Pathology and Medical Malpractice

Academic and Trainee Empirical Review of Cases by State of Texas Physicians

Timothy Craig Allen, MD, JD,¹ Mehary Stafford, PhD,² and Bryan A. Liang, MD, PhD, JD³,⁴

From the ¹Department of Pathology, The University of Texas Medical Branch, Galveston, TX; ²Office of Strategic Initiatives, University of Texas System, Austin; and ³Department of Anesthesiology and ⁴San Diego Center for Patient Safety, University of California, San Diego.

Key Words: Economic evaluation; Management/administration; AP general

DOI: 10.1309/AJCPQLK63BQFDODF

ABSTRACT

Objectives: This study examines whether the assumptions that pathologists understand the medical malpractice negligence rule and have a clear single standard of care are reasonable.

Methods: Two hundred eighty-one Texas academic pathologists and trainees were presented 10 actual pathology malpractice cases from publicly available sources, representing the tort system’s signal.

Results: Of the respondents, 55.52% were trainees, and 44.48% were pathology faculty. Only in two cases did more than 50% of respondents correctly identify the behavior of pathologists as defined by legal outcomes. In only half of the cases did more than 50% of pathologists concur with the jury verdict.

Conclusions: This study provides further evidence that physicians do not understand the legal rule of negligence. Pathologists have a poor understanding of negligence and cannot accurately predict a jury verdict. There is significant divergence from the single standard of care assumption. Alternative methods to provide appropriate compensation and to establish physician accountability should be explored. Additional education about medical negligence is needed.

There are two primary rationales for the medical malpractice tort system’s existence.¹⁻⁴ It is expected that the system will (1) ensure that patients who are injured by physician malpractice will receive appropriate compensation for their injuries³ and (2) provide adequately strong physician incentives to “promote safety and reduce patient injury to a socially defined level and cost.”³,⁴,⁶ The latter expectation is based on two assumptions: that physicians theoretically understand the legal rule of negligence with which their professional actions are judged by society so that they can be appropriately affected by it³ and that there is a single accepted standard of care that exists to assess physician actions. Because the medical profession itself defines the standard of care, physicians should be expected, through their medical training and experience, to know the standard.³

Whether the medical malpractice tort system accomplishes its goal of supplying physicians with the appropriate incentives to promote safety and reduce patient injury has
been questioned. The billions of dollars spent on the medical malpractice system annually\(^3\) will be wasted if physicians in fact do not understand the medical malpractice negligence rule or do not comport with an understood single standard of care.\(^3\)

Pathologists have critical roles in particular areas that have been affected by potential variations in standards, resulting in negative clinical and legal consequences.\(^6\)-\(^12\) Importantly, it appears that both academic faculty and resident-level physicians are affected by legal rules and systems and indeed, specifically for pathology, have very limited previous training in medical-legal interfaces.\(^13\) Consequently, we wished to determine if pathology residents and faculty were knowledgeable about the negligence rule to which pathologists are held and how well their standard of care assessments compared with actual malpractice case results. Using a questionnaire directed at academic pathologists and their postgraduate pathology trainees in the state of Texas, this study examined whether the assumptions that physicians understand the definition of medical malpractice negligence and if they have a clear single standard of care are reasonable ones.

