The Autopsy in Deaths Under Fifty

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Dr James Clark, later Sir James Clark, physician to Queen Victoria, when visiting Fouquier at La Charité in Paris 160 years ago, was greatly impressed by the value of the autopsy in advancing knowledge and in teaching. The Parisian example led to postmortem examination of the majority of patients dying in hospital in the UK, in other European countries and in America. During the past quarter of a century, however, the hospital autopsy rate has fallen[1,2] and differences of opinion about the value of the procedure[3-15] have led the Royal College of Pathologists to set up an enquiry into the matter. This article sets out some information collected by the Medical Services Study Group, which was established by the Royal College of Physicians in 1977, its terms of reference being to improve patient care in any way possible by means of medical audit.

Its first survey was an analysis of deaths under the age of 50 occurring in the medical wards of hospitals in the West Midlands and Mersey Regions in England and the Grampian Health Board in Scotland[16]. Physicians in all the hospitals were asked to lend the case notes of their patients who had died, between the ages of one and 50 years, during 1978 and 1979. In addition, they were requested to send a personal confidential comment on the case, where appropriate, and in many instances they were kind enough to give supplementary information and clarify doubtful issues. In a number of cases coroners also supplied copies of relevant reports. The total number of case notes received was 1,290, and here are the first 1,000 considered from the point of view of autopsies. For various reasons[16] the ascertainment rate in our study was only about 60 per cent, but we think that as regards postmortems it is probably unbiased since when our survey began, autopsy analysis was not one of the objectives. In any case, if there is bias, it will almost certainly be in the direction of minimising the true autopsy rate.

Results and Comments

Table 1 shows that, of the 1,000 patients, 471 had an autopsy, 260 (26 per cent) as part of routine hospital practice and 211 (21.1 per cent) at the request of the coroner, the Home Office or the Procurator-fiscal. The autopsy rate of 47.1 per cent is much higher than the national rate (England about 27.3 per cent in 1975 and Scotland 23 per cent in 1974[1,2]) and this is thought to be because all the 1,000 patients studied were under 50 years of age. The higher autopsy rate in the Grampian Health Board (67.3 per cent) compared with that in the West Midlands (50 per cent) and Mersey (40.9 per cent) Regions is surprising, as the rate is known to be lower in Scotland[17] because of the few postmortems asked for by the Procurator-fiscal. The probable explanation is that all the Grampian deaths took place in the teaching hospital while the comparable hospitals in the Mersey and West Midlands Regions made virtually no contribution to our study, almost all their cases coming from the District General Hospitals. The higher rate in the West Midlands as compared with the Mersey Region is due to the greater number of coroners’ autopsies in the West Midlands, probably reflecting different attitudes by coroners in the two Regions.

Our study gave us the opportunity to assess the quality of the autopsies. This was done by studying the reports, their relevance to the clinical problem, the degree of co-

| Region                        | Total case notes scrutinised | Total autopsies | Total autopsy rate % | Hospital No. | Autopsy No. | Coroner, etc No. |
|-------------------------------|-------------------------------|----------------|---------------------|--------------|-------------|-----------------|
| Grampian Health Board (pop. around 1½ million) | 52 | 35 | 67.3 | 34 | 97.1 | 1 | 2.85 |
| Mersey (pop. around 2½ million) | 413 | 169 | 40.9 | 102 | 60.3 | 67 | 39.6 |
| West Midlands (pop. around 5 million) | 535 | 267 | 50.0 | 124 | 46.4 | 143 | 53.5 |
| Total                         | 1,000 | 471 | 47.1 | 260 | 55.2 | 211 | 44.7 |
operation by the physicians, the extent of the histology and the promptness with which the latter was carried out and reported. In the Grampian Health Board the standard was thought to be uniformly very good, and in the Mersey and West Midlands Regions it was good in some autopsies and adequate in nearly all, but in a small number of coroners' autopsies it was considered that the standard should have been better.

Table 2 gives the information on two District General Hospitals, A and B, serving large industrial conurbations in the West Midlands. The differences are considerable, especially in the proportion of cases in which the coroner felt it necessary to intervene. In England and Wales it is well known that coroners' attitudes vary, many requiring an autopsy in all the deaths reported to them, others in as few as 55 per cent of deaths[17]. The coroners' requests in both hospitals contrast strikingly with the fact that in the Grampian Health Board only one of 35 autopsies was carried out at the request of the Procurator-fiscal. The Procurator-fiscal, however, has no obligation to establish the precise cause of death, but he must investigate any sudden, violent, suspicious or accidental death, or death from an unknown cause reported to him. Nevertheless, usually, he requires an autopsy only when a crime has been committed or there is a possibility of death having been caused through negligence[17].

