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RESCISSIONS

The following material is rescinded:

a. Manual

M-2, Part VI, Chapter 8, dated March 20, 1990, and Change 59

b. Circulars

10-88-122

## CHAPTER 9. POST-MORTEM EXAMINATIONS

### 9.01 PURPOSE

The purpose of this chapter is to provide policy for all Department of Veterans Affairs (VA) medical centers for the performance of post-mortem examinations. Special emphasis is placed on categories in which autopsies must be performed, using the post-mortem examination as a quality assessment tool. The post-mortem protocol for former prisoners of war (POWs) (see App. 9B) is introduced for use in all VA medical centers and referral sites where autopsies may be performed on former POWs.

### 9.02. POLICY

All VA medical centers will provide post-mortem examination services. The availability of these services will be made known to the family of each decedent, and the medical staff will attempt to secure authorization for post-mortem examination in all deaths. It is mandatory that the protocol in Appendix 9B be used for all post-mortem examinations on former POWs, regardless of the site where the post-mortem is conducted.

a. The Chief of Staff is responsible to the Director for overall management of post-mortem examination services since several services in the VA medical center are involved.

(1) The scope of this management includes:

(a) Arrangements for securing post-mortem examination authorizations;

(b) Provision of sufficient competent staff for the examinations and for timely completion of post-mortem examination reports;

(c) Maintenance of suitable facilities and appropriate coordination with funeral directors and local authorities.

(d) Ensuring that post-mortem examination findings become a continuing component of the VA medical center's internal monitoring of medical practice.

(2) Findings on all post-mortem examinations will be presented to the medical staff on a regular basis as expeditiously as possible. Such reviews will occur with the frequency appropriate to the level of activity in the medical center but at least once each quarter.

b. The Chief, Pathology and Laboratory Medicine Service, is responsible for the professional aspects of post-mortem examination, including:

(1) The custody of bodies co-signed to the post-mortem examination suite;

(2) Performance of the post-mortem examination diagnoses;

(3) Preparation of appropriate protocols and reports;

(4) Retention and disposition of gross post-mortem examination tissue, (blocks, microscopic slides); and

(5) Professional support of clinical and administrative activities related to the post-mortem examination.

c. There will be legal authorization by the next of kin for post-mortem examination in all instances before any prosecution is begun, except as provided in 38 Code of Federal Regulations (CFR) 17.155.

(1) Whenever possible, the physician responsible for the care of the patient at the time of death is the designated person to request permission from the next of kin to perform an post-mortem examination.

(2) The Decedent Affairs Clerk for Medical Administration Service (MAS) can provide assistance in obtaining permission for post-mortem examination.

(3) The original copy of the authorization, Standard Form (SF) 523, Authorization for Autopsy, or transcript of recorded telephone conversation, will be filed in the deceased's medical record.

(4) Requests and authorization for post-mortem examination by the next of kin will be honored provided the necessary legal requirements are met.

d. Post-mortem examination may be performed for medicolegal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 (see Ch. 8).

### 9.03 PHILOSOPHY OF POST-MORTEM EXAMINATIONS

a. The post-mortem examination is a significant instrument of continuous monitoring activity as part of the Systematic Internal Review Program of the health services review organization within each VA medical center. It confirms, or establishes, the cause of death and assists in determining the manner of death.

b. The discrepancies between pre-mortem and post-mortem diagnosis can be used as a tool for making post-mortem examination an integral part of a quality assurance program. Quality assurance implies the quantitative evaluation of differences between pre-mortem and post-mortem findings for determining whether they fall within predetermined acceptable standards, or permissible range. NOTE: To date no acceptable range of discrepancies between pre-mortem and post-mortem diagnoses has been determined nationally.

b. The accrual of medical knowledge and the quality of medical care is dependent in large measure on the continuing flow of information from post-mortem examination findings. Permission for post-mortem examination must be pursued in all death cases, even though permission is specifically encouraged in certain listed categories.

NOTE: Despite the decline in post-mortem examination rates, the value of the post-mortem examination has been enhanced rather than diminished by advances in diagnostic technology and remains a vital component in the assurance of good medical care.

### 9.04 POST-MORTEM EXAMINATION RATES AS A PERCENTAGE OF HOSPITAL DEATHS

a. Veterans Health Administration (VHA) policy for post-mortem examination rates encourages the maximum number of post-mortem examinations on patients within a wide range of clinical categories rather than to seek a fixed post-mortem examination rate as a percentage of all hospital deaths on randomly selected patients.

b. Patient categories, listed in subparagraphs c. (1) and (2), are targeted for post-mortem examination and are expected to yield critical information by which to judge the quality of care and pre-mortem diagnostic accuracy in VA medical centers. A policy of substituting post-mortem examination selection by diagnostic category rather than by prescribed percentage does not necessarily imply the post-mortem examination rate would be low. NOTE: In general medical and surgical VA medical centers, with excellent cooperation between clinicians and laboratory physicians, the rate may exceed 50 percent.

c. Any conscious selection process may introduce a bias. This factor must be considered when identifying patients for post-mortem examination who have expired from specified categories of disease. The advantage of a conscious selection process is that it augments medical education. The disadvantage is that it detracts from the post-mortem examination as a truly randomized quality assurance factor. True random selection of patients for post-mortem examination eliminates this bias.

