Medicolegal Issues in Pathology

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• The various methods used by risk managers to assist clinicians in handling medicolegal risk, including improving communication with patients and better dealing with medical records issues, are not particularly of benefit to pathologists. An understanding of tort law, the theory of negligence, the principle of standard of care, and the role of the expert witness helps the pathologist generally assess and manage risk and put it into context with daily pathology practice. An understanding of the litigation process and techniques to better handle a deposition and high-risk specimens or diagnoses are of practical value in avoiding a lawsuit or increasing the likelihood for good outcome in medical malpractice litigation.

(Arch Pathol Lab Med. 2008;132:186–191)

The role of the pathologist in patient care is evolving, and pathologists are taking a generally more active role in their patients’ care. Still, an obvious but major difference between pathologists and clinicians is that pathologists, with some exceptions, have little direct patient contact on a routine basis. Hospital risk managers and others who attempt to limit pathologists’ medicolegal risk are confounded by pathologists’ lack of direct patient contact (Brenda Hart, JD, oral communication, April 2004) because appropriate direct communication with patients and patients’ families is generally the best way for clinicians to avoid lawsuits.1–5 Davis6 noted in 2006 that “people rarely sue a physician whom they like and respect, and articles addressed to clinicians emphasize the importance of being forthright with and respectful of all patients. Because of the nature of the practice of pathology in the United States, few pathologists are in a position to get to know the patients for whom they provide services.” For pathologists, the most frequent form of communication that decreases medicolegal risk occurs in the form of a clear, well-written surgical pathology report. The report also decreases medicolegal risk by documenting any phone call or other direct communication with a clinician regarding a case.7 The College of American Pathologists and the Association of Directors of Anatomic and Surgical Pathology have emphasized the importance of pathologist-clinician communication as part of good overall pathology practice,7,8 and appropriate direct pathologist-clinician communication plays an important role in reducing medicolegal risk. However, pathologists—distanced from the general clinician-patient relationship that allows opportunities for routine or focused, intense communication that reduces the clinician’s overall medicolegal risk—cannot include strong patient communication skills within their medicolegal defense armamentarium.

When educating clinicians in methods of lowering medicolegal risk, risk managers and others who attempt to assist physicians in reducing medicolegal risk frequently focus on medical record issues such as informed consent, handwriting, record clarity, late entries, lack of continuity, and record spoliation.9–11 However, they find discussion of these issues to be of little benefit when dealing with pathologists (Brenda Hart, JD, oral communication, April 2004). The surgical pathology report, consisting of one or a few pages, will be scrutinized word-by-word by plaintiff’s attorneys and expert witnesses if a lawsuit occurs. However, the medical records issues mentioned previously are much less germane to the pathologist because the dictated and transcribed surgical pathology or cytopathology report is entered into the electronic medical record with a few keystrokes and is then no longer available to the pathologist for changes without the production of an addendum report or amended report. Risk managers therefore find themselves at something of a loss when educating these nonclinician pathologists about methods of reducing the risk of lawsuits.

Pathologists get sued for misdiagnosis.12,13 However, although a correct diagnosis is the best way of avoiding being named in a medical malpractice lawsuit, it is not a guarantee against being named in one. Lawsuits are filed against physicians for many reasons.6,14 Further, because of the time needed for discovery, attorneys may not have completed discovery before the statute of limitations runs, so they often “incorrectly” name physicians in a lawsuit to make sure all potentially liable parties are named.5 As such, a pathologist may become involved in a lawsuit in which the surgical pathology report is not an immediate issue.

Risk managers are also well aware of the potential for serious mental and physical harm to physicians, including pathologists, caused by lawsuits.15 A physician’s medical malpractice lawsuit is a personal crisis, and a physician’s perception of the possibility of being sued is so dramatic as to be likened to the physician’s perception of the prospect of his or her own death.6 The litigation process may last for several years. Concerns regarding reporting to the

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National Practitioner Data Bank add additional anxiety.\textsuperscript{16,17} The incidence of lawsuits against pathologists continues to increase as patients and their attorneys increasingly recognize pathologists’ roles in patient care and diagnosis.\textsuperscript{18} Along with, and probably partly as a result of, the media attention given to Papanicolaou smear misdiagnosis during the last several years, as well as the general strengthening of patient autonomy presently occurring, patients, increasingly aware of pathologists, are more comfortable asking for second opinions or reviewing their pathology reports.\textsuperscript{18} Therefore, to minimize or avoid medicolegal risk, pathologists need to be aware of these risks and know how best to respond, rather than react in panic when a lawsuit is threatened or occurs.

