An Analysis of Medico-legal Claims against Dermatologists in Australia from a Single Medical Indemnity Insurer

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Risk mitigation practices are essential to protecting patients from harm and reducing medical practitioner exposure to unnecessary reputational damage and economic loss. Despite traditionally being perceived as a "low-risk" specialty, published data on medico-legal claims against dermatologists in Australia are currently lacking. This article reviews the sources of medico-legal claims against dermatologists in Australia from a single medical indemnity insurer over the most recent three years. The failure to meet patient expectations was the largest source of claims against dermatologists, followed by adverse outcomes. Improved communication from practitioner to patient remains the most effective step to preventing medico-legal claims. Medico-legal claims, when they occur, are more successfully defended when thorough documentation processes are in place.

Keywords: *dermatology; medico-legal; medical indemnity; malpractice; claims; risk mitigation*

INTRODUCTION

Medico-legal claims can result in significant financial and emotional costs on medical practitioners. A claim against a medical practitioner, whether successful or not, can result in: reputational damage; lost productivity and lost income through practice downtime; higher insurance premiums or loss of coverage; potential medical board investigations; substantial legal costs to defend claims; and out-of-pocket compensation costs if court-awarded damages exceed insurance indemnity limits.

Dermatologists are not immune from medico-legal claims and risk mitigation is an essential aspect of modern medical practice. It is necessary to reduce patient harm and protect a doctor's right to practice unencumbered.

Traditionally, dermatology was thought to be a "low-risk" specialty compared to highly interventional specialties such as surgery and obstetrics. However, as skin surgery and cosmetic interventions form a greater proportion of some dermatology practices, this view may change over time.

To date, published data on medico-legal claims against dermatologists in Australia are scarce.

RESULTS

Avant Mutual Group, the largest of five medical indemnity insurers operating in the Australian market, provided a percentage breakdown of professional indemnity claims against dermatologists in Australia over the most recent three years. The main sources of claims against dermatologists were: patient expectation not met (31%), adverse outcomes (29%), doctor's manner or behaviour (15%), diagnostic error or delay (13%) and communication or consent failure (12%) (Figure 1).

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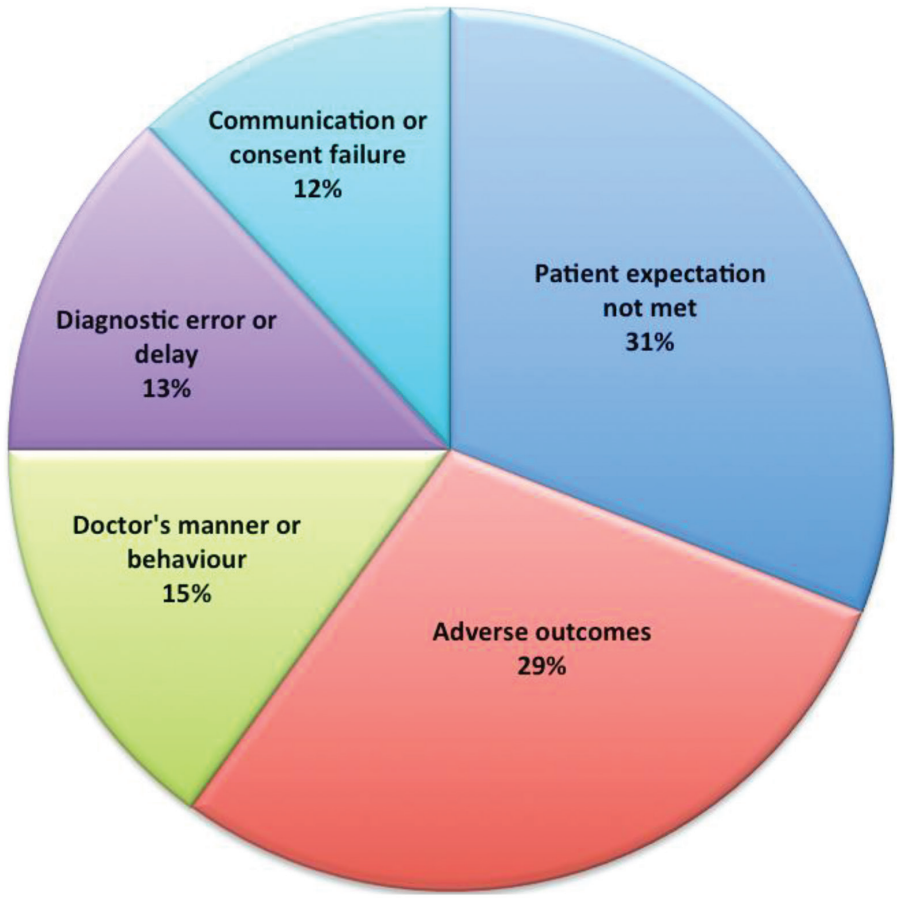
FIGURE 1. Source of claims against dermatologists in Australia (Avant Mutual Group, 2014–2017).



