

Liability Exposure
Malpractice Claim Patient
Selection Criteria
Risk Management
Evaluating Insurers

What You May Not Have Learned
in Your Residency

— *What every plastic surgery resident
needs to know*



Standard of Care
Effective Informed Consent
Spread of Risk
Patient Characteristics

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AMERICAN SOCIETY OF
PLASTIC SURGEONS



THE DOCTORS COMPANY

What You May Not Have Learned in Your Residency



WHAT EVERY PLASTIC SURGERY RESIDENT NEEDS TO KNOW

Although all physicians are aware that practicing medicine in the United States is virtually impossible without some form of liability insurance, many physicians have only a limited understanding of how the American system of professional liability insurance really works. It is important for every practicing physician to understand not only some of the technical language regarding insurance but also the various types that are available. The first part of this brochure, “Insuring the Practice of Medicine,” will help doctors understand the distinguishing features of an effective insurance program.

Despite the unquestionable excellence of current plastic and reconstructive training programs in most residencies, traditionally there has been an inadequate degree of exposure to a variety of nonclinical problems that present themselves almost from the inception of practice. The second part of this brochure, “Medical Liability and the Plastic Surgeon,” will help familiarize the new surgeon who is emerging into practice with some of the most common situations with which he or she is likely to be confronted.

Insuring the Practice of Medicine

Virtually all practicing physicians in the United States require medical malpractice insurance. Though it is legally required in only a few states, the vast majority of hospitals and other health care institutions mandate that all medical staff members be insured. Specialty insurance companies that provide only professional liability insurance and multi-line companies that cover this type of risk and many others provide this coverage.

About two-thirds of America's doctors are insured by mutual or reciprocal companies. These are owned by the physician policyholders and are not responsible to outside shareholders. Virtually all of these companies specialize in professional liability insurance with limited or no exposure to other lines of business. The remaining one-third of doctors are insured by publicly traded commercial carriers that are owned by shareholders rather than policyholders.

The fundamental business principle that applies to all American businesses also applies to insurance companies: income must cover expenses. For insurance companies, the major categories of expenses are as follows:

1. *Losses* represent the payments made to plaintiffs as a result of jury verdicts or settlements.
2. *Legal Defense* represents the legal costs associated with settling or litigating individual claims; these are primarily defense attorney and expert witness fees.
3. *Operating Expenses* include all other expenses incurred by the insurance company. Such expenses include underwriting, claims administration, finance, computer systems, marketing, and agent commissions.

There are a number of areas, however, in which insurance differs from other businesses. The most important area is the need to collect an appropriate amount of premium today in order to cover the costs of losses and legal defense that often occur four to six years in the future. By definition, actual future costs are unknown at the time the insurer must price and sell the policy. If insurers seriously underestimate future costs and fall into insolvency, the physician is left without the liability protection that he or she has paid for, but the liability remains. Therefore, the choice of a malpractice insurance company is an important decision for physicians. The true value of a policy (as opposed to its cost) may not be apparent until years after the purchase, when a claim must be defended and possibly paid.

The following principles of insurance and definitions of key terms are intended to facilitate that choice:

SPREAD OF RISK

Physicians as a group, knowing that some of them will be sued and have to pay litigation costs and losses, pool resources to share the total burden of the group. In any given year, not every physician will be sued, but all will contribute to cover the costs of those who are. In return, the individual physician is protected in similar fashion when he or she is the target of litigation. By assembling a large enough group, the burden on any individual, even with

a large claim, can be reduced. The law of large numbers puts prediction of outcomes on a sounder statistical footing.

UNDERWRITING

The insurance company reviews every physician applicant and divides the group into multiple subgroups that share similar risk profiles. Some of the attributes that significantly affect risk include the level of education and training, specialty, the state and county where the practice is located, nature of the practice, unusual practice profiles, clinical setting, and previous litigation history. This means, for example, that a neurosurgeon in Florida will be asked to pay a very different premium from a pediatrician in California.