**TORT LAW**

To understand how to address risk and how to respond to a lawsuit or its threat, a pathologist must gain a basic understanding of tort law, on which medical malpractice law is based. For all of its importance in the legal arena, the term *tort* is rarely used in common parlance. A 1996 physician study by Liang\textsuperscript{19} showed that “physicians were ignorant about the common law of tort, and their perceptions regarding the legal definition of negligence were clearly incomplete and incorrect.” A tort is “damage, injury, or a wrongful act done willfully, negligently, or in circumstances involving strict liability, but not involving breach of contract, for which a civil suit can be brought.”\textsuperscript{20} Lawsuits based on tort law are civil actions brought in civil court and are separate from criminal law jurisprudence.

Liability for a tort may attach to a person based on that person’s actions by several principles: intentional tort, recklessness, negligence, and strict liability. The theory of intentional torts comes into play when a defendant in a lawsuit has acted with deliberate intent to do harm to another or in circumstances in which there is substantial certainty that harm will occur. The defendant’s conduct is sometimes referred to as *nutious, purposeful, or knowing*. Reckless conduct, also termed *wilful and wanton* behavior, is conduct that is considered more than mere negligence or carelessness but considered less than intentional behavior. Driving an automobile very fast through a busy school zone while late for work might be regarded as reckless conduct, and liability would attach under a theory of recklessness. Often imposed on manufacturers under the law of product liability, strict liability—also referred to as *liability without fault*—is the theory of liability used to hold a defendant liable even in circumstances in which that defendant used all possible care to avoid being negligent and had no intention of causing harm.

It is the principle of negligence, however, that dominates the law governing most unintentional torts, including medical malpractice, and it is on the theory of negligence that a pathologist must focus.\textsuperscript{21} Negligence is defined, in relevant part, as “[c]onduct which falls below the standard established by law for the protection of others against unreasonable risk of harm; it is a departure from the conduct expectable of a reasonably prudent person under like circumstances.”\textsuperscript{22} The negligence principle involves 4 major elements: (1) an actor owes a duty of care to another, (2) there is a breach of the applicable standard for carrying out the duty, (3) as a proximate cause of the breach of duty an injury results, and (4) compensable damages or injury to the plaintiff occurs. To be negligent, a pathologist must commit an error that rises to the level of a breach of duty of care to the patient. The determination of whether the pathologist has a duty at all, or whether it has been breached, goes to the principle of standard of care.

**THE STANDARD OF CARE**

The principle of standard of care purportedly has its modern origins from an 1837 English case, *Vaughan v. Menlove*.\textsuperscript{23} In *Vaughan*, the plaintiff owned 2 cottages in the County of Salop, which he rented to 2 tenants.\textsuperscript{23} The defendant was a neighbor who built a haystack, or rick, near the plaintiff’s land.\textsuperscript{23} If hay is stacked from moist grass, bacterial fermentation may raise the temperature within the haystack above 130°F in which a chemical reaction produces flammable gas that can ignite.\textsuperscript{24} Farmers must be careful to avoid this “spontaneous combustion.”\textsuperscript{24} “[T]he hay was in such a state when put together, as to give rise to discussions on the probability of fire; that though there were conflicting opinions on the subject, yet during a period of five weeks, the Defendant was repeatedly warned of his peril...”\textsuperscript{21,23,25} “Being advised to take the rick down to avoid all danger, he said ‘he would chance it.’”\textsuperscript{23,25} “He made an aperture or chimney through the rick; but in spite, or perhaps in consequence of this precaution, the rick at length burst into flames from the spontaneous heating of the materials; the flames communicated to the Defendant’s barn and stables, and thence to the Plaintiff’s cottages, which were entirely destroyed.”\textsuperscript{23,25} The *Vaughan* court noted that the standard of care was determined by whether the defendant “proceeded[ed] with such reasonable caution as a prudent man would have exercised under such circumstances.”\textsuperscript{23,25} This concept is generally phrased today as a “reasonable person” standard of care.

