Aesthetic Surgery Journal

Commentary

Commentary on: Malpractice Litigation in Plastic Surgery: Can We Identify Patterns?

OXFORD UNIVERSITY PRESS

Samuel O. Weaver, JD

Editorial Decision date: January 24, 2020; online publish-ahead-of-print April 21, 2020.

A running joke among medical malpractice defense attorneys is that anyone with $35 and access to a fax machine can sue a physician. The unfortunate reality is that the only foolproof way a physician can avoid medical malpractice lawsuits is by retiring and moving to the Bahamas. This rings particularly true for plastic surgeons. "Malpractice Litigation in Plastic Surgery: Can We Identify Patterns?" analyzes the recent litigation landscape in plastic surgery across the United States based on a comprehensive search in the Westlaw legal database.[1] The article's goal is to identify patterns in these lawsuits and ultimately prevent them from recurring. Although this analysis is detailed, it is necessary to note its limitations. The majority of all malpractice claims are resolved via state trial court decisions, jury verdicts, or settlements. Westlaw, however, typically only obtains published appellate court decisions from state and federal courts.[2] Consequently, most plastic surgery malpractice claims during the relevant time period would not be documented in the Westlaw database. Nevertheless, these results are useful in determining the best ways to avoid such claims. Although there may not be a sure-fire guide to prevent lawsuits, this Commentary focuses on some basic strategies within 2 key areas that plastic surgeons should incorporate into their regular practice. Utilizing appropriate bedside manner and proper documentation will function as a 2-pronged defense that will substantially decrease the likelihood that a patient brings a viable claim against you.

BEDSIDE MANNER

Taking the time to carefully explain a procedure and its complications, listen to the patient, substantively answer his or her questions, and just generally be nice—maybe even crack a joke or two if that is your style—functions as a powerful litigation prophylactic, preventing a potential malpractice claim before it ever gets started. The reason behind this is quite simple: patients are less likely to sue physicians who they like, and there is a direct correlation between a physician's communication skills and how well-liked he or she is by his or her patients. This notion remains true when patients experience bad outcomes and even when errors were committed.[3,4] From a practical standpoint, this makes sense. You do not want to make people that you are fond of suffer. Potential malpractice plaintiffs will consider the effect that a lawsuit has on the physicians when deciding whether to pursue a malpractice claim.

To provide an example, a friend recently contacted me seeking advice about a potential lawsuit against his surgeon. The physician made a technical error during the surgery that led to multiple remedial procedures and a significantly prolonged recovery time. After explaining in detail what a malpractice lawsuit would look like for both my friend and also the physician, including the stresses and potential damage to the physician's career and reputation, my friend ultimately decided not to even contact a plaintiff's attorney to evaluate his claim. The primary reason he decided not to pursue a lawsuit? He believed the physician was a "good man." The moral of the story:

Mr Weaver is an Attorney at The Weathington Firm, Atlanta, GA.

Corresponding Author:
Mr Samuel O. Weaver, 191 Peachtree Street NE, Suite 3900, Atlanta, GA 30303, USA.
E-mail: sweaver@weathington.com

be nice and communicate with your patients. If you cannot motivate yourself to do this out of the goodness of your heart, do so out of your own self-interest. Doing so may just prevent a would-be plaintiff from electing to proceed with a lawsuit against you.

DOCUMENTATION

The second step in the 2-pronged defense for preventing malpractice claims involves detailed and thorough documentation. While the bedside manner can deter would-be plaintiffs from making the decision to actually pursue a claim, proper documentation can thwart malpractice claims even after a patient has made the decision to move forward with a lawsuit. Broadly, we advise that you provide detailed medical notes such that your records clearly state what you did AND your thought process for doing it. We strongly recommend that you write detailed progress notes instead of relying on drop-down entries from EMR. To understand why, consider this brief summary of how medical malpractice lawsuits work from the plaintiff's side.

