

Medicolegal Aspects of Otolaryngologic, Facial Plastic, and Reconstructive Surgery

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Many operations performed by otolaryngologists, facial plastic, and reconstructive surgeons fall under the designation of elective surgery. Success in this type of surgery is primarily measured by the patient's satisfaction. If a surgical treatment does not satisfy the patient or if a complication does occur, elective surgery patients may be more likely to undertake medicolegal action than mandatory surgery patients. Indeed, Otolaryngologic, facial plastic, and reconstructive surgery does carry a high risk for litigation.^{1,2}

For decades, patients were content with a paternalistic beneficence of physicians. However, this has changed considerably in the last 30 years.³ Nowadays, optimal patient-physician relationship is an alliance with equals, characterized by honesty, trust and mutual respect (see Vuyk and Zijlker in this issue of *Facial Plastic Surgery*). Rapport between the surgeon and patient is essential.⁴ This is stressed by the fact that lack of rapport has been documented as the major cause of medical malpractice claims.⁵

Elective surgery should be a shared decision of physician and patient based on mutual frank information exchange. Informing the patient before treatment is of crucial importance. Nowadays, it is the patient's right to be informed about his or her condition and possibilities for treatment, including risks and benefits. This primary patient's right together with the physician's obligation to disclose is the basis for informed consent. Furthermore, it is of im-

portance to realize that the patient's ability to accept the surgical result may even be highly correlated with the degree to which the patient has been prepared. Moreover, a patient who is well informed before treatment will be more inclined to accept problems arising during or after treatment,² thereby reducing the chances of seeking legal redress.⁶

The goal of this article is to describe medicolegal aspects of doctor-patient information conveyance in Otolaryngologic, facial plastic, and reconstructive surgery. Proper preoperative information is the basis for informed consent. The consequences of lack of consent are described. The legal importance of documentation is stressed. Medicolegal aspects of complications are discussed.

PREOPERATIVE INFORMATION

General Considerations

Because this type of surgery is elective, a complete informed discussion presented to the patient by the physician is mandatory. Physicians should never be evasive or withhold information. The surgeon must honestly, in understandable terms and as completely as possible, tell the patient of his recommendations for treatment, alternatives, and the specific risks of the surgery planned. The risks should be discussed in detail, including usual and unusual potential

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complications. The risks of surgery in general, including unpredictable events that might happen randomly, should be mentioned. The patient should be informed whether there are any features in his medical profile that pose a greater risk than to the average patient.

The patient must be made to understand that the goal of facial plastic surgery is to improve appearance, that perfection might not be achieved, and that there is always a chance that the functional, aesthetic, and psychological expectations might not be fully satisfied. The patient should also be informed of the possibility of a secondary procedure. The patient should be properly instructed as to what to expect on the day of surgery. Discharge instructions should be clear, specific, and in writing. Availability during the first days is essential. It should be realized that in spite of careful preoperative education, patients may still have an unrealistic outlook about the potential benefits and risks of facial, plastic surgery procedures.⁷

Printed Consultation

It has been shown that presenting information in a structural fashion helps the patient remember more potential complications of surgery.⁸ Printed consultation outlines or checklists containing the required information to meet the Standard for informed consent can be useful in supplementing the memorized consultation.⁹ These types of lists (Tables 1 and 2) keep the consultation focused and help prevent unintentional omissions. The surgeon can check each item, indicating the item has been presented. The printed outline becomes the permanent record of the event. A copy can be given to the patient to reinforce the consultation.

From a medicolegal standpoint, patient information brochures, describing the various procedures, including benefits and risks, may become accurate records of what has been presented to the patient, in case some disagreement should occur in the future.

Photographs and Computer Imaging

Photographs can be useful to inform, providing they are representative of the spectrum of results that can reasonably be expected. Photographs may educate the patient as to possible postoperative asymmetries, irregularities, and scars of the proposed procedure. Description or diagrams of scars, expected after facial plastic and reconstructive surgery may not adequately convey the true character of scars inherent in these procedures. Indeed, photographs are acceptable adjuncts for establishing in-

formed consent if the photographs provide information that enables the patient to understand better risks and complications of the proposed procedure. Photographs showing only good results may create a warranty and possibly unrealistic patient expectations. Such photographs, used as a promotional item, may be characterized in court as implied or expressed guarantees.

