NAME International Newsletter

VOLUME 5, NO. 1, 2021

Index

NAME MEETING 2020

Laura Knight, MD
NAME 2020 Program Chair

COVID-19 may have taken away our ability to meet in person in Denver, CO, USA this fall, but it did not stop us from having a great meeting! A very successful virtual meeting was held Oct 16 – 17, 2020, hosted on the GoToWebinar platform. NAME leadership pivoted seamlessly to the online format once it became clear that the pandemic would be an ongoing concern for the remainder of 2020; the safety and wellbeing of our members was our number one priority. NAME professionals Dee McNally and Tara Snethen worked tirelessly to prepare for the new online format, and NAME affiliate member Louis Jares of MTF served as technical coordinator and trainer prior to and during the meeting to help propel us to success!

You may recall that the pandemic hit in early 2020, with the first surge of cases right around the time that potential presenters were submitting their abstract proposals. It was a time of great uncertainty, and we appreciate the presenters who submitted anyway and had faith in our ability to ensure that their abstracts would be presented, somehow! The virtual meeting boasted 50 platform presentations and 60 poster presentations on a wide array of topics ranging from toxicology to trauma to pediatric deaths to death certification. A record-breaking 885 individuals registered for the meeting, and it is likely that even more may have watched the meeting via an office login. Speaking as the Scientific Program Chair and long-time member of the Program Committee, I was ecstatic to see so many people able to participate in our annual meeting. Furthermore, the meeting was recorded and is available online for viewing through the end of December 2020 for those who registered but were unable to attend in real time. (For more info, see: https://www.thename.org/2020-meeting-instructions).

In addition to the Scientific Program, NAME and the NAME foundation also hosted the annual auction event and the annual NAME Foundation fundraiser CME event virtually. Lively discussion boards in the online lounge area also kept participants engaged during the NAME meeting, and a virtual scavenger hunt led us through the sponsors/vendors' areas. All in all, NAME 2020 was a huge success!

