



NAME *International Newsletter*

JULY 2018 - VOLUME 3, ISSUE 2

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NAME ANNUAL MEETING

**OCTOBER
12-16, 2018**



**WEST PALM BEACH,
FLORIDA**

Barbara Sampson, MD, PhD, 2018 Program Chair

For this year's annual meeting, NAME received an unprecedented number of excellent submissions, ensuring that the sessions will be of the highest scientific standard. Highlights include a dedicated discussion of the Las Vegas Shooting, presentations on challenging areas of neuropathology (such as epilepsy and pediatric head trauma), cardiovascular pathology (including cardiomyopathies and devices), and of course the latest data regarding the opioid epidemic. There are also several talks concerning the most pressing legislative and administrative issues facing Forensic Pathologists/Medical Examiners and Medicolegal Death Investigators today. I look forward to meeting you in October!

NAME SPECIAL FEATURE



Erin Brooks, MD, Chair

Ad hoc-Bioterrorism and Infectious Disease Committee

Erin Brooks, MD, Chair

Paul Chui, DMJ

Karen Kelly, MD

John Matthew Lacy, MD

Micheline Lubin, MD

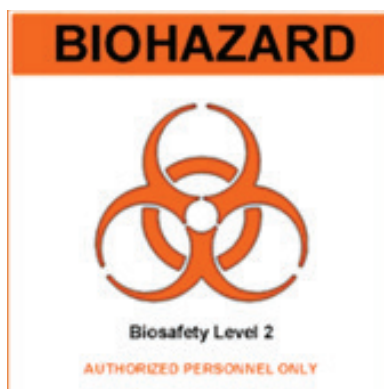
Lakshmanan Sathyavagiswaran, MD

Leah Schuppener, DO

Suzanne Utley, MD

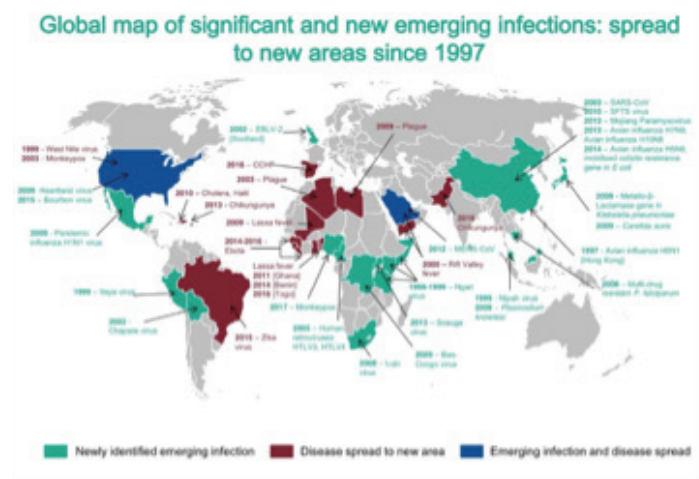
Steven White, MD, PhD

Medical Examiners and Coroners (ME/Cs) continue to play a critical role in the recognition of emerging infectious diseases and infectious disease surveillance overall. As infectious disease deaths are often sudden and unexplained, they are likely to fall under ME/C office statutory jurisdiction; autopsy pathologists may be among the first healthcare professionals to encounter an infected individual and attempt disease diagnosis.

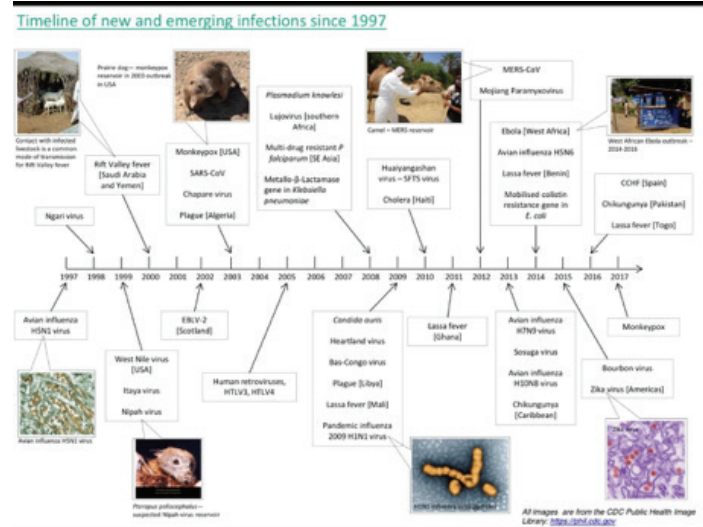


Among the infectious diseases in which autopsies have played a key role in disease identification and further elucidation of disease pathogenesis are hantavirus

pulmonary syndrome, acquired immunodeficiency syndrome (AIDS), West Nile virus, and severe acute respiratory syndrome (SARS)—to name a few. Samples obtained at autopsy are used to track the national and international incidence and mortality of diseases such as pediatric influenza, Creutzfeldt-Jakob disease, Nipah virus encephalitis, and Dengue fatalities. In addition to contributing to infectious disease surveillance, autopsy diagnoses can also be critical in enabling timely prophylaxis and/or treatment of contacts of decedents with communicable diseases.



