General Surgeon/Dr B

A Report by the

Health and Disability Commissioner

(Case 07HDC05410)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer/complainant
Dr B	Provider/General surgeon

Complaint

On 3 April 2007 the Commissioner received a complaint from Mrs A about the services provided by Dr B. The following issues were identified for investigation:

- *The appropriateness of the care provided by Dr B to Mrs A between 18 March 2005 and 9 March 2006.*

An investigation was commenced on 10 July 2007.

Information reviewed

Information was obtained from:

- Mrs A
- Dr B
- Dr C (Plastic and Cranio-Maxillofacial surgeon)
- Dr D (General Practitioner)

Independent expert advice was obtained from plastic and reconstructive surgeon Dr Sally Langley.

Information gathered during investigation

Background
In 2005, Mrs A, aged 39, felt that after the birth of her four children she had excess skin around her abdomen. She decided to have a "tummy tuck" to remove the excess skin.

Mrs A rang a number of private plastic surgeons in another area to enquire about having a "tummy tuck". Then, while reading the local newspaper, Mrs A saw an advertisement for a private hospital (the Hospital).

The procedures listed as available at the Hospital included "Tummy Tucks". At the bottom of the advertisement, it reads "Fixed price. No wait. We accept self referral. For an instant quote phone …"

Because no referral was required from another medical practitioner, and she thought that it would be good to have the procedure done locally to save on travel costs, Mrs A rang the Hospital to get more information. She subsequently made an appointment to see Dr B on 18 March 2005.

Dr B is a vocationally registered general surgeon. He had been registered as a general surgeon in New Zealand since 1978. He initially practised as a general practitioner and visiting surgeon, then at his own private hospital. Dr B has performed over 100 abdominoplasties.[1] Dr B is not currently practising as a general surgeon.

18 March 2005
Mrs A first consulted Dr B on 18 March 2005. The clinical records from this consultation state:

> "Initial Consultation: re abdominoplasty liposuction[2] flanks upper medial thighs has lost 12 kgs. Was 89 kgs now 76kgs."

Dr B also documented that Mrs A was taking Duramine, a weight-loss medication, and was a non-smoker. Under "Allergies" it is noted that tape could cause a rash.

Dr B stated that, during this consultation, he provided Mrs A with an explanation of the abdominoplasty and liposuction procedures, including advice about healing, complications and the appearance of the scar. Dr B said that he informs all his patients that after surgery they will have a large scar that runs across the bottom of the abdomen, which in about 99% of cases initially looks bunched. However, he stated that this will generally improve with time and the scar will fade. He added that about 10% of cases require minor revision at the end of the scar.

In contrast, Mrs A recalls that, when she explained to Dr B that she wanted to have a "tummy tuck", he said that this would definitely be possible and recommended she also have liposuction to help achieve her desired results. Mrs A asked to see some photos of other similar procedures undertaken by Dr B. Mrs A recalls seeing one set of photos. Mrs A agrees that there was "some discussion" about the procedure. However, while she was aware that the surgery would result in a scar, Dr B did not go into any details about the extent or what she could expect the scar to look like.

[1] Abdominoplasty or "tummy tuck" is cosmetic surgery of the abdomen involving the removal of excess skin and fat.
[2] The surgical removal of local fat deposits by applying suction through a small tube.

10 August 2005
Dr B saw Mrs A again on 10 August 2005 to discuss the proposed surgery. The records document that during this consultation Dr B discussed scar healing and possible complications such as seroma formation.[3] Dr B also noted an umbilical hernia which he would repair during the procedure.

Dr B advised that, prior to surgery, he asks his new patients who are requesting cosmetic procedures to talk to other patients who have previously had the surgery, "to give a full idea of what is involved about this surgery". Accordingly, at the end of this consultation, Dr B introduced Mrs A to a patient who had undergone a similar procedure the previous day. Mrs A recalls meeting one of Dr B's patients, but because the surgery had been completed only the previous day the wound was covered. Mrs A was therefore unable to see the extent of the scarring or the eventual outcome.

