

From the Operating Room to the Courtroom: A Comprehensive Characterization of Litigation Related to Facial Plastic Surgery Procedures

Peter F. Svider, BA; Brieze R. Keeley, BA; Osvaldo Zumba, MD; Andrew C. Mauro, BA;
Michael Setzen, MD; Jean Anderson Eloy, MD, FACS

Objectives/Hypothesis: Malpractice litigation has increased in recent decades, contributing to higher health-care costs. Characterization of complications leading to litigation is of special interest to practitioners of facial plastic surgery procedures because of the higher proportion of elective cases relative to other subspecialties. In this analysis, we comprehensively examine malpractice litigation in facial plastic surgery procedures and characterize factors important in determining legal responsibility, as this information may be of great interest and use to practitioners in several specialties.

Study Design: Retrospective analysis.

Methods: The Westlaw legal database was examined for court records pertaining to facial plastic surgery procedures. The term “medical malpractice” was searched in combination with numerous procedures obtained from the American Academy of Facial Plastic and Reconstructive Surgery website.

Results: Of the 88 cases included, 62.5% were decided in the physician’s favor, 9.1% were resolved with an out-of-court settlement, and 28.4% ended in a jury awarding damages for malpractice. The mean settlement was \$577,437 and mean jury award was \$352,341. The most litigated procedures were blepharoplasties and rhinoplasties. Alleged lack of informed consent was noted in 38.6% of cases; other common complaints were excessive scarring/disfigurement, functional considerations, and postoperative pain.

Conclusions: This analysis characterized factors in determining legal responsibility in facial plastic surgery cases. Several factors were identified as potential targets for minimizing liability. Informed consent was the most reported entity in these malpractice suits. This finding emphasizes the importance of open communication between physicians and their patients regarding expectations as well as documentation of specific risks, benefits, and alternatives.

Key Words: Medicolegal, facial plastic surgery malpractice, litigation, liability.

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INTRODUCTION

Recent decades have witnessed the rise of numerous local, regional, and national organizations designed to oversee and improve the quality of health-care services in the United States.^{1–4} Despite this enhanced

scrutiny, medical error rates continue to vastly exceed error rates quoted by other industries.⁵ Adverse events secondary to medical error account for nearly \$30 billion in unnecessary expenditures and up to 98,000 avoidable hospital deaths nationwide each year.^{6,7} Much of the consumer backlash against this phenomenon plays out in U.S. courtrooms, where medical malpractice cases collectively account for nearly \$10 billion in costs for health-care providers each year.⁸ Of course, not all of these cases relate to medical error, and studies have shown that rates of malpractice claims are plateauing, with the majority of such cases not resulting in payment to plaintiffs.^{9,10} Nonetheless, malpractice cases still account for a substantial expense of time, money, and energy in the health-care industry, with increased costs transferred to consumers.¹¹

Compared to physicians from other specialties, plastic surgeons have a higher-than-average lifetime risk of malpractice litigation and its associated expenses. Nearly 15% of all U.S. plastic surgeons face at least one malpractice claim annually, as compared to just 7% of physicians in all specialties combined.¹⁰ For claims resulting in indemnity payments, plastic surgeons pay an average of nearly \$200,000 per case.¹⁰ Although literature on specific claims is sparse, a 2010 review

From the Department of Otolaryngology–Head and Neck Surgery (P.F.S., J.A.E.), Department of Neurological Surgery (J.A.E.), and Center for Skull Base and Pituitary Surgery (J.A.E.), University of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark, New Jersey; University of Medicine and Dentistry of New Jersey (P.F.S.), Robert Wood Johnson Medical School, New Brunswick, New Jersey; Mount Sinai School of Medicine (B.R.K.), New York, New York; Department of Surgery (O.Z.), University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, New Jersey; University of Michigan Law School (A.C.M.), Ann Arbor, Michigan; Rhinology Section (M.S.), North Shore University Hospital, Manhasset, New York; and Department of Otolaryngology (M.S.), New York University School of Medicine, New York, New York, U.S.A.

