interest here: from the point of view of the two countries' respective legal systems, the key question in determining whether or not a death should be investigated is whether the death was 'unusual' (Japan) or 'unnatural' (England and Wales). The ways in which the process of death investigation is negotiated in practice also relates to areas noted by Lock as important in the context of organ donation, in particular the interaction between bereaved relatives and medical and legal professionals, and also concepts of the body and its (in)alienability after death. This is thus a topic where a number of perspectives and domains of interest intersect – anthropological, medical and legal – and where the issues raised have important theoretical and practical implications. This article aims to contribute to these wider debates.

1 Background: Finding the Field

The impetus for the research presented here arose initially not from a theoretical perspective but from a practical one. In the early 2000s, in Japan there was a growing concern that the causes of deaths, in particular preventable deaths, in hospitals were not being adequately investigated, and that important lessons about patient safety and risk management were therefore not being learned. This concern was exacerbated by a number of high profile cases of medical error which were widely reported in the Japanese press from the late nineties onwards. The first of these cases to attract widespread media coverage involved the death of a patient from the accidental injection of disinfectant at Hiroo hospital in Tokyo in 1999. [3] The repercussions of this case in particular were significant, and led to a debate over the interpretation of the law relating to the reporting of death, and calls for changes in practice regarding the reporting of medical-related deaths.

conceptions of nature see Teich, Porter and Gustafsson 1997; on Japanese images of nature see Asquith and Kalland 1997, as well as the work on new medical technologies referred to above.

3 See Kishi et al. 2010 for an analysis of changes in the reporting of medical-related events in the Japanese press since the nineties. The authors note a sharp rise in the number of newspaper reports on medical error after the Hiroo incident (Kishi et al. 2010, 33).

In the course of this debate on the reform of the death reporting system in Japan, a particular focus has been the requirement in article 21 of Japan's Medical Practitioners Law, which requires physicians to report any 'unusual death' (*ijōshi*)[4] to the police. Until the late nineties, this provision had attracted little attention, and had not been generally interpreted as applying to medical-related deaths. However, in the Hiroo case, the director of the hospital was prosecuted, and eventually convicted, of violation of article 21, as well as falsification of the death certificate (Higuchi 2008, 258-60). Since this case, article 21 has become the centre of an intense debate on death reporting in Japan, with a number of commentators pointing out that the obligation to report an 'unusual death' to the police, combined with the absence of any independent mechanism for investigating medical-related deaths, acts as a disincentive to doctors to report such deaths, as it would make them potentially subject to a criminal investigation (Yoshida et al. 2002, Yoshida 2005, Ikegaya et al. 2006). This in turn has serious implications: it seems likely that some cases of medical error are not being reported, and lessons are therefore not being learned (Yoshida 2005); and there is also evidence that high-risk patients are being turned away from hospitals because of anxiety among medical providers that such cases may ultimately involve the hospital in a criminal investigation if the treatment provided is unsuccessful (Starkey, Maeda 2010, 4).

Some important recent initiatives have therefore centred around the suggestion that an independent system for investigating medical-related deaths should be established to replace the current criminal investigation system. In September 2005, a small scale independent investigation system, the Model Project for the Investigation of Medical Practice-Associated Deaths was launched on a trial basis. This was initially in four areas of Japan (Tokyo, Osaka, Nagoya and Kobe) in which a medical examiner system existed, and later expanded to cover ten areas (Nakajima et al. 2009).[5] And in 2008, the Ministry of Health, Labor, and Welfare proposed a new 'third party' system of death reporting, whereby instead of reporting patient deaths to the police, as required under the provisions of article 21, doctors would report to a 'Medical Safety Investigation Committee' which would include pathologists, internists and lawyers as well as patients' representatives (Starkey, Maeda 2010, 4).

In 2010, this resulted in the establishment of the Japanese Medical Safety Research Organisation, later in October 2015, a new medical ac-

4 *Ijōshi* is often translated as 'unnatural death' in the literature and by professional bodies – for example, this is the translation used by the Japanese Society of Legal Medicine on their website. This is consistent with the terminology used in the English legal system, as discussed in greater detail below. However, here I have preferred to use the more literal translation of 'unusual death'.

5 See also Fukayama's 2008 review of the model project.

cident investigation system came into effect, establishing independent centres (Medical Accident Investigation and Support Centres) whose role is to investigate 'unforeseen' deaths caused by medical treatment referred to them for investigation by medical institutions. However, there are significant ambiguities in this new system: it is not clear what constitutes an 'unforeseen' death; at the time of writing article 21 remains in force with considerable uncertainty as to which deaths are meant to fall under the remit of the new system, as well as to which should be classified as unusual deaths falling under the scope of article 21. The suggestion is that article 21 should be interpreted as having a much narrower scope than previously, but this remains to be clarified.

Trying to establish an independent investigation system, concerned Japanese professionals, working together with the Ministry of Health, Labor and Welfare, have been interested to examine independent systems of death investigation used in other countries, notably the coronial system which is used in a number of countries, including the UK, and considering what aspects of such systems might be suitable for introduction in Japan. As a part of this background research, Professor Yoshida, a forensic pathologist working at the University of Tokyo closely involved in the model project for the investigation of Medical Practice-Associated Deaths in Japan, asked me to look at the coroners' system of England and Wales, and consider what aspects of this system might be transferable to Japan.

Between 2005 and 2007, I undertook a preliminary study for this project, focusing on coroners' offices in England and Wales.[6] As part of this research, I conducted in-depth interviews with six coroners, two of whom had both medical and legal qualifications, with the remaining four having only legal qualifications,[7] and one coroners' officer in various regions of England, I also attended several coroners' inquests, plus one autopsy. In addition I interviewed several hospital doctors and one bereavement officer.[8] I did not approach any bereaved families for this study, but I have consulted documents produced by organisations representing bereaved

6 I gratefully acknowledge the support of Professor Yoshida, and of the Daiwa foundation and the Sasakawa foundation for this project.

7 Until June 2013, coroners could have either medical or legal qualifications, though in practice a large majority had only legal qualifications. From June 2013 all newly appointed coroners must have legal qualifications, although existing coroners with only medical qualifications are able to retain their current posts. The minimum qualifications for coroners in England and Wales are discussed further below.

8 Although I have not identified them by name in order to preserve their anonymity, I am very grateful to all the coroners, coroners' officers, and medical professionals who gave so generously of their time, and provided invaluable insights into the death reporting and investigation system in England and Wales.

families as well as other published reports in order to gain an insight into their perspectives. Professor Yoshida also generously made available to me the results of his team's research in Japan, which I have drawn on in the section on Japan below.

This research was conducted at a time when the English system of death investigation was also under public scrutiny following a succession of high profile scandals in the later nineties, which raised questions about the reporting and investigation of medical-related deaths. Some key events in UK were the public inquiry launched in 1998, regarding the high death rate in children undergone cardiac surgery at the Bristol Royal Infirmary between 1984 and 1995 – the Royal Liverpool Children's Inquiry, set up in 1999 following the organ retention scandal, centering on the Institute of Child Health at Alder Hey in Liverpool – and the Shipman Inquiry carried out from 2001 to 2005, into the case of Harold Shipman, a general practitioner (GP) who was convicted in 2000 of the murder of 15 of his patients. [9]

Taken together, these inquiries raised serious questions about aspects of death reporting and certification, and also the treatment of bodies, in particular with regard to post mortem examinations and the retention of human tissue. All these are issues that concern the coroner under the system currently deployed in England and Wales, therefore in light of these scandals the coronial and death registration system came under review in England, as did the treatment of human tissue. In 2003 the Luce Report, "Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review" was published, followed the year after by the Human Tissue Act, regulating the removal, storage, and use of human organs and other tissue, ultimately replacing the Human Tissue Act of 1961 and the Human Organ Transplants Act of 1989. The Human Tissue Authority was established as licensing and regulating authority in order to oversee the implementation of this Act.

Also in 2004, the British government published a position paper on the reform of the Death Registration and Coronial System, followed by a draft Coroners' Bill in 2006. The draft bill came under criticism from both the Coroners' Society of England and Wales and the British Medical Association, resulting in some changes to the proposals and a further period of consultation and discussion. The resulting Coroners and Justice Act was eventually passed in 2009, but subsequently underwent further modification,[10] with a further period of consultation on the Bill in 2012. A set of revised

9 For further details see reports listed in the "Websites, reports, legislation and statistics" section of the bibliography.

10 For example, the newly established post of Chief Coroner was first scrapped, as part of a programme of government cutbacks in 2010, and then reinstated, with the first Chief Coroner appointed in May 2012 (Palmer 2012).

coroner rules and regulations, and a new statutory framework for coroner investigations and inquests, were implemented in July 2013.[11]

The early 2000s, then, was a period when the process of death reporting and investigation, particularly in regard to medical-related deaths, came under intense public scrutiny both in Japan and in England. Both systems have been heavily criticised and have been undergoing major change, a process that is continuing.

The initial research for this paper was largely conducted prior to the recent legislative reforms outlined above. But despite recent legislative changes, the material presented here remains relevant, partly in so far as it relates to informal processes of decision making and negotiation within the two systems, but also because in part the reforms have left many key features of the two systems intact, as I argue further below.

The key issue addressed here is that of how decisions are reached regarding which medical-related deaths should be reported and investigated within the two systems. On what basis is this decision made? How does the decision making process differ in Japan and in England, and how does this relate to the different institutional and legal frameworks in the two countries? What ambiguities and points of tension arise in the reporting and investigating systems? The next section of this paper discusses the system of death reporting and investigation of medical deaths in Japan, followed by a discussion of the situation in England. In the concluding section I compare the two, and reconsider the broader theoretical issues identified at the beginning of this paper in the light of this material.

