The perils of cosmetic surgery/medical tourism

Laurence Vick

Abstract
The article discusses a case involving negligent aesthetic surgery. The surgery took place in a Belgian clinic and was performed by an Italian surgeon.

"MR" V DR VALERIO BADIALI (D1) ELYZEA COSMETIC SURGERY GROUP (D2)

Background

The Claimant then aged 38 underwent Bilateral Facelift and Bilateral upper and lower eyelid surgery performed by an Italian surgeon (D1) at D2's clinic in Brussels in June 2005 after initial discussions with D1 at D2's Harley Street premises. She had seen D2's website and promotional material in England (D2 advertises widely in England and their website has a co.uk suffix); she signed the contract in English and paid for her surgery in Sterling after the initial meeting with D1. D2's literature asserted that "Elyzea's plastic surgeons who provide consultations are fully registered with the British GMC and most of them are listed on the Specialist Register for Plastic Surgery".

No adequate medical records were disclosed by either Defendant but it was inferred from the Claimant's injuries that she had suffered complications during her surgery, specifically a bleed within her left cheek which caused a build-up of pressure. She suffered damage to the infra-orbital and greater auricular nerves, damage to her left upper lip and damage to the skin of her face lateral to both eyelids and to the front and behind both ears. D1 agreed to undertake further surgery in October 2006 to improve the appearance of the scarring to her face and to remove a retained suture from her right cheek. This failed to improve the Claimant's scarring. The Claimant was given no warning by D1 or D2 as to the risk of nerve damage or of any injury similar to that which she suffered.

After the unsuccessful corrective surgery D1 failed to respond to the Claimant's emails and telephone calls and D2 maintained the position they had held throughout that they were not responsible and that under Belgium law any litigation must be directed to the surgeon.

It later transpired that D1 faced complaints from numerous dissatisfied patients and he returned to Italy after D2 were assumed to have terminated their relationship with him.

Instructions were received from the Claimant in May 2008 and we agreed to enter into a CFA. All correspondence sent on behalf of the Claimant including Letters of Claim were ignored by D1 and D2.

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Proceedings

Once it became apparent that the Italian surgeon D1 was untraceable, on the basis that the Claimant had entered into a contract with the clinic to provide the package of care the decision was taken to focus on D2. The Claimant pleaded that D1 was either an employee or agent of D2 for whom they were vicariously liable. All communications to D2 were sent to their London premises and Brussels head office. D2 chose not to obtain legal representation throughout the proceedings (save for the penultimate hearing for the assessment of damages). Proceedings were issued on a protective basis in June 2008 and the Court subsequently agreed to extend time for service of proceedings and granted permission under CPR 6.33 to serve on D1 and D2 outside the jurisdiction. Proceedings were served on D2 at their London premises in February 2009. The Court granted further extensions of time to attempt service on D1 in Italy to April and July 2009.

In the absence of any response from D2 Judgment was entered in default in April 2009 for damages to be assessed. As it had been impossible to serve directly on D1, deemed service was carried out under Article 140 of the Italian Code of Civil Procedure.

All correspondence to D2was ignored and the only contact was two telephone calls from Brussels to the Claimant's solicitors. D2 failed to comprehend that they had been found to be liable and that Judgment had been entered against them. In these telephone calls they insisted that the Claimant had sued the wrong party and that under Belgian law liability lay with the surgeon. They admitted that they had themselves been attempting to trace D1 in Italy because of problems with his surgery carried out on other dissatisfied patients.

The Claimant's expert medical evidence confirmed that she was suffering from numbness of the left side of her face, lack of symmetry of the left side of her face, abnormality of movement of the left upper lip, prominent scarring of the face lateral to the eyelids on the left and right and in front and behind the ears on the left and right and a palpable firm area within the subcutaneous tissues of the left cheek. The numbness, lack of symmetry and abnormality of movement were due to nerve damage which was likely to be permanent and it was unlikely that any further treatment would improve the symptoms. Similarly, the palpable area to the left cheek and scarring were likely to remain permanent features. The Claimant's psychiatric expert confirmed that she was suffering a chronic adjustment disorder secondary to the operation and its physical effects, that the condition was likely to be

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amenable to improvement with cognitive behavioural therapy and was likely to remain with some level of low mood, anhedonia (the inability to experience pleasure from activities) and sensitivity towards other people in the foreseeable future. The Claimant's liability expert, a Consultant Reconstructive and Aesthetic Plastic Surgeon, confirmed that D1 had placed scars inappropriately at a site where the risk of hypertrophy had eventuated, the scars behind the ears were of poor quality and were hypertrophic, suggesting that he had failed to ensure that the wounds at the site were closed without tension either at the primary or revision procedure; one or more of the terminal branches of the greater auricular nerve destined for the cheek was damaged during the face lift surgery, suggesting that the plane of dissection was inappropriately deep at this point.