Medical malpractice claims are complex, lengthy, and expensive. Because many patients do not have the means to finance a medical malpractice claim, plaintiff's attorneys typically take these cases on a contingency fee basis, where they receive a fixed percentage of the total recovery in the case. In other words, the attorney assumes all of the financial risk in exchange for a portion of the overall recovery (typically 30-40% of the total recovery). If there is no recovery, the plaintiff does not owe the attorney any money. This means that the attorney must front all costs of litigation, including hundreds of hours of manpower, the hiring of experts, and costs of travel. In a complex medical malpractice case with experts across the country, the costs of litigation can easily exceed $100,000. As such, strong plaintiff's attorneys—the ones who you do not want suing you—will devote a significant amount of time researching and evaluating a potential case before actually accepting it. A good plaintiff's medical malpractice attorney will tell you that he or she turns down over 90% of the cases that he or she receives. This investigation always starts with a meticulous review of the medical records, a primary source of information that a jury will likely consider when evaluating a case if it proceeds to trial. As such, laying out certain critical information in your medical documentation often causes a smart attorney to decline the case.

Medical malpractice trials are really just storytelling events. The plaintiff will first present his or her side of the story to the jury, and then the physician gets the opportunity to convey his or her side. Once both parties have told their stories, the jury will decide which version they believe. Documentation is critical because it serves as the strongest storytelling tool for both sides. In general, a physician who is forced to defend him or herself in a medical malpractice lawsuit may testify in 1of 3 ways:

1. Reference to the documentation in the medical records
2. Explaining his or her independent recollection of the events that took place, and /or
3. Discussing his or her customary practice, or the normal course of conduct when treating a patient in similar circumstances.

Of these 3 ways to tell your story, reference to the medical records (accompanied with a gentle explanation for your actions in laymen's terms) is the most powerful form of testimony. Juries tend to find it the most credible because the medical records were prepared contemporaneously with the care provided and before any litigation was considered.

To illustrate this point, consider my firm's recent defense of a "failure to warn" case. The defendant dermatologist prescribed a tetracycline, a very common and relatively safe medicine, to treat the patient's acne. The patient developed an extremely rare side effect, pseudotumor cerebri, which resulted in permanent vision damage. To be clear, there was no allegation that the medication prescribed was in any way improper. The plaintiff simply alleged that the physician failed to appropriately warn her about the possibility of pseudotumor cerebri or vision loss. The physician was able to defend himself by testifying as to his normal course of conduct, i.e. that he always tells his patient to call his office immediately if he or she begins to experience dizziness or blurred vision when prescribing this medicine. However, had the dermatologist merely documented that he had discussed side effects generally when treating this patient, she likely never would have been able to find an attorney willing to accept her case, and hence no lawsuit.

Although comprehensive documentation in general is important, this Commentary will briefly highlight documentation with respect to informed consent, which is particularly significant in plastic surgery. According to the article, nearly three-quarters of all plastic surgery lawsuits arise out of elective cosmetic procedures. In these elective cosmetic surgeries, it is imperative to thoroughly document that you explained the procedure, explicitly discussed the possibility of an unfavorable outcome, and discussed alternatives to the surgery—prior to obtaining informed consent.

Although obtaining informed consent is critical anytime you perform a surgical procedure, it holds special importance in these elective procedures because many times the allegations that the procedure was defective rests on the

patient's subjective belief that there was a bad outcome. In many of these cases, the lawsuit will proceed like this:[1] patient receives surgery;[2] patient is unhappy with how he or she looks after surgery or there is an unfavorable outcome;[3] patient states he or she would never have proceeded with the surgery had the physician adequately explained the potential for a unfavorable outcome. If you documented that possible outcomes were discussed, expectations were tempered, and the patient expressly stated that he or she understood these risks and still elected to proceed with the procedure, these cases become much weaker from a plaintiff's attorney's perspective when determining whether to accept the case. This holds especially true in elective procedures where a portion of the injury is the patient's subjective unhappiness with his or her appearance after the surgery. These types of patients are much less likely to evoke strong feelings of sympathy—which can lead to large verdicts—from a jury, especially when it is clear they were fully aware of the possibility of an unfavorable outcome before proceeding with the elective procedure.

CONCLUSIONS

Unfortunately, lawsuits are just a part of the practice of medicine in today's society. Although you may not be able to avoid them, proper bedside manner and detailed documentation will substantially reduce the likelihood that a patient brings a viable claim against you.

Disclosures

The author declared no potential conflicts of interest with respect to the research, authorship, and publication of this article.

Funding

The author received no financial support for the research, authorship, and publication of this article.

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