Avoiding the Legal "Blemish"

Medicolegal Pitfalls in Dermatology

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ABSTRACT

In today's legal environment, it is unlikely that a physician will complete a medical career without being introduced to the legal system in some way. Despite this, medical education often does not incorporate a basic teaching of general legal principles, and many physicians are left unaware of some of the important legal aspects of practicing medicine. The purpose of this article is to provide a background of the essential legal principles of a malpractice action as well as review the fundamentals of the legal process, provide published caselaw of prior dermatological pitfalls, and ultimately, provide suggestions to better prepare the dermatologist to practice medicine. (*J Clin Aesthetic Dermatol.* 2009;2(12):35–43.)

Throughout the first year of law school, a favorite question of legal professors is, "Can the party sue?" The answer is always the same—yes. Anyone can sue and for just about any reason. Although this may be somewhat of an unrealistic position, the underlying message of this statement should not be overlooked—dermatologists do get sued. Even though dermatologists enjoy lower malpractice rates than many other specialists, they are not exempt from medical malpractice actions. It is therefore essential for dermatologists to become familiar with the basic mechanism of a legal malpractice action and to educate themselves on some of the more common legal pitfalls in practice.

This article addresses the basic concepts of a malpractice action as well as reviews important legal concepts, such as informed consent. In addition, this article discusses actual legal cases that have found both in favor of and against dermatologists and the alleged negligent medical basis of those actions. Finally, suggestion points are provided throughout the article for how practicing dermatologists can better prepare themselves to hopefully avoid a lawsuit.

WHAT IS THE PROCEDURAL PROCESS BEHIND A LAWSUIT?

The procedural process of a lawsuit is an area of law often not understood and usually an area that formulates many questions. While this article is not intended to provide the entire nuts and bolts of the legal system, the authors will begin by addressing the basic "skeleton" of the legal process—from filing the complaint to trial.

The conception of a lawsuit starts with the filing of what is known as a complaint. Under the complaint, the plaintiff (patient) will list just that—his or her "complaints," which are referred in legal terms as the plaintiff's "causes of action." Under the causes of action, the plaintiff will also list the allegations and facts that purportedly support his or her claims. Generally, in a negligence malpractice action, a plaintiff has two years to file the complaint from the time the patient knew or should have known of the negligent action, although this timeframe may vary depending on the jurisdiction in which the complaint is filed. If the plaintiff fails to file the complaint within this timeframe, he or she is generally barred from bringing suit against a physician (under the concept of the statute of limitations).

Once the complaint is filed, it often has to be served on the physician within 180 days. Personal service is required on the physician or his or her agent or designee by a process server. After service is properly made, an "answer" will need to be prepared by the physician within 20 days. Thus, expeditious contact should be made with the malpractice

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DISCLAIMER: While informative lessons can be learned from this article, dermatologists who have any legal question or concern should always consult with an attorney before taking any action. Moreover, readers should also be aware that the law and legal standards may not only vary from case to case, but also from jurisdiction to jurisdiction.

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carrier so that the complaint can be referred to an attorney for assistance. Once the attorney files the requisite pleadings, a discovery conference will eventually be set, and a discussion of the discovery timeframes will be established as well as the needed discovery modalities. Discovery is a broad term that can be thought of as the time allotted to gather the facts and evidence necessary to support each party's claims and defenses. Discovery includes such items as interrogatories (written questions that are answered by the physician and reviewed by the lawyer), requests for production of documents (a list of documents that the patient would like the physician to provide), and depositions. Depositions are familiar to most, and comprise a series of questions asked by an opposing lawyer to the patient, physician, witness, or expert witnesses under oath—usually conducted at a law office or court reporter's office. During the discovery process, various motions by either party may be filed for a variety of reasons. Once discovery is finalized, the next phase is the trial. From start to finish, a lawsuit can take up to five years or more, although most are generally completed within a shorter timeframe. However, if served, dermatologists should anticipate exercising patience as there is no guarantee of a specific timeframe. Noting that not all jurisdictions are the same, this is a very general overview of the procedural process of a lawsuit.

WHAT COMPRISES THE BASICS OF A NEGLIGENCE MALPRACTICE ACTION?

Most often a dermatologist will be sued for malpractice based on a negligence cause of action. In order for a patient to recover for a negligence action against a dermatologist, four basic elements must be established (and proven by a preponderance of the evidence) in every case. Those elements include the following: 1) a duty owed to the patient; 2) a breach of that duty owed; 3) the breach of the duty owed was the cause (both actual and proximate cause) of the patient's injuries; and 4) the patient must show damages as a result of the physician's actions.

