

DEVELOPING THE APPROACH TO POSTMORTEM PRACTICE IN ACUTE HOSPITALS

Peter W Johnston

Abstract: There is potential to improve the management of death and bereavement in acute hospitals and an opportunity to do so. The author suggests ways in which improvements might be brought forward, with particular reference to education of health care professionals and the public about the role and value of the postmortem. Reform of the consent process for autopsy to include the opportunity of involvement of pathologists at an early stage is proposed. The provision of the chance for relatives to receive feedback of post-mortem data again with pathologist input is also suggested in tandem with the offer of bereavement counselling for grieving families. The potential value of the postmortem in managing bereavement should be studied. It is acknowledged that such intervention could be costly in resource terms, but if value can be discerned, it may well be worthwhile.

Key Words: death, bereavement, postmortem, autopsy, necropsy, counselling, pathology

Introduction

This paper sets out to consider what we in the hospital community can do to support families through bereavement with particular reference to the potential role of the postmortem examination in this process. It does not review the findings of the reports associated with revelations at Alder Hey (Report 1) or the findings of the McLean Report (Report 2). Neither does it debate the moral and ethical questions raised by past practices or the effects of their revelation. A body of literature already exists on this subject (e.g. Bauchner and Vinci, 2001; Hunter, 2001). The present article is intended to contribute to the discussion on how we can develop and improve our handling of death and maximise the value of postmortem information in acute hospitals. The developments proposed build on reported and first hand experience of supporting families who have been upset by what they have learned about post-mortem examinations carried out, in some instances, many years previously.

The publicity that has suddenly highlighted the postmortem has had an unexpected outcome. It has presented us with a singular opportunity: we can now engage the health care professions and the pub-

lic as never before on the subject of death, its management and investigation. In acute hospitals, death is still considered a failure of the system and the “we have lost a patient” attitude prevails. Let us not forget that pathology has overwhelmed the patient and our best efforts have not assuaged it progress. Indeed, it may have been wrong for us to attempt to stand in the way of the inevitable. For death remains thus. Chaplains obviously think constructively about this already as a recent article in this Journal demonstrates (Gordon, 2000). Medical students, are taught, “to comfort always” as a sine qua non of good practice. As members of the caring professions, then, we must be equipped to deal personally and professionally with death and the questions it poses for us and for the relatives of those who die and so be in a position to deal effectively with it.

How best can we achieve this? Let us explore ways in which we might address this question, paying particular attention to issues associated with post-mortem examination. In summary, we need to

- educate doctors, nurses and other health care workers and the public about autopsy practice and the benefits for individual families and for medical education and audit that can stem from it;

- reform the consenting process so that patients and relatives are involved and feel ownership of the it and, at the same time, ensure pathology input to give guidance and reassurance as to potential outcomes
- incorporate postmortem feedback by pathologists to relatives as part of a bereavement counselling service in acute;
- monitor and audit any new practices with an eye to future development.

Education

Medical students need to learn about death, how it happens, pathological processes that produce it and what it looks like. They need to know about bereavement and how to deal effectively with recently bereaved people in a positive and practical manner. Trusts need to be able to offer services that manage death actively and deal with the questions a death brings forward in an open and helpful manner. What steps can we take towards attaining these goals?

Experience suggests that many doctors lack specific knowledge about autopsy procedures – what actually happens – and potential outcomes. Exposure to pathology as an undergraduate has become less because pathology has been to a greater or lesser extent removed in revised curricula, following the implementation of the General Medical Council's document "Tomorrow's Doctors" (Anon, 1993). Many doctors now start practising having never seen a postmortem let alone considered the issues surrounding it. This apparent deficit has been compounded by the reduction in postmortem rates and, in relation to those autopsies that take place, a reduced proportion of cases where permission has been granted to use material derived from the examination as a learning resource. Undergraduate curricula require to incorporate adequate exposure to and assessment of pathology and its effects on human function; not just the management of its outcomes. Part of this must include exposure to the autopsy. A way of doing this might be that, like for other practical procedures, students would be required to have a set number of postmortems written up in a log book, revisiting the subject at various stages in their programme.

Bereavement is another must, to understand the nature of grieving and its potential consequences, as

well as practical measure that might be taken to help people deal with grief reactions. Objective structured clinical examination (OSCE) stations could be used to assess students' learning in this area. It might be useful to consider what contributions to such student learning and assessment chaplains might make because of the experience chaplains have of such situations. This would help reinforce, in the minds of students, the benefits of having chaplains and medical staff function as parts of a multidisciplinary team in dealing with death in acute hospitals.

