General Surgeon, Dr B

A Report by the

Health and Disability Commissioner

Case 07HDC07867

Complaint and investigation

On 9 May 2007, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Dr B. The following issue has been investigated:

- *The adequacy of information and appropriateness of care Dr B provided to Ms A from April 2004 to 20 February 2007.*

The parties involved in this case are:

Ms A	Consumer
Dr B	Provider /general surgeon
Ms C	Nurse
Dr D	Anaesthetist
Dr E	General practitioner
Dr F	Plastic and reconstructive surgeon
Dr G	Plastic and reconstructive surgeon
Dr H	Plastic and reconstructive surgeon

Independent expert advice was obtained from Dr David Glasson, plastic and reconstructive surgeon (see Appendix A).

Relevant information

Ms A
In October 2004, Ms A (then aged 52) underwent cosmetic surgery performed by Dr B at a surgical centre (the Centre), with satisfactory results.

Dr B
Dr B holds registration with the Medical Council of New Zealand in a vocational scope of practice in general surgery. He is a Fellow of the Royal Australasian College of Surgeons. Dr B has more than 30 years' experience as a surgeon. He established the Centre as a facility for day-stay cosmetic surgery. The Centre includes consulting rooms, an operating theatre, and a recovery room. Dr B has practised cosmetic surgery exclusively at the Centre since it opened.

Dr B spent six months training in plastic surgery during his surgical training in New Zealand, and two weeks training in liposuction technique overseas. He has attended several conferences of the American Society of Plastic Surgeons (including sessions on abdominoplasty and liposuction), and has performed many successful abdominoplasty and liposuction procedures.

Although Dr B describes himself as a "specialist cosmetic surgeon" in promotional brochures for the Centre, he is not registered within the vocational scope of plastic and reconstructive surgery, and his competence in cosmetic procedures has never been independently assessed by the Royal Australasian College of Surgeons. Since May 2005, Dr B has worked in a collegial relationship with Dr F, a plastic and reconstructive surgeon.

Liposuction surgery

Dr B briefly discussed liposuction and abdominoplasty surgery with Ms A in 2004, after he had performed cosmetic surgery on her. The discussion was very brief, and Dr B intended only to provide general information about the procedures.

In April 2005, Ms A contacted the Centre to enquire about liposuction surgery. She spoke to the Centre's practice nurse, Ms C, who booked a consultation with Dr B for 27 May. On 11 April, Ms C wrote to Ms A, who lives in another region, to confirm her consultation on 27 May and a proposed surgery date of 23 June. She also provided a brochure and information sheet on liposuction, and information about the cost of the procedure, payment methods, accommodation arrangements and postoperative care. This information did not specify any of the risks involved in liposuction surgery.

Ms A was originally booked to see Dr B on 27 May, but this appointment was postponed (Ms A cannot recall why). On 31 May, Ms A attended her first preoperative consultation with Dr B to discuss treatment for excess skin and fat over her abdomen and excess fat over her hips. Although Dr B did not record Ms A's Body Mass Index in the Centreal notes, it was 36.4 (obese).[1] Dr B conducted a physical examination of Ms A's abdomen and hips, and advised her that the best results would be achieved by undergoing liposuction of her hips and upper abdomen prior to abdominoplasty.[2] He did not discuss medical or psychological factors, in particular Ms A's weight, nor did he contact Ms A's GP.

Dr B showed Ms A "before and after" photographs of other patients who had undergone tummy tuck, liposuction, and both. He also presented pictures of some patients who had had liposuction prior to planned abdominoplasty, but for whom liposuction proved sufficient. Dr B advised Ms A that she should not expect this, but presented it as a possible "pleasant surprise". Dr B explained both procedures to her, including the incisions used for abdominoplasty, and discussed postoperative dressings, swelling, scarring, pain and the possibility of altered skin sensation.

Dr B believes that he told Ms A some of the risks and side effects associated with liposuction and abdominoplasty, and that he specifically discussed the possibility of

[1] Dr D recorded Ms A's weight as 118kg in the anaesthetic admission questionnaire (31 May 2005), and Dr H recorded her height as 180cm (3 May 2007). This gives a BMI of 36.4. A BMI over 30 is regarded as obese.

[2] Dr B uses "tummy tuck" and "abdominoplasty" interchangeably to describe the procedure he performed on Ms A. The procedure is referred to as "abdominoplasty" throughout this report.

ripples and divots from liposuction, and the risk of peri- and postoperative bleeding and infection from abdominoplasty.

At the end of the consultation, Dr B obtained written consent from Ms A for the liposuction operation, and booked her for surgery at 7.30am on 23 June 2005. The consent form listed some of the risks involved in liposuction surgery:

> "Liposuction may cause bruising, lumpiness, dimpling, sagging of the skin, scarring, numbness, minor depressions and periodic swelling of the lower legs — such effects are usually temporary but can be permanent. Additionally, there are risks associated with any operation and anaesthesia, including blood loss, deep vein thrombosis and chest infections."

Dr B also photographed Ms A's abdomen and hips, provided her with a pathology request form for blood tests, and prescribed a course of antibiotics to be taken before surgery. Ms C measured Ms A for a supportive binder to be worn after surgery, and provided Ms A with a written postoperative information sheet that provided brief information about what to expect after liposuction surgery in terms of bleeding, swelling, bruising, pain, dressings, and general information about postoperative activity and eating. Ms A was advised that, after the abdominoplasty, she would need to wear the binder for three days, without removing it for any reason, then continue wearing the binder for three weeks, removing it only to take a shower.

On 23 June 2005, Ms A returned to the Centre to undergo liposuction surgery. There is no record of any preoperative discussion between Ms A and Dr B directly before the surgery, but Ms A recalls that Dr B advised that he could only remove a maximum of five litres of fat, because any more would be dangerous in a day-stay centre. Ms A said that Dr B reassured her that five litres "would be enough". Ms A was anaesthetised by Dr D. Dr B removed 1770 ml of fat from her upper abdomen and hips. The start and finish times for the surgery are not recorded in the Centreal notes. Ms A was discharged at 4pm, and was reported to be in minimal pain with no nausea or bleeding.

Ms A returned home the next day, and her general practitioner, Dr E, removed her stitches on 30 June 2005.

On 4 August, Ms A attended her six-week postoperative appointment with Dr B. He took photographs of her abdomen and hips, and noted that, although her wounds were settling and there had been "some reduction in volume", Ms A had a large skin excess in her lower abdomen, and still required an abdominoplasty.

Abdominoplasty surgery

On 19 January 2006, Ms A contacted Ms C to arrange for abdominoplasty surgery, and she was booked in for surgery on 30 March. Ms C posted Ms A a promotional brochure about abdominoplasty surgery, and a letter confirming the surgery date and the cost of the procedure, and outlining payment methods. Ms C also enclosed a prescription for antibiotics and a pathology request form for blood tests.

On 30 March, Ms A arrived at the Centre, and Dr B briefly went over the abdominoplasty procedure and postoperative care with her. The purpose of this discussion was to review the information presented during the 31 May 2005 consultation. Ms A and Dr B then signed the consent form and Dr B performed the abdominoplasty. Ms A was anaesthetised by Dr D. The start and finish times for the surgery were not recorded in the Centreal notes. Dr B fitted the binder around Ms A's abdomen after performing the operation.

Ms A was discharged at 3pm, after approximately four hours' recovery, having been told to telephone Ms C or Dr B if she had concerns. Ms A spent the night at a local motel. At approximately 8pm, Ms A experienced a bleed from her umbilical wound[3] and telephoned Ms C, who promptly attended her at the motel. Ms C applied more dressings, but did not think that the bleed was significant, and Ms A was not overly concerned. Ms C telephoned Dr B to check that he was happy with her management of Ms A's bleed, and maintained contact with Ms A throughout the night. Ms C saw Ms A at approximately 7:30am, on her way to the Centre, and confirmed that Ms A was happy to wait until 10am to see Dr B for her first postoperative assessment.

At 10am, Dr B assessed Ms A. He removed her binder and dressing, and did not note any fresh bleeding. He re-sutured the umbilical wound that had bled overnight. Dr B redressed the abdominoplasty wound and reapplied the binder.

Ms A returned to her home to recover. Her GP, Dr E, removed her sutures on 8 April 2006. Ms A contacted Ms C on 10 April 2006 and reported that her wounds were healing well. She was to see Dr B for her second postoperative assessment on 4 May 2006, although she was told to telephone earlier if she had concerns.

Postoperative care and follow-up surgery

On 20 April, Ms A telephoned Ms C because she felt that her abdomen was swollen and bloated, especially when she took the binder off. Ms C told Ms A to keep wearing the binder and to telephone her again if she was concerned.

On 4 May, Ms A attended her second postoperative assessment with Dr B. He documented in the Centreal notes that the wound was healing "excellently" and, although Ms A's lower abdomen was swollen, he could not feel any free fluid, and believed that the problem would resolve. Dr B advised HDC that "she clearly had developed a haematoma". However, Ms A states that Dr B "did not tell me exactly what it was". Dr B told Ms A to continue wearing the binder, and that he would see her for her third, and final, postoperative assessment in four months' time.

Ms A continued to wear the binder as instructed, but the swelling in her lower abdomen did not resolve. Ms A recalls that she telephoned Ms C on 21 or 22 May to

[3] The umbilical wound is created when the surgeon relocates the umbilicus to a more natural position following abdominoplasty.

complain about the abdominal swelling and was told that it was caused by a "blood clot".

On 26 May, Ms A consulted her GP about the swelling. Dr E immediately diagnosed a large haematoma in Ms A's lower abdomen and contacted Ms C and told her that she thought the haematoma was enlarging, rather than reducing. Dr E stated:

> "I was somewhat horrified at the state of the haematoma that was evident, and rang [Dr B's] nurse myself. She was reluctant to commit to anything, but I absolutely insisted, during the phone call, that the situation was most unsatisfactory and that [Dr B] was obliged to see [Ms A] as soon as possible, to attend to the haematoma."

Later that day, Dr E referred Ms A for an ultrasound to confirm that the swelling was a haematoma. Ms C contacted Ms A to advise her that Dr E was organising an ultrasound, and booked an appointment with Dr B on 6 June 2006.

On 29 May, Ms A had an abdominal ultrasound and the report was received by the Centre that afternoon. Ms C telephoned Ms A to confirm her appointment on 6 June, and booked her in for surgery on 7 June (Dr B believed that further surgery would be necessary).

On 6 June, Dr B assessed Ms A. He found her to have a large haematoma from her umbilicus to her pubic area. Dr B consulted Dr F, who advised that the haematoma could be aspirated by liposuction.[4] Dr B recommended liposuction of the haematoma to Ms A, but cautioned her that the lump would not disappear altogether, and open surgery might be required. Ms A consented to the surgery, and Dr B took blood samples and photographs, and prescribed an antibiotic.

