Plastic Surgeon, Dr B

A Report by the

Health and Disability Commissioner

(Case 10HDC00509)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. In 2008, Mrs A consulted her GP, Dr C, regarding her prematurely aged facial appearance.

2. Dr C advised Mrs A to contact a plastic surgery clinic (the Clinic) about facial rejuvenation surgery. Mrs A contacted the Clinic and was given an appointment to meet plastic surgeon, Dr B, to discuss her concerns. Mrs A was sent information on the Clinic and the procedures available.

3. On 3 July 2008, Mr and Mrs A travelled from her home in a rural location, to the Clinic, situated in a main centre, to discuss Mrs A's options for facial rejuvenation surgery with Dr B in a 45-minute consultation. Dr B took Mrs A's medical history and examined her. He advised her that she was a candidate for limited incision facelifting procedures such as the MACS-type (minimal access cranial suspensionplasty). The potential risks of surgery were discussed.

4. Dr B made no clinical record of the consultation, but wrote to Mrs A on the same day summarising the consultation and their discussions. The letter expressed Dr B's belief that the MACS procedure would achieve Mrs A's goals. The letter quoted that the cost of the procedure would be $31,000 including GST, which included all costs associated with routine care except prescription charges and laboratory blood tests that may be necessary.

5. Enclosed with the letter was an information pamphlet titled "What happens next …" This information was sent to Mrs A by the Clinic's office co-ordinator, Ms D. Mr A emailed Ms D the next day confirming that Mrs A wished to proceed with the surgery once she had received answers to various questions.

6. Mr and Mrs A followed up with several other emails asking for further information, which were mainly replied to by Ms D. Mrs A signed a written consent form for surgery on 26 August 2008.

7. On 9 September 2008, Dr B performed an endoscopic brow lift, limited incision facelift, necklift, pinch lower blepharoplasty and upper eyelid blepharoplasty at a private hospital.

8. Dr B wrote to Dr C on 11 September to provide details of the surgery and postoperative management. He telephoned Mrs A three times in the immediate postoperative period to check on her progress. Dr C removed Mrs A's sutures and staples.

9. Initially, Mrs A was satisfied with her recovery and the outcome of the surgery. However, by 5 January 2009 Mrs A became concerned by sagging of the surface skin that lay on her cheek bones and contacted the Clinic for reassurance. Ms D advised that the final result would not be evident for at least 9–12 months.

10. Mrs A saw Dr B on 2 September 2009, for her postoperative review and said she was concerned by the outcome. She stated that the consultation, which was conducted in a treatment room, made her feel inadequate, humiliated and insignificant.

11. Mrs A was also concerned that Dr B was not clear about the cause of the failure to achieve the anticipated results.

12. Subsequently, Dr B advised Mrs A that, to achieve the results she wanted, she would require further surgery under general anaesthesia at the cost of $19,000.

13. Mrs A had further surgery carried out by a different plastic surgeon.

Decision

14. Dr B did not, either at the consultation or in subsequent emails, give Mrs A an adequate explanation of the options available regarding facial rejuvenation surgery, including an assessment of the expected risks, side effects, benefits and costs of each option. The accumulation of defects in the informed consent process pointed to a pattern of sub-optimal provision of information. As a result, Dr B breached Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights (the Code).[1] As Mrs A did not receive sufficient information, she was not in a position to make an informed choice and give informed consent. Therefore, Dr B also breached Right 7(1) of the Code.[2]

Complaint and investigation

15. On 4 May 2010, the Commissioner received a complaint from Mrs A about the services provided by Dr B. The following issues were identified for investigation:

- *Whether Dr B provided Mrs A with adequate information in 2008 about her options regarding facial rejuvenation surgery to enable her to be fully informed, make an informed choice, and give informed consent.*
- *Whether Dr B provided Mrs A with an appropriate standard of facial rejuvenation surgery in September 2008, including her postoperative care.*

16. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Consumer's husband
Dr B	Provider

Also mentioned in this report:

Dr C	Mrs A's GP
Ms D	Clinic's office co-ordinator

17. Independent expert advice was obtained from plastic surgeon Dr David Glasson (**Appendix A**).

[1] Right 6(1) of the Code states "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."

[2] Right 7(1) of the Code provides "services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of the Code provides otherwise."

Information gathered during investigation

18. Mrs A, then aged 49, became concerned in 2008 about the premature aging of her face. Mrs A sought the advice of her GP, Dr C, who referred her to the Clinic.

19. Mrs A contacted the Clinic and was given a consultation appointment and sent information on the procedures available. The information in the pre-consultation information pack contained a copy of a women's magazine article about one of Dr B's patients who had had a volumetric facelift, a promotional brochure about the Clinic, and the Clinic's general information and practice policies and a document entitled Policies Form. This states:

> "It is **your responsibility** to ensure you have had all of your questions and concerns answered prior to having a procedure performed. It is [*the Clinic's*] duty to openly and fully discuss the relevant surgical issues with you before consenting to perform the procedure you are requesting."[3]

20. On the second page of the form there is a heading "Unfavourable Outcomes" in which it states: "Every effort is made to ensure the best surgical outcome for every patient, but from time to time complications and poor outcomes do occur." The form states that if the unfavourable outcome was due to a recognised risk of the procedure, the patient would be responsible for the associated costs, whereas if the unfavourable outcome was due to a technical error by the surgeon, then the Clinic would not charge a fee for its correction but the patient may still face additional costs from the operating facility, such as consumables used and the anaesthetist's fee.

Consultation

21. On 3 July 2008, Mr and Mrs A travelled to the Clinic to consult Dr B. According to Mrs A, Dr B demonstrated what the proposed surgery would do by lifting areas of her face with his fingers. She said that when he did this the volume, contours and definition of her face became more youthful, smooth and more defined. Dr B recommended that she have the skin lifted and tightened in her neck and showed her the effect that could be achieved with surgery.

22. Mrs A said that Dr B made it clear that the lines around her mouth, which were of particular concern to her, would not disappear with the surgery. She could expect them to soften as a result of the lift of her middle face which would also lift the skin at the sides of her mouth, resulting in the lines becoming less noticeable.

23. Mrs A said that Dr B suggested that following surgery she might consider, as a second stage, having laser work done, but he thought that she might no longer feel the need once she saw the softening effect that the facial surgery would have. She recalls that he was very enthusiastic about her having a brow lift and eyelid work as this would open the area around her eyes and "bring life" to them.

[3] The emphasis is in the original document.

24. Mrs A told HDC that she expressed concern that she had thin skin and wondered how that might affect surgery and subsequent healing. She says Dr B assured her that although she had excess skin, it was of good depth and would respond very well to surgery. He was confident that she was a good surgery candidate. Mrs A said "Dr B was very confident that was he was showing us was realistic and achievable, at **no time** did he say that what he was showing us to expect might not happen".

25. Mrs A recalls that Dr B said that she would be left with no noticeable scarring, and that she would be happy with the result. He told her the incision would be behind her ears but did not otherwise explain how the surgery would be done. Mrs A said that Dr B told her to research the surgery herself, so she bought a book[4] from him. She said that although the book gave a general outline of the MACS surgery, she later discovered that the procedure Dr B performed differed from what was described in the book.

26. Mrs A stated that at the preoperative consultation, she and her husband discussed non-surgical options with Dr B, but he said he believed this would not give her the "refreshed youthful results" she was seeking. Mrs A said Dr B discussed blepharoplasty[5] as a stand-alone option, however, he explained that this would not work due to the position of her brow and because she wanted an "open eye look". Mrs A also recalls that they discussed laser and other non-surgical options, but Dr B was of the opinion that, in her case, these procedures were a Stage 2 or follow-on option. Mrs A stated that Dr B was very confident that what he was showing her and her husband was "realistic and achievable" and "at no time" did he say that what he was telling them to expect might not happen.

27. Mrs A said that Dr B advised her of the following complications:

Unfavourable scarring and wound healing
Bleeding and infections
Visual changes
Nerve sensation changes

28. Dr B advised HDC that this was a 45-minute consultation. He says he that took Mrs A's medical history and examined her face. He noted that she had sun-damaged skin, rhytids (wrinkles) and descent of the facial soft tissues, early static horizontal forehead wrinkles, frown lines and crows feet, and a moderate degree of excess neck, and upper and lower eyelid skin.

29. Dr B said he discussed potential complications of the surgery, including unfavourable scarring, wound healing, asymmetry, bleeding, infection, visual changes and nerve damage.

[4] "Your Complete Guide to Cosmetic Plastic Surgery", produced by the New Zealand Foundation for Cosmetic Plastic Surgery.
[5] Surgical modification of the eyelid.

30. Dr B recalls that he told Mrs A that facial rejuvenation surgery was not the complete answer and second-stage procedures were likely to be required to enhance and maintain the result achieved. He says that he warned Mrs A that she may need skin tightening by laser techniques following her procedure.

31. Dr B advised HDC that he discussed short scar facelifting, SMAS[6] lifting and volumetric lifting with Mrs A at the preoperative consultation. He said he explained to her that each of these techniques allows progressively greater control and refinement of the result by the surgeon, and as such, better results.

32. Dr B advised HDC that he tells his patients that if the changes they are seeking can be achieved by lifting the skin in front of each ear using two fingertips, then they are a candidate for limited incision facelifting procedures such as the MACS-type (minimal access cranial suspensionplasty). Dr B said that in assessing Mrs A's suitability for MACS, he elevated her tissues to demonstrate what the procedure can achieve, and she said she felt this was adequate. Dr B stated that he assessed Mrs A's skin laxity, because it is not possible to perform facial rejuvenation without doing so.

33. Dr B noted that as Mrs A was, "keen to avoid the full length/extended incisions associated with some techniques", he placed greater emphasis on treatment of her periorbital region and neck. Dr B said that he made it clear that the MACS lift cannot deliver everything that a full length SMAS or a volumetric facelift delivers. However, he did not record this advice in his reporting letter to Mrs A.

34. Dr B provided a quote for the surgery of $31,000, which would only apply for one month, after which time the quote was subject to increase. The fee was required to be secured by a non-refundable $500 deposit. All costs were required to be paid two weeks prior to surgery and a penalty would be incurred if the patient decided not to proceed. The cost was not itemised into its components. Mrs A said "The fee and the time in which we had to make a decision was a huge shock".

35. Dr B stated that he encourages second, and further, consultations. This is usually not an issue with patients who live locally. However, the situation is more complex when patients, as in Mrs A's case, live five hours away and will incur substantial expense and inconvenience attending further consultations. However, Dr B did not recommend a further consultation in his reporting letter to Mrs A.

