

# Pathology

## Claims Data Snapshot

2023



**This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Pathology is identified as the primary responsible service.**

## **Keep in mind...**

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

# Specialty benchmarking

Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

|                      |               |   |  |   |
|----------------------|---------------|---|--|---|
| <b>Severity Tier</b> | <b>High</b>   | Hematology/Oncology, Pathology, Pediatrics                            | Anesthesiology, Neurology                            | Emergency Medicine, Neurosurgery, OB/GYN  |
|                      | <b>Medium</b> | Family Medicine, Nephrology, Physiatry, Urgent Care                   | Cardiology, ENT, Gastroenterology, Internal Medicine | Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology |
|                      | <b>Low</b>    | Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology | Ophthalmology, Plastic Surgery, Pulmonology          | Hospitalists  |
|                      |               | <b>Low</b>  | <b>Medium</b>  | <b>High</b>   |
|                      |               | <b>Frequency Tier</b>   |  |   |

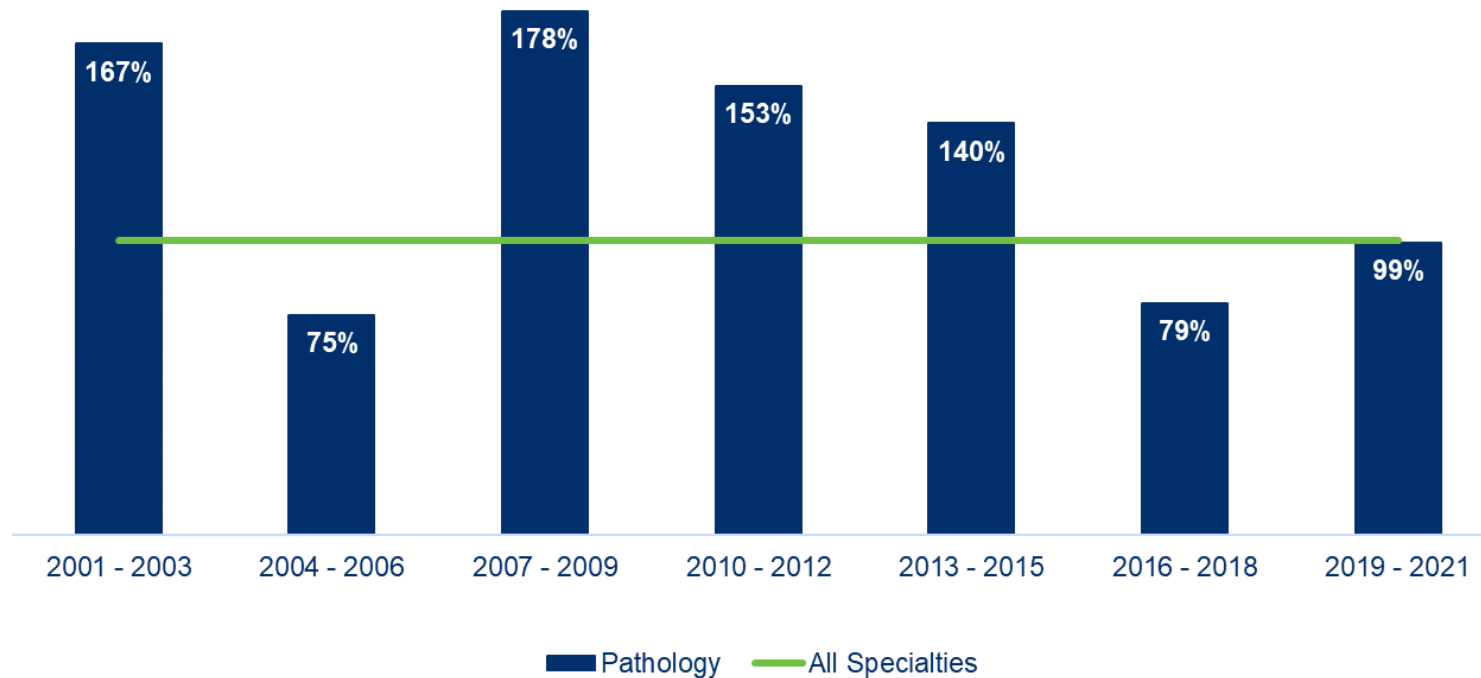
Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

# Specialty trends – Pathologists

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

Pathologists have a higher financial severity per case and a lower claim frequency compared to all specialties.

