

Informed consent to cosmetic surgery – does a broader duty of disclosure exist?

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OPSOMMING

Ingeligte toestemming tot kosmetiese chirurgie – bestaan daar 'n wyer blootleggingsplig?

Kosmetiese chirurgie is 'n algemene, wêreldwye verskynsel en die gewildheid daarvan, ook in Suid Afrika, neem die afgelope tyd toe. Radikale, nie-terapeutiese prosedures het indringende gevolge vir beide die mediese reg en die mediese etiek. In hierdie verband word die Suid-Afrikaanse en Kanadese wetlike raamwerke met betrekking tot ingeligte toestemming ondersoek. Aandag word gevestig op die feit dat daar 'n gebrek is aan unieke vereistes vir ingeligte toestemming tot suiwer nie-terapeutiese en kosmetiese prosedures binne die Suid-Afrikaanse wetlike raamwerk. Die stand van sake is nie ideaal nie. Met verwysing na die Kanadese regsposisie word aanbevelings gemaak wat pasiënte se outonomie en veiligheid in geval van ingeligte toestemming tot suiwer nie-terapeutiese en kosmetiese prosedures beter sal beskerm en bevorder.

1 INTRODUCTION

Medical techniques and technology are increasingly being used for purposes that seemingly deviate from the traditional goals of medicine. Medical techniques and technology are often implemented, not to prevent or cure illness, but to fulfil a patient's personal, individual and ostensibly non-medical wishes.¹ These wishes are often aimed at improving certain human characteristics beyond their normal healthy state.² A prime example of wish-fulfilling medicine is cosmetic surgery. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and boost their self-esteem.³

1 Buyx "Be careful what you wish for? Theoretical and ethical aspects of wish-fulfilling medicine" 2008 *Medicine, Healthcare and Philosophy* 134.

2 Bordo "Material girl: The effacements of postmodern culture" 1990 *Michigan Quarterly R* 657; Gimlin "Cosmetic surgery: Beauty as commodity" 2000 *Qualitative Sociology* 80.

3 Examples of popular surgical cosmetic procedures include abdominoplasty (the removal of excess skin and fat from the abdominal area); blepharoplasty (the removal of excess fat, skin and muscle below the eyes in order to improve drooping upper eyelid skin and puffy bags below the eyes); rhinoplasty (the reshaping of the nose, typically achieved by changing the shape of the tip or bridge or removing dorsal humps); the augmentation and enhancement of the breasts; and liposuction (the removal of exercise-resistant fat deposits with a tube and a vacuum device).

Cosmetic surgery can therefore be distinguished from reconstructive plastic surgery in the sense that reconstructive surgery is normally performed in order to improve the body's function, although it may also be done to achieve a normal appearance.⁴ The pursuit of beauty by means of cosmetic surgery is big business in modern societies and South Africa is catching up very fast in this particular area. With the rise of cosmetic surgery, the contemporary body, instead of being a dysfunctional object requiring medical interventions, has become a primary symbol of identity and a commodity, not unlike "a car, a refrigerator, a house, which can be continuously upgraded and modified in accordance with new interests and greater resources".⁵ Cosmetic surgery has in fact become a "modern body custom".⁶ As exciting as this might be from both a medical and a consumerist point of view, certain legal and ethical issues must not be overlooked. The fact remains that cosmetic surgery involves the performance of very invasive surgical operations on otherwise healthy individuals for the sake of improving appearance.

2 WHY DOES THE RELATIONSHIP BETWEEN A COSMETIC SURGEON AND HIS OR HER PATIENT DIFFER FROM THE TRADITIONAL DOCTOR-PATIENT RELATIONSHIP?

The performance of cosmetic surgery necessitates a degree of ethical conduct on the part of the cosmetic surgeon that surpasses the level of ethical conduct normally required between a physician and patient, because of the fact that the relationship between a cosmetic surgeon and a patient differs from the traditional physician-patient relationship.⁷ This is essentially due to the distinction, albeit tenuous, between elective and non-elective forms of medical treatment. Distinguishing between elective and non-elective medical treatments is difficult, but cosmetic surgery is usually elective in the sense that cosmetic surgery is opted for by a patient more freely and not for reasons of medical necessity in the usual sense of the word.⁸ In some countries the courts have been hesitant to accept a distinction between elective and therapeutic or non-elective procedures, as all operations are elective in the sense that the patient always has a choice whether or not to undergo the procedure.⁹ What these courts have not taken into consideration, is the fact that there is a very real distinction between situations where the patient has very little choice about undergoing the procedure, as the treatment is indicated as the best or only option, and situations where the patient can comparatively afford not to undergo the procedure. This standpoint was

4 Examples of reconstructive surgeries include breast reconstructions; cleft lip or palate repairs; flap surgeries; surgeries to correct webbed toes or fingers; reduction mammoplasties; the reconstruction of facial features after trauma; scar revision and skin grafts.

