Plastic Surgery and the Malpractice Industry

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Summary: The current status of the plastic surgeon in the medical liability spectrum and ways to avoid litigation are explored by using pooled national data from the Medical Professional Liability Association, private information from Applied Medico-Legal Solutions RRG, and a detailed literature search. The medical liability system in the United States costs $55.6 billion, or 2.4 percent of total health care spending. Plastic surgery accounts for 3.31 percent of reported claims and 3.16 percent of paid claims. Total payments for plastic surgeons represent 1.75 percent of the total paid for all specialties. Malpractice awards are relatively light for plastic surgeons. Nevertheless, they still have a 15 percent chance per year of being sued. However, 93 percent of cases will close with a dismissal or a settlement, and only 7 percent will go to trial. Of these, the plastic surgeon will prevail in 79 percent. Most importantly, 75 percent of all cases will result in no payment. To minimize the chances of a lawsuit, plastic surgeons should maintain excellent communication with their patients and participate in shared decision-making. They should take a leadership role and buy in to the performance of perioperative checklists, embrace patient education, and actively participate in Maintenance of Certification. They should be transparent in their dealings with patients by preoperatively declaring their policies on revisions, refunds, complications, and payments. Plastic surgeons must maintain complete and accurate medical records and participate in hospital-based programs of prophylaxis. They should be aware that postoperative infection is the single costliest adverse outcome and proactively deal with it. (*Plast. Reconstr. Surg.* 147: 239, 2021.)

This article reviews the place of plastic surgeons in the liability spectrum and provides a practical guide to plastic surgeons seeking to avoid litigation (Fig. 1). Although malpractice has ancient roots,[1] the word itself was coined by Sir William Blackstone in 1768,[2] in his *Commentaries on the Laws of England*. *Mala praxis* was defined as a private wrong, not a breach of contract. The first case in the United States occurred in 1794. Although only three cases occurred between 1812 and 1835, the numbers exploded after 1850. By the late 1800s, certain principles had become accepted:

1. Jury trial.
2. Tort cause of action replaced that of contract. Here, process was judged rather than outcome.
3. Contingency fees (a contingency fee is any fee for services provided where the fee is payable only if there is a favorable result; some jurisdictions have limited the percentage that attorneys can charge, often on a sliding scale) enabled impecunious plaintiffs to sue.
4. *Res ipsa loquitur* ("the thing speaks for itself") became accepted where the incident "does not happen in absence of negligence" (e.g., a sponge left in a wound).

The Massachusetts Medical Society first offered malpractice insurance in 1919. Ten years

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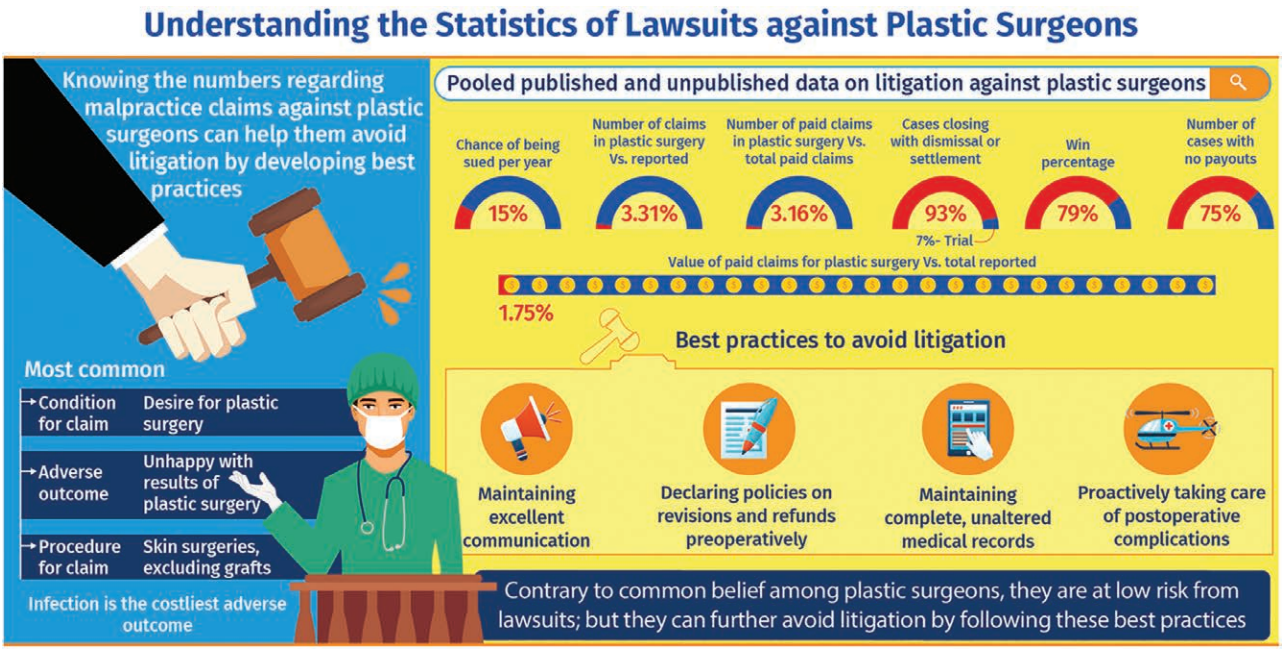