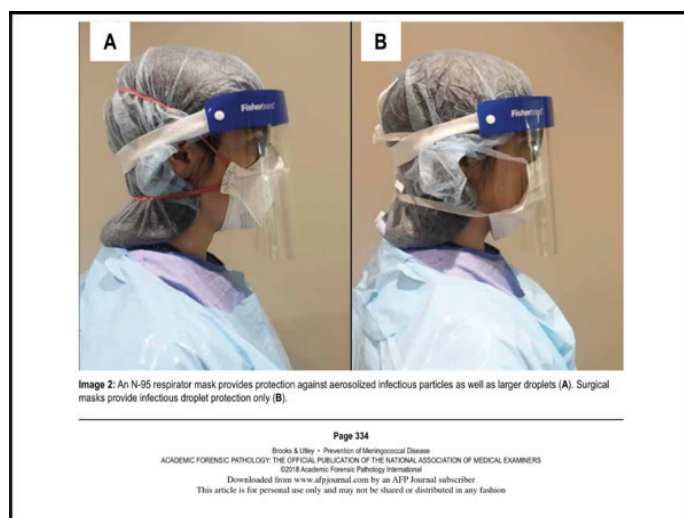
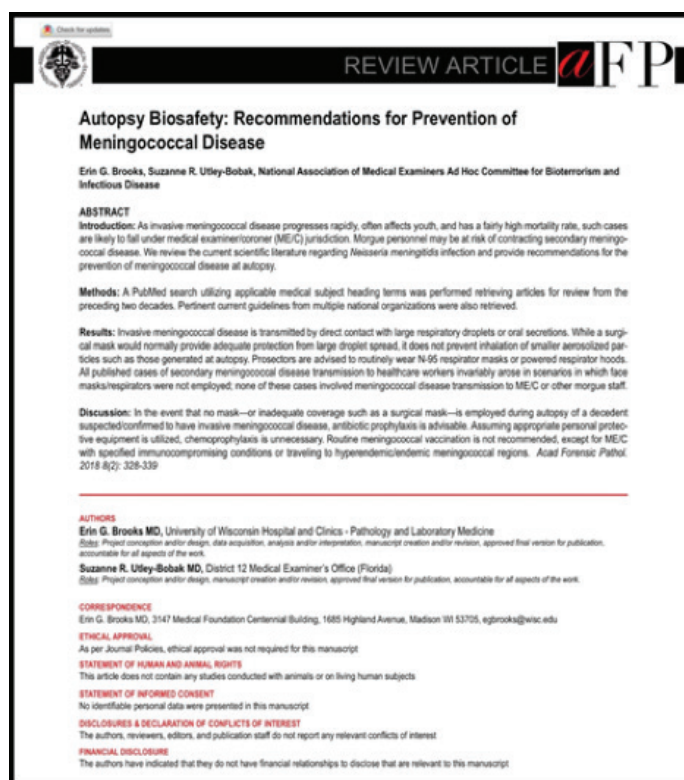
While the majority of infectious disease deaths encountered by ME/C arise due to natural causes, the possibility of bioterrorism-related infections must also be considered.



According to the Centers for Disease Control and Prevention (CDC), bioterrorism is defined as “the intentional release of viruses, bacteria, or other germs that

can sicken or kill people, livestock, or crops.” An example of this would include the 2001 anthrax outbreak in which the intentional distribution of anthrax spores via the U.S. Postal Service seriously injured 22 people and culminated in 5 deaths. MEs were key members of the response team, performing autopsies to document disease findings such as bacterial tissue distribution and confirming the cause of death to be anthrax and the manner to be homicide. Earlier in 1979, autopsy pathologists had likewise played a key role in recognizing inhalational anthrax cases arising due to accidental discharge from a former Soviet bioweapons laboratory. An expansive list of other potential bioterrorism agents/diseases can be found on the CDC electronic site.

The National Association of Medical Examiners Bioterrorism and Infectious Disease (NAME BT & ID) Committee is a long-standing ad hoc committee charged with providing infectious disease and bioterrorism surveillance education to fellows and members. The focus of this educational outreach is broad and has varied over time; most recently, it has involved biosafety recommendations, updates regarding emerging infectious diseases and newer diagnostic modalities, and ME/C gap analysis surveys. As ME/Cs have long been recognized as a group at risk for secondary acquisition of disease, biosafety has become a major focus. Autopsy prosectors may be exposed to a wide array of both bloodborne and aerosolized pathogens. The prevalence of certain infectious diseases (e.g. human immunodeficiency virus and hepatitis B/C virus) are disproportionately higher in forensic populations than in the general population due to overrepresentation of intravenous drug users, homeless, and medically noncompliant persons at autopsy. One focus of the NAME BT & ID Committee has been to disseminate ‘best practice’ recommendations to assist in mitigating the risk of secondary infectious disease transmission to prosectors; for instance—in response to NAME member concerns—the committee reviewed current scientific literature regarding *Neisseria meningitidis* infection to provide evidence-based recommendations for the prevention of transmission of meningococcal disease at autopsy (as published in the June 2018 issue of *Academic Forensic Pathology*.)