Discussion

Patient Expectation Not Met

This is the largest source of professional indemnity claims against dermatologists, and is highly weighted towards areas of practice that involve cosmetic outcomes. Often the treatment outcome falls below the patient's expectation. Common examples include patient claims that cosmetic benefit was less than expected or post-treatment scarring worse than expected.

Good practitioner–patient communication and management of patient expectations can help mitigate risks against such claims. As cosmetic outcomes are typically subjective, pre- and post-treatment clinical photographs can be useful in demonstrating benefit to patients or defending claims.

Service quality falling below expectation is another source of claims in this category. Real examples have included long waiting times for appointments, short or rushed consultations, administration of local anaesthetic, or patients feeling pressured towards treatment options they do not desire.

Patient claims have also resulted from dermatologists refusing to provide a treatment that the patient demands, for example seeking isotretinoin for acne or a biologic treatment for psoriasis where the patient does not meet eligibility criteria.

Another large source of claims under this category is consultations initiated by patients for the purpose of seeking a medical report to support a desired financial outcome, such as an insurance claim

or government entitlement, particularly where the medical report provided does not support the patient's desired outcome. Such patients may be more litigious by nature or by virtue of circumstance.

Adverse Outcomes

The majority of claims of this nature involved foreseeable complications of treatment such as infection, scarring or side-effects of medication. Arguably, many of these claims could have been avoided by appropriately communicating treatment risks with the patient (thus, there is some overlap here with the category of communication or consent failure). Appropriate post-treatment follow-up with patients can help reduce the magnitude of complications, and therefore protect against medico-legal claims.

Claims of this nature were more successfully defended where dermatologists evidenced detailed clinical notes and/or signed patient consent forms that documented discussions of treatment risks with the patient.

In a small minority of cases the adverse outcome following treatment was of such magnitude that a claim was likely regardless of proper consent practices. In one case, an elderly patient died following a bleach bath due to burns that became secondarily infected. In another case, a patient required index finger amputation due to necrosis following Nd:YAG laser treatment of a wart.

Educating patients on early signs of complications and clear instructions on when to seek urgent follow-up care is essential to preventing harm.

Communication or Consent Failure

Claims of this nature relate to the failure of dermatologists to inform patients of adverse results, adequately explain processes, or obtain fully informed consent. There is significant overlap between this category and management of patient expectations.

Communication failures typically occurred where practitioners did not have systems in place for tracking or following up results. In one case, a patient had a skin lesion removed that was presumed to be benign. Histology demonstrated a squamous cell carcinoma (SCC), but neither the patient nor the general practitioner was advised of the results, nor did the patient have any scheduled dermatology follow-up.

Another case occurred when a patient was referred by a dermatologist to a surgeon for removal of a presumed SCC on their eyelid. The patient waited 12 months to attend the surgeon, by which time the lesion had invaded locally requiring removal of the patient's eye. The basis of the claim was the dermatologist's alleged failure to inform the patient of the potential significance of the lesion and the need for prompt treatment, thereby a failure to adequately explain the process.

Practitioners should be aware that informed consent does not extend to the provision of treatment by other individuals unless explicitly stated. In one example, a patient complained that a nurse performed a procedure where consent was only provided to the doctor. Here, consent to have the procedure performed by the nurse should have been explicitly obtained and documented.

Another claim involved a dermatologist who referred a patient to a surgeon of the dermatologist's choosing, rather than one preferred by the patient. Patients should be advised that they are free to choose their doctor, and providing the patient with a list of local specialists is recommended.

Failure to obtain financial consent is an increasing source of malpractice complaints. Patients should be advised of out-of-pocket costs prior to expensive treatments, such as excisions, and dermatologists should have their patients sign a financial consent form. Practitioners should also advise patients of expected third-party costs, such as laboratory or pharmaceutical costs.

