Introduction

Dermatology is a relatively low-risk specialty, but certain conditions and procedures can increase the risk for a malpractice claim. When evaluating patients with potentially life-threatening diseases, such as suspected melanoma, dermatologists should be particularly attentive. Working collaboratively with access to consultations and dermatopathology opinions may help dermatologists reduce their lawsuit risks and improve patient outcomes.

Overview of Dermatology Claims

Dermatology claims represent a small portion of total medical malpractice cases. Information from the PIAA’s national database of medical professional liability claims shows dermatologists were named in 1,098 out of 96,454 closed claims (1.1%) between 2003 and 2012 (Figure 1). The PIAA is a national trade organization for professional liability insurance companies.
Among 28 specialty groups included in the PIAA analysis, dermatology ranked 21st in the number of closed claims. Although the average risk of a lawsuit for most specialties is 7.4%, dermatologists have only a 5% average risk.

In terms of payments made, dermatologists fared better than other specialties, with an average indemnity per claim of $213,451, 35% less than the overall average of $325,914. In total, dermatology claims accounted for about $60 million in indemnity payments during the ten-year period from January 1, 2003, through December 31, 2012.

Per-Dermatologist Claims Experience

As a dermatologist, your overall likelihood of being sued is relatively low; however, by the time a physician is 70-years-old, there is a 75% chance he or she has been sued, even in low-risk specialties. Few recent reports have evaluated the prevalence of malpractice suits in dermatology, but the American Medical Association’s 2007-2008 Physician Practice Information Survey indicates that nearly one in three dermatologists have been sued previously. Furthermore, approximately 8.9% of dermatologists have been sued 2 or more
In addition, the number of reported claims in dermatology has increased steadily since 1998.\textsuperscript{1}

According to the PIAA data, dermatologists aged between 35-54 years experience the majority of malpractice claims (62.5%).\textsuperscript{1} Solo practitioners account for more claims than group or institutional practices (58.3%), and dermatologists with previous claims experience make up a greater percentage of claims as well (66.9%).\textsuperscript{1} It is important to note that without information on the relative number of dermatologists from each demographic, conclusions cannot be drawn about whether these demographics are at greater risk or merely overrepresented in the dermatology population.

**Figure 2.** Dermatology Claims Demographic Breakdown, 2003-2012

Data from Reference 1
Most Prevalent Medical Allegations in Dermatology

What are the most common malpractice allegations against dermatologists? There were a total of 1,098 claims brought against dermatologists insured by PIAA-member companies from January 1, 2003, through December 31, 2012. Twenty-two percent of these claims were closed with an indemnity payment, and the total indemnity paid was $59,339,273.1 The 10 most prevalent allegations cited are described in Table 1. The three most common complaints are no medical misadventure, improper performance, and error in diagnosis.1 “No medical misadventure” means that the allegation in the claim was NOT one of medical misconduct against the dermatologist named in the lawsuit. Instead, patient harm may have been attributed to systems failures, communication problems, or other non-medical errors. The total indemnity for the “no medical misadventure” claims was low when compared to the indemnity for other allegations, and payments were made for only 5% of the claims in this category.

Table 1. The 10 Most Common Allegations in Dermatology Claims Based on PIAA data, 2003 2012.

<table>
<thead>
<tr>
<th>Allegation</th>
<th>Closed Claims</th>
<th>Total Indemnity (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medical misadventure*</td>
<td>330</td>
<td>$2.50</td>
</tr>
<tr>
<td>Improper performance</td>
<td>275</td>
<td>$11.02</td>
</tr>
<tr>
<td>Errors in diagnosis</td>
<td>186</td>
<td>$24.08</td>
</tr>
<tr>
<td>Medication errors</td>
<td>68</td>
<td>$4.69</td>
</tr>
<tr>
<td>Failure to supervise or monitor case</td>
<td>60</td>
<td>$2.36</td>
</tr>
<tr>
<td>Failure to recognize a complication of treatment</td>
<td>40</td>
<td>$3.30</td>
</tr>
<tr>
<td>Improper supervision of residents/other staff</td>
<td>27</td>
<td>$1.19</td>
</tr>
<tr>
<td>Failure to instruct or communicate with patient</td>
<td>24</td>
<td>$0.44</td>
</tr>
<tr>
<td>Performed when not indicated or contraindicated</td>
<td>20</td>
<td>$1.16</td>
</tr>
<tr>
<td>Wrong body part or patient</td>
<td>16</td>
<td>$0.14</td>
</tr>
<tr>
<td>Totals for top 10 allegations</td>
<td>1,046</td>
<td>$50.87</td>
</tr>
</tbody>
</table>