Computer imaging can be used advantageously as a communication tool in facial plastic and reconstructive surgery. By enhancing communication and understanding, the patient-physician relationship may be improved.¹⁰ The key to successful use of computer imaging is to be honest and ethical in what you produce on the screen. It must be stressed to the patient that it is only an estimate of an outcome for a particular procedure. A similar strategy is of importance when drawing on the patient's photographs. Enhancement of the patient's ability to visualize proposed changes in facial features may allow improved, truly informed preoperative consent.

At the time of introduction of computer imaging in facial plastic surgery, medicolegal consequences of these realistic prediction tracings were not clear. However, there has been no reported incidence of legal problems due to breach of implied warranty resulting from inappropriate or inaccurate imaging.¹¹

Disclosure of Limitations of Expertise

The physician must have that degree of skill ordinarily possessed by physicians of his professional status in similar circumstances. He is expected to exercise that skill in the care of the patient.¹² The patient has the right to presume that a physician is competent in the proposed course of medical care.¹³ Medical ethics dictate the physician's duty to act in the best interest of the patient. This implies that if the doctor is not competent, his or her obligation is to refer the patient to someone who is.¹³ If the patient is injured because the physician failed to refer the patient to a more qualified physician, then the physician may be found negligent.^{12, 14, 15} To protect against this charge, it is wise for otolaryngologic and facial plastic surgeons to be sure that their training is adequate. Ultimately, however, individual physicians must judge whether they are properly trained to perform a procedure before adding it to their armamentarium.¹⁴

DOCUMENTATION

The surgical report is of primary importance in professional liability and may offer the best defense

Table 1. Outline for Rhinoplasty Consultation

Patiënt name .	Date:.
General	Trade-offs Temporary
Realistic expectations—key to success	<input type="checkbox"/> Discomfort (pain/sensitivity)
Why you are here <input type="checkbox"/> Change nasal shape <input type="checkbox"/> Improve nasal breathing	<input type="checkbox"/> Discoloration
Examination	<input type="checkbox"/> Numbness
<input type="checkbox"/> Face—asymmetry	<input type="checkbox"/> Nasal blocking
<input type="checkbox"/> Nose—asymmetry	<input type="checkbox"/> Restricted activity
<input type="checkbox"/> Irregularity	<input type="checkbox"/> Swelling (up to 1 year, extremely rarely longer) Permanent
<input type="checkbox"/> Skin thickness	<input type="checkbox"/> Scars
<input type="checkbox"/> Scars	<input type="checkbox"/> Numbness Special risks Implants
<input type="checkbox"/> Nose	<input type="checkbox"/> Infection
Problem	<input type="checkbox"/> Removal
Extrusion	<input type="checkbox"/> Extrusion
Shape of nasal skeleton (bone, cartilage) is changed. The skin	Risks/complications Nose
has to adapt itself to this new shape.	<input type="checkbox"/> Bleeding/ blood collection*
Goals	<input type="checkbox"/> Infection
<input type="checkbox"/> Establish normal proportion, symmetry, and harmony of the nose and face	<input type="checkbox"/> Sensory change
<input type="checkbox"/> Improvement rather than perfection ,	<input type="checkbox"/> Asymmetry
Improving shape rather than overall size	<input type="checkbox"/> Imperfection
Reestablish (apparent) midline position	<input type="checkbox"/> Nasal function (unimproved/deteriorated)
Improve nasal function	<input type="checkbox"/> Skin redness
Limitations	<input type="checkbox"/> Skin damage/wound separation Auricular donor site
<input type="checkbox"/> Facial asymmetry/disharmony	<input type="checkbox"/> Bleeding/ blood collection*
<input type="checkbox"/> Magnitude of change limited	<input type="checkbox"/> Infection
<input type="checkbox"/> Skin thickness (thick, thin)	<input type="checkbox"/> Sensory change
<input type="checkbox"/> Previous surgery	<input type="checkbox"/> Scar
<input type="checkbox"/> Goals may only be partially met	<input type="checkbox"/> Change in position
Alternatives	<input type="checkbox"/> Shape
<input type="checkbox"/> No treatment (any adverse consequences?)	Even though the risk and complications cited above occur infrequently, there are the ones that are peculiar to the operation or are of greatest concern. Other complications and risks can occur but are even more uncommon.
<input type="checkbox"/> Surgical correction	Any and all of the risks and complications can result in: <input type="checkbox"/> Additional surgery <input type="checkbox"/> Hospitalization <input type="checkbox"/> Time off work <input type="checkbox"/> Expense to you
Surgical technique	On occasion, surgical revisions may be indicated following the original surgery. If planned or performed within 1 year after the original surgery, there will be no charge by the surgeon, but a facility fee will be charged by the hospital for use of the operating or treatment room.
<input type="checkbox"/> Anesthesia	No guarantee. The practice of medicine and surgery is not an exact science; although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone as to the results that may be
<input type="checkbox"/> Operating room	
<input type="checkbox"/> Incisions	
<input type="checkbox"/> Biomaterials	
<input type="checkbox"/> Donor site	
<input type="checkbox"/> Sutures	
<input type="checkbox"/> Dressings	
<input type="checkbox"/> Postoperative hospitalization	
<input type="checkbox"/> Restrictions	
<input type="checkbox"/> Return to normal activity	
obtained.	
Comments:	
Date _____ Surgeon: _____	
Copy of consultation to to be given to patiënt. Copied and provided to patiënt by:	

