

The Role of the Autopsy in Medical Malpractice Cases, II

Controversy Related to Autopsy Performance and Reporting

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• **Context.**—We studied 99 appellate court records in cases of alleged medical malpractice and found no relationship between discrepant clinical and autopsy findings and outcome of litigation. Standard-of-care issues and not diagnostic accuracy were at the heart of every case.

Objective.—To characterize and discuss issues related to the autopsy and/or pathologist behavior that were raised in court records of medical malpractice litigation.

Design.—In 18 appellate court records, issues were raised about quality of autopsy performance and reporting or about death certification. The details of these controversies are succinctly reported here in a manner intended

to be instructive to pathologists who perform autopsies in a hospital setting or on a private fee-for-service basis.

Conclusion.—Autopsy reports are intended to provide objective medical information in a coherent format to the patient's medical record, to the attending physician and other concerned staff physicians, to other health care professionals, and to the families of the deceased. Inevitably, occasions arise that require legal counsel to be added to this list of parties with a legitimate interest. Our findings emphasize that incomplete, incoherent, obfuscated, or delayed reporting of autopsy findings do not meet professional standards, are unethical if intentional, and may be counterproductive. (*Arch Pathol Lab Med.* 2002;126:1032-1035)

We reported in a separate article results of a study of 99 appellate court decisions to determine how autopsy results were used in medical malpractice litigation.¹ We sought to determine whether there is a legitimate basis for fear among physicians that damaging information from autopsies will be introduced as evidence in malpractice lawsuits.²⁻⁴ The large discrepancy between the incidence of unexpected autopsy findings (54 [57%] of 93 cases), and a court finding for the plaintiff (19 [19%] of 99 cases) indicates that factors other than autopsy findings are at the heart of a decision that malpractice has occurred. The purpose of this report is to present and discuss the implications of controversies related to the performance and reporting of autopsies and death certificates that were identified during the course of the original review.

METHODS

We studied cases that were adjudicated within state court systems, where most malpractice cases are tried. We relied on the appellate court summary of the medical record and the critical elements in the trial record on which the claims and counterclaims of the litigants were based. The written opinions of an appellate court typically contain a summary of the legal history, medical history, the basis for the claim, the legal issues on which the appeal is founded, a discussion of how legal precedents apply

to the particular case, and conclude with a reasoned decision by the court.

AUTOPSY CONTROVERSIES

Controversial issues related to the autopsy per se, to the death certificate, or to both were common in the study group. Eighteen separate issues were raised, many of which were central to the resolution of the cases. The following selected examples are instructive.

Quality of the Autopsy

Outcome of a malpractice case may depend on the quality of the autopsy, specifically on the awareness of the pathologist of clinical issues, particularly those that are of potential medicolegal interest, and the thoroughness of the autopsy dissection with respect to those issues.

Example 1.—The autopsy pathologist found acute pulmonary embolism, but no source, in an adult who died a few days after surgical repair of an ankle fracture. Details of the extent of effort made at the time of autopsy to identify a source for pulmonary emboli were not available. The court ruled that a fracture cannot be established as the proximate cause of death in the absence of evidence that the emboli originated at the fracture site. In this case, the standard of care for treatment of a fracture was found to be acceptable. The defendant-physician was acquitted.

Comment.—With respect to a search for a source of pulmonary emboli, the standard of autopsy practice is not well defined and varies between institutions. The minimal acceptable approach is to search for a source within the confines of a conventional exposure of the viscera and probably should include massaging the contents of the femoral veins into the pelvis.

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Example 2.—The autopsy pathologist found massive acute pulmonary embolism in an obese woman who died at home, a few hours after hospital discharge following a hysterectomy several weeks before. While in the hospital, she had developed deep calf vein thrombosis, was treated with dextran, developed chest pain 2 days before death, and was discharged after a normal chest radiograph was obtained. There was no information in the autopsy report that pertained to the question of whether the episode of chest pain 2 days prior to sudden death may have been caused by a previous episode of pulmonary embolism. Physician inertia in the face of increased risk for, and clinical evidence of, a previous episode of pulmonary embolism was alleged. The defendant-physician was acquitted.