Assessment of Damages

An initial hearing took place before the Recorder in June 2011 in the absence of D2 when he insisted that the assessment be adjourned for the Claimant to obtain further expert evidence establishing the causation of her injuries in addition to the condition and prognosis evidence already disclosed. A further hearing before a Circuit Judge in September 2011 was adjourned after A Belgian lawyer applied by letter so they could instruct solicitors to commission their own expert evidence. The Judge agreed to this adjournment on condition that D2 make a payment on account of the Claimant's damages of £45,000.00 and pay a sum on account of costs within 28 days. No payment was made by D2 and a final hearing took place before the Circuit Judge on 2 March 2012, with no attendance from D2, and damages were assessed. The award of £113,148.96 comprised £30,000 general damages, interest on those damages of £1,669.53, £71,671.06 special damages plus interest of £8,808.37. The Claimant's solicitors' costs were also assessed with the inclusion of a 100% success fee. Steps are now being taken to enforce those damages and costs against D2.

Choice of Jurisdiction

The decision was taken to seek jurisdiction in England and Wales. There were no jurisdiction or choice of law/applicable law clauses in the contract with D2 and no written agreement or documentation between the Claimant and D1. Neither of the Defendants challenged jurisdiction. The Order granting permission to serve outside the jurisdiction under CPR 6.33 was made on the Claimant's without notice application in which she relied on the fact that proposed Defendant D1 an Italian national domiciled in an EU Member State and proposed Defendant D2 carried on business in Belgium and London, both EU Member States, where the claim was one in which the court had power to determine the case under the Judgments Regulation.

In the without notice application the Claimant relied on the fact that D2 advertises and solicits business and holds clinics in this country; the contract was written in English and concluded in England and payment for surgery was made in Sterling. Additionally D2 promoted the fact that D1 was one of their GMC registered surgeons performing operations at their clinic, many of whom were listed on the Specialist Register for Plastic Surgery.

The claim was pleaded in contract and tort. Taking the two European Conventions to which the UK is party, the Brussels and Lugano Conventions, there are presumptions first, that a Defendant should be sued in the State where a tort occurred and second, that he should be sued in his own Member State. Whereas RTAs and other accidents abroad may be caught by this, medical tourists will normally have entered into a contract with the foreign clinic and under EU consumer contract rules can elect to sue in their home court rather than in the country where the surgery was carried out.

As well as the absence of a jurisdiction clause the Defendants had made no reference to applicable law in any "choice of law" clause by which many foreign clinics stipulate that the law of their home country is to be applied in determining any claim against them. We pleaded that English Law should be applied and this was not challenged. Had this been contested the Private International Law (Miscellaneous Provisions) Act 1995 would have been relevant for the purposes of deciding applicable law. This establishes the general rule under Section 11 of the Act that the applicable law will be that of the country in which the events constituting the tort occured. Where elements of those events occur in different countries the applicable law in a personal injury action is taken to be the law of the country where the individual was when he suffered his injury. The general rule as to choice of applicable law may be displaced in accordance with Section 12 if it can be established in all the circumstances that it is substantially more appropriate for the applicable law to be the law of, in this context, the patient's home country. This involves identifying factors connecting the tort to England and comparing the significance of the factors pointing either way (substantially more appropriate). Had the Defendants sought to argue these issues the Claimant was assisted by the fact that she could rely on the EU consumer contract provisions.

D2 did not seek to challenge the Order granting permission to serve outside the jurisdiction and we did not face any *forum non conveniens* arguments proposing Belgium as a more appropriate alternative forum.

Summary

General Damages: £30,000 plus interest £113,148.96
Special Damages: £71,671.06 plus interest £8,808.37
Date of Assessment: 2 March 2012
Total Award: £113,148.96
Negligent Bilateral Facelift and Bilateral upper and lower eyelid surgery carried out by D1 at D2's Brussels clinic.

Medical tourism (or Medical Travel)

Medical tourism, where patients travel for medical treatment from their home or "source" country to another, the "destination" country, has become a rapidly growing global phenomenon but remains a little understood sector, certainly in the UK. It is not a new phenomenon. Footballers and other top athletes in the UK have travelled abroad for many years to see

leading surgeons to keep their careers on track. Patients are now travelling abroad for a much wider range of treatment.