A duty owed to the patient is established by the presence of the physician-patient relationship and the requirements of a physician in this fiduciary relationship. A physician's duty requires that he or she provide the same standard of care as other dermatologists in good standing so as to protect the patient from unreasonable risk or harm. A duty owed can be thought of as the obligation the dermatologist owes to his or her patient to always have the patient's best interest in mind and to utilize the skill and knowledge of a competent dermatologist in implementing services to the patient.

Once a duty owed is established, a breach of the duty must be shown to have existed. A breach stems from a dermatologist failing to perform an action that he or she had a duty to do. In other words, his or her actions fell below the standard of care expected of a competent dermatologist in good standing. A simple example of this is the failure to provide proper informed consent to a patient by not, for instance, disclosing the important risks of a treatment.

In addition, a patient must also show the breach caused the patient's injuries. A way of thinking about causation is that it is not only the actual cause of the patient's injuries (i.e., if the physician had not failed to check the patient's drug allergies, the patient would not have taken the sulfa medication and developed Stevens Johnson Syndrome—SJS), but also the proximate cause of the patient's injuries (i.e., whether the injuries that occurred were "foreseeable" as a result of the physicians actions).

Finally, the patient must show damages. A patient might argue that it was negligent to prescribe a penicillin-based antibiotic because of a noted penicillin allergy in his or her history; however, the patient takes the medication and suffers no adverse reaction. While it may have been a breach of the physician's duty to the patient to provide the antibiotic, no damages ensued and so the patient would likely not have a viable negligence action against the physician.

All of these elements must be proven to sustain a *prima facie* case of negligence. Once a plaintiff has presented evidence to support his or her *prima facie* case, it is up to the dermatologist's lawyer to provide a convincing defense to interrupt any notion by the jury that the allegations have been proven by a preponderance of the evidence.

INFORMED CONSENT

Before some common causes of dermatology mishaps and errors that have introduced dermatologists to the legal system are discussed, informed consent must be addressed. The doctrine of informed consent is a common basis for malpractice lawsuits. In its basic form, the doctrine of informed consent is that a physician will obtain consent from a patient, absent an emergency, before treating or operating on the patient.[1,2] This doctrine implies that it is the duty of a doctor to disclose pertinent information to a patient. The implied consent doctrine can be found under statute in most states. Caselaw is prevalent on this issue.

In Nevada, the lead author's home state, Nevada Revised Statute 41A.110 provides the framework for obtaining informed consent and is likely similar in nature to other states, and thus will be used for discussion. Under Nevada's implied consent statute, medical consent is obtained if the physician has explained to the patient in general terms, without specific details, the procedure to be undertaken, the alternative methods of treatment, and the general nature and extent of the risks involved without enumerating such risks, and the physician has obtained a signature for the same.[3] This statute only provides the general framework for when implied consent has been obtained, but unfortunately, the statute cannot provide specific details as to whether the physician, for example, indeed provided adequate alternative methods of treatment for a malignant melanoma or provided the appropriate risk factors for the procedure in treating this malignancy.

In most jurisdictions, including Nevada, the standard for when informed consent has been established is under a "professional" standard, which states that the physician has a duty to disclose information that a reasonable dermatologist

would disclose.[4] This standard must be determined by expert testimony regarding the custom and practice of the particular field.[4] Thus, dermatologists should ensure the patient is adequately informed and uncertainties are discussed.

A good piece of advice for any dermatologist is to take the time to discuss the treatment as well as alternatives and risks/benefits involved in the treatment, then ask the patient if he or she has any questions. While some offices have preprinted forms for procedures, it is important to review these forms to ensure that they contain the necessary elements for informed consent. Dermatologists should not just allow patients to read the form and sign it without explaining the consent form to them and ensuring the patients' questions are answered. After meeting with the patient, the dermatologist should consider documenting in the medical record that the treatment, alternatives, and risks were discussed (in addition to the signed form)—to ensure that he or she in fact reviewed the information with the patient. Although generally not an issue in dermatology offices, a brief assessment should also be made to make certain the patient has the capacity to formulate an informed decision.

