

Malpractice Litigation in Plastic Surgery: Can We Identify Patterns?

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Abstract

Background: Malpractice litigation has a significant impact on healthcare costs and important professional implications for healthcare providers.

Objectives: The authors sought to comprehensively characterize the litigation landscape in plastic surgery across its different subspecialties.

Methods: The authors utilized the Westlaw legal database to conduct a comprehensive search of malpractice cases in the United States in the following categories: cosmetic, reconstructive, hand, craniofacial, and gender affirmation surgery. They conducted both a Boolean and a natural language search to identify cases in which a plastic surgeon was the defendant. Data were analyzed employing descriptive statistics, logistic regression, and relative risk calculations.

Results: In total, 165 cases were included. Most surgeons accused of malpractice worked in a private setting (148 [90%]). Among the 22 (13%) cases that contained information on board certification status, most surgeons were board certified (17 [77%]). Resident involvement was mentioned in only 5 (3%) cases. The majority of cases were successfully defended by surgeons (98 [60%] vs 65 [40%]), particularly in craniofacial surgery (risk ratio: 1.54; $P = 0.03$; 95% CI: 1.03–2.3). Surgeons who successfully defended a case were more likely to benefit from summary judgment ($P = 0.005$).

Conclusions: Malpractice litigation is commonplace in medical practice, and no specialty is spared. Legal outcomes were in favor of plastic surgeons in the majority of cases, particularly those that proceeded to summary judgment. Surgeons can avoid litigation by maintaining detailed office and surgical notes, always obtaining informed consent, adequately following and monitoring patients after surgery, and ensuring compliance by communicating frequently and effectively.

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Malpractice is an unnerving and sensitive topic for all physicians. In a system that places increasing emphasis on quality outcomes and harsher penalties for patient dissatisfaction, tolerance for adverse outcomes and medical errors has diminished. Surgeons, in particular, are caught between a high care standard that often ignores cost and a series of federal mandates that emphasize low-cost care.¹ Combined with increasing patient expectations, this often creates a window for malpractice litigation. In the past, malpractice cases were quoted to be responsible for approximately \$10 billion in costs for healthcare providers.² Of those, plastic surgeons are more than twice as likely than

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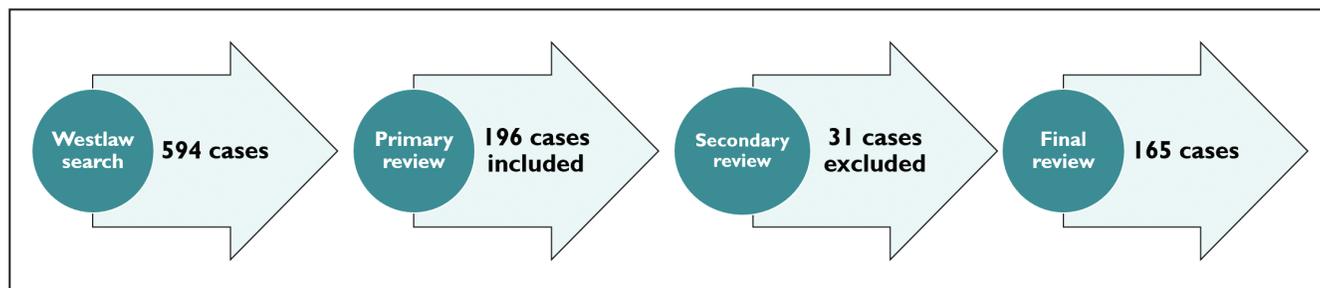


Figure 1. Timeline of search and review of cases.

other physicians to face at least 1 malpractice claim annually (15% vs 7%).³ The majority of such malpractice suits described in existing literature stem from breast surgery and reconstruction; facial cosmetics including blepharoplasty, rhinoplasty, and facelift; as well as abdominoplasty.

Growing malpractice suits have also led to increasing insurance costs. With some degree of geographic variation, malpractice insurance fees now often approach the 6-figure range.³ As Ruberg noted, this has affected practice patterns in larger academic centers where plastic surgery department revenue is dominated by reconstructive rather than cosmetic surgery.⁴ Looming malpractice threats have also affected surgeons' practice patterns to minimize their susceptibility. These include obtaining informed consent in the office with clear documentation and preferentially avoiding geographic regions with notoriously higher rates of malpractice litigation such as New York.⁵

Few reviews of malpractice litigation in plastic surgery have been published. Previous analyses on the topic have focused on specific categories including facial cosmetics and breast surgery.⁶ Their findings have repeatedly stressed the importance of informed consent and proper patient selection.⁷ Claims against poor cosmetic results, excess scarring, or limited expertise have also surfaced intermittently.⁸ Given the evolution of current malpractice litigation, it is important to understand the nature of current lawsuit trends. In this study, we sought to comprehensively characterize the litigation landscape in plastic surgery across its various categories.