Another focus of the NAME BT & ID Committee has been to assist in educating ME/Cs about novel diseases and diagnostic techniques. Emerging infections are defined as “new, reemerging, or drug-resistant infections whose incidence has increased within the past 2 decades or whose incidence threatens to increase in the near future.” With the advent of commercial air travel, infections are no longer confined by geographic boundaries, and the potential for rapid disease spread is a perennial concern. One example of this situation would be the rapid global spread of Severe Acute Respiratory Syndrome (SARS) due to infected patients traveling great distances via aircraft.

In order to keep ME/Cs updated regarding diagnostic features and potential laboratory testing options for such key infectious diseases, the NAME BT & ID Committee recently organized the 2018 Interim NAME Scientific Meeting on the topic of ‘Emerging Infectious Diseases and the Medical Examiner’ with keynote speaker Dr. Sherif Zaki of the CDC Infectious Disease Pathology Branch. Other ongoing initiatives by our committee include collating and publishing gap analysis survey results on topics such as ME/C preparedness to handle highly infectious decedents.

TWO PART NAME INTERNATIONAL FEATURE: INDIA



I. Education in Forensic Medicine India by Dr. Maneesha Pandey

II. The Medicolegal Death Investigation System in India by Dr. George Paul

I. EDUCATION IN FORENSIC MEDICINE IN INDIA



Dr. Maneesha Pandey, Deputy Coroner/ Forensic Pathologist, Lucas County Coroner's Office, Toledo, Ohio.

I was a third year medical student from a class of 100 when I was first introduced to Forensics. It was early 1990's and at that time, all the third year medical students had to rotate for about a month through Forensic Medicine. I studied medicine in Kottayam Medical College, Kottayam, Kerala India.



Image of hospital building from the Kottayam Medical College Website.



Ward in Kottayam Medical College, Kerala, India.

The rotation was not a choice. It was a requirement. I had been told a few horror stories of the rotation by some seniors who clearly did not like it. Perhaps if I had not been exposed to Forensics at that time I may have never become a forensic pathologist.

All the students had to document 20 autopsies they observed in a notebook. The cases had to be deaths from different cause and manner. My first day I saw an autopsy of a person who had died in a motor vehicle crash. I remember it being very bloody. A large man just had an apron on and a pair of gloves. He removed the organs, weighed them, and then a Police surgeon came to examine them. Pieces of organs were taken in jars and saved for future evaluation. The autopsies I remember were those of a motor vehicle crash, motor cycle crash, hangings, dowry deaths (primarily thermal injuries), drowning, alcohol toxicity, falls from height, strangulation, young children with accidents, poisoning (drug related and also related to dowry deaths), upper gastrointestinal hemorrhage, abandoned bodies. I did not see a lot of shootings.

At the end of the rotation I was enthralled by the experience and I wanted to explore becoming a Forensic Medicine expert.

In India, Forensic Pathology is referred to as Forensic Medicine and Toxicology or as legal Medicine. First, one has to complete MBBS (basic medical education degree). A postgraduate degree in Forensic Medicine is given after three years of study. Most of the Forensic Medicine expert graduates work in Department of forensic medicine and Toxicology in medical colleges.

The job of a Forensic Medicine specialist consists of performing autopsies, clinical forensic examination, teaching medical students and being an expert witness. The number of autopsies conducted in each department varies from 100 to 5000 depending on jurisdictions. In addition they are required to perform thousands of clinical forensic examinations.

Indian Academy of Forensic Sciences is the largest institute of Forensic Medicine experts in India with a membership of about 1000 specialists.



Indian Academy of Forensic Medicine was founded on 12 May 1972. (from the Indian Academy of Forensic Medicine website)



This diagram summarizes the Medical Jurisprudence in India (taken from the Indian Academy of Forensic Sciences website).

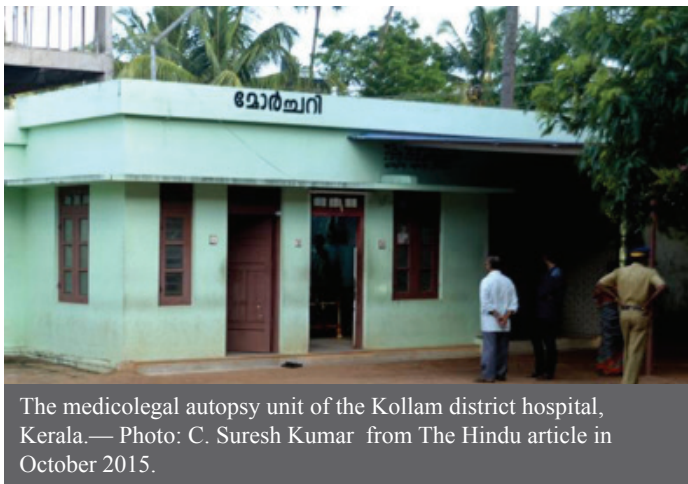
ATTACHED ARE SOME OTHER AGENCIES OF FORENSIC MEDICINE.





Police surgeon examined the organs, and then explained to us the cause of death. He would then meet with the families, and police of the deceased to tell them the cause of death. I was exposed to radiology, anthropology, odontology during the rotation.

A Police Surgeon is a designation which originated from United Kingdom. In India, one has to be a Medical Consultant in Forensic Medicine (MCFM). Home department can then appoint them as Police surgeons to perform medico legal autopsies in their jurisdictions.



