Cosmetic Surgery on Patients with Body Dysmorphic Disorder: The Medical, Legal and Ethical Implications

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Introduction

The issue of cosmetic surgery performed on patients with body dysmorphic disorder (“BDD”), a form of mental illness in which sufferers experience great distress and preoccupation with imagined or exaggerated physical flaws, exists at the intersection of the medical, legal, and psychiatric fields. The perspectives and professional judgments of practitioners and scholars in all three sectors will inevitably conflict, as members of each group—in good faith, and based on their respective training, experience, and varying levels of risk aversion—try to formulate policies and procedures for determining whether and when BDD is a contraindication to cosmetic surgery. Where there is disagreement as to under what conditions and with what precautions a plastic surgeon may safely perform an elective procedure on an individual with BDD, the potential for legal liability is more likely to arise. Unsurprisingly, each group also has a differing opinion as to the best manner to deal with recalcitrant physicians who negligently or knowingly ignore professional, legal, and ethical norms and standards, and operate on inappropriate surgical candidates who suffer from BDD.

This article will examine psychiatric research, medical practices, and legal precedent in an effort to uncover a compromise position that will satisfy the interests and address the concerns of the members of all three fields. Of course, balancing the patient’s interests in both bodily autonomy and protection from unscrupulous doctors must remain the foremost priority. Thus, the first part of the article discusses the body dysmorphic disorder diagnosis, placing it in the broader context of the increasing normalization of cosmetic surgery nationwide. It then offers practical suggestions for recognizing the disorder in surgical candidates, making adequate disclosures to the patient, and completing the proper recordkeeping to help foreclose the possibility of future legal liability.
The second part of the article considers the potential legal claims an aggrieved patient might have against her plastic surgeon if she consented to and received her operation while suffering from BDD. Specifically, the article discusses the possibility of claims sounding in the failure to obtain informed consent, battery, breach of fiduciary duty, and breach of contract. The public policy rationales underlying each doctrine overlap; as a result, the common law in some jurisdictions holds that certain claims are superseded by others. Moreover, state legislatures may pass medical malpractice statutes that further limit the availability of any given legal claim that a patient suffering from a mental disorder may assert if she later regrets her unnecessary cosmetic surgery. Although there is a dearth of judicial precedent directly on point, other cases dealing with plastic surgery offer predictive value that is likely to gain increasing relevance as the cosmetic surgery industry continues to grow, the body dysmorphic disorder diagnosis gains greater recognition throughout the medical profession and the general public, and more patients who are dissatisfied with their surgical results or who feel that their doctor took advantage of them decide to seek redress through the legal system.

The final part of the article addresses the appropriate forum for determining whether a physician’s decision to perform an elective procedure on a BDD patient accorded with the currently prevailing standard of care, and if it did not, what the appropriate legal and regulatory response ought to be. The sanctions available to state licensure boards should constrain the potential for abusive physician behavior. However, achieving the goals of professional responsibility and patient safety, while simultaneously protecting doctors from both unwarranted lawsuits and unreasonable board actions, is most likely when the medical and legal systems work in coordination. The objective of this article is to promote such cooperation by presenting and analyzing the positions and priorities of the medical, psychiatric, and legal sectors, as well as to develop policies that will achieve the appropriate balance between respecting patient autonomy and defending patient health.

Part One: Body Dysmorphic Disorder and Cosmetic Surgery
The first portion of the article examines the intersection of body dysmorphic disorder and cosmetic surgery from the perspective of the scientific and medical communities. Especially because so much of medical malpractice jurisprudence derives from the customs and standards that physicians impose on themselves, understanding what cosmetic surgeons, psychiatrists, and medical researchers believe constitutes acceptable behavior and ideal policy will help to shape the proper legal disposition of cosmetic surgery cases involving body dysmorphic patients. The first section in this part explains the diagnostic criteria, symptomology, and incidence in the population of body dysmorphic disorder. In order to place the problem in context, the second section describes the contemporary trend of the increasing commercialization and prevalence of cosmetic procedures within the general public. This section also notes evidence of backlash resulting from this phenomenon, both to individual patients’ psychological wellbeing and to the medical profession in general.