Comment.—Familiarity with the clinical history prior to performance of the autopsy in this case would have alerted the pathologist to the possibility of a previous episode of pulmonary embolism and prompted attention to gross and microscopic features of chronicity. The goal of autopsy performance is not limited to identification of the immediate cause of death, but should include an effort to identify processes that correlate with all known potentially significant facts in the medical record.

Delays or Inconsistencies in Reporting

Delays or inconsistencies in reporting may affect the outcome of a trial adversely for either the defendant or the plaintiff.

Example 1.—A summary judgment was entered for the defense without the autopsy report first having been entered in evidence by either the defendant or the plaintiff. Late discovery of the autopsy report, which was favorable to the plaintiff, provided the basis for reversal of this judgment. The appeals court held that the statute of limitations clock began when the late report was received.

Comment.—Late discovery of an autopsy report has multiple causes, including late completion of the report, absence of a discussion of autopsy findings with surviving kin, and lack of familiarity with the right of responsible kin to request and review a copy of the medical record. It was not clear how discovery of the autopsy report by the plaintiff's attorney came to be delayed in this case.

Example 2.—Court held that multiple "versions" of an autopsy report (preliminary, final, and addendum to the final) and the death certificate (initial and amended), in both of which the cause of death was changed in a way that appeared to favor the defendants, compromised credibility of the conclusions. The defendant was convicted of negligence on the basis of undisputed clinical facts, namely, that massive aspiration of gastric contents occurred during an emergency cesarean section performed under open-drop ether anesthesia. There was clear evidence of miscommunication between the surgeon and anesthetist about whether intubation had been accomplished when the abdominal incision was made.

Comment.—It is acceptable, indeed desirable, autopsy practice to issue prompt preliminary and final reports, with or without amendments as needed, and to amend death certificates on the basis of information obtained at autopsy after the death certificate has been signed and filed. In this particular case, the cause of this patient's death was deemed clinically obvious and confirmed by the preliminary autopsy report. The subsequent efforts to change the cause of death to amniotic fluid embolization

based on microscopy of the lungs were unconvincing to the court, whatever the merits may have been.

Internal Inconsistencies or Flagrant Omissions in Autopsy Reports

Internal inconsistencies or flagrant omissions in autopsy reports cause concern and fuel conspiracy theories.

Example 1.—The plaintiff alleged, but did not prove, conspiracy involving a pathologist to conceal poor care in a case in which a patient developed a false aneurysm at a femoral artery puncture site for cardiac catheterization. Progressive anemia followed and he died. Massive gastric hemorrhage was described in the preliminary autopsy report, but was omitted in the final report, which listed severe coronary artery disease as the cause of death.

Example 2.—Plaintiff's attorney suspected concealment because he noticed an omission when he compared the final diagnosis list with the descriptive information in the body of the autopsy report.

Example 3.—A surgeon was successfully sued after a patient died as a consequence of a bowel perforation following hernia repair. The pathologist failed to mention events that preceded death in his autopsy report or any findings ascribed to the complications of the surgical procedure and was accused by the surviving spouse, who had requested the autopsy, of conspiracy with the surgeon to conceal the facts in the case. In noting that the pathologist's action was not germane to the case against the surgeon, the appeals court described this autopsy reporting failure as a deviation from acceptable practice. The surgeon settled with the plaintiff out of court.

Comment.—Attention of a pathologist to details of reporting are essential to the utility and veracity of the autopsy report. A chronological synopsis of essential clinical events should be extracted from the medical record before the autopsy is begun and helps to guide the process. It is helpful to know the questions posed by clinicians and to address each one during the dissection, when choosing samples for microscopy, and in the final report. The summary should include a brief clinical review and a cause-of-death statement that is patterned after the entries on the standard death certificate. Before verification of the final report, discrepancies between the preliminary and final diagnosis lists and between the gross and microscopic findings and the final diagnoses should be addressed. Major discrepancies between the diagnoses and cause-of-death statement should be resolved, or if no resolution is possible, should be commented on in the summary.

Admissibility of Autopsy Information

Admissibility of autopsy information may be challenged successfully if rules of discovery are violated.