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Send correspondence to Jean Anderson Eloy, MD, FACS, Associate Professor and Vice Chairman, Director of Rhinology and Sinus Surgery, Department of Otolaryngology–Head and Neck Surgery, UMDNJ–New Jersey Medical School, 90 Bergen St., Suite 8100, Newark, NJ 07103. E-mail: jean.anderson.elay@gmail.com

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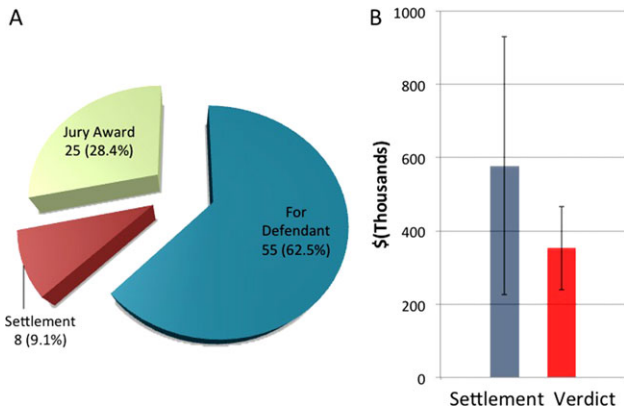


Fig. 1. (A) Case outcomes in litigation related to facial plastic surgery. (B) Mean payment in cases resolved with out-of-court settlement and jury awards. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

published in the *British Journal of Plastic, Reconstructive, and Aesthetic Surgery* found that the majority of litigation cases against plastic surgeons dealt with issues of incomplete consent, poor cosmetic result, excess scarring, or lack of expertise in performing a given procedure.¹² Multiple studies have reported that breast-related surgeries are most likely to result in malpractice litigation, followed by procedures involving the hand and malignant skin lesions.^{12,13}

Previous examinations of litigation in plastic surgery, rhinology, head and neck oncology, and thyroid disease have been performed.¹⁴⁻¹⁸ To the best of our knowledge, however, there has been no comprehensive analysis of malpractice litigation in facial plastic sur-

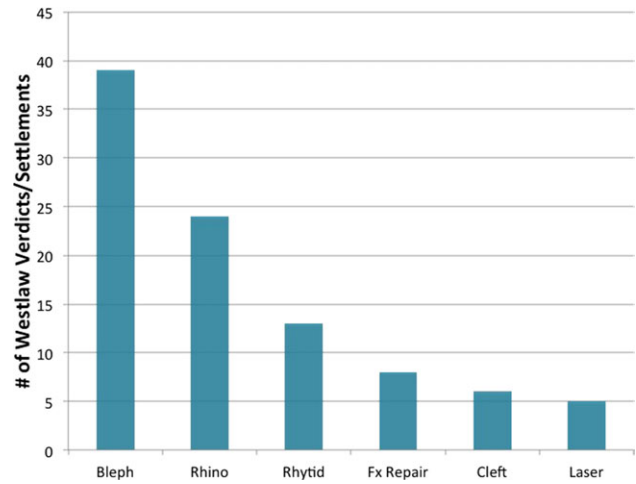


Fig. 2. Most commonly litigated facial plastic surgery procedures. Bleph = blepharoplasty, Cleft = repair of cleft lip and/or cleft palate, Fx Repair = repair of facial fracture, Rhino = rhinoplasty, Rhytid = rhytidectomy. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

gery. The primary objective of this analysis was to comprehensively examine malpractice litigation in facial plastic surgery procedures to characterize factors important in determining legal responsibility.

MATERIALS AND METHODS

We searched the Westlaw legal database (Thomson Reuters, New York, NY) for jury verdicts and settlements pertaining to facial plastic surgery procedures. The term “medical malpractice” was searched in combination with the following procedures from the American Academy of Facial Plastic and