Data from Reference 1

*No medical misadventure means there was no allegation of medical misconduct against the physician named in the lawsuit. The allegations are instead related to non-medical issues.
The second most frequent allegation in the PIAA dermatology claims report for 2003-2012 is improperly performed procedure. The top procedures alleged to be improperly performed are shown in Table 2.

The third most frequent allegation in dermatology claims is error in diagnosis. The top conditions associated with these claims are listed in Table 3.

Although allegations of errors in diagnosis are made in only 17% of all dermatology claims, suits related to errors in diagnosis account for 40% of all indemnity payments for the specialty. This highlights the high rate of paid-to-closed claims (31.7%) in cases related to diagnostic errors. The average indemnity payment for a diagnostic-error claim is well over the average of all dermatology claims at $408,188. (The average indemnity for all dermatology claims is $213,451.) Furthermore, “diagnostic procedures of the skin”—the third most common procedure in the improper performance category—is also linked to diagnosis, and the average indemnity payment for this type of claim is even higher at $466,500.1

Table 2. Top 5 Procedures Associated with Allegation of Improperly Performed Procedure in Dermatology Claims, 2003-2012

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Closed Claims</th>
<th>Total Indemnity (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operative procedure on skin</td>
<td>172</td>
<td>$5.9</td>
</tr>
<tr>
<td>Injections and vaccinations</td>
<td>16</td>
<td>$0.1</td>
</tr>
<tr>
<td>Diagnostic procedure</td>
<td>15</td>
<td>$1.3</td>
</tr>
<tr>
<td>Operative procedure on blood vessels</td>
<td>13</td>
<td>$0.2</td>
</tr>
<tr>
<td>Misc. physical procedure</td>
<td>10</td>
<td>$0.2</td>
</tr>
<tr>
<td>Totals for top 5 procedures</td>
<td>226</td>
<td>$7.7</td>
</tr>
</tbody>
</table>

Data from Reference 1
Table 3. Top 5 Conditions Associated with Allegation of Error in Diagnosis in Dermatology Claims, 2003-2012

<table>
<thead>
<tr>
<th>Condition</th>
<th>Closed Claims</th>
<th>Total Indemnity (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasms of the skin</td>
<td>28</td>
<td>$2.74</td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td>24</td>
<td>$4.62</td>
</tr>
<tr>
<td>Disorder of the skin and subcutaneous tissue</td>
<td>16</td>
<td>$2.21</td>
</tr>
<tr>
<td>Benign neoplasms of the skin</td>
<td>10</td>
<td>$0.96</td>
</tr>
<tr>
<td>Disease of nail</td>
<td>7</td>
<td>$2.08</td>
</tr>
<tr>
<td>Totals for top 5 conditions</td>
<td>85</td>
<td>$12.61</td>
</tr>
</tbody>
</table>

Data from Reference 1

One of the main reasons dermatologists are sued, PIAA data indicate, is because a patient believes he or she was injured by an improper performance of a procedure or a misdiagnosis associated with a skin malignancy. Of the skin-malignancy claims, those involving malignant melanoma had the highest average indemnity amount. PIAA data suggest that a dermatologist experiencing a malpractice claim may be most likely to be facing an allegation that he or she improperly performed a biopsy procedure or mistakenly interpreted a skin lesion, especially one that turned out to be a melanoma.

In a 2017 study that evaluated 80 melanoma malpractice cases, misdiagnosis was alleged to be a factor in more than three-quarters of the claims. Of the cases studied, 40% were resolved in the defendant dermatologist’s favor and 60% in the plaintiff patient’s favor (40% of these at trial and 20% in pre-trial settlements).

