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DERMATOLOGIC DISQUISITIONS AND OTHER ESSAYS
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Medicolegal issues

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Abstract The legal landscape in dermatology is constantly evolving. Dermatologists should nurture strong physician-patient relationships with proper informed consent and stay abreast of legal issues as they pertain to today's practice of medicine. Medicolegal issues that have risen to the forefront include wrong-site surgery, delegation of procedures to nonphysician operators, and compounding of medications. Additionally, although the marriage of health care and technology has facilitated our practice of medicine, it has opened doors to new medicolegal pitfalls associated with the use of electronic medical records, teledermatology, and even social media. This contribution will highlight some of the common medicolegal issues in dermatology along with recommendations to minimize exposure to litigation.

Introduction

As dermatologists, we strive to provide our patients with the highest level of dermatologic care. The physician-patient relationship is fundamental to achieving this goal. A strong relationship with effective communication, shared decision making, and realistic expectations allows both the physician and patient to have a positive experience. Most physicians strive to achieve this, yet almost two thirds of physicians age 55 and older in the United States have been sued at least once during their career.[1] Even though this percentage is significantly lower for dermatologists, we are still cognizant and concerned with today's litigious environment. One study analyzed malpractice data from 1991 through 2005 and found that the mean indemnity payment was $117,832 for dermatology.[2] Returning to the basics of the physician-patient relationship can help resolve medicolegal issues even when outcomes may not always go as expected. Herein, we will highlight some of the prominent medicolegal issues in today's health care environment and identify methods to reduce potential risks.

Informed consent process

Dermatologists routinely perform numerous medical, surgical, and cosmetic procedures. The informed consent process is essential for any procedure as a way to build the physician-patient relationship and is the bedrock of protection for both the physician and patient. A successful informed consent involves both a discussion between the physician and patient with regard to the risks, benefits, and alternatives of a particular procedure and documentation of their discussion. Interestingly, some patients may even use their smartphone to record your conversation with them with or without your knowledge.[3] Many states, including California, have laws in place making it illegal to record a conversation without prior consent. Although this can strengthen the physician-patient relationship by allowing the patient to recall important details of your conversation, the recording can also be used in a medical liability case and be misrepresented; thus, physicians should exercise caution when allowing a patient to record a conversation.

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Surgery site identification

An integral aspect of informed consent for surgery is to assist with correct surgery site identification. A survey of 300 Mohs surgeons revealed 14% of malpractice litigation to be a result of wrong-site surgery.[4] Another study found that Mohs surgeons incorrectly identify biopsy sites 5.9% of the time when using only pathology reports, biopsy diagrams, and palpation—without photographs.[5] To complicate things, patients often forget where a biopsy was taken and have difficulty identifying the site themselves. Incorporation of prebiopsy photographs of skin lesions led to 100% accuracy in biopsy site identification.[5] Biopsies in some anatomic locations, such as the scalp, however, are often difficult to identify even with a photograph, particularly if a long time has elapsed between the biopsy and the Mohs procedure; moreover, photographs that are too close-up, blurry, or lacking identifying landmarks can also complicate surgery site identification. Supporting staff can be trained in how to take photographs that are appropriately distant and, when possible, contain landmarks to assist with identification. Additional methods reported in the literature include triangulation from fixed anatomic landmarks, ultraviolet-fluorescent tattoos of biopsy sites, and even biopsy "selfies" taken by patients.[6–8] One study surveyed experts in dermatologic surgery and found a strong consensus for taking a high-quality photograph with at least one visible anatomic landmark for identifying the biopsy site.[9] Although wrong-site surgery is an uncommon occurrence for dermatology, the dermatologic surgeon should have a consistent and accurate method of identifying the correct biopsy site.

Delegating tasks to nonphysicians

Due to our vast number of procedures, we have gradually delegated, where legally and ethically allowable, many tasks to nonphysician operators. This can be an avenue for litigation if they are not properly trained. A study examined 28 years of legal cases secondary to cutaneous laser surgery and found an increasing trend of litigation, with a peak in 2010. Failure to properly hire, train, or supervise staff was the most common allegation, followed by failure to properly perform the treatment or operate the laser. Nearly 40% of the cases involved a nonphysician operator, which included both allied health professionals and nonhealth professionals, such as aestheticians and technicians. Even if the physician supervisor did not perform the procedure, he or she was still named as a defendant.[10] Whereas dermatologists are trained to recognize skin injury and how different skin types respond to various forms of trauma, nonphysician operators may incorrectly proceed with an injurious procedure for failure to recognize signs of skin injury such as urticaria or erythema. One way to avoid this problem may be to have the dermatologist select setting parameters and, when practical, implement the use of test spots before allowing the procedure to be delegated to a technician. If a nonphysician operator is performing the procedure, the physician should be available in accordance with governing state rules and regulations, which vary by state.

Compounding medications

As we have expanded our treatment armamentarium for both common and rare dermatologic conditions, we have trended back to compounding to fill the niche of medications not readily available from the pharmaceutical industry. This allows for tailored treatments, which meet the unique needs of patients and result in better outcomes[11]; however, compounding has been brought to the forefront of the national media, most notably, with the multistate outbreak of fungal meningitis in 2012 associated with methylprednisolone acetate injections.[12] Ultimately, two pharmacists from the compounding pharmacy were charged with 25 murders in 7 states. As dermatologists, we should support continued access to compounded products with appropriate safeguards and be aware of the potential pitfalls associated with compounding. Dermatologists are ultimately responsible for advocating for the care and safety of patients in their practices.

Electronic medical records

We have entered an era where health care and technology are undeniably intertwined. Although technology offers increased efficiency in some aspects of medicine, it has also opened additional doors for medical liability. Electronic medical records (EMRs) now document every interaction with a patient and are easier to follow than paper chart trails; thus, timely documentation is helpful in the event that records are subpoenaed for a case. Patient tracking features can be our best friend, unless we forget to address the inbox and alerts in a timely manner. The ability to clone chart notes is a temptation and may save time but should be done cautiously. Erroneous data can be transferred while cutting and pasting, and chart notes that are too generic and repetitive will start to lose their significance. When using text templates for consent discussions and procedure notes, information specific to the individual patient can be included. For example, if performing a Mohs surgery on the temple area, an annotation to the consent template about risks of temporal nerve damage can be made to indicate a personalized informed consent discussion with the patient. Procedure note templates should be carefully updated to reflect an accurate account of events for each individual patient (eg, if cautery was used for hemostasis instead of aluminum chloride or if a #15 blade was used instead of a flexible blade). When documenting the physical examination with templates, anatomic sites not actually examined should