36. Dr B stated: "Neither [Mrs A], nor I, have a contemporaneously recorded detailed description of what exactly was said with regard to outcome expectations. I have no reason to suspect that I varied from my normal facial aging consultation approach and this assertion is verified by my letter clearly indicating the issue was addressed in terms of selecting the most appropriate face lifting technique for her".

[6] Superficial Musculo Aponeurotic System (a gliding connective tissue membrane under the cheek and interior neck).

Records

37. Dr B made no record of the consultation. He advised that his practice is not to record medical notes of consultations. The letters he sends to the patient and GP are his record of the assessment and discussions regarding the treatment options.

38. Dr B wrote to Mrs A the same day summarising the consultation and detailing what was discussed about facial rejuvenation. He acknowledged her wish to "achieve a refreshed appearance with more open eyes and fewer lines around the mouth". He noted that during the consultation they had discussed her desire to improve the contour and appearance of her neck and lower face and various facelifting options including skin-only, mini-lifts, SMAS and volumetric lifts. He stated in the letter that he had neglected to mention during the consultation the relationship between smoking, increasing BMI, diabetes, age and complications, and that these four risks are the large determinants for the likelihood of significant complication. He noted that Mrs A did not have any of those factors.

39. In the letter Dr B stated:

> "I believe this surgery will achieve your goals. Once fully healed and recovered some patients opt to have further enhancements made ('stage 2') such as fat grafting, skin resurfacing, etc; most however, feel it unnecessary. I believe you are a good candidate for the facial rejuvenation surgery discussed."

Ongoing communication

40. Dr B provided HDC with an electronic print-out showing all communication (by email and telephone) between Mr and Mrs A, the Clinic office co-ordinator Ms D and him.

41. On 3 July 2008, Ms D sent Mrs A an email attaching a copy of Dr B's letter recording the consultation and an information pamphlet entitled "What happens next …" Ms D suggested two dates for the surgery for Mrs A to consider — 9 September or 15 September.

42. On 4 July 2008, Mr A emailed Ms D to confirm that Mrs A would proceed with the surgery once she had received answers to various questions, but requested an earlier date, between 24 August and 31 August 2008, for the surgery. Mr A also asked if the area between Mrs A's eyebrows would be incorporated in the brow lift, and if it was "possible to have pictures of what the end result of the component or overall surgeries would look like".

43. Mrs A also emailed Ms D on 4 July, stating that she had concerns about the positioning of her head and neck for surgery as "it has only just occurred to me whilst reflecting on what the procedures may involve and recollection of the mention that an incision will be made under my chin to allow access to stitch the bands". She said she had some difficulty in tilting her head backwards and asked for clarification on that matter.

44. In response to these two emails, Ms D replied that the Clinic had no ability to generate a simulated after-picture, but referred Mrs A to the New Zealand Cosmetic Surgery

website, as a "fair representation of what can be expected". The only available date for surgery was 18 August. She also said that she had spoken to Dr B who advised her that the relevant platysma neck band "should be easily reached with minimal to no extension" and that her central forehead area would be included in the endoscopic brow lift.

45. On 7 July, Mrs A emailed Ms D stating, "I have viewed the website and read the book that I purchased from your practice". Mrs A stated that her mouth droop and the lines around her mouth were the aspects of the aging process that prompted her to consider plastic surgery. She asked Ms D for clarification of the information on page 44 of the book that a facelift can be expected to last five to ten years, and the information about laser resurfacing on page 100. She wanted to know whether laser resurfacing would be an option for her.

46. On 18 July, Ms D emailed Mrs A, "Please find following [Dr B's] response to your questions; … Most plastic surgeons use the five to ten year expression to mean that at this point further surgical rejuvenation of a patient may be worthwhile if the patient desires it". In the email, Ms D said Dr B could not give an estimated price for laser resurfacing as he does not perform that procedure and that he had stated, "I believe I alluded to the potential for resurfacing as part of the second stage in your case. I believe that the degree of rhytids (wrinkles) and age related change that you exhibit is beyond what can be successfully and easily treated with laser alone".

47. On 25 July, Mrs A emailed the Clinic accepting the date of 9 September 2008 for the surgery.

48. On 4 August, Mrs A emailed Ms D with further questions – the identity of the "specialist anaesthetist" that would be assisting Dr B and when her preoperative blood tests should be done. Mrs A advised Ms D that she and her husband would be in the city from 8 to 12 September and asked if Dr B could do her follow-up appointment (scheduled for 19 September) on 12 September before they left. Ms D answered Mrs A's questions about the anaesthetist and the blood tests and advised her that the 19 September appointment was for suture removal and this could be done by her own GP.

49. On 26 August, Mrs A emailed the Clinic advising that she had talked to her GP about possible complications of the proposed surgeries, one of which was facial nerve palsy. She asked that Dr B provide her with information about this complication. She also provided details of the arrangement she had made to pay the balance of Dr B's fee. Mr A advised they were posting back the "Policies form".

50. Dr B emailed Mrs A stating that it would be unusual to damage the main nerve, and that, "The style of lift you are having has a lower rate of nerve damage as the nerves are not dissected out, I do not have a published rate for this style of lift. Personally, I have had a few cases of transiently bruised nerves they have returned to full function during the recovery phase".

Consent

51. On 26 August 2008, Mrs A signed a Request for Surgery form for "Limited incision face lift, open central neck lift, endoscopic brow lift and four eyelid blepharoplasty under general anaesthetic", and forwarded the consent form to the Clinic. Dr B countersigned the form on 9 September 2008.

52. The form stated "I agree that this procedure is being performed for cosmetic reasons and no guarantee can be made as to the exact result of this procedure … All of the information I have given to [Dr B] is true, accurate and complete. I am undergoing treatment of my own will and thereby absolve [Dr B] and any other associated persons of any blame resulting from complications or unexpected results". In contrast, the policy form provided before the consultation stated that if there was an unfavourable outcome due to a technical error by the surgeon, then [the Clinic] would not charge a fee for its correction, but the patient may still face additional costs from the operating facility, such as consumables used and the anaesthetist's fee.

Surgery

53. Mr and Mrs A travelled to the city the day before the surgery. Dr B advised HDC that he did not arrange a preoperative consultation for that day because he intended to see Mrs A at the hospital directly before the surgery.

54. On 9 September 2008 Dr B performed the surgery on Mrs A at a private hospital.

Postoperative care

55. In the first 24 hours post-surgery Mrs A experienced significant upper abdominal/chest pain. The hospital records show that Mrs A reported to nursing staff that she felt she could not breathe and that her throat was swollen and sore. At 6am on 10 September Dr B was advised about Mrs A's condition by one of the surgical ward nurses, who told him that Mrs A described the discomfort as similar to her standard GORD (gastro-oesophageal reflux disease), but more intense. The nurse advised Dr B that Mrs A's cardiovascular readings were normal but she had pins and needles in the fingers of her right hand. Mrs A had declined pain relief and an ECG. Dr B advised the nurse that if Mrs A continued to report shortness of breath, the under-chin suture might need to be removed. He said he would call in to see Mrs A later in the morning.

56. When Dr B visited he found Mrs A sitting up in bed reporting upper abdominal pain which she described as intense and 10 out of 10. Dr B's impression was that she was not physically distressed, but he arranged for her to have additional pain relief and recommended that she have an ECG. Dr B reviewed the ECG print-out with the anaesthetist and decided it was normal.

57. Dr B arranged for a gastroenterologist to provide an opinion on her condition. The gastroenterologist considered that the high doses of Metamucil that Mrs A had been taking preoperatively, as preparation for the surgery, may have contributed to her symptoms. Dr B was later advised by the ward nursing staff that, after Mrs A had a shower and sedation, she slept comfortably.

58. Dr B reviewed Mrs A again at 4.30pm and told her that the ECG and chest and abdominal X-rays were all normal.

59. Mrs A was discharged on 11 September and returned home.

Follow-up care

60. On 11 September 2008, Dr B wrote to Mrs A's GP, Dr C, providing her with a copy of his operation note and asking her to remove the sutures and staples from Mrs A's eyelids and chin on 15/16 September and staples from her scalp on 22/23 September. He also telephoned Mrs A at home to enquire how she was after her flight home. Mrs A stated that she had been "amazed" that Dr B had made the effort to contact her to enquire how the flight home had gone.

61. On 12 September, Dr B telephoned Mrs A who assured him that she was having no problems. He advised her to "stay with the follow-up plans".

62. On 15 September, Mrs A emailed the Clinic stating that she was "fascinated observing the changes", and asked Ms D to thank Dr B.

63. On 19 September, Dr B again telephoned, and spoke to Mr A. Dr B recorded that there were "no problems reported".

64. On 23 September, Mrs A emailed photos of herself to the Clinic to show Dr B how the healing was progressing, noting that her right eyebrow was slightly drooped and there was more hooding of that eyelid when compared to the left. She said: "[I]s this aspect likely to become more even as time progresses. This is something I would have asked if I had been attending for my post op visits. Don't want to sound anxious — just asking the question as I don't actually know what to expect".

65. Dr B responded to the email by telephoning Mrs A. He made a computer note of the call as "No answer. Discrete [sic] message left. To call back if she needs to discuss anything". Mrs A emailed the Clinic later that day to acknowledge Dr B's message and advise that she was "absolutely fine" with the information Dr B provided and "with no further concerns am happy to let time do its work".

66. On 31 October, Mrs A emailed Dr B to give an update on the progress of her recovery. She advised that her face was still softening and the lumps in her cheeks were gradually reducing. The excess skin behind her ears was also smoothing out, and the incisions had healed with minimal scarring. She said, "My right eye still remains less open than the left (which looks great) however, I suspect that they as the rest of my face are still settling. I no longer feel concerned as to how old I look as I know I look fresh and well. Thank you". Ms D acknowledged receipt of the email.

67. On 5 January 2009, Mrs A emailed the Clinic stating:

> "Over the months since having the facelift surgery my face has undergone several changes during the healing process. To me it appears that my forehead continued to undergo subtle smoothing and tightening following the softening of the tissue and I was wondering if this process is also to be expected to occur with the area from below my eyelids to my jaw line. … My cheek muscles are firm and the shape of my lower face is good, however as the softening has progressed the skin below my eyes has become soft and puffy and the surface skin layer on my cheek

> bones has sagged resulting in the nasolabial folds and folds at the corners of my mouth being more defined than they have been. Could you please advise me as to whether this sagging is likely to remain or will this layer tighten with time."

