Complications following bilateral breast reduction, abdominoplasty, and liposuction (03HDC05435, 28 October 2005)

Breast and general surgeons ~ Private hospital ~ Liposuction ~ Bilateral breast reduction ~ Preoperative marking ~ Abdominoplasty ~ Postoperative complications ~ Preoperative information ~ Cosmetic surgery ~ Visiting surgeon ~ ACC ~ Medical misadventure ~ Hernia repair ~ Team surgery ~ Limit of competency ~ Documentation ~ Rights 4(1), 4(2), 6(1)(a), 6(1)(b), 6(1)(d), 6(1)(e)

A 51-year-old woman complained about the care provided by a private hospital when she underwent a bilateral breast reduction ("mammoplasty"), an abdominoplasty with abdominal liposuction, and liposuction of the upper arms. At the time, the woman weighed 108kg, and had a clinical history of hypertension, depression, and left-sided sciatica. She had chosen to have three procedures performed together to save time and the need for repeat general anaesthetics. Her surgery was performed by two breast/general surgeons and a locum general surgeon, with assistance from a breast surgeon visiting from overseas. During surgery, an umbilical hernia was encountered and repaired. The woman subsequently experienced postoperative complications (bleeding and infections). She lost both a nipple and her umbilicus through necrosis, and required surgery. She subsequently required corrective surgery.

It was ultimately the lead surgeon's responsibility to make a safe decision to proceed with the surgery on the day. Doctors are not beholden to their patient's requests to provide clinically inappropriate services. His decision to simultaneously perform two major surgical procedures and liposuction was ill-advised and clinically inappropriate. In relation to this issue, he did not exercise reasonable care and skill, and breached Right 4(1). The surgeon's decision to engage two other surgeons to perform the abdominoplasty and liposuction — even if under his supervision — was unsafe, unwise, and inconsistent with the Medical Council's guidelines regarding collaboration and teamwork. In these circumstances the lead surgeon breached Rights 4(1) and 4(2).

The lead surgeon was responsible for ensuring that appropriate approval and temporary registration had been obtained to legitimise the visiting surgeon's attendance and any participation in surgery on his patients. The decision to allow her to participate was a breach of Right 4(2). The blood supply to the woman's nipple was impaired. The lead surgeon failed to perform the bilateral mammoplasty with reasonable care and skill, and breached Right 4(1).

It was held that the decision to provide upper arm liposuction should have been made in consultation with a plastic surgeon. The lead surgeon performed a procedure that was inappropriate for his patient's circumstances, and did not perform it to an appropriate standard, breaching Rights 4(1) and 4(2).

Ultimately, each surgeon was responsible for ensuring that the abdominal surgery was provided with reasonable care and skill, irrespective of who performed specific aspects. Abdominoplasty was a major surgical procedure for the woman and, given her weight and medical history, it was inappropriate to combine it with any other procedure. Combining it with abdominal liposuction undoubtedly contributed to the three-month delay in her wounds healing. The lead surgeon and two other surgeons were held to have breached Rights 4(1) and 4(2).

A patient's signature on a form is not in itself proof that all necessary information has been provided in a way that enables the patient to understand it. The nature of the proposed surgery (though not all the technical details) must be explained.

The lead surgeon failed to convey a balanced assessment of the risks and benefits of simultaneous surgery, together with a frank explanation of the qualifications, responsibilities, and status of the surgeons who were to be involved. In these circumstances, he breached Rights 6(1)(a), 6(1)(b), and 6(1)(d).

The lead surgeon should have explained to the woman the results of her surgery and the nature of her complications, and advised her of the plan for her postoperative management, including the shared care arrangement. His failure to provide this information in the postoperative period was held to be a breach of Rights 4(2), 6(1)(a), and 6(1)(e).

In relation to record-keeping, both the lead surgeon and the other breast/general surgeon failed to meet the standards expected of experienced surgeons participating in a major surgical procedure in a private hospital. Accordingly, they breached Right 4(2).

The lead surgeon and the other breast/general surgeon were referred to the Director of Proceedings, who issued proceedings against the lead surgeon. The Health Practitioners Disciplinary Tribunal found that the lead surgeon failed to gain informed consent from the woman; failed to maintain adequate records; and failed to provide adequate postoperative information. The surgeon appealed the Tribunal's finding of professional misconduct. The appeal against the Tribunal's substantive decision was allowed, but only to a limited extent — one finding in relation to a sub-sub-particular of the charge being set aside. Otherwise, the Tribunal's substantive findings stand. The High Court substituted a fine of $5,000 for the $7,500 fine imposed by the Tribunal. Other penalties imposed by the Tribunal, including a recommendation of a competence review, were not disturbed on appeal. The Director was entitled to costs on the appeal, it having been largely unsuccessful.

The Director did not issue proceedings in relation to the other surgeon.

Link to Health Practitioners Disciplinary Tribunal decision:
http://www.hpdt.org.nz/portals/0/med0637ddecdp070anon.pdf