# Case Study:

*James Robb, Senior Vice President, Claims*

We are seeing an increasing number of cases involving allegations critical of the level of supervision, as well as of the delegation of responsibility for patient care, by physicians to non-medical employees. In the following case, the treatment was rendered by a medical assistant who had completed a two-year Medical Assistant program at one of the State University of New York schools.

The patient was a 29 year-old African-American female who first consulted our insured dermatologist in September of 2001 with a complaint of acne on the right side of her face. A diagnosis was made of Grade IV acne vulgaris, and the patient was treated with Accutane, Tetracycline, facial cleansers, and vitamin supplements. She continued to see our insured dermatologist through May of 2004, when the possibility of a chemical facial peel was discussed. The patient was planning to get married in July of 2004 and felt that the procedure would help her improve her complexion. The patient decided that she wanted to undergo the procedure which was to be a chemical peel employing salicylic acid.

The patient returned in June of 2004, and the dermatologist delegated the administration of the chemical peel to his medical assistant who was to administer the peel utilizing a 30% salicylic acid solution. Instead of using salicylic acid, the assistant mistakenly applied a solution of trichloroacetic acid (thought to be a 20% solution). It was unclear how the error occurred. However, it was noted that both types of these solutions, although appropriately labeled, were stored in the same cabinet. We were never able to determine with certainty what percent trichloroacetic acid was actually administered, since far stronger solutions of trichloroacetic acid were stored along with the 20% solution. Compounding the problem, the medical assistant returned the bottle containing the solution utilized in the procedure to storage right after the incident and said she was unable to recall what solution she utilized.

When the solution was administered, the patient testified that she immediately complained of pain and asked the medical assistant if this was normal. The patient claims the assistant reassured her and said that the procedure had to continue. However, the medical assistant finally stopped the procedure when the patient began to scream in pain. The medical assistant denied the patient complained of pain, but noticed the patient's face was developing a "frosted appearance" after completing the first pass of solution over the entire face. When this occurred, she immediately stopped. An attempt was made to wash the solution off the patient's face with water, and then ice cubes were applied. In addition, the patient's face was placed in front of an air conditioning unit. After being examined by the dermatologist, the patient was allowed to leave the office and return home. That evening, she called the dermatologist's emergency service number and spoke to him. The dermatologist told her to apply Aquaphor ointment, an over-the-counter skin protectant, and to keep her face moist. The patient was also instructed to return to the office in one week, which she did.

When the patient returned to the dermatologist's office one week later, it was noted that there were areas of severe depigmentation which were treated with cold water compresses, in an attempt to hydrate the skin, and an application of an anti-inflammatory topical steroid. The patient appeared for several additional visits, but went on to develop significant second degree burns, infection, areas of depigmentation, and extensive permanent hypertrophic scarring, resembling keloid scarring.

While the attending dermatologist attempted to maintain that his individual treatment may have been defensible, it is clear that he would have been vicariously liable for the actions of his employee. This case was settled before trial for a total of $1.7 million. ❖