# Two become one: Ethics in dermatologic surgery

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**CASE SCENARIO 1**

An 81-year-old man with a 0.8- × 1.1-cm nodular basal cell carcinoma on the right preauricular skin and an additional 0.6- × 0.7-cm nodular basal cell carcinoma on the right lateral cheek, 0.8 cm medial to the preauricular lesion, presents for Mohs micrographic surgery. He has a history of numerous nonmelanoma skin cancers on the face with various subsequent reconstructions and consequent scars.

**CASE SCENARIO 2**

A 49-year-old woman with 0.8- × 0.9-cm invasive squamous carcinoma on the left lateral upper cutaneous lip and an additional 0.6- × 0.6-cm nodular basal carcinoma on the right lateral upper cutaneous lip presents for Mohs micrographic surgery. The lesions are 0.8 cm apart. These are her first skin cancers and she is concerned about scarring as she has a high-profile, public relations job.

**Concerning the removal of the cancer and reconstruction, the surgeon should:**

**A.** Combine the surgeries and reconstruction into a single lesion.
**B.** Perform 2 separate surgeries for the 2 separate lesions and combine the reconstruction.
**C.** Perform 2 separate surgeries and 2 separate reconstructions.
**D.** Perform 2 separate surgeries and consult a plastic surgeon for the reconstruction.

## DISCUSSION

The prevalence of skin cancer and the associated treatment costs have risen dramatically in recent years.[1] Dermatologists have been in the news for high health care expenditures, and there may be a public misperception of dermatologists and the work they do.[2] Regardless of perceptions, however, any health care delivery has economic implications, both for society and for the affected individual. Moreover, there are ethical and legal dimensions to health care delivery. The principles of patient autonomy, beneficence and avoidance of harm (primum non nocere) are paramount in the decision-making process. These principles are strongly influenced by access to information. In day-to-day practice this often translates into spur-of-the-moment decision-making in which the underlying ethical principles are only implicit. Generally, in a world of finite resources and increased demands to access health care, allocation choices have both economic and moral implications. Medicare and other insurance carriers impose restrictions on the decision-making process. However, within the framework of the available resources, patients have a right to appropriate care and health care providers must act in the patient's best interest.

In day-to-day dermatology practice, it is not uncommon to face individuals with multiple

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nonmelanoma skin cancers, which can, at times, be in close proximity. This raises diagnostic challenges because closely adjacent lesions on clinical examination may represent a single pathophysiologic entity. It also raises surgical challenges as the removal of one tumor may overlap with the removal of a closely adjacent tumor. Moreover, even if the surgical defects do not overlap, the repairs might. These challenges are complicated by the economic consequences of one decision over another. The removal of 2 lesions could result in higher reimbursement for the provider than the removal of one lesion. Similarly, separating the removal of the tumors from the reconstruction by different dates or different (unrelated) providers could result in higher reimbursement, while imposing the burden of extra visits on the patient. Economic decision-making, like clinical decision-making, has ethical implications and needs to be analyzed within the applicable moral paradigms. These paradigms are at least partly influenced not only by objective patient factors, such as anatomy and local skin physiology, but also by subjective patient wishes. Medical ethics grants the patient significant autonomy in decision-making. Arguably, cosmesis is a prime example of patient autonomy superseding a surgeon's preferences in many circumstances as medical decision-making plays only a limited role. For example, if the patient preferred secondary-intention healing despite a prolonged healing period and possibly worse cosmetic outcome, the surgeon will often have to acquiesce, even if he or she does not agree with the patient's decision. The surgeon might dislike secondary-intention healing as cosmetically inferior but, as long as the patient has adequate access to information about the consequences of the decision, the patient's autonomy determines the patient's best interests and, thus, the clinical outcome.

Although the economic implications of surgery at 2 separate but closely approximated sites have been extensively discussed and billing for such procedures has become almost an art form,[3] the ethics of such surgery has not been previously focused upon. From a patient's and insurer's economic perspective, the least expensive treatment option would likely be preferred. From a surgical reconstruction perspective, the strategy will depend on the type of tumor, anatomic site, patient's age and comorbidities, local skin physiology, and the proximity of the lesions. In addition, the patient may have preferences independent of any aforementioned variables, such as a desire to limit the surgical time to the shortest possible period. Generally, these factors are both qualitative and quantitative. The subclinical extent of a tumor can be measured by microscopic analysis. Similarly, the laxity of a patient's skin, although not necessarily agreed upon by all observers, is a measurable variable. However, not all measurable variables are also quantitative variables. For example, the patient's age is typically a guidepost that needs to be viewed in the appropriate clinical context. A 75-year-old individual without comorbidities and without a lengthy list of medications may tolerate more extensive or prolonged surgery than a 51-year-old individual with stage-IV kidney disease and congestive heart failure. Similarly, a patient's unwillingness to undergo complex surgical reconstruction because of anxiety may be more easily addressed than a patient's unwillingness to undergo the same reconstruction because of shortness of breath in the setting of severe pulmonary disease. Even the proximity of lesions is not a purely mathematical variable. If 2 adjacent lesions are separated by the border of 2 distinct cosmetic subunits, the surgeon will be more careful in trying to avoid crossing this border than if the lesions are within the same subunit. Thus, a 6-mm distance between 2 lesions on the mid aspect of the cheek may be less relevant than a 4-mm distance between a lesion on the nasal ala and another on the medial aspect of the cheek. All of these factors play into the decision-making process and, in the interest of full disclosure, need to be adequately explained to the patient. On the basis of full information, the patient may exercise the right to autonomy and influence the decision-making process, while the health care provider will have to adhere to the fundamental principles of beneficence and avoidance of harm.

In conclusion, surgical decision-making is an ethical process dependent on moral paradigms, which are often only implicit. These paradigms, in turn, are dependent on differential weighing of multiple factors, including quantitative variables, such as tumor size, and qualitative factors, such as patient preferences. Many times, the process may appear straightforward but there will be occasions when more complex analysis is required. In dermatologic surgery, as in all medicine and surgery, the patient's best interests are paramount. From a moral perspective, the best possible outcome depends on whether the patient has been given adequate access to information to exercise the right to autonomy and whether there are any other factors that, implicitly or expressly, influence the decision-making process. The surgeon needs to be aware of limitations imposed by economic constraints and individual patient