Fig. 1. Visual abstract/infographic. Plastic surgery occupies a small part in the spectrum of medical liability expenditure, but most plastic surgeons will be sued *at least* once in their lifetime. Common sense, safe surgical practices, and good communication play a big part in their avoidance.

later, their members "now have the service of a mutual insurance against unjust suits for alleged malpractice." This likely encouraged lawsuits by providing "deep pockets" for their clients, but the benefits outweighed the risks.[1]

Consumer protection legislation expanded in the 1920s, 1930s, and 1960s, and as the threshold for litigation decreased with an increasingly educated population, the principle of informed consent, emerging in the 1960s and 1970s, provided more grounds for lawsuits, as did the growing complexity of medicine.[1] Landmark jury awards publicized in the 1970s led to the first modern "malpractice crisis" begetting "tort reform" a decade later. Differing state legislation has produced wide variations in both the size of settlements and the cost of insurance premiums across the country.[1,3] Malpractice crises are somewhat cyclical, possibly related to downturns in the economy.[3]

Neither the federal government nor 32 states require medical liability insurance or minimum carrying requirements. However, without one or the other, hospital privileges are virtually unobtainable.

There exists a body of medicolegal opinion on methods of minimizing the risk of a malpractice lawsuit.[4,5] Suggestions include keeping up to date; maintaining meticulous documentation; developing a good doctor-patient relationship, and the obligatory use of checklists. Some talk about the three C's: compassion, care, and competence.[6] One author boils it down to the phrase: love thy patient.[7] To this must be added: ideas to impose fail-safe systems to prevent patients slipping through the net; effective communication with patients, their caregivers, and relatives; and, when things go wrong, a transparent, honest explanation and a willingness to apologize. However, the effectiveness of such laudable advice is rarely backed up by statistical analysis.[8]

The insurance industry maintains national statistics on malpractice cases by specialty. The Medical Professional Liability Association in 2016 published the most recent.[9] These data are not available to the public.

MATERIALS AND METHODS

We performed a PubMed search of the past 40 years using the phrases "malpractice insurance," "surgical malpractice," and "plastic surgery malpractice." Secondary searches followed on specific issues such as saying sorry, checklists, informed consent, and so forth. Publications concerning malpractice, the associated industry, and best practices for limiting medicolegal exposure were closely reviewed. Studies using statistical methods were prioritized for inclusion here. This material was combined with pooled data from the Medical Professional Liability Association.[9] Also used were

unpublished data and opinion from Applied Medico-Legal Solutions Risk Retention Group, a medical professional liability carrier operating in 49 states and covering plastic surgeons under a Preferred Aesthetics Program.[10]

RESULTS

Medical errors are the third leading cause of death in the United States.[11] James estimates 400,000 preventable deaths annually.[12] The yearly medical liability costs, including defensive medicine, are projected at $55.6 billion, or 2.4 percent of total health care spending.[13] The data obtained will answer a series of questions.

Are We Currently Amid a Malpractice Crisis?