(1) Surgical Service. Post-mortem examinations should be sought on:

(a) Not less than 50 percent of patients dying with a history of transplant of:

1. Heart,
2. Kidney,
3. Liver,
4. Lungs,
5. Skin, or
6. Pancreas.

(b) Cardiac surgical patients who had cardiac surgery within the period of their hospital admission.

(c) Unexpected postoperative deaths.

(d) Patients dying from postoperative complications, such as, but not limited to:

1. Sepsis, shock, hemorrhage, or vascular disease.
2. Disruption of the following anastomotic connections, as:
  - a. Gastrointestinal, and
  - b. Tracheobronchial.

(e) Deaths resulting from:

1. Invasive diagnostic procedures;
2. Endoscopic procedures;

3. Cardiopulmonary insufficiency;

4. Renal insufficiency;

5. Hepatic insufficiency; and

6. Transfusion reaction.

(f) Deaths under anesthesia.

(g) Deaths following an unscheduled readmission within 15 days of discharge for the same or related surgical condition.

(2) Medical Service. Among patients who expire on the Medical Service wards, the medical staff should attempt to secure post-mortem examinations on not less than 50 percent of patients dying under the following circumstances:

(a) Deaths during, or within 1 week from, the performance of a diagnostic, or therapeutic procedure, such as:

1. Cardiac catheterization,

2. Angioplasty,

3. Dialysis,

4. Exercise tolerance test,

5. Endoscopy, and

6. Bronchoscopy.

(b) Sudden and unexpected death during hospitalization. This category refers to patients with a treatable condition, or those in whom the clinical course revealed marked improvement.

(c) Death of patients on whom a diagnosis was not made in life, despite extensive clinical evaluation.

(d) Death from nosocomial infections not adequately resolved by laboratory studies, or antibiotic treatment, during the life of the patient.

(e) Deaths during trials of new, or experimental, therapeutic agents.

(f) Post-mortem examination to recover expensive, or dangerous, implanted prostheses, such as:

1. Automatic implantable cardioverter defibrillators;

2. Nuclear driven cardiac pacemakers (see par. 9.07); and

3. Items which could explode during cremation. NOTE: When explanted at post-mortem examination, the prostheses will be returned to the service that implanted it. If the service has no use for the prostheses, it will be sent to Acquisition and Materiel Management (A&MM) Service.

(g) Death following an unscheduled readmission within 14 days of discharge for the same, or related, medical condition.

(h) Any patient who dies on a Medical Service ward following an organ transplant.

(3) Mental Health & Behavioral Sciences Service. The medical staff should attempt to secure post-mortem examinations on not less than 50 percent of patients who expire on psychiatry bed services. Of particular interest are those patients who expire under the following conditions:

(a) Death following unscheduled admission from:

1. A VA Nursing Home Care Unit,
2. A domiciliary,
3. A State, or community, nursing home as a transfer;
4. A VA psychiatric hospital to a general medical and surgical hospital; or
5. A psychiatry bed service to a medical bed service within the same facility

(b) Unexpected deaths.

(c) Violence to self or others (this requires consultation with the medical examiner).

(d) Patients receiving therapy with multiple pharmaceutical agents.

(4) Neurology Service. Among patients who expire on a Neurology Service ward, staff should attempt to secure post-mortem examinations on not less than 50 percent of patients dying under the following circumstances:

(a) Death during, or within 1 week of, the performance of a diagnostic, or therapeutic, procedure, such as angiography, or a neurosurgical procedure.

(b) Death during, or within 48 hours of, lumbar puncture of a myelogram.

(c) Death from infectious diseases, particularly slow viral disorders such as Jakob-Creutzfeld Disease or Human Immunodeficiency Virus (HIV). NOTE: Caution should be exercised during these post-mortem examinations.

(d) Death from Alzheimer's or other dementias.

(e) Sudden and unexpected death during hospitalization.

(f) Death of patients on whom a diagnosis was not made during life, despite extensive clinical evaluation.

(g) Death during therapeutic trials of new, or experimental, therapy.

(h) Death following an unscheduled readmission within 14 days of discharge for the same or related neurological condition.

(i) Death following an unscheduled admission from:

1. VA nursing home unit;
2. Domiciliary;
3. A State, or community, nursing home, as a transfer; or
4. A VA medical center with a major psychiatry mission to a Neurology Service in a VA medical center with a general medical and surgical mission.

(5) Additional Categories Targeted for Subsequent Post-mortem Examinations

(a) Deaths with Medicolegal Significance

1. Certain deaths which occur in a VA medical center will be of potential medicolegal significance. These deaths may be called Medical Examiner, or Coroner's cases, in that they must be reported to a local investigatory agency and/or the United States Attorney through the District Counsel, in accordance with requirements of 38 CFR Section 17.155(c)(d), and 38 United States Code (U.S.C.) Sections 5701(f)(2) and 7332.

a. If the report of a death is made to the local investigatory agency of jurisdiction and they decline jurisdiction, and if the United States Attorney has been informed of the death and has no objections, then a post-mortem examination may, and indeed should be, performed on the remains providing WRITTEN CONSENT IS OBTAINED FROM THE NEXT OF KIN.

b. Under certain circumstances, detailed in 38 CFR, Section 17.155, the Director may cause an autopsy to be performed in the absence of consent from the decedent's next of kin.

c. Cases which are considered medicolegal significance, but are not limited to:

(1) Unnatural or violent death, whether due to suspected accident, homicide, suicide, or undetermined means.

(2) Death directly related or apparently attributable to prior military duties.