Table 3 shows a much lower autopsy rate in two West Midlands 'county town' District General Hospitals (C and D), serving large rural areas, compared with that in the two District General Hospitals serving large industrial conurbations. Moreover, hospital D has a much lower rate than hospital C. The standard of autopsy in hospitals C and D was high and we did not think their lower rates resulted from any lack of morbid anatomists. The main factor appeared to be the physicians' attitudes to postmortems and their unwillingness, as well as that of their junior staff, to ask relatives for permission[18]. Furthermore, they are less likely to have major teaching commitments than those in hospitals A and B.

Table 4 compares the clinical diagnosis with the autopsy findings in the three Regions and categorises the cases into 4 groups: (a) in which (in our view) the clinical diagnosis was fully confirmed at autopsy and no other pathology was revealed (76.6 per cent of the total autopsies); (b) those where there were minor discrepancies between the clinical diagnosis and the autopsy or when additional pathology was revealed but unrelated to the cause of death (12.1 per cent); (c) those where there were major discrepancies between the clinical diagnosis and the autopsy findings (4.2 per cent); (d) where the clinical cause of death was uncertain (7 per cent). Tables 5 and 6 amplify categories (c) and (d).

Table 2. Comparison of autopsies in two large District General Hospitals in England serving comparable industrial conurbations.

| District General Hospital | Total case notes scrutinised | Autopsies | Autopsy rate % | Hospital No. | Autopsy % | Coroner % |
|--------------------------|-------------------------------|-----------|----------------|-------------|-----------|-----------|
| A                        | 99                            | 66        | 66.7           | 7           | 10.6      | 59        | 89.3      |
| B                        | 98                            | 56        | 57.1           | 36          | 64.3      | 20*       | 35.9      |

*Coroner informed in another 4 but no autopsy requested

Table 3. Comparison of autopsies in two 'county town' District General Hospitals in England serving large rural areas.

| District General Hospital | Total case notes scrutinised | Autopsies | Autopsy rate % | Hospital No. | Autopsy % | Coroner % |
|--------------------------|-------------------------------|-----------|----------------|-------------|-----------|-----------|
| C                        | 60                            | 23        | 38.3           | 14          | 60.9      | 9         | 39.1      |
| D                        | 55                            | 15        | 27.3           | 8           | 33.3      | 7         | 46.6      |

Table 4. Comparison between clinical diagnosis and autopsy findings in all three Regions.

| Confirmation or discrepancy | No. | Percentage of total autopsies |
|-----------------------------|-----|------------------------------|
| (a) Clinical diagnosis fully confirmed and no significant additional pathology demonstrated | 361 | 76.6 |
| (b) Clinical diagnosis confirmed but minor discrepancies or additional pathology revealed | 57  | 12.1 |
| (c) Major discrepancies between clinical diagnosis and postmortem findings | 20  | 4.2  |
| (d) Uncertain clinical diagnoses, some of which were clarified by autopsy (see Table 5) | 33  | 7.0  |
| Total                       | 471 | 99.9 |

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(a) The fact that three-quarters of the patients were correctly diagnosed clinically may be because the patients were relatively young and therefore likely to have been ‘interesting cases’ and also because confusing multiple pathology will have been present less often; lastly, the assessment was made by clinicians, not pathologists.

In (b), of the 57 instances of minor discrepancies, the most common were the finding of symptomless gallstones, the identification of a ‘primary’ in patients dying from carcinomatosis in which further investigation had been thought inappropriate, and acute pancreatitis[13], a not uncommon terminal phenomenon, particularly in those dying from alcoholism. Bowel ischaemia was an undiagnosed finding in four patients, all of whom had widespread arterial degenerative disease.

In (c), Table 5 gives details of the 20 cases in whom there were considered to be major discrepancies. Cases were placed in this category if we considered that prior knowledge of the autopsy findings would have altered the management or treatment of the patient. Even so, there were difficulties and there would certainly not be uniform agreement on the cases to include or exclude.

