Dermatologist, Dr A

A Report by the

Health and Disability Commissioner

(Case 00HDC10159)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Provider / Dermatologist
Mrs B	Consumer
Ms C	Registered Nurse / Director of Nursing
Dr D	Plastic and Reconstructive Surgeon
Ms E	Registered Nurse
Dr F	Advisor to ACC

Complaint

On 4 October 2000 the Commissioner received a complaint from Mrs B about services received from Dr A. The complaint is summarised as follows:

- *In October 1999 dermatologist Dr A performed a neck and chin lift on Mrs B at his clinic. Prior to the surgery Dr A did not fully inform Mrs B of the risks associated with the neck and chin lift procedure.*
- *Dr A did not perform the surgery with appropriate care and skill and as a result Mrs B was left with baggy skin under her chin and sensitive and acne scarred skin.*
- *Three months later Dr A, for no charge, performed the same procedure again which also was unsuccessful. Dr A made a further attempt to remove the excess skin under local anaesthetic. Dr A did not perform this surgery with appropriate care and skill and as a result Mrs B was left with a visible scar in line with her chin, from chin to throat.*

An investigation was commenced on 9 November 2000.

Information reviewed

- Consultation records and videos supplied by Dr A
- Relevant medical and ACC records
- Interviews with Mrs B, Dr A and Ms C
- Information from Dr D
- Information from the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons and the Medical Council of New Zealand
- Independent advice from Dr Graeme Blake, plastic and reconstructive surgeon, and Dr Paul Salmon, dermatologic surgeon

Information gathered during investigation

Dr A
Dr A is a registered medical practitioner, vocationally registered as a dermatologist by the Medical Council of New Zealand. The Council defines dermatology as relating to "diseases of the skin, hair and nails, treated by drugs, surgery, phototherapy and laser therapy". Dr A describes himself as a dermatologic surgeon and states that he has extensive qualifications for dermatologic surgery.

Mrs B – first consultation
Mrs B consulted Dr A on 7 September 1999, for a neck lift. Mrs B was concerned about fatty deposits under her chin and on her upper neck. Mrs B advised me that Dr A explained briefly to her that the procedure involved liposuction to the chin and just under the chin on her neck. He explained that the procedure could be performed on the Friday, she would recover over the weekend and she would be able to return to work on Monday. Mrs B thought that this sounded "brilliant".

Mrs B was concerned about the possible outcome of this procedure due to discussions she had had with an overseas plastic surgeon shortly before coming to New Zealand. Mrs B had approached the overseas plastic surgeon about liposuction to her chin and neck. She explained that the surgeon did not recommend this procedure, explaining that liposuction could leave her with unevenness and dents in the skin and possibly a loose flap of skin in the neck from where the fat had been removed. Mrs B put her specific concern about being left with such a flap of loose skin to Dr A, informing him that this was what the overseas surgeon had told her.

Dr A did not recall being told about the overseas surgeon by Mrs B, and requested that documentation be provided from the doctor himself. Dr A advised me that the statement attributed to the unidentified surgeon was "totally unfounded".

Mrs B recalled that Dr A told her that the overseas surgeon's advice was "absolute nonsense"; there would be no unevenness after the procedure and no flap of skin left. (Dr A advised me, "I never, ever use this expression.") He explained to her that due to the nature of the skin, it would "bounce back automatically". Mrs B said that that sounded like exactly what she needed and that she trusted Dr A 100%. Her discussion with Dr A at this consultation further convinced her to have the procedure. Mrs B understood from what Dr A adamantly told her that this was a simple procedure without any risks. He advised her, "They do this procedure a lot in America." She was convinced that this was the right procedure for her, particularly considering that the outcomes looked good, it took place over a weekend, and she could return to work the following week. Mrs B also agreed to a chemical skin peel to remove some acne scars from around her upper lip, mouth, and down to her chin. Mrs B was not satisfied with the result of the chemical peel, but did not wish to make this treatment part of her complaint.

Mrs B explained that after seeing Dr A she went into another room with Ms C, Director of Nursing at Dr A's clinic. Ms C took Mrs B's photograph, transferred an image of her face on to the computer screen, and then demonstrated graphically how the fat would be

removed from Mrs B's neck and chin area. This picture was not saved and Mrs B was not given a copy of it. (Dr A explained that patients are not told that the results of the procedure will be perfect or that the computer image is an exact replication of the expected result.) Mrs B said she was given a video about liposculpture. She viewed the video at home and found it had nothing to do with the face, but concerned liposuction to the upper thighs. There was no discussion about risks of the procedure on the video.

Dr A recalled that Mrs B consulted him about a standard problem and said that they would have had a standard discussion about that problem, although he does not specifically remember the discussion. As she asked about her fatty neck and acne scarring on her chin, that is what they discussed. Dr A explained that Mrs B complained of having a double chin and feeling a bit full around her face. They discussed her neck and how they could make her neck look better – by removing the fat from her neck using liposculpture. With reference to the acne scarring on Mrs B's chin, Dr A stated that the simplest way to deal with that issue was to resurface the skin using either a laser or a chemical peel. After discussion they chose to use a chemical peel.

Dr A explained that liposculpture involves a number of different things according to the patient's specific problem. In Mrs B's case, it simply involved removing the excess fat from her neck. Although additional steps are often used in addressing similar problems to Mrs B's, removing the fat should have been adequate for her problem.

Dr A explained that at this first consultation he would have described to Mrs B what the surgery entailed, ie, that he would remove the fat from her neck by liposculpture, by drilling two or four small holes in her neck and using a microcannula, either 2mm or 1.8mm in diameter, under local anaesthetic. In this way he would take the fat out of her neck, jaw and jowls to give the best possible contour.

Dr A stated that patients commonly ask him what happens to the skin around the region of concern after the procedure. His usual response would be that normally the skin will tighten or contract back into position, because it is only being held out by the fat that pushes it out. Dr A explained that taking into account Mrs B's relatively young age, 41 years at the time of the procedure, he would have expected her skin to contract after the liposculpture procedure. In Dr A's experience it would surprise him if somebody with young skin did not contract following this procedure.

Dr A explained to me that the possible risks of this liposculpture procedure are minimal. The procedure is performed only under local anaesthetic, and he believes that the biggest question is whether or not the skin will be even afterwards. Dr A described this as a cosmetic outcome, rather than a risk. He advised that he considered uneven skin to be more of a "nuisance" than a "risk" as such, and that this can be "improved even more" by a secondary procedure. Dr A stated that no blood is lost, no infections are contracted, there are only small holes in the skin, and the scarring is minimal.

Dr A informed me that he explained the risks of the procedure orally to Mrs B, as described on the written consent form:

> "These problems will normally always disappear with time, but it is possible some skin firmness, lumpiness or irregularity may persist permanently. If loose skin is excessive in the treated areas it may or may not conform to the new contour."

Concerning the procedure used to gain a patient's consent, Dr A explained that on the day of the consultation, either he or Ms C cover all questions. He stated:

> "So either I or [Ms C] talk about, you know, the risk of infection, or the risks of this or that, so we go through all those things, probably double, I do it and then she does it, OK."

The risks include the risk of infection, minimised by antibiotics; blood loss and pain, controlled by the local anaesthetic; and any unevenness, for which a second procedure may be performed. Using microcannulas instead of big cannulas minimises trauma to the underlying tissues. Dr A will demonstrate a microcannula during the pre-operative consultation.

The patient is then seen by Ms C, who explains the nursing aspects of what will happen. This includes when the patient arrives, and how long he or she will be at the clinic, and whether there will be bandages or dressings. On the day of surgery, patients have another opportunity to ask Dr A or Ms C, or the receptionist, about anything they have not understood. A copy of the consent form is provided at the pre-operative consultation so that patients have an opportunity to take it away and read and consider it at their leisure.

Ms C, Director of Nursing at the clinic, is a registered nurse and an associate member of the Institute of Management. Ms C explained that she first met Mrs B on 7 September 1999 following her initial consultation with Dr A. After seeing Dr A, Mrs B discussed pre-operative procedures with Ms C. Ms C stated that Dr A would have introduced Mrs B to her and described which procedures had been agreed on – in this case liposculpture to the neck, jaw and jowls, and a chemical skin peel. Ms C advised that her discussion with the patient is a continuation of that undertaken by Dr A, and covers the nursing related aspects of the procedure, including pre- and post-operative issues.

Ms C advised me that she would have explained the liposculpture and chemical peel instructions to Mrs B. A set of pre-operative instructions would have been given to Mrs B, explaining the procedures and what to expect, as well as a sample copy of the consent form to take home, read and think about. Any required prophylactic prescriptions, and pre-operative instructions concerning medications and foods to avoid around the time of surgery, and details of transport arrangements following surgery, would also have been discussed. Mrs B was also given a video concerning the technique for liposculpture. Dr A stated that the purpose of the video was to give a general idea of what the liposuction technique is about – the technique is "the same basically for all areas of the body".

Ms C pointed out that the consent form for surgery discusses: the goal of liposculpture; the possibility of an irregular outcome, and improvement rather than perfection; that final results are not apparent for three to six months in some cases because the tissue needs time

to heal; that bleeding is extremely rare and numbness is transitory; allergies; that laboratory tests cover blood clotting times; and the suitability for anaesthesia, if relevant.

Following this consultation, Mrs B telephoned the clinic on 9 September 1999 to discuss the medications she was taking. The phone message recorded that Mrs B enquired about Aropax, an antidepressant, and whether drinking wine at a dinner party would be acceptable. Ms C advised that she consulted with Dr A, then returned Mrs B's call to explain that it was all right to continue taking Aropax, and not to drink wine as "we didn't want her bruising".

First liposculpture procedure
Mrs B said that after seeing Ms C and obtaining a sample copy of the consent form to consider she was booked in for the following week for the actual procedure. When Mrs B arrived at the clinic on 13 September Dr A and Ms C were present. There was no anaesthetist. Ms C administered a local anaesthetic. Mrs B said that prior to the surgery Dr A did not tell her anything about potential adverse outcomes, apart from mentioning the possibility of swelling and bruising which would disappear quickly. The procedure took about an hour.

