# Pathology

## Claims Data Snapshot

2025

MedPro Group

MLMIC

MLMIC Insurance Company

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# Introduction



**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 2014-2023 in which Pathology is identified as the primary responsible service.**

Also included are Clinical Laboratory, Phlebotomy and Blood Bank cases. See page 6 for more detail related to overall case volume.

**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.**

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

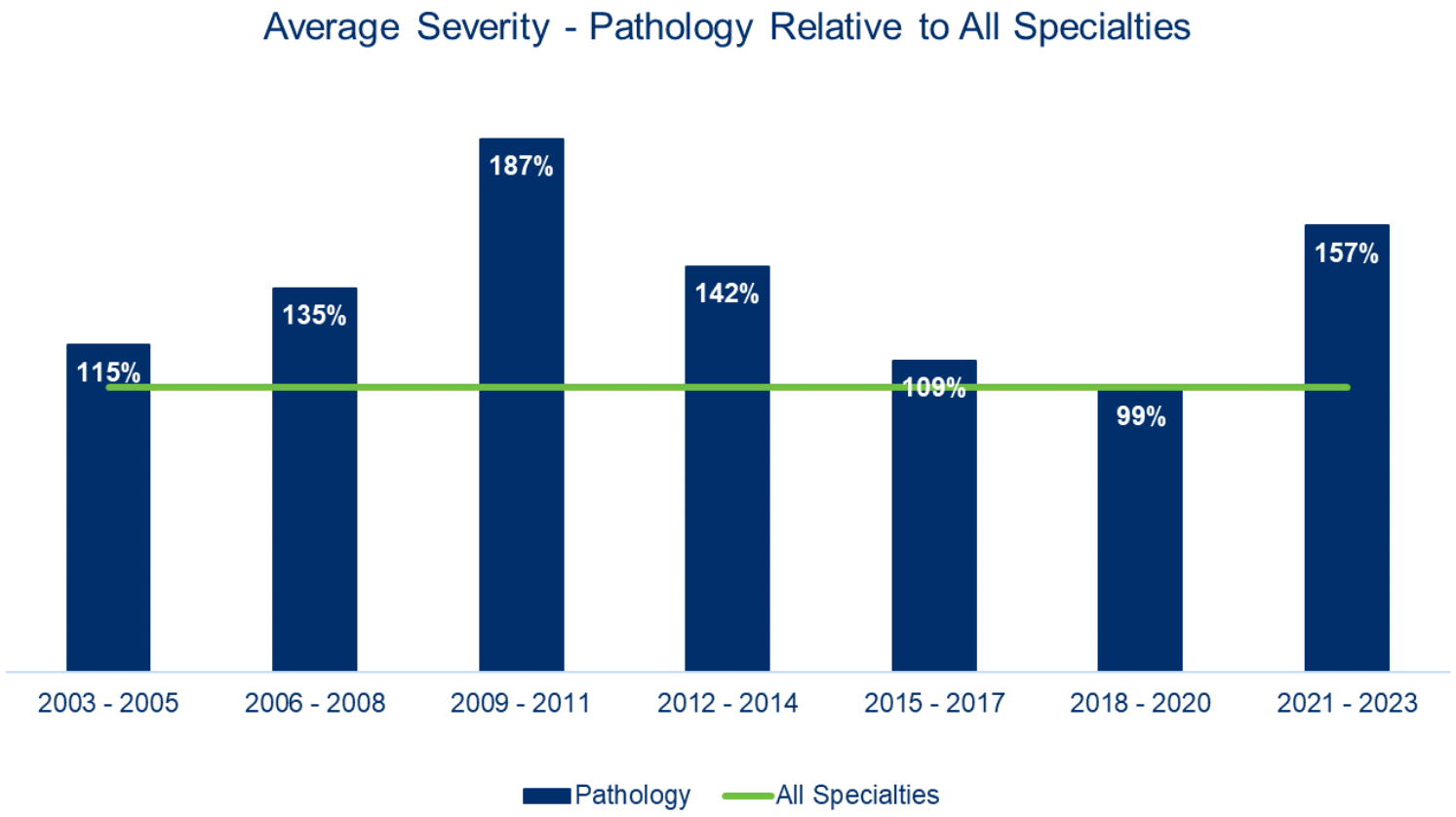
Frequency Tier

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

# Specialty trends – Pathology



**Pathology has a higher financial severity per case and a lower claim frequency compared to all specialties.**




| Frequency Tier |
| --- |
| High |
| Medium |
| Low |

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

# Key Points - Clinically Coded Data



- 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; skin cancers account for 16% of the neoplasm volume; no other particular cancer accounts for a significant proportion. These cases primarily involve misinterpretation of test specimens.
- Hospital policy and procedure cases, which account for 5% 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 an overall narrow diagnostic focus, are key drivers of clinical Pathology case severity.

