examination has relevance in arriving at the cause of death or an interpretation of the events leading up to death. It does not cover incidental lesions unrelated to the nature of the death - though in most instances it can legitimately be argued that *all* abnormalities must be investigated to determine their relevance. However, the retention of tissues for teaching and research is not covered by the coroner's permission and *the coroner cannot grant such permission*, as it is not within his remit to do so. He can *forbid* the use of any tissues for such purposes, but positive permission must be obtained under the terms of the Human Tissue Act, 1961, (*see below*). One of the most obvious examples of this, is the retention of pituitary glands for hormone extraction. In spite of frequent claims to the contrary, the coroner has no authority to give permission for such removal. A significant proportion of the contents of pathology museums are undoubtedly from coroner's cases and are, in the strict terms of the law, illegally retained.

'Clinical' autopsies

In respect of hospital autopsies, the position is quite clear. The retention of tissues is exactly the same in its legal aspects as for the donation of tissues for transplantation. Under the Human Tissue Act 1961, permission for autopsy is obtained either by the ante-mortem request of the patient (a rare occurrence) or more usually, by the absence of objection expressed by a relative. As the Act was poorly drafted, the degree of relationship is not stated, but the person in charge of the body (the Health Authority or their agents, ie administrators or doctors) gives permission for autopsy on positive consent being granted in writing on a printed form (which itself has no statutory authority). However, it is the most convenient way of proving the absence of objection by a near relative. In respect of tissue retention, the usual post-mortem consent form has a sub-clause (which can be deleted by the relatives if they so wish) which allows tissues to be retained for therapeutic, teaching or research purposes. Once signed, with the clause intact, the pathologist is entitled to remove and retain any organs which he deems necessary or suitable for the stated purposes. Although not yet put to the legal test, it is likely that the same concept of 'informed' consent applies as with live patients, in that it would be both unethical and certainly a matter of bad public relations for the hospital, if some major mutilation was inflicted without any information or express request being made to the relative at the time of signing of the consent form.

Apart from any potential legal consequences, the alacrity with which the media seize upon any alleged irregularities in relation to mortuaries and post-mortem matters in general, make it essential that all aspects of autopsy procedure and retention of material is conducted with the greatest discretion.

Guidelines for the retention of human tissue removed at operation

It is not practicable to retain indefinitely all human tissues removed at operation, and it is often impossible to foresee which tissues may be needed at a later date for clinical or for medicolegal purposes. It is reasonable to keep all tissue for that minimum time which allows the clinician in charge of the case to comment on the histological report and allows further samples to be taken if additional clinical problems come to light as a result of the report. The time should also enable the clinician to inform the pathologist of any possible medicolegal complications. When these are foreseen, it is suggested that the tissue should be kept for a minimum of one year, and if relevant and practicable a photographic record of the macroscopic appearances should be retained for a minimum of ten years.

It is therefore suggested that the minimum time for the retention of surgical specimens is four weeks; if possible this should be four weeks from the date of the issue of the report on the specimen. No maximum time limit is recommended.

Currently the statutory limit for initiation of legal action is often extended, but the very great majority of actions are initiated within ten years. It is therefore suggested that blocks and slides should be kept for a minimum of ten years. Because a significant number of patients return for several biopsies over a much longer period, the current practice of retaining slides for thirty years or even longer is commended.

Report of the Standing Intercollegiate Committee on Oncology on the relationship between Haematology and Clinical Oncology

The training of haematologists is now supervised jointly by the Royal Colleges of Physicians and Pathologists through the Joint Committee on Higher Medical Training. These Colleges have recommended that higher specialist training in haematology should be preceded by a period of general medical training at the end of which the qualification MRCP would be obtained. Trainees would spend a total of five years in posts recognised by the two Colleges and qualify MRCPath before becoming accredited. These haematologists, as well as many now in practice, have experience in the use of cytotoxic drugs and their various consequences, and, in many cases, also have experience of bone marrow transplant and other specialist procedures. However, it is not considered that the person so trained would be equipped to undertake the care of non-haematological malignancy and such responsibility is likely to fall to the haematologist under only exceptional circumstances and where the person concerned has special expertise qualifying for this.

The role of the consultant haematologist with respect to oncology is primarily in relation to the clinical care of patients with leukaemia and other haematological malignancies and secondarily to contribute his expertise and laboratory services to the management of patients with any form of malignant disease under the care of the medical oncologist, radiotherapist or surgeon.

There are different local arrangements for the management of solid lymphoid tumours as expertise varies between specialists from area to area, but collaboration between haematologists, clinical oncologist and radiotherapists is to be desired.

Comment from Professor A J Bellingham (*King's College School of Medicine*)

The majority of haematologists will be intensely disappointed, if not angry, at the above report. The question raised is whether any other specialty has its limits with another so clearly defined? The designation of the specialist caring for a patient with a specific disease varies from area to area. To suggest that haematologists, who because of their laboratory and clinical training are generally the most experienced group in the management of bone marrow failure, should have anything but full clinical care of patients with haematological malignancies, including lymphoid tumours and bone marrow transplantation, is to deny what is already recognised practice in many places.

In a few areas, such haematological patients are cared for by medical oncologists but equally in others, care of patients with solid tumours requiring chemotherapy is undertaken by haematologists.