Next, the third section examines a number of recently published studies indicating that body dysmorphic disorder should be considered a contraindication to cosmetic surgery. As a counterpoint, the section also includes the position of some cosmetic surgeons that the disorder need not always preclude elective surgery, particularly if the patient suffers from a mild manifestation and receives psychological counseling throughout the process. The fourth section of this part analyzes the current clinical policies of both cosmetic surgeons and psychiatrists as distinct medical specialties, as well as the opinions of medical ethicists and researchers, to formulate appropriate standards of care for providing cosmetic surgery to individuals with BDD. Finally, the fifth section of Part One compiles the findings from the first four sections to provide practical suggestions for cosmetic surgeons who can anticipate confronting patients with body dysmorphic disorder in the course of their clinical practice. These recommendations pertain to recognizing the symptoms of BDD during preoperative patient consultations, as well as to making adequate disclosures and taking the proper precautions necessary to avoid malpractice liability in the future.

A. Body Dysmorphic Disorder (“BDD”)
Body dysmorphic disorder ("BDD") is classified in the DSM-IV (the most prominent handbook for categorizing and diagnosing mental disorders) as a somatoform disorder characterized by an obsessive preoccupation with an imagined or exaggerated defect in the individual’s physical appearance.\(^1\) This preoccupation, the manifestations of which typically first appear during adolescence or early adulthood, causes the individual clinically significant distress and interferes with normal functioning in other areas of her life.\(^2\) For a BDD diagnosis, the preoccupation must not be attributable to another mental illness (such as an eating disorder).\(^3\) Approximately 1 to 2 percent of all people are afflicted, women and men in equal numbers.\(^4\)

Although any body part can become the subject of the BDD sufferer’s obsession, the most frequent areas of focus are the skin, hair, and nose.\(^5\) There is notable gender differentiation: men are more likely to become preoccupied with their genitals, height, hair and body build, while women tend to be more concerned with their weight, hips, legs, and breasts.\(^6\) Over time, BDD patients on average will report concerns—ranging from highly specific descriptions of perceived flaws to vague complaints about general areas of the body—about five to seven different aspects of their appearance.\(^7\) The vast majority of sufferers attempt some form of non-psychiatric self-treatment, focused not on changing their dysfunctional behaviors or thought processes, but rather on trying to fix their supposed flaws.\(^8\) As a result, an estimated 30 to 40 percent undergo at least one surgical procedure, 50 to 60 percent obtain dermatological services, and 10 percent receive dental treatments.\(^9\) This article’s focus is confined only to the legal and medical

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\(^2\) DSM-IV-TR, supra note 1, at 507.

\(^3\) Id.

\(^4\) Rhoda Fukushima, Face Value: Some People Get Cosmetic Surgery for Reasons that are Not Just Skin Deep, ST. PAUL PIONEER PRESS (Minnesota), July 30, 2007, at D1.

\(^5\) Crerand, supra note 1, at 171.

\(^6\) Id.

\(^7\) Id.

\(^8\) Fukushima, supra note 4.

\(^9\) Id.
treatment of those individuals with BDD that are pursuing a major elective cosmetic operation.

B. Cosmetic Surgery in the Broader Context

In recent years, the stigma attached to undergoing plastic surgery has dissipated, and a wide array of procedures formerly available only to a small, wealthy segment of society are becoming mainstream. Many of the medical professionals performing these procedures credit the influence of reality television shows and media coverage portraying plastic surgery in a positive way for driving the heightened demand for cosmetic work. Improvements in technology have helped to reduce (though by no means eliminate) scarring and recovery time, and the prospect of receiving an upfront payment rather than dealing with insurance claims has induced many physicians to shift the focus of their business to cosmetic procedures, making it easier for individuals nationwide to find a provider. As a result, the American Society of Plastic Surgeons reports that nearly 2 million cosmetic surgeries were performed in 2006, up 2 percent from the previous year, with nearly 11 million total cosmetic treatments performed when minimally invasive procedures like Botox injections and chemical peels are included. Breast augmentation, liposuction, rhinoplasty (a “nose job”), eyelid surgery, and abdominoplasty (a “tummy tuck”) were the most popular surgeries for women, while men, who now constitute approximately one fifth of the patient base, favored rhinoplasty, eyelid surgery, liposuction, hair transplantation, and male breast reduction.

Notwithstanding the increasing normalization of cosmetic surgery in popular culture, recent studies have discovered heretofore unrealized long-term psychological