2 Japan

2.1 Negotiating 'Unusual' Death

As noted above, article 21 of the Medical Practitioners' Law in Japan states that all 'unusual deaths' (*ijōshi*) must be reported to the police within 24 hours. However, there is some debate over what constitutes an unusual death, particularly in the context of medical-related deaths, since the category of *ijōshi* is not defined by law. Article 21 has been part of Japanese law since 1874, but understandings of 'unusual death' in court decisions, academic opinions, and government statements, have shifted over time. Pre-war, the Supreme Court defined unusual death as "a death in any situation that caused doubt as to simple death by disease" (cited in Higuchi

11 At the time of writing a post implementation review was underway to assess the impact of these changes.

2008, 259).[12] In 1981, the Ministry of Health and Welfare explained that article 21 existed to facilitate the detection of crime, as doctors would be in a position to observe signs of crime in bodies that they examined: "Since dead bodies or stillborn babies sometimes show signs of crimes including murder, assault resulting in death, damage to a corpse, and criminal abortion, for the convenience of the police, obligation to report such unusual cases has been prescribed" (cited in Higuchi 2008, 259).[13]

As Higuchi (2008) notes, there is no mention here of possible medical error or negligence. However, in 1994 the Japanese Society of Legal Medicine (JSLM) suggested that the category of 'unusual death' should comprise "all deaths except those for which there is firm evidence that the death resulted from an internal disease process" (Japanese Society of Legal Medicine 1994).[14] The JSLM divides such deaths into a number of possible categories, including unexpected or suspect deaths associated with medical practice. Criteria listed by the JSLM on their website for considering a medical-related death as 'unusual' are:

- When the death occurred either during, or relatively soon after a medical procedure such as: injection, anaesthetic, operation, medical examination/test, childbirth
- When the medical procedure itself may have contributed to the death
- When the death occurred suddenly during, or immediately after a medical procedure and the cause of death is unclear
- When there is a possibility that there may have been a medical error or medical negligence

In 1995 the Ministry of Health and Welfare endorsed these guidelines (Higuchi 2008, 259), however, they have been criticised by the Japan Surgical Society (Nippon Geka Gakkai) on the grounds that if all deaths during medical procedures were reported this would have a detrimental effect on medical care, and would destroy the relationship of trust between the doctor and the bereaved. Furthermore, the society argued that if these guidelines were accepted as an interpretation of the law, this would violate doctors' rights not to incriminate themselves (Japanese Society of Legal Medicine 1994).

The last of these objections is particularly revealing: the problem here, as Yoshida (2005) and others have forcefully argued, is that the obligation to report an unusual death to the police along with the absence of an independent authority that can investigate medical-related deaths with-

12 Cited in the Report of Court Decisions, vol. 24, issued 28 September 1918, page 1226.

13 Yamauchi, T. [Head, General Affairs Division, Health Service Bureau, Ministry of Health and Welfare]. Interpretation of the Medical Care Law and Medical Practitioners Law/Dental Practitioners Law. Revised 14th edition. Tōkyō: Igaku-tushinsya 1981, 360-1.

14 All translations are the Author's, unless otherwise specified.

out addressing questions of civil or criminal liability, acts as a powerful deterrent to reporting by medical staff. Reporting of a death to the police triggers an investigation in which the medical staff involved potentially become suspects. As Leflar and Iwata (2005, 217) note: "the possibility of criminal sanctions and adverse reputational consequences could create, in the minds of medical personnel, the incentive to cover up medical mishaps".[15] As mentioned above, the introduction of the new independent third party medical accident investigation system in October 2015 aims to address these concerns, nonetheless at the time of writing article 21 still remains in force. While the intent appears to be to apply a new, more restrictive definition of unusual death – which would exclude many medical-related deaths – exactly which deaths will continue to fall under the scope of article 21 and which will be referred to the new investigation system, remains unclear, although this due to be clarified by June 2016. In sum, the category of 'unusual death' remains a disputed one in medical and legal circles, and the extent of the duty to report medical-related deaths is also unclear.

Following the Hiroo case, concern over the reporting of deaths in hospital was heightened among medical professionals, as the hospital director was prosecuted, and convicted, under the provisions of article 21, for failing to report an unusual death. In the wake of this case, media reporting of medical accidents increased markedly (Kishi et al. 2010, 33), and several professional bodies, including the Japan Surgical Society, without retracting their previous objections to the JSLM guidelines, called for voluntary reporting of medical-related deaths to the police as a means of accountability, and in order to restore public trust in the medical profession (Leflar, Iwata 2005, 218). In terms of actual numbers of reports made of medical-related death, a steep increase is observable in the reports of such deaths after the Hiroo case. Medical accidents (including injuries as well as deaths) reported to the police jumped from 31 in 1998 immediately before the incident, to 124 in 2000, and 248 in 2003 (*Nihon Keizai Shinbun* April 30 2004, cited in Leflar, Iwata 2005, 219).[16] As shown by Starkey and Maeda (2010) the vast majority of the increase in reporting of medical-related deaths following the Hiroo incident was accounted for

15 The reporting of an unusual death to the police does not always trigger a criminal investigation – after reporting, the death may be placed by the police into one of three categories: criminal case, suspicious case, or non-criminal case, depending on the circumstances of the death and the police investigators' judgement (Fujimiya 2009, 57). However, the possibility that the death could be categorised as a criminal case, and thus subject to criminal investigation, remains a real issue for medical staff faced with decisions on whether or not to report a death.

16 There was a fall in reports in 2004 and 2005, followed by an increase again in 2006 and 2007 to similar levels to the 2003 figures, see Starkey, Maeda 2010.

by reports made by physicians – reporting of patient deaths by next of kin did not increase significantly over this period. Prosecutions of healthcare providers have also increased markedly since the Hiroo incident, although only a little under a quarter of these resulted in a criminal trial (Starkey, Maeda 2010).[17] As Leflar and Iwata point out (2005, 219), this tends to indicate that the threat of criminal proceedings does not inevitably lead to medical providers concealing medical accidents. In a privatised system such as that which exists in Japan, where hospitals compete for patients and adverse publicity is itself a powerful sanction, there may be an incentive for hospitals to take the initiative in revealing medical-related deaths and thus appearing to be accountable and transparent, rather than risking a scandal of the sort that happened at Hiroo.

However, overall, the reporting of unusual deaths in Japan remained low both in comparison with England and Wales, and with other nations with a system based on the English coronial system. According to Yoshida (2005), between 2000 and 2001, the total rate of deaths reported as unusual (including not only medical-related deaths, but also homicides, suicides, and accidents) was only 12% for Japan as a whole, with an autopsy rate of 1.3%. This contrasts sharply with the figures for England and Wales for 2001: 37.8% of deaths in that year were reported to the coroner, with an overall autopsy rate of 22.8%.[18] The figures for England and Wales are admittedly relatively high (cf. Luce et al. 2003, 19). However, figures taken from a range of jurisdictions in countries using some variant of the coroners' system, including Ireland, parts of Canada, Australia, New Zealand, and the United States, show an overall autopsy rate over the same period ranging between 7% and 11% – much lower than the figures for England and Wales, but far higher than in Japan (Yoshida 2005; Luce et al. 2003, 19).

While the fear of exposure to a possible criminal investigation is probably a factor in the low rates of reporting of medical-related death, other factors may also play a part. One recent study found that of 274 respondents to a postal survey of members of the Japan Society of Internal Medicine regarding the reporting of medical-related death, over 60% did not know the JSLM definition of unusual death. The authors of this study also concluded that doctors were strongly influenced in their decisions on the reporting of deaths of patients under their care by the question of whether

17 See also Sawa 2008 on the criminalizing of medical malpractice in Japan, and debates surrounding the interpretation of article 21.

18 Since 2001, the rate of reporting deaths to the coroner in England and Wales has increased to 45% according to official figures, while the rate of autopsy has decreased somewhat to 40% of deaths reported to the coroner, giving an overall autopsy rate of 18%. (Ministry of Justice May 2015). These figures, and some problems with the reliability of statistics on deaths reported to the coroner, are discussed further in the section on the coroner's system in England and Wales below.

or not they had obtained 'informed consent' for the procedure, with doctors tending to believe that having obtained informed consent exempted them from the requirement to report a death, even when this resulted from medical error (Ikegaya et al. 2006, 114-6).

2.2 Informed Consent: Agency, Autonomy, and the Importance of the Family

In considering these findings, it is important to bear in mind that 'informed consent' is not necessarily understood in the same way in Japan as it is in the USA or the UK (Leflar 1996; Long 2005, 82-6). Leflar (1996, 11) cites in this regard the 1990 report by the Japan Medical Association's Bioethics round table that stated: "we must consider our history, cultural background, national character, and national feelings in creating a concept of 'informed consent' appropriate for Japan". Again according to Leflar (1996), the category of 'informed consent' in Japan seems to encompass a wide range of practices, from a detailed explanation to the patient of a procedure altogether with its potential risks, benefits, and possible alternatives, to a generalised conversation between the patient and the doctor, or even an explanation to the patient's relatives about the risks involved in a procedure, without involving the patient at all. Low, Nakayama and Yoshioka (1999, 180) note that, in the debate on how informed consent should be interpreted in Japan, those arguing for adaptation to the Japanese cultural context emphasised the involvement of the family in the decision making process on the basis that: "the Japanese are family and group-oriented and, because of this, Western rules such as informed consent which are based on the concepts of the primacy of the individual are not appropriate for Japan". Kimura, one of the founders of bioethics in Japan, has commented on this issue:

> The principle of autonomy, usually referred to as one of the important bioethical principles in the Western social context, might not apply effectively within the Japanese cultural tradition. This is because Japanese culture, nurtured in Buddhist teaching, has developed the idea that the egoistic self should be completely suppressed. To be autonomous and independent as an individual has been regarded as an egocentric idea, one which does not address the need for people to be dependent on each other in the family, social, economic, and political community. (Kimura 1992, 151, cited in Long 2005, 85)

The importance attached by doctors and other medical staff in Japan to the views of the family of the patient has also been documented by Fetters and Danis (2000), in a comparative study on Japanese and US physicians' car-

egiving practices and approaches to withholding life-sustaining treatments. Fetters and Danis contrast the importance accorded to ascertaining the patient's family's views in Japan with the tendency among physicians in the United States to emphasise the patient as independent agent and decision maker, and to correspondingly de-emphasise the role of the patient's family in medical decision making. For a minority of the US physicians surveyed, this even extended to viewing the family's involvement as obstructive.