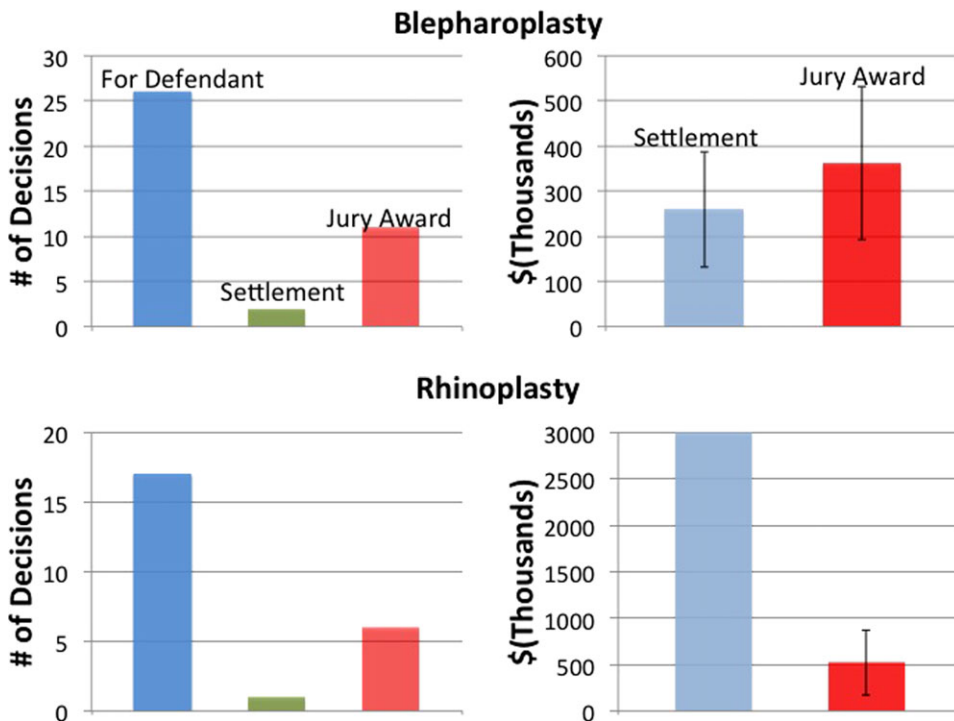


Fig. 3. Breakdown of decisions (left) and payments (right) for the two most commonly litigated procedures. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

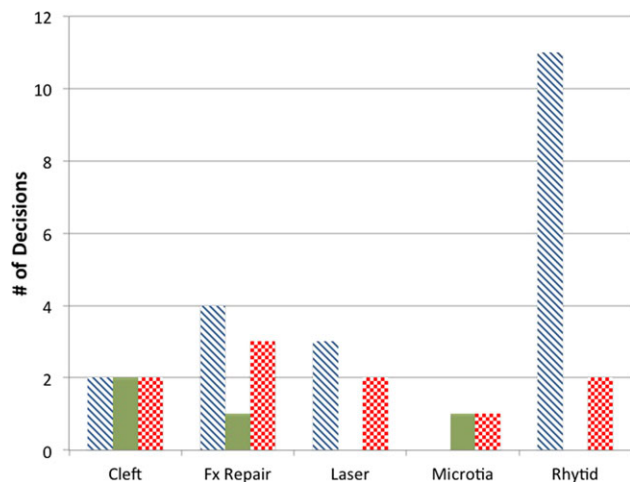


Fig. 4. Breakdown of decisions for other commonly litigated procedures in this analysis. Left (diagonally striped) bars represent decisions for defendants, middle (solid-colored) bars represent out-of-court settlements, right (checked) bars represent jury awards for damages. Fx Repair = repair of facial fracture. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

Reconstructive Surgery (AAFPRS) website (number of initial results in parentheses): forehead lift (n = 3), rhytidectomy (n = 8), otoplasty (n = 1), microtia (n = 2), rhinoplasty (n = 28), skin resurfacing (n = 1), “laser surgery” and “facial” (n = 11), blepharoplasty (n = 45), mentoplasty (n = 0), cleft lip (n = 4), cleft palate (n = 14), and platysmaplasty (n = 2). Additional terms to study litigation related to repair of facial fractures were also searched: zygomaticomaxillary (n = 0), tripod fracture (n = 1), zygomaticomaxillary complex fracture (n = 1), zygomatic arch (n = 3), cheekbone fracture (n = 1), orbital floor fracture (n = 1), orbital fracture (n = 5), Lefort (n = 3), temporomandibular joint fracture (n = 1), mandibular fracture (n = 3), facial trauma (n = 4), and nasal fracture (n = 4). There

were 88 cases included in this analysis after exclusion of the following: duplicate cases that were found in different searches (n = 18), cases not relevant to facial plastic surgery procedures (n = 31), and non-medical-malpractice litigation (n = 3).

Procedure, alleged cause of malpractice, specialty of defendant(s), case outcome, location, and specialty of expert witnesses were recorded. Information about whether physicians described as facial plastic surgeons were fellowship trained was not available from the Westlaw legal database. Attempts to obtain the fellowship training experience of the surgeons in the 17 cases involving otolaryngology defendants were made, using state licensing boards as well as individual practice websites. Information was found for nine of 17 otolaryngology defendants and included six non-fellowship-trained and three fellowship-trained otolaryngologists. Statistical analysis was conducted using Fisher exact testing for categorical variables and Mann-Whitney *U* tests where appropriate (MedCalc Software, MariaKerke, Belgium).