A HYPOTHETICAL CASE ILLUSTRATION DEMONSTRATING THE CONCEPT OF NEGLIGENCE AND INFORMED CONSENT

To provide a case illustration of the above concepts, consider a patient who presents to a dermatology office with a history of intravenous (IV) drug abuse. The patient's diagnosis is psoriasis and the patient is interested in tumor necrosis factor alpha (TNF-α) inhibitor treatment after attempting other failed modalities. The first potential pitfall for the physician is failing to review the patient's history. During the history, the physician should check important information, such as the patient's medical history, social history, and drug allergies. In this case, it would reveal that the patient has a history of IV drug abuse—a potential high risk for tuberculosis (TB) infection. Next, a discussion of the risks and benefits and alternative treatments should be discussed. An explanation of the risk of developing disseminated TB in a patient with latent TB when using a TNF-α inhibitor is clearly mandated by a physician's duty to disclose and obtain complete informed consent for treatment.

Next, the physician should offer purified protein derivative (PPD) testing for possible latent TB. The argument in a negligence action would be whether requiring testing for TB before providing TNF-α inhibitor therapy is the standard of care now in dermatology (and thus not providing testing is a breach of the physician's duty). While testing does not currently appear to be written as mandatory in the package inserts for some of the biologic agents used to treat psoriasis, it is recommended when prescribing a TNF-α inhibitor. Testing is also mentioned in a black box warning. Although published caselaw against a physician was not found on the issue of the standard of care, all dermatologists should avoid becoming the named defendant defining this issue. With patients in a high-risk group such as this, dermatologists should consider offering testing not only before treatment, but also yearly to monitor for changes.

What happens to the IV drug-abusing patient who is later found to have disseminated TB and was not offered testing? Aside from the duty of informed consent and TB testing, the other remaining elements are causation and damages. If a plaintiff can show disseminated TB, damages will be proven. The additional question to be answered is whether the TNF-α inhibitor is the proximal cause of the patient's disseminated TB or might the patient have already had disseminated TB prior to therapy. The likely inference in this scenario is not in the physician's favor. Thus, by providing the benefits and risks of treatment and ensuring testing before treatment, the physician not only protects the patient, but also protects his or her interests by establishing the patient's current state of health before treatment as well as assuring that the appropriate medications are given and informed consent obtained. Importantly, all of these precautions will help the physician avoid the rigor of a lawsuit.

WHAT IS THE CURRENT LEGAL ENVIRONMENT OF DERMATOLOGY?

Dermatologists undoubtedly enjoy lower malpractice rates than many other specialties.[5] However, the premiums paid by dermatologists, as with other specialists, have trended upward in past years. In a recent survey, it was noted that premiums increased by 24.4 percent in 2003 and 16.7 percent in 2004.[6] Dermatologists in the past have also been found to avoid the brunt of litigation dollars against physicians. In a study reviewing closed claims against physicians from 1975 to 1978, only 0.7 percent of total paid claims were attributed to dermatologists, even though dermatologists accounted for 1.4 percent of all practicing physicians.[6] To put this in perspective, however, this study was performed before the increase in dermatological cosmetic procedures and the advent of isotretinoin and newer medications, such as biologics.

The Physicians' Insurance Association of America (PIAA) has compiled information on medical claims against dermatologists, among other specialties. According to PIAA data from 1985 to 2001, the most prevalent "medical misadventure" was operative procedures on the skin (289 claims), followed by malignant neoplasms (93 claims) and malignant melanoma (77 claims).[7] The most common medical diagnosis involved in malpractice claims was malignant neoplasms, followed by acne and dyschromia.[8] In addition, in an article by Read and Hill[7] wherein they reviewed both Westlaw and Lexis searches (the major caselaw computerized reporters) of legal cases in combination with jury verdict searches, the authors found that the most common conditions forming the basis of reported claims involved melanoma, followed by malignant neoplasms of the skin, then acne, and cosmetic procedures.[7] Interestingly, adverse reactions to medications only comprised two of the cases found or less than one percent of the total cases. The lead author's review of Westlaw of reported cases in the past five years also revealed the

misdiagnosis and treatment of neoplasms as a common basis of lawsuits.

Ultimately, the common trend of these similar litigated issues may simply be due to the larger percentage of these conditions seen in dermatology and thus comprise a larger percentage of the cases filed. The bottom line, however, is that lawsuits against dermatologists tend to involve similar litigated issues of the past. While there is no way to completely avoid lawsuits in dermatology, lessons can certainly be learned from past cases in an attempt to avoid these errors.