The medicolegal autopsy unit of the Kollam district hospital, Kerala.— Photo: C. Suresh Kumar from The Hindu article in October 2015.

As is true of forensic pathologist in USA there has been a shortage of Police Surgeons in certain states of India due to shortage of forensic medicine experts. Ordinary autopsies can usually done by any medical practitioner, however any medico legal death such as homicides, dowry deaths, and deaths under suspicious circumstances have to be done by a Police surgeon. In 2014 as per a circular, it was decided that there should be at least two forensic experts posted in all hospitals that report 100 autopsy cases on an average each year (per The Hindu article from October 2015).

After graduating from medical school my path led me to the USA, and there I completed my residency in Pathology and fellowship in Forensic Pathology. Everyday, I consider myself fortunate to have been exposed to the Forensic Medicine rotation in my medical school. I definitely owe my love for Forensics to that one-month rotation.

II. MEDICOLEGAL DEATH INVESTIGATION SYSTEM IN INDIA: PAST AND PRESENT



Dr. George Paul, Singapore, Senior Consultant Forensic Pathologist & Branch Director- Infrastructure, Forensic Medicine Division, Health Sciences Authority, Singapore-former Associate Professor Forensic Medicine, Maulana Azad Medical College, New Delhi

Feature contribution by Dr. Maneesha Pandey, Deputy Coroner/ Forensic Pathologist, Toledo Ohio, USA

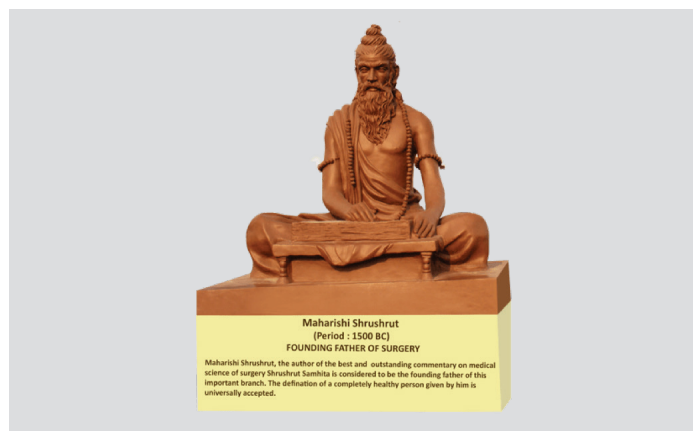


HISTORY

Ancient Indian civilization existed in periods much earlier than that of Mesopotamia, as evidenced by the excavation findings of the Harappan and Mohenjodaro civilizations of 2500 BC, and nearby Mehrgarh – the latter dated to 8500 BC, making the latter a serious contender for the title of ‘cradle of civilization’.

The code of civil and criminal society was enshrined in various Sanskrit texts of knowledge known as the Vedas, which are as ancient as these civilizations. They are oral traditions, sometimes transcribed to bamboo, cloth and paper written text, which were often lost the elements. These oral traditions continue till date, with Sanskrit couplets memorized and passed on as hymns, verses and incantations through generations by word of mouth. A subsequent derivation from these was Manus Smrithi or Law-Code of Manu, again an oral tradition, which was derived from the various Vedas, and which was first written down in 1900 BC, thus predating the Hammurabi Code. It thus appears to be one of the oldest law codes of the world. Jurisprudence at that time was in the hands of the monarchy, who were permitted to intervene only when the public forums or ‘sabhas’ of justice appeared biased or issuing unjust verdicts. Kautilya or Chanakya’s Arthashastra described the various mechanisms of death and the necessity of autopsy.

Sushruta, who authored Samhita in 600 BC – an ancient treatise on practise of Ayurvedic surgery, wrote extensively on many aspects of forensic medicine, including appearances in various poisonings and injuries, mechanisms of death, etc. The ancient Indians believed in all landed assets belonging to the state, and their jurisprudence dictated greater civil restitution – i.e. greater punishments of the higher status individual, compared to the very poor (i.e. all men were not equal before law).



The complex region of India as we know today was invaded by many successive invaders, attracted by its economic might. From the 1st century CE to 1000 CE the Indian economy was the largest economy in the world. Successive waves of invaders from surrounding regions ruled parts of India.

The Dutch East India Company set up its trading posts in 1616. King Charles II of England was given Bombay as dowry for Catherine of Braganza’s hand, which began the presence of the British in India. There was fierce competition between the Dutch and British, which was quelled when William Duke of Orange from Holland took the British throne, leading to redistribution of the trade, with the wealthier spice trade of Indonesia passing to the Dutch and the textile trade to the British.

The ‘ancient ways’ of India held all property to be held as common property, without individual deeds or titles. Women had nearly equal status in society as men. Laws of possession came into existence when private ownership of property came into existence with modifications of these values, through codes like Laws of Manu – the latter introducing the dominance of patriarchal structure of society and inheritance, with the institution of marriage establishing the exclusiveness of sex relations through marriage – linked to retention of property after death, by passing it to his child – as a part of him. Subsequently, the dowry system was introduced to encourage the in-laws to give equal status to the bride in her new home, when her ‘share’ of property was given at marriage, or in lieu of her share, an equivalence for her inheritance. Only the Nair women of Kerala and women from Meghalaya in North East India are the few matriarchal societies.

