Texas Society of Pathologists
Historical Vignette
Texas Tragedies and the Evolution of the Medical Examiner System in Texas

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Introduction

Historically, the need for investigation of deaths involving accidents, crime, epidemics and other issues of interest and importance to the public led to the institution of the position of coroner in local jurisdictions of many countries; and in some locales, these duties were assigned to justices of the peace.

Coroners often have been elected positions with widely varying responsibilities. According to the Webster New World Dictionary, Second College Edition (1972), a coroner is a public officer whose chief duty is to determine by inquest before a jury the causes of any deaths not obviously due to natural causes. As documented in Wikipedia, a coroner is not necessarily a pathologist or medical examiner. This has been the situation historically and is still the reality in multiple jurisdictions in the United States and the United Kingdom. In contrast, medical examiners are medical doctors, physicians who have specialized in anatomical and/or forensic pathology. In the United States, the standard for medical examiners is certification by the American Board of Pathology in at least anatomic and forensic pathology. In addition to medical examiners, there are recognized forensic scientists with a variety of advanced degrees and certifications. Accreditation of a county medical examiner program is by the National Association of Medical Examiners (NAME).

These qualifications, certifications and accreditations are aimed at maintaining high standards of forensic science and practice in order to provide for the public good. However, recognition and adherence to these high standards has come gradually to most regions of most countries. Often various crises and dramatic circumstances have proven necessary to move the process forward. A case in point is the evolution of the medical examiner system in Texas. My chief source for this vignette is: Marilyn M. Baker. *The History of Pathology in Texas*. Texas Society of Pathologists, 1996.

Beginnings in Texas

The Texas Society of Pathologists (TSP) took an active interest in forensic death investigation dating back into the early history of the TSP. In 1942, following Dr. John Andujar's request, the TSP established a committee to investigate the activities of justices of the peace, coroners, and medical examiners. In 1945,
TSP took note that a model bill for implementation of coroners and medical examiners in Texas had been prepared and legal advice was being sought before presentation to the Legislature.

Medical examiner offices started to be established in major jurisdictions and counties around the state of Texas. In 1955, collaboration between the TSP and the Texas Medical Association (TMA) led to the Texas Legislature passing a bill sponsored by Robert Baker of Houston which gave authority to County Commissioners to set up a medical examiner system in the four areas of Dallas, Fort Worth, Houston, and San Antonio. In June 1955, San Antonio became the first city to initiate a medical examiner system in Texas. By the early 1960s, two formal medical examiner systems had been established, one in San Antonio and one in Houston. Commissioners of the City of Fort Worth had not yet appropriated the money for a system, and Dallas was currently setting up a modified forensic pathology program. In 1965, Dr. Truman C. Terrell, a leader in Texas pathology, was appointed as the first medical examiner in Tarrant County. On June 1, 1957, the legendary Dr. Joseph Jachimczyk arrived as the first formally trained medical examiner in Texas, following forensic pathology training at Harvard and legal training just short of a law degree at Boston Law School. In 1960, he was named the chief medical examiner for Harris County. By 1995, Dr. Jachimczyk and his staff had investigated 250,000 deaths, about half of which had autopsies. Dr. Jachimczyk did not retire from his position until August 31, 1995, at the age of 71, after 38 years on the job.

**Tragedy in Dallas**

In the words of Marilyn Baker, on November 22, 1963, American optimism met total shock as President John F. Kennedy was assassinated and Governor John B. Connally was severely wounded in Dallas. Texas physicians not only cared for them at Parkland Memorial Hospital, but they would be the last to care for the alleged perpetrator of the shootings, Lee Harvey Oswald, and for the man who subsequently shot him, Jack Ruby.

The clinical pathologists at Parkland Memorial Hospital provided their usual services for President Kennedy; however, the forensic pathologist was not allowed to do his job. The Warren Commission later concluded that a single bullet had resulted in the President’s death, and this view was maintained by pathologists at the Naval Medical Center in Bethesda, Maryland, where the autopsy was performed (JAMA, May 27, 1992). Nevertheless, there would be much debate regarding the wounds of the President and the Governor. This led to a proliferation of conspiracy theories.

