

Chapter 48

Liability of Plastic Surgeons

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Tort Claims

Other Risks

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.¹ Obviously, none of these fields of practice is the exclusive domain of the board-certified plastic surgeon. For example, orthopedic, plastic, and some general surgeons are all trained in hand surgery and share eligibility for the same Certification in the Subspecialty of Surgery of the Hand,² 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 nonsurgically 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.

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 his or her specialty, and second, he or 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 training³ 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 nonexistent. While more than a few states have recently turned their attention to the regulation of office surgery,⁴ 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 than their board-certified brethren, at least in terms of claims frequency.⁵ 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

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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.⁶ Medical battery occurs when there is a lack of any consent to perform a particular 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 his or her consent, either explicitly by signing a document, or implicitly by some action or inaction. For example, a patient who extends their arm for blood to be drawn is impliedly consenting to venipuncture and a patient who voluntarily relates their medical history to their 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 he or 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.⁷

The tort of lack of informed consent, in most jurisdictions, is defined by statute or case law,⁸ 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.

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 the 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.⁹ 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 his or her employees.

Claims Experience

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.¹⁰ 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 be 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 disenchanting by an objectively reasonable, but subjectively disappointing, result.

For example, a young man who unrealistically believes that excessive wideness of the tip of 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 troubled group of patients are those futilely seeking to improve one particular feature, perhaps a scar or their nasal tip, whose correction has defied the attempts of previous surgeons. In any of 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 suboptimal result necessitate further surgery and the surgeon has not discussed the possibility beforehand, the patient may seek to defray their costs through malpractice litigation.

Litigation may also arise in the context of Body Dysmorphic Disorder (BDD), a psychological syndrome well known 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 their daily life is affected.¹¹ 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 comorbidities include episodes of depression in as many as 60%, obsessive compulsive disorder in 29%, and tendencies to suicide and violence.¹² It is estimated that 0.2% to 7% of the general population is affected by BDD and as many as 2% to 15% of those seeking cosmetic surgery.¹³ Operating on BDD patients runs the risk of disturbing their fragile psychological equilibrium 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.¹⁴

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

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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 performed aesthetic operation, it accounted for 44% of all aesthetic surgical malpractice claims as tracked by the Doctors Company.¹⁵ 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 1990s. Nonetheless, it was the the third most commonly performed aesthetic procedure in 2004¹⁶ and the number of associated legal actions remains high.

While the BIC had profound effects on plastic surgeons, including the filing of numerous lawsuits, there were few settlements or judgments against them.¹⁷ 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.¹⁸ 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 nonexistent 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.¹⁹ 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.

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.²⁰ Nonetheless, the procedure is commonly performed and may not breach the standard of care assuming that the patient has been adequately informed.²¹ 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 postaugmentation 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 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 petite 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 he or 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 1980s, liposuction has become the most commonly performed cosmetic surgical procedure.²² 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.²³ In 1999, the PIAA, a consortium of professional liability insurers insuring 60% of U.S. physicians in private practice, reported on their pooled data for liposuction claims dating from 1985.²⁴ 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 of 27% 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 nonfatal PIAA liposuction claims occurred in a hospital setting versus 21% in physicians' office facilities, those data are skewed by the 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.²⁵ Claims frequency increased dramatically with increasing volume of fat removal, suggesting that anesthesia and fluid balance problems present the greatest risk of death 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.²⁶

Rhinoplasty

Overall, rhinoplasty accounts for approximately 8% of aesthetic surgery claims.²⁷ 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% to 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 suboptimal 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.

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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.²⁸ 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 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 panniculus 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.²⁹ When the surgery is primarily cosmetic, unexpectedly wide or prominent scars are common allegations that more often result from inadequate informed consent 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 been replaced by limitations on the extracted liposuction volume.³⁰ 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,³¹ 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 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 25 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 pre-treatment 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 undercorrect, that outcome is clearly preferable to overcorrection that calls attention to itself and is all but impossible to reverse. Obviously, a thorough preoperative 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 injection³² 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, overinjection 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 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 bylaws 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.³³ The code requires that testifying members be familiar with the procedure in question and must have at least 3 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, 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 testimony,³⁴ while another has heavily fined an expert witness for providing false and misleading testimony that led to a mistrial.³⁵ In addition, the North Carolina Medical Board revoked the license of a neurosurgeon whose expert testimony was found to be misleading,³⁶ and a Georgia court permanently barred a vascular surgeon from testifying in Georgia because of "apparently untruthful testimony."³⁷