Long (2005, 87-92), writing on end-of-life care and disclosure (or non-disclosure) of a terminal illness diagnosis, concurs that the involvement of the family is thought as important for many in Japan, but points out that there is a debate on the subject of informed consent in Japan, arguing that various 'scripts', or possible narratives,[19] for understanding informed consent co-exist. The first of these is labelled by Long as "the medical school script", in which emphasis is placed on the authority of the doctor, who is assumed to be acting in the best interests of the patient. The "developed nations script", is described by Long as "based on American bioethics and international human rights standards", and assumes that "the patient is an autonomous agent whose decisions must be respected by medical staff and family as long as he or she is competent" (Long 2005, 88).[20] Both the remaining scripts suggested by Long, the 'caregiver' script and the 'family autonomy' script, emphasise the importance of the family. Importantly, these scripts locate ideas of personhood and hence the appropriate locus of decision making in the relationship between individual and family, although with some subtle differences, for example the incorporation of the notion of surrogacy in the decision making process for the family autonomy script. Practically, Long argues that different individuals may draw on different scripts, hence the continuing debate in both medical and legal circles on what informed consent should mean in Japan, and how it should be applied.

Returning to the question of medical-related deaths, it seems that where a death has occurred following medical treatment, the notion of 'informed consent', with its attendant ambiguity concerning the involvement of family members in the process, may blur into the broader area of obtaining the "understanding of the bereaved relatives" (*izoku no nattoku*). This was identified by both the Ikegaya study cited above, and also by another study by Kawai[21] as a key factor in influencing the decision of doctors on whether

19 Long draws here on the concept of 'scripts' as used in sociological studies of death – see e.g. Seale 1998. She defines scripts as "symbolic narratives of behaviour, thought, and interaction, by which culturally appropriate decisions can be made", and also notes that they are "porous and flexible, open to culling and merging in creative new ways" (Long 2005, 205-7).

20 Long also recognises that actual practice in the United States and western Europe does not always correspond to this ideal.

21 Mr. Kawai's study is unpublished.

a death should be reported to the police (Ikegaya et al. 2006; Kawai et al. s.d.). In initial discussions that I had with Mr. Kawai and others in professor Yoshida's research team about doing a parallel questionnaire study to Kawai's study in England, the idea of asking a question about the importance of obtaining informed consent "either before or after death" was raised. This is a logically impossible question in the English system, which locates the capacity to give informed consent with the individual patient, but makes sense in (one possible) Japanese view in which informed consent may also closely involve the family.[22] It is also interesting to note here that generally the term 'informed consent' is used in English by Japanese medical professionals, perhaps contributing to the lack of clarity and debates about its meaning. The Japanese language alternative sometimes used is *setsumei to dōi* – literally, "explanation and agreement" (Long 2005, 83). However, this does not indicate who is doing the explanation or the agreement, or at what stage in the process.

Ikegaya et al. note in this regard, "even giving an explanation to interested parties after a death is apparently seen by Japanese physicians as a safeguard that relieves them of the duty of reporting [medical-related deaths]" (Ikegaya et al. 2006, 116). This is not the only factor influencing the decision whether or not to report a death: the most important consideration found by Kawai's study was whether or not medical error had occurred. In cases of clear medical error a majority of doctors said that they would report the death, regardless of the attitude of the bereaved relatives. But in cases where it was not clear whether or not a medical error had occurred, or where there was no medical error, the attitude of the bereaved relatives had a very significant influence on the doctor's decision on whether or not to report the death.

2.3 Attitudes of Relatives to Death Investigation and Autopsy

It also emerged from Kawai's study that bereaved relatives sometimes oppose the reporting of medical-related deaths to the police even when medical error appears to be involved. This raises some further questions. Why do bereaved relatives appear in some cases to be reluctant for further investigations into the death, even when there is good reason to suppose

22 For another account showing a similar blurring of agency between family and patient with reference to decisions concerning autopsy see Long 2005. In Long's account the decision of a widow not to allow an autopsy on her husband, despite his expressed wish for one before his death, is referred to by a family friend as illustrating the fact that "people do change their minds". As Long notes, this shift does not seem to be thought of by the friend in terms of a change in the subject making the decision – again illustrating the common tendency in Japan for the notion of personhood and agency to extend to include close family members (Long 2005, 173).

there has been a failure in medical treatment which may have contributed to the death? And, given that the Japanese law allows in addition to medical staff also next of kin or others (such as newspaper reporters) to report unusual deaths to the police, why has the rate of reporting of medical-related deaths by next of kin in particular remained low, despite the high profile media coverage of a succession of medical scandals?[23]

More in-depth research is needed on these questions, even though at least three possible explanations could be suggested. The first, and simplest, explanation is that bereaved relatives are primarily concerned to have an adequate explanation of why the patient has died. If they are offered one that they find acceptable and understandable, they may see no particular need, or benefit, in taking further action. Starkey and Maeda point out in this regard that there are "significant barriers to pursuing civil litigation in Japan, such as high start-up costs, lengthy trials, and low chance of success" (Starkey, Maeda 2010, 4). Criminal litigation may be a more realistic option, but long delays are still likely. There is a debate as to whether the relatively low rate of litigation in Japan is due to a culturally based aversion to resorting to the courts as a means of conflict resolution, or whether it is due to structural problems such as delays in cases coming to trial, and shortages of lawyers and judges.[24] However, the fact remains that resorting to police and courts as a means of resolving disputes is relatively uncommon in Japan, it is probably not the obvious first course of action that would occur to most bereaved families.

A second possible explanation is that the patient-doctor relationship in Japan is very hierarchical, hence it is difficult for the patient to question the authority of the doctor.[25] In this context, bereaved relatives may also find it difficult to challenge the doctor's explanation of the death or to pursue it further. Still, the importance attached by medical professionals´ answers in Kawai et al.'s survey about getting the bereaved relatives´ understanding and acceptance of doctor's explanations of the death suggests that this acceptance, rather than being automatic, requires that doctors make an effort to obtain it.

A third possible explanation is that the bereaved relatives may be averse to a police investigation because this is likely to involve an autopsy. Ohnuki-Tierney (1994, 235-6) notes the importance in Japan of the body being intact, a notion extended to the body in life as well as after death, as does Namihira (1988, 1997), who has also argued that beliefs about ancestral spirits, personhood, and body affect the ways in which the body is treated

23 See Starkey, Maeda 2010 for an analysis of rates of reporting of medical-related death in Japan post Hiroo.

24 For more on the debate on this issue see Haley 1978, 1982; Ramseyer 1988; Dean 2002.

25 See e.g. Low, Nakayama, Yoshioka 1999, 174-6.

after death in Japan, tending to inhibit both autopsy and organ removal for transplants. The idea of cutting into a dead body may be perceived as lacking in respect, or even inflicting suffering on the deceased – in one questionnaire study conducted in the eighties regarding the donation of bodies for medical research, the word *kawaisō*' or 'poor thing' was used by some respondents in this regard (Namihira 1988, cited in Lock 2002, 223-4). Namihira (1997) notes that personhood for the Japanese continues after death, and that the body continues to be an important aspect of personhood even after death, and therefore must be treated with respect, and in accordance with the correct ritual procedures. The idea of death as a process in Japan, according to which the newly dead body continues to be treated as a person during a succession of death rituals preceding cremation, is well documented (Suzuki 2000), and Lock (2002, 224) notes that although expressed belief in ancestral spirits may be waning in contemporary Japan, the social importance of complying with Buddhist associated funeral ritual in Japan continues to be marked, and this in turn probably reinforces reluctance to agree to "medical intrusions into a newly dead body". However, Lock also notes that aversion to autopsy is not unique to the Japanese: separate studies cited by Lock (2002, 225) show that a high percentage of respondents in Oregon and in Sweden were uncomfortable with the idea of autopsy, a finding replicated in my preliminary study of attitudes in England, as discussed further below. This suggests that it may be simplistic to attribute Japanese attitudes solely to specific 'cultural' or religious factors.

The importance of attitudes concerning the integrity of the body in Japan is also suggested by a questionnaire study of 126 bereaved families where the deceased had undergone a forensic autopsy between 2002 and 2006 (Ito et al. 2010). The deceased in this survey had died from a range of causes, including homicide and traffic accidents as well as medical-related death; although the study was very small scale – so we need to be cautious about drawing too sweeping conclusions – it is interesting to note that little over a third of respondents reported negative feelings about the autopsy, with the main reason for this being "I fear that the body would be mutilated" (Ito et al. 2010, 104). However, the study also found that over half of those surveyed initially took a positive view of the decision to conduct an autopsy. The main reason given for this was wishing to know the cause of death (around a third of all respondents).

The study also suggested that the families' wish for accurate information about the cause of death was often disappointed, leading to "frustration and anger" (Ito et al. 2010, 103). Problems in communication with bereaved families were reported both before and after the autopsy. In Japan, if a police investigation is launched, the consent of the bereaved family is not required in order to conduct an autopsy (this parallels practice in other death investigation systems, for example in England and Wales, as explored further below, and has some obvious benefits in preventing rela-

tives from blocking an investigation in which in some instances they could be implicated).[26] It is common practice for a police officer to give some explanation to the family regarding the autopsy prior to the procedure. However, so far these officers have received no special training for this role, and this study showed that a large majority (70.7%) of the respondents were dissatisfied with the explanation given by the police (Ito et al. 2010, 103). The authors note that: "More detailed information was requested by 36.4% on purpose, institution and processes related to a forensic autopsy" (Ito et al. 2010, 103). In response to the concerns raised by this study, a leaflet has now been produced for bereaved families explaining the purpose and processes of the autopsy, also police liaison officers have begun to be instructed for autopsy cases (Ito et al. 2010, 105); however, it is too early to assess the impact of these changes.

A further problem with forensic autopsies has been that disclosure of the autopsy results is restricted, since these are part of a criminal investigation. In about two thirds of the cases in Ito et al.'s study the autopsy results were conveyed to bereaved relatives by police officers, but not all the families concerned felt that the information given was sufficient. A large majority (82%) "wished to hear from the person who conducted the autopsy" (Ito et al. 2010, 104). In the case of medical-related deaths, this lack of explanation for autopsy results may contribute to the decision of bereaved relatives to initiate litigation against physicians (Ito et al. 2008). Nor are autopsy findings fed back to the hospital involved – they can only be used for prosecution or litigation (Yoshida 2005, 127). The criminal autopsy procedure for medical-related death is thus perceived as highly problematic even by professionals operating within the system.[27] Yet it does little to address queries that bereaved relatives may have about the death, except in so far as the answers to these queries may eventually come to light in subsequent litigation. The new system for reporting and investigating medical-related deaths which came into effect in 2015 is supposed to address these issues, as it includes a provision for reporting the results of investigations to the bereaved families; however, at the time of writing it is too soon to assess how this will work in practice.