68. Ms D responded to the email of 5 January, stating that Dr B advised that the final result would not be evident for at least nine to twelve months which was the reason the follow-up appointment was delayed for twelve months. She gave Mrs A a date for her final follow-up appointment with Dr B.

69. On 21 January and 9 February, Mr A emailed the Clinic asking Ms D if she had passed Mrs A's comments onto Dr B. On 12 February Ms D forwarded a further email from Mr A onto Dr B noting that she had "finally got hold of [Mrs A] and explained that I had replied to their emails and left messages on her mobile". Ms D noted that she had passed on Dr B's recommendations and that Mrs A was happy to receive confirmation that after four months this is the final result. Mrs A had asked Ms D if she should proceed with laser, or wait until she had been seen Dr B for her long-term follow-up.

70. On 16 February, Ms D noted that she had left a message for Mrs A that Dr B was happy for her to proceed with laser at that time. There is no further record of any email or telephone communication between Mr and Mrs A and the Clinic until 20 July 2009, when Mrs A telephoned to reschedule the time for her one-year follow-up appointment for 2 September to fit in with flight times.

Postoperative review

71. Mrs A advised HDC that, by the time she saw Dr B on 2 September 2009 for her postoperative review, she considered the surgery had resulted in minimal improvement in the appearance of her face, apart from her upper eyelids. She felt that other areas were worse than before the surgery.

72. Mrs A said that she had told Ms D in advance of the 2 September appointment that she was not happy with the results of the surgery.

73. Dr B stated that when he saw Mrs A on 2 September, although there was a clear aesthetic improvement overall, he was disappointed that her outcome was not as good as he had anticipated. He said that he openly discussed this with Mrs A. The main area of concern was the mid and lower facial tissues which he felt needed further elevation. Dr B advised Mrs A that the only solution was further surgery and that this repeat surgery was an unusual situation in his practice. He thought it might be possible to do it with only a local anaesthetic. He recalls that he told Mrs A that he needed time to think the issues through.

74. Mrs A said that the post-surgery consultation with Dr B was drastically different from the consultation prior to the surgery in July 2008. Mrs A stated that the post-surgery interview was conducted in a clinical environment in Dr B's treatment room. Mrs A stated:

> "[Dr B] took neither the time nor provided an environment conducive to discuss my disappointing results. … Nor did he ask any questions, or give any

explanation as to why the surgery had failed to give the anticipated and pleasing results that he said would be achieved."

75. Mrs A stated that the greatest concern to her when she told Dr B she was not happy with the result, was that she found him "intimidating". He was vague about the causes of the poor outcome and told her it was not a "biggie", that he would "sort it out" and would "see her right".

76. Dr B believes that Mrs A's one-year follow-up consultation was "not inappropriate in content or location", but he concedes that "with the benefit of hindsight" it could have been conducted more effectively. He said that his intention of holding the consultation in the treatment room, which is spacious and does not have a desk but a group of chairs, is to encourage greater rapport.

77. Mrs A stated that she left the consultation believing that the "work to give me the results that I should have had was not a major". Dr B told her that he might be able to perform the additional surgery under local anaesthetic, although he needed to consider whether it might be easier with a general anaesthetic. Mrs A said, "I also made him aware that we were financially challenged at the time and he said he understood". Mrs A said she was shocked when Dr B quoted $19,000 for the additional surgery. However, she was relieved that Dr B agreed that the results were not as expected and talked about what needed to be done to improve them.

78. Mrs A said that Dr B told her that he did not know why the first surgery had failed. She felt that he made no effort to investigate the reasons, prior to suggesting the repeat surgery. She said that she was expected to make a decision about the additional surgery with no understanding or knowledge of the outcome that she could expect. She had no idea from the consultation that she would need a four-hour surgery.

Follow-up action

79. Dr B advised HDC that, after further consideration of Mrs A's situation, he decided he could not satisfactorily perform the required additional surgery under local anaesthetic and so wrote to her on 2 September 2009 quoting a sum of $19,000 for doing it under general anaesthetic. He said that the eventual quote was "far more than either of us had foreseen during the consultation, but still represented a substantially discounted price in recognition of her being an existing patient with an underwhelming result".

80. On 7 September, Dr B wrote to Dr C to advise her of the consultation. He stated that Mrs A had "indicated a desire to have a further attempt at lifting/tightening around the midface" and noted that he would advise Dr C if Mrs A elected to have further treatment.

81. On 17 November 2009, Mrs A wrote to Dr B stating that she felt her appearance was worse than before the surgery and she had expected that he would rectify the problem with either very little or no cost. She requested a full refund.

82. On 11 December 2009, Dr B responded in writing advising Mrs A that he was "saddened" that she felt she could not return to see him to discuss her concerns. He

responded to her comment that he made her feel "inadequate, humiliated and insignificant" at the September 2009 consultation. He said he would never want any of his patients to leave any interaction with him feeling that way, and that he had tried to think what he might have said that would have made her feel like that. Dr B agreed with her that the result was disappointing but did not feel a refund was justified. He stated that he had discussed her case with his peers and had also raised it for discussion at the November meeting of the New Zealand Foundation for Cosmetic Plastic Surgery. Dr B stated:

> "I could never and did not make a promise that you would not be among the number of patients who for various reasons have an unfavourable outcome. I note that during the month before your surgery you had the consent form, policies form and information pack. The questions you asked after getting the information reassured me that you were giving the documents the required careful and thorough consideration that I asked you to give them …
>
> I do not agree that the result is a worsening of your appearance. I do not agree that your result failed to meet our expectations around the cheek area. As you initially advised me, the result was looking good initially and then for no apparent reason some months postoperatively deteriorated."

83. On 21 December 2009, Mrs A again wrote to Dr B reiterating her concerns about the service he provided to her.

84. On 22 January 2010, Dr B replied to Mrs A stating that the reason he used his treatment room when he saw her postoperatively, instead of his office, was that often these consultations require a degree of treatment and access to dressings and equipment. He said that, in light of her concerns, he will revisit the postoperative room's design to see if improvements can be made. Dr B said he was sorry that her result was "not all we hoped it would be" but reminded her that she had been advised that the end result could not be guaranteed.

Further surgery

85. Mrs A advised HDC that she since consulted another plastic surgeon about further surgery. She said the surgeon who performed the additional surgery spent hours with her explaining what was needed and what he could do. Mrs A stated she now fully understands what is required for informed consent. She said she did not want anyone else to go through what she has and wants Dr B to make changes to his practices.

Additional information

Mrs A

86. Mrs A advised HDC that she was concerned that Dr B saw her for a total of less than two hours. She said, "His contact with me has been minimal due to the arrangement of his practice. I do feel like a financial commodity – [Dr B] knows very little about me as a person, an aspect, which I suspect, makes it easier for him to disregard me".

87. Mrs A said that she was not fully informed throughout the process, and that "Communication and informed consent were both minimal and rushed". She believes she did not receive a good standard of care from Dr B. She said there was the matter

of the epigastric/chest pain that she suffered in the hospital, which he did not consider warranted ordering an ECG at the time he was first informed about it. Mrs A stated:

> "I have felt and continue to feel that [Dr B's] main interest in me is as a financial commodity and not as a client seeking objective, proficient professional advice, honest guidance and the safest processes and procedures possible. …
>
> The unexpected results of this surgery have had a huge impact on my confidence and well being. [Dr B] has failed to realise this and continues to respond without genuine consideration of what impact this has had on me. I cannot adequately express the distress that this experience has had on myself, or my family. It has been a devastating time. I have felt devalued, disregarded and disrespected by [Dr B]."

Dr B

88. Dr B stated:

> "I did not, and do not, believe a technical error was made, nor do I believe the proposed operative technique or my patient care was inappropriate. Detailing the anticipated breakdown of the proposed fee may have been helpful to show that I had taken into account [Mrs A's] previous outcome and had substantially reduced, but not waived, my surgical fee."

Responses to provisional opinion

Mrs A

89. Mrs A responded to the information gathered section of the provisional opinion, stating:

> "I do not support all of [Dr B's] accounts of events, however I feel that any further discussion on these matters would at this point fall into the 'he said', 'she said' category and this I wish to avoid, as I believe that it is time to move toward a conclusion. …
>
> My hope is that persons seeking and securing [Dr B's] services can have a similar positive experience as the experience that I was fortunate to have enjoyed with the second surgeon."

Dr B

90. Dr B responded to the provisional opinion, stating that while disappointed with the findings and disagreeing with a number of matters in the opinion, he respected the opinion. Dr B stated:

> "I very much want to put this matter behind me and also at the same time enable [Mrs A] to obtain closure. Accordingly, I do not propose to debate the matter further but in saying that I would not wish it to be understood that I thereby accept the provisional opinion, for that is not the case.

> At all times I was endeavouring to do my best for [Mrs A] and I remain very sorry that she is unhappy with my management of her case. I have no hesitation in apologising to [Mrs A] for this.
>
> I can also advise that I have already reviewed my practice with regard to record-keeping, both well prior to receiving your provisional opinion but also, in particular, since I received it. I have made a change to my practice in that I no longer now only record the information gleaned at the consultation with the patient in the report which I send to the patient. Rather I now have a separate record in the patient record for those observations. …
>
> As to the informed consent processes, I have undertaken a thorough review of my practice and indeed this has involved feedback from colleagues with whom I have spoken. I do not consider that there is a need for any change as such to my informed consent practice but I can assure you that I have a heightened awareness of the need to look out for circumstances where there may be room for misunderstanding between myself and the patient. …"

Opinion: Breach — Dr B

91. Mrs A was concerned about her facial appearance, in particular, the lines around her mouth and at the sides of her eyes. As noted by my expert, plastic surgeon Dr David Glasson:

> "Patients' expectations of cosmetic surgery vary, but are often high. Their high expectations may be due to a combination of optimism about, and confidence in 'modern surgery'. This belief is often supported by modern media, the medical industry, and to some extent by medical practitioners themselves with their websites and print material. … Surgeons must provide a balance where they can put the complications in perspective, but not encourage unrealistic expectations."

92. Mrs A was undergoing elective surgery at considerable personal expense. In such circumstances a reasonable patient needs to be given balanced information about the costs and merits of the available alternatives, to enable the patient to make considered decisions. In this case, I am concerned about Dr B's processes for informed consent, record keeping, and the follow-up consultation.