Average Severity - Pathology Relative to All Specialties



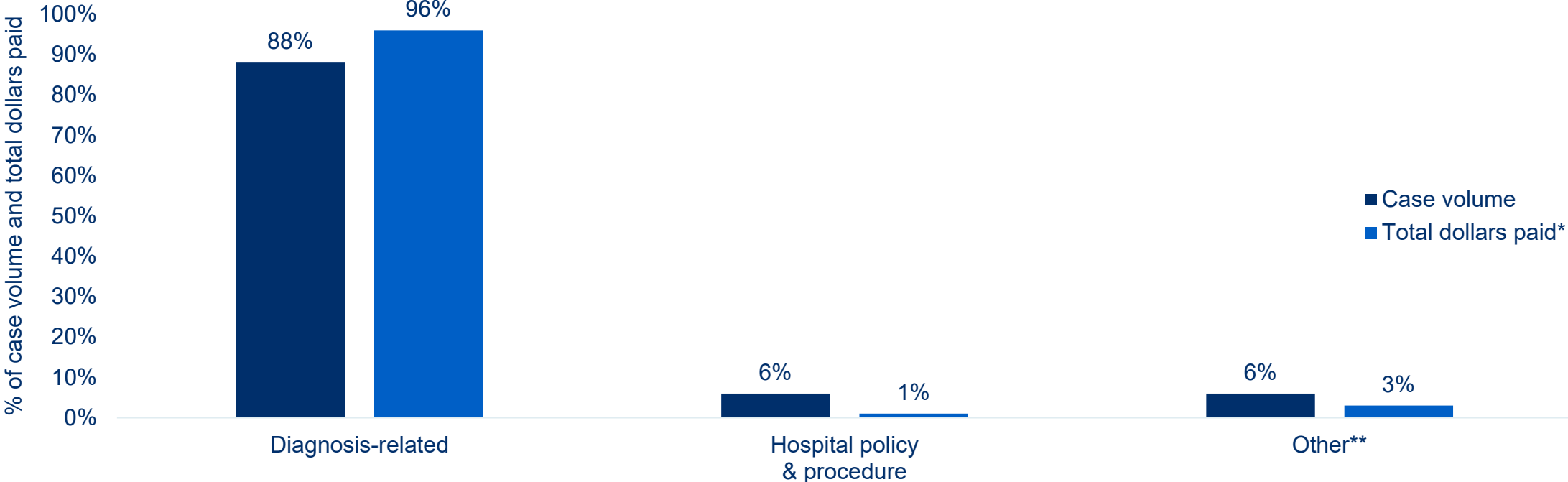
# Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- As expected, **diagnosis-related allegations account for the vast majority of pathology case volume**. Almost three-fourths of these involve benign and malignant neoplasms. The types are varied, with no one particular cancer accounting for a large portion of cases. Skin melanomas, breast, colorectal and genitourinary cancers are among the most frequently noted. These cases primarily involve misinterpretation of test specimens.
- **Hospital policy & procedure cases**, which account for 6% of case volume, reflect failures to follow post-mortem and safe specimen-handling processes.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Although there is just one service noted to be primarily responsible for the patient's outcome, **there is often an overlap of errors and missteps along the continuum of care**.
- **The majority of all pathology cases involve a contributorily responsible medical or surgical specialty**. Multiple contributing factors can be applied to every case; not all of them are applicable to the pathologist. Clinical judgment factors, specifically pathologist misinterpretation of diagnostic studies, and then an overall narrow diagnostic focus, team communication failures, and failures to follow policies/protocols (especially in the hospital policy allegations) are key drivers of both clinical and financial Pathology case severity.

# Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.



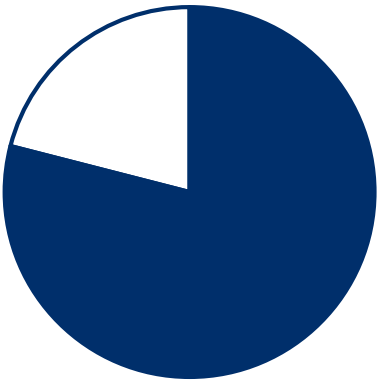
MedPro Group + MLMIC cases opened 2012-2021, Pathology as responsible service (N=144); \*Total dollars paid = expense + indemnity; \*\*Other includes allegations for which no significant case volume exists