Dr B advised that he provides an information sheet to all his patients outlining the procedure, its risks and benefits, and the expectations in relation to scarring. Mrs A denies receiving a copy of the information sheet and stated that she never received any written information about the procedures.

The consent form, signed by Mrs A on 23 August 2005, states that "[t]he nature, purpose and possible complications of the procedure(s), the risks and benefits reasonable to be expected, and the alternative methods of treatment that are available have been clearly explained to me". It also states that the results of the procedure cannot be guaranteed.

Surgery — 23 August 2005
On 23 August 2005, Dr B performed an abdominoplasty on Mrs A, together with liposuction of her inner thighs and flanks. Dr B explained that the procedure included "dissection from ribcage to pubic region and removing skin and fat below umbilicus, and approximation muscles from the epigastrium to pelvis". He used a horizontal incision. The clinical records document that 1.5kg of skin and fat was surgically removed, as well as 500ml of fat by liposuction.

Mrs A stayed overnight in the Hospital and was discharged following a wound check on 24 August. Dr B advised Mrs A, as he does with all his patients following abdominoplasty surgery, to wear an abdominal binder to help reduce the chance of seroma formation. He told Mrs A where she could buy one. Mrs A recalls that Dr B told her to buy some lycra tights that would come up over her abdominal area.

[3] A collection of serous fluid.

Postoperative care
Dr B advised that it is his standard practice to review his patients following surgery at least once a week until the wound has healed. Following surgery, Mrs A was seen 11 times[4] for routine postoperative wound checks and care.

Mrs A advised that her wound leaked profusely after surgery, and she had to permanently keep pads on the wound to prevent the fluid from leaking. During a postoperative consultation Dr B attempted to drain the wound. Mrs A explained that Dr B stuck a pair of scissors into the wound and "jiggled" them about until fluid came out. Mrs A believes that the reason for this excess fluid was because Dr B did not insert a drain postoperatively.

Dr B advised that Mrs A had a seroma collection (a pocket of serous fluid) that had to be drained three times. On the first occasion, on 2 September 2005, Dr B explained that he opened the stitched wound. The clinical records document that a large collection of stale blood was drained. On 4 and 5 September 2005, Dr B was able to aspirate 50ml on each occasion through the same incision. There is very limited documentation of this treatment, and no reference to any explanation or advice provided to Mrs A.

Dr B advised that the seroma formation would not have caused any delay to the healing of the wound or any other major complications. Seroma collection occurs in about 10% of major abdominoplasties and would not be affected by the placement of a drain, since drains are only useful for the drainage of blood in the first 48 hours postoperatively. Dr B uses drains in about 95% of operations; however, if he assesses there to be only a small amount of bleeding at the time of the operation he does not insert a drain. There is no documentation in relation to this issue in Mrs A's clinical records. To minimise the risk of seroma formation, Dr B inserts stitches to reduce the "dead space" where the skin layer has been separated from the muscle. He also advises patients to wear abdominal binders, as mentioned above.

Further treatment
Because she was not totally happy with the end result of the abdominoplasty, Mrs A returned to see Dr B again on 16 February 2006. The clinical records from this consultation document that Mrs A was "considering liposuction upper abdomen and scar revision". This was scheduled for 23 February 2006 but was deferred until 2 March 2006 owing to staffing issues.

On 2 March 2006, Mrs A had liposuction of her upper abdomen. The clinical records document that 400ml was aspirated. At this time Dr B also performed a small scar revision. The clinical records document "small scar revision on right side and left side dented scar line elevated".

[4] 26 and 29 August, 2, 4, 5, 6, 8, 12, 15, 20 September, 2 November 2005.

A routine follow-up consultation was carried out on 9 March 2006. No details of this consultation are recorded in the clinical records.