Example 1.—The original autopsy report in a case of stroke following neck trauma was silent on the issue of the cause of the stroke. Plaintiff hired an independent pathologist to perform a second autopsy, quietly arranging to have the body disinterred. The conclusion based on the second autopsy, that the basilar artery had been damaged by trauma, was concealed from the defendants, no photographs were made, and the remains were cremated. Because plaintiff's lawyers failed to amend the pretrial discovery documents in a timely fashion as the new information from the second autopsy became available, the trial court upheld a motion to exclude the second autopsy re-

port and any related testimony. A summary judgment for the defendant was upheld on appeal.

Example 2.—A family contracted for a private autopsy rather than a hospital autopsy in the case of a woman who developed fatal complications, including pleural/pulmonary fibrosis after coronary bypass surgery. Plaintiff alleged that silicone from an old breast implant ruptured during surgery and entered the pleura, where it caused a reaction resulting in death. The autopsy report and testimony based on the autopsy were excluded for violation of discovery rules, which require that reports, expert opinions, and material evidence germane to a lawsuit be available to both parties prior to trial. A finding of no negligence by the surgeon was upheld on appeal.

Comment.—In recent years, advertisements by pathologists and businesses providing autopsy services for a fee are commonly seen. The number of autopsies that are privately contracted outside hospitals may have increased, but no published data are available. Surviving kin who suspect substandard care may perceive an autopsy performed by a hospital employee to be potentially compromised by conflict of interest. Whether or not valid, this belief may be the basis for preferring an independent pathologist. Our finding of cases in which the results of private autopsies have been excluded from court proceedings because of violations of pretrial discovery rules is instructive to plaintiffs, to those who represent their interests, and to pathologists who perform private fee-for-service autopsies.

Example 3.—A defendant-physician tried unsuccessfully to have an autopsy report excluded based on confidentiality of the doctor-patient relationship. The patient died of pneumonia, according to the autopsy report, 24 hours after having been seen by an emergency room physician who had not ordered a chest radiograph, despite having been told of recent green sputum. The defendant argued that he had not seen the green sputum himself and detected no evidence for pneumonia on auscultation. A trial court finding of no negligence was upheld on appeal.

Example 4.—An appeals court held that an autopsy report and testimony by the pathologist who prepared it is not privileged information. The court noted that patient privilege is waived 90 days after filing a wrongful death claim. (This standard may vary among the individual states.)

Example 5.—The original trial court erred in disallowing introduction of autopsy evidence because of the manner in which it was introduced, generally as evidence, rather than specifically in support of witnesses for the plaintiff. This judicial error and several others were the basis for reversal of the original acquittal of a surgeon and anesthesiologist by the appeals court, which ordered a new trial. The case involved a child who had a tonsillectomy despite a low-grade fever, remained in coma after surgery, and died 24 hours later. Pneumonia was diagnosed at autopsy. The final outcome of the case is unknown.

Example 6.—The appeals court ruled that the trial court erred in excluding written commentary on autopsy findings prepared for the plaintiff's attorney by the pathologist who had performed the autopsy. The appeals court cited this as one of several errors in granting plaintiff's appeal for a new trial after the defendant-physician had been acquitted. The appeals court concluded that a case summary containing opinions on the cause of death prepared by a

pathologist, whether part of the official autopsy report or prepared separately from the autopsy report at a lawyer's behest, is discoverable and admissible.

DEATH CERTIFICATE ISSUES

Many studies have documented that major discrepancies are common between diagnoses entered on death certificates and autopsy diagnoses. Discrepancies of this kind, which may be the basis for lawsuits, can be avoided by filling out the death certificate after the provisional autopsy diagnoses are available. We did not find enough information from death certificates in the court records to perform a systematic evaluation of discrepancies with autopsy-based opinions regarding the cause of death. We did find that death certificate diagnoses are often successfully challenged in medical malpractice litigation. We also found several instances in which discrepancies between the cause-of-death statement on the standard death certificate and the autopsy report were the basis for lawsuits alleging negligence directed against physicians.

Example 1.—The autopsy report indicated that no cause of death was found in a patient who died suddenly, shortly after having been operated on for a bleeding peptic ulcer. The death certificate listed bleeding peptic ulcer as the cause of death. Plaintiff, based on information regarding the cause of death from the death certificate, assumed that bleeding had not been controlled and sued. The autopsy findings were instrumental in securing acquittal for the defendant-surgeon.