The consent form for liposculpture surgery was signed by Mrs B and dated 13 September 1999:

> "CONSENT FOR LIPOSCULPTURE SURGERY
>
> I, *[Mrs B]* (our patient) authorise [Dr A] to perform the operation of *liposculpture surgery on my neck/jaws/jowls & chin peel*.
>
> I have had the opportunity of asking questions about the procedure, its limitations and possible complications.
>
> I clearly understand and accept the following:
>
> The goal of liposculpture surgery, as in any other cosmetic procedure, is improvement not perfection.
>
> The final result will not be apparent for 3 to 6 months following the operation.
>
> In order to achieve the best possible result 'secondary procedure' may be required. This is extremely unlikely but if it is performed there will be a charge for that further surgery.
>
> Areas of cellulite will be changed little by liposculpture.
>
> Liposculpture surgery is a contouring procedure and is not performed for the purpose of a weight reduction.

Strict adherence to the post-operative regime discussed by [Dr A] and Nurse [Ms C] (that is wearing an elastic garment afterwards, do the correct exercise and diet) is necessary in order to achieve the best possible results.

Alternatives to body contouring have existed for many years, but most are associated with lengthy scars and some have serious complications. [Dr A] has discussed the alternatives with me.

Although complications following Tumescent Liposculpture surgery are very uncommon, I understand that they can occur.

- If bleeding was a problem, this would be extremely rare, then hospitalisation and blood transfusion would be needed. If there is any blood clot under the skin it would require surgical drainage.

- Natural skin irregularities, lumpiness, hardness and dimply [dimpling] may appear after the operation. These problems will normally always disappear with time, but it is possible some skin firmness, lumpiness or irregularity may persist permanently. If loose skin is excessive in the treated areas it may or may not conform to the new contour.

- Infection is certainly rare, but should it occur, treatment is with an antibiotic and if needed surgical drainage.

- Numbness or increased sensitivity of skin over treated areas may last for months. It would be rare again for this to become any problem.

- Because of the small size of the punctures made, any scarring would be rare, but a scar is a possible outcome.

- Dizziness may occur during the first week following surgery particularly on standing from lying or sitting. If this occurs be careful while walking. Do not attempt to drive a car if you are dizzy.

- Allergic or toxic response to anaesthetic are extremely rare but possible.

In addition to these possible complications, I am aware of the general risks inherent in the procedures and anaesthetic administration. My signature certifies that I have discussed the above material thoroughly with [Dr A] and Nurse [Ms C] and understand the goals, limitations and possible complications of liposculpture surgery and I wish to proceed with the operation.

My signature below authorises [Dr A] to perform the appropriate operation, treatment or technical procedure that may be advisable in the treatment of my case. I also give permission to have any anaesthetic administered as deemed necessary or advised."

Ms C explained that the consent form is signed on the day of surgery, and is witnessed by the office manager. The office manager admits the patients to the surgery; they are then

seen again by Ms C, who asks if they have any further questions. Ms C explained that although the consent form is signed just prior to the operation itself, patients have already been sent home with a sample copy of the consent form following discussions in the pre-operative consultation, so that they can read and consider it at their leisure.

Ms C recalled that on the day of surgery Mrs B appeared to be anxious about the procedure. Ms C took pre-operative photographs of Mrs B before Dr A arrived. Dr A drew an outline of the area to be sculpted on to Mrs B's face. Ms C advised me that Dr A asked if Mrs B had any further questions. Ms C injected the local anaesthetic, infiltrating it according to the special technique she has been trained in, and cleaned the area to be operated on. An intravenous line was inserted and Mrs B was given 2mg of Hypnovel, a sedative, which has a calming effect. Ms C was not involved with the surgery itself – another theatre nurse was on duty that day.

Dr A recalled no problems or difficulties with undertaking the liposculpture or chemical peel. The records kept of this procedure show that 50ml of fluid was extracted in total, 25ml supernatant fat and 25ml infranatant blood-tinged anaesthetic. The infiltration began at 7.50am, the suction began at 8.15am and the procedure ended at 8.35am. Dr A also recorded: "Excellent contour, plus TCA 46% around the mouth and Jessners" (TCA and Jessners are the preparations used for the chemical skin peel).

Outcome of first procedure
Mrs B had been taken to the clinic by taxi (paid for by the clinic). After the procedure, Mrs B remained sitting in the clinic for about 20 minutes and had a cup of tea before Ms E, another nurse at the clinic, took her home. Mrs B had a bandage that went about her chin and face. She was told to leave it on for about 24 hours.

Ms C advised me that following liposculpture a supportive lycra dressing is applied to the area sculpted to cover the two little holes that were made under the chin. The dressing drains the local anaesthetic out of the sculpted area, making it a little soggy, and is worn for 24 hours following the procedure. There are no sutures. The wounds usually stop draining within 24 hours, sometimes 48 hours, seal over and literally just vanish into two tiny white dots. Ms C explained that there is not normally any bruising or bleeding, but there can be some.

Ms C also explained that patients are usually taken home following their surgery, and are subsequently telephoned to check their progress. Ms E performs any required home visits for follow-up care, and patients are given telephone numbers to call 24 hours if any issues arise. Dr A explained that post-operative care is delegated to his nurses (at the time Ms E and Ms C), but he is always available for consultation should a problem or something out of the ordinary arise.

Mrs B confirmed that she had been instructed to remove the bandage after 24 hours. However, she removed the bandages on the evening of the surgery as she phoned the clinic with concerns regarding bleeding and "tremendous swelling".

Ms C advised me that on 13 September 1999, her colleague, Ms E, was responsible for after-care advice. At approximately 8pm, Mrs B spoke to Ms E, who told her that if the bleeding described by Mrs B went down any further into her chest she would contact Dr A. However, Ms E assured Mrs B that bleeding was to be expected for a few days and that it would disappear and dissolve.

Ms E recorded her telephone discussion with Mrs B on 13 September as "2000 hours, a lot of oozing, has changed the dressing three times, bruising down the neck, spoke to [Ms C]". Ms C advised me that she discussed Mrs B's concerns with Ms E that evening, and that there was also a message on her cellphone from Mrs B at 8.08pm stating that "everything is all right, I have no problems".

Mrs B spoke to Ms E at 8.20pm, which was recorded as "bleeding has stopped. Going to bed. Has taken two sleeping pills."

On 14 September 1999 at 10.00am Mrs B called the clinic and advised that she was "much better. Bruised, swollen, but feeling great." Further calls reported Mrs B to be all right at 6.00pm on 14 September, and again on 17 September, but by this time she was also expressing concern about her uneven and bruised neck.

On 22 September there was another telephone discussion between Ms C and Mrs B. Ms C's notes recorded that Mrs B advised that she had "settled quickly, no problems, three days, post-operatively". On 4 October Mrs B telephoned the clinic to advise that she had had a rash for two weeks since using sun block and it had not improved. She had seen another dermatologist, and wanted another appointment with Dr A. Mrs B said that her skin was worse than ever following the chemical peel.

Mrs B advised me that she had not been told to expect this bleeding before the procedure, but had been told about the possibility of some bruising and swelling. (Dr A responded that this was because bleeding is not a problem, and that what Mrs B described was "expected blood tinged fluid".) Her face was "a little sore" both during and after the procedure, although the chemical peel was very painful and compounded the soreness.

Mrs B advised me that the bruising and "bleeding into the skin" continued for two weeks. She described heavy bleeding from the holes where Dr A had inserted cannulas to suck out the fat. The bleeding seemed to get worse and formed a V-shape pointing down from her neck area towards her upper chest before finally dissipating.

Dr A explained that he expects there to be very little bruising or bleeding following this procedure, as the local anaesthetic used has "something in it that actually stops the bruising". The normal outcome is minimal bruising and minimal swelling. Bruising and bleeding such as that described by Mrs B is the exception rather than the rule.

Follow-up consultations

On 5 November 1999 Mrs B returned to Dr A for follow-up of the initial surgery. Mrs B thought that it would be a miracle if her skin cleared up, as she could see no discernible difference after six weeks, and the area looked "terribly uneven". She described the

appearance as "denty, with bumps and lumps, all under my chin". Mrs B had expected that six weeks following the surgery the swelling would have gone down and she had understood that there would be "no bumps, lumps or flaps left". I note that Dr A's consent form states that the final result will not be apparent until three to six months after the operation. It appears that Dr A suggested a secondary procedure at this consultation, which he would provide free of charge, to rectify the unevenness.

Mrs B's next contact with Dr A was on 23 February 1999. Dr A recalled that Mrs B's chin was uneven, so he proposed taking more fat out to even it up. This was a secondary procedure, which he described as uncommon, but normal when trying to attain symmetry. He specifically recalled discussing it with Mrs B during the February consultation. Dr A advised me that he said, "I'll take more fat from there and there." The consent form for the initial procedure states that a secondary procedure may be required to achieve the best possible result, although this is "extremely unlikely".

Dr A also clarified that although the consent form states that secondary procedures will be charged for, it is his normal practice not to charge for these, although there may be a small theatre fee. The statement that it will be charged for is in case the secondary procedure is major, rather than a minor one like Mrs B's.

Mrs B said that at the February consultation Dr A told her that he would perform the liposculpture procedure again, free of charge, in order to improve the result. Mrs B wanted to discuss with Dr A the reasons why the first procedure had not worked, as she was not convinced that another one would fix it. She said Dr A made no comment about whether having to repeat the procedure was unusual or extraordinary, did not explain why the first procedure had not given the desired result, and just said that the second surgery would fix the lumpiness.

Second liposculpture procedure

On 3 March 2000 Mrs B had a secondary liposculpture procedure for unevenness on one side of her chin. Dr A performed the procedure with Ms C present. Dr A recorded: "Small amounts fat, sculpted from face and neck", and described the second liposculpture procedure as straightforward and involving the removal of a few "teaspoons" of fat. He explained that a secondary procedure is mainly a fine-tuning process. When asked whether he recalled any complications or irregularities, Dr A stated that there would not have been a complication, as the procedure was minor and consisted only of a local anaesthetic in the two areas and the removal of fat.

Ms C confirmed that she was present when Mrs B returned for the secondary procedure, and said that they would have had a routine pre-operative discussion. Consent would have been obtained in the same manner as for the first procedure. Mrs B signed an identical form to the first one on 3 March, which was again witnessed by the office manager. This time the surgery was described as a "secondary procedure – chin and left cheek", and Mrs B drove herself to and from the clinic.

Ms C's post-operative telephone call to Mrs B recorded that she was "comfortable, no questions".

