
Getting consent for necropsies

Perhaps we should seek consent to show necropsies to students

Editor—Sayers and Mair highlight the reasons for which hospital (consent) necropsies are performed and for which clinicians are now faced with the task of seeking informed consent—to confirm the cause of death, to answer diagnostic queries, and to obtain samples and material for research and teaching.1 Another key use of a necropsy, not mentioned on the consent form, is in undergraduate teaching. Many medical students will encounter the necropsy during their training, either witnessing the whole procedure or as a demonstration of the pathological findings of the procedure in which organs and tissues are displayed (perhaps with the patient’s body in the background) before their return to the body. Should explicit informed consent be obtained to use necropsy in this way? The short report by Westberg et al in the same issue serves to highlight the importance of obtaining consent for students to witness invasive procedures such as a vaginal examination, even though most patients do not object.2 Necropsy is no less invasive. Whether patients and relatives would object to a group of students viewing the body after death is not known. It is established, however, that “an important precondition for good education of medical students is that patients are prepared to participate in training.”3 Failure to obtain consent denies the autonomy of both the patient and the relatives.

Some people argue that, once death has occurred and the decision to allow a necropsy has been taken, the worst is over and therefore the presence of students at the necropsy is of no consequence and does not require consent. This denies relatives the opportunity to be altruistic and know of the benefits that come to students from the procedure. We should be as concerned that consent is adequate as we are with who obtains it.

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Most relatives give consent once reasons for necropsy are explained

Editor—As pathologists performing a large number of perinatal autopsies, we read Sayers and Mair’s personal view with a mixture of sadness and disbelief.1 We do not want to increase the relatives’ and (in our case) parents’ grief with detailed descriptions of postmortem procedures. But current levels of information available mean that most already know the basics, and people want to have a choice. Most of the detailed explanations of what is going to happen to tissues and organs at a postmortem examination have been added to the consent form at the insistence of parents’ pressure groups.

Teaching is essential for new doctors, all of whom need to learn at least the basics of pathology if they are going to be capable clinicians. Most of the research projects requiring postmortem tissues are clinico pathological studies. Almost all of them use tissues that will be reviewed by clinical diagnosticians anyway. Because we now need consent to retain even tissues used for diagnosis, clinicians could explain that this retention might help relatives in the future (including in future pregnancies and similar diseases in another member of the family).

Most pathologists retain full organs for teaching and training or research only at the specific request of a clinician. We are surprised that some doctors are prepared to give parents and relatives the consent form and let them deal with it by themselves in such a traumatic period.

Until recently there has not been much training in communications skills in medical schools, but surely opting out of the patient–doctor relationship at this time is not an answer. The main reasons for a hospital necropsy are to explain to the relatives what happened to the patient and to help the clinician understand the disease process. It is not the pathologist who primarily benefits from a necropsy.

In our experience, most parents (and most hospital postmortem examinations are performed in perinatal cases) agree to the requests in the consent form for a postmortem examination once the reasons are explained to them, especially by a doctor they have met and trust. We are surprised that Sayers and Mair find it acceptable for a person whom the parents or relatives have never met before to come and talk to them at this time or at the time of the necropsy.

If clinicians want to discuss any aspect of the necropsy, including the reasons for requests other than diagnosis, we are all happy to help.

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Genetics mediate relation of birth weight to childhood IQ

Editor—Matte et al reported an association between birth weight and childhood IQ.1 To control for confounding by maternal and family factors they examined this relation in sibships of the same sex and found an association between birth weight and IQ.
within male sibships. This association may be mediated by genetic factors.

The impact of genetic factors on this association can be determined through the investigation of birth weight and IQ in twin pairs. Differences within dizygotic twin pairs are a function of both genetic and non-genetic factors, whereas differences within monozygotic twin pairs are almost completely caused by non-genetic factors. If genetic factors mediate the association between birth weight and IQ it is expected that for dizygotic twin pairs the association between intrapair differences in birth weight and IQ is absent.

Our results suggest that genetic factors mediate part of the association between birth weight and IQ, at least until age 10. We found an association between intrapair differences in birth weight and IQ in dizygotic twin pairs. As twin pairs share influences such as prenatal factors, socioeconomic status, parental smoking, and parental age, the influence of these confounders is negligible. In addition, in monozygotic twin pairs, in whom intrapair differences reflect only environmental influences, the association between intrapair differences in birth weight and IQ is absent.

1. Matte TD, Bresnahan M, Begg MD, Susser E. Influence of variations in birth weight within normal range and within sibships on IQ at age 7 years: cohort study. BMJ 1991;303:810-4. (11 August.)

**Quality of care for people with dementia**

**Change in attitude is needed**

**Error**—Ballard et al draw conclusions from observing residents’ activities in establishments providing care for people with dementia that few specialist professionals would disagree with: that standards are poor and must be raised.1 Their methodology, however, is potentially misleading if service providers use the dementia care index alone as an indicator of improved quality of care. Dementia care mapping measures the subjective experience of the service user across three dimensions (type of activity, degree of comfort, and time). Standardisation of data is achieved through thorough accredited training, and the dementia care index is derived from aggregation of observations. Typically in our experience, the activity is observed during the working hours of people other than nurses and rarely during early mornings, evenings, and nights.

Dementia care mapping refers to a standardised six hours of mapping in each home in the study but fails to extrapolate general and relevant data on the quality of the services provided across a 168 hour week. When longitudinal studies have used the dementia care index as an indicator of quality of care, they have shown that the experience of the service user is more variable than the service provider.

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<td>98.7 (13.2)</td>
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