

FEATURE ARTICLE IN FOCUS

How not to be sued

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Introduction

Medical negligence cases in Australia have reached a peak number. Between 2018 and 2023 in Queensland alone, the state health service was forced to pay out AU\$390 million in compensation for 1049 medical negligence claims.¹ In 2024, in NSW a single class action relating to breast augmentation surgery resulted in an AU\$25 million dollar payout.²

An Australian study by Bradfield and colleagues in *BMJ Open*³ looked at psychosocial factors predisposing medical practitioners to legal action. Of the 12,134 doctors in the study, including a wide range of general practitioners (GPs) and specialists from 11 specialties, they found that 'unhappy and overworked' doctors were more likely to be sued. Doctors who had suffered a recent injury or illness, worked in rural areas, or who were older, male and performed surgical procedures, were also more likely to have a medical negligence claim brought against them.

Plastic surgeons are among the most litigated-against specialties.⁴ This is largely driven by cosmetic surgery. A brief internet search for law firms advertising services for cosmetic surgery negligence claims turns up more than 30 Australian firms actively practising their expertise in that area. This number appears to have increased substantially in the last 10 years.

There are many reasons why claims are escalating in number and in the cost of individual settlements to insurers, creating a snowball effect on insurance premiums. Just a few are the public's increasing awareness of their legal rights, sensational media publicity about 'botched jobs', unrealistic internet advertising by some practitioners, the online presence of influencers tied to dubious practitioners, high profile lawsuit cases, including some large class actions and, unfortunately, the 'dog-eat-dog' nature of cosmetic surgical practice in the last few decades.

The legally-required standards of practice in many areas are now much higher than decades ago. As of 1 July 2023, the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia have introduced a proscriptive document, *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures* (the Ahpra Guidelines).⁵ Doubtless, these guidelines will be used in court to

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establish a legal framework of standards that will be expected to be adhered to by all practitioners of cosmetic surgery.

Having 35 years of clinical experience as a plastic surgeon, I am fully aware of the ever-present risk of being sued. I have had threats of court action on three occasions. Only the first one had any merit, as a result of a genuine complication. The other two were spurious, bordering on vexatious, and were settled out of court by the (two different) insurers for small sums. Both were eminently defensible but the cost of court action is so high that most insurers prefer a small settlement with the litigant signing a release statement, rather than an expensive court case.

I have been in medico-legal practice for four years. In that relatively short time, I have had the opportunity to forensically examine a large number of cases involving plastic and cosmetic surgery in several Australian jurisdictions. I have found there are many factors that increase the likelihood of a patient suing. This article is an attempt to lay down a pathway for plastic surgeons, especially those starting out, to avoid the daunting prospect of a legal action for negligence.

Some of my advice will appear overly didactic. I mean it to be. In medico-legal practice, it's all about 'opinion'. The following advice contains several opinions. I mean them also.

The different pathways that lead to a satisfied patient...or to disaster

The referral process

As a specialist, whether seeing a patient with a melanoma or one wanting breast augmentation, a referral from a GP is important. It creates a two-way pathway of information, which allows both the patient and the GP to own part of the treatment program. For most of my own clinical practice, 'pure' cosmetic surgery did not require a GP referral. That was a mistake of omission, in my opinion.

Since 1 July 2023, the Ahpra Guidelines have mandated that cosmetic referrals need to come from another doctor, usually the patient's GP, and they must be independent of the doctor performing the surgery (Guideline 2.1).

Communication back to the referrer

Part of the consultation process involves communication back to the GP or referring doctor, whether by email, phone or letter.

As a young registrar in a public hospital in the 1970s, I recall a noted general surgeon of one of Sydney's oldest teaching hospitals, who had the unwavering habit of calling the GP immediately after every elective surgery procedure that I witnessed him perform. He had a very large private practice.

In my opinion, it is better to avoid using terms in every letter such as, 'It was a pleasure to see Ms Blogs'. GPs well know that not all patients are a pleasure to see. They want the clinical facts without the 'roses'.

The consultation process

Allow enough time

In my opinion, the standard 15-minute surgical consultation is woefully inadequate for most cosmetic procedures. A minimum of 30 minutes is necessary and quite often longer is needed. If the process is getting too drawn out, I respectfully suggest that a second consultation must occur and sometimes, even a third.

In my medico-legal practice I have seen many occasions where that did not happen. Arrangements for surgery were rushed and dissatisfied patients' legal statements of claim made prominence of that fact.

Listen

In my experience, more surgical mistakes are made by not listening carefully to the patient than from any other cause. In plastic surgery, it may be as subtle as a few words that alert the surgeon to unrealistic expectations.

