

COMMENTARY

# Real-world Medicolegal Issues in Dermatology and Dermatopathology

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Medicolegal exposure is a pervasive challenge in both dermatology and dermatopathology. Despite advancements in diagnostic and therapeutic technology, malpractice litigation continues to affect clinicians and laboratories. Errors can occur at multiple stages, from biopsy technique and clinical judgment to histopathologic interpretation and patient follow-up. This article seeks to examine the medicolegal landscape affecting dermatologists and dermatopathologists, identify recurring sources of litigation, and provide practical strategies to minimize legal risk while upholding high standards of care. The majority of malpractice cases in dermatology and dermatopathology do not stem from gross negligence but from miscommunication, documentation lapses, sampling errors, and system-level failures. Common issues include delayed melanoma diagnosis, failure to recognize aggressive nonmelanoma skin cancers, incomplete biopsies, mismanaged follow-up, and inadequate documentation of informed consent. Systemic pressures such as managed care, private equity ownership, and unrealistic patient expectations further amplify exposure risk. Complete elimination of malpractice risk is impossible. However, dermatologists and dermatopathologists who practice meticulous clinicopathologic correlation, document decision-making, communicate clearly, and maintain professional boundaries within corporate systems can significantly reduce exposure. **KEYWORDS:** Dermatology malpractice, dermatopathology risk management, clinicopathologic correlation, diagnostic error, electronic medical records, informed consent

Dermatology and dermatopathology share a unique intersection of diagnostic precision and patient communication. Malpractice risk in these fields arises at every stage of care, from the initial patient consultation and biopsy to histologic interpretation and postdiagnostic management. Although the frequency of lawsuits against dermatologists remains relatively low compared to procedural specialties, claim severity has increased due to high-profile melanoma and cosmetic cases. This article expands upon traditional risk-management discussions to include not only laboratory and interpretive pitfalls but also medicolegal challenges that occur in clinical dermatology practice.

## THE MEDICOLEGAL LANDSCAPE

National data suggest that approximately 7% of United States physicians face a malpractice claim annually,<sup>1</sup> and dermatologists are not immune. The most frequent allegations include delayed melanoma diagnosis, failure to biopsy suspicious lesions, improper excision margins, complications from cosmetic procedures, and lack of informed consent. In dermatopathology, errors commonly involve interpretive mistakes, insufficient clinical information, or failure of clinicopathologic correlation.<sup>2</sup>

While many cases are defensible, litigation consumes substantial time and emotional energy. Malpractice payment trends summarized in the National Practitioner Data Bank further underscore the persistence of this

exposure across specialties.<sup>3</sup> Most claims hinge less on whether an error occurred and more on how the physician communicated and documented their reasoning.

## COMMON SOURCES OF LITIGATION

**Diagnostic delay and missed lesions.** Melanoma remains the leading cause of litigation in dermatology. Cases often involve failure to biopsy evolving pigmented lesions or reliance on nonvalidated imaging technologies. When biopsies are performed but are superficial or partial, both the dermatologist and dermatopathologist share potential liability. In addition to melanoma, delayed recognition of aggressive nonmelanoma skin cancers—particularly poorly differentiated squamous cell carcinoma and infiltrative basal cell carcinoma—also contributes to litigation, often centered on sampling error or failure to escalate management.

**Procedural and cosmetic complications.** Adverse effects from laser procedures, fillers, and surgical excisions can prompt claims even when the technique was appropriate. The key medicolegal safeguard is informed consent—documented discussion of risks, alternatives, and expected outcomes.

**Communication failures.** Misinterpretation of reports, lack of follow-up on positive findings, and failure to notify patients of pathology results remain major contributors to legal action. Systems that ensure result acknowledgment and follow-up scheduling protect both patient and physician.

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### THE EMR PROBLEM: CANNED LANGUAGE AND AMBIGUITY

Electronic medical record (EMR) systems were intended to improve accuracy and efficiency, yet many dermatologists have found that they introduce new medicolegal hazards. Autopopulated or "canned" terminology, such as "neoplasm of uncertain behavior" or "rash, unspecified," is frequently inserted by default into requisitions and clinical notes. These vague designations fail to convey meaningful diagnostic suspicion or clinical context to the dermatopathologist. When combined with inadequate histories or missing lesion descriptions, they undermine clinicopathologic correlation and can lead to diagnostic error.

From a medicolegal standpoint, such generic terminology creates a paper trail that suggests a lack of clinical judgment. When a subsequent diagnosis of melanoma or aggressive carcinoma is made, the record may be interpreted as evidence that the clinician did not recognize the potential seriousness of the lesion.

Clinicians should override EMR default language and provide descriptive, hypothesis-driven information such as "rule out basal cell carcinoma vs. irritated seborrheic keratosis, left cheek, 6-mm papule." Dermatopathologists should flag insufficient clinical data and state in their reports that the information was incomplete (eg, "Diagnosis limited by nonspecific clinical information provided ['rash unspecified']. Recommend clinicopathologic correlation.")