FORENSIC PATHOLOGY IN THE UNITED STATES

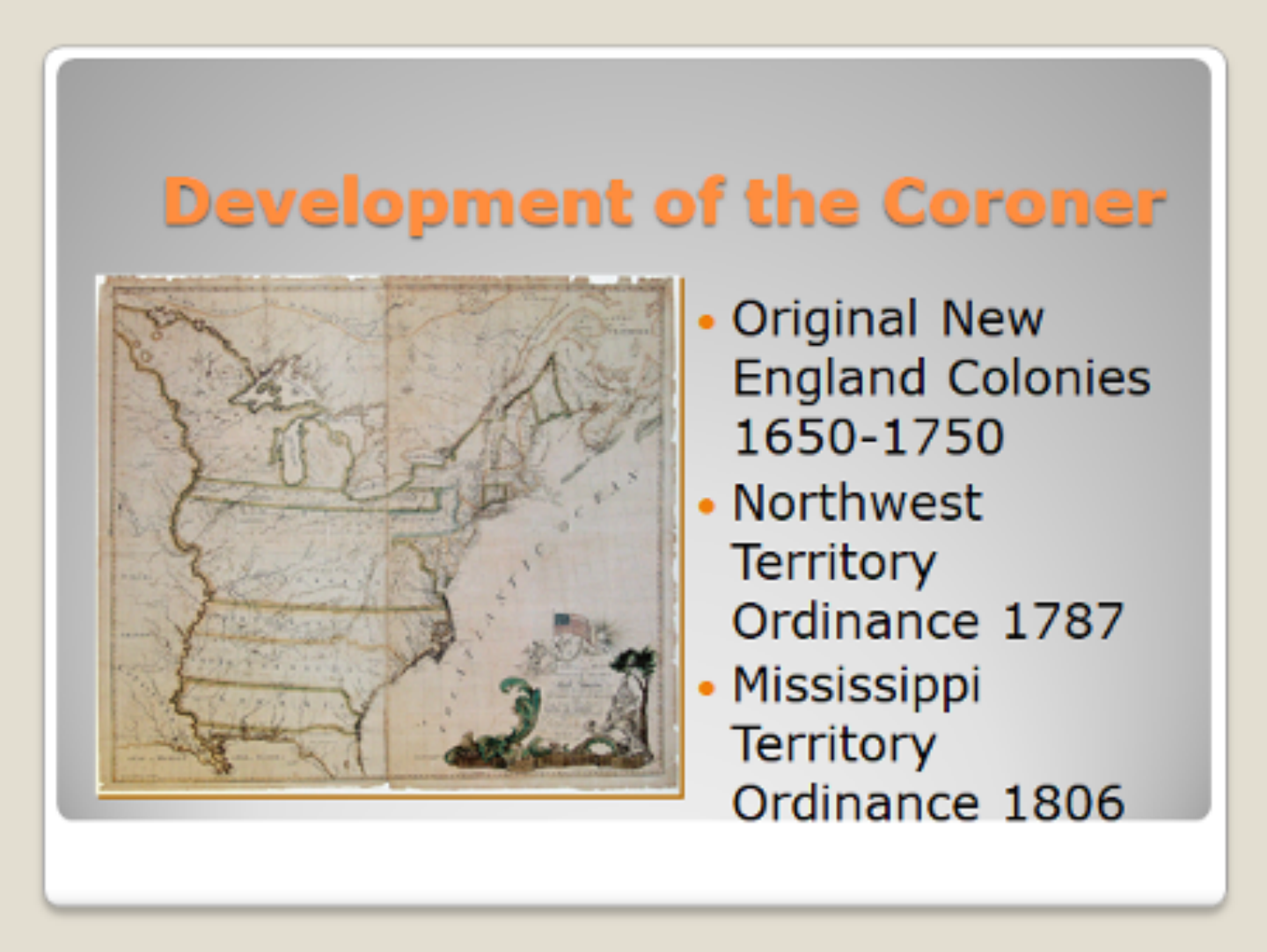
Jeffrey Jentzen MD, PhD

ENGLISH LAW COMES TO AMERICA

The American colonies inherited their legal traditions including death investigation practices from England. The English King relegated the power to investigate deaths in its colonies with local government officials such as justices of the peace, sheriff, and coroner, based on their English models.

Anglo-American jurisprudence with its adherence to the lay jury, adversarial legal procedures, and representative system of government increasingly controlled by political parties and the diminished the role of the medical expert, helped to develop the peculiar system of American death investigation. Unique to the Anglo-American system, the coroner's inquest jury had the statutory duty to determine not only the cause of death but also the manner of death. Legislative acts of the colonies such as the Massachusetts Bay Laws 1770, literally copied from the English law, instructed coroners to "declare of the death of this man, whether he died of felony, or by mischance; and if of felony, whether of his own, or of another's; and if by mischance, whether by the act of God or man . . . ."

In contrast to the continental system, where judges established the manner of death along with pronouncements of guilt, the initial inquest rulings of American coroners determined whether a crime had been committed or the death simply the result of natural or accidental causes. This single process allowed the coroner and his inquest jury the power to determine whether a specific case would advance to trial or be cut short in deference to the accused and avoid further prosecution. The coroner's verdict served as a formal check and balance restraining overreaching justices and frustrating aggressive prosecutors. Autopsies were relatively common in colonial America and physicians regularly consulted to provide evidence in provincial courts especially in cases of contested causes of death such as infant murder. Following the Revolutionary War, implementation of a new Constitution (1783), and Northwest Territory Ordinance (1787), embedded the office of coroner into individual state constitution and evolved with the changing legal structure of the nation.



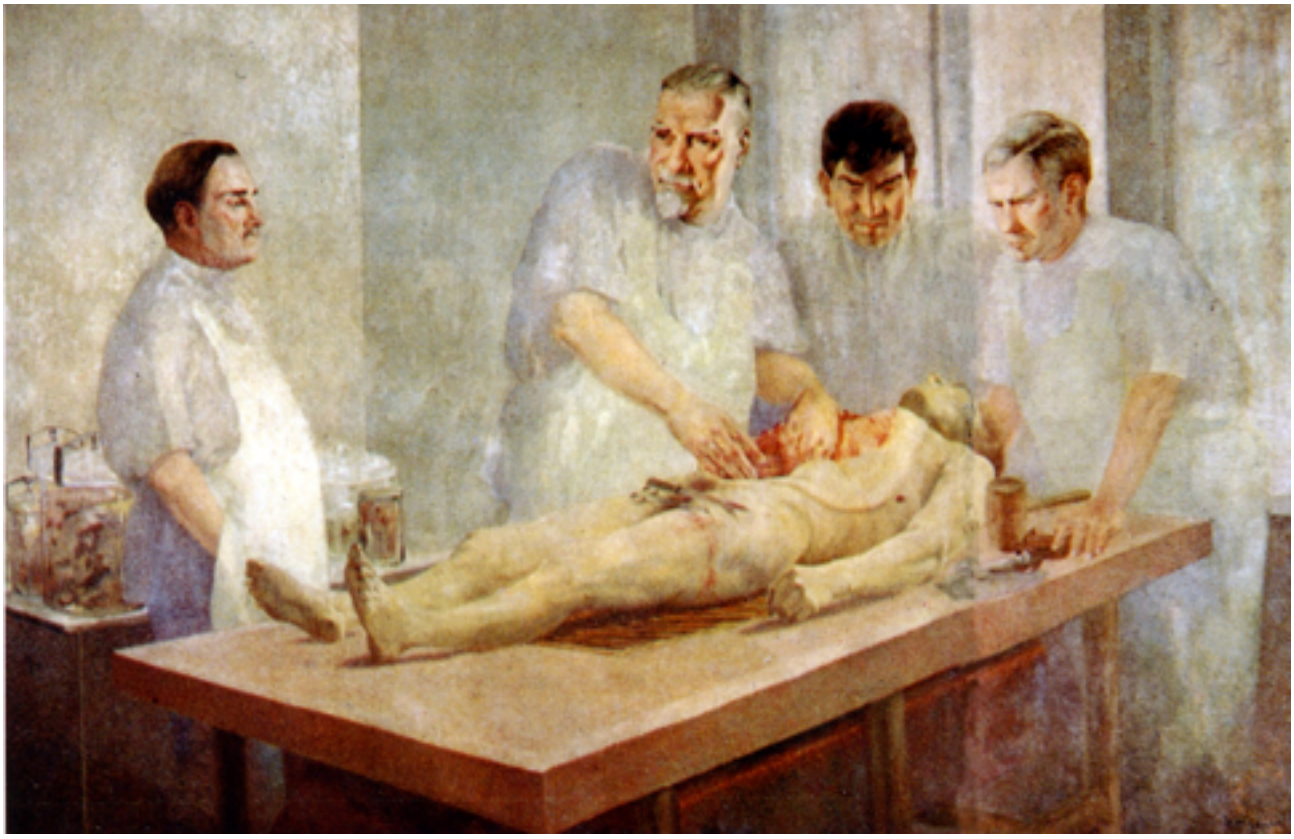
Map of Northwest Ordinance 1787 illustrate original state and expanding territories.