Outcome of second procedure
Mrs B explained that about six weeks following that secondary procedure, her neck area was still "lumpy and denty", but she also now had a flap of skin where her "double chin" had been.

Mrs B contacted the clinic on 3 May and told Ms C that she wanted to see Dr A again as she had a loose flap of skin left on her neck. Ms C spoke to Dr A, who said that he would need to see Mrs B.

When Mrs B next saw Dr A he agreed that there was a flap of skin on her neck, and told her that in these cases, in the United States, a "simple little procedure" is performed to remove the flap of skin. He assured her that this was common in America, was very simple, and would remove the loose skin. The procedure would be performed under local anaesthetic, she would have stitches for about seven days, and there would be no visible scar. Dr A would perform the procedure free of charge.

Dr A stated that advice is always given on possible scarring, and commented that Mrs B must have realised that there would be a visible scar.

Mrs B said that she questioned Dr A strongly about what he was going to do. Dr A told her he was going to do a vertical cut and remove the "wee flap of skin". She asked why the incision was not horizontal, and suggested two cuts below each ear and then pulling the skin taut. Mrs B said they had "quite a little discussion" on where the cut would be, as she did not want to be scarred. She said Dr A made it quite clear that there would be no problem with scarring and the flap of skin would be gone. She said he "convinced me totally".

Mrs B was not provided with written information or a video about this procedure. She said she did not know if the procedure had a name, but that Dr A reassured her that there would be no problems. Dr A explained that this surgery simply required loose skin to be removed, was a routine operation, and he expected it to heal nicely. Surgery was arranged for the following week.

Dr A recalled that Mrs B was now complaining that her skin was loose, which surprised him. As a specialist dermatologist Dr A is aware that skin will contract following liposculpture. However, in Mrs B's case the skin did not contract as he had expected. Dr A advised me that there were two possible ways to address this, both requiring dermatological surgery, his specialty. He explained that he has been trained in all forms of cosmetic surgery, and that cutting skin and liposculpture procedures were pioneered by dermatologists. One choice was to excise the loose skin in the midline, resulting in a fine vertical linear scar from just under the chin to the hyoid bone, and the other was to do a neck lift and pull the skin tight from the sides of the neck. Dr A recommended the excision because it was relatively easy to remove a bit of loose skin, a standard operation by cosmetic surgeons. The excision had to be vertical as the loose skin was vertical.

Excision of skin flap
When Mrs B arrived at the clinic on 30 May for the skin excision procedure, Dr A, Ms C and Ms E were present, but there was no anaesthetist.

Mrs B signed another consent form on 30 May, once again witnessed by the office manager. The form was identical to those she had signed for the two liposculpture procedures, but the surgery was described as a "secondary procedure. Neck – excision flap of skin."

The records indicate that the procedure took half an hour, a simple diagram of the excision was drawn, and 6.0 and 5.0 Maxon sutures were used.

Excision outcome
After the procedure, Mrs B had a little plaster under her chin on her neck. Ms C recorded, following a telephone call to Mrs B on 30 May after the procedure, that Mrs B was having no problems, and there was "no ooze".

Mrs B returned to the clinic on 4 June and Ms E removed her stitches. Ms E did not recall anything unusual about Mrs B's wound when she removed the sutures, and recorded: "4 June, Sutures removed today. Wound excellent. Sent home with tape." Ms C explained that tape means skin tape to support areas across the wound to make sure that it has good union.

At this appointment Mrs B noticed that there was a vertical scar on her neck but thought it would settle with time. She did not think too much of the scar at that point, as it was very soon after the procedure. She did not see Dr A at this appointment.

Ms C had another telephone discussion with Mrs B on 28 June. Ms C advised Mrs B to return and see Dr A and recorded:

> "Phoned [Mrs B], 28 June 2000. Excision concern. Very tight scar. Pulls ++ [excessively]. On lifting her neck, Not easing out."

Scar
When Mrs B realised the scar was not going to disappear she went back to Dr A. Mrs B said that the scar felt very tight, it pulled at her skin and restricted movement in her neck. Mrs B told Dr A at an appointment on 29 June that this was the worst outcome she could possibly have.

Dr A explained that when Mrs B returned, concerned about the scar on her neck, the scar was hypertrophic or thickened. It then became keloid. (Keloid refers to an overgrowth of fibrous scar tissue following trauma to the skin. It does not resolve spontaneously but may be flattened by applied pressure or corticosteroid injections. A hypertrophic scar is similar but will resolve over a period of time.)

On the original medical assessment form Mrs B indicated that she had previously experienced scarring. When asked about the significance of this question, Dr A explained that people usually answer that question with reference to an appendix or Caesarean scar, so

he will ask them what they mean. He wants to know about a tendency to keloid. In Mrs B's case Dr A has no record of her tendency to keloid, and he noted that she had previously undergone breast augmentation and abdominoplasty surgery with no comment about a tendency to keloid.

Dr A explained that acute hypertrophia or keloid scarring can happen with any skin, but in some areas, such as the chest and shoulders, it will happen more often. It does occur in the neck, possibly because movement has aggravated the wound. Normal treatment of such a scar is with steroids, which dissolve the scar and take out the thickness. Dr A expected that a recent scar like Mrs B's would respond to steroid injections. Dr A administered a steroid injection of Kenacort-A on 29 June and intended to review the scar a few weeks later. He recorded that there was vertical hypertrophic scarring and that Mrs B was to be reviewed in three weeks.

Dr A proceeded with a course of steroid (Kenacort-A) injections. Mrs B said that he injected around and straight into the scar, not under local anaesthetic, and she found the process "excruciatingly painful". He told her this was to "relax" the scar and to prevent further pulling. She said that she confronted him with the way the scar looked and he said that nothing could be done except perhaps creating a zigzag shape through the scar to minimise the severity of the scar's appearance, but she would still end up with a scar.

On 25 July 2000, Dr A again injected the scar with Kenacort-A. Dr A recalled that at this consultation Mrs B told him that her lower face was uneven when she lowered her chin down to her chest. He advised her that the normal position is to look straight ahead, and she agreed that on that angle the contours were excellent.

The next consultation was on 9 August. Dr A recorded: "Scar softer, query? 30-40% better. Query? Should settle with this further injection." He injected the scar a third time. Dr A recalled that the scar was responding well to the injections. It was softening and loosening and becoming less of a problem. At the August appointment Dr A discussed re-excision of the scar with a W-shaped excision, but also explained that the normal treatment would be simply to use steroids.

Dr A stated that if Mrs B had continued to have the steroid injections, her scar would have improved. He also would have offered her a free-of-charge W-excision of the scar, had Mrs B wanted this. This would have loosened up the vertical scar, making further keloid scarring less likely.

Mrs B claims that she is "physically scarred for life" with a scar 6.5cm long. Dr A states that this is an exaggeration and is not true. He estimates that the scar was between 4 and 4.5cm long, as this is the average scar length, unless Mrs B is tipping her head back to stretch the neck and the scar to its full length. Dr A says that Mrs B is not physically scarred for life as the scar can be corrected with either steroid injections or a W-plasty incision.

Dr D

Mrs B explained that after the steroid injections she was very upset, as treatment appeared to be getting her nowhere, so on 24 August 2000 she went to see plastic and reconstructive surgeon Dr D for a second opinion. Dr D said there was very little he could do and suggested making a zigzag shape through the scar, but as she could have ended up with a zigzagged scar he did not recommend that course of action. Dr D gave her four to five cortisone injections under local anaesthetic and did not charge her for anything.

Mrs B then telephoned the clinic to explain what she had been told. Ms C recorded that Mrs B said that she had seen a plastic reconstructive surgeon, who took pictures to present to members of Plastic and Cosmetic Surgeons' meetings and advised her that nothing could be done to correct the scar. Mrs B had been told to contact the Medical Council and present her story to them. She was also seeing her lawyer to sue for damages, and would sell her story to the media for compensation. The plastic and reconstructive surgeon told her that it was against all the rules of surgery to make a vertical incision.

Dr D's records of his consultations with Mrs B are as follows:

> "24 Aug 2000 24/8/00
>
> Past History …
>
> 1. Breast augmentation
>
> 2. Abdominoplasty
>
> No allergies.
>
> History of Complaint …
>
> [Mrs B] went to see [Dr A] at the later half of 1999 as a result of his advertising to discuss the fullness in her upper neck. She had a submental lipodystrophy plus excess skin as was seen today from pre-operative photographs. An agreement was made by [Dr A] and [Mrs B] to carry out liposuction to correct this. The first liposuction episode took place in September 1999 and left [Mrs B] with quite marked irregularities of her submental skin.
>
> To try and correct that a further liposuction episode took place in February 2000 and this left her with a lot of loose skin under her chin and upper neck.
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> She again consulted with [Dr A] who assured her that it would be a simple matter to excise the skin in a vertical manner. I'm informed by [Mrs B] that [Dr A] said that this was a simple and straightforward procedure. No warnings were given about the possibilities of adverse scarring.
>
> A transverse ellipse was therefore removed in May 2000. Almost immediately the scar was tight and has remained so ever since. The scar in fact has become tighter and

lumpier. In the last two months a series of four injections of cortisone has been carried out into the scar to try and soften it. It has begun to soften it a bit, but it is still very obvious, red, hard and forms a web across the anterior part of her neck.

On Examination …

There is a scar running vertically from the submental region onto the upper part of the neck measuring about 6-7cms. It is hypertrophic especially in its posterior part where it runs across the gap between the submental plane and the vertical neck plane.

A long explanation has been given of the reasons for this scarring. As [Mrs B's] scarring from her other operations has not been hypertrophic it is almost certainly the direction of the scar and the fact that it transgresses across the web between the submental plane and vertical neck plane.

I explained that further injections of cortisone may help and that probably that is the first line of defence. An alternative is to do either multiple or single Z plasty redirection of the scar. Unfortunately I have had to warn [Mrs B] very carefully about the high possibility of further hypertrophic scarring in these Z plasty scars. Photographs taken and this to be discussed with other colleagues before any final decision made. To write to [Mrs B] when discussion has taken place, but [Mrs B] may contact us to do further injections of cortisone.

31/8/00

Triamcinolone injection using Kenacort 40. See again in three weeks.

18/9/00

The scar is softer and the skin fold pulled up by it much less obvious. Small amount of further Triamcinolone 40 injected. See again in three weeks.