PITFALLS AND ERRORS—PUBLISHED CASELAW OF PHYSICIAN MALPRACTICE ACTIONS

Cases involving prescription medications. One of the areas involving potential litigation in medicine involves prescription medications—and dermatology is no exception. Although Read and Hill reported that adverse reactions to oral medications are not a large percentage of the reported legal cases and claims, filed lawsuits over prescription medications have occurred and will likely continue to occur especially in light of future advances in medications, such as biologics and the future litigation over such issues as isotretinoin side effects. As such, a review of prior caselaw involving prescription medication errors is important. The caselaw presented here is provided to illustrate a few of the common medication writing errors, but it is also presented in order to provide insight as to what might be legally expected from a dermatologist when writing prescription medicines.

As a general rule, physicians must exercise reasonable care in prescribing medications. It cannot be emphasized enough that a thorough review of the patient's history be conducted prior to prescribing medications—most notably history, such as pregnancy/last menstrual period and drug allergies. Reviewing patient history might seem obvious, but there is ample caselaw on this issue.[9] It is unlikely a court will sympathize with a physician who writes a prescription medication in ignorance of a patient's listed medication allergy. Not surprisingly, in Baylis,[10] a physician was held liable for an anaphylactic reaction a patient suffered from cephalexin when a prior allergic reaction to cephalexin was written in the chart and the nurse was told by the patient of a penicillin allergy.[10] In Walsted,[11] a physician was found liable for prescribing ampicillin when an allergic reaction to penicillin had been listed in a previous hospital record.[11] Ultimately, if a drug reaction is listed anywhere (from present or past visit) in the chart, the physician will likely be held responsible for any harm. Thus, as most physicians do—all dermatologists should write patient allergies clearly on the front of the chart and ensure that the allergies are updated on every visit.

There are situations in which physicians were able to avoid liability for allergic reactions. In Tangoro,[12] a patient brought suit for developing anaphylactic shock secondary to penicillin. The patient was asked about prior allergies to penicillin, but reported no adverse reactions and appropriately, the court found in favor of the physician. In the case of Regan v. Gore,[13] the patient testified that she verbally informed the physician that she was allergic to sulfa medication. The patient was given a sulfa medication and developed a stroke. However, there was no notation in the chart indicating the patient was allergic to sulfa (only codeine), and the physician and nurse both testified that it was standard practice to document allergies. The court found in favor of the physician noting that given it was the physician's inveterate policy to document allergies to medications and only codeine was written, it was reasonable for the jury to find the patient had only informed the physician about an allergy to codeine and not sulfa.[13] The important suggestion here is to ensure that it is common protocol to document all hypersensitivities/allergies to medications in your practice. Moreover, allergy testing before prescribing medication has been held by at least one court to be unnecessary. In Slack,[14] expert witnesses testified regarding the impracticability of testing for possible drug reactions in advance of treatment and how it is economically unfeasible to test all patients for possible adverse drug reactions.[14] The court held in favor of the physician and found the physician was not negligent for failing to test the plaintiff prior to prescribing the medication.

In addition to allergies, the question has arisen as to what adverse effects a physician has a duty to disclose concerning a prescribed medication. Unfortunately, there is no absolute guideline on this issue. Some cases appear to suggest that the more "rare" or "remote" side effects may not require disclosure by the physician. In Watkins,[15] the patient was prescribed quinacrine (Atabrine, an anti-malarial drug) by his dermatologist for the treatment of discoid lupus erythematosus (DLE).[15] The patient was warned of the possibility of his skin turning yellow, and eventually developed exfoliative dermatitis. On the issue of adequately warning the patient about side effects of the drug, the district court found that "the physician was not required, under recognized standard of acceptable professional practice in medical profession and specialty of dermatology, to warn the patient about rare side effects of the drug and the physician did warn about common side effects." This was supported by the appellate court that further held that "[u]nder the recognized standard in the medical profession and the specialty of dermatology, [the physician] was not required to warn [the patient] about rare side effects including exfoliative dermatitis and erythema multiforme."

In Akers,[16] the patient brought a malpractice action after developing cataracts secondary to the long-term use of potent topical corticosteroids for psoriasis.[16] The appellate court supported the district court's findings in favor of the physician. The court noted that the patient was informed of the material risks involved with the treatment of potent topical corticosteroids, and even though the physician did not warn of the risk of cataracts, the court noted that there was a dispute among the experts as to whether cataracts were a known risk. The court also noted that while there was disagreement regarding the length of use and potency levels, there was expert testimony that the treatment met the standard of care. Further, in Woods,[17] a dermatologist had provided a course of gold injection therapy for DLE. The

patient developed jaundice from hepatitis caused by the course of treatment. In finding for the physician, the court noted that through the testimony, it was not the customary standard of practice to inform the patient of all the risks involved, nor to recite the symptoms. Also in Bullock,[18] the patient was prescribed quinacrine (Atabrine) for DLE and developed liver dysfunction. The patient alleged the physician failed to warn of possible liver dysfunction and thus, informed consent was not obtained. The court noted that the patient must prove the risk is inherent in the medical procedure undertaken so as to influence a reasonable person's decision to consent. In finding in favor of the physician, the court found that liver dysfunction was not a material risk of taking quinacrine (Atabrine).

