

Can the Dead Autopsy Be Exhumed?

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Not that many generations ago, we were all taught that the gold standard of quality assurance in medicine was the autopsy. Many of us still believe it.

In addition, the autopsy was also often referred to as the single greatest teaching tool in medicine. A large percentage of hospital deaths from natural causes were posted routinely, and physicians gathered around for “death rounds,” which in some areas were the actual autopsy table, and in more organized arenas, auditoria, often designated as CPCs, or Clinical Pathologic Conferences.

The only ones who may have gotten weary of all these autopsies were perhaps the pathology residents, often overwhelmed with them and needing at least 100 to fulfill their anatomic pathology residency requirements, and the hospitals, who were required to post at least 25 percent of their expirations to maintain their Joint Commission accreditation.

Then, a cascade of a very significant regulatory, technological, medico-legal, and of course economic events all but killed the autopsy.

Probably the first and most deadly blow was the waiving of the Joint Commission’s 25 percent autopsy requirement for hospital accreditation. The exact truthful reason for this is unclear, for while it was claimed that technological diagnostic advances, notably emerging CT, left the pathologists with little more to add, no doubt there were heavy lobbying efforts from hospital spin-doctors to kill the autopsy, because it was a revenue eater and not a revenue producer. I have never seen a hospital whose leaders designed an effective innovative policy for quality assurance, but many times I have seen them huddle together for the purpose of “what do we need to do to pass this next exam?”—just like medical students.

Another blow was more of an attitude than a regulation, although it partially justified the Joint Commission action. This was the feeling that the emerging imaging technologies, first CT but soon followed by ultrasound and MRI, had advanced to the point that slicing by knife was not as accurate as computer slicing. This attitude gained credibility with physicians, and especially pathologists who were sick of performing autopsies. (They never got paid for them, and there has never been any third-party reimbursement for autopsies.) Even the most careful and thorough pathologist may slice a liver every inch or so, but a high-resolution CT study can slice that liver every few millimeters. It is very hard to argue with that!

Of course the medico-legal forces were devastating as well, and although every pathologist can boast anecdotally that his findings or testimony has saved a colleague millions of dollars in a malpractice suit, the total effect was potentially devastating for physicians, and every autopsy report was a possible field day for the malpractice attorneys. Not only was the autopsy a non-reimbursable financial drain of time, personnel, and money, but it opened the door for litigation. While pathologists may tell you that each autopsy he did showed a significant, previously undiagnosed surprise, those surprises were fodder for the malpractice industry.

The most obvious example is that of finding incidental malignancies in patients dying of other natural causes. While it may have consoled many families to know that Grandpa’s death from the sudden heart attack may have saved him from a longer, more agonizing death from cancer, many physicians, families, lawyers, and even pathologists feel that dying *with* cancer is the same as dying *from* cancer, and attorneys can see this as another million-dollar missed-cancer case. Conversely, successfully treated cancers may produce few or no viable tumor cells visible microscopically, and I have seen attorneys reward the treating physician’s brilliant and miraculous work by suing him for treating a patient with no cancer for cancer. Wordings of every autopsy report had to be carefully examined like tissues under a microscope so as not to open this dangerous legal door. In many cases words were omitted or hidden.

Then the HIV (human immunodeficiency virus) scare and epidemic followed. Hospitals were required to conform to “universal precautions,” which meant that every piece of tissue in the lab, and every drop of blood, had to be assumed to be HIV positive. Physicians were then mandated in many states to attend BBP (blood-borne pathogen CME) in order to renew their medical licenses.

While a tiny needle biopsy of tissue could reasonably be sterilized by a few minutes in formalin, large specimens like placentas were fixed for at least a week or so, and how could universal precautions be met for whole cadavers? Panic ensued. I know pathologists who performed posts on HIV-positive cadavers, and have nicked themselves during the procedure, only to find out the patient’s HIV status afterward. Although the reported incidence of lab accidents like this resulted in a less-than-one-percent chance of seroconversion, what do you think the percentage of sleepless nights was? At this point it seemed as though the autopsy would never be resurrected—and it hasn’t been.

The primary reasons for autopsy rates dropping from 25 percent to less than five percent in the last four decades can be related to one unifying factor: money. It never was a revenue producer for anybody, except malpractice attorneys, and most of the autopsies performed today have medico-legal overtones. During the final days of the autopsy, most of my requests were from families looking for money.

I have always considered the autopsy to represent truth, an extremely rare commodity in medicine, law, government, and society in this information age. Truth is getting harder to find, except perhaps when people happen to have their cell phones with video working during the progress of an event.

Perhaps Jack Nicholson’s Marine Col. Jessup in *A Few Good Men* was right when he barked at Tom Cruise’s demand for truth, “You can’t handle the truth!”

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