“[O]ne characteristic of malpractice litigation is the requirement that at trial the plaintiff must prove that the defendant(s) breached a ‘standard of medical care’ or ‘practice’ that a physician or other health care provider in his or her field should have followed.”\textsuperscript{26} Although all physicians need to have an understanding of the principle of standard of care, elucidating the principle’s exact nature is difficult. Because one of the main purposes of medical malpractice liability is to deter health care providers from rendering substandard care,\textsuperscript{27} one circular interpretation of care meeting the standard of care would be any medical care other than substandard care. Another definition of standard of care incorporates the use of physicians’ normally possessed skill—“[t]oday the typical standards for medical malpractice actions require that ‘a doctor must use that degree of skill and learning which is normally possessed and used by doctors in good standing in a similar practice in similar communities and under like circumstances.’”\textsuperscript{28} Yet another definition considers physicians’ average degree of skill when determining the standard of care—“[t]echnically, the standard requires ‘the physician have knowledge of and perform with a degree of skill and care, accepting modern developments, that an average member of the profession would offer his patients’”\textsuperscript{29}, or stated another way, “[t]he average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality, in light of the present state of medical and surgical science.”\textsuperscript{30} Another definition of medical care meeting the standard of care is care delivered by a reasonably competent physician—“[t]he legal principle of the medical
‘standard of care’ usually is defined by case law or statute for each jurisdiction and is some version of ‘that degree of care which would be rendered by a reasonably competent physician practicing under the same or similar circumstances.’”31 Also, standard of care has been defined as physician care that meets minimal levels of competence and judgment— “[t]he critical legal benchmark in determining a physician's failure to fulfill his or her professional responsibility is the concept of the standard of care. The standard of care is breached whenever the physician fails to fulfill the minimal duty of care by failing to meet the minimal levels of competence and to exercise minimal levels of judgment.”32 As well, a physician may meet the standard of care by adhering to customary practice— “[g]enerally, only failure to adhere to customary practice constitutes negligence or malpractice.”33 However, customary physician practice may not be deemed to have met the standard of care “should customary medical practice fail to keep pace with developments and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care.”32,34 The standard of care is considered to be based on standards in place when the alleged injury occurred.32

The standard of care might be more easily defined by what it is not.35 The legally required standard of medical care is not perfect care or care that creates a perfect result; nor is it “what a physician would have done in his or her own practice (on a good day), which the physician assumes others also do.”31 Indeed, “legal scholars state that standard of care testimony is more apt to reflect what experts think that they and their colleagues would do, rather than what most physicians actually do.”31,36 Nor is the standard of care “what the physicians were taught to do in training, what textbooks recommend, or what clinical guidelines say it is,” even though guidelines “may indicate things that peers believe to represent optimal care, best practices, or recommended practices under the best available evidence.”31

Authors have labeled the standard of care “unpredictable and excessively discretionary”35 and have found “little agreement among practitioners as to what constitutes the acceptable standard of care and how it might be discerned in legal cases.”31 However, although “[t]he standard of care concept is currently embodied by physicians as a discredited legal term that has been long ignored by the medical profession . . . [t]he standard is nevertheless at the center of medicine's opportunity to improve and formulate a sustained, preventive ethics response to the professional liability crisis.”32

In summary, the standard of care—a little agreed-on, complex, confusing, and discredited legal term—refers to medical care that is not perfect or excellent care, not care based on one’s own assumptions or bias, and not care following “best practice” guidelines but is non-substandard, ordinary, average, customary, normally possessed, reasonably competent, minimally competent, frequently overestimated care that is measured at the time of the occurrence of the alleged malpractice. As aptly noted by Richard Epstein,36 “Everyone supports a standard of reasonable care, but everyone interprets it just a little bit differently.”

**EXPERT WITNESSES**

In a medical malpractice lawsuit, the issue of standard of care turns practical—how it is determined and applied in that specific case. Evidence determining what the standard of care is, and whether the standard has been breached, is always necessary in medical malpractice cases because the plaintiff must prove that the defendant breached the standard of care before the defendant can be found liable.30 In most medical malpractice cases, that determination is primarily based on testimony of expert witnesses. In short, the responsibilities of an expert witness are to (1) define a standard of care, (2) opine as to whether the standard of care was breached, and (3) opine as to whether any injury was caused by the breach.37 Expert witness testimony regarding the extent of the plaintiff’s injuries and regarding economic, psychological, and social consequences of the injury may also come into play during the litigation process;32; however, for the purposes of assessing defendant liability the focus is on expert witness testimony regarding the standard of care.