26 Hospital autopsies require the consent of a relative, but this is not required for forensic autopsies, which are carried out in cases involving deaths reported to the police as 'unusual' (Ito et al. 2010, 103).

27 See Yoshida 2005 for a more detailed critique of this system.

2.4 Summary: Issues Surrounding the Reporting of Hospital Death in Japan

The situation in Japan regarding the reporting of hospital death is one in which the legal requirements have for some time been unclear, and subject to debate. One key element in this has been the question of how the category of 'unusual death' is interpreted. As we have seen, interpretations of the category of 'unusual death' have shifted considerably since its formulation in the late nineteenth century, and the application of this category to medical-related deaths has been particularly contentious. Recent legislative changes have raised the possibility of limiting the scope of this category, but the details of exactly how this will be worked out are still being discussed.

In navigating the classification of hospital deaths and deciding whether or not to report these for further investigation, the interaction between the attending doctor and the bereaved family has been crucial; in particular, the issue of whether or not the doctor succeeds in obtaining family's acknowledgement of the doctor's account of the reasons for the death. This seems unlikely to change: the provisions of the new medical investigation system place explanations from the hospital to the bereaved at the centre of the process, allowing medical professionals to retain a great deal of discretion in determining whether or not to report a death for further investigation.

In making this decision, often doctors may have been motivated, at least in the past, partly by a wish to avoid a possible criminal investigation by the police. On the other hand, in deciding whether or not to push for further investigation the bereaved family may be influenced by a range of factors that include the doctor-patient relationship, their assessment of the likely outcome of embarking on a police investigation (at least under the pre-2015 system), and a possible wish to avoid autopsy – a wish which is probably influenced by a combination of beliefs concerning the integrity of the body and dissatisfaction with the way in which the autopsy system operates. Although the recent reforms address some of these issues, many remain likely to continue to influence the process of death reporting and investigation in Japan.

3 England and Wales: 'Unnatural' Death and the Coroner

3.1 Legal Framework

In the UK there are two different systems of death investigation in the case of certain categories of death (including some medical-related deaths): the coroners' system which covers England Wales and Northern Ireland, and the Scottish system of the procurator fiscal. In this paper I am concerned with the coroners' system in England and Wales.

The office of coroner in England dates back at least to the late twelfth century, possibly earlier. Initially it had a varied role, encompassing not only the investigation of cases of sudden death, but also raising revenue for the crown – an important aspect of the medieval justice system (Dorries 2004, 2-3). In the ensuing centuries, the role of coroner has changed dramatically however, alongside broader changes in English society and in the justice system,[28] so that now the main role of the coroner is determining the cause of deaths within or near the coroner's area[29] in certain defined circumstances. In brief, these deaths fall under one of the following three headings:

a. the deceased died a violent or unnatural death
b. the cause of death is unknown, or
c. the deceased died while in custody or otherwise in state detention. (Parliament of the United Kingdom 2009, 1-2)[30]

Until June 2013, coroners were required to have held a qualification as a solicitor, barrister, or medical practitioner for at least five years, although in practice most had been qualified for far longer. The vast majority of coroners have a legal qualification – in 2003 only about 18 of 123 coroners in England and Wales held a medical qualification, and most of these also had a legal qualification (Dorries 2004, 14). From June 2013, all coroners have been required to hold a legal qualification, although existing coroners with only a medical qualification may continue in their current posts. Many coroners are part time, but also they work part time as solicitors in private practice.

An important feature of the coroner's office is its independence: coroners are independent judicial officers, although they are appointed and funded by local authorities they can only be removed by the Lord Chancellor or by the High Court. As Dorries (himself a coroner) points out, this independence is crucial given that coroners are frequently called on to investigate deaths involving a range of official bodies, including NHS trusts, the police, and the government.[31] However, a drawback of the sys-

28 For an overview of the coroner office's history in England and Wales see Dorries 2004, 2-8.

29 The coroner's jurisdiction has in the past also included military personnel killed while serving abroad.

30 These provisions are substantially the same as those in the 1988 Act, which this Act replaces. At the time of writing, parts (though not yet all) of the 2009 Act were on the point of coming into effect.

31 One example of this is the conduct of military operations in the recent war in Iraq, which occasioned criticism of the Ministry of Defence amongst others in a succession of high profile inquests into the deaths of UK military personnel. The former assistant coroner for Oxfordshire, Andrew Walker, was particularly noteworthy in this respect, and received widespread attention in the media both in the UK and in the US. Some indicative examples

tem is that the autonomy enjoyed by individual coroners has contributed to considerable variation and inconsistency in local practice among coronial jurisdictions – one coroner that I interviewed referred to these jurisdictions as effectively "little fiefdoms".

This variation in local practice has led to some confusion in death reporting, as explored further below, and was strongly criticised in the Luce report on Death Certification in England, Wales, and Northern Ireland in 2003:

> The phrase we have heard more than any other during the Review is "the coroner is a law unto himself". Virtually every interest has complained of inconsistency and unpredictability between coroners in the handling of inquests and other procedures. Many of those who have experienced the system, whether families, lawyers and doctors who work alongside it, the police or voluntary bodies […] have all made the same point. (Luce et al. 2003, 71)[32]

From the perspective of the wider legal framework, the coroners' investigation is linked to the death certification system. In order for a death to be registered, there must be a recorded cause of death. In a large proportion of cases, a medical practitioner is able to sign a medical certificate of cause of death (MCCD), this then enables a death certificate to be issued by the registrar of births, deaths, and marriages. At the time of writing, there was no statutory obligation for a doctor to report deaths to a coroner,[33] this was legally the duty of the registrar, however, the registrar cannot accept a MCCD for certain types of cases, as discussed

of newspaper articles on Andrew Walker and his criticism of the war conduct in Iraq are: Adam, Karla; Sullivan, Kevin (2006). "Coroner Says US Forces Unlawfully Shot Reporter". *The Washington Post*, 14 October. URL `https://goo.gl/0DBebu` (2017-04-12); Lyall, Sarah (2007). "Coroner Rules Death of British Soldier in Iraq Unlawful". *The New York Times*, 16 March. URL `https://goo.gl/471QFP` (2017-04-12); Norton-Taylor, Richard (2006). "Soldiers Shot After Ambush in Iraq Killed Unlawfully, Coroner Rules". *The Guardian*, 3 October. URL `https://goo.gl/ru0cNb` (2017-04-12); Seamark, Michael (2007). "Coroner Who Stands Up for Grieving Families". *MailOnline*, 6 February. URL `https://goo.gl/lGZNcN` (2017-04-12); Simpson, Aislinn (2008). "Andrew Walker: The Coroner Who is a Thorn in the Side of the Ministry of Defence". *The Daily Telegraph*, 17 October. URL `https://goo.gl/Xtx1W5` (2017-04-12).

32 In an attempt to remedy this problem, the Coroners and Justice Act 2009 created the office of Chief Coroner. One of the main responsibilities of this role is to "provide support, leadership and guidance for coroners in England and Wales", as well as to set national standards for coroners, oversee training of coroners, and to provide an annual report on the coronial service to the Lord Chancellor (Judiciary of England and Wales Website, Office of the Chief Coroner). The first holder of the post was appointed in May 2012.

33 The Coroners and Justice Act 2009 (clause 18.1) gives the Lord Chancellor the power to "make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware", however, no suggested regulations had been published at the time of writing.

further below, so it is important that doctors understand when a MCCD can and cannot be issued, and how it should be filled out. Advice on when the death should be referred to the coroner is given in the booklet of medical certificates of cause of death issued to doctors (Dorries 2004, 57), and there are also guidelines that may vary locally on the basis of the coronial jurisdiction.[34]

In practice, a majority of deaths reported to the coroner each year are referred voluntarily by a doctor, with most of the remainder referred by the police in cases of sudden death, plus a small number (around 2%) referred by the registrar, often in cases where s/he is unable to accept the doctor's certificate (Dorries 2004, 52). Generally, this arises from a failure on the part of medical staff to recognise what constitutes a reportable death. Some categories of reportable death are fairly clear-cut – for example, the regulations for the registration of births and deaths by the registrar state that deaths must be reported to the coroner "if the deceased was not seen by the certifying medical practitioner either after death or within 14 days before the death" and in any case "which appears to the registrar to have occurred during an operation or before recovery from the effects of an anaesthetic" (Registration of Births and Deaths Regulations 1987, cited in Dorries 2004, 58). However, others are less clear, in particular the requirement for the Registrar to report to the coroner any death which "the Registrar has reason to believe to have been unnatural or caused by violence or neglect". The categories of 'unnatural' and 'caused by […] neglect' are especially problematic as discussed further below. Several recent studies have demonstrated confusion on the part of medical staff as to which deaths are reportable,[35] as well as variation in local coroners' practice, and have drawn the conclusion that there may be significant underreporting of medical-related death to the coroner (cf. Start et al. 1993, Booth et al. 2003).

3.2 Defining an 'Unnatural Death'

One important issue here is when a death should be considered as 'natural' or 'unnatural'. As for the category of 'unusual death' in Japan, there is no statutory definition in the UK of what constitutes an 'unnatural' death. The Coroners' Benchbook suggests that death from natural causes may be defined as "the result of a naturally occurring disease running its [full] course" (cited in Dorries 2004, 40). For deaths which take place in hospital,

34 For further discussion of this variation see Start et al. 1993, 1039.

35 Both the studies cited here attribute this confusion in part to inadequate training on death certification given to new doctors, aggravated by the variation in local coroners' practice.

however, reaching a judgement as to whether or not this is the case may involve assessing the importance of a number of other factors – for example, drugs treatments, complex medical technologies used, post-operative complications, and possible mishaps (such as a fall) in the hospital. A further issue is whether lack of care (or neglect) was a contributory factor in the death – even if the underlying cause of death could be said to be a naturally occurring disease.