METHODS

We queried the Westlaw (Thomson Reuters) legal database to identify malpractice cases in plastic surgery in the United States between February 2000 and August 2017. Utilizing both Boolean and natural language, we conducted a comprehensive search for cases in which a plastic surgeon or practice was the defendant. The following plastic surgery categories were included: aesthetic/cosmetic, reconstructive, hand, craniofacial, and gender affirmation surgery. We employed search terms to exclude cases in orthopedic surgery, neurosurgery, otolaryngology, and ophthalmology. The jurisdictions included all US state and

federal courts. Between October 2017 and January 2018, S.S. and M.A.C. performed a primary review of all cases to include only those that met the 2 primary relevance criteria: (1) had a plastic surgeon as the named defendant, and (2) medical malpractice was the cause of action.

Next, S.S., M.A.C., and C.W. performed a comprehensive secondary review of the cases between February and April 2018. We perused each case to obtain background information related to the characteristics of the case and parties involved including patient sex and age where available, type and timing of the claimed error, patient outcomes leading to litigation, year and jurisdiction of the event, practice setting (academic vs private), resident involvement, surgeon board certification status, and type of procedure. Legal factors of interest included allegation and legal outcomes such as resolution (court decision, summary judgment, or settlement), appeal requests, winning party, and payout amounts where applicable. For cases in which there were disagreements, these were discussed between at least 2 of the 3 reviewers until the facts of the case were clarified.

We employed descriptive statistics to characterize our study population. Pearson's chi-squared test was used to explore potential associations between plaintiffs' complaints and legal outcomes as well as the relationship to board certification and resident involvement. We also performed a logistic regression to identify which factors were related to an increased or decreased odds of surgeons winning the litigation. Statistical analysis was performed using Stata 13 (StataCorp, College Station, TX).

RESULTS

Review of Cases

With our search criteria, we identified a total of 594 cases through Westlaw. Subsequently, 3 of the coauthors (S.S., M.A.C., and C.W.) performed a primary review of cases, after which 196 cases were found to meet the 2 primary relevance criteria: (1) had a plastic surgeon as the defendant; and (2) the primary allegation was in fact medical malpractice. During the secondary review process, 31 cases were excluded because of duplicate records or incomplete

Table 1. Demographic Characteristics of Plaintiffs and Defendants (n = 165 unless otherwise specified)

Plaintiffs	n (%)
Age, y	
Mean (SD)	42 (15.8)
Range	18-65
Sex, n (%)	
Female	147 (89)
Male	18 (11)
Defendants	
Surgeon board certification	
No information	143 (87)
Board-certified	17 (10)
Not board-certified	5 (3)
Practice setting	
Private	148 (90)
Academic	14 (8.5)
Other	3 (1.5)
Resident involvement	
No residents mentioned	160 (97)
Resident mentioned	5 (3)

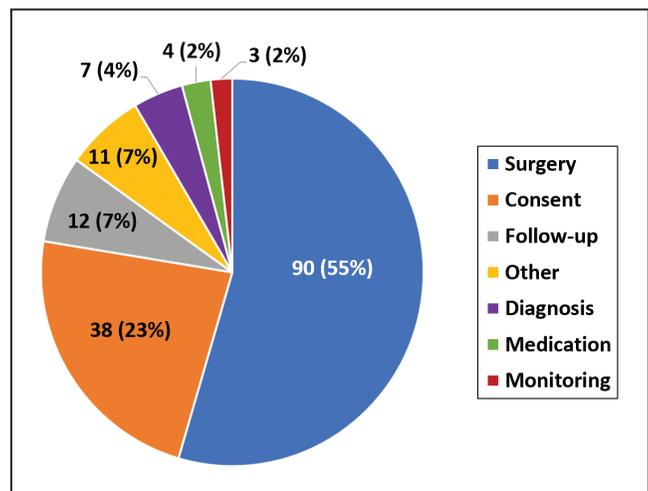
information. The 165 included cases were then perused to extract background and legal information (Figure 1).