GP review
Mrs A remained unhappy with the result of the abdominoplasty carried out by Dr B. However, it was not until she went to see her general practitioner, Dr D, that she realised that the scar was "rather unsightly". Dr D advised:

> "I saw [Mrs A] on one occasion only regarding her abdominoplasty, on 12 October 2006. On that occasion we discussed revision of the scar as she was unhappy with the appearance. She was unwilling to even consider returning to [Dr B] to discuss revision and I felt that a plastic surgeon could produce the result that she desired, especially as she was looking for a revision of a scar. I felt that specialist techniques were needed in these circumstances."

Dr D subsequently provided Mrs A with a list of plastic surgeons in the region. Mrs A made an appointment to see plastic surgeon Dr C in April 2007.

Revision surgery
On 2 April 2007, Mrs A consulted Dr C. In his clinic letter to Dr D following this consultation Dr C stated:

> "[Mrs A] reports that she is very happy to be rid of her apron, however she is unhappy about the depressed and puckered nature of her scar."

Dr C noted that, on examination, the abdominoplasty scar appeared "… quite depressed and widened …". Dr C also commented on the orientation of the incision and the appearance of the umbilicus and the surrounding skin. Dr C recommended she undergo a major revision of the abdominoplasty.

In his letter dated 2 April 2007 to Dr D, Dr C stated:

> "Although her primary concern is the abdominoplasty scar I think if anything was done it would be better to re-elevate the abdominoplasty flap and thin out all of the subscarpal fat and concurrently re-drape the periumbilical skin so that this area looks more natural and with this exposure placation of the lower two thirds of the abdominal wall could be performed in the mid line."

This procedure was subsequently carried out on 22 May 2007. Mrs A advised that her abdomen now looks much more natural and she is now happy with the outcome of the surgery.

Mrs A is very upset about the care provided by Dr B and the additional costs she incurred for Dr C to carry out revision surgery. At the time of bringing her complaint, Mrs A was also concerned that Dr B is continuing to carry out similar surgery on other patients. (Dr B ceased practice in September 2007.)

Independent advice to Commissioner

The following expert advice was obtained from Dr Sally Langley:

"My name is Sally Jane Langley. I have worked as a plastic and reconstructive surgeon in Christchurch since 1990. I gained my medical degree, MbChB Otago, in 1980 and completed plastic and reconstructive surgery training in 1987, FRACS(Plast) 1988. I work at Christchurch Hospital and also in private practice in Christchurch. My work includes most of the spectrum of plastic and reconstructive surgery and includes abdominoplasty operations. I do about 20 of these operations a year.

I have been asked by the Commissioner to provide expert advice about whether [Dr B] provided an appropriate standard of care to [Mrs A] reference 07/05410.

I have read Appendix H, Guidelines for Independent Advisors.

I have read all the documents listed sent by [the HDC] investigator.

…

I have been asked to provide advice on the following points:

1. *In your professional opinion were the services provided to [Mrs A] by [Dr B] appropriate?*

   The services provided by [Dr B] were adequate.

2. *What standards apply to this case?*

   The expected standard relates to those outlined by the Medical Council of New Zealand: 'The duties and responsibilities of a doctor registered with the Medical Council of New Zealand' and the 'Statement on Cosmetic Procedures'.[5] The points to be taken into account are pre-operative consultation, informed consent, operative technique, and post-operative care. The surgeon should only undertake a procedure within his/her scope of practice. The procedure should be done in an adequate facility.

   The *pre-operative consultation* should include a full review of medical and surgical history, medications, allergies, smoking, alcohol consumption, social support, and should ascertain what the patient desires to achieve. The surgeon should examine the relevant part of the patient's body. There should be a full

[5] The Medical Council's 'Statement on Cosmetic Procedures' was not promulgated until 2007; however, the key principles in relation to information disclosure and consent were widely recognised in 2005.

discussion of the patient's problem and what procedure can be done for it with alternatives mentioned. The patient should be given opportunity to ask questions. The surgeon should discuss post-operative care, outcome, possible complications and their management. The surgeon should advise whether there is anything the patient can do to prepare for the surgery e.g. weight loss, smoking cessation, medical or anaesthesia assessment. The surgeon should assess the patient's motivation for the procedure and ensure realistic expectations. The surgeon should arrange a second (follow-up) consultation prior to the surgery. It is advisable to provide a written document outlining the procedure and possible complications. It is helpful to show diagrams of the operation and pictures of patients who have had similar procedures and it can be helpful to meet other patient(s) who have had similar operations.