As Dorries (2014, 41-6) notes, the difficulties in determining whether or not a death should be defined as 'unnatural' have resulted in some high profile court cases since the nineties, the definition is thus the subject of evolving case law. Two particularly important cases in this regard that are widely referred to are the Thomas case and the Touche case. These cases effectively illustrate the problems involved in the determination of how medical treatment related deaths should be classified.

In the 1992 Thomas case, a young woman died of an asthma attack following the failure of the ambulance service to respond promptly. Although the coroner initially refused to hold an inquest on the grounds that asthma is a natural cause of death, the bereaved family applied for a judicial review, on the grounds that the death was 'unnatural' because in this case 'natural causes' had been "aggravated by a lack of care". The High Court agreed with the family's submission and allowed the judicial review, but this judgement was subsequently overturned by the Court of Appeal. However, the dissenting judge in the Court of Appeal judgement presided over another hearing in 2001 relating to the death of Mrs Laura Touche from a cerebral haemorrhage, which may have been related to eclampsia, following her delivery of twins by caesarean section. The coroner initially considered an inquest to be unnecessary, but a subsequent judicial review heard medical evidence that if Mrs Touche had been monitored the cerebral haemorrhage would probably have been avoided, therefore an inquest was ordered. The coroner appealed against this finding, but lost on the grounds that Mrs Touche's death was "at least contributed to by 'neglect' and thus […] unnatural" (Dorries 2014, 44).

Another issue to be considered is whether a particular condition can be considered a naturally occurring disease process. One recent subject of controversy in this regard is MRSA (Methicillin-Resistant Staphylococcus Aureus). One senior coroner that I interviewed told me that even though coroners tend to take the view that it is natural, they might take a different view if there was a specific incident leading to it. However, this is at the coroner's discretion, indeed a cardiac surgeon working in a different coronial jurisdiction informed me that in the jurisdiction where he worked all cases involving MRSA are reported to the coroner and will then go to inquest. Hence it seems that there is some inconsistency in the ways in which the problem of MRSA is dealt with, reflecting the considerable autonomy that coroners have in taking a view of what deaths should and

should not be investigated – although their decision-making in this regard is always potentially subject to legal challenge, as the Thomas and Touche cases demonstrate.

3.3 Reporting Deaths to the Coroner

Given these ambiguities, who decides how the particular cases should be dealt with, and how are these decisions reached with regard to medical-related deaths? In most cases, a medical certificate of cause of death is issued directly by the attending doctor,[36] and the death can then be registered with the registrar of births, marriages, and deaths, and a death certificate issued. However, where the doctor has doubts as to whether or not they can issue a medical certificate of cause of death, they may first contact the coroner's office – and indeed are encouraged to do so by the official guidelines on death reporting.[37] The coroner's office can advise on whether or not a formal referral is necessary, and whether a medical certificate of cause of death (MCCD) can be issued. In some cases the coroner may decide, after discussion with the doctor, that there is enough information to indicate that death is from natural causes and no further investigation is necessary. At this point, practice varies – sometimes these cases will be recorded by issuing a special form to the registrar (form A) which confirms that the death has been reported, and no further action is needed. This is essential for cases which the registrar would otherwise be obliged to report to the coroner, but some coroners argue that form A should be used more generally (Dorries 2004, 79-80). Another possibility is to record the case as "no further action" without issuing a form A – and it is also theoretically possible not to record the enquiry at all. Which of these options is used varies not only depending on the case concerned, but also depending on the coronial jurisdiction. One consequence of this which was pointed out to me in my interviews with coroners is that statistics on the number of deaths reported to the coroner, and also on the percentage of cases where no further action is taken, are unreliable, given that one coroner's jurisdiction may consider all telephone enquiries from doctors to count as reporting the death to the coroner, while others may only count those which are subsequently investigated further.

36 The published guidance for doctors completing Medical Certificates of Cause of Death in England and Wales states that "there is no clear legal definition of 'attended', but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient's medical history, investigations and treatment" (Office for National Statistics' Death Certification Advisory Group 2010, 3).

37 Office for National Statistics' Death Certification Advisory Group 2010, 3.

Overall, it seems likely in any case that more deaths are discussed informally with the coroner's office than are formally recorded as having been reported to the coroner. With this caveat in mind, it appears that the proportion of deaths reported to coroners has seen a marked rise over the past fifty years, levelling off over the past decade to a fairly stable rate of between 45% and 47%, with the figure for 2014 at 45% of registered deaths. Of these, 40% underwent post-mortem examinations (Ministry of Justice 2015, 9). Although these figures refer to all registered deaths, and do not indicate what proportion of these was medical-related or occurred in hospital, the high rate of reporting, in conjunction with the likelihood that not all deaths discussed with coroners' offices by doctors are recorded in the statistics of deaths formally reported, is indicative of the relative willingness of medical professionals to refer deaths to the coroner in England. This reflects in part the view taken both by bereavement officers in hospitals and by doctors that, if there is any possible question mark over the death, it is better to consult the coroner. One consultant to whom I spoke said "most of us see the coroner as a good backstop", while for hospital trusts the practice of referring cases to the coroner helps with transparency for the trust. For example, in cases where the bereaved family complain that care was generally negligent or that there was a misdiagnosis, the act of reporting the death to the coroner may be interpreted as showing that the trust has been transparent.

An important point to bear in mind here is that the coroner's duty in England and Wales is to determine the cause of death, not to address questions of civil or criminal liability. The contrast here with the Japanese system, where the reporting of a hospital death automatically triggers a criminal investigation, appears striking. It seems likely that this difference in the investigation systems between the two countries is a major factor in accounting for the very noticeable difference in the rates of reporting of deaths. Basically, the argument here is that medical professionals are more likely to be willing to report deaths in England and Wales because they do not get involved as subject of a criminal investigation. In other words, they do not feel threatened by the process.[38]

However, the actual process of death reporting within the English system is not always smooth. One coroner that I interviewed described it in the following terms:

> The patient dies, the relatives are told, and an appointment is made with the bereavement office in the hospital, where the relatives can collect a medical certificate as to the cause of death (MCCD). This is taken by

38 This argument has been forcibly made by Professor Yoshida, who has been closely involved with efforts to reform the Japanese death investigation system.

> the relatives to the registrar who gives them a certified entry of the copy of the register of births and deaths. Half an hour before the relatives are due the bereavement officer will be chasing the junior doctor – the junior doctor hasn't done it yet and says, "Oh, we must refer it to the coroner", or the bereavement officer says, "You must refer this to the coroner", then they call the coroner's office and they say if they can issue the certificate or not. So the coroner's office must make decision very quickly on whether or not a certificate can be issued. We have to know what questions to ask – it's a gut feeling.

3.4 Coroners and Medical Staff: Communication Issues

The issue arises here of how coroners and coroners' officers, most of whom lack medical training, can evaluate what they are told by doctors. Even putting to one side any possible intention to mislead, it was noted by the hospital bereavement officer that I interviewed that there can be problems of communication between medical staff and coroners or coroners' officers owing for example to doctors' tendency to use technical medical terminology. She commented that doctors need to be reminded to explain what has happened in lay terms to the coroner, or coroner's officers, while one of the coroners that I interviewed who had both medical and legal training suggested that "a medically qualified coroner may spot cases where the care was inadequate, we are less likely to have the wool pulled over our eyes by medical professionals […] a medically qualified coroner […] may be more likely to spot medical issues when doctors are being economical with the truth".

In contrast, the non-medically qualified coroners that I interviewed felt that their legal training combined with their experience "on the job" and the possibility of bringing in medical experts from outside the coronial service when necessary equipped them to deal with medical cases. They also pointed out coroners' society of England and Wales also runs training courses to help with these issues, and this has in the past included a course specifically on hospital deaths. But these coroners also acknowledged that they remained dependent on the accounts given by doctors to a great extent. One commented "Janet Smith (the chair of the Shipman Inquiry)[39] criticised coroners for trusting doctors too much, but I think it is necessary to trust doctors". Another explained:

39 This was the inquiry into the murder by the GP Harold Shipman of at least 15 of his patients over a period of many years – one key question addressed by the inquiry was how Shipman had been able to continue killing his patients for so long without being detected, and what shortcomings in the existing system for certifying and investigating deaths (including the coroners' system) might have contributed to this.

> I rely on the honesty of the reporting doctor. If he says a load of nonsense, probably a load of nonsense is all we know. But most doctors reporting are pretty junior – coroners' officers pick up a lot – they know what follows and what doesn't. People die in hospital of a narrow range of events. We ask for example had she or he had a procedure? Was it an expected death? If you want to cover up though, you just don't report it to the coroner. There should be a penalty for this – currently it's not a criminal offence.

More bleakly, another commented:

> How effective is the system re:[regarding] medical-related deaths? It relies on trust […] the system isn't going to stop another Shipman.

The question of the lack of specific expertise of most coroners in medical-related matters was noted by the Luce report (2003), which recommended the establishment of a system of statutory medical assessors to support coroners where necessary. This recommendation was adopted in modified form in the Briefing on the Coroners and Justice Bill 2009, which provides for a new medical examiner service to work alongside the coroners' service. However, the implementation of this provision was delayed pending an impact assessment on the funding implications, and has since been repeatedly deferred. Although there have been six successful pilot trials of the scheme, at the time of writing it has yet to be implemented.

3.5 Coroners and Bereaved Relatives

A further contentious issue is the possible influence of bereaved relatives in the process of death registration and decisions regarding death investigation and autopsy. The doctors that I interviewed were adamant that in England, unlike Japan, the views of the bereaved relatives have no relevance in this process, and that decisions as to whether or not to report deaths are made solely on the merits of the case. Dorries' widely referenced guide to law and practice in coroners' courts is equally definitive, stating that "A decision not to refer a case because of potential distress to relatives or embarrassment to colleagues is wrong and cannot be justified in law" (Dorries 2014, 66).

However, some coroners offered a different perspective. One suggested that a reluctance on the part of doctors to ask the relatives for an autopsy could inhibit the referral of some deaths to the coroner:

> No-one is prepared to sit down with relatives to talk through the process. They send down the most junior doctor. They don't want to ask the

> relatives for an autopsy. If they say – "oh well, bronchial pneumonia" then that will lead to fewer and fewer autopsies. Bereaved relatives' attitudes have a negative effect, they inhibit the decision to report the death to the coroner.