Demographic Characteristics of the Parties Involved

The mean age of patients filing a complaint was 42 years (n = 15, SD 15.8) ranging from 18 to 65 years. Plaintiffs were predominantly female (147 [89%]) compared with male (18 [11%]). In relation to defendants, most surgeons accused of malpractice worked in a private setting (148 [90%]) compared with academic hospitals (14 [8.5%]). Among the 22 (13%) cases that contained information on board certification status, most surgeons were board certified (17 [77%]). Resident involvement (ie, a resident mentioned in a case as a defendant or co-defendant) was noted in only 5 (3%) cases. Demographic characteristics of plaintiffs and defendants are summarized in Table 1.

Analysis of Cases

When broken down by subspecialty, most cases were about cosmetic procedures (122 [74%]) followed by reconstructive surgery (26 [16%]). The most common type of

**Figure 2.** Component of care where malpractice allegations were cited.

error cited in legal proceedings was gross negligence (126 [77%]), followed by errors of commission (10 [6%]) and omission (9 [6%]). The malpractice allegation was most commonly about the surgical procedure (90 [55%]), followed by the informed consent process (38 [23%]) and follow-up (12 [7%]) (Figure 2). The most common clinical outcome that led patients to pursue litigation was “disfigurement” (70 [42%]), followed by “injury” (40 [24%]) and “psychological distress” (15 [9%]). Regarding operative timing, most errors occurred intraoperatively (84 [51%]) compared with the preoperative (22 [13%]) or postoperative (27 [17%]) periods. Of note, 31 (19%) cases cited errors in more than 1 operative period. Case characteristics are presented in Table 2.

Legal Outcomes

In relation to legal outcome, the majority of cases were successfully defended by surgeons (98 [60%] vs 64 [40%]), particularly in craniofacial surgery (risk ratio [RR]: 1.54; $P = 0.03$; 95% CI: 1.03–2.3) (Table 3). A logistic regression adjusted for patient sex and practice setting showed no statistically significant association between the odds of surgeons winning a trial and the type of error (odds ratio [OR]: 1.4; $P = 0.14$; 95% CI: 0.87–2.47) or the component of care where the alleged malpractice took place (OR: 0.87; $P = 0.17$; 95% CI: 0.71–1.06). However, regarding patient outcome, when compared with “injury,” surgeons were more likely to win cases that cited “disfigurement” (OR: 5.3; $P < 0.001$; 95% CI: 2.14–13.12) or “psychological distress” (OR: 8.1; $P = 0.007$; 95% CI: 1.76–37.78) as the outcome experienced by patients. In contrast, they were more likely to lose cases that cited “death” (OR: 0.4; $P = 0.36$; 95% CI: 0.05–2.87) or “injury” (OR: 0.26; $P = 0.18$; 95% CI: 0.03–1.87) as the reason for litigation, although these results were not statistically significant.

Table 2. Case Characteristics (n = 165)

Category	n (%)
Subspecialty	
Cosmetic	122 (74)
Reconstructive	26 (16)
Craniofacial	10 (6)
Hand	1 (1)
Gender affirmation	1 (1)
Other	4 (2)
Type of error	
Gross negligence	126 (77)
Commission	10 (6)
Omission	9 (5)
Other	19 (12)
Component of care where error occurred	
Surgery	90 (55)
Informed consent	38 (23)
Follow-up	12 (7)
Diagnosis	7 (4)
Medication	4 (2)
Monitoring	3 (2)
Other	11 (7)
Patient outcome leading to complaint	
Disfigurement	70 (42)
Injury	40 (24)
Psychological distress	15 (9)
Death	13 (8)
Disability	7 (5)
Other	20 (12)
Operative period where error occurred	
Intraoperative	84 (51)
Postoperative	27 (17)
Preoperative	22 (13)
Multiple	31 (19)

The court decision was most commonly a judge verdict (118 [73%]), followed by a jury verdict (37 [23%]). A settlement agreement took place in 3 (2%) cases. A payout

Table 3. Winner of Litigation by Plastic Surgery Subspecialty

Specialty	Winner	
	Plaintiff n (%)	Surgeon n (%)
Cosmetic	50 (41)	71 (59)
Reconstructive	11 (42)	15 (58)
Craniofacial ^a	1 (11)	8 (89)
Hand	0	1 (100)
Gender affirmation	0	1 (100)
Other (burn, pediatric)	2 (50)	2 (50)
Total	64 (40)	98 (60)

