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REVIEW ARTICLE

Pre-operative considerations in aesthetic facial surgery

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Abstract
This article reviews the common pitfalls in the complex process of pre-operative assessment for facial plastic surgery. Legal guidelines and best practice are discussed, and attention is directed mainly towards the consenting and psychological issues surrounding this area of surgery.

Key words: Aesthetics; Informed Consent; Psychological Phenomena and Processes; Body Dysmorphic Disorders; Preoperative Period

Introduction
Facial plastic surgery is no longer merely the preserve of celebrity and the financial elite. In recent years, the public's perception of facial aesthetic surgery, offset by increased availability and relative reduction in price, has led to increased demand.[1,2] Finance companies have begun to offer loans specifically for cosmetic procedures, and for those on a limited budget, it is not uncommon to travel abroad in pursuit of cheaper surgery.[3,4] The perception of cosmetic procedures has evolved, from a peculiar narcissistic activity of the elite, to almost universal tolerance and acceptance. This shift has occurred in a remarkably short space of time. One only has to browse a newspaper, watch a television advert, or inadvertently open 'spam' e-mail to see that aesthetic surgery is something that is now being marketed to the public at large.

Elective facial plastic surgery occupies a rather distinct realm from many other forms of surgery. It is more emotive than other procedures, since the aim of surgery is to correct a perceived or actual cosmetic defect rather than to improve a functional limitation, as is the case with, for example, a hernia repair or a joint replacement. The face is a uniquely and universally visible area of the human body, and central to an individual's identity, self-perception and self-esteem. Patients seeking aesthetic surgery can often present with very non-specific personal opinions of themselves, such as 'I don't like the look of my nose' or 'my eyes look tired'. This is in contrast to the majority of patient consultations dealing with concrete signs and symptoms such as pain or functional limitation.

Further questioning often reveals deep-seated issues, such as a fear of ageing, under-confidence with their appearance, and difficulties in forming relationships which the patient attributes to how others perceive their body.[5] Their perception is that undergoing an operation would 'heal' these issues, when in practice this is rarely the case. In effect, facial plastic surgeons may act to correct a physical flaw, but in reality many patients are seeking alleviation of psychological issues, be it low self-esteem, self-loathing or just wanting to 'fit in'.[6,7]

The fact that facial plastic surgery has quite a strong private sector following, and that the reasons for presentation are often tangled within rather complex psychological issues, mean that most practitioners are involved in some form of litigation at least once in their careers. This of course is reflected in the higher insurance premiums demanded for practising facial plastic surgery.

A review of litigation cases for rhinoplasty procedures was published in 2009, and demonstrated that the most common reasons for litigation after rhinoplasty were firstly 'not obtaining a valid consent', and secondly 'post-operative cosmetic deformity' (which seemed to have stemmed from mismanagement of the patient's pre-operative expectations).[8]

The purpose of this review is to cover the topics related to pre-operative preparation for facial aesthetic surgery. Firstly, we will discuss patient selection issues, problem personality types, understanding psychological disorders, and pre-operative assessment of a patient's expectations. The second part of this

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paper will deal with the consenting of these patients, including the medico-legal basis of consent and documentation, followed by a list of reasonable risks and complications patients should be notified about when consenting to a facial plastic operation.

It is beyond the scope of this paper to give a full account of the discussion to be had with patients prior to consenting them for surgery. Rather, we have set out to delineate the complications which need to be documented to fulfil a medico-legal duty of care.

Patient selection

Whether the patient who seeks surgery has a deformity that is plain to see, or a subtle imperfection that is not visible even to the trained eye, it is naïve to assume there is no relationship between their perceived body image and their psychosocial well-being.[9]

This relationship can become so deep-seated that it eventually becomes a 'chicken and egg' scenario, the one being dependent on the other. Surgery can be hugely rewarding for some of these patients, addressing their primary physical concern which in turn benefits their psychological concerns. However, surgery is not appropriate for all such patients.[10]

Most surgeons perform a well-rehearsed, stepwise physical examination of their patient; however, few practise a similarly rigorous psychological examination to identify those patients who are unsuitable for facial plastic surgery. It is a much more delicate subject, and a potential minefield that most would quite happily avoid. Nevertheless, its importance, particularly within this field of surgery, cannot be emphasised enough.

