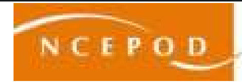
The Coroner's Autopsy: Do we deserve better?



Professor Peter Furness
Chairman of Specialist Advisory Committee in Histopathology
Royal College of Pathologists

The Royal College of Pathologist's mission statement includes: 'to promote excellence in the practice of pathology.' "That's what drives the viewpoint of this college, in relation to the report," Professor Furness explained. In that context, he emphasised that the College had originally requested that the NCEPOD investigation be done. "We hope it converts anecdotes that we'd all heard into solid evidence; that will allow us to do something to sort things out and improve things in the future." To that extent, he considered the investigation to be a good example of professional self-regulation.

The headline criticism is this: one in four reports are 'poor' or 'unacceptable', when judged against standards set by the RCPath. Specific criticisms included not examining the brain, not doing histology, not adequately examining the heart, not investigating epilepsy properly. Professor Furness stressed that the College does not condone 'cutting corners' on quality of practice. But he suggested that it was important to understand what might be causing some of these problems.

Professor Furness asked: "What is the coroner's autopsy ***for***?" The answer, he suggested, is to identify the cause of death. But to what level of detail should the cause of death be investigated?

A recent study at a major UK teaching hospital found major misdiagnoses in 39% of hospital post-mortems in patients who had died after detailed clinical study in the intensive care unit. Professor Furness pointed out that, if causes for referral to the Coroner have been excluded, is acceptable to allow a doctor to complete a death certificate without further investigation. So if the Coroner is not involved, major missed diagnoses in 39% of deaths are acceptable to society. Society does not seem to demand any greater certainty. He added: "I am not saying that's right, but just pointing out that that's the way it is at the moment."

When considering what a coroner's autopsy is trying to achieve, Professor Furness suggested a spectrum of possibilities. These include: merely to identify or exclude homicide; to identify or exclude unnatural death; to provide a *plausible* cause of death; to provide an *accurate* cause of death for national statistical purposes; or to provide as much information about the cause of death as state-of-the-art medical science can provide.

"Whereabouts on this continuum of investigation do we want to go?" he asked. The report suggested a cut off point somewhere between providing a 'plausible' and an 'accurate' cause of death, in terms of what constituted a 'poor' or 'unacceptable' report. "The Royal College of Pathologists' advice is that we should get as far down this continuum as we can, with the resources available," he said. To achieve this, the College has developed guidance in several areas. However, he noted that this was only guidance, not law; and the mechanisms for certifying natural causes of death, as mentioned above, raise the possibility that the College is demanding better investigations than society actually wants.

Considering further issues impacting on autopsy, Professor Furness noted: "We've had a number of startling events, which have rocked this college and its membership. We've had Bristol, Alder Hey, a public enquiry and public consultation, the Human Tissue Act and now the Human Tissue Authority." He considered that the improved regulation was absolutely necessary but warned: "The effect of the whole pack-

age has been to leave pathologists not quite sure that the public wants to go the extra mile in cutting up dead bodies, and also slightly worried that if we do a bit more than authorised, are we laying ourselves open to legal challenge?"

Professor Furness outlined two scenarios to illustrate the dilemmas in this area. "An elderly person in a nursing home, fairly rapidly deteriorates and dies. Cause of death not evident or perhaps not seen by a doctor, so the death is referred to the coroner and a post-mortem is started. The pathologist finds coronary artery atheroma – it would do as a cause of death, but it's fairly ubiquitous in elderly people in nursing homes. But there's also bronchopneumonia. A very plausible cause of death. Should the pathologist carry on and examine the brain?" Before the meeting he had put that question to a small and totally non-scientific group of lay people, and he reported that they had responded 'What on earth for?'

As pathologists, he noted that they knew that examining the brain might reveal other things. An intracranial haemorrhage might be the cause of the bronchopneumonia. Some forms of intracranial haemorrhage imply bangs to the head, perhaps not natural causes, thus justifying why the College recommends always examining the brain. But he warned that this may not be understood by tabloid newspapers, with news stories such as 'distraught relative said the pathologist had already worked out that my mother had died of bronchopneumonia – why did he carry on and saw the top of her skull off?'

In another scenario, an elderly person died in a nursing time. "This time, tumour nodules are found, the apparent primary site is the lung, – the cause of death is clear. Disseminated carcinomatosis. Natural causes. Should we take samples for histology?" Professor Furness asked. "Our advice is yes, because without it we don't know the tumour type. Knowing the tumour type might sometimes show the primary site to be another organ. Very occasionally, it could turn out to be a type that might have further implications – such as mesothelioma, which is usually caused by asbestos, which is usually due to occupational exposure. So we have a justification for taking tissue; but pathologists are very worried about the public reaction to retaining tissue, in addition to the all the resource issues."

Does society want post-mortem examinations to this high standard? "We need to know exactly where we stand, and we don't," he said.

The report looked at whether or not tissue should have been retained for histology. One of the reasons for criticism was cited as: '*tissue retention may have assisted in elucidating particular features of the death but may not necessarily have been required to determine the cause of death*.'