The surgeon should gain *informed consent* for the operation. This is a staged process starting at the initial consultation. The written consent should be obtained at a pre-procedure consultation and confirmed on the day of surgery. Written information should be provided.

The surgeon should be *competent* to undertake the operation planned. The surgeon should operate within his/her *scope of practice*. A category 1 cosmetic procedure may be performed by a doctor registered in a relevant scope of practice. This surgeon has the necessary training, expertise and experience in the procedure being performed and whose competence in the procedure has been independently assessed. The doctor must hold a relevant post-graduate surgical qualification recognised by the Council as allowing registration within a relevant vocational scope. A doctor who is not registered in an appropriate vocational scope of practice may also perform a category 1 procedure if he or she is in a collegial relationship with a doctor registered in the appropriate vocational scope.

Appropriate *post-operative care* should be available via the operating surgeon. This includes contact details, instructions re wounds and medications, follow-up appointments, symptoms of concern, and who to contact if surgeon not available. (1, 2)

3. *Were these standards complied with?*

There is not much information documented by [Dr B] at any step.

Pre-operative consultation: All dates of clinic attendances and operations are documented with very little detail. It is possible that [Dr B] covered all relevant areas advised for a 'cosmetic' consultation but there is minimal documentation.

[Dr B] did see [Mrs A] twice before surgery and she did see a patient who had just had an abdominoplasty. [Mrs A] received some written information about abdominoplasty from [Dr B]. I have seen the documents Patient Information —

Abdominoplasty, and [the] Hospital Abdominoplasty consent form. I am not sure which of these [Mrs A] would have seen, or whether she had an earlier version. [Dr B] refers to having adopted the consent form in the last 12 months [letter dated 18 July 2007]. [Mrs A] would not have been informed that [Dr B] is not a specialist registered plastic and reconstructive surgeon and that he may be working outside his scope of practice.

***Informed consent*:** [Mrs A] has signed the consent form for 'Abdominoplasty Liposuction flanks & inner thighs' on 23/8/05. This is an adequate generic consent form. The adequacy of the consent process is not assessable since there is so little documented.

***Surgical Facility*:** [Dr B] works in his own hospital as a sole surgeon, as far as I know. He does not have collegial support and is not working with oversight. I do not know of the standard of his hospital.

***Post-operative care*:** [Dr B] is the sole provider of post-operative care. He or his nurse undertake all assessments and care. Contact details and care plans are known to the patient. He has indeed seen [Mrs A] on a number of occasions and even saw her in her own home. I do not know what arrangement is made if [Dr B] is not available but expect a patient would contact a general practitioner or hospital emergency department if unwell.

4. *Please comment on the type of incision used (horizontal rather than a suprapubic incision which curves towards the ASIS — referred to in [Dr C's] clinic letter).*

   The incision used by [Dr B] is acceptable. Many traditional 'classic' abdominoplasties have been done using this incision. It is a well described technique. The type of incision/scar comes down to the surgeon's training and experience and also is related to trends in modern practice. Many of us prefer the scar which is more curved i.e. extending from approximately anterior superior iliac spine (ASIS) to ASIS across the suprapubic area. Many plastic surgeons do indeed leave a more transverse scar. Also the scar is somewhat related to the patient's build. Diagrams similar to those [Dr B] has sent from a text book are widely printed in plastic surgery texts. I feel the type of incision is acceptable practice. (5, 6)

5. *Please comment on [Dr B's] decision not to insert a drain following a major abdominoplasty.*

   Most plastic and reconstructive surgeons would insert one or two drains for an abdominoplasty especially if liposuction has been done. [Dr B] has referred to placing stitches from the subcutaneous region to the muscle to eradicate the dead space. His operation note makes no reference to this. There is a modern trend to do these quilting or progressive tension sutures. They do decrease the

amount of fluid drainage and have decreased the need for seroma drainage. This has allowed the removal of drains early prior to discharge from hospital. [Dr B] has said on that the use of drains is only adequate for 48 hours or so post-operatively and that they are useful for blood draining and are more important to give a clue of excessive post-operative bleeding. He says they have no influence on seroma formation.