ACTUARIAL SCIENCE AND FINANCIAL MARKETS

Actuaries use a variety of complex mathematical models to estimate future loss and legal defense costs based on past experience, estimates of future trends in claims severity and frequency, and the anticipated composition of the risk pool. These models must reflect the impact of past and prospective changes in the economic (e.g., inflation) and legal (e.g., tort reform) environments. Since there is a time gap from the collection of premiums to the closing of the average claim file, these models must also reflect the value of investment income. Part of the fiduciary responsibility of any insurance company is to responsibly invest premium until the money is needed to pay future losses and expenses. The investment income collected during that period can be used to subsidize the actual cost of premiums. For this reason, insurance rates are sensitive to the state of the investment markets, and primarily to interest rates.

CLAIMS-MADE COVERAGE

The majority of medical malpractice insurance policies for physicians since the late 1970s is sold on a claims-made basis. This form requires that a covered event must occur and the claim made (reported) during the policy period. Claims-made coverage can be extended back by adding *nose* coverage, in which the insurer agrees to cover claims made during the policy period based on events that occurred prior to the inception date of the policy. When a physician retires or chooses to move to a different insurance carrier, he or she may obtain *tail* coverage. This provides insurance for a covered event occurring during the policy period, even if the claim is not reported until after the policy terminates. In the case of a physician moving from one carrier to another, the individual can choose between a tail policy with the expiring carrier and nose coverage with the new carrier to accomplish the same purpose.

INCURRED LOSS AND RESERVES

Incurred loss represents the sum of losses actually paid plus a reserve for the costs of anticipated future losses. Loss reserves are an estimate of the eventual cost of claims reported but still open and claims that have occurred and will be covered but have not yet been reported to the insurance company. The latter type of loss reserve is needed only for occurrence insurance and tail coverages.

PROFIT OR LOSS

For most insurers, income is the sum of premium and investment income minus the cost of claims, underwriting, and other operating expenses. The combined ratio is defined as losses plus expenses divided by premium. It is a measure of the percentage of each premium dollar going to losses and expenses. A combined ratio of 100 percent means that the company's claims losses and expenses exactly equal the premium collected.

SURPLUS

An insurance company's assets minus its liabilities equal its surplus. This represents the capital base of the company and in a mutual or reciprocal insurance company belongs to the policyholders. It is necessary to maintain significant surplus to support company operations and to maintain solvency during those years when unpredictably high losses are incurred. Insurance companies are regulated by state departments of insurance that require certain amounts of surplus to back each dollar of premium and reserves.

Medical Liability and the Plastic Surgeon

Most liability problems in plastic surgery arise from the aesthetic or elective segment of practice. In the vast majority of cases, this segment of your experience will not stand out prominently in your preoccupations until you have been out of residence for a good number of years. We urge you, however, to consider three general observations that will be applicable during your entire career:

1. The plastic surgeon who performs elective surgery is generally not assuming care of a sick person to make him or her well; rather, it is a matter of trying to make a well person better. This is a concern that few other physicians face, and it is a heavy responsibility.
2. The results of your work are always judged by your patient according to entirely personal (and often unrealistic) standards. It is your responsibility to erase any misconceptions before you pick up the scalpel—it is too late afterward.
3. How well you succeed depends as much on your surgical competence as on your ability to communicate and on the image that the patient has of you as a professional. The vast majority of medical liability disputes have their roots not in surgical misadventure but, rather, in misunderstandings and in the breakdown of the doctor-patient rapport.

LEGAL PRINCIPLES APPLIED TO PLASTIC SURGERY STANDARD OF CARE

Malpractice is defined as treatment that is contrary to accepted medical standards that produces injurious results in the patient. Most medical malpractice actions are based on laws governing negligence. Thus, the cause of action is usually the “failure” of the defendant-physician to exercise that reasonable degree of skill, learning, and care ordinarily possessed by others of the same profession in the community. Whereas in the past, the term “community” was accepted geographically, it is now based on the supposition that all

doctors keep up with the latest developments in their field. Community, then, is generally interpreted as a “specialty community.” The standards are now those of the specialty as a whole without regard to geographic location. This series of norms is commonly referred to as “standard of care.”

In practical terms, what all of this means is that if you are practicing in a small community, you can still be held to the “standard of care” of the university medical center in the big city. You should also be aware that the philosophy of “consent to surgery” has gradually evolved through decisions by the U.S. Supreme Court. Although these decisions are mostly unrelated to medical care, their impact has gradually converted the obligation of disclosure prior to surgical treatment considerably for those of us heavily involved in largely elective surgery. Details are provided in the following section.