5 Finkelstein *The fashioned self* (1991) 87; Gimlin 2000 *Qualitative Sociology* 80; Adams "Motivational narratives and assessments of the body after cosmetic surgery" 2010 *Qualitative Health Research* 757.

6 Sullivan *Cosmetic surgery, the cutting edge of commercial medicine in America* (2000) 10.

7 Atiyeh *et al* "Aesthetic/cosmetic surgery and ethical challenges" 2008 *J of Aesthetic and Plastic Surgery* 829.

8 Healy "Duties of disclosure and the elective patient: A case for informed consent" 1998 *Medico-Legal J of Ireland* 28; Buyx 2008 *Medicine, Healthcare and Philosophy* 135.

9 *Sidaway v Bethlem Royal Hospital Governors* 1985 1 All ER 643 (HL); *Gold v Haringey Health Authority* 1987 2 All ER 888 (CA).

expressed quite eloquently by McCarthy J in the Irish case of *Walsh v Family Planning Services Ltd*,¹⁰ when he held that:

“All surgery, in a sense, is elective although the election may have to be implied from the circumstances rather than determined as express . . . A patient’s condition may be such as to demand surgical intervention as the only hope for survival. Such may be called non-elective surgery. The patient given the choice between enduring pain and having limb replacement surgery or fusion surgery may technically be electing as between pain and the surgery but the election may be more apparent than real. An extreme of elective surgery would be what is purely cosmetic- simply to improve the natural appearance rather than to remedy the physical results of injury or disease. Even it may have an element of quasi-medical care because of the psychological reaction of the patient to personal appearance. A like argument may be advanced in respect of contraceptive surgery, male or female. Such surgery does not have a direct effect on the health or wellbeing of the patient nor in prolongation of life; it may alleviate marital stress or other domestic pressure and in that sense be therapeutic. Essentially, however, it is for the improvement of the sex life of the couple concerned.”

Cosmetic surgery, as an example of elective surgery, is a treatment which comparatively the patient can afford not to undergo.¹¹ Conventionally, a patient experiencing specific symptoms seeks help from a physician and the physician makes a subsequent diagnosis based on objective scientific knowledge.¹² The diagnosis is followed by the performance of a suitable treatment, provided of course that the physician has obtained the patient’s informed consent to the administration of such treatment.¹³ Conversely, cosmetic surgery patients generally have no symptoms and therefore a resultant diagnosis is impossible.¹⁴ When performing cosmetic surgery, cosmetic surgeons are subjecting otherwise perfectly healthy individuals to medical risks, side effects and complications for benefits that are, arguably, non-medical.¹⁵ The treatment selection is determined, or at the very least guided, by the patient’s wishes.¹⁶ The patient chooses to have cosmetic surgery, rather than the surgery being an absolute necessity, therefore the decision whether or not to undergo surgery is a joint process.¹⁷ Communication between the cosmetic surgeon and the patient takes place on a different level, as the patient typically expects to relate more democratically with the cosmetic surgeon.¹⁸ Positions of interaction are therefore uniquely different for both the patient as well as the cosmetic surgeon.¹⁹ In the case of therapeutic or

10 *Walsh v Family Planning Services* 1992 1 IR 496 517–518.

11 Healy 1998 *Medico-Legal J of Ireland* 27.

12 Nordenfelt “The concepts of health and illness revisited” 2007 *Medicine, Health Care and Philosophy* 58; Buyx 2008 *Medicine, Healthcare and Philosophy* 135.

13 *Ibid.*

14 Buyx 2008 *Medicine, Healthcare and Philosophy* 135; Heyes and Jones “Cosmetic surgery in the age of gender” in Heyes *Cosmetic surgery: A feminist primer* (2009) 145.

15 Devereaux “Cosmetic surgery” in Gordijn and Chadwick *Medical enhancement and posthumanity* (2009) 164; Buyx 2008 *Medicine, Healthcare and Philosophy* 134.