From the 16th century, Britain’s ship-surgeons served on Indian soil as the crown’s ‘surgeons’, till the setting up of the Surgeon General by the British East India Company in 1610. At the time of the rule of the various states of India by various Western principalities, criminal law was left to the various princely rulers and kings and princes of small kingdoms scattered in these regions. In an attempt to unify criminal procedures, various districts published state government’s promulgated medical manuals and rules defining duties and responsibilities.

At a district level, the Civil Surgeon oversaw and reported on important medico-legal issues and cases including autopsies. This Civil Surgeon was also called as Police

Surgeon or Chief Medical Officer (CMO). He was the designated chief Medico-Legal expert in the district. Fees for such examinations were separately prescribed in those manuals and their rules. Clinical examination fees were less than those of post-mortem examination fees. Unfortunately none of these CMO's were trained in Forensic Medicine, hence a great laxity and variability in reporting of findings and opinions was seen. This is true even today.

FIRST MEDICO-LEGAL AUTOPSY IN INDIA (1963)

The first recorded medico-legal autopsy in India was performed in 1693 by Dr Edward Bulkley on Mr Wheeler, Chief Justice of Choultry, Madras, who died on 28 August 1693. The first medical school in India based on western medicine principles was established in Calcutta in 1822, and converted to a Medical College in 1835, at which time Madras Medical College also came into being. Meanwhile the French, ruling in Pondicherry, established the Ecole de Médecine de Pondichéry in 1823, which is now JIPMER- Jawaharlal Institute Postgraduate Medical Education & Research. The Portuguese established the Goa Medical College in 1842 in Goa. The first chair of Forensic Medicine was established in Madras Medical College in 1857. It was at this time that Sir William Hershel wrote up his principles of dactylography, which Sir Francis Galton made into the systematic method of fingerprints identification in 1892.

INDIA'S INDEPENDENCE

India's independence, led by Gandhi, the Indian National Congress and others in 1947 resulted in a democratic republic union of Indian states and partitioning off of East (now Bangladesh) and West Pakistan.



In 1947, at the time of Independence, there were 565 princely/ native states – not ruled by the British directly, who later joined the union of India, including the King of Kashmir and the Nawab of Hyderabad. But East India Company and later British government's rule of India reduced India's economy from the richest in the world in CE 1000 to the poorest in the world at the time of its Independence.

MEDICAL COUNCIL OF INDIA



Today, medical education and standards are regulated by the Medical Council of India (MCI), a federal statutory body, founded in 1933 by act of parliament. They conduct periodic inspections of departments, undergraduate and postgraduate exams. They also regulate the training hours, curriculum, examinations and quality of medical teachers. postgraduate exams. State government medical councils work on MCI's behalf to register medical licenses to practice.

INDIAN PENAL CODE AND CRIMINAL PROCEDURE CODE (CRPC)



The Muslim rulers, including the Mughal kings and those surrogate rulers of the British, applied Mohammedan Criminal Law to all the territories. After the 1857 rebellion, the crown took over the administration of India. Unable to work with common law because the various customary laws and practises, which were alien to the western rulers, the Portuguese promulgated the Portuguese Civil Law System, all practised in Portuguese, and also included the Court of Inquisition for heresy, etc. Portuguese jurisprudence was repealed after liberation of Goa in 1961, with the Indian Civil and Penal Code in place, with practise in English. Lord Macaulay led the effort to pass the Indian Penal Code in 1960 and the Criminal Procedure Code (CrPC) in 1861. The coroner's system of death investigation was enacted in the presidencies of Bombay and Calcutta in 1871. The Coroner's system was repealed from both cities by 1951, with the relevant sections of CrPC applicable to the whole of Union of India. The CrPC was revised in 1972, and has since gone through multiple revisions, the last amendment being 2013. During British rule, appeals of judicial punishments by the Indian courts, after appeals in the Presidency courts in Madras, etc. culminated in the Privy Council, London, whose role as final court of appeal died out in India after Independence, the highest court of appeal being the Supreme Court of India. Capital crimes, if permitted, have a last resort for commutation by the President of India.

The medium of jurisprudence in India is English. National language Hindi or regional languages are permitted for recording evidence from non-English speaking witnesses. These are then officially translated to English. The higher courts of appeal (the state High Court for each state and last-tier final appeal in the federal Supreme Court) all transact in English. All arguments, verdicts and appeals are in English.

ONE UNIVERSAL DEATH INVESTIGATION IN INDIA

India has one universal death investigation system throughout the country. The CrPC dictates a magisterial system of inquiries into deaths. It requires reporting of all sudden, unexpected or unnatural deaths to be reported directly to the magistrate or to the nearest police station or police officer (who then report to the magistrate). If there is no District Magistrate or divisional magistrate (who may belong to the judicial services, or even to civil administration services), then superintendents of police or

police commissioners (in Metropolises) undertake these coronial functions of inquiries into deaths.

After reporting to the 'magistrate', the police officer proceeds to the location of the dead body to start his preliminary inquiry. Where death is unnatural or from unknown causes, the police officer – as investigating officer (IO) would accompany the body to designated places where a post-mortem examination can be conducted, to determine the cause of death. Full autopsies are expected, as the autopsy surgeon is expected to clarify that everything else was 'normal' or did not contribute to or cause death. The IO would also affect examination of toxicological and biological samples by state or central (federal) forensic science laboratories requested by the doctor conducting the post-mortem.