**Materials and Methods**

**Questionnaire**

In January and February 2013, one of us presented a questionnaire developed by us \(\bib{Appendix 1}\) to pathology faculty and their postgraduate trainees (residents and fellows) at seven Texas academic pathology departments. The faculty and trainees were contacted through their pathology department chairs or designees explaining the study and requesting a Grand Rounds or equivalent opportunity to have surveys completed by those who were interested in participating. Questionnaires were collected by one of us at the end of each session. Additional questionnaires were left at each institution visited, and some faculty and trainees unable to participate in the group sessions completed the questionnaire later. These questionnaires were collected as a group by the institution and returned to us or were returned directly to us by the participant. The questionnaire contained 10 medical malpractice cases involving pathologists, and these cases were gleaned from the legal literature (Lexis-Nexis, www.lexis.com, New York, NY; accessed November 21, 2012) by one of us. Specifically, the cases were identified from a Lexis-Nexis jury verdict search for the term pathologist. Information presented in each case was taken from the Lexis-Nexis case reports. These case reports were chosen for the questionnaire because they are the best public source of as-detailed-as-possible pathology medical malpractice cases that are practically accessible, representing the most detailed tort law signal to physicians. The facts were set forth using language as close to the verdict reports as possible. No significant facts were removed. While other physicians’ or institutions’ behavior might have been included in the case information, specific information regarding other physicians or institutions in their capacities as defendants in the medical malpractice lawsuits was blinded (eg, a specific named hospital was referred to as Hospital A). The jury verdict was reported only as it regarded the pathologist. The answers to the cases in the questionnaire and our reasoning in determining those answers are available from us on request. Utilizing our medical and legal expertise, we determined the answers based solely on the case information presented in the questionnaire.

**Sample Size**

Questionnaires were provided to a total of 281 academic pathologists and postgraduate pathology trainees from seven participating institutions, all of whom completed the survey.

**Coding**

The first group of 10 items was associated with the care rendered by a pathologist in each of the cases. Respondents were asked to evaluate the defendant pathologist’s care on a Likert scale (A = Correct; B = Most likely correct; C = Can’t tell; D = Not correct; E = Most likely not correct). “Correct” and “Most likely correct” are merged together. “Most likely not correct” and “Not correct” are also combined. The number of “Can’t tell” responses ranged between 28 and 70, and they are always coded as the wrong answer.

The second group of 10 items was related to concordance with jury verdicts. Respondents were asked to predict actual jury verdict, and responses are coded to indicate the respondent’s concordance with actual jury verdicts.

**Methodology**

Analysis of variance (ANOVA) was conducted to determine whether there are significant differences between the means of evaluation and concordance scores among pathologists based on categorical variables (two or more groups). The dependent variables are total pathologist behavior evaluation and concordance scores. A separate analysis was conducted for each category.

**Results**

**Descriptive Statistics Across Groups**

Surveys were completed by 281 pathologists and trainees. Of these respondents, 156 (55.5%) were residents and fellows and 125 (44.5%) were pathology faculty. Sixteen (5.7%) had been defendants in a medical malpractice lawsuit; eight (2.8%) had served on a jury in a medical malpractice lawsuit;
93 (33%) were faculty with 6 or more years of practice experience; and 65 (23.13%) were senior residents or fellows. Differences between attending physician status and fellows were not significant, nor was there any correlation of results when comparing residents with faculty in their years of experience, having formerly served on a jury, or having formerly been a party to a medical malpractice lawsuit.

**Evaluation Scores/Concordance Percentage**

Table 1 shows the percentage of respondents who correctly identified the pathologist’s behavior and their success in predicting jury verdict by case as defined by the legal system. As shown in Table 1, only in two cases did more than 50% of respondents correctly identify the defendant pathologist’s behavior. Conversely, five cases had less than 50% pathologist concordance with actual jury verdict.

**ANOVA Results**

Essentially no differences were identified between any of the groups. A one-way ANOVA between groups was conducted to explore the difference in evaluation scores of pathologists at seven institutions. Despite reaching statistical significance ($F[6,274] = 2.93, P < .01$), the actual difference in mean scores between the institutions was quite small ($\eta^2 = 0.06$). A statistically significant difference was also noted at the $P < .05$ level in concordance scores for the seven institutions ($F[6,274] = 4.55, P < .01$). The actual difference in concordance mean scores between the institutions was slightly higher than that observed in evaluation scores ($\eta^2 = 0.09$). However, analysis by institution explained only 9% of the variance in concordance scores among pathologists.

