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Editorial

The changing autopsy

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By tradition, the autopsy is primarily an opportunity to teach and learn medicine. The Latin phrase "Hic locus est ubi mortui vivos docent", sometimes found on autopsy amphitheaters and meaning "this is the place where the dead teach the living", is an expression of this view. Indeed, in the last years of the previous century, interest in the autopsy sometimes led to surgeons performing post-mortem examinations before the pathologist had been notified to truly see for themselves, rather than be shown by someone else. The great European pathologists, and their heirs across the great oceans, saw the autopsy from this perspective, and this has been transmitted to our day. Until the mid-sixties, this interest caused the frequent performance of postmortem examination.

The last 20 years have seen a remarkable change. The autopsy is no longer popular, and indeed is seen with more or less candid disfavor by a great many physicians. There have been many studies dissecting the multiple causes for this decline (Friederici 1988). As the party responsible for obtaining the autopsy consent, the attending physician is the gatekeeper in the key position to determine whether a postmortem examination will or will not be done – with no penalty for failure to ask. Simultaneously, there has been a growing public demand for determining the accuracy of medical diagnosis, the quality of medical practice, and the effectiveness of medical treatment. Over-reliance on high-tech methods of diagnosis have caused remarkable discrepancy rates between clinical conclusions and autopsy findings even in common causes of death (Zarling et al. 1983; Anderson et al. 1989). In certain diseases, the accuracy of diagnosis seems to have actually decreased in the last 50 years (Anderson et al. 1989). Independently from learned papers in professional journals, the publication of mortality rates and of accreditation deficiencies for hospitals in the United States reflect a public demand for objective, verifiable information on the quality of medical care, as opposed to perceived or claimed subjective impression. Review of the outcome of medical diagnosis and treatment clearly must include the auditing of deaths through the autopsy.

The vogue of malpractice litigation undoubtedly influences the demand for autopsy: con for many physicians, pro for some families. The reasons for medical fallibility have been examined, unnoticed by most physicians, and negligence is only one of four major causes of failure, and possibly the least of the four (Gorovitz and MacIntyre 1975). It would seem that physicians would stand to gain from documenting how rarely negligence does indeed play a role in untoward outcomes. Amongst moral issues that govern medicine and physicians, three factors specifically argue in favor of postmortem examinations (Pellegrino 1987; Pellegrino 1989):

a. the trust the physician invites from his patient and society at large, without which medicine cannot be and the doctor cannot function;

b. the non-proprietary nature of medical knowledge which creates a collective covenant between physicians and society, including the obligation for the physician to separate fact from fiction and to expand medical knowledge; and

c. the oath taken by the physician upon graduation which constitutes a public promise and commitment, and a pledge to further the collective good above personal interest.

When these principles are applied specifically to the autopsy, the clinician, the hospital, and the pathologist each have their own obligations. The post-mortem examination is not only an opportunity to learn for the benefit of future patients, but also an audit of medical care received by the deceased (Pellegrino 1987; Pellegrino 1989).

There have been many reviews analyzing the manifold reasons which have led to the decline of the autopsy, and editorials have emphasized the need for the autopsy as a quality assurance instrument. The reviews and the editorials tacitly share an unspoken common denominator: the autopsy is viewed as an optional, discretionary

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exercise whose need is determined by a party who may have a conflict of interest, namely the attending physician. However, to fulfill its mission the postmortem audit must be done in a systematic, methodical manner. This will require change at many levels.

Change must begin with medical education. Many young physicians now graduate without having seen an autopsy and without knowledge of its role and potential. Pathologists must change to accept the autopsy as a major commitment and responsibility, including appropriate documentation and evaluation, and requiring a thorough knowledge of modern clinical methods. Teaching in pathology must change, with the pathology chairman acting as a responsible role model for students, young pathologists in training, and clinical colleagues. Pathology Societies must change and adopt as a major responsibility the education of the public regarding the autopsy. Hospitals must change and upgrade autopsy facilities to the level adequate for thorough post-mortem studies; such facilities could double for the harvesting of donor organs. Hospitals also must ensure that their pathologists are adequate for the job in autopsy pathology in addition to their other responsibilities in diagnostic pathology. Hospitals should scrutinize their pathologists' autopsy performance with the same care used for the performance of clinical practitioners. Autopsy information should be reviewed methodically as a gauge to the quality of medical care, and not just be filed never to be read again. The procurement of the autopsy permit must change by charging someone other than the attending physician with this responsibility, perhaps transplant procurement nurses. While the responsible physician may help in the process, his fear or opposition must not be allowed to block the autopsy. The payers of health care, whether private or public, must change and learn that the small cost of postmortem audits will help control the large cost of unnecessary or inappropriate health care. Last but not least, the pathologist must be paid for his responsibility as post-mortem auditor upon receipt of the completed report, perhaps by the responsible third partly directly. Just as the cost of auditing is a worthwhile expense associated with bookkeeping, and the cost of industrial quality control is justified to ensure survival in the competition among manufacturers of industrial goods, the small cost of the post-mortem audit will help society keep overall health care costs down, will help hospitals ensure the quality of care necessary to survive against their competitors, and will help health care providers earn the trust of the public they serve. This has been expressed succinctly in six words: the goal is the public trust (Lundberg 1983).

The magnitude of the necessary changes may be daunting, and no party alone can accomplish this. Pathologists, however, as key participants, must begin by a) making sure they are up to the task professionally, and b) by speaking up and starting with the education that is necessary.

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