With the current medical liability crisis looming, pathologists continue to face unique challenges. This issue reviews pathology closed claims data from 1995 to 2001. Misadventures (i.e., allegations) in these claims included 54 percent diagnosis error, 5 percent improper supervision of residents or other staff, 7 percent improper performance and 31 percent no medical misadventure. (Please see graph.)

No medical misadventure represents those claims in which a physician was named in a claim but it was determined there was no negligence or inappropriate medical care. For example, a gynecologist receives a pathology report for an abnormal PAP test, but fails to notify the patient and appropriately follow up. There is a delay in diagnosis of cervical cancer with resultant injury to the patient. The patient files a claim naming not only the gynecologist, but also the pathologist. The pathologist is dismissed from the claim based on findings of no medical negligence. Also included in this category are those claims filed against a physician group or corporation.

The most common organ sites involved in these claims included cervix/uterus, breast, prostate, meninges, colon and duodenum.

During this period, 68 percent of claims closed with no indemnity payments. The largest indemnity payment was $750,000 for the misadventure of failure to diagnose cancer. While a significant number of claims closed without indemnity, substantial legal expenses are incurred in defending each claim against a physician.

Data indicate that challenging areas for pathologists include interpretation of PAP smears, breast and prostate needle biopsies, and melanoma diagnoses.

**Risk Management in pathology**

- When a pathologist is asked to review a slide in consultation and to render an opinion, that opinion should be documented in a written pathology report.

- If senior pathology residents are utilized as locum tenens, it is recommended that a fully trained pathologist be available for consultation or review as necessary. By closely monitoring and reviewing the work of residents, claims involving vicarious liability may be avoided.

- If a pathologist intends to seek consultation with another pathologist(s) after a written report is released, indicating that a diagnosis is “provisional” and not “final” alerts the attending
physician that a final report is pending. Those in solo practice may arrange cross-consultation with their nearest colleague. After obtaining other opinions, the pathologist then issues a subsequent final report. Comprehensive and consistent communication between the pathologist and attending physician facilitates quality patient care and good outcomes.

- Indicating on the pathology report “sampling error” or “inadequacy of specimen” may help decrease allegations of diagnosis error when a diagnosis is based on an unsatisfactory specimen resulting in a false positive or false negative. Pathologists have a responsibility to inform the clinician that an unsatisfactory specimen has been obtained and request a repeat PAP, larger tissue sample, etc.

- Under diagnosis and over diagnosis are problematic as a liability for pathologists. The closed claim that follows is an example of over diagnosis resulting in unnecessary surgery. Errors involving under diagnosis often occur in cases of malignancy resulting in a claim of wrongful death or decreased life expectancy.

- Poor communication between clinicians and pathologists is a perennial problem. A review of pathology claims reveals that misdiagnosis may result from the lack of clinical history. This reflects the importance of communication between the pathologist and clinician in arriving at a correct pathological diagnosis.

- Computer generated reports are frequently used. Review by the pathologist prior to release and a signature documenting that action will help assure the accuracy of the report.

Reference
Troxel, David; Pathology: A Report of Claims Review Panels, 2000, TDC.

Pathology closed claim study
The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of a physician led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Clinical presentation
A 68-year-old female was admitted with a diagnosis of dysphagia and a history of non-healing gastric ulcer disease for several months.

Physician action
Esophagogastroduodenoscopy was performed along with gastric antrum biopsy. The biopsy specimens were interpreted by the defendant pathologist as showing well differentiated adenocarcinoma. Twenty-six days later, the patient underwent surgery at a different hospital involving a subtotal gastrectomy, resection of a portion of the transverse colon and a cholecystectomy.

The surgical specimens sent to pathology were interpreted as showing no cancer. A second read was done by the head of the pathology department and were interpreted as negative for cancer. The first slides from the biopsy were then requested, reread and found without cancer.

Allegations
It was alleged the defendant over-read the biopsy specimens, resulting in unnecessary removal of much of the patient’s stomach. It was alleged she suffers from “dumping” syndrome, some loss of bowel and bladder control, constant diarrhea, indigestion, anemia, excessive weight loss, and severe depression.

Legal principle/case analysis
Negligence is the failure to use ordinary care, that is, failure to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances. Two TMLT physician consultants opined the cancer could have been excised at the time of the original biopsy. Another consultant noted potential deficiencies in the defendant’s report. He felt deeper levels of the paraffin blocks should have been examined to clarify the nature of the process and might have indicated a lack of malignancy. There was no discussion to reveal if a reactive process was considered and how it was excluded. Since the specimen was described as well differentiated, this consultant said it would closely resemble normal glands. This would argue for the greatest caution in separating benign, reactive glands from tumor glands. The defendant did not seek a second opinion among his peers. This is common practice in pathology groups. Obtaining more specimen levels, intradepartmental consultation, and gathering more clinical information can help make a correct pathological diagnosis.

Plaintiff experts described the physician’s interpretation as substandard. Each felt the surgeon would have taken a more conservative approach and the patient would have a lower incidence of postoperative complications.

Disposition
This claim was closed with a six-figure settlement on behalf of the pathologist.