With an estimated 49 million Americans disenfranchised by their healthcare system and many forms of treatment excluded from cover much of the literature and data comes from the US where medical tourism is big business. This is changing here. Medical journals have been publishing papers on the topic and more is being done to understand the impact of medical tourism on the healthcare services of both home and destination countries.

Many countries across the world, supported by their governments, promote the availability of a wide range of elective, often complex, forms of medical treatment including cosmetic, dental, bariatric, infertility, stem cell therapy, ophthalmic, cardiac, orthopaedic and other surgery to overseas patients attracted by low costs and the high standards of care described in promotional material and websites. The term medical tourism does not accurately reflect the intentions of most patients or the sophisticated medical treatment available in these destinations; the recreational value of travelling abroad is of limited importance to patients with complex medical problems - medical travel is the term preferred by many commentators including the WHO.

A government-funded NIHR University of York-led study into medical tourism and the economic implications of inward and outward medical tourism for the NHS is due to report later this year after an 18 month investigation. The other side of the coin is that the NHS receives significant sums from "in-bound" medical tourists travelling to the UK for treatment at our leading hospitals. This is likely to increase when the current 2% cap on the amount NHS trusts are permitted to receive from treating private patients is increased to 49%. This study will also gain a deeper understanding of the cost to the NHS of rectifying failed surgery carried out at foreign clinics

Because of the way in which clinics and agents market their services there is a tendency to down-play the risks of surgery in their promotional material which is aimed to *persuade* the would-be medical tourist. Many patients, particularly those seeking cosmetic surgery or weight-loss surgery have unrealistic expectations and may allow the prospect of undergoing treatment in a sunny foreign location overcome their judgment. Although this is stating the obvious, care needs to be taken by clinics to manage these expectations and ensure that patients understand the nature of the treatment they are undergoing and the risks they face.

When these operations go wrong they have the potential to go very wrong and the experience can be deeply traumatic for the patient. Medical tourism patients cross international boundaries and the jurisdiction issues can be a minefield for the patient's lawyer. Foreign clinics may not appreciate that if they target patients in other countries they can be sued in the patient's jurisdiction.

No two countries appear to have the same laws and procedures - time limits are different, some countries have damages caps or award damages on a tariff basis. Securing jurisdiction in the patients' home country has obvious advantages for the patient but any judgment still has to be enforced and turned in to cash within the clinic's jurisdiction. Alternatively, if proceedings are brought in England, the clinic's liability insurance - if it has any - must cover what to the clinic is a judgment from a foreign jurisdiction.

Issues over the system of law to be applied to the case even if jurisdiction is secured in the patient's home jurisdiction adds to the complications. Care needs to be taken because of the different limitation periods throughout the EU. When deciding applicable law our Courts will generally apply the law of the foreign clinic's country to the substantive elements of the case but our own law to the procedural elements. The duty of care and standard of care are unlikely to differ greatly from one country to another but our Court may decide that the foreign law governs the limitation period to be applied. Many countries have shorter limitation periods than our 3 years: Spain one year, Slovakia Cyprus Poland and Denmark 2 years and some countries do not recognise the concept of a continuing tort or do not extend the commencement of the running of time to reflect date of knowledge. Few EU countries appear to have the equivalent of a Section 33 discretion procedure to disapply their limitation periods.

If in doubt on the relevant period and whether time runs from the initial surgery or any subsequent treatment the patient may have no option but to pursue a claim in the foreign clinic's jurisdiction. The calculation of damages and heads of claim under which damages can be claimed will generally be regarded as procedural and our own law will apply. This is going to be relevant if the foreign jurisdiction (the Claimant is seeking to avoid) awards damages on a tariff basis or if damage awards in that jurisdiction are subject to a cap.

It may be necessary to seek advice from a clinical negligence lawyer in the foreign jurisdiction to be sure of the limitation position and how the foreign jurisdiction deals with date of knowledge and continuing tort.

Despite offering the package of care to the patient clinics may seek to divert blame to surgeons with whom the patient had no contract.

Key issues raised by medical tourism

Accreditation

Establishing the record of a surgeon, hospital unit or clinic is difficult enough in the UK, NHS or private. Ten years post-Kennedy the record of our paediatric cardiac units can only be obtained by means of FOI applications and morbidity results for many NHS operations are impossible to obtain. Researching the record of a surgeon or clinic operating in a foreign country's private health sector is even more difficult.

Much of the treatment available at foreign clinics is going to be of a high standard. The fundamental problem is that foreign clinics market their services with great skill and it is difficult to test these advertisements and establish the record of a clinic and the surgeons they employ or sub-contract.