On 7 June, Dr B performed the liposuction procedure to aspirate Ms A's abdominal haematoma. She was again anaesthetised by Dr D. The start and finish times for the surgery were not recorded in the Centreal notes. Ms A was discharged at 1pm and provided with a "Lipo Post-Op Care" form, which advised her to take pain relief as required, and to wear her binder continuously for three days, then for a further three weeks removing it only for showers. Following an uneventful night, Ms A returned home to recover. Ms C documented "to talk to her next week" in Ms A's clinical notes on 7 June, but no further discussion took place.

On 6 July, Ms A consulted Dr E because fluid had again collected in her abdomen. Dr E advised Ms A that she would have to consult Dr B about it, and recorded that Ms A was "really despondent" about her ongoing problems.

[4] Dr F stated that the use of "liposuction techniques" to aspirate haematomas is standard practice.

Ms A returned to Dr B on 24 July with a recurrence of the haematoma. He advised her to undergo open surgery to excise the haematoma completely, and booked her for surgery on 11 August.

On 3 August, Ms A sought a second opinion from Dr G, a plastic and reconstructive surgeon. Dr G wrote to Dr B on 4 August, noting that he (Dr B) was planning to surgically remove the haematoma. Dr G advised that "this situation is best treated by opening the seroma/haematoma, obliteration of the walls and multiple quilting sutures with a drain being left in for some days to ensure no further collection develops".

Dr B performed the excision surgery on 11 August, and Dr D provided anaesthesia. The start and finish times were not recorded. Dr B states that he did not receive Dr G's letter until after the surgery, and that he "did pretty much as [Dr G] suggested ... other than the quilting sutures". Dr B inserted a drain, but it was removed by Ms C the next day so that Ms A could return home.[5] Although Ms C advised Ms A to leave her abdominal binder in place for at least three days, Ms A left it in place for a week. Ms A was not provided with any other postoperative information, and Dr B did not send Dr E any report on the surgery.

Ms A telephoned Ms C on 12 and 14 August and reported that there was no pain or oozing from her wounds, and no fluid build-up in her lower abdomen.

On 22 August, Ms A contacted Ms C to report that she had removed the binder, and had no problems with swelling or recurrence of the haematoma. However, two days later Ms A contacted Dr B to report that she had a collection of fluid in her lower abdomen. Dr B arranged for her to return on 28 August to have the fluid aspirated with a liposuction cannula. Although Dr B reported that he removed 900 ml of fluid, there is no record of any discussion about the surgery, and no signed consent form. Dr B advised HDC that he "expected the fluid removal to allow the internal raw surfaces to appose each other and become adherent, thus obliterating the space".

Ms A telephoned Dr B on 8 September to report abdominal swelling. He reassured her that some swelling was to be expected as she healed, and it would most likely resolve if she continued to wear the abdominal binder.

On 22 September, Ms A contacted Ms C because her abdomen was very swollen, and she thought it would require draining. Ms C made an appointment for Ms A to see Dr B on 26 September. Although Dr B did not record a diagnosis, he unsuccessfully attempted to aspirate fluid from Ms A's abdomen, and referred her for an ultrasound to confirm recurrence of the haematoma. Dr B advised Ms A that the haematoma would likely resolve over time.

[5] I note that Dr G had recommended to Dr B (in his letter of 4 August) that a drain be "left in place for some days".

An ultrasound scan on 29 September confirmed a recurrent haematoma, which did not resolve over the next three weeks. On 16 October, Dr B telephoned Ms A, who said that she wanted to have the haematoma excised, but was unable to afford the anaesthetic fees. Dr B telephoned Ms A on 18 October and agreed to cover the anaesthetic fees. Ms A was booked for the excision surgery on 9 November. There is no record of Dr B examining Ms A before booking the surgery, or discussing treatment options with her.

On 9 November, Ms A returned to the Centre and signed a consent form directly before the surgery. Dr D again provided anaesthesia. Dr B excised the haematoma and inserted a suction drain to remove fluid from the obliterated space.

Ms A stayed overnight and returned home on 10 November, following a postoperative assessment by Dr B. Later that day, Dr B documented that Ms A had pierced the drainage tube with a safety pin, causing a leak and loss of suction. Dr B noted: "Check tomorrow — if minimal drainage, remove drain." However, Dr B advised HDC that he did not know that the drain had been pierced. Dr B did not attempt to remedy Ms A's punctured drain and she was attended by the district nursing service on 11 and 13 November. On 13 November, the district nurse telephoned Dr B, and he advised her to remove Ms A's drain because it was no longer draining fluid.

Ms A contacted Ms C on 27 November because she was concerned about swelling. Ms C assured her that some swelling was to be expected following surgery. The swelling resolved over the next few months.

Dissatisfaction and complaint

Although Ms A did not suffer a recurrence of the haematoma, she was dissatisfied with the results of her abdominoplasty. At her last postoperative appointment with Dr B on 20 February 2007, Ms A expressed her dissatisfaction to Dr B. He told her to wait for at least six months before further surgery. Dr B did not accept responsibility for her complications or unsatisfactory results, which he believes he dealt with in an "accepted orthodox way".

Ms A sent Dr B a letter of complaint on 21 March. She complained that Dr B was slow to respond to her complications and was annoyed at her for seeking a second opinion from Dr G. Ms A sought a refund to cover the cost of all her surgery and related expenses. Ms A stated:

> "You made me feel like an inconvenience, and a whinger ... This has been a harrowing journey for me."

Dr B responded on 23 March. He stated that he had responded promptly and appropriately to Ms A's complications, and was not annoyed at her for seeking a second opinion. Dr B stated that the loose skin in Ms A's lower abdomen was normal, and not related to the haematomas. He apologised "[if] you felt I treated you like a 'whinger'" and explained that "it was the problems I was frustrated with, not you".

Ms A found Dr B's explanations unacceptable and complained to HDC on 7 May 2007.

Subsequent events

ACC
On 13 July 2007, ACC accepted Ms A's claim that she had suffered a treatment injury. ACC accepted the claim, citing independent expert advice from Dr Sally Langley, a plastic and reconstructive surgeon. Dr Langley advised:

> "[Ms A's] large weight is a contributing factor to her complications. Ideally [Dr B] should have advised weight loss first. There is not mention of screening for bleeding tendencies. ... Some measures could have been taken early on to decrease the risk of this occurring namely: insertion of 2 probably large bore suction or dependent drains; hospitalisation for this large abdominoplasty in a patient who is obese, quilting of the deep surface of the fat to the fascia[6] and muscle."

Medical Council of New Zealand
On 12 June 2007, HDC notified the Medical Council of New Zealand of the investigation of Ms A's complaint against Dr B. In September 2007, Dr B agreed to a voluntary undertaking not to perform any abdominoplasty procedures until the outcome of this investigation is reported to the Council. In November 2007, Dr B advised the Council that Dr F was willing to supervise any abdominoplasty procedures he wished to perform. Dr F clarified that Dr B would only be allowed to perform abdominoplasty procedures that were supervised and approved by him, both in terms of preoperative (including assessment/selection) and postoperative care. This arrangement was accepted by the Council.

Dr F
Dr F continues to support Dr B in a collegial relationship, although he has withdrawn his support for Dr B performing advanced procedures, including complex abdominoplasty.

In relation to Ms A's surgery, Dr F stated:

> "The choice of procedure for this patient could be criticised from the beginning, in fact I believe that this is the root cause of the outcome [Ms A] has. A two-stage procedure [such as Dr B performed] at an outpatient or day case basis, is unlikely to treat the complex issues of appearance of [Ms A's] trunk ..."

Dr B
Dr B has made a number of changes to his practice in light of this case, and following discussion with Dr F. He now includes quilting sutures and the use of drains as part of

[6] Scarpa's fascia is a strong connective tissue in the lower abdominal wall.

his decision-making, and routinely sutures Scarpa's fascia, to reduce tension on the skin and scar.

Dr B has reviewed the type of surgery he performs, and has voluntarily ceased performing abdominoplasty surgery. If he resumes abdominoplasty surgery in the future, he does not intend ever again to perform abdominoplasty surgery on patients with a BMI greater than 30. Dr B stated that he has become more vigilant in screening patients, and has developed a lower threshold for referring patients to specialist practitioners.

Response to Provisional Opinion

The majority of the parties' comments on my provisional opinion have been incorporated into the previous section. Remaining comments are outlined below:

Ms A
Ms A believes that some procedures and telephone contacts were not recorded in her notes. Ms A recalls that she underwent an additional aspiration procedure between 28 August and 26 September 2006, and that many telephone calls to Ms C were not recorded.

Dr B
Dr B noted that he has practised cosmetic surgery for over 10 years without any serious complaint about his surgery (prior to Ms A's case) and attributes the lack of complaints "in large part to [being] a very careful and caring practitioner".

Dr B does not accept that Ms A was not a suitable candidate for liposuction, and provided anecdotal reports of satisfactory results he had achieved for other obese patients. He also disputes the conclusion that Ms A was not a suitable candidate for abdominoplasty, and that bariatric and/or apronectomy procedures may have been more beneficial for her.

Dr B maintains that he used appropriate haemostatic and surgical techniques in treating Ms A:

> "The late development of the haematoma tells against it being caused by inadequate haemostasis … I feel very strongly that the use of diathermy alone does not imply a substandard surgical technique.
> …

> [It is] Dr Glasson's view that I had 'a lack of appreciation' of the principle of dead space minimization. That is absolutely incorrect. An appreciation of this principle is precisely why I use a binder."

Dr B does not accept that the remedial aspiration and excisions were not carried out with reasonable care and skill.

Although Dr B accepts that his discussions with Ms A were not adequately documented, and that his written records were not of an appropriate standard, he believes that Ms A was provided with adequate information to give informed consent for the liposuction and abdominoplasty surgery, and subsequent procedures.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights 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.

...

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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; ...

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Other relevant standards

The Medical Council of New Zealand's publication *Good medical practice, A guide for doctors* (2004) states:

> 1. Patients are entitled to good standards of medical care. The domains of competence that follow are medical care, communication, collaboration, management, scholarship and professionalism.
>
> **Medical care**
>
> **Good clinical care**
>
> 2. **Good clinical care must include:**
>
> - an adequate assessment of the patient's condition, based on the history and clinical signs and an appropriate examination
> - providing or arranging investigations or treatment when necessary
> - taking suitable and prompt action when necessary
> - referring the patient to another practitioner, when indicated.
>
> 3. **In providing care you must:**
>
> - recognise and work within the limits of your competence: know what you do not know or cannot do capably.
> - be willing to consult colleagues.
> - keep clear, accurate and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients and any drugs and other treatment prescribed.
> - keep colleagues well informed when sharing the care of patients.

Opinion: Breach — Dr B

Introduction

The Medical Council of New Zealand does not recognise cosmetic surgery as a discrete vocational branch. The nearest equivalent is plastic and reconstructive surgery, which is a subspecialty of surgery recognised by the Royal Australasian College of Surgeons. In case 00HDC10159 (25 March 2003), I discussed the lack of guidelines for cosmetic surgery in New Zealand. At that time, the Medical Council recommended that all invasive cosmetic surgery procedures (such as liposuction) be undertaken by a vocationally registered plastic and reconstructive surgeon. As a consequence, I recommended that any practitioner performing invasive cosmetic surgical procedures should explain to patients:

1. that the Medical Council recommends that the procedure be undertaken by a plastic and reconstructive surgeon;

2. the extent of their registration; and

3. their relevant qualifications and experience performing invasive cosmetic procedures.

