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LIABILITY OF SURGEON

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LIABILITY OF PLASTIC SURGEONS

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Surgeons, regardless of their specialty or subspecialty, have generally pursued specific and traditional guidelines that give them courage and simultaneously bolster the stature of surgery. Surgeons master their profession by being familiar with the foundations and generalizations of medicine. An admirable surgeon is perceived as being moderately bold, not prone to unwarranted disputations, and who only operates upon patients after much premeditated studies. Prior to every surgical procedure, the surgeon sees to it that he/she is provided with every asset necessary for successful surgery. In some ways, the surgeon seems to have burdens over and above colleagues in other medical specialties.

The signs of a good surgeon include a temperate, moderating disposition, coupled with a cautious utterance of prognoses. Such a surgeon is logical, knows his/her spoken language so as to be able to communicate and understand their patients in both speech and written words. The surgical opinions are supported by proper reasoning when needed. In addition, good surgeons have ingenious creativity with the ability to adapt to either unforeseen situations or complications. They are stern, yet fearful of unanticipated situations, and are constantly aware of the reality that the operation itself is but one incident, no doubt the most dramatic, in the constellation of events between the illness and expected recovery. This chapter deals with some of the unanticipated situations, complications, and surgical errors that confront surgeons.

Sterling qualities of surgeons are their mental, mechanical, and moral attributes. The first is founded on knowledge acquired by education, prescribed training, examinations, licensure, personal studiousness, and intellectual inquisitiveness. The second deals with manual dexterity leading to individualize technical skill, which is learned, perfected, and embellished during surgery

residency training. Third and foremost is the moral attribute which equates with judgment that is gained in the vineyard of professional life. Of this trinity, the greatest is the last. From it arises the ethical conduct, moral behavior, individualized judgment, and the need to avoid legal pitfalls. Without the moral sense, that is no security, sanity, safety, or salvation in the surgical practice. It is the basis upon which valued decisions are made. Additionally, it is legally protected against the onslaught of unfavorable allegations of negligence.

Case Presentation

Case I

The Arizona case of *Murphy v. Board of Medical Examiners*¹, involves an insurance company Medical Director who made a "medical decision" that overruled the surgeon's recommendation to perform a cholecystectomy, thereby denying pre-certification for treatment. On December 29, 1992, Dr. M contradicted the advice of the patient's surgeon and her referring physician by refusing to pre-certify a patient's laparoscopic cholecystectomy; he stated that the surgery was "not medically necessary."

Despite the refusal to pre-certify, the surgery was performed by the patient's surgeon. Following the cholecystectomy, the surgeon registered a complaint against Dr. M with the Board of Medical Examiners. In February of 1993 the Board sent Dr. M a copy of the surgeon's complaint and requested a response. Dr. M responded by questioning whether the Board of Medical Examiners could review his action because he was "not involved in patient care and not involved in the practice of medicine." Dr. M provided the requested information "as a courtesy" and to avoid "a claim of unprofessional conduct." In October 1993, the Board ordered an investigation and subpoenaed the insurance company documents concerning 20 cases in which the company's Medical Director, Dr. M, denied pre-certification. The insurance company objected to the

¹ *Murphy v Board of Med. Examiners*, 949 P.2d 530 (Ariz. Ct. App. 1997).

subpoena and said that the Board lacked jurisdiction because Dr. M worked for an insurance company and that he was not practicing medicine. The case was appealed.

The Appellate Court ruled that although Dr. M was not engaged in the traditional practice of medicine, to the extent that he rendered medical decisions his conduct was reviewable by the Board of Medical Examiners. The Appellate Court found that Dr. M substituted his medical judgment for that of the patient's surgeon and determined that the surgery was "not medically necessary." The Court ruled that such decisions were not insurance decisions but, rather, medical (surgical) decisions because they required Dr. M to determine whether the procedure was "appropriate for the symptoms and diagnosis of the condition," whether it was to be "provided for the diagnosis, care or treatment," and whether it was "in accordance with standards of good medical practice in Arizona."

Case II

The Louisiana case of *Fusilier v. Dauterive*,² involved a laparoscopic cholecystectomy. In 1989, plaintiff F was diagnosed by an abdominal ultrasound test to have a gallstone in her gallbladder. She elected not to have a cholecystectomy at that time. On May 8, 1990, plaintiff F visited for the first time Dr. D, a general surgeon, complaining of nausea, indigestion, epigastric discomfort, and fatty food intolerance. Repeat abdominal ultrasound confirmed the the diagnosis of cholelithiasis. Dr. D initially treated the patient conservatively, by observation and symptomatic treatment. However, the plaintiff's symptoms became more severe, and Dr. D discussed treatment alternatives and recommended surgery. Meantime, plaintiff F's surgery was delayed because she developed congestive heart failure, which was treated by her family physician and improved.

² *Fusilier v. Dauterive*, 764 So.2d 74 (La. 2000).

On November 9, 1990, she was admitted to the IG Hospital to undergo a laparoscopic cholecystectomy. Dr. D performed the cholecystectomy, during which time he was **observed** by Dr. R, a gynecologist, who was familiar with the use of the trocar, needle, and other instruments used in laparoscopy. Dr. F did not participate in the actual performance of the surgery. The gallbladder was successfully removed.

Following the completion of the laparoscopic cholecystectomy, the anesthesiologist noticed blood coming from the patient's mouth. Laparotomy revealed perforations of the duodenum, mesentery and aorta. While attempting to repair the perforations, the surgeon punctured the plaintiff's intestine and her splenic capsule, which necessitated a colostomy.

The plaintiff incurred a tremendous blood loss, causing severe hypotension on several occasions during the operation. To stabilize the plaintiff's condition, the medical staff administered thirty-eight units of blood, nine units of plasma, and eight liters of Plasmalite. Eventually, the bleeding was controlled, but the patient was still hypotensive. Her abdomen was then closed, and she was taken first to the recovery room in critical condition, then to the Intensive Care Unit.

The post-operative course was complicated with recurrence of congestive heart failure; the development of adult respiratory distress syndrome, which required extended ventilatory support; continued blood loss over the first weeks of her recovery, requiring intermittent blood transfusions; the performance of a tracheostomy after several failed attempts to wean the plaintiff from the ventilator; and insertion of a PEG feeding tube to facilitate nutritional intake.

On December 24, 1990, plaintiff F was discharged from the hospital. Five days later, she was re-admitted to the hospital with sepsis, internal herniation with infarction of the ileum, and significant adhesions in her abdomen. She

underwent an abdominal exploration, relief of the abdominal adhesions, a small bowel resection, a right hemicolectomy, and an excision of her colostomy.

On January 18, 1991, she was admitted to a skilled nursing facility, where she remained until February 14, 1991.

Medical Review Panel. Following surgery, the plaintiff F discovered that the surgeon had never performed a laparoscopic cholecystectomy on a human prior to the one he performed on her, and that the only training Dr. D had received concerning the procedure was during a two day course entitled "Surgical Laser in Laparoscopic Cholecystectomy" in May, 1990. The course consisted of one day of lectures and one day of participation in handling the instruments to remove the gallbladder of a pig.

The plaintiff filed a claim with the Medical Review Panel on October 25, 1991. On August 6, 1992, the panel concluded that the plaintiff had not proven that Doctors D and F, and the IG Hospital deviated from the standard of care which is required of physicians, health care providers, their staff and/or employees of the same specialty. The panel specifically concluded that:

1. Dr. F who acted as an assistant, both pre-operatively and post-operatively, was never assigned to treat the plaintiff;
2. The equipment at IG Hospital was adequate and appropriate; the credentialing for laparoscopic cholecystectomies was appropriate as to requiring the physician to attend a "hands-on" course; there is no "standard" accrediting method for all hospitals -- each hospital is different, yet most have similar criteria;
3. Dr. D obtained adequate and appropriate consent; he demonstrated appropriate skill as a general surgeon; the complication experienced by plaintiff is a known complication which, once discovered, was treated and handled appropriately.

On November 6, 1992, the plaintiff filed a petition in District Court for damages, naming Dr. D, Dr. F, and IG Hospital as defendants. The petition alleged *inter alia* that defendants deviated from the accepted standards of medical practice for Health Care providers and caused injuries and damages to the named plaintiff. The plaintiffs specifically asserted that defendants:

1. Failed to comply with the appropriate standard of care;
2. Failed to have the proper training and experience to take those actions necessary so as to avoid an accident of the type which occurred to plaintiff;
3. Utilized inadequate equipment and personnel;
4. Failed to secure informed consent;
5. Failed to warn of, recognize or properly treat medical risks and emergencies.