Diagnostic Error or Delay

Claims due to diagnostic errors most commonly occur when skin malignancy is missed or misdiagnosed as benign, and the patient suffers harm as a result. Detailed clinical notes of examination findings and clinical photographs may assist with defending such claims.

Conversely, claims are brought by patients that undergo treatment for presumed skin malignancy that is subsequently demonstrated to be benign on histopathology. A well-documented consent process is important for preventing and defending such claims.

Diagnostic delays may result from communication failures between diagnostic facilities and practitioners, between practitioners, or from practitioner to patient. Again, communication emerges as a key contributor to these outcomes, and having active tracking mechanisms in place so that significant patient results, if overlooked, are not forgotten.

Doctor's Manner or Behaviour

Claims of this nature fell into two subgroups of roughly equal proportions. The first comprised of dermatologists being allegedly insensitive or rude to patients. Dermatologists should be sensitive to how certain comments may be interpreted by patients, and the importance of adopting a professional manner at all times. It is a reality too that smart phones may allow patients to record consultations easily.

The second subgroup related to allegations against male doctors making inappropriate contact or comments to female patients. The latter highlights the importance of having a chaperone present when performing examinations of a sensitive nature. It is also important to communicate to the patient what the examination will involve and obtaining appropriate consent prior to commencing.

Review of Literature

To date, no detailed studies have been published on medical malpractice claims against dermatologists in Australia.

A 2009 cross-sectional survey by Nash et al compared malpractice claim data across a number of medical specialties in Australia.[1] The study concluded that doctors were more likely to be involved in medico-legal matters if they were male, worked in high-intervention areas of medicine (surgery and obstetrics), and worked longer hours. However, the study did not include isolated dermatology data in its results.

A 2014 Australian Government report published data for medical indemnity claims across public sector hospitals (excluding Western Australia) and the private sector for the financial year 1 July 2012 to 30 June 2013.[2] Over that period, there were 4,225 incidents resulting in new indemnity claims. Only three of those claims involved dermatology as a specialty, or less than 0.1% of total claims despite representing 0.8% of medical practitioners. This suggests dermatology is low-risk compared to other specialties. Interestingly, 149 claims (3.5%) involved skin and related structures but these involved other specialties in the vast majority of those cases. General practice, general surgery and orthopaedics topped the list of total claims respectively.

Studies of medico-legal claims in the United States suggest that dermatology is low-risk compared to other specialties based on the aggregate number of claims, rate of claims per physician, and the average value of those claims.

Jena et al analysed 15 years of malpractice data for a single insurer covering 40,916 practitioners in the United States from 1991 to 2005.[3] Of 25 specialties analysed, dermatology had the fifth lowest rate of malpractice claims, with just over 5% of dermatologists experiencing a malpractice claim on an annual basis. As expected, obstetrics and the surgical specialties had the highest annual rates of malpractice claims, ranging from 10.5% for urology to 19.1% for neurosurgery. The data also demonstrated that

[1] L Nash et al, "Australian Doctors' Involvement in Medicolegal Matters: A Cross-sectional Self-report Study" (2009) 191 Med J Aust 436.

[2] Australian Institute of Health and Welfare, *Australia's Medical Indemnity Claims 2012–13. Safety and Quality of Healthcare Series No. 15*, Cat No HSE 149 (2014).

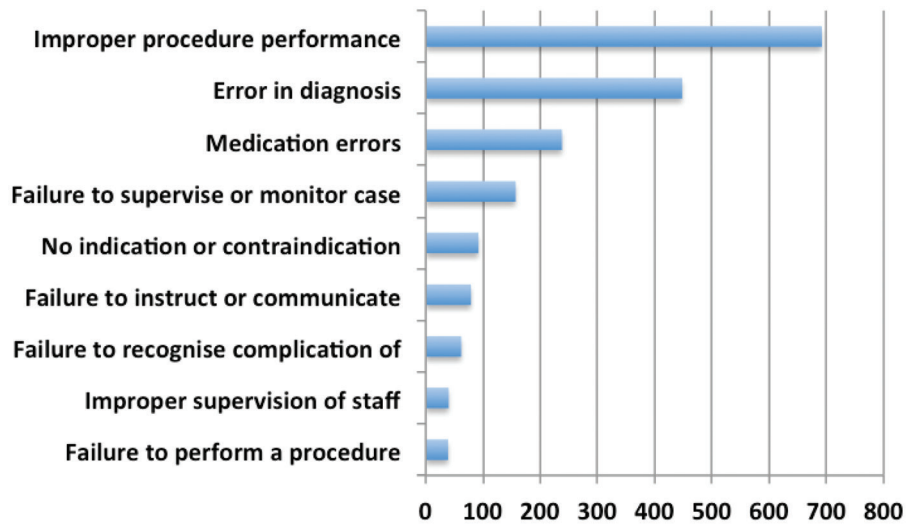
[3] A Jena et al, "Malpractice Risk According to Physician Specialty" (2011) 365 N Engl J Med 629.