State and federal court records containing jury verdicts and settlements varied tremendously in content, as some cases were far more detailed than others. All data were collected in August 2012.

RESULTS

Data from 88 cases pertaining to facial plastic surgery were obtained. Decisions were made from 1984 to 2012 (median year, 2002). The median patient age was 51 years (range, 2–81). Of the cases included, 62.5% were decided in the physician’s favor, 9.1% were resolved with a settlement, and 28.4% ended in a jury awarding damages for malpractice (Fig. 1). Settlement awards trended higher than jury awards, although this difference was not statistically significant (Mann-Whitney *U* test, $P > .20$). The most commonly litigated cases were blepharoplasties and rhinoplasties (Fig. 2). The majority of cases involving these two procedures were resolved in the defendant’s favor (Fig. 3). The breakdown of

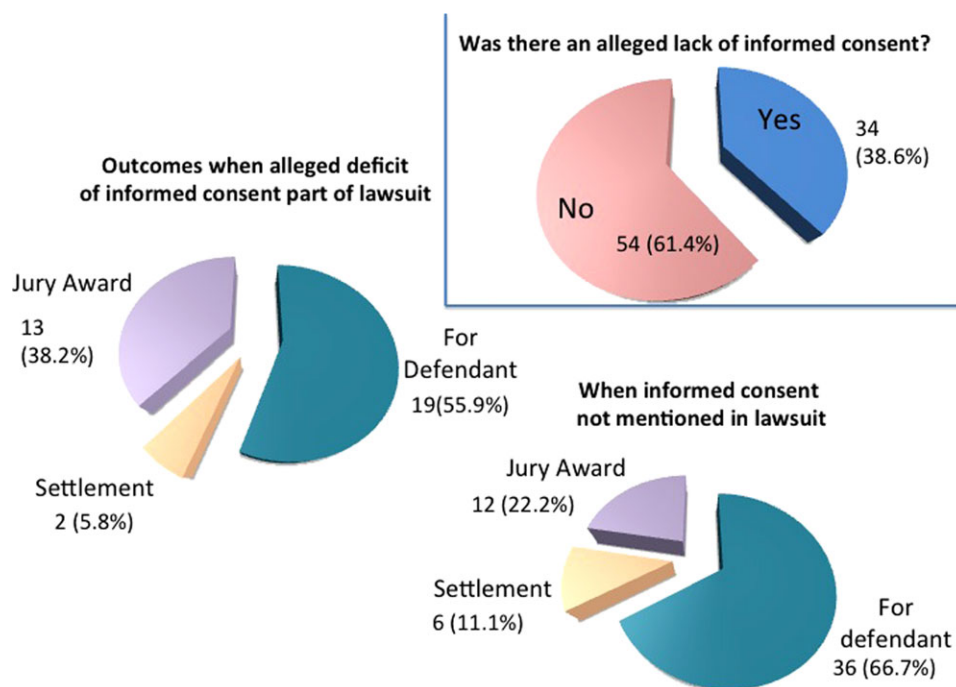


Fig. 5. Involvement of informed consent in litigation. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

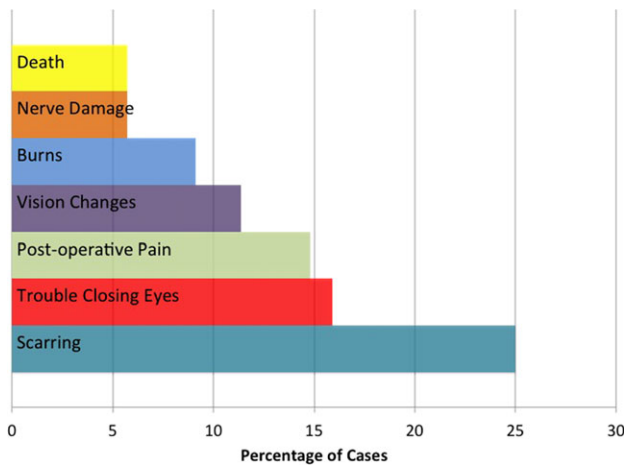


Fig. 6. Contributing factors in cases alleging malpractice. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

decisions in other commonly litigated procedures were less favorable toward physician defendants (Fig. 4), with the exception of rhytidectomies.

