Liability in plastic surgery. A Romanian forensic perspective

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Abstract: Plastic and cosmetic surgery covers a wide range of medical interventions, dealing with either restoration of form and function or enhancing morphological characteristics. Objective complications in plastic surgery are rare as the mortality is very low, vital organs are rarely affected, and the patients are usually healthy (the purpose being usually corporal enhancement not repair). Recently an increasing number of malpractice cases had gained mass-media attention, leading to a nationwide and even international debate about the standards of healthcare in Romania. The purpose of this study is to determine the main characteristics of plastic surgery malpractice cases in Romania. Malpractice claims in plastic surgery were analyzed on a four year period (2006-2010); the cases found (13) were analyzed by using descriptive statistical methods. The study group included eight males and five females, with a medium age of 40 years; cases were divided into traumatic, cosmetic and non-traumatic. The main reason for malpractice claims was related to a medical care deficit followed by procedure deficit. Most malpractice claims were in agendo only three being ommissive and are usually due to medical negligence.

Key words: Plastic surgery, Malpractice claims, Liability, Malpractice

Plastic and cosmetic surgery covers a wide range of medical interventions, dealing with restoration of form and function by reconstructing traumatic (traffic accidents, burns, stab or gunshot wounds), congenital (cleft lip, chest-wall, craniofacial, breast, vaginal defects) or acquired conditions (tattoos, leprosy, etc.) and molding non-pathological (physiognomic) features – blepharoplasty, rhinoplasty, mastopexy, peeling, abdominoplasty, etc. [1, 2]. Cosmetic and plastic surgery is considered to be more prone to litigation as people wishing to enhance their appearance are less likely to tolerate imperfections and often have unrealistic expectations regarding the procedure. The benefits are mostly psychological and therefore results are harder to quantify making malpractice claims more prone to subjective criteria. A very important part in malpractice genesis in plastic surgery is represented by the patient’s personality. For example, Napoleon [3], studying the correlation between personality type and plastic surgery outcome found the following: narcissistic personality is significantly less satisfied with the outcome compared to the normal group; histrionic personality is either extremely satisfied or extremely unsatisfied with the outcome, borderline personality was the most dissatisfied with the outcome, any complication being transformed into a catastrophe; obsessive-compulsive personality type was also extremely dissatisfied with the outcome, although they reluctantly agreed the end-result to be better than the preoperative state. To be noted that in his study group only 29% were considered normal [3].

Objective complications in plastic surgery are rare as the mortality is very low, vital organs are rarely affected, and the patients are usually healthy (the purpose being usually corporal enhancement not repair). Subsequently, objective scales to quantify postoperative complications in surgical cases have limited applicability in plastic surgery [4,5]. Some scales, specifically designed for plastic surgery were recently developed [6, 7], the most used in clinical practice being the Cambridge scale (Table 1). According to it, the purposes of a plastic intervention are: to obtain a pleasant aesthetic

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appearance, a normal function, complete removal of the pathological process (if present), and a minimal mortality and morbidity. For each category four degrees were developed, as follows:

1. result leading to a normal appearance,
2. a quantifiable deficit is present, but the patient is satisfied,
3. a quantifiable deficit is present, not needing surgical reintervention, but the patient is dissatisfied,
4. a quantifiable deficit is present, requiring surgical reintervention. Even if the deficit is close to normal but the patient is dissatisfied the result is included in stage 3.

Recently an increasing number of malpractice cases had gained mass-media attention, leading to a nationwide and even international debate about the standards of healthcare in Romania [8,9,10]. Plastic surgery hasn’t yet gained too much consideration in this direction, mostly due to a limited number of interventions. The purpose of this study is to determine the main characteristics of plastic surgery malpractice cases in Romania.

Material and method
Due to the limited number of malpractice cases in plastic surgery in Romania we obtained the cases from three different sources: Superior Discipline Committee of the Romanian Medical College Board, Superior Council of Legal Medicine and Reports of New Medico-Legal Expertise from the National Institute of Legal Medicine, on a four year period (2006-2010). Cases were included in a PSPP database (GPL alternative to SPSS), on which various descriptive statistical methods were applied.