*Must be off all aspirin-containing product for 2 weeks before surgery. Check all medications with us; some other medications may also affect clotting.

for the surgeon in case of litigation.¹⁶ The surgeon has to be sure the record of the patiënt's history is complete and adequate. Courts in the United States have maintained that the written record is superior to human memory.¹⁷ In case of a dispute over facts between the patiënt and the physician, juries are more apt to believe the written account and will always regard the medical record as having greater validity than the patiënt's undocumented testimony pertaining to events that occurred months or even years previously. All decisions between doctor and

patiënt that contribute to informed consent must be recorded in writing, which is an important protection against later dispute. It is important not to criticize the work of other physicians in the medical record, unless the writer is prepared to defend such imputations in court.¹⁴ In that sense humorous or derogatory remarks may have potential legal implications.

The surgery should be described in adequate detail and should include information about all anatomic areas treated. Information should be recorded

Table 2. Outline for Otoplasty Consultation

Patient name. _____ General Realistic expectations—key to success Why you are here: change shape and position of external ear Examination ___ Face ___ Shape ___ Width ___ Ear ___ Relative height ___ Specific shape/position, Asymmetry protrusion Goals . Establish normal contours and symmetry . Reestablish normal position . Improvement rather than perfection . incomplete correction rather than overcorrection Limitations ___ . All humans are asymmetric: ___ Symmetry may not be achieved ___ Goals may only be partially met Surgically ___ Anesthesia ___ . Operating room ___ Incisions ___ Unabsorbable deep sutures ___ Cartilage scoring ___ Cartilage shave ___ Absorbable skin sutures ___ Dressings ___ "Day-care" ___ Supporting head band ___ Restrictions ___ Return to normal activity	Date: _____ Trade-offs Tell me ___ Discomfort (pain/sensitivity) ___ Discoloration/swelling ___ Numbness ___ Head band ___ Restricted activity ___ Permanent ___ Scar ___ Sensitivity ___ Numbness Risks/complications ___ Bleeding or blood collection* ___ Infection ___ Sensory change ___ Suture extrusion ___ Asymmetry ___ Recurrence Even though the risk and complications cited above occur infrequently, there are the ones that are peculiar to the operation or are of greatest concern. Other complications and risks can occur but are even more uncommon. Any and all of the risks and complications can result in _____.
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No guarantee. The practice of medicine and surgery is not an exact science; although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone, as to the results that may be obtained.
 Insurance usually covers otoplasty, preauthorization will be obtained before proceeding with surgery,
 Comments: _____
 Date _____ Surgeon: _____

Copy of consultation to be given to patient.