(3) Death related to vehicular, aircraft, or vessel accidents.

(4) Sudden death not caused by readily recognizable disease.

(5) Death due to disease which may constitute a hazard to the public health.

(6) Death occurring within 24 hours of invasive diagnostic or therapeutic procedures.

(7) Death due to known or suspected therapeutic misadventure.

(8) Death due to suspected negligence, incompetence or criminal activity of any staff member (see Ch. 4).

(b) Additional Groups That Could yield Valuable Findings at Post-mortem Examination. These groups include veterans:

1. Who served in Desert Storm, alleged to have been exposed to toxic or infectious agents;

2. Exposed to radiation during the atom bomb detonation in the United States, Hiroshima and Nagasaki; and

3. Known to have been POWs.

NOTE: For post-mortem examinations performed on former POW's, the guidelines provided in Appendix 9B must be followed.

a. These guidelines include observing routine autopsy procedures and special procedures which would include morphologic study of tissue samples from:

(1) Peripheral nerves including sections of skeletal muscles with dorsal root ganglia;

(2) Spinal cord at several levels including cervical widening;

(3) Medulla at the level of the hypoglossal nucleus;

(4) Midbrain;

(5) Hypothalamus including mammillary bodies and wall of third ventricle;

(6) Thalamus;

(7) Hippocampus;

(8) Optic nerves, and

(9) Cortex from each cerebral lobe.

b. Sections from the nervous system should be stained for myelin and axons in addition to the hematoxylin and eosin strains.

c. Further recommendations include taking specimens from the testes, prostate, bladder and kidney.

(1) Half of each testis should be fixed.

(2) Material from the prostate should include the capsule and the urethra.

(3) Sections from the bladder should include any obvious lesions; if none, sample should include the trigone.

d. Most importantly, attention would be directed toward the search for and identification of diseases and disorders not expected in the post-mortem examination of a non-military patient.

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e. In addition to the customary examination and reporting of pathologic material, a duplicate set of slides, blocks and representative wet tissue will be forwarded to the Armed Forces Institute of Pathology (AFIP).

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(1) All material for shipment to AFIP will be packed in the usual manner and addressed to the Director, Armed Forces Institute of Pathology, "Attention Desert Storm/Radiation/POW (choose appropriate designation) Registry."

NOTE: Strong clinical and laboratory staff interest and support are mandatory for success in a program structured to anticipate a high post-mortem examination rate among designated patient categories such as those identified.

#### 9.05 PERFORMANCE OF POST-MORTEM EXAMINATIONS

a. A complete clinical record and a listing of clinical questions, or concerns related to possible post-mortem examination findings, must be furnished to the pathologist by the clinical attending physician, prior to beginning the post-mortem examination.

b. Post-mortem examination constitutes one aspect of the practice of medicine and will be performed by a qualified, licensed, physician, normally a pathologist credentialed and qualified in anatomic pathology.

(1) Some of the activities may be delegated to suitably trained allied health personnel; however, only under the direct, personal supervision of a qualified pathologist (see Chs. 7 and 15).

(2) Members of the house staff who perform post-mortem examinations must be under the direct supervision of a pathologist.

c. There will be positive identification of the deceased by the physician who will check the name and other identifying data attached to the deceased, and compare these with information recorded on SF 523. NOTE: If there is uncertainty regarding identification, a physician, or nurse, who knew the deceased during life will make the necessary identification.

d. There will be strict adherence to the family's wishes as recorded on the SF 523.

e. Care must be exercised that there is no undue delay in performing the post-mortem examination which would inconvenience the family of the decedent.

f. As soon as possible, the pathologist will notify the attending physician as to the time of post-mortem examination, and will arrange to demonstrate the gross findings.

g. Embalming prior to post-mortem examination, whether by arterial injection or by intracavitary trocar injection, is prohibited because of the risk of these procedures causing anatomic alterations, making it impossible to determine if these changes preceded embalming.

h. Universal precautions as recommended by Centers for Disease Control (CDC) will be vigorously enforced for preventing transmission of blood borne infectious diseases including Acquired Immunodeficiency Syndrome (AIDS), hepatitis B, or hepatitis C.

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(1) Other current recommendations from the CDC and Occupational Safety and Health Administration (OSHA) for protecting health care workers will be followed.

(2) Current authoritative references should be consulted for guidelines on protecting all house staff, students, and other Pathology and Laboratory Medicine Service personnel

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involved in post-mortem examinations on patients dying with the epidemiology and modes of transmission of Human Immunodeficiency Virus (HIV), or hepatitis infection.

(3) Extreme care should be employed to prevent injury from needle sticks, or from other sharp instruments, contaminated with blood of an infected patient. If personnel encounter an accidental injury such as a cut, or needle stick, during a post-mortem examination of a patient, the injured personnel should be evaluated clinically and serologically for evidence of HIV-1, hepatitis B, or other infections, as soon as possible after the exposure, and if seronegative HIV-1, retested after 6 weeks, and on a periodic basis thereafter (i.e., 3, 6, and 12 months, following exposure to determine if disease transmission has occurred).

i. Post-mortem examinations (normally encompassing both gross and microscopic studies) will be conducted in a professional manner. The objective of these examinations is the full exposition of the patient's disease processes, the limits thereof, and the patient's response to therapy.

(1) The body will be left in the best possible condition.

(2) Special examinations should be coordinated with appropriate funeral directors and VA authorities, as indicated.

