Summary of Comments

Regarding: Proposed Standards for Forensic Autopsy Performance

The attached document includes all comments received from NAME members who were solicited to review and provide comments regarding NAME's proposed Standards for Forensic Autopsy Performance.

As provided for by the NAME Standards Committee, the comments are being made available for review by the NAME membership.

34 different people provided the various comments shown. No significant editing of content has been done except to remove a few proper names of people or places, in order to provide a greater degree of anonymity of those who responded or those to which allusions were made. Spelling or typographical errors were not corrected. The NAME membership was informed that all comments would be made available to the membership for review, and all are provided in this document.

Each comment is preceded by the Letter and Number of the particular proposed Standard to which that comment applies. Those reviewing the comments will need to have a copy of the proposed Standards available to facilitate comment review. Copies were mailed to all NAME members, and a copy is also available on the same web site as this document.

August 2, 2005

General Comments

The preface could be improved. It reads like a first draft.
There needs to be an escape clause to the effect that any given Standard may be waived at the professional discretion of the forensic pathologist.
Section D,E,&F: makes no provision for ABP Cert. anatomic pathologists to perform "forensic autopsies". A significant number of "forensic autopsies" are performed by non-FPs. It is not realistic that all "forensic autopsies" be performed by FPs. There are not enough of us. Just as there are not enough hematopathologists to read every bone marrow biopsy in the country. There must be a provision for ABP cert. APs to perform medicolegal ordered autopsies.
Not included, but worth consideration to be included based on personal experience, **I think a C7.4 should be added to read: "the forensic pathologist or representative takes photograph of identifying tag(s)/band(s) with the case number in the photograph.** In 2002, it was suggested that I "mixed up" the paperwork on two boys that I had performed autopsies on. Both were 14-years-old with similar physical features. The boys had been "misclaimed" and therefore misidentified (one in the emergency department and one in the pediatric ICU) by their parents. Their autopsies were both conducted on the same day. By chance, the name on one of the toe tags could be read and the case number was clearly visible. If this were not the case, it would have been much more challenging to prove that I had not mixed up the cases in the morgue. We now take photographs of the identifying tags/bands with the case numbers clearly visible
On page IV, the N.A.M.E. Standards Committee and External Review Panel members are listed as Dr. with their degrees behind their names. Shouldn't it be one or the other?
The last sentence in the introduction to Section B is "This section also addresses forensic autopsy workload." Unfortunately, forensic autopsy workload was removed at the last Atlanta meeting – the sentence in the introductory paragraph should either be eliminated or (*preferably*) the autopsy workload limitation should be re-inserted.
Another that needs to be addressed is that the "Board Certified" forensic pathologist must be taken out. There are a number of forensic pathologists that are excellent and have not passed their boards as yet. Do you exclude them? While it may serve to limit the supply and therefore increase the individual income of those with boards, you are going to over restrict the supply and be unfair to many who have worked long and hard to be a forensic pathologist and either not passed the boards or have not as yet.
RE: standard G29 and I31 G29.1 thru G29.3 are listed, but the table lists G29.1-G29.4 (same for I31.1-13 but the table has 14 items).
General comment: I don't see the purpose of including these "voting" table results and certainly they have no place in the final standards.
I think a goal of every ME office should be to post all "coroner's cases" and that our standards should discourage "walk-by inspections" or "sign outs". I think a brief autopsy to document cause of death is better than an academic autopsy on some cases and no autopsy on others. One group presented data a couple years ago to illustrate the inaccuracy of guesses, and my experience since my retirement verifies this ("private autopsies on sign outs by the local ME.)
I have one question, the standards don't address workload. Is there another document that specifically addresses workload standards for medical examiners/ forensic pathologists?
Section G: This section is unclear. You say "all" infants, but not "all" explosion, gunshot and charred. Do you really mean "all" for all four types? Don't you mean to say "a FP should generally X-ray infants who have died in a circumstance to suggest a reasonable possibility of childabuse?" Likewise "explosion victims who have died in a circumstance suggesting that recovery of metalic shrapnel may have criminal or civil evidentiary value."? Same for gunshot and charred? By the way - another problem:

"The forensic pathologist or rep shall: G25.1 x-ray all infants. G25.2 x-ray explosion victims. G25.3 x-ray gunshot victims. G25.4 x-ray charred remains." I don't x-ray all victims in any of these categories. I don't even bring in all infants reported as dying, let alone x-ray them. I don't have enough explosion victims to say what I usually do, but I can sure imagin situations where x-raying would be meaningless. All gunshot victims - even suicides and homicide suicides? All charred remains, even with only the hand charred? What does this G25 series really mean? Are there exceptions?
I find these very workable. The terminology is not at all confusing. I would suggest that the standards be adopted.
Does section B4 including forensic pathologists and residents/fellows apply to all later sections where only the words "forensic pathologist" are used? Maybe at the beginning, i tshould state that when "for. path." is used, it also includes residents/fellows.
Since NAME has chosen to label these as "minimum standards", rather than recommended guidelines, it occurs to me that if I disagree with as little as one standard I must resign from NAME. To remain in NAME means that I endorse and must live by each and every one of these standards. If I don't follow each and every one, irrespective of having perfectly logical and defensible reasons for doing so, I risk being labelled (potentially by a lawyer in court) as incompetent for not adhering strictly to these minimum standards. If I resign from NAME I am not bound by the minimum standards, and can more easily defend a decision for examination of the body that makes perfect sense given the circumstances and the scene that the case presents. Somehow I doubt that this is NAME's intent, and I would therefore ask you to reconsider whether these should be considered minimum standards versus recommended guidelines.
B6 - Put it back in, we need it.

