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This article covers some of the main issues in breast surgery malpractice cases. Plastic surgery is fundamentally different from other fields of medicine, because it is nearly always elective. Instead of facing surgery unwillingly for an unexpected illness, most plastic surgery patients get to go shopping at their leisure for improved body parts. Their surgery often happens in the doctor’s private surgical suite, not a hospital. This scenario presents a paradox for the malpractice trial lawyer.

**The Likeability Factor**

Every trial lawyer wants, and usually needs, the jury to like their client. In cases of mastoplasty, or breast plastic surgery, plaintiff’s counsel must be concerned that, except in cases of post-mastectomy or post-accident breast reconstruction, the plaintiff will be subtly portrayed by the defense as a vain woman who wanted Kim Kardashian breasts. If surgery went badly, it will be implied that she willingly and foolishly assumed the risk. Tough luck.

But that’s not necessarily the case. Many women have mastoplasty on uninjured breasts for their emotional well-being. Wanting to feel good about one’s self isn’t always mere vanity. Each of us, no matter how accomplished or well-liked, ultimately links his or her self-esteem to appearance and physical presentation. Breasts are basic to nearly every woman’s sexual identity. Some women with unusually small breasts may go through life with a sense of denied femininity, confidence and sexuality. For some, there is only one way to restore basic feminine self-confidence: breast implants. The artificial implant may ironically be necessary to make some finally feel natural.

Overall size is not the only issue. Some women, rather than being blessed with a “matched pair,” face the mirror and see that nature has given them two breasts of a dramatically different size and shape. A very minor size difference between the two breasts is normal, but a woman with breasts of noticeably different shape and cup size from each other has a problem. Fitting into clothes is a challenge, requiring specially fitted bras and padding. She may have trouble with intimacy, fearing her partner will reject her asymmetric look. To feel fundamentally comfortable with her body and even to fit her clothes, she may turn to the plastic surgeon.

Thus, the plastic surgery malpractice plaintiff may be a very sympathetic figure, not a narcissist. Having hoped to cure a poor self-image through surgery, she may now be the victim of a horrible hoax. Disappointment in appearance may be replaced by the outright anguish of scars and physical distortion.

While the plastic surgery plaintiff may face an image problem with the jury, the defendant also has a reciprocal image problem not common in other malpractice cases. Usually, the defendant plastic surgeon has not saved anyone’s life. He has not maintained anyone’s health. He may be perceived as having “sold” someone on elective surgery. If surgery
went badly, the onus may be on him to explain why he recommended this risky elective procedure.

Thus, plaintiff and defendant will battle for the jury’s sympathy in such cases. Is the defendant a fine surgeon who did his best to satisfy a vain woman, or is plaintiff a poor soul seeking help, who got sold a bill of goods by a cash-motivated doctor? These questions of sympathy and motivation lead directly into the substantive area of informed consent.

**Lack of Informed Consent**

Nowhere is informed consent more fundamental than in plastic surgery. To cure an injury or disease, a treatment with risks is usually more attractive than the problem. In that case, it is sometimes hard for the patient to claim, as the law requires, that she would have refused the treatment if given all the facts. In plastic surgery however, there is no illness to be cured. The risks of surgery therefore take on an even greater importance. A risk of any significance is almost never justified when the patient can almost always leave well enough alone. The burden is on the plastic surgeon to establish and document a careful, caring and detailed informed consent procedure. Instead of a provocative woman who rushed into surgery to get unnecessary big breasts, we may find that his small breasted patient cautiously investigated surgery in the nervous hope that it would improve her self-image. Surely she deserved the full opportunity to consider her risks before submitting to the knife, including a cooling down period. A hesitant woman would proceed with plastic surgery only if the doctor assured her that it would help. She relied upon his advice. On the other hand, if the plaintiff, out of pure vanity, sought a needless breast augmentation that was not right for her, the defendant physician had a duty to discourage her or refuse to proceed. He is not a mere order-taker. He is a physician held to ethical precepts. Although the encounter is initiated by the patient, it is the surgeon who, in the final analysis, must bear the responsibility for recommending and deciding upon surgery. In the event of harm, the PJII standard for lack of informed consent is easily met: Had a reasonable person been properly informed of the risks, a jury might easily conclude she would have said “no,” and gone without the surgery.