The jury verdict, which was in favor of the defendant surgeons and hospital was affirmed by the appeal's court . However, the Supreme Court of Louisiana granted a writ of certiorari (i.e. accepted to review the case) to determine whether the jury's determination that the defendant surgeon was not negligent in performing the surgery and that his negligence was not a cause of plaintiff's injuries. The Louisiana Supreme Court held that the jury's determination was *manifestly erroneous* in finding that the defendant did not fail to inform plaintiff of material risks to the surgery. And, after reviewing all of the evidence and testimony, the Court held that the jury was *manifestly erroneous* in concluding that Dr. D was not negligent. Accordingly, the Louisiana Supreme Court reversed the court of appeal's decision to affirm the jury's verdict and remanded this matter to the court of appeal to assess damages. In essence, the Supreme Court in a nice way informed the trial judge that he/she should have ruled as a matter of law that Dr. D was negligent, and that the jury's role should have been to assess damages only.

ISSUES

The first case presented above points out a number important issues that pertain to a physician, medical director, who is employed by an insurance company for the purpose of pre-certifying patients without ever having seen the patient. Denial of pre-certification, i.e. substituting judgment for the treating physician, by the medical director is considered “practicing medicine”, and is thereby subject to review by the State Board of Medical Examiners. Secondly, the patient’s surgeon is in charge and is fully responsible for the safety and welfare of the patient. The surgeon acted appropriately in a timely fashion and then reported the matter to the authorities by filing the complaint.

Surgical Judgment

Surgical judgment is a priceless treasure. As a privilege, it is not acquired easily. It is sown in the field of honesty, grows in the soil of knowledge, and is watered by the perspiration of hard work. Being tempered in the heat of failure, it is nurtured into maturity by the wisdom born through the painful labor of sad experiences. Proper judgment breeds legal protection and ethical propriety, because good, rational judgment upholds proper norms that are morally correct and legally defensible.

Surgeon-Patient Relationship

There are hazards in surgery that demand an alertness against them. One hazard relates to the surgeon-patient relationship. The surgeon should always maintain the human element in professional relationships with patients, their relatives, and other inquiring friends. Because most patients are not well educated on the subject of the surgery, the surgeon should explain the nature of the disorder and the surgery contemplated in laymen terms, while being respectful and courteous. This implies allowing sufficient time to the patient, answering questions, and explaining anticipated diagnostic procedures, as well as programmed therapy, with their merits and demerits.

Mechanical Aids and Devices

The surgeon should convey the impression that he/she is not dependent entirely upon mechanical equipment to arrive at a diagnosis. This eliminates the notion that surgeons are relegated to a secondary role, and refutes their being labeled as mechanical technicians. Misimpression of mechanical technical surgeons leads to the concept of absent compassion, which further lends credence to the dehumanization of surgical care. When a sympathetic understanding exists between the patient and the surgeon, legal intransigencies rarely occur. What is of equal importance is the rise in confidence as the patient passes from the diagnostic phase to the active treatment.

Surgeons know that mechanical ancillary diagnostic and/or treatment facilities are not infallible. Failure in diagnosis occurs even with sophisticated, complicated equipment. Furthermore, sufficient training in the use of new equipment, such as the laparoscope, is mandated prior to use by the surgeon. Insufficient training and experience with a surgical technique can lead to disastrous surgical errors complications, as occurred in the case presented above. Caution should be exercised when using newer equipment and techniques. The rising popularity of laparoscopic cholecystectomy, lithotripsy, adhesiolysis, and laparoscopic laser appendectomy may give rise to a false sense of security that may tempt surgeons into a state of the legal lethargy. Every surgical encounter, utilizing instrumentation poses a risk to the patient, even in the hands of an expert. The surgeon must be candid with the patient and must disclose his/her experience, knowledge and complication rate.

When instruments are used, the hands that hold them are the control. The instruments must be used for the purpose manufactured and in the manner recommended. Limitations of use as instructed are to be followed. If proper procedure and maintenance are proven when misadventures occur, then the manufacturer may be culpable under the law of products liability.

However, an instrument is not to be blamed for human error. Iatrogenic errors, misadventures or accidents are mishaps that may happen to individual

patients during medical/surgical diagnosis and/or treatment. Such an unfortunate occurrence is independent of the natural course of the illness for which the patient sought relief. The iatrogenic episodes are random events. They are unpredictable, unanticipated, and similar to those accidents occurring in non-medical life. These experiences are not the result of discernible errors in conception, design, or implementation of a medical/surgical practice.

Instruments that have been used for ten years are considered to be old. This is a reasonable estimation that is acceptable both medically and legally. Monitors, laboratory equipment, and all other mechanical supplementary modalities must be tested periodically for accuracy.

Surgical consultation

A surgical consultant can become involved legally in a malpractice action, even when there was no active participation by him/her in patient treatment. This occurs when the treating physician follows the advice given by the surgical consultant. The greatest protection for the surgeon is the written consultation report, disagreeing with the therapeutic procedure performed, when liability is claimed. The surgical consultant's report should remain attached to the hospital records, and a copy must be retained in the consultant's private office files.

A request for a surgical consultation should be answered only when one is properly qualified to render an honest responsible opinion on the subject at issue. Surgical consultants can be sued for mishandling a consultation request. It is legally dangerous to participate in opinion rendering in a specialty beyond the surgical consultant's expertise. Likewise, surgeons can incur legal involvement by failing to answer a consultation, even as they can be involved by answering it.

Before each surgical procedure, the anesthesiologist is an automatic consultant whose findings are to be considered seriously. As a specialist, the anesthesiologist's opinion should be respected. Acknowledgement of the patient as a total human person is the preamble to safe physiologic conduction through

intravenous, gaseous, or spinal anesthesia. Pre- anesthesia evaluation is an advisory respite examination that can warn against complications, even death. Anesthesiologists assess the physical, as well as the psychological, status of the pre-operative patient. The anesthesiologist should be regarded not only as a specialist in his/her field, but also a risk evaluator, a respiratory physiologist and a pharmacologist.

Diagnostic Problems

One source of surgical malpractice is likely when an exploratory operation is performed, and no disease is found. Before surgery is undertaken, the surgeon should perform all necessary tests and biopsies in an effort to increase the diagnostic accuracy pre-operatively. However, a biopsy should never be performed if that procedure would compromise future care.

Common errors that contribute significantly to professional liability losses are errors in diagnosis, failure to provide continuous, acceptable, quality medical care, and attempts at procedures or treatments beyond the training, experience and skill of the surgeon.

Medical Care Before Surgery

When an elective surgical procedure is being contemplated, the indication for the surgical procedure requires close scrutiny and evaluation. When possible, remediable medical intervention should be tendered before deciding surgery is the best or only way. Examples include correction of hypokalemia, control of diabetes, control of severe hypertension, stabilization of vital signs and hemodynamic status, and consideration of side effects of medications that the patient may be taking. Evidence of right heart strain or significant pulmonary hypertension interposes an objective contraindication to pulmonary resection. Infectious problems should be cleared, or at least controlled, before elective surgery is undertaken.

Timeliness of surgical treatment is paramount. A surgeon must not delay surgery because of a personal or professional problem. Problems generally occur during so-called off-duty hours. However, they require the same diligence, if not more, since support personnel are frequently less experienced, whether it involves x-ray or laboratory personnel, house staff, or nurses. Additional partners or shared coverage may be needed, if the surgeon's practice demands are overburdening. Competent, alternative coverage is important in times of such need.

Wrong Side Surgery

Operating on the wrong side is simple human negligence that is inexcusable. The surgeon should always verify the x-rays of the patient, the position of the patient on the table in the surgical suite, and to carefully review the medical records prior to starting the operation.

Operating on the wrong side is the result of moments of inadvertence. One method of avoiding surgery on the wrong side is to insert a needle into the suspected area and injecting a radiographic material not only to determine the correct site but also the exact location. The needle can be left in situ, and methylene blue or a radio-opaque substance can be injected to help in continued identification of the operative site. In so doing, the patient will be spared an unwanted and unneeded surgical procedure.

Vascular Injuries and Wound Problems

Vascular injuries are rarely due to negligence, but vascular compromise due to delayed correction is inexcusable. This can only be decreased by a high degree of constant suspicion. When it is considered, a prompt arteriogram is indicated and early intervention mandated. In cardiopulmonary bypass surgery, for example, central nervous system anoxia or toxic injury can occur during a cardiopulmonary bypass from underperfusion or embolization of the aortic or mitral valves by a calcium plaque or a left atrial/left-ventricular clot. The

subclavian artery and vein are not an uncommon source of injury. Such injuries are readily recognized, and these vessels must be restored to normal function before completing the operation.

