Low-tech autopsies in the era of high-tech medicine: continued value for quality assurance and patient safety.

Editorial

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Low-Tech Autopsies in the Era of High-Tech Medicine

Continued Value for Quality Assurance and Patient Safety

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It's back. The autopsy question, that is. It will not go away quietly. In 1983, in a theme issue on autopsy, JAMA announced that it was "declaring war on the nonautopsy."[1] We have, in truth, based on outcomes, lost most of the battles since then. But we have not lost the war. Today marks a new offensive.

Autopsies have traditionally been performed to:

disadvantaged children will continue to pay a price in terms of educational underachievement, vulnerability to substance abuse, and the many negative consequences of antisocial and criminal behavior.

Felton Earls, MD

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Autopsies have traditionally been performed to:

1. establish the cause of death,
2. assist in determining the manner of death (ie, homicide, suicide, etc),
3. compare the premortem and postmortem findings,
4. produce accurate vital statistics,
5. monitor the public health,
6. assess the quality of medical practice,
7. instruct medical students and physicians,
8. identify new and changing diseases,
9. evaluate the effectiveness of therapies such as drugs, surgical techniques, and prostheses,
10. reassure family members, and
11. protect against false liability claims and settle valid claims quickly and fairly.[2-6]

Preservation of the autopsy has been said to be a "fundamental principle of all clinical research."[7]

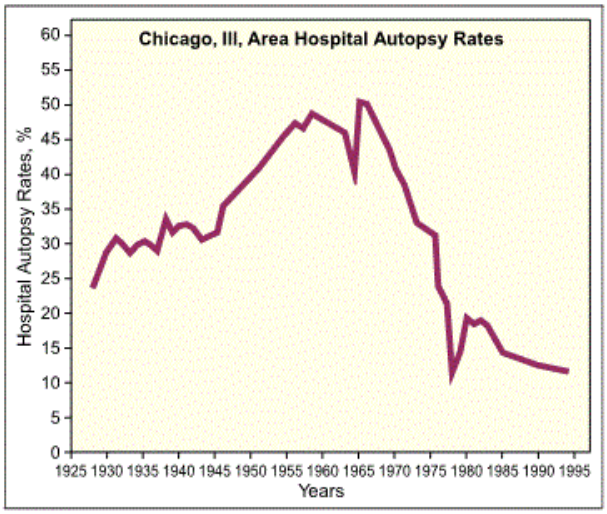
But the autopsy has come on hard times since the 1960s.[8] The Institute of Medicine of Chicago, Ill, has kept autopsy data for Chicago area hospitals (a reasonable sample for urban areas) since 1923 (Figure). The autopsy rates for hospital deaths at nonteaching hospitals nationally now average below 9%; many hospitals have autopsy rates at or near 0% despite many deaths. No one seems to know what proportion of nursing home deaths are autopsied, but it appears to be between 1/100 and 1/1000.[9]

See also p 1245.

Everywhere I go to speak on quality of care and point out these chilling autopsy figures, physicians, policymakers, and the public ask me what happened. I tell them I do not know and that reasons for the dramatic decline in autopsy rates are many and complex.[4] Many thousands of words have been written about the impending "death" of the autopsy in the past 30 years. Various calls to arms have been issued. The autopsy is not dead, but it slumbers deeply, apparently the victim of a vast cultural delusion of denial. It is not exactly a conspiracy of silence or necessarily a massive intentional cover-up, but it is a movement with millions of players, all in complicity for widely varying reasons with the final result of "do not bother me with the truth" on the sickest patients—the ones who die.[1]

In fact, there is still a giant gap between what high-tech diagnostic medicine can do in theory in ideal circumstances (very much, very well) and what high-tech diagnostic medicine does do in practice in real-life circumstances (not nearly so well), when human beings have to decide what, where, when, how, and why to use it. This gap becomes especially obvious when one looks at patients sick unto death.

Two 1998 reports validate the continued truth that there is an approximately 40% discordance between what clinical physicians diagnose as causes of death antemortem and what the postmortem diagnoses are. In one recent study with such results (44.9% discordance) at the University of Pittsburgh, Pa,



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