A1	Second sentence: These officials, which officials? Suggest The officials responsible for the medicolegal agency must…
	I have to agree with others that this is not a forensic pathologist's standard but an institutional standard. It would better be placed under the NAME's accreditation standards for offices.
A1.1	Problem: The current wording makes all agencies that are part of law enforcement or that use law enforcement personnel as investigators guilty of malpractice. Severity: Severe. Proposed Solution: This sounds like an indirect standard. What are the root problems you are trying to address? Is it really only that a ME may be part of the DoJ? Or is it a matter of conflict of interest, undue influence, etc.? Is it that you really have a problem with the place I work? That you have a problem with Sheriffs? I would suggest that the committee sit down and list "why" they have a problem with a Sheriff running a department, and make "those" the standards. I assume it has to do with conflict of interest, but I don't know. If it's just that you don't like Sheriffs then make it specific to Sheriffs. That would tell people "why" being under a Sheriff is bad. If NAME simply makes it a standard, it will be ignored. On the other hand, if the question is autonomy then it can be explained. For instance, you can might say "No authority that inherently represents a conflict of interest, such as law enforcement, shall direct or attempt influence the conduct of an investigation, consultation, or reporting of a medicolegal investigation by a ME office." That would not make being part of DoJ malpractice, but instead address the real issue - that of autonomy and influence.

	I think the wording should be changed to something like "operate without any influence from law enforcement that may cause a conflict of interest".
A2.7	Too all inclusive does this mean all AIDS patients? Cases of well documented meningitis in hospital a month before death? Give us a brake!
A2.8	What is a full investigation?? I hope not an autopsy. This could be cost prohibitive if you are not more specific or require an autopsy in every unattended death. Please tell us what actually want here.
	Should be removed, as a large number of expected natural deaths occur without the presence of a physician, yet the physician is willing to sign the DC and as long as police investigation reveals no unusual or suspicious circumstances, their is no need for a "full ME investigation" of this category of death.
	There are many deaths in which the physician is not in physical attendance when the patient dies, but nevertheless, do not require a formal forensic death investigation. Such cases would include expected deaths in nursing homes and hospice deaths. Most offices, and certainly not ours, do not have the resources to investigate every one of these deaths. Therefore, the standards should exclude such deaths and specify that those deaths in which the patient dies outside of a medical facility, such as a nursing home or hospice situation, and who has not seen his or her physician in days, weeks or longer, should be investigated.
	In general, all the standards, when referring to the pathologist specifiy forensic pathologist. There are not a sufficient number of forensic pathologists to investigate all the deaths that need investigation, include autopsy. For example, my partner and I serve as the Chief and Deputy Chief Medical Examiner, respectively, for an adjacent county of 250,000 people. We oversee the medical examiner investigators in that county and many cases are sent to us for autopsy. However, we utilize a private pathology group in that county to perform the more "basic" autopsies, such as naturals, uncomplicated suicides, and accidents. We are always available for consultation by the non-forensic pathologists and are consulted by them as needed in cases that they perform. It simply is not physically possible, however, for my partner and I to perform all of the autopsies in that county. Therefore, a statement such as "a pathologist certified in anatomic pathology may, at the discretion of the chief medical examiner, may perform certain uncomplicated autopsies as long as he/she consults as needed with a forensic pathologist and as long as their final reports are reviewed by a
	forensic pathologist" would be acceptable.
	Clarify what unattended by a physician means. MD is present? Cared for patient 1 day, 1 week, 1 month? Last saw patient within days? Weeks? Months? Prefer suspicious deaths not under care of a physician.
B3	Makes no allowance for delayed traumatic deaths, such as the many deaths that occur days following MVA where lethal injuries are well documented by medical records and an autopsy may not be necessary to accurately determine COD. Also implies that these "forensic autopsies" shall be performed by a FP. This would not be possible given the number of FPs, and certainly a competent ABP certified AP can perform a number of these autopsies. Forensic Path is a subspecialty area of Pathology and should be considered as other subspecialty areas. Not every bone marrow biopsy is read by a ABP cert. Hematopathologist and not every "forensic autopsy" can or should be performed by a forensic pathologist.