Wound infections occur with the best of efforts to prevent them, even in clean cases. When they do occur, the standard of care requires taking bacterial smears and cultures. This should be followed by a prescription for an appropriate antibiotic. These measures should be routine when early resolution does not occur with simple local procedures.

Foreign Bodies Left Behind

As a complication of surgery, foreign bodies usually involve broken instruments with retained pieces, needles, and sponges. In order to avoid this type of adverse incident when a major cavity is opened, instrument, needle and sponge counts should be demanded before closing. A second count should be taken when the skin is closed. If there is an error, there is still time to remove the foreign body before the anesthetic has worn off. If such a scenario occurs post-operatively, x-ray should be taken as soon as it is convenient after the patient is stable. The patient and/or family should be informed promptly, followed by appropriate documentation.

Other Surgical Complications

Esophageal procedures are fraught with problems and potential liability losses. It is well known that perforation during an esophagoscopy may be unavoidable, particularly where there is an impacted foreign body that is sharp, which may have already penetrated the wall of the esophagus. The surgeon should remember that unrelieved, violent vomiting leads to spontaneous rupture. Esophageal anastomotic leaks are common following an esophagectomy. They are also common with colon interposition. Through and through permanent sutures are said to facilitate a leak. Thus, many surgeons advise at least two-

layer anastomosis. Some surgeons use absorbable sutures internally and permanent sutures in the serosa.

Recurrent laryngeal nerve injury may be unavoidable in a mediastinoscopy, an aggressive pulmonary resection for a pulmonary malignancy, or when the nerve is incorporated in an aneurysm of the aorta. If the lesion is unilateral, the opposite cord often migrates across the midline, resulting in a functional speech voice. Other corrective procedures are successful if the diagnosis is made and the procedure implemented promptly.

Carotid endarterectomies maybe performed without the use of shunts, in some elective cases or in managing traumatic aneurysms. However, juries are not sympathetic to end results that are unsuccessful, even when they are beyond the control of the surgeon. The rationale for not using shunts either in elective or traumatic carotid surgery should be well-documented and fortified with concurring data.

Tracheal incubation can result in death when the endotracheal tube is wrongly placed, either into the esophagus or too far down the respiratory tract, ending up usually on the right side of the bronchus and obstructing the left-sided flow. Portable x-rays should not be needed to make the diagnosis. Auscultation of the chest should afford immediate diagnosis if there is reason to suspect a catastrophe during an emergency.

Tracheostomy is a relatively simple procedure, but dire consequences causing injury to the carotid vessels or loss of control of the trachea may occur, unless the procedure is performed with precision by knowledgeable physicians.

Subclavian lines should be inserted with the patient's head down, if possible, to reduce the risk of air embolization. Venous cannulas should be sutured and anchored to the skin to avoid embolization.

Stab wounds can be the source of liability suits for the physician serving in the emergency room, particularly when death occurs. Consultation should be secured early in emergencies to avoid complications, particularly when lack of proper care can lead to extensive, permanent, adverse results.

Continuity of Care

One of the causes of malpractice action involves who is in charge. The surgeon is in charge of the surgical case, and timely decisions should be made by the surgeon, taking into consideration the recommendations of consultants, such as the radiologist, the intensivist, pulmonologist, infectious disease specialist or the cardiologist. From the pre-hospital phase through rehabilitation, the surgeon must direct the care of the patient who has undergone surgery. The surgeon should be involved in the total continuum of care. Emergency physicians, intensivists, and other consultants should not be primarily responsible for triage, decision making, or specific treatment recommendations of known surgical patients. However, although the surgeon must directly manage the primary care of the surgical patient, consultants invariably are necessary for proper total care. Consultants must not impose their orders, but rather cite their opinions in the progress note.

Guidelines/Statements by the American College of Surgeons

The American College of Surgeons³ provides numerous statements or guidelines for management of surgical patients, e.g. Guidelines for standards in cardiac surgery, which were first published in 1991 and updated by the Advisory Council for Cardiothoracic Surgery and approved by the College's Board of Regents in October 1996. Additionally, the American College of Surgeons has several publications that consider surgical liability, including:

³ http://www.facs.org/fellows_info/guidelines/cardiac.html

- *Professional Liability Information Kit*; it contains information for surgeons involved in a medical malpractice lawsuit, including claims management, the expert medical witness, the psychological trauma of the medical malpractice lawsuit by doctor Sarah C. Charles, and about the deposition.
- *Disclosing Surgical Error: Vignettes for Discussion*; it provides teaching tools to stimulate dialogue regarding strategies for communicating effectively about surgical errors and adverse outcomes with patients and their families.
- *Surgical Patient Safety: Essential information for surgeons in today's environment*; it provides guidance and leadership in evolving areas of patient safety as well as strategies for preventing crime-side surgery, use of blood and blood components for their safe implementation, and patient safety in trauma care.
- *Professional Liability/Risk Management: A Manual for Surgeons*, second edition, 1997.

Survival Strategies and Safeguards

The following represent sundry survival safeguards against allegations of surgical negligence:

- Every injury to the face, head, or neck demands a complete neurological examination to eliminate the presence of intracranial and/or spinal cord injury. In emergency departments, many facial, cranial, ear, and nose lacerations are repaired without written notation that a neurologic injury has been eliminated.
- In neck surgery, injury to the internal jugular vein is a common vascular accident, especially in cancer removal. Hemorrhage and air embolism may occur. Suture needle injury to the carotid artery is not a rarity.
- Pathologic disturbances within the abdominal cavity remain a challenge to surgical diagnosticians. Appendicitis continues to be a frequent cause for acute abdominal signs and symptoms. It is still a difficult diagnosis in many

cases. Women can have equivocal findings more frequently than men. The presence of cystitis can be confusing, but the dilemma can generally be resolved by a urinalysis. Right-sided ovulation pain is not so easily differentiated. Pelvic inflammatory disease can be confusing, particularly in somewhat older females, but pain on uterine manipulation should alert the diagnostician to its presence. Ureteral calculi can be confusing and should be strongly suspected if red blood cells are found on urinalysis, particularly in males.

- Blunt trauma to the abdomen can produce perforations in the intestinal tract, as well as to solid organs such as the spleen and the liver.
- In the management of patients with severe trauma, especially to the abdomen and spinal column, diagnostic thought must be given to kidney injuries with/without retroperitoneal hemorrhage and hematomyelia.
- The diagnostic importance of vaginal and anorectal examinations has been proven repeatedly.
- Lymphadenopathy is generally not due to acute primary injuries.
- Every traumatic derangement of bone has associated soft tissue damage of varying degrees. Often, the tendon, ligament, muscle, and skin disruptions may be more extensive than the bone damage warrants. Soft tissue injury may cause post-traumatic complications, including nerve impairment.
- Pelvic fractures frequently are associated with injury to the urinary bladder or pelvic organs with accompanying bleeding.
- Following accidental injuries to the lower extremities, a non-healing, ulcerating wound may be due to cancer.
- Vascular injuries are known to accompany injuries to bones, ligaments, and tendons, which should be identified and treated with other injuries.
- In automobile accidents, the line of force striking the body does not have to be severe to produce serious injuries.
- Narcotic addicts can have symptoms suggesting gastrointestinal diseases.

- Neck node biopsies and excisions should be planned considering the possibility of future radical neck dissection. The facial nerve needs identification when pre-auricular and parotid biopsies are performed.
- With appropriate advice as to examination, mammography and biopsy of breast lumps are critical. All deserve careful physician follow-up. Mammograms are not infallible and should be repeated, along with a repeat physical examination of any breast lump, a possible biopsy, and even second opinions. Breast surgery is emotionally traumatizing to all women. The fear of recurrent cancer is as distressing as the woman's concern about disfigurement.
- Statistics indicate that biliary surgical injuries occur in reverse frequency to the experience of the surgeon. A young surgeon should do as many cases as possible with an experienced surgeon, before assuming primary responsibility, particularly with less experienced assistance. There is no substitute for complete knowledge of the anatomy of the biliary tract and surrounding organs, particularly since there are frequent abnormalities.
- Rectal surgery is fraught with medicolegal hazards, often resulting in substantial awards when there is a bad result that can be traced to negligence, since the defects are so dehumanizing. At best, hemorrhoidectomy patients face their first bout evacuation with anxiety over anticipated pain. Frequently, patients will avoid a bulk laxative, which could assist in needed dilation during the healing stage. The surgeon should place sufficient columns of the uninterrupted mucocutaneous junction to reduce the likelihood of circumferential stricture. Severance of the anal sphincter is extremely demoralizing to the incontinent patient, and causes many practical and social problems. If it occurs, it should be repaired.
- Patients undergoing hernia repairs have been known to end up with an atrophic testicle, resulting from torsion of the testicle, injury its blood supply, or nerve entrapment.
- Excised pigmented skin lesions should always be followed by microscopic evaluation.

