Correspondence

Ethics and necropsies

Other people's views on one's profession are often revealing, and Professor DN Baron's recent leading article about the ethical duties of pathologists was especially illuminating. One of the first of these towards whom we have such responsibilities was very interesting, though, as a pathologist interested in publicising the benefits of the necropsy, I was surprised that patients' families were not included in the list.

Professor Baron's classification of our duties towards others can, in fact, be applied neatly to necropsy practice. For instance, there is clearly potential and actual death, the need for non-maleficence towards relatives, who might be dismayed by a necropsy, and our duty of beneficence towards our clinical colleagues and the general public, who gain from the audit and educational aspects of the necropsy. The continuing fall in necropsy rates could be ascribed to a progressive change in the relative importance awarded to these two principles. Estimates of maleficence towards relatives are clearly subjective, and some would argue that some clinicians exaggerate the maleficence of the necropsy towards relatives.1

The quest for justice, another duty quoted by Baron, may also conflict with other ethical duties. One obvious example is that the value of Coroners' necropsies to clinicians and others may be reduced by strict adherence to medicolegal concerns. Duty to patients is considered the patient's autonomy needs to be considered by some pathologists, such as those involved in research programmes in which permission for eventual removal of the brain is sought before death.2

Any amateur philosopher could expand on this list of principles; perhaps Professor Baron could be persuaded to provide a professional analysis.

EW BENBOW
Department of Pathological Sciences, University of Manchester, Oxford Road, Manchester, M13 9PT


Professor Baron comments:
My leading article dealt with problems related to patient care. As Dr Benbow rightly points out a full discussion of the ethical (and legal) responsibilities of pathologists must incorporate those related to necropsies, which includes responsibilities to patients' families. A further example of the way that problems of pathologists are ignored in medical ethics generally is found in an excellent discussion in a new textbook of the relation of persons to bodies, and our consequent thoughts and actions, which does not even mention the necropsy.3

I believe, lie in three stages: (1) before; (2) during; (3) after.
(1) We accept that performing necropsies has a beneficial effect towards clinicians, other pathologists, and the public as future patients by acting to increase and update our knowledge of disease, to be balanced against non-maleficence to relatives who may be distressed by the proposal, or even to a few clinicians who may not like their diagnosis to be shown as wrong. I believe that it would be unethical, because of adding to the strain on the relatives, for the pathologist (who has almost certainly not previously met them nor the patient) to interview them. This is not to argue—though this has been reported.4 It is the obligation of pathologists however, to encourage the performance of necropsies by influencing clinicians as to their general importance.5 In addition, where a pathologist knows that in a particular case there has been a major diagnostic problem, or the possibility of grave therapeutic misadventure, he has to stimulate the responsible clinical staff to make the request. If there is no response then in serious cases he may have been justified in taking further the need for a necropsy, by reporting to the coroner,6 the ethical imperative being beneficence to society in reducing medical error.

(2) Most would believe that a body commands respect, at least as a reminder of the person that it once was.7 Discussion of this major topic, and its relation to necropsies, is outside the scope of this letter; in some societies, for example, a body has to be buried without interference. The ethical obligation not to mutilate the body does not therefore depend only on the obligation not to distress the relatives. A particular instance of such non-maleficence is the parts of the body subsequently seen by the relatives, primarily face and hands, should not be altered without informing them of the need. No distinction may be made between the care owed to living and to dead patients: for example, pathologists have a duty to perform necropsies on HIV positive patients if required, provided that management have been done in providing appropriate facilities and assistance.8 Before starting the necropsy the pathologist must check that consent has been formally granted by the next of kin or executor, and whether any restrictions have been placed on the extent of the necropsy. Specific permission is needed for tissue to be removed for research; and the consent form can include a section agreeing to this; judges might adopt the view that unauthorised action amounted to a common law offence of unlawful interference with a corpse.9 An American case yielded US$150 000 in damages for distress to a widow whose husband's brain had been removed at necropsy without permission.10

(3) The obligation to inform the relatives of the result of the necropsy rests with the clinician, to whom has been sent the pathologist's report and which they now have a legal right to read: it would be unethical for the report to be sent directly to the relatives because they may need elucidation and counselling by the person who has cared for the patient. If the clinician asks the pathologist to send the relatives a copy of the report, or requests that he joins in the discussion with the relatives, or the relatives come themselves, or if the committee is directed for an explanation, it would be a beneficent act to help—in the latter case the clinician should be told of the discussion.

Dr Benbow mentions the obligation of justice. In the current context this applies to the problems that histopathologists, as all pathologists, have in balancing the demands on the resources available to their departments. The more resources that are put into necropsies the less are available for other purposes, which emphasises the need to establish their worth.9


Value of face masks at post mortem examination

There have been many studies performed and letters written regarding the risk of transmission of infectious diseases by being splashed with body fluids. These risks have been particularly recognised by orthopaedic and maxillofacial surgeons due to their use of power tools.3 Both the Howie code and the Advisory Committee on Dangerous Pathogens state that full face protection should be worn in high infectious cases at post mortem examination. In our experience this is rarely done in routine cases as full face visors are uncomfortable to wear and may obscure vision.

In certain circumstances the need for eye protection at post mortem examination, but to our knowledge, the risk from contact with the nasal and oral mucosa and the skin of the face (which may be broken) has not been studied. Contamination through contact of infected blood with oral mucosa and inapparent skin lesions has been reported.5

Although this route may rarely result in transmission of infectious diseases, the increasing prevalence of HIV increases the potential for such exposures. The magnitude of the risk is not known as there are no data on the frequency with which exposure of contaminated blood with skin, oral, and nasal mucosa occurs.