Since the 1970s, tort reform helped reduce frivolous lawsuits and excessive jury awards.[3] Major provisions are as follows:

1. Caps on noneconomic damages ("pain and suffering").
2. Limitations on the proportion of contingency fees collected by attorneys.
3. Limitation of the collateral source rule (the collateral source rule is an American case law evidentiary rule that prohibits the admission of evidence that the plaintiff or victim has received compensation from some source other than the damages sought against the defendant), preventing plaintiffs from "double-dipping" for damages already covered by insurance.
4. Reduction in the statute of limitations.
5. Periodic payments (rather than lump sum) that may be stopped when no longer needed.
6. Tightening expert witness requirements and preventing spurious expert testimony.
7. Alternate dispute-resolution mechanisms.

Thirty-five states have imposed tort reform, mostly caps on noneconomic damages. This provision has proven by far the most effective.[14] As a result, the average plastic surgery settlement during 2011 to 2015 decreased from $242,346 (2006 to 2010) to $171,031, a drop of 29.4 percent (Fig. 2). However, the number of closed claims (settled, dismissed, or withdrawn) increased from 1196 (2006 to 2010) to 1812 (2011 to 2015). The average total payout from 2006 to 2010 was $71,007,268, increasing to $80,042,358 (2011 to 2015). Because the total payout from 1991 to 1995 was $91,373,219 for 2366 closed claims, the effect of tort reform becomes obvious.[9]

Where Are Plastic Surgeons in the Liability Spectrum?

The per-claim indemnity paid in plastic surgery is one of the lowest in medicine (Fig. 3). Between 2006 and 2016, plastic surgery claims were 3.31 percent of reported claims and 3.16 percent of paid claims. Payouts were only 1.75 percent of the total for all specialties (Table 1).

From 2011 to 2015, 58 percent of plastic surgery settlements resulted in payments less than $100,000, with 3 percent greater than $1 million. The highest was $2 million compared with $13 million for obstetrics-gynecology.

What Is the Likelihood of Being Sued?

Plastic surgeons have a 15 percent chance annually of being named in a malpractice lawsuit:

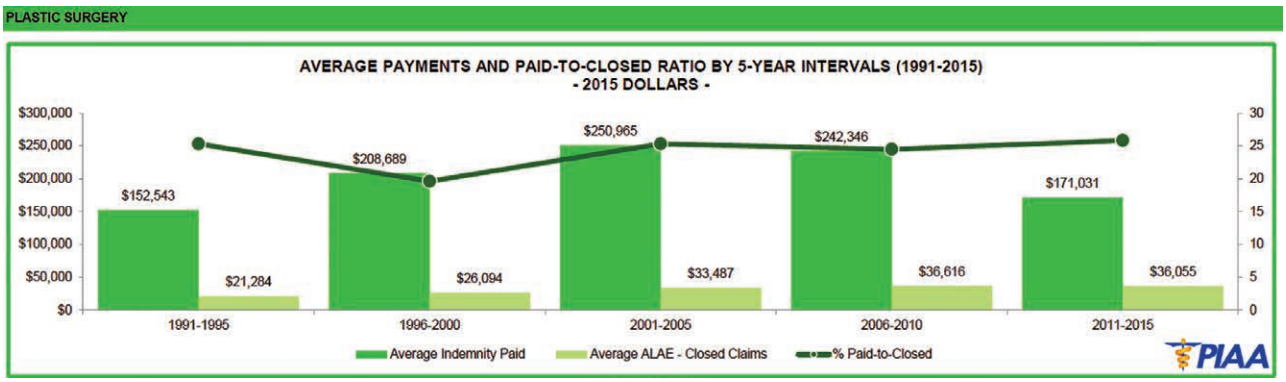

Fig. 2. The trend in indemnity payments for plastic surgeons in the United States. Allocated loss adjustment expenses (*ALAE*) represent the nonindemnity costs. Closed claims include those settled plus those dismissed or withdrawn. Thus, a paid-to-closed ratio of 25 means that only 25 percent involved a payout. [Reprinted with permission from the Medical Professional Liability Association (formerly known as the Physician Insurers Association of America). Medical professional liability specialty-specific series: Plastic surgery, 2016 Edition, Physician Insurers Association of America. Copyright, 2016.]