CORONERS AND CORRUPTION

The United States developed the most decentralized, fragmented, and least bureaucratized central state administrative apparatus of any modern democracy. As a consequence of the retention of local autonomy in criminal justice activities by the states, mandated by the federal Constitution, electoral politics affected criminal justice more directly and extensively in America than in any other liberal democracy. Rules and procedures for criminal and civil procedures varied from state to state and in the great majority of states the local positions of county coroner, district attorney, state judges, sheriff, and police chief were all elective. Physicians argued that coroners were selected on the basis of political affiliation rather than scientific training.

In 1865, the State of Maryland became the first state to legislate that coroners must be physicians. In 1877, Massachusetts became the first state to appoint physician medical examiners to the investigation of sudden death. Unfortunately, the statute limited the medical examiner's investigation to obvious violent deaths, which restricted the investigative authority of the medical examiner. The increasing involvement of physicians in death investigation catalyzed the creation of the Medico-Legal Societies in both Massachusetts and New York, provided a forum for physicians and lawyers to present and discuss medicolegal cases and served as a sounding board for legislators on improving medicolegal practice. These medico-legal societies published their transactions and papers in the first American journals dedicated to forensic medicine.

By the late nineteenth century in response to urbanization, the proliferation of immigrants, and an increasing fear of urban crime, the Progressives in America ignited a nation-wide call for improvements in death investigation and the removal of corrupt coroners. Responding to allegations of political corruption, in 1915 New York City successfully replaced the coroner with scientifically trained physician medical examiners.