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10 See David Phelps, Nipping, tucking off years: Aging baby boomers are leading a surge in cosmetic surgery procedures, STAR TRIB. (Minneapolis, MN), Sept. 9, 2007, at 01D. As the article quotes one center’s nurse manager, “Every time Oprah does a special on a procedure, the phones start ringing.” Id.
11 Id. One surgeon notes that while he would be reimbursed $350 from Medicare if he performed a medically indicated surgery to fix droopy eyelids, the same procedure done for cosmetic purposes would net him $2,000. Id.
12 Fukushima, supra note 4.
13 Phelps, supra note 10.
14 Fukushima, supra note 4.
15 Phelps, supra note 10.
16 Fukushima, supra note 4.
hazards associated with the procedures. This research reaffirms the seriousness of undertaking any such elective operation and suggests that the segment of the population that receives cosmetic surgery may display unique mental health concerns. Cosmetic surgery patients as a group tend to have poorer body image and a higher incidence of using psychiatric medication relative to the general population. For instance, one study showed 18 percent of cosmetic surgery patients were on antidepressants, compared to only 5 percent of the control group. Although many plastic surgery patients tell their doctors that they are satisfied with the experience and results in the short term, no studies have been conducted on improvements to body image lasting more than two years, so the long-term repercussions on self-esteem are not fully understood. Importantly, however, five separate studies, involving tens of thousands of patients, have found that individuals who receive cosmetic operations have a significantly increased risk for suicide later in life. The correlation is most pronounced in women with breast implants, where the risk of suicide is 4.5 times higher than average in the 10 to 19 years after surgery, and 6 times higher after 20 years. Moreover, the breast augmentation patient has triple the risk of death related to substance abuse or other mental illness compared to the average woman.

The author of one of the studies speculated that many of these individuals had psychological problems, such as body dysmorphic disorder, before the surgery, which were not improved and may even have been exacerbated following the procedure. Noting that approximately 6 to 15 percent of all cosmetic surgery patients suffer from BDD, some psychologists concur that the prevalence of the disorder likely explains the increased suicide risk. Another researcher concluded that these findings “warrant increased screening, counseling and perhaps post-implant monitoring of women seeking

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18 *Id.*
19 *Id.*
20 *Id.*
21 American Political Network (“APN”), *Cosmetic Breast Implants Linked to Increased Rates of Suicide*, 10 AM. HEALTH LINE 17 (Aug. 9, 2007).
22 *Id.*
23 *Id.*
24 Nowak, *supra* note 17.
cosmetic breast implants.” This background must shape policies regarding the appropriate treatment and care for BDD patients who desire cosmetic surgery.

C. Cosmetic Surgery and the BDD Patient

Numerous research studies indicate that BDD should be considered a contraindication to cosmetic surgery. One study suggests that although a substantial proportion of patients are pleased with their eventual cosmetic results, complaints about operations that were irreproachable “technically as well as from the perspective of the cosmetic result” are still fairly common, even in the absence of a psychological disorder. The authors of this study attributed dissatisfaction in these cases to “poor negotiation about the operation” and insufficient provision of information that leads to misguided expectations about the eventual outcome. This problem will likely be compounded in patients with BDD, whose perceptions and expectations are distorted even before the initial consultation.

That the performance of plastic surgery on a BDD patient will often violate the basic minimal standards of medical care is further indicated by the growing body of evidence that “cosmetic medical treatments typically produce no change or, even worse, an exacerbation of [BDD] symptoms.” For instance, one study found that 91 percent of procedures provided no reduction in BDD symptoms; even those patients who thought the “defect” looked improved remained dissatisfied overall, either because they feared that the supposedly flawed feature would revert to its former appearance or because they developed concerns about another part of the body. This phenomenon of “substitution” is a particular problem in body dysmorphic cosmetic surgery patients, contributing to the high rate of individuals who undergo multiple or repeat procedures. Such patients will initially focus on a specific perceived flaw, but over time (and perhaps following the cosmetic procedure) their attention will shift to another imagined anomaly which they

25 APN, supra note 21.
27 Id. at 245.
28 Crerand et al., supra note 1, at 174.
29 Id.
begin to believe needs correction as well. In these BDD cases, “a completely useless operation is seen to have been performed, in the sense that not even the most perfect surgical outcome is capable of resolving the patient’s psychiatric disorder.”

In support of this proposition are the previous studies that have shown that approximately two thirds of BDD patients who request surgery for imagined or slight defects are able to obtain it, and in some cases to repeatedly receive elective procedures, despite the substantial research demonstrating the such patients rarely benefit from the operations. Indeed, as noted, the findings indicate that the severity of BDD is often worsened following surgery, with the degree of satisfaction decreasing with each additional procedure. Cosmetic surgeons seem to acknowledge that BDD patients generally have poor postoperative outcomes, but they evaluate the total number of patients with BDD that they see for an initial consultation to be significantly lower than the levels found in several studies. Moreover, only 30 percent believe that BDD is always a contraindication for an elective procedure. This discrepancy between the generally negative outcomes found in the literature on cosmetic intervention in the BDD patient population and the more positive views that plastic surgeons hold suggests that cosmetic surgeons, as an isolated medical specialty, may not be able to adequately self-regulate in this context.