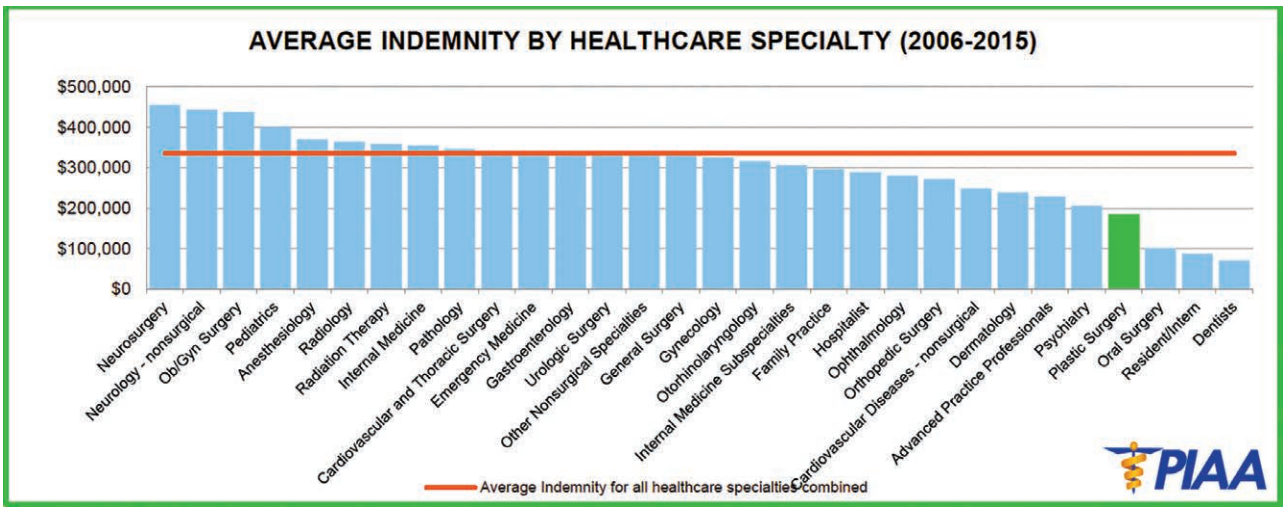

Fig. 3. Average indemnity paid per specialty from 2006 to 2016. [Reprinted with permission from the Medical Professional Liability Association (formerly known as the Physician Insurers Association of America). Medical professional liability specialty-specific series: Plastic surgery, 2016 Edition, Physician Insurers Association of America. Copyright, 2016.]

Table 1. Payouts for Plastic Surgery Compared with All Other Specialties

Specialty	Closed Claims	Paid Claims	Total
Plastic surgery	3008	761	$141,361,756
All other	90,743	24,106	$8,089,431,691

thus, most will be sued at least once. Thirty-eight percent of paid claims are for injuries sustained at ambulatory surgical facilities and 32 percent are for hospital mishaps. Among the latter, 63 percent occur in nonteaching hospitals, although the indemnity paid in teaching hospitals is higher. Twenty-four percent arise from office-based treatment. Over 75 percent of claims result in no payment.[9]

Twenty percent of claims are against previously sued practitioners, whereas only 5.6 percent are against those never sued (74.4 percent of cases were unspecified). Sixty-two percent of defendants practice solo, 32 percent are in group practice, and 2.5 percent are employed. Domestic and foreign medical graduates are represented proportionally.

The average plastic surgery litigant is a 35- to 49-year-old woman (78 percent are female) who waited 16.5 months to file. The case will take 27.5 months to close and 93 percent will do so. Of 7 percent going to trial, physicians prevail in 79 percent.[9]

In a survey of American Society for Aesthetic Plastic Surgery members by Boyll et al.,[15] 82 percent reported that at least half of their practice was aesthetic. If more than 75 percent cosmetic, the surgeons were 2.5 times likelier to have their lawsuits described as aesthetic.