	There should be a clarification differentiating acute deaths from deaths occurring months or years after the event. A person dying in a coma 10 years after drug related arrest, in my opinion does not necessarily need to be autopsied. However, under policy B3.7 it would be. Likewise, would someone dying from hypoxic encephalopathy weeks after a resuscitated electrocution would have to be autopsied?
	An obvious interpretation of the combined standards, would suggest that autopsies are required in the case of judicial executions. This would follow standard B3.3, B3.4, and B3.7. I raise this question, since I was involved, and will continue to be involved, with federal executions at a Penitentiary. This issue was raised in a published letter to a journal due to the influence of the courts and the use by prisoners to claim religous objections to autopsies. If NAME is to be consistent with the standards presented, there should be a statement regarding this particular situation.
	The last line of this standard allows for no professional discretion. However, even in a homicide, there are going to be cases where it is hard to argue why an autopsy is necessary. For instance, a man shot 20 years ago with resultant quadriplegia who dies from complications of his immobilization. This is well documented in medical records. The assailant already been convicted of assault, and has served his time. The family is adamant they do not want a post. The DA cannot and will not file any more charges. This is a real case. We did not do an autopsy, and I would defend that decision to the end. We should ALWAYS allow for professional discretion.
B3.4	There are a proportion of deaths in custody where the circumstances and scene are clear enough that external examination of the body (usually supplemented with toxicology) is sufficient to answer all legal questions arising from the death. Hangings, where it is clearly documented that no one else could have played a role in the death, are the best example of this. We do external examinations in these types of cases fairly routinely, and are able to answer all relevant legal questions arising from the death (Please note: all of these deaths go to Public Fatality Inquiry before a Judge in our jurisdiction, and no legal concerns have been raised about the fact that autopsies are not routinely performed). I believe that discretion should be allowed here on a case-by-case basis.
B3.5	A proportion of occupational deaths involve a witnessed traumatic event (eg. a "beam" falling from a crane) with obvious lethal injuries. An autopsy is not going to add any further information to these cases, and, in my mind, represents a waste of taxpayers' resources. I believe that discretion should be allowed here on a case-by-case basis.
B3.6	Some cases of electrocution are witnessed, clearly documented, and have visible electrical injuries. I am at a loss to understand what additional information an autopsy will provide in these cases. I believe that discretion should be allowed here on a case-by-case basis.
B3.7	Add “unless there has been hospitalization and sufficient medical evaluation to allow for death certification”.
B3.8	Add “unless there has been hospitalization and sufficient medical evaluation to allow for death certification”.
B3.10	Not EVERY skeleton. We get prehistoric Native American and historic graves washed up or accidently dug up.
	add "or forensic anthropologist"

	The forensic pathologist may wish to have skeletonized remains examined by a forensic anthropologist.
B3.12	I think this should read "the forensic pathologist deems a forensic autopsy is necessary to determine manner of death or collect evidence". I think the most important objective of the forensic pathologist is to determine the manner of death. Although the cause of death is important, I think it is secondary to the manner of death. An autopsy is not necessary if the manner of death is undoubtably deemed to be natural, even if the cause of death is not necessarily known for certain.
B4	Standard B4 is the single most important standard in the set. It essentially removes the use of un-boarded physicians as independent experts or contractors for forensic work, which is a good thing. I would like for it to require a medical license, as well. However, as written it might create an unnecessary burden unless the language is slightly amended to permit, under the strictest of "line-of-sight" or "within reach" supervision, the utilization of unlicensed and un-boarded physicians and pathologist's assistants as prosectors.
	B4.1 the medically-licensed and board certified forensic pathologist, or resident in pathology or physician or pathologist's assistant with direct, immediate and hands-on supervision of the forensic pathologist performs all autopsies
	B4.3 same language for the folks performing dissections
	B4.4 leave this one alone, it works great
	Does this standard mean that a medical student who is directly supervised by a forensic pathologist cannot perform an autopsy?
B4.1	"residents in pathology" should be "residents in forensic pathology"
	Change to indicate that the forensic pathologist directly supervises the pathology resident. A strong statement about the importance of a forensic pathologist supervising and performing forensic autopsies introduces this section. Then parts B4.1 and B4.3 allow pathology residents to perform autopsies and dissections without explicitly stating under the direction of a forensic pathologist. I'm hoping this was inadvertent. I can't support standards that criticize "non-forensic" pathologists doing forensic autopsies but allow inexperienced residents to do them without direct supervision.
B4.2	Should read forensic pathologist or resident.
	potmortem should read postmortem.

	postmortem misspelled
	typo; should be "postmortem"
	"residents in pathology" should be "residents in forensic pathology"
B4.3	a competent path asst can open the bowel under direct supervision of FP.
	need to include medical students
	Under the direction of a forensic pathologist, an assistant may perform such functions as opening the intestinal tract. Organs commonly causing death, such as the brain, heart, and lungs, should always be examined by the forensic pathologist.
	Include medical students under the supervision of the forensic pathologist: According to the curent version we couldn't even let them cut a lung after watching us cut one, & during our direct supervision
	Change to indicate that the forensic pathologist directly supervises the pathology resident. A strong statement about the importance of a forensic pathologist supervising and performing forensic autopsies introduces this section. Then parts B4.1 and B4.3 allow pathology residents to perform autopsies and dissections without explicitly stating under the direction of a forensic pathologist. I'm hoping this was inadvertent. I can't support standards that criticize "non-forensic" pathologists doing forensic autopsies but allow inexperienced residents to do them without direct supervision.
B5.1	I think laboratory should be spelled out in a document like this. Lab is slang. In additin, if you're going to leave the format as is, it should be pathologist has requested. I think it would better just to say results/reports requested.
B5.3	Forensic pathologist who do autopsies for other jurisdictions do not have the legal authority to rule the official cause and manner of death. You are creating an impossible to meet standard.
B5.4	Forensic pathologist who do autopsies for other jurisdictions do not have the legal authority to rule the official cause and manner of death. You are creating an impossible to meet standard.
	This standard would automatically make death investigations in a significant portion on the country substandard, even with the disclaimer about local, state and federal laws in the preface, and is clearly aimed at eliminating the current coroner systems. The standards should be free of such agendas, and should instead focus on quality death investigation. Even among forensic pathologists, there is frequently disagreement as to how