Unfortunately, in the absence of proper oversight, a large number of surgical candidates stand to be adversely affected. For instance, one team of plastic surgeons recruited 56 patients (45 women, 11 men) who visited their clinic for cosmetic procedures and had them submit to a thorough psychiatric screening. The doctors conducted a general initial evaluation and obtained the psychiatric history of each patient, then investigated the possible presence and severity of BDD, as well as the potential

31 Id.
33 Id.
34 Id. at 521 (citing a 2002 study of members of the American Society for Aesthetic Plastic Surgery).
35 Id.
comorbidity of other personality disorders, through a number of clinical evaluative tools. The researchers diagnosed BDD in 53% of the patients—45% of the men and 55% of the women—although for the vast majority (82%) it was only a “mild” manifestation. As an ethical matter, the doctors refused to schedule patients with moderate to severe BDD for surgery, and referred them for psychiatric treatment instead. The doctors did agree to operate on those patients who presented with mild BDD, but only after receiving the approval of a psychiatrist who followed up with the patient after the operation.

The study’s authors were emphatic that such elaborate preoperative psychological testing or psychiatric consultation is unnecessary for every patient as a matter of course, since “[s]evere BDD is in effect a disorder that can hardly be missed during a thorough presurgical” consultation. While a plastic surgeon need not effectively adopt psychiatry as a subspecialty, however, “it is undoubtedly of the essence that a plastic surgeon be adequately trained to understand the psychological implications associated with cosmetic surgery.” The doctors describe the medical and ethical obligations of modern cosmetic surgeons, and the potential legal implications should they fail to meet these standards:

We should all be professionally capable of conducting a brief psychological screening to investigate the motivations and expectations of our patients, their psychiatric condition and history, and their perception of their body image. Patients with a psychiatric history, if dissatisfied with their postoperative results, may exploit their psychiatric problems to sue the surgeon, claiming that their condition prevented them from clearly and completely understanding the modalities of the operation and its possible outcomes.

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37 Id.
38 Id. The 9 percent (5 out of 56) of patients who presented with moderate to severe BDD seems to align with the frequently cited 6 to 15 percent, see supra text accompanying note 24, of all cosmetic surgery candidates who have BDD.
39 Vindigni, supra note 30, at 306
40 Id. at 306-07.
41 Id. at 307.
42 Id.
Clearly, then, the members of the medical profession are aware of the possibility that body dysmorphic disorder can distort the patient’s competency to offer any type of consent, leaving the operating surgeon vulnerable to legal liability if she provides the cosmetic procedure anyway. Many researchers are prepared to impose on cosmetic surgeons an expectation that they will “acquire the knowledge and expertise required to evaluate patients carefully,” and that they will have the prudence “to refuse the services requested in dubious cases.” More detailed analysis of the implications of these and similar findings on standards of care appear in subsequent sections of the article.

However, even in a study that found a higher rate of satisfaction among BDD patients with the results of the operation on the particular treated body part compared to the findings of past research—possibly helping to explain why cosmetic surgeons tend to have a more optimistic view than most researchers of the effects of cosmetic procedures on the BDD population—the authors nonetheless concluded that a BDD diagnosis is a contraindication for surgery. First, all but one patient still had BDD five years after the surgery was complete, and all but one had developed a new site of preoccupation. Moreover, as measured by psychological testing, the BDD patients experienced no significant reduction in handicap, which prior to surgery was already at a markedly higher level than patients without BDD, whose disability was negligible. Finally, the pervasive comorbidity of other psychological disorders among BDD patients at the five-year follow-up further militates against performing cosmetic procedures in this segment of the population.

Further underscoring the complexity of the issue of BDD patients and cosmetic surgery is the difficulty in identifying and differentiating BDD patients from individuals without the disorder. Dissatisfaction with one’s body image—defined as “a multidimensional construct that encompasses perceptions, thoughts, and feelings about the body”—is thought to be pervasive throughout the general population, although for most individuals the degree of appearance-related anxiety or disgust does not reach the

43 Id.
44 See infra Sections 1.D, E.
45 Tignol et al., supra note 32, at 523.
46 Id.
47 Id.
48 Id.
psychopathological levels seen in BDD. Indeed, one study found that cosmetic surgery candidates as a group did not express more dissatisfaction, criticism, or preoccupation with their overall appearance than Americans in general, although they did display significantly greater dissatisfaction with the particular body part for which they were considering cosmetic surgery. Of these surgical candidates, 7 percent met the diagnostic criteria for BDD.