In October 2007, after Dr B had operated on Ms A, the Medical Council published a Statement on Cosmetic Procedures, which stated that a surgical cosmetic procedure may be performed:

> "by a doctor registered in a relevant vocational scope of practice, who has the necessary training, expertise and experience ... and whose competence in the procedure has been independently assessed".

However, the Council goes on to state:

> "A doctor who is not registered in an appropriate vocational scope of practice may also perform a [surgical cosmetic] procedure if he or she is in a collegial relationship with a doctor registered in the appropriate vocational scope and that colleague is satisfied that the doctor's training is appropriate and he or she is competent to perform the procedure."

Although Dr B is a general surgeon practising cosmetic surgery, in his promotional brochure, he advises patients he incorporated plastic surgery as part of his training

I do not believe that the general public can be expected to understand the distinction between a general surgeon practising cosmetic surgery, and a plastic and reconstructive surgeon practising cosmetic plastic surgery, particularly given the lack of clear guidelines at the time Ms A sought treatment. The natural implication from his advertising is that Dr B specialises in cosmetic surgery, including liposuction and abdominoplasty, and that he has the appropriate qualifications to do so.

Expert advice

While a doctor with a general surgery scope of practice may be able to perform the procedures undertaken by Dr B, the degree of skill and care expected when doing so is the same as if the procedure were performed by a doctor with a plastic and reconstructive surgery scope of practice. Accordingly, I sought advice from Dr Glasson, a plastic and reconstructive surgeon who is experienced in liposuction and abdominoplasty.

Standard of care

Preoperative assessment — liposuction and abdominoplasty
When assessing Ms A's suitability for cosmetic abdominal surgery it was important to take into account that she was obese, with significant excess fat over her abdomen, hips, lower back and upper buttocks. At the preoperative consultation on 31 May 2005, Dr B advised Ms A that best results could be achieved if she underwent liposuction of the upper abdomen and hips before he performed an abdominoplasty. Dr B also advised Ms A that he occasionally found that liposuction alone produced satisfactory results and, while she could not expect this, it might happen.

Dr Glasson advised that the use of liposuction in Ms A's case was "fruitless", and an abdominoplasty was not a suitable procedure for her. Ms A's obesity significantly reduced the benefits of cosmetic body shaping surgery, and Dr B could not have reasonably expected good results from the proposed surgery. Dr Glasson advised: "The limitations of liposuction and abdominoplasty in obese patients is common knowledge in Plastic Surgery ... [Dr B] should have been aware of [this]."

The New Zealand Association of Plastic, Reconstructive and Aesthetic Surgeons advises that "individuals are poor candidates for liposuction if they weigh over 15kg above their medically defined ideal body weight".[7] Ms A was 37 kilograms over her maximum healthy weight of 81 kilograms.[8]

Dr Glasson advised that Ms A should have been informed of more suitable alternatives, and encouraged to lose weight. Dr Glasson stated:

> "Patients with high BMI should be advised about the importance of weight loss for health and to maximise the benefits of surgery. Patients with high BMI should also be advised about weight loss surgery (bariatric surgery), which may be more beneficial to them."

Dr Glasson believed that, at the most, Dr B could have offered to perform an apronectomy, where the redundant lower abdominal roll is removed. An apronectomy

[7] "Liposuction — a guide for patients" — a pamphlet published by Mi-tech publishing and distributed by the New Zealand Association of Plastic, Reconstructive and Aesthetic Surgeons to its members.

[8] A 180cm woman who weighs 81kg has a BMI of 25. A healthy BMI is 18.5 to 25.

would have assisted Ms A to exercise, and is associated with fewer complications than abdominoplasty.

Dr B does not accept that Ms A was not a suitable candidate for liposuction and abdominoplasty surgery, noting that he has performed liposuction and/or abdominoplasty on many large patients, with acceptable results. Nevertheless, I consider that recommending liposuction and abdominoplasty to Ms A, and anticipating reasonable benefit from the procedures, showed poor judgement on Dr B's part, and that Ms A was not a good candidate for liposuction and abdominoplasty.

Operative technique — abdominoplasty
When performing the abdominoplasty, Dr B should have taken Ms A's obesity into account, particularly with a view to controlling bleeding (haemostasis). Dr B's operation record states that he maintained "haemostasis with diathermy",[9] but Dr Glasson advised that this *may* have been insufficient to control the bleeding. He stated:

> "Haemostasis usually requires a combination of diathermy and ligation or the tying off of blood vessels. ... There are usually some large vessels to control during the ... operation, and these require ligation to ensure control. In obese patients, these perforator vessels may be larger than normal, with greater need for ligation technique."

In addition to the exclusive use of diathermy, Dr B did not perform other aspects of the surgery with adequate skill. In particular, he did not use quilting sutures to limit the dead space created by removal of skin and fat, or use drains to remove accumulating fluid, or suture the superficial fascia. Dr G had specifically recommended to Dr B that he use "multiple quilting sutures with a drain being left in place for some days to ensure no further collection develops".

Dr Glasson noted that the use of quilting sutures and a drain are especially important in obese patients. Although Dr B used a binder to help minimise dead space, Dr Glasson did not consider this sufficient. He advised:

> "[A]n important principle of surgery is the prevention of dead space, where collections can occur. To close an abdominoplasty without quilting sutures and drains shows a lack of appreciation of that principle."

Dr B maintains that he used appropriate haemostatic and surgical techniques when operating on Ms A and that her haematoma was not attributable to technical failure.

It is not possible to determine exactly when the haematoma was formed, or what caused it. However, I am left with the overall impression that Dr B's operative

[9] Diathermy involves cauterising and sealing blood vessels to stop bleeding.

technique in performing the abdominoplasty surgery on Ms A did not minimise potential harm to her, and increased the likelihood of postoperative complications.

Postoperative management
During the night after the abdominoplasty surgery, Ms A suffered a postoperative bleed, which was appropriately managed by Dr B and Ms C. However, Ms A subsequently developed a haematoma in her lower abdomen, and this complication was poorly managed by Dr B.

Five weeks after the abdominoplasty, Ms A attended a postoperative appointment at which Dr B recorded significant swelling in her lower abdomen without free fluid, and recommended that she continue wearing the binder. He scheduled a follow-up appointment in four months' time. Dr B advised HDC that "[Ms A] clearly had developed a haematoma ... I explained how a haematoma is caused and the reason I expected it to resorb...". However, Dr B did not make any reference to a haematoma in the Centreal notes, and Ms A complained that he "did not tell me exactly what it was".

Dr Glasson advised that Dr B should have referred Ms A for an ultrasound to investigate the swelling, regardless of whether he recognised it to be a haematoma, and appropriate treatment should have been commenced immediately. Dr B's plan to continue with the binder and review in four months' time was "inadequate". Dr Glasson stated:

> "In my opinion, postoperative complications were not well managed. ... The key error occurred at the visit five weeks after abdominoplasty. ... If [Dr B] had recognised the problem, and intervened at this stage, the haematoma may well have been successfully managed. He did not and [Ms A] had recurrent problems requiring multiple procedures."

Dr B failed to investigate Ms A's abdominal swelling or provide appropriate treatment for the haematoma. Even if Dr B genuinely believed that the haematoma would resolve on its own, four months was far too long for a follow-up appointment to assess the effectiveness of his treatment plan.

Although Dr B did consult Dr F on how best to manage Ms A's haematoma, he did so at nine weeks postoperatively, and only after Ms A's GP had arranged for an ultrasound and telephoned Dr B to insist that he see Ms A to reassess the haematoma.

Dr B went on to perform two aspirations and two excision surgeries on Ms A's recurrent haematoma between June and November 2006. These procedures were also performed without adequate care and skill. Dr B could not reasonably have expected aspiration alone to treat a large chronic haematoma. He did not use quilting sutures to close the cavity after each excision, and his use of a drain was very brief. Dr Glasson advised:

> "Aspiration of a chronic haematoma is unlikely to work, and the excision omitted good control of dead space."

I conclude that Dr B failed to appropriately manage Ms A's recurrent haematoma. His failure to provide adequate and timely treatment not only contributed to Ms A's unsatisfactory end result, but also led to her undergoing unnecessary anaesthesia and surgery, which carried additional risks because of her weight.

Conclusion
In my opinion Dr B was ill advised to perform liposuction or abdominoplasty surgery on Ms A. There were problems with his operative technique for the abdominoplasty, and he did not manage Ms A's postoperative complications appropriately. As noted by Dr Glasson:

> "[Dr B] did not provide an appropriate standard of care that could be expected of a doctor who is a registered General Surgeon who practices exclusively in Cosmetic Surgery ... I consider the failure to meet the standard of care was major."

In these circumstances, Dr B breached Rights 4(1), 4(2) and 4(4) of the Code.

Information

Under Right 6(1)(b) of the Code, every consumer has the right to the information that a reasonable consumer, in that person's circumstances, would expect to receive, including an explanation of the options available and associated risks and benefits. Right 7(1) provides that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent.

Preoperative information — liposuction and abdominoplasty
Ms A and Dr B briefly discussed liposuction and abdominoplasty surgery in October 2004, when Ms A underwent cosmetic surgery. Ms C sent her information sheets and brochures about liposuction in April 2005, and sent similar information about abdominoplasty surgery in January 2006. The information sheets provided only general information about pre- and postoperative appointments and costs, and the brochures were promotional, rather than informative. None of the information discussed risks or limitations of the surgery.

Dr B first met with Ms A to discuss liposuction and abdominoplasty surgery on 31 May 2005. Dr B's notes from that consultation do not record detailed information about the possible risks and postoperative complications associated with liposuction and abdominoplasty surgery. Although the consent form for liposuction, signed that day, contains information on general risks associated with liposuction, it does not mention any limitations or possible disappointment with the end result. The consent form for abdominoplasty surgery, signed 30 March 2006, states only that "the nature of the operation has been explained to me along with the expected results and possible unexpected effects".

Dr B stated that he provided Ms A with a general description of liposuction and abdominoplasty surgery during the consultation on 31 May 2005, and information

about known risks and complications of the procedures. There is no indication that Dr B provided information specific to Ms A's characteristics, in particular that her obesity would significantly limit the cosmetic result of liposuction and tummy tuck, increase the risks involved in surgery, and make her more vulnerable to postoperative complications. Nor did Dr B tell Ms A (as he later advised HDC) that "the results of the procedure are somewhat inconsistent".

Dr B also failed to discuss other surgical and non-surgical options for improving the appearance of Ms A's hips and abdomen. Dr B should have offered advice on diet and exercise, and discussed the benefits of weight loss (bariatric) surgery and/or apronectomy. Instead, he limited the discussed treatment options to the proposed surgery.