- Cosmetic surgery should be left to board-certified specialists.

Conclusion

To be a surgeon is a vocational gift bestowed upon a selected few when compared to the nation's population. It is a unique distinction which benefits other people, while sustaining an inner realization of accomplishment. Many social restraints affect the work and behavior of surgeons due to controls originating within professional ranks, from external government agencies, state board regulations, legislative statutes, and common law derived from court decisions. While it is undoubtedly correct that medical/surgical malpractice allegations will not disappear, nonetheless medicosurgical progress far outweighs the legal threat of negligence. Prophylaxis against surgical malpractice is the goal to achieve rather than attempt to cure malpractice or go to court to defeat the accusation.

Golden rules

1. When time, opportunity, and adequate medical facilities are available, the law requires the surgeon to employ those fact-finding modalities in common usage to arrive at a diagnosis.
2. A decision as to when to perform surgery lies within the realm of judgment. No surgical procedure should be delayed for the surgeon's convenience. Primary concern must be for the welfare of the patient.
3. Even with all the updated, state-of-the-art machinery, patients do die. All probabilities must be explained to patients or their surrogates prior to commencing any complex diagnostic or operative procedure.
4. Improper communication between surgeons and patients can be interpreted legally as misinformation. If surgeons are considerate and listen to patients, they will be respected as persons and honored for professionalism. Patients will be reticent to think of the lawsuit.

5. Performing unnecessary surgery nips at the conscience, which inevitably becomes defensibly disturbed.
6. A surgeon not well-trained in his field of endeavor invites legal problems. Surgeons must pay attention to their own personal identity, respect their patients, and practice the surgical terrain they know. Otherwise, the surgeon wastes energy in defensive making mechanisms under the shadow of malpractice allegations.

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Liability of Plastic Surgeons

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Although the lay public generally equates “plastic surgery” with cosmetic surgery, the specialty actually encompasses many more areas of surgical practice. In fact, the residency training of a plastic surgeon eligible for certification by the American Board of Plastic Surgery (ABPS) includes seven separate general areas of surgical expertise: burns, cancer (non-skin), congenital, skin (including cancer), trauma, bone and joint, and cosmetic.⁴ Obviously, none of these fields of practice is the exclusive domain of the board certified plastic surgeon. For example, both orthopedic, plastic and some general surgeons are trained in hand surgery and share eligibility for the same Certification in the Subspecialty of Surgery of the Hand,⁵ while plastic surgeons, oral surgeons, and otolaryngologists are each trained in the treatment of facial fractures. Conversely, other fields, once the province of plastic surgeons, have mostly been overtaken by other specialists such as urologists in the reconstruction of male genitalia.

It is in the field of cosmetic surgery, however, that plastic surgeons have found competitors from the most diverse array of surgically and non-surgically trained physicians. Numerous specialties, from family practice to gynecology, from dermatology to ophthalmology are represented in areas of aesthetic practice. What drives this interest is, of course, the fact that most often, cosmetic surgery is paid for directly by the patient, free of the discounted fees and hassles of third party reimbursement. In addition, many physicians may be lured into the field by the deceptively simple nature of certain cosmetic procedures such as liposuction or the injection of skin fillers.

⁴Am. Bd. Plastic Surgery, Oral Examination Information, *available at* http://www.abplsurg.org/oral_examination_information_a.html (as of Dec. 31, 2005).

⁵Am. Bd. Plastic Surgery, Hand Examination Information, *available at* http://www.abplsurg.org/examination_information.html (as of Dec. 31, 2005).

This influx of physicians into the field of cosmetic surgery has been facilitated by the fact that medical licenses issued by the states are permits to practice in all fields of medicine and surgery, allowing at least in theory, a licensed physician to practice in any specialty. In reality, however, there are two significant limitations on physicians' scope of practice: first, the practitioner must obtain hospital and operating room privileges in the choice of her specialty and second, she must obtain professional liability insurance coverage in that specialty. Most hospitals and outpatient facilities require board certification or eligibility in a recognized specialty as a precondition to practice or operate within their facilities, and most insurers employ similar requirements for insurance coverage in a particular specialty.

How then are physicians who have little or no formal residency training⁶ in cosmetic surgery able to practice in the field with relative impunity? The answer is that these practitioners confine their surgery to their own offices where state scope of practice regulation traditionally has been minimal or non-existent. While more than a few states have recently turned their attention to the regulation of office surgery,⁷ they typically do not impose limits on who may practice based upon prior board certification. Where training requirements exist, as for the administration of conscious sedation, regulations provide alternative pathways for attaining state certification. Other rules limiting the scope or magnitude of certain operations or those imposing facility, equipment and personnel standards, usually apply universally to all practitioners regardless of training.

Although professional liability insurers classify their coverage and premiums based upon a physician's formal training, many are less stringent in their training requirements for ancillary coverage of cosmetic procedures than might be imagined. Underwriting experience suggests that office based, non-board certified cosmetic surgeons present no greater malpractice insurance risk

⁶In addition to Plastic Surgery, residencies in Otolaryngology (ENT) provide training in cosmetic surgery although it is limited to procedures on the face. These surgeons generally designate themselves as Facial Plastic Surgeons.

⁷See, e.g., Ohio Admin. Code § 4731-25 (2005), Fla. Admin. Code Ann. R. 64B8-9.009 2(e) (2005).

than their board certified brethren, at least in terms of claims frequency.⁸ This finding most likely reflects the fact that these surgeons generally avoid high-risk procedures, extensive procedures, combinations of procedures and procedures performed under general anesthesia. Board certified practitioners from the specialties of plastic surgery, otolaryngology, and ophthalmology account for the vast majority of high-risk aesthetic facial operations and board certified plastic surgeons are responsible for virtually all of those on the breast and abdomen and extremities. Thus, the discussion of tort liability as it pertains to cosmetic surgery generally will not distinguish between those who are board certified surgeons and those who are not. However, this chapter will reserve the term “plastic surgeon” for those surgeons certified by the ABPS while “cosmetic surgeon” will be applied generally to any practitioner performing cosmetic surgery.

TORT CLAIMS

Causes of Action

Medical Negligence. The majority of tort claims filed against plastic surgeons are for medical negligence. This includes claims for improperly performed surgery, postoperative complications (typically bleeding or infection), and long-term problems such as scarring or deformity. In addition, it includes direct claims against the surgeon arising from the administration of local and general anesthesia, for errors or delays in diagnosis, and misjudgments and omissions in the plan of treatment. A more detailed discussion of medical negligence will be presented in the context of specific types of surgery.

Medical Battery and Lack of Informed Consent. Allegations involving issues of consent are so pervasive in legal actions against plastic surgery that in some areas of practice they actually outnumber claims for medical negligence.⁹ Medical battery occurs when there is a lack of any consent to perform a particular

⁸ For liposuction, however, non-board certified cosmetic surgeons have a 20% higher rate of payment per claim and a 40% higher payment per claim. J.G. Bruner, R.H. de Jong, *Lipoplasty Claims Experience of U.S. Insurance Companies*, 107 *Plast. Reconstr Surg.* 1285, 1288 (2001).

⁹ See, e.g., *id.* at 1286.

medical or surgical procedure making it the appropriate claim for an operation performed on the wrong limb or on the wrong patient. In essence, it is a lack of valid consent for what was done and arises from a failure of the patient to give her consent, either explicitly by signing a document, or implicitly by some action or inaction. For example, a patient who extends her arm for blood to be drawn is impliedly consenting to venipuncture and a patient who voluntarily relates her medical history to her physician is impliedly consenting to a doctor-patient relationship.

Most often, allegations of battery are made in conjunction with a series of other claims such as negligence or a lack of informed consent. Usually these claims are ancillary to, or simply restatements of the other claims and have little impact on the overall outcome. When there truly has been an unconsented procedure, a proper claim of battery may avail the patient of a longer statute of limitations or the opportunity to collect punitive damages. In the context of plastic surgery, battery claims frequently arise when the surgeon performs a procedure allegedly never discussed with the patient such as inserting a different type of breast implant than the patient expected or inserting a chin implant during a rhinoplasty without prior discussion.

Of course, surgeons are granted significant leeway in the method or extent of performing an operation if deviations are dictated by the findings during the surgery. Thus, if in the course of a breast augmentation the surgeon identifies an unexpected lump, it is unnecessary to awaken the patient to obtain her consent for a biopsy, consent being implied. However, as part of a complete informed consent dialogue, the surgeon should explain that events or findings during the operation might require a departure from the original plans. Where the possibility of a specific modification of plans is predictable, as in a biopsy during breast augmentation, the surgeon should explain that to the patient preoperatively. This may not prevent a claim for battery but it makes it easier to defend.