Consultation

93. Mrs A was sent an information pack before she attended the only preoperative consultation. Dr Glasson describes the information pack as "promotional material with no specific information about facial rejuvenation. The contents included a magazine article about a patient with a good result from facial surgery, and a newsletter. This material would generate some confidence about Dr B's practice, and promote expectations".

94. Mrs A attended the consultation intending to discuss non-surgical options, but Dr B advised that these would not achieve her objectives.

95. As stated by Dr Glasson, consent is a process, and the communication of realistic goals and limitations of surgery is crucial, particularly in the field of cosmetic surgery. In his view, two preoperative consultations would be common practice, because the second consultation allows a chance for the patient to ask questions and express concerns, having reflected on the information initially provided. In addition, the surgeon is then able to obtain a better understanding of the patient's needs and wants, and have another opportunity to examine the patient and discuss any review of the initial surgical plan.

96. Following the initial consultation with Dr B, Mr and Mrs A raised a number of concerns by way of email communications. Dr Glasson advised me "the surgeon must respond as carefully to emails as he would to questions in a face to face consultation … I think there is some risk allowing email to replace a consultation. Email lacks verbal cues and body language, which are important in communication and which are part of a real consultation".

97. In this case, as Mrs A was seeking substantial additional information, it would have been preferable for Dr B to have suggested a second consultation.

Information provided

98. Mrs A stated that Dr B assured her at the consultation that, although she had excess skin, it was a good depth and would respond very well to surgery. He was confident that she was a good surgery candidate and should the surgery proceed, she would be very pleased with the result.

99. This impression was reinforced by Dr B's letter to Mrs A of 3 July 2008, confirming the preoperative consultation. In the letter, the potential complications mentioned are unfavourable scarring, wound healing, asymmetry, bleeding, infection, visual changes and nerve damage. There is no information recorded about the possibility of the surgery being unsuccessful in the absence of these complications. On the contrary, the letter stated:

> "I believe this surgery will achieve your goals. Once fully healed and recovered some patients opt to have further enhancements made ('stage 2') such as fat grafting, skin resurfacing, etc; most however, feel it unnecessary. I believe you are a good candidate for the facial rejuvenation surgery discussed."

100. The reporting letter Dr B sent to Mrs A did not suggest to her that a further consultation was recommended. There was a further opportunity for a consultation when Mrs A returned to the city prior to the surgery, but Dr B considered this was not necessary, as he would see her on the day of the surgery.

101. Mrs A was provided with written material and purchased the book "Your Complete Guide to Cosmetic Plastic Surgery". The book has a section on face lifts, but Dr Glasson advised that it does not fulfil all of the requirements for adequate information prior to the giving of consent to a procedure. Dr Glasson said, "While the book

provides excellent background information, I consider it too 'soft' to qualify as a basis for informed consent ... this book can aid in the communication that eventually leads to the patient making an informed decision".

102. Dr B did not supply any written information specific to the MACS lift. Dr Glasson suggested a number of other handouts that would have been more appropriate for a person considering this surgery.

103. Dr B did not describe the surgical process and told Mrs A to research it herself. I accept that background reading may be useful to enable patients to obtain information so they are better placed to ask questions, however, patients should be directed to relevant, accurate information.

104. Dr B advised HDC that he considers the choice of an MACS lift, which contributed to the poor result, was made because Mrs A did not want a more extensive approach. He said he warned her that she may need subsequent skin tightening with laser and "made it very clear that a MACS lift cannot deliver everything that a full length SMAS … delivers". This information was not documented in Dr B's reporting letter to Mrs A.

105. Dr B stated that Mrs A wished to avoid the full length incisions of some face lifts. However, there is no documentation of Mrs A's wish to avoid full length incisions. In [Dr B's] reporting letter after the first consultation, he states simply that four facelift options were discussed. He does not document the goals and limitations of these options. For example, there is no record that he advised Mrs A that the MACS technique might limit the treatment of the skin laxity. Dr Glasson said, "When I examine the notes in retrospect, as the result of [Mrs A's] complaint, the decision making by Dr B resulting in a short scar face lift is not apparent".

106. As advised by Dr Glasson:

> "It is the job of the surgeon to advise the patient what technique he believes is best, accepting that surgery is not an engineering exercise, and there are many variables. If the patient wants a short scar technique then the limitations must be explained. If the surgeon believes an alternative method is more appropriate, then he must explain why, and explain the 'risk/benefit balance'."

107. If Dr B thought that, in Mrs A's case, the MACS operation could not deliver everything that a full length SMAS or volumetric facelift delivers, then that advice should have been given and carefully recorded.

108. Dr B provided mixed messages to Mrs A about the consequences of an unfavourable outcome. The policy document, sent before the consultation, acknowledged that if an unfavourable outcome was due to a technical error by the surgeon, then the Clinic would not charge a fee for its correction. However, the consent form stated that no guarantee could be made as to the exact result of the procedure and that, by signing the form, Mrs A "absolve[d] [Dr B] and any other associated persons of any blame resulting from complications or unexpected results".

109. In response to the provisional opinion, Dr B advised that, since these events, he has reviewed his practice in relation to informed consent, which involved asking for feedback on his practice by colleagues. Dr B does not consider that he needs to make any changes to his informed consent processes, but "will look out" for misunderstanding between him and his patients in future.

Quotation

110. The quote of $31,000 was valid for one month only and was required to be secured by a non-refundable $500 deposit. All costs were to be paid two weeks prior to surgery and a penalty would be incurred if the patient decided not to proceed. The cost was not itemised into its components.

111. I agree with Dr Glasson that the financial information provided to patients should be transparent.

Recordkeeping

112. Following the consultation and receipt of the reporting letter, Mrs A was left with an overly optimistic prognosis, with minimal expectation that the surgery might be unsuccessful.

113. Dr B said that he provided full information about the possibility of the surgery failing to achieve the expected result. He stated, "I have no reason to suspect that I varied from my facial aging consultation approach", however, he does not have a contemporaneously recorded description of what he actually said with regard to outcome and expectations.

114. Dr Glasson advised that using the consultation reporting letter as the medical record limits the detailed recording of the initial consultation. For example, it may have limited Dr B's recording of reservations about Mrs A's understanding and expectations, and his analysis of the problems and the development of a treatment plan.

115. This Office has frequently emphasised the importance of record keeping. Baragwanath J pointed out in his decision in *Patient A v Nelson Marlborough District Health Board,*[7] that it was desirable that the law should in future impose on the doctor an obligation to establish and maintain a written and signed record.

116. It is through the medical record that health care providers have the power to produce definitive proof of a particular matter. This Office has stated[8] "in my view this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted".

[7] *Patient A v Nelson Marlborough District Health Board* (HC) BLE CIV–2003–406-14, 15 March 2001.
[8] Opinion 08HDC10236, 28 November 2008, at page 11.

117. I accept that the policy form sent to Mrs A did refer to the possibility of unfavourable outcomes. It stated: "We cannot guarantee the end result. From time to time complications and poor outcomes occur. These unfortunate events are regrettable and stressful for everyone concerned, particularly because they frequently require additional time and financial input from the patient." However, in my view, an adequate record would have included details of alternative techniques discussed, and why they were dismissed. Adequate documentation would have demonstrated Dr B's reasoning for selecting the surgical technique he did. In the absence of an adequate record, I am not satisfied that this information was provided to Mrs A.

118. In response to the provisional opinion Dr B stated that he had reviewed his record-keeping practice and he now keeps a separate record of consultations in the patient's file, in addition to providing his patients with a letter confirming a consultation.

Conclusion

119. This Office has previously stated:[9] "[S]urgery does not come with a money back guarantee. However, patients do need to be informed of significant risks that may arise in the course of treatment."

120. The consent form signed by Mrs A stated "no guarantee can be made as to the exact result of this procedure". However, a reasonable consumer in Mrs A's circumstances requires information about the possibility that the particular surgery might not be successful and the possibilities for further treatment and the costs involved, should it not be successful. This Office has stated,[10] "Information about the possibility of failure of [a procedure] was information that a reasonable consumer in these circumstances would expect to receive, in light of the medical and financial implications should this occur". In addition, Mrs A should have been informed of the risks, benefits, costs and likely outcomes of each of the alternative options available.

121. The written information Dr B provided to Mrs A in 2008 was inadequate, as it was not specific to the MACS procedure. In addition, Mrs A was not given an intemised quote for the costs of the procedure.

122. I accept Dr Glasson's advice that "the whole interaction could have been better managed and recorded. There was not just one misstep leading to a problem, but a series of inadequate or incomplete strategies". Mrs A was not adequately informed, either at the consultation or in subsequent emails, of the reasons for selecting the MACS procedure, that the choice of surgical procedure might decrease the likelihood of the desired result being achieved, and that one of the other procedures (SMAS) might have been more effective.

123. The accumulation of defects in the informed consent process points to a pattern of sub-optimal provision of information. As a result, Dr B breached Right 6(1)(b) of the Code. As Mrs A did not receive sufficient information, she was not in a position to make an informed choice and give informed consent. Accordingly, I find Dr B breached Right 7(1) of the Code.

[9] Opinion 09HDC00795, 15 September 2009.
[10] Opinion 09HDC00795, 15 September 2009.

Follow-up consultation

124. Mrs A's follow-up consultation did not take place until 12 months following her surgery. In Dr Glasson's view, one year after surgery is a long time to wait to assess the result as, in his opinion, a stable state will have been reached by three months post-surgery. Although follow-up is more difficult for patients who live a distance away from the surgeon's city, the possibility of earlier follow-up was not offered to Mrs A.

125. Dr B advised HDC that the New Zealand Foundation for Cosmetic Plastic Surgery's (NZFCPS) "Good Practice Guide" lists the longer-term follow-up as occurring between six and 12 months for most procedures.

126. The record of the follow-up consultation on 2 September 2009 is minimal. Dr Glasson notes "the consultation at one year, on 2/9/09, was surprisingly briefly recorded. This must have been a difficult consultation, and Dr B must have known Mrs A was unhappy. I would expect a surgeon in this situation to make a full record of the consultation, and even include some verbatim quotes".

127. The Medical Council of New Zealand's statement "The Maintenance and Retention of Patient Records"[11] requires doctors to keep clear and accurate patient records that report:

- Relevant clinical findings
- Decisions made
- Information given to patients
- Any drugs or other treatment prescribed.