The study’s authors concluded that their findings “raise[] several questions regarding the utility of the [BDD] diagnostic criteria with cosmetic surgery patients.” For instance, “a physical feature that appears to be within the range of normal variation to the untrained eye may be judged as an observable and correctable defect by the plastic surgeon.” That is, the surgeon’s expertise lies in her ability to listen to a prospective patient’s complaints about a physical feature, and to perceive how and why the feature is flawed in order to transform it in a way that more closely resembles the aesthetic ideal. The doctor may not realize the extent to which the patient’s self-image is distorted if the doctor herself does in fact notice subtle ways in which the body part could be improved, as she has been trained to do, even if most people would describe the patient’s feature as average or acceptable. The ambiguity would be even more confounding when the surgical goal is to “enhance” rather than to “fix,” as would be the case with making large breasts even larger through breast implants. As a result, the authors argue that “perhaps the degree of emotional distress and resulting behavioral impairment are more accurate indicators of body dysmorphic symptoms in this population.”

As this literature, considered in the aggregate, implies, there is no universal consensus among medical scholars, ethicists, researchers, and practitioners about precisely how to handle surgical candidates with BDD who wish to obtain cosmetic procedures. The majority viewpoint would recommend against operating on an individual with a known or obvious case of severe BDD, for the sake of both the patient’s own wellbeing and the doctor’s risk of legal liability. However, there is room for debate

50 Id.
51 Id.
52 Id.
53 Id.
about how far the surgeon’s responsibilities should extend with respect to discovering and diagnosing even mild manifestations of underlying BDD, and whether the doctor has an affirmative duty to refuse or to actively dissuade a patient that she suspects of having BDD from getting surgery. The following section therefore considers the potential implications of these medical studies on the appropriate legal standard of care for cosmetic surgeons.

D. Establishing a Standard of Care for BDD Surgical Candidates

In the medical field, the professional norms that guide physicians’ daily behavior also frequently form the basis for their legal responsibilities and shape the outcome of malpractice trials. The expert testimony of a doctor is critical to explaining deviations from the standard of care in medical negligence cases, for instance, and the informed consent laws in many jurisdictions obligate a doctor to disclose only what other reasonable physicians would under the circumstances. While the courts will not allow the medical profession to perpetrate manifest injustice in the provision of care under the guise of self-regulation, it is consistent with the traditional interaction between law and medicine to anticipate that the opinions of cosmetic surgeons and psychiatrists will weigh heavily in formulating the legal obligations a cosmetic surgeon has to a BDD patient. Thus, this section incorporates the results of medical research, clinical practice, and professional norms to predict the basic standards of care that the courts will expect doctors to abide by when they consider individuals with symptoms of BDD for cosmetic surgery.

54 See, e.g., Annemarie Bridy, Confounding Extremities: Surgery at the Medico-Ethical Limits of Self-Modification, 32 J.L. MED. & ETHICS 148, 154 (2004) (“[I]n creating professional norms, the medical profession to a great extent autonomously defines the legal standards to which its members will be held.”).

55 See, e.g., 61 AM. JUR. 2D Physicians, Surgeons, Etc. § 321 (2007) (“In the great majority of malpractice cases, a plaintiff must establish by expert testimony both the standard of care and the defendant's failure to conform to that standard.”).

56 Id. at § 172 (explaining that in some jurisdictions the physician will be required to disclose what “a reasonably prudent physician would be expected to disclose under like circumstances,” while in others the standard is based on what a reasonable person or the particular patient would want to know).

57 Bridy, supra note 54, at 154 (“Canterbury teaches that where autonomously defined professional guidelines or customs fail to adequately protect patients’ health or their rights, those guidelines or customs will be subject to judicial abrogation or redefinition.”).
I. Psychological Screening During Preoperative Consultation:

Generally, leaders of the plastic surgery industry assume that both patients and doctors have a responsibility to familiarize themselves with the psychological implications of undergoing a cosmetic procedure, and to be prepared to raise or answer appropriate questions about patient psychology during the preoperative consultation. Moreover, there seems to be a professional expectation that “[e]xperienced plastic surgeons can usually identify troubled patients during a consultation.” Such doctors may “decline to operate on these individuals,” or “they may recommend psychological counseling to ensure that the patient's desire for an appearance change isn't part of an emotional problem that no amount of surgery can fix.”