Copied and provided to patient by:
 Additional surgery ___ Hospitalization ___ Time off work
 ___ Expense to you
 On occasion, surgical revisions may be indicated following the original surgery. If planned or performed within 1 year after the original surgery, there will be no charge by the surgeon, but a facility fee will be charged by the hospital for use of the operating or treatment room.

*Must be off all aspirin-containing product for 2 weeks before surgery. Check all medications with us; some other medications may also affect clotting.

about the type of anesthesia used. The use of a suitable standard operation report is convenient and is especially useful to ensure that all appropriate parts of the record are included. The operation report must be redacted immediately after the procedure and should contain the indication for the surgery, the surgical procedure, and the type of anesthesia, the sequence of surgical steps, and all problems encountered. A schedule of postoperative care should be written down.

Preoperative and postoperative photographs are a mandatory, objective form of documentation for otolaryngologic, facial plastic, and reconstructive surgery. Photographs should be taken of the patient in a standard pose. Obtaining photographs in standard pose may well be a proof of the doctor's best intentions and should avoid any postoperative suspicion of "doctoring" or falsification of photographs. Photographs should be in the chart prior to surgery

Details, such as preexistent asymmetries, irregularities, and scars, deserve additional objective standardized photographic documentation.

Finally, records should not be released to individuals other than the patient without proper written authorization of the patient. If records are properly released, only copies should be allowed to leave the office and the original should be maintained.

INFORMED CONSENT

The primary aspect of informed consent is the duty to disclose.³ Informed consent is based on shared decision from physician and patient, with the

physician understanding the relevant values of the patient and the patient understanding the nature of disease and intervention, including risks and benefits.¹⁸ All details should be explained, so that a reasonable person could understand the procedure and could then refuse the surgery based on the potential problems. The most common problems should be included within the consent. The patient needs all information necessary to enable him to make an intelligent decision as to whether to submit to a

proposed treatment and to make the consent valid. The only alternatives that need to be discussed are those that involve the same or a similar risk level and benefits as those found in the proposed form of care.

The consent is valid if the patient has: (1) substantial understanding of the disease and the nature of the intervention, including both the benefits and the risk; (2) the ability (capacity or competence) to provide authorization to the physician to proceed; and (3) substantial freedom from control by others.¹⁸ It is both a legal and moral responsibility of the surgeon that patient consent is obtained before the procedure is performed.¹⁹

Informed consent is not to be confused with a *consent form*. The purpose of a written consent form is to document that a process of informed consent has taken place to protect the physician if the process is later disputed.¹⁸ There is no legal obligation to obtain a signed consent prior to surgery.^{3,19} The consent form does suggest that the surgeon has spent time with the patient explaining the operation, including risks and benefits to him. Such form is little more than a formal acknowledgement of the patient education process.¹²

Apart from the consent form, the surgeon still has to enter in the chart what has been told to the patient.

LACK OF CONSENT

The surgeon should understand that consent does not extend to procedures that are not part of the treatment consented to. Under common law, any unauthorized touching of a patient constitutes a battery. The touching that takes place in a clinical situation is not a battery if the patient gives consent. Thus, a surgical procedure done without consent, whether expressed or implied, is a battery and the surgeon can become liable.

The standard of disclosure is not to be measured by what a reasonable doctor would have told the patient, but what a prudent patient would be expected to know.²⁰ To prove lack of informed consent, the patient would have to show: (1) a physician's failure to disclose; (2) breach of that duty; (3) injury to the patient.^{20,21}

COMPLICATIONS

Complications are an inescapable consequence of any surgical procedure. Because a large part of otolaryngologic, facial plastic, and reconstructive surgery falls under the designation of elective surgery, postoperative complications are particularly distressing to both physician and patient.¹ If the stan-

dard of care for developing informed consent was met, the patient has been provided with information regarding risks and complications.⁸ From jurisdiction of European Courts, it may be concluded that complications with an incidence of more than 1% have to be mentioned to the patient, especially if a risk is about 1% and is so obviously vital to an informed choice that no reasonably prudent surgeon would fail to explain.¹⁵

The information about complications should be in the context of the surgeon's experience, not that of a world class surgeon who publishes low complications rates due to his experience and competence.¹ Physicians have the obligation not only to warn patients of the complications, but also to make the patient understand what this complication means.