By Texas law, the autopsy should have been performed in Dallas. JAMA writer Dennis Breo reported the predicament faced by the Chief Medical Examiner of Dallas, Earl Rose, MD, in a detailed interview given by
Dr. Rose (see: “JFK’s death – the plain truth from the MDs who did the autopsy”, At Large, with Dennis L. Breo, JAMA:267, No. 20 (May 27, 1992), pp. 2794-2804; “JFK’s death, part II- Dallas MDs recall their memories”, pp. 2804-2807.)

Dr. Vernie A. Stembridge, then chairman of the department of pathology at The University of Texas Southwestern Medical School, had been asked by Dr. Rose to accompany him to talk with the Secret Service in an attempt to persuade the agents that the autopsy should be done in Texas. They, however, were not successful. Dr. Stembridge then urged Dr. Rose to accompany the body and the Kennedy entourage to Washington, but Dr. Rose felt strongly, “as a very principled person,” that the autopsy should be done according to law in Texas and that he should not make the trip to Washington. Dr. Stembridge and others agree that the ensuing secrecy helped foment the conspiracy theories that were to surround the autopsy.

In 1992, Dr. Stembridge encouraged Dr. Rose to participate in the interview with Dennis Breo to provide an accurate record of the situation in Dallas following the Kennedy assassination. You can read excerpts of the dramatic story related by Dr. Rose to Dennis Breo in Marilyn Baker’s The History of Pathology in Texas (pp. 227-229).

Dr. Rose was a member of the 1977 House Select Committee on Assassinations and supported its autopsy conclusions. He agreed that the two wounds to the neck and head came from behind and above and that there was no room for doubt on the finding. Several years after the situation, Dr. Rose resigned as medical examiner in Dallas.

Dr. Stembridge felt, and many agreed, that by raising consciousness of the need for a strong, autonomous medical examiner system in Dallas, the Kennedy assassination led to the development of a better system for Dallas and the state of Texas. One aspect of the system was the requirement that the medical examiner in Dallas serve on the faculty at The University of Texas Medical Center and therefore adhere to criteria for a faculty appointment. Similarly, in later years, this approach would be essentially adopted in San Antonio and other medical examiner offices.

In the 1960s, pathologists and the TSP grappled with a number of issues, including the changes brought on by the enactment of Medicare and Medicaid. For the next several years, TSP continued to seek passage of a statewide medical examiner bill, but made only incremental progress.
Another Texas Tragedy

During the 1960s, there was some optimism about development of the medical examiner system in the state. Travis County was considering the establishment of a system “occasioned by a Grand Jury recommendation to the Commissioners Court.” Texas pathologists supported the effort in Travis County and offered their help in setting up a system.

Tragedy, however, struck again before anything could be implemented, as dramatically described by Marilyn Baker. On August 1, 1966, a young man in Austin, Charles J. Whitman, after killing his wife and his mother, climbed the famed tower of The University of Texas and began shooting wildly across the campus. By the time he was subdued with a gunshot wound to the head, he had killed sixteen and wounded thirty-one people.

Following the catastrophe, Texas Governor John B. Connally, who had himself suffered severe gunshot wounds in the public attack in Dallas only three years earlier, appointed a special “Blue Ribbon” committee to study the incident. Among the committee of thirty-two were pathologists Kenneth M. Earle, MD, then chief of the neuropathology branch of the Armed Forces Institute of Pathology, a Texan and former dean of The University Of Texas Medical Branch at Galveston; Joseph A. Jachimczyk, MD, senior consultant in forensic pathology, Houston; Tate M. Minkler, MD, assistant pathologist and medical systems analyst and William O. Russell, MD, head of the Department of Pathology and chief of the Section of Anatomical Pathology, both of The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston; and Coloman de Chenar, MD of Austin. R. Lee Clark, MD, director, and Robert D. Moreton, MD, assistant to the director and professor of radiology of The University of Texas M.D. Anderson Hospital and Tumor Institute, were among other members of the committee. In addition to a number of recommendations pertaining to mental health, counseling, violence, and campus safety, the committee echoed a position promoted for a number of years by the Texas Society of Pathologists—that a statewide medical examiners’ office should be developed.