Preoperative information — remedial aspiration and excision
On 6 June 2006, Dr B met Ms A for a preoperative consultation before aspirating the haematoma. Although Dr B did document a discussion with Ms A about the possibility that she might require open surgery to excise the haematoma if liposuction aspiration was ineffective, there is no record of any discussion about risks and complications associated with the surgery. The consent form, which was signed by Ms A and Dr B on 6 June, was a standard consent form for liposuction, rather than aspiration, and did not contain appropriate information about the nature of the surgery, risks and alternatives.

On 11 August 2006, Dr B excised Ms A's abdominal haematoma. He did not record any preoperative consultation, although Ms A did sign a consent form for the operation in the morning. The consent form states: "The nature of the operation has been explained to me along with the expected results and possible unexpected effects." However, there is no record that Ms A was provided with this information, and she does not recall such a discussion.

Ms A suffered another collection of fluid, which was drained on 28 August 2006. Although Dr B recorded that 900ml of fluid was drained from Ms A's abdomen, he did not document any discussion about the procedure or that he obtained consent from Ms A.

On 26 September 2006 Dr B unsuccessfully attempted to drain further fluid from Ms A's abdomen. Again, there is no record of any discussion with Ms A, or evidence that he obtained her consent for the procedure.

The haematoma did not resolve over the next three weeks, and on 9 November 2006, Dr B performed another excision. Ms A signed a consent form on the morning of the surgery, but it merely stated that "[t]he nature of the operation has been explained to me along with the expected results and possible unexpected effects". The Centreal notes do not document any preoperative discussion between Ms A and Dr B when she could have been provided with this information, and she does not recall such a discussion.

Overall, I am not convinced that Dr B adequately explained the nature of the aspiration and excision surgeries to Ms A, or discussed the risks and possible side effects associated with both.

Conclusion
In his response to my provisional opinion, Dr B accepted that he did not clearly document his preoperative discussions with Ms A, but advised that he spends "considerable time with patients to clarify what is being proposed, how it is done, what results can be expected, and what are potential negative effects or problems with the proposed management". However, Ms A does not recall any detailed discussion prior to the liposuction and abdominoplasty surgery or the remedial aspiration and excision procedures. In relation to Dr B's claims, I note the comment of Baragwanath J in *Patient A v Health Board X*,[10] that it is through the medical record that doctors have the power to produce definitive proof of a particular matter.

In the absence of any documentation to support Dr B's claims, I remain of the opinion that Dr B did not provide Ms A with adequate information to make an informed choice or give informed consent for the liposuction and abdominoplasty surgery or the remedial aspiration and excision procedures, and breached Rights 6(1) and 7(1) of the Code.

Documentation

Ms C's entries in the Centreal notes are thorough and descriptive, and clearly document her interactions with Ms A. In contrast, Dr B's clinical notes are very brief and do not contain sufficient detail to justify his actions or substantiate his retrospective account.

Dr B advised HDC that he discussed Ms A's proposed liposuction and abdominoplasty surgery in detail at the 31 May 2005 consultation, yet his contemporaneous notes do not reflect this. Dr B's documentation for the preoperative consultation consist of a single-sided sheet entitled "Liposuction Preoperative Consultation" with a diagram marked "V large XS fat all areas", indicating the upper and lower abdomen, hips, lower back and upper buttocks, and a list of matters to be discussed.[11] Another page is headed "pre-op" and includes a list: "consent, bloods, photos, corset, prescript[ion]: doxycycline".

While Dr B placed a tick next to each item in the lists to indicate that he covered them during the consultation, he failed to record the actual discussion he had with Ms A, and did not document any discussion specifically about the abdominoplasty surgery.

In his response to my provisional opinion, Dr B stated:

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[10] *Patient A v Health Board X* (High Court Blenheim CIV-2003-406-14, 15 March 2005).

[11] The matters listed were: Time off; Mobility; Pain; Dysaesthesia; Swelling; Bruising; Scars; Waves; Adhesive Dressing; Supportive Garments; Dimples; G/A.

> "I accept that my notes need to be more detailed to ensure that my records support the assertion that patients do have all the information they require to make an informed [choice]. I now do this by recording in more detail what I discuss."

Dr B advised HDC that at the five-week postoperative appointment of 4 May 2006 "[Ms A] had clearly developed a haematoma", and that he provided her with a thorough explanation of her condition and his proposed treatment plan. However, neither the diagnosis nor his discussion with Ms A was recorded in the Centreal notes.

Dr B failed to record other important details in Ms A's clinical notes. He did not document that she was obese with a body mass index of 36.4, and did not record start or stop times for any of the operations, or the length of time spent in postoperative recovery before discharge. Dr B also did not photograph Ms A's abdomen at the final consultation on 20 February 2007.

In summary, Dr B did not keep clear, accurate and contemporaneous patient records of the standard expected of a registered doctor, and breached Right 4(2) of the Code.

Care co-ordination

Right 4(5) of the Code states that every consumer has the right to cooperation among providers to ensure quality and continuity of services. In practice, this means that patient care should be well coordinated between providers.

After the first consultation, on 31 May 2005, Dr B should have made contact with Ms A's GP, Dr E, to check the information Ms A had provided about her past health, medications, attempts at weight loss, and whether there were any physical or psychological contraindications to the proposed liposuction and abdominoplasty.

Although Dr E removed Ms A's sutures following the liposuction and abdominoplasty, and became very involved in managing her postoperative complications following the abdominoplasty, Dr B did not write to her after each surgery, or update her on his management of Ms A's recurrent haematoma.

Dr B did not write to Dr E until 15 June 2007.[12]

A surgeon should always report to a patient's GP on any surgery performed and necessary follow-up. As noted by Dr Glasson, "Communication is important, especially when difficulties may be anticipated with an obese patient." The fact that Ms A and her GP were in one city, whereas Dr B was in another, made timely reporting by Dr B all the more important.

In this case, Dr B did not communicate with Dr E to ensure quality and continuity of care for Ms A, and accordingly breached Right 4(5) of the Code.

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[12] Dr B was notified of this investigation by letter dated 12 June 2007.

Non-referral to Director of Proceedings
The significant shortcomings in the care and information Dr B provided to Ms A, leading to findings that he breached the Code, necessitate consideration of whether he should be referred to the Director of Proceedings for possible disciplinary proceedings.

On balance, I have decided not to refer Dr B to the Director of Proceedings. I have taken into account that Ms A's primary concern is for public safety, and that Dr B has voluntarily restricted his practice to cease performing abdominoplasty surgery. In my view, the public interest will be best served by holding Dr B accountable for breaching the Code, and referring him to the Medical Council of New Zealand with a recommendation that his competence be reviewed. An anonymised version of this report will be placed on the HDC website, and a copy naming Dr B will be sent to the Royal Australasian College of Surgeons. Little more would be achieved by the additional step of disciplinary proceedings.

Recommendation

I recommend that Dr B comply with the Medical Council of New Zealand's "Statement on cosmetic procedures" (October 2007) in his future practice.

Follow-up actions

- Dr B will be referred to the Medical Council of New Zealand in accordance with section 45(2)(b) of the Health and Disability Commissioner Act 1994, with a recommendation that the Council consider whether a review of Dr B's competence is warranted.

- A copy of this report will be sent to the Medical Council of New Zealand, to Dr F and the Royal Australasian College of Surgeons.

- A copy of this report, with details identifying the parties removed, except for the name of my expert advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Independent advice to Commissioner

The following expert advice was obtained from Dr David Glasson:

> "I have been asked to provide an opinion to the Commissioner on case number 07/07867. I have read and agree to follow the Commissioner's guidelines for Independent Advisors.
>
> **My qualifications:**
>
> MB ChB Otago 1978, and FRACS (Plastic) 1987.
>
> I have practised as a registered specialist Plastic Surgeon in Wellington since 1988. I worked as a part time consultant at the Wellington Regional Plastic Surgery Unit from 1988–2005. I have had a private practice since 1988, and have been in full time private practice since 2005. I have a broad experience in Plastic and Reconstructive Surgery, and am very familiar with many cosmetic procedures including liposuction and abdominoplasty. My Continuing Professional Development Program in Plastic and Reconstructive Surgery with the RACS is current.
>
> **My referral instructions from the Commissioner are:**
>
> **Purpose**
> To provide independent surgical advice to assist the Commissioner to form an opinion on whether [Dr B] provided an appropriate standard of care to [Ms A].
>
> **Complaint**
> The following issue is subject to investigation:
>
> - The adequacy of information and appropriateness of care [Dr B] provided to [Ms A] from April 2005 to 20 February 2007.
>
> **Expert Advice Required**
> To advise the Commissioner whether, in your professional opinion the care provided to [Ms A] from April 2005 to 20 February 2007, by [Dr B] was of an appropriate standard. In particular:
>
> 1. Please comment generally on the standard of care provided to [Ms A] by [Dr B] from April 2005 to 20 February 2007.
>
> 2. What standards apply in this case? Were those standards complied with?
>
> If not covered above, please comment on the following:

3. Did [Dr B] provide [Ms A] with adequate information to make an informed decision to undergo liposuction and abdominoplasty? If not, what information should have been provided?

4. Did [Dr B] provide [Ms A] with appropriate treatment for her condition?

5. Did [Dr B] perform the liposuction, abdominoplasty, and remedial procedures with adequate care and skill?

6. Did [Dr B] appropriately manage [Ms A's] postoperative complications? If not, what should have been done?

7. Are there any aspects of the care provided to [Ms A] by [Dr B] that you consider warrant additional comment?

If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

Sources of information: supplied by the Commissioner

Supporting Information
- Letters of complaint from [Ms A], dated 21 March 2007 and 7 May 2007.
- Information from [Dr B].
- Information from [Dr H].
- Information from [Dr G].
- Information from [Dr E].
- Copy of [Ms A's] clinical notes from [the Centre] from 11 April 2005 to 20 February 2007 (including typed transcript)

Also: Liposuction A guide for patients Published by the Australian Society of Plastic Surgeons, and NZ Association of Plastic Surgeons.

Factual summary:
Assembled from Commissioner's summary, AND supporting information.

In April 2005, [Ms A] made enquiries about having liposuction at [the Centre]. The practice nurse, [Ms C], booked a consultation with cosmetic surgeon [Dr B] for 27 May, and posted an information sheet to [Ms A], who lives in [another city], on 11 April.

COMMENT: the information consists of promotional brochures about '[The Centre]' and 'Liposuction', which provide only introductory information. The

third document 'Information for Liposuction Patients' states that initial and preoperative consultations will be required. The fourth item advised the date of the first consultation, and confirmed the booking for liposuction surgery, with details of costs.

[Ms A] was booked for liposuction prior to the first consultation with [Dr B].

1st Consultation:

31/5/05: [Ms A] attended her consultation with [Dr B] on **31 May** to discuss treatment for excess skin and fat over her abdomen and excess fat over her hips. [Dr B] advised [Ms A] that best results would be achieved if she underwent liposuction of her hips and upper abdomen prior to abdominoplasty.