The term Informed Consent is somewhat of a misnomer in that it suggests something the patient must do, say, or sign. In fact, informed consent is

something the physician must do and there need not be any actual written or verbal assent by the patient. In essence, it is the process by which the physician discloses to the patient everything that the she needs to know about the procedure or treatment contemplated. Certainly, some written record of exactly what the physician said should be maintained in the patient's chart and, in some jurisdictions, the patient's signed acknowledgment creates a rebuttable presumption that informed consent was given.¹⁰

The tort of lack of informed consent, in most jurisdictions, is defined by statute or case law,¹¹ and is distinct from ordinary medical negligence. In others, it is merely a form of medical negligence. In all jurisdictions, however, the event or consequence that was not disclosed must materialize and be the proximate cause of the patient's injury. Generally, the more acute and dire the patient's pretreatment medical condition, the less the need for lengthy and extensive disclosure. What is material for a patient with a gunshot wound to the chest is perhaps limited to the fact that without surgery he likely will not survive, plus some broad estimate of the chances of success. What is material to a patient inquiring about a facelift is the knowledge of everything about the operation, including its anticipated benefits, its major and minor risks, available alternative treatments, the recovery process, expenses, and the experience of the surgeon. Alleged failure to fulfill these extensive disclosure requirements is a prime reason for the high frequency of informed consent claims in plastic surgery. Furthermore, patients who have undergone cosmetic surgery often have some degree of dissatisfaction with the results of their surgery despite the fact that there were no technical errors or complications. This leaves them with little legal recourse other than a claim alleging a lack of informed consent. From the patient's perspective, when a complication occurs, the surgeon's reminder that it was discussed before surgery is a valid explanation, when a complication occurs without prior discussion, the same explanation becomes an excuse.

¹⁰ See, e.g., Ohio Rev. Code Ann. R.C. § 2317.54 (2005).

¹¹ See, e.g., *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 346 N.E.2d 673 (1976).

Vicarious Liability. Plastic surgeons operating in a hospital or outpatient center face essentially the same legal liabilities as other surgeons in dealing with the facility's borrowed servants such as nurses and operating room technicians. When these individuals perform a task in accordance with rules of the facility, as in moving a patient or counting sponges, the facility is vicariously liable for their actions. When performing a task under the direction of the surgeon, as in cutting a suture or administering a medication, the surgeon is vicariously liable. In his own office operating room, the plastic surgeon is vicariously liable for all acts of his employees whether administrative or technical. When the plastic surgeon employs a borrowed servant such as a nurse anesthetist, there may be shared liability. The anesthetist is responsible for acts utilizing her special technical skills and the surgeon is legally charged with her supervision. Even if the surgeon is a competent supervisor, he may be deemed the "captain of the ship" and vicariously liable despite his lack of any technical culpability. Analogous situations may arise when the plastic surgeon employs other skilled borrowed servants, for example, laser technicians or itinerant aestheticians.

Breach of Privacy. Plastic surgeons routinely photograph their cosmetic and reconstructive patients. In fact, demonstration of some competence in photography is a requirement for board certification.¹² These photographs are an essential part of the patient's confidential medical record. With an appropriate patient consent or release they may be used in scientific or commercial publications or in scientific presentations. Intentional or inadvertent publication of photographs without a properly signed patient release may lead to claims for breach of privacy or confidentiality and may violate provisions of HIPAA. Oral or written publication of stories about celebrity patients and their operations may have similar legal consequences for the surgeon. Often, these breaches originate not with the plastic surgeon but with her employees.

Claims Experience

¹² See *supra* note 1.

Overview. Plastic surgeons' high frequency of malpractice claims is primarily related to their practice of cosmetic surgery. In fact, the average plastic surgeon regularly performing aesthetic surgery can expect a legal claim or incident every 2.4 years.¹³ Fortunately, the severity of these claims, i.e., the final settlements or judgments, is relatively low and more commonly, nonexistent. Unfortunately, deaths resulting from aesthetic surgery are becoming a not uncommon occurrence, bringing with them a dramatic increase in the severity of claims.

Underlying the high frequency of claims is the fact that patients seeking aesthetic surgery usually generally are not suffering from any illness or injury. The surgeon is not being called upon to correct a pathologic problem but rather to improve upon a more or less "normal" condition. Any operation resulting in a condition that did not exist before, for example, unexpected scarring, is obvious and distressing. Even if some measure of improvement is obtained, if it does not meet the patient's expectations, there may a disproportionate degree of disappointment. Numerous articles in the plastic surgery literature discuss the psychological motivations that drive patients to seek aesthetic surgery. Most make the point that when the patient's emotional concern is disproportionately high in comparison to an objective measure of the physical deformity, the stage is set for a patient likely to be disenchanted by an objectively reasonable, but subjectively disappointing result.

For example, a young man who unrealistically believes that excessive wideness of the tip his nose is the cause of his social and professional failures, may be emotionally staking his entire future on the results of a nose reshaping operation. Similarly, a middle-aged woman whose husband is straying may unrealistically believe that if only her skin were smoother and her breasts did not sag, her husband would return. Other patients, unable to cope with the consequences of aging in a sensible manner may exhibit an "addiction" to plastic surgery, seeking to correct every visible vestige of physical senility. Another

¹³ Mark Gorney, *The wheel of misfortune: Genesis of malpractice claims*, 26 Clin. Plast. Surg. 15, 16 (1999).

troubled group of patients are those futilely seek to improve one particular feature, perhaps a scar or their nasal tip, whose correction has defied the attempts of previous surgeons. In any these situations, failure of the surgeon's results to meet the patient's expectations may lead to disappointment, anger and eventual litigation.

Financial considerations are also a potent dynamic in the frequency of cosmetic surgery claims when patients consciously or unconsciously measure their surgical result against their economic investment. Contrary to stereotype, most aesthetic patients are not celebrities or wealthy individuals but rather average persons who have saved their pennies or forgone necessities to pay for their procedure. Any surgical failure leads to severe and painful economic regret that may be prolonged if the patient is still making time payments on a loan. Not uncommonly, when complications or a sub-optimal result necessitate further surgery and the surgeon has not discussed the possibility beforehand, the patient may seek to defray her costs through malpractice litigation.

Litigation may also arise in the context of Body Dysmorphic Disorder (BDD), a psychological syndrome well know to cosmetic surgeons and recently popularized in the lay press. It is characterized by an extreme concern with some bodily feature that the patient considers so unattractive and so noticeable that her daily life is affected.¹⁴ Often these patients will avoid social contact, perhaps venturing out only at night despite the fact that to an objective observer the physical problem is relatively minor or a variant of "normal." These individuals will usually have a history of multiple surgeries, multiple surgeons and even multiple lawsuits. Their psychological co-morbidities include episodes of depression in as many as 60%, obsessive compulsive disorder in 29%, and tendencies to suicide and violence.¹⁵ It is estimated that 0.2 – 7% of the general population is affected by BDD and as many as 2 – 15% of those seeking cosmetic surgery.¹⁶ Operating on BDD patients runs the risk of disturbing their fragile psychological equilibriums

¹⁴ Penzel, HL, *Body Dysmorphic Disorder: Recognition and Treatment*, 2 Medscape Psychiatry & Mental Health 1 (1997) available at http://www.medscape.com/viewarticle/431513_print.

¹⁵ I.D. at 2.

¹⁶ ID.

and more likely than not, their obsession and dissatisfaction with the surgery. Cosmetic surgeons should tailor their history taking to identify such individuals and avoid operating on them. In an ominous development, one BDD patient's recent lawsuit claimed that not only did her plastic surgeon fail to identify her condition but that as a BDD patient; she had no legal capacity to consent.¹⁷

Despite cosmetic surgeons' awareness of these psychological minefields, they often ignore their training and better judgment and proceed with surgery. The foremost driving force is the extreme competitive and economic pressures of maintaining a thriving aesthetic practice. Ironically, the very effectiveness of modern marketing techniques used by these surgeons may tend to lure into their consultation rooms the very individuals whose minimal physical and major psychological problems they should be avoiding. It is also likely that cosmetic surgery not only attracts emotionally vulnerable patients, but surgeons whose psyches are inordinately driven by ego satisfaction, overconfidence and risk taking.

