

Hospital trusts fall short of recommended standards on post mortem consent

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Many hospital trusts in England and Wales are falling short of the recommended standards on obtaining consent for a post mortem, indicates a snapshot survey of practice published online in the *Journal of Clinical Pathology*.

Active [informed consent](#) became a key tenet of post mortem exam procedures following the organ retention scandals at Bristol Royal Infirmary and The Royal Liverpool Children's Hospital, which prompted the enactment of the 2004 Human Tissue Act.

The Act stipulates that consent must be actively sought from either the individual while alive, or when this is not possible, from a nominated representative or close family member. Breaches of the law attract a [prison sentence](#) and a fine.

The authors obtained staff policies on post mortem procedures from 26 [hospital trusts](#) in England and Wales. They compared the content with guidelines set out by the regulator in this area, the Human Tissue Authority (HTA).

They focused particularly on whether the policies explained: the law behind consent to post mortem; the consent process; which staff members should take consent; and training requirements for consent takers.

The HTA guidance states that every hospital should provide staff with a

documented consent procedure, and have relevant experience and understanding of the procedures involved.

The guidance also says that staff should be trained in dealing with bereavement and have witnessed a post mortem themselves, and specifies that responsibility for obtaining consent "should not be delegated to untrained or inexperienced staff."

Out of the 26 post mortem policies scrutinised, one failed to explain the legislation governing consent to a post mortem; more than one in 10 (12%) of policies did not outline a clear process for how consent for the procedure should be obtained.

Furthermore, 12% of policies did not specify which staff members should take consent for a post mortem, and almost one in four (23%) of policies failed to state the training requirements of those responsible.

One in three (35%) trusts did not stipulate any requirements for the consent taker to be sufficiently experienced; over half of trusts (58%) did not specify that consent takers needed to be trained in [bereavement](#); and over two thirds (69%) did not recommend that consent takers should have witnessed a post mortem.

Some 12% of policies failed to outline the consent process in full, including failing to describe when families should first be approached, or which staff members should talk to families before they are presented with a consent form.

"Given the sensitive nature of consent discussions, it is vital that the process is conducted in an appropriate manner," write the authors. Adequate and clear guidance for this is therefore essential they add, highlighting "the significant shortcomings" their analysis revealed.

They point out that hospital post mortem rates have been falling steadily, despite the importance of the procedure in understanding disease and enhancing medical education. And a clumsy, poorly informed approach to families when a loved one has just died is unlikely to reverse that trend.

The authors acknowledge that policies do not necessarily reflect actual practice, and some of the trust policies may also have subsequently changed.

But they emphasise that in the current climate of financial cutbacks, "it would be feasible for trusts to see [post mortems] as an easy target to limit investment to the detriment of the medical profession. Hence it is vital for the HTA to uphold standards and continue to ensure that the consent process is always carried out in a satisfactory manner for all concerned."

More information: Paper: [www.jcp.bmj.com/lookup/doi/10. ... clinpath-2013-201869](http://www.jcp.bmj.com/lookup/doi/10.1136/jcp.2013.201869)

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