**Discussion**

This study focused on the accuracy/signal of the tort system to pathologists using publicly available information. In theory, the legal system sends a clear signal to the physician through the tort system regarding the standard of care. We measured this signal in relation to the other stated “reality” of the legal system: that the physicians agree with the outcomes because the profession itself sets the standard. Hence, the signal to physicians from the legal system should be the definition of malpractice (in theory) but also the empirical assessment of whether physicians interpret the signal from the system (these case reports) in the same way as defined by tort adjudications. The standard of care is established by pathologists and, again in theory, the court’s holding should be consistent with this single standard, expressed in expert testimony, and if so, whether it was breached. However, the diverse nature of the assessments in this study suggests that the signal is not clear or empirically accepted by many pathologists.

Although jury verdicts are not themselves an objective standard, they purportedly reflect that standard. Importantly, this signal is not well studied, particularly for pathologists, and using readily available public materials. Summarized case briefs are the primary signal that pathologists are provided by the legal system; they do not have access to full trial records, reports, and other insights. Consequently, using these materials (which provide more details than brief medical or lay articles, and which, unlike trial transcripts, are accessible) to evaluate pathologist assessments is essential to assess the strength, accuracy, and clarity of these signals from the legal system.

We find that pathologists, regardless of training or attending levels, disagree significantly with jury verdicts involving pathology practice. Clinical disagreement with legal trials in anatomic and clinical pathology settings from a professional perspective is in conflict with legal theory and consistent application and a single standard of care in malpractice cases.

The medical malpractice system’s ability to perform its key function of supplying physicians with the appropriate incentives to promote safety and reduce patient injury has been previously questioned. Physicians have been shown to have an incomplete, and in some cases incorrect, understanding of the medical malpractice system’s legal rule, including the legal definition of negligence.1,3 Physicians have also been shown to be ignorant of the common law of medical malpractice and to have no knowledge of medical malpractice case law.1,2 Further, physicians have been found to assess cases and decide cases differently from medical malpractice juries.1,3 They also have shown limited if any knowledge regarding potential liability in typical forums, such as the tumor board, including passive liability.14

Previous studies have involved family practice/internal medicine physicians,3 anesthesiologists,2 and radiologists.1 However, pathologists and pathology trainees have not been widely studied as to their understanding of medical malpractice and jury verdicts. In this study, we performed this analysis
and found that both academic pathologists and pathology trainees significantly disagreed with legally based assessments of pathology care. Our findings support those of prior studies of other physician subspecialties but extend them to both pathology and physician trainees—that is, pathologists, pathologist residents, and fellows—who show no significant agreement with actual jury verdicts. In addition, their determination of the defendant pathologist’s behavior in each case shows no significant agreement with our determination of correctness based on our expertise and understanding of medical malpractice law.

This lack of understanding and agreement is not influenced by academic pathologist vs trainee status, senior vs junior trainee status, or by number of years for which an academic pathologist has been in practice. Regardless of these variables, correct identification of a pathologist’s actions and concordance with actual jury verdict are less than 50% for most of the cases; in eight of the 10 cases, fewer than 50% correctly identified whether the defendant pathologist’s behavior was correct according to the jury verdict. In the two cases in which more than 50% of respondents correctly identified the pathologist’s behavior as correct, one case (case 10) was only barely above 50% (50.89%), and the other—the best of all the cases—was barely above 60% (60.14%).

Pathologists agreed with the jury verdicts in 50% of the cases, including one case in which the jury verdict was deemed incorrect by the authors. In combination, it appears that the legal system is not sending a clear, appropriate signal regarding the standard of care or legal rule to pathologists in high-intensity academic settings, and the ideal of tort law—the professional definition and consistent application in court of the standard of care—seems unfulfilled.

Variation in understanding and applying the clinical standard of care is challenging. Review of evidence-based care indicates that wide variations exist in what care is provided when deemed clearly appropriate. Yet it appears that an even greater chasm is presented by the legal system and pathology. This may be explained by a host of factors, including limited education of pathologists in law, the complexities of pathology in the patient-physician paradigm of care, and the variation of care standards in current practice. There appears to be at least some verification for this in our study.