**Scars Are Expected**

Plastic surgery can eliminate scars. But a major procedure like a mastoplasty necessarily causes scars. In a breast augmentation, the opening for the implant is quite large, and causes a scar. Usually, this scar is tucked into the inframammary fold. The inframammary fold is the crease where the bottom, or posterior portion of the breast, attaches to the chest wall. However, as this scar is located underneath the breast and in a fold, it is generally hidden from view, allowing an aesthetically pleasing result. In a mastopexy, or breast reduction, breast tissue must be removed, and the resulting scar is thus impossible to hide. It is usually a vertical scar in the center of the breast, starting at the bottom of the areola, and ending in the inframammary fold. While scars are often necessary to a plastic surgery procedure, disfiguring scars are rare and thus suspect as possibly caused by surgical technique below the standard of care.

**Excessive Scarring in Mastopexy**

As explained above, a mastopexy, or breast reduction, usually requires a vertical scar leading from the areola base to the inframammary fold. While this scar is unavoidable, the plastic surgeon must minimize it. A wide, spreading scar is to be avoided. Improper surgical procedure may result in excessive scarring though wound separation, or wound dehiscence. This can occur through failure to leave enough skin to cover. The opening where tissue is removed to reduce the breast is called a skin flap. Enough skin must be left after excision so that the flap closes easily. It is a departure to close the skin flap under too much tension. If the sutures are closed under too much tension and pull at each other, they
will likely separate, causing skin loss at the margins. This leaves an open wound, or wound dehiscence, which can close in only one way: with spreading scars. Such scars can be not only wide, but thick and red. Failure to properly close the wound in this way can be compounded by infection, which will worsen the scar even further. In some cases, the whole contour of the breast may become distorted.

**Symmetry**

Breast symmetry is a fundamental principle of breast surgery aesthetics. When the breasts are symmetrical preoperatively, but asymmetrical after, the surgical technique is suspect. While no outcome is perfect, the plastic surgeon must avoid major discrepancies of contour, volume, and position of the nipple areolar complex.

**Symmetry and the Inframammary Fold**

The inframammary fold is a vital landmark for the breast. It is composed of connective tissue affixed to the chest wall. Located at the base of the breast, it supports much of the weight of the breast. If an inframammary fold is moved, it must be resecured to the chest wall. Both inframammary folds should be at the same level on the chest wall. If they are not, the surgeon may have performed the procedure improperly. One should not be noticeably higher than the other.

**Symmetry and the Nipple Areolar Complex**

The Nipple Areolar Complex is an important structure and landmark. It is the visual focal point of the breast. Both nipples, or nipple-areolar complexes, must face forward, and appear on the center of the breast. If they do not, symmetry may have been improperly sacrificed.

**Augmentation Errors**

In breast augmentations, the patient receives one or more breast implants to enlarge one or both breasts. This procedure comes with a risk of reoperation for eventual implant failure. However, the surgeon must insert the implant properly, or early reoperation will be guaranteed. Most implants are inserted under the pectoralis major muscle in the chest. This is called a “sub-pectoral” or “retropectoral” implant. The surgeon must dissect and create a pocket under the muscle for the implant. Thorough physical examination and planning are necessary to ensure that the pocket the surgeon creates is the right size for the implant. If the pocket is too big, the implant may move. If the pocket is too small, or the inframammary fold is not well secured to the chest wall, the implant may become inferiorly malpositioned, or “bottom out.” This is when the implant stays under the skin, but falls below the sub-pectoral pocket, protruding below the inframammary fold, onto the chest wall below the breast. If the pocket is too small, the surgical wound itself may also separate and cause a spreading scar, or wound dehiscence. The wound must also be closed adequately, through multiple layers of stitches. Failure to follow this technique may also cause wound dehiscence.

In all plastic surgery, aesthetics is important. The aesthetic goal of augmentation must grow out of careful doctor-patient communication. As discussed above, size alone is not the only factor to consider. Symmetry, shape and contour are key elements. There are many variations on these themes: Implants placed too high; implants placed too low; uneven positions of the inframammary folds. Also, implants may be placed too far apart, or laterally malpositioned. This causes a spread-out look. Implants may be placed too close together, causing medial malposition, or symmastia. This causes a squeezed-in look.