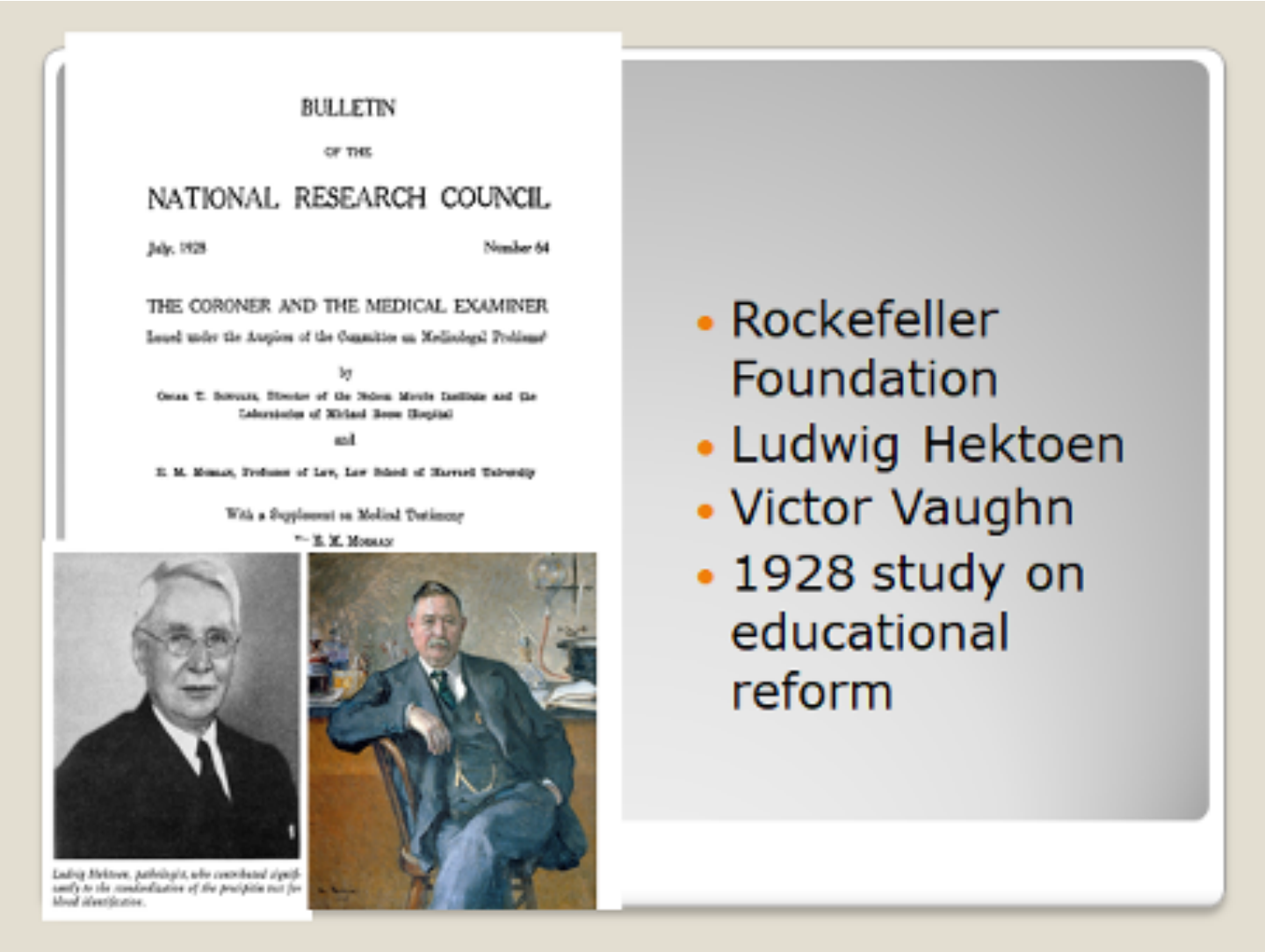


Medical examiners performing an autopsy in New York City morgue 1932.

In 1928, Essex County New Jersey (Newark) became the second major county to establish a medical examiner system and Maryland became the first state in 1938 to create a statewide medical examiner system.

THE CREATION OF A MEDICAL SPECIALTY

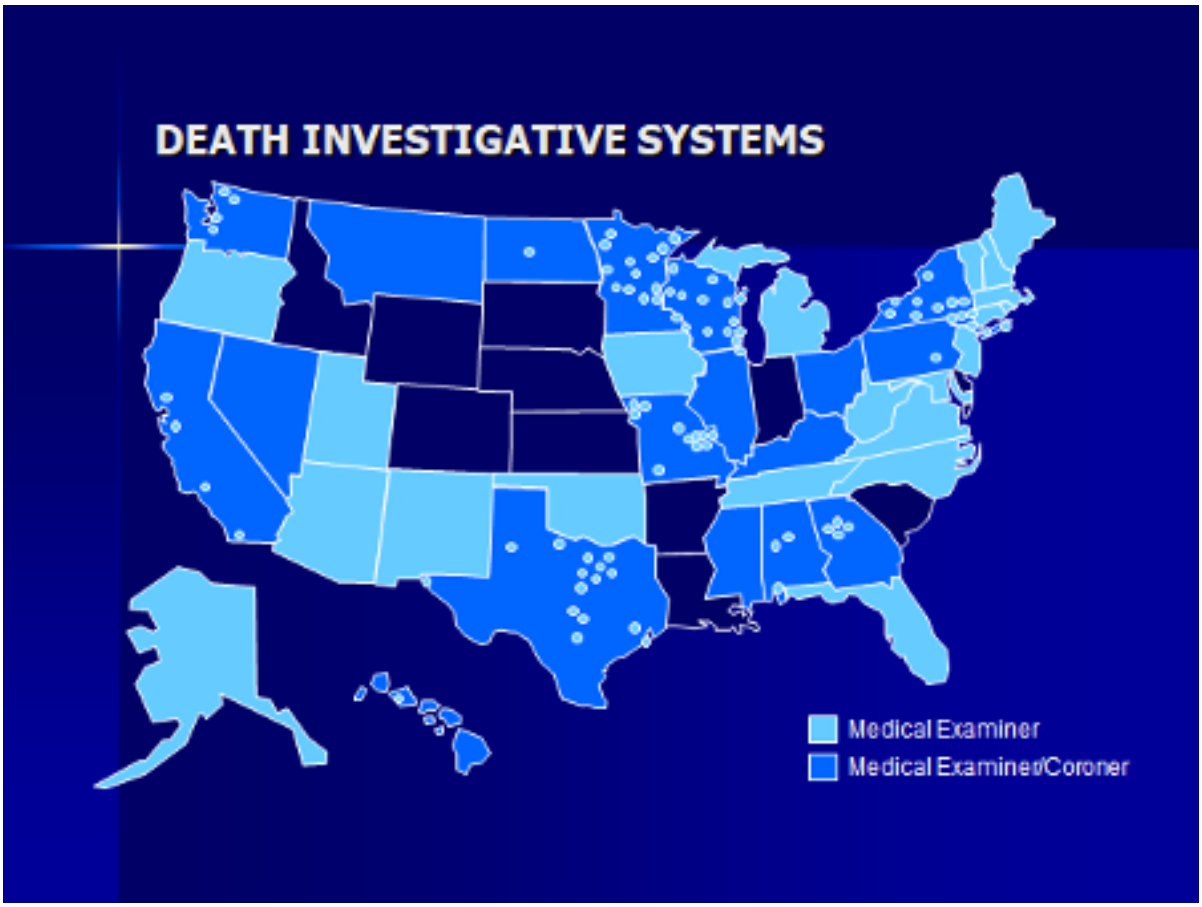
In the early twentieth century elite physicians began to include forensic medicine as a natural adjunct to their pathology practices. Philadelphia pathologist William Scott Wadsworth (1868-1955), Harrison Stanford Martland (1883-1954) in Newark, and George Burgess Magrath (1870-1938) and Timothy Leary (1870-1954) in Boston performed thousands of autopsies as the coroner's pathologists and became the first generation of full-time pathologists committed to the practice of forensic medicine. Leading American pathologists Ludvig Hektoen (1863- 1951), a Chicago bacteriologist and immunologist and Victor Vaughan (1851- 1929), the renown bacteriologist and Chairman of Pathology at the University of Michigan, sought to improve legal medicine. The pathologists convinced the Rockefeller institution to fund the study. The National Research Council (NRC) publicized the work of the committee in the 1928 publication *The Medical Examiner and the Coroner,* which openly called for the removal of the lay coroner.

