

Autopsy and Malpractice Considerations

IN “Autopsy Utilization in Medicolegal Defense of Anesthesiologists” the authors attempt to correlate autopsy findings with possible culpability in unexpected surgical deaths.¹ The first paragraph of their discussion highlights the inherent difficulty in using narrative data of autopsy findings in claim reports without access to the original autopsy reports. The thoroughness and quality of the autopsy itself simply cannot be evaluated. Although the College of American Pathologists has guidelines regarding the autopsy report, these guidelines are concerned primarily with appropriate layout and components of the report such as if the descriptions of the external and internal examination are in the body of the report, whether a provisional anatomic diagnosis list has been generated and dispersed to appropriate parties within 24 h, and if autopsy reports have been released within 30 days of the autopsy.^{2,3} The quality or correctness of the autopsy findings is not assessed. In this study, the quality of the thoroughness of the autopsy is paramount; otherwise, the conclusions in this particular study, although important, can only be superficial.

The quality of the autopsy reports for the investigation of intraoperative deaths, as in any type of death, can vary widely. If such deaths fall under the coroner or medical examiner’s jurisdiction, the often understaffed forensic pathologists are usually reluctant to take on these cases because of the increased time requirement associated with determination of cause of death and high possibility of associated time-consuming civil litigation. In addition, some members of the forensic pathology community think that such investigation belongs in the arena of the hospital pathologist because the performance of autopsies was viewed in the past as quality assurance and control for the hospital.

Unfortunately, the performance of the hospital autopsy has decreased, as the authors have already pointed out, partly because of decreased reimbursement and associated perceived lack of importance. This negative attitude has, without a doubt, carried over to the pathologists and hospitals charged with performing the autopsies. The negative view of the autopsy is reinforced by the time constraints often placed on hospital pathologists to perform the autopsy. Often the pathologist is expected to review the patient’s hospital chart (which may be extensive), attempt to contact the appropriate clinicians for their assessment, and perform a sometimes complicated dissection, often in addition to performing other duties such as examining surgical pathology specimens

within a short amount of time. This rushed atmosphere, in addition to decreased incentive due to lack of reimbursement for a standard hospital autopsy and negative attitude toward the task, is not conducive to thorough examination of the cause of hospital deaths. Such an environment may also encourage assigning a cause of death to any grossly apparent pathology without critically examining whether or not the pathology actually contributed to death.

The authors allude to a model for the investigation of intraoperative deaths based on committee review where committee members consist of experts in surgery, anesthesiology, and pathology. The committee investigates those deaths where the patients have been classified as at low risk for surgical and anesthetic complications. Patients at low risk are determined using the American Society of Anesthesiologists classification of physical status. In this classification scheme, the patients are rated I through V where a higher classification denotes a greater intraoperative risk. A subclassification of patients who undergo emergent surgeries is flagged with “E” after their classification number. The authors advocate the adoption of more uniform medical and pathologic investigative procedures such as the one detailed in Reay *et al.*⁴; however, adoption of such procedures will be slow without increased reimbursement to cover the cost of not only the basic autopsy procedure but also toxicology testing and special autopsy procedures.

In this article, the authors state that patients in claims for death with autopsy tended to be younger and healthier than those in claims for death without autopsy. Presumably, these patients would have corresponded to lower classification numbers in the American Society of Anesthesiologists classification of physical status. It would be interesting to classify this cohort of patients according to the American Society of Anesthesiologists classification to determine whether these patients fell into one predominant classification. In addition, the authors suggest that the autopsy results helped the defense of the anesthesiologists because other causes of death or significant comorbidities were present. A more interesting paragraph could include more explicit examination of just how the information may have helped the anesthesiologist. Likewise, how were the autopsy results specifically harmful to the anesthesiologist? Given the varying quality of the performance of autopsies that probably exists across this country, the significance of autopsy findings in malpractice cases needs to be carefully scrutinized.

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