	manner should be certified. It is more important that manner be assigned by a person who has access to all of the available knowledge, and has had training in the use of the manner classification system. If we are going to say “This is the standard” then we should mean it. If we REALLY mean “This is what we should all STRIVE towards”, then these should be guidelines. This standard should read something like: Manner of death should be determined based on all of the available information. Where applicable, the opinion of the forensic pathologist involved in the case should be considered.
	add 'if appropriate' at the very end - A coroner's office may be involved.
C7	4th sentence: Clumsy. I suggest, When traditional identification methods fail…
	RE standards C7 and C8: I'm not quite sure what the differences are between these two items and maybe they should be combined. It seems to me that item C7.3 should be under C8.
C7.2	Problem: "Case number" is too specific. Severity: Trivial. Proposed Solution: "Case identifier" (see discussion for I31.4)
C7.3	This implies that this is done in ALL cases, whether ID is an issue and even if there is no autopsy. If we mean in all cases that an autopsy is performed, it should say that. If we mean in cases where ID is an issue, it should specify that.
	put 'as appropriate' at the very end.
C8	In G28.3, a forensic anthropologist is in the list of special scientific services the forensic pathologist should have access to. Considering this, a forensic anthropologist should evaluate unidentified bodies before disposition to determine an age range and if, by chance the remains are skeletonized, provide a profile of the remains
	(1st sentence) What does disposal mean in this context/ Burial? Cremation?
C8.2	Not cost effective the one in 1000 cases where this may possibly be helpful could be exhumed for less money and time, than doing all those x-rays on 1000 bodies.
D9.5	Clumbsy, at best. I'd leave out as presented. It doesn't fix it, but it's better.
	Problem: There is no excuse for not photographing and describing the body. Technology for doing both is trivially inexpensive. Severity: Minor. Proposed Solution: "forensic pathologist or representative photographs and describes decedent as presented."

D9.6	NOT IN EVERY CASE. Why can't you guys use a little common sense? Although useful in some cases, in most cases this is only waste of valuable time particularly in places with in-house full service crime labs who have well trained trace evidence professionals who don't want the evidence lost by excessive handling in the morgue. They need to work with properly dried clothing in their lab where they have the needed equipment and facilities and time to do a complete and proper exam.
	Amend with "where indicated" or "in conjunction with evidence technicians" or similar language. I do agree that the forensic pathologist should examine clothing particularly when the decedent arrives clothed. I think there are exceptions. There may be cases where the clothing has limited value for interpretation of injuries but major value in the collection of trace or pattern or DNA evidence. If the clothing is already in the custody of the crime lab, perhaps in the midst of being processed (as in a delayed death), I may not request that it be brought for my examination. I view the collection of trace evidence in the same way. In some cases it would be my responsibility; in other cases, I would defer to other agencies. It would be ridiculous to call back an article of clothing that is in a protected drying compartment in a crime lab back to a morgue environment so I could look it over with a magnifying lens. The way this standard is written is too absolute in this regard.
D9.7	I do not "identify and collect" all the trace evidence on the clothing, such as semen on the clothing of a rape victim. I collect the CLOTHING and make sure it is preserved so that it can be studied in more detail. Should read "preserves the clothing, and where indicated, identifies and collects…."
	Amend with "where indicated" or "in conjunction with evidence technicians" or similar language. I do agree that the forensic pathologist should examine clothing particularly when the decedent arrives clothed. I think there are exceptions. There may be cases where the clothing has limited value for interpretation of injuries but major value in the collection of trace or pattern or DNA evidence. If the clothing is already in the custody of the crime lab, perhaps in the midst of being processed (as in a delayed death), I may not request that it be brought for my examination. I view the collection of trace evidence in the same way. In some cases it would be my responsibility; in other cases, I would defer to other agencies. It would be ridiculous to call back an article of clothing that is in a protected drying compartment in a crime lab back to a morgue environment so I could look it over with a magnifying lens. The way this standard is written is too absolute in this regard.
D10	This query is regarding D10 Physical Characteristics. This section states that the forensic pathologist shall: D10.1 document apparent age . . . D10.4 describe hair . . . D10.7 document prominent scars, tattoos, skin lesions, and amputations, etc. etc. Does this section mean that only the forensic pathologist can determine the eye color? As I practice now, my deputy medical examiner and/or I will check the teeth, eye color, hair color and length. One person will look at the decedent and the other will write everything down on our examination forms. But as this standard states 'The forensic pathologist shall: . . .' I assure you that my deputy and pathologist assistant can determine the gender of a decedent as well as I can. My Deputy medical examiner is not a physician. Also, I am assisted by a pathologist assistant that will measure hair length etc. Precluding them from assisting me will hinder my practice.
D10.2	CHANGE THE WORD "GENDER" TO "SEX"!! Ask our forensic anthropology colleagues about this!!! How I remember it is, SEX is between the legs and GENDER is between the ears. At autopsy, I often have no idea what "gender" the individual was, but I can usually determine the sex of the individual.
D10.10	A detailed description of the anus in EVERY CASE? This is just too anal. Don't you guys have a life? Are you capable of making reasoned decisions on when something is required or not?
D11	D116. need to add: Describe evidence of tissue/organ procurement

