Medical Professional Liability Claims for Mohs Micrographic Surgery From 1989 to 2011

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IMPORTANCE Few studies specifically address lawsuits involving Mohs surgery.

OBJECTIVE To better characterize the types of medical professional liability claims involving Mohs surgery.

DESIGN, SETTING, AND PARTICIPANTS Retrospective legal document review of an online national database. Any legal proceeding involving the search words Mohs and cancer was included.

MAIN OUTCOMES AND MEASURES Number of medical professional liability claims involving Mohs surgery for factors including year of litigation, location, physician specialty, injury sustained, cause of legal action, and verdict.

RESULTS Forty-two cases were identified, which occurred from 1989 to 2011. Of the cases identified, 26 involved non-Mohs surgeons as the primary defendant, mostly due to a delay of or failure in diagnosis (n = 16), cosmetic outcome issues (n = 8), lack of informed consent (n = 7), and a delay of or failure in referral to a Mohs surgeon (n = 6). Common causes for litigation against Mohs surgeons as the primary defendant (n = 16) were lack of proper informed consent (n = 5) and cosmetic outcome issues (n = 4). Only 1 case against a Mohs surgeon was judged for the plaintiff.

CONCLUSIONS AND RELEVANCE The most common lawsuits pertaining to Mohs surgery list non-Mohs surgeons as the primary defendants. Closer coordination between non-Mohs surgeons and Mohs surgeons may help minimize risk to both parties and lead to better patient care. Small sample size is the primary limitation, in part owing to exclusion of out-of-court settlements from the database.

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Further insight regarding the specifics of closed claims (eg, claims with decisions) is found in a voluntary registry known as the Data Sharing Project, a database established in 1985 by the Physician Insurers Association of America. Of the nearly quarter million closed claims reported in this database from 1985 to 2008, only 1.1% involved dermatologists, ranking dermatology 19th among the 28 medical specialties studied. Of the 2704 closed claims in dermatology, 775 (28.7%) resulted in a payment to the plaintiff, with a median and average indemnity payment of $35 000 and $137 538, respectively. Improper performance of a procedure represented the most common claim, followed by error in diagnosis. Diagnostic error comprised the highest average indemnity paid.

Although aforementioned studies have contributed to our understanding of legal claims against dermatologists, it is unclear how these data relate to the subspecialty of Mohs sur-
surgery. The first study to specifically address Mohs surgery involved a survey of Mohs surgeons indicating that only 11% of respondents had ever faced litigation, with wrong site and functional outcome as the most common causes of the legal claims. Specific concern within the subspecialty is evidenced by higher malpractice insurance premiums for Mohs surgeons with a high rate of cosmetic or surgical activity, even without considering the few who purchase separate insurance policies for cosmetic surgery in addition to basic professional liability policies. The objective of this study was to better characterize medical professional liability claims involving Mohs surgery.

Methods

The legal research database WestlawNext, a primary source used by attorneys to gather legal information and available by subscription to the public, was used to conduct a database search related to Mohs surgery. This resource has been used in other works seeking to identify case law relevant to medical malpractice claims. Documents within this database are public record and include legal cases, jury verdicts and summaries, and trial court documents. In an effort to be exhaustive, queries were not limited by state or date. Our search terms included the words Mohs and cancer, and inclusion criteria included cases related to the clinical surgical practice. Physician specialties were defined within the legal documents and verified by a search for the defendant physicians in their corresponding societies’ websites (eg, American Academy of Dermatology, American College of Mohs Surgery, American Society of Mohs Surgery). The study design was evaluated and considered exempt by the University of Connecticut Institutional Review Board.

Results

The query generated 123 documents that were independently reviewed for relevance. Each applicable document was further classified by the year of action, location of the action, rationale for the lawsuit, judgment/settlement, anatomical site of surgery, and the provider’s specialty of practice.

Forty-two cases from 1989 to 2011 met the search criteria and involved lawsuits referring to Mohs micrographic surgery. Incidentally, most of the documents found in this study were not directly applicable to the lawsuits involving Mohs surgeons (eTable 1 in the Supplement). Twenty-six of these lawsuits were against other providers involved in diagnosing and treating skin cancer, mostly general dermatologists (n = 19) (Figure 1). The most common reason for legal action in these cases was a delay of or failure in diagnosis (n = 16), cosmetic outcome issues (n = 8), lack of informed consent (n = 7), and a delay of or failure in referral to a Mohs surgeon (n = 6) (Figure 2). Plastic surgeons were litigated against in 4 such cases, with 3 involving multiple procedures on the face, including electrodesiccation and curettage, excisional biopsies, and frozen section excisional biopsies with recurrence of the skin cancer before a referral was made to a Mohs surgeon. Overall, the most frequent anatomical site of surgery in all cases (N = 42) involved the nose (n = 14) (Figure 3). The most common locations of lawsuits were New York (n = 8) and California (n = 8), with the northeastern United States being the region with the highest number of cases (n = 15) (Figure 4).