Under the current system of professional norms, among the types of individuals who generally will be advised to seek counseling are patients with unrealistic expectation, patients who have consulted multiple surgeons and are impossible to please, and patients “who are obsessed with a very minor defect.” Surgical candidates in this last category, which may encompass individuals who exhibit BDD symptoms in a mild form, may nonetheless receive surgery “as long as they are realistic enough to understand that surgical results may not precisely match their goals.” Regardless of whether a substantial portion of fellow doctors would agree to operate in these circumstances, however, a cosmetic surgeon would be wise to record the opinion of a mental health professional who has worked closely with the patient, stating that the patient is psychologically prepared and that the surgery is likely to have beneficial effects, before proceeding. Similarly, surgery on candidates who have a diagnosable mental illness involving delusional or paranoid behavior is usually contraindicated, although even here

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58 See, e.g., THE AMERICAN SOCIETY OF PLASTIC SURGEONS (ASPS), PSYCHOLOGICAL ASPECTS: YOUR SELF-IMAGE AND PLASTIC SURGERY (2007), available at http://www.plasticsurgery.org/patients_consumers/planning_surgery/psychological_aspects.cfm (“[Y]our individual circumstances and your self-image must be considered. Ask your surgeon if there is anything you don't understand about the possible psychological aspects and effects of your planned procedure.”).

59 Id.

60 Id.

61 Id.

62 Id.
professional organizations maintain that operations are not completely ruled out if the surgeon “work[s] closely with the patient's psychiatrist.”

Cosmetic surgery groups and professional societies also presume that their member physicians will have a candid conversation with their patients about how the patient feels about her appearance, how she believes others see her, and how she would prefer to look and feel. While the burden is on the surgeon to probe these issues, however, she must rely on the patient’s honesty so that both parties can come to a mutual understanding about the procedure and its anticipated effects. This information regarding the nature and reciprocal expectations of the surgeon/patient relationship is disseminated to prospective patients by the largest and most renowned organization of board certified plastic surgeons. It should be considered authoritative, though perhaps not conclusive, on the minimal proper standard of care. Since these policies may actually be quite liberal with respect to surgery on BDD patients given the recent medical literature, doctors who fail to comply with these basic precautions without justification will likely be liable for some form of medical malpractice.

Balancing the concerns discussed in the medical literature with the safety and psychological satisfaction of BDD patients, with the right of mentally healthy patients to receive an operation without undue scrutiny and the right of surgeons to provide these services without excessive interference and inefficiencies, an appropriate compromise may be to require surgeons to conduct a rudimentary preoperative psychological screening and to hold them responsible for missing or ignoring the more egregious cases of BDD. While it is unfair and unrealistic to expect surgeons to present every potential client with a series of complex psychological tests, and to either undertake the extra training needed to interpret the results themselves or to pay a mental health professionals to review them, many cognitive and behavioral indicators of the disorder should be readily apparent to the observant and interested physician.

2. Efforts to Obtain Subjective Informed Consent:

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63 Id.
64 Id.
65 See supra Section 1.C.
In the absence of any evidence of coercion or deception, a signed informed consent form generally raises a strong presumption that the doctor did in fact fulfill her duty of disclosure. As a result, these forms are ubiquitous throughout the medical profession. Ideally, these documents would serve an informational or signaling function in addition to their value in relieving the doctor from potential liability. That is, physicians have noted that patients often remember little of what is discussed during the consultation, particularly when the patient’s mentality is centered on the drive to receive the operation, so a written document which delineates the risks and drawbacks of an elective procedure and which requires the patient to take the affirmative act of signing her name ought to cause the patient to pause and take notice of the seriousness of the surgery. However, as physicians have long recognized, many patients sign these forms “either without reading them or without absorbing their content.” One way a cosmetic surgeon can further ensure adequate patient understanding is to insist on a second consultation during which the doctor can check the patient’s comprehension of the meaning of the forms. Not only does such a policy demonstrate the surgeon’s commitment to obtaining the patient’s subjective informed consent rather than simply discharging a legal duty in the most expedient way possible, it also gives her an opportunity to observe the patient a second time for any symptoms of BDD.

3. Refusal and Dissuasion:

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66 See, e.g., Hoofnel v. Segal, 199 S.W.3d 147, 151 (Ky. 2006) (“The existence of a signed consent form gives rise to a presumption that patients ordinarily read and take whatever other measures are necessary to understand the nature, terms and general meaning of consent.”); Mitchell v. Kayem, 54 S.W.3d 775, 781 (Tenn. Ct. App., 2001) (“Generally, the law presumes that a person who has signed a document, after having an opportunity to read it, is bound by his signature. This presumption applies in informed consent cases; thus, the existence of a signed consent form gives rise to a presumption that the patient gave his consent, absent misrepresentation, inadequate disclosure, forgery, or the patient's lack of capacity.”) (internal citations omitted).