There are more specific suggestions about the autopsy. As noted above, the profile of pathology as an undergraduate subject has diminished. This must be addressed in postgraduate medical training to make up for lost opportunities. Generic programmes of learning towards developing skills in obtaining consent are already being contemplated and seeking consent for autopsy could be incorporated within such programmes. In addition, doctors in general need to be made more aware of the role of the autopsy as an audit tool. Part of this, is the training of pathologists to look more deeply into the patient's condition and management along with the requesting doctor at the time of the autopsy. The postmortem is more than simply establishing a cause of death. It can be used to address questions about the nature and extent of disease, the response of body systems to pathology and of the pathological process to defence mechanisms. It can address issues of response to treatment and efficacy of investigative methods used during the patient's life. Asking appropriate questions is thus vital and is bound to require discussion between relevant parties. This is an issue with resource implications for a variety of groups, but if we are genuine in our attempts to examine and audit practice and contribute to the evidence base, we must see fit to invest in the autopsy component of audit. The autopsy rate is very low compared to past practice yet significant additional information that could have affected patients' antemortem management is regularly added by autopsy (Cameron and McGoogan, 1981, Robinson and Marley, 1996; Tse and Lee, 2000). Autopsy consistently remains the "gold standard" for information surrounding people who die.

Reform

Pathologists, for many years, have been considered (and have considered ourselves) as being “behind the scenes”, doctors whose contact with patients has been minimal. With fine needle aspiration clinics and integrated clinical meetings, the front line clinical nature of pathology is beginning to be perceived. The organ retention issue has made this abundantly clear. There might well be potential benefit in extending the clinical role of the pathologist to include direct patient contact in dealing with matters pertaining to postmortem examinations. Many pathologists will welcome such an extended role; others will not. Still more (and perhaps from both groups) will see the need for training in handling new situations. If the reforms suggested below are to succeed, the opportunity for pathologists to develop new clinical skills will need to be resourced adequately.

We need to involve the public, doctors, nurses and other groups in a process of change towards fulfilling these needs and educators to facilitate it. It might be said to be unwise to suggest developing new aspects of the service that impact on pathology in the current manpower shortage, but the logical solution to the needs described above is to have pathologists involved in all of them. This includes the consenting process. This may be facilitated by developing a role for a specially trained group of people, who would, at the request of the consultant responsible for the terminal care of the patient in question, discuss and answer questions from relatives about the process of postmortem examinations. The matter of consent could rest primarily with such staff. It would be essential, however, that they have immediate access to pathologists.

The involvement of pathologists first hand in the consent process for autopsy parallels the way in which anaesthetists see patients preoperatively and discuss the anaesthetic procedure to be used and the likely consequences. Potential difficulties and risks can be discussed and an informed judgement reached on the part of both the doctor and the patient/relative. Problems in organising such a system may well occur, but where autopsy is proposed, a more formalised consenting process might be useful to replace the current, often difficult, circumstances. Straight forward fact sheets encompassing commonly asked questions might form a useful starting

point from which to broach the subject of autopsy. This could then lead on to discussion as part of the consent process. Any questions at this stage might usefully be referred to the pathologist. All discussion should be fully documented as part of the patient's case record.

The main advantage of pathologists' involvement in the consent process is that pathologists can tell relatives what can or cannot be done under specific circumstances. For instance, an autopsy cannot provide detailed information about a degenerative neurological condition without taking the brain and spinal cord, retaining it for adequate fixation and processing before histological examination to allow diagnosis; pathologists cannot comment on the classification of a tumour without keeping tissue for microscopic diagnosis. This, in turn requires that tissue is kept for processing and later microscopy, all of which requires several days or, in the case of whole organs, several weeks. Conversely, limitation of ability to answer questions could be explained if limited consent was to be given. The point is simply that if a postmortem is to be carried out, it is our collective duty to ensure we make best use of the opportunity – the dead person and his or her family, deserves no less. This does not mention our obligation to learning, audit and research. Experience suggests this point is well accepted by families. It is necessary to acknowledge, however, that such a scheme will have resource implications as it represents development of the role of the pathologists beyond what is currently the norm.

There is a further advantage for patients and pathologists. Pathologists would be visible as integral to the care of patients and their relatives. This would have advantages for relatives who would see the human face of pathology and realise pathologists are, like their colleagues, caring doctors, not the imagined ghoul as recently suggested. Other specialities would also usefully see this role and pathologists themselves would benefit from being recognised as central players in such a clinical care scheme. This may even have advantages for recruitment into the discipline.

Education and awareness of the public are also matters of central concern. It is necessary to talk more openly than has been the case about post mortem care. The fact sheets about postmortems referred to above might be quite widely available, for example

in GP surgeries and in routine hospital admission packs – we can no longer tacitly ignore the fact that death is a potential outcome from a hospital admission. Risk assessment is not about assessing the risk of missing the bus. When doctors talk to patients about risk, the discussion is about chances of survival and of regaining independence. Patients, it is argued, are no strangers to considering this issue. Accurate information must be widely available, not hidden away or considered too unpleasant to discuss.

All this implies that relatives are eager for involvement and access to full information. The McLean Report (Report 2) makes it clear that options regarding the autopsy procedure and the handling of material used for microscopic diagnosis have to be offered to relatives. Some, maybe many, relatives will not wish such information. Giving it to them when they do not want it may be harmful (Alexander, 1999). We must be sensitive to patients' and relatives' wishes respecting the level to which they want to be informed. This may be difficult given current guidance.