^aRR, 1.54; *P* = 0.03; 95% CI: 1.03-2.3.

amount was mentioned in 21 cases, the median value of which was US \$600,000 (interquartile range: \$1,500,000 [\$100,000-\$1,600,000]). The monetary award was given to a surgeon in only 1 case. Of note, 73 (44%) of the cases were resolved by summary judgment. The majority of cases that proceeded to summary judgments were successfully defended by surgeons (52 [72%]) compared with plaintiffs (20 [28%]) (*P* = 0.005). Most cases were appealed (140 [85%]). The top 3 jurisdictions where litigation occurred were New York (30 [18%]), Texas (22 [13%]), and California (13 [8%]) (Figure 3). Patient and legal outcomes are summarized in Table 4.

DISCUSSION

Malpractice litigation has a significant impact on health-care costs and important professional implications for healthcare providers involved.^{9,10} Understanding the factors implicated in malpractice cases is critical to recognize patterns and identify opportunities to address common errors. Because there is a greater risk of malpractice among surgeons,¹¹ it is important for physicians in different surgical specialties to become familiar with the litigation landscape that is most relevant to them. In plastic surgery, the vast majority of cases reviewed were related to cosmetic surgery among female patients. Most plastic surgeons involved in malpractice worked in a private setting, and most errors were related to the surgical procedure itself at different operative timepoints. In most cases (87%), there was no information about board certification. Only 22 cases contained this information, and among those, 17 confirmed that the surgeon was board certified. Westlaw case reports only specify if the physician was board certified and do not list the specific specialty. However, our search specifically used terms

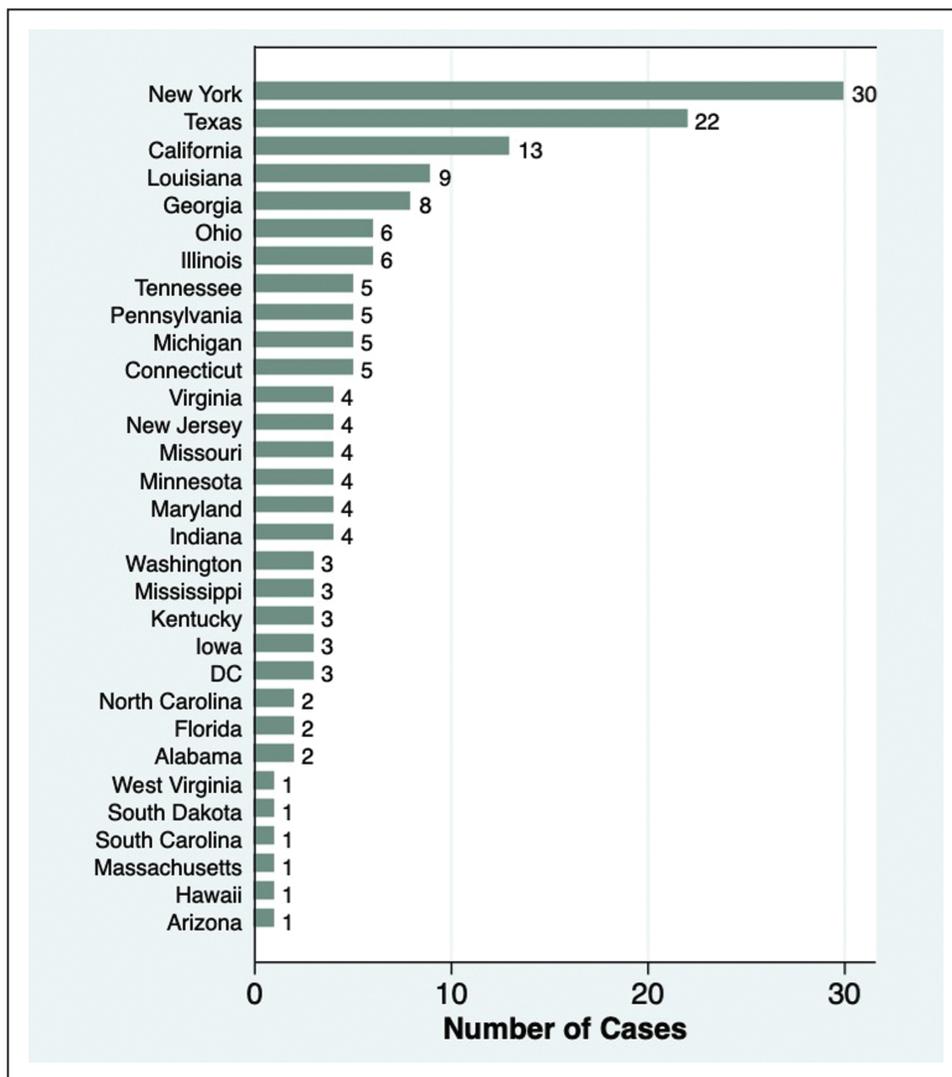


Figure 3. List of jurisdictions where plastic surgery malpractice cases took place.