A key implication of these findings is that the medical malpractice system has not evolved from previous work, which has found its assumption of physician knowledge and consistency with legal conclusions divergent from professional medical opinion. This alone is of concern because without consistent standards of accountability, physicians may believe the best approach is defensive medicine, that is, ordering or performing an overabundance of unnecessary testing and care. Yet it is well known, in particular to pathologists, that each test and medical intervention has associated risks of iatrogenic injury. Clearly, a misunderstanding of legal obligations and protections against lawsuits may actually increase that risk as pathologists act to alleviate perceived notions of liability. Consequently, the unclear message being sent by the tort system to pathologists may be a contributing risk in itself to patient safety and increasing medical errors.

Although one might desire an attorney duty in a given case to carefully explain standard-of-care judgments and how to apply them, unfortunately, no recognized attorney duty to explain standard-of-care applications exists. Indeed, because physicians do not often access attorneys except in malpractice and other adverse situations, the opportunity for any legal-medical teaching and learning is limited. As well, the unsupported, anecdotal “lore on the floors” often complicates understanding. There should be much more professional society emphasis on the practical nature of the unclear legal system and strategic assessment of the best means to ensure quality and safety for the patient rather than conjecture on the applicable standard of care.

In addition, the variations in care as adjudged by jurors and study respondents does not seem to extend to other legal risks (and knowledge). For example, the minority practice doctrine, which permits variations from majority practice standards if adopted by a reasonable fraction of physicians, would appear to be important to review in variation-of-care contexts. Yet without knowledge of the acceptability of more than one standard of care from a legal perspective, pathologists and trainees may bring incorrect and inappropriate perspectives to patient care that can create risks to today’s and the next generation of patients, as misinformation is perpetrated through medical training, the lore on the floors, and inadequacy of the curriculum in providing this basic information.

Further, additional concerns are important to consider in the context of health care reform implementation. With cost containment and organizational reform such as Accountable Care Organizations (ACOs) becoming critical players in care delivery, any relative increases in costs may lead to lower payments for services. In this setting, the pathologist is incentivized by nonclinical factors—increased financial risks from a muddied tort system and patient care costs that may not be within his/her control or even knowledge if participating in ACOs—thus taking even more attention and situational awareness away from clinical care. Increased distractions from sources that deeply affect patient safety and confusion in legal standards and rules are part of that practice equation.

There are clear challenges as well for professional standards. A single standard of care in all settings is unrealistic at best when considered from a human variation perspective. Yet the underlying presumption under standard medical rubrics is that there is one standard, and not following that standard is considered inappropriate medical action. But in practice, that
standard is a personal one for that physician, and academic training often emphasizes the physician’s expertise rather than a comprehensive, critical, and sustained effort to obtain the most recent evidence-based approaches. \(^\text{15}\) Standardization of care, dynamically revisited as to systems approaches, quality assurance, and policies reflecting best practices, can provide both clinical evidence and consistent reevaluation of clinical approaches best suited for the particular patient’s condition and profile. Professional education should take a leading role in this endeavor, particularly as the plethora of medical information sites that may not be appropriately vetted for quality health information, may be commercially based, and/or may have no commitment to evidence-based care is likely to emerge in the future. \(^\text{25}\)

Moreover, organized pathology should be prominent in promoting professional and lay education on patient safety and partnership. Without direct communication with patients in general, the opportunity to address typical risk management of lawsuits using techniques such as active listening and other communication techniques is limited. \(^\text{4}\) However, professional leadership and public advocacy for better patient care can also provide the opportunity to raise awareness about pathology, the pathologist, and expertise. Indeed, cutting-edge issues such as unfettered online laboratory testing (and “interpretation”) that make suspect claims \(^\text{26}\) without any evidence or authoritative review are important health policy issues that require informed pathology leadership to educate the professional and lay public.

