Who asks permission for an autopsy?

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ABSTRACT – A survey was undertaken of all hospitals with more than 400 beds in North East Thames Region to ascertain the way in which permission for an autopsy was obtained, in an attempt to explore reasons for declining autopsy rates. We found that there was a considerable variation in autopsy rates, and in the systems within hospitals whereby permission for autopsy is sought. The responsibility for requesting an autopsy is often delegated to younger doctors who have not received any training in how it should be done. A sensitive lay person can achieve high rates of permission for autopsy. Most consultants interviewed stated that they requested less autopsies now than 5 or 10 years ago. They seldom attended autopsies, and one-third of pathologists have given up contacting the clinician before an autopsy.

Autopsy rates have decreased in the past 40 years in the United States [1] and in the United Kingdom [2]. There appears to be less emphasis on the use of autopsies in teaching, and many physicians believe that, owing to the more invasive investigations introduced since the war, few surprises are likely at autopsy. Other reasons, more evident in the United States, include fears of litigation if something unexpected is revealed, and probably also a lack of reimbursement for autopsies [1]. Nonetheless, a number of studies have shown that unexpected findings do result from about 20% of all autopsies, and in one study about 11% of them yielded findings that ‘would probably have led to a change in therapy and improved survival’ [1].

Personal experience of one of us (A. H.) suggested that there was a considerable variation among hospitals as regards the procedure for deciding whether an autopsy should be done. We have audited autopsy rates and the way in which permission for autopsies is obtained in hospitals in North East Thames Region.

Methods

There are 15 hospitals in the Region with more than 400 acute beds [3]. The student authors arranged to interview a consultant pathologist at each of these hospitals (a senior registrar at one). Answers to the following questions were sought:

1. What is the clinical autopsy rate? (This is the number of hospital post-mortems performed each year as a percentage of the total number of deaths in the hospital each year; autopsies performed by coroners’ pathologists are excluded.)
2. Is there a hospital policy as to how permission for an autopsy should be obtained from the next of kin?
3. Do the clinicians responsible for the deceased patient’s prior management usually attend the autopsy?
4. Are there adequate facilities for a greater number of autopsies?
5. How much time elapses after the autopsy before the hospital consultant receives the report? Is the information sent also to the family doctor? Is the next of kin informed about the result of the autopsy? If so, how?

Each consultant pathologist was asked to estimate the proportion of major unexpected additional findings at autopsy, and to suggest reasons for the reported decline in autopsy rate. The pathologists were also asked for the names and registry numbers of the five most recent deceased patients to have had a hospital post-mortem. The student authors then interviewed the clinicians concerned. They were asked in general terms for their views about autopsies, and whether or not they regularly attended them. House officers were asked to complete a questionnaire about their views and their actions in the past year. If a lay administrator (often termed a bereavement officer) was involved, he or she was also interviewed.

Results

Clinical autopsy rates

Clinical autopsy rates could be obtained for only 11 of the 15 hospitals, and a further two hospitals gave what they considered to be reasonably accurate estimates. Figure 1 shows the rates over the years 1976 to 1989, although information is incomplete for many hospi-
tals; it also shows a considerable variation in autopsy rate among the hospitals, and a general decline in rate over time. Of the 15 pathologists, 3 said they were unaware that there was a general decline in autopsy rates, but 8 knew and were concerned that the rate was declining in their own institutions.

Who requests the autopsy?

There was considerable variation as to who within each hospital decided whether an autopsy should be requested. Pathologists reported that very often the decision appeared to rest with the junior staff rather than with the consultant who had been in charge of the patient’s management. The overwhelming impression of the student authors who spoke to the house physicians was that the policy on their firm was vague and ill-defined.

When permission to carry out an autopsy was requested from next of kin, in 8 of the 15 hospitals a doctor asked; in 4 of the 15 the policy was that a doctor on the firm usually asked, but very often the job passed to a member of the administrative staff owing to clinical pressures, or simply because the administrator sees the patient first. In 3 of the 15 hospitals an administrator was responsible for asking permission but would seek support from the clinician if it was considered very necessary that an autopsy be obtained.

Do clinicians usually come to the autopsy?

Seven of the 15 pathologists informed the clinician concerned 10 minutes before the autopsy began, and two insisted upon the clinician’s attendance. Five of the 15 no longer bothered to notify the patient’s physician.

Resources

The pathologists were asked whether a greater number of autopsies could be performed with their available facilities and staff. Twelve of the 15 reported that it would be possible, but 3 said no more could be done without additional facilities or staff.

Fig. 1. Clinical autopsy rates at eleven hospitals in North East Thames Region. Data from coroners’ cases are excluded, as are those from hospitals that could provide only estimated rates.
Communication of results

All the pathologists claimed to send the result of the autopsy to a consultant in charge of the deceased patient, and 7 of the 15 claimed to send it also to the family doctor. Two pathologists did not know to whom the reports were sent. Of the 9 pathologists who were asked how soon their reports were available, 7 replied that they were completed and delivered within 2 weeks.