D11.2	To list the reason to record rigor mortis as "a sign of death that cannot be captured by photography" is totally ridiculous. The lack of a heartbeat or respiration also cannot be captured by photography. Should those be recorded as well? Rigor mortis, if ever recorded, is not done so as a sign of death. It may give some indication of time since death, but little else. Recording of rigor in most cases, in my opinion, is a waste of time, effort and ink, but when it is recorded it is not because it is an otherwise unrecordable sign of death.
D11.3	Use of the word “artifact” is not appropriate. It should read “postmortem changes” and perhaps “evidence of embalming” or “signs of embalming”.
D11.4	Use of the word “artifact” is not appropriate. It should read “postmortem changes” and perhaps “evidence of embalming” or “signs of embalming”.
E12	E12.1-E12.5: all these collections should be done prior to cleaning the body, not just E12.1 collections
E12.2	Change “combings” to “combings or tape lifts”
E12.3	i suggest "finger nail scrappings AND (not or) clippings"
E13.4	NOT IN EVERY CASE! NOT IN EVERY CASE.
	Add the word “significant”. I do not think it is necessary to do this on every individual old scrape and bruise on an alcoholic, unless there is a reason to do so in an individual case.
E13.5	Add the word “significant”. I do not think it is necessary to do this on every individual old scrape and bruise on an alcoholic, unless there is a reason to do so in an individual case.
E13.6	Add “if applicable”.
E14	E 14 Change from "Photographic Documentation" to "Color photographic documentation". There are still medical eaminer offices who use only black and white photography on cases of homicides.
	Problem: There is no indication of image quality requirements, but there are requirements for photography. The interesting thing is that if there were no requirements for photography, then there would also be no quality requirements. If you create a requirement for photography but do not provide a requirement for quality, then the default forensic science standards apply. These standards are much more rigid and demanding that just about any ME office currently uses. For instance, the standards do not allow JPEG images, which virtually all ME offices use. It has strict

	requirements for archiving, documentation, etc. I know. I helped write them, and some of the standards explicitly refer to autopsy imagery – though these are expected to apply to crime scene photographers visiting an autopsy rather than to a ME photographer. But, in a vacuum, the courts will apply them to all imagery.
	I wrote to the list two years ago that the SWGIT preferred to defer to expertise domain standards groups with respect to the issue, and suggested that NAME promulgate some; if NAME had image quality standards, our standards explicitly defer. For instance, we defer to the NIST latent print standards for pixel requirements. However, if those individual domain standards do not exist, then the courts will look to existing standards. There is already case law where the SWGIT standards have been used in deciding whether or not to allow imagery, it has been made part of the ASCLD/LAB accredation, and it is a resource used by the National Association of State Courts (see: http://www.ncsconline.org/WC/Education/KIS_SciTecGuide.pdf
	If there are no NAME standards to use, then the courts will eventually start asking if you are using SWG/ASCLD/NIST standards. Trust me. You do not. There is thus no way for you to prove that your autopsy photographs are valid. The courts are beginning to require that in almost all other areas -- crime scene, fingerprints, DNA gels, shoeprints -- and will eventually start asking if you can prove that autopsy photographs meet some standard. The standards committee can avoid all this by adding a trivial photography standard requirement -- something as simple as "The photographs should be of adequate quality to display the details of interest to the pathologist. The ME office should assure the integrity of autopsy images."
	At that point, the question of JPEG vs TIFF go away and the question merely becomes if you can see what you want to see. You will still run into problems with demonstrating image authenticity, but it at least gets you away from the SWGIT ballpark. Severity: Minor now, increasingly severe over the next few years. Proposed solution: Add "The photographs should be of adequate quality to display the details of interest to the pathologist. The ME office should assure the integrity of autopsy images." to the current standards, and create more meaningful standards in the future.
	in the statement poriton - 2nd sentence regarding reference scale - 2nd & 3rd line "-shall include a reference scale in each photograph of a wound or injury…." is a proposed change. I think the case number and a scale should be in all photographs.
E14.1	Add "significant" See discussion in E13.4 or E13.5
E15.3	I agree that gunshot wounds should be described from anatomic landmarks, however I do NOT think the standards should demand "the top of the head or sole of the foot." Describing the location of a wound on the abdomen is much better done in reference to the umbilicus or sternal notch. The top of the head conveys no meaningful information. I think the standards should read "...by measuring from fixed anatomic landmarks deemed appropriate by the forensic pathologist".
E15.4	Locate cutaneous wounds by measuring from anatomic landmarks - could include sid eof head wounds where reference to anterior or posterior midline is pointless, & reference is better made to something else like th eupper anterior attachment of the ear.
E16	E16. 4 and E16.5 ADD: description, like GSW descriptions in 15.3 and 15.5