Of course, this study has limitations. Respondents were academic pathology faculty and trainees in Texas. Surveys of private practice pathologists, as well as pathologists from other geographic areas, would be valuable for comparison. Also, studies of physicians in other subspecialities would be of benefit for comparison. Finally, professional educational efforts to highlight law, its provisions, and its challenges would be important to evaluate to determine if this approach can offer an important risk management tool to conserve valuable social resources and promote quality and safety in pathology care.

In conclusion, this large study of academic pathology faculty and trainees supports prior studies showing an extremely poor understanding by physicians of medical malpractice law, for which they are held accountable by society, and their poor prediction and concordance with jury verdicts. This study provides further evidence that physicians do not understand the legal rule of negligence by which their professional actions are judged. Nor does this study support the fundamental concept that there is a single accepted standard of care that exists to assess physician actions. As evidence continues to mount that traditional medical malpractice fails to adequately provide physician incentives to promote safety and reduce patient injury, it is now time for society to seriously explore alternative methods to both provide appropriate compensation to injured patients and to establish physician accountability. In the meantime, there is a clear need for additional education of pathology faculty and trainees on medical negligence, the tort system, the standard of care, and the limitations of the legal system.

Address reprint requests to Dr Allen: Dept of Pathology, The University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555.

Acknowledgment: The authors thank Patricia D. Hurn, PhD, The University of Texas System Executive Vice Chancellor for Health Affairs, for her assistance with this study.

### Appendix 1

#### Pathology Case 1

**Facts**

Plaintiff, a 37-year-old man, was admitted to the hospital in 1986 for a workup of neurologic symptoms indicating probable multiple sclerosis. A routine chest x-ray showed a shadow on his right lung. Plaintiff was thoroughly examined by an internist, who reached a probable diagnosis of clear cell carcinoma, a malignant tumor. At surgery, a grapefruit-sized growth was found, obliterating the central portion of the plaintiff’s right lung and intertwining with and invading the pulmonary artery. Defendant pathologist who did the frozen section analysis during the operation told the surgeon that this was in all likelihood a clear cell carcinoma. The surgeon, therefore, decided to remove the entire lung. Defendant pathologist doing the postsurgical evaluation determined that the growth was, in fact, a fungal infection, *Cryptococcus*.

**Plaintiff Claimed**

Although a very serious infection, it could have been cured with antibiotic treatment, and removal of the lung was not necessary. Plaintiff contended that Defendant pathologists were negligent in failing to advise the treating physicians of their uncertainty with regard to the samples tested; had they done so, they would have learned of the differential diagnosis and could have pursued the potential of fungal infection.

**Defendant Argued**

There was no uncertainty in their determination that the abnormality was a tumor, and they properly conveyed that information to the treating physicians. Defendant pathologists also argued that Plaintiff’s lung was so severely compromised by the fungal infection that it was no longer functional.
Question 1: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 2: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 2

Facts
Plaintiff, a 58-year-old man, saw a urologist in 1991 for a lesion on his penis and was admitted to the hospital for circumcision and biopsy of the lesion. Defendant pathologist did not perform a microscopic examination on the foreskin; however, based on the biopsy, he rendered a diagnosis of epithelial dysplasia. Ten months later, Plaintiff was diagnosed with squamous cell carcinoma of the penis, requiring surgical removal of the glans penis.

Plaintiff Claimed
Defendant pathologist misread the biopsy as epithelial dysplasia when, in fact, it was carcinoma in situ, a noninvasive skin lesion that was treatable with topical creams. Plaintiff also contended that Defendant pathologist should have performed a microscopic examination of the foreskin.

Defendant Argued
He had properly read the biopsy slides as indicating epithelial dysplasia. Defendant pathologist further maintained that it was not routine procedure to perform a microscopic examination of the foreskin unless indicated by a macroscopic examination.