to exclude cases in orthopedic surgery, neurosurgery, otolaryngology, and ophthalmology and to only include cases in which a plastic surgeon or practice was the defendant. Therefore, for the cases that mention board certification, it is in plastic surgery.

Legal Outcomes

In relation to legal outcomes, it is important to note that in most cases, the court decision was in favor of plastic surgeons. After reviewing the cases in which surgeons prevailed, some circumstances that may result in a positive outcome include cases where patients could not secure expert testimony, filed suit outside the statute of limitations, or interfered with standard postoperative care by supplementing their own medication. On the contrary, surgeons lost cases that deviated from the standard of care, for example, by removing too much skin, utilizing the wrong size

implant, inflicting serious injury, or failing to provide adequate postoperative monitoring.

Although surgeons successfully defended 60% of cases, it is in the defendant's best interest to avoid the burden of lawsuits by exhausting nonlitigious measures first. Such measures include meeting with the patient to discuss their concerns, offering corrective procedures, and ensuring compliance throughout the operative process by communicating frequently and effectively.¹²⁻¹⁴ Many of the cases unsuccessfully defended by the surgeon were proven, usually through expert testimony, to be significant departures from standard of care. It is the physician's responsibility to exercise good judgement and maintain a sound understanding of what constitutes the standard of care for their particular specialty and the procedures performed.

Interestingly, there was no statistically significant association between the odds of surgeons winning a trial and the

Table 4. Legal Outcomes (n = 165 unless otherwise specified)

	n (%)
Court decision	
In favor of surgeon	98 (60)
In favor of plaintiff	65 (40)
Type of decision	
Judge verdict	118 (73)
Jury verdict	37 (23)
Settlement	3 (2)
Other	2 (1)
Summary judgment	
Yes	73 (44)
No	92 (56)
Appealed	
Yes	140 (85)
No	25 (15)
Payout amount (n = 21)	
Median	600,000
IQR	1,500,000 (100,000-1,600,000)

Payout amounts in US dollars. IQR, interquartile range.

type of error or the severity of outcomes. In fact, previous reports indicate that lawsuits correlate not to outcomes but to whether the surgeon is seen as being compassionate about the outcome.¹⁵ In our review of cases, we did not find reports about payouts being adjusted based on how the jury perceives the surgeon. Instead, many of the rewards are based on the price of correcting procedures, legal fees, and damages associated with psychological distress and lost wages.

Surgeons who successfully defended a case were also more likely to benefit from a summary judgment compared with plaintiffs, which merits a discussion of this type of judicial process.

Summary Judgment Cases

Previous surveys of medical malpractice have not discussed relevance of summary judgment in malpractice cases.^{9,10,16,17} Defendant surgeons succeeded in 72% of the cases resulting in motions of summary judgment. A motion for summary judgment is ruled for 1 party when the facts of the case are believed to be undisputed. Should the facts of the case be deemed indisputable by the judge during discovery, the judge may grant or deny the defendant's

motion for summary judgment depending on whether the judge determines the law was violated. In a typical trial, 2 general topics of validity are argued. Attorneys may argue over the application of law, leaving the judge to determine its validity. Attorneys may also argue the facts of the case, which then falls to the jury to decide. In a summary judgment, the facts of the case are agreed by both parties to be indisputable, and the only decision to be made is over the question of law by the judge. When summary judgment is granted, the case is dismissed in the phase of discovery and will not continue to a jury trial.