It is wise to delve into the sources of information the prospective patient has used or brought to the consultation, especially if they are internet-based. When referring to such information, avoiding the use of derogatory terms (eg, 'rubbish', 'misinformation') will create a better atmosphere. In my opinion, the best approach is simply to reply to a patient's internet research, by saying, 'This is the information I can give you from my experience', and/or 'according to the scientific literature', etc.

Involvement of family or friends

It is always wise to privately obtain the patient's consent for another person to attend the consultation before the consultation begins.

Privacy considerations aside, when a patient comes with a family member and wants them to be part of the consultation, focus should be

maintained on the patient. However, careful attention to the personal dynamics between the patient and a relative or friend may sometimes show up a red flag. Examples include potential coercive control, interference in the consultation process by the other person or the other person trying to 'take over' the interview.

I have seen cases where a close relative was the prime mover in precipitating a negligence case, not the patient themselves.

With regard to minors, the current Ahpra Guidelines state:

4.3 The medical practitioner should, to the extent that it is practicable, have regard for the views of a parent or guardian of the patient under 18, including whether the parent or guardian supports the surgery being performed.⁵

Obviously, the younger the patient is, the more applicable this becomes.

Provision of visual information

While it is tempting to show patients your best results from surgery (and I have been guilty of that), realistic expectations should be fostered by showing realistic or average results. One can show a range of outcomes, especially when it comes to scars.

Particular care needs to be taken when using preoperative computer morphing programs, which supposedly show a patient what they will look like after the surgery. Such computer images are often searchable legally and may be used for comparison with the actual surgical result in a lawsuit. A disclaimer may not protect you.

The second consultation

For all cosmetic procedures it was always wise to have a cooling-off period. That is now mandated by the Ahpra Guidelines for seven days (Guideline 3.8). Furthermore, a second consultation is also now mandated (Guideline 3.1).

Although a realistic discussion of expectations should be part of the first consultation, it must be a significant focus of the second consultation. A second consultation is not just a wrapping up and 'let's get the paperwork done'.

In my opinion, and this is very much confirmed by legal opinion, the provision of a long sheet of potential complications for either the surgeon

or the patient to tick off is substandard practice, unless there is substantial notation by the surgeon concerning discussion with the patient about the most important ones. What goes down well in court is to see a surgeon's personal notes describing in some detail certain risks or complications that could take place. That is part of the overall standard of medical record keeping mentioned below.

What is critical when it comes to any lawsuit is the proof that the surgeon actively discussed in realistic terms the possibility of complications or poor results and how they would be dealt with, and also that they accurately recorded that discussion.

Patient assessment

*A 'No' uttered from the deepest conviction is better than a 'Yes' uttered merely to please, or worse, to avoid trouble. **Mahatma Gandhi***

It is a major error to operate on everyone who consults you. At times a denial will cause the patient distress. You can't always reveal your reasons, but a kind explanation should be followed by suggestions of alternative pathways, if available.

For prospective patients under the age of 18, psychological assessment for cosmetic surgery cases is now mandated by Ahpra Guideline 4.4. This assessment must be by a recognised test or performed by a recognised psychologist, psychiatrist or GP trained in such testing.

When you suspect a case of body dysmorphic disorder or frank psychosis, deal gently but firmly when saying 'no'. Be very aware of the unpredictability of a person suffering from schizophrenia.

Assessment for surgery is about deciding on appropriate technique, not convenience. Cost is a frequent consideration for patients and it is tempting to suggest a cheaper, quicker procedure, even if you know in your 'heart of hearts' that the result will be inferior. Resisting that temptation is wise, in my opinion.

Limited training will sometimes lead to the use of inappropriate technique. The old saying, 'When all you have is a hammer, everything looks like a nail', is particularly applicable to liposuction. Its inappropriate use in patients who clearly needed excisional surgery is an all-too-common cause of legal action.

The advice you give

The advice you give must be based on fact and preferably backed by peer-reviewed science. Your experience is important but you aren't god. It is extremely unwise to make unsubstantiated claims, such as, 'I've done thousands of these procedures', when you've done 100 or less. It is especially unwise to tell a patient who has suffered a complication that it is the 'first one I've ever had'. Even if it is, it doesn't help them, and they then begin to think that you don't know how to fix it.

The Judeo-Christian Bible has a bit of wise advice in this area:

'You shall not bear false witness' (Exodus 20:16) and 'Be sure your sins [lies] will find you out' (Numbers 32:23).

In my medico-legal experience I have seen a number of cases where practitioners have blatantly lied in order to supposedly protect themselves. However, the truth almost always surfaces. It's best it doesn't do so in court.