This examination can be broadly divided into analysing a patient's motivation for surgery and what they expect from the operation.[10–12] It is important to note that, for all the subsequent subsections, should the consenting surgeon have any concerns, referral to either a clinical psychologist or a psychiatrist with expertise in this area may be appropriate.

Motivation for surgery

Those patients who request surgery due to external pressures are in general less likely to be pleased with the final result. Examples include pressure from family and friends, or patients who are undergoing an emotionally distressing period in their life (e.g. marital separation or death of a spouse). One should also be wary of patients who are considering facial plastic surgery without involving their spouse or family. Suggesting they bring close family members to a consultation may provide one with some insight into how the patient views themselves and how they interact with others.

Expectations

There will always be patients with completely unrealistic expectations. These patients may bring in photos of their 'perfect' nose (usually currently residing on the face of a well-known celebrity) or rulers specifying the exact measurements of their desired nose. Those patients with unreasonable aspirations for the surgery should be firmly steered towards more attainable results.

Naïve ideas about the surgery being able to save a marriage or secure employment should also be tempered with the advice that surgery results only in a minor alteration in the patient's physical appearance. Improvement in self-esteem and other psychological benefits are not under the control of the surgeon.

Aside from these two categories, one should be wary of particular problem patients who represent 'expensive faces' in the industry. The ability to identify these patients can be an art in itself, and development of this skill will save both the surgeon and the patient much distress in the future. An attempt has been made to divide these patients into problem personality types versus those with specific psychological disorders.

In addition to these specific problems, it is also important to be aware of patients who are excessively critical of their previous surgeon. These patients should be approached with great caution.

Problem personality types

It is widely accepted that male patients are more prone than their female counterparts to unrealistic expectations from aesthetic surgery, to the extent that an acronym has been attributed to the typical 'red flag' male. Experienced surgeons will regularly warn about patients exhibiting the SIMON (single immature male over-expectant narcissistic) trait.[11]

It is not always easy to identify personality traits, and some patients are very capable of masking them during their relatively short consultation. It is therefore of the utmost importance to have an awareness of such traits, and to keep an eye out for red flag statements or behaviour.[10–14] It is also important to note that female patients can also exhibit similar characteristics, and that caution is required with such patients be they male or female.

Perfectionists and narcissists

Closely related to the problem of unrealistic expectations, perfectionist and narcissist patients often point out barely perceptible imperfections in their appearance which they wish to correct. These patients will also be disappointed by minor asymmetry or the appearance of surgical scars.

Excessively demanding patients and 'VIPs'

Celebrities, chief executives and leaders in industry are accustomed to 'getting what they want when they want'. This attitude is at odds with the imprecise science of surgical results, wound healing and the ageing process. An approach would be to explain this clearly and unequivocally to patients so they are under no illusion that things may not occur when and how they would like them to. There are also those

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patients who may for example argue about stopping smoking before facelift operations. Again, being calm and standing firm in the face of a clearly domineering character is the approach most likely to succeed.

One should also consider individuals who have famous facial flaws, but are instantly recognisable for these traits. For example, celebrities such as W C Fields, Gérard Depardieu and, more recently, Owen Wilson are all actors with noses for which most surgeons would normally not hesitate to offer cosmetic alteration. The decision of whether this will affect the patient's professional persona is reserved for the client's public relations team, but the surgeon should also discuss this in tandem.

Passive, unfocussed and/or indecisive patients

'I'll leave it all up to you doctor' and 'I'll accept anything you think is right' are red flag comments that should alert clinicians to this personality trait. These patients tend not to be able to clearly express what they are expecting from the operation, which will invariably lead to post-operative disappointment. Also, these patients may become 'needy' and very much dependent on others whilst in the post-operative recovery stage.

Other subtypes

These include patients who have been operated upon multiple times before, rude or over-flattering patients, and those who you simply just don't get on with.[10] The wise surgeon will also exercise caution with the unkempt patient and those lacking in personal hygiene.

