4. Overview and discussion

Future practice

A start to improve future practice has been made. There was the production of the Position Paper 'Reforming the Coroner and Death Certification Service' in 2004[5]. In mid-2006, a draft Bill on reform of the coronial system was promulgated[6], which should become an Act and pass into practice in 2008 or 2009. It is hoped that widespread consultation among all the interested parties takes place, to address in particular the question of the required level of quality for an autopsy service, and for this to be adequately resourced and funded. In the view of NCEPOD, it is regrettable that reform of the death certification system has not been included alongside coronial reform. How causes of death are considered and which deaths are referred to a coroner are two sides of the same coin. To improve the management of death requires improvement of both aspects.

In the meantime, there could be a more standardised approach supported by audit. And parts of the existing legislation could be utilised more to enhance the quality of autopsies and their reports. For example, Coroners Rule 6 states that the examination should be made "by a pathologist with suitable qualifications and experience and having access to laboratory facilities". This permits specialisation, whereby particular types of cases are examined by those who have more knowledge and experience of the types of pathology found in a particular scenario of death. It already happens for forensic (suspected homicide) cases and, increasingly, paediatric cases. It also increasingly happens with maternal death although there was none in this study sample. The Confidential Enquiry into Maternal and Child Health has consistently argued for specialist pathologists to perform these often difficult cases[7]. The data from this study show that specialist neuropathologists and paediatric pathologists achieved higher quality ratings than other pathologists. Other categories identified that could benefit from more specialist input include sudden unexpected cardiac death which might be inheritable cardiomyopathy, epilepsy, and illicit drug-related death. Secondly, under section 20 of the Coroners Act, 'special examinations' by pathologists who possess 'special qualifications' may be requested to undertake autopsies that require further analysis of samples from the body, such as histology and toxicology (see Glossary). This also supports the concept of increasing specialisation.

Costs have been alluded to in this report. Not only are there costs for histopathology and other analytical investigations, there are also the basic fees paid to pathologists for performing the autopsies and providing reports (see Glossary). These come out of local authority budgets, and naturally there is pressure to contain costs. The expansion of specialist autopsies as indicated above, though beneficial to families and national statistics, will cost more than the present pattern of coronial autopsies. A second future cost pressure that follows from the Recommendation on continuing professional development (CPD - below) would be the time allotted, as 'supporting activity', for pathologists to undertake CPD on autopsy practice. This would be borne by trusts in the case of hospital-employed pathologists. Many of the recommendations contained in this report have increased cost implications, and cannot take place just by expecting pathologists and coroners to modify their behaviours. The local authority and trust budgets need to be factored into desired improvements in the coronial autopsy system.

As several pathologists and coroners have commented when considering the variable quality of the autopsy process: "What do you expect for £87.70?" (the current fee for a standard autopsy without further investigations).

Continuous professional development for pathologists and coroners

This is the first time that coronial autopsy reports have been reviewed by the two interested professional groups in conjunction. The advisors met on many occasions in varying combinations of pathologists and coroners, to assess the cases in the study. After the first few sessions, all volunteered the opinion that the exercise of reviewing the reports of a wide range of pathologists covering a wide range of cases was professionally very helpful to them. The consultant pathologists realised what a wide range of approaches other consultant status colleagues utilise, some poorer and some better than their own practice; and all indicated that they would change their autopsy examination and report standards immediately, to improve their own practice. The SpR pathology advisors learned how varied their seniors could be when examining a range of death scenarios. The coroners observed autopsy reports that had been accepted and acted upon by other coroner colleagues, of a wide range in quality, and learned that there are many ways of producing results that support (or not) the given causes of death; they indicated they would be more questioning of their local pathologists in future. Thus reviewing this material is an excellent form of training and of continuing professional development. It should become part of pathologists' and coroners' training exercises and, once in post, regular mutual audits within departments or between jurisdictions carried out, in order to maintain the critical attitude and high professional standards.

This supports one principal recommendation; that regular audit of autopsy reports should be introduced nationally. With agreed national standards of what should be contained in such reports, this will both reduce the great variation and raise the mean standards of quality.

Autopsy training and histopathology

With the decline of the consented autopsy, the bulk of autopsy experience for those in pathology training comes through coronial work. During training, the numbers of autopsy cases actually performed by trainees is variable; the RCPath sets a minimum of 100 cases in the guidelines for those preparing to sit its part 2 (final) MRCPath. It is uncommon for trainees to have sole responsibility for a coronial autopsy case, yet once they have achieved consultant status, they may be expected to undertake a variety of cases, and may have a sharp learning curve.