Drains are primarily used for drainage of serosanguinous fluid. Drains are not expected to cope with excessive bleeding which occasionally occurs. They have been kept in for many days, possibly 2–3 weeks in patients having abdominoplasty operations. Patients have often gone home with drains in. The rate of seroma formation after abdominoplasty has been high but this high figure may not be documented in scientific papers or books. We have all seen a decrease in the quantity of serous fluid drainage and seroma formation with the use of the high-lateral tension abdominoplasty (Lockwood) and the use of sutures to close the dead space.

It is not wrong to have not used a drain for a modern abdominoplasty with high-lateral tension and quilting sutures. (3)

6. *Please comment on the use of an abdominal binder following a major abdominoplasty.*

   It is not imperative to use a binder or support garment after abdominoplasty.

   This will reflect the individual surgeon's practice. [Mrs A] did use a lycra bike pant garment and this sounds like what many surgeons would recommend. Whether the surgeon provides the garment or the patient purchases it is not relevant. The reason for using a binder or wearing a garment is to try and compress the space between the abdominal flap and the muscle to encourage healing of this layer and discourage seroma formation. We have all seen significant seroma problems even with the use of a binder or garment. (3).

7. *Do you consider [Dr B] was practising outside his scope of practice?*

   Yes, I do consider that [Dr B] was practising outside his scope of practice. I understand that he is a general surgeon and is not a specialist registered plastic and reconstructive surgeon. I understand he is not working in a collegial relationship with a plastic and reconstructive surgeon and is not working with oversight. He has a long history of undertaking abdominoplasty operations and refers to having done about 100 abdominoplasties over 25 years so will have gained some personal experience. Abdominoplasty is generally considered a cosmetic operation and mostly fulfils the criteria of a category 1 cosmetic operation. However many are done for physical reasons such as hygiene, adherent tight painful scars, discomfort. Many are not purely cosmetic. A general surgeon could be considered competent to undertake this operation.

There are a number of general surgeons who have done abdominoplasties in recent years. They may not master some of the more cosmetic aspects of the operation but can still provide an adequate result. I feel that is the case here.

8. *Any other comments you wish to make*.

Overall I consider the abdominoplasty result for [Mrs A] is adequate and acceptable. It is not a perfect or ideal result. It does have shortfalls such as a wide scar with some depression, some fullness between the umbilicus and the pubic area, and mild 'dog-ears' laterally. It is possible that the rectus fascia has not been adequately plicated or the placation has given way. It is possible that the superficial fascia has not been sutured well. The shape of the umbilicus is adequate. I have seen many of my colleagues umbilicus's look similar. … There is flatness around the umbilicus but surgery to de-fat the peri-umbilical area could have decreased the blood supply to the lower abdominal skin. [Dr B] has undertaken further liposuction and scar revision prior to the photographs sent. The further surgery done by [Dr C] will have improved the appearance to some extent but there are new shortfalls [in] the result.

[Dr B] has mentioned that 'experts in the field' say not to combine upper abdominal liposuction with abdominoplasty because of the increased risk of tissue necrosis and gangrene. (5) This liposuction can be done as a secondary procedure. This may have been the case here but the documentation is poor. I suspect the liposuction done at the time of the abdominoplasty was to the flanks and inner thighs only. To do no upper abdominal liposuction at the time of abdominoplasty is common practice. Surgical removal of subscarpal fat can leave the lower abdominal flap too thin which is the case following [Dr C's] surgery.

My concern with [Dr B] and [Mrs A's] abdominoplasty is related to [Dr B's] scope of practice. As I have said some general surgeons do undertake this operation and it is not exclusively a cosmetic procedure.