INFORMING YOUR PATIENTS BEFORE THEY CONSENT

In the language of medical liability, no concept has received as much misinterpretation as “informed consent.” A clear understanding of what informed consent means and the responsibility it imposes is particularly important in claims against surgical specialties, where a substantial portion of treatment is elective.

Simply stated, informed consent means that adult patients who are capable of rational communication must be provided with sufficient information about risks, benefits, and alternatives to make a decision and expressly give permission for a proposed course of treatment. In most states, physicians have an *affirmative duty* to disclose such information. This means that you must not wait for questions from your patients; you must volunteer the information.

The central thesis of this legal doctrine is this: The patient must be given all information about risks that are relevant to a meaningful decision-making process. It is the prerogative of the patient, not the physician, to determine the direction in which it is believed his or her best interests lie.

REFUSALS

Doctors now must also warn patients of the consequences involved in failing to heed medical advice by refusing treatment or diagnostic tests. Though patients have a right to refuse, it is essential that you carefully document such refusals and their consequences and that you verify and note that the patient understood those consequences.

Documentation is particularly important in cases involving possible malignancy, where rejection of tests may impair diagnosis and refusal of treatment may lead to a fatal outcome. Remember to date all such entries in the patient record. Finally, all of this information is wasted unless it is documented. For legal purposes, if it is not in the medical record, it never happened!

When the patient is unable to communicate rationally, as in many emergency cases, there is a legally implied consent to treat. The implied consent in an emergency is assumed only for the duration of that emergency. If at all possible, however, it is safer to obtain the consent of the patient’s closest relative.

The treatment of minors carries the responsibility of obtaining consent from the parents or legal guardians. The exception in most states is the “emancipated minor.” Emancipated minors include those who are pregnant, married, or legally free and financially independent, as well as those serving in the military. In an emergency, however, you must not delay in treating a minor or an incompetent person when such delays might adversely affect the outcome of the case. In such circumstances, anything less than prompt attention and treatment will increase your exposure to liability.

In situations where the nature of the tests or treatment is purely elective, as with cosmetic surgery, the disclosure of risks and consequences may need to be expanded. Office literature can provide additional details about the procedure. In addition, an expanded discussion should take place regarding the foreseeable risks, possible untoward consequences, or unpleasant side effects associated with the procedure.

Written verification of consent to diagnostic or therapeutic procedures is crucial as a claims prevention technique. A simple handwritten notation that includes the entry’s date and time can make the difference between a totally defensible case and one that is lost. A simple entry of several lines might suffice. Also remember, however, that in an increasing number of circumstances, laws now require the completion of specifically designed consent forms. If your records disclose no discussion or consent, the burden will be on you to demonstrate legally sufficient reasons for such absence.

THERAPEUTIC VALUE OF INFORMED CONSENT

Obtaining informed consent need not be an impersonal legal requirement. When properly conducted, the process of obtaining informed consent can help establish a therapeutic alliance and launch or reinforce a positive doctor-patient relationship. If an unfavorable outcome occurs, that relationship can be crucial to maintaining patient trust. By weighing *how* you say something more heavily than *what* you say, you can turn an anxiety-ridden ritual into an effective claims prevention mechanism. Pertinent literature refers to this as the “sharing of uncertainty.”

To allay anxiety, you may seek to reassure your patients. In doing so, however, be wary of creating unwarranted expectations or implying a guarantee. Consider the different implications of these two statements:

1. “Don’t worry about a thing. I’ve taken care of hundreds of cases like yours. You’ll do just fine.”
2. “Barring any unforeseen problems, I see no reason why you shouldn’t do very well. I’ll certainly do everything I can to help you.”

The therapeutic objective of informed consent should be to replace some of the patient’s anxiety with a sense of his or her participation with you in the procedure. Such a sense of participation strengthens the therapeutic alliance between you and your patients. Instead of seeing each other as potential adversaries if an unfavorable or less than perfect outcome results, you and your patients are drawn closer by sharing acceptance and understanding of the uncertainty of clinical practice.