A joint statement from the Coroners' Society of England and Wales, and the Royal College of Pathologists summarised the need for autopsy experience through coronial work and made particular note of the responsibility of the supervising consultant who is accountable for the case[8]. Most autopsy training is now, of course, based on coronial autopsies, as consented autopsy numbers have declined. Reports from the histopathology training committees indicate that in most of England and Wales, access to such cases is satisfactory. However, in London and the south-east there are significant problems, mainly because of the preponderance of public mortuaries which are not affiliated to hospitals, and therefore not used for training.

A related issue is taking tissue for histopathological examination when it is critical for diagnosis. As the study showed, many cases could have been better evaluated had histopathology been performed. Factors acting against the taking of samples include:

- cost;
- lack of need if an acceptable registerable medical cause of death can be stated, even if it is not the most accurate cause of death;
- the workload implication for the coroner's office in communicating with the next of kin.

The practical outcome is that, as demonstrated in the study and contemporary surveys, there is less tissue analysis being done. In consented autopsies there is usually permission given for microscopic examination of all relevant organs; but such cases are much less common than they were. How are trainees going to get experience in the detailed analysis of tissues from autopsy, so that when it matters, they can make a considered opinion on the findings and therefore on the cause of death? This also needs a more widespread consultation, including the public who should be informed of the importance of taking tissue samples, and retaining organs when appropriate (whether for diagnostic, academic research or future teaching purposes), so that the results of the examinations on their relatives can be as complete as possible. Accuracy and quality may be compromised by not taking tissue samples; and when this is made clearer, NCEPOD believe that the public would support more such investigations.

Impact of existing autopsy practice guidelines on performance

Since there have been concerns about coronial autopsy practice going back to at least 1970 as highlighted in the Brodrick Report[9] (long before1989 when NCEPOD started reporting), why is it that there has not been a systematic improvement in the quality of autopsy reports and diagnoses?

The Royal College of Pathologists is an advisory body, not a statutory regulatory body like the General Medical Council. For more than a decade it has produced guidelines on autopsy practice and autopsy report depiction. They are descriptions of an idealised best practice, aimed towards fulfilling the stated objective of addressing all issues raised by a death; they have never been endorsed by the coronial system of England and Wales. There is no statutory obligation for pathologists in the UK, some of whom will not be members or fellows of the RCPath anyway, to read, let alone follow these recommendations. There is no obligation on the part of coroners to demand autopsy performance and report quality to these levels. All this reflects a lack of audit of the product of the autopsy. Pathologists (in the UK at least) pass a difficult exam, of which the autopsy component has become more stringent in recent years[8]. With reinforcement they maintain standards, but without a defined set of quality demands and standards against which to match practice, it is easy to cut corners in diagnostic accuracy. UK based pathologists will doubtless wish to maintain the high standards to which they were trained, but extraneous factors including the lack of an agreed set of quality standards, an absence of audit, poor resources and limits imposed by others makes it all too easy to allow standards to fall so that the fullest outcomes from autopsies are not realised.

This NCEPOD report goes beyond all the previous reports that have considered autopsy reports, from both coronial and consented autopsies. It has a wider remit in considering all deaths, not just those in hospitals. For 15 years, the NCEPOD reports have exhorted the performance of more autopsies, better communications with clinicians, better consideration of medical interventions in leading to death, better examination of the body and organs, more histopathology studies, more clinicopathological correlation evaluation, and better statements on causes of death. There have been some notable improvements documented, from analysis of in

hospital perioperative deaths: a trend of following the guidelines on autopsy reports after 1993, and the greater inclusion of operation data in cause of death statements. But the numbers of reports that are categorised as poor or unacceptable does not seem to have changed, and the restrictions on diagnostic organ retention and taking tissue samples have increased judging from the current sample.

It is NCEPOD's belief that at least some of the reasons for this include the lack of unitary oversight on death certification and coroners, with no single department or body taking responsibility and accountability. Indeed, the service is part local and part national. Pathologists, for the most part, operate within the NHS. Coroners are appointed by local authorities, answerable to the Lord Chief Justice and, to the extent that they are managed at all, come under the Department of Constitutional Affairs. The Registrars of Death answer to the Office of National Statistics which in turn comes under the aegis of Her Majesty's Treasury. With such disparate and fragmented systems, it is perhaps small wonder that bringing about effective change is so difficult. However, perhaps a more fundamental issue concerns the role of the autopsy in health care and the reasons for the decline in the consented autopsy. Issues such as the Bristol and Alder Hey inquiries, the Shipman case and a general diminution of trust in medical professionals by the general public have all played their part in refusals of consent for autopsy (or is it that clinicians are now too timid to ask for a consented autopsy?). If the future of the consented autopsy is a bleak one, and the sole means of audit of death certification is to be the coroner's autopsy, it is important for the necessary statutory provisions to be enacted to make this 'fit for purpose' and effective. What is not appropriate is to criticise the present coroner's system for failing to provide that for which it was never intended or designed.