References:

1. Medical Council of New Zealand. Good Medical Practice: The duties and responsibilities of a doctor registered with the Medical Council of New Zealand. October 2004.
2. Medical Council of New Zealand. Statement on Cosmetic Procedures. 2007.
3. Andrades, P Prado, A and Danilla, S. Progressive tension sutures in the prevention of post-abdominoplasty seroma: a prospective, factorial and randomized clinical trial. PRS 2007 (120)4:6–7.
4. Gradinger, GP, Rosenfield, LK, Nahai, FR. Abdominoplasty, chapter 63 in The Art of Aesthetic Surgery: Principles and Techniques, ed Foad Nahai QMP 2005.

5. Lockwood, Ted. High-Lateral-Tension Abdominoplasty with Superficial Fascial System Suspension. PRS 1995 96(3):603–615.
6. Te Ning Chang and Richard Baroudi. Abdominoplasty Techniques, chapter 122 in Plastic Surgery ed Mathes Elsevier 2006."

Further advice
The following additional advice was obtained from Dr Langley:

"You have written to me on 6.11.07 requesting further comments. I will answer them as follows:

1. An abdominoplasty for medical reasons I would generally term an apronectomy. This refers to the more simple removal of the flap of lower abdomen which hangs off the abdomen. This is the flap of loose skin and adipose tissue. It is regularly seen with obesity and in particular following significant weight loss. A cosmetic abdominoplasty is one done with the primary objective of improving the appearance of the abdomen. For a cosmetic abdominoplasty I consider that the result is to have a good line for the scar, a good shape of the abdomen in the suprapubic area, umbilical region and hips.

   An abdominoplasty or apronectomy for more medical reasons tends to be done more simply without so much attention to the shape of the suprapubic area, umbilicus or hips. It is possible that there may be some residual prominence or dog ear formation at the hips and either loss of the umbilicus or low placement of the umbilicus. There is in a way a subtle difference between what I would call a cosmetic and a medical abdominoplasty. I would feel that any abdominoplasty or apronectomy performed by an experienced plastic and reconstructive surgeon would include the consideration of the appearance of the scar, umbilicus and hip shape. I would accept that an apronectomy done for medical reasons by a general surgeon may have some shortfall in the quality of the appearance of the suprapubic area, scar and hip dog ears.

2. I do consider that [Dr B] has performed an adequate cosmetic abdominoplasty. I have seen many abdominoplasty results done by colleagues which are similar and also I have seen many pictures in journal articles and surgical text books with similar results. However, in this modern era a better result would generally be achieved by an experienced plastic and reconstructive surgeon.

   I do not consider that [Dr B] has the right skills and experience to perform a cosmetic abdominoplasty. He is, I understand, a general surgeon without plastic and reconstructive training. He is not working with a peer group of plastic and reconstructive surgeons. He seems to have some familiarity with some aspects of modern abdominoplasty technique but they were not manifest in the result shown for this patient.

With respect to the patient's propensity to scarring I would consider that a plastic and reconstructive surgeon would discuss patient's scarring tendency. I consider that the only time that the patient's scarring tendency would have an effect on the surgeon's choice is if the patient has demonstrated markedly hypertrophic scarring of the abdomen with previous procedures. Otherwise it is a balance between gaining a better shape and a longer scar.

It is frequently seen that a dog ear develops at one or both hips following an abdominoplasty. lf the dog ears are small, these are often revised with local anaesthetic alone at the surgeon's office. This may be done on both sides at one sitting or on two occasions. Certainly more adequate scar revision or more extensive scar revision could be done under a general anaesthetic as a day surgery operation at a day surgery centre or hospital. Whether a more major scar revision is undertaken, depends on what the patient requests, what the surgeon is prepared to offer, and what the patient can afford with respect to further hospital charges.

The result of an abdominoplasty also depends on the state of the patient's abdomen prior to the procedure. For [Mrs A] I have not been able to review her pre-operative state with respect to adiposity, size, scarring etc. The result of the surgery depends to some extent on the pre-operative condition appearance of the abdomen.