67 See, e.g., Julien Reich, Factors Influencing Patient Satisfaction with the Results of Esthetic Plastic Surgery, 35 ESTHETIC SURG. 5, 10 (1975) (explaining one cosmetic surgeon’s motivation to begin using “information sheets” describing a given procedure and the necessary postoperative care).

68 Id.

69 Id.
There is statistical evidence that it is fairly common for qualified plastic surgeons to refuse to operate on patients when they believe that the desired treatment is “unnecessary.” Similarly, other researchers have found that 84 percent of cosmetic surgeons have at some point refused to operate on a patient whom they suspected of having BDD specifically. These findings not only reflect an ethical norm within the profession, but also could help to establish a minimal standard of care under which surgeons would be obligated to decline candidates who display symptoms of BDD. If the patient were to “doctor shop” until she found someone who would complete the desired work, any surgeon who did eventually agree would likely expose herself to liability for medical negligence, due to her deviation from professional standards by performing a contraindicating operation.

Cosmetic surgeons may object that they see many patients who do not have any mental illness, but who wish “to correct slight imperfections or to enhance ‘normal’ features.” Such surgical candidates, whose appearances would seem acceptable and certainly free from any major deformities to an objective observer, drive much of the industry’s business. Doctors will likely be reluctant to alienate these patients by “accusing” them of having BDD because they display, at least superficially, one of the symptoms of the disorder. Moreover, it is inefficient for all parties—the surgeon, the psychiatrist, and the patients themselves—to expend time and money “proving” that every patient is sufficiently psychologically stable for surgery. Thus, it may be reasonable for a surgeon to have a policy of requiring additional evidence of BDD, such as personally witnessing the patient obsessively scrutinize her supposed flaw or discovering that the patient has avoided social interaction as a result of her insecurity, before insisting on a comprehensive psychiatric evaluation as a condition to performing the operation.

4. Ethical Codes and Professional Norms:

70 Crerand, supra note 1, at 171-72 (noting two studies which found that 21 to 35 percent of all requested cosmetic treatments were not received, primarily because of physician refusal).
71 Id. at 172.
72 Id. at 169.
Although ethical codes do not have the force of law independently, particular tenets that are widely acknowledged and followed may convert to such a status under a “standard of care” analysis contemplating how the average physician would behave. Members of the American Academy of Facial Plastic and Reconstructive Surgery, for instance, pledge to uphold and abide by a series of ethical mandates structuring their practice and interactions with patients.\footnote{See Code of Ethics (Am. Acad. Of Facial Plast. and Reconstr. Surg. 2000).} Such surgeons are obligated to make the welfare of their patients their primary concern,\footnote{Id. at pmbl.} and to seek consultation from a colleague when facing “doubtful or difficult cases, or whenever it appears that the quality of medical service may be enhanced thereby.”\footnote{Id. at § 14.} Personal “reward or financial gain is a subordinate consideration,”\footnote{Id. at § 19.} and surgeons are authorized to perform only those operations that are “calculated to improve or benefit the patient.”\footnote{Id. at § 21.} Advertising is also limited and regulated by professional guidelines to avoid misleading potential patients.\footnote{Id. at pmbl.} Moreover, although an ethical obligation is not necessarily a legal obligation as well if it has not gained general acceptance within the profession, evidence that a cosmetic surgeon deviated from the ethical norms or codes of any particular associations to which she belong during the course of the physician/patient relationship may help to persuade the factfinder that the cosmetic surgeon was also willing to disregard the general standard of care in operating on an individual with BDD.

Implementing a protocol for properly handling BDD is not just ethically mandated for the protection of the patients, but is in the surgeon’s self-interest as well. One survey reported that 29 percent of aesthetic surgeons had been threatened with legal action by a patient with BDD.\footnote{Crerand, supra note 1, at 175.} Ten percent had received threats of physical violence as well as legal action.\footnote{Id. at pmbl.} Such statistics further buttress the “growing consensus” in the legal and medical literature that the risks to both the physician (of legal liability) and the patient (of experiencing no improvement in body image) of providing cosmetic surgery to

