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Body Contouring

Editorial

Reflections From a Plastic Surgeon—Personal Perspectives Following a Fatal Critical Incident

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I write to share a fatal critical incident that reshaped my practice and personal perspective of life, with the hope that it may help others develop awareness and insight to deal with similar crises in practice.

Ten years ago, I performed a Brazilian butt lift (BBL) with autologous fat transfer under general anesthesia. Surgery and early recovery were uneventful. On Day 5, the patient developed fulminant necrotizing fasciitis, which progressed to multiorgan failure, and died on Day 6. A root-cause analysis and coroner's inquest later confirmed that the infection was an unpredictable, rare event.

Although necrotizing soft-tissue infections (NSTIs) following gluteal augmentation are uncommon, their occurrence has been documented. For instance, a recent case report described a severe NSTI in a young woman postgluteal augmentation, underscoring the unpredictable and devastating nature of such infections.[1] Another report has similarly drawn attention to this rare but serious complication following BBL procedures.[2]

I would like to share my experiences with readers in order for them to gain insight into the aftermath of a rare but devastating fatal critical incident that can potentially have adverse impacts on a surgeon's personal life and professional career.

PSYCHOLOGICAL IMPACT ON THE PRACTITIONER

The immediate psychological effects can be devastating on the surgeon as a caring physician. After going through this, my experiences are as follows:

1. I acknowledged the event. I spent significant time with the patient's family members to express my unconditional apology for the unfortunate event happened.
2. I acknowledged its impact on me as the surgeon. I was able to discuss my fear, guilt, insomnia, and emotional vulnerability by transparently talking through it with my hospital colleagues and known senior plastic surgeon colleagues across the globe, from whom I could get a better insight into the situation.
3. I remained in regular contact with a mentor(s) and experts who I know in the field. I was in daily contact with a senior aesthetic plastic surgeon, from whom I learned the procedure.
4. I tried to get a thorough understanding of what happened in the incident. I discussed the fatal critical incident at length with colleagues at the hospital and the other clinical and nursing staff to have a better understanding of it.
5. I maintained a daily routine to avoid destructive coping mechanisms and remained grounded in personal and professional practices to remain steadfast. I continued regular prayer, reading the Bhagavad Gita (spiritual textbook), and meditative practices in my own time for spiritual and mental support. I also used to take regular walks outside to ensure physical and mental wellness.

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6. I organized my colleague surgeons' support for my professional work. I was supported by colleague plastic surgeons to continue my clinical activities in a supervised fashion, ensuring their availability if I would require their support.
7. I did not isolate myself. I continued my clinical activities and my reconstructive charity trip to Madagascar Mercy Ship, which helped me remain continuously occupied with professional activities. I was made aware that personal psychological trauma can lead to self-harm or even suicide following such a very unfortunate incident in a medical professional's career.
8. I had supportive family and friends around me. My wife, sons, brother, mother, and friends were all extremely loving and supportive in coping with the crisis. Many of my friends and professional colleagues stayed nearby to ensure a continuous stream of help where needed.
9. I sought specialist experts' advice and support from the medicolegal team to process my obligation to engage in the hospital root-cause analysis and coroner's inquest.
10. The expert support was helpful in dealing with media attention and responding to media questions.

PROFESSIONAL AND INSTITUTIONAL CONSEQUENCES

In such cases, most practitioners are until going to experience consequences that we often do not consider till such an event occurs. Although circumstances vary depending on local and national contexts, I share the following for broader reflection:

1. In accordance with corporate hospital practice in the United Kingdom, my practicing privileges were suspended until the root-cause analysis and coroner's inquest conclusion.
2. Revalidation (recertification) by the General Medical Council (which is specific to the United Kingdom) was deferred. In the United States, this may be similar to state medical license renewal.
3. My professional indemnity status was adversely affected.
4. In accordance with standard hospital protocol, communication with hospital staff was restricted during the investigation period.
5. Online search results continued to appear and affect patient confidence for a few years. There was a decline in my private practice caseload and considerable financial loss.
6. Surgeons should have adequate understanding and, if possible, training to understand and, if requested, provide independent expert opinion. This independent expert opinion should be factual, accurate, and neutral.