Feedback

A useful component of a new active bereavement management service would be that relatives could be invited to feedback clinics where they, in the presence of the doctor who referred the case to the pathologist for postmortem, could be given information obtained at autopsy and the findings and their potential implications discussed. For example, the finding of a large heart in a sudden collapse in the absence of ischaemic damage might suggest a cardiomyopathy which would, in turn, indicate the value to the family of genetic and functional investigations and allow calculation of risk factors for future generations. It has been acknowledged that access to such information that others might classify as "difficult" can be beneficial to families if they wish to have it; conversely, withholding information may also be damaging (Alexander and Klein, 2000). It would also provide the opportunity for relatives to receive bereavement counselling to help manage grief reactions in a positive way. It is suggested that provision of postmortem data may be valuable to relatives in managing their grief and so may facilitate bereavement counselling. This hypothesis could form the basis of an interesting and useful study to establish what, if any, benefits arise, to whom and

how they may be optimised as the literature suggests it has not yet been tested explicitly (Doyle, 2000)

Resource implications arise again: a feedback clinic would probably get through about three cases in a session on the basis of 45 – 60 minute appointments. And so additional pathology consultant sessions could be calculated on this basis. Some disciplines (most notably neonatal paediatrics and obstetrics) already routinely see relatives (essentially parents) following a death and autopsy for the purpose of feeding back to the family. For other clinical specialties and for those already dealing with bereavement, resource implications would need to be included. Similarly, counsellors would need to be employed. Secretarial and administrative costs associated with this service expansion would also need to be included. The formal study and audit of such a scheme would also have cost implications but would provide evidence crucial to continued implementation.

A potential difficulty arises in circumstances where a death becomes the subject of investigation by procurators fiscal or equivalent legal authority. Access to information gathered by the postmortem might necessarily or simply by established practice be restricted. This situation might be seen as unhelpful by doctors and relatives alike. Although informal routes for the flow of information doubtless exist, these may not be optimal and very probably rely on opportunity and good working relationships between staff concerned. This is an area of practice that might usefully be examined to maximise the benefit of autopsy derived information for relatives for whom the range of choices has diminished because of the legal nature of the investigation.

Conclusion

So, where does this leave us with the autopsy? It is interesting reading comments related in recent reports that relatives value the information provided by postmortems. This is backed by recent local experience among relatives who are experiencing great difficulty dealing with the retention of organs from postmortem examinations and the consent process they underwent before hand. The most difficult thing for these people appears to be their lack of input and loss of control of a situation, not the subsequent procedure. The conclusion is that postmortem services need to be made more personal and

acceptable to relatives. Doctors, nurses and other health care professionals (and funeral directors) need to be educated about postmortem practice and the benefits the information provided can supply to grieving relatives as well as to doctors and medicine in general. We need to manage death as part of the normal process of care in acute hospitals and transfer the focus of care from the dead to the living relatives with the offer of bereavement counselling. This will need time, effort and money, research and development. Some of this will be hard and pathologists are already overstretched. But, if we and our political masters are genuine about improving health care and involving patients in their own management, these are steps we might just have to take.

Acknowledgements

I am grateful to Rev J Falconer and Dr ES Gray for their encouragement and comments in the preparation of this paper.

References

ALEXANDER DA. 1999 Human reactions to trauma – their features and management. Chapter in “Pre-Hospital Medicine - the principles and practice of Immediate Care”, GREAVES I, PAXTON K (eds.). Arnold, London, UK.
ALEXANDER DA, KLEIN S. 2000 Bad news is bad news: let’s not make it worse. *Trauma* 2:11-18.
ANON. 1993 Tomorrow’s Doctors. Recommendations on undergraduate medical education. London: General Medical Council.

BAUCHNER H, VINCI R. 2001 What have we learnt from the Alder Hey affair? *British Medical Journal* 322:309-10.
CAMERON HM, MCGOOGAN E. 1981 A prospective study of 1152 hospital autopsies: II. Analysis of inaccuracies in clinical diagnoses and their significance. *Journal of Pathology* 133:285-300.
DOYLE LW. 2000 Effects of perinatal autopsy on counselling. *Lancet* 355:2093.
GORDON T. 2000 Reflections on religious dogmatism in the care of dying and bereaved people. *Scottish Journal of Healthcare Chaplaincy* 3(2):18-22.
HUNTER M. Alder Hey condemns doctors, management, and coroner. *British Medical Journal* 322:255.
REPORT 1. 2001 Royal Liverpool Children’s Enquiry. London: Stationery Office. www.rclinquiry.org.uk/
REPORT 2. 2001 Independent Review Group on the Retention of Organs at Post Mortem. Edinburgh: Stationery Office. www.show.scot.nhs.uk/scotorgrev
ROBINSON IA, MARLEY NJ. 1996 factors predicting cases with unexpected clinical findings at necropsy. *Journal of Clinical Pathology* 49:909-12.
TSE GM, LEE JC. 2000 A 12-month review of autopsies performed at a university-affiliated teaching hospital in Hong Kong. *Hong Kong Medical Journal* 6:190-4.

*Peter Johnston is Consultant Pathologist,
Department of Pathology, Aberdeen Royal
Infirmary.*