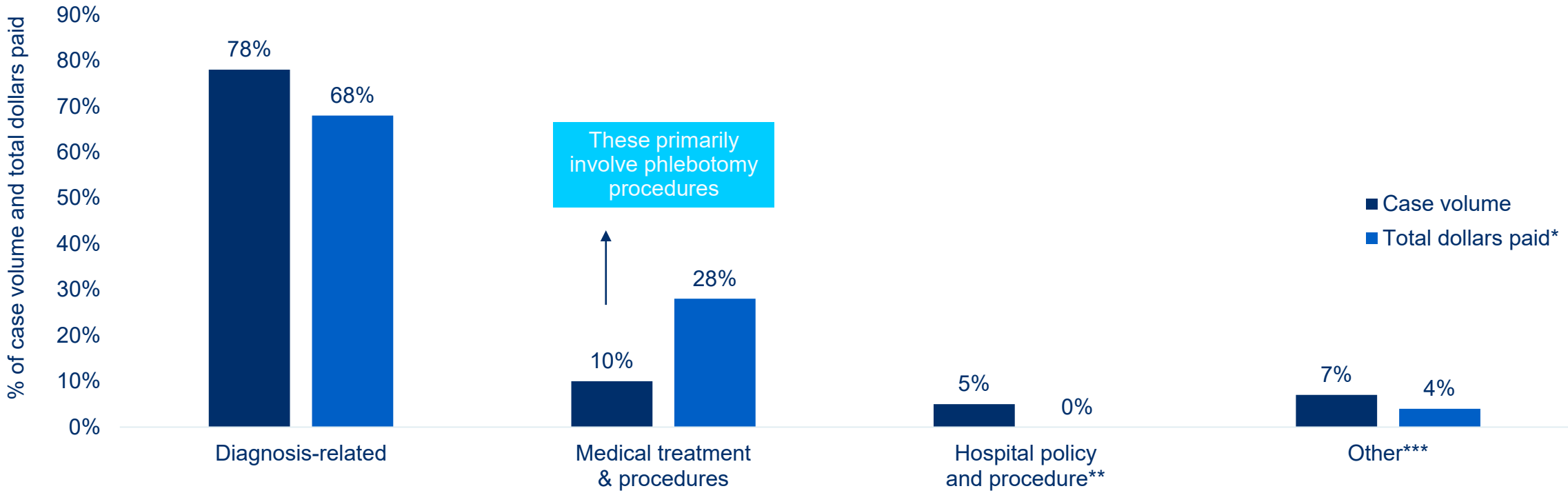
MedPro Group + MLMIC cases opened 2014-2023, Pathology as responsible service (N=178)

# 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.

See footnote below for the distribution of Pathology-area specialties included in this analysis.

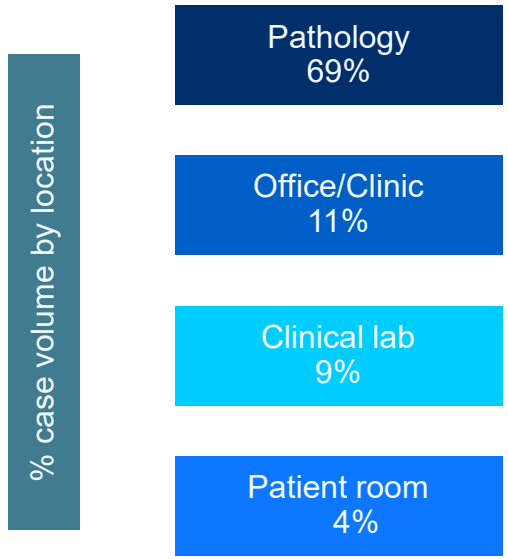



MedPro Group + MLMIC cases opened 2014-2023, Pathology as responsible service (**total N=178**; Pathology = 149; Clinical Lab = 19; Phlebotomy = 8; Blood Bank = 2); *Total dollars paid = expense + indemnity;
**Hospital policy and procedure cases include failures to follow post-mortem and safe specimen-handling processes; ***Other includes allegations for which no significant case volume exists;