The views of pathologists

The following unprompted reasons were given by the pathologists for the declining autopsy rate (after informing two that the rate was declining). According to 13 of the 15, lack of motivation by clinicians was the most common reason. Comments made were that clinicians did not appreciate the importance of the autopsy, that they placed more reliance upon diagnostic tests, and that many patients were under a number of clinicians and no one of them felt primarily concerned. Other remarks related to fears of litigation and of exposing failure. Further reasons given were social factors, including increasing resistance from relatives, refusal from some ethnic minorities and religious groups, and media reporting about autopsies. One pathologist thought that funeral undertakers often dissuaded relatives from giving consent. The pathologists also considered that the source of the request for an autopsy was important, and 5 of the 15 believed that the increasing involvement of administrators was responsible for the decline in rate. Lack of appropriate skills on the part of clinicians and administrators when requesting permission was also mentioned by 4 of the 15 pathologists.

The views of administrators

With one exception, the administrators were not aware of any decline in the autopsy rate, and even appeared largely unaware as to the purpose and importance of autopsies. The administrators thought that the principal reasons for a refusal were that many relatives considered autopsies to be distasteful, that relatives were aware of their legal right to refuse, and that for some religious groups and ethnic minorities autopsies were not allowed. Some administrators remarked that senior registrars were more likely than house officers to obtain permission.

The views of consultants

Of the 36 consultant general physicians and surgeons interviewed by the students, 58% said that they requested fewer autopsies now than 5 and 10 years ago, and only 6% thought they now requested more. Most (72%) were aware of the declining autopsy rate, mentioning that the increasing number of diagnostic tests enabled more definite diagnoses to be made during life. A few (8%) also remarked that pathologists themselves did not seem to be pressing for more autopsies. Some (17%) also considered that, because the proportion of elderly patients dying in hospital was increasing, there was less reason for autopsies since death then seemed to be more natural and any more autopsies would be wasteful at a time of resource constraint. As regards the declining rate of autopsies, 14% of the clinicians remarked upon a poor approach by those requesting the autopsy, and 42% mentioned increased resistance from relatives. Very few of the clinicians attended autopsies themselves but most (83%) expected a member of their staff to be present. In contrast to the views of pathologists about communication, only 47% of the clinicians found that reports were usually received within 2 weeks. Delays of up to 6 months were reported, and some claimed that they never saw the results. None of the clinicians considered litigation an important factor in the declining autopsy rate.

The views of house officers

A total of 74 house officers were interviewed, about five from each hospital. Figure 2 shows that they believed the responsibility of asking for an autopsy was usually theirs; most of them willingly accepted this responsibility but only a few had received any guidance on how best to carry out the task. The mean estimate of their success rate was 79% (n = 60); they thought that they were more likely to succeed than an administrator but much less likely than senior staff (Fig. 2). The mean estimate of the proportion of deaths leading to an autopsy on their firm was 17% (n = 56).

Discussion

This audit of autopsies in North East Thames Region has revealed a marked variation in autopsy rates, in the attitudes of pathologists and clinicians, and in the systems within hospitals whereby permission for autopsy is sought. The pathologists' perception of their efficiency in communication with the clinicians is at variance with the clinicians' perception of a relative failure in communication.

Opinions vary as to what autopsy rate is desirable. Wells [4] has pointed out that, from the point of view of quality assurance in medical care, it is not necessary to aim for a high autopsy rate since a sample of relatively small size should, if suitably chosen, be as adequately informative as a large sample. Others [1, 4, 5] emphasise the educational importance of autopsies. A proper course of action might be to continue as at present in seeking permission for autopsies on patients who had given rise to exceptional diagnostic difficulty or when autopsies were considered likely to reveal pathological material of considerable educational interest. This group could be regarded as an educational group of autopsies. A further quality assurance group of autopsies could be chosen by appropriate random sampling of all deaths within a hospital.
Our findings suggest that each clinical firm should review its policy about its need for autopsies, and about who should ask for permission. We feel that, as a courtesy to the patient’s family, the person who makes the request should be a clinician. In the case of surgical firms, however, there are logistical difficulties in that all the members might be in the operating theatre at the time of the relative’s visit. Our study showed that a sensitive administrator can achieve high autopsy rates. Experience, as well as personality, presumably plays some part in this, yet nearly 80% of the house officers stated that they had not received any advice on how to set about requesting permission. There is a need to review and improve the system whereby autopsy reports reach the clinicians concerned (including the family doctor) and the relatives. If it be held that a primary role of autopsy is educational, and that it plays a part in audit of medical care, it is essential that senior clinicians attend autopsies.

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