Untruths can even include exaggeration, especially if it is misleading and causes a patient to make decisions that are based on reassurances that can't be substantiated.

I have read a number of legal case files, where the proceduralists consistently told their patients how 'fabulous' they looked after surgery, when their patients clearly did not agree. Although in politics a lie repeated often enough may end up being believed, in malpractice cases it doesn't work that way.

The consent process

In public hospitals, there is a longstanding practice of having the patient sign a consent for surgery upon admission. Unfortunately, this has created a precedent that leads to potential abuse. A patient may be asked to sign a consent document or a list of acknowledged risks and complications, as little as a half an hour or less before the procedure. This is not acceptable in 2025. The only exception might be life-saving emergency surgery. And certainly, once a premedication has been given, such a 'consent' is not valid in law.

The consent process should occur when the informed decision is made for surgery, after appropriate consultation, and preferably in the consultant's office. The Ahpra Guidelines now

mandate that the consent process should not take place at the first consultation (Guideline 3.5).

In medico-legal practice, I have seen a number of cases where a patient was handed a sheet of potential complications and a consent form to sign less than 30 minutes before their procedure. On each occasion the opportunity to discuss risks and complications was not possible.

In cosmetic surgery, most patients have already paid substantial amounts in advance. That becomes an added pressure should they be asked to sign a consent form or list of complications immediately prior to a procedure. They would also, after taking time off work and making arrangements for recovery, feel obliged, despite some misgivings, to go ahead regardless.

Provision of literature and online content

Although the Royal Australasian College of Surgeons and some surgical societies have produced generic pamphlets on a considerable number of surgical procedures, they cannot be relied upon to replace adequate consultation. For a start, there is no guarantee the patient will read them.

Online material is a potential source of misleading information. Giving the patient a reputable online referral source, such as the Australian Society of Plastic Surgeons website (plasticsurgery.org.au), should be encouraged as much as 'Dr Google' searches should be discouraged, in my opinion.

One's own website may be a source of misleading, exaggerated or inaccurate information. The Australian Society of Plastic Surgeons has guidelines on the member portal for appropriate use of website promotion,⁶ as do the Ahpra Guidelines at 11.1.

Stepping outside your area of expertise or experience

This has long been a contentious issue for the young surgeon starting in consultant practice. Again, when a particularly difficult condition is seen, especially in an area where one has little training or experience, a brash attempt to 'fly by the seat of one's pants' may prove a legal nightmare. Far better to have a close relationship with several senior and experienced colleagues. Most will be flattered for you to ask their advice. It is sometimes best to refer the difficult case to them and always to ask if you could come and assist with any procedure they might perform. This is

particularly true when difficult and unexpected complications follow a procedure. Learning is a lifetime experience.

The procedure

Most medical negligence cases in plastic and cosmetic surgery boil down to what happened in the operating theatre. Technical expertise does not guarantee perfect results. Mishaps can occur, errors of judgement happen, and unexpected findings can result in unexpected outcomes.

Surgical discipline in the operating theatre is the responsibility of the lead surgeon, who should set the atmosphere. That should be convivial, free of bullying and abuse, efficient but free-flowing where appropriate. Especially in long lists, adequate breaks between cases and adequate hydration are important.

In respect of mishaps, I will refer to an incident experienced many years ago in a hospital where I was working. The patient was having very prolonged surgery to a leg, initially under tourniquet. The tourniquet's pressure control box was attached to the rail on the edge of the operating table and was underneath the hanging surgical drapes, operated by the anaesthetist but obscured to the surgical team's view.

At the end of the first stage and after 90 minutes of tourniquet time, the tourniquet was let down. The affected leg was then covered by drapes, while the surgical team went to another body area to raise a free flap. Inadvertently, the assistant surgeon leant against the operating table and accidentally (and silently) bumped the switch on the tourniquet box hidden under the drapes to the on position. This resulted in the tourniquet being reinflated for another two hours, completely unbeknown to anybody. The patient subsequently had a completely numb and semi-paralysed leg for several days. It was only by good fortune that the leg gradually recovered, but this took a number of weeks.

As a result of this, a blanket ban was placed on tourniquet control boxes being affixed to operating tables throughout the hospital.

In microsurgery, especially replantations at night, surgeon fatigue can play a big part in potential complications. This is hard to control, but in elective surgery, overbooking of large lists with the resultant surgeon fatigue is a recipe for an eventual disaster.³ List booking is eminently controllable.

Postoperative care

In recent times it has become popular to use nurses for patient follow-up. While there are aspects of the team approach that are commendable, in my opinion the close personal care of the surgeon will reduce the risk of dissatisfied patients.

