Litigation Within Dermatology & Dermatopathology

• Misdiagnosis of melanoma is a key problem

• The Doctors Company (1990-2001)
  – “skin cancer” and/or “melanoma”

  • 8.6% of all claims against pathologists
  • 14.2% of all claims against dermatologists
Too much litigation versus too many errors?

• Harvard Medical Practice Study (1990)
  – 31,000 medical records examined
  – “Negligence” only by consensus
  – 1 out of 25 harmed by medical error
  – Only 4% of injured actually made claims
“Stop Being Polite…. and Start Getting Real”

• Errors occur everyday (truly)

• If you believe you personally do not make errors while on the job you are:
  – delusional
  – ignorant
  – delusional and ignorant
• 1452 claims
• 90% with medical injury
• 60% due to wrongdoing by MD
• 72% *without* error → no compensation
• 73% *with* error → compensation
• Litigation fees ~ $52,000
• Time to resolution ~ 5 years
Half Full or Half Empty

- 90% of suits involved actual medical injury
- Courts “right” ~ 75%
- Only 0.4% of claims “frivolous”

“Careful & Deliberate”

- 10% of claims *without* injury
- 75% is a “C”
- ~ $52,000 & 5 yrs to adjudicate

“Wasteful & Fickle”
Purpose of Malpractice Law

“To identify a party injured because of substandard care and compensate the party, so as to make them whole.”

• Malpractice is *tort law*

• It is a *civil action*

  – “Preponderance of the evidence” (>50%)
Principles of Malpractice

• Civil matter
• Governed by state law (50 variants)
• Purpose is to make an injure party whole (to the extent that money can)
• No jail sentences (except for contempt)
• Rarely are punitive damages even sought (there are reasons why this true)
Elements of Malpractice

Six elements of a *prima facie* case

1. Duty
2. Standard of Care
3. Breach of Duty
4. Cause in Fact
5. Proximate Cause (Legal Cause)
6. Damages

(failure to prove a single element is fatal)

“Causation”
Simple Pyramidal Structure

Duty To Act

Negligent Action or Inaction

Damage from Negligent Action/Inaction
Duty

• “Contractual” agreement to provide care with proper professional skill
• Opposed to “curbside,” “hallway,” or “sidewalk” consultations
• Courts traditionally reluctant to assign duty to those with only tangential relationship
• Use of “images” (telederm) or actual patient materials (slides) may make one liable

Baker KD, The Federation of Defense & Corporate Counsel
http://www.thefederation.org/documents/baker-sp02.htm
Varying Standards of Care

• Some states:
  – “reasonably prudent physician” of same background, training, experience

• Other states:
  – knowledge and skill common to members in good standing
    (conformity to “customary practice” but also with consideration of a “respectable minority”)

Notes

The outcome does NOT have to be favorable!

You do NOT have to be “correct”!
Breach of Duty & Causation

• Concept of contributory negligence

• Cause in Fact (“But for,” causation)
  – Determined by jury
  – Did that actions actually lead to the result?

• Proximate Cause (legal causation)
  – Determined by the judge
  – Was the result foreseeable?
  – Is it “reasonable” to hold the party accountable?
US Attorneys Not Really Interested in “Close Calls”

- Average cost of lawsuit
  - Plaintiff’s Atty. = $125-250k

- “Where’s Waldo” cases
  - some pigmented lesions are difficult for **ALL** experts

- Farmer, et al. (1996)
  - 37 “classic” melanomas & 11 “expert” dermpaths
  - unanimity for “melanoma” in just 11 cases (30%)
“Chilling not only to physicians, but to patients, and sobering to lawyers for plaintiffs.”