Not just anyone can testify as an expert witness in a case. Legal requirements vary among the states, and federal court standards also differ, but in general, “[t]o qualify as a medical malpractice expert, a physician must have sufficient knowledge, education, training, or experience regarding the specific issue before the court to qualify to give a reliable opinion on the relevant issue.”33,38 Expert witness testimony is considered even more important in medical malpractice cases than in general negligence cases because in the medical malpractice setting “courts have generally deferred to professional standards, supplied through expert testimony as to customary medical practice.”33 The plaintiff has to meet a burden of proof that, among other things, the defendant's actions did not meet the appropriate standard of care. “Ordinarily, to carry this burden the plaintiff must find a medical expert who is qualified and willing to testify that the standard of care was violated. Typically, defendants, too, must find their own experts to testify that the standard of care was not violated.”39 “[S]tandards of care are routinely interpreted oppositely by expert witnesses . . . [and] both sides devote considerable effort to screening and disqualifying consultant experts whose views do not represent the ‘standard’ the attorney needs to make the case. The attorney is doing his or her job.”39 This situation frequently leads to concerns about expert witness shopping by attorneys, “hired guns,” and the ‘battle of the experts.”9,29,40,41

“[T]he appropriate role of an expert witness is that of an educator, not an advocate”—the expert witness has a basic obligation of candor to the tribunal, rather than to any participant in the proceeding.32

**LAWSUIT PROCEDURES**

A pathologist should communicate with the pathologist’s risk management department or insurer—the specific individual to be notified varies according to each pathologist’s circumstances—at the first indication of any potential problem with a specimen or a case. One should not wait until a lawsuit is filed or even until a notice letter has been received. Early communication maximizes the pathologist’s chance of successful resolution of the situation, possibly even avoiding a lawsuit altogether. When an indication of a potential problem arises, one should not under any circumstances alter the patient’s records—including glass slides. The defendant's formal involvement in a lawsuit starts with the service of a summons and a copy of the plaintiff’s complaint.32 Because service is stressful, it is important to think about and determine the necessary steps to take immediately on being served be-
fore such a moment occurs. The pathologist should immediately notify the appropriate risk management individual, as noted previously. Then the pathologist, even in an understandably agitated frame of mind, should not talk about the case to anyone other than the pathologist's attorney or an agent of the attorney for whom attorney-client privilege attaches. Under no circumstances whatsoever should the pathologist get in contact with or discuss the case with the plaintiff or the plaintiff's attorney. The defendant pathologist is by definition a fact witness (as opposed to an expert witness) in the case and as such should reasonably expect to be deposed as the case moves forward. During the deposition, the plaintiff's attorney could very likely ask the pathologist to name everyone with whom the case was discussed. Other than the defendant's attorney or attorney agent for whom attorney-client privilege attaches, all others with whom the case was discussed might become fact witnesses themselves and potentially could be deposed in the case, with their testimony becoming part of the litigation. As the process of litigation is likely to proceed slowly and last for several years, the defendant pathologist must remain resolute and resist the urge to talk about the case.

“Discovery” refers to a period of time after a lawsuit has been filed, and before a trial, in which the exchange of information concerning the lawsuit occurs between plaintiff and defendant. So that all necessary information is revealed to both parties—to prevent any surprises at trial—discovery is construed broadly to include lots of information that may or may not be relevant to the issue at hand and that may not be admissible as evidence during the trial. One method of discovery comes in the form of written questions—called interrogatories—the answers to which are under oath and admissible in court. These are often written in "legalese" and may contain numerous repetitive-sounding questions. Interrogatories, along with other forms of written discovery—requests for admissions and requests for production of documents—are typically answered with the assistance of an attorney.