128. Mrs A was concerned that the consultation took place in a treatment room rather than in Dr B's consultation rooms. Dr B advised that he uses his treatment room when he sees patients postoperatively because often these consultations require a degree of treatment and access to dressings and equipment. Dr B has said he will review the postoperative room's design to see if improvements can be made.

129. Dr Glasson observed that at a consultation occurring 12 months after surgery, it would be unlikely that dressings and equipment would be required.

130. Mrs A stated that she had advised Ms D prior to this consultation that she was unhappy with the outcome. Mrs A recalls that when she met with Dr B, his attitude was vastly different from that of the first consultation and, although he acknowledged that there was a problem with the surgery, he could not explain why the problem had occurred. Dr B denied any technical error, but proposed further surgery. While he indicated to Mrs A that he might be able to perform the additional surgery under local anaesthetic, he wished to take time to consider the matter.

131. Following the consultation, Dr B wrote to Mrs A stating that the surgery would need to be under general anaesthetic and would cost $19,000, including the surgeon, hospital and anaesthetist. When Mrs A asked for a breakdown of costs, she was

[11] October 2005.

advised, "[Dr B] does not give out a break down of costs". As concluded by my expert Dr Glasson, "a patient is entitled to know to whom their money is being paid … transparency at this time may have helped defuse a deteriorating situation".

132. On 17 November 2009, Mrs A sent Dr B a letter stating that she felt her appearance was worse than before the surgery and she had expected that Dr B would rectify the problems with very little cost. She requested a full refund. On 11 January 2009, Dr B responded that he agreed the result was disappointing, but did not feel that a refund was justified.

Conclusion

133. In my view, although Dr B acknowledged that the result of the surgery was disappointing, the consultation and subsequent communications were not ideal. It was unsatisfactory to fail to provide an explanation of why the surgery was unsuccessful, not keep a detailed record of the consultation and refuse to provide a breakdown of costs.

Additional comment

Management of postoperative chest discomfort

134. Mrs A is concerned that Dr B did not act in a timely manner to the epigastric/chest discomfort she experienced in the immediate hours following the surgery, and that an ECG should have been done earlier in case her pain was cardiac. My expert Dr Glasson considered that this episode was assessed and managed well, and there is no indication that this had a bearing on her unsatisfactory surgical outcome. Mrs A was discharged on 11 September with no further problems.

Recommendations

135. I recommend that Dr B:

- apologise to Mrs A for his breaches of the Code. The apology is to be sent to HDC by **16 March 2012** for forwarding to Mrs A.

Follow-up actions

- A copy of the final report will be sent to the Medical Council of New Zealand.
- A copy of the final report with the details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal Australasian College of Surgeons, who will be notified of Dr B's name.

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

Independent advice — Plastic surgeon, Dr David Glasson

"I am a Plastic Surgeon in Wellington, registered as a specialist in Plastic Surgery in 1988. I am in full time private practice where I provide a wide range of reconstructive and cosmetic procedures. I am familiar with facial rejuvenation, including laser resurfacing.

I am mentioned in [Dr B] records as a Plastic Surgeon [Mrs A] might consult regarding laser surgery. I do not believe this compromises my provision of this report.

[…] My relationship with [Dr B] is professional and not personal. I believe I have provided an impartial and fair assessment of this case.

I have been asked to give preliminary advice on a complaint received from [Mrs A], This is a difficult case to review as there is a great quantity of information to read and assess.

[At this point Dr Glasson states the factual background and the questions asked. This has been omitted for the purposes of brevity.]

Photos supplied from HDC
From [Dr B]:

1. 2/7/08, before surgery.
2. 1/9/09, 1 year after surgery.

From [Mrs A]:

1. Early post op.
2. 1/9/09.
3. In a document titled 'Comparative photos', there are images taken 21 days after surgery by [Dr B], and l3 days after surgery by an unnamed surgeon in September 2009.

Comments on photos:
The pre op photos:

1. 49 years old; with obvious premature aging.

2. [Dr B's] comments made in his letter to [Mrs A] are accurate, but:

   a. The wrinkles around the mouth are deep: he described them as fine.

   b. Skin quality is a significant contributor to her aged appearance e.g. deep wrinkles around her eyes and mouth. Facelift surgery does not address that. Skin rejuvenation such as chemical peeling and laser resurfacing do.

The post op photos at 1 year:

1. Brow and upper lid there has been some result from the surgery. Asymmetry is noted; the right brow is lower than the left, and consequently there is asymmetry of the eyelids (less exposure of the pretarsal lid on the right, compared with the left).

2. Nasolabial fold and cheek — minor change.

3. Jowl — smoother.

4. Anterior neck — improvement.

5. Deep wrinkles around the eyes and mouth unchanged.

[Mrs A's] photos:

1. The early post op photos are unremarkable.
2. The photos at 1 year show her demonstrating the excess skin on her cheeks and neck.

Analysis

This complaint is essentially about the unmet expectations of the patient, and the subsequent management of the patient with a disappointing result.

Patients' expectations of cosmetic surgery vary, but are often high. Their high expectations may be due to a combination of optimism about, and confidence in 'modern surgery'. This belief is often supported by modern media, the medical industry, and to some extent by medical practitioners themselves with their websites and print material. Alternatively, patients may be unrealistically fearful of surgery if they have become focused on media reports of 'surgical disasters'.

Surgeons must provide a balance where they can put complications in perspective, but not encourage unrealistic expectations.

I have analysed this complaint by considering 3 periods of care: preoperative, perioperative, and postoperative.

1. Pre operative period:
    a. Before the first consultation
        i. The pre consultation pack provided by [Dr B] was promotional material with no specific information about facial rejuvenation. The contents included a magazine article about a patient with a good result from facial surgery, and a newsletter. This material would generate some confidence about [Dr B's] practice, and promote expectations.
    b. Consultation and assessment
        i. [Dr B] does not make a specific medical note to record his history, examination, and counselling of the patient. His post consultation letter

to the patient serves also as that record. His clinical photographs are part of the patient's record, and are of excellent quality.

ii. I wonder whether this system may limit the detailed recording of the initial consultation. For example, it may limit his recording of reservations about patient understanding and expectations, and of his analysis of the problems and the development of a treatment plan.

iii. He notes [Mrs A's] goals: ... 'a refreshed appearance with more open eyes and fewer lines around the mouth'. And: 'Your desire to improve the contour and appearance of your neck and lower face.'

iv. Was the skin laxity accurately assessed?

1. [Mrs A] was 49, with obvious premature aging. [Dr B's] notes do not comment specifically on the skin quality in terms of looseness or redundancy. I cannot comment on this from assessing photos. One needs to move and stretch the skin to assess this. The post op photos from [Mrs A] seem to show abundant skin laxity remaining after the surgery at 1 year.

c. Selecting the appropriate procedures from the range of facial rejuvenation operations. Was the planning appropriate?

i. [Mrs A] had the signs of premature aging affecting the forehead, eyelids, cheeks and neck. Also, the deep creases affecting the skin below the eyebrows, crow's feet, lower lids, upper and lower lips, chin and anterior cheeks are significant contributors to her facial appearance.

ii. Surgeons will differ as to the indications for each procedure. The final decision is influenced by the patient's input and budget. Priorities have to be set and careful decisions made.

iii. Browlift and upper eyelid reduction are appropriate. The choice of endoscopic versus open browlift is a professional one and will vary with a surgeon's experience with the techniques. The eyelid surgery, both upper and lower, is appropriate in my opinion. The asymmetry of the eyebrows and upper eyelids after surgery has been noted above.

iv. The neck surgery was designed to treat the anterior platysma band, and has been effective.

v. Facelift surgery can reposition and redrape tissues, but will not affect the deep facial creases without additional treatment e.g. filling techniques, laser resurfacing.

vi. There is a range of facelift operations. Most are designed to reposition the SMAS layer which is composed of a sheet of muscle and fascia extending from the neck up over the jawline, cheek and temple. With aging, the SMAS descends. [Dr B] recommended a technique called a MACS lift which is done through a shortened incision in front of the ear and which relies on sutures to suspend the SMAS. The conventional facelift has incisions which also extend behind the ear and backwards into the hairline. The SMAS may be dealt with by undermining and

suture suspension, or excision technique. Either method allows for an effect on the SMAS layer. Excising excess skin differs. The conventional method with the longer scar does allow for greater freedom for the surgeon to manage the skin. The short scar techniques limit this element of the rejuvenation.

vii. I conclude that the selection of the MACS lift, rather than a more conventional facelift contributed to the poor result in the cheeks.

d. Informing the patient and the provision of written information

i. In [Dr B's] policies document states that 'possible written information was supplied ...'

ii. If written information was supplied, copies were not enclosed for review. Surgeons will often provide written information specific to each procedure. If he has not developed his own versions, Patient Guides are published in Australia and are approved by Australian and New Zealand Plastic Surgery organisations. These are readily available and suitable. Examples are enclosed.

1. The Facelift Guide comments in the 4th paragraph about chemical peels, dermabrasion and laser resurfacing: '... may be undertaken at the same time as facelift. The aim of these treatments is to treat sun damaged skin and crow's feet around the eyes and fine lines around the mouth, which are not removed by facelift surgery'.

2. This information, clearly stated may have been valuable to [Mrs A] in this pre-operative period.

e. Ensuring good understanding: a 2nd consultation did not occur, but there was an exchange of emails

i. Many surgeons will know the value of a second consultation after a cooling off period when the patient has passed through an initial phase of excitement.

ii. This can be difficult to provide for patients who live some distance away.

iii. Is a 'Q and A' by email as good as a face to face consultation? I doubt it, as all the non verbal cues are missing from email, and there is no opportunity for the surgeon to re-examine the patient and modify the initial surgical plan. Nor is it possible to show the patient again the effect of surgery, in a mirror. But email is practical and may be preferred by patients.

iv. [Mrs A] sent an email on7/7/08, after the first consultation:

1. [Mrs A] explains that she tried lying on her back to get some idea of the facelift effect. The drooping is reduced, but 'the lines in particular around the corners of my mouth remain very obvious. This is very disappointing ... it was these and the mouth droop that prompted me to consider plastic surgery. …'

2. She refers to a book 'Your complete guide to cosmetic plastic surgery' purchased from [Dr B's] practice. On p100 the effect of laser resurfacing on lip lines is shown. She states this treatment is of importance to her, and asks whether she should have this treatment prior to surgery. She is aware it can be done as a second stage, '… however I don't want to be … feeling disappointed due to this area remaining obviously lined'.

