



Autopsy (Policy Number 91-01)

Policy Statement

ASCP believes that the performance of autopsy is a professional service of the pathologist to the patient.

Background and Rationale

This statement is in accordance with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)¹ and the College of American Pathologists (CAP)² recommendations. ASCP recommends that permission be obtained in certain types of hospital deaths for the benefit of the patient and the nation's health. Important uses of the autopsy in modern society include: quality assurance of medical diagnosis; early identification of environmental, infectious and occupational hazards to health (including bioterrorism); public education; and evaluation of new forms of therapy and new diagnostic modalities. The Society also urges that the performance of autopsy be appropriately compensated.

The purposes of the autopsy have evolved dramatically during the past several decades. Until this century, the primary uses of autopsy were (1) determination or confirmation of the cause and mechanism of death, (2) research into the nature of disease and the identification of specific diseases, (3) improvement in the practice of medicine through application of autopsy findings to clinical practice, and (4) education of medical students. However, the autopsy today has the potential to serve a much broader range of societal and medical concerns. The new uses of the autopsy include (1) quality assurance of medical diagnostics and service, (2) a reservoir of tissues and organs for transplantation and research, (3) public education, (4) the development of accurate mortality statistics, (5) the early identification of environmental, infectious and occupational hazards to health, (6) information documentation for future legal, financial, and medical evaluation (7) evaluation of new forms of therapy and new diagnostic modalities, and (8) continuing education of physicians.

A. The JCAHO Crosswalk of 2003 Medical Staff Standards to 2004 Medical Staff Standards³ states that "the medical staff, with appropriate hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed" on patients who die in the hospital. Societal and medical purposes would be well served if autopsies were performed in all cases, but the ASCP recognizes that this is not possible. We therefore recommend that permission be obtained in certain cases of deaths in the hospital that are not subject to forensic medical legal authority:

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1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
2. Deaths in which the cause is not known with certainty on clinical grounds.
3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death, and provide reassurance to them regarding the same.
4. Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards.
5. All obstetric deaths.
6. All neonatal and pediatric deaths.
7. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness that may also have a bearing on survivors or recipients of transplant organs.
8. Deaths known or suspected to have resulted from occupational or environmental hazards.
9. Sudden, unexpected, or unexplained deaths in the hospital that are apparently natural and not subject to a forensic medical jurisdiction.



Several categories require special consideration.

10. Unexpected or unexplained death occurring during or following any dental, medical, or surgical diagnostic or therapeutic procedure.
11. Natural deaths that are ordinarily subject to a forensic jurisdiction, such as persons dead on arrival at the hospital and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
12. Deaths resulting from high-risk infections and contagious diseases, including AIDS. Pathologists and staff should agree on policies and procedures for handling such cases.
13. Deaths of organ/tissue transplant recipients who have received a non-living related transplant within 60 days prior to death.

B. It is not sufficient simply to instruct the medical staff to request autopsy in these or other cases. Hospitals should develop a coherent set of policies that encourage families to consent to an autopsy. These regulations should be in accordance with the regulations set by the Food and Drug Administration.⁴ Among the possible initiatives are the following:

1. Development of a pamphlet to be included in informational material made available to the patient's family describing the procedure and its values. Patients and relatives can be encouraged to consult with their primary physician regarding this matter. Cases in these two categories generally fall under the jurisdiction of a coroner or medical examiner, but on occasion they may be waived by such a forensic authority. In these cases, the importance of such autopsies to medical practice and the public good suggests that the hospital personnel encourage autopsy consent by the legal next-of-kin.
2. Institution of an Office of Decedent Affairs or its equivalent within the hospital organization. The mission of this office would be to make it easier for dying patients, their families, and involved members of the medical staff to deal with the details surrounding dying and death in the hospital environment, as well as to prepare families for the autopsy request and to institute methods for improving the rate of consent.
3. In-service programs, especially designed for nurses and social workers, to ensure that these personnel provide much-needed assistance in facilitating efforts to obtain autopsy consent and counseling.
4. Educational programs for students and house staff in teaching hospitals on the implications of interpersonal contacts with families in regard to autopsy permission, including ethnic and religious consideration.
5. Assurance that autopsy reports are completed and in the hands of the proper individuals no later than 60 days after death.
6. Assurance that the relatives are fully informed, under appropriate circumstances, of the autopsy findings. This is best accomplished by the patient's personal physician in cooperation with the hospital pathologist. It must be widely understood by relatives and hospital staff, however, that autopsy findings are readily available to appropriate relatives on request to the personal physician or the pathologist, and in accordance with privacy laws and regulations.
7. Pursue safe, effective health care through use of the autopsy. The current liability system inhibits the use of the autopsy. Encourage a blame-free environment by which autopsies may be performed more readily through medical liability reform and health care system improvements.

- C. The JCAHO Crosswalk⁵ also requires that “findings from autopsies are used as a source of clinical information in quality assurance activities.” The significant information that is obtained from autopsy that can be most useful for quality assurance activities is the congruence or discrepancy between major clinical diagnoses and major diagnoses made at autopsy.

The degree of congruence is a measure of the quality of medical diagnostics, the use of which requires statistical analysis, analysis of possible reasons for discrepancies, and design of programs to ensure that, to the extent possible, similar discrepancies will be minimized in the future. Somewhat more sophisticated analysis, especially if the number of autopsies is large, will pinpoint trouble spots, common discrepancies, etc, that may require special attention. The ASCP firmly believes that the autopsy is necessary to monitor clinical judgment in the medical community. For quality assurance purposes alone, the autopsy is a critical service.

Thus, to ensure that autopsies have an optimal impact on quality of care, we encourage hospitals, through their administrative and medical staffs, to institute rigorous policies and identify the responsible people to achieve the following:

1. Full participation of a representative pathologist in the institutional Quality Care Committee or other staff committee with such designated responsibility.
2. Use of a standardized routine to present and analyze diagnostic discrepancies involving rough quantification of the magnitude of the discrepancy.
3. Efforts to discover if the discrepancy was necessary or avoidable.
4. Elucidation of the circumstances that led to the diagnostic error.
5. Rigorous educational efforts to minimize the possibility that similar errors will reoccur.
6. Ensure that appropriately trained staff and adequate facilities are available for the performance of autopsies.
7. Ensure that professional services for the autopsy are appropriately remunerated. Without compensation, autopsies are often not viewed as the truly valuable medical procedure they are.

References

1. Joint Commission on Accreditation of Healthcare Organizations. (January 1, 2004). Crosswalk of 2003 Medical Staff Standards for Hospitals to 2004 Medical Staff Standards for Hospitals. Retrieved January 5, 2005 from http://www.jcaho.org/accredited+organizations/hospitals/standards/new+standards/ms_xwalk_hap.pdf.
2. Hutchins, G.M. et al. Practice Guidelines for Autopsy Pathology, Autopsy Reporting. *Arch Pathol Lab Med*. 1999, 123:1085-1092.
3. Joint Commission on Accreditation of Healthcare Organizations. (January 1, 2004). Crosswalk of 2003 Medical Staff Standards for Hospitals to 2004 Medical Staff Standards for Hospitals. Retrieved January 5, 2005.
4. Food and Drug Administration, Federal Register, 21 CFR 1271
5. Joint Commission on Accreditation of Healthcare Organizations. (January 1, 2004). Crosswalk of 2003 Medical Staff Standards for Hospitals to 2004 Medical Staff Standards for Hospitals. Retrieved January 5, 2005 from http://www.jcaho.org/accredited+organizations/hospitals/standards/new+standards/ms_xwalk_hap.pdf.