My comments about [Dr B] are based on the New Zealand Medical Council's publication 'Good Medical Practice'. Although [Dr B] undoubtedly complies with many of the points listed with respect to maintaining a good standard of practice, he is inadequate with respect to recognising his own limits of professional competence. By that I mean that patients may believe that he is a fully trained plastic and reconstructive surgeon and able to deliver the type of more cosmetic abdominoplasty that is requested for this case."

Response to Provisional Opinion

Dr B

In relation to the adequacy of the information provided to Mrs A, Dr B maintains that his clinical records contained all the relevant information. While Dr B acknowledged their brevity, he submitted that as a sole practitioner his records were of no use to anyone other than himself.

Dr B reiterated his belief that the information he provided to Mrs A preoperatively was "thorough and informative" advising that he showed Mrs A photos and gave her the opportunity to meet with another patient.

Dr B also advised that, following the procedure, Mrs A completed an assessment form in which she categorised all aspects of his care as either very good or excellent.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 6

Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Other relevant standards

Medical Council of New Zealand, *Good Medical Practice — A guide for doctors* (2004), 'Domains of competence' states:

> "3. In providing care you must:
>
> Recognise and work within the limits of your competence: know when you do not know or cannot do capably; …
>
> Keep clear, accurate, and contemporaneous patient records …"

Opinion: No breach — Dr B

Standard of care
Under Right 4(1) of the Code, every consumer has the right to have services provided with reasonable care and skill. Following surgery Mrs A was unhappy with the resultant scar, describing it as "rather unsightly". Mrs A subsequently sought review from a plastic surgeon, Dr C. Dr C's clinical records document that on observation Mrs A's scar appeared "quite depressed and widened …". Dr C recommended further surgery to improve the appearance of the scar and her abdomen.

Dr Langley advised that general surgeons can perform abdominoplasties, and noted that several general surgeons have specialised in abdominoplasties in recent years. Dr Langley commented that "they may not master some of the more cosmetic aspects of the operation but can still provide an adequate result".

However, Dr Langley had some concerns about Dr B's practice. Applying the Medical Council of New Zealand's (MCNZ) *Statement on Cosmetic Procedures*, Dr Langley noted that Dr B was not working in a collegial relationship with a plastic surgeon and was not working with oversight. I note, however, that the MCNZ's *Statement on Cosmetic Procedures* did not come into effect until 2007 and Dr B was not required to participate in a collegial relationship at the time when these events occurred.

In August 2005, the applicable MCNZ standard was *Good Medical Practice*, which required a doctor to recognise the limits of his or her competence. Dr Langley identified some general concerns about Dr B's insight into his own practice, noting:

> "I do not consider that [Dr B] has the right skills and experience to perform a cosmetic abdominoplasty … he seems to have some familiarity with some aspects of modern abdominoplasty technique but they were not manifest in the result shown for this patient."

In Dr Langley's opinion, a better result would generally be achieved by an experienced plastic and reconstructive surgeon. However, she considers that overall, Dr B performed Mrs A's cosmetic abdominoplasty to an adequate standard, noting:

> "I have seen many abdominoplasty results done by colleagues which are similar and also I have seen many pictures in journal articles and surgical text books with similar results."

I accept Dr Langley's advice that Mrs A's cosmetic abdominoplasty and liposuction were performed to an appropriate standard. Accordingly, Dr B did not breach Right 4(1) the Code.

I do, however, intend to bring Dr Langley's concerns about Dr B's practice to the attention of the Medical Council.

Opinion: Breach — Dr B

As noted above, I am satisfied that Dr B performed the abdominoplasty and liposuction procedures to an appropriate standard. However, a surgeon's responsibility extends beyond the actual operation. In this case, it was also important to ensure Mrs A was provided with adequate information preoperatively so that she could make an informed decision about surgery. In my opinion Dr B failed to provide adequate information preoperatively and maintained inadequate clinical records. The reasons for my opinion are set out below.

Information
Mrs A found out about Dr B through an advertisement in the local newspaper. Mrs A subsequently made an appointment to see Dr B to discuss surgery on 10 March 2005.