Psychological disorders

Although there is considerable overlap between these disorders and some of the personality types mentioned before, patients with psychological disorders should be considered as a more difficult category.[15]

Body dysmorphic disorder

> Body dysmorphic disorder… is characterised by a preoccupation with an imagined defect in one's appearance, or in the case of a slight physical anomaly, the person's concern is markedly excessive. [Body dysmorphic disorder] is characterised by time-consuming behaviours such as mirror gazing, comparing particular features to those of others, excessive camouflaging tactics to hide the defect, skin picking and reassurance seeking.[17]

Body dysmorphic disorder has an estimated prevalence of 0.5–0.7 per cent;[16] however, due to the character of the disease there is a higher incidence of patients with body dysmorphic disorder presenting to the facial plastic surgeon. Helpfully, the National Institute for Health and Clinical Excellence has proposed five questions that may help diagnose those with body dysmorphic disorder: (1) do you worry a lot about the way you look and wish you could think about it less?; (2) what specific concerns do you have about your appearance?; (3) on a typical day, how many hours a day is your appearance on your mind? (More than 1 hour a day is considered excessive.); (4) what effect does it have on your life?; and (5) does it make it hard to do your work or be with friends?[17]

The National Institute for Health and Clinical Excellence clearly states that all patients who are suspected of or diagnosed with body dysmorphic disorder should be referred to a psychiatrist (who specialises in body dysmorphic disorder) before any surgery.

It is important to note, however, that even after receiving a specialist psychiatric opinion, the decision to operate must rest with the surgeon. Extreme caution must be exercised in deciding to operate on any patient with body dysmorphic disorder, as surgery is rarely the correct option for these patients, even if their psychiatrist has no objection to surgery going ahead.

Eating disorders

Anorexia and bulimia are related to body dysmorphic disorder in so much as patients have a distorted body image which causes them to go to extreme lengths to correct the 'problem'. These patients tend to seek sculpting procedures such as facial liposuction techniques, and even the removal of healthy parotid glands.

Although they are often pleased with the post-operative result, it does little for their overall body image and their subsequent quality of life.

Depression

Clearly, there is a difference between the 'unhappy' patient and one who is clinically depressed; however, both should be regarded with the utmost caution. Patients with a depressive personality will tend to focus on the negative aspects of the surgery rather than the positive, and low motivation and energy often make for a torrid post-operative recovery (Table I).[19–21]

Advice from the patient's general practitioner, or if necessary from a psychiatrist, is recommended before considering any surgery.

TABLE I
WORLD HEALTH ORGANIZATION ICD-10 SYMPTOMS OF DEPRESSION[21]

The individual usually suffers from depressed mood, loss of interest & enjoyment, & reduced energy leading to increased fatigability & diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:
– Reduced concentration & attention
– Reduced self-esteem & self-confidence
– Ideas of guilt & unworthiness (even in a mild type of episode)
– Bleak & pessimistic views of the future
– Ideas or acts of self-harm or suicide
– Disturbed sleep
– Diminished appetite

ICD = International Classification of Diseases

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Consenting for facial plastic operations

After ensuring that the patient is a candidate for facial plastic surgery, the pre-operative preparation may begin. In this section, the legal aspects of consenting are described as well as the various forms of documenting the consultation. These are followed by a list of risks and complications that one should notify a patient about when considering a facial plastic operation. For all procedures, provision of written information regarding the specific procedure is vitally important, and such provision should be documented in the patient's medical records.

Informed consent and the law

Informed consent is '…that consent which is obtained after the patient has been adequately instructed about the ratio of risk and benefit involved in the procedure as compared to alternative procedures or no treatment at all'.[9] Knowing how much information to tell the patient, however, remains a matter of extensive debate. The two basic tests that doctors should consider are the 'Prudent Patient Test'[22,23] and the 'Subjective Standard'.[24,25]

The Prudent Patient Test expects the doctor to consider what a reasonable or average patient (or, for example in Ireland, ultimately a jury), would want to know for a given operation.

