

A photograph of an operating room. In the center, a patient bed is covered with a white sheet and a white pillow. Above the bed, a large circular surgical light fixture with multiple glowing lamps is suspended from the ceiling. The room is filled with medical equipment, including monitors on stands, shelves with supplies, and a green-covered table in the background. The walls are light green, and there are windows with blinds. The overall atmosphere is clinical and sterile.

Cosmetic Surgery

By Theresamarie Mantese,
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Legal and Ethical Considerations

and Informed Consent

Introduction

Cosmetic surgery is no longer a luxury for the wealthy and glamorous. You don't need to look any further than newspaper advertisements containing discount coupons for a wide array of cosmetic procedures, television series publicizing every imaginable procedure from face-lifts to feet re-molding, and the proliferation of celebrities displaying for the ever-watchful public every conceivable body reformation, to document the ever-increasing popularity of cosmetic surgical procedures. In fact, the range of cosmetic surgery appears to have no imaginable limits. To illustrate, the Cleveland clinic has approved its doctors' petition to be the first institution worldwide to perform a human face transplant.¹ Recently, the world's first partial face transplant was performed in France. This operation has raised heated ethical concerns among professionals and laypersons alike.² Ironically, in a time when health care costs have reached uncontrollable levels, cosmetic surgery appears to constitute a wholly separate market driven by an expanding consumer demand.

Statistical information helps elucidate the growth of the market for cosmetic procedures. According to the most comprehensive survey released by the American Society for Aesthetic Plastic Surgery, the total number of cosmetic procedures increased by nearly 8.3 million in 2003; surgical procedures represented 12 percent of the total, and nonsurgical procedures increased by 22 percent.³ Botox injections continued to rank first among *all* cosmetic procedures (surgical and nonsurgical combined), increasing 37 percent from 2002.

The five most popular *surgical* cosmetic procedures in 2003 were liposuction (384,626), breast augmentation (280,401), eyelid surgery (267,627), rhinoplasty (172,420), and female breast reduction (147,173). Breast reduction may be covered by insurance, depending on the terms of the policy and individual patient factors.⁴

The top five *nonsurgical* cosmetic procedures were Botox injection (2,272,080), laser hair removal (923,200), microdermabrasion (858,312), chemical peel (722,248), and collagen injection (620,476). Human-derived collagen products (CosmoDerm, CosmoPlast) were used in 29 percent of collagen-injection procedures. Hyaluronic acid (Hylaform, Restylane) was used in 116,211

procedures and calcium hydroxylapatite (Radiance) was used in 31,913 procedures.⁵

Accordingly, attorneys representing plastic surgeons and other health care professionals practicing in this area should revisit the professional standard of care related to informed consent for cosmetic surgery. Not surprisingly, the standard for informed consent relative to cosmetic surgery is more stringent than the standard for non-elective surgeries. As cosmetic surgery becomes more available through reduced costs, economic incentives, and aesthetic objectives, this standard will always be fluid. Our discussion will focus on how Michigan courts have applied the concept of informed consent, particularly in cases involving cosmetic surgery, and how other jurisdictions have applied this concept.

Professional Standard of Care and Informed Consent

Informed Consent and Non-Elective Procedures

A physician has a duty to warn a patient of the consequences of a medical procedure.⁶ As early as 1930, the Michigan Supreme Court recognized that if a physician treats or operates on a patient without consent, he or she has committed an assault and battery and may be liable for damages. Likewise, if consent has been given but the scope of the consent is exceeded, the physician has committed an assault and battery.⁷ The necessary consent may be express or implied. The duty of informed consent is further complicated by the silence of Michigan courts on whether the duty to disclose in a medical malpractice case should be tested by an "objective" or "subjective" standard.⁸ Ultimately, no Michigan case has decided the standard of review, as the standard has not been relevant to the case at issue, and thus, courts have declined to rule on the matter.⁹

Generally, "informed consent" requires that the patient be informed of the risks of treatment, the prognosis, and alternative treatments before consenting to treatment. In a medical malpractice case, the plaintiff bears the burden of proving all of the following: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged

breach and the injury.¹⁰ This standard is also applicable to an informed consent claim.¹¹