Case Study: A Closed Claim for Failure to Diagnose Melanoma

Independent studies and data from the PIAA reveal that patients filing lawsuits against dermatologists often assert that there was a misdiagnoses of a malignant melanoma or other skin neoplasm. An American Academy of Dermatology survey found that about 64% of dermatologists use outside dermatopathology services for interpretation of biopsies while 36% interpret slides themselves. The following case concerns a dermatologist who initially
read his own slides of a patient’s lesion and apparently later sent the samples for a pathology opinion.6

**Case Study: Failure to Diagnose Melanoma**

In 2003, a 62-year-old man presented to a dermatologist with a persistent lesion on his left thumb. The dermatologist’s physician assistant (PA) examined the lesion, performed a biopsy, and informed the dermatologist that her clinical impression was that the lesion was squamous cell carcinoma. The dermatologist examined the sample, confirmed the diagnosis of squamous cell carcinoma and performed a Mohs micrographic excisional surgery to remove the patient’s lesion.

Two years after the undergoing the excision, the patient had a routine health check-up at his primary care physician’s office. The physician discovered a lump under the patient’s arm and referred him to an oncologist and surgeon. Left axillary adenopathy was present on CT. The patient underwent radical left axillary node dissection and was diagnosed with a malignant metastatic spindle-cell neoplasm, Stage IIIC.

The oncologist then obtained the pathology slides that the dermatologist used to make the original diagnosis of squamous cell carcinoma. The oncologist confirmed that the original lesion was indeed malignant melanoma, and that the thumb was the primary cancer site. It had metastasized to the patient’s lymph nodes and other organs. The patient filed a claim of malpractice against the dermatologist and PA.

During the deposition period for the lawsuit, a pathology report was found in the patient’s medical record. The author of the report was a pathologist who had reviewed the slides of the original thumb lesion at the request of the dermatologist. He had determined that the patient most likely had melanoma rather than squamous cell cancer. Although this report had been sent to the dermatologist and had been filed in the dermatologist’s record for the patient, the findings had never been conveyed to the patient.

The expert witnesses for the plaintiff (patient) testified that the failure to diagnose and treat the melanoma represented a significant deviation from the standard of care for the practice of dermatology. They said that if the correct diagnosis had been made at the time of the first biopsy rather than 27 months later, the plaintiff’s chances for survival would have been 80% to
90% instead of 20%. After mediation, both the dermatologist and the PA agreed to settlement of the case. Their professional liability insurer payed the full limits of the policies for both providers.6

Avoidable Mistakes

Several preventable errors occurred in this case, which if addressed, would have resulted in a better outcome for both the patient and the dermatologist. Despite the dermatologist’s lack of pathology background, he proceeded to diagnose the patient with squamous cell carcinoma. Although dermatopathology is part of a dermatologist’s training and board examination, a lack of board certification or fellowship training in dermatopathology is a significant risk factor for being sued.7 This underscores the importance of consulting with board certified dermatopathologists when a diagnosis may be questionable. Many allegations related to melanoma could be avoided with a multidisciplinary approach.8

It seems that the dermatologist in this case did consult with a pathologist eventually, after he had diagnosed and operated on the patient. However, he did not follow up with the patient after he received the pathologist’s analysis, which conflicted with his own diagnosis. It is not clear if he saw and disregarded the pathology report or if it was filed in the patient’s record with no review. No matter which circumstance occurred, the consequence was that the patient did not get the benefit of the new information. In all situations where dermatologists send biopsies out for initial interpretation or for additional analysis, there should be a fail-safe follow-up process in place that ensures the incoming reports are received, reviewed, communicated to the involved patient, noted in the record, and incorporated into ongoing care of the patient.

Some other factors that could result in diagnostic problems are as follows.