(3) Authorization for removal of organ, or tissue, for donation is accomplished by completion of SF 523B, Authorization for Tissue Donation.

j. Photographic documentation is an essential component of the post-mortem examination and facilities should be readily available.

k. During all post-mortem examinations, disposable gloves and shoe coverings should be worn as well as gowns, masks and eye-coverings as described in the CDC and OSHA recommendations that are noted in M-2, Part VI, Chapter 15.

(1) Hands should be washed immediately if they become contaminated with blood.

(2) At the completion of the post-mortem examination and after all instruments have been washed in soap and water, the instruments must be disinfected as recommended by CDC using any of the following:

(a) Hydrogen peroxide, 3 percent, from 5 to 10 minutes, or

(b) Sodium hypochlorite (house bleach) 1/10 dilution, or

(c) If formalin is used, 10 minutes should be satisfactory.

(3) The instruments should be thoroughly rinsed in tap water and dried before reuse. Sterilization of instruments can be accomplished by machine, or by hand-cleaning, by trained personnel wearing appropriate protective attire.

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l. Following an post-mortem examination the tables and floors should be flushed clean with a sodium hypochlorite solution under adequate ventilation.

m. Soiled linens for sterilization must be collected and placed in a plastic bag and appropriately marked.

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n. Materials for disposal must be placed in an appropriately labeled biohazards bag.

#### 9.06 POST-MORTEM REPORTS

a. Provisional anatomic diagnoses will be forwarded to the chief of the appropriate clinical service and to MAS for inclusion in the patient's medical record within 1-work day (or 24 hours) and telephoned to the patient's primary care physician.

b. The Chief, Pathology and Laboratory Medicine Service, is responsible for establishing and maintaining a system for coding diagnoses, thereby enabling retrieval and compilation of cases.

(1) Final post-mortem examination diagnoses must be coded by employing a recognized system of coding, e.g., Systematized Nomenclature of Medicine (SNOMED) or Systematized Nomenclature of Pathology (SNOP).

(2) The system selected must be capable of retrieving diagnostic information as needed.

c. SF 503, Post-mortem Protocol, will be completed as the face sheet on all completed post-mortem examinations.

(1) The completed post-mortem examination with final copy of succeeding pages will be made a part of the patient's record within 60 days, unless exceptions for special studies are established by the medical staff.

(2) The format and extent of the gross and microscopic descriptions will depend upon local practices, but sufficient information will be included to support the diagnoses rendered on the SF 503.

d. The following form at the post-mortem examination protocol is suggested as likely to correspond to clinical interest:

- (1) Clinical diagnosis,
- (2) Final anatomic diagnoses including neuropathologic findings,
- (3) Gross and microscopic findings, including clinical summary,
- (4) Discussion to correlate clinical and post-mortem information,
- (5) Completion of quality assurance survey, and
- (6) Draft of lay letter to next of kin if requested.

e. Only a qualified licensed pathologist, board certified in anatomic pathology, will provide a final written diagnosis for gross and microscopic post-mortem examination findings. If a resident in pathology signs an post-

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mortem examination report, it will be countersigned by a board of certified anatomic pathologist.

f. The Chief, Pathology and Laboratory Medicine Service, will be responsible for providing data on post-mortem examination findings to the clinical service chiefs for use in their systematic internal reviews.

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(1) The post-mortem examination quality assurance survey to be completed after each post-mortem examination should satisfy this requirement.

(2) The Chief, Pathology and Laboratory Medicine Service, will present post-mortem examination findings at regularly scheduled mortality review conferences.

g. The original SF 503, with all succeeding pages, will be placed in the patient's medical record. A copy of the post-mortem report will be retained in the Pathology and Laboratory Medicine Service.

h. The Chief, Pathology and Laboratory Medicine Service, will provide the Chief of Staff, with a copy of the post-mortem examination report in any case in which the post-mortem examination findings raise the possibility of a claim against VA.

i. Post-mortem examination findings may be disclosed in accordance with the limited disclosure provisions of 38 U.S.C. Section 5705. In any case where there is the slightest indication of potential claim, no action will be taken to release information without first consulting with the District Counsel. NOTE: Disclosure is limited by confidentiality statutes.

#### 9.07 RECOVERY OF PACEMAKERS/IMPLANTABLE DEFIBRILLATORS AND PROCEDURES FOR RETURNING AND/OR DISPOSING OF THESE DEVICES

a. Veterans with pacemakers and other implantable devices are registered via the National Pacemaker/Device Registry at the VA Medical Center, Washington, DC. NOTE: Currently about 2,000 permanent pacemakers are annually implanted by 98 VA medical centers.

(1) Explanted pacemakers, which are removed because of evidence of unexplained clinical failure or because of a FDA recall, will be sent by the Chief, A&MM Service of VA medical centers to the Eastern Cardiac Pacemaker Surveillance Center, VA Medical Center, 50 Irving Street, NW, Washington, DC, 20422. The explanted pacemaker should be accompanied by a completed VA Form 10-0049, Explanted Cardiac Pacemaker Prosthesis (ECP) Data. A shipping label and a request for reimbursement by the manufacturer must be provided.

(2) Explanted pacemakers removed due to replacement or cremation can be tested locally and returned to the manufacturer for credit or sent in accordance with subparagraph a(1). If an individual medical center lacks the capability to evaluate an explanted model, it should be returned as stated in subparagraph a(1).