In contrast, the patient in Bowman[19] brought a negligence claim against a dermatologist who prescribed methoxsalen (Oxsoralen, Valeant Pharmaceuticals, Aliso Viejo, California) for a chronic skin condition. The patient, while using Oxsoralen, suffered second- and third-degree burns after being out in the sun too long. It was found that the physician did not warn of the danger of burns with the drug and the package insert as well as the Physician's Desk Reference (PDR) advised of the drug's potential to cause severe burns.

Which adverse effects need to be disclosed depends on the type of medication, and the extent of information required to be disclosed legally may change depending on the jurisdiction in which the dermatologist resides. With the advent of the information superhighway and personal digital assistants (PDAs), an argument can be made that more may be expected of today's physician including informing the patient of the more significant common adverse effects. For example, in a patient taking doxycycline, it would be important to warn of photosensitivity, and with sulfonamide (sulfa) medication, the physician should warn the patient of the risks of SJS and toxic epidermal necrolysis (TEN), but possibly not a remote adverse effect, such as aseptic meningitis, absent any known predisposing condition. The more information the physician gives the patient, the better for both the physician and the patient. Whatever information is required can change from case to case and depends on the requisite standard of care in the jurisdiction.

In emergent situations, some courts found it justified for failing to warn the patient of remote adverse effects. In Shinn,[20] a patient was given phenytoin for seizures and was not warned of the possibility of SJS. The court held that in a life-threatening circumstance in which the treatment administered resulted in adverse affects that were rare, a physician may not be liable for failing to obtain informed consent. In Niblack,[21] a court found in favor of a physician who treated a patient with dexamethasone for pseudotumor cerebri. The patient later developed aseptic necrosis. The physician failed to warn against the possibility of aseptic necrosis. In holding for the physician, the court found that the risk of aseptic necrosis was only a remote possibility in comparison to the immediate likelihood of the patient developing permanent loss of vision or life. With this noted, there are not a vast number of day-to-day dermatological emergencies and thus, in a clinical situation for a nonemergency, care should be taken to warn of potential common and significant adverse effects. The severity of disease and necessity for treatment also has been a reason to excuse a duty to warn of an adverse effect. In Jackson,[22] the patient had a positive PPD test and was given isoniazid (INH) for treatment, but was not told of the risk of possible hepatitis, which the patient later developed. The court found in favor of the physician and noted that a reasonable person in the patient's position would have consented to INH treatment even with the knowledge of the risk of hepatitis.

If a dermatologist decides to utilize a medication for a purpose other than indicated on the manufacturer's package insert or as noted in the PDR, the use of the medication should be viewed as an acceptable application of the medication by competent physicians in the dermatology community. Even if it is common dermatology practice to use a medication in some other manner that is not approved by the US Food and Drug Administration (FDA) and is not provided for by the PDR or package insert and the patient later develops an adverse reaction, it should be noted that some courts have gone as far as to hold that information contained in a PDR or a manufacturer's package insert as *prima facie* evidence of a physician's standard of care.[23] In other jurisdictions, this information is merely some evidence of a physician's standard of care, and in yet another, it has been determined to have no legal significance.[24] In many jurisdictions, however, it is likely that the expert's testimony will be what is relied on to determine the medical community's accepted application of a medication, while a PDR or a manufacturer's package insert, if admitted, will be used as supplemental evidence of this standard. For example, in Morlino,[25] the court found that the PDR did not establish the standard of care in a negligent malpractice action against a physician for prescribing an antibiotic to a pregnant patient; instead, the court found the PDR and package insert could be used as additional evidence only if supported by expert testimony.[25] In Hogle v. Hall,[26] a dermatologist was found liable in district court after prescribing isotretinoin (Accutane) to a pregnant patient.[26] The district court found that the physician had failed to follow guidelines appearing in the PDR for Accutane.