The gold standard for surgery has always been personal postoperative attendance of the surgeon on the day of the surgery, with wound inspection if necessary, and on the next day if still in hospital. The surgeon should attend wherever possible on the day of discharge and make a note of same. The patient should personally be seen by the surgeon at the first postoperative office visit wherever possible, unless delegated to another trusted doctor, and the visit recorded in the notes. Delegation of procedures to a nurse, such as drain removal, dressing change and suture removal, should be recorded by the surgeon.

It has become apparent that younger plastic surgeons wish to work less hours,⁷ but I suspect not at the expense of reduced income. This may be playing into the area of delegation of care to others. But you can't have your cake and eat it too.

Management of complications

In my opinion, there are a number of 'dos and don'ts' about complications. I will list some of mine below.

Never blame the patient

I have witnessed several occasions where poor results were blamed on the patient. The commonest one is weight gain or weight loss being responsible for a poor result. Not only is blaming the patient, even in a subtle way, a cop-out of personal responsibility, but it puts the patient offside and greatly increases the chance they will sue you.

Do not use your preoperative list of complications to avoid responsibility

Poor results and complications won't go away just because the patient was warned of the possibility. Telling them that they signed a form recognising the risk is tantamount to saying, 'I told you so.'

Own the complication

Acknowledge a poor result or complication, rather than attempt to hide, obfuscate or deny it. The earlier this happens, the less likely the patient is to sue you. You should then set about a plan to fix the complication and discuss it comprehensively with the patient.

Have a plan to deal with complications

A positive approach requires a supportive surgeon, a plan to fix the problem and a reassurance that the patient won't be out of pocket, if at all possible. The latter becomes a bug-bear for some surgeons, especially those who do not have access to a public hospital, and it's a significant problem when the patient has no health insurance.

I would suggest talking to your hospital administrator about fees. Be prepared to (hopefully rarely) be out of pocket. From what I have witnessed of currently-charged cosmetic surgery fees, no plastic surgeon is going broke by sometimes subsidising a needy case.

It is sometimes tempting to try to deal with complications like a haematoma or localised infection under local anaesthetic in the office environment. Suffice it to say that I have seen enough cases in malpractice to advise extreme caution in doing so. If it goes to court, it doesn't look good that the prime reason for doing so was simply financial.

Notify your defence insurer of complications that might result in legal action early

This has been a recommendation of defence insurers for decades and acts both as a legal referral base, and a source of good advice and potential documentation that could assist any later claims.

Record keeping in general

It has been emphasised time and again that contemporary, clear and comprehensive medical record keeping is the strongest defence the surgeon has against an unwarranted legal claim. That that advice is not taken up universally has been my medico-legal experience. I have seen numerous examples of records that are illegible, undated or brief to the point of being useless.

What is even more concerning is the occasional attempt to fake a contemporaneous record by writing it after the event and dating it before the event. That amounts to fraud and, if proven, it will destroy one's defence altogether.

Legally, the quality of the record is judged on its content, its comprehensiveness, its relevance and its truthfulness.

In plastic and cosmetic surgery high quality photography, both preoperative and postoperative, is an important part of the medical record. It should be stored digitally, backed up and at a resolution that is appropriate in 2025. In my opinion, the minimum standard is 4K.

In recent years, artificial intelligence (AI) powered speech-to-text software has become available to health practitioners. This has the potential to reduce the risk of legal action by patients.⁸ A patient interview can be digitally transcribed to text in real time. Apart from the obvious time and cost savings, other advantages include the contemporaneous nature of the consultation, immediate review and editing by the doctor, and possible reduction in the legal risks associated with having absent, overly brief, sketchy or inaccurate records on file. These records can be securely encrypted and uploaded to a patient electronic medical record.

Potential downsides are the increased availability of these to a litigious patient and the fact that what was not said will not be in the record. Various technical software issues can also occur and lead to inaccurate record keeping.

Conclusion

Increasing medical negligence claims mean increasing insurance premiums. Increasing premiums create upward pressure on surgical fees, which create greater risks of legal action. This is a positive feedback cycle, otherwise known as a death spiral. The currently-popular practice by some legal firms of 'no win, no legal fees' gives an incentive for dissatisfied patients to take legal action. Active steps to reduce this seemingly inevitable trend are, in my opinion, critical.

Over-reliance on the fact that one is covered by medical indemnity is a poor substitute for conducting one's practice at the highest possible standard.

It is regrettable that cosmetic surgery has become, in many places, a business. Business has customers. As doctors, we have patients, not customers. I am reminded of a professor, who would ask us as medical students, when confronted by an elderly lady patient, 'What would you do if this was your mother?'



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