1. Low-power magnification

Low-power magnification examination of pigmented lesions may lead a physician to incorrectly categorize malignant melanoma as a benign nevus due to the architectural similarity of nevoid melanoma and benign nevus.9-12 Dermatoscopic examination may be useful. Pathologic examination with high-power magnification is essential to evaluate for hypercellularity, cytologic atypia, and the presence of dermal mitoses—all characteristics of nevoid melanoma.9

2. Partial biopsy (punch, superficial shave, and incisional biopsies)

The heterogeneity of a melanocytic lesion, by nature, makes it difficult to predict a location in the lesion where a punch biopsy will provide relevant clinical findings sufficient for diagnosis.9,13 Indeed, punch and shave biopsies were responsible for the majority of histopathologic misdiagnoses of melanoma.14 Nonetheless, US dermatologists often rely on partial biopsies, with only 34% of biopsies performed using excisional techniques.15 Whenever
possible, biopsies of suspected melanoma should be complete excisions, which allows pathologists to completely examine diagnostic features and assess Breslow thickness among other prognostic factors.16

3. Miscommunication and lack of communication

Some clinicians are hesitant to share clinical findings with dermatopathologists for fear of prejudicing findings.9 New evidence, however, indicates that provision of a clinical impression aids dermatopathologists and is an important component of dermatopathology requisition forms.17-19 Dermatologists should attempt to include important clinical information in requisition forms as opposed to simple directives such as “rule out melanoma.” The most important information includes lesion size, location, clinical impression, sampling method, and patient age.9,17

4. Incomplete documentation of uncertainty

When presented with difficult cases in which the initial diagnosis is uncertain, dermatologists and pathologists should seek second opinions. In these situations, open and honest documentation about the difficulty of diagnosis is extremely beneficial.9 Such documentation helps both the clinician and the patient in establishing that differing opinions may exist, so that a patient is informed when seeking second opinions or making treatment decisions. Furthermore, clear documentation may contribute to the defense of a malpractice suit.

5. Patient refusal of further diagnostic pursuit

Sometimes patients will present with lesions but will then refuse to get biopsies or decline further investigation. In such cases, it is a good idea to attempt to have a discussion to uncover what is behind the patient’s refusal of care. Is the patient afraid of receiving bad news? Is the patient experiencing some change in his or her financial circumstances and concerned about healthcare costs? Has the patient’s insurer denied coverage for certain types of testing? If you understand the motivation for a patient’s denial of care, you can further explain to make sure the patient understands the situation and is making an informed decision when refusing care. If a patient’s insurer denies coverage for a test you believe is necessary, recommend the test to your patient anyway, and document your discussion in the patient’s record.

American Academy of Dermatology Melanoma Biopsy Guidelines

The American Academy of Dermatology (AAD) has published detailed guidelines for biopsy and diagnosis of melanoma.20 Although dermatologists are encouraged to consult the full guidelines, an abbreviated summary of the section on biopsy follows:
AAD Recommendations for Biopsy

- Preferred biopsy technique: narrow excisional biopsy of entire lesion with negative margins deep enough to ensure lesion is not transected
- Acceptable: partial sampling in circumstances such as facial or acral location, low clinical suspicion or uncertainty of diagnosis, or very large lesion
- Recommended: repeat biopsy if initial biopsy specimen is inadequate for diagnosis or microstaging of primary lesion

AAD Recommendation on Information to Be Provided to Pathologist

As described previously, thorough communication with the histopathologist is an important component of sample interpretation. The AAD recommends the following information be provided to a histopathologist.

<table>
<thead>
<tr>
<th>Essential</th>
<th>Strongly Recommended</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Age</td>
<td>Biopsy technique (excisional or incisional)</td>
<td>Clinical description and level of clinical suspicion</td>
</tr>
<tr>
<td>Gender</td>
<td>Size of lesion</td>
<td>Dermatoscopic features</td>
</tr>
<tr>
<td>Anatomic location</td>
<td></td>
<td>Photograph</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Macroscopic satellitosis</td>
</tr>
</tbody>
</table>


Do these AAD recommendations represent the legal standard of care? Are they to be applied in all cases? No. As the AAD states, “These guidelines should not be interpreted as setting a standard of care....The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the disease.”\(^\text{20}\)
The Cost of Delayed Melanoma Diagnosis