E18.1	Add: And type
E18.3	"describe" the injury pattern. Does this mean only shape? Should not the wording include to describe the color, presence of contusion and/or abrasion and/or laceration. If present, they all need to described. To say "describe the injury pattern" seems to mean describe only the shape.
E18.4	Swab bite mark - if - appropriate time interval and not subsequent to long time and medical treatment with wound cleaning.
	Change to “swab recent or fresh bite mark with evidentiary value”. I have had cases where there where bite marks weeks old---- I am not going to swab those. I have had bites on the abdomen where there was a laparotomy, and the belly had been prepped for surgery---- Not going to swab that. Have had a bite on a drive-by gang shooting; his girlfriend got angry with him the night before and jumped him, smacked him and bit him. Had nothing to do with him getting mowed down the next night in the street by a rival gang. Not going to swab that either.
F19.2	Give me a brake! Every minor incidental adhesion needs a description in EVERY CASE? Where is your common sense.
	Go back to the "old" working & leave out "abnormal". All body fluids should be described even if normal in type and (??).
F19.3	I have only one hair to split for task F19.3 "document abnormal position of medical devices." I don't oppose the standard, but perhaps it needs clarification. I formerly documented ET tube placement until I was in my own hospital's E.R. gathering data on a new death when I heard a nurse tell another "No don't take that out, put it back in. The pathologist wants all tubes and lines left in place." I peered past the curtain, and sure enough, there she was blindly (without a laryngoscope) reinserting the ET tube. Not surprisingly at autopsy the tube was in the esophagus. There were unrelated standard of care issues surrounding that case and a suit was filed. Had I not witnessed the postmortem blind re-intubation, I'd have inappropriately documented an abnormal location for a medical device and the tort case would have been improperly even more convoluted than necessary. Ever since then I say in my report only that "there was an endotracheal tube in the OROPHARYNX." I document IN MY NOTES ONLY which hollow viscus it was located inside, but it doesn't become part of my written report.
	Given all the postmortem handling of the body during preparation to depart the E.R., transfer to the morgue and during x-ray procedures, I don't feel comfortable saying anything further in my report. It's too easy for the tube to slide partway out, and then to be pushed back into the wrong location.
F20.3	Add "residents in pathology" to "the forensic pathologist or residents in pathology dissect and describes organs". This is already similarly stated in B4.3 so you may be able to get rid of F20.3.
	For pathologist - or resident/fellow or supervised medical student.

F21.5	Change from “strips the dura” to “removes the periosteum” or “removes the dura mater”.
F22.1	Add: Obvious homicidal and suspicious
F22.2	Airway, singular.
	You do not need the forensic pathologist to personally remove the neck organs in EVERY CASE!
	a competent path asst under direct supervision of FP can remove the neck organs. Could be changed by removing the first two words of this standard "remove and", the remainder of the standard could be left as is.
	A competent trained assistant can remove neck organs/airway tissue. A competent trained assistant can, under the direction of the forensic pathologist, remove bullets and other evidence. As a well-known forensic pathologist famously said, "a trained monkey can do an autopsy". The important point that we should emphasize in our standards is that the brain and experience of the forensic pathologist are important, not his/her hands. What trumps the physical performance of the autopsy is the opinion, experience and, ultimately, judgment of the forensic pathologist in interpreting the results of that autopsy. Certainly, some portions of the autopsy should be performed by the forensic pathologist as I've described above, but getting hung up on having the pathologist do literally every aspect of the autopsy when a competent, trained and trusted assistant can help with the autopsy under the direction of the forensic pathologist is quite acceptable.
	Forensic pathologist or representative shall remove neck organs. How about - The forensic pathologist shall examine neck organs and airways after removal by the forensic pathologist or representative.
F22.4	States neck organ dissection is to be performed in neck trauma cases. I disagree. It should be performed in all autopsied cases. Gunshot/stab wound/blunt force victims as well as individuals who die from other circumstances can also have airway trauma. How are you going to find trauma if you don't look? How else are you going to find an obstructive bolus lodged above the larynx? In addition, it's a pertinent negative finding. If you're talking standards, this is a pretty basic one.
	Why did you get rid of the term "layered"? It now implies that one does not need to dissect the anterior neck in cases other than neck trauma cases.
F23.1	Correlate with, not to.
F23.4	a competent path asst can remove bullets under direct supervision of FP. Could be changed to "directly supervise or recover...."

	A competent trained assistant can remove neck organs/airway tissue. A competent trained assistant can, under the direction of the forensic pathologist, remove bullets and other evidence. As Joe Davis famously said, "a trained monkey can do an autopsy". The important point that we should emphasize in our standards is that the brain and experience of the forensic pathologist are important, not his/her hands. What trumps the physical performance of the autopsy is the opinion, experience and, ultimately, judgment of the forensic pathologist in interpreting the results of that autopsy. Certainly, some portions of the autopsy should be performed by the forensic pathologist as I've described above, but getting hung up on having the pathologist do literally every aspect of the autopsy when a competent, trained and trusted assistant can help with the autopsy under the direction of the forensic pathologist is quite acceptable.
F24.2	add 'as appropriate' immediately before 'injuries to skeletal system.' X-raying an insignificant skeletal injury is of no value.
F24.3	add 'as appropriate' immediately before 'injuries to internal organs…' Histologic or photographic confirmation of a soft tissue contusion is of no value.
G25	Letters that stand-alone should be capitalized, such as U-turn, T-shirt, X-ray, and an A+ in social studies class. (Capitalize the “X” in X-ray.)
	Consider adding G25.5 X-ray stab victims
	Problem: In those jurisdictions that do not perform autopsies on all gunshot suicides, there is no particular reason to do x-rays. For instance, the Georgia policy is not to perform an autopsy on a gsw suicide in which there is a single entrance and single exit. If, in fact, there is a single entrance and single exit, and there is not going to be an autopsy, there is no reason to do an x-ray; it will not find a projectile.
	Similarly, in some cases of charred remains, there is no purpose in performing x-ray examination. In particular this is true in cases where there are only cremains. If all you have are calcined fragments of bone, you do not need an x-ray to see if there is a bullet there. You need a sieve. Severity: Minor. Proposed solution:
	G25.3: "x-ray gunshot victims when there is the possibility of an undiscovered projectile."
	G25.4: "x-ray charred remains when there is the possibility of an undiscovered projectile."
	G25.5 Addition: X-ray decomposed (putrefied) remains
G25.1	Add: (Full skeletal series)