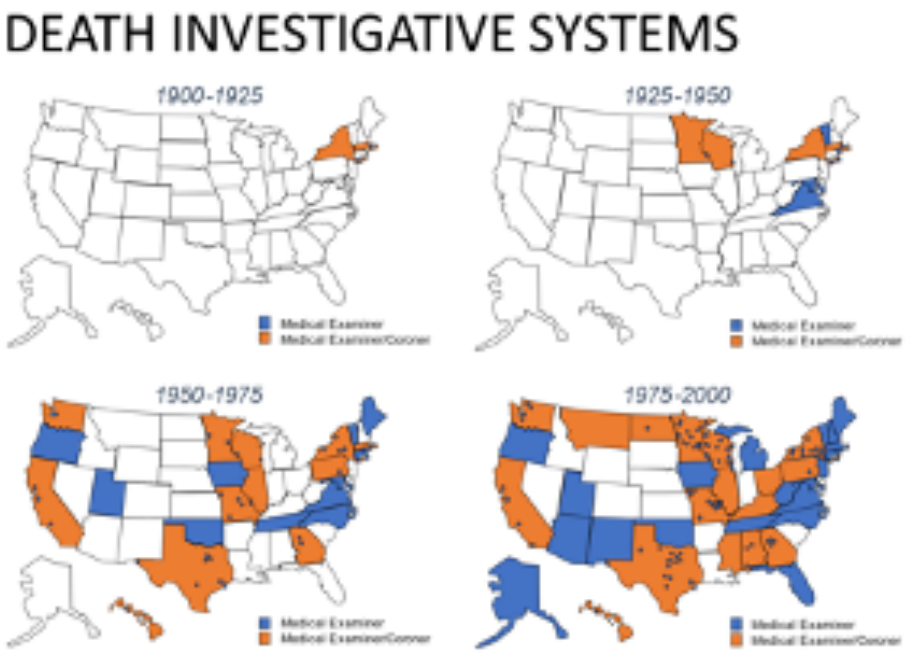


The 1928 National Research Council (NRC) *The Medical Examiner and Coroner* call for abolishing the coroner system.

They called for the establishment of medicolegal institutes similar to those in continental Europe affiliated with state universities and staffed by academic pathologists trained in legal medicine.

In 1932 Harvard Medical School established the first academic chair of legal medicine in the United States and appointed Dr. George B. Magrath (1870-1938) to the position. In 1938, Harvard created the first Department of Legal Medicine with Alan R. Moritz, who developed Harvard's research program in forensic medicine and the first forensic fellowship training program. A survey of seventy-seven US medical schools that same year revealed that only 6.5 percent gave a course in legal medicine, 58 percent gave lectures on the subject, and 35 percent did nothing (Burns, 286). By the end of the twentieth century, medical examiner reform had stalled leaving only 60 percent of the American population was under the jurisdiction of physician medical examiners, with the remaining 40 percent still controlled by coroners.