THE DEPOSITION

Another method of discovery is the deposition. The defendant's deposition in a medical malpractice case is an extremely important event in the process of the lawsuit and several articles have addressed its importance and how it might be best approached by a physician. A deposition is testimony of a witness, in this case, the pathologist defendant—a fact witness as opposed to an expert witness retained by the parties' attorneys—taken under oath before a court reporter. The words spoken by the witness are treated as courtroom testimony and the proceeding is conducted in accordance with the applicable state or federal court rules. A deposition is a discovery device—the plaintiff’s attorney asks the witness oral questions, to which the witness responds orally. It may be performed in a formal or an informal manner and is held in one of a variety of places such as an attorney’s office, physician’s office, hotel room, or court reporter’s office. Persons present at the deposition include the deponent pathologist, attorneys for the parties, a court reporter, and a videographer if the deposition is being video-recorded. In some cases the plaintiff may be present. From the deposition comes a written transcript that is a word by word account of all that is said in the deposition. One should keep in mind that in some cases an audiorecording or videorecording may be produced as well. Generally the deponent is entitled to a copy of the deposition to clarify an answer or correct spelling. It is not an opportunity to change an answer.

Various authors have vividly described the medical malpractice deposition: "The other side would love to hear all of their thinking . . . because they will give that to their experts to tear apart and come up with 30 other reasons why [that explanation] wasn't right." And the fun part of the deposition is that there isn’t going to be a judge there to rein you in so you can ask them anything you want. Some deponents have even been asked to empty their pockets at a deposition. "Also, the plaintiff’s attorney can be so punishing in their questioning that the witness would rather settle than face a repetition of the experience at trial. These tactics are considered ethical . . . " "Everything in the deposition is teased out, taken out of context, used against you." With that in mind, it is helpful to remember that the plaintiff’s attorney generally is attempting to meet several goals during the defendant’s deposition. One goal of the attorney is to become educated about the subject at issue—learn what knowledge the pathologist possesses and what the defense attorney’s strategies for the case are. To address this, the pathologist deponent is generally advised to avoid volunteering information, and to simply answer yes or no when appropriate, or to answer questions in short sentences. That is sound advice, but pathologists are very often educators, so limiting an answer and not expounding on a subject seems unnatural and uncomfortable. Unless the pathologist’s attorney counsels otherwise, the pathologist should not agree during the deposition to supply any document or other information to the plaintiff’s attorney.

Another very important goal of the plaintiff’s attorney is to judge the effectiveness of the defendant pathologist were the case to go to trial. One should dress professionally and always appear professional, polite, and calm. Although one may be emotionally tested during the deposition, it is necessary to keep one’s emotions in check. Pathologists should explain medical terms in a way that the lay public can understand to decrease the risk of appearing arrogant to a jury. Although the pathologist is a stranger to the deposition, the attorneys may know each other as well as the court reporter and videographer. As preparations for the deposition are underway, they may visit with each other and make small talk and may joke with each other. The defendant pathologist, most likely nervous and vulnerable to succumbing to some temporary release through joining in the small talk, should nonetheless avoid entering into any chit-chat and should certainly avoid joking during the entirety of the deposition process. Some defendants, personally and professionally involved in the proceedings, may reasonably find such informal chatting between the defendant's attorney and the plaintiff’s attorney off-putting; however, such behavior is considered acceptable and is frequent at depositions. Being aware of it and anticipating it may help keep it in perspective. Indeed, that face-to-face interaction may help forge or strengthen a professional relationship between the attorneys that ultimately may benefit the pathologist during settlement negotiations.

Another goal of the plaintiff’s attorney during the deposition is to impeach the pathologist’s credibility. To the jury, the credibility of the defendant is one of the most
important features of any case. The pathologist must therefore be truthful and consistent in answering questions. If unsure of an answer, simply state, “I don’t know” or “I don’t remember.” Pausing briefly before answering each question asked by the plaintiff’s attorney gives the pathologist a moment to carefully consider the answer and gives the pathologist’s attorney an opportunity to object to the question if necessary.

There are common misconceptions about a deposition that should be remedied. The deposition is not a forum to defend oneself—the pathologist is present at the deposition as a fact witness, not as an expert witness. Neither is it a forum to tell one’s story. The pathologist’s attorney is not going to elicit the story then, and the plaintiff’s attorney is simply interested in garnering facts that will help the plaintiff’s case. It is also not a forum to prove one is a smart doctor—state “I don’t know” when it is a sufficient answer.