(3) All VA medical centers need to ensure that credit is sought for explanted/pacemakers still under warranty. If sent to the Eastern Pacemaker Surveillance Center, they will use the mailing label provided and including the request for reimbursement. A report on the operating characteristics of the explanted pacemaker will be sent to the originating VA medical center, to the manufacturer and to the Federal Drug Administration (FDA). If evaluated at the individual medical center, the pacemaker should be returned directly to

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the manufacturer for possible credit. All generators should be non-invasively analyzed such that VA can obtain credits toward new devices.

b. Cremation. When an autopsy is performed, SF 523 will document the removal of the pacemaker. Otherwise, the Chief, Pathology and Laboratory Medicine, or designee, shall seek authorization (documented on SF 507, Clinical Record Report) from the family to remove the pulse generator.

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(1) If the pulse generator is not removed from the body, the Death Certificate must clearly state its presence. For example:

NOTE: BODY CONTAINS A PACEMAKER WHICH INCLUDES A BATTERY OR POWER SOURCE.

(2) Pathology should dispose of generators as required by the medical center's Biomedical Engineering Section.

#### 9.08 QUALITY IMPROVEMENT IN THE POST-MORTEM EXAMINATION SERVICE

a. Performance standards will be established by the Chief, Pathology and Laboratory Medicine Service, at each medical facility to ensure the:

- (1) Pathologists' skills are sufficient,
- (2) Post-mortem examination is performed accurately, and

(3) Post-mortem examination report addresses the questions of clinical concern to the patient's physician.

b. The post-mortem examination can be used as an outcome measure to assess clinical diagnostic accuracy. Thus the post-mortem examination can be established as an integral part of a quality assurance program to provide continuing medical education for physicians and medical students.

(1) A program for quality improvement in anatomic pathology encompasses both external and internal components. The internal quality assessment program requires a mechanism which integrates the post-mortem examination findings with the clinical diagnoses.

(2) The programs should be designed as an open-ended on-going quality assurance operation capable of monitoring performance of both clinician and pathologist (see App. 9A).

(3) Any program for quality improvement in anatomic pathology should have the following components: process control; quality assessment, or a system documented evaluation; and quality control, or remedial action program, to correct identified problems.

(a) Process Control

1. Process control is a mechanism for insuring:

a. Proper identification of the medical record of the patient to be autopsied;

b. Proper identification of the decedent including release of body to funeral director;

c. A post-mortem examination permit properly signed by the next of kin;

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- d. Maintenance, or specimen identity, throughout processing;
- e. Control of reagents; and
- f. Examination of gross and microscopic tissues by qualified individuals.

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2. The post-mortem examination protocol should be reviewed for appropriateness of terminology and absence of typographical errors, or inadvertent mistakes, by the pathologist.

(b) Quality Assurance. The most important element in quality assurance is an on-site system (internal quality control) for timely documented second review of post-mortem examination microslides and protocol.

1. Each VA medical center will have a procedure for selecting cases for second review by a qualified pathologist.

2. If a disagreement between the initial and reviewing pathologist as detailed under b.(1) occurs, additional consultation must be obtained.

(c) Quality Control or Remedial Actions. The process and quality assessment procedures may identify defects in the post-mortem examination service system. It is the responsibility of the Chief, Pathology and Laboratory Medicine Service, to institute actions for correction, including additional training of staff and to document both the problems and the actions.

c. Internal Quality Control - Mandated Second Review of Cases. Commencing on the date of this policy, each Chief, Pathology and Laboratory Medicine Service, or in the absence of a permanent Chief, the Chief of Staff, will, if there is sufficient staff, ensure that the second review of post-mortem examination cases is performed promptly, on no less than a quarterly basis, for at least 10 percent of all post-mortem examination cases diagnosed in that medical center. The Chief, Pathology and Laboratory Medicine Service, at each VA medical center will establish the procedures to be followed in conducting a second review, and, in cases of disagreement, a third opinion should be obtained.

(1) The mechanism for selecting post-mortem examination cases for review should ensure representation of those likely to have posed diagnostic problems such as tumors, or controversial cases, where the pathologist's diagnosis was at variance with the surgeon's opinion.

(a) Review of a resident's diagnosis by a staff pathologist does not constitute a second review in this context. Each case selected for second review by the procedures described in the preceding paragraphs will be recorded in a log book with notation as to agreement, or disagreement, between reviewers and actions taken.

(b) Remedial action will be documented in the log book.

(c) Results of an internal peer review by a VA pathologist, or a peer review by non-VA consultant pathologist, the consultant pathologist's review of the case in instances of disagreement will be brought to the attention of the Chief, Pathology and Laboratory Medicine Service, and Chairperson of the Tissue Committee.

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(d) These records, if prepared by VA medical facility personnel are not protected by 38 U.S.C. Section 5705. However, the minutes of these reviews by the Tissue Committee are protected by the statute.

(2) In VA medical centers with two or more pathologists, reviews could be arranged from within the staff.

(a) The reviewing pathologist should initial and date the post-mortem examination reports when there is concurrence with the diagnosis.

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(b) In cases where there is disagreement, a third opinion should be obtained expeditiously either from local consultants such as qualified pathologists at an affiliated medical school or from the AFIP with the request for consultation.

(3) In VA medical centers with less than two pathologists, a documented second opinion must be available on all major post-mortem examination diagnoses, including malignant neoplasms, from either local consultants, a readily accessible VA medical center, or the AFIP with request from consultation.