16 Simon “Physician’s duty to screen patients for elective surgery” 1978 *Arizona LR* 670; Buyx 2008 *Medicine, Healthcare and Philosophy* 135; Heyes and Jones in Heyes 5.

17 Wright “Management of patient dissatisfaction with results of cosmetic procedures” 1980 *Archives of Otolaryngology Head and Neck Surgery* 466; Heyes and Jones in Heyes 5.

18 Wright 1980 *Archives of Otolaryngology Head and Neck Surgery* 467; Ezekiel and Emanuel “Four models of the physician-patient relationship” 1992 *J of the American Medical Association* 2221.

19 Wright 1980 *Archives of Otolaryngology Head and Neck Surgery* 467; Buyx 2008 *Medicine, Healthcare and Philosophy* 134.

non-elective operations, the patient is often reluctant to consent to surgery and must even be persuaded by the physician, whereas the cosmetic surgery patient requests the operation and sometimes actually talks the cosmetic surgeon into performing it.²⁰ The cosmetic surgeon does not play a crucial role in determining the course of treatment and primarily acts as a source of information to the patient.²¹ Due to the above-mentioned differences between cosmetic surgery and conventional therapeutic medical treatment, it is submitted that the process of informed consent to cosmetic surgery must be approached differently than informed consent to therapeutic interventions.

3 INFORMED CONSENT AND THE CURRENT DUTY OF DISCLOSURE IN SOUTH AFRICAN MEDICAL LAW

Currently, the nature and scope of the information that must be disclosed by a physician in order to obtain a patient's informed consent to medical treatment is set out in section 6 of the National Health Act.²² The physician must give the patient a general idea, in broad terms and in layperson's language, of the nature, scope, consequences, risks, dangers, complications, benefits and disadvantages and prognosis of, and also the alternatives to the proposed intervention, as well as the patient's right to refuse treatment.²³ The Act does not distinguish between

20 Wright and Wright "A psychological study of patients undergoing cosmetic surgery" 1975 *Archives of Otolaryngology Head and Neck Surgery* 145.

21 Buyx 2008 *Medicine, Healthcare and Philosophy* 135.

22 61 of 2003. S 6 of the Act provides as follows: "User to have full knowledge

(1) Every health care provider must inform a user of –

- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal."

23 Carstens and Pearmain *Foundational principles of South African medical law* (2007) 885. See also para 3.1.3 of the Health Professions Council of South Africa's "Guidelines for good practice in the health care professions, seeking patient's informed consent: The ethical considerations" which states that: "Patients have a right to information about any condition or disease from which they are suffering. This information should be presented in a language that the patient understands. The information which patients want or ought to know, before deciding whether to consent to treatment or an investigation, includes: details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated; uncertainties about the diagnosis, including options for further investigation prior to treatment; options for treatment or management of the condition, including the option not to treat; the purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects; for each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment; advice about whether a proposed treatment is experimental; how and when the patient's condition and any side effects will be monitored or re-assessed; the name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team; whether students will be

elective or non-therapeutic and non-elective or therapeutic forms of treatment. The same informed consent requirements are therefore applicable to all forms of medical interventions. Referring to the current legal position, Carstens and Pearmain state that all material and usual risks should be disclosed.²⁴ However, there is no need to disclose unusual or remote risks, unless they are serious or typical, respectively, or the patient makes enquiries about them.²⁵ In order to determine whether a risk is material, the test for materiality as set forth in *Castell v De Greef*²⁶ must be applied.

Castell v de Greef, a 1994 decision of a full bench of the Cape Provincial Division, originally introduced the doctrine of informed consent into South African medical law. It remains the definitive ruling regarding the standard of disclosure required for informed consent to medical treatments.²⁷ The plaintiff in *Castell v de Greef* was a forty-four-year-old woman with a history of breast cancer. She had consulted with the defendant cosmetic surgeon at some length and eventually agreed upon the simultaneous performance of a subcutaneous mastectomy and breast reconstruction²⁸ in order to minimise her chances of developing breast cancer once more. Unfortunately the plaintiff contracted an infection and experienced significant necrosis of the breast tissue as a result of the operation. She suffered significant pain, embarrassment and psychological trauma, and had to undergo several additional surgical procedures to repair the damage. The plaintiff subsequently sued the defendant for damages. One of the causes of action was that, prior to the mastectomy, the defendant had been under a duty to warn the plaintiff of the material risks and complications associated with the procedure as well as any alternative procedures which might minimise, reduce or exclude such risks or complications. The plaintiff averred that she had not given informed consent to the procedure, as the defendant had failed to properly disclose the material risks and complications.