Professor Furness pointed out that, in terms of the Human Tissue Act, the coroner authorises the post-mortem for the purposes of the coroner, and is not in a position to authorise anything that goes beyond that. The coroner needs to know 'the cause of death' – however that is interpreted. The wording of the report indicated that pathologists should retain tissue even when retention '*may not necessarily have been required to determine the cause of death.* "So if we're doing things that go beyond the purposes of the coroner, how can that be lawful, without consent?" He suggested that professional people tended to play safe when faced with such uncertainty. "And that is what – I think – is driving quite a lot of not taking tissue, as well as all the resource issues."

What might the coroner's autopsy achieve beyond the immediate aims of the coroner? Professor Furness suggested that it could provide many benefits:- information for the next of kin, to help their understanding and to improve their medical care; teaching and training of health service staff; audit; and research to improve future medical care. "But if we do anything further than what is required for the purposes of the coroner, we need consent," he said.

This can engender confusion, Professor Furness warned. As an illustration, he displayed a draft flow chart at one stage suggested by the Department of Health for investigating sudden cardiac death in adults. This required pathologists to take a tissue sample, pending appropriate consent. "The tissue sample they're talking about is the whole heart. After we've done that, it says get consent. So I had to point out that the Department of Health was proposing something which would make pathologists do something illegal under the Human Tissue Act" he said.

“What ought to be happening is what Michaela Willis has already suggested. Communication is one of the issues in this report. What if, at an early stage, the coroner’s officer also has the job of providing some explanation and finding out if the family just want a post-mortem that will exclude foul play; or whether the family actually want to get to the bottom of what went on, as far as medical science will allow. And while he’s at it, what about the family being asked if they are happy to assist society with teaching, training and research, and all the other things we would like to use coroner’s post-mortems for? And the coroner’s officer then passes the history, with all information from the family, to the pathologist. Before the post-mortem starts.” If that happened, we would know what we should do, and we would have appropriate consent, Professor Furness said. But such a mechanism would require a much longer discussion with bereaved relatives, in every case. This would have resource implications.

Considering further possible reasons as to why some pathologists might be cutting corners in performing an autopsy, Professor Furness noted there were major workforce issues for histopathologists in England. Their workload has been increasing but the manpower supply has not been keeping pace. “We’ve got more and more vacant posts, so pathologists are working under pressure to keep up with the NHS work they do diagnosing disease in biopsies from the living.”

For most pathologists, coroner’s post-mortems are additional to NHS work on biopsies from living patients, so they tend to be fitted in at the beginning of the day. “That’s not the best way to organise it,” suggested Professor Furness. There is also an increasing trend towards subspecialisation in histopathology, with fewer recently trained pathologists being willing to perform coroner’s autopsies. “I know of at least one major teaching hospital in the UK where there is currently great difficulty in finding histopathologists to fill the rota for coroner’s post-mortems. Those left doing them are under more and more pressure.”

He reported that the College [RCPath] is considering a new system whereby newly trained histopathologists will not necessarily be validated to undertake independent post-mortems. This should make post-mortems more of a subspecialty, which should drive up standards. “But that’s not going to happen if pathologists are being employed to do this work as part-time add-on, in the way that it’s organised at the moment.”

Considering what the public wants from autopsies, Professor Furness reported a small audit in Leicester, showing that ***of those who were asked for consent***, 51% gave consent to a hospital post-mortem before the adverse publicity on organ retention, and 49% gave consent afterwards. “So the fall in the ‘consent’ post mortem rate is not due to a change in public attitudes. It’s due to doctors not asking for consent. This is a change in medical profession, wrongly assuming that the public won’t want to give consent.” He also argued that gaining consent required altruism from doctors. “It’s going to take the best part of an hour of your time, it’s emotionally draining, and it has a one in three chance of demonstrating that you’ve missed something.”

What can we draw out of all this? “I think we – the nation, not pathologists acting alone - have to answer the question: - Are we concerned to ascertain the cause of death beyond just excluding foul play? If we’re not, then why should a coroner’s post-mortem without further consent be used for those purposes? In that case, then, with great reluctance, we need to rethink the College guidance. We need double standards; a coroner’s standard, and a different standard for consented post-mortems, because they are trying to do different things.”

However, Professor Furness thought that this would be extremely regrettable. “Personally, I think if you are going to do a post-mortem, then it’s a disrespect to the deceased not to get as much information from the process as you possibly can. We should obtain as much benefit for science and for the family of the deceased as medical science and resources allow.” All post-mortems should be performed to the Royal College of Pathologists’ standards, he argued. Referring to the need for altruism from doctors when ask for consent for a post mortem, he suggested: “Should not a post-mortem examination be offered, as a right, after every death?”

Summing up, Professor Furness stressed that the Royal College of Pathologists argues for the highest possible standards in all aspects of pathology practice, and cannot condone ‘cutting corners’. But pathologists work in a framework set by society. He suggested that the Government has to define more precisely the purpose of the coronial autopsy. This should preferably be to the College’s published standards. But if society defines a different standard, pathologists need to know. There needs to be greater accountability and audit of pathologists who work for coroners, preferably to College standards. It is important to clarify the circumstances that justify a coroner’s autopsy. There also needs to be proper funding of services at a local level. Better communication is needed, bringing in the consent process before the post-mortem starts.

“The current review of the coronial law being undertaken by the Department for Constitutional Affairs is a golden opportunity to sort this out”, he concluded. “We hope the opportunity will be taken”.