Audit study of next of kin's satisfaction with clinical necropsy service

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The public may have considerable appreciation of the nature and purposes of necropsy,¹ but these attitudes could change when people are faced with requests for necropsies on members of their own family. We investigated the level of satisfaction of bereaved relatives with a clinical necropsy service.

Subjects, methods, and results

We selected 206 consecutive requests for clinical necropsies for inclusion in our study. At least six months (range 6-14 months) after the requests had been made, a specially trained academic psychologist tried to contact the relatives whose consent had been requested. Sixty seven of the relatives were excluded because they could not be contacted, they gave incomplete information, or there were issues of confidentiality or litigation. Of the remaining 139 relatives, 75 participated in the study—31 by the preferred method of personal interview, 31 by postal questionnaire, and 13 by telephone interview. Consent for necropsy had been given by 44 (59%) of the participants and 36 (56%) of the non-responders. Our open ended survey focused on how necropsy requests were made, relatives' reasons for their response, interference with funeral arrangements, and communication of results.

The doctors who made the requests were 39 house officers, 13 senior house officers, 13 consultants, six senior registrars, and four registrars. Thirteen relatives were distressed by requests, primarily because of a lack of warning, poor timing, and failure to explain the reasons for the request. Distress did not affect relatives' response to the request, nor did the requesting doctor's clinical grade. Table 1 summarises the other main findings related to request procedures.

The commonest reasons for refusing necropsy consent were failure to see any purpose for an necropsy, belief that the deceased had suffered enough, and dislike of the idea of a necropsy. Religious objections were rare. The commonest reasons for giving consent were to help others, desire for more information about deaths, and to assist medical science or research. Four necropsies interfered with funeral arrangements, always because of poor communication between mortuary staff and funeral directors. Only 17 relatives obtained necropsy results, and in three cases these were delayed for over a month. Delay in the issue of necropsy reports

was the commonest reason for relatives not receiving results. The main benefits reported by the relatives who received results were reassurance and peace of mind. Four relatives reported no benefit.

Comment

Although this is essentially a local study, many of its findings may be relevant nationally. The high number of relatives distressed by requests for necropsies is unacceptable. No guidelines currently exist about this procedure despite the fact that the best clinical care can be undermined by failure to respond sensitively to bereaved relatives.² Any loss of public support for necropsies will compromise efforts to increase necropsy rates for research, education, and audit. Our study of relatives' satisfaction with a clinical necropsy service is the most comprehensive attempted in Britain and could provide a basis for the development of standards for this area of healthcare provision.

The high number of relatives distressed by necropsy requests points to a need to train all grades of doctors in communication skills for dealing with death and dying.³ Trained bereavement officers can help doctors. Hospital codes of practice should be developed and supplemented by revised necropsy consent forms and sympathetic literature for public information. For the benefits perceived by most of the relatives who received necropsy results to be realised fully, there must be early communication with the family. Timely production of reports must be a priority in pathology departments, and relatives should be able to discuss findings with hospital doctors or general practitioners.

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1 Start RD, Saul CA, Cotton DWK, Mathers NJ, Underwood JCE. Public perceptions of necropsy. *J Clin Pathol* 1995;48:497-500.

2 Department of Health, NHS Executive. *Reports of the health services commissioner*. 1995. (Advance letter EL(95)81.)

3 Sherwood SJ, Start RD. Asking relatives for permission for a post mortem examination. *Postgrad Med J* 1995;71:269-72.

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Table 1—Views of relatives who were asked to give consent for clinical necropsy about the request procedure. Values are numbers of participants

Question*	Answer				Total
	Yes	No	Unsure	None	
Were you given a satisfactory explanation of what a necropsy would involve?	36	19	3	17	75
Were you told that you could limit the extent of the necropsy?	4	47	3	21	75
Were you given the opportunity to read through the consent form?	33	14	11	17	75
Did you fully understand what the consent form said?	26	2	3	2	33
Did the person who asked for your consent give you enough time to make your decision?	55	9	2	9	75
Did you reach the decision by yourself (Yes) or with others (No)?	28	44	0	3	75
If a joint decision was made was there any disagreement between you and other relatives?	5	36	0	3	44
Did you feel under any pressure from hospital staff to give permission?	5	64	3	3	75
Do you now regret the decision that you made about the request for necropsy?:					
Consent given	3	40	1	0	44
Consent refused	4	24	2	1	31

*Not all questions applied to all participants.

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