dermatology had the lowest mean payout per plaintiff claim of 25 specialties analysed, averaging $117,832 per payout compared to the mean payout of $274,887 across all specialties.

Schaffer et al analysed 23 years of US malpractice data from the National Practitioner Data Bank.[4] The study analysed 280,368 malpractice claims paid out from 1992 to 2014 (they did not include unpaid claims in their analysis). Dermatology again recorded the smallest mean payout of $189,065 compared to a mean of $329,565 across all specialties. Of the 25 specialties analysed, dermatology had the seventh lowest rate of paid claims, calculated at 11.6 claims per 1,000 physician years. This dropped to 6.2 claims per 1,000 physician years over the most recent five-year period of the study (2009–2014), demonstrating that dermatologists were taking effective steps to reduce their risk of malpractice claims. Forty five point one percent of all paid claims against dermatologists were attributed to alleged errors in medication or treatment. Interestingly, 14.4% of the 2,712 paid claims against dermatologists were against the top 1% of offending clinicians in that specialty. This proportion was the highest of any specialty, suggesting that the risk of medico-legal claims was more clinician dependent in dermatology than in other specialties.

The most comprehensive study of dermatology malpractice claims was published by Moshell et al in 2012.[5] The authors analysed malpractice data from a data-sharing registry of 22 US insurers from 1985 to 2008. Of 239,756 claims closed over that period, 2,704 (1.1%) involved dermatologists. Of those 2,704 claims, 775 (28.7%) resulted in paid plaintiff compensation. The most common cause for a claim against dermatologists was allegedly improper procedure performance. Error in diagnosis was the second most common cause, with melanoma the most common diagnostic error leading to a claim (and the most costly based on average payout per claim). Non-melanoma neoplasms and benign neoplasms also represented a significant number of claims and high average payouts. In contrast, inflammatory disorders represented relatively few claims and had very low average payouts. This suggests that dermatologists should have a low threshold for performing biopsies on suspected neoplasms, especially pigmented lesions. Other causes for claims from this study are listed in Figure 2. Moshell et al also looked at associated medical and legal issues in addition to the primary reason for those claims. Informed consent was an associated issue in 260 claims (~10%). Problems with clinical records; problems with history or examination; equipment malfunction; and laboratory error, were also associated with a high number of claims.

FIGURE 2. Causes of claims against US dermatologists 1985–2008 (Moshell et al, 2012).



[4] A Schaffer et al, "Rates and Characteristics of Paid Malpractice Claims among US Physicians by Specialty, 1992–2014" (2017) 177 JAMA Intern Med 710.

[5] A Moshell, P Parikh and W Oetgen, "Characteristics of Medical Professional Liability Claims against Dermatologists: Data from 2704 Closed Claims in a Voluntary Registry" (2012) 66 J Am Acad Dermatol 78.

CONCLUSION

In Australia medico-legal risks remain an ongoing concern in dermatology practices. Data provided by Avant demonstrate that malpractice claims against dermatologists can be prevented through better communication with patients. Such measures include obtaining informed consent, advising patients of risks and complications of treatment, managing patient expectations, and having tracking mechanisms in place to follow up patient results. Malpractice claims, when they do occur, are more successfully defended with good documentation and detailed clinical records, which may include securely stored patient photographs and signed patient consent forms for high-risk interventions. Studies from the United States demonstrate that malpractice risk can be mitigated by following accepted guidelines for performing procedures and establishing a diagnosis, particularly for lesions suspicious for neoplasms. Comprehensive data on malpractice claims against dermatologists in Australia are still needed to identify key areas of medico-legal risk in the profession, so that better risk mitigation processes can be implemented. Accurate data could best be obtained through a direct survey of Australian dermatologists in relation to their malpractice claim history.