Zenilman et al.[16] reviewed 187 closed cases from a single carrier in four New York teaching hospitals over 15 years. Most surgeons were sued mid-career, and injuries occurred during common operations. Only 25 percent of suits were for emergencies, agreeing with other studies: Rogers et al.[17] noted 24 percent, Gawande et al.[18] noted 23 percent, and Griffen et al.[19] noted 25 percent. Furthermore, physicians were likelier to win lawsuits arising from emergency cases. Overall, no cases were lost at trial, and 73 percent resulted in no payment. The Physician Insurers Association of America figures for plastic surgery were 3 percent and 75 percent, respectively.[9]

What Scenarios Lead to a Malpractice Claim?

Between 2011 and 2015, desire for plastic surgery was the commonest "medical condition" (26 percent), and an operative procedure involving the skin—excluding skin grafting—was the most prevalent (32 percent) and costly procedure. Improper performance of a procedure dominated the accusations (60 percent), but failure to supervise or monitor (6 percent), failure to recognize a complication (4.5 percent), error in diagnosis (3 percent), and treatment delay (0.8 percent) were also listed.[9]

Unhappiness with the results of plastic surgery was the commonest adverse outcome (20 percent of claims), followed by infection (10 percent). However, despite the lower percentage, infection was overall the costliest aggregated adverse

outcome, averaging $228,874 payout and over $7 million total (versus $59,459 and $5 million, respectively).

Carriers classify nine injury levels: emotional only, insignificant, minor temporary, major temporary, minor permanent, significant permanent, major permanent, grave, and death. Minor temporary was the costliest plastic surgery injury category ($17,255,626), with payment averaging $125,041 (for 138 paid claims). Death occurred in 4 percent of closed claims, with a total payment of $12,816,249 (31 paid claims). The average payment per death was $413,427, exceeded only by grave injury at $1 million per case (two paid claims).[9] Procedures resulting in a lawsuit are, in order:

1. Surgery on the skin excluding skin grafts.
2. Breast implantation including removal of implant.
3. Breast reduction.
4. Rhinoplasty and septorhinoplasty.
5. Nonelective breast surgery.
6. Elective breast surgery without implants.
7. Blepharoplasty.

The first exceeded all others combined, in both number of claims paid and total liability.[9]

How Do I Minimize the Chances of Being Sued?

All medicolegal experts recommend staying up-to-date.[3–8] Plastic surgeons are now expected to participate in Maintenance of Certification,[20] which involves Continuing Medical Education, now a requirement for hospital privileging and state licensing. *Plastic and Reconstructive Surgery* publishes a series of review articles on topics acting as Maintenance of Certification modules for surgeons.[21] Professional societies educate members by symposia, webinars, podcasts, newsletters, and the provision of videos and patient education materials.[22]

The World Health Organization recommended using surgical checklists in 2008.[23] A multinational group prospectively collected data from 3733 consecutively enrolled patients undergoing noncardiac surgery. They subsequently collected data on 3955 consecutively enrolled patients subjected to the World Health Organization Surgical Safety Checklist. The endpoint was the rate of complications within the first 30 postoperative days. A mortality rate of 1.5 percent before the checklist declined to 0.8 percent afterward ($p = 0.003$). Inpatient complications of 11.0 percent declined to 7.0 percent after introduction of the checklist ($p < 0.001$).[24]

In a retrospective review of 294 surgical claims, de Vries et al.[25] found that failure in diagnosis and perioperative injuries were the commonest scenarios. Cognitive contributing factors were present in two-thirds. Of 412 contributing factors, a perioperative checklist might have intercepted 29 percent. The checklist might have prevented 40 percent of deaths and 29 percent of incidents leading to permanent damage.

Boyll et al.[15] surveyed plastic surgeons regarding lawsuits. Those surgeons using procedure-specific education brochures and those participating in carrier-mandated courses had significantly lower incidences of claims.

Informed consent issues can result in unhappiness with the results of plastic surgery, the largest cause of malpractice lawsuits.[9] A survey of American Society for Aesthetic Plastic Surgery members by Hagopian et al.[26] showed that most consent forms focused on disclosure instead of patient understanding. Although total information was adequate, there was concern regarding information overload and retention. They reiterated that the best informed consent is a process of shared decision-making.[27–29] With bidirectional communication, the patient is informed of and understands the nature, risks, and benefits of the proposed treatment and alternatives, and the clinician is informed of and understands the goals, values, and informed preferences of the patient.[30–34]

They advocated the provision of a standardized set of data using patient decision aids kept current by standards established by certifying bodies to reduce inherent cognitive biases on the clinicians' part. The patient decision aids could be written text or brochures, but the use of a Web-based system and other visual aids was also foreseen. The content should conform to national health literacy, numeracy, and usability guidelines, with the choice of medium based on patient preferences. Unfortunately, evidence strongly suggests that current practice is not reflective of shared decision-making, and there is a general paucity of shared decision-making research in the context of aesthetic plastic surgery.[28,35,36]

Should I Apologize?