Augmentation Mammoplasty. The insertion of a thin silicone polymer shell containing saline or a silicone gel into a surgical pocket beneath the breast or muscles of the chest wall is the standard technique for performing augmentation mammoplasty. In 1998, at a time when mammoplasty was the most commonly preformed aesthetic operation, it accounted for 44% of all aesthetic surgical malpractice claims as tracked by the Doctors Company.¹⁸ The percentage of claims is now somewhat lower due to the increased popularity of other procedures such as lipoplasty and a subsidence of the wave of litigation that followed the Breast Implant Crisis (BIC) of the nineties. Nonetheless, it was the third most commonly performed aesthetic procedure in 2004¹⁹ and the number of associated legal actions remains high.

¹⁷ Lynn v. Hugo, 96 N.Y.2d 306, 752 N.E.2d 250, 728 N.Y.S.2d 121 (2001)

¹⁸ The wheel of misfortune. Genesis of malpractice claims. Gorney, M. Clin Plast Surg 1999 Jan;26(1):15-9, v

¹⁹ Am. Soc. Plastic Surgery, 2000-2004 Nat. Plast. Surg. Statistics, available at http://www.plasticsurgery.org/public_education/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=16158.

While the BIC had profound affects on plastic surgeons, including the filing of numerous lawsuits, there were few settlements or judgments against them.²⁰ Most claims that actually named a plastic surgeon were filed as a means of breaking federal diversity so that a corresponding suit against an implant manufacturer could be brought in a plaintiff-friendly state court.²¹ The BIC arose chiefly in response to media generated hysteria that falsely implicated implants as a cause of various systemic diseases, primarily connective tissue disorders. This led to billions of dollars in settlements by the manufacturers before, and even after, scientific research had proven a causal relationship to be either non-existent or extraordinarily rare. Currently, most claims against implant manufacturers are based on a loss of implant shell integrity with leakage or rupture and local complications due to seeping gel.

The most frequent cause of litigation following augmentation mammoplasty is capsular contracture.²² Normally, after a breast implant or other medical device such as a pacemaker or orthopedic hardware is implanted, it is walled off from the surrounding body tissues by a paper-thin fibrous capsule. This capsule, despite its thinness, is relatively inelastic and while its presence is inconsequential for most implanted devices, in the case of a breast implant it may defeat the objective of maintaining a naturally soft breast. If the capsule shrinks tightly around the implant, the breast feels firm, regardless of the implant's inherent softness. Although the majority of capsules do not contract enough to cause noticeable firmness, in a significant minority the contracture leads to firmness varying from barely detectable to a melon-like hardness. Accompanying the firmness may be telltale visible bulging of the breast or a perceived sensation of tightness or pain. The exact proportion of affected implanted breasts varies from study to study, ranging from 5-10% to 40-50%. In 10-25% of patients, sufficient firmness develops in one or both breasts to require some form of treatment.

²⁰ The anatomy of a crisis. One perspective. O'Brien, C. Clin Plast Surg 1999 Jan;26(1):1-8, v at 7

²¹ Ibid at 4

²² The wheel of misfortune. Genesis of malpractice claims. Gorney, M. Clin Plast Surg 1999 Jan;26(1):15-9, v

The exact cause of symptomatic capsular contracture remains unknown and treatments of the overly firm breast due to it are limited. The simplest is the surgeon's forceful manual compression of the breast until the capsule ruptures with a near instantaneous softening of the breast. Unfortunately, recurrence is frequent and complications such as internal bleeding, breast deformity and implant rupture are possible. Because implant manufacturers warn against manual compression, the complicit plastic surgeon is placed in some legal jeopardy by this "off-label" use of a medical device. While not illegal, such use may invalidate professional liability insurance coverage and should litigation ensue, create the impression that something impermissible was done.²³ Nonetheless, the procedure is commonly performed and may not breach the standard of care assuming that the patient has been adequately informed.²⁴ The alternative remedy is reoperation with incision or removal of the capsule, repositioning of the implant, and/or implant exchange. Again, the recurrence rate is high, leaving women with the unappealing alternatives of enduring firm breasts or having their implants removed.

Although it is rare that capsular contracture can be directly attributed to any specific act of surgical negligence, lawsuits for its occurrence or the expenses incurred from reoperation are common. Most are premised on allegations of a lack of informed consent or breach of warranty. Other complications frequently claiming a lack of informed consent include those for dissatisfaction with post-augmentation breast size, numbness or alterations in nipple sensation, and unexpected scarring. Add to these, surgical negligence claims for infection, malpositioned or asymmetrical implants, gel leakage and implant extrusion, and it becomes evident why breast augmentation carries a high risk of litigation.

Breast Reduction and Mastopexy. Breast reduction typically involves not only removal of breast tissue and fat, but trimming and rearrangement of the overlying skin and repositioning of the nipple. In the majority of cases surprisingly

²³ Going off-label with breast implants Dowden, R. V.; Reisman, N. R.; Gorney, M. *Plast Reconstr Surg* 2002 Jul;110(1):323-9; discussion 330

²⁴ ID.

long and complex skin incisions are necessary. When the breast is bared, the resulting scars are noticeable or even unsightly, and are the commonest cause of litigation. As the scars are an unavoidable consequence of the surgery, the legal issues usually center on a failure of informed consent. Although the majority of plastic surgeons present pre and postoperative photographs during their consultations, they tend to show their better results fearing that women will be dissuaded by more realistic results. Large women with huge and extraordinarily pendulous breasts may view their condition as a health problem with associated back and neck pain, shoulder grooving, difficulties with hygiene, interference with exercise, and an inability to wear normal clothing. In these cases, health insurance coverage may be available. The women tend to be so appreciative of their surgery and relief of symptoms, that they generally are forgiving of unsightly scars. Conversely, more petit women with only moderate breast enlargement commonly view their procedures as cosmetic and judge their scars more harshly.

Reduction mammoplasty has the potential for areas of skin or nipple being deprived of their normal blood supply with subsequent tissue loss. Although infrequent, this may lead to severe scarring, deformity and the necessity for revisional surgery that can often be traced to negligence in the preoperative planning or execution of the surgery. Loss of nipple sensation and asymmetry in the size and shape are common sequelae of breast reduction but only rarely involve technical negligence. These problems, of course, may lead to informed consent claims.

Mastopexy entails reshaping of the breast, typically to remedy ptosis (sagging) from pregnancy, senescence, or developmental anomalies. Mastopexy always involves some rearrangement of the skin and nipples but often requires ancillary volume adjustment by tissue removal or augmentation. It is the most technically challenging breast procedure and carries a predictably high incidence of at least some recurrent ptosis and widening of the scars. Women undergoing the procedure tend to be exceptionally critical, not only of their preoperative appearance, but of their postoperative result. Not surprisingly, litigation is

frequent and can often be traced to unrealistic preoperative discussions and photographs.

Breast Reconstruction Following Mastectomy. Despite the availability of several techniques for breast reconstruction and their recent technical refinements, many outcomes still fall short of ideal. Not only must a breast mound and nipple be recreated but the results must match the existing breast. When the procedure immediately follows mastectomy, women are spared the agony of viewing their disfigurement, but the surgeon is deprived of the opportunity to demonstrate that she has corrected a deformity. The patient's comparison is made to an unoperated breast rather than to a missing breast.

Reconstruction using an implant is one of two basic surgical approaches and is the standard method for immediate reconstruction. Most mastectomies involve removal of so much skin that the initial implant must be gradually expanded to stretch the remaining skin. This can be accomplished with specially designed implants or tissue expanders that are eventually replaced with a permanent implant. In most cases it is difficult to duplicate the normal pendulosity of the opposite breast, requiring that it undergo its own surgery to achieve symmetry. In addition to all of the potential complications of cosmetic mammoplasty, the surgeon must work with a limited skin cover that has been deprived of its normal blood supply from the underlying breast. Complications from loss of skin integrity, infection and malpositioning of the implant are not uncommon. Legal problems can arise both from technical missteps and inadequate informed consent particularly regarding the patient's overall expectations and the number of procedures required.

Reconstruction is also possible by transferring the patient's own skin, fat and muscle from the back or abdomen. When there is adequate donor tissue and a skillful surgeon, the results may surpass those using an implant. The risks though, are greater, as not only must a breast be reconstructed, but a large donor wound must be closed. In the case of an abdominal donor site, hernias and injury to the abdominal contents are possible. Loss of the entire transferred tissue mass is rare but disastrous, and even lesser tissue losses may be difficult

to manage. Again, technical excellence and experience, coupled with an exhaustive informed consent are necessary to avoid legal repercussions.