Risk management considerations
A retrospective review affords many advantages. With a post-claim review, the defendant physician acknowledged he missed the correct diagnosis. Examining deeper levels of the specimen, seeking a second opinion among colleagues, and conferring with the attending physician are suggestions made by the consultants on this claim. Other risk management challenges for pathologists have also been discussed in this article.
The medical malpractice crisis and your physician-owned trust
by Howard Marcus, MD, Chairman, TMLT Board of Governors

Two thousand two has been a tumultuous year for Texas physicians. Caught up in a crisis swirling with accusations that bad doctors are harming patients, physicians are also facing unprecedented premiums for medical malpractice protection and continued high frequency and severity of claims and lawsuits. In this unfriendly climate, doctors are frustrated, insurance carriers are frustrated, and patients who cannot find needed physician services like OB are frustrated. The medical liability crisis in our state has progressed to the point where our patients are feeling the impact, and, as physicians, we cannot allow it to continue. Fundamental and long-term changes to our civil litigation system must occur if we are to effectively solve the problems of spiraling liability insurance premiums and limited patient access to care.

In 1999, TMLT alerted policyholders that a potential medical liability crisis was looming. Since then, the Trust has worked steadily and diligently as your advocate. TMLT staff members have researched and written numerous articles on the crisis for county medical society publications and for the Reporter newsletter; TMLT executives have traveled statewide to provide detailed presentations to meetings of county medical society and specialty society members; and, the TMLT Board of Governors has communicated updates on the crisis by letter to our policyholders in an effort to keep Texas physicians informed.

We have also worked to marshal the support of others in the medical community. TMLT became a founding member of the Texas Alliance for Patient Access (TAPA). A unique coalition of professional associations, health care organizations, specialty societies and insurance carriers, and medical clinics and groups, the TAPA consortium has grown rapidly in less than one year from seven members to 100 participating organizations. TAPA is focused on increasing access to health care through meaningful medical liability reform. Such reform, we believe, will result in long-term benefits to patients and to the health care system.

TAPA is modeled after the successful California consortium, (Californians Allied for Patient Protection) which has sustained the California MICRA reforms of the 1970s. Those reforms, which include a $250,000 cap on non-economic damages, have resulted in fairness and stability for patients and health care providers. At the same time, California patients who are truly injured are justly indemnified as they have full access to the courts without limits on compensation for medical bills or economic losses.

This past year, TMLT met with Texas Insurance Commissioner Jose Montemayor on several occasions to brief the Department of Insurance with our latest data and to advise the department of our view of developing trends in Texas. TAPA members also met Commissioner Montemayor who reviewed the current crisis and gave an overview of the fundamental problems in the tort system which are undermining access to care. The Commissioner restated his position that the medical liability and patient access crisis are the result of increases in claim frequency and severity.

TAPA has been successful in lining up initial funding, organizing legislation and research committees, and in hiring an experienced team of lobbyists to execute the legislative agenda. TMLT has provided valuable expertise to the TAPA legislation committee which includes expert defense and appellate counsel and claims executives. The TAPA legislation committee has meticulously written a comprehensive and detailed tort reform package of more than a dozen bills which have been endorsed by our association partners. TAPA’s health care liability reform agenda, modeled after California’s MICRA statute, addresses frequency and severity of claims and physician and hospital reforms. Specifically, proposed reforms include:

- limitation of $250,000 on non-economic damages per claimant in a claim against a health care provider
- allow for the periodic payment of future damages in excess of $100,000
- allow evidence of collateral source payment to be introduced
- limitation on attorney contingency fees
- procedural issues that address frequency of claim and cost of litigation, such as prohibition of pre-suit depositions, elimination of cost bond and expert report filing extensions, clarification of expert witness qualifications
- establish charitable immunity for health care providers
- limitation on liability for prescribing of drug or device.

Today both TAPA and TMLT are represented at the Texas Capitol by skilled and influential lobbyists. We are rapidly gaining support and sponsorship for our proposals with key legislators. TAPA has also worked closely with Governor Perry’s office since last winter. Some of this effort was reflected in Governor Perry’s tort reform initiative of March 2002. During the legislative session, TAPA will continue to work closely with the political advisers and lobbyists of our many consortium members in order to focus and unify reform efforts.

The November elections have demonstrated that the people of Texas are behind our efforts for meaningful and sustainable tort reform. Texas voters understand that the out-of-control tort system has made health care more costly and less available. They realize that unless reforms are passed in 2003, more doctors, nursing homes and hospitals will close their doors or restrict patient access in order to survive.

What can you do? Join this effort now! Physicians in California came together at a time of crisis, and were able to pass one of the nation’s strongest reform packages that is still working today: We need to do the same in Texas.

For additional information please call (512) 306-1616 or email galitski@tapa.info.
Let Texas Medical Liability Trust and the Texas Medical Association help you launch your practice into HIPAA compliance. Your flight crew will provide you with the latest HIPAA information, forms, sample policies and procedures.

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 bastard

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For more information or to register, please contact the TMA at (800) 880-1300 ext. 1452 or visit the practice management section of TMA’s web site at www.texmed.org