[Dr B] provided [Ms A] with verbal and written information about liposuction and abdominoplasty, and obtained written consent for the liposuction procedure. He also took blood samples, photographs, and prescribed a course of antibiotics to be taken before the surgery. [Ms C] measured [Ms A] for a supportive corset to be worn after the liposuction surgery.

COMMENT: The contemporaneous note provided by [Dr B] of this consultation, is a single sheet with a diagram marked 'V large XS fat all areas' indicating the upper and lower abdomen, hip rolls, and lower back, upper buttock. There is a ticked list of matters to be discussed. On another page is the following: 'Consent bloods photos corset prescription doxycycline'. This appears to be the extent of the notes taken at the time.

There is no record of [Ms A's] weight or BMI.

There is an anaesthetic admission questionnaire under [Dr D's] name (anaesthetist). This was presumably filled out on the day of surgery. The patient's weight is recorded as 118kg.

[Dr H's] record, when [Ms A] was seen for second opinion in May 2007, gives a height of 180cm. Therefore the BMI is 36.4 at time of surgery. A BMI of over 30 indicates obesity. Some define morbid obesity as BMI >35, others use >40.

[Dr B] makes no record of her obesity in his contemporaneous notes.

In the CONSENT FOR LIPOSUCTION signed by [Ms A] and [Dr B] on 31/5/05, section 1 states that liposuction is not a treatment for general obesity. This is true. Liposuction is not done to remove excess fat from all over the body.

Elsewhere the consent states liposuction is 'a means for reducing localised fat deposits that are difficult or impossible to remove by diet and/or exercise'.

However, obesity severely limits the value of liposuction even for the treatment of localised fat deposits, and that point is not stated.

Obesity of this degree may also cause difficulties with anaesthetic management.

There are therefore 2 issues with appropriate patient selection

1) safety: proceeding with surgery in a day case unit

2) value of liposuction in an obese patient.

[Dr B's] account to the HDC of this consultation is a retrospective one describing his recollection. He advised [Ms A] about liposuction, or abdominoplasty, or both. He showed results in some patients who had liposuction who were told initially they might require abdominoplasty as well, but in whom liposuction proved sufficient. He advised [Ms A] that she should not expect this, but it was presented as a possible 'pleasant surprise'.

In my opinion, given her obesity, and the pre operative appearance the use of liposuction as planned was fruitless.

There may have been a case for so called 'large volume liposuction', but that procedure requires inpatient monitoring and has significant risks.

In my opinion, liposuction was not indicated here, even as a planned preliminary to abdominoplasty.

[Ms A] would have been better advised to investigate bariatric (weight loss) surgery, such as gastric banding.

At the most, an apronectomy where the redundant lower abdominal roll alone is excised could have been done, followed by a weight loss programme.

23/6/05: [Ms A] went ahead with [Dr B's] recommendations, and on 23 June, underwent **liposuction of her upper abdomen and hips at [the Centre].**

Aspirated volumes were: Abdomen 1700ml, right hip 950, left hip 600. TOTAL 3250 ml.

COMMENT: in his report to HDC [Dr B] gives more detail about the technique.

He explains that despite 'a significant reduction in all areas treated' the result was disappointing and that he has found that 'over the 100's of liposuction cases that I have done, that the results of the procedure are somewhat inconsistent'.

This account of his experience was not recorded as being given to [Ms A] in the **pre** operative consultation.

4/8/05: follow up. [Dr B] records 'Still has large excess in lower abdomen — will probably need a tummy tuck'.

In **January 2006**, [Ms A] contacted [the Centre] and booked the abdominoplasty and preoperative consultation for 30 March. On 19 January 2006, [Ms C] posted an information sheet, antibiotic prescription, and a pathology request form to [Ms A].

COMMENT: the written information was a promotional brochure and general instructions regarding the surgery. This can not be considered sufficient for informed consent.

30 March, 2006: [Dr B] again discussed the procedure and postoperative care with [Ms A] and obtained written consent. [Ms A's] blood test results were also reviewed, and [Dr B] confirmed that she had taken the prescribed antibiotic.

COMMENT: there is no written note regarding the pre op discussion. There is a signed consent.

In his report to the HDC [Dr B] gives a detailed account of the advice he gave regarding abdominoplasty presumably at the consultation in May 2005. Some technical points about quilting sutures and drains are included which may be for explanation to the HDC, rather than to the patient at the time. Some of the detail is wrong.

For example, he advises that some surgeons who use drains remove them at 3–4 days, if not earlier. However, it is common practice to leave drains until a volume of less than 30mls/24hrs is collected, and then remove the drain. While it may then be possible to remove the drain after several days, drains may be required for 10 days or more.

30/3/06: [Ms A] underwent an **abdominoplasty** later that morning. [Dr B] fitted her with a binder/corset after performing the operation, and she was discharged after approximately four hours recovery. Although she experienced a bleed from the umbilical wound that night, this was repaired by [Dr B] on **31 March**. [Ms A] then returned [home] to recover.

COMMENT: [Dr B's] operation record describes his method. Of note is the use of 'haemostasis with diathermy'. Often there are large perforator vessels that require more definite treatment than diathermy to ensure bleeding is controlled. In obese patients these vessels can be larger than normal, and the use of ligation with Ligaclips is common practice. This may be relevant to the later problems with haematoma. Also, the suture material used is of light

calibre, and indicates that the superficial fascial system (Scarpa's fascia) was not repaired as a separate layer — a manoeuvre plastic surgeons would consider routine. No quilting sutures or drains were used.

[Dr B] saw [Ms A] the following morning as she had some bleeding overnight. [Ms C] had attended to her at the motel and recorded the event thoroughly. She arranged for [Ms A] to be seen by [Dr B] in the morning.

At the examination on 31/3/06 [Dr B] noted the bleeding had occurred at the margin of the umbilicus and an extra suture was placed. He did not record any abdominal swelling which might indicate that a haematoma was present beneath the abdominal skin flap.

20/4/06: 3 weeks post abdominoplasty: [Ms A] contacted [Ms C] and complained of swelling and bloating.

At her 5-week postoperative consultation, [Dr B] noted a haematoma in her lower abdomen. [Dr B] believed that the haematoma would re-absorb and advised [Ms A] to continue wearing the binder/corset.

COMMENT: 4/5/06 5 WEEK POST OP VISIT:

[Dr B] recorded 'Swelling ++ in lower abdomen — does not ballotte i.e. not free fluid. Continue binder See 4/12 (4 months)'.

In his report to HDC he states 'she clearly had developed a haematoma. I expected this would resorb, with consequent reduction of swelling. I explained how a haematoma is caused and the reason I expected it to resorb …'.

[Ms A] states in her letter to [Dr B] that he did not tell her 'what it was'.

Question: Did [Dr B] identify the problem? There is no contemporaneous record that he did diagnose it.

He did note that the swelling did not ballotte. What inference can be drawn from that? A seroma, which is a collection of watery fluid under the skin, does ballotte i.e. shift like a puddle under the skin. A haematoma, which is still semi solid, does not. However he makes no written conclusion from the absence of this sign. If he recognised the swelling as a haematoma, he presumably would have written the diagnosis in his notes.

If uncertain why did he not investigate with ultrasound?

Is it reasonable to expect this unidentified 'swelling ++' to go away?

If he did diagnose a large haematoma at 5 weeks after surgery, then it is wishful thinking to predict it will resorb without intervention.

It seems the complication was not recognised, no investigation was done, an overly optimistic prognosis was given to the patient, and no treatment was offered other than to keep using the binder.

On **26 May**, [Ms A's] GP, [Dr E], rang [Dr B] expressing concern over [Ms A's] haematoma, which she felt was enlarging. An ultrasound confirmed a large organising haematoma.

COMMENT: [Dr E's] record describes 'very large firm swelling below umbilicus, obviously haematoma. Most of lower abdo is involved'. She arranged an ultrasound and contacted the nurse [at the Centre], who arranged for [Ms A] to be seen by [Dr B] on 6/6/06, with surgery booked for the next day.

[Dr E] notes in her letter to HDC of 15/6/07 that [Dr B's] nurse '… was reluctant to commit to anything, but I absolutely insisted … that the situation was most unsatisfactory, and that [Dr B] was advised to see [Ms A] as soon as possible, to attend to the haematoma'.

Ultrasound 29/5/06: 'organised haematoma … 12cm in depth, … 27cm transversely'.

On 7 June, [Dr B] **aspirated fluid** from the haematoma, but by 24 June, it had recurred.

COMMENT: [Dr B] recorded a large haematoma, and he had discussed management with [Dr F], Plastic Surgeon at [a public] Hospital. He recommended aspiration using liposuction technique, and that an open procedure may be necessary.

7/6/06 Surgery: aspiration of 2900 mls of haematoma. 10 weeks after abdominoplasty

COMMENT: this procedure is at best optimistic. Chronic haematomas form a wall of scar tissue around them, and simple aspiration is unlikely to solve the problem. Re-accumulation of fluid within the sac is likely unless the haematoma wall is excised, and the dead space obliterated.

24/7/06: [Dr B's] notes: 'the space has filled again'.

3/8/06 : [Ms A] consulted [Dr G], Plastic Surgeon for a second opinion. He noted a large haematoma. He agreed to write to [Dr B] with management advice. He wrote on 4/8/07 with technical points recommending obliteration of the wall, use of quilting sutures and drains.

On 11 August 2006, (2nd procedure for haematoma) [Dr B] **excised the haematoma** from the lower abdominal wall and inserted a drain. 900 ml of

fluid was evacuated, and the haematoma sharply dissected from the muscle wall. The drain remained in situ for 24 hours.

COMMENT: No quilting sutures were used to obliterate dead space, as recommended by [Dr G].

[Dr B] states he did not receive this letter before he operated on 11/8/06. But 'I did pretty much what he suggested in any event, other than the quilting sutures'.

He omitted this important technique to close the dead space.

The nurse removed the drain the following day. This is very soon given the circumstances. In my opinion the drain should have been left in place until measuring less than 30ml/24 hrs.

[Ms A] was advised to continue using her binder for 3 days.

On **24 August**, [Ms A] contacted [the Centre] to report fluid in her abdomen, and this was aspirated on **28 August**. (3rd procedure for haematoma).

COMMENT: 900 ml of fluid was removed with liposuction cannula.

[Ms A] contacted [Dr B] on **8 September**, to report that she and her GP were concerned that fluid was building up again, and on **22 September**, [Ms A] told [the Centre] that her abdomen required draining again, and an appointment was made for **26 September**.

[Dr B] unsuccessfully attempted to aspirate fluid on **26 September**. (4th procedure for haematoma).

COMMENT: [Dr B] arranged an ultrasound and advised '… let time pass for resolution'.

29/9/06: Ultrasound : 11.9 x 6.1 x 12.5 cm collection … recurrent haematoma

COMMENT: given the result which indicates a significant collection, why did [Dr B] do nothing?

9/11/06: (5th procedure for haematoma). [Dr B] **excised the haematoma** from the abdominal wall. A drain was left in situ until 13 November.

COMMENT: the drain was removed at 4 days, even though 200 mls had been drained that day.