Foreign clinics have gone some way to address this by means of accreditation schemes. Over 400 hospitals in 39 countries have been accredited by the US JCI body (Joint Commission International), a ten-fold increase over the numbers in 2004. Accreditation is not a familiar concept in the

UK but we may see similar schemes when private health companies seek to demonstrate their ability to deliver safe healthcare as the current fragmentation of the NHS continues.

Regulatory issues

There is a lack of any uniform international approach to the regulation and approval of medical devices that might be used by foreign clinics and medical tourists are vulnerable to the different regimes in destination countries with less stringent regulation.

The recent scandal over PIP breast implants where the manufacturers used industrial instead of medical-grade silicone to cut costs has demonstrated that regulatory standards in the UK and elsewhere in Europe are lower than in the US where the FDA generally imposes stringent requirements for the approval of medical devices.

The German regulator failed to uncover the problems at the PIP factory in France. There has been limited collection of data on implants and medical devices across Europe. The scandal over DePuy Articular Surface Replacement (ASR) bone-on-bone hip implants has also highlighted varying approaches between different countries.

Ethics

Medical tourism raises many difficult ethical as well as complex legal issues.

The impact of medical tourism on the healthcare services of destination countries is an important issue and the concern is that countries keen to attract medical tourists may provide a better service or better facilities to medical travellers than to their own nationals and doctors may be lured away from local hospitals to state of the art hospitals built for wealthy foreign patients.

A major patient-protection concern is that some forms of treatment may be unproven or regarded as experimental or even, in the case of female genital surgery for example, illegal in the UK but readily available in certain medical tourism destinations. Stem cell treatment has no global regulatory framework or agreed international framework but many forms of treatment are available at foreign clinics. Reproductive or fertility tourism - travelling abroad for assisted conception - is becoming increasingly common and increasing numbers of couples travel abroad to access assisted reproductive technology and surrogacy programmes. In addition to the highly complex legal issues there are significant risks associated with international surrogacy. Commercial surrogacy is prohibited in the UK on policy grounds. The Hague Conference on Private International Children Law has identified surrogacy as a "pressing socio-legal problem" and is investigating ways of regulating surrogacy internationally.

Medical tourists travelling abroad are at risk of infections and may present a public health threat on their return. The effect of reports in 2011 of the NDM-1 and other superbugs resistant to antibiotics is not known but this is also a potential hazard faced by the medical tourist.

Medical tourism can have a distinctly ugly side. There is reported to be a booming market in human organs from living and dead donors for transplant surgery. Global demand for organs far exceeds the available supply. 50–100,000 Americans are said to be on waiting lists for various organs in the US where less than 15,000 donors are found each year. China is reported to carry out 10,000 organ transplants annually. Until recently this was unregulated and the Chinese government has admitted that in the past some organs have come from executed prisoners.

EU

The EU Directive on Cross Border Healthcare Europe, in place by 2013, will see patients reimbursed by their home State for the cost of treatment received in other EU countries. The Directive requires that all EU Member States provide transparency about their range of services, prices and quality of treatment.

The jurisdictional aspects of overseas medical treatment are highly complex. The clinic may have inserted jurisdiction and applicable law clauses in their contracts. Barriers to claiming compensation may be insurmountable. These legal hurdles and the difficulties faced by patients needing corrective treatment and continuity of care - with a clear route to obtain redress if things go wrong - must be resolved if medical tourism is to expand and truly form an additional tier in the provision of healthcare available to patients in the UK.

Conclusion

Medical tourism may well be anathema to Claimant lawyers and patient support groups but some patients will travel abroad to take advantage of low costs and exercise freedom of choice – whatever the risks involved. Can we blame a patient who travels abroad for gastric band surgery currently advertised for just over £3000 including 2 nights hotel accommodation for patient and companion and the option of follow-up care (at extra cost) on return to the UK - compared with £7–8,000 at a private clinic in the UK? This operation might be subject to a 2–3 year NHS waiting list or could be unavailable on the NHS because their BMI criteria have not been met. Or couples who seek fertility procedures unavailable in the UK at overseas clinics promoting the fact that they comply with ESHRE (European Society of Human Reproduction and Embryology) cross-border reproductive care standards?

It is essential for the medical tourist to take out a medical travel insurance policy available from a specialist provider even if it does not cover all conceivable eventualities and consequences.

Gaining an accurate understanding of the extent of the current medical tourism market in the UK is not easy but this is an industry that is almost certainly going to expand here, if not at the highly optimistic levels predicted by some commentators.