# Clinical Severity\*

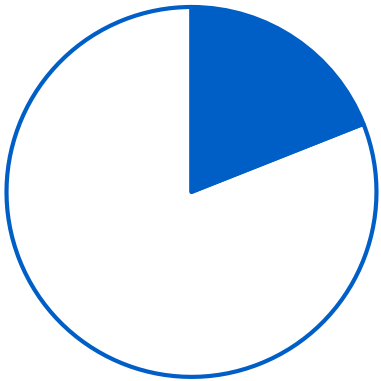
| Clinical Severity Categories | Sub-categories                 | % of case volume | <p><b>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</b></p> |
|------------------------------|--------------------------------|------------------|---|
| <b>LOW</b>                   | Emotional Injury Only          | <b>10%</b>       |   |
|                              | Temporary Insignificant Injury |                  |   |
| <b>MEDIUM</b>                | Temporary Minor Injury         | <b>34%</b>       |   |
|                              | Temporary Major Injury         |                  |   |
|                              | Permanent Minor Injury         |                  |   |
| <b>HIGH</b>                  | Significant Permanent Injury   | <b>56%</b>       |   |
|                              | Major Permanent Injury         |                  |   |
|                              | Grave Injury                   |                  |   |
|                              | Death                          |                  |   |

MedPro Group + MLMIC cases opened 2012-2021, Pathology as responsible service (N=144); \*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

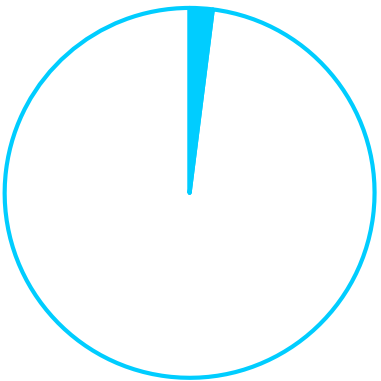
# Claimant Type & Location



**Ambulatory**  
**79%**



**Inpatient**  
**19%**



**Emergency**  
**2%**

| Top Locations | % of case volume |
|---------------|------------------|
| Pathology     | 81%              |
| Office/clinic | 9%               |



# Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

## Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

**Contributing factors** are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

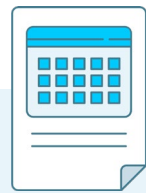
**Multiple factors are identified in each case** because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