(a) All cases with a disagreement between the clinical and pathological diagnosis must be reviewed by a second qualified pathologist.

(b) The second reviewer will either make a signed and dated note on the laboratory copy of the post-mortem examinations report, or provide a separate comment for attachment to the laboratory file copy of the post-mortem examination report and original post-mortem examination report, as a part of the patient's medical record.

d. Quality Assurance for Post-Mortem Examination Section. Following the completion of each post-mortem examination, the pathologist and the primary care physician will complete a quality assurance information sheet as part of the Quality Assurance Program for the post-mortem examination section.

(1) A sample survey sheet may be found in Appendix 9A.

(a) This should be overprinted on VA Form 10-0114h, or 10-0114i, Documentation of Internal Monitors.

(b) It may be duplicated and used by VA medical centers, or modified as appropriate for local needs, and made part of the quality assurance program.

(2) A numeric code may replace the patient's name.

(3) The purpose of this survey is to provide selected post-mortem examination information on a continuing basis for integration with the medical center's quality assurance program, thereby monitoring both the pathology and clinical services.

(4) If another format is to be used locally, it should include the following information:

(a) Underlying disease and cause of death.

(b) Pre-mortem diagnoses (including all tissue diagnoses, i.e., biopsies, cytology, etc.).

(c) Pre-mortem clinical questions posed by the physicians who cared for the patient.

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(d) Answers to any questions, to the extent possible, arising from the post-mortem examination findings.

(e) All important unexpected findings.

(f) All discrepancies in pre-mortem and post-mortem diagnoses.

(g) Clinical significance of post-mortem examination findings.

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(5) References to the medical literature regarding quality assurance for post-mortem examination and examples of forms and their role in quality assessment programs are contained in paragraph 9.13. The collected data serve as a mechanism for medical audit to yield internal feedback on diagnostic accuracy and error rate.

e. Use of Information from Quality Assurance Survey. A periodic tabulation of major and minor discrepancies of post-mortem examination findings from all post-mortem examinations taken from these surveys will be presented to the clinical services and to the Chief of Staff for discussion at regularly-scheduled meetings such as mortality conferences, or organ review sessions, at least once each quarter as specified by 38 CFR 17.507(a)(4)(xi). These sessions will constitute a self-examination or internal review process.

(1) Records of these sessions that constitute statistical information and that do not implicitly, or explicitly, identify individual patients, or VA employees, or individuals who participated in the conduct of the medical quality assurance review, are not quality assurance records protected by 38 U.S.C. Section 5705.

(2) Otherwise the records of these sessions are confidential, privileged and restricted in redisclosure, with financial civil penalties for violation.

(3) These records must be maintained in accordance with VA Regulation 17.527 and will not be retrieved by personal identifiers.

(4) All such records must be stamped as so identified and protected by 38 U.S.C. Section 5705.

f. Disposition of the Quality Assurance Survey. Since the survey serves as an internal monitoring function and may not be filed and retrieved by a personal identifier, these forms and information contained therein will not become part of the medical record. They must be maintained in a separate quality assurance protected file, in accordance with 38 CFR Section 17.507(a)(4)(xi), so that they become a part of the medical center's quality assessment program.

#### 9.09 USE OF POST-MORTEM EXAMINATION TISSUES FOR DIAGNOSTIC, SCIENTIFIC, OR THERAPEUTIC PURPOSES

SF 523, makes provision for the removal and retention of tissues for diagnostic, scientific or therapeutic purposes. If the autopsy procedure is to include the removal of tissues not covered by permits in the VA medical center, a SF 523-B, Authorization for Tissue Donation, must be executed by the person authorized to grant permission for autopsy.

a. Special permission must be obtained for removal of organs and tissues for transplantation in accordance with M-2, Part XIV, Chapter 7.

b. M-3, Part I, Chapter 9, "Ethics, Confidentiality and Clinical Research," mandates that research using tissues, or organs, removed at autopsy will be in

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conformity with a written protocol approved by the local Research and Development (R&D) Committee and by its Subcommittee on Human Studies, before the research begins. When approved, that protocol will contain guidance for VA personnel concerning post-mortem examination tissues used in research.

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## 9.10 CONFIDENTIAL TREATMENT OF POST-MORTEM EXAMINATION RECORDS

a. If tissues, or records, are to be sent from VA for examination in non-VA laboratories or by investigators, such persons can be given access to such items only within the restrictions imposed by laws governing the disclosure of information, e.g., the Privacy Act of 1974, 38 U.S.C. Sections 5701, 5705, and 7332.

b. Some of these statutes address the disclosure of information about patients in an individual identifiable format. If the examiner requires that the slides and records contain veterans' name or other confidential information, there must be a prior written agreements that the:

(1) Recipient of the slides and records will not redisclose any information in an identifiable form without prior specific VA authorization;

(2) Information will be safeguarded from disclosure NOTE: VHA Records Control Schedule (RCS) 10-1, provides disposition instructions for agency records. Conversion of temporary paper records to laser disc storage and disposal of the paper record, do not require the National Archives and Records Administration's approval; and

(3) The slides and records will be returned to VA when there is no longer a need for the recipient to retain them in order to accomplish the purpose for which they were originally supplied.

c. To the extent that any of the records discussed in this chapter are medical quality assurance records subject to 38 U.S.C. 5705 and 38 CFR Sections 17.500 through 17.540, they may be disclosed only in accordance with the statute.

d. When it is necessary to release records or slides in a manner other than that defined, the District Counsel should be consulted prior to the release.