The incidence of melanoma is currently increasing throughout the US, particularly in adults under 50 years, yet melanoma-related mortality rates appear to be decreasing or at least remaining steady.\textsuperscript{21-23} The decrease in melanoma death rates is in part due to advances in treatment, such as the new biologic drugs ipilimumab, nivolumab, and pembrolizumab.\textsuperscript{24} In addition, prompt detection of melanoma is considered one of the key components of decreasing melanoma-related mortality.\textsuperscript{25} The 10-year survival rate for patients with localized melanoma is 95%, but the survival rate decreases for those with lymph node involvement (68%) and distant metastases (10% to 15%).\textsuperscript{26}

As illustrated in the case study, a delay in melanoma diagnosis can have severe consequences on disease prognosis and outcomes. In a prospective population-based study, longer diagnostic intervals were associated with increased mortality,\textsuperscript{27} indicating that early diagnosis is an important component of melanoma care. Similarly, initial misdiagnosis of melanoma as chronic wounds, nevi, or other conditions significantly decreased the 5-year disease-free survival rates and the 5-year overall survival rates.\textsuperscript{28} Since misdiagnosis can delay accurate diagnosis by approximately 9 months,\textsuperscript{28} early proper diagnosis is critical.

The gravity of diagnostic errors is evidenced by the overrepresentation of errors in diagnosis among those claims involving the most serious injuries. For example, in the PIAA data for dermatology claims, even though errors in diagnosis account for 17% of all claims, they represent approximately 35% of claims involving significant permanent injury, 63% of claims involving major permanent injury, 69% of claims involving grave injury, and 28% of claims involving death.\textsuperscript{1} Similarly, claims related to malignant melanoma were overrepresented among claims involving grave injury and death.\textsuperscript{1} Indeed, the large indemnity payments related to malignant melanoma diagnostic errors are likely in keeping with the fact that these errors generally cause substantial patient injuries.

Concerns about Overdiagnosis

Overdiagnosis of melanoma has emerged recently as a concern due to the “disastrous consequences of an unrecognized melanoma,” which are substantially greater in magnitude than the “negligible consequences” of re-excision and sentinel node biopsy.\textsuperscript{29} Most dermatopathologists acknowledge that malpractice concerns influence their decisions to order specialized pathology tests and obtain recuts.\textsuperscript{7} Although overdiagnosis is a concern when it leads to overtreatment, increased scrutiny of biopsies and use of specialized tests cause relatively negligible harm, which should be considered when weighing the risks of unrecognized melanoma.\textsuperscript{29}
Summary and Additional Risk Management Recommendations

- Excluding claims alleging no medical misadventure, the two most prevalent allegations found in the PIIA dermatology claims study are improperly performed procedures and errors in diagnosis. Although there are fewer claims pertaining to diagnostic errors, this category accounts for the highest total indemnity payment.

- A multidisciplinary approach to melanoma diagnosis can help prevent missed or delayed diagnoses of disease.

- Strategies to reduce the risk of missed or delayed diagnosis of melanoma include complete excision of the lesion in most cases, recognizing key cytological features associated with melanotic lesions, repeat biopsy in cases of inadequate sampling, sending excised lesions for histopathological analysis, and obtaining second opinions in marginal cases.

- Communicate with the histopathology lab by providing the necessary clinical findings, including clinical impressions, in the requisition forms.

- Dermatologists should become familiar with relevant practice guidelines of their specialty and understand the role of guidelines in clinical decision-making. Practice guidelines are an aid to the dermatologist’s clinical decision-making, not a substitute for it. Guidelines do not represent the legal standard of care.

- The AAD melanoma guideline on biopsy is rated II B, meaning moderate strength of recommendation based on inconsistent or limited evidence, the best that is available at this time. Watch for the emergence of stronger evidence and updated guidelines in the future.

- When departing from a guideline that is well-accepted and supported by strong evidence, document the rationale for your actions.

- Patients have a right to be informed about their conditions and receive answers to their questions. Discuss the risks, benefits and alternatives to proposed treatment, and the risks of doing nothing. This conversation should be documented in the medical record. If the patient refuses recommended testing or treatment, this “informed refusal” should be documented as well.
Bibliography: Risk Issues in Dermatology: Melanoma

Note: Web links can change over time. If link no longer works, web-search the article by title.

Resources


References