[Ms A] did not suffer a re-occurrence of her haematoma, but was dissatisfied with the results of her abdominoplasty.

20/2/07: [Ms A] had final consultation with [Dr B].

COMMENT: No photos of the final result are included.

3/5/2007: [Ms A] saw [Dr H], Plastic Surgeon [in Ms A's region], for an opinion. He concludes the abdominoplasty was inadequate, and states that revisional surgery is likely, though at 108kg '… she is still a little too heavy to benefit from further surgery.'

Her weight at surgery was 117 kg and height 180 cm. BMI was 36. [Dr H] recorded her weight at 108 kg.

17/6/07: [Dr B's] first written communication with [Ms A's] GP [Dr E].

6: SPECIFIC QUESTIONS: EXPERT ADVICE REQUIRED

Question 2 will be answered first.

2) What standards apply in this case? Were those standards complied with?

- [Dr B] is a registered specialist surgeon in General Surgery and a Fellow of the Royal Australasian College of Surgeons.
- He now practices Cosmetic Surgery.
- Cosmetic Surgery is usually considered to be in the scope of practice of Plastic and Reconstructive Surgery.
- In his promotional brochure, [Dr B] advises patients he incorporated plastic surgery as part of his training. The implication to patients is that he is qualified to do Plastic Surgery.

Therefore, the standards that should apply to [Dr B's] practice should be not less than those expected of a registered specialist Plastic Surgeon.

1) Please comment generally on the standard of care provided to [Ms A] by [Dr B] from April 2005 to 20 February 2007.

In my opinion, standards of care expected of a registered specialist plastic surgeon were not met in respect of:

a. patient assessment and treatment planning,

b. patient information,

c. informing patient of alternatives,

d. record keeping,

e. technique of abdominoplasty surgery,

f. postoperative management,

g. recognition, investigation and management of the specific complication,

h. communication with the General Practitioner.

1a. Patient assessment and treatment planning

When [Ms A] consulted [Dr B] she had a BMI of 36.4 (weight 118kg according to anaesthetic record, height 180cm according to [Dr H]). A BMI over 30 indicates obesity. Body contouring surgery is much more difficult to do in obese patients, and the results much less satisfactory than in those of normal or 'overweight' BMI. In his contemporaneous notes, [Dr B] has no record of [Ms A's] weight, height or BMI, and there is no record of his specifically advising her of the limitations of this surgery in patients of her body build. There is no record of his advising about potential anaesthetic difficulties related to obesity.

[Dr B] proposed sequential surgery, with liposuction first. There was an inference given that the result of liposuction may be sufficient and that [Ms A] may not require abdominoplasty. This shows poor assessment skills for 2 reasons.

Firstly, liposuction in the obese makes very little difference unless very large volumes are aspirated e.g. 10 litres or more. Large volume liposuction is a major procedure, with significant risks, performed as an inpatient and requires intensive patient monitoring. Presumably [Dr B] did not intend to do this.

Secondly, the result of liposuction is partly dependent on the ability of the skin to retract and to mould to the reduced fat volume beneath. In obese patients, skin shrinkage is often poor, especially in the lower abdomen where the skin has been very stretched. This is the case for [Ms A], as is evident in her pre op photos. Therefore, even if a lot of fat is removed by liposuction, a redundant roll of skin and fat will remain. Abdominoplasty will still be necessary.

1b. Patient information

The brochure sent prior to the first consultation was promotional rather than informative. It is advertising. The Consent form does list 'risks', but omits mentioning limitations and possible disappointment with the result.

Enclosed is an information pamphlet on Liposuction provided by the NZ Association of Plastic Surgeons. Under the section on Limitations: 'Individuals

are poor candidates for liposuction if they weigh more than 15 kgs above their medically defined ideal body weight'.

1c. Informing patient of alternatives

Patients with high BMI should be advised about the importance of weight loss for health and to maximise the benefits of surgery. Patients with high BMI should also be advised about weight loss surgery (bariatric surgery), which may be more beneficial to them.

In my opinion, for a patient like [Ms A], it might be helpful to offer an 'apronectomy' only. This operation removes the redundant roll from the lower abdomen, and can relieve symptoms, and improve skin hygiene and the ability to exercise. The surgery involves no undermining of the abdominal tissues, and minimises dead space, avoiding some of the complications of abdominoplasty. There is no record that this was offered by [Dr B].

1d. Record keeping

[Dr B's] contemporaneous records are very brief and do not provide evidence of an adequate consultation prior to surgery, or during the follow up period.

1e. Technique of abdominoplasty

In my opinion, the technique used by [Dr B] was poor, especially considering [Ms A's] obesity. Haemostasis (stopping bleeding) usually requires a combination of diathermy (electrocautery by heat sealing) and ligation or the tying off of blood vessels. [Dr B's] operation record states he used diathermy only. There are usually some large vessels to control during the undermining part of the operation, and these require ligation to ensure control. In obese patients, these perforator vessels may be larger than normal, with a greater need for ligation technique.

Abdominoplasty creates a large dead space beneath the undermined skin/fat flap. Dead space should be minimised as fluid tends to collect in it. Also, the skin fat flap can move over the muscle wall beneath (shearing), delaying the sticking together of these separated layers. Surgeons use quilting stitches to tack down the skin/fat flap to the muscle wall, drains, and sometimes pressure garments, to limit the dead space and shearing. Again, in obese patients with heavy tissues, these manoeuvres are even more important. [Dr B] does not routinely use these methods and relies on a binder only.

Closure: there is no mention of the suturing of the superficial fascia (Scarpa's fascia, a strong connective tissue layer). This is a routine step in abdominoplasty.

1f. Postoperative management

This is more difficult when patients live some distance from the practice, and mandates close communication with the GP (see 1h). [Dr B's] nurse kept good progress notes, and seemed attentive, attending the motel to see [Ms A] at night. [Dr B] resutured the umbilical wound on Day 1 following abdominoplasty which was effective. However the management of the haematoma complication was poor.

1g. Recognition, investigation and management of the haematoma

At the 5 week consultation on 4/5/06, [Dr B] recorded the swelling, but proposed no provisional diagnosis, and ordered no investigation such as ultrasound. Ultrasound is a quick, easy, and relatively cheap investigation which would have diagnosed either a seroma or haematoma. Appropriate intervention could then have been planned with a better chance of resolution. When seromas and haematomas are of long duration, a wall of scar tissue forms around them and they become more difficult to treat with simple measures such as drainage, and are more likely to require surgery.

[Dr B] advised [Ms A] to continue with a binder and to return for review in 4 months. This is an inadequate treatment for what he described at the time as 'swelling++', and for an event he later reported as 'she clearly had developed a haematoma'.

10 weeks after abdominoplasty, on 7/6/06 [Dr B] aspirated 2900mls of fluid from the haematoma. By then, the haematoma had been present for at least 7 weeks. [Dr B] had liaised with [Dr F], a Plastic Surgeon, who had endorsed this technique. In my opinion this was a very optimistic technique to use. Re accumulation of fluid within the cavity was probable, and did occur.

On 11/8/06, [Ms A] had surgery when the haematoma was excised and drained. No quilting sutures were used to close the cavity. The drain was removed at 24 hrs, which is early. Fluid accumulated again.

On 24/8/06 [Ms A] had a 3rd procedure for haematoma, when 900 ml of fluid was aspirated with liposuction equipment. Fluid accumulated again.

On 26/9/06 [Ms A] had a 4th procedure when an attempt to aspirate fluid was not successful. An Ultrasound confirmed a recurrent collection. No treatment was recommended. Why not?

On 9/11/06, 6 months after the abdominoplasty, [Ms A] had a 5th procedure when the haematoma was again excised by [Dr B]. The surgery was successful.

[Dr B] did seek advice from a Plastic Surgeon once prior to the first aspiration, and denies receiving written advice from [Dr G] (obtained by [Ms A]) before operating in August 2006. [Dr B] advised [Ms A] that he had not had this

complication before and did not know what to do. If this was the case, [Dr B] could have referred her to a Plastic Surgeon and arranged an ACC claim.

1h. Communication with the General Practitioner

From the information provided, [Dr B's] first written communication with the GP was 17/6/07. There was no letter to Dr E after the first consultation. Communication is important, especially when difficulties may be anticipated with an obese patient. The GP letter is an opportunity to check on the patient's past health, medications, attempts at weight loss, and whether there are any contraindications to the surgery — either medical or psychological. There were no letters after the liposuction or the abdominoplasty, nor letters to advise about progress with management and ongoing problems.

3. Did [Dr B] provide [Ms A] with adequate information to make an informed decision to undergo liposuction and abdominoplasty? If not, what information should have been provided?

See 1a and 1b above.

- His contemporaneous records do not show evidence of adequate information being provided. In particular he should have explained the limited role of liposuction and abdominoplasty in obese patients, and the higher rate of complications.

- He could have suggested an apronectomy only to remove the redundant lower abdominal roll, which can be appreciated by these patients.

- He could have referred her to a bariatric surgeon for an opinion about weight loss surgery. Cosmetic surgery following bariatric surgery will give a better outcome to the patient.

- An example of the quality of written information that can be provided to patients is enclosed.

4. Did [Dr B] provide [Ms A] with appropriate treatment for her condition?

Not in my opinion.

5. Did [Dr B] perform the liposuction, abdominoplasty, and remedial procedures with adequate care and skill?

I can not comment on the technique of liposuction from the records provided. It is the appropriateness of the liposuction, rather than the technique, that is questionable. The pre and post op photos show minimal differences.

I do not consider the abdominoplasty was performed with adequate skill, as explained above.

Techniques to stop bleeding may have been insufficient.

- Control of dead space is a basic surgical principle. Common techniques include the use of quilting sutures, drains, and pressure garments. [Dr B] relied on a binder only.

- The method of closure did not include repair of Scarpa's Fascia which should be routine practice.

The remedial procedures:

- Aspiration alone of a chronic collection is optimistic at best.

- The haematoma excision omitted the use of quilting sutures and the drain use was very brief.

6. Did [Dr B] appropriately manage [Ms A's] postoperative complications? If not, what should have been done?

In my opinion, postoperative complications were not well managed. The key error occurred at the visit 5 weeks after abdominoplasty, on 4/5/06.

- [Dr B] did not assess the swelling sufficiently at the 5 week visit.

- He did not investigate with ultrasound.

- He advised [Ms A] to continue with the binder presumably hoping the swelling would resolve. This was poor advice.

[Ms A] had complained of swelling 3 weeks after abdominoplasty. So, by 5 weeks, the haematoma had been present for at least 2 weeks, but almost certainly longer allowing time for it to accumulate. If [Dr B] had recognised the problem, and intervened at this stage, the haematoma may well have been successfully managed.

He did not and [Ms A] had recurrent problems requiring multiple procedures.

Subsequent procedures were not well managed. Aspiration of a chronic haematoma is unlikely to work, and the excision omitted good control of dead space.

See 1g above.

7. Are there any aspects of the care provided to [Ms A] by [Dr B] that you consider warrant additional comment?

I consider the major points have been covered.