# Clinical Severity* & Most Common Locations



| Clinical severity* categories | Sub-categories | % of case volume | Definitions |
|---|---|---|---|
| **LOW** | Emotional Injury Only | **11%** | Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay |
| | Temporary Insignificant Injury | | Lacerations, contusions, minor scars, rash; no delay in recovery |
| **MEDIUM** | Temporary Minor Injury | **34%** | Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed |
| | Temporary Major Injury | | Burns, drug side effect; recovery delayed |
| | Permanent Minor Injury | | Loss of fingers or loss or damage to organs; includes non-disabling injuries |
| **HIGH** | Significant Permanent Injury | **54%** | Deafness, loss of limb, loss of eye or loss of one kidney or lung |
| | Major Permanent Injury | | Paraplegia, blindness, loss of two limbs or brain damage |
| | Grave Injury | | Quadriplegia, severe brain damage, life-long care or fatal prognosis |
| | Death | | Death |
| | | **13%** | **% of cases resulting in patient death** |




MedPro Group + MLMIC cases opened 2014-2023, Pathology as responsible service (N=178); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

# Contributing Factors



## 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

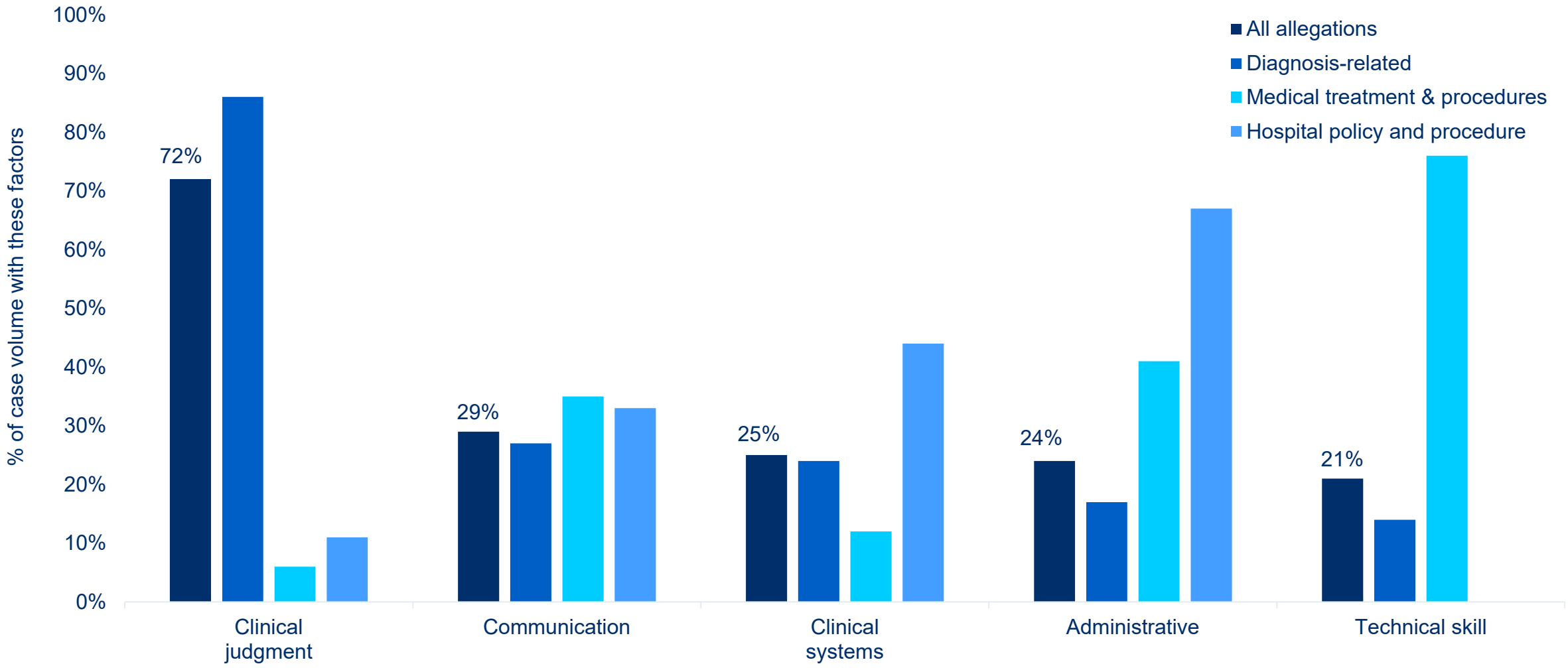
# Contributing Factor Category Definitions