EFFECTIVE INFORMED-CONSENT DOCUMENTS

No permit or form will absolve you from responsibility if there is negligence; nor can a form guarantee that you will not be sued. A well-drafted informed-consent document is proof that you tried to give the patient sufficient information on which to base an intelligent decision. Such a document, supported by a handwritten note and entered in the patient's medical record, is often the key to a successful malpractice defense when the issue of consent to treatment arises.

The format of the consent form does not have to represent an orgy of open minded disclosure nor should it be a vague list of meaningless generalities. To be effective, the document should follow the same format used by commercial pilots before takeoff. There should be a box or line beside each statement, which the patient acknowledges by placing his or her initials. It should end with a statement, signed and witnessed by both the surgeon and the patient, the content of which is that all questions were answered satisfactorily and that the patient wishes to proceed.

A sample of an informed-consent document is included at the end of this brochure. For additional information, documentation, and risk management and patient safety resources, please visit www.thedoctors.com/patientsafety. If you have questions, please contact Robin Diamond, senior vice president of Patient Safety, at (800) 421-2368, extension 1291.

PATIENT SELECTION CRITERIA

Contemporary plastic and reconstructive surgeons practicing in the United States will find it virtually impossible to end a 30- to 40-year career unblemished by a claim of malpractice.

However, well over half of these claims are preventable. Most claims are based on failure of communication or on patient selection—not on technical faults. Patient selection is the ultimate inexact science. It is a mixture of surgical judgment, gut feelings, personality interactions, the strength of the surgeon's ego, and, regrettably, economic considerations. Regardless of technical ability, a surgeon who appears cold, arrogant, or insensitive is far more likely to be sued than a surgeon who relates at a “human” level. Obviously, a person who is warm, sensitive, and naturally caring, with a well-developed sense of humor and a cordial attitude, is less likely to be the target of a malpractice claim. The ability to communicate clearly is probably the most outstanding characteristic of the claims-free surgeon. It is the *sine qua non* of building a good doctor-patient relationship. Unfortunately, the ability to communicate well is a personality characteristic that is difficult to learn in adulthood.

CHARACTERISTICS OF TROUBLE-PRONE PATIENTS

The list of possibly troublesome patient types includes those who:

- harbor great or unrealistic expectations
- have an excessively demanding character (which indicates a failure to grasp limitations)
- reveal an indecisive nature (which indicates questionable motivation)
- are emotionally immature (which indicates romanticized visions of what surgery will achieve)

- appear to have a secretive nature (which might indicate guilt regarding the proposed procedure)
- have a disapproving family (the doorway to litigation)
- are “surgiholics” (which might indicate that the patient has significant psychological problems)
- make you feel uncomfortable, who you don’t like, or who don’t like you (fertile ground for disputes).

Generally speaking, there is a clear risk-to-benefit ratio to every surgical procedure. If the risk-to-benefit ratio is favorable, the surgery should probably be encouraged and has a high degree of probability of success. If the risk-to-benefit ratio is unfavorable, the reverse not only applies, but the unintended consequences of the unfavorable outcome may also turn out to be completely disproportionate to the surgical result. The only way to avoid this debacle is to learn how to distinguish those patients whose body image and personality characteristics make them unsuitable for the surgery that they seek.

PSYCHOLOGICAL AND PSYCHIATRIC ASPECTS OF MODIFYING ANATOMY

There are basically two categories that make the patient a poor candidate for elective aesthetic surgery. The first category is anatomic unsuitability (you cannot make an elegant garment out of sackcloth). The second, more subtle, category, which is equally—if not more—important, is psychological inadequacy. The patient’s strength of motivation is critical. It has a startlingly close relationship with the patient’s satisfaction postoperatively. Furthermore, a strongly motivated patient will have less pain, a better postoperative course, and a significantly higher index of satisfaction regardless of the result. Although these characteristics are impossible to predict with absolute accuracy, it is possible to establish some objective criteria for patient selection.

ANGER

Patients feel both anxious and bewildered when elective surgery does not go smoothly. The borderline between anxiety and anger is tenuous, and the conversion factor is uncertainty—fear of the unknown. A patient who is frightened by a postoperative complication or who is uncertain about the future may surmise: “If it is the doctor’s fault, then it is the doctor’s responsibility to correct it.”