Denial by patients of the possibility of postoperative complications is a very troublesome problem.⁷ Many patients seem totally unaware that, however remote, complications are indissolubly connected with surgery and might indeed happen to them. Regardless of the reason of denial, a potential complication may pose a medicolegal problem. The inhibition of the patient's ability to hear and to comprehend stresses the importance of documenting informed consent.

Having prepared the patient in the appropriate way does make an enormous difference in handling of a postoperative complication. Many patients who feel that the surgeon made every effort to inform and felt that the surgeon was honest, conscientious, concerned, and thorough will be less inclined to file claims, even in the presence of unsatisfactory results or untoward complications.²² Patients who are adequately informed are more likely to regard a complication as a known risk and a complication may be more readily accepted regardless of the cause. However, if a complication occurs without forewarning, a discussion of the complication will be easily perceived by the patient as excuses. Doubts about the surgeon's honesty, conscientiousness, concern, and competence will severely tax the patient-doctor relationship. No matter how thorough the consultation or how complete the information provided on the risks and complications, the surgeon will still be held liable if the complication resulted from negligence.

Adequate handling of a complication even in a forewarned patient is in the best interest of patient and doctor. Hear the patient out and give adequate medical as well as emotional support and respect. Good medical ethics dictate that complications must be discussed openly and in clear terms with the patient and should never be denied. Providing information to maintain informed consent is a continuous process and not just a moment in time. Modification in treatment and care must be made to

reflect changing conditions and circumstances and the Information provided during the initial consultation must be continuously updated.⁸ Try to deal with facts. Tell the patients what can be done and what cannot be done. If possible, never take hope away. Document the problem carefully with chart entries and, if possible, photographs. Be available. Inform nursing personnel that the patient should have easy access to you.

Any time the patient questions the physician's competence in handling the complication, it is best to obtain a second opinion. It is recommended that this be done by the physician by telephoning the consultant in front of the patient, so that the patient understands your concerns and what has been said and what you are asking the consultant to do. Friendly consultation is not meant to minimize the complication. The patient must be helped by showing concern and recognition of the problem. All efforts should be made to soothe unpleasant feelings. Inflammatory statements should be prevented.

In case of malpractice action, obtain legal advice. The way physicians react in case of litigation is often emotional: either strong resistance with aggression and anger with respect to the plaintiff or a sense of guilt. However, do not give way to one's feeling too easily. Still try to work on improving the patient-doctor relationship, if possible. Good documentation in case of malpractice action is imperative. This also means that changes should never be made in the patient's record. The fact that the records have been changed may be explained in court as follows: the doctor made changes because he felt he was negligent.

The doctor must defend the rights and dignity of the patient²³ and this is hopefully acknowledged and recognized by the patient. The doctor must never for a moment or in the least degree resign his conscience to the litigator. The previously mentioned conditions would make lawsuits unnecessary. It is our feeling that from the psychosocial perspective of the patient and the doctor lawsuits are better prevented. During the lawsuits, the patients are emotionally confronted with their problem and have to relive an unhappy situation. Sometimes only after years of litigation does the patient get recognition of the problem. The economic compensation may only be the second goal. This statement is not meant to imply that all lawsuits against doctors are unjustified. Many patients are encountered who undoubtedly have a firm basis for action.

FINAL COMMENT

Good communication, rather than poor results, is the most important denominator of litigation be-

tween patient and physician in otolaryngologic, facial plastic, and reconstructive surgery. Adequate preoperative counseling is the key to patient satisfaction and prevention of legal action. Informed consent may well be considered the legal counterpart of good medical ethics. Dissatisfaction is often a result of improper patient information and a failure to establish or maintain rapport between patient and surgeon.

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