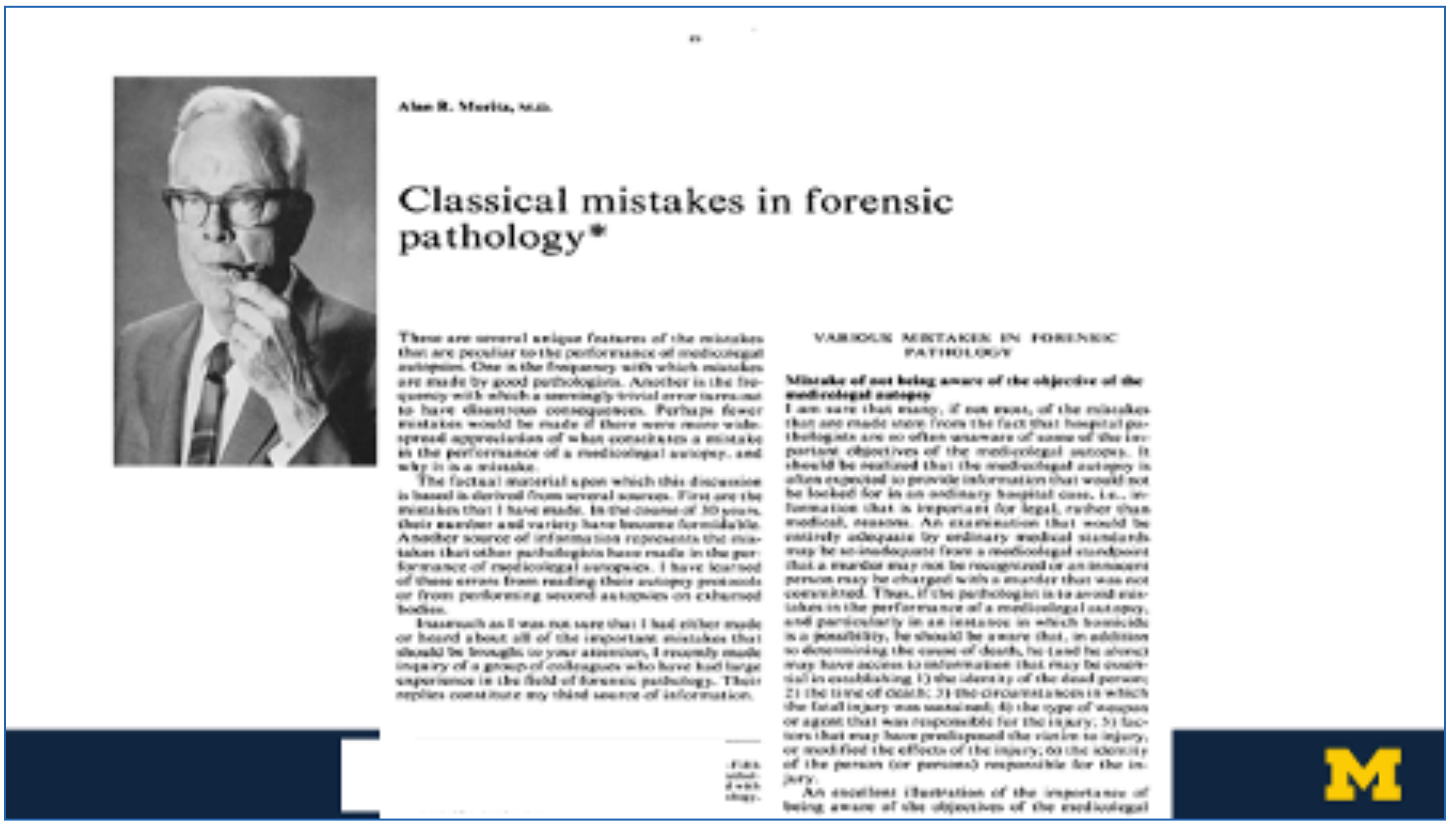


United States map illustrating the distribution of medical examiner and coroner jurisdictions in 2000.

FORENSIC EDUCATION TAKES SHAPE

One claim that supporters of the medical examiner system could not refute was the paucity of trained forensic pathologists. By the mid-twentieth century, professional pathology groups assisted by the American Medical Association stepped in to assist in the professionalism in forensic pathology. Pathology had become a separate medical specialty in America in 1936 and governed by the American Board of Pathology. In 1958, pathologists working within the College of American Pathologists, a national professional pathology society, successfully created the subspecialty of forensic pathology through the American Board of Pathology. Forensic pathology became officially defined as the subspecialty within the field of pathology that deals with the investigation of cause and manner of death and the performance of medicolegal autopsy and ancillary studies. Pathologists could qualify for board certification either through demonstrating previous experience in the field "grandfathering" or completing a year of specialized training in forensic pathology.

Training programs in forensic were led by forensic pathologists who developed broad "schools" of practice. Each program developed a unique theory of practice based on the procedures and philosophy of the chief medical examiner and influenced by the realities of the local politics and culture. The Massachusetts program, dominated by Harvard, was heavily weighted toward academics, while Miami emphasized the importance of autopsies and Minneapolis the stressed death scene investigation by requiring pathologists to go to death scenes. These programs formed the foundation for teaching forensic pathology in America.



Alan R. Moritz, M.D.

Classical mistakes in forensic pathology*

"Classic Mistakes in Forensic Pathology" a lecture and publication given by Alan Moritz in 1958.

Although forensic training centered on the medicolegal autopsy, fellow trainees also received training in toxicology methods and interpretation, criminalistics, anthropology, firearms analyses, and courtroom testimony. At first primarily a male-dominated specialty, by the end of the twentieth century there were more females in American forensic fellowship training than males.

1 The federal government also participated in the training of forensic pathologists to supply the needs of the military. In 1950s the Armed Forces of Pathology (AFIP), the successor to the Army Medical Museum and long concerned with the pathology of trauma, established a unit devoted to forensic pathology. By 1958, the unit had developed an active teaching program and a registry of interesting forensic pathology cases. In conjunction with the support of the College of American Pathologists, in 1962 the AFIP offered the first fellowship training program using the facilities of the Baltimore Medical Examiner Office. In 1988 Congress created the Office of Armed Forces the Medical Examiner (OAFME) as a component of the AFIP. Located in Washington, the OAFME provided training for active-duty forensic pathologists and investigated deaths of military personal, persons on military bases, and war-related fatalities. Postmortem examinations were performed at the military mortuary in Dover, Delaware.