I do have an additional concern about [Dr B's] insight into his practice of Cosmetic Surgery. I believe this lack of insight may have influenced his care of [Ms A].

For example:

7a. [Dr B] states:

'But I do not accept that this complication occurred because of the techniques used or not used during her care, nor did it recur as a consequence of inappropriate treatment when the diagnosis of haematoma was made'.

I believe that there **are** definite technical deficiencies which may have caused the haematoma, such as the use of cautery only for haemostasis rather than Ligaclips for large blood vessels. The omission of quilting sutures may have allowed the shearing of the tissue layers causing bleeding. Dead space was not controlled leaving a space for a collection to form.

The recurrence of the collection is due to technical deficiencies. The use of suction evacuation and pressure was very optimistic for treatment of a chronic haematoma. Recurrence was likely using that technique.

He alludes to his training in the principles of surgery. However, an important principle of surgery is the prevention of dead space, where collections may occur. To close an abdominoplasty without quilting sutures and drains shows a lack of appreciation of that principle.

7b. [Dr B] states:

'It was accepted generally … that performing liposuction in the upper abdomen is contra-indicated at the same time as abdominoplasty, as it can give rise to problems with vascularity of the skin flaps'. This is not true.

Plastic surgeons **will commonly use liposuction** as an adjunct to abdominoplasty at the same time, when it can improve the results significantly. Information is presented in the Plastic Surgery literature and at conferences on the safe use of liposuction, and the modifications to the abdominoplasty technique to preserve adequate circulation.

7c. [Dr B] explains that he advised [Ms A] about liposuction and abdominoplasty and how occasionally abdominoplasty had not been required because the result of the liposuction was surprisingly good. I do not consider that point can be made to a patient of [Ms A's] shape. My opinion is supported by inspection of the before and after photos provided, where there is no apparent change in the lower abdominal roll.

7d. [Dr B] states that he expected the haematoma to resorb, and that this was the course he had always taken, and that such a strategy is described by other surgeons.

I can not accept that conservative management of a 2900ml haematoma can reasonably be expected to succeed.

7e. [Dr B] comments on his training. He had six months experience presumably as a Registrar in Plastic Surgery at [a public] Hospital. [His FRACS was in General Surgery and he later specialised in General Surgery.]

He does not mention any specific training, fellowship or assessment by his peers in this area of practice. He alludes to his experience only. Presumably then, he is self taught.

7f. In 20 years of General Surgery before cosmetic surgery, he did 'a lot more technically challenging procedures than these (cosmetic surgery)'.

He gives Paediatric and Neonatal surgery as examples. These were procedures for which he **did** have specialty training.

He states that cosmetic operations are not so technically demanding, and the assumption drawn from this is that specialty training is not required. I disagree, and find his view naïve.

The practice of any surgical specialty does demand knowledge of, and expertise in the performance of the operations. But, even more important is the training in the correct assessment of the patients and their problems, and the formation of a treatment plan selected from the menu of options. There is also expertise required to anticipate and deal with complications. A formal training programme will cover all these aspects.

Practising a surgical specialty is not just learning how to do an operation, and I think this may be the situation in which [Dr B] finds himself.

A well performed cosmetic surgery operation is technically demanding. Attention to good technique will minimise complications and optimise results. Failure to follow meticulous technique may result in complications and poor outcomes, as in this case.

7g. re Changes to practice, [Dr B] states 'Since August 2006, I now routinely suture Scarpa's fascia'.

It is good that he now does that, but it is considered an essential part of layered wound closure for Plastic Surgeons. Registrars learn this working in public hospitals doing abdominal closure in TRAM flap surgery for example.

7h. re Changes to practice: [Dr B] states that he now 'will include (quilting and drains) as part of my decision making'.

It is unusual for these techniques not to be in a plastic surgeon's armamentarium. His failure to use them is an example of the lack of adequate training and a lack of technical sophistication.

7i. 'based on this experience … I will probably in the future refuse to operate on someone of [Ms A's] size. This point has been reinforced at recent conferences'.

The limitations of liposuction and abdominoplasty in obese patients is common knowledge in Plastic Surgery, and is not a recent opinion. This view has been presented at meetings for a long time and [Dr B] should have been aware of it.

7j. [Dr B] found himself with a complication that he had little experience of, and that he had difficulty managing. From his notes and delaying tactics, it appears he was uncertain how to proceed. He could have referred [Ms A] to a Plastic Surgeon.

FINAL COMMENT

I believe [Dr B] did not provide an appropriate standard of care that could be expected of a doctor who is a registered General Surgeon who practices exclusively in Cosmetic Surgery.

There were errors at the following levels:

- Assessment and treatment planning
- Patient information
- Informing patient of alternatives
- Standard of record keeping
- Assessment of possible safety issues treating an obese patient in a day case unit
- Technique of abdominoplasty
- Recognition of the complication (haematoma)
- Failure to investigate the haematoma
- Management of the haematoma

- Awareness of technical options
- Communication with the GP
- Failure to refer or seek further advice when the complication recurred.

In view of the sequence of errors and the resulting distress and poor outcome for [Ms A], I consider the failure to meet the standard of care was major.

(2) [Ms A's] management has been poor and would incur the disapproval of peers. I believe this disapproval would be between moderate and severe. It is difficult to qualify this without knowing the consequences of the grading."

Additional Expert Advice

Dr Glasson provided the following additional advice, having reviewed [Dr B's] response to my provisional opinion:

"Please comment on [Dr B's] concerns regarding:

A. Your opinion that liposuction in [Ms A's] case was 'fruitless', and she was not a suitable candidate for liposuction

[Ms A] had a BMI of 36.4. A BMI of over 30 is obese and some define >35 as morbidly obese. It is an indicator that there was a very thick fat layer over the abdominal wall, confirmed by [Dr B's] examination note ('v large xs fat all areas'). So, [Ms A] was a large woman, seeking cosmetic surgery, to look better.

Patients are poor candidates for liposuction if they weigh more than 15 kg above their ideal body weight (NZAPRAS guide for patients). The technique is most effective for patients at or near their ideal body weight.

Liposuction in the obese, where fat layers are very thick, has a marginal effect, unless very large volumes are aspirated (e.g. 10 litres or more). Such 'megalipoplasties' are major operations requiring ICU type post op care. This was not [Dr B's] intention.

He had also implied that preliminary liposuction might obviate abdominoplasty as an unexpected surprise. Such an outcome for [Ms A] was very unlikely.

The liposuction surgery aspirated 1770 ml from the abdomen, a moderate volume. My question is: what was he hoping to achieve with liposuction in such a patient? Taking in to account [Dr B's] stated experience, I consider recommending liposuction, and anticipating reasonable benefit from it, showed poor judgement.

Was liposuction 'fruitless' i.e. being without reward? [Dr B] himself described the result as disappointing. He wrote that 'the results of the procedure (liposuction) are somewhat inconsistent'. Abdominoplasty was still required.

In my opinion, a disappointing result was predictable, and unlikely to be of any real benefit in this patient. The achieved result supports that view.

I stand by my opinion that she was not a suitable candidate for liposuction, and that the operation achieved little, if any, benefit.

B. Your comments that [Dr B's] haemostatic technique may have been insufficient in [Ms A's] case

There are perforator vessels passing from the muscle layer of the abdominal wall to the overlying fat layer, which are divided during the undermining in abdominoplasty. They need to be controlled so that bleeding does not occur from the cut ends. These vessels vary in size and many can be controlled with diathermy (electrocautery; heat sealing). Some of these vessels can be large, particularly in obese patients and will be more surely controlled with a ligature e.g. tied off with suture, or more commonly, clipped with a crushable Ligaclip. [Dr B] used only cautery.

In this case, the overlying skin and fat layer was thick and heavy. Quilting sutures were not used to adhere the skin–fat layer to the abdominal muscle layer underneath. This may have resulted in a shearing effect, with the skin–fat layer sliding over the muscle wall. The shearing of these layers may have abraded a vessel end, setting off bleeding, and the haematoma formed. This is speculation, but it is a possible explanation for how and why the haematoma occurred. This may not have occurred if the larger perforator vessels had been ligated.

For all abdominoplasties, I have Ligaclips available, and would have anticipated using them in such a case, to provide more certainty with the control of the larger perforators. Therefore, his haemostasis technique MAY have been insufficient.

An alternative explanation is that the haematoma started forming within hours of the surgery. There was bleeding on the night of surgery, and the nurse attended [Ms A]. [Dr B] placed sutures in the umbilical wound the following morning. He did not record whether there was any sign of haematoma being present or absent. However, in a large patient, a small haematoma might not be obvious initially. Formation of a haematoma early after surgery indicates that the haemostatic technique may have been insufficient.

Therefore, whether the haematoma began soon after surgery, or in a delayed fashion, more effective haemostatic technique may have avoided its occurrence.

C. Your advice that quilting sutures should be used routinely in abdominoplasty surgery.

Quilting sutures are placed between the abdominal wall muscle layer and the overlying skin and fat which have been separated from each other by the

abdominoplasty. The sutures allow for more controlled distribution of tension, and advancement of the upper abdominal flap inferiorly as it is redraped during closure. Importantly, the sutures prevent shearing of the layers, allowing them to adhere to each other. They reduce the dead space, limiting the space available for seromas or haematomas to form. Plastic surgeons who use this technique report a reduction in their seroma rates, and more rapid healing. That is certainly my experience.

It is a well established technique, used in other operations also e.g. TRAM flap abdominal closure in breast reconstruction surgery, and in Latissimus dorsi flap donor site closure on the back.

References:

Baroudi R, Ferreira C, Contouring the hip and abdomen. Clinics in Plastic Surgery, vol 23, no 4, Oct 1996, p 551–573.
Pollock H and Pollock T, Progressive tension sutures; a technique to reduce local complications in abdominoplasty. Plast Reconstr Surg 105: 2583, 2000.
Mladick R. Progressive tension sutures to reduce complications of abdominoplasty. Plast Reconstr Surg 107: 619, 2001.

Also comment on [Dr B's] comments:

D. '(The) results of my surgery are consistent with published literature, and what I did was a reasonable line of treatment'

a. Regarding [Dr B's] results, I cannot comment without an audit of [Dr B's] patients.

It should be said that results published in the literature are not necessarily all good. The purpose of the publication may be to demonstrate high or low complication rates, and good or bad cosmetic results. The message of most publications in this field is to show how a variation in technique may improve results and reduce complications. The articles will describe limitations of techniques in the authors' experience. Baroudi's description of quilting sutures in 1996 is a good example of a technical innovation which reduced complications of abdominoplasty,

b. Was his treatment of [Ms A] 'a reasonable line of treatment'?

I maintain my reservations about assessment and treatment planning of [Ms A]. There was not discussion about alternatives such as bariatric (weight loss) surgery. A fully informed patient might elect liposuction and abdominoplasty, aware of the compromised results which can be achieved in obese patients. However I consider that liposuction as a preliminary to abdominoplasty (with the suggestion that liposuction alone may suffice) was overly optimistic in a patient of this body shape.