### CLINICOPATHOLOGIC CORRELATION AND SHARED RESPONSIBILITY

In the dermatology-dermatopathology relationship, communication is central to patient safety. Dermatopathologists depend on precise clinical data, while dermatologists rely on well-contextualized histologic findings. Misalignment between clinical impression and pathology report invites error.

A defensible workflow includes providing complete clinical data (eg, site, duration, morphology, and clinical photos) and encouraging bidirectional feedback when reports seem discordant. Pathologists should explicitly note specimen limitations and suggest rebiopsy when warranted. Specialty-society consultation guidelines similarly emphasize the importance of formal second

opinions and clear communication in difficult or discordant cases.<sup>4</sup>

### THE RISING RISK FROM VARIABLE TRAINING AND EXPERIENCE IN BIOPSY PRACTICE

An emerging medicolegal issue involves the performance of skin biopsies by clinicians with varying levels of dermatologic training and diagnostic experience. While many practitioners can competently obtain tissue samples, variability in technique and diagnostic acumen can increase the risk of inadequate sampling, mislabeling, or incomplete clinical descriptions. These limitations reduce the effectiveness of clinicopathologic correlation and can compromise diagnostic accuracy.

To mitigate this risk, laboratories should establish protocols that require adequate clinical data fields, and dermatopathologists should be empowered to request clarification before finalizing reports. Educational outreach and collaborative feedback between dermatology specialists and referring clinicians can improve diagnostic accuracy and reduce exposure for all involved.

### DOCUMENTATION AND REPORT LANGUAGE

A clearly written, measured report reduces risk. Definitive statements in ambiguous situations can later be construed as negligence, while vague language may cause confusion. Balanced communication—acknowledging uncertainty and providing recommendations—offers protection.

For example:

- "Assessment is limited by partial sampling. Recommend rebiopsy for complete evaluation."
- "Atypical melanocytic proliferation with features concerning for but not diagnostic of melanoma. Correlation and excision are advised."

Similarly, dermatologists should document informed consent, rationale for deferring biopsy, and patient education. When patients decline recommended procedures, refusal should be recorded in detail.

### DIGITAL PATHOLOGY, TELEDERMATOLOGY, AND AI

The growth of digital dermatology platforms introduces new risk domains. Teledermatology

must adhere to the same standards of care as in-person care, including proper documentation and secure image storage. In digital pathology, validation according to standards set by the College of American Pathologists (CAP;  $\geq 60$  cases,  $\geq 95\%$  concordance) is required before sign-out.<sup>5</sup> Artificial intelligence (AI) tools can assist triage and pattern recognition but should not replace human interpretation. All algorithmic outputs and digital audit logs are potentially discoverable in litigation and should be carefully archived.

### ETHICAL DISCLOSURE AND RISK COMMUNICATION

Transparency following errors can mitigate legal consequences. Structured disclosure, including stating facts, explaining ongoing review, and avoiding premature admissions of liability, builds trust. Institutions should maintain standardized policies for error communication, ideally involving risk management personnel.

### MANAGED-CARE AND PRIVATE-EQUITY CHALLENGES

Incentive-driven practice environments can undermine quality if productivity targets discourage adequate consultation or time for documentation. Dermatologists and dermatopathologists should ensure contractual protections preserve clinical independence, consultation rights, and malpractice coverage. Clauses limiting case volume and ensuring CAP-accredited standards can provide critical safeguards.

### CASE EXAMPLE: THE MISSED LENTIGO MALIGNA

A 68-year-old patient with a long-standing facial macule underwent a superficial shave biopsy. The initial dermatopathology report noted "atypical melanocytic hyperplasia—cannot exclude early melanoma," with a recommendation for excision. The clinician opted for observation after the patient expressed cosmetic concerns about excision. Two years later, the patient presented with an invasive melanoma requiring extensive surgery. Both the dermatologist and the dermatopathologist were named in the suit. Clear documentation of the original recommendation and documented patient refusal ultimately led to dismissal of the claim.

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This case underscores the critical importance of written clarity.

### PREVENTION STRATEGIES

- Override vague EMR language with descriptive, lesion-specific terms
- Foster open communication between dermatologists, dermatopathologists, and referring clinicians
- Maintain thorough, contemporaneous documentation
- Use validated technologies responsibly and document all AI or telemedicine decisions
- Conduct peer-review under Patient Safety and Quality Improvement Act (PSQIA)-protected frameworks<sup>6</sup>
- Advocate for manageable workloads and autonomy in corporate settings

Taken together, these measures reflect the broader negligence principle that reasonable precautions are evaluated by balancing the burden of safeguards against the probability and gravity of potential harm.<sup>7</sup>

### CONCLUSION

The medicolegal environment for dermatology and dermatopathology

continues to evolve, shaped by technology, corporatization, and expanding scopes of practice. The increasing use of autogenerated EMR terminology and variability in biopsy technique across clinical settings threaten diagnostic accuracy and continuity of care. Yet the core principles of defensive practice remain constant: communicate clearly, document diligently, correlate clinically, and uphold ethical transparency. Physicians who do so not only protect themselves but also strengthen trust in the specialty. Excellence, anchored in professionalism and precision, remains the most durable defense.

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