## 9.11 RETENTION OF POST-MORTEM EXAMINATION MATERIALS

a. Pathology and Laboratory Medicine Services copies of post-mortem examination reports will be disposed of in accordance with (RCS) 10-1. (Retention requirements can be found in App. 2C.)

(1) Binding in book form, or storing on laser discs, is strongly encouraged.

(2) RCS 10-1 provides disposition instructions for paper records only. Disposition approval for laser disc storage must be obtained.

(3) The Chief, Pathology and Laboratory Medicine Service, will ensure appropriate retention and disposal of anatomic pathology materials as follows:

(a) Wet tissue will be retained only so long as it serves a useful purpose.

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(b) A set of representative paraffin blocks will be retained for at least 5 years. They may be retained longer at the discretion of the pathologist provided there are suitable storage facilities. In cases with only one representative block of tissue, the block will not be used for quality control procedures.

(c) A set of stained microscope slides representative of each post-mortem case will be retained indefinitely and stored to remain available for reference.

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periods for wet tissue, slides and blocks may vary from those suggested by the College of American Pathologists (CAP). VA retention periods will be followed rather than those of CAP.

b. Specimens may be retained after completion of the post-mortem examination and presented at conferences. Cases with unusual findings may be set to the AFIP as a consultation case.

c. Use of photographs to record gross and microscopic features is encouraged. Files of photographs including electron micrographs will be retained as long as they are considered to be useful.

d. Museum specimens and post-mortem materials retained for authorized research projects; organized teaching collections may be exempted from the retention provisions.

#### 9.12 POST-MORTEM EXAMINATION SUITE

a. Each VA medical center will have a properly equipped post-mortem examination suite commensurate with local needs. There will be satisfactory ventilation, temperature control, and good lighting.

b. There will be sufficient refrigerated holding space to accommodate post-mortem examination specimens. The temperature of the refrigerated holding area will be monitored by a recording thermometer which will be checked daily (a.m.) by facility personnel.

c. Equipment will include:

- (1) Post-mortem examination table(s), with necessary attachments;
- (2) Lifting devices;
- (3) Necessary instruments;
- (4) Scales;
- (5) Facilities for disinfection;
- (6) X-ray viewing boxes;
- (7) Photographic and dictating equipment; and
- (8) Equipment to collect specimens for toxicological and microbiological studies.

d. There will be arrangements for proper disposal of discarded material.

e. Post-mortem examination tables, instruments and non-disposable clothing will be cleaned and disinfected after the completion of each post-mortem examination.

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f. The post-mortem examination suite will be maintained in a clean and sanitary condition.

g. The specific infection control policies and procedures applicable to the post-mortem suite will be reviewed by the Infection Control Committee at least annually.

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SAMPLE OF A FORMAT FOR A  
POST-MORTEM QUALITY ASSURANCE SURVEY  
(To be completed jointly by pathologist and clinician)

This document (or information contained herein) is deemed CONFIDENTIAL AND PRIVILEGED under provisions of 38 United States Code 5705. This material shall not be transmitted to anyone without proper consent or other authorization as provided by law or regulation.

PATIENT'S NAME _____	SERVICE _____
SOCIAL SECURITY NUMBER _____	CLINICIAN _____
VAMC _____	AUTOPSY NO _____
PATHOLOGIST _____	DATE _____

I. Post-mortem Pathologic Diagnoses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Clinical Pre-mortem Diagnoses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. CLINICAL SIGNIFICANCE OF POST-MORTEM FINDINGS:

Comment or Check  
Appropriate Category

- |   |       |
|---|-------|
| a. Major disagreement in diagnosis  | _____ |
| b. Major unsuspected or additional diagnosis                                      | _____ |
| c. Significant clarification of differential diagnosis but no major disagreement: | _____ |
| (1) Diagnosis suspected but not confirmed   | _____ |
| (2) Diagnosis among 2 or more equally considered                                  | _____ |
| d. Confirmation or verification of major diagnosis                                | _____ |

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e. Autopsy indeterminate; does  
not clarify or resolve  
major issue

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Comment or Check  
Appropriate Category

IV. Clinical Factors Related to  
or Contributing to Cause of  
Death (Check where applicable)

- a. Unremitting course of disease
- b. Error in judgment or treatment plan
- c. Result of complication or therapeutic procedure
- d. Unrecognized diagnosis with pre-mortem evidence which existed by:
  - 1. Physical exam
  - 2. Patient complaint or symptom
  - 3. Clinical course
  - 4. Inattention to or misinterpretation of diagnostic tests

e. Other

V. Summary comment

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GUIDELINES FOR PERFORMING POST-MORTEM EXAMINATION ON  
FORMER PRISONERS OF WAR (POWs)

1. Background

a. A Special Registry was established in 1980 at the Armed Forces Institute of Pathology (AFIP) for pathological material from former POWs of World II, the Korean Conflict and Vietnam Era.

b. It is estimated that approximately 96,000 former prisoners of war from World War II, the Korean Conflict and the Vietnam Era were still living in 1980. Follow-up studies on former prisoners of war have documented the rate and type of morbidity and disability, both psychological and physical, and have detailed as well the differences in disease patterns between those held prisoner in the Far East and those held captive in the European theater of operations.