Question 3: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 4: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 3

Facts
In 1987, Plaintiff, a 62-year-old retired maintenance supervisor, fell and injured his chest. Subsequent chest x-ray showed a shadow or mass in the left upper lobe of the lung. Fine-needle aspiration of the lesion was diagnosed by Defendant pathologist as “positive for undifferentiated carcinoma, not small cell carcinoma.” Plaintiff underwent surgery. Defendant pathologist examined the left upper lobectomy and found no cancer, but instead, a walled-off abscess infection. Plaintiff obtained a discovery order requiring Defendant pathologist to identify and describe at deposition, while viewing the pathology slides under a microscope, which cells in which slides he relied upon in rendering his diagnosis of cancer. Photomicrographs were taken during the deposition of the various fields on the slides so identified by Defendant pathologist. At Defendant pathologist’s deposition, Defendant could find no cancer cells or cells diagnostic of cancer but did identify “abnormal,” “high abnormal,” “suspicious,” and “highly suspicious” cells which he claimed had the characteristics of cancer cells.

Plaintiff Claimed
Three of the slides contained several groups of atypical or abnormal cells, but no cells were clearly cancer cells or cells diagnostic of cancer. A proper pathology report would have included that information and a recommendation for further diagnostic testing and clinical correlation.

Defendant Argued
Many cells were “consistent with” Defendant pathologist’s diagnosis of cancer. Further, cytology has a known false-positive rate, and Defendant pathologist’s diagnosis falls within proper standards of pathology practice.

Question 5: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 6: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 4

Facts
Plaintiff, a 49-year-old part-time flight attendant, presented with a breast lump in 2007. Fine-needle biopsy was performed, and Defendant pathologist diagnosed the specimen as “positive for breast cancer.” Subsequent lumpectomy showed no cancer; however, Plaintiff claims she experienced nerve damage resulting from the surgery.

Plaintiff Claimed
Defendant pathologist misread the fine-needle biopsy, leading directly to Plaintiff’s undergoing an unnecessary lumpectomy, resulting in nerve damage. Plaintiff’s expert pathologist testified that it was obvious from the first review of Plaintiff’s specimen that the cells were not cancerous but clearly displayed atypical cells of a condition called fibroadenoma that may mimic cancer. Plaintiff’s expert pathologist stated that Defendant pathologist should have been able to tell the difference.

Defendant Argued
Defendant pathologist admitted that he had misread the plaintiff’s specimen but maintained that his actions were within the standard of care. Defendant pathologist testified that the reading of pathology slides is not an exact science and that statistically, across the country, pathology readings have only a 70% accuracy rate. Defendant pathologist further stated that, looking at the slide today, he would still say it looks like cancer. Defendant pathologist’s partner testified that he had coreviewed the Plaintiff’s specimen and had signed off on the diagnosis of cancer.

Question 7: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 8: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 5

Facts
In 1988, Plaintiff, a 35-year-old woman who worked as a stockbroker and a nurse, received an excisional breast biopsy specimen diagnosed by Defendant pathologist as a premalignant condition known as atypical ductal hyperplasia. Based on this report, no treatment of any kind was rendered. Nineteen months later, Plaintiff noticed a small lump in her breast immediately...
beneath the breast biopsy scar. A second biopsy was performed and the original slides were reviewed. It was determined that the plaintiff had a very small focus of intraductal cancer in her breast in the original biopsy specimen.

Plaintiff Claimed
The intraductal cancer would have been curable to nearly a 100% certainty if it had been diagnosed correctly by the Defendant pathologist, so it could then have been treated promptly. However, during the 19-month delay in treatment, Plaintiff developed invasive cancer, which had spread to her lymphatic system and now in all likelihood would result in her death.

Defendant Argued
Atypical hyperplasia and intraductal carcinoma are so similar in appearance that a physician cannot be held responsible for confusing the two. Further, regardless of whether there was any negligence in diagnosis, the cancer had already metastasized at the time of the original biopsy.