Other coroners that I interviewed also indicated that in conversations with doctors calling in to ask whether or not they could issue a death certificate, one consideration was the attitude of the bereaved family in this regard:

> A ninety-four year old man dies, suffering from aspirational pneumonia. If he has had a fall, this should be reported to the coroner. The doctor would need to tell the coroner about the medical history, and explain why the fall played no part in the death. The coroner's officer would then speak to the family – if they were happy that the fall had played no part in the death, a death certificate would be issued. In this case, we are relying on the doctor's assessment. The only way to check this would be to do a post-mortem, but we are reluctant to do this in the case of a very elderly person. There is perhaps an issue of ageism here. If the family are not happy, then we might hold a post-mortem. But we are not medical ombudsmen, it doesn't automatically follow that the coroner will order a post-mortem. Often the family is complaining about the care received – the important thing is to establish whether this is relevant to the cause of death.

Taken together, these comments suggest that although perceptions of the attitudes of bereaved relatives may in some cases inhibit reporting of death, in other cases the relatives may actively push for an investigation. Sometimes, this may influence decisions on whether or not a particular death is investigated. One coroner expressed this quite bluntly:

> We respond to people who shout the loudest. I am less influenced than most coroners because I don't think it's right.

The perception of bereaved families, in contrast, has often been that they are insufficiently involved in the process. INQUEST, a group of lawyers providing information and representation at coroners' inquests, comment in the Briefing on the Coroners and Justice Bill 2009 regarding the situation prior to the enactment of this bill:

> The legal rights of bereaved families in the proceedings are artificially and unnecessarily restricted, and their current place within it is anomalous and inadequate […] the administrative framework is not directed at their full inclusion in the process. There is inadequate provision of information and support to bereaved families facing inquests at all stag-

> es which affects their capacity to participate effectively in the inquest process. There is no government-funded information service for families. Thus they often come to us having not been advised they can be legally represented during the process, nor have they been given […] sufficient information about the inquest proceedings. (INQUEST 2009, 4)

The involvement of bereaved relatives has been an important concern in the reform of the coroners' service. The Luce Report recommended putting bereaved families "at the centre of the death investigation process" (Luce et al. 2003, 142); based on the recommendations of this report, a draft charter for bereaved people was produced in 2009. This was subsequently issued as a "Guide to Coroner Services" setting out the "general standards that you can expect during a coroner's investigation" (Ministry of Justice, s.d., 1). This gives detailed information about the process of a coroner's investigation, including the family's right to legal representation. From the point of view of this paper, a particularly significant provision in the guide is the statement that "where possible, coroners will take account of your religious and cultural needs whilst acting in accordance with the law when ordering a post-mortem examination and the type of examination to be performed". The guide also includes the information that in some parts of the country, for the payment of an additional fee, non-invasive techniques such as CT (Computerised Tomography) or MRI (Magnetic Resonance Imaging) scans may be available as an alternative to the standard post-mortem, and "may be preferred by people who have a strong objection to an invasive examination of the body". The guide does also stress that these techniques may not be suitable for all cases, and the decision as to whether or not they are appropriate will be made by the coroner, however, the inclusion of this information is indicative of a recognition of the strong objections voiced by many in England and Wales to autopsies, evidence that an aversion to autopsy is by no means unique to Japan.

3.6 Autopsy and Beliefs Concerning the Treatment of the Body

As will be apparent from the above discussion, the decision to conduct a post mortem is sometimes a source of conflict with bereaved families, especially in cases where an invasive post-mortem runs counter to religious or cultural prescriptions regarding the treatment of the body after death. This has been a particular difficulty in cases involving orthodox Jewish or Muslim families, as noted in the Luce Report (Luce et al. 2003, 156-7). In both cases, there is a belief that body should be buried within 24 hours, and that it should remain intact. This was explained by one Muslim surgeon, addressing a conference on *Life and Death in Judaism and Islam,* held at Cambridge University in 2010, in terms of a duty of care to the deceased,

who should be treated with gentleness, dignity and respect, as the soul is present nearby feeling what is happening to the body. In addition, maiming the body is *haram*, or forbidden.[40] Similarly, for orthodox Jews there is a requirement to respect the body after death, this is also linked to the idea of the resurrection of the body, which means that the body be intact.

Religious specialists from both communities seem to agree that these considerations are over-ridden by legal requirements, in particular in cases where it is necessary to perform a post-mortem in order to establish the cause of death. The necessity of performing a post-mortem is often stressed by coroners in their conversations with families in these situations, and they may also call on religious specialists, or religiously based arguments, to help mediate with the families. For example, one coroner reported on his conversations with Muslim families:

> They tend to say, the Koran says you can't have an autopsy. But I know the Koran doesn't say that – it says you mustn't have an autopsy unless it's necessary.

Another response to the religious requirements of particular communities that I encountered was that of (unofficially) expediting autopsies for Muslims (in one area with a significant Muslim community) in order to allow the body to be buried as soon as possible, although this seemed highly variable depending on the jurisdiction, and some coroners were vehemently opposed to any such practice as they saw it as favouring one section of the local community over others.

A further measure, as indicated in the guide quoted above, is to look at possible alternatives to post-mortems as a means of ascertaining cause of death, for example CT or MRI scans. MRI scans were introduced as an alternative to autopsy in Manchester in 1997, at the instigation of the local Jewish community, and in cooperation with the local coroner (Bisset et al. 2002, 1423). The use of this method has since been extended to the local Muslim community, in part at the instigation of local coroner, who has been active in seeking to inform local Muslims through the mosques that this may be a possibility in some cases. There have also been some cases of Christian families using this service. MRI scans are used as an alternative to the invasive autopsy in Manchester for certain specific types of case – generally non-suspicious deaths where there is a fairly good symptomology and previous hospital history – but are not appropriate for all cases. MRI scans are also considerably more expensive than the standard autopsy, an issue that has been dealt with in the Manchester case by the

40 Paper presented by A. Alzetani, 26 May 2010, conference on *Life and Death in Judaism and Islam*, St Edmund's College, Cambridge.

coroner's office providing the equivalent of the cost of a standard autopsy. The remainder is borne either by the family, or by a special fund organised for this purpose – funds have been created by the North Manchester Synagogue group and by the Central Mosque in Manchester.

Both interest in and provision of alternative non-invasive autopsies has continued to grow in recent years, despite some studies casting doubt on their reliability compared to the conventional post-mortem.[41] Between 2006 and 2008 pilot studies on non-invasive autopsies were run in Manchester and Oxford. In 2012, the Department of Health published a report noting that "if our multi-ethnic, multi-cultural society is increasingly unwilling to accept conventional autopsy, consideration must be given to the provision of a non-invasive autopsy service that meets both the expectations of the public and provides the most reliable information possible", and recommending "an integrated, phased implementation programme for a national cross-sectional autopsy imaging service based on a regionalised service provided by 30 mortuary-based imaging centres in England" (National Health Service Implementation Sub-Group of the Department of Health Post Mortem, Forensic and Disaster Imaging Group [PMFDI] 2012, 13-4). In 2013 a digital autopsy facility was opened in Sheffield by the Chief Coroner for England and Wales, and two more digital autopsy facilities have opened in England since then.

In a further recent development, in July 2015 a High Court judgment in a case brought by a Jewish family objecting to an invasive post mortem ruled that "a non-invasive procedure should be considered when the family requested it on religious grounds if there were 'a reasonable possibility' that it could establish the cause of death; if there were 'no good reason' to order an invasive autopsy; and if it would not impair the findings of an invasive autopsy should that subsequently prove necessary" (*Jewish Chronicle*, 28 July 2015). This judgment could be interpreted as placing the onus on the coroner to demonstrate a good reason for an invasive autopsy, although it is also careful to allow both for cases where it is unlikely that a non-invasive autopsy would establish the cause of death, and for the possibility of a subsequent invasive autopsy if the findings of the non-invasive autopsy were deemed inconclusive by the coroner. This seems to open the door to a possible two-stage approach to autopsy in at least some cases. Although it is potentially expensive, this is indeed the process recommended by the new digital autopsy facilities, who stress that the digital autopsy results will always need to be reviewed by the coroner, and may need to be followed up by a conventional post mortem, depending on the findings.

41 See Roberts et al. 2012; Underwood 2012. It should also be pointed out however in this context that the standard coroner's autopsy has also been the subject of criticism in an extensive recent study (NCEPOD 2006).

It is also important to note that opposition to invasive post mortems is not confined to those from the Muslim and orthodox Jewish communities – coroners that I interviewed reported widespread aversion on the part of families to the idea of their loved one being 'cut up', and one coroner commented: "very often they say: hasn't he gone through enough? Why do you want to do this to him?". The extent of opposition to the idea of an invasive post mortem can be gauged from an opinion survey commissioned for the Luce Report (2003), which found that 38% of respondents would be upset by "the thought of a post-mortem examination on someone they knew" with the most common reason given for this "the feeling that the procedure was upsetting and distasteful" (Luce et al. 2003, 155). At the extreme end of this, instances of repeated telephone calls, abuse, and even threats (including death threats) from families and friends of the deceased in response to the prospect of a post-mortem were reported by coroners and coroners' officers that I interviewed.

Resistance to autopsy is not universal though: a slight majority (56%) of those surveyed for the Luce Report reported that they would not be upset by a post mortem on someone they knew, with the main reason given for this "the need to be sure about the cause of death". And the report also notes that "Four fifths of those who were upset at the thought of a post-mortem said that they would feel better about it if they thought that the results would improve 'medical knowledge of a particular disease or illness'" (Luce et al. 2003, 155). In this respect, it is relevant to note that bereaved families in England and Wales have considerably greater rights to information relating to the findings of the post-mortem than is the case in Japan. The family have a right to be represented by a doctor at the post mortem if they request this, they may also ask for copies of the post-mortem report and of any other relevant documentation, although there is also a proviso that coroners may withhold documents in certain circumstances for legal reasons.