The law requires that the preliminary inquiry be conducted by a magistrate in cases of deaths in custody ('officer-involved-homicides and shootings') and homicides and suicides within 7 years of marriage involving harassment for dowry. If the public prosecutor (DA) identifies someone who is to be charged for the crime in leading to death, then the formal coronial inquiry is deferred till the prosecution is over. If conviction takes place, then that is adduced into the coronial findings of the Magistrate.

QUALIFICATIONS OF FORENSIC MEDICINE SPECIALISTS

Considering the vastness of India and its population and the non-availability of qualified forensic pathologists/ forensic medicine specialists, state health departments declare what experience the general duty medical officer (GDMO) should have in clinical practise, before he can conduct post-mortem examinations. Where required, these GDMO's may preserve tissue and send them to Pathology departments for histo-pathological reporting. There aren't enough funds allocated to Forensic Pathology services of districts and states to hire forensic pathologists for each and every district. The large cities like Mumbai and Delhi as well as teaching and research institution such as medical colleges have nearly all their cases autopsied by forensically trained doctors (except the civil/ police surgeon).

In most districts, as a legacy of British times, Civil Surgeon is the senior-most medical officer, and is also the senior medico-legal expert who would deal with clinical forensic

examinations and forensic autopsy cases. Often, they have no training or interest in acquiring skills in Forensic Pathology. Often the junior most GDMO's conduct post-mortem examinations and the Civil Surgeon opines in court on the process.

The advent of various medical schools/ medical colleges in many of the cities led to the public university colleges, and forensic departments being designated centres for forensic autopsies. Civil surgeon still continues to have greater authority and has seniority in government service over these teaching institutions.

Recently few private medical schools have forensic departments which do not do autopsies. However, they still tend to have influence over the regional and national forensic committees. Meanwhile the southern state of Kerala has designated equivalent status of Police Surgeon to various professional teachers of Forensic Medicine departments.

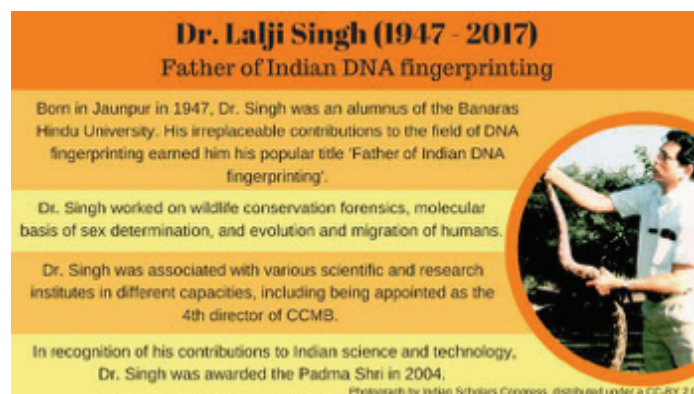
Every undergraduate medical student on graduation is expected to competently conduct a post-mortem and a clinical forensic examination as well as an age estimation report of a juvenile. Medical Council of India (MCI), to this effect, has a separate undergraduate para-clinical examination in Forensic Medicine and Toxicology, which they have to clear in order to progress to the final professional clinical subjects, with prescribed at least 88 contact student hours as lectures, demonstrations, tutorials and practicals with log books, etc. The examiners are expected to ensure that proper assessment of this competence takes place through effective theory and practical examinations. The private institutions however do not necessarily follow the appropriate recommendations.

FORENSIC FOLLOWUP INVESTIGATIONS AND TOXICOLOGY

One of the major issues in forensic work in India is follow-up investigations. The actual toxicological examination of preserved material from post-mortem cases does not start until 6 to 9 months after the autopsy. The specimens tend to get stored in room temperature as the Police stations, where they are generally kept do not have dedicated storage cold rooms or refrigerators for these specimens. Much against the forensic guidelines in most of the places the organ parts are stored inappropriately. The common practice continues to be storage of parts of the liver,

spleen and kidneys in one jar, as well as the stomach and intestines with their contents, in another jar. These are all in saturated brine solution, along with blood and urine in vials. Often, by the time these jars and the tubes with the biological fluids are opened in the toxicology laboratories – anywhere from 6 months to even 2 to 3 years after their preservation, they have decomposed to a putrid mass, and hence, all their reports, despite sophisticated laboratory instrumentation available in the labs, is 'negative for common poisons'.

Another difficulty in Forensic practice in India is lack of funding of forensic departments and facilities. There are no institutions with in-house Cat scans or access to PMCT. Most radiological imaging is done so by portable Xray machines which are requested from hospitals.



Dr Lalji Singh of Centre for Cellular and Molecular Biology (CCMB) Hyderabad, developed his own restriction enzymes from the Banded Krait's venom and successfully set up his own method, which was regularly in use. Recently, more universal methods and automated systems using SLP's, STR's and SNP's have been implemented, and DNA profiling is robust, with the government trying to pass the DNA Profiling Bill 2007, which would allow profiles of suspects to be saved in databases with deletion from it if acquitted. This bill in this present form is vehemently opposed by many groups, especially where misuse of the data attracts a mere US\$ 1000 fine, and the absence of strong privacy laws in the country.