**Preoperative Planning**

Careful preoperative planning is essential. The surgeon must make precise measurements of the breast width. The surgeon must measure the distance from the sternal notch in the neck and from the mid-clavicle to the nipple areolar complex. The patient’s size, weight and torso width must be taken into consideration so that
the breasts are in proportion to the rest of the body. A small woman will not accommodate large implants, and it would be a departure to give her implants acceptable only for a larger woman. The patient must be carefully marked on her skin before surgery; this is literally a roadmap for the surgeon to follow during the operation. Complications happening very soon after surgery are suspect for poor planning or poor surgical technique.

**Damages**

Negligent breast surgery, whether due to poor preoperative planning or poor surgical technique, often leads to two possible outcomes: permanent deformity, or reoperation, or both. Reoperation carries a higher risk of complications than the initial surgery, including worsened scarring, infection and compromise of blood supply to the breast. Even if repair reoperation improves the deformity, the patient may still be left with permanent residual deformities. The degree of deformity and/or the risks of reoperation will affect damages in any given case. The more numerous the deformities, the greater the damages. One malpositioned implant reflects one measure of damages. A malpositioned implant plus wound dehiscence, plus asymmetry, all from the same procedure, reflects another.

Reported verdicts and appellate damages decisions in New York mastoplasty malpractice cases show a wide range of values for pain and suffering. The following case citations report the sum in each case for both past and future pain and suffering awards combined: In *Dehaarte v. Ramenofsky*, 20 Misc. 3rd 1124(A), 867 N.Y.S.2d 373 (Kings Co. 2008), plaintiff sued for a lost nipple following subcutaneous mastectomy for male gynecomastia, or male oversized breasts. The trial court reduced the jury’s award of $2,250,000 to $335,000. In *Severance v. Landsman*, 004575/2006, a Suffolk County jury awarded $1,250,000 (later reduced by agreement to $190,000), when a plastic surgeon used oversized breast implants in an augmentation, causing bottoming out and excessive scarring. In *Weiner v. Jacobs*, 101267/2006, a New York County jury awarded $200,000 for overcorrection of gynecomastia, causing disfigurement. In *Epstein v. Neumann*, 8591/2005, a Nassau County plaintiff received $311,000 when tension on the suture resulting from excessive implant size caused spreading scars and ptosis. In *Glover v. Naishad*, 009906/2005, a Nassau County jury awarded $120,000 when a plastic surgeon failed to diagnose and treat a hematoma prior to performing breast reduction surgery, resulting in scarring and asymmetry. In *Hertz v. Grossman*, 1893/2005, a Kings County jury awarded $200,000 for failure to treat a post-operative infection, causing scarring and hospitalization. In *Sutch v. Yarinsky*, 292 A.D. 2d 715, 739 N.Y.S. 2d 214 (3d Dep’t. 2002), the Appellate Division upheld the jury’s award of $800,000 when a 26 year old female plaintiff lost the entire nipple areolar complex of her left breast, leaving in its place a large scar. In *Baez v. Dombroff*, 142 A.D. 2d 705, 530 N.Y.S. 2d 847 (2d Dep’t 1988), the Court sustained $750,000 out of the original $2,625,000 verdict, for heavily scarred breasts after a mastopexy.

As well, one should always be cognizant of defense verdicts: *Reid v. Israeli*, 003937/2005, Queens County; *Newson v. Gallagher*, 032930/2002, Queens County; *Rosario v. New York Hospital & Imber*, 1727/1984, New York County.

**Conclusion**

The foregoing represents only a basic sampling of the issues which may arise in breast plastic surgery, or mastoplasty cases. It should serve as an aid in issue identification when a potential client walks into the office.

**Biography**

Mitchell D. Kessler based this article upon research he performed for a medical malpractice case which he tried to a successful conclusion. At New York Law School, he won the trifecta in the Froessel Moot Court Competition: Best Oralist, Best Brief and Best Team. Some of the notable cases he has handled are chronicled in his book, *May It Please the Court*. He is an associate at Levine & Grossman in Mineola, New York.