Selected autopsy materials on Whitman were provided to the committee, but its study was limited because the autopsy was not performed until approximately twenty-four hours after death; the body had received arterial and trocar embalming before the initial examination; many parts of the brain were damaged by the penetrating fragments of bone created by the gunshot wounds; all pieces of the brain were not recovered; and the brain had been sectioned at the time of the autopsy. The committee presented its findings in the auditorium of the Texas Medical Association in Austin and offered its final pathologic diagnosis on Whitman. These included the findings resulting from the multiple gunshot wounds to the head and face, contusions and lacerations of the brain, subarachnoid
hemorrhage and cerebral edema. Two pieces of tumor reportedly removed from the right temporo-occipital white matter by Dr. Coloman de Chenar on August 2, 1966, demonstrated glioblastoma multiforme.

The committee’s report stated that the tumor removed by Dr. de Chenar of Austin, who provided autopsy services under the Travis County coroner’s system, microscopically exhibited the features of “a glioblastoma multiforme with a remarkable vascular component of the nature of a small congenital vascular malformation, and contained widespread areas of necrosis with palisading of cells characteristic of the tumor.”

The task force concluded that “the relationship between the brain tumor and Charles J. Whitman’s actions on the last day of his life cannot be established with clarity. However, the highly malignant brain tumor conceivably could have contributed to his inability to control his emotions and actions. Without a recent psychiatric evaluation of Charles J. Whitman, the task force finds it impossible to make a formal psychiatric diagnosis.” Later, some members of the task force indicated certain doubts that the tumor, if it existed, was the cause of the violent outburst, and have leaned toward a psychiatric diagnosis.

Just as the assassination of President Kennedy ultimately led to development of a medical examiner system in Dallas County, so did the Whitman massacre at The University of Texas at Austin spur into action the development of the system in Travis County. Nevertheless, the development of the system was not immediate, and there would be many delays.

A Medical Examiner System in Dallas

Dr. Vernie Stembridge guided a cooperative effort to link a new medical examiner system in Dallas between the county commissioners, the city police department, and The University of Texas Southwestern Medical School. It was designed to assure autonomy, quality, and efficiency in the forensic process. As chairman of the school’s department of pathology, Dr. Stembridge then invited Charles S. Petty, MD, to move to Dallas from Indianapolis to head the Southwestern Institute of Forensic Sciences, which combined under the medical examiner’s office medicolegal autopsies, toxicology, and criminalistics. All professional appointees would be required to have a faculty appointment. The location of the unit was considered important politically as well as scientifically. As was the case in Travis County, there would not always be smooth sailing.

When Dr. Petty arrived in Dallas in June 1969, he had in hand a letter signed by the county judge stating what the county would do, and by implication, would not do in the new situation. Dr. Petty, being a former
officer in the Navy, well understood the multiple nuances of the term *torpedo*. One never knew, however, he said later, where the county judge stood on any given issue, and often, the judge would caution, “we don’t want to move too fast.” Later, however, he would agree to Dr. Petty’s requests.

On an interim basis for two and one-half years, the medical examiner operation was housed at Parkland Memorial Hospital, but, as Dr. Petty observed, hospital pathology runs “countercurrent” to forensic pathology because the needs are different. “A hospital must handle a large volume, and be prompt. Surgical specimens are the priority,” he said. Therefore, the hospital sometimes was clogged with bodies awaiting autopsy.

Meanwhile, plans were being drawn for a separate building for the medical examiner. Even so, when he inquired about the surveyor’s plat, he was told to oversee the survey himself—which he did. In addition, the land required deeding from three different political units—The University of Texas Southwestern Medical School, the county hospital district, and Dallas County.

Controversy frequently boils around a medical examiner system, with the examiner trapped in a no-win situation. Dr. Petty recalled one difficult situation in Dallas around 1970. Newspaper articles “were terrible,” he said, and he was ready to leave Dallas. But Dr. A. J. Gill, former dean of the medical school, hooking his cane over his left arm, said, “I think there’s something that can be done. I’ll see to it.”

Dr. Gill formed a committee of three physicians, three hospital administrators, and three morticians. Though Dr. Petty recalls the meetings as difficult, the problem was worked out after several discussions.

The key to forensic pathology, Dr. Petty has stated, is investigation, and often, “things really aren’t what they seem to be.” By team effort, he reported that a good criminal investigation system was established in Dallas, and, among other activities, the Rape Crisis Center was later added to his responsibilities. The Rape Protocol established by Dr. Petty and The University of Texas Southwestern Medical School obstetrics department would become the basis for most rape protocols in the United States.

