

Critical Diagnoses and Duty to Warn in Forensic Pathology: an Evaluation of Ethics and Proposed Reporting Recommendations

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Disclosure

- The authors have documented that they have no financial relationships to disclose or conflicts of interest to resolve.

A catalyst case



9-year-old female with no medical history except one-week upper respiratory illness with cough



Became cyanotic and unresponsive



Died following attempted resuscitation



No known or suspected trauma



Bilateral hemothoraces



Extensive mediastinal soft tissue hemorrhage



Dissection of ascending aortic arch



Delicate tissues

Spontaneous aortic dissection in a 9-year-old

- Cause of death: “aortic dissection due to probable connective tissue disorder, unspecified type”
- No other risk factors for aortic dissection
- Suspected vascular Ehlers Danlos Syndrome
- Mother found to be pregnant
- Prompt contact made with family
- What is the responsibility of our office to notify this child’s family/physician?

Standards

- **No standard currently exists regarding the notification of unexpected autopsy findings to family or clinicians.**

Background

- What is a critical value?
- Implications in Anatomic Pathology
- Applications in Forensic Pathology



The task

- What is a critical value in forensic pathology?
- What is the ethical duty of a forensic pathologist to notify next of kin?
- What is the legal liability if such findings are not reported?

Legal Precedent

- *Pate v. Threlkel*
 - Woman diagnosed with **Multiple Endocrine Neoplasia (MEN-1)**
- *Safer v. Estate of Pack*
 - Woman diagnosed with Familial Adenomatous polyposis related colorectal cancer

Proposed guidelines

Adopt standardized, national set of guidelines for notification of forensic critical values

Scenarios to consider notification of next of kin or decedent physician

Establish timeline for notification

Suggest methods for documentation of communication

Proposed guidelines: Recommended cases

- Marked (>75%) coronary artery disease in a non-obese person less than 30 years of age without concern for stimulant use.

Proposed guidelines: Recommended cases

- Findings suggestive or diagnostic of hypertrophic cardiomyopathy or other heritable cardiomyopathies.

Proposed guidelines: Recommended cases

- Pulmonary thromboembolism/deep vein thrombosis **without** trauma, surgery, instrumentation, or other risk factors.

Proposed guidelines: Recommended cases

- Unexpected heritable conditions such as connective tissue disorders or heritable cancers with risk of sudden death.

Proposed guidelines: Recommended cases

- Carbon monoxide poisoning if unexpected

Proposed
guidelines:
Who to
contact

Identify next-of-kin or other suitable contact, in some cases decedent's primary care physician

Obtain telephone numbers, mailing address, or email address

Proposed guidelines: Timing

- Timing should be driven by the nature of the condition and ability to diagnose the respective pathology
- Consider notification of contact as soon as a diagnosis is made, rather than waiting for finalization of report.

Proposed guidelines: What to communicate

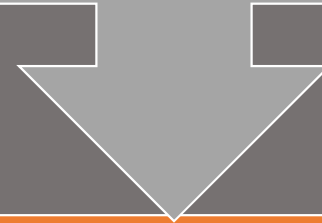
- Comment in summary section of autopsy report or other location in records addressing finding and potential impact on surviving family

Proposed guidelines: what to communicate

- “In the course of examination of (the decedent), findings suggestive of a potentially heritable (disorder) were identified. While this office does not have the capacity for genetic testing or the ability to offer clinical care, we strongly recommend that blood relatives discuss the information with their own physician to determine if preventative measures are necessary. It is also recommended to bring a copy of the examination report to these discussions with your physician. In this case, blood was collected and stored for future private testing as requested. This recommendation was communicated to family on (date).”

What is the investment?

These cases would represent a small overall investment of time



NC OCME estimates 1 dozen cases/year

4.5 million population

31 counties

1600 annual autopsies

Limitations

- Family/physician contacts may not be forthcoming even after extensive investigation
- Condition already diagnosed
- Offices should not be responsible for education or referrals
- Avoid redundancies in reporting

Plans at OCME

Currently developing best practices

Discussions with internal agency legal specialist to balance minimization of liability as well as burden on pathologist.

Draft final best practices to disseminate among all NC Regional Autopsy Centers.

Acknowledgments

- Tracy Yorkdale, NC OCME Autopsy Facility Manager
- Kim Janssen, M.D. NC OCME Associate Chief Medical Examiner
- Michelle Aurelius, M.D. NC OCME Chief Medical Examiner

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