Saying "sorry" to patients after a bad outcome is advocated as a means of maintaining trust and empathy while reducing chances of a lawsuit.[37] In some states, however, this may be admissible as evidence of wrongdoing or guilt, and doctors there have been advised against apologizing.

To reduce lawsuits and litigation expenses, state legislators are changing the laws to exclude

expressions of sympathy, condolences, or apologies from being used against doctors in court. By December of 2018, 39 states had provisions protecting medical professionals apologizing or making sympathetic gestures.[38]

Opinion supports the concept of transparency and humility in sustaining a doctor-patient relationship.[37,39–42] People like to be treated with respect, empathy, and courtesy. Empathy—the recognition of someone as a fellow human being—is essential to trust and cooperation. Indeed, after a surgical error, an apology from the surgeon can help both parties heal and prevent a lawsuit. The converse is also true: lack of empathy can exacerbate harm that has already occurred.[43]

Should I Refund Fees to Unhappy Patients?

Most data on refunds come from dental journals[44–47] and medicolegal opinion on medical practice websites.[48] Because a satisfied patient is less likely to sue, many surgeons consider providing refunds to unhappy patients when options for revision are limited or rejected. However, any "demand" for money or services must be promptly reported to the insurer, because it might fall within the definition of a claim.[10]

Refunds should be accompanied by a full release (a contractual agreement by which one individual assents to relinquish a claim or right under the law to another individual against whom such claim or right is enforceable) and hold harmless agreement (an agreement or contract in which one party agrees to hold the other free from the responsibility for any liability or damage that might arise out of the transaction involved)[4] for the physician executed by the patient before money changes hands. It should deny liability on the physician's behalf; be completely confidential; and declare that the patient fully releases the physician from any further obligation, payment, lien, and so forth. In the experience of the Applied Medico-Legal Solutions RRG legal counsel,[10] patients genuinely interested in resolving a dispute without further legal remedies will execute a full release agreement.

If noninsurance payments such as refunds come from a surgeon as an individual, the amounts do not need to be reported to the National Practitioner Data Bank; however, if they come through his or her corporation, they do.[48,49] To sidestep the reporting requirement, the surgeon would therefore have to pay in after-tax dollars. Having the carrier involved early in the process is strongly advisable.

What Sort of Policy Should I Have?

The best carriers act as resources for their members, providing advice on letters of intent, online reputation management, complaints to the medical board, Health Insurance Portability and Accountability Act violations, demands for refunds, and threats to sue. Useful recommendations on choice of carrier often come from surgeons who have been defendants themselves.[10]

Commonly, insurance policies are either "claims made" or "occurrence." In claims-made policies, a "tail" will have to be purchased to cover claims arising during the previous policy's coverage but reported after its termination. An occurrence policy is costlier but preferable because it covers this eventuality.[10,50]

Do Malpractice Issues Vary by Location?

Variations in tort reform in different states affect malpractice awards and therefore insurance premiums: a plastic surgeon in Manhattan Beach, California, may pay $35,000 per year, whereas his or her colleague in Manhattan, New York, would pay $70,000 for identical coverage.[10] However, risks are distributed unevenly even within states. Upstate rural New York has some of the fewest claims in the country and therefore premiums are much lower than in neighboring cities. However, even in some large cities such as Buffalo, rates are much lower than in New York City itself. This is because the more affluent the city, the larger and more frequent the awards. This may be related to custom, the density of attorneys, or the degree of conservatism within the community. Arguably, conservative juries lean toward conservative awards. Lower awards mean lower premiums.[10]

The Medical Records Are Inaccurate: How Do I Correct Them?