An alleged lack of informed consent was noted as a contributing factor for litigation in a considerable proportion (38.6%) of cases (Fig. 5). Although a higher proportion of cases in which informed consent was not an issue were resolved in the physician's favor (66.7% vs. 55.9%), this trend did not reach statistical significance (Fisher exact test, $P = .21$).

The most common complaints contributing to litigation were excessive scarring/disfigurement, difficulty closing one's eyes, and postoperative pain (Fig. 6). Nearly half of the cases included in this analysis involved a plastic surgeon as the defendant, with otolaryngologists being the defendant in approximately 20% of litigation cases (Fig. 7). Plastic surgeons, ophthalmolo-

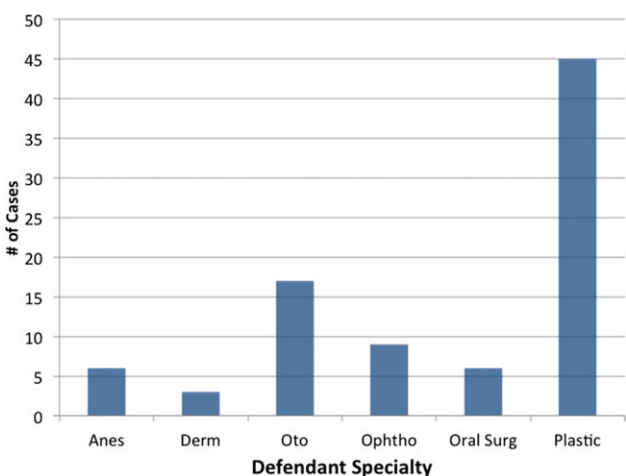


Fig. 7. Defendant specialty in facial plastic surgery malpractice litigation. Anes = anesthesiologist, Derm = dermatologist, Ophtho = ophthalmologist, Oral Surg = oral surgeon, Oto = otolaryngologist (including those with facial plastic surgery fellowship training), Plastic = plastic surgeon. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

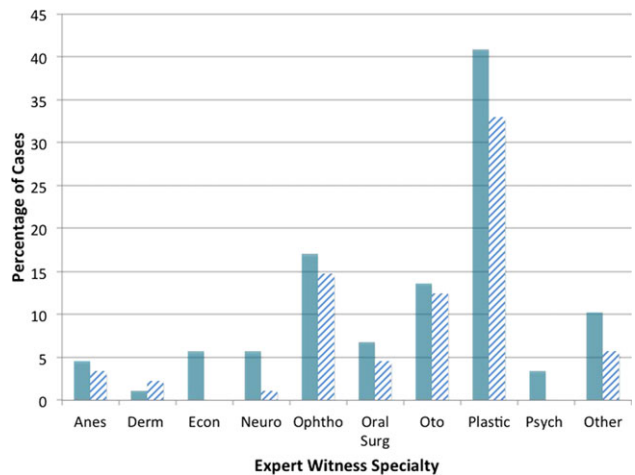


Fig. 8. Expert witness specialty in facial plastic surgery malpractice litigation. Left (solid-colored) bars represent expert testimony on behalf of plaintiffs, right (diagonally striped) represent defendant experts. Anes = anesthesiologist, Derm = dermatologist, Econ = economist, Neuro = neurologist, Ophtho = ophthalmologist, Oral Surg = oral surgeon, Oto = otolaryngologist (including those with facial plastic surgery fellowship training), Plastic = plastic surgeon, Psych = psychiatrist. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

gists, and otolaryngologists were the most commonly called upon expert witnesses in litigation (Fig. 8). Economists testified on behalf of the plaintiff in 5.7% of cases and were not found to be witnesses for defendants in any case. Thirty-four cases (38.7%) occurred in California, with Florida found to be the second-most litigious state (10.2%) (Fig. 9).