The coroners to whom I spoke emphasised the importance of involving families in the death investigation process and of explaining to them the purpose of autopsy, indeed such an explanation is recommended by the Coroners' Model Charter of 1999 (Dorries 2004, 125). Sometimes, the coroner might postpone the post-mortem examination for a day or so to allow the family to reflect, and to take legal advice – in fact, families have no power to block an autopsy, although it is possible for them to ask for a judicial review if they do not wish an autopsy to take place. This possibility of a judicial review does seem to influence some coroners' decisions on whether to conduct a post-mortem – one coroner told me:

> It does influence my decision on post-mortems – if [the family] are violently opposed to it I think I will have to deal with it in the High Court – the judge will ask, why do you need to do this for the sake of

scientific certainty when the family is upset? So sometimes I do give in, but other times I dig my heels in.

3.7 Holding an Inquest

If the cause of death remains unclear after the autopsy, or "if there is cause for the coroner to suspect that the deceased died a violent or unnatural death, or died in prison", an inquest must be held (Ministry of Justice 2012, 11). In deciding whether or not to hold an inquest, the question of whether the death can be considered 'natural' therefore again comes to the fore. In many cases the autopsy will establish clearly whether or not the death is due to a cause that can be considered 'natural' (for example a naturally occurring disease process). In cases where a natural cause of death can be established by the autopsy no inquest will generally be held; although, as noted above, there are ambiguous cases, particularly in medical-related deaths, including possible cases of neglect, failure in medical treatment, or a disease that may be considered as arising 'unnaturally' (such as MRSA), where the decision as to whether or not the death should be considered natural and therefore whether or not to hold an inquest is not clear cut. These ambiguities have led to cases (for example the Touche case discussed above) where the coroner's decision not to hold an inquest has been challenged.

The inquest itself is inquisitorial, not adversarial, and is concerned with establishing certain defined facts surrounding the death: the identity of the deceased, the time and place of death, and how the death came about. Witnesses are questioned in order to establish the facts surrounding the death, in the case of medical-related death it can be an important means for bereaved families to obtain an explanation that they may have had difficulty getting directly from medical professionals, since the coroner can compel medical staff involved in the treatment of the deceased to give evidence to the court. Close family members[42] or their legal representatives also have the opportunity to ask questions of witnesses in the inquest. [43]

The coroner's inquest is not concerned with settling questions of civil or criminal liability, and the coroners rules (cited in Dorries 2004) specifically prohibit the verdict from being "framed in such a way as to appear

42 Legally, "properly interested persons" are entitled to examine witnesses at the inquest. This includes, but is not limited to, close family members, specifically "a parent, child spouse, and any personal representative of the deceased" (Coroners rules, rule 20, cited in Dorries 2004, 412).

43 One failing of the system, however, is that there is little provision for legal aid for bereaved families to obtain representation at inquests – they are generally reliant on their own resources for this.

to determine any question of (a) criminal liability on the part of a named person, or (b) civil liability" (rule 42, cited in Dorries 2004, 416). However, in parallel to this, there is specific provision in the coroners rules that "a coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly" (rule 43). In 2008, this rule was amended so that anyone receiving such a report is now obliged to send a written response to the coroner. In addition, these reports and the responses to them are copied to the Lord Chancellor and to all "properly interested persons" (a category which includes immediate family), and a summary of these reports is published twice a year (Ministry of Justice 2012, 17). These provisions help to address the concerns of bereaved families, for whom it is very important not only to establish a clear narrative explaining the circumstances that led to their relative's death, but also to establish that, where appropriate, lessons have been learned. A legal group working to help families in their dealings with the coronial system notes:

> the majority of bereaved families we work with are motivated by the hope that there will be accountable learning. A recurring theme common to virtually every family with whom we journeyed through the coronial system is simple: an unswerving desire that other families should not have to suffer the often preventable ordeal which they have had to endure. (INQUEST 2009, 3)

Another feature of the inquest which links to this concern to prevent similar deaths from occurring in the future is the growing use of the narrative verdict,[44] which permits a greater exploration of the circumstances surrounding the death than is afforded by the narrower format of short form verdicts, such as 'natural causes', 'accidental death' or 'misadventure'.[45]

44 Statistics show that 'unclassified verdicts', which include narrative verdicts, have risen steeply since 2001, when they comprised less than 1% of all verdicts, until the most recent figures at the time of writing, which showed that unclassified verdicts accounted for nearly 15% of all verdicts in 2011. The majority of this increase seems to be due to the increase in use of narrative verdicts, a trend which has been encouraged by recent case law, in particular the House of Lords Middleton judgement in 2004 (Ministry of Justice 2012, 7-8)

45 There is a list of suggested verdicts in notes relating to the relevant section of the Coroners Rules 1984, but this is not binding, and there is some variation in usage among coroners.

4 Conclusion

The comparison of the Japanese and English systems of death reporting and the investigation of medical-related deaths presented above can be summarised under three main headings. Firstly, autopsy and attitudes to the body; secondly, processes of decision making and the role of bereaved families in this process; and thirdly, the role of legal and institutional frameworks. These in turn have implications for notions of personhood, and are also intertwined in some interesting ways with discourses of cultural difference.

4.1 Autopsy and Attitudes to the Body

Although small scale, the Ito et al. (2010) study cited above indicated that in Japan not all bereaved relatives oppose autopsy – a significant proportion of those surveyed were in favour of autopsy in order to find out the cause of death. Similarly, as we have already seen, the wish to be sure about the cause of death was also the main reason given by those surveyed in England for the Luce Report, who did *not* oppose autopsy for stating that they would not be upset by a post mortem being conducted on someone they knew. However, as explored in detail in the material presented above, there is a division of opinion on this in England as in Japan. Many in England *are* resistant to autopsy, a resistance that seems linked to beliefs about the body and, implicitly, personhood. These beliefs may have a religious base, as for orthodox Jews and Muslims, but they may also be much less clearly articulated, and lack an easily identifiable ideological framework. Remarks by bereaved relatives cited by coroners, such as "hasn't he gone through enough?" or "why do you want to do this to him?", suggest a view of the newly dead body as still retaining attributes of personhood, thus requiring care. It is hard to see much difference here with the description of dead bodies donated for medical research in Japan by questionnaire respondents as *kawaisō*, or 'poor thing', suggested by Namihira as evidence for a Japanese culturally based aversion to autopsy and organ transplants (Namihira 1988, cited in Lock 2002, 223-4).

While I would not dispute that there is extensive evidence in studies of death and dying, and death rituals in Japan, supporting the idea that from a Japanese perspective personhood does not end with the death of the physical body, my argument here is that attitudes towards dead bodies in England suggest similarly complex ideas of personhood and death as a process of transition, even if these have a very different cultural and religious base. The differences between the two countries in this regard may be less clear cut than it at first appears. It is also important to note

here that neither England nor Japan are monolithic in terms of religion and beliefs around death, although the variation is perhaps more obvious in the English case. Also, in neither country are beliefs concerning the body the only factor influencing attitudes to autopsy. The wish of bereaved relatives to have a full explanation concerning the death is also an important common theme – the performance of an autopsy does not necessarily provide it in the Japanese case; a problem which, in turn, contributes to the relatively negative evaluation of autopsies by many bereaved families in Japan.

4.2 Processes of Decision Making and the Role of the Family

Another point of interest is the importance of informal processes of decision making regarding the reporting and investigation of medical-related death in both countries,[46] in particular concerning whether or not a death is considered officially reportable to the relevant investigative authority – in Japan until very recently, and still in some cases, the police, more recently the newly established Medical Accident Investigation and Support Centre, or the coroner in England and Wales. Some confusion is evident among medical professionals in both Japan and in England and Wales as to which deaths are reportable, partly because of the difficulties and ambiguities inherent in the categories of 'unusual' or 'unnatural' death. In the Japanese case this is exacerbated by conflicting interpretations and guidelines issued by different concerned organisations – we might note the debate between the Japanese Society of Legal Medicine and the Japan Surgical Society in this regard. And in England and Wales there is some local variation depending on the coronial jurisdiction.

A further factor to consider here is the influence of bereaved relatives on the process. Here, there is an interesting difference in the way in which this is articulated in the two countries. In Japan the attitude of the bereaved relatives is clearly recognised as important in the decisions of medical staff as to whether or not to report the death. The 'understanding' of the bereaved relatives in respect of the explanation offered by the medical staff regarding the death is seen as key, and may be more or less explicitly linked with the idea of 'informed consent', where the locus of consent is not necessarily solely the patient, but also the patient's immediate family. This could again be linked to notions of personhood, and the

46 The importance of informal relations and processes of decision making within a range of organizations in industrialised societies has been one key focus of the emerging anthropology of organizations (Wright 1994; Gellner, Hirsch 2001) and has been explored in a number of ethnographic studies. For an overview of recent work in this area see Van Maanen 2001.

often advanced idea that in Japan personhood is relational, and involves the immediate family and nexus of social relationships.[47]

In England, in contrast, the expressed ideal is that the bereaved family *should* have no influence on the decision as to whether or not a death is reported to the coroner. Nevertheless, as noted above in interviews of several coroners included in this study, the views of bereaved relatives did, in some circumstances, play a role in the decision-making process. This may link to dominant discourses concerning the idea of the 'professional' and the importance of 'professional objectivity' and 'neutrality', as well as to a different idea of personhood, where the deceased is viewed as clearly separate from his or her relatives. The idea that professionals in positions of responsibility should have discretion to make a range of decisions in which they should not be subject to influence from interested parties is deeply rooted in England, but scarcely universal or immune from challenge.[48] And indeed, in the UK alternative discourses emphasising (equally socially constructed) ideals of 'accountability', 'transparency' and the importance of the 'customer', 'client' or 'service user' have become prominent in recent decades, not only in the field of medicine (as evidenced by the growing use of 'charters', such as the National Health Service patients' charter, setting out what patients can expect from various areas of the health service) but also in other professionalised fields such as education.[49] So perhaps in England, as in Japan, we can see multiple 'scripts' of the kind suggested by Long (2005). In the context of the reporting and investigation of medical-related death, high profile scandals such as the Shipman and Bristol Royal Infirmary cases referred to above have also contributed to a shift where government policy is now pushing for a re-evaluation of the role of bereaved relatives in the death investigation process. However, at present, still much remains at the discretion of the coroner; this seems likely to continue to be the case even after the implementation of the 2009 act.