ORGAN AND TISSUE RECOVERY FOR FORENSIC CASES IN INDIA



Maneesha Pandey, MD

Traditionally India has very low organ donation rate. Per Directorate general of health services (DGHS) Transplantation of Human Organs Act (THOA) 1994 was enacted to provide a system of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs. The most important aspect of the act was to recognize brain death as legal which paved way for organ donation. Transplantation of Human Organs (Amendment) Act 2011 was enacted. Some of the important amendments under the (Amendment) Act 2011 was to include tissue recovery along with organs, definition of near relatives (to include grandparents and grandchildren), having retrieval centers, swap donation provision and to have mandatory transplant coordinator in hospitals who are registered. The brain death certification was also simplified to give intensivist and anesthetist the power to pronounce it as long as they are not members of the transplant team. DGHS are also encouraging promotion of organ donation from deceased persons with postmortem being possible after organ retrieval. In 2015, the first successful cadaveric transplant of both hands to one individual took place.

Historical Aspects – Cadaver Transplantation - India

1967 - First successful cadaver Kidney Transplant in India at KEM Hospital, Bombay

1994 - First successful heart transplant done at AIIMS, N.Delhi

1995 - First successful multi-organ transplant done at Apollo Hospital, Chennai

1998 – First Successful Lung transplant, Madras Medical Mission Hospital, Chennai

1999 – First Pancreas Transplant, Ahmedabad

SOME COMMON FORENSIC CASES IN INDIA:

The usual frequency of Forensic case in descending order are accidents mostly traffic, also industrial and those from domestic accidents, followed by suicides. Homicides are the next commonest, with the two most common being from assaults with blunt objects followed by sharp weapons. Firearm assaults are fewer due to restrictions on availability of these because of licensing under Arms Act to legally own a firearm. Automatic heavy caliber firearm fatalities usually involve armed law enforcement or army officers, or terrorist shootings.

The 1980's and 1990's saw young brides being killed by their in-laws because of dissatisfaction over dowry. The most common manner to kill the brides was by setting them alight after pouring kerosene oil over them with the expectation that they could be mistaken as domestic accidents. The next commonest group is the sudden unexpected deaths in adults from sudden cardiac deaths, strokes, infectious diseases and undetected malignancies.

Hanging is universal method of suicide present in nearly all districts. In and around Delhi and its northern and western neighboring states, suicide by burning oneself after pouring cooking medium kerosene oil is still prevalent. In these circumstances, determining whether it was a suicide because she was being harassed for dowry or a homicide is difficult. This has led to the in laws being held responsible for death unless proven otherwise in a trial especially if her parents/siblings lodge a police report of harassment for dowry in deaths within 7 years of marriage.

India needs a robust system which holds its so-called experts accountable. Currently, many so called experts get away with all kinds of statements and opinions, confident that they would not be challenged, or even if so, the court would uphold their opinions as final because of their professional titles, and there are no punitive consequences of such opinions in the form of civil suits or even criminal cases against them. Periodic skill up-gradation (through course credits) and re-certification is non-existent. The Daubert principles should come into play with the higher courts holding the scientist accountable with reproducible results. Forensic Pathologists and Forensic Medicine practitioners need to not be influenced by the politics and importance of cases to 'shift their emphases' in opinions, to play to the circumstances. And with experience comes

circumscription in opinions, and a desire to keep out of the limelight. India also needs to invest in updating facilities and training in its Forensic Medicine departments/ centres, with funding for research, updating existing facilities and attending international conferences and overseas training. To have forensic pathologists in each district is a medico-legal dream at the current moment, because of the paucity of budget allocation for posts and equipment/ facilities.

NAME Members and Languages Spoken Other Than English

1. Eric Pfeifer – German
2. Peter H. Markesteijn – Dutch
3. John Hunsaker – German
4. Thomas Gilson – German
5. Sarah Avedschmidt - Spanish
6. Steve Cohle – Spanish
7. Othon J. Mena - Spanish
8. Carl Schmidt – Spanish and French
9. Marianna Eserman – Russian, fluent
10. Frank Peretti – Italian, Fluent
11. Thambirajah Balachandra – Tamil, Sinhala
12. Jackie Martin – Spanish, some Italian
13. Masahiko (Mike) Kobayashi – Japanese, fluent
14. Paul Chui – Mandarin/Chinese, fluent
15. Shiping Bao - Chinese
16. Shaku Teas – Hindi/Urdu
17. Mario Rascon – Spanish
18. Elena Bulakhtina – Russian, fluent
19. Mitchell Weinberg - French, basic
20. Pete Speth – German
21. Edward Chmara – Russian, Polish
22. Abraham Philip – Hindi, Marathi, Malayalam, Kannada, Urdu
23. Karen Kelly – French
24. Francisco Diaz – Spanish, fluent
25. George Paul – Hindi, Bengali, Punjabi, Malayalam
26. Lee Marie Tormos – Spanish
27. Tim Dutra – Spanish, some Portuguese
28. Clare Bryce – French
29. Tim Fagen - Spanish and French, with conversational Italian and Mandarin
30. Paul Mellen - German, Irish Gaelic
31. Judy Melinek – Hebrew
32. Lorraine Lopez-Morell—Spanish
33. Nika Aljinovic – Croatian
34. Cristin Rolf – German
35. Louis Jarez – Czech
36. Marius Tarau – Romanian. Arterial language.
37. John Hu – Chinese
38. Maneesha Pandey – Hindi
39. Luby Dragovic – Serbian, Croatian, Macedonian, Slovenian
40. Murali Murali – Kannada, Hindi
41. Luisa Florez – Spanish (fluent)
42. Priya Banerjee – Bengali
43. Giancarlo Di Vella – Italian (fluent)
44. Timothy Williams – German
45. Agnieszka Rogalska – Polish (fluent)
46. Steckbauer – German (fluent)
47. Linda Kocovski – Macedonian, French
48. Nika Aljinovic – Croatian, Serbian, Montenegrin, Bosnian
49. Kanu Virani – Gujarati, Sanskrit
50. Marisa Jacob - Antillean Creole
51. Lana Lesnikova - Russian, Danish
52. Dilhani Amarasinghe – Sinhalese
53. Hyejong Marshall - Korean
54. Mitra Kalelkar - Hindi, Bengali