- A.B. Ackerman, 1996.
Do we **really** want to eliminate lawyers?
The Doctor’s Defense

• Attack *validity* of the required elements
  – “there was no breach the standard of care”

• Assert an “*affirmative defense*”
  1. Conflicting legal duty *(psychiatrists)*
  2. Consent *(most often employed defense for procedures)*
  3. Statute of Limitations *(variable length)*
Standard of Care is ALWAYS Established *de novo*

- Expert testimony (difficult to secure & expensive)
- P’s costs often fronted by the attorney
  - in exchange for a ~1/3 interest in any award
- Trial expenses ~ $50,000 - $100,000
- ~ 500 hours of prep = $75,000 - $100,000

Honorable Gary Trawick, Judge, Superior Court, North Carolina
Advocating for “Patient’s Compensation” (analogous to Worker’s Compensation)
Statute of Limitations

• Time period when a suit must be filed
• Varies from state-to-state
• Tolled in children until a certain age
  – age of “majority,” simply a specified age
• Point of argument in many situations:
  – begins when one is “reasonably” alerted to an injury and not simply “date of service”
Anonymous Pt v. Anonymous Derm
Virginia 1997

- Plaintiff sought care for mole upon leg
- Derm biopsied → interpreted as benign
- Two years later → pt. visited a surgeon
- Surgeon requested medical records
- Derm then re-assessed slide and amended the path report → “melanoma”

Was suit timely?
Court Decision

• SOL did not begin at misdiagnosis
• RULING: SOL began 2 years from when the melanoma “moved from epidermis into the dermis”

(When the heck was that?)
Show Me the Money!

- Special damages
  - medical bills (past, present, future)
  - lost wages (past, present, future)

- General damages
  - pain & suffering (*per diem* vs. lump sum)
  - loss of enjoyment/consortium

RARELY PUNITIVE DAMAGES!
For states/entities with damage caps there may be an even greater disincentive to sue.

Would you risk $125,000 for a 1 in 5 shot at $150,000?
What are the issues discussed with damage caps... 

are such caps ethical? 

are such caps legal?
Do Caps Save Money

• Both economic and non-economic damage caps exist

• Conflicting evidence over whether:
  – non-economic damage caps save money
  – economic damage caps are ethical
“Defensive” medicine costs continue to increase.
Oregon’s Unique Situation

• Clarke v OHSU
  – $12M+ damages
  – state was substituted for MDs/RNs
  – result - $200k remedy
  – law was unconstitutional “as applied” to case
Structure of US Court System

United States Supreme Court

State Supreme Court

State Appellate Court

State District Court

Federal Circuit Court

Federal District Court
"That $250,000 wouldn't pay for my medication for the rest of my life," [the patient] responded. "$250,000 for my kind of injury, it's nothing. It's a pittance."
Apology Laws

- Now exist in 29 states
- Protect doctor against use of certain statements in situation of:
  - “perceived” medical error
  - negative outcome
- Vary from state to state
Colorado Apology Law

- Broadest in the nation
- C.R.S. 1-25-13
  - protects “any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence…”
- Doctor can apologize, describe in detail any mistakes and the information is inadmissible
Texas Apology Law

• Narrower than Colorado’s apology law
• TCP&R Code Sec 18.061(a)(1):
  – protects statements that “expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident.”
• However, unlike Colorado's law, it does not bar a doctor's admission of liability or fault
How might this work…

• Imagine after a procedure the following statement is made:

  “I am sorry for your pain. I mistakenly failed to close your wound properly and that failure caused your pain and suffering.”

• Colorado – entire statement protected
• Texas – only “I am sorry…” is protected.
• Doctors with fewer claims:
  - used more orientation/education
  - laughed and used more humor
  - spent slightly longer in routine visits (mean 18.3 vs. 15.0 min)

“Sometimes when your first you are last.”
Dermatology & Dermatopathology Litigation
• The Doctors Company
  – 1998 to 2001 → 144 pathology claims
  – 23 (16%) were misdiagnosis of melanoma
    (second only to breast cancer for litigation potential)
• **Melanoma** 13% of all pathology claims (44/335)

  - False negative 95% (42/44) but false positive 5% (2/44)