	There are cases on infants where I do NOT think x-rays are mandatory. An example would be an infant who dies in the hospital, there for a natural disease process, who dies as a result of a medication dilution error. Also, an infant who dies in an MVA probably does not need an x-ray in most cases. There are other examples, I am sure. What this standard I assume is addressing is abuse. Therefore, it should be that specific. "X-ray all infants where abuse is known or suspected, or where the COD is unknown"
G25.2	If there is extended hospitalization, probably not necessary. I can also think of some industrial accidents where an explosion was part of the process, yet do not feel the victim needed to have been x-rayed. Standard should read "X-ray explosion victims when there is a potential for the recovery of evidentiary material".
G25.4	I think charred remains should be X-rayed on an individual case basis.
G26	Proposed standard on "Specimens for Laboratory Testing" is somewhat vague because it does not specify the types of laboratory testing. It should be divided into two types, namely "Toxicology" and "Clinical Chemistry Testing (vitreous humor)". Toxicology testing is usually required in all cases of homicides, suicides and accidental deaths. But when the manner of death is certified as "natural" either after an autopsy or an external examination only, the minimum autopsy standard should NOT require collection of specimens for toxicology testing.
	Vitreous humor is practically the only specimen that can be used for postmortem clinical chemistry testing. It is essential to test vitreous humor in making the diagnosis of diabetic ketoacidosis in forensic autopsies. The minimum autopsy standard should require the access to the laboratory for a quick test and/or confirmatory clinical chemistry testing of vitreous humor. I do not think the vitreous humor should be routinely collected for toxicological testing. Blood and urine, when available, should be minimum specimens for toxicology testing. Of course other specimens such as bile, liver, brain are desirable.
G26.1	It should be vitreous fluid.
	Change to "Collect blood and urine; collect vitreous if indicated"
	Collect gastric contents in cases of suspected toxic ingestions.
G27	I believe histological examination should be performed more extensively as a confirmation of what has been observed macroscopically.
G27.1	Change to "perform histological examination in cases with no gross anatomic cause of death." (Drug intoxication as a cause of death is a diagnosis of exclusion. I have had deaths with potentially "lethal" levels of drugs that showed severe myocarditis microscopically.)
	al needs to be added to Anatomical (for correct grammar)

	Should have added, “unless the remains are skeletonized or otherwise rendered unsuitable for histologic exam”
G28	Problem: These facitlity issues are better addressed in accredation than here. They are not performance issues. Performance issues would mean the ability to do x-rays and the ability to weigh bodies and organs. The most obvious solution is to have the infrastructure in house, but if a system can perform the required task, it should meet the standard regardless of whether or not something in "on site." The committee is simply incorrect in the claim that it is necessarily impractical to use other facilities for radiology services. If, in fact, a ME office can do so in a reasonable, practical, and safe manner,why not simply admit it? Severity: Moderate. Proposed solution:
	G28.6: radiology services
	G28.7: weighing and measurement services
G28.1	Change to “perform histological examination in cases with no gross anatomic cause of death.” (Drug intoxication as a cause of death is a diagnosis of exclusion. I have had deaths with potentially “lethal” levels of drugs that showed severe myocarditis microscopically.)
	al needs to be added to Anatomical (for correct grammar)
G28.6	This has been discussed on the listserve, but I fail to see why the equipment has to be on-site. If the pathologist can get timely x-rays when they are necessary, and the body is handled appropriately so that evidentiary material is not disturbed, who cares where the equipment is? It is better to have good quality films, than poor quality films taken by untrained people on equipment that may not be in top operating condition. This standard should have the term “on-site” removed, and replaced with something like access to “timely radiographic studies”.
	add 'timely' before 'on-site radiologic..' I have an off-site contract company that comes and does our x-rays. It is satisfactory.
	Change to “access to radiographic equipment” Eliminate “on site” The standard should address availability/use of imaging by the forensic pathologist and not define how it should be done. Specifics of how other testing/consultation is done (laboratory testing, anthropology and odontology consultation) are not defined. Radiographic imaging is similarly an ancillary test/consultation and the standard should be similar. This is different from the necessary on site availability of scales used for every autopsy that must be at the autopsy site. I would argue that the statement that moving bodies for imaging is “not reasonable, practical or safe” is not objective. Bodies are moved, sometimes for great distance, for autopsy itself so there are safe and usual means of transportation. Reasonable and practical are very much dependent on jurisdiction and practice.
	As an example, in my jurisdiction, we use an on-call radiology service that is available 24/7 and brings portable machines, with grids and contrast if necessary. I order lots of studies in all the usual circumstances (burns, decomposition, identification, gunshot, sharp and blunt trauma, detailed pediatric films-not infantgrams) as well as vascular injection studies and evaluation of cardiovascular devices. There have been no complaints from the radiologists I consult with regarding the images. I can use my budget dollars for more imaging rather than for maintenance of imaging