3. This email should perhaps have alerted [Dr B] to [Mrs A's] priorities and expectations.

v. [Dr B] did have the opportunity to consult with [Mrs A] again on the day before surgery when she came to [the city]. [Dr B] advised he did not need to see her on the day *before* surgery as he could see her directly before surgery at the hospital.

f. Managing expectations is a process

i. The surgeon must be sure he understands the patient's expectations, and how realistic they are.

ii. The surgeon must ensure surgery will address a patient's concerns, or explain clearly which of her concerns will not be affected.

1. I think [Dr B] may not have appreciated [Mrs A's] concern about the wrinkles, despite stating 'Your ideal facial surgery result ... a refreshed appearance with more open eyes and fewer lines around the mouth'.

2. [Mrs A's] email of 7/7/08 could have alerted him to pay more attention to this issue.

3. In his letter of 3/7/08 he states: 'Once fully healed some patients opt to have further enhancements made (Stage 2) such as fat grafting, skin resurfacing etc; most however feel it is unnecessary.' This rather downplays the influence of the facial wrinkling on her overall appearance, and her concern about it.

g. Financial information provided

i. [Dr B] provides a quote for the total cost of surgery, and receives payment in whole from the patient. He then pays the other parties the hospital and anaesthetist. The cost is not itemised into its components. The patient does not know what his fee is, nor the other costs.

ii. The quote is valid for one month only. That would seem to add pressure to the patient to decide quickly about surgery. It seems rather stringent given that costs are unlikely to change significantly month by month.

iii. Payment made to the surgeon and hospital BEFORE surgery is routine for self funded surgery. Many anaesthetists will send an account AFTER the surgery.

iv. [Dr B] provides clear information about payments and financial penalties for cancellations, for which he is the sole arbiter.

2. Peri-operative period: Surgery and inpatient stay:

   a. The operation note is provided.

   b. The episode of epigastric pain.

      i. Is well recorded by [Dr B] and the nursing staff.

      ii. [Mrs A] is concerned that an ECG should have been done earlier in case her pain was cardiac. However she explained that the pain was like her usual reflux symptoms, though more severe, and she declined an ECG.

      iii. [Mrs A] advises she was not hyperventilating. The nurses record does show a respiratory rate of 22/min, which is hyperventilating.

      iv. The episode was assessed and managed well in my opinion.

3. Post surgery period

   a. How is early post surgical care managed for distant patients?

      i. GP management — is not ideal but is a convenient compromise. Some GPs will be reluctant to be involved as they may have had very little exposure to cosmetic surgery patients. [Dr B] advised the GP he could be contacted at anytime.

      ii. There were no early complications requiring [Dr B's] direct supervision.

      iii. A follow-up with the surgeon at 1 week does have value as an opportunity to discuss concerns about swelling, bruising, asymmetries etc. The surgeon's nurse can remove all sutures. But such a visit is costly to the patient who must travel a long distance.

   b. When should the surgeon review the patient after surgery?

      i. 1 year seems a long time to wait after surgery to assess the result. [Dr B] believes this is when a final result is achieved. In a way, a final result is never achieved — facelift surgery does not stop the clock, it just resets the starting point for ongoing aging.

      ii. By 3 months, in my opinion, a stable state has been reached. Scars may still be immature, but swelling will have resolved, and any asymmetries at that stage are unlikely to resolve spontaneously 'with time'. If there is scar hypertrophy (thickening), it will be developing by then.

      iii. Many surgeons will have seen their patients on several occasions within that 3 month period to monitor progress and support them. It can be very reassuring for both patient and surgeon.

      iv. Follow-up is more difficult for patients who live away from the surgeon's city. But some patients are prepared to take the time to attend the surgeon's rooms when the role of follow-up is explained. If they are worried about anything, they will be keen to return.

   c. Poor outcomes and the unhappy patient. What happened at the 1 year follow up?

      i. Surgeon and patient communication

1. [Dr B] greeted her with the comment 'I have just seen a woman who claims I have given her the worst 6 months of her life'. This is a clumsy opening for a consultation with a patient who he knows he is unhappy with her surgery: poor communication.
2. [Dr B] acknowledged there was a problem, and [Mrs A] appreciated that: good communication.
3. At this stage, it is not helpful to invoke consent forms that state poor outcomes may occur. To the patient, this will sound too much like evading any accountability.
4. The 1 year follow-up in a treatment room
    a. [Dr B] explains that he does this so that any equipment needed is ready to hand. This is very unlikely to be required at a 1 year appointment.
    b. [Dr B] had been forewarned by [Mrs A] that she was disappointed. He might have been better prepared to see her in his consultation room, and ensure he had plenty of time allowed.

ii. Surgeon responsibility and accountability for care

1. It is difficult to manage complications. It is evidence that surgery and its practitioners are fallible. There may be an initial denial and reluctance to accept responsibility.
2. Patients are understandably worried and anxious about whether they will be supported by the surgeon, and not abandoned.
3. Patients who are helped through a complicated course are usually very appreciative of their care.
4. [Mrs A] feels that [Dr B] accepted the result was disappointing, but he could not explain why it had occurred; that he denied any technical error; and he proposed further surgery at high cost that he would not itemise.
    a. The perception is given of a lack of accountability, and transparency from the surgeon.

iii. The role of ACC: treatment injury

1. [Dr B] could have made a claim to ACC on the basis of treatment injury. He had accepted that the result was disappointing. This can be seen as a complication of surgery. The final decision as to whether this would qualify is for ACC to make.
2. [Mrs A] at least deserved this application.
3. If ACC accepted the claim, then [Mrs A] would be relieved of the financial consequences of second opinions and further surgery.

iv. Referring for 2nd opinion

1. [Dr B] stated he could not explain the reason for the disappointing result.
2. He advised that further facelift surgery was required.
3. He could have offered to arrange a second opinion from a colleague. This can be very useful for both parties. He states he asked colleagues about the result, but [Mrs A] herself was not offered the opportunity.
4. Another surgeon may provide a different perspective with respect to remaining excess skin and the role of laser resurfacing. For example, would laser resurfacing provide a better (and cheaper) benefit by treating the facial wrinkles and skin quality, rather than further attempts to redrape and remove excess skin (which will not affect the deep wrinkles, again.)

v. Managing the financial implications

1. Some surgeons never charge for revisions. Others do. It is a matter of individual practice policy.
2. Those who do charge feel that if they do not, it may be seen as an acknowledgement of fault.
3. Those who do not charge may feel they do have some accountability, and accept that 'it is the putting right that counts'. Also, it is well known that medico issues may finally eventuate over disagreements about money.
4. [Dr B] offered to do further surgery for $19,000 (total cost, including surgeon, hospital and anaesthetist). When [Mrs A] asked for a breakdown of costs, she was advised '[Dr B] does not give out a breakdown of costs'. This would not seem fair to a patient in the circumstances. [Mrs A] knew of another patient treated by a different surgeon who had revision of a rhinoplasty at no charge. A patient is entitled to know to whom their money is being paid. I guess that at this time [Mrs A] was wishing to know how much [Dr B] would retain as his fee. Transparency at this time may have helped defuse a deteriorating situation.

Other issues mentioned by [Mrs A]

1. Her expectations were not met.
   a. That is undeniable.
   b. What were the contributing factors? In my opinion there were 2:
      i. Communication
         1. Perhaps the balance of promotion and reassurance about outcome and risk outweighed the information conveyed about limitations and aspects of aging that would not be treated.
      ii. Surgical plan

1. I believe a short scar technique was unlikely to treat the skin laxity as well as a conventional facelift. (Note: there may be varying opinions about this, but this is a fair statement).

2. She felt there was pressure to make a decision and proceed with the initial surgery.

   a. The quoted fee holds for 1 month and must be secured with a non refundable $500 deposit. All costs must be paid 2 weeks prior to surgery. A penalty is incurred if the patient does not proceed. [Mrs A] felt that a prompt response was required to secure a date for surgery.

   b. Holding the quoted fee of $31,000 for only 1 month would put pressure on a patient to make a prompt decision as the implication is that the costs will rise after that period. [Mrs A] stated 'The fee, and the time in which to make a decision were a huge shock'. She felt pressure to confirm surgery to avoid any increase.

      i. Why does [Dr B] have this policy? Most practitioners and hospitals only review costs annually.

         1. The risk of this financial policy is that it might make an uncertain patient decide to proceed with surgery before having sufficient time to carefully consider the decision.

         2. The benefit is financial to the surgeon.

   c. I agree with [Mrs A] that such financial policies would create pressure on a patient to make a decision. At this stage, decision making must be on the basis of clinical information, and an understanding of goals and limitations, risk etc Also, the patient must have a clear quote for the proposed surgery to know whether it is within her budget. There are effectively 2 forms of consent —informed surgical consent and informed financial consent.

3. [Mrs A] feels like a "financial commodity". This is understandable:

   a. There is a non refundable booking fee.

      i. Some surgeons have this policy. They argue that it encourages the patient to focus on making a decision, and to make a commitment to proceed and keep the arranged appointments.

   b. She was charged $20 for copies of her pre and post operative photos.

      i. These photos are part of the patient's records. Provision of copies for no charge would seem reasonable.

   c. Quotes valid for only 1 month. This has been addressed.

   d. Strict cancellation policy and penalties: this is explained elsewhere in this report.

      i. What is the actual cost incurred to [Dr B] when a patient cancels 1 week before surgery, other than lost income for himself, and inconvenience?

ii. There will be no hospital cost, and no anaesthetic fee for which he is liable. If he schedules another patient in to that operating list, he has lost nothing.

iii. The presumed purpose of the policy is to prevent last minute changes of mind by patients, and tie them in to proceeding with the surgery. [Dr B] reports that since he has adopted this policy he has indeed had no such cancellations.

iv. The policy about cancellation is very strict. It may backfire afterwards if a patient with doubts continues with surgery to avoid the penalty, and is afterwards not happy. The patient may experience 'buyer's remorse', and complain.

e. Revision surgery was proposed.

i. [Mrs A] states she had inadequate explanation about what was planned.

ii. She was quoted $19,000, valid for 1 month.

1. [Dr B] refused to itemize this at her request.

4. [Mrs A] seeks a refund of $19,000 quoted for revision surgery.

a. Understandable, given the irremediable breakdown in the relationship

b. It is reasonable for a patient to presume there has been an error by the surgeon when a disappointing result occurs (whether there has been or not).

i. The Policies form states that there will be no surgeon's fee for the correction of problems arising from a technical error.

ii. [Dr B] denied error had occurred.

iii. He also would not itemise his quote of $19,000. [Mrs A] would be unable to see if there was a fee for [Dr B] in that quote.