Example 2.—The death certificate pertaining to the death of a newborn infant came to the attention of the parents several years later. It listed diagnoses of subdural hematoma and ruptured falx cerebri, based on the autopsy findings. This information had been concealed during a counseling session with their physician, who had attributed death to anomalies. A summary judgment for the defendant based on argument that the statute of limitations had expired was reversed by the appeals court, which held that the statute of limitations clock began when the death certificate was discovered, not when the infant had died.

Comment.—Apparent disagreements between autopsy diagnoses and death certificate diagnoses are not unusual and may or may not be substantive. The major problem is that the death certificate is usually completed before the results of autopsy are available. Waiting until the provisional autopsy diagnoses are available would eliminate most major discrepancies. Disagreements may also result from practice preferences, such as not including clinical diagnoses in a list of anatomic diagnoses, or from honest difference of opinion about the clinical significance of an autopsy finding. That issue is best resolved by discussion with another pathologist and/or the attending physician before completing the autopsy report.

COMMENT

In most of the 99 cases that we studied, the autopsy findings were clearly summarized in the trial proceedings in a way that indicated competent performance and reporting had resulted in understanding of the meaning and significance of the autopsy findings by the litigants and the court. Additionally, the autopsy findings as summarized by the appeals court, in the vast majority of cases, provided plausible correlation to clinical events given the circumstances of death.

The courts raised issues related to the manner in which autopsies were performed and the manner in which information derived from autopsies was reported in about 15% of the cases studied. Without having access to the autopsy reports or to the physicians involved, we were at a disadvantage in our efforts to clearly understand the basis for each of these controversies. Specific questions about autopsy performance noted by the case reviewers included extent of dissection, given the questions posed by the death; lack of microbiological studies in a case in which overwhelming sepsis had been misdiagnosed as a viral syndrome; and lack of a scientific basis for a post-mortem diagnosis of anaphylactic shock in a death that occurred unexpectedly following injection of lidocaine hydrochloride prior to drainage of an abscess. More general questions seemed to be related to variation in the formats used, particularly with respect to inclusion of clinical information, clarity of expression, internal consistency, and problems caused by delay or suspected concealment of information that may have been helpful to either the plaintiff or the defense. Specific problems noted in the study of appellate court decisions were discussed in previous sections. The authors are unaware of a published scientific study of quality issues in autopsy reporting. An excellent guide to performance and reporting standards for the autopsy is available.⁵

In several of the cases cited in this report, we suspect that a pathologist may have recognized the potential for a claim of malpractice due to an unexpected outcome and may have reacted in a manner intended to provide protection to a colleague by writing an autopsy report that evaded the clinical questions raised by the sequence of events that preceded death. This concealment may have taken various forms, such as writing a report that was cryptic, omitting or obscuring clinical or pathologic details, avoiding comment on the significance of important autopsy findings, emphasizing a less plausible but hopefully less litigious finding as the cause of death, or not including in the autopsy report a clinicopathologic summary with a cause-of-death statement. In several instances, it appeared that delay in issuance of a final report, whether intentional or not, materially affected the conduct of a

malpractice suit. Delay, in particular, may contribute to suspicion of concealment or conspiracy and thereby fuel the anger that often underlies a decision to bring suit against a physician.

Delayed reporting or obfuscation of autopsy findings that are potentially embarrassing to a colleague is pointless for 2 reasons. The courts held in several cases that the starting point of the statute of limitations begins when the autopsy report is received or discovered. More importantly, our analysis of 99 cases demonstrates that there is little to fear from unexpected autopsy diagnoses in a medical malpractice action. Medical malpractice is not about medical diagnostic errors; it is about the standard of care. We determined that diagnostic error, per se, had no effect on the final outcomes in a large group of medical malpractice cases, selected only because an autopsy had been done and the original trial court decision had been appealed.¹ Respect for families by pathologists and by families for the intellectual honesty of pathologists who perform autopsies requires forthright autopsy reporting. Relaxation of professional reporting standards or purposeful deception deny the fiduciary or trust nature of the physician-patient relationship.⁶

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