In (d), Table 6 lists the 33 patients (21 of them coroners’ cases) in whom the clinician was unable to make a definite diagnosis during life. In 14 of these the clinical uncertainty was because the patient was brought in dead, or died either in the casualty department or within a few hours of admission, and in 9 of the 33 the autopsy still left major queries regarding the cause of death. The postmortem information is given in the last column of the table and those cases in which the patients were considered to be potentially treatable at some stage of their illness are now commented on. Case 27 (salmonella gastroenteritis) was moribund on admission and died within 5½ hours, a rectal swab taken during life giving the diagnosis after death. In Case 30 (influenzal epiglottitis) the patient was brought in dead but temporarily resuscitated; the fatal outcome might well have been averted by earlier admission. In Case 373 (brucellosis) the diagnosis of a disease rare in this country was only revealed by a positive blood culture reported after death. Case 391 (acute bacterial meningitis), though eminently treatable, died undiagnosed, gross physical and mental disability due to cerebral palsy having obscured the nature of the illness. In Case 510 (intestinal obstruction due to diverticulitis) the condition was certainly remediable, and in Case 662 (intussusception) surgical treatment would have been curative had the condition been recognised earlier.

Among the 53 patients in groups (c) and (d) there were three with pulmonary embolism undiagnosed during life, which contrasts with the much larger proportion found in the series of Waldron and Vickerstaff[19] and Cameron and McGoogan[8]—again, probably because of the younger mean age of the patients we studied.

Discussion

We feel that this study gives useful information on a series of relatively young patients not primarily selected to assess the frequency or value of autopsies. Our chief finding is the marked variability of autopsy rates, both between and within Regions, and clearly there is no uniformity of opinion between clinicians, coroners and pathologists on the role of the autopsy. Everyone has his own views and we think it worth mentioning the biases of two clinicians.

Pathologists tend to think that what they say is the last word, yet while this is obviously so quite often, the converse is not infrequently true, particularly with stillbirths or neonates. Here, as we noted in our Rhesus deaths surveys[20,21], the actual cause of death was often unknown and ‘the cause’ was attributed to anatomical abnormalities or, worse still, vague unsubstantiable conditions such as ‘intrauterine asphyxia’ or ‘placental insufficiency’ (which were also remarked on by Gau[22]). In saying this, we appreciate that ‘cause unknown’ may give rise to difficulties both with the relatives and with the coders.

Various authors, particularly Cameron and McGoogan and Waldron and Vickerstaff, attach considerable importance to ‘prospective’ as compared with ‘retrospective’ autopsy studies, but in fact all autopsies are retrospective and dummy certificates filled in by the clinician before death seem to us more artificial (bets can be hedged) than spontaneous and often valuable notes written by consultants and their juniors before death.

A last point concerns the 75 per cent accuracy in our survey. This high figure[1,6–8,11,13,19,23,24] may well be partly because we as clinicians made the decisions and not the pathologists, and partly because our series was composed of relatively young individuals. As regards the proportion of cases coming to autopsy, there is little to choose between our series and that of Cameron and his colleagues[2] if one only considers the under-50 deaths in their series.

It is not generally appreciated that though the number of hospital autopsies has fallen greatly the total number of autopsies done by NHS pathologists has increased, and correspondingly, deaths referred for autopsy by the coroner have gone up from 43,000 in 1949 to 145,000 in 1979 and very few of these were unnatural deaths. In Scotland there has been no similar increase, the primary objective of the Procurator-fiscal being to exclude crime or negligence, and only about 25 per cent of cases come to autopsy. The great majority of coroners’ cases are carried out speedily and are not witnessed by the clinical team, which means that there is a great waste of educational material. On the other hand, clinicians are not free from criticism. Too often it is felt that nothing new is likely to be learned from a postmortem, deaths are ‘biochemical’; and there is reluctance to approach relatives. Both sides need to improve. On the one hand, the number of coroners’ autopsies should be substantially reduced, and on the other, the clinical team should regard a postmortem as providing an opportunity for reviewing the entire body of evidence, clinical, laboratory and radiological, as well as the autopsy findings, and to trace the course of the disease, its diagnosis and response to treatment. Each autopsy would then become a mini-CPC (as it is already in some centres) and an excellent form of medical audit.
Table 5. Major discrepancies between clinical diagnosis and autopsy findings.