Liposuction (Lipoplasty). Liposuction is the removal of facial, breast, thigh or body fat using a thin metal cannula connected to a suction apparatus. Through small, strategically placed incisions, relatively large masses of fat can be reduced in volume, typically under local anesthesia supplemented by some form of sedation. Since its development and refinement in the 1980's, liposuction has become the most commonly performed cosmetic surgical procedure.²⁵ Spurred by an increasing number of anecdotal reports of adverse results and deaths from liposuction, the American Society of Plastic Surgeons (ASPS) surveyed its members in 1998 as to their experiences.²⁶ In 1999, the PIAA, a consortium of professional liability insurers insuring 60% of US physicians in private practice, reported on their pooled data for liposuction claims dating from 1985²⁷. Fully two-thirds of the 292 PIAA liposuction claims involved complaints of lack of informed consent or breach of warranty. This compares with a rate 27% rate across the entire spectrum of medical and surgical claims. Severity of injury ratings were also lower than for other procedures, with correspondingly lower average indemnification for liposuction claims (\$95,000) than for other aesthetic procedures (\$157,000). However, the rate of indemnification for these claims was higher than for other claims (41% versus 32%).

While 65% of the non-fatal PIAA liposuction claims occurred in a hospital setting versus 21% in physicians' office facilities, those data are skewed by fact that lipoplasty procedures were initially performed in a hospital setting. On the other hand, the ASPS survey included reports of a startling 95 liposuction fatalities of which 48% occurred in physicians' office facilities.²⁸ Claims frequency increased dramatically with increasing volume of fat removal suggesting that anesthesia and fluid balance problems present the greatest risk of death

²⁵ ASPs procedural statistics, 2005.

²⁶ F.M.Grazer, R.H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 *Plast Reconstr Surg.* 436 (2000).

²⁷ Lipoplasty claims experience of U.S. insurance companies. Bruner, J. G.; de Jong, R. H., *Plast Reconstr Surg* 2001 Apr 15;107(5):1285-91

²⁸ F.M.Grazer, R.H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 *Plast Reconstr Surg.* 436 (2000).

following liposuction. This risk is magnified in an office setting where there may be limited staff and resuscitative equipment. Consequently, several states now impose limitations on in-office liposuction.²⁹

Rhinoplasty. Overall, rhinoplasty accounts for approximately 8% of aesthetic surgery claims.³⁰ Although surgery to reshape the nose was first described in the late nineteenth century, it remains the aesthetic procedure requiring the utmost in craftsman-like skill, experience, artistic judgment, and preoperative planning. It is also the procedure where the final surgical result least reliably approximates the surgeon's judgments during the surgery, thereby adding a significant element of unpredictability. Secondary procedures may be required in 15-25% of cases and are a common factor in inciting litigation. Complicating these technical issues is the fact that many patients' hopes and expectations often exceed the abilities of even the most adept surgeon. The recent availability of computer simulations, whose digital modifications of a nose exceed existing surgical expertise, has further aggravated the situation. Not surprisingly, some degree of patient dissatisfaction with their noses' final appearance is all but universal. When there has been a sub-optimal informed consent that fails to emphasize the procedure's technical limitations and its inherent unpredictability, litigation is the result. In all but the most egregious cases, surgical negligence is not the issue.

Rhinoplasty and internal airway surgery may also be undertaken to improve difficulties in breathing. As one's ease of breathing is highly subjective, it is not uncommon for the problem to remain unimproved after surgery or for breathing problems to appear after cosmetic surgery when there were previously none. Consequently, cases alleging postoperative breathing difficulty account for a significant percentage of claims.³¹ Considering that irregularities in the anatomic configuration of the nose are present even in individuals with no subjective complaints, it is not surprising that experts may identify postoperative

²⁹ See, e.g., Fla Admin. Code Ann. R. 64B8-9.009 2(e) (2005)

³⁰ Mark Gorney, *The wheel of misfortune: Genesis of malpractice claims*, 26 Clin. Plast. Surg. 15, 16 (1999).

³¹ Phil Haeck, *Compromised Airway Can Lead to Rhinoplasty Claims*, Plast. Surg. News, Sept. 2005, at 37.

irregularities than can be related to breathing complaints regardless of whether or not a causal relationship truly exists.

Abdominoplasty. Reshaping of the abdomen is commonly referred to as a “tummy tuck,” a particularly misleading appellation that belies its more appropriate classification as a major surgical procedure. Classically, the operation is purely cosmetic and is designed to remedy the skin laxity, striae (stretch marks) and abdominal wall protrusion that often follow pregnancy. More recently, the procedure has been adapted to eliminate the substantial panniculous typically associated with massive weight loss, particularly following bariatric surgery. In this circumstance, there may be medical and dermatologic conditions that warrant health insurance coverage.

Claims associated with abdominoplasty comprise approximately 3% of all aesthetic surgery litigation.³² When the surgery is primarily cosmetic, unexpectedly wide or prominent scars are common allegations that more often result from inadequate informed than surgical negligence. Skin loss, occasionally even requiring skin grafting, can arise in the absence of technical negligence or may be related to faulty preoperative planning, excessive thinning of the skin, or a failure to exclude unhealthy individuals and those who smoke. Complaints related to a distorted or malpositioned umbilicus are also common and suggest errors in technique.

Abdominoplasty following massive weight loss is almost universally associated with minor or major wound healing problems and the need for appropriate informed consent is obvious. Although surgeons routinely employ measures to avoid pulmonary and fat emboli that may be associated with abdominoplasty, patients must be cognizant of this risk. Currently, there is legitimate scientific controversy concerning the allegedly high risk of pulmonary emboli and pulmonary edema, including fatal outcomes, when abdominoplasty and abdominal liposuction are combined. In 2004, Florida instituted a moratorium on the combined procedures when performed in an office surgery setting that has

³² Mark Gorney, *The wheel of misfortune: Genesis of malpractice claims*, 26 Clin. Plast. Surg. 15, 16 (1999)

been replaced by limitations on the extracted liposuction volume.³³ Until the issue is settled, prudent surgeons will either avoid the combination or take extreme precaution in both risk disclosure and their surgical regimens.

Chemical Peels, Laser Resurfacing and Dermabrasion. These procedures are utilized to alleviate facial scarring from acne or other causes, lessen the fine lines and wrinkling associated with aging, and ameliorate the abnormal pigmentation associated with excessive sun exposure and various dermatologic conditions. Peels and lasers produce a controlled burn that effectively removes the upper layers of skin, while dermabrasion removes these layers mechanically. Subsequent regeneration of new skin layers from the surviving deeper skin elements produces a smoother and more evenly pigmented surface. The deeper the peel or laser treatment, the more dramatic the effect, the shortcoming being that these treatments result in loss of normal skin thickness and diminished pigmentation. Overly aggressive and uneven treatments invite scarring, as do treatments that encroach on especially vulnerable areas such as the borders of the jaw. On occasion, scarring can be severe, disfiguring, and difficult to remedy. Not unexpectedly, legal complaints related to scarring and depigmentation are common,³⁴ even in the absence of technical negligence. Again, a detailed and realistic informed consent is essential.

Blepharoplasty (Cosmetic Eyelid Surgery). Most cosmetic eyelid surgery is undertaken to alleviate drooping, redundant skin and to eliminate the “bags” caused by protruding orbital fat. Skin removal from the upper lids is relatively straightforward, particularly in older individuals where there is considerable excess. Excision of lower lid skin, including some of the closely adherent underlying muscle, requires far more precision and judgment. Aggressive resection can lead to temporary or permanent sagging of the lower lid (scleral show) or less commonly, severe shortening (ectropion) of the lid requiring grafting or reconstruction. These problems are the most common cause

³³ Fla Admin. Code Ann. R. 64B8-9.009 2(e) (2005)

³⁴ Overall, legal claims arising from the use of these modalities account for 3% of aesthetic claims.

of legal complaints and may be traced to technical negligence. Elimination of bulging fat is traditionally accomplished through the same incisions used for skin excision, but to avoid external incisions and the risk of ectropion when there is little extra skin, incisions on the inner aspect of the lid may be employed.

Operating on structures close to the eye always carries some slight risk of ocular injury and visual impairment. These extremely rare complications typically develop in association with postoperative bleeding beneath the skin, particularly when there has been some delay in recognition of the problem or in instituting treatment. Such bleeding can occur when the surgeon has failed to adequately evaluate the patient's bleeding history, medications, smoking habits and blood pressure. Evidence will generally point to a failure in early postoperative follow-up by the surgeon and subsequent legal actions are difficult to defend.

Blepharoplasty is always associated with some postoperative discoloration in the orbital region that in severe cases may take months to resolve and occasionally may be permanent. This problem, and temporary sagging of the lower lids, requires detailed informed consent to avoid an angry and litigious patient. Some individuals will bitterly complain of dry and irritated eyes following surgery, problems that can be avoided by an appropriate preoperative history, preoperative testing, and postoperative medications.

