1 Ensuring Quality in the Hospital Autopsy

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Despite an unceasing stream of publications extolling the value of postmortem examination (1–12), the hospital autopsy rate continues to decline. Estimates, published in the 1990s, of the overall autopsy rate in the United States are as low as 5%, with the rate in academic institutions estimated at 11% (13,14). Several factors contribute to this. One is the notion that the autopsy will not reveal information above and beyond that gained from current sophisticated imaging studies. Another is the clinicians’ concern about resultant litigation. A more fundamental reason, however, is the lack of vigor on the part of the clinician to seek permission from the family (15). The physician attending the death may be too quickly distracted by other competing concerns and responsibilities, or more likely, (s)he is unfamiliar with the family of the deceased. This latter situation is frequent in teaching hospitals, where a house officer with no prior contact with the patient attends the death and feels uncomfortable in requesting permission for autopsy. These obstacles notwithstanding, it this author’s opinion that any academic teaching hospital must make a genuine and persistent effort to achieve a hospital autopsy rate of at least 25%.

PATHOLOGIST’S ROLE IN PROMOTING THE AUTOPSY

Although the chairs of clinical departments must be motivated to help with this goal, autopsy personnel can take a number of steps to encourage hospital autopsy permissions. These steps involve effective and timely communication with the clinician.

Before commencing the evisceration, the prosector should call the clinical resident and/or the attending to discuss the patient’s history. When the prosector is relatively inexperienced, it is preferable to have the pathology attending contact the clinical attending. Either way, this conversation allows the clinician to express any specific questions (s)he may hope to have answered by the autopsy, as well as simply to describe the events that led to the patient’s death. When the initial dissection is completed, the clinicians again should be called and informed of the gross pathological findings. During that conversation, the prosector should invite the clinicians to the morgue to view the findings themselves. The examination of the organs soon after the patient’s death offers a significant learning experience for clinical attendings, as well as house staff and medical students. Any digital photographs of significant abnormalities should be emailed to the clinicians within the same day of the postmortem examination. Generally, the timely receipt of these photographs is much appreciated, because the clinicians will be quickly distracted by their responsibilities to their living patients. Photographs of the gross findings are very effective teaching tools, especially in morbidity and mortality and other clinical conferences. In fact, gross photographs are probably most effective, since both autolysis and the clinicians’ relative inexperience with histology lessen the value of microscopical images. Further discussion on photography may be found at the end of this chapter.

Most hospital autopsy services generate a preliminary report. This report of the major gross findings, preferably organized pathogenetically, should be distributed within 24 hours of the initial prosection. Residents should be inculcated in the importance of sending copies of this and the final report to the patient’s referring physician(s) including those from outside hospitals. Lastly, a short turn-around time between initial dissection and distribution of the final autopsy report will also be much appreciated by clinicians. Many clinicians consider autopsy reports received after one month to be useless and irrelevant, as they have already had their conference with the family. Further discussion of the hospital autopsy report may be found in Chapter 12.

These efforts toward timely communication, eagerness to demonstrate the pathologic findings to the clinicians, provision of gross photographs, and prompt distribution of the final report will help treating physicians understand the value of the service and make them more receptive to seeking autopsy permissions in the future (15).

The permission form for autopsy should be as brief as possible, so that the family can understand it, but be as inclusive as possible to allow the pathologist to gain maximum yield from the procedure. A sample permission form is found as Fig. 1-1. It is the nearest relative who must sign the permission form. Most states have statutes that list the next of kin in descending order of priority. Generally, that list is spouse, reciprocal beneficiary, an adult child, either parent, an adult sibling, a grandparent, the individual possessing a durable power of attorney, the guardian

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I (Print Full Name) _____ hereby grant permission for a complete postmortem examination, including the removal and retention or use for diagnostic, scientific, educational, or therapeutic purposes of such organs, tissues and parts as the physicians in attendance at (Name of Institution) _____ may deem desirable, on the remains of (Print Full Name of Deceased) ______

This authority is granted subject to the following restrictions (if none, write "none"):

_______________________________________________________________________________

The following special examinations are requested: ______________

I am the nearest relative of the deceased and entitled by law to control the disposition of the remains.

Signature: __________ Date & Time: ________ Relationship: __________

Mailing Address: __________________________

Telephone Number: __________________________

Permission obtained by: (Print Full Name): ________ Title: __________

Second witness (required if telephone permission): (Print Full Name): ________

Title: __________ Signature: __________ Date & Time: __________

Fig. 1-1. Proposed text for an Autopsy Permission Form.

IN CASES WITH THERAPEUTIC COMPLICATIONS When an autopsy is to be performed on a patient who has possibly died as a result of a medical or operative complication, communication with the clinician is even more important. Given the potential medicolegal implications, the pathology attending must discuss the case with the physician and should invite her (him) to be present during the procedure. Adequate photography is essential in these cases, and the resulting images will then be available for later reexamination and possible presentation in morbidity and mortality conferences. If the complication is of a hemorrhagic nature, photographs should be taken prior to evacuation of the blood, so as to document the extent of the hemorrhage. When a site of bleeding is found, this site must also be adequately photographed. Abnormalities encountered during the resection should be documented with great attention to accuracy and detail. An excellent array of photographs will promote and enhance such accuracy. Therapeutic complications may be dramatically demonstrated at autopsy, and all personnel must maintain a calm and objective demeanor throughout the procedure, whether clinicians are present or not. Although clinicians may wish to help with the dissection, they should be tactfully dissuaded whenever the pathologist is concerned that tissue relationships may be altered before full understanding of the process is achieved. On the other hand, having a surgeon present during resection of a complex operative site can be of great help.

When the final report is nearly completed, it is absolutely essential that the clinical attending be invited to review the report before its signing and distribution. This extra step will rectify any differences of opinion that exist between the clinician and