| | |
|---|---|
| Administrative | Factors related to reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols |
| 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, diagnostic decision-making, 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

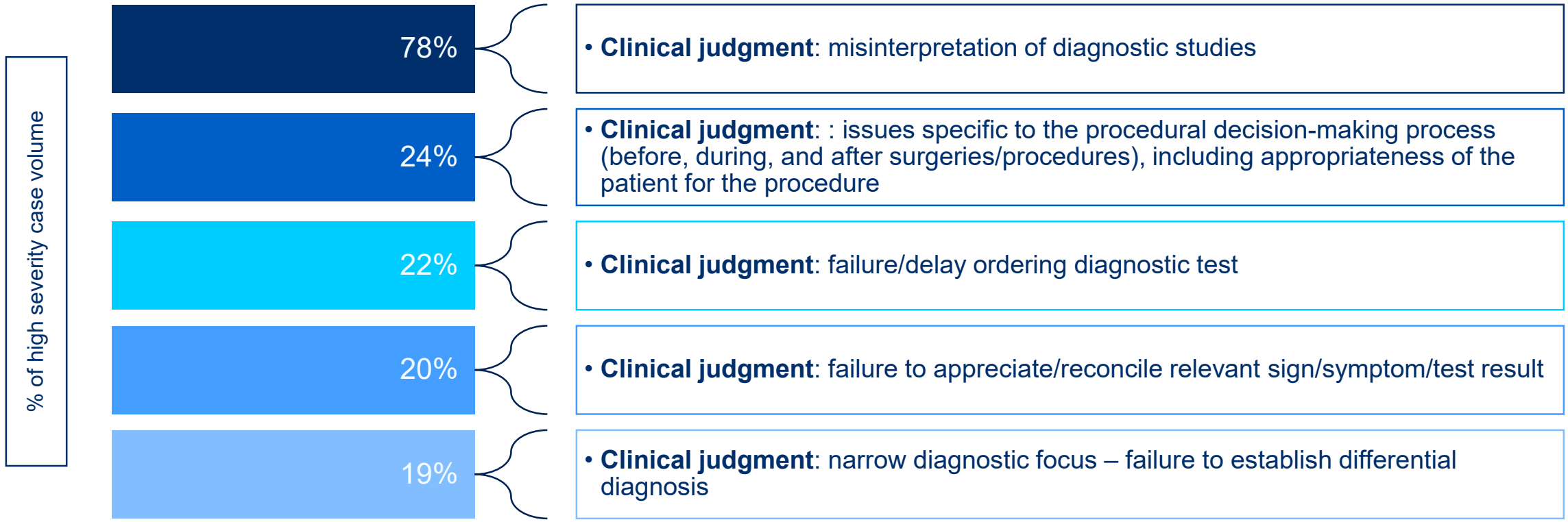





MedPro Group + MLMIC cases opened 2014-2023, Pathology as responsible service (N=178); More than one factor per case, therefore totals >100%

# Focus on Most Common Drivers of Clinical Severity






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 an overall narrow diagnostic focus, are key drivers of clinical Pathology case severity.