In my report I explained that an apronectomy which removes only the redundant roll from the lower abdomen, and avoids extensive undermining, may have been a more prudent approach as dead space is minimized and healing less complicated. With a BMI of 36.4, bariatric surgery was still her probable best option.

E. I do not accept that the haematoma was caused because of my operative technique the delay before the haematoma developed tells against this

How long was the 'delay before the haematoma developed'? When did it actually occur?

The date of surgery was 30/03106.

There was bleeding from the umbilical wound that night and [Dr B] resutured the umbilical wound the following day. This bleeding could have been from the skin edges of the umbilical wound, or perhaps from some deeper bleeding under the abdominoplasty skin–fat flap escaping through the umbilical wound. Possibly, this presaged future events. There may have been a small haematoma developing then that was not clinically obvious, particularly in an obese patient.

On 20/4/06 [Ms A] noted her abdomen was swollen and contacted [Ms C]. I suspect she had a large haematoma at that stage, and it had been slowly accumulating from shortly after surgery. Perhaps a vessel was bleeding intermittently. A vessel can bleed, a clot then forms and the bleeding stops, then it may begin again if there is traction or movement of the tissues which disturbs the clot. The shearing of the layers could cause this to happen.

On 4/5/06 [Dr B] noted the lower abdomen was swollen, and believed the problem would resolve. He advised HDC that a haematoma had developed. He cannot be sure when it developed, but obviously it had developed sometime prior to 4/5/06. I suggest it may well have been there by 20/4/06, and had possibly been accumulating from very soon after the operation.

Therefore he cannot say that 'delay' before the haematoma developed indicates his technique was not at fault. He can only really talk of the delay before it was detected. It is possible the haematoma was accumulating from the day after surgery. This results from an imperfect technique.

What is known is that a haematoma did develop between the date of surgery, and the date of detection. It is possible it started to accumulate very soon after the operation. Most haematomas after operations do start within hours of surgery, and are caused by bleeding vessels. Imperfect haemostasis with cautery and ligation can cause vessels to bleed after operations, and a haematoma may result.

It is difficult to give any explanation other than technical failure for the occurrence of haematoma. There can be underlying clotting disorders which make post operative bleeding complications more likely, but there is no record of a history suggesting this.

All operations have a haematoma rate. They do occur, and all surgeons experience them. When a haematoma occurs in one of my own cases I always consider technical failure as the cause.

Haematomas require recognition (clinical +/ ultrasound) and intervention.

F. There are a number of articles in the literature which do not support the assertion that obesity creates greater intra-operative risk

This is true e.g. Davies K E et al, Obesity and day case surgery, Anaesthesia, 2001 Nov; 56(11): 1112.

But there are others that do e.g. Lahiri A et al, Anthropometric Measurements and their value in predicting complications following reduction mammaplasty and abdominoplasty. Annals of Plastic Surgery. 56(3): 248 50, March 2006.

Surgeons and anaesthetists do anticipate problems that are more likely to occur in obese patients. I note that Dr Langley's comments to ACC ('hospitalization for this large abdominoplasty in a patient who is obese...'), and [Dr F's] indicate this.

Obesity makes anaesthesia and surgery more difficult and is a risk factor for this sort of surgery in the following ways, e.g.:

- Anaesthesia — intubation and maintenance of airway, ventilation, extubation and airway management in recovery;
- Technical — thick heavy tissues, harder to manipulate, more shearing of tissues
- Complications —
    - more seromas, infections, wound breakdowns, fat necrosis, skin necrosis, delayed healing
- Cosmetic result more difficult to achieve."

Appendix B

MEDICAL COUNCIL OF NEW ZEALAND

OCTOBER 07 www.mcnz.org.nz

Statement on cosmetic procedures

Purpose of this statement

01 This statement outlines the standards expected of doctors who perform cosmetic procedures[1]. The statement may be used by the Health Practitioner's Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which your conduct is measured.

Potential for conflicts

02 Providing a cosmetic procedure does not improve a patient's physical health and safety and it is often difficult to determine whether the treatment is in the patient's best interests.

03 Take great care to ensure that patients who undergo a cosmetic procedure receive the appropriate information, give their fully informed consent and are free from exploitation.

04 The clinical relationship between a doctor performing a cosmetic procedure and a patient may also be complicated by the consumer's heightened expectations of the results that can be achieved and the provider's opportunities for commercial advantage. You should recognise these conflicts and have a duty not to allow them to cloud your professional judgement.

05 Do not abuse your patient's trust. The investigations or treatment you provide or arrange must be made on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.

Definition

06 Council has defined "cosmetic procedures" as follows:

"Operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient's appearance or self esteem."[2]

Expectation of training, skill and expertise

07 *Good medical practice* outlines the duties and responsibilities of a doctor registered with the Medical Council. This states that "In providing care you must recognise and work within the limits of your competence."[3]

08 Treatment should therefore only be provided if you have the appropriate training, expertise and experience in the particular cosmetic procedure being performed to deal with all routine aspects of care and any likely complications.

09 You are responsible for ensuring that you have the necessary training, expertise and experience to perform a particular cosmetic procedure with reasonable care and skill[4].

The categorisation system

10 Cosmetic procedures vary in the level of risk and complexity associated with them. To assist it in setting standards the Council has classified different procedures in accordance with the types of providers involved, the type of facility in which they are performed and the level of risk to the consumer:

1 Patients are advised that this statement only addresses the standard of care expected of doctors. If you seek care from a health practitioner who is not a doctor then you should obtain advice from the relevant professional body.

2 The statement does not cover procedures which improve a patient's physical health and safety other than by improving their appearance and self-esteem.

3 Page 3. *Good medical practice*. Medical Council of New Zealand. October 2004.

4 If you do not comply with this requirement you may be subject to a competence review by the Council if there is reason to believe that your competence may be deficient.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Category 1

- A surgical procedure that involves cutting beneath the skin, such as breast augmentation, breast reduction, rhinoplasty, surgical face lifts, liposuction and otoplasty.
- Most commonly performed in a day procedure centre or hospital, with an anaesthetist present.
- May be performed by a doctor registered in a relevant surgical scope of practice[5]; who has the necessary training, expertise and experience in the procedure being performed; and whose competence in the procedure has been independently assessed[6].
- Category 1 procedures which involve cutting the skin and into subcutaneous fat may also be performed by a dermatologist who has satisfied the requirements of the New Zealand Dermatological Society's advanced dermatologic surgical training programme; who has the necessary training, expertise and experience in the procedure being performed; and whose competence in the procedures has been independently assessed[6].

Category 2

- A non-surgical procedure (although in some cases it may involve piercing the skin), such as non-surgical varicose vein treatment, ultrasound guided sclerotherapy, endovenous laser ablation for vein removal, laser skin treatments, use of CO_2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.
- Most commonly performed in day procedure centres or doctors' clinics with or without an anaesthetist.
- May be performed by a doctor registered in general practice or relevant alternative vocational scope of practice[7]; who has the necessary training, expertise and experience in the procedure being performed; and whose competence in the procedure has been independently assessed[6].

Advertising and promotion

11 Advertising and promotional material should not foster unrealistic expectations.

12 False and misleading advertising is unacceptable. Do not claim a falsely high success rate or overstate your qualifications.

13 Patients can find medical titles misleading. To minimise confusion you should avoid using titles such as "specialist" which refer to an area of expertise unless you are registered with the Council in an appropriate vocational scope.

Obtaining consent

14 Because performing elective procedures may involve a conflict of interest, obtaining the patient's informed consent is particularly important. The informed consent process should start at the initial consultation and should involve a two way communication process which results in the patient feeling confident that they have enough information to agree to the procedure.

15 Selection of patients for category 1 cosmetic procedures must start with an effective assessment of the patient's motivation for seeking treatment. Steps should also be taken to ensure that the patient has realistic expectations and that any preconceived ideas based on advertising and media sources have been ascertained and addressed.

16 There should be an opportunity for a patient to be referred for psychological evaluation if you have concerns about their motivation. Such doubts might arise, for example, if you suspect the patient has a body dysmorphic disorder or a personality disorder.

[5] For this purpose, 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 and that colleague is satisfied that the doctor's training is appropriate and he or she is competent to perform the procedure.

[6] Independent assessment may occur through a branch advisory body training programme or through a credentialing process.

[7] A doctor who is not registered in an appropriate vocational scope of practice may also perform a category 2 procedure if he or she is in a collegial relationship with a doctor registered in the appropriate vocational scope and that colleague is satisfied that the doctor's training is appropriate and he or she is competent to perform the procedure.

Onsite counselling services are not necessarily required, but you should know how to access such services. This requirement is especially relevant when category 1 procedures are being provided.

17 A patient's informed written consent should be obtained at a pre-procedure consultation within a reasonable time period before the day of the procedure and consent must be reconfirmed on the day the procedure occurs. Obtaining informed consent is the responsibility of the doctor treating the patient.

18 There should be a period of reflection of seven days between any initial consultation and the performance of a category 1 cosmetic procedure.

19 At the time of the initial consultation for a category 1 procedure, provide patients with written information in lay language which includes:

- Realistic information about what is involved with the procedure.
- The range of possible outcomes (including worst case scenarios).
- The risks associated with the procedure.
- Recovery times and requirements.
- Other options for addressing the clinical problem.
- The patient's rights as a consumer.
- How to make a complaint if something goes wrong.
- Information about your qualifications and experience.

20 Where specific and recognised ethical standards for obtaining informed consent exist (such as the Harry Benjamin guidelines in the treatment of gender dysphoria), you should follow these.

21 Following any category 1 procedure, provide patients with written information in lay language which tells them:

- How to contact the doctor if complications arise.
- Details of who they can contact if the doctor is not available.
- The usual range of post-operative symptoms.
- Where to go if the patient experiences unusual pain or symptoms.
- Appropriate instructions for medication and self care.
- Details of the dates for follow up visits.

Providing care

22 The operating doctor is responsible for all aspects of preoperative, operative and post operative care. Delegation of care must be appropriate and arranged in advance of any procedure.

23 Carry out all surgical procedures in facilities where there are adequate and appropriate backup services available to address any foreseeable operative complications.

24 You should keep the patient's general practitioner informed of all category 1 procedures, with the patient's permission.

25 Provide appropriate follow up. At a minimum follow up for a category 1 procedure requires that you be available personally for at least two weeks post procedure, or to have a formal arrangement with another suitably qualified practitioner who has full access to the patient's history.

Audit and review

26 If you perform cosmetic procedures you must participate in clinical audit or reporting on a number of clinical indicators. Ideally this should occur annually and should contribute towards the mandatory requirements for continuing professional development and recertification. Where this will not count towards continuing professional development and recertification (for example where the procedures do not form part of your vocational scope) then you should be in a collegial relationship with another doctor and audit and review should take place as part of that relationship.

Related Council statements and resources

- Information and consent (April 2002).
- Legislative requirements about patient rights and consent (October 2005).
- Responsibilities in any relationships between doctors and health related commercial organisations (December 2003).

9 October 2007

This statement is scheduled for review by October 2010. Legislative changes may make the statement obsolete before this review date.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.