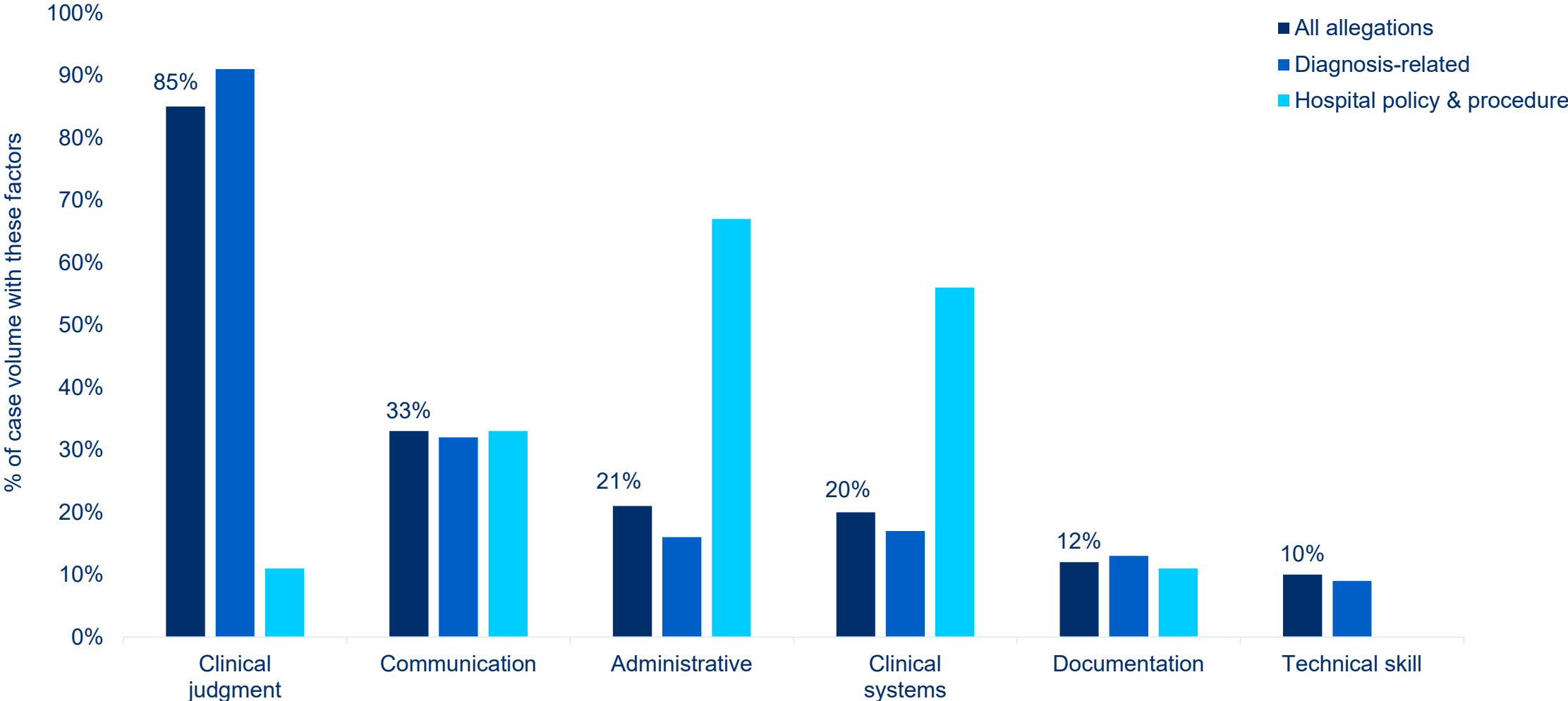
Technical skill

# Contributing Factor Category Definitions

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | **CONTRIBUTING FACTORS** | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

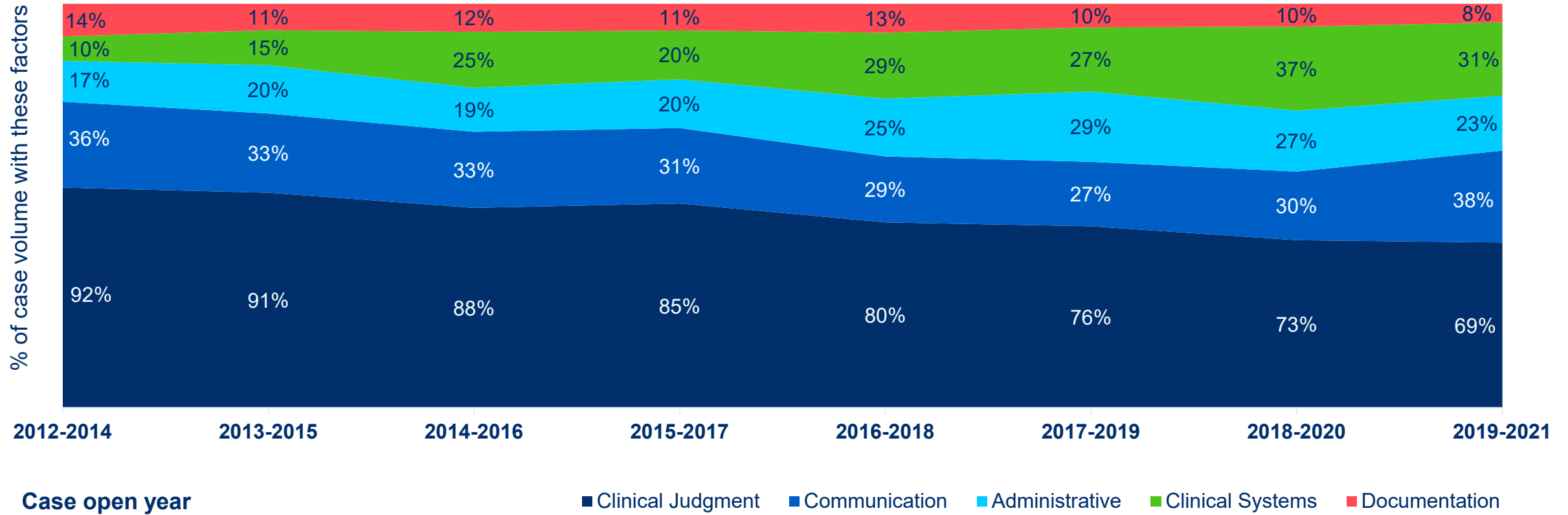
|                      |  |
|----------------------|--|
| Administrative       | Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory  |
| Behavior-related     | Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct  |
| Clinical environment | Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)   |
| Clinical judgment    | Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope |
| Clinical systems     | Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections   |
| Communication        | Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology  |
| Documentation        | Factors related to mechanics, insufficiency, content   |
| Supervision          | Factors related to supervision of nursing, house staff, advanced practice clinicians   |
| Technical skill      | Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures  |

# Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Pathology as responsible service (N=144); More than one factor per case, therefore totals >100%

# Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

# Focus on Most Common Drivers of Clinical and Financial Severity

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

|  |   |   |
|--|---|---|
| Factors associated with high clinical severity outcomes  | (CJ) misinterpretation of diagnostic studies (78%)                          | % of high severity case volume                            |
|  | (CJ) failure/delay in ordering diagnostic test (31%)                        |   |
|  | (CJ) failure to appreciate/reconcile signs/symptoms/test results (20%)      |   |
|  | (CJ) failure/delay in obtaining consult/referral (17%)                      |   |
| Factors associated with the costliest indemnity payments | (CJ) misinterpretation of diagnostic studies (76%)                          | % of cases closing with indemnity paid with these factors |
|  | (CO) suboptimal communication among providers about patient condition (23%) |   |
|  | (AD) failure to follow policy/protocol (18%)                                |   |

Although there is just one service noted to be primarily responsible for the patient's outcome, there is often an overlap of errors and missteps along the continuum of care. The majority of all pathology cases involve a contributorily responsible medical or surgical specialty. Multiple contributing factors can be applied to every case; not all of them are applicable to the pathologist. Clinical judgment factors, specifically pathologist misinterpretation of diagnostic studies, and then an overall narrow diagnostic focus, team communication failures, and failures to follow policies/protocols (especially in the hospital policy allegations) are key drivers of both clinical and financial Pathology case severity.

# Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care\* below.

## Phase 1

|  |                                      |
|--|--------------------------------------|
| <b>Initial diagnostic assessment</b><br><br><b>58%</b><br>of cases | Patient notes problem & seeks care   |
|  | History & physical                   |
|  | Patient assessed, symptoms evaluated |
|  | Differential diagnosis established   |
|  | Diagnostic testing ordered           |

## Phase 2

|   |   |
|---|---|
| <b>Testing and results processing</b><br><br><b>87%</b><br>of cases | Performance of diagnostic tests                           |
|   | Interpretation of diagnostic test results                 |
|   | Test results transmitted to/received by ordering provider |

## Phase 3

|   |  |
|---|--|
| <b>Follow-up and coordination</b><br><br><b>43%</b><br>of cases | Physician follows-up with patient                |
|   | Referrals/Consults                               |
|   | Patient information communicated among care team |
|   | Patient compliance with follow-up plan           |

MedPro Group + MLMIC cases opened 2012-2021, Pathology as responsible service (N=144); \*each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

# Focus on Diagnosis-Related & Hospital Policy & Procedure Allegations

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Hospital policy and procedure cases include failures to follow post-mortem and safe specimen-handling processes.





**The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Pathologists.**

**We're relaying these true stories as lessons** to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

# Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

**\$325,000**

## CONTRIBUTING FACTORS

### Behavior-related

Patient non-adherence with treatment regimen

### Clinical judgment

Failure to appreciate/reconcile relevant signs/symptoms/test results

Patient assessment – narrow diagnostic focus – chronic\previous diagnosis assumed

Misinterpretation of diagnostic studies

## DELAY IN DIAGNOSIS OF MELANOMA RESULTING IN DEATH

A male patient in his late 60s, with a history significant for smoking, basal cell carcinoma and a family history of skin cancer, had been under the care of a Dermatologist for many years. Many biopsies had been performed throughout the years, some positive for basal cell carcinoma. At one point, there was a 16-month gap between office visit. Then, the patient returned, with **complaints of a lump on his back**. The area was **biopsied and was positive for basal cell carcinoma**. Three months later, the patient returned, **complaining of a persistent lump on his chest**. A shave biopsy was performed, and a Dermopathologist (Path) **diagnosed the specimen as a melanocytic nevus, compound type with architectural disorder with mild cytologic atypia (benign dysplastic nevus), margins involved**.