(2006 ACS estimates: 63k melanomas, 217k breast cancers)
“Breakdown” of 42 False Negative Claims

• Erroneous “diagnoses” involved:
  
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spitz nevus</td>
<td>3</td>
</tr>
<tr>
<td>Dysplastic nevus</td>
<td>3</td>
</tr>
<tr>
<td>Spindle cell SCC</td>
<td>3</td>
</tr>
<tr>
<td>Atypical fibroxanthoma</td>
<td>1</td>
</tr>
<tr>
<td>Missed desmoplastic melanoma</td>
<td>2</td>
</tr>
</tbody>
</table>

No explanation for the other 30 cases.

No case details or information regarding financial outcomes.
Laser “accidents” 2
Cosmetic filler 1
Isotretinoin complications 3
Missed melanoma 6
Chloroquine 1
TEN/SJS 1
NMSC 1
Potent steroids 2
Light therapy 1
Connective tissue disease 1
Cryosurgery 1
Merkel cell 1
Balanitis obliterans with SCC 1
“It’s unlikely you will ever be sued...”
I. Beware of “Low-Power” Imitators
Histology of Nevoid Melanoma
Cellular Atypia & Mitoses
Deep
II. Beware of Partial Biopsy
Punch?
III. Beware of Inflamed Lesions
(which could be hiding melanoma)
Case

- 79 year-old man
- Pigmented lesion on chest
- “r/o NUB”
Histology
IV. Beware of Spitz nevi
Heightened Suspicion
Melanoma v Spitz Nevus
(“All or Nothing”)

Signs indicating strong possibility of melanoma:
• Age > 20 years
• Predominantly epithelioid cells
• Larger lesions (> 0.6 to 1.0 cm)
• Lesions on sun-damaged skin
• Broadly transected lesions
• Lesion with multiple populations of melanocytes

Classic Spitz Nevus
Spitzoid Melanoma
V. Beware of Regressed Lesions

“Better the Devil you know than the Devil you don’t know.”

- Old English Proverb
Case

• June 2004
• Sent by barber for lesion upon scalp
• Biopsy performed → interpreted by dermatologist as “blue nevus”
Histology of Original Biopsy
September 2006
VI. Beware of Desmoplastic Melanoma and Spindle-Cell Imitators
Desmoplastic Melanoma
VII. Beware of confusion with dysplastic nevi (Clark’s nevi)
Always Look at All the Sections
Always Look at All the Sections
VIII. Work as a Team
Pre-Analytical Error

- Crap in = Crap out
  - “r/o melanoma” on *everything*
  - “r/o cancer”
  - “rash”
  - “238.2” for everything
- Multiple specimens in the same bottle
- Curetting of a pigmented lesion
- Mismarking shaves, punches, excisions
IX. Do no harm!

“Don’t cost someone else their skin just to save your own.”
The Phenomenon

• As a response to medicolegal pressure two responses:
  – Becoming “malignant”
  – “Fence sitting” or “hedging”

• Neither improves patient care
• Both contribute to increased costs
Over-Call

• Excessively malignant diagnosis

• Being excessively “malignant” may yield damages

“We don’t loot and plunder like that anymore.”
Melanoma?
Entities Easily Confused with Melanoma

- Clonal Nevus
- Deep Penetrating Nevus
Clonal Nevus
“Classic” DPN
Lichenoid Inflammatory Pseudonesting

• “63 year-old helicopter pilot”
• “brown plaque on neck”
• “r/o melanoma vs other”
Follow Up Call

“Whit, would it matter to you that it was kind of purple colored… and he had other smaller lesion on the opposite neck?”
“Can I see the patient?”
X. Acknowledge Difficult Cases

“It was pride that changed angels into devils; it is humility that makes men as angels.”

- Saint Augustine
Humility Is Not Just Good for Your Character…

• Acknowledge differences in opinion:
  – “We understand full-well the conundrum…”
  – “This is a difficult case…”

• “Consensus Conference”

• Document the names and opinions involved
Thank you.