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Medicolegal liability in surgical pathology: a consideration of underlying causes and selected pertinent concepts

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Malpractice actions against surgical pathologists are still relatively uncommon, but they have increased in frequency over time and are associated with sizable indemnity figures. This discussion categorizes areas of liability in surgical pathology into three groups: those that represent health system flaws (problems with specimen identification, or transportation, or both; lack of clinical information or erroneous information; sampling effects and defects; and poorly reproducible or poorly defined diagnostic or prognostic criteria), others that exist at the interface between the system and individuals (allowing clinicians to bypass pathologic review of referred specimens; acceding to clinical demands for inadvisable procedures; and working in a disruptive environment), and truly individual errors by pathologists (lapses in reasoning; deficiencies concerning continuity in the laboratory; invalid assumptions regarding recipients of surgical pathology reports; over-reliance on the results of "special" tests; and problems with peer consultation). Finally, two important topic areas are discussed that commonly enter into lawsuits filed against surgical pathologists; namely, "delay in diagnosis" of malignant neoplasms and "failure to provide adequate prognostic information." Based on a review of the pertinent literature, we conclude that the clinical courses of most common malignancies are not affected in a significant manner by delays in diagnosis. Moreover, the practice of using "personalized external validity" for supposedly prognostic tests is examined, with the resulting opinion that prognostication of tumor behavior in individual patients is not reliable using anything but anatomic staging systems.

Malpractice actions (MAs) in anatomic pathology are steadily increasing in frequency.[1] Nonetheless, when they are compared with suits filed against other medical specialists, the absolute number of pathology-related MAs is relatively small. According to the extensive analyses of this topic that have been published by Troxel,[2–7] approximately 8% of pathologists in California—the most populous state in the U.S.—are named in lawsuits each year. Viewed in another fashion, a MA against any individual pathologist would be expected no more often than every 12 years.

Those data may seem reassuring, but another important piece of information is not. That is, the average monetary judgment (indemnity) was approximately $450,000 for pathologists who were found legally responsible in MAs evaluated by Troxel,[6] among "closed" (jury-verdict) cases. This figure corresponds to a ranking that is sixth on the roster of relative liabilities for all medical specialties, behind neurology, neurosurgery, obstetrics and gynecology, pediatrics, and radiation oncology, and ahead of cardiology, anesthesiology, and cardiovascular surgery.[8] This situation exists largely because entire treatment plans often are predicated

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on pathologic interpretations; hence, mistakes in the laboratory may well translate into serious misdirection of clinical care. Thus, despite the still-modest visibility of pathologists in the U.S. tort law system, awards to plaintiffs who win MAs against them are disproportionately high.

This overview of malpractice suits in pathology will exclude cytopathology, because it is discussed specifically in another article in this issue of *Seminars*. Also, autopsy-related MAs do exist as well, but they are rare.[9] Even so, many of the general comments made herein on laboratory error are generic, and they apply equally to virtually all anatomic pathology cases.

Problem areas in surgical pathology regarding malpractice lawsuits

There have been several previous papers in pertinent journals, addressing specific subject areas of malpractice risk in surgical pathology. In relative order, these concern the diagnosis of melanoma (considered separately in this issue); hematopoietic disorders, breast carcinoma; various gynecologic diseases; soft tissue sarcomas; lung diseases; gastric carcinoma; prostatic carcinoma; and carcinoma of the urinary bladder.[2–7,10–14]

A series of publications has offered possible solutions to these problems, which are typically topical and educational in nature.[10–15] These are largely covered in the remainder of this issue of *Seminars,* and therefore we will not recount them here.

Most recently, Renshaw and Gould[16] have reexamined error in surgical pathology in a more global fashion, attempting to provide an overarching approach to its reduction or elimination; this, we believe, is the more appropriate tactic. The solution they identified—that of routine "blinded" (second-person) real-time review of all surgical pathology cases—has been proposed, and even implemented, by others in the past.[17] Most practice groups have not adopted the method because it is time- and labor-intensive, and the clinicians of today increasingly place a high premium (very probably ***too*** high) on the rapidity of pathologic reporting. Nonetheless, as the risk of MAs in pathology grows, blinded review may need reconsideration as a way of limiting liability and augmenting reproducibility. Renshaw and Gould[16] do address the concerns that others have expressed over the feasibility of this process: *"Why would any group consider doing any of this? It is a lot of work, and as the results have shown, it does not identify very many errors."* [Incidentally, the same study showed that only 5% of errors in surgical pathology were associated with indisputable clinical significance]. . . *"If you think that the practice of pathology is unlikely to be influenced by the desires of insurers and the government, do not bother. But, if you think it is inevitable for these groups to ask for more quality assurance data, and if you want those data to actually correlate with quality, then your best course is to try and* **provide** *data that actually correlate with quality."*

The latter technique is, perhaps, more of an issue in community practices than it is in academic centers with pathology housestaff training programs. That is true because several people—typically including senior residents and fellows as well as faculty members—examine each surgical pathology specimen contemporaneously in the second of those settings. Also, as outlined by Foucar,[18,19] errors in surgical pathology have several underpinnings, only a small minority of which actually concerns the knowledge and ability of individual pathologists. Most of the time, mistakes originate in the medical system outside the pathology laboratory; or in flawed epistemology as applied to pathologic diagnosis of specific conditions. In the first of those circumstances, solutions lie in systems-remediation; in the second, reanalysis of the accuracy and precision of proposed diagnostic criteria is needed by the specialty as a whole.[18]

Many plaintiffs' attorneys (and the media[20]) prefer to ignore those realities, insisting instead that individuals—not systems or criteria—comprise the foundation of virtually all medical errors. In the following discussion, I attempt to provide additional details for mistakes in three categories: medical systems errors; errors at the interface between the system and individual practitioners; and true mistakes or misjudgments by single pathologists.

Systems flaws that produce errors in surgical pathology

Medical systems have a complex composition with many layers and parts. In addition, growing requirements to satisfy U.S. and state governmental and health-agency-related regulations definitely affect the functionality of the overall structure. Generally speaking, the more complicated and organizationally bulky a health system is, the greater the risk of error arising in and from it.[21–23] Several common problems affecting surgical pathologists including the following considerations:

Problems with specimen identification, or transportation, or both

Any pathologist who has been in practice for even a short time is familiar with the fact that biopsies and surgical specimens may come to the laboratory with deficiencies in patient identification or anatomic designation, and the latter data may also be changed by people ***in*** the pathology department. This is a particular conundrum in dealing with tissue samples that are closely similar in appearance and which come in batches from specialty clinics. For example, groups of prostate biopsies, breast core biopsies, skin biopsies, and others commonly arrive in the laboratory all at the same time. If even two of them are associated with transposed demographic information, a disastrous diagnostic mistake may eventuate, and it is impossible for the pathol-