The court examined the international trends regarding informed consent, and concluded that it was time to shift the focus from a physician-centred approach to a more patient-oriented approach.²⁹ The court held that a physician is under a legal duty to obtain the patient's informed consent to any medical intervention.

involved, and the extent to which students may be involved in an investigation or treatment; a reminder that patients can change their minds about a decision at any time; a reminder that patients have a right to seek a second opinion; where applicable, details of costs or charges which the patient may have to meet.”

24 Carstens and Pearmain 885.

25 *Ibid.*

26 *Castell v De Greef* 1994 4 SA 63 (C).

27 Note that the Supreme Court of Appeal in *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA) accepted the patient-centred approach as set forth in *Castell v de Greef*, yet simultaneously applied the paternalistic reasonable doctor test. The Supreme Court of Appeal essentially failed to choose between these two mutually destructive approaches and applied both. It is therefore submitted that the precedent set by *Castell v de Greef* still holds, as the Supreme Court of Appeal did not explicitly overrule the subjective patient-centred approach as set forth in *Castell v de Greef*. In this regard, see Wilson “When is a risk of medical treatment material?” 2006 *De Rebus* 22. This point is also argued by Carstens and Pearmain 886–887.

28 That is, the surgical removal of as much of the breast tissue as possible with a simultaneous reconstruction of the breasts using silicone implants.

29 *Castell v De Greef* 74.

The court held that physician must therefore ensure that (a) the patient is aware of the nature and extent of the harm or risk associated with the procedure; (b) the patient appreciates and understands the nature and the extent of the harm or risk; (c) the patient actually consents to the harm or assumed the risk; and lastly (d) that the patient gives comprehensive consent that extends to the entire operation, inclusive of its consequences.³⁰ The court clearly acknowledged the constitutive relationship between knowledge, appreciation and consent. A patient is usually an ignoramus in medical matters and as such the physician, as an expert, is saddled with a legal duty to provide the patient with the necessary information that will ensure knowledge and appreciation on the part of the patient. It is the inequality of knowledge so inherent to the physician-patient relationship that necessitates appropriate information from the physician in order to procure the patient's informed consent.

Ultimately, the court held that the plaintiff had been aware of all the material risks prior to the performance of the procedure and that she had in fact given informed consent. The plaintiff's action based on lack of informed consent was therefore dismissed. In defining the standard of disclosure when obtaining informed consent to medical procedures, the court rejected the earlier judgement of *Richter v Estate Hammann*³¹ in which it was held that a physician's conduct, by informing a patient of the material risks accompanying the proposed treatment or procedure, should be evaluated in terms of the standard of the reasonable medical practitioner. The court in *Castell v de Greef* held that only material risks need to be disclosed.³² In formulating the test for materiality, the court referred to the Australian case of *Rogers v Whitaker*³³ in which it was held that the test for materiality is not simply a matter of current expert medical opinion. In this case, a patient was rendered completely blind in one of her eyes as a result of a remote risk eventuating following surgery on her right eye. When considering whether to have the operation, the patient questioned her physician comprehensively about the possible complications in respect of both eyes. The likelihood of the risk eventuating was extremely low, a mere 0,007 percent. The defendant physician argued that the test for materiality is a matter of current expert medical opinion. However, the court found that the matter could not be determined solely with reference to the current state of responsible and competent professional opinion and practice. Similarly, the court in *Castell v de Greef* concluded that materiality is not a question that is to be concluded on the basis of expert medical evidence alone.³⁴ Expert medical evidence may however be used in order to identify the risks associated with a particular treatment and it may also have a bearing on the materiality of those risks. The court then adopted substantially the same test for materiality as set forth in *Rogers v Whitaker*. In terms of this test, a risk is material if, under the circumstances of the specific case, a reasonable person in the patient's position, if warned of the risk, would probably attach significance to it;³⁵ or the physician is or should reasonably be

30 *Castell v De Greef* 80.

31 [1976] 3 All SA 497 (C).

32 *Castell v De Greef* 80.

33 *Rogers v Whitaker* 1992 175 CLR 479.

34 *Castell v De Greef* 81.