Results
The study group included eight males and five females, with a medium age of 40 years; female cases had a higher mean age (42 years) as compared to males (36 years) and the age pyramid shows a more leptokurtic distribution for the female group. In six cases the plastic surgery intervention was made for a traumatic pathology, in five for aesthetic purposes and in two for non-violent pathological conditions. Traumatic cases consisted of five burned victims and one poly-traumatized patient (traffic accident). Aesthetic interventions were made for breast augmentation, abdominoplasty, and peeling. Death occurred in four traumatic cases and in two aesthetic interventions (both associated with anesthetic procedure, during breast augmentation – one case, and during abdominoplasty – one case). The main reason for the malpractice claim was related to a medical care deficit (eight cases), followed by procedure deficits in three. Most malpractice claims were in agendo (10 cases), only three being ommissive (in omitendo).
Eight claims had at the base a presumed medical negligence, other causes being encountered only once (medical ignorance, superficiality, against humanity, refusal to act, fraud).

Discussions
The results of this study are purely descriptive as the number of cases was insufficient to draw statistically significant conclusions. They can however suggest specific trends regarding plastic surgery liability in Romania.

Worldwide, most plastic surgery claims are associated with cosmetic surgery (especially breast implants, rhinoplasties, blepharoplasties and abdominoplasties); in our study group more than half were associated with pathological, severe conditions – burns, poly-trauma, in which cases the final outcome of the plastic intervention is often far from the previous, normal morphological state. Also our cases had a high severity index (six deaths out of 13 cases), especially if we keep in mind two particularities of plastic surgery patients: (1) a very low overall mortality and (2) a particular psychological profile – low self-esteem, lacking familial or societal approval, excessively demanding, with great surgery related expectations, etc., with a litigation index.

Most malpractice claims are associated with medical negligence; data analysis suggests they are usually due to insufficient/inefficient physician-patient communication, derived from an incorrect informed consent (especially due to a superficial risk assessment) or superficial personal history (not identifying known pathological conditions which finally interfered with the selected treatment).

Obtaining an informed consent for a plastic/cosmetic intervention should always include [11-14]:
- A free discussion about risk, benefits, treatment alternatives; this discussion must always be conducted by the physician doing the procedure (not its resident, nurse, etc.)
- The surgeon must emphasize that the patient is free to accept or refuse the procedure and to give detailed information about the risks associated with the procedure and also with the refusal of the proposed course of action. This step is especially important in cosmetic surgery as the patient is healthy; operative risks, even small, must be balanced with a potential positive result. From a bioethical point of view in cosmetic surgery interventions, beneficence is sometimes placed higher than non-maleficence, a situation almost always associated with an increased frequency of malpractice claims (primum non-nocere usually prevails over beneficence in curative medicine, except for oncological cases).
- A risk must be presented as substantial by the physician to the patient if a medium person would consider it significant.
- The physician should not disclose specific information to the patient if by doing so it would severely affect its health or surgical outcome. This is usually the case in oncologic patients, who sometimes are unaware of their condition; this decision is usually taken together with patient’s family. Beneficence should therefore prevail upon informed consent.
- The presence of a witness during the informed consent is unnecessary and usually not recommended (otherwise we could dispute a breach in patient-physician confidentiality). This is not the case in pediatric or some psychiatric and oncological patients. The informed consent should however be signed by a witness; his signature however only documents the act of taking an informed consent and not the information exchanged during it.
- Patients use to remember more details shortly after the discussion; to augment the number of details they will remember it is recommended to provide supplemental, audio/video/online materials;
- Besides the informed consent, the surgeon must write a preoperative note in which to state the fact that he explained the patient any risks and benefits, the patient understood the risks and he agrees with the procedure.
- Informed consent should not be taken nor modified shortly before the intervention, especially is the patient is already sedated.
Most frequently the accused action in plastic surgery malpractice claims in Romania is a medical care shortfall. Usually the patient/closed ones are unable to determine whether the diagnostic and/or treatment algorithm was correct or not; they can however detect obvious medical care deficits, especially related to patient observation or drug administration. Often the physician is accused for not treating the patient with a “good” drug; analgesics or even well-known antibiotics like Ampicillin® are regularly not considered good enough and, if complications appear, treatment errors are often accused by the patient/family. If however the used drugs have uncommon names, are expensive, and/or the physician explains the patient how “good” or “strong” they are, the liability risk significantly decreases.

As a conclusion the relative rarity of malpractice claims in plastic surgery in Romania is mostly due to:

- A small number of interventions; as the number increases each year an increase in malpractice claims is to be expected;
- Long and expensive civil/penal procedures associated to often small compensatory payouts;
- Reduced intervention-related risk. In Romania malpractice claims are usually filled by the family in lethal cases, and only exceptionally for an incorrect medical action/inaction with non-lethal consequences. Even in plastic surgery, almost half the claims are associated with the death of the patient.

References