(1) Each POW group had a mortality ratio higher than that of a matched control group. The experience of both European and Japanese prisoners of World War II suggests a positive association of stress in prison with later mortality. Mortality ratios have been greater in the Korean and Japanese prisoners than in prisoners from the European and Mediterranean areas of World War II.

(2) Sequelae of POWs are both physical and psychiatric; however, these sequelae have been more prevalent in the Japanese and Korean POWs than in the European POWs.

(a) Parasitic disease, tuberculosis, cardiovascular-renal disease, gastrointestinal and liver disease as well as neurological disorders have all been major causes of disability.

(b) Many of these former POWs have been left with permanent impairments.

(c) Review of injuries, illnesses, and psychiatric disorders among POWs of the Vietnam Era indicates the most common physical illnesses diagnosed in Army POWs on repatriation were:

1. Helminthiasis,
2. Avitaminosis,
3. Bacterial skin infections and dermatophytosis,
4. Peripheral nerve injury,
5. Hearing loss,
6. Diseases of the retina and optic nerves,

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7. Malaria,
8. Amoebiasis,
9. Acute upper respiratory infections,
10. Dental problems, and

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11. Compressed fractured vertebrae.

(d) Some former POWs are considered to be at risk because of the extended period of time during which they were subjected to protein, calorie and vitamin malnutrition.

(e) The term "premature aging" has been applied to prisoners who were in their teens when captured. Late adolescence is a vulnerable time to undergo the stress of malnutrition.

NOTE: The wide range of diseases, deficiencies and disabilities to which all POWs were exposed, emphasizes the importance of extending the medical follow-up in these patients whenever possible.

2. Autopsy

Obtaining permission for autopsy examination on former POWs is strongly encouraged. Autopsies performed on former POWs should be in accord with the accepted autopsy protocol currently in use.

a. In addition to the routine autopsy procedures, morphologic study should be made of tissue samples from:

(1) Peripheral nerves, including sections of skeletal muscles with dorsal root ganglia;

(2) Spinal cord at several levels including cervical widening;

(3) Medulla at the level of the hypoglossal nucleus;

(4) Midbrain;

(5) Hypothalamus, including mammillary bodies and wall of third ventricle;

(6) Thalamus;

(7) Hippocampus;

(8) Optic nerves; and

(9) Cortex from each cerebral lobe.

b. Sections from the nervous system should be stained for myelin and axons in addition to the hematoxylin and eosin stains.

c. Further recommendations include taking specimens from the testes, prostate, bladder and kidney.

(1) Half of each testis should be fixed.

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(2) Material from the prostate should include the capsule and the urethra.

(3) Sections from the bladder should include any obvious lesions. If none, sample should include the trigone.

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(4) Sections from the kidney should include cortex and pelvis.

d. Most importantly, attention should be directed toward the search for and identification of diseases and disorders not expected in the autopsy of a non-military patient.

NOTE: Familiarity with the spectrum of diseases likely to affect former POWs will enable the pathologist to render a more complete medical assessment of patients in this select group.

3. All pathological material (surgical, cytologic, and autopsy) from POWs will be examined and reported in the customary manner at each medical center. A duplicate set of slides, blocks and representative wet tissue will be forwarded to the AFIP.

a. All material for shipment to AFIP must be packaged in the usual manner and addressed to the Director, Armed Forces Institute of Pathology, "Attention Former POW Registry."

b. The packaged specimens must be further identified by affixing VA Form 10-5558, a POW label. This label measures 2 1/2 X 5/8 inches and has the letters POW in green on a white background.

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1. Transmitted is a new chapter to Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part VI, "Pathology and Laboratory Medicine Service," Chapter 9, "Post-mortem Examination."

2. Principal changes are:

- a. Paragraph 9.01: Describe the purpose of the policy.
- b. Paragraph 9.02: Provides policy guidance for the performance of post-mortem examinations.
- c. Paragraph 9.03: Discusses the philosophy of post-mortem examinations.
- d. Paragraph 9.04: Lists the categories targeted for post-mortem examinations.
- e. Paragraph 9.05: Provides guidance for post-mortem examinations.
- f. Paragraph 9.06: Describes requirements for post-mortem reports.
- g. Paragraph 9.07: Defines requirements for the recovery of pacemakers and implantable defibrillators.
- h. Paragraph 9.08: Discusses requirements for quality improvement in the post-mortem section.
- i. Paragraph 9.09: Defines the legal requirements regarding the use of post-mortem tissue.
- j. Paragraph 9.10: Provides requirements for the confidential treatment of records.
- k. Paragraph 9.11: Provides the requirements for the retention of post-mortem materials.
- l. Paragraph 9.12: Provides guidance for equipping the post-mortem suite.
- m. Paragraph 9.13: Lists references.

3. Filing Instructions

Remove pages

Insert pages

9A-1 through 9B-5

9-i through 4-53

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4. RESCISSIONS: M-2, Part VI, Chapter 8, dated March 20, 1990, and change 59; and VHA Circular 10-88-122.

S/ Dennis Smith for  
John T. Farrar, M.D.  
Acting Under Secretary for Health

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Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

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Change 1

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1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part VI, "Pathology and Laboratory Medicine Service," Chapter 9, "Post-mortem Examination."

2. Principal change: All reference to Chapter 16 has been changed to Chapter 15 due to renumbering of all chapters in this M-2, Part VI.

3. Filing Instructions

Remove pages

Insert pages

9-7 through 9-10

9-7 through 9-10

4. RESCISSIONS: None.

S/ by Dennis Smith for  
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