35 This forms the basic or objective leg of the test.

aware that the particular patient, if warned of the risk, would probably attach significance to it.³⁶

To give effect to the individual or subjective leg of the test as set forth in *Castell v De Greef*, the particular patient's circumstances will have to be considered. It is unlikely that a physician will always be aware of such personal idiosyncratic circumstances, therefore it would be reasonable to expect the physician to make thorough inquiries.³⁷ In terms of the second leg of the test, one might ask whether a cosmetic surgeon should reasonably be aware of the fact that cosmetic surgery patients are likely to attach significance to all risks, even remote and unusual ones. There are no medical indications for cosmetic surgery. This could mean that the scope of risk information provided to the cosmetic surgery patient must be wider as there is no obvious medical reason for the patient to run those risks.³⁸ Giesen³⁹ is of the opinion that it is necessary to disclose even remote risks in the case of purely elective procedures that carry no inherent therapeutic benefit. He specifically states that very rigorous disclosure standards should be imposed in the case of purely cosmetic procedures.⁴⁰ According to Giesen, the maxim applicable in such cases reads as follows:

"A comprehensive and even detailed explanation of the possible consequences and risks (including less frequent or rare risks) of the proposed procedure is all the more indicated and indispensable the less urgent the treatment or operation seems to be and the more likely it would seem that this particular patient, if properly informed, might, even with regard to a rare risk, decide to forego the procedure rather than to submit to it."⁴¹

4 A BROADER DUTY OF DISCLOSURE: THE CANADIAN POSITION

The Canadian position on informed consent for elective procedures is of significant importance to the present discussion. The general rule concerning informed consent was formulated and refined by the Supreme Court of Canada in 1980 in the landmark case of *Reibl v Hughes*.⁴² In this case, the court had to decide whether a patient had given proper informed consent to a carotid endarterectomy procedure that had left him paralyzed at the one side of his body. *Reibl v Hughes* was a landmark case, as it clearly rejected the old, paternalistic standard of disclosure (the reasonable physician standard) and replaced it with a new, more patient-centred approach (the reasonable patient standard). The court held that a physician has a duty to disclose all material risks associated with a procedure. Material risks are those risks which the physician knows or ought to

36 This forms the individual or subjective leg of the test.

37 Thomas "Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure" 2007 *SALJ* 191.

38 Cantor "Cosmetic dermatology and physician's ethical obligations: More than just hope in a jar" 2005 *Seminars in Cutaneous Medicine and Surgery* 159; Janssen "Informing patients about small risks: A comparative approach" 2006 *European J of Health Law* 165.

39 *International medical malpractice law: A comparative law study of civil liability arising from medical care* (1988) 107.

40 *Ibid.*

41 *Idem* 333.

42 1980 14 CCLT 1 (SCC).

know a reasonable person in the patient's position would consider relevant.⁴³ These are risks which either frequently materialise or risks which have very serious consequences when they do materialise.⁴⁴ It is now well established in Canadian law that the duty of disclosure is not confined to risks, but extends to all material information that a reasonable person in the patient's position would consider relevant.⁴⁵ In particular, the patient must be informed of any available alternatives to the proposed treatment, as well as the material risks associated with the alternative treatments. Furthermore, if the physician knows or should know that the particular patient deems some unique fact relevant to the decision whether or not to undergo the prescribed treatment, the physician must disclose that fact as well.⁴⁶ In order to determine what a patient might deem relevant, the physician must consider the physical, mental and socio-economic status of the patient.⁴⁷ In *Zamparo v Brisson*,⁴⁸ the court held that if the physician is not that well acquainted with a particular patient he or she must give the patient advice based on the presumption that the patient is an ordinary or average person. Thereafter, the physician must ask the patient whether there are any special facts that might distinguish the patient from an ordinary or average person.⁴⁹ The patient may then add facts which remove him from the average class and provide the physician with additional information upon which to base his or her recommendation.⁵⁰

Canadian medical law is unique in the sense that several cases have stated that different rules apply to elective interventions. Although Canadian courts initially characterised cosmetic surgery as therapeutic, on the basis that it is psychologically beneficial, this approach is no longer followed.⁵¹ In many cases the cosmetic surgery involved did not hold any therapeutic benefits, but courts felt compelled to identify it as such, as it was thought that all non-therapeutic surgical interventions were illegal.⁵² The term "elective procedures" is used by Canadian courts to refer to medical procedures of which any therapeutic benefits are

43 Ferguson "Informed consent to medical treatment" 1984 *Advocates Quarterly* 178; Kenneth *Consent. A guide for Canadian physicians* (2008) 7.