In the interim, medical examiner systems evolved slowly in locations around the state. Corpus Christi pathologists in 1971 submitted to the Texas Legislature a bill amending Article 49.25 of the Code of Criminal Procedure, 1965. When enacted the bill permitted two or more counties to create a medical examiner’s district and to jointly maintain a medical examiner’s office. The Texas Society of
Pathologists hoped the legislation would bring the state one step closer to “the desired goal” of a uniform statewide Medical Examiner System.

Moving Forward

Gradually, medical examiner systems spread across the state. In mid-1977, Robert Bucklin, MD, became the first medical examiner in Travis County, bringing to nine the number of counties in the state with a chief medical examiner. Roberto Bayardo, MD, succeeded him in 1978.

In the 1980s, proposed organ transplantation legislation was controversial. One bill aimed to amend the justice-of-the-peace or medical examiner system so that, barring a known objection at the request of a Texas nonprofit medical facility performing organ transplants, various organs could be removed for transplantation. The TMA House of Delegates adopted a position stating that the individual's right to choose the disposition of a loved one’s body was paramount, but that, after reasonable attempts to contact next of kin had failed, the coroner had the right to authorize the removal of suitable organs for transplantation purposes.

There also were continuing efforts to expand the medical examiner system in Texas. Supporting data from a Texas Medical Association study showed that justices of the peace had pronounced 14,000 people dead in Texas in 1985 and requested 2,465 autopsies and that medical examiners pronounced 13,000 deaths and requested 6,000 autopsies. It was suggested that a regional system should be developed as an alternative to the existing county-by-county basis. Because of economic conditions, however, it was felt that a law could not be passed and funded. Since only the Lubbock area of the state was thought to be not well covered, a bill therefore focused on that area.

Status of Long-Sought Goals

Although the Texas Society of Pathologists had never been successful in its bid to the Legislature for a statewide medical examiner system, forensic expertise was spreading across the state during the 1990s. Thirteen counties now had medical examiner offices, Lubbock the newest one, and Bexar, Harris, Travis, Dallas, Collin, Ector, El Paso, Galveston, Johnson, Nueces, Tarrant-Parker-Denton, and Wichita counties. Not all counties actually had autopsy facilities however. Some of the larger counties provided those services on a contractual basis.

For a variety of reasons, fewer hospital autopsies were being performed, a fact overwhelmingly lamented by pathologists, who, despite the capabilities of scanning equipment, felt that the ‘final diagnosis” was still essential. What once had been a learning opportunity had become clouded by threats of litigation and an unwillingness to pay the costs.
Pathologists, depending on the situations in their own communities, had varying perspectives on the status of pathology in the mid-1990s. Some were optimistic, some were not—but all agreed that pathology was a vitally important specialty and the backbone of scientific medicine.

End of an Era

A distinguished cadre of Texas pathologists retired in the 1990s. Among them were two inimitable leaders in forensic pathology who had established a new day for medical examiner systems in Texas, helping to bring Texas beyond the ancient and unscientific justice-of-the-peace system. In Dallas, Dr. Charles S. Petty, chief medical examiner, retired in 1991. On August 31, 1995, Dr. Joseph A. Jachimczyk of Houston retired at age seventy-one as chief medical examiner of Harris County, having been the first formally-trained forensic medical examiner in the state.

Forward into the Future

At the close of the twentieth century, it was time to turn the page on the history of pathology in Texas and peer into the future. However, “the more the change, the more it is the same” (Alphonse Kerr).

In the current session of the Legislature, there is active consideration of Senate Bill 312 “Relating to the regulation and certification of medical examiners and the conduct of autopsy and inquest investigations by justices of the peace and medical examiners.” In essence, passage of this bill will reauthorize the medical examiner system in the more populous regions of the state while maintaining credentialing standards for individuals appointed as chief medical examiners and deputy medical examiners. Such reauthorization debate is a time of mischief for diluting standards. The TSP and TMA are joining forces in preserving the forensic standards which were hard fought for and were achieved in part, unfortunately, by the tragedies of the Kennedy assassination and the Whitman massacre. In essence, passage of this bill will reauthorize the medical examiner system in the more populous regions of the state and establish credentialing standards for individuals appointed as chief medical examiners and deputy medical examiners.