Informed Consent and Elective Procedures

In the practice of cosmetic surgery, the standard for the duty of informed consent is crucial. Particularly, cosmetic surgery is generally elective. A malpractice claim is typically triggered when a patient is dissatisfied with the result. Michigan courts recognize that evidence of a bad result alone is not enough to establish a malpractice claim.¹² Unfortunately for the cosmetic surgeon, it is difficult for a patient to comprehend that a meritorious malpractice claim is not equivalent to the unavoidable risks of a contemplated cosmetic procedure that results in the patient's disappointment with the outcome. This is particularly true when you consider that all surgery carries with it unavoidable risks because of obvious trauma to a patient's body.

It has been recognized that cosmetic surgery mainly provides a psychological benefit to an individual.¹³ As a result, a surgeon may confront patients with body image and personality issues that make it difficult to decide what risks and benefits to disclose.¹⁴ It is significant that malpractice claims in cosmetic surgery appear to arise not so much from technical fault but from a surgeon's failure to disclose risks to a patient.¹⁵ Studies have shown that several factors may contribute to an individual's desire for cosmetic surgery, including such intangible feelings as "to feel better about myself," "have more self-confidence," and "improve my self-esteem"¹⁶—making it difficult for a surgeon to evaluate what risk factors to disclose to any given patient.

Ethical Considerations

Inherent in the practice of cosmetic surgery are perplexing ethical considerations. A plethora of ethical concerns arise because the benefit of cosmetic surgery is much harder to perceive than other functional operations.¹⁷ The question that emerges is whether a surgeon may ethically put a patient through a cosmetic procedure—even when there is well-informed consent—simply to satisfy the excesses of a consumer-driven demand. At some point, we must question whether a surgeon has a responsibility to say "no," even when a patient has been fully informed but demands the operation anyway.¹⁸

Obviously, cosmetic surgeons will be forced to address the ethical issue of whether a patient should receive more cosmetic surgery even when no *legal* issue exists. Although the ethical dilemma is currently at the nascent stage, it will continue to evoke more studied thought and refinement as more individuals turn to cosmetic surgery for less definable reasons. Included in this category is the increasing rate of the number of corrective revision surgeries or "redos." While these cases fall short of malpractice, "they leave patients unsatisfied and determined to risk surgery again, if they can afford it."¹⁹ This ethical

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dilemma is accentuated in *Lynn G v Hugo*,²⁰ in which the plaintiff underwent a full abdominoplasty, or "tummy tuck," and was dissatisfied with the result because of an unsightly scar on her abdomen.

The *Hugo* case is important from a procedural standpoint. The case started with the trial court's denial of the surgeon's motion for summary judgment. The appellate division of the New York Supreme Court affirmed the trial court's decision, which was further appealed on a certified question. The court of appeals reversed the appellate division and trial court's decision. The court of appeals granted summary judgment for the surgeon, stating that the evidence was insufficient to raise a fact question on whether the patient

had capacity to consent and whether the consent was informed.

The pivotal fact in deciding the case was the plaintiff's claim that she lacked capacity to consent to the procedures because she suffered from Body Dysmorphic Disorder (BDD), a preoccupation with slight or imaginary imperfections that causes considerable distress or functional impairment. The facts showed that over a six-year period, the plaintiff underwent a series of elective surgeries, including eyelid surgery, facial liposuctions, eyebrow tattooing, and wrinkle and skin growth removals. While the plaintiff's experts could only opine that the plaintiff's depression and obsession with her appearance was consistent with BDD, the defendant's expert determined that the plaintiff did not suffer from BDD or any other "major psychiatric disorder" that would impair her ability to consent.

What is striking about these facts is the question of whether the surgeon should have ethically refused to operate on the plaintiff patient even if the surgeon did not commit legal malpractice. Equally perplexing is determining the criteria that the surgeon should use to decide ethical issues. Of course, ethical decisions could be gauged by a sense of the surgeon's own value system of what is "right" and "wrong," as long as there is no issue of malpractice. This standard is not very satisfying when confronted with our notions that a profession should look to the highest standards for its members and not the very lowest standard. Interestingly, the American Medical Association does not promulgate specific standards for cosmetic surgery, despite the fact that cosmetic procedures do not provide a medical benefit and, therefore, "the only possible medical result is harm, so a physician must proceed with particular caution."²¹ Additionally, the American Academy of Cosmetic Surgery, the largest organization representing cosmetic surgeons in the United States,²² also fails to provide any ethical recommendations to cosmetic surgeons.