12/10/00

The scar under the chin is softer but still somewhat tight, and has widened a little. I don't think any injection should be carried out today. See again in one month.

[Mrs B] has mentioned the possibilities of a facelift to try and improve the band under her chin. I think it is too early to consider something like that, but a full discussion needs to take place at some stage.

9/11/00

The scar is now very soft and shows no sign of contracture across the neck, unless she extends her neck fully.

I think at this stage no further treatment is indicated and I think the scar should be left to mature. See again in three months.

19/11/01

[Mrs B] has returned to have a further discussion about her scar and the possibilities of improving her appearance. The scar under her jaw remains very red, although it has softened. It obviously has lost its indurated thick scar tissue but it remains wide, especially over the inferior two thirds and tight along its length. [Mrs B] still feels as if the scar restricts her ability to extend her neck. We have talked again about the possibilities of improving it with a Z plasty but the fear of further hypertrophic scarring I think will prevent any such action being taken.

We have therefore covered the subject of a facelift to tighten the skin of her cheek where it has become irregular as a result of her lipo-suctioning. The lipo-suctioning was carried out almost from her malar prominences down right across her neck.

Full explanation of facelift procedures has been given. It has been stressed that this is a long operation and therefore has considerable general anaesthetic risks, and these have been enlarged on.

We have also discussed in detail the positioning and types of scar, the possibilities of skin loss and irregularities of results and asymmetries.

I have stressed the possibilities of nerve damage both of sensory and motor parts. Photographs taken."

Dr D described Mrs B's situation to me as follows:

"Enclosed is a copy of my records on this unfortunate patient.

I have also included a copy of her photographs to indicate the extent of her scars.

This unfortunate result seems to have arisen from two basic mistakes made in her treatment.

The first of these is to liposuction a thick upper neck in an individual with slightly loose and mature skin. Such procedures are quite often accompanied by a failure of the skin to take up the slack caused by the reduction in volume. In very young individuals where the skin is thick and elastic, such looseness of the skin is less likely.

Having established the looseness of the skin by two attempts at lipo-suctioning, the then more serious mistake was made of removing an ellipse of skin extending from a point just under the chin vertically downwards across the webbing of the neck. The placement of a scar in this direction is notorious for causing both a tight scar and also a change in the scar called hypertrophic scarring.

In the few articles in the plastic surgical literature where excision of skin is carried out under the chin for cosmetic reasons, the closure of the wound is always with a large Z plasty which transforms the major part of the scar into a transverse one rather than this

longitudinal direction. Even so, such scars are nearly always very obvious, also have the risk of becoming hypertrophic, and it is not one carried out lightly.

If, as [Mrs B] has indicated to me that no warning was given of the risks of either procedure, the situation is even more lamentable."

ACC

On 26 June 2002 ACC accepted Mrs B's claim for medical misadventure on the basis of medical error, on the basis that Mrs B's consent to the skin excision procedure was not properly informed. She had signed a consent form identical to those she had signed for liposculpture, and had not had the risk of scarring properly explained.

ACC obtained expert advice from Dr F, dermatologist, and considered a report from Dr D, the plastic surgeon who subsequently treated Mrs B.

Dr F made the following comments in his report to ACC, in relation to the informed consent for the excision procedure:

"It appears that surgical alternatives to the vertical elliptical excision were not discussed with [Mrs B]. ([Dr A's] notes are extremely brief and show no documentation of any such discussion.)

While the consent form for the two liposuction procedures appears to be quite adequate, the consent form signed by [Mrs B] for the elliptical excisional surgery is quite inappropriate for the procedure i.e. this third consent form she signed is the same as the previous two liposuction consent forms and bears no relevance to excisional surgery. As such this third consent form only talks about scarring related to puncture wounds which is quite clearly inappropriate here."

Dr F made the following comments in his report to ACC, in relation to the excision of loose skin:

"There is some debate as to how to deal with this loose redundant skin under the skin/upper anterior neck. I have discussed this in an anonymous fashion with two experienced practitioners in this field, one a head and neck/facial plastic surgeon and one a dermatological surgeon. The consensus was that the best procedure to deal with this would be a neck lift but this is quite an extensive and expensive plastic surgical operation. If local surgery were to be performed then usually a horizontal or T shaped surgical incision would be made under the chin with removal of the redundant skin and if possible, tightening of the underlying tissue. Certainly there is an increased risk of prominent scarring by making a vertical incision down the anterior neck. [Mrs B] gives no history of previously having shown a tendency to hypertrophic scarring and therefore it may be assumed that the orientation of the scar combined with the increased likelihood of a scar in this site becoming hypertrophic has played a major part in the development of the unsightly scar."

Dr F considered that there was a causal link between the surgery and the scar, and recommended that ACC accept that Mrs B had suffered a personal injury, because of the excisional procedure.

Dr D disagreed strongly with the surgical technique that Dr A used to excise the redundant flap of skin under her chin. Dr D commented in his report to ACC:

> "To correct that, an excision of skin was then carried out. The ellipse of skin removed had its long axis running from the chin region vertically downwards across the angle of the neck. Such excision of skin in plastic surgical training has always been regarded as extremely hazardous. Even if hypertrophic scarring were not to occur a tight band is nearly always created across the angle of the neck; however, hypertrophic scarring of that sort is a very common occurrence and avoided at all cost."

ACC accepted that Mrs B has suffered a personal injury through the development of hypertrophic scarring under her chin following the excision of loose skin by Dr A. Although ACC based its decision to uphold Mrs B's claim on the lack of informed consent, it was noted that the decision to perform a vertical excision was very unwise.

Specialist comment
The Commissioner sought further comment from the New Zealand Medical Council, the Royal Australasian College of Physicians, and the Royal Australasian College of Surgeons.

The New Zealand Medical Council was consulted regarding the various external organisations to which Dr A belongs. Dr A's qualifications listed are not recognised by the Council for registration purposes; membership of the various external organisations is by application and is not based on an accredited training programme and examination. The Council does not recognise cosmetic surgery as a discrete vocational branch. Vocational registration is available only in recognised branches of medicine. The nearest equivalent is plastic and reconstructive surgery, which is a sub-speciality of the Royal Australasian College of Surgeons, and has a Council-approved postgraduate qualification, 'Fellow of the Royal Australasian College of Surgeons'. I note this is not one of Dr A's qualifications.

The Royal Australasian College of Physicians was asked to advise whether vocational registration as a dermatologist extends to providing cosmetic surgery and, if so, whether there are any limits on the cosmetic surgery services that may be provided. The Royal Australasian College of Physicians is the specialist training organisation responsible for the oversight of dermatological training. The New Zealand CEO of the College of Physicians commented as follows:

> "The definition of 'cosmetic surgery' is very wide and can extend from removing cancerous lesions from the skin to more extensive reconstructive surgery. Practitioners vocationally registered as dermatologists would be trained to remove cancerous lesions and undertake surgery for this. … [I]f practitioners are moving into more extensive reconstructive surgery … further training would be undertaken in this area."

The Royal Australasian College of Surgeons was asked whether a medical practitioner without specialist surgical qualifications can undertake the procedures Dr A performed for Mrs B. The New Zealand Manager of the College of Surgeons commented as follows:

> "Doctors undertaking liposuction (an invasive surgical procedure) or excision of an ellipse of neck skin should be appropriately trained and that training should be assessed and recognised through the vocational registration process. While the surgeries may not be technically demanding, expertise is required in assessment, patient counselling, surgical planning (and equally important advising against surgery) and post-operative care. The Royal Australasian College of Surgeons is not aware that dermatological training includes surgical training to a level suitable to carry out such surgical procedures. Therefore it follows that it is considered inappropriate for a dermatologist to undertake such procedures.
>
> In relation to the particular case referred to in your correspondence, the surgical comment is that 'it would appear that two liposuction procedures of the chin and neck were carried out under local anaesthetic resulting in an unacceptable result which required skin excision which was carried out in a vertical direction. This demonstrates poor patient assessment with inappropriate primary procedure, resulting in unacceptable result. The subsequent excision was carried out in a vertical line which is contraindicated in neck surgery and appears to have resulted in an unacceptable scar which required cortisone injections.'"

Independent advice to Commissioner

Plastic and reconstructive surgeon
The following independent advice was obtained from a plastic and reconstructive surgeon, Dr Graeme Blake:

> "I have summarised the events leading to this complaint from the information supplied.
>
> [A letter arrived on] 3 October 2000 [stating] that [Mrs B], in October 1999, responded to an advertisement for a 'neck and chin lift'. I presume this date is incorrect as [Dr A's] first procedure was on 13 September 1999.
>
> Following consultation, she was provided with a video … She was also offered a chemical peel of the chin and lower face.
>
> Following this consultation, [Dr A] carried out liposculpture of the neck/jaw/jowls and a chin peel on 13 September 1999. On [Dr A's] operation sheet, it was noted that this was carried out under local anaesthetic. The name of the Anaesthetist, […], is crossed out. On the payment schedule, $4800 was requested for the operation, $1000 for the theatre fee and $450 to be paid to [the anaesthetist]. [The anaesthetist's] name does not appear on the theatre record and IV Hypnovel was given by [the theatre nurse] (? Nurse

? Doctor). The procedures took 45 minutes according to the theatre record and one hour according to [Dr A's] record. A total of 50ml was aspirated.

On 3 March 2000, a secondary procedure on [Mrs B's] chin and left cheek was carried out – according to the theatre records, this procedure lasted 55 minutes, involved further liposculpture and 70ml was aspirated. There was no cost sheet for this procedure, so presumably it was 'free'.

On 3 May 2000, [Mrs B] complained of a flap of skin – note made by [Ms C]. [Mrs B] was keen to have this corrected as soon as possible. [Dr A] presumably did not see [Mrs B] until she attended for her third operation on 30 May 2000. This operation, from the diagram on the operation sheet, involved the excision of a simple vertical ellipse in the neck, lasting 30 minutes and carried out under local anaesthetic.

Subsequently on 29 June 2000, 25 July 2000 and 9 August 2000, steroid was injected into the scar. On 9 August 2000, further excision with a W-plasty was discussed.

[Dr A's] letter of 25 January 2001 states that he did performed a 'Cook Neck Operation' in October 1999 [13 September 1999 was the date of the first liposculpture procedure] and that the operation was performed exactly as Dr Cook performs it. He also discusses his choice of a vertical excision of excess skin. He states that this excision technique is performed by Members of the American Academy of Cosmetic Surgery.