There are some other important rules to remember when being deposed, including a few things not to do. A deposition is an adversarial proceeding and should not be considered in any manner “routine” to the lawsuit. When deposed, listen carefully to the entire question and make certain the question is clear before answering. The pathologist may ask that a question be repeated if necessary. Do not attempt to rephrase a question or speculate during the deposition. Do not accept as part of a question a summary of facts if there is any question about the accuracy of those facts. Avoid using “always” or “never” or any other such absolute term. Avoid saying “to be honest” or “honestly” or other such terms or phrases that suggest that prior answers were not truthful. Unless told otherwise, do not take anything with you to a deposition. Finally, do not verbally spar with the plaintiff’s attorney; the attorney will almost certainly outperform a pathologist in such a situation, to the detriment of the pathologist’s defense of the case. These rules are not exhaustive and do not replace advice from counsel; however, these are good rules of thumb to consider in anticipation of a deposition.

Marshall in 1995 described plaintiffs’ attorneys and tactics they use during the deposition in a clever but still useful way. The “pal” plaintiff’s attorney dresses casually, holds the deposition in a relatively informal setting, and jokes and banter with others before the deposition in an attempt to convince the deponent that the deposition itself is informal so there is no need to be careful about what is said. The pathologist should recognize this tactic for what it is and, keeping in mind the formal and serious nature of the deposition, remain focused on answering the questions truthfully. The “freight train” plaintiff’s attorney will, during the deposition, begin asking questions in a rapid-fire manner in an attempt to “run over” the pathologist, resulting in flustered, un-thought out, quick answers. If this occurs, the pathologist should remain calm and answer each question one at a time, unhurriedly, in complete sentences, to break the rapid-fire rhythm of the questions. The “butterfly” plaintiff’s attorney will move from one line of questioning to another, back and forth, confusingly, in an attempt to elicit conflicting statements. The pathologist should recognize and ignore this tactic and focus on answering out-of-order and repetitive questions consistently. The “time bomb” plaintiff’s attorney saves the most difficult, contentious, and complicated questions until the end of the deposition, when fatigue increases the risk of inconsistent or incorrect responses. If fatigued, the pathologist should ask for a short break and then focus on remaining attentive through the duration of the deposition. The “ignoramus” plaintiff’s attorney—who I prefer to call the “Columbo” plaintiff’s attorney—appears ignorant during the deposition. In an attempt to get the deponent to volunteer information, this attorney may leave time after an answer, and use body language, to prompt the deponent to add more to an answer than the question required. The pathologist must recognize this tactic and, stifling the educator reflex, merely respond to the question asked and no more.

COMMON MISDIAGNOSES

Aside from the legal aspects, it is helpful to consider as a practical matter what specimens or diseases traditionally put the pathologist at greatest risk for an error that results in a medical malpractice lawsuit. The definition of error itself is unclear and Frable noted in a 2006 article that, with the various methods used to report surgical pathology error rates, it may be difficult to distinguish error versus diagnostic variation. Nonetheless, some authors have determined the most common misdiagnoses that lead to pathologist medical malpractice litigation. Epstein in 2001 noted that the most common misdiagnoses resulting in lawsuits against pathologists concerned breast biopsies and fine needle aspirates, malignant melanoma, and lymphoma. Kornstein and Byrne examined jury verdict and settlement data in 2007 and identified, among cases that progressed to the point that either a settlement was made or a jury verdict was rendered, the alleged missed diagnosis of malignant melanoma on skin biopsy was the most common medical malpractice lawsuit against pathologists, with less common cases involving breast, gynecologic, lung, genitourinary, soft tissue, hematopathologic, head and neck, gastrointestinal/hepato-biliary, and thyroid specimens. Troxel has noted that almost one third of medical malpractice claims against pathologists involve the misdiagnosis of malignant melanoma as Spitz nevus or “dysplastic” nevus or the like. Papanicolaou tests remain a major litigation risk, and that risk is well-documented in the pathology literature.

Regarding medicolegal risk with autopsies, overall familiarity with the clinical history is important in maintaining autopsy quality, and pathologists must be aware that delays in reporting, internal inconsistencies, and flagrant omissions may appear to plaintiffs and their attorneys as acts of concealment or conspiracy with clinicians.

CONCLUSION

As a plaintiffs’ attorney declared, “No matter how much you think you know about medicine, you’re not an expert on malpractice law. Your lawyer wouldn’t try to take over for you in the operating room, so don’t tell him how to handle your case. And don’t assume that you’re smarter than us plaintiffs’ lawyers. Remember: Once you’re sued, you’re in our OR.” Possibly so, but we do not have to be under anesthesia.

References