The Subjective Standard invites the doctor to first judge the individual patient's values and beliefs about the operation in question, and then provide a level of information that would complement this individual.[25]

The General Medical Council (GMC) states, in its 2008 guidance on this matter:

> No single approach to discussions about treatment or care will suit every patient, or apply in all circumstances. Individual patients may want more or less information or involvement in making decisions depending on their circumstances or wishes.[26]

There are similar statements throughout this 2008 GMC document which appear to advocate the Subjective Standard approach. Both tests, however, provide the doctor with very little assistance in deciding exactly what risks and complications should be communicated to the patient. The challenge posed in assessing exactly what a patient would or would not want to know in a short consultation, and in being able to defend oneself in court on this basis, is indeed a cause for concern.

Doctors should also be mindful of the need to respect a patient's autonomy, particularly regarding those who may voluntarily choose not to receive the full details of the procedure.[27]

The GMC therefore states that clinicians should adopt a process of 'information exchange', and devotes chapters to 'partnership'.[26] This encourages the patient to ask questions and the doctor to communicate the risks and complications within this discourse. Even this approach has its disadvantages, as clearly it would favour knowledgeable and articulate patients.

Documentation of this conversation produces its own challenges and may ultimately lead to the video recording of all consultations as legal evidence. Additionally, doctors are reminded that they should ensure that their patients have understood all that has been explained to them. Other than aggressive cross-examination and written tests, this seems unmanageable. There have been several trials that have tested a patient's understanding of the consenting process. Many of the solutions are currently difficult to implement in the National Health Service (NHS); they include the use of video and computer software to check understanding.[28–34] The doctor is again called upon to use his or her discretion when considering whether a patient has understood enough to make an informed decision about consenting for an operation.[35]

Documentation

The importance of making a written record of a consultation with a patient cannot be overstated. Even if one is able to accurately recall and describe a consultation in vivid detail to a court, without clear documentation it is impossible to corroborate one's version of the events in question.

The dated Bolam (1957)[36] concept of functioning within parameters that are considered acceptable by a responsible body of medical opinion no longer stands alone, and has been superseded by a series of subsequent judgments.

The Bolitho (1997)[37] case modified the Bolam ideology by allowing the judge to consider whether the actions taken by the 'responsible body of medical professionals' stand up to logical analysis. In this way, judges may infrequently overturn expert medical advice.

The cases of Sidaway (1985)[38] and Chester versus Afshar (2004)[39] have emphasised how important it is for medical professionals to state not only all the common or frequently occurring risks of a procedure, but also those risks which are rarer but significant, despite being very unlikely to occur. Documentation of the consenting process is also fraught with difficulty. As stated previously regarding the creation of an information exchange, there is now an increasing compulsion on the part of the surgeon to record not only the risks that the patient was informed about, but also to diligently note down the questions asked and the responses given. Even those clinicians who bombard their patients with reams of information, in an attempt to protect themselves from litigation, will find that a well-prepared lawyer will manage to circumnavigate their defence. This is a complex and evolving area of the law, and will probably change in the future.

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Within the sphere of facial aesthetic surgery, there are other elements of documentation that should also be considered as an adjunct to standard clinical history-taking and note-keeping. Below, we consider medical photography, image manipulation software, revision policies and the involvement of other medical professionals.

Medical photography

This should ideally be undertaken by a professional medical photographer, under standardised conditions as set out in the National Guidance of the Institute of Medical Illustrators.[40] Attempting to complete this task with non-standard equipment can lead to spurious results.[41,42] Medical photography images are useful for peri-operative planning and are a good record of the 'before and after' appearance of the patient. They can also prove invaluable when counselling unhappy post-operative patients.

One should be mindful of using these images for the education of other professionals, and of the relevant patient consent procedure. There is often poor adherence with the NHS Confidentiality Code of Practice,[43] the Data Protection Act,[44] and the requirement for registration with the Data Commissioner when acting in a private capacity.[45] If used appropriately, one may use medical photography images to show prospective patients the various stages of healing after specific operations, and the final end results. However, providing patients with an impressive portfolio containing only one's best results may result in inflated expectations and possible disappointment.