Proper monitoring of adverse effects is also an important issue. This is especially true for dermatological medications. Examples of when dermatologists have found themselves liable have involved drugs such as Accutane and oral and topical corticosteroids. In Cooper,[27] a dermatologist was found to have breached the standard of care when he prescribed dexamethasone (Decadron) for recurrent dishydrotic eczema that was found to be prescribed in excessive doses for excessive periods of time and without appropriate monitoring. The patient eventually developed avascular necrosis that required hip replacement surgery. In Moyer,[28] two consecutive physicians prescribed Accutane to a patient. The patient's triglyceride and cholesterol levels were increased before Accutane was prescribed and had been "high" at only one point after treatment. The patient eventually developed cardiac disease requiring quadruple bypass surgery and sued for malpractice suggesting a

negligent connection between the prescribed Accutane and the cardiac disease. The case was ultimately dismissed based on statute of limitations issues, but not before a lengthy lawsuit.

There are several suggestions to reduce risk based on the above caselaw. Several of the suggestions are often commonsense approaches to treating the patient, but unfortunately, are not always carried out. To begin with, dermatologists need to be familiar with common and potentially significant adverse effects of medications. There are not many clinical dermatological emergencies, so some time should be taken to inform patients of potentially common adverse effects before providing the medication. Dermatologists must also always check the patient's history before prescribing a medication for the particulars, such as allergies, pregnancy, and significant past medical history. Such questions, as well as documenting and reviewing the answers, do not take a significant amount of time and should become rote practice. Also, dermatologists must become familiar with routine testing standards for medications and stay ahead of the changes that may be made to those standards. For example, if prescribing a TNF-α inhibitor, perform a PPD not only before treatment, but also consider possibly yearly testing. The patient's expert witness may just testify that this is the standard and a jury may be persuaded by such testimony. Additionally, documentation is important. Although testimony will be provided at trial, it is better to assume that the four corners of the medical record are what will be presented as having occurred during the visit. If, for example, a dermatologist informed a patient about the risks of a medication, the dermatologist should document that he or she in fact did so.

Cases involving diagnosis and treatment of skin disease. As with prescription medications, the lack of informed consent also applies to procedures and is a potential legal snare for dermatologists. The possibility for error can occur in such areas as failing to warn of the risks involved in a procedure, failing to discuss alternatives, and making representations regarding the outcome of a procedure, to name a few.[29] While in a limited review of cases, the jury and courts have been relatively sympathetic to the physician's position, this is not to say dermatologists have never had to compensate a patient for wrongdoing as discussed below.

In regard to failing to warn of the possible risks involved in a procedure, one example is a suit that was brought against a physician whose nurse had caused three disfiguring, permanent scars after draining acne cysts. The jury found that there was no liability even though the physician and nurse failed to obtain proper informed consent regarding the risks of the procedure, since even if the risks were provided, a reasonably prudent person in the patient's position would not have declined the procedure.[30] Nonetheless, even though this physician was able to avoid liability, it is better practice to ensure that the physician sees all patients before a procedure is performed, no matter how trivial it may seem, and ensure that the important risks are explained as well as document what the patient has agreed to.

In addition to failing to enumerate risks, some physicians have been sued for representing more than they could deliver. Cosmetic dermatological procedures are a potentially viable area for these types of errors, but are equally applicable to general dermatological procedures as well. In the Lerner matter, the patient alleged the physician made various representations as to the success of his tattoo-removal procedure, such as "Don't worry. The operation is a simple thing to do."[31] The patient later developed unsightly scars. The physician was found to have described the nature of the operation performed and he testified that he performed the procedure according to the proper and approved practice. The court found in favor of the physician and held the doctor is not a guarantor of good results. The court dismissed the case, without evidence that the doctor guaranteed a good result. However, in Korman,[32] the patient brought a negligence claim against the physician for extreme scarring she developed after breast surgery, despite a consent form signed by the patient acknowledging the risk of scarring and despite the physician discussing on prior visits that the likelihood of scarring was possible.[32] It was noted that when the patient asked about the risks of scarring from her breast reduction surgery, the physician informed the patient not to "worry about it, I've done hundreds of these" and "I think that you'll be happy with the results." Given the findings, the court set aside summary judgment in favor of the physician. The valuable lesson here is to frankly discuss the treatment and risks, but not to minimize a potentially significant risk, even if it is unlikely to occur or is an outcome that has not yet occurred in your practice. Dermatologists should keep within the informed consent form and the risks delineated therein that are acknowledged by the patient. By downplaying the risks or suggesting a guarantee of success, physicians may be perceived as misrepresenting the procedure to induce the patient to undergo the procedure, should a poor result occur.