44 Ferguson 1984 *Advocates Quarterly* 179; Kenneth 8.

45 Picard and Robertson *Legal liability of doctors and hospitals in Canada* (1996) 129.

46 *Ibid.*

47 Ferguson 1984 *Advocates Quarterly* 180. In this regard, see para 3.1.4 of the HPCSA's "Guidelines for good practice in the health care professions, seeking patient's informed consent: The ethical considerations" which states that: "When providing information, health care practitioners must do their best to find out about patients' individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. Health care practitioners should not make assumptions about patients' views, but discuss these matters with them and ask them whether they have any concerns about the treatment or the risks it may involve. Health care practitioners should provide patients with appropriate information, which should include an explanation of any risks to which they may attach particular significance."

48 *Zamparo v Brisson* 1981 16 CCLT 66 (Ont CA).

49 Ferguson 1984 *Advocates Quarterly* 180.

50 *Ibid.*

51 Somerville "Medical interventions and the criminal law: Lawful or excusable wounding" 1980 *McGill LJ* 82; Somerville "Structuring the issues of informed consent" 1981 *McGill LJ* 765.

52 Somerville 1980 *McGill LJ* 82.

secondary.⁵³ It can safely be said that cosmetic surgery has now been categorised as an elective procedure by the Canadian courts.⁵⁴ In terms of Canadian law, the fact that a procedure is not medically required, but merely elective, must be brought to the attention of the patient, as he or she might choose to postpone or forego the treatment.⁵⁵ As far as the scope of disclosure in the case of an elective procedure is concerned, the court in *White v Turner*, a leading case on this subject, held that when an operation is elective, “even minimal risks must be disclosed to patients”.⁵⁶ According to the court, this statement rings even more true if the predominant aim of the surgery is a cosmetic one. In *Hankins v Papillon* it was held that:

“In the cases of plastic surgery, however, where the decision to be made by the patient is more subjective and personal than therapeutic, I believe the doctor has a duty to be especially careful to disclose completely all the risks, and certainly, any special risks, as well as the consequences for the patient should such risks materialise. In matters of this kind, there is normally no urgency, the relevant problems can be explained to the patient, and the patient can weigh the medical risks against his own non-medical desires and priorities. Since there is no therapeutic need for the operation, a patient might well decide that he would prefer to live with a blemish rather than take the risk.”⁵⁷

In *White v Turner*, Linden J described “unusual or special risks” as follows:

“As for ‘unusual or special risks’, these are those risks that are not ordinary, common, everyday matters. These are risks that are somewhat extraordinary, uncommon and not encountered every day, but they are known to occur occasionally. Though rare occurrences, because of their unusual or special character, the Supreme Court has declared that they should be described to a reasonable patient, even though they may not be ‘material’. There may, of course, be an overlap between ‘material risks’ and ‘unusual and special risks’. If such a special or unusual risk is quite dangerous and fairly frequently encountered, it could be classified as a material risk. But even if it is not very dangerous or common, an unusual or special risk must be disclosed.”⁵⁸

With reference to cosmetic surgery of the breast, Linden held that the possibility of scars opening up and requiring further surgery and the risk of keloid scarring were “special and unusual risks” that should have been disclosed.⁵⁹ He also found that the possibility of imperfect breast shape, asymmetry of the breasts, stretch marks and scars were material risks that should have been disclosed.⁶⁰ Mr Justice Linden further held that where an operation is elective, as it was in that particular case, even minimal risks must be disclosed to the patient.⁶¹ *A fortiori*, in a case where the predominant aim is a cosmetic one, possible risks affecting

53 Picard *Legal liability of doctors and hospitals in Canada* (1984) 91; *Hajgato v London Health Association* 1982 36 OR2d 669 (Ont HC) 680.

54 Picard 91; *White v Turner* 1981 15 CCLT 81 (Ont CA); *Mac Donald v Ross* 1983 24 CCLT 242 (NS SC TD); *Guertin v Kester* 1981 20 CCLT 225 BCSC; *Hankins v Papillon* 1980 14 CCLT 198 (Que SC).

55 Picard 92; *Reibl v Hughes*; Somerville 1981 *McGill LJ* 756; Ferguson 1984 *Advocates Quarterly* 57.

56 *White v Turner* 103.