	devices and I can use my space more efficiently rather than having an X ray machine in it. I am certain this arrangement has not led to less use of X rays. I see no difference in calling in a tech with an X-ray machine and calling in a tech to use the X-ray machine sitting in an office as would be allowed by the current standard. I also do send bodies off site for postmortem CT scans, apparently not a safe or reasonable thing to do.
G29.3	Delete. Add, "list of analytes tested for" or similar wording. It is critical to know what the test was for, such as enumerating ethanol: negative; methanol: negative; acetone: negative. I do not think listing the methodology is critical. Clinical laboratory reports on living patients do not list the methodology of their analyses. If the forensic pathologist asks for a clinical lab test (vitreous electrolytes; serum antibody) the methodology will not be indicated on the report. The toxicology report requirements should be similar to clinical lab requirements.
I31	last full line: Microscopics should be microscopic examination.
	unclear if this pertains to autopsies and ext. exams only, or to just autopsies. This standard would require a significant increase of scarce resources if these standards are to be applied to all the ext. exam only (often referred to "sign out") cases. Again, not possible to have FPs perform all ext. exams and autopsies that are under a medicolegal jurisdiction in the US.
	One thing that needs to be modified or deleted is under "Documentation and Reports". We are a coroner's system and our county does about 29-30 cases by contract. Each of their county coroners is responsible for doing the death certification and putting in the manner, mode and cause(s) of death due to the fact that they have access to the investigative information in each case that we do not have many times. Therefore, although the forensic pathologist who does the case can suggest these things (if the coroner doesn't object) he can not include the manner of death. There is much more to a case than just the gross, histo, tox, etc. and investigation by the coroner' investigator and/or the LE agency is critical to the manner, in a statutorily different county.
	Add: A readable document
I31.4	Problem: As a trivial wordsmithing issue, I don't think that "case number" is what you want. I assume that what the committee is really concerned with is that each case have a *unique* identifier. I know of some systems, for instance, that have a limited number of case numbers and begin over again after at time. Theoretically, an office would be within standards by giving every autopsy a case number of "1." Further, technically, a case number precludes the use of alpha characters. Sure, in the abstract sense even letters are numbers, but in the general usage they are not. Severity: Trivial. Proposed solution: "include a unique case identifier."
I31.10	This is essentially a repeat of B5.3 and B5.4 and for the same reasons is an impossible standard to meet where patholgist is performing the autopsy for another jurisdiction where he/she does not have legal authority of rule cause and manner of death.
I31.11	This is essentially a repeat of B5.3 and B5.4 and for the same reasons is an impossible standard to meet where patholgist is performing the autopsy for another jurisdiction where he/she does not have legal authority of rule cause and manner of death.
	For unnatural deaths, should include "how injury occured" line along with manner of death, e.g. Homicide (shot by another)

	add 'if appropriate' at the very end. A coroner's office may have two separate reports, the pathologists' and the coroner's.
I31.12	To clarify, each forensic pathologist attending the autopsy.
	Name of each forensic pathologist employed in that office? Participating on that case?
	What is meant by “title”? Is “M.D.” sufficient?
I31.13	I see no compelling reason to date the signature on the autopsy report. We have not done that here from the beginning of time and do 1100 autopsies a year and NEVER NEVER has this been a issue in court or anywhere else. Sounds like somebody's pet peeve?
Term/Definition	Comment
4. Forensic Autopsy	The definition of "forensic autopsy" listed in the appendix is too broad. By the NAME definition there clearly are "non-forensic" or "hospital" autopsies that become "forensic" autopsies only by virtue of who happened to authorize the autopsy. An unsophisticated funeral director coroner for example could make most any postmortem examination a "forensic" autopsy. By this definition wouldn't a "hospital" pathologist doing an autopsy ordered by the coroner not be doing a "forensic" autopsy which by the Standards can only be done by a forensic pathologist? By sticking to this broad definition of a "forensic" autopsy one could argue that NAME in effect is potentially dictating autopsy Standards for the whole practice of pathology. The NAME forensic autopsy definition fails to address the differences between autopsies done for a stab wound, an autopsy done to find hanta virus, and an autopsy done on a senator that happens to die at home of his end-stage lung cancer. Why we are doing the autopsy, and not who's ordering it, should frame the definition of what is, or is not, a "forensic" autopsy.
5. Forensic Pathologist	This is absolutely unfair and wrong! Anyone employing an uncertified forensic pathologist 3 years out of training would not meet minimum standards. This creates the entire set of standards impossible to meet as there are not that many certified forensic pathologists in the world to do all the autopsies in US.
	There is no reference to those of use who did not take a A.C.G.M.E. approved fornsic pathology fellowship but instead used our experience to obtain our Forensic Board Certification after passing the American Board of Pathology Forensic Pathology certification exam. This option is no longer available with the last one of us getting certified by this method in 2000. Your current definition excludes those of us who became certified by this method.
	I note in definition #5 that my status as a forensic pathologist is taken away by the definition of a forensic pathologist as "completing a ACGME approved forensic pathology fellowship program." I am boarded in AP, my first two years of work in an ME office were deemed equivalent to a fellowship, I past the FP exam and the American Board of Ptahology (ABP) granted me a certificate in forensic pathology in 1981. Now NAME, which I have supported for 25 years, is going to take my status away? Hey, I'm only 55, and it wasn't so long ago that pathologists had an acceptable alternate route to FP board certification. This definition of what a fornesic pathologist is really should be changed to "certified in FP

	by the ABP".
	How does this sound as an alternative...A physician who is certified by the American Board of Pathology in Forensic Pathology or is formally educated, having successfully completed training in an Accreditation Council on Graduate Medical Education (A.C.G.M.E.) approved forensic pathology fellowship program or international equivalent. Anyone completing training after one year following the adoption of these Standards shall become certified by the American Board of Pathology in anatomical and forensic pathology within three (3) years of completion of that training.