United States military mortuary in Dover, Delaware.

In addition, the AFOME was charged with any investigation of death of the United States President and other senior politicians of the U.S. government.

Despite the creation of board certification, legislated standards and court procedures could not limit the performance of medicolegal autopsies to board-certified forensic pathologists. This eventually created a fractured specialty where non-board-certified pathologists continued to compete for medicolegal autopsies with pathologists with board certification in forensic pathology. Many pathologists failed to recognize the benefit of board certification and declined to obtain extra training. Despite early advances, forensic pathology lacked funding, governmental regulation, and the professional stature of European counterparts. The diluted requirements for certification left many forensic pathologists questioning whether the specialty existed at all.

PROFESSIONAL ORGANIZATIONS

American death investigation continues to be a patchwork of jurisdictions located at the county or state level with varying practices and procedures. Unlike continental European countries where the police controlled the investigation and determined the need for autopsy, American coroners and medical examiners were mostly detached from law enforcement and delegate the scene investigation to lay death investigators. These investigators examined bodies, took photographs, and interviewed the family and witnesses regarding the circumstances of the death. Many forensic pathologists eschew going to crime scenes and instead used the lay investigator as their eyes and ears at the death scene. Frequently, because these investigators were retired policemen in search of additional governmental pensions, police influence has continued in many medical examiner and coroner offices.

In order to establish political support for medical examiners, forensic pathologists created a professional organization, the National Association of Medical Examiners (NAME) in 1966.

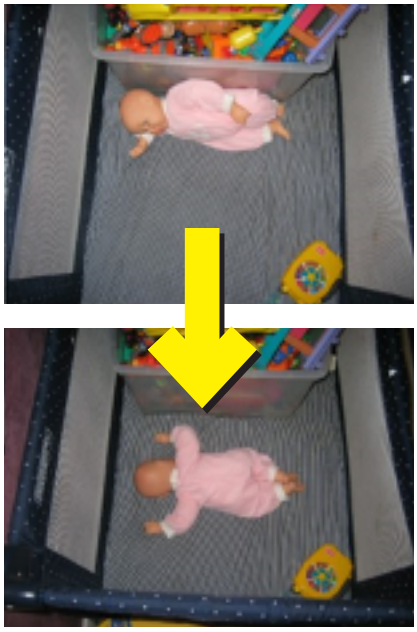
National Association of Medical Examiners (NAME) organized in 1966.

NAME was dedicated to removing coroners and replacing them with physician medical examiners. NAME provided annual educational programs on topics of forensic pathology and legal medicine. In 1977, NAME created an Inspection and Accreditation Program to provide guidelines for the support and administration of medical examiner offices. Although voluntary, accreditation signified that the office had at least maintained minimum standards endorsed by a consensus of the profession. The accreditation process provided politicians the benchmark information to access the quality of the death investigation system and medical examiners the support to request needed resources. Although never able to remove the coroners completely, NAME was recognized as the professional voice of forensic pathology in the United States. A similar professional organization for coroners, the International Association of Coroners, developed an accreditation program modeled on the NAME program. Without a government mandate or institutional control, relatively few medicolegal offices attempted to attain or maintain accreditation.

In 2003 the National Institutes of Justice published the first cohesive American standards for death scene investigation. For the first time, procedures and practices to be performed at the death scene were formally delineated. The publication in 1996 of the Death Scene Investigation: A Guide for the Professional Death Investigator helped to establish the profession of death investigator by outlining the essential skills and laying a foundation for professional certification. Ten years later the National Association of Medical Examiners established The Forensic Autopsy Performance Standards, which provided formal recognition of the differences between hospital and forensic autopsies. The Standards not only addressed the variability in practice of forensic pathologists in areas of autopsy performance, scene investigation, and procedures for identification, but also provided a consensus document on acceptable practice and emphasized the importance of including experts from other fields.

Figure 8 Training programs and guidelines developed to assist death investigation and standardized forensic autopsy practice.

By the late-twentieth century, the United States federal government recognized defects in death investigation and public health data collection. Standardizing and improving data collection at infant death scene investigations and national reporting of all sudden, unexplained deaths in infancy (including SIDS) became a national priority. With the 1996 redefinition of Sudden Infant Death Syndrome (SIDS) (1989), the Centers for Disease created the Sudden, Unexplained Infant Death Investigation Reporting Form (SUIDIRF). This comprised a national protocol for conducting scene investigations for sudden, unexplained infant deaths (SUID). The SUIDI form contained data points for the collection of content on interviews, collection of both birth and medical histories, and scene information demonstrated by doll-reenactments.



Placed Position: Placed down on right side.