Having reviewed the information forwarded to me, including reviewing the Videos and obtaining a copy of the paper 'Cook Weekend Alternative to the Facelift' – Dermatologic Clinics October 1999, I would advise the following in reply to your request:

[Mrs B] had liposculpture and a chemical peel on 13 September 1999. There is no mention of a Cook Neck Operation and no evidence that this was carried out. The Cook Operation involves liposculpture of the face, neck and jowls, followed by laser resurfacing of the platysma and underside of the dermis, vaporisation of subcutaneous fat, resection of a small ellipse of submental skin in a transverse line, separation of the neck septae and plication [surgical technique in which size is reduced through tucks or folds] of the platysma with or without chin augmentation. Dr Cook claims his patients experience no-to-minimal postoperative bruising and discomfort. In my opinion, there is a potential for irregularity and contour deformities, temporary partial facial palsy and skin necrosis with this technique, particularly if carried out by inexperienced operators. Keloid scar problems with a scar correctly located, would be very rare.

The Cook Procedure is not a standard accepted procedure in New Zealand, but what is a standard procedure? It appears there are no regulations on who can carry out surgical procedures. [Dr A] is not a qualified surgeon and I have been advised that none of the Organisations of which he claims to be a member, are accredited by the American Board of Medical Specialties. He is, however, recognised as a Specialist in Dermatology.

> The … liposuction technique is one of the accepted methods of carrying out liposuction. The video supplied by [Dr A] however, makes no mention of its use in the face and neck and hence to provide a copy of the video to [Mrs B] was, I consider, totally misleading and inappropriate for the procedure done.
>
> Steroid injection is used in the treatment of hypertrophic scars to reduce fibroblastic proliferation and to soften the scar. The cause of the hypertrophic scar is the problem in this case – ie the scar was placed in the incorrect line. Neither the Cook nor the procedure [used by Dr B] place scars in this direction.
>
> Although mentioned in his notes, at no stage has [Dr A] performed a standard neck lift and he does not have the surgical qualifications to carry out this procedure.
>
> I think the videos are obnoxious. They are not [Dr A's] personal videos and have simply been edited by him with a welcoming introduction and very little positive information. I personally think that a traditional full consultation and examination, with discussion of all the relevant details, is much more appropriate. There is no evidence of a full consultation in [Dr A's] records. Signing a consent form is an easy way out unless it is fully discussed. [Dr A's] records, although copious in terms of paper content, contain very little of substance.
>
> The photographs supplied by [Dr A] prevent any informed comment. The postoperative photo has been taken looking down at the patient. Hence the neck scar is only just visible. The photographs supplied by [Mrs B] are more informative. The scar is plainly obvious confirming the incorrect orientation. There has, however, been some benefit from the liposculpture.
>
> I commented on the costings in my summary of the procedures. There was also another costing sheet dated, I think, 7 May 2000, although difficult to decipher. This mentioned a further cost of $6250 or $6850. I am not quite sure what his fee applied to or whether it was charged. The fee of $6250 for the procedure which was carried out, is, I consider, grossly excessive for the stated maximum one hour involved and what was performed operatively.
>
> After assessment of the preoperative photographs and with a knowledge of what is required surgically to correct these cases, I consider that [Dr A] is not qualified to carry out the type of surgery he claimed he performed.
>
> If any of this report requires further elucidation, please contact me."

Dermatologic surgeon

The following independent advice was obtained from an independent dermatologic surgeon, Dr Paul Salmon:

> "Thank you for the opportunity to provide an opinion regarding this case. The reader is referred to: 'Guidelines of Care for Liposuction', J Am Acad Dermol 45(3) 325-486. The complaint is outlined in three parts:

1. *In October 1999 Dermatologist [Dr A] performed a neck lift and chin lift on [Mrs B] at the […] clinic. Prior to the surgery [Dr A] did not fully inform [Mrs B] of the risks involved in neck and chin lift procedures.*

Dealing with the first complaint:

First Point: [Dr A] did not perform a neck and chin lift, he performed liposculpture of the neck, jaw and jowls areas, and a chemical peel to the chin, as described on the consent form.

Whilst [Mrs B] answered an advertisement for 'The Weekend Facelift' it seems clear from the documentation that this is not what [Dr A] felt the ideal procedure would be. Instead he suggested she would be best managed by liposculpture alone and chemical peel for acne scarring.

[Mrs B] did sign consent forms before her procedure outlining in considerable detail possible complications of the surgery, of which it is noted that excessive looseness of the skin is possible and in addition, scarring. The preoperative and postoperative instructions supplied to [Mrs B] for peeling and liposculpture are also comprehensive and easy to read using layman's terms throughout.

The video may be considered supplementary to this documentation.

The documentation suggests that [Mrs B] was well informed of the benefits and risks of the procedure and likely postoperative course. Despite being informed of the possible side effects and/or complications of this procedure, [Mrs B] decided to go ahead with this surgery of her own free will. Patients remember little of what they are told during a consultation and have poor recall after reading information leaflets. ('Informed consent: patients listen and read, but what information do they retain?' Turner P and Williams C NZMJ Vol 115 #1164 25 Oct 2002.)

A note on side effects of the procedure is appropriate here. Perhaps the extent of post-operative bruising was not emphasised enough in the patient information. Bruising after liposculpture is an expected (harmless) and often prominent feature, as is copious drainage of residual tumescent solution which patients may interpret as 'bleeding' – (in fact the drainage is less than 1% blood). [Mrs B] may have been less alarmed after her procedure if the extent of these side effects were emphasised preoperatively.

In summary then, I see no justification for complaint 1.

2. *[Dr A] did not perform the surgery with appropriate care and skill and as a result [Mrs B] was left with baggy skin under her chin and sensitive and acne scarred skin.*

Dealing with the second complaint:

There is no good information in the medical literature regarding an acceptable percentage of patients having neck and jowl liposculpture who need a secondary revision. Secondary revision is sometimes necessary after liposculpture surgery (as it is after many types of reconstructive and aesthetic procedure). That the patient needed a secondary procedure because she was unhappy with the result of her first procedure, is perhaps not unusual or in any way indicative of lack of care and skill.

While, after tumescent liposculpture, it is not essential that the patient be seen in the immediate postoperative course, it may be preferable for patient reassurance. The patient did receive several postoperative phone calls from the nurses and appeared to be reassured from these. [Mrs B] was booked for postoperative follow up with [Dr A] at 6 weeks, at which time she did have some concerns regarding her appearance. [Dr A] consulted with her at the time. I might add that at 6 weeks following a liposculpture procedure it may be expected for there to be some induration and unevenness to the skin. This does not often resolve till the patient is out at 10-12 weeks postoperatively.

[Mrs B] signed a similar consent form again and [Dr A] performed a second revision or 'touch up' procedure to [Mrs B's] chin and left cheek on the 3rd March 2000, fully six months after her original procedure. This is an appropriate length of time to wait for any secondary procedure, as the final result after liposculpture may take up to six months.

Following this secondary procedure [Mrs B] unfortunately developed a loose fold of skin in the midline of the submental area. This procedure was carried out in a very similar fashion to the first procedure. This was a smaller procedure and [Dr A] felt there was no need for IV sedation. The procedure was carried out under local anaesthesia only, which is entirely appropriate for this procedure. Indeed I carry out this procedure entirely under local anaesthesia myself. The postoperative course appears to be unremarkable in terms of outcome and care, except for the asymmetry which appears to have been treated successfully during the second procedure. I am not clear about the postoperative follow up for the second procedure on 3rd March.

Prediction of an ideally aesthetic contraction of the submental skin following liposculpture remains largely part of the art of medicine. It is based upon the clinician's gauge of existing dermatochalasis of the skin relative to submental and subcutaneous fat deposition, the possible presence or absence of subplatysmal fat, actinic damage, thickness of the dermis and elasticity of the skin.

From the preoperative photograph she certainly looks like a suitable candidate for the procedure, though I could not be 100% sure without the benefit of having made the preoperative examination myself. Frankly, whether she was suitable for this procedure or not, no one is now in a position to comment.

While being left with excessively baggy skin is a recognised complication of this procedure, it would be unusual for a patient of this age to be left with such a fold of loose skin after this procedure, however obviously each case needs to be assessed

individually. One must assume that [Dr A], as a dermatologist and practitioner of liposculpture, was well qualified to make the decision about whether this was the best procedure for this patient. Certainly in a patient with a history of 'bad scarring' liposculpture might be the procedure of choice.

As to [Mrs B's] claim that she was left with a sensitive and acne scarred skin: increased sensitivity of the skin is a common side effect following re-surfacing procedures, the more deeply the resurfacing procedure, the more common it is to have problems with increased sensitivity of the skin. There can often be postoperative sequelae of a minor but annoying nature such as skin rashes and increased sensitivity to facial creams. This settles with time. It is plain from the photos that [Mrs B] had acne scarring on her chin before the procedure. Her acne scarring is not as a result of the peeling procedure. I can see no evidence of inappropriate skill or care following her peeling procedure, other than perhaps the absence of a postoperative visit with the nurse to check her peeling progress in the 10 days following her peel. I am not sure whether there were postoperative visits which were not recorded in the notes, but it is apparent from the photograph that there was no significant postoperative complication from this procedure. [Dr A] has considerable experience with chemical peeling of the skin.

3. *Three months later [Dr A], for no charge, performed the same procedure again, which was also unsuccessful. [Dr A] made a further attempt to remove the excess skin under local anaesthetic. [Dr A] did not perform this surgery with appropriate care and skill and as a result [Mrs B] was left with a visible scar in line with her chin, from chin to throat.*

Clarity would be plainer if the first sentence of this complaint appeared with the second complaint above.

I will address therefore the last two sentences of this complaint.

Here it is timely to take issue with comments made by [Dr D]. His comment that 'liposuctioning of the thick upper neck in an individual with slightly loose and mature skin is quite often accompanied by failure of the skin to take up the slack caused by the reduction of volume' is not entirely accurate. He states that the procedure is more likely to be successful only in very young individuals. This is certainly not my experience, in which I have had excellent results in patients of the same age as [Mrs B], and indeed older. Patients in their mid forties may commonly have this procedure carried out entirely successfully. The critical point is the evaluation of the individual patient's own skin.

I must however, agree with [Dr D] that vertical excision of the excess skin under the chin was an error of clinical judgement.