KEY CONSIDERATIONS FOR SURGICAL PRACTICE

This experience prompted several insights that may be helpful for surgical colleagues:

1. It is essential for surgeons to fully understand their practicing privileges, contractual obligations, and malpractice insurance provisions, because critical incidents may result in immediate suspension or loss of cover.
2. In such an event, it is a customary national practice in the United Kingdom that the root-cause analysis is performed as part of clinical governance and risk management. An independent expert's report is an integral part of the process.
3. Surgeons must anticipate the possibility of media interest following a fatal critical incident and prepare accordingly. Media responses should be timely, factual, and measured, avoiding speculation or premature conclusions. Engaging a specialist in healthcare communications or medicolegal media management is highly advisable to protect the surgeon's professional integrity and ensure that patient confidentiality is respected and maintained.
4. Strong peer support networks, such as structured communication platforms among surgeons, can provide practical guidance and emotional reassurance. Peer support programs have been shown to mitigate the stress healthcare professionals' experience and can improve well-being following adverse events and critical incidents.[3]

The surgeon should to engage in the hospital process, for example, internal investigation, root-cause analysis, and coroner's inquest, with factual accuracy and with support from the medicolegal expert's guidance and support.

In response to this tragic, fatal critical incident, I have taken decisive steps to enhance patient safety and professional accountability. These steps may not apply to everyone reading this editorial, but I share them as examples. I have ceased performing BBLs, adopted stricter patient-selection protocols, discontinued combined procedures, and now routinely involve experienced colleagues for longer operations.[4]

ADVANCING COLLECTIVE LEARNING AND SUPPORT

Alongside peers, I co-founded the Cosmetic Surgery Clinical Governance Forum and the Consortium of Aesthetic Plastic Surgery Clinic Owners.[5] These platforms facilitate regulatory challenges and medicolegal experiences, fostering a culture of shared learning and continuous improvement.

Lastly, I urge our professional societies to develop concise, practical modules that are tailored for plastic surgeons who experience catastrophic events. This should encompass hospital protocols, indemnity pathways, regulatory responses, and media engagement strategies. This would empower clinicians to act swiftly and decisively to safeguard patients and uphold public trust in the face of critical incidents.

It is my sincere hope that this editorial prompts reflection and discussion among aesthetic surgeons and our professional associations, ultimately contributing to a more resilient and prepared surgical community.

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REFERENCES

1. Cárdenas-Camarena L, Cárdenas-Cruz C, Godínez IG. Necrotizing fasciitis due to Acinetobacter baumannii complex following body contouring surgery: first case report. *Plast Reconstr Surg Glob Open*. 2025;13:e6715. doi: 10.1097/GOX.0000000000006715
2. Matthews MR, et al. Necrotizing Soft Tissue Infection as a Result of a "Brazilian Butt Lift" Procedure. *Trauma Acute Care*. 2017;2. doi: 10.21767/2476-2105.100046
3. Lane MA, Newman BM, Taylor MZ, et al. Supporting clinicians after adverse events: development of a clinician peer support program. *J Patient Saf*. 2018;14:e56-e60. doi: 10.1097/PTS.0000000000000508
4. Hardy KL, Davis KE, Constantine RS, et al. The impact of operative time on complications after plastic surgery: a multivariate regression analysis of 1753 cases. *Aesthetic Surg J*. 2014;34:614-622. doi: 10.1177/1090820X14528503
5. Vadodaria S, Riaz M, McDiarmid J, Shankar TK, Srinivasan J, Joshi E. Unity amidst adversity amongst aesthetic plastic surgeons in the United Kingdom during COVID-19 lockdown. *Aesthet Surg J Open Forum*. 2025:ojaf041. doi: 10.1093/asjof/ojaf041