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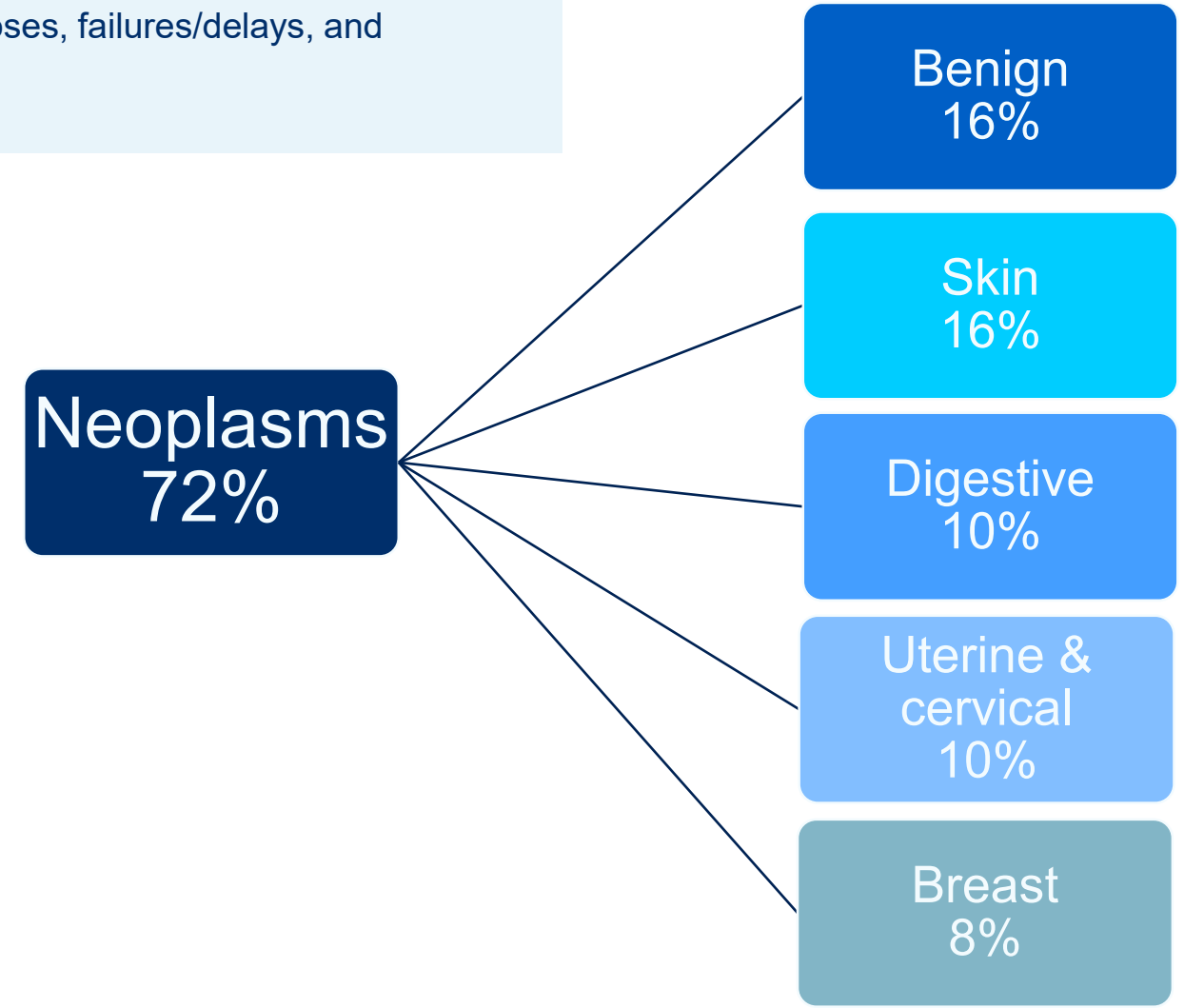
# Focus on Diagnosis-Related Allegations



Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the top diagnoses* in these cases.




MedPro Group + MLMIC cases opened 2014-2023, Pathology as responsible service (N=178); *as a percentage of all diagnosis-related allegations

# 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

**Initial diagnostic assessment**

**50%**
**of cases**

- Patient notes problem & seeks care
- History & physical
- Patient assessed, symptoms evaluated
- Differential diagnosis established
- Diagnostic testing ordered

## Phase 2

**Testing and results processing**

**90%**
**of cases**

- Performance of diagnostic tests
- Interpretation of diagnostic test results
- Test results transmitted to/received by ordering provider

## Phase 3

**Follow-up and coordination**

**39%**
**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 2014-2023, Pathology as responsible service (N=178); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

# Risk Mitigation Strategies



- **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 and 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 and 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.