The patient’s perceptions may clash with the physician’s anxieties, insecurities, and wounded pride. The patient blames the physician, who in turn becomes defensive. At this delicate juncture, the physician’s reaction can set in motion or prevent a natural chain reaction. The physician must put aside feelings of disappointment, anxiety, defensiveness, and hostility in order to understand that he or she is probably dealing with a frightened patient who is using anger to gain control of the situation.

The patient’s perception that the physician understands this uncertainty and will join with him or her to help to overcome it may be the deciding factor in preserving the therapeutic relationship and forestalling a visit to an attorney.

It should come as no surprise that the overwhelming majority of all malpractice claims lodged against plastic and reconstructive surgeons is concentrated in a handful of aesthetic surgery operations. Sources of dissatisfaction can range from a catastrophic result to something as unpredictable as a patient's hidden emotional agenda or a simple communication failure.

SCARRING

Most surgeons assume that the patient understands that healing entails the formation of scar tissue. Unfortunately, it is seldom discussed in the preop consultation. In plastic and reconstructive surgery, the appearance of the resulting scar can be *the* major genesis of dissatisfaction in the following procedures:

- breast reduction
- breast augmentation
- face lift/blepharoplasty
- post bariatric revisions
- abdominoplasty
- brachioplasty
- large flap transfers.

We strongly advise surgeons to include an explicit description of the scar's location, probable appearance, anticipated change with time, and possible need for revision as part of their routine. Explain to each patient that how each individual heals is a factor of his or her genetic package—not the surgeon's skill. Your best defense is to mark the anticipated scars with a heavy colored pen and photograph what you marked for your records.

CONCLUSION

If you are certified by or eligible for American Board of Plastic Surgery certification, your insurance carrier has proof that you possess a very high degree of competence. That is a good start. With close attention to detail and continuing efforts, it is possible for a plastic surgeon to minimize the unpleasant prospect of a medical malpractice claim during his or her entire career. To reduce the likelihood of a claim, apply these simple principles: maintain good communication and rapport with the patient through good times and bad, restrict your practice to those procedures that you feel thoroughly comfortable performing, and document your activities with close and careful attention.

ABDOMINOPLASTY

Post Bariatric Surgery Abdominal Reconstruction

Abdominoplasty, or “tummy tuck,” is a major surgical procedure designed to remove excess skin and fat from the lower abdomen and may involve tightening of muscles of the belly wall. Post bariatric surgery and successful large weight loss produces excess skin and fat that form rolls, folds, or an “apron” requiring removal. This procedure inevitably involves large and sometimes unsightly scars. These are inevitable and their final appearance depends on your own genetic healing characteristics that have little to do with the surgery. Occasionally, other complications may also occur.

Patient’s
Initials

- _____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- _____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- _____ I understand and accept that the most likely material risks and complications of abdominoplasty have been discussed with me and may include but are not limited to:
- *allergic reactions*
 - *asymmetries of contour*
 - *bleeding*
 - *change in sensation or numbness of abdominal skin*
 - *changes in shape or appearance of pubic hair*
 - *delayed healing*
 - *disappointment*
 - *“dog ears” (skin excess at scar end)*
 - *extended hospital stay*
 - *failure to alleviate symptoms of rash and back pain*
 - *genital region numbness*
 - *hematoma (blood clots under skin)*
 - *infection*
 - *loss of skin from insufficient circulation (requiring further surgery and skin graft)*
 - *loss of umbilicus (belly button) or displacement to the side*
 - *need for more surgery for secondary surgical corrections*
 - *pain (may be prolonged)*
 - *permanent scars that may be unsightly*
 - *pulmonary embolism (blood clots in the lung)*
 - *seroma (fluid collection under the skin)*
- _____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- _____ I understand and accept the risks of blood transfusion(s) that may be necessary.
- _____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.
- _____ I understand that skin and tissue relaxation may follow plastic surgery after weight loss. This natural loosening or stretching of skin after surgery is unpredictable, and may require additional surgery.
- _____ I am aware that smoking during the three to four week pre- and postoperative periods is prohibited as smoking could dramatically increase chances of complications.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

Continued

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