Rhytidectomy. (Facelift). Facelift involves the surgical elevation of the facial and/or forehead skin, cutting or tightening of the underlying muscles and soft tissues, removal of excess fat and finally, excision of redundant skin. The major source of complaints involves dissatisfaction with the usually well-hidden, but often apparent scars. While prominent scars may be related to technical errors, usually that is not the case, requiring that informed consent be meticulously detailed. Bleeding and skin loss which commonly lead to excess scarring are usually related to failures in excluding smokers and those with bleeding tendencies, or to improper management of patients with high blood pressure. Temporary injuries to the facial nerve are not uncommon and may produce drooping brows or crooked smiles. When the injuries are permanent, litigation is avoidable only through empathetic and continuing emotional support

by the surgeon and evidence that the issue was thoroughly discussed preoperatively.

Injection of Skin Fillers and Botulinum Toxin. Over the past twenty-five years, a variety of injectable filler materials have become available to ameliorate depressed scars and creases, or to augment normal features, principally the lips. Some products, such as Zyderm™ collagen, are processed from bovine tissues, and carry a risk, despite pretreatment skin testing, of allergic reactions that often lead to product liability suits. Newer synthetic fillers are less likely to be allergenic. While patients may be disappointed by treatments that under-correct, that outcome is clearly preferable to over-correction that calls attention to itself and is all but impossible to reverse. Obviously, a thorough pre-operative discussion is necessary.

Injections of liquid silicone are currently forbidden by the FDA and have a long and convoluted history that is beyond the scope of this chapter. Even pure, sterile, medical-grade liquid silicone can migrate from its injection site and cause visible or palpable nodules. Industrial grade liquid silicone is unsterile and unscrupulous practitioners who inject it are usually not physicians, at least not in the United States. Complications from injecting these products, particularly into the breast, nose or penis can be horrific. In fact, injection of any filler material into these locations, including use of the patient's own fat, is likely to lead to complications and litigation that is indefensible.

Botulinum toxin that has been suitably diluted and prepared for subcutaneous injection³⁵ is not a filler material but rather a paralytic agent. It is effective for cosmetic use by selectively preventing the contraction of targeted facial muscles, thereby eliminating the wrinkles, creases and furrows normally produced. As the effect usually lasts for only several months, over-injection is a self-limiting problem. Recently, inexpensive imports have become available that are not FDA approved and extremely potent. Injection of these materials is not only unwise and perhaps illegal, but can lead to respiratory paralysis, death and indefensible lawsuits. Physicians who inject even approved materials at "Botox

³⁵ (Botox™)

parties” run the risk of violating state medical practice acts by failing to keep proper medical records with an appropriate history and physical exam, and failure to adhere to regulatory standards for an operating facility.

OTHER RISKS

Disciplinary Actions

Professional Societies. In an effort to prevent false and misleading statements, the bylaws of the ASPS impose strict limitations on the content of members’ advertising. At one time, even the display of pre and postoperative photographs was forbidden, although that prohibition has been relaxed. Generally, members may not claim that they possess some unique talent or ability, or that only they perform some particular operation. Members are also subject to discipline for offering surgical procedures as prizes in commercial or charitable promotions because the surgeon is in effect, agreeing to operate on a patient that he or she has not yet seen or examined. Sanctions for by-laws violations may include letters of censure, suspension or even expulsion from the Society. Discipline by a professional society can have serious consequences for a physician as hospitals and state medical boards routinely require reporting of such incidents. State medical practice acts usually incorporate professional codes of ethics by reference, so that discipline by a professional society may constitute a technical violation of state law.

It is well settled that the practice of medicine encompasses the provision of written or oral testimony as a medical expert witness. Plastic surgeons who provide false or misleading testimony violate the ASPS Code of Ethics and are subject to disciplinary action.³⁶ The code requires that testifying members be familiar with the procedure in question and must have at least three years experience. Plastic surgeons may also sign a voluntary affirmation of compliance that lists the ASPS expert witness standards. Penalties for providing improper testimony include censure, suspension or expulsion from the Society. In addition,

³⁶ Amer. Soc. Plast. Surgeons, Code of Ethics, § 2 IV (2005)

a testifying physician may not accept fees contingent upon the outcome of the underlying case. To date, most disciplinary cases have arisen in the context of the expert plastic surgeon offering false or misleading opinions as to the applicable standard of care for a particular surgical procedure or circumstance. At least one court has upheld the legality of a professional society's expulsion of a member for improper testimony³⁷ while another has heavily fined an expert witness for providing false and misleading testimony that led to a mistrial.³⁸ In addition, the North Carolina Medical Board revoked the license of a neurosurgeon whose expert testimony was found to be misleading³⁹ and a Georgia court permanently barred a vascular surgeon from testifying in Georgia because of "apparently untruthful testimony."⁴⁰

State Medical Boards

Regulation of plastic surgeons' conduct is similar to that of other physicians and is discussed elsewhere in this text. Generally, the states do not take action against physicians for solitary incidents of medical malpractice absent some evidence of "gross" negligence, usually conduct resulting in death or serious injury. However, in recent years several high profile incidents involving plastic surgeons have generated local and national media attention leading to medical board scrutiny. The common denominators have been a history of numerous claims of medical malpractice, incidents of death or serious injury occurring in an office operating environment, and patients who have undergone multiple cosmetic procedures in a single session. As already noted, a significant number of office surgery deaths involving cosmetic procedures, particularly large volume liposuction, have prompted various jurisdictions to increase their oversight of office surgery. Regulations typically have imposed requirements for accreditation of office operating facilities, requirements for specialized training in

³⁷ *Austin v. Amer. Assoc. Neurological Surgeons*, 253 F.3d 967 (7th Cir. 2001).

³⁸ **WOJCICKI v. Caragher, 2004 WL 3120099 (Mass.Super.)**

³⁹ Damon Adams, *Physician Loses License Over Expert Testimony*, AMNews, Aug. 19, 2002.

⁴⁰ Tanya Albert, *Medical Expert Barred From Georgia Court Forever*, AMNews, Dec. 13, 2004.

anesthesia skills for the surgeons and their staff, and limitations on specific surgical procedures, principally liposuction.

Hospitals

There has been an increasing reluctance of plastic surgeons, along with other surgical specialists, to comply with the emergency room (ER) on-call coverage requirements that are usually a condition of medical staff membership. The problem has centered on the difficulty plastic surgeons have had in obtaining adequate reimbursement from third party payers for ER services. For many plastic surgeons who perform most, if not all of their surgery in their offices or freestanding outpatient facilities, there may be little advantage to maintaining hospital privileges when balanced against the legal risks and reimbursement difficulties incumbent in taking ER call. This has led some plastic surgeons to voluntarily withdraw from hospital staffs or in hospitals rescinding surgeons' privileges. In other instances, hospitals have agreed to pay plastic surgeons and other specialists for ER coverage.

Third Party Payors

A recurring conflict between plastic surgeons and managed care organizations centers on which reconstructive surgical procedures are covered under a patient's health care contract. As most contracts exclude payment for cosmetic surgery, the issue has focused on the definition of "cosmetic." For example, at one time, many managed care plans refused to cover breast reconstruction after mastectomy, deeming it "non-functional" and therefore, cosmetic in nature. Although federal and state legislation has remedied that situation by mandating coverage for reconstructive surgery on both the affected and non-affected breasts, such a resolution is almost unique.⁴¹ Disputes commonly arise over whether correction of a post-traumatic nasal deformity is cosmetic or whether coverage should be granted for breast reduction. A current

⁴¹ Maine mandates coverage for breast reduction when it is considered medically necessary, see, ME ST T. 24-A § 2761 (20005).

focus of contention is whether surgery for removal of an abdominal panniculus remaining after bariatric surgery should be covered by health insurance. In most instances, the decision is made on a case-by-case basis with the plastic surgeon serving as the patient's advocate. However, the surgeon who too frequently or too zealously advocates for her patients runs the risk of being terminated from the managed care plan.

Regulatory Agencies

Plastic surgeons performing breast implant surgery either for cosmetic or reconstructive purposes are subject to Food and Drug Administration's regulation of these devices under the Medical Device Act. Following the wave of adverse publicity and legal actions affecting breast implants in the early 1990's, the FDA imposed a moratorium on the use silicone gel filled implants except for a few tightly controlled clinical investigations. In most cases, plastic surgeons were restricted to the use of saline filled implants, which carry a significant risk of deflation. There do not appear to have been any instances of administrative actions or tort claims against plastic surgeons for violations of these regulations.

In 2005 the FDA approved the applications of two companies⁴² to market silicone gel implants for both cosmetic and reconstructive use in accordance with strict record keeping and informed consent protocols. These restrictions and protocols were not available at the time of publication and what, if any, legal risks they spell for plastic surgeons remain to be seen.

⁴² Mentor & Inamed.