According to Dr B, during the preoperative consultations he gave Mrs A information about both abdominoplasty and liposuction, including a discussion about possible complications and expected outcomes. Dr B advised that this information was also provided in a written information sheet. Furthermore, at the end of the second consultation on 10 August 2005, Dr B introduced Mrs A to a patient who had undergone an abdominoplasty the previous day. Dr B advised that he asks all new patients requesting a cosmetic procedure to talk to other patients who have already undergone a similar procedure, so that they are able to "see the results and have a full idea of what is involved in the surgery".

In contrast, Mrs A says that although she knew there would be a scar, she does not recall Dr B providing her any details about the size or the extent of scarring. She denies receiving any written information and there is no record of information sheets being handed out in her clinical notes. Mrs A did meet a patient who had undergone a

similar procedure, but because the surgery had only been completed the previous day the wound was covered in dressings. Mrs A was also shown a photo of another patient who had had the procedure. She thought it looked like a good outcome.

The provision of adequate information, including information about options, costs, risks and likely outcomes is a key requirement in any situation where health and disability services are being provided. It is particularly important in the context of cosmetic procedures where the procedure being carried out is elective and has no medical benefit, and the consumer often has heightened expectations about what can be achieved. In addition, there is an inherent conflict of interest because the surgeon stands to benefit financially if the consumer agrees to proceed. It is therefore particularly important that a patient considering cosmetic surgery receives enough information at the preoperative consultation to have a realistic expectation about the final outcome before deciding whether to proceed.

In my view, any health professional offering a cosmetic procedure should provide the consumer with relevant information about the extent of their qualifications and experience. I refer to the following statement in Opinion 00HDC10159:[6]

> "… [I]n my opinion any medical practitioners undertaking invasive cosmetic surgical procedures should explain to patients considering such a procedure (1) that the Medical Council recommends that the procedure be undertaken by a plastic or reconstructive surgeon; (2) the extent of their registration; and (3) their relevant qualifications and experience."

I accept that Dr B discussed some information with Mrs A. I also acknowledge that the consent form, signed by Mrs A on the day of surgery, states "[t]he nature, purpose and possible complications of the procedures, the risks and benefits reasonable to be expected and the alternative methods of treatment that are available have been clearly explained to me". However, I am not satisfied that Dr B gave Mrs A adequate information about the size and extent of scarring involved in this procedure. Mrs A saw only one set of photos, where the patient had achieved a good outcome, and met another patient whose wound was still under dressings. This did not give Mrs A enough information about the range of possible outcomes for the procedure. There is also no evidence that Dr B explained the extent of his registration, qualifications and experience.

Accordingly, I conclude that Dr B breached Right 6(1) of the Code by failing to provide adequate information about the proposed procedures and his own registration, qualifications and experience.

[6] 25 March 2003, available at www.hdc.org.nz.

Documentation
Dr B advised that preoperatively he discussed the proposed abdominoplasty and liposuction procedures in detail with Mrs A. Following surgery, Dr B reviewed Mrs A on 11 occasions and on three of these occasions he aspirated a seroma.

Dr B's clinical records are very brief and do not contain any detail of what information was discussed with Mrs A, or of his treatment of Mrs A's seroma.

In response to my provisional opinion, Dr B acknowledged the brevity of his medical records. However, he submitted that because he was a private practitioner working in his own private hospital his records were of no use to anyone else. This is not an acceptable reason for failing to properly document a patient consultation. Doctors in sole practice are subject to the same professional obligations to maintain good medical records as any other medical practitioner. Medical records need to be full, accurate and legible so that they can be accessed by the patient, and by other health professionals who may subsequently treat the patient.

In my opinion, Dr B failed to comply with his professional responsibility to keep proper records and breached Right 4(2) of the Code.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report with details identifying the parties removed, except the name of Dr B, will be sent to the Royal Australasian College of Surgeons.
- A copy of this report, with details identifying the parties removed, will be sent to Women's Health Action and the Federation of Women's Health Councils Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.