| Case No. | Ante-mortem diagnosis of fatal illness                                      | Autopsy Coroner's (C) Hospital (H) | Postmortem diagnosis of cause of death                          |
|---------|---------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------|
| 92      | Carcinoma of bronchus                                                    | C                                  | Pulmonary infarction                                           |
|         | Cerebral metastases                                                      |                                    | Carotid artery thrombosis                                      |
|         | ? Encephalitis                                                           | H                                  | Cerebral infarction                                            |
| 192     | Acute abdomen (death occurred in theatre)                                | H                                  | Acute renal failure                                            |
|         |                                                                           |                                    | Haemolytic uraemic syndrome                                     |
| 246     | Primary biliary cirrhosis                                                 | H                                  | Volvulus                                                      |
| 249     | Polycystic disease                                                       | H                                  | Biliary cirrhosis                                              |
|         | Chronic renal failure                                                    |                                    | Stone in common bile duct                                     |
| 260     | Bronchopneumonia                                                         | H                                  | Polycystic disease                                             |
|         |                                                                           |                                    | Chronic renal failure                                          |
|         |                                                                           |                                    | Retroperitoneal lymphoma                                        |
| 423     | Bronchopneumonia                                                         | H                                  | Mesothelioma of pleura                                         |
| 522     | ? Subarachnoid haemorrhage                                               | H                                  | Cerebral abscess                                               |
| 534     | Bronchitis                                                               | C                                  | Bronchitis                                                     |
|         | Uncertain                                                                |                                    | Softening right cerebral hemisphere                            |
|         |                                                                           |                                    | ? Herpes encephalitis                                          |
| 541     | Down’s syndrome                                                          | H                                  | Down’s syndrome                                                |
|         | Congenital heart disease                                                 |                                    | Congenital heart disease                                      |
|         |                                                                           |                                    | Cerebral abscess                                               |
| 599     | Malignant hypertension                                                    | C                                  | Malignant hypertension                                         |
|         | ? Cerebral tumour                                                        |                                    | Pituitary infarcts                                             |
|         |                                                                           |                                    | No brain tumour                                               |
| 645     | Epilepsy                                                                 | C                                  | Cerebral infarction                                            |
|         | Subdural haematoma                                                       |                                    | Bronchopneumonia                                               |
| 647     | ? Cerebral abscess                                                       | C                                  | Cerebral abscess                                               |
|         | Negative burr holes and needling                                         |                                    |                                                               |
| 716     | Thromboembolism                                                          | H                                  | Renal carcinoma                                                |
|         |                                                                           |                                    | Carcinomatosis                                                 |
| 723     | Alcoholism                                                                | H                                  | Bleeding gastric ulcer                                         |
|         | Bleeding varices                                                         |                                    | Alcoholic liver disease                                        |
| 749     | ? Carcinoma of kidney                                                    | H                                  | Renal vein thrombosis                                          |
|         | ? Renal abscess                                                          |                                    | Thromboembolism                                                |
| 792     | Superior mesenteric artery thrombosis                                     | H                                  | Renal carcinoma                                                |
|         | Myocardial infarction                                                    |                                    | Cerebral and renal infarcts                                    |
| 805     | Epilepsy                                                                  | H                                  | Epilepsy                                                       |
|         | Pleural effusion                                                         |                                    | Pulmonary tuberculosis                                         |
| 853     | Subarachnoid haemorrhage                                                 | C                                  | Left ventricular failure                                       |
|         |                                                                           |                                    | Hypertension                                                   |
|         |                                                                           |                                    | No subarachnoid haemorrhage                                    |
| 859     | Alcoholic cirrhosis                                                      | H                                  | Carcinomatosis                                                 |
|         |                                                                           |                                    | Carcinoma of bronchus                                          |
| 973     | Chronic renal failure                                                    | H                                  | Myocardial infarction                                          |
|         | Left ventricular failure                                                 |                                    | Pulmonary oedema                                               |
|         | Pulmonary oedema                                                         |                                    | Healed peptic ulcer                                            |
|         |                                                                           |                                    | Kidneys normal                                                 |

Perhaps the middle course is to have fewer autopsies but with near-mandatory attendance by at least one senior member of the clinical team at any that are carried out. There is also a good case for supporting the view of Cameron and his colleagues[6] that, in addition, an agreed proportion (say 20 per cent) of deaths over and above those selected should have a postmortem carried out (‘partial audit’). This would test the accuracy of...
Table 6. Diagnostic value of autopsy where clinical diagnosis as to the cause of death was uncertain. *(Continued on facing page)*