The surgeon must maintain accurate medical records. The medical record should never be fraudulently altered.[4,51–53] This is easily uncovered by the plaintiff's attorney and frequently results in a verdict against the physician. Falsifying medical records is a crime, for which a doctor can be criminally prosecuted. Furthermore, falsification of records is an independent civil cause of action (fraudulent concealment or spoliation of evidence), exposing the physician to punitive damages. If a change must be made, a single line must be drawn through the incorrect passage and the correction entered nearby. This must be signed and dated. Many insurance policies will exclude indemnity and/or defense coverage when a practitioner falsifies the medical record.

DISCUSSION

In this lull in the "malpractice crisis," complacency should be avoided. Stability is attributable to tort reform,[3] but things could change. In California, a 2020 ballot measure, the Fairness to Injured Patients Act, would raise the $250,000 cap to $1.2 million. The present limit was established in 1975 by the Medical Injury Compensation Reform Act. Proponents of the Fairness to Injured Patients Act want "inflation to be considered." Proposals would facilitate circumvention of the cap entirely for cases of catastrophic injury and death.[54,55] This could turn tort reform on its head and plunge the nation's largest state into a new "malpractice crisis."

Separate from the danger to tort reform is a sense that the professional liability market is "hardening." This means the costs are likely to increase and obtaining insurance is likely to become, well, harder. The reason is an increase in large settlements against hospitals, who now employ nearly 50 percent of physicians and are perceived to have deeper pockets.[56–59]

Because unhappiness with the results of plastic surgery constitutes the largest segment of litigious patients,[9,60] plastic surgeons should adopt a shared decision-making approach of informed consent with their patients to avoid unrealistic expectations, particularly because recent studies have shown shared decision-making to be largely deficient.[27–36] The American Society of Plastic Surgeons has an informed consent resource available to members with forms covering most procedures.[61] Some have recommended including a patient evaluation of the consent process[62,63] to prevent the later claim: "If I had understood, I would have never undergone the procedure!"

Preoperative receipt of brochures is associated with a lower incidence of lawsuits.[15] These too, are available through the American Society of Plastic Surgeons, and also through manufacturers in support of their products.[64] The American Society of Plastic Surgeons distributes videos to enhance patient education and understanding. The future may bring Web-based (or device-based) interactive forms not only providing patient education but also measuring understanding and recording consent.[65,66]

The costliest aggregated adverse outcome against plastic surgeons is infection.[9,10] Infections are common, and the plaintiff's attorney will search the medical record, not just to establish the cause—an act of commission—but to identify whether the surgeon committed acts of omission: Was the patient given prophylactic antibiotics? Were the antibiotics and dosage appropriate? Should a seroma have been aspirated? Was the decision to incise and drain postponed too long? Were swabs sent for culture and sensitivity? Were the results correctly acted on? Did the patient fall through the cracks? Was an infectious disease consultation sought at the appropriate time? An infection represents a red flag and should be managed judiciously.

Perioperative checklists have been shown to decrease nontechnical errors such as wrong-site surgery and failure to administer prophylactic antibiotics, yet they remain somewhat dependent on surgeon commitment. A recent study found that surgeons' engagement, their buy-in, and clinical leadership were critical to promote conversations in which all team members actively participated.[67] Surgeons should actively and enthusiastically participate in this process.

Professional societies, regulatory bodies, and the Accreditation Council for Graduate Medical Education continually work to improve education, training, evaluation, Maintenance of Certification, and surgical safety. It behooves the plastic surgeon to participate in their initiatives. Oddly, the raising of standards by the medical profession has historically increased the expectations of the public and provided a lower threshold for medicolegal claims.[1] However, few would argue that processes that prevent mistakes, eliminate misunderstandings, enhance patient safety, and maintain surgical standards are against the surgeon's interest.

Finally, exposure to litigation often revolves around the doctor-patient relationship. Affability, transparency, empathy, body language, personality, and respect of cultural and sexual diversity are all part of the mix. How a surgeon treats the patient, the spouse, children, and relatives is vital in building a trusting relationship. Being honest about policies regarding refunds, revisions, payments, and arrangements for cover when out of town are essential components. With a relationship built on mutual understanding and respect, lawsuits are uncommon.[10] As one medicolegal expert opined: love thy patient.[7]

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