5. [Mrs A] was never told of possible disappointment with result.

a. She has no recollection of these words being used when consulting with [Dr B].

b. There is a section in the request for surgery form "unfavourable outcomes", which indicates that:

i. 'from time to time ... poor outcomes do occur.'

ii. that if this is due to technical error by the surgeon, then a surgical fee will not be charged for its correction. Additional fees will apply e.g. hospital etc.

c. [Mrs A] was not provided with written information specific to her surgery apart from [Dr B] post consultation letter of 3/7/08.

i. Enclosed are examples of available Patient Guides which can be provided to patients.

The HDC request

I have been asked to:

1. Review the complaint

   a. Done

2. Review the dinical records

   a. Done

3. Review [Dr B's] response

   a. Done

4. Comment on any communication issues including those raised in the complaint and others might identify. In my opinion:

   a Overall the impression given to [Mrs A] was rather promotional, and not sufficiently balanced with information about limitations. This may have set the scene for later disappointment.

   b. There was no detailed written information given in addition to [Dr B's] post consultation letter. See enclosures. These Patient Guides give useful and balanced information to patients that they can read at their leisure.

   c. After the initial consultation, there was no second consultation prior to surgery. Instead, there was 'Q and A' by email, which may have contributed to this complaint. This is convenient for patients from out of town, but is not as valuable as a second face to face consultation for both patient and surgeon.

   d. The 1 year follow-up appointment.

      i, The setting in a clinical room, and the introduction were poorly planned, as [Dr B] would have anticipated a difficult consultation.

   e. There are clear financial policies detailed to patients by [Dr B]. However the quotes are not itemised and are not transparent to patients. They have a right to know the fee being paid to surgeon, anaesthetist and hospital.

   f. The financial policies could be seen to create some pressure for the patient to make decisions about surgery, and a financial obligation to proceed.

   g. An offer to 'put things right' with no additional surgical fee would have demonstrated some goodwill, and preparedness to put the patient first.

5. Comment on whether the care was reasonable in the circumstances

   a. Assessment of [Mrs A] at the first consultation

      i. [Dr B] seemed to understand [Mrs A's] goals. He may have underestimated the importance of her deep wrinkles to her, and their contribution to her overall aged facial appearance.

      ii. As a result of not treating these wrinkles, [Mrs A] would still see them as features of aging. Their persistence after surgery would detract from other improvements achieved by surgery.

      iii. He may have underestimated the degree of skin laxity.

   b. The surgical plan

i. [Dr B] advised [Mrs A] he does not perform laser resurfacing himself and he explained how she might receive an opinion about that procedure. This review does not criticise. [Dr B] for not offering laser treatment. The point is that he may have underestimated the importance of skin quality to her overall appearance, and how the persistence of these wrinkles might disappoint her and affect her perception of the surgery. He may not have clearly advised her as to what his planned surgery would not do.

ii. He selected a short scar MACS lift technique. As explained above, this method is less effective in the management of skin laxity, where a conventional facelift allows for greater freedom for skin redraping and excision of redundancy.

iii. Other techniques for the brow, lids and neck were reasonable in my opinion.

c. The care in hospital

i. The episode of epigastric pain was well recorded and managed.

d. Follow up after surgery

i. This is difficult for patients living out of town. Travel to [the city] is time consuming and expensive. But patients will do it; such surgery is a big event in their lives and they want to do the best for their outcome. It does maintain the doctor patient relationship.

ii. There is value for patient and surgeon from face to face follow up during the recovery period. At 1 week, sutures and staples are ready for removal and this is a valuable time to advise and explain to the patient the expected progress of swelling and bruising.

iii. No follow up until 1 year does seem a very long non-contact time to me, even considering email communication.

e. No ACC claim

i. Treatment Injury claims can be made to ACC.

1. Medical Insurance companies such as Southern Cross frequently insist that ACC claims are made first when the surgeon has recommended revision surgery for procedures covered by the insured person's policy (no cosmetic surgery is covered).

2. This is a situation where [Dr B] could have offered to initiate a claim under the Treatment Injury provisions. It would have shown, at the least, that he had some appreciation of the financial demands [Mrs A] was facing.

3. If accepted by ACC, she would have been able to continue with [Dr B], or transfer to another surgeon of her choice, without further expense.

Final comment

I have sympathy for both patient and surgeon. It is possible to see a series of events lead ultimately to this unhappy situation.

Yours sincerely
David Glasson MB,ChB; FRACS (Plastic Surgery)"

Further independent advice from Dr David Glasson:

"Thank you for your email 8/10/10 with [Dr B's] response to my report. You ask for:

1. My thoughts regarding his response to my report.
2. Re: Clinical documentation. Is it of such poor quality 'as to be concerning', or whether it is 'just sloppy'?
3. Re: informed consent. Was the information given to [Mrs A] sufficient for her to make an informed decision and to provide informed consent?

1. [Dr B's] response

My comments:

a. Pg 13 1.b.iv [Dr B] advises he assessed skin laxity.

i. My point was whether it was assessed as the excess skin remaining after surgery was disappointing for [Mrs A]. The result of the operation suggests that he underestimated the skin laxity, and overestimated the effect a MACS lift would have.

b. Pg 13 1.c.i [Dr B] advises that [Mrs A] wished to avoid the full length incisions of some face lifts. Emphasis would be placed on treatment of the area around the eyes and neck.

i. There is no documentation of [Mrs A's] wish to avoid full length incisions. In [Dr B's] letter after the 1 consultation he states simply that facelift options were discussed. He does not document which options, nor the goals and limitations of these options. For example, there is no record that he advised her that the (short scar) MACS technique might limit the treatment of the skin laxity.

ii. Patrick Tonnard is the surgeon who has developed and promoted the MACS facelift. He readily modifies it at operation by adding extra incisions along the hairline behind the ear to allow for more skin excision if required. There is no record that [Dr B] was prepared for this, or had discussed it with [Mrs A].

c. Pg 14 1.c.vi– vii [Dr B] takes issue with my use of the term 'facelift'. He explains that short scar techniques were described before the advent of SMAS techniques. He says that short scar techniques are widely practised

as valid facial rejuvenation techniques, and that it was an appropriate option for [Mrs A].

i. The history of facelift surgery is long. Early facelifts show scars that were in front of the ear, and now would be considered 'short scar facelifts'. However they were not the same as modern short scar techniques. The early surgery dealt only with the facial skin, without treatment of the underlying tissue — the SMAS. Skoog described the SMAS lift in the 70s, and it has been the cornerstone of modern facelifting techniques ever since. There are many variations of SMAS lift, but all involve the elevation of the SMAS in some way. After the SMAS is treated, the next step in the operation is the excision of excess skin. In the 'conventional facelift' there are incisions made not only in front of the ear, but also in the groove behind the ear and extending back into the scalp behind the ear. This gives a great degree of freedom to deal with skin excess in the cheeks and neck.

ii. The MACS Uft attempts to avoid the scar extension behind the ear i.e. it is a 'short scar technique'. However it is a SMAS technique, where the SMAS is elevated with sutures, without dissection of the SMAS as a separate layer. The MACS lift, as used by [Dr B], did not predate the conventional face lift I referred to. The MACS lift was described by Tonnard in 2002 as a version of a SMAS lift without scars extending behind the ears. Tonnard describes his MACS operation as a development of the 'S' (a short scar technique) which he abandoned as it was not 'surgically sound'. So, while the MACS lift is a short scar facelift, it is a modern development and does not predate the advent of SMAS techniques as [Dr B] claims.

iii. The MACS lift is not a substitute for other types of facelift in all patients. It is within the armamentarium of surgeons, and is suitable for some patients, but not all. Dr Tonnard has subsequently described the need to add skin excisions in the scalp margin behind the ears to deal with neck skin laxity.

iv. So, to be clear, while a MACS lift is a short scar operation, it is not the same as the early facelifts, which predated the description of the SMAS tissue plane, and which were skin only techniques. My use of the term 'conventional facelift' was to describe a SMAS type facelift where the scars pass from in front of the ear, up behind the ear, and backwards into the scalp.

d. [Dr B] advises he explained that 'he made it clear that a MACS lift can not deliver everything that a full length SMAS ... delivers'.

i. This is a very important point. This advice was not documented anywhere in the notes that I was provided with.

e. [Dr B] explains that my conclusion that the MACS lift contributed to the poor result should be seen in context of a patient choosing not to have a more extensive approach. He warned [Mrs A] she may need subsequent skin tightening with laser.

i. It is the job of the surgeon to advise the patient what technique he believes is best, accepting that surgery is not an engineering exercise, and there are many variables. If the patient wants a short scar technique the limitations must be explained. If the surgeon believes an alternative method is more appropriate, then he must explain why, and explain the 'risk-benefit' balance. If [Dr B] sincerely believed the MACS method would give the result [Mrs A] was expecting, then, given the result, an honest mistake was made. If he thought that the MACS operation would compromise the effect, then that should have been carefully recorded.

ii. A comment on laser resurfacing and skin tightening. Laser resurfacing can be safely performed at the same operation as facelift. The main effect is on skin texture and wrinkles from sun damage and aging. Skin tightening achieved by laser is limited. Laser resurfacing is done on facial skin which will heal in a predictable way. Laser resurfacing is not generally used on neck skin as healing may be poor and scars result. Some practitioners are using very light treatments on the neck. However, laser resurfacing could not be expected to tighten neck skin after facelift.

f. P14, e. i–iii. Second consultations. [Dr B] explains that it is difficult for patients who live out of [the city] to attend for a second consultation.

i. I accept that. However such a consultation in this case may have led to a better understanding for both patient and surgeon of expectations and limitations. That extra face to face time might have avoided this complaint.

ii. [Dr B] did have the opportunity to consult with [Mrs A] again on the day before surgery when she came to [the city]. [Dr B] advised he did not need to see her on the day before surgery as he could see her directly before surgery at the hospital.

g. P 16, 3.b. The follow-up at 1 year.