Excision of skin in the submental area should be undertaken in the transverse direction. This corresponds to the lines of relaxed skin tension in this area. Incision perpendicular to lines of relaxed skin tension across a flexure of the body will more predictably than

not, result in webbing and sometimes hypertrophic scarring and contracture. A W-plasty mitigates against this effect by aligning the vectors of scar contraction more with the lines of relaxed skin tension and can be very successful when used in this area. There are indeed published accounts of W-plasty in this area, such as that by Ehlert TK et al in Archives of Otolaryngology Head and Neck Surgery 1990, June;116(6):714-7. It may have even been possible to remove this excess vertical band with a single or possibly staged horizontal submental ellipse.

A further waiting period and use of judicious cortico-steroid injections may have been helpful to get this type of flap to resolve after the procedure.

Other than this a facelift procedure could be contemplated but would be risky with a history of bad scarring. An alternative procedure would have been a Z or W-plasty to remove the excess skin, but once again, risky with a history of bad scarring.

Obviously the decision to excise the skin was one approached with some trepidation by [Dr A]. The patient did report a tendency to scar badly in a pre-operative consent. I have not examined [Mrs B] so I cannot comment on the state of other scars on her body, such as those left from her breast augmentation or abdominoplasty. It may have been helpful if he had documented his opinion of these scars and any others before embarking on an excisional procedure. This is not to say that a stretched or keloid scar in one area necessarily means a patient will get one when operated on in another, particularly the face, or that patients report bad scarring accurately. It is in fact my experience that patients are notoriously bad at accurately reporting the scarring property of their skin or the characteristics of their scars. Patients will often call a widened stretched, but atrophic scar, hypertrophic or keloid. The tendency to hypertrophic scarring of the skin is therefore somewhat unpredictable, however it is more likely to occur where the skin is incised at right angles to the lines of relaxed skin tension, and particularly on the neck across a flexure.

I do take issue here with [Dr D's] approach to the patient. By the patient's account he was somewhat pessimistic and perhaps even nihilistic. His advice that nothing could really be done to mitigate the scar and advice against corrective W or Z plasty are likely to have encouraged the patient along litigious paths. His later advice that the patient should have a facelift is hard to reconcile. I fail to see how this will in any way improve the patient's scar. Furthermore, the patient might just as well develop hypertrophic scars from her facelift as from a Z-plasty.

From her photographs, [Mrs B] may well benefit from revision Z-plasty, perhaps with postoperative management with either intralesional 5-Fluorouracil and/or Triamcinolone into the postoperative scar. Even before such treatment, further management is warranted with 5-Fluorouracil and/or Triamcinolone, plus/minus cryotherapy till at least two years postoperatively to allow for maximal improvement of the scar.

In summary then, the only criticism I can make of [Dr A's] care of this patient is his decision to excise the loose submental skin in a vertical (sagittal) plane with a simple ellipse."

Response to Provisional Opinion

Dr A, in response to my provisional opinion, submitted written comments from three doctors, Drs G, H and I, whom he described as international experts.

Dr G stated that generally the vertical incision Dr A described has fallen out of favour, "because of the vertical banding you have experienced". However, Dr G commented that to use a vertical incision is not malpractice, or outside an acceptable standard of care. Dr G requested further information as to the position and length of the vertical incision from Dr A. (It does not appear that any further information was provided to Dr G by Dr A.) Dr G stated that he now avoids external incision in the neck "at all costs" because he cannot "predict who is going to head with a satisfactory scar and who is going to form a keloid or vertical band".

Dr G agreed with Dr A that a "W-plasty or Z-plasty" can be used to disperse the scar. Depending on the length of the scar "it should be most amenable to surgical correction".

Dr A submitted that Dr G's comments show that the vertical incision is "an acceptable and correct operation".

Dr H stated that surgical excisions, both vertical and horizontal, are well represented in the literature and said: "We both know what your adversaries are up to. If the patient is willing to select the vertical submental scar and does not want a full cheek-neck lift to solve the problem, then the selection of the vertical approach is valid." Dr H also stated that a plastic surgeon who says there is no treatment for a hypertrophic scar displays "gross ignorance of medicine".

Dr A submitted that the comments by Dr H show the scar can be treated easily.

Dr I wrote: "I cannot comment on your specific case, but in some cases the skin excision is an acceptable technique, but the scar must be well placed. The Academy can not write … letters for the surgeons with complications and we cannot be responsible for your outcomes."

Dr A was highly critical of the comments made by Dr D, the plastic and reconstructive surgeon who provided Mrs B with a second opinion. Dr A referred to the comments made by his world authorities, who have a better knowledge and insight into liposuction procedures than Dr D, who in his opinion is relatively inexperienced.

Dr A also disagreed with the decision of ACC to accept Mrs B's claim for medical misadventure on the basis of medical error, on the basis that Mrs B's consent to the skin excision procedure was not properly informed. Dr A stated that this was "not true", and he did explain the risks of scarring. In response to ACC's comment that the decision to perform the vertical incision was unwise, Dr A stated that it was an acceptable decision at the time, although "as it turned out" (with the benefit of hindsight) it was unwise.

Dr A described the opinion provided by the Royal Australasian College of Surgeons – that he made a poor patient assessment and that the vertical excision he subsequently performed was contraindicated – as "totally nonsense".

Dr A also notified me of his admission to the American Academy of Facial Surgery, which he describes as "the world's leading group of surgeons in the field of Facial and Plastic Surgery". He submitted that this appointment makes "a nonsense" of the critical comments by Drs de Geus and Blake, and of the comments by the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons.

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.*

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 ; …

Opinion

Information about liposculpture
Under Right 6(1)(b) of the Code every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of the options available, and an assessment of the expected risks, side effects, benefits, and costs of each option. Mrs B alleges that Dr A did not fully inform her of the risks involved in liposculpture of the neck and chin and subsequent procedures.

I note that the original complaint and notification, based on the complaint information provided at that time, incorrectly refers to a neck and chin lift procedure in October 1999. Investigation has shown that, in fact, the first procedure was liposculpture of the neck, jaw, and jowls (and a chemical chin peel), not a neck and chin lift procedure. (Mrs B has specifically not raised as part of her complaint any issue relating to the chemical peel she received, and therefore the chemical peel procedure has not been considered as part of this report.)

The initial procedure was, in fact, performed by Dr A on 13 September 1999, not in October. Following this, Dr A undertook two corrective procedures. The second procedure, described in the medical records as "Secondary procedure, chin and left cheek", took place on 3 March 2000. The third procedure took place on 30 May 2000, and was described as "Secondary procedure/neck, excision flap of skin".

Dr A's consent process in relation to each of the three procedures is considered below:

1. Initial procedure
Mrs B received information about the proposed procedure on three occasions: (1) during her initial consultation with Dr A; (2) on review of the take-home information; and (3) in discussion prior to the procedure.

Mrs B consulted Dr A on 7 September 1999. He briefly explained to her that the procedure involved liposuction to the chin and just under the chin on her neck.

Mrs B recalled that she put to Dr A her specific concerns about being left with a flap of loose skin, as the overseas plastic surgeon had previously warned her about resultant unevenness. Mrs B alleges that Dr A replied emphatically that there would be no unevenness after the procedure and no flap of skin left. He explained that, because of the nature of the skin, it would "bounce back automatically". Mrs B understood from what Dr A adamantly told her that this was a simple procedure without any risks. Mrs B was also shown a computer generated image by Dr A's nurse, Ms C, which was graphically enhanced to show an image of what her face would look like after the procedure. I note that this image was not saved or provided to Mrs B.

My expert advisor, Dr Graeme Blake, plastic and reconstructive surgeon, commented as follows:

> "I personally think that a traditional full consultation and examination, with discussion of all the relevant details, is much more appropriate. There is no evidence of a full consultation in [Dr A's] records. Signing a consent form is an easy way out unless it is fully discussed. [Dr A's] records, although copious in terms of paper content, contain very little of substance."

However, subsequent to Dr Blake's advice Dr A provided me with more detail about what information is generally provided during an initial consultation. Dr A does not specifically recall the discussion that day. He recalled that Mrs B consulted him about a standard problem and said that they would have had a standard discussion. They discussed her neck and how they could make her neck look better – by removing the fat from her neck using liposculpture.

Dr A explained that on the day of the consultation, either he or Ms C cover all questions, including the risks of infection, minimised by antibiotics; blood loss and pain, controlled by local anaesthetic; and any unevenness, for which a second procedure may be performed.

(I note that while Dr A is under the impression that his nurse goes through the risks as well, his nurse has reported that the issues that she discusses with the patient generally relate specifically to follow-up and nursing care issues. Thus, it appears that the primary responsibility for the discussion of risks is appropriately with Dr A.)

Dr A stated that patients commonly ask him what happens to the skin around the region of concern after the procedure. His usual response would be that normally the skin will tighten or contract back into position, because it is only being held out by the fat that pushes it out. Dr A explained that taking into account Mrs B's relatively young age – 41 years at the time of the procedure – he would have expected her skin to contract after the liposculpture procedure.

Dr A, in his response to my provisional opinion, commented that he advised the risks of the procedure orally to Mrs B, as described on the written consent form:

> "These problems will normally always disappear with time, but it is possible some skin firmness, lumpiness or irregularity may persist permanently. If loose skin is excessive in the treated areas it may or may not conform to the new contour."

Dr A explained to me that the possible medical risks of this liposculpture procedure are minimal. The procedure is performed only under local anaesthetic, and the main question is whether the skin will be even afterwards. Dr A considers that potential unevenness is more of a "nuisance" than a "risk".

I question Dr A's description of the risks of this procedure as a possible "nuisance" rather than a "risk". While I accept there are minimal medical risks, and the operation itself is cosmetic, all medical and cosmetic risks should be canvassed, to ensure that a prospective

patient has all the information necessary to make an informed decision. The failure of cosmetic surgery to achieve a desired outcome often has a significant adverse effect on the psychological well-being of a patient.

There were no witnesses to the discussions held on 7 September 1999. Therefore, I am unable to determine precisely what was said. However, it appears that the risks of the procedure were discussed. It is common ground that the positive benefits of the surgery were discussed, and possibly emphasised by Dr A and his staff. Although I find Mrs B's comments to be credible, in light of Dr A's optimistic view of the probable outcomes of the procedure, I am not able to conclude that Dr A did not discuss the risks of the procedure with Mrs B.