In this context, an important contrast between the English and Japanese systems is in the locus of informal interactions surrounding decisions over whether or not to report a death, whether or not an autopsy and further investigation should take place. In Japan, the critical interactions are between medical staff, in particular the attending doctor, and the bereaved

47 The idea of the relational self in Japan has been written about extensively – see e.g. Rosenberger 1992. For a discussion of the idea of personhood as embedded in the family in the context of medical decision making see Long 2005, 89-92.

48 Parallels can be drawn here with anthropological studies of bureaucracy, its operations within specific localised frames, which have provided a useful critique of the Weberian model of 'rational' impersonal bureaucracy. See e.g. Gupta 1995, 384.

49 This includes higher education, where the discourse of student as customer or consumer of educational services has become widespread.

relatives. In England and Wales, the coroner's office provides an interface in this process, interacting with, and sometimes mediating between, the medical staff and bereavement service in hospitals on the one hand, and bereaved relatives on the other. The concerns of relatives can at present be expressed mainly through two channels: either to the hospital, particularly via the bereavement services of the hospital, or to the coroner, or the coroner's officers. The opinion that some medical professionals expressed to me that the views of the bereaved relatives are 'irrelevant' in the English context is not quite accurate: it would be more accurate to say that the channels by which these may be expressed are different from in Japan – their views may not be relevant to doctors directly in their decisions as to whether or not to report a death to the coroner, but they may influence the advice given by the bereavement service to doctors as to whether or not to report deaths where the circumstances of the death are ambiguous. They may in practice, as discussed above, also influence the decision of the coroner as to whether to proceed with a further investigation into the death.

Another important contrast is in the power relations involved. As we have seen, in Japan the lack of an interface between medical staff, bereaved relatives, and the police, has meant that in the pre-2015 system at least the critical decision on whether or not to report a death for further investigation took place as a result of discussion between bereaved relatives and the attending doctor. There is a clear power imbalance here – the prestige of the doctor role, and the respect that patients and their families are meant to accord doctors in Japan, combined with most families' lack of medical knowledge, thus the doctor's version of events is very hard for families to challenge. While the studies cited above have demonstrated the importance that doctors attach to gaining the families' 'understanding' of events, in the absence of detailed qualitative information on the interactions between doctors and families in these discussions, it is impossible to know how this understanding is obtained, or measured. It may be that families feel in most cases that they have little choice but to accept the doctors' explanation, and while they have the option to pursue the matter directly with the police, or other relevant investigative authorities, they may feel reluctant to do so for the reasons explored above. This is an area that would benefit from further qualitative research.

On the other hand, in the Japanese case there is a strong incentive for doctors to provide an explanation of events to bereaved relatives, in sufficient detail to satisfy any doubts or questions that the relatives may have (or at least feel able to express). In contrast, in the English case I came across repeated complaints from coroners and coroners' officers that medical staff in many cases did not make the time to sit down and "talk through" with relatives what had happened. One important role of the coroner's inquest is to allow relatives, or their legal representatives, to

put questions to medical staff involved with the deceased's care. I attended several inquests where the eventual finding was that the death could not have been avoided, in some cases because of rare complications which led to the unforeseeable and unpreventable death of the patient during medical procedures. Although in these cases no fault was found with the medical care provided, it seemed from the questioning from relatives during the inquest that this had been the first opportunity they had had to gain a full explanation from medical staff of what had gone wrong and why. Such an explanation is clearly very important to the bereaved, however, it seems that it may not always be forthcoming without the intervention of the coroner, who has the power to compel doctors and other medical staff to give evidence.

Although it would seem desirable in many ways for such explanations to be provided at a much earlier stage, directly from medical staff to the bereaved, the intervention of the coroner, and possibly a subsequent inquest, does have some advantages. In addition to the thorough investigation of cause of death that an autopsy or other alternative post mortem examination may provide, in terms of power relations the coroner is in a much stronger position than are the bereaved relatives, if compared to doctors and other medical staff. Legally, as already noted, he can compel them to provide information and to give evidence if the case goes to inquest. The doctor-patient relationship in England too is hierarchical, and the doctor role has considerable prestige. It is often difficult for patients or their families to get the information and explanations that they want from hospital doctors,[50] and in England too, bereaved relatives may lack the knowledge to effectively question medical staff. The intervention of the coroner can redress this problem to some extent, although the debate over to what extent non-medically qualified coroners in particular can effectively evaluate the information given to them by doctors has been noted above.

Still, the interaction between coroner and doctor is an interaction between two professionals, where the coroner has powers available to him that are not available to bereaved relatives. It is also qualitatively different to the interaction between police and medical staff, the other part of the triad of possible interactions that has until very recently characterised the

50 For example, the Bristol Royal Infirmary Inquiry noted that: "While the evidence is polarised, there is a strong sense that on many occasions communication between parents and some staff was poor. There does not appear to have been any deep thinking about how to communicate information to parents in advance of surgery, nor any systematised approach to doing so. While some parents felt that they had been significantly helped to understand what the surgery and subsequent intensive care involved, we were also told of doctors and nurses drawing diagrams on scraps of paper, or even a paper towel. The sense is gained that informing parents and gaining their consent to treatment was regarded as something of a chore by the surgeons" (The Bristol Royal Infirmary Inquiry 2001, "Final Report: Parents' experiences: communication").

investigation of hospital deaths in Japan, as the coroner is not leading a criminal investigation, and is specifically barred from determining questions of civil or criminal liability. Investigation of a death by a coroner is therefore not necessarily, or even usually, perceived as a threat by medical staff, in marked contrast to the situation in Japan when a police investigation is launched. Although Japan is now introducing an independent system of investigation of medical accidents in order to address this problem, as noted above, the obligation to report an unnatural death to the police under article 21 still stands at the time of writing, and it remains to be seen how this will be reconciled with the new system of medical accident investigation, and how effective the new system will be.

4.3 Institutions, Individuals, And Discourses Of Cultural Difference

A final difference to note between the two systems is somewhat counter-intuitive, at least from the perspective of those familiar with the extensive anthropological literature on Japan. This concerns the implications of the differing legal frameworks for the investigation of medical-related deaths in Japan compared to England and Wales. In supposedly 'groupist' Japan, the investigation, when one takes place, has been on particular individuals and on identifying who is to blame for the death. In contrast, in England and Wales, often popularly supposed to lie at the individualistic end of the spectrum in comparison to Japan, the coronial system is non-adversarial, and places the emphasis on identifying the cause of death. And as noted above, coroners are specifically barred from allocating blame to individuals. Additionally, in identifying the cause of death in complex medical cases, it is very likely that a number of factors will be involved, potentially leading to a focus on problems with systems rather than a focus on individuals. The growing use of narrative verdicts in coroners' courts has given further scope for identifying system problems. This emphasis on system failure, rather than individual failure, is also consistent with broader approaches to risk management in medicine in the UK and elsewhere in Europe and the United States.[51] Japanese health care professionals have been exploring these approaches with interest in recent years, but they have yet to become well established in Japan.

Overall, then, this comparison between the systems of investigation into medical-related death in Japan and England and Wales adds to the growing body of literature, suggesting a much more complex view of differences in the views of personhood, the body, and in the relative weighting of in-

51 See e.g. Reason, Carthey, de Leval 2001 on "vulnerable system syndrome" and risk management. The authors of this article are highly critical of the tendency to blame individuals rather than exploring broader problems with systems.

dividual and group than can be captured in the rather crude opposition between groupist Japan and individualistic West familiar from populist *nihonjinron* (theories of the Japanese) models.[52] In dealing with the common problems posed by rapidly changing medical technologies and ambiguities surrounding the classification of death as natural or unnatural, or unusual, a range of institutions, medical and legal, and of 'scripts' for understanding and dealing with death, and the treatment of the dead body come into play. Although there are important differences between the Japanese system and that of England and Wales, there are also overlaps, thus the differences do not always play out in the way one might expect. The notion of 'culture' too is deployed in some interesting ways, appealed to as a mode of resistance to some forms of intervention (notably autopsy), not only in Japan but also amongst the Muslim and orthodox Jewish communities in England and Wales, with reference to beliefs about the body and its correct treatment after death. However, this resistance is not universal in Japan, and extends beyond the Muslim and orthodox Jewish communities in England and Wales, suggesting that we need to take a critical view of the ways in which the notion of 'culture' is appealed to. Long's notion of multiple scripts co-existing again seems fruitful in this context.

Another theme here is the globalisation of ideas[53] – debates over the notion of 'informed consent' in Japan, for instance, show the ways in which bioethics has both global and local dimensions – apparently globally applicable concepts such as informed consent turn out to be subject to local interpretation and debate. Similar processes could be traced for notions of risk management in medical settings, and indeed the impetus for this study, as explained at the beginning of this paper, arose from an interest in Japan to find out more about death investigation systems in other countries. Nor is this interest in comparison with other countries' approaches confined to Japan: in the UK the Luce Report also compared the English and Welsh systems with other systems of death investigation and certification in the search for recommendations for improvements (Luce et al. 2003, 18-9). Increasingly, ideas relating to bioethics, biomedicine more generally, and the ways in which the body is dealt with in medico-legal frameworks before and after death are the objects of global debates and exchanges, which interact with, modify, and are modified by, local interpretations and practices.

Finally, all this needs to be placed in the frame of an examination of the evolving legal systems and power relations between the various partici-

52 For an excellent recent critique of *nihonjinron* (a genre which has been very popular in Japan) see Befu 2001.

53 Appadurai's (1990) 'ideoscapes' are relevant here – although the unevenness evident in the ways in which ideas relating to bioethics are disseminated is more reminiscent of Tsing's image of globalisation as an "uneven and contested terrain" (Tsing 2000, 330).

pants in the process in both countries, which act as important constraints.[54] The impact on all this of recent legislative reforms both in Japan and in the UK remains to be seen.

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54 Financial constraints are also an important dimension. In the course of this study, coroners that I interviewed frequently remarked on the problems created by the under-resourcing of the coronial service in England and Wales, a problem that seems likely only to get worse in the economic crisis prevailing at the time of writing. The problem of resourcing has already led to delays in the implementation of legislative reform of the coronial service, as well as modification of a number of recommended reforms. For a recent discussion of this issue by the coroner for South London, who is also medical secretary of the coroners society of England and Wales, see Palmer 2012.

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