Image manipulation software

The ability to manipulate a digital image of the patient in order to show what one intends to achieve can be fraught with unintended consequences.[46] The patient may regard the final agreed image as a guaranteed post-operative result, and compare their appearance disdainfully to the computer-generated one. If used sparingly, however, image manipulation software can be a useful adjunct to communication between the surgeon and the patient.[47]

Revision policy

A frank discussion about one's revision policy is prudent, particularly if this is initiated by the patient themselves. One should explain that many post-operative complications are beyond the control of the surgeon, and that the patient should diligently follow the aftercare guidance (i.e. stopping smoking, avoiding sunbathing, avoiding strenuous exercise etc). Many surgeons would also insist on a post-operative period of healing before considering revision surgery, as many issues correct themselves during the first year or so. When available, it may be useful to disclose an up to date personal revision rate, in an appropriate setting.

When a revision operation or a 'touch up' does seem to be appropriate, the surgeon should consider reducing or waiving their fee in order to avoid ill feeling. It would therefore be sensible to clearly outline the fee structure in place, so that the patient fully understands that the surgeon's fee is separate from the anaesthetic and hospital fees. Understanding that these other costs are the responsibility of the patient may avert future disputes.

Involvement of other medical professionals

The GMC states that referring general practitioners should be copied into any correspondence involving their patient, and also that, with the patient's consent, they should receive a report of any specialist consultation that occurs.[48] Such communication can elicit invaluable information on the suitability of the patient for an operation, an issue often not highlighted during a facial plastic consultation.[49] If necessary, documentation of any psychiatric referrals should also be included in the patient's report, and made available for the general practitioner.

It is important to note that if the patient specifically requests that their general practitioner not be informed of the consultation, then this must be respected. The GMC provides advice on how to manage this situation appropriately.[50] However, the surgeon should be mindful of the consequences of not informing the general practitioner, as the surgeon would in this case be fully responsible for the patient's aftercare.[51] It goes without saying that one should be extremely wary of this sort of situation.

Risks and complications

The specific risks and complications associated with facial plastic procedures should be discussed in detail, allowing the patient to explore these issues through interrogation of the facts. This should give patients the chance to question matters that concern them most. Auditing one's own results is necessary in order to disclose personal complication rates, thereby improving the quality of the information given.

Rather than describing all possible risks and complications recorded in the literature, the authors suggest a 'reasonable' list for rhinoplasty and pinnaplasty (the facial plastic operations most commonly performed by ENT surgeons), as well as for other facial plastic procedures, as shown in Table II.

Conclusion

Facial plastic surgery can be an immensely rewarding specialty (both in terms of job satisfaction and financial return), although there are drawbacks to playing such a 'high stakes' game. Increasingly, litigation is damaging promising and established careers alike.

Surgeons who are adept at recognising and communicating effectively with problem personality types, and who understand the importance of declining to operate, tend to have happier patients. Acquiescing to

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TABLE II
REASONABLE SURGICAL RISKS AND COMPLICATIONS TO DISCUSS WITH FACIAL PLASTIC SURGERY PATIENTS

Rhinoplasty
– Haemorrhage resulting in potential return to operating theatre
– Facial bruising
– Infection
– Numbness
– Hypertrophic or keloid scars
– Skin changes
– Septal perforation
– Loss of sense of smell
– Need for revision rhinoplasty
Pinnaplasty
– Bleeding
– Infection
– Numbness
– Asymmetry of the ears
– Revision surgery
Other facial plastic operations
– Visible suture marks
– Hyper- or hypopigmentation
– Hypertrophic or keloid scarring
– Recurrence of original lesion (e.g. keloid, neoplasia)
– Need for revision
– A less than perfect outcome
– Flap complications: poor colour match, infection, necrosis or failure

operations on patients who may be better advised not to proceed with surgery can be detrimental to one's peace of mind. Protecting oneself with detailed documentation and a meticulous approach to consent may prevent lost court cases; however, the stress of dealing with even the most 'open and shut' case can weaken even the most enthusiastic surgeon over time. The GMC encourages surgeons to '…keep up to date with developments in your area of practice'.[52] In parallel to this, we recommend that surgeons pay heed to the evolving nature of this area of law.

We can only recommend simply to understand the law as it currently stands, follow GMC guidance and document what one can. In addition, we recommend that consultants should not feel the need to deal with every case in isolation, but rather should call upon the assistance of colleagues if at all required. Too many junior consultants fall into the trap of feeling they must deal with every situation by themselves, when, occasionally, swallowing one's pride can make a better foundation for a far more successful career.

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