The Dermatologist called patient to report the findings, and to schedule a follow-up appointment for further mole removal. One month later, the patient called to advise the Dermatologist that his insurance coverage was changing next month, and that he would call to schedule a second biopsy at that time. **Patient did not return to the office until three months later; the skin on the chest biopsy area was now clinically different, more nodular with color change**. The patient was referred to a dermatological surgeon.

**The lesion was removed, and found to be malignant melanoma**. Further diagnostic work-up revealed **metastatic melanoma, Stage IV, with spread to axillary nodes**. Despite treatment, the patient died a year and a half later.

**Pathologist expert review identified portions of the original chest biopsy that raise the possibility of a malignant melanoma - consistent with severely atypical compound melanocytic lesion, and could not support the original pathology findings**.

Dermatology experts supported the Dermatologist's plan of care based on the pathology report.

# Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

**\$575,000**

CONTRIBUTING FACTORS

**Administrative**

Adequacy of staffing

Protocol not followed

**Clinical environment**

Busyness

**Clinical judgment**

Misinterpretation of diagnostic studies

Patient assessment – narrow diagnostic focus – chronic\previous diagnosis assumed (by subsequent treating providers)

INCORRECT DIAGNOSIS OF HODGKIN'S LYMPHOMA IN PATIENT WITH MONONUCLEOSIS RESULTING IN UNNECESSARY CHEMOTHERAPY AND RADIATION

A female college student in her early 20s presented to her primary care provider (PCP) with complaints of unintentional weight loss (13 lbs) and diffuse lymph node enlargement at the base of her skull. **A mononucleosis test was negative; no additional testing was done.** Her PCP recommended a cervical lymph node biopsy; this was performed and read by a Pathologist as inconclusive. The patient was referred to a surgeon for lymph node excision.

The patient underwent the **node excision** by a General Surgeon. The **Pathologist interpreted it as showing “classical nodular sclerosing Hodgkin’s Lymphoma”**. At this point, the patient withdrew from college and returned home (to a different state) for treatment. The patient was started on chemotherapy followed by radiation treatment.

**Per hospital policy, all positive diagnoses were to be sent for a second opinion. The Pathologist did not send specimen for second opinion; he later stated that he assumed the providers treating the patient in her home state would do so. They did not.**

Six months later, the patient was told she was disease free. She graduated from college and began working as a pathology research assistant at a hospital. Several of the pathologists at the hospital took an interest in her diagnosis and requested to review the original slides. **Four pathologists reviewed the original slides and noted the Hodgkin’s Lymphoma diagnosis was incorrect and that the slides actually revealed mononucleosis.**

The patient is at risk for long term side effects related to unnecessary chemotherapy and radiation, including possible fertility issues.

During the subsequent investigation, it was determined that at the time of the patient’s diagnosis, the **pathology department at the hospital was very busy and understaffed**. The Pathologist was the only one on staff, and was interpreting almost 10,000 specimens per year.

# Risk Mitigation Strategies

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- **Clinical judgment**
  - Be aware that inadequate patient assessment might be a result of cognitive biases, inadequate medical and family history taking, or inadequate sharing of information among providers. Recognize that delays in obtaining consults/referrals are one of the top driving factors behind diagnostic claims.
- **Communication**
  - Ensure efficiencies in the sharing and discussing of test results and consultative reports among other providers. Encourage verbal sharing of subtle changes which are not individually noteworthy when multiple providers are involved.
- **Clinical environment**
  - Recognize that weekend & night shifts can impact the timeliness of assessments, response to consult requests, and return of test results. Focus on eliminating any variation in processes during 'off' hours.
- **Clinical systems**
  - Focus on 'closing the loop' with regards to receiving, reporting and acting on test results, including incidental findings. Insist upon care coordination – determine which next steps belong to which provider.
- **Administrative**
  - Ensure that policies/procedures are well-constructed and that staff awareness & training is a priority.
- **Document.**
  - Discrepancies or gaps in the details/timing of care and clinical decision-making make it much more difficult to build a supportive framework for defense against potential malpractice cases.
- **Engage patients as active participants in their care.**
  - Consider the patient's health literacy and other comprehension barriers. Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.

# MedPro Group & MLMIC Data

**MedPro and MLMIC are partnered with Candello**, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

**Derived from the essence of the word candela**, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

**Using Candello's sophisticated coding taxonomy to code claims data**, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

**Leveraging our extensive claims data**, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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