| Case No. | Known pre-existing disease | Antemortem diagnosis but actual cause of death uncertain | Period in hospital before death | Autopsy Coroner's (C) Hospital (H) | Postmortem diagnosis of cause of death |
|----------|-----------------------------|--------------------------------------------------------|-------------------------------|-----------------------------------|----------------------------------------|
| 27       | Vagotomy and gastrojejunostomy for chronic duodenal ulcer | ? Gastroenteritis with acute renal failure | 5½ hours | C | Salmonella gastroenteritis. |
| 30       | None | ? Angioneurotic oedema | 'B.I.D.' Resuscitated but died 8 hours later | C | Influenza epiglottitis. |
| 60       | Myocardial infarction Peripheral vascular disease | ? | 3 years out-patient and in-patient investigation of pre-existing disease | C | Atheromatous stenosis of coeliac axis and superior mesenteric artery. Ischaemia and gangrene of small and large intestine. |
| 61       | Obstructive airways disease | ? | 5 days | H | Haemopericardium due to dissecting aneurysm. Carcinoma of bronchus. |
| 65       | Asthma Hypertension | ? | B.I.D. | C | Myocardial infarction. |
| 75       | None | ? but patient hypertensive | 28 hours | C | *Uncertain. Enlarged left ventricle and old myocardial infarction. Bronchopneumonia. Pulmonary oesophageal fistula due to ruptured oesophagus. Thromboembolism. |
| 104      | Healed pulmonary tuberculosis Schizophrenia | ? | 5 days | C | Polyarteritis nodosa. Adenocarcinoma of lung. Malignant pericardial effusion. |
| 112      | Healed pulmonary tuberculosis Alcoholism | ? | 6 days | C | Uncertain. Uncertain. Unexplained renal, pulmonary and cerebral arterial thromboses. Pericarditis (cause undefined). |
| 211      | None | ? | 2 months | H | Cardiac arrest in Casualty |
| 226      | None | ? | 2 hours | H | |
| 244      | Asthma | ? | 4½ hours | C | |
| 245      | None | ? Cerebral infarction | 17 days | H | |
| 253      | Asthma | ? | 4 days | H | |
| 286      | Treated myxoedema | ? | 8 hours | C | |
| 332      | None | ? | Cardiac arrest in Casualty | C | |

*Indicates not providing a satisfactory explanation of the illness and death.

Clinicians and pathologists, a highly necessary activity, in our view.

Summary

This paper surveys the first 1,000 cases of our ‘deaths under 50’ project, from the point of view of autopsies performed, the Regions involved being the West Midlands and Mersey and the Grampian Health Board. The number of autopsies carried out was 471, 26 per cent of the 1,000 as part of routine hospital practice and 21 per cent at the request of the coroner, the Home Office or the Procurator-fiscal. The high total figure of 47 per cent relates to the young age and often sudden death of the patients.

Our first principal finding was the marked variability in the postmortem rate, both within and between Regions, indicating lack of uniformity of opinion between physicians, coroners and pathologists on the role of the procedure. Our second was that in three-quarters of the cases the clinical diagnosis was fully confirmed and no other pathology revealed. This high accuracy probably reflects that the assessment was made by two clinicians and also that the age group under survey meant that
| Case No. | Known pre-existing disease | Antemortem diagnosis but actual cause of death uncertain | Period in hospital before death | Autopsy Coroner’s (C) Hospital (H) | Postmortem diagnosis of cause of death |
|---------|-----------------------------|--------------------------------------------------------|-------------------------------|---------------------------------|--------------------------------------|
| 357     | Blind, hemiplegic and epileptic following RTA | ? | Cardiac arrest in Casualty | C | Myocardial infarction. |
| 363     | None | ? Subarachnoid haemorrhage | 4 days | C | Uncertain. |
| 367     | Asthma Diabetes mellitus Hypertension | ? | 11 hours | H | Frontal meningioma with haemorrhage. Myocardial infarction. |
| 373     | None | ? (blood cultures reported positive for B. melitensis after death) | 8 days | C | Evidence of septicaemia and myocarditis but no cause established. |
| 391     | Cerebral palsy | ? | 18 hours | C | Acute bacterial meningitis (no organism isolated). |
| 401     | Depression | ? | 3 days | H | Uncertain. |
| 510     | None | ? | 3 days | C | Sigmoid obstruction due to diverticulitis |
| 532     | None | ? Electrocution | B.I.D. | C | Uncertain ? Electrocution. |
| 561     | Cerebral palsy Blind. Epileptic | ? | 6 hours | C | Acute pancreatitis. |
| 581     | None | ? | B.I.D. | C | Myocardial infarction. |
| 629     | None | ? but patient had marrow depression and lymphadenopathy | 3 days | H | Hodgkin’s disease (patient transfused and lymph node biopsy planned but died before it could be done). |
| 662     | None | ? Intestinal obstruction and acute renal failure | 2 days | H | Intussusception |
| 694     | Asthma Turner’s syndrome | ? | 2 days | H | Dissecting aneurysm of aorta. |
| 756     | None | ? | B.I.D. | C | Aortic stenosis. |
| 878     | None | ? | 11 hours | C | Uncertain. |
| 879     | None | ? | 6 days | H | Membrano-proliferative glomerulonephritis. Pulmonary oedema. |
| 894     | None | ? Thromboembolism | 2 days | H | Uncertain. Not thromboembolism. |
| 939     | Systemic lupus erythematosus | ? | 24 hours | C | *Acute pyelonephritis. |