Cases involving cosmetic dermatological procedures continue to be a common basis for lawsuits. Lawsuits have included matters from fillers to tattoo removals. For example, in Beckwith,[33] a patient brought an action against a physician who used an "infrared coagulator device" for tattoo removal. The patient later developed burns and full-thickness skin necrosis. The patient alleged the physician's use of the infrared coagulator fell below the standard of care and the physician should have instead used an ultra-short pulsed neodymium-doped yttrium aluminium garnet (Nd:YAG) laser. The physician initially prevailed on a motion to dismiss, but the appellate court later reversed the district court order and remanded the matter back for further proceedings. In another cosmetic case, the patient in Osburn[34] brought a medical malpractice action against a physician after the patient sustained facial eruptions and swelling after silicone injections to the face. The above cases are only a few examples of issues that have arisen in cosmetic dermatology. There are, of course, many more cases involving cosmetic matters, and given the rise in cosmetic procedures, it is likely that more malpractice actions involving cosmetic dermatology will continue to present in courts.

Physicians have also been exposed to lawsuits for failing to diagnose a skin lesion as well as for issues surrounding treatment decisions. As we previously noted, the most common conditions forming the basis of negligence claims have been malignant neoplasms, including melanoma. In Dible,[37] a physician was sued for erroneously diagnosing a basal cell carcinoma (BCC) as a squamous cell carcinoma (SCC) as well as for failing to inform the patient of a viable alternative to radiation therapy.[37] After diagnosis, the patient was referred for radiation therapy, rather than for what the patient alleged was a safer, more effective alternative therapy—Mohs micrographic surgery. In holding for the physician, the court found that not only did the physician rely on the pathology report from other physicians in making the diagnosis (whose reports did not fall below the standard of care), but that radiation is a recognized therapy for both BCC and SCC.

There are several recent cases involving lawsuits for failing to timely diagnose and treat neoplasms. In Dunn,[38] a dermatologist was sued for not diagnosing an SCC in a timely manner. In Nichols,[39] a physician was sued for removing a "spot" without the lesion being sent for pathology review. The "spot" recurred and another physician diagnosed the condition as melanoma. The key lesson here is any lesion removed should be sent for pathology interpretation. In yet another case, a physician was sued for failing to identify and treat a skin lesion that was thought to be a sebaceous cyst. This "cyst" was found later to be a malignant fibrous histiocytoma.[40] Another case involved a plastic surgeon who was sued for a biopsied lesion that was diagnosed as melanoma *in situ*.[41] The physician had failed to report the findings to the patient after the biopsy results were obtained. The patient never received follow-up care for the malignancy and the patient eventually died a few years later. In Lawrinson,[42] a dermatologist biopsied a lesion that turned out to be a Merkel cell tumor. The results of the biopsy were known before the follow-up visit. On the follow-up visit, the lesion was larger and more erythematous, but on that visit and the subsequent visit, the dermatologist informed the patient the lesion was healing well. By the third visit, the dermatologist indicated he did not know what to do and so the patient went to another dermatologist who sent the patient for surgery. The patient had most of the left side of his face removed. In total, the patient was subject to approximately a two-month delay before the surgery. The patient argued that this delay resulted in a much larger portion of the face being removed and undergoing radiation treatment. The physician argued lack of causation as the patient would have had to undergo the same treatment even if treatment was begun two months prior. The appellate court agreed with the jury's determination in support of the patient, noting that the patient likely suffered more injury due to the delay, than if he would have had surgery two months earlier.

In regard to choice of treatment options, the courts have ruled in support of dermatologists in several opinions when choosing which treatment to employ for a dermatological condition. In Akers,[16] the court found in favor of a dermatologist who used long-term potent topical corticosteroids in the treatment of psoriasis. The court determined that although there was a disagreement regarding the length of use of the potent topical corticosteroid, there was expert testimony to establish that the treatment met the accepted standard of care. In Thompson,[43] a dermatologist was sued for using cryosurgery for skin cancer on the patient's nose on separate occasions over an 11-month period. Despite the cryosurgery treatment, the condition worsened and eventually resulted in the loss of the patient's nose, which required reconstructive surgery. The court found, through the expert's testimony, that the use of cryosurgery was not inappropriate and even though a better alternative may have been employed, ruled in favor of the dermatologist. In Roberts,[44] the court found in favor of the physician who had treated the patient at three months of age for a capillary hemangioma on the cheek with dry ice to the lesion. The patient eventually developed scar tissue. The court found that there was no medical evidence that the treatment administered was in any manner improper, and that the treated lesion, even though having healed with scarring, healed in the usual and expected manner. In yet another matter involving a physician's proper selection of treatment, a physician was sued for removing a capillary hemangioma surgically rather than simply monitoring the lesion.[45] The patient was an infant and developed a capillary hemangioma on the side of the leg near the knee. The physician determined that surgery was appropriate as the lesion had steadily grown and was ulcerating. After surgery, the patient eventually developed extensive scarring along the leg. The patient's expert testified that the physician performed the surgery unnecessarily. Ultimately, the case was found to be a "battle of the experts" and the jury resolved the conflict in favor of the physician.