US MEDICAL EXAMINER OFFICES ACCEPTING INTERNATIONAL VISITORS AND/OR TRAINEES

Medical Examiner	Office	City	State	Contact Information
Jon Lucas James Ribe Christopher Rogers	CME/C County of Los Angeles	Los Angeles	California	jribe@coroner.lacounty.gov crogers@coroner.lacounty.gov
John Thornburg		Monterey	California	831-755-3761
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WHY SHOULD YOU JOIN NAME AS AN INTERNATIONAL CORRESPONDING MEMBER?

J IN US!

The National Association of Medical Examiners



The Organization for Forensic Pathologists
and Medicolegal Death Investigators
www.thename.org

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International Corresponding Membership is \$90 (US\$)/year

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- ✓ Access to member only sites on NAME website
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- ✓ Access to consultants
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NAME is here for you!

When you contact NAME or attend the meetings, we want you to feel comfortable.



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APPLICATION FOR INTERNATIONAL CORRESPONDING MEMBER

"International Corresponding Members" shall be physicians or other practicing medicolegal death investigators who reside outside of the United States of America or Canada. International Corresponding Members shall be forensic pathologists, physician medical examiners, physician coroners, and those engaged in the teaching or practice of legal medicine, provided, however, that the foregoing examples are provided for clarity, and mere possession of any of the foregoing job titles does not automatically qualify any individual for membership as an International Corresponding Member, nor does lack of such title automatically disqualify any individual who is a practicing medicolegal death investigator.

Customer number (from NAME web site – REQUIRED):		
Applicant:		
Governmental Agency (Federal, State, Local) with which Affiliated:		
Agency:		
Address:		
City:	State:	Zip:
Telephone:	Fax #:	Email
Office Type:	Medical Examiner	Coroner ME/Coroner
		Other:
Director:		
References: (Two Members of National Association of Medical Examiners)		
Name:	Name:	
Address:	Address:	
Telephone:	Telephone:	
Applicant Information		
Official Title:	Length of Time at Agency:	
Medical School:	Date Graduated:	
Degree Attained:	Year of Licensure:	State(s)
Residency Training:		
Board Certifications:		
Forensic Pathology (Year)	Anatomic Pathology (Year)	
Clinical Pathology (Year)	Other: (Year)	
Memberships in Other Societies:		
AAFS AMA ASCP CAP Local Medical Society		
Other:		
Years in Forensic Field:	Area of Interest:	

Please submit a copy of your license, a copy of your Curriculum Vita, and ONE (1) letter of recommendation from a member of N.A.M.E.

FUTURE MEETING

NAME 2018 annual Meeting

October 12-16, 2018

Hilton West Palm Beach

Forensic Pathology in the Palm of Your Hand

NAME 2019 Interim Meeting

February 19, 2019

Baltimore, MD

NAME 2019 Annual Meeting

Kansas City, MO

NAME 2020 Annual Meeting

Denver, CO

JOIN NAME TODAY!

Contact Dee McNally

at name@thename.org
Or KimcollinsMD@gmail.com

Languages that NAME members speak other than English

- | | |
|---------------|----------------------|
| 1. Italian | 21. Punjabi |
| 2. German | 22. Bulgarian |
| 3. Dutch | 23. Irish Gaelic |
| 4. Spanish | 24. Hebrew |
| 5. Portuguese | 25. Croatian |
| 6. French | 26. Czech |
| 7. Russian | 27. Romanian. |
| 8. Polish | Arterial |
| 9. Tamil | language. |
| 10. Sinhala | 28. Serbian |
| 11. Mandarin | 29. Macedonian |
| Chinese | 30. Slovenian |
| 12. Chinese | 31. Serbian |
| 13. Japanese | 32. Montenegrin |
| 14. Korean | 33. Bosnian |
| 15. Hindi | 34. Gujarati |
| 16. Urdu | 35. Sanskrit |
| 17. Marathi | 36. Antillean Creole |
| 18. Malayalam | 37. Danish |
| 19. Kannada | 38. Sinhalese |
| 20. Bengali | |

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