57 *Hankins v Papillon* 881.

58 *White v Turner* 99.

59 Picard 95.

60 *Ibid.*

61 *White v Turner* 103.

the appearance of the breast should be classified as material.⁶² In *Videto v Kennedy*⁶³ the court, referring to a case of an elective laparoscopic sterilisation, held that the fact that an operation is elective means that it need never have been performed in the first place. The court conceded that whilst it may be unnecessary or even a harmful to warn the patient of minimal or rare risks in the case of an operation that is medically necessary, the frequency of the risk becomes irrelevant when the particular operation is unnecessary for the patient's medical welfare.⁶⁴ The trial judge in *Videto v Kennedy* held that even minimal risks (three chances in a thousand) should be disclosed.⁶⁵ In *La Fleur v Cornelis*,⁶⁶ the defendant cosmetic surgeon performed a rhinoplasty on the plaintiff, an attractive young woman who wanted to reduce the size of her nose. He failed to inform her about the 10 percent risk of scarring. The surgery left a scar and indentation on the plaintiff's nose which could not be removed by further surgery. Despite the fact that the scar was noticeable, the results were not monstrous and the plaintiff remained attractive. Regardless, the plaintiff sued the defendant, alleging negligence based, *inter alia*, on the fact that he had failed to inform her of the risks involved. The court held that when a physician performs surgery on an otherwise healthy body for cosmetic purposes only, a very high degree of risk disclosure is required, because the procedure is not medically necessary and the results plainly visible.⁶⁷ There is also Canadian authority that requires a physician to disclose and explain alternative methods or techniques to a patient who wants to get sterilised.⁶⁸ Some argue that this rule can be generalised to apply to all elective procedures.⁶⁹ Canadian law seemingly acknowledges the fact that a cosmetic surgery patient is usually very eager to proceed with the procedure prior to consulting with the physician.⁷⁰ The physician needs to temper the patient's enthusiasm with a sobering conversation about all the possible risks and complications.⁷¹ Even though a physician is required to inform the patient of the elective nature of the procedure, it has been held that a physician does not have an obligation to advise the patient whether or not to have the surgery.⁷² The physician must therefore provide the patient with all the relevant information, but ultimately it is for the patient to decide whether or not to undergo the surgery.⁷³

5 WHAT ABOUT THERAPEUTIC PRIVILEGE?

Cosmetic surgeons tend to provide patients with only a limited amount of information on the risks involved. A very detailed account of the risks involved is considered to be redundant, as patients are thought to be frightened unnecessarily

62 *Ibid.*

63 *Videto v Kennedy* 1981 17 DLR 307 (Ont HC).

64 *Ibid.*

65 Ferguson 1984 *Advocates Quarterly* 181.

66 *LaFleur v Cornelis* 1980 28 NBR2d 569.

67 Picard 499.

68 *Zimmer v Ringrose* 1981 16 CCLT 51 (Alta CA) 60.

69 Picard 93; *Sunne v Shaw* 1981 CS 609 (Que SC).

70 Svoboda *et al* "Informed consent for neonatal circumcision: An ethical and legal conundrum" 2000 *J of Contemporary Health Law and Policy* 73.

71 *Ibid.*

72 *Zamparo v Brisson*.

73 Picard and Robertson 126.

by such accounts.⁷⁴ This state of affairs is unacceptable. It is not conducive to the attainment of proper informed consent. Furthermore, it is paternalistic, as cosmetic surgeons consider patients to be in need of information only up to the point that they feel reassured about a procedure's safety. It suggests that a decision about safety has been made prior to the informed consent process and that patients are only informed about the outcome of that decision, which is that the procedure is safe.⁷⁵ Withholding information that might scare a patient cannot be justified on the basis of non-maleficence or therapeutic privilege, as cosmetic surgery isn't medically necessary. A physician will only be able to justify withholding information regarding the risks and dangers concomitant to a procedure on the basis of therapeutic privilege if the patient's state of mind is such that full awareness of the drastic nature of the treatment indicated could be therapeutically detrimental to such a degree that his or her recovery may be prejudiced.⁷⁶ However, should a patient decide to forego the cosmetic procedure after hearing a comprehensive explanation of possible risks, it won't do any harm to his or her health. Cosmetic surgery might have both psychological and functional benefits for the patient, but it is not an essential operation in the sense that it treats a life threatening condition. The patient must therefore be very clear in his or her own mind that he or she truly understands the possible complications and that the benefits outweigh the risks of the operation.⁷⁷ Withholding information from a cosmetic surgery patient can therefore not be justified on the basis of therapeutic privilege.