Dr A advised me that the process of consent also included take-home material consisting of a sample consent form and a video, and an opportunity for discussion and questions on the day of the procedure.

Mrs B was given a video which she viewed at home and found concerned liposuction to the upper thighs. There was no discussion about risks of the procedure on the video, which she regarded as generally irrelevant. My surgical advisor, Dr Blake, was critical of the video and commented as follows:

> "The video supplied by [Dr A] however, makes no mention of its use in the face and neck and hence to provide a copy of the video to [Mrs B] was, I consider, totally misleading and inappropriate for the procedure done."

It is not disputed that the video did not provide Mrs B with any relevant information about the specific risks of the proposed liposuction to the neck. My dermatologic surgery advisor, Dr Salmon, considered the video to be supplementary information. Dr A commented that the purpose of the video was for general use and that the technique is basically the same for all areas of the body. Whilst I accept that the technique is generally the same, there are clearly different risks involved in terms of outcome in relation to the cosmetically sensitive regions of the face. I note that it was not specifically conveyed to Mrs B that the video did not discuss the risks of the procedure that was proposed. I consider that without the provision of further detail the video was inadequate as a means of conveying relevant information.

Mrs B was provided with a consent form which, as noted above, she was to read at home at her leisure, and could discuss any questions on the day of surgery, prior to signing.

Dr Salmon commented:

> "[Mrs B] did sign consent forms before her procedure outlining in considerable detail possible complications of the surgery, of which it is noted that excessive looseness of the skin is possible and in addition, scarring. The preoperative and postoperative instructions supplied to [Mrs B] for peeling and liposculpture are also comprehensive and easy to read using layman's terms throughout."

Dr Salmon suggested on the basis of the documentation that Mrs B was well informed of the benefits and risks of the procedure and likely post-operative course. Dr Salmon also commented that arguably the extent of post-operative bruising was not emphasised enough in the patient information and that Mrs B may have been less alarmed after her procedure if the extent of possible side effects had been emphasised pre-operatively.

I accept that the documentation provided appears to have been generally sufficient, although more information on post-operative effects would have been optimal. However, I do not consider that it is generally sufficient simply to provide patients with written information about the risks of a procedure, in circumstances where the positive outcomes have been highlighted in discussion with the patient.

Mrs B said that on the day of the procedure Dr A did not tell her anything about potential adverse outcomes, apart from mentioning the possibility of swelling and bruising which would disappear quickly. As noted above, Dr A does not specifically recall the discussions on the day of the procedure. Ms C recalled that on the day of her surgery, Mrs B appeared to be anxious about the procedure, and that Dr A drew an outline of the area to be sculpted on to Mrs B's face and asked if she had any further questions.

Overall, although I consider that the information disclosure process was less than optimal, and that Dr A probably highlighted the positive benefits and significantly minimised the negative risks, I do not consider that Dr A breached the Code in relation to the information he provided to Mrs B prior to the first liposculpture procedure.

2. Second procedure

Mrs B returned to Dr A for a follow-up appointment on 8 November 1999. Mrs B could see no discernible difference after six weeks, and the area looked "terribly uneven". She described the appearance as "denty, with bumps and lumps, all under my chin".

Dr A recalled that Mrs B's chin was uneven, so he proposed taking more fat out to even it up. This was a secondary procedure, which he described as uncommon but normal when trying to attain symmetry. He recalled discussing this with Mrs B at a consultation on 23 February 2000. Dr A said, "I'll take more fat from there and there."

Mrs B said that at this appointment Dr A told her that he would perform the liposculpture procedure again (free of charge, in order to improve the result). Mrs B advised me that she wanted to discuss with Dr A the reasons why the first procedure had not worked, as she was not convinced that another one would fix it. She said Dr A made no comment about whether having to repeat the procedure was unusual or extraordinary, and did not explain why the first procedure had not given the desired result. He simply said that the second surgery would fix the lumpiness.

Dr A stated that the relevant information is explained in the patient consent form, which Mrs B signed on the day of the second procedure. He advised me that the second procedure was "in essence" the same as the first procedure, which was fully explained.

On 3 March 2000 Mrs B had a secondary liposculpture procedure for unevenness on one side of her chin. Ms C confirmed that she was present when Mrs B returned for the secondary procedure, and said that they would have had a routine pre-operative discussion. Consent would have been obtained in the same manner as for the first procedure. Mrs B signed an identical form to the first one. The surgery was described as a "secondary procedure – chin and left cheek".

I accept that the risks of the procedure were described on the consent form, but consider it remained important for Dr A to discuss any concerns Mrs B had regarding the results of the first procedure. (I acknowledge that it may not be necessary to repeat all the risks involved with secondary liposculpture surgery, but certainly any risks that are different from the initial procedure should be discussed.)

As with the first procedure, the most important component of consent would have been the discussions, which occurred during the initial consultation (on 23 February). There were no witnesses to those discussions and I am unable to determine precisely what was said. Dr A has said that it was unnecessary to fully explain the second procedure again, as it was the same as the first. However, in my opinion it was important that Dr A engaged in a dialogue with Mrs B regarding her concerns. Dr A has not provided any evidence to suggest he answered her questions at that time. It is not a sufficient answer that the second procedure was very similar to the first procedure.

Accordingly, in my opinion Dr A did not provide Mrs B with adequate information prior to the second liposculpture procedure, and breached Right 6(1)(b) of the Code.

Information about skin excision procedure

Mrs B advised me that when she consulted Dr A in May 2000, following the two liposculpture procedures, he agreed that there was a flap of skin under her chin, and proposed that he perform a "standard operation" to remove the flap of skin. He assured her that this was common in America, was very simple, and would remove the loose skin. Mrs B said they had "quite a little discussion" on where the cut would be, as she did not want to be scarred. Dr A explained that this surgery simply required loose skin to be removed, was a routine operation, and he expected it to heal nicely. Surgery was arranged for 30 May 2000.

Dr A said that two choices were discussed – the option of a neck lift or a vertical incision. He advised me that he recommended the excision because it was relatively easy to remove a bit of loose skin, a standard operation by cosmetic surgeons. The excision had to be vertical, as the loose skin was vertical.

Dr A stated that advice is always given on possible scarring, and commented that his patient must have realised that there would be a visible scar.

As noted above, my advisor, Dr Blake, commented that there is no evidence of a full consultation in Dr A's records. Dr F, dermatologist, made the following comments in his report to ACC, in relation to the informed consent for the excision procedure:

> "It appears that surgical alternatives to the vertical elliptical excision were not discussed with Mrs B. ([Dr A's] notes are extremely brief and show no documentation of any such discussion.)
>
> While the consent form for the two liposuction procedures appears to be quite adequate, the consent form signed by [Mrs B] for the elliptical excisional surgery is quite inappropriate for the procedure i.e. this third consent form she signed is the same as the previous two liposuction consent forms and bears no relevance to excisional surgery. As such this third consent form only talks about scarring related to puncture wounds which is quite clearly inappropriate here."

I agree that the consent form for the excision procedure is not adequate. Mrs B signed a consent form identical to those she had signed for liposculpture, which was not relevant to the third procedure Dr A undertook.

Furthermore, it appears that Mrs B did not receive an adequate explanation of the risk of scarring, and was not provided with information about alternative procedures. In his response to my provisional opinion Dr A stated – for the first time – that he gave advice about possible scarring. However, he has not provided any evidence to support this claim, nor any detail of the advice he gave Mrs B. In these circumstances, I consider the lack of warning of scarring in the consent form to be of primary significance.

Accordingly, in my opinion Dr A did not provide Mrs B with adequate information prior to the skin excision procedure, and breached Right 6(1)(b) of the Code.

Standard of liposculpture procedures

Under Right 4(1) of the Code, every consumer has the right to have services provided with reasonable care and skill. Mrs B is concerned that the liposculpture procedures that Dr A undertook for her did not result in the cosmetic enhancement expected.

Dr A recalled no problems or difficulties with undertaking the first liposculpture procedure on 13 September 1999. However, when Mrs B consulted Dr A six weeks after the surgery, it was agreed that she was left with some uneven and baggy skin under her chin. Dr A proposed further liposuction to remedy the unevenness.

On 3 March 2000 Mrs B had a secondary liposculpture procedure which she said Dr A described as straightforward and involving the removal of a few teaspoons of fat, with no complications actually occurring, or indeed being possible. However, six weeks following the secondary procedure, Mrs B's neck area was still "lumpy and denty", and she had an unsightly flap of skin forming under her chin, which required further surgery.

My dermatologic surgery advisor, Dr Salmon, commented that secondary revision is sometimes necessary after liposculpture surgery and that the requirement of a secondary procedure does not necessarily indicate a lack of care and skill. Both procedures were carried out in a similar fashion and appeared unremarkable. Dr Salmon noted that the asymmetry that developed after the first procedure appears to have been treated successfully

during the second procedure. However, after the second procedure, Mrs B developed a loose fold of skin underneath her chin. He commented:

> "Prediction of an ideally aesthetic contraction of the submental skin following liposculpture remains largely part of the art of medicine. It is based upon the clinician's gauge of existing dermatochalasis of the skin relative to submental and subcutaneous fat deposition, the possible presence or absence of subplatysmal fat, actinic damage, thickness of the dermis and elasticity of the skin.
>
> From the preoperative photograph she certainly looks like a suitable candidate for the procedure, though I could not be 100% sure without the benefit of having made the preoperative examination myself. Frankly, whether she was suitable for this procedure or not, no one is now in a position to comment.
>
> While being left with excessively baggy skin is a recognised complication of this procedure, it would be unusual for a patient of this age to be left with such a fold of loose skin after this procedure, however obviously each case needs to be assessed individually. One must assume that [Dr A], as a dermatologist and practitioner of liposculpture, was well qualified to make the decision about whether this was the best procedure for this patient."

My surgical advisor, Dr Blake, commented that the liposuction technique used by Dr B is one of the accepted methods of carrying out liposuction and that the photographs supplied by Mrs B show that there was some benefit from the liposculpture.

My advisors had no specific clinical concerns about the way the two liposculpture procedures were performed, and considered that some cosmetic benefit resulted. (Dr Blake's reservations about the appropriateness of Dr A performing this procedure are discussed below, under the subheading "Scope of practice".) I have been provided with no evidence to suggest that the two liposculpture procedures were not performed by Dr A to an appropriate standard. Accordingly, in my opinion Dr A did not breach the Code in relation to the standard of his liposculpture surgery.