Question 9: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 10: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 6

Facts
In 2011, Plaintiff developed sharp pains in her side and underwent a computed tomography scan that showed ovarian overgrowth. She consulted with a surgeon, who performed an exploratory laparoscopy, removed portions of the tumor from a number of locations within the pelvis, and sent them to pathology for frozen section analysis. Defendant pathologist called the surgeon in the operating room and reported the tumor as “adenocarcinoma.” The surgeon performed a total hysterectomy and bilateral salpingo-oophorectomy. Defendant pathologist’s final diagnosis was adenocarcinoma. On that basis, Plaintiff underwent chemotherapy. Plaintiff’s side effects to the chemotherapy were so severe that she sought potential clinical trials at a well-known cancer research hospital. Plaintiff was informed by that hospital that she did not have adenocarcinoma but a borderline tumor. She should not have received chemotherapy because it does not improve the survival of patients with borderline tumors.

Plaintiff Claimed
The slides reflected the absence of any frank invasion or other signs that would support a diagnosis of adenocarcinoma. Plaintiff’s expert contended that the tumor was clearly a borderline tumor or tumor of low malignant potential.

Defendant Argued
Defendant’s experts maintained that the slides displayed features consistent with adenocarcinoma and that defendant exercised permissible medical judgment. Defendant pathologist testified that the slides clearly reflected adenocarcinoma and that Plaintiff’s position should be rejected; this caused Plaintiff to argue that the Defendant pathologist’s final diagnosis was adenocarcinoma. On that basis, Plaintiff underwent chemotherapy. Plaintiff’s side effects to the chemotherapy were so severe that she sought potential clinical trials at a well-known cancer research hospital. Plaintiff was informed by that hospital that she did not have adenocarcinoma but a borderline tumor. She should not have received chemotherapy because it does not improve the survival of patients with borderline tumors.

Question 11: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 12: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 7

Facts
Plaintiff, a 41-year-old woman, was found by her obstetrician to have a swelling in the left axillary area in 1988; 3 months before the birth of her first child. Within a week after delivery, she developed signs of redness, swelling, and hardness in the left breast, which had become painful and exhibited a coarse roughening of the skin, known as “peau d’orange.” Plaintiff was referred to a breast surgeon who drained an abscess and performed a biopsy. A culture was performed at that time, confirming the clinical diagnosis of mastitis. Defendant pathologist rendered a benign diagnosis. The surgeon indicated that he believed from the gross signs that Plaintiff had a 60% chance of having cancer and that he was relieved when the biopsy findings were negative. Plaintiff’s symptoms progressed over the next several months, and she began suffering back and hip pain. Ultimately, a hip biopsy was found to contain metastatic carcinoma; a second breast biopsy led to a diagnosis of inflammatory breast cancer, a particularly virulent form of breast cancer. She died 6 months later.

Plaintiff Claimed
The failure to diagnose breast cancer with the first biopsy resulted in a much more rapid and invasive metastasis to the spine and hip, as a result of which Plaintiff was confined to a wheelchair for the remainder of her life. Plaintiff further contended that, although a timely diagnosis may not have offered a cure, it would have lengthened her life. Specifically, Plaintiff claimed that Defendant pathologist was negligent in conducting a proper microscopic study and thereby failed to diagnose inflammatory breast cancer in time.

Defendant Argued
Of the cells examined, 99.9% were, in fact, benign inflammatory cells that were reflective of mastitis. Defendant pathologist maintained that it was reasonable to fail to discover the small amount of cancer cells because they were obscured by the benign inflammatory cells; to which Plaintiff countered that the cancer cells were alongside the benign cells and were not hidden by them; they could have been detected had Defendant pathologist used the most powerful magnification level of the microscope.