Furthermore, several studies have shown that providing the patient with additional information concerning the purpose and effects of an operation might actually have a positive therapeutic effect.⁷⁸ Patients who were comprehensively informed concerning the nature, risks and benefits of a procedure have been shown to be less anxious before and after the operation, have less pain, use fewer post-operative medications and recover faster than patients who received only routine care during the process of informed consent.⁷⁹ Furthermore, despite the lack of data available on the medical and psychological impact of a good rapport between patient and cosmetic surgeon, at least one study has found a significant link between the surgeon's emotional reaction to the patient and the post-operative course.⁸⁰

74 Fraser "The agent within: Agency repertoires in medical discourse on cosmetic surgery" 2003 *Australian Feminist Studies* 34; Panfilov and Larkin *Cosmetic surgery today* (2005) 6; Grimm "Informed consent for all! No exceptions" 2007 *New Mexico LR* 39.

75 Fraser 2003 *Australian Feminist Studies* 34.

76 Van den Heever "Therapeutic privilege in the South African medical law" 1993 *De Rebus* 625.

77 Godwin "Do they listen? A review of information retained by patients following consent for reduction mammoplasty" 2000 *British J of Plastic Surgery* 124.

78 Wallace "Informed consent to elective surgery: the 'therapeutic' value?" 1986 *Social Science and Medicine* 32.

79 *Ibid.*

80 Thomas and Ritchie "Preoperative assessment of older adults" 1995 *J of the American Geriatrics Society* 811; Grossbart and Sarwer "Psychosocial issues and their relevance to the cosmetic surgery patient" 2003 *Seminars in Cutaneous Medicine and Surgery* 142.

6 CONCLUSION AND RECOMMENDATIONS

In light of new medical technologies, it is unlikely that standard informed consent procedures still adequately serve their original intention. Medical treatments were far simpler and there were far fewer elective procedures when the doctrine of informed consent was developed.⁸¹ It is submitted that informed consent should be contextualised by creating different categories of informed consent for different procedures.⁸² A category of informed consent to purely elective cosmetic procedures should therefore be created and should ideally have a broader duty of disclosure associated with it than say, the duty of disclosure associated with medically necessary surgeries or lifesaving emergency surgeries. It cannot be argued that more stringent disclosure requirements in the case of purely elective procedures would place unnecessary pressure on an already overburdened medical profession. Purely elective procedures, cosmetic surgery in particular, form only a very small part of medical practice. One might ask whether physicians could reasonably be expected to place medical treatments into legalistic categories in advance of every instance of disclosure.⁸³ The answer is yes, physicians are perfectly capable of understanding the law. In the case of cosmetic surgery, one could safely assume that most, if not all, cosmetic procedures are essentially elective even if they do contain some element of therapeutic benefit. Moreover, the distinction between elective and therapeutic procedures is a medical or contextual distinction; it is not inherently legalistic at all.⁸⁴ Physicians will always hold the authority to determine whether and to what extent their patient's wish to undergo a particular surgery contains a medical component, but the extent to which the surgery is therapeutic or purely elective will be formed based upon an analysis of the facts which should be readily known to a physician after a basic consultation with his or her patient.⁸⁵ The fact that the elective-therapeutic distinction will usually not be clearly evident actually strengthens the case for requiring cosmetic surgeons to discover exactly what their patients anticipate and hope for, especially where it is possible that the patient can afford to not undergo the surgery. Ultimately, it is in the cosmetic surgeon's best interest to adopt a broader duty of disclosure and to spend quality time obtaining informed consent. When complications do occur, a patient is less likely to take legal action against the cosmetic surgeon if they feel that he or she had made every effort to inform them of all the possible risks and felt that he or she had been honest, conscientious, concerned and thorough.⁸⁶

81 Atwell "The modern age of informed consent" 2006 *Univ of Richmond LR* 598.

82 *Idem* 602.

83 Healy 1998 *Medico-Legal J of Ireland* 28.

84 *Ibid.*

85 *Ibid*; Pitts-Taylor *Surgery junkies: Wellness and pathology in cosmetic culture* (2007) 153.

86 Cole "Informed consent: Considerations in aesthetic and reconstructive surgery of the breast" 1988 *Clinics in Plastic Surgery* 548.