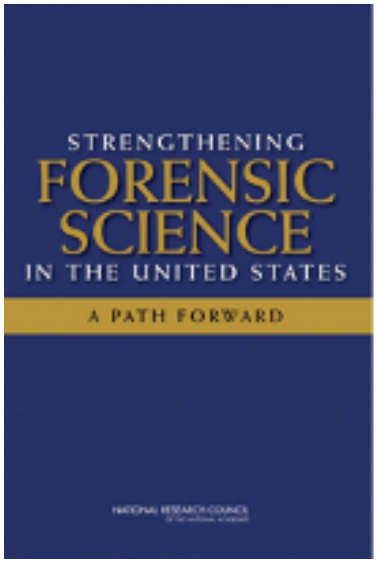
Placed Position: Prone head turned slightly to right.

Doll reenactment at death scene according to SUIDI Guidelines facilitated the investigation of infant deaths.

In 2020 the CDC released an updated version of the SUIDIRF.

The federal government also funded and participated in other research through the development of a National Violent Injury Reporting System (NVDRS), National Missing and Unidentified Persons System (NamUs.gov), Opioid Drug data recording and others.

In 2009 the National Academy of Science released the two-year study on the state of death investigation in the United States, *Strengthening Forensic Science in America: The Path Forward.*



Based on its findings, the **NAS report** made thirteen recommendations, including the creation of an independent, scientific science, investing in research and standards setting, addressing cognitive bias in the practice of forensic testing and educating judges and legal practitioners.

The 2009 Strengthening Forensic Science in America: The Path Forward.

The report called for the accreditation of all forensic facilities including medical examiner offices and certification of forensic pathologists and investigators. The report further supported the role of academic institutions in partnering with medical examiner offices to provide scientifically based death investigation and research in forensic science. It also mandated that only board-certified forensic pathologists should be allowed to perform autopsies on suspected homicide cases. For the first time the report indicated the federal government's intention to abolish lay coroners. The report established board-certified forensic pathologists as the gold standard and lead experts in death investigation. In doing so, it significantly enhanced the professional authority and status of the forensic pathologist, something the medical community was unwilling or unable to accomplish.

At the beginning of the twenty-first century United States physicians and the public came to acknowledge the medical expertise of the forensic pathologist. With the advent of stricter legal rules governing expert medical testimony in state and federal courts, inspection and accreditation programs, increasing expectations of the work of medical experts, and the complexity of medicolegal cases, untrained pathologists have been less inclined to become involved

in medicolegal cases. With the paucity of autopsies for educational purposes, academic medical centers once again included forensic pathology into their departments. The federal government of the United States recognized the fragmentation and importance death investigation and began to activity fund and support research, standards, and best practices in death investigation.

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Do you have an idea, comment or Suggestion?

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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:		
Last Name	First	Middle Initial
Governmental Agency (Federal, State, Local) with which Affiliated:		
Agency:		
Address:		
City:	Zip:	State:
Telephone:	Fax #:	
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:)	
◯ AFS ◯ 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.

Application for International Corresponding Member Page 2

I hereby make application for membership in the National Association of Medical Examiners. I hereby agree to abide by the Bylaws of the Association and such changes and amendments to same as may hereafter be properly adopted. I hereby agree to revocation of my membership, if granted, in the even that any of the statements hereinafter made by me are found to be false, and to hold the National Association of Medical Examiners and its members, officers and agents free from any damage or complaint by reason of any they, or any of them, may take in connection with this application.

CODE OF ETHICS AND CONDUCT

As a means to promote the highest quality of professional and personal conduct of its members, the following constitutes the Code of Ethics and Conduct which is endorsed and recommended to be adhered to by all members of the Association:

A. Every member of the Association shall refrain from exercising professional or personal conduct adverse to the best interests and purposes of the Association or to the medical examiner profession.

B. No member of the Association shall materially misrepresent his or her educational training, experience, area of expertise, certification, membership status within the Association, or official title or position in a medicolegal system.

C. Every member of the Association shall refrain from providing any material misrepresentation of data upon which an expert opinion or conclusion is based.

D. Except for the President and Chairperson of the Board of Directors, no member of the Association shall issue public statements which appear to represent the position of the Association without specific authority first obtained from the Board of Directors.

E. All applicants for membership and annual renewal of membership shall affirm by their signatures that they have read, understood, and endorsed the Code of Ethics and Conduct in this Article X.

Signed:

_____

Date:

_____

JOIN NAME TODAY!

Contact Dee McNally

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

Languages that NAME members speak other than English

1. Afrikaans
2. Antillean Creole
3. Arabic
4. Bemba
5. Bengali
6. Bosnian
7. Bulgarian
8. Chinese
9. Croatian
10. Czech
11. Danish
12. Dutch
13. Filipino
14. French
15. German
16. Greek
17. Gujarati
18. Hebrew
19. Hindi
20. Irish Gaelic
21. Italian
22. Japanese
23. Kannada
24. Korean
25. Lithuanian
26. Macedonian
27. Malayalam
28. Maltese
29. Mandarin Chinese
30. Marathi
31. Montenegrin
32. Nyanja
33. Persian
34. Polish
35. Portuguese
36. Punjabi
37. Romanian. Arterial language.
38. Russian
39. Sanskrit
40. Serbian
41. Sinhala
42. Slovenian
43. Spanish
44. Tamil
45. Ukrainian
46. Urdu
47. Yoruba

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