Standard of skin excision procedure

Mrs B also complained that when Dr A undertook surgery to remove the excess skin under her neck, she was left with a visible scar, running from her chin down her throat.

Dr A advised me he was surprised that Mrs B's skin has not contracted following the second liposculpture procedure. Dr A said this could be addressed by either excising the loose skin in the midline, or performing a neck lift and pulling the skin tight from the sides of the neck. Dr A recommended the excision to Mrs B because it was relatively easy to remove a bit of loose skin, and this was a standard operation undertaken by cosmetic surgeons. He commented that the excision had to be vertical as the loose skin was vertical.

Dr A performed the excision for Mrs B on 30 May 2000 at his clinic. The medical records indicate a routine procedure. Mrs B noticed the development of a vertical scar on her neck, and returned to consult Dr A on 29 June 2000.

Dr A explained that when Mrs B returned, the scar was hypertrophic, or thickened. It then became keloid. Normal treatment of such a scar is with steroids, which dissolve the scar and take out the thickness. Dr A proceeded with a course of cortisone injections.

On 24 August 2000, Mrs B sought a second opinion from Dr D, a plastic and reconstructive surgeon. Dr D considered that the cortisone injections had softened the scar slightly, but it was still very obvious, red, hard and formed a web across the anterior part of her neck. Dr D continued with more cortisone injections into the scar (under local anaesthetic). Dr D said there was very little he could do and suggested making a zigzag shape through the scar, but as Mrs B could end up with further hypertrophic scarring, he did not recommend that course of action.

My surgical advisor, Dr Blake, commented as follows:

> "Steroid injection is used in the treatment of hypertrophic scars to reduce fibroblastic proliferation and to soften the scar. The cause of the hypertrophic scar is the problem in this case – ie the scar was placed in the incorrect line. Neither the Cook nor [Dr B's] procedures place scars in this direction ... The scar is plainly obvious confirming the incorrect orientation."

My dermatologic surgery advisor, Dr Salmon, commented that the vertical excision of the excess skin under the chin was an error of clinical judgement. He stated:

> "Excision of skin in the submental area should be undertaken in the transverse direction. This corresponds to the lines of relaxed skin tension in this area. Incision perpendicular to lines of relaxed skin tension across a flexure of the body will more predictably than not, result in webbing and sometimes hypertrophic scarring and contracture."

In my opinion, Dr A's recommendation to excise the loose skin was reasonable in the circumstances, although it does not appear that alternative procedures were discussed. However, both my advisors, Dr Salmon and Dr Blake, considered that the technique of a simple vertical incision was inappropriate and carried an excessive risk of scarring.

Adverse comment regarding the vertical incision was also made by plastic and reconstructive surgeon Dr D, and dermatologist Dr F.

Dr A, in response to my provisional opinion, provided comments from North American experts. Dr A stated that these "international experts" support his approach towards the operation and management of the scar and that their comments should be given more credence than my independent expert advice.

Dr G stated that generally the vertical incision Dr A described has fallen out of favour "because of the vertical banding you have experienced". However, Dr G commented that to

use a vertical incision is not malpractice, or outside an acceptable standard of care. He requested further information from Dr A regarding the placement of the scar. Dr G also stated that he now avoids external incision in the neck "at all costs" because he cannot "predict who is going to head with a satisfactory scar and who is going to form a keloid or vertical band".

Dr H stated that surgical excisions, both vertical and horizontal, are well represented in the literature. He stated: "If the patient is willing to select the vertical submental scar and does not want a full cheek-neck lift to solve the problem, then the selection of the vertical approach is valid."

Dr I stated: "I can not comment on your specific case, but in some cases the skin excision is an acceptable technique, but the scar must be well placed. The Academy can not write … letters for the surgeons with complications and we cannot be responsible for your outcomes."

None of the three doctors was able to offer specific comment on the nature of Mrs B's scarring, and it is apparent they did not have detailed information or photographs of the scarring. Dr G requested more information about the placement of the scar and considered that the outcome for the patient depended on the length and position of the scar. Dr I stated that he could not offer specific comment. Dr H placed responsibility on the patient for accepting the consequences of choosing a vertical excision. Dr H did not offer specific comment on Mrs B's scarring.

I acknowledge that the expert comments indicate that in certain circumstances it may be appropriate to use a vertical incision. However, these general comments do not persuade me to discount the specific advice from my independent experts about the choice of vertical excision in this case, particularly in light of Dr G's comment that the vertical technique has fallen out of favour. I note that my advisors have provided specific comment based on the relevant clinical information, including medical notes and photographs of the scarring. They have offered specific opinion on Mrs B's case and are of a unanimous opinion.

Dr A submitted that his admission as a Member of the American Academy of Facial Plastic Surgery was recognition of his skills and knowledge in the area of facial plastic surgery. However, the issue under consideration is the specific standard of care that Dr A provided to Mrs B in this instance.

I am satisfied that Dr A's use of a vertical excision in the neck area was not an appropriate clinical technique in this instance. In my opinion, in excising the loose skin under Mrs B's neck by vertical incision, Dr A failed to exercise reasonable care and skill and breached Right 4(1) of the Code.

Other comment

Appropriateness of liposculpture
During the course of this investigation I also received comment on whether Mrs B was an appropriate candidate for liposculpture. This issue is beyond the scope of my investigation, which considered the standard of the surgery performed. However, it appears the outstanding clinical issue was the appropriateness of Dr A's decision to perform liposculpture on Mrs B in light of the condition of her skin.

Plastic and reconstructive surgeon Dr D, whom Mrs B consulted after Dr A, was critical of the treatment that Mrs B received. He commented that in his opinion it was an error to consider liposuction in an individual with slightly loose and mature skin, since this often results in a failure of the skin to retract.

My dermatologic surgery advisor, Dr Salmon, considered that Mrs B was a suitable candidate for the procedure. Dr Salmon stated:

> "Here it is timely to take issue with comments made by [Dr D]. His comment that 'liposuctioning of the thick upper neck in an individual with slightly loose and mature skin is quite often accompanied by failure of the skin to take up the slack caused by the reduction of volume' is not entirely accurate. He states that the procedure is more likely to be successful only in very young individuals. This is certainly not my experience, in which I have had excellent results in patients of the same age as [Mrs B], and indeed older. Patients in their mid forties may commonly have this procedure carried out entirely successfully. The critical point is the evaluation of the individual patient's own skin."

It is not necessary for me to resolve these differing opinions about Mrs B's suitability for liposculpture.

Scope of practice
There is also a divergence of views between my advisors concerning Dr A's qualifications to perform cosmetic surgery. This reflects the lack of current guidelines for cosmetic surgery in New Zealand.

My surgical advisor, Dr Blake, was concerned at Dr A's comments that he performed a 'Cook Neck' procedure, because of Dr A's lack of specialist training as a surgeon.

I note that although Dr A initially advised he performed the Cook neck procedure, he subsequently clarified that he performed only step one of the Billy Cook operation. However, Dr A indicated that he is confident in performing the entire Cook neck procedure, if he deems it appropriate. Dr A explained that he has been trained in all forms of cosmetic surgery, and that cutting skin and liposculpture procedures were pioneered by dermatologists.

Dr Blake expressed concern that these types of procedures should be carried out only by a qualified surgeon, and that there is an increased risk of complications when the procedure is not performed by a trained surgeon.

My dermatologic surgery advisor, Dr Salmon, did not comment directly on Dr A's qualifications, but considered that Dr A is appropriately qualified:

> "One must assume that [Dr A], as a dermatologist and practitioner of liposculpture, was well qualified to make the decision about whether this was the best procedure for this patient."

The New Zealand Medical Council advised me that Dr A's external qualifications do not fulfil the requirements for vocational registration as a surgeon, and noted that membership of the various external organisations cited by Dr A is by application and not based on an accredited training programme and examination. The Council recommends that all invasive cosmetic surgical procedures are carried out by a vocationally registered plastic and reconstructive surgeon.

The Royal Australasian College of Physicians, which is responsible for the oversight of dermatological training, advised as follows:

> "The definition of 'cosmetic surgery' is very wide and can extend from removing cancerous lesions from the skin to more extensive reconstructive surgery. Practitioners vocationally registered as dermatologists would be trained to remove cancerous lesions and undertake surgery for this. … [I]f practitioners are moving into more extensive reconstructive surgery … further training would be undertaken in this area."

The Royal Australasian College of Surgeons advised me that any invasive surgical procedure should be performed only by a trained surgeon:

> "Doctors undertaking liposuction (an invasive surgical procedure) or excision of an ellipse of neck skin should be appropriately trained and that training should be assessed and recognised through the vocational registration process. While the surgeries may not be technically demanding, expertise is required in assessment, patient counselling, surgical planning (and equally important advising against surgery) and post-operative care. The Royal Australasian College of Surgeons is not aware that dermatological training includes surgical training to a level suitable to carry out such surgical procedures. Therefore it follows that it is considered inappropriate for a dermatologist to undertake such procedures."

This case raises the broader issue of the appropriate boundaries between dermatological surgery and plastic and reconstructive surgery in relation to cosmetic surgery in New Zealand. I note that the Medical Council recommends that invasive surgical procedures be undertaken by a vocationally registered plastic and reconstructive surgeon. Liposculpture surgery is clearly an invasive surgical procedure that Dr A, who is vocationally registered as a dermatologist, is not qualified (at least by vocational registration) to perform. Given the

current situation in New Zealand, in my opinion any medical practitioners undertaking invasive cosmetic surgical procedures should explain to patients considering such a procedure (1) that the Medical Council recommends that the procedure be undertaken by a plastic or reconstructive surgeon; (2) the extent of their registration; and (3) their relevant qualifications and experience.

Actions

I recommend that Dr A take the following actions:

- Apologise in writing to Mrs B for breaching the Code. This apology should be sent to the Commissioner's Office and will be forwarded to Mrs B.
- Review his practice in light of this report.

Further actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- Copies of this report, with identifying features removed, will be sent to the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the New Zealand Dermatological Society, the New Zealand Foundation for Cosmetic Plastic Surgery, and the New Zealand Association of Plastic, Reconstructive and Aesthetic Surgeons.
- A copy of this report, with identifying details removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.