Fifty necropsies were performed on adults by three junior pathologists wearing standard surgical face masks, one during evicration and one for dissection of the organs. At the end of each procedure, the number of splashes on the external surface of each mask were counted with the aid of a hand lens. Power tools were not used.

Of the 15 masks, 8 had a second splash either evicration, organ dissection, or both, in 20 out of the 50 (40%) cases. In nine out of

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the 50 (18%) cases splashes occurred during evisceration, and in six of these pleural effusions, adhesions, or ascites were present, suggesting a predictable increased risk. During organ dissection, splashes occurred in 13 of the 50 (26%) cases, higher perhaps than during evisceration because of the longer time period, working closer to the material and the use of water for cleaning purposes. There was no difference in the splash rate among pathologists in terms of method of evisceration and dissection. Those splashes occurring during organ dissection more often went unnoticed and were not as predictable as those during evisceration.

Therefore, we suggest that surgical face masks should be worn routinely by pathologists at every post mortem examination as the risk of infection is often unknown. The cost is low and although inconvenience with breathing and misting up of spectacles may be found initially, these reduce with extended use.

A R BAIRD
K O WOLFE
W E KENYON
Department of Histopathology,
Broadgarth Hospital NHS Trust,
Thomas Drew, Liverpool L16 3LW

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**Book reviews**


Claman and his group are well known for their work on mast cells and dermatological aspects of immunology. He is also an excellent writer, as confirmed by the current volume. The first chapter provides a useful up-to-date general review of Immunology. Numerous diagrams serve to help the reader through the complexities of the lymphoid system and of histocompatibility. The next three chapters deal with immunological aspects of the mother-fetus relationship and the maternal immune response to her fetus during a normal pregnancy. This is an excellent review of the continuing enigma of how the fetus survives as an allograft on the mother. The final two chapters describe clinical situations which result from abnormalities of the maternal-fetal immunological relationship. Some of these, such as Rhesus disease, are non-contentious. Others, especially immunopathological aspects of recurrent pregnancy loss, are among the most vigorously argued of all current topics in medicine. Happily, Claman provides a very thoughtful and unbiased review of this area. This book could be profitably read by all those involved in research into the immunology of pregnancy and by practising obstetricians. For those with a more superficial interest in the subject, there is a very useful summary at the end of each chapter.

T CHARD


When I was invited to review this book my first action was to assess whether it dealt with the “Sheffield Memorandum” and realised its significance. The “Sheffield Memorandum” was produced by five Sheffield consultant pathologists and was the most important piece of evidence submitted to the Hadfield Committee, set up by the ACP to consider the formation of a college of pathology practice. If the book did deal with this, the chances were that it was good. It did, and it is.

The book traces the history of British pathology from its origins in Europe in the 18th century. Some of the earliest collections of pathological specimens date from 1726 at St Bartholomew’s Hospital, London, where a Treasurer and Almoners Order Book records rooms for laying out the dead before burial and for anatomical and chirurgical preparations. Almost every paragraph contains a gem, and it is clear that the fundamental principles of the role of pathology in medical teaching and practice remain the same throughout history. Examinations have advanced since Smollett was asked, “If during an engagement one should be brought to you with his head shot off, how would you behave?” when being examined at Surgeon’s Hall, London. Questions for the Edinburgh MD, at about the same time, were arranged in groups to include anatomy, medicine, pharmacy and chemistry and examples of early questions on anatomy referred to whether or not there were valves in arteries or whether cutting is easier in the erect posture, and what is a muscle. Two cases were given for diagnosis and the history was in Latin; and the student had to defend in public his “inaugural dissertation”.

Even in the 1820s one of the commonest student complaints was the shortage of post mortem examinations and the reluctance of relatives to give permission. The Lancet in 1823 regretted the lack of attention paid to morbid anatomy for “without it the nature of disease can never be understood”, and cases in which no lesions could be found to account for symptoms were well known. Malpractice suits were well established at this time—“if a surgeon commit an error in the practice of his profession, from a deficient knowledge of Anatomy by common law of the land, the patient or sufferer may recover heavy damages”. The importance of the necropsy in medical audit was quickly recognised.

The chapters dealing with the development of pathology in the 20th century led to the formation of the British Society of Pathologists in 1927 (renamed the Association of Clinical Pathologists in 1930) and the College of Pathologists are particularly important and form a useful addition to information already recorded by WD Forster in his book Pathology as a Profession in Great Britain published in 1908. The author had been directly involved in much that went on. As a vice president of the council and president of the ACP, and of the first Council of the College.

This is a most enjoyable book. I strongly recommend it and not only to the medically qualified.

WR TIMPERLEY


This pocket-sized paperback is intended as a pictorial guide to surgical pathology for senior undergraduates and trainee surgeons and is part of a series of colour guides on various aspects of medicine from this publisher.

The format is that of short text with colour illustrations on the facing page. The overall arrangement is easy to follow but the photomicrographs are of variable quality and sometimes do not show what they are supposed to. The surgical illustrations are better. The text covers a lot of material in the style of short notes, under the headings of aetiology, incidence, microscopic and macroscopic appearances, and prognosis for each entity. This it does fairly well but there are some surprising omissions, for example, in the gastrointestinal section Helicobacter is not mentioned and although Dukes’ staging is referred to, it is not explained as might be expected in a book aimed partly at undergraduates even where breeding is at a premium.

Overall, this is a fairly useful pocket guide but could be much improved by

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A R Baird, K O Wolfe and W E Kenyon

J Clin Pathol 1993 46: 973-974
doi: 10.1136/jcp.46.10.973-b

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