

Death Investigation

Medical Examiner Mistakes in Tennessee: A Proposed Model for Formal, Comprehensive Death Investigation Peer Review

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Abstract: Forensic pathology is the practice of medicine, and as such is distinctly different from the majority of other forensic disciplines. Formal, standardized medical examiner/forensic pathology peer review is much less well developed than other medical specialties. Properly conducted standardized peer review would improve outcomes by reducing error, helping refine established standards of practice, encouraging objective defensible diagnoses and conclusions, and ultimately increasing public trust in the profession. Major barriers to forensic pathology peer review include: an extremely small pool of specialists, small specialist groups within each office, potential conflicts of interest, and concerns regarding immunity and privacy of those involved in the peer review process.

Due to the structure of the medical examiner system in Tennessee, forensic pathology peer review is varied throughout the state. Tennessee is a county based medical examiner system with five regional forensic centers where autopsies are performed. The regional forensic centers are independently operated (two of the regional forensic centers are operated by county governments, one by a private professional corporation, and two by affiliation with universities) and each is responsible for establishing its own policies and procedures for peer review. Although Tennessee has statutory protections for records produced as part of a physician peer review (The Tennessee Patient and Safety Quality Improvement Act of 2011), discussion remains about whether medical examiners are covered as 'health care organizations' and 'health care providers' as defined in the statute. As yet, the protections have not been legally challenged.

A Tennessee statutory requirement that all autopsies be performed at facilities accredited by the National Association of Medical Examiners (NAME) has improved the overall quality of death investigation throughout Tennessee. The National Association of Medical Examiners (NAME) accreditation standards only ensure a minimum standard for quality assurance, peer review, and performance monitoring activities. The NAME standards do not provide a framework or suggestion for how these baseline standards should be accomplished. The NAME Ad-Hoc Study of Quality Improvement by Peer Review in the Medical Examiner Office Committee is developing quality assurance/quality improvement programs for use in medical examiner offices, and the Committee is currently surveying members about participation in a centralized, inter-office peer review. Results of the survey will be presented.

A standardized, comprehensive death investigation peer review process for forensic pathologists will be presented and discussed. This quality improvement plan is modeled after clinical peer review strategies. The proposed plan includes a 'template' style case evaluation, and has specific recommendations for the selection of cases for peer review, the suggested procedures for the review, and recommendations for reporting review results. The case selection process for review is tiered and includes both random selection of cases and specific trigger events. The proposed model reporting format is also tiered, allowing for diagnostic discrepancies that may simply be differences in professional judgement as opposed to an 'incorrect' diagnosis. The model could be easily adapted to assess the effectiveness and consistency of services provided by others such as death investigators and non-forensic pathologist medical examiners.