Poor performance in the carrying out of a procedure has subjected a dermatologist to a negligence judgment where the dermatologist dropped acid on healthy tissue while attempting to remove warts, and the patient suffered burns and scarring.[46] In Machacek,[47] a dermatologist treated a wart on the eyelid of a patient with topical cantharidin-podophyllin liquid. The patient later developed a 40-percent corneal abrasion/chemical burn. The patient sued alleging that the dermatologist should have referred the patient to a specialist because the removal of a wart on the lid margin was outside the physician's area of expertise. The patient also sued the physician for using cantharidin-podophyllin liquid on the face despite warnings from the manufacturer and for allowing the medication to get into the patient's eye. The jury found in favor of the dermatologist and determined her care did not fall below the applicable standard of care. In Hines,[48] a patient sued for negligence on the basis of the removal of a dermatofibroma. The patient argued that an excessive amount of skin was removed during a surgical excision, which resulted in highly visible scarring. This case was also resolved in favor of the dermatologist.

There are several observations to be gained based on

the above cases. Again, dermatologists must properly inform their patients of the treatment, the alternatives, and risks involved. For example, if cryotherapy is to be used, the dermatologist needs to inform the patient of potential hypopigmentation or hyperpigmentation without attempting to minimize the risks or guarantee a better outcome than is absolutely certain. Also, dermatologists need to correlate their pathology findings with their clinical findings. If there is some question regarding the diagnosis, dermatologists should not hesitate to obtain an additional pathology reading before implementing treatment. On the other hand, if the diagnosis is certain and requires timely action, dermatologists should not unnecessarily delay treatment or wait for a future follow-up visit that may be scheduled months later. They should make efforts to ensure the patient is seen in an approprtiate timeframe. If a patient cannot come to the office for any reason or the patient creates the delay, the dermatologist must document this as well as his or her attempt to reach the patient, for this may be considered a factor for contributory negligence on the part of the patient should a lawsuit arise. Further, dermatologists must understand the various treatment modalities and ensure that they are within the dermatology community standards. A dermatologists must also always review the patient's chart, including past medical history (such as cardiac history), allergies, pregnancy, social history, and current medications (such as recent antibiotics and anticoagulation therapy), to avoid overlooking simple, but potentially important and dangerous consequences. Moreover, the physician must document his or her interaction with the patient, including diagnosis and treatment. If the patient refuses a course of treatment or is nonadherent with medication or follow-up visits, the dermatologist should document those encounters in a professional manner. Finally, although the details are outside the purview of this article, physicians who manage their own practices must take the time to become reasonably familiar with the basics of the law governing healthcare and business practice, as it not only relates to patients, but also to employees. Dermatologists should familiarize themselves with Medicare changes, the Health Insurance Portability and Accountability Act (HIPPA), the Family Medical Leave Act (FMLA), the Fair Labor Standards Act (FLSA), Title VII (dealing with discrimination/harassment issues), the American with Disabilities Act (Titles I and III), and the Age Discrimination in Employment Act (ADEA). Seminars are often given on these areas of law and contacting the local State Bar Office in your community is a good place to start to find this information.

Finally, there is an abundance of medicolegal issues that cannot all be addressed in the framework of this article. Moreover, the issues that have been may not only vary from case to case, but also state to state. The only certainty is that the law is ever changing. Thus, as always, dermatologists who have any legal questions or concerns, should consult an attorney before taking action.

CONCLUSION

Many dermatologists will become familiar with the legal process during their careers. Dermatologists should become familiar with the law and keep current on the trending legal issues involving not only dermatologists, but also physicians in general. Knowledge of the law and of prior litigated issues is a good way to avoid becoming the party to a suit. Dermatologists should always keep current on the advances in dermatology and always keep the best interests of the patient in mind. These simple rules will prove beneficial to any dermatologist attempting to avoid the legal system.

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