DISCUSSION

Understanding the factors involved in determining legal responsibility takes on special importance in today's litigious environment. An examination of medicolegal issues in a subfield such as facial plastic surgery, where a considerable proportion of procedures may be

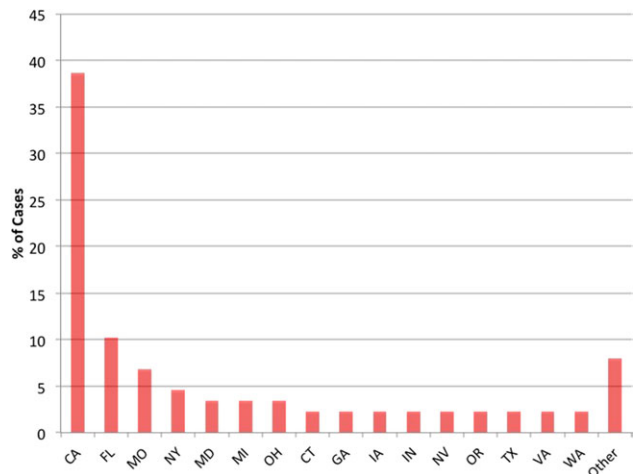


Fig. 9. Location (by state) of malpractice litigation related to facial plastic surgery procedures. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

considered elective, reveals several interesting and useful trends. A perceived lack of informed consent was the single most common factor (38.6% of cases) seen among the cases included in this analysis (Fig. 5). This finding stresses the importance of explicitly covering potential complications in a discussion of risks, benefits, and alternatives with patients; the operating physician can considerably limit liability by having an open and realistic discussion concerning the factors shown in Figure 6, as appropriate for the procedure being performed.

Several specific elements are crucial in determining whether plaintiffs are eligible for recovery of damages in medical malpractice: duty, breach of duty (standard of care), harm, and clear causation. Instructions from judges to juries indicating that these conditions need to be strictly adhered to are likely responsible for the significant proportion of cases that have made it to court and been resolved in the defendant's favor (Fig. 1). In the vast majority of the 55 cases decided in the physician's favor, mistakes were acknowledged or at least apparent to juries, but the elements required for negligence were not all met.

Not all procedures in this analysis had a favorable decision profile for physicians. Two-thirds of malpractice cases involving repair of cleft deformities ended in payment, and half of malpractice cases involving facial fracture repair were decided in the physician's favor (Fig. 4). It is important to emphasize that the sample of these procedures included in Figure 4 is not sufficient to draw any definitive conclusion, and the paucity of cleft and fracture cases may indicate that only the most egregious of errors are pursued and make it to the courtroom.

Dissatisfaction with postoperative appearance played a significant role in litigation. One-quarter of facial plastic surgery litigated cases had excessive scarring and/or perceived disfigurement as a primary reason for litigation (Fig. 6). This finding emphasizes the need for open communication between surgeons and their patients preoperatively, including examining expectations and explicitly describing these possible complications. Functional considerations, such as lagophthalmos, ectropion, visual deficits, nerve damage, and postoperative pain were also common complaints and may need to be detailed further in preoperative informed consent to minimize liability.

Nearly 40% of the cases included occurred in California, suggesting a highly litigious environment. This finding is surprising, as California's Medical Injury Compensation Reform Act of 1975 (MICRA) caps noneconomic damages (pain and suffering) at \$250,000 in an attempt to discourage frivolous legal action. A higher number of cosmetic procedures potentially may be a reason for the disproportionate representation of California in these statistics.

To the best of our knowledge, this is the first comprehensive review of malpractice litigation focusing on facial plastic surgery procedures. Characterization of the factors used in determining legal responsibility is invaluable in educating practitioners in this rapidly growing field. There are, however, several potential limitations to this analysis. Not all cases may have progressed far enough before reaching an out-of-court settlement to be included in public court records, such as in those avail-

able in the Westlaw database. Consequently, this study probably does not include every facial plastic surgery litigated case and may be underestimating the actual number of these malpractice cases. In addition, there was significant heterogeneity in the collected data. Lastly, although this analysis covered the most common procedures and used the AAFPRS website for guidance, there may be less commonly performed facial plastic surgery procedures that were not included in this analysis.

CONCLUSION

Facial plastic surgery is a rapidly emerging field with considerable overlap in the procedures performed by plastic surgeons, otolaryngologists, and ophthalmologists. This analysis characterizes the most commonly litigated cases and factors important in determining legal responsibility. The most common reasons for alleging malpractice were scarring/disfigurement and functional considerations. Informed consent takes on special importance as the single most mentioned entity in these malpractice suits, emphasizing the importance of open communication between surgeons and their patients regarding the expectations of a procedure, as well as potential risks, benefits, and alternatives. Outcomes were favorable to physicians in the majority (62.5%) of cases examined.

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