Certain factors may increase the likelihood that a summary judgment motion will be granted in favor of the defendant surgeon. Surgeons and their staff are required to keep detailed operative notes and copies of signed statements, which are ideal items of evidence to be presented as the factual background in a motion for summary judgment. In a malpractice case, the plaintiff must prove that the standard of care was not met. Decisions regarding the standard of care are often determined utilizing expert testimony by surgeons in the same field. This is particularly important for plastic surgeons who perform elective cosmetic surgery. Patients that enter a malpractice suit because they are displeased with the results of their cosmetic surgery must be able to prove that a standard of care was not met. This can be difficult to prove because an expert witness is required to prove that standard of care was not met during the procedure. Expert witnesses primarily scrutinize medical records to determine if the standard of care was met. The patient's overall satisfaction with their appearance is highly subjective and does not factor into their testimony.^{18,19} Furthermore, summary judgment is ideal for malpractice defense because it allows the defendant to avoid a jury trial and be dismissed quickly. Jury trials may take years to conclude, and a lengthy trial can take a considerable toll on the effectiveness and reputation of the surgeon.²⁰

Payout in Malpractice Cases

Of the cases where payout was specified, the amount was highly variable. The total payout in a malpractice case is the sum of the 3 categories of damages: economic damages, non-economic damages, and punitive damages. Economic damages are characterized as quantifiable expenses such as past and future medical expenses and loss of wages. Non-economic damages are unquantifiable expenses relating to pain and suffering.

Economic damages were observed to make up significantly less of the total payout compared with non-economic damages. In *Tipton vs Campbell*, \$47,548 of the total \$1,797,548 award payout was allocated for past and future medical expenses.²¹ In *Krushena vs Meslemanni*, \$14,000

of the total \$142,000 payout was allocated for economic damages.²² Non-economic damages are determined by a jury and are therefore subject to the attitudes and sympathies of the jury towards both plaintiff and defendant. To curb exorbitant non-economic damages in medical malpractice suits, individual state legislatures can choose to implement caps on non-economic damages relating to pain and suffering. The state of New York, where the highest number of cases reviewed were based, does not have a cap on non-economic damages. California, meanwhile, had the second highest number of cases reviewed and, in addition, has a cap of \$250,000 on non-economic damages. However, it is important to note that the cap on non-economic damages in California applies only to professional negligence. In the case *Perry vs Shaw*, the plaintiff received a \$1,030,000 payment of non-economic damages when they were able to prove that the defendant surgeon's negligence amounted to battery when he performed an operation that the patient did not consent to.²³

Non-economic damages comprise a significant amount of the total payout in a malpractice case.²⁴ An awareness of the severity of non-economic damages in a jury case might be a factor in the observed preference for summary judgment by defendant surgeons. Furthermore, states with no cap on economic damages are particularly challenging for surgeons in private practice, as they are considerably more likely to engage in malpractice litigation than surgeons in an academic practice. In *Fledderman vs Glunk*, the court ordered the defendant surgeon to pay \$3,525,000 in compensatory damages and \$15,000,000 in punitive damages following the death of a patient during an ultrasonic-assisted liposuction procedure.²⁵ This case took place in Pennsylvania, a state that does not implement caps on economic and non-economic damages. At the time of the case, there were no caps on punitive damages either. Following economic concerns regarding excessive punitive damages, the Pennsylvania Legislature limited the amount of punitive damages to double the amount of compensatory damages by passing the Medical Care Availability and Reduction of Error Act in 2002. The defendant surgeon filed for bankruptcy following the decision in favor of the plaintiff in the malpractice case.

Limitations

We acknowledge important limitations to our study, particularly related to the legal database used. Westlaw reports federal trial court cases, but at the state level the majority of cases are appellate and not trial court decisions. Approximately only 10% of trial court cases are appealed, and federal courts rarely have medical malpractice cases because it would require diversity jurisdiction between citizens of different states. This greatly limits the

fact situations available for review. Furthermore, the information in each case report varies; not all case reports specify certain factors such as patient age, board certification status, physician subspecialty, or resident involvement.

CONCLUSIONS

Although legal outcomes are in favor of plastic surgeons in the majority of cases, physicians must be cognizant of the litigation landscape in this specialty in order to reduce the burden of litigation. A basic understanding of the factors implicated in malpractice claims can help surgeons exercise care to avoid common pitfalls. Outside of operative errors, poor discussions when obtaining consent, deficient care before and after surgery, and a failure to set appropriate expectations are likely to lead to lawsuits. Surgeons can avoid litigation by maintaining detailed office and surgical notes, always obtaining informed consent, adequately following and monitoring their patients after surgery, and ensuring patient compliance by communicating frequently and effectively. Additionally, it is important for the practicing surgeon to become familiar with the different outcomes of malpractice litigation and what factors may lead to a summary judgment that can help the defendant avoid lengthy and expensive trials.

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