Question 13: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 14: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 8

Facts
Plaintiff, an 81-year-old woman, was found by her obstetrician to have a swelling in the left breast during self-examination in 2010. She visited a surgeon, who took a tissue sample and sent it for frozen section analysis. Defendant pathologist prepared the frozen section slide and examined it, tentatively concluding that infiltrating ductal carcinoma was present. He decided to consult with another pathologist on duty, who also believed the sample showed cancer. As a result, the surgeon performed a radical mastectomy. Examination of permanent slides showed that Defendant pathologist had been in error. Cancer had not been present in Plaintiff’s breast.
Pathology Case 9

Facts

Plaintiff, a 58-year-old man, was suffering flu-like symptoms in 2001. He sought treatment and underwent a computed tomography-guided needle aspiration of a right lung nodule. The results were interpreted by Defendant pathologist. Without seeking a second opinion, Defendant pathologist broke the news that Plaintiff had lung cancer. To make matters worse, Defendant pathologist further reported that Plaintiff had only 6 months or less to live. The news was emotionally devastating to Plaintiff and his wife. After the diagnosis, Plaintiff was so distraught that he gave up on his two businesses and eventually sold them. He was treated by an oncologist but only to receive supportive care while he waited to die. This grim situation continued for the next 4 months until it was discovered that the diagnosis was completely incorrect and Plaintiff did not have cancer at all. Although relieved to learn he was not facing impending death, Plaintiff thought he should be compensated for the devastating impact the misdiagnosis had on his life. Plaintiff first presented the matter to a medical review panel, which issued an unanimous opinion that Defendant pathologist had not breached the pathology standard of care.

Plaintiff Claimed

Defendant pathologist had breached the standard of care by misinterpreting his biopsy results and misdiagnosing him with cancer.

Defendant Argued

The standard of care was not breached.

Question 17: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 18: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Pathology Case 10

Facts

In 2004, Plaintiff sought medical attention because of a prolonged pain in his throat. He had been diagnosed with acid reflux earlier that year. His physician detected a mass in his throat and, suspecting cancer, sent a biopsy specimen to the pathology laboratory. Defendant pathologist performed a frozen section biopsy and issued a definitive diagnosis of cancer. After reviewing slides from the paraffin block, Defendant pathologist confirmed and reiterated her findings. Plaintiff was referred to an otorhinolaryngologist who, based on the pathology report, did not order a second biopsy. He performed a total laryngectomy on Plaintiff. The pathologist who examined the specimen reported no cancer in the slides produced from the excised tissue. The pathologist requested the original biopsy materials from Defendant pathologist, who, along with the original slides, sent a handwritten note indicating that Plaintiff’s diagnosis was a particularly “difficult case.”

Plaintiff Claimed

Defendant pathologist negligently misdiagnosed the original biopsy, causing him to undergo a total laryngectomy. Plaintiff now has a tracheostomy stoma through which he breathes and attempts to speak. He has no real voice. He can no longer smell because he does not breath through his nose. His tastes are limited to sour, sweet, bitter, and salty. In addition, he has suffered loss of strength and full use of his right arm because of the neck dissection. He cannot lie on his right side because of pain.

Defendant Argued

The diagnosis was within the standard of care.

Question 19: On the basis of your clinical knowledge and training, was the care rendered by the physician (check one):
(a) Correct
(b) Most likely correct
(c) Can’t tell
(d) Most likely not correct
(e) Not correct

Question 20: What do you think the jury decided? (check one):
(a) For patient
(b) For physician

Question 21: Please indicate whether you are a faculty member or a resident:
(a) Faculty
(b) Resident

Question 22: Have you ever been a defendant in a medical malpractice lawsuit?
(a) Yes
(b) No

Question 23: Have you ever served on a jury in a medical malpractice lawsuit?
(a) Yes
(b) No

Question 24: If a faculty member, have you practiced:
(a) 0-5 years
(b) 6-10 years
(c) >10 years
If a postgraduate trainee in pathology, are you a senior resident (final year of residency) or fellow?
(d) Yes
(e) No

References