Conclusion

It is difficult to predict how the ever-increasing demand for cosmetic surgery will impact the duty of physicians to obtain informed consent before performing a procedure. Sometimes unlikely or remote complications occur even in what may be considered routine

procedures, as in a recent case in which two patients were paralyzed after undergoing Botox treatments.²³ If current trends are an indication of the development of more comprehensive standards, it appears that full and complete disclosure will be continually scrutinized. The consent process will no longer be a perfunctory form process, but may involve more elaborate procedures, such as psychological screenings and videotaped pre-operative consultations. While malpractice claims may be the linchpin for defining informed consent, the medical profession itself will have to provide its own ethical guidelines for physicians, who before now were part of a very competitive, commercially driven elective surgery practice. ◆

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Footnotes

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2. "Face Transplants: Medicine's New Ethical Dilemma," *MSN Health & News*, December 7, 2005, <http://articles.health.msn.com/id/100112040>.

3. American Society for Aesthetic Plastic Surgery, *Quick Facts: Highlights of the ASAPS 2003 Statistics on Cosmetic Surgery*, August 12, 2004, p 3.
4. American Society for Aesthetic Plastic Surgery, *2003 ASAPS Statistics—8.3 Million Cosmetic Procedures: American Society for Aesthetic Plastic Surgery Reports 20 Percent Increase*, November 9, 2004.
5. *Id.*
6. *Lincoln v Gupta*, 142 Mich App 615, 624; 370 NW 312, 318 (1985), citing *Roberts v Young*, 389 Mich 133; 119 NW2d 627 (1963) ("the hospital did not have a duty to obtain the informed consent of [the patient where the physician] . . . was [patient's] private physician").
7. *Franklyn v Peabody*, 249 Mich 363, 366; 228 NW2d 681, 682 (1930).
8. *Robins v Katz*, 151 Mich App 802, 810; 391 NW2d 495 (1986).
9. *Howard v Zamorano*, unpublished opinion per curiam of the court of appeals, decided Oct 14, 2004 (Docket No 244610).
10. *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994).
11. See *Paul v Lee*, 455 Mich 204, 211–213; 568 NW2d 510 (1997), overruled on other grounds by *Smith v Globe Life Ins Co*, 460 Mich 446, 455–456 n 2; 597 NW2d 28 (1999).
12. *Paul*, supra at 212. See also *Wischmeyer v Schanz*, 449 Mich 469, 484; 536 NW2d 760 (1995); *Locke* supra at 231.
13. *Medical Litigation in Cosmetic Surgery*, 23 Med & Law 479, 482 (2004).
14. *Id.*
15. *Id.*
16. *Ethics and Aims of Cosmetic Surgery: a contribution from an analysis of claims after minor damage*, 19 Med & Law 237, 238 (2000).
17. *Id.*
18. *Unqualified Doctors Performing Cosmetic Surgery: Policies and Enforcement Activities of the Federal Trade Commission, Part II: Hearing Before the Subcomm. on Regulation, Business Opportunities, and Energy of the Committee on Small Business*, 101st Cong D283 (1989) (reproducing advertisements with titles such as "Reshape Your Future," "Be a Knockout," "Free What Ifs," "Dreams," "Facts & Figures," and "If You'd Like to Know How Cosmetic Surgery Changed My Life, Call Me").
19. "After Cosmetic Surgery: The 'Do Over,'" *New York Times*, August 4, 2005, <http://www.nytimes.com/2005/08/04/fashion/thursdaystyles/04surgeries.html>.
20. 752 NE 2d 250 (NY 2001).
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22. *About AACS* (visited Dec. 22, 2004), http://www.cosmeticsurgery.org/about_aacs.html.
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