*Indicates not providing a satisfactory explanation of the illness and death.

Confusing multiple pathology, so often found in older patients, was largely eliminated.

In 20 of the 471 cases there were major discrepancies between the diagnosis during life and the autopsy findings such that a prior knowledge of the latter would have altered the management of the patient. There were also 33 patients, many of them coroners’ cases, and some brought in dead or dying, in whom the clinician was unable to make a diagnosis. Only five of these, following postmortem, were considered to have had conditions potentially treatable earlier in their illness, and in 9 of the 33 the postmortems still left major queries about the cause of death. Brief notes are given on these two groups of problem cases.

General points are:
1. The great increase in the last 30 years in coroners’ postmortems, many of which are not witnessed by the clinical team.
2. The lack of interest of many clinicians—deaths are regarded as ‘biochemical’—and the resulting disinclination of young doctors to approach relatives.

In our view both these attitudes are wrong because they neglect the educational aspects of postmortems.

It is suggested that the number of coroners’ autopsies
should be substantially reduced and that a postmortem should become a mini-CPC in which the course of the whole disease can be traced.

In our view a good case has been made out by Cameron and his colleagues[6] for the selection of an agreed proportion (say 20 per cent) of autopsies over and above those selected on the usual grounds, so that the accuracy of both clinicians and pathologists can be tested in random cases.

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The British Museum

'I have heard by some people that you talk of removing your great treasures to Chelsea. I hope it is not with a thought of passing any of your time with them there, for I shall much dread the change of climate . . . so near the water and so bleak and exposed every way to the weather.' That was the plea of young Philippa Stanley to her octogenarian relative Sir Hans Sloane. But the old man did purchase the manor of Chelsea from William Cheyne in 1712 and proceeded to remove his squirrel-horde of antiquities from his old house in Bloomsbury. Such collections were fashionable at the time. John Tradescant, the gardener whose effigy is carved into the stairway of Hatfield House, had left his collection to Elias Ashmole who offered it to the University of Oxford in 1677. Sloane's collection was very much grander. The items arrived at the manor house in Chelsea loose in carts. They were 'tossed from a cart to a man on a ladder, who tossed them in at a window, up one pair of stairs to a man who caught them as men do bricks.' So wrote Sloane's factotum, Howard, who had first been employed to catch mice in the garden at one penny for every three mice.

The treasures were eventually displayed for many curious and noble visitors and Sloane took steps to leave the whole collection to the nation. He died in his 93rd year in 1753. One of his trustees was Horace Walpole who wrote to a friend 'You will scarce guess how I employ my time; chiefly at present in the guardianship of embryos and cockle-shells. Sir Hans Sloane is dead and has made me one of the trustees to his museum, which is to be offered for £20,000 to the King, the Parliament, the Royal Academies of Petersburg, Berlin, Paris and Madrid. He valued it at four score thousand; and so would anybody who loves hippopotamuses, sharks with one ear and spiders as big as geese. You may believe that those who think money the most valuable of all curiosities will not be purchasers.' However, six months after Sloane's death Parliament passed 'An Act for the purchase of the museum or collection of Sir Hans Sloane, Bart., and of the Harleian collection of manuscripts, and for procuring one general repository for the better reception and more convenient use of the said collection, and of the Cottonian Library in addition thereto.' So a new set of 'Trustees for the British Museum' was appointed and they bought Montagu House, then long unoccupied and nearby Sloane's old home in Bloomsbury. The house had been built by Ralph Montagu who, in 1690, had married the widow of the Duke of Albemarle who had taken the young Sloane to Jamaica and helped found his fortune as a fashionable doctor.