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

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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 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 payors for ER services. For many plastic surgeons who perform most, if not all, of their surgery in their offices or free-standing 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 nonaffected breasts, such a resolution is almost unique.³⁸ Disputes commonly arise over whether correction of a posttraumatic nasal deformity is cosmetic or whether coverage should be granted for breast reduction. A current 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 his or 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 regulation of these devices under the Medical Device Act. Following the wave of adverse publicity and legal actions affecting breast implants in the early 1990s, the FDA imposed a moratorium on the use of 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 companies³⁹ 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.

Endnotes

1. American Board of Plastic Surgery, Oral Examination Information, available at http://www.abplsurg.org/oral_examination_information_a.html (as of Dec. 31, 2005).
2. American Board of Plastic Surgery, Hand Examination Information, available at http://www.abplsurg.org/examination_information.html (as of Dec. 31, 2005).
3. In 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.
4. See, e.g., Ohio Admin. Code §4731-25 (2005), Fla. Admin. Code Ann. R. 64B8-9.009 2(e) (2005).
5. 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).
6. See, e.g., *id.* at 1286.
7. See, e.g., Ohio Rev. Code Ann. R.C. §2317.54 (2005).
8. See, e.g., *Bruni v. Tatsumi*, 46 Ohio St. 2d 127, 346 N.E. 2d 673 (1976).
9. *ABPS, supra* note 1.
10. Mark Gorney, *The Wheel of Misfortune: Genesis of Malpractice Claims*, 26 *Clin. Plast. Surg.* 15, 16 (1999).
11. H.L. Penzel, *Body Dysmorphic Disorder: Recognition and Treatment*, 2 *Medscape Psychiatry & Mental Health* 1 (1997), available at http://www.medscape.com/viewarticle/431513_print.
12. *Id.* at 2.
13. *Id.*
14. *Lynn v. Hugo*, 96 N.Y. 2d 306, 752 N.E. 2d 250, 728 N.Y.S. 2d 121 (2001).
15. Gorney, *supra* note 10.
16. American Society of Plastic Surgeons, *2000–2004 Nat. Plast. Surg. Statistics*, available at http://www.plasticsurgery.org/public_education/loader.cfm?url=/commonsspot/security/getfile.cfm&PageID=16158.
17. O’Brien, *The Anatomy of a Crisis: One Perspective*. 26 *Clin. Plast. Surg.* 1–8(1999), at 7.

18. *Id* at 4.
19. Gorney, *supra* note 10.
20. R. V. Dowden, N. R. Reisman, & M. Gorney, *Going Off-Label with Breast Implants*, 110 *Plast. Reconstr. Surg.* 323–29 (2001), discussion 330.
21. *Id.*
22. ASPS Procedural Statistics (2005).
23. F.M. Grazer & R.H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 *Plast. Reconstr. Surg.* 436 (2000).
24. Bruner & de Jong, *supra* note 5.
25. Grazer & de Jong, *supra* note 23.
26. See, e.g., Fla. Admin. Code Ann. R. 64B8-9.009 2(e) (2005).
27. Gorney, *supra* note 10.
28. Phil Haeck, *Compromised Airway Can Lead to Rhinoplasty Claims*, *Plast. Surg. News*, (Sept. 2005), at 37.
29. Gorney, *supra* note 10.
30. Fla. Admin. Code, *supra* note 26.
31. Overall, legal claims arising from the use of these modalities account for 3% of aesthetic claims.
32. Botox™.
33. American Society of Plastic Surgeons, Code of Ethics, §2 IV (2005).
34. *Austin v. Amer. Assoc. Neurological Surgeons*, 253 F. 3d 967 (7th Cir. 2001).
35. *Wojcicki v. Caragher*, 2004 WL 3120099 (Mass. Super.).
36. Damon Adams, *Physician Loses License Over Expert Testimony*, *AMNews* (Aug. 19, 2002).
37. Tanya Albert, *Medical Expert Barred from Georgia Court Forever*, *AMNews* (Dec. 13, 2004).
38. Maine mandates coverage for breast reduction when it is considered medically necessary *see* ME ST T.24-A §2761 (2005).
39. Mentor and Inamed.