Sixteen cases involved lawsuits against physicians performing Mohs surgery as the primary defendants (eTable 2 in the Supplement). The earliest lawsuit dates back to 1999, and 10 of the cases occurred after 2005. The most common allegations of plaintiffs included lack of proper informed consent (n = 5) and cosmetic outcome issues (n = 4) (Figure 5). Of the 16 cases, 6 contained a final verdict, whereas the other 10 results pertained to nondispositive motions and appeals. Only 1 of the 6 verdicts was found in favor of the plaintiff. This case involved 35 counts of Medicare fraud in Florida in which the defendant was found guilty of fabricating diagnoses of skin cancers with resultant unnecessary Mohs surgical procedures. The award in this case exceeded $3.6 million.
Discussion

The most common legal claims generated in our query involved non-Mohs surgeons as the primary defendants \( (n = 26) \), with common allegations being a delay of or failure in diagnosis \( (n = 16) \), cosmetic outcome issues \( (n = 8) \), lack of informed consent \( (n = 7) \), and a delay of or failure in referral to a Mohs surgeon \( (n = 6) \). Although general dermatologists were the primary defendants in 19 of these lawsuits, plastic surgeons were involved in 4 cases; 3 involved multiple procedures on the face, including electrodesiccation and curettage, excisional biopsies, and frozen section excisional biopsies with recurrence of the skin cancer before a referral was made to a Mohs surgeon. For recurrent skin cancers, Mohs surgery is appropriate in the vast majority of cases.\(^9\) Moreover, plastic surgery literature indicates that Mohs surgery offers superior cure rates with excellent cosmetic outcomes for the treatment of skin cancers.\(^10\) Clearly, closer coordination of care between non-Mohs surgeons and Mohs surgeons may help minimize the occurrence of legal claims against both parties and improve patient outcomes, considering that common reasons for lawsuits include cosmetic outcome issues and a delay of or failure to refer to a Mohs surgeon that may be ameliorated by the timely inclusion of a Mohs surgeon in a patient’s care. Recently agreed upon appropriate use criteria for Mohs surgery may also help dictate standardized use of the technique and reduce cases based on these common themes.\(^9\)

The most frequent anatomical site of surgery in our study involved the nose \( (14 of 42 cases) \). This finding is not surprising since the nose is one of the most common anatomical sites where Mohs surgery is used.\(^11\) In addition, in terms of cosmetic outcome, the nose is a primary concern for many patients because of its centrofacial prominence.\(^12\)

New York \( (n = 8) \) and California \( (n = 8) \) had the highest number of cases, and the northeastern United States was the region with the highest number of cases \( (n = 15) \). While data

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The most common allegations listed by the plaintiffs included lack of proper informed consent \( (5 of 16) \) and cosmetic outcome issues \( (4 of 16) \).
on the number of Mohs surgical procedures performed per region are lacking, based on population alone, the northeastern United States only accounts for 17.2% of the nation's population, which disproportionately correlates with a higher number of liability claims in our study.13

The most common reason for legal action against Mohs surgeons (n = 16) as the primary defendants in our study is a lack of proper informed consent (n = 5) and cosmetic outcome issues (n = 4), emphasizing the continued need to discuss and document the facts, implications, and future consequences of Mohs surgery in addition to alternative treatment modalities. In contrast, a prior survey study of Mohs surgeons found the most common reasons for legal claims to be surgery on the wrong site and functional outcome issues.4 A major flaw of a survey study on this topic is that the American Medical Association self-reported claims in low-risk specialties are consistently underestimated,14 which raises concerns of underreporting of court settlements or third-party arbitration by an insurance company, that bypass the risk associated with an uncertain jury determination of a verdict.16 Furthermore, the database does not clearly distinguish between the 2 aspects of Mohs surgery and reconstruction, an important limitation that prevents clarifications beyond the specifics in our article. Second, several of the cases are incomplete, consisting of motions or appeals rather than verdicts, while other lawsuits are still pending (eg, open claims). Third, the search terms, although fairly specific, may exclude cases that do not involve explicit dermatologic vocabulary. Last, the legal documents evaluated are not official medical records with definitive descriptive details and accordingly could not be verified for accuracy.

Conclusions

To our knowledge, this study is the first large-scale evaluation of Mohs surgery-related litigation, and the findings are likely representative of the current jurisprudence related to its practice. Previous studies have concluded that general dermatology is a relatively low-risk field, and our data suggest that Mohs surgery is also a low-risk field associated with minimal legal action.2,3 Moreover, most claims with judicial pleadings relating to Mohs surgery are against non-Mohs surgeons. Data regarding causes of legal action are vital for Mohs surgeons who are committed to maximizing patient safety and reducing potential perioperative patient risks, with the secondary benefit of reduced susceptibility to lawsuits and lower malpractice insurance premiums.7 In particular, closer coordination between non-Mohs surgeons and Mohs surgeons may help minimize risk to both parties and lead to better patient care.