I have nothing further to add to my report.

h. P 16, 2.c. [Dr B's] comments on the consultation at 1 year held in a treatment room He concedes it could have been conducted more effectively. He comments that patients may feel empowered in the room.

i. [Mrs A] would not agree with this premise. She did not find the environment suitable.

i. P17, 3.c.iii ACC. [Dr B] comments that an aesthetically disappointing result would not qualify as 'injury'.

i. That is contrary to my own experience, have made claims on behalf of referred patients with poor outcomes where treatment injury has been accepted.

ii. ACC does not seem to make decisions based on precedent. In my experience, ACC suggest making the claim on the appropriate forms, and they will rely on their advisors to make a decision.

j. P 17, 3.c.iv Referring for a 2nd opinion.

i. My reading of the information provided shows [Dr B] suggested a second opinion be sought prior to surgery, but it was not clear that it was recommended or arranged after surgery.

k. P18, 1.b.i [Dr B] refers to the Book 'complete guide to cosmetic plastic surgery' published in NZ in 2005. It has a section on facelift. [Mrs A] had bought a copy of this book and referred to it prior to surgery.

i. This is a publication designed to demystify cosmetic surgery. It is helpful as an introduction to this field and can indicate to the patient the important questions to ask the surgeon. It has a useful role in communication but does not qualify in my opinion as sufficient for informed consent. This book can aid in the communication that eventually leads to the patient making an informed decision.

l. P18,1.b.ii Short vs long scar [Dr B] agrees it is easier to treat skin laxity with a longer incision. He considers [Mrs A] was suitable for a short scar method.

i. This has been sufficiently dealt with in my report.

m. Financial issues.

i. I have nothing to add to my report which expresses my opinion.

n. Detailed information [Dr B] explains why he did not provide [Mrs A] with handouts about her procedures. I had enclosed examples of these handouts with my report. They are published by Mi-Tec Medical Publishing and are endorsed by the Australian Society and the New Zealand Association of Plastic Surgeons. He explains that the 'Facelift' handout did not relate to the MACS lift. He again notes [Mrs A's] possession of the NZFCPS book 'Your Complete Guide ...'

i. The same Australian publisher does provide patient information handouts for eyelid and browlift surgery, but these were not provided either.

ii. The book 'Your Complete Guide ...' is available to the public and is useful for people considering surgery. However, I have reservations about its being considered as sufficient written information to establish informed consent The Mi-tec 'Facelift Surgery, A Guide To Patients' is more detailed and specific than the 'Your Complete Guide ...' book. Although the Mi-tec 'Guide ...' does not specifically describe the MACS technique, there is much in it that is relevant to all types of facelifts. The 'Your Complete Guide ...' book was published for sale to the public: the Mi-tec handouts are designed to be given to patients at a surgical consultation.

iii. As noted, I believe the NZFCPS book 'Your Complete Guide ...' deepens understanding about the surgery, and it can complement communication, but I do not consider it is a substitute for more focused information.

2. Documentation

Is it of such poor quality 'as to be concerning', or is it just 'sloppy'?

a. I do not find the documentation sufficient. In the circumstances where [Mrs A] has made a complaint, [Dr B] has responded with a full account. Unfortunately there is not a contemporaneous record as evidence to support his later account of events.

b. [Dr B] does not make a specific medical note to record his history, examination, and counselling of the patient at the initial consultation. His post consultation letter to the patient serves also as that record. In my report I expressed the opinion that this practice limits the detailed recording of the initial consultation, For example, it may limit his recording of reservations about patient understanding and expectations, and of his analysis of the problems and the development of a treatment plan.

c. It is impossible to know exactly what transpired at the initial consultation. [Mrs A] was apparently left with an impression of the surgery, risks, and outcomes that were more optimistic than [Dr B] intended, as far as I can judge from his submissions to the HDC. [Dr B] may well have been very cautious, but his account of the initial consultation, recorded in the form of the letter to [Mrs A], does not record the points he said he made.

d. For example, see point 1d above. In his response to my report, [Dr B] advises that he 'made it clear that a MACS lift can not deliver everything that a full length SMAS delivers'. This is a very important point. This specific advice to [Mrs A] was not documented anywhere in the notes that I was provided with.

e. The initial consultation is vital in any new doctor — patient relationship. It is when the surgeon and patient get to understand the patient's concerns and how the surgeon may be able to help. A lot of information is exchanged about what can, and cannot, be achieved. Realistic goals are explained, but also, and more importantly, the limitations of treatment. There does need to be very careful documentation.

f. A full record would allow a reviewer to understand [Dr B's] reasoning for selecting the surgical technique he did for [Mrs A]. A full record would include details of alternative techniques discussed, and why they were dismissed. Compromises described to [Mrs A] would be recorded e.g. how a short scar technique might limit the skin removal. When I examined the notes in retrospect, as the result of [Mrs A's] complaint, the decision making by [Dr B] resulting in the choice of a short scar face lift is not apparent.

g. The recording of the episode of chest pain in hospital is very good.

h. The consultation at 1 year, on 2/9/09, was surprisingly briefly recorded. This must have been a difficult consultation, and [Dr B] must have known that [Mrs A] was unhappy. I would expect a surgeon in this situation to make a full record of the consultation, and even include some verbatim quotes.

i. I consider the documentation to be rather cryptic. I have concerns about the letter to the patient being the only clinical record of [Dr B's] initial consultation with [Mrs A]. Some doctors do use their clinical note to communicate to the GP, by copying it to the GP. But, I doubt it is common practice for a surgeon to use his letter to the patient as his record of the initial or any subsequent consultations.

j. I think the quality of the documentation is of concern, particularly for [Dr B], as it makes it very difficult for him to defend himself against accusations. A thorough contemporaneous record is of great value when clinical practice is challenged or reviewed.

k. Is the documentation of such poor quality as to be concerning? I do not think there is anything about the documentation which is deliberately misleading or false. I think it is incomplete and insufficient to satisfy retrospective review in the circumstances.

3. Informed consent

Was the information given to [Mrs A] sufficient for her to make an informed decision and to provide informed consent?

a. Consent is a process. In the field of cosmetic surgery, which is elective, the communication of realistic goals and limitations of surgery is crucial. This often requires telling patients things they do not want to hear about scars, defects persisting after surgery, incomplete correction, asymmetries, and disappointment.

b. Preparing the patient to be able to make an informed decision involves a number of elements:

i. Face to face consultation with the surgeon.

1. To my mind, this is by far the most valuable component. For major cosmetic procedures such as facelift, where the result of surgery is clearly visible and any problems cannot be concealed, 2 preoperative consultations would be common practice.

2. The second consultation is of great value to the patient and surgeon. The patient has a chance to ask questions, express concerns, check that something very specific will be treated or not, enquire about recovery time, review complications etc. Sometimes, the patient may shift her focus having the benefit of the first consultation and written material.

3. The second consultation is also very valuable for the surgeon. Apart from getting a better understanding of the patient's needs and wants, he has another opportunity to examine her, assess the tissue quality, review his initial surgical plan, and discuss any amendments with the patient.

4. This is difficult for out of town patients, but important decisions are being made with irreversible consequences.

ii. Written material can be provided both prior to consultation and at the first consultation.

1. Patients will usually do some research for themselves prior to seeing their doctor, often on the internet. Most Plastic Surgeons have websites with varying levels of information about procedures and their indications. Some baseline information prior to consultation is useful.

2. After the first consultation, written information can be supplied specific to procedures for which the patient may be eligible e.g. the Mi-tec publications, or other handouts the surgeon may have prepared reflecting his own practice. Financial indications can also be provided, as budget is a vital factor in final decision making.

3. There is then time for the patient to consider the pros and cons, what her real goals are, and the risk/benefit ratio. At the second consultation there will be specific follow up questions from the patient.

iii. Email is a great communication technique, and has become very valuable. It allows the exchange of information, Q and A, and the attachment of digital photos. It does however take time. The surgeon must respond as carefully to emails as he would to questions in a face to face consultation. Obviously, it is very convenient and practical for out of town patients.

1. I think there is some risk allowing email to replace a consultation. Email lacks verbal cues and body language, which are important in communication and which are part of a real consultation.

iv. [Dr B's] policies document states that '... whenever possible written information was supplied ...'.

1. As explained in my report [Mrs A] was sent promotional material prior to her first consultation.

2. After that she received no specific handouts about facelift, browlift or eyelid surgery. [Dr B] has explained that the Mi-tec handout on facelift did not address the MACS lift specifically, so he did not provide it. In my opinion, the handout contains information (apart from the description of technique), that is relevant to any facelift regardless of the method used.

3. [Dr B] did not supply any written information specific to MACS lift.

v. The book 'Your complete guide to cosmetic plastic surgery', published in 2005 was written by the NZ Foundation for Cosmetic Plastic Surgery. It is available to the public. [Mrs A] had bought a copy from [Dr B].

1. I have discussed this in section 1. While the book provides excellent background information, I consider it too 'soft' to qualify as a basis for informed consent. It is however a good basis for subsequent communication leading to informed decision making.

2. For example, on page 42: '... in the case of younger women with good neck skin elasticity, only a minor tightening ... and removal of excess skin is required to create good results. The lesser procedure is known as a mini-facelift. Variations include the ... MACS lift'. This information is important and should lead to questions from the patient about whether she might be suitable for this technique or not e.g. is my skin too loose? As it stands, the information is not specific enough.

vi. In conclusion:

1. The initial written information supplied to [Mrs A] prior to her consultation was promotional.
2. There was only one face to face consultation. There was subsequent email communication. However the importance of a second preoperative consultation, for both patient and surgeon, has been explained above, (3b). The opportunity for a second consultation was there on the day before surgery, but [Mrs A] was not seen then by [Dr B],
3. No written information was given specific to MACS facelift, browlift, or eyelid surgery.
4. The book 'Your Complete Guide ...' does not qualify as detailed written information provided to a patient making a focused decision about surgery after the initial consultation.
5. Therefore, I have to conclude that [Mrs A] did not receive sufficient information to make an informed decision, on which to provide informed consent.

Yours faithfully

David Glasson"

Further independent advice from Dr David Glasson:

"You have asked whether I consider [Dr B] did, or did not, meet the required professional standard, and if not, whether his peers would view this as a minor, moderate, or severe departure from the standard.

I have thought long and hard about this unfortunate case, and have read my reports again. I think that the whole interaction could have been better managed and recorded. There was not just one misstep leading to a problem, but a series of inadequate or incomplete strategies.

The key point is that I do not consider [Mrs A] received sufficient information to provide informed consent. This is a major failing in any medical interaction, and is

very important in cosmetic surgery where the unexpected results of surgery are clearly visible.

Therefore, I conclude that [Dr B] did not meet the required professional standard in his dealings with [Mrs A], I think his peers, given all the details of the case, would consider this a moderate departure from the standard."