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  \item \footnote{See Code of Ethics (Am. Acad. Of Facial Plast. and Reconstr. Surg. 2000).}
  \item \footnote{Id. at pmbl.}
  \item \footnote{Id. at § 14.}
  \item \footnote{Id. at § 19.}
  \item \footnote{Id. at § 21.}
  \item \footnote{Id. at pmbl.}
  \item \footnote{Crerand, supra note 1, at 175.}
  \item \footnote{Id.}
\end{itemize}
an individual with BDD greatly outweigh any potential benefit, such that BDD “should be considered a contraindication for cosmetic treatment.”81 Nonetheless, while an estimated 30 percent of cosmetic surgeons believe that BDD is always a contraindication for surgery, others are willing to concede that individuals with mild forms of the disorder might be able to benefit (or at least would not be harmed) if proper psychiatric care were provided in conjunction with the cosmetic procedure, or if previous surgeries had caused visible damage to the patient’s appearance such that the surgery at issue had a reconstructive purpose.82 Thus, while it is difficult to delineate a precise national standard of care or professional consensus for managing BDD patients, a litigious plaintiff would likely be able to find an expert witness who would testify that any symptoms of BDD should have put the cosmetic surgeon on notice that no operation should have been performed at all. At minimum, therefore, a doctor will appear to have violated the standard of care if she operates on a patient without performing any type of BDD screening, or if she notes the possible presence of BDD but does not follow up with a psychiatric consultation or referral.

E. Suggested Protocol for Reducing Risk of Liability

The suggestions contained in this section do not guarantee that the cosmetic surgeon will accurately identify all patients with BDD who will approach her seeking an elective procedure. Nor will these recommendations prevent an aggrieved patient from suing a cosmetic surgeon, although following them is likely to advance the surgeon’s defense by establishing her sensitivity to BDD patients’ needs and her carefulness in providing patients with all the necessary information to make an informed decision. These suggestions derive in substantial part from the same scholarly literature and prudent clinical practices discussed in Section 1.D, which further bespeaks the likelihood that the surgeon who adopts them will also comport with general standards of care.

1. General Psychological Screening:

81 Id.
82 Id. at 176.
A number of medical professionals believe that because of the high rate at which BDD patients seek cosmetic surgery, a general psychological screening is necessary for all patients.\(^83\) This could be done through an interview, a self-report questionnaire, or both, and should explore the patient’s motivations and expectations for the surgery, her psychiatric status and history, her body image, and the presence of any BDD symptoms.\(^84\) Where there is evidence of BDD, the individual should be referred to a mental health professional, who can better evaluate whether the patient is psychologically suited for cosmetic surgery, and who can monitor and treat the patient for any underlying psychiatric disorders regardless of whether the cosmetic operation is ever performed.

2. Symptoms of BDD:

Certain behaviors should signal to doctors that extra precautions may be necessary to ensure that the prospective patient is psychologically prepared to submit to cosmetic surgery. For convenience, these indications are grouped in several categories, as follows:

(a) Behavioral manifestations during consultation. During the course of a preoperative consultation, the doctor may notice the patient obsessively checking her reflection in mirrors or other reflective surfaces, often unconsciously.\(^85\) The patient also may attempt to mask the supposed deformity, such as through hairstyle, make-up, or clothing.\(^86\) Finally, the surgeon may notice the patient picking at her skin or adjusting her body position to “improve” or hide her area of concern.\(^87\)

(b) Statements made to the surgeon. As mentioned, part of cosmetic surgeon’s responsibility is to inquire into the candidate’s motivations and expectations going into the procedure. The doctor should further investigate the possibility of BDD in an individual who criticizes and requests changes to multiple aspects of her appearance.

\(^83\) Id. at 171.
\(^84\) Id.
\(^85\) Vindigni, supra note 30, at 307.
\(^86\) Id.
\(^87\) Crerand, supra note 1, at 171.
during a single appointment; whose perspective on the possibilities of plastic surgery has been skewed by celebrity culture and reality television shows; and who has unrealistic expectations about how the physical alterations will affect other areas of her life.\textsuperscript{88}

(c) \textit{Admitted behavior outside of the consultation}. The cosmetic surgeon may ask the patient about specific ways her preoccupation with her “flawed” body part affects her life, either as a matter of general policy or because other behavioral indicators have suggested the possible presence of BDD. The patient may also disclose on her own initiative how her struggles with her appearance have affected her life. Specifically, the patient may confess to having uncontrollable, intrusive thoughts about the supposed flaw, which the physician may observe are held with delusional intensity.\textsuperscript{89} She may also describe her body image insecurity or preoccupation as interfering with her vocational or academic performance, as well as with her social interactions.\textsuperscript{90} A surgical candidate who attributes her sense of emotional or physical isolation from others to an imperceptible flaw also will almost always require the oversight of a mental health professional before any cosmetic operation should be performed.

(d) \textit{Surgical history}. Many patients with BDD have an extensive history of cosmetic surgery and other less invasive cosmetic procedures (such as collagen injections and tooth whitening).\textsuperscript{91} Since cosmetic surgery “addicts” often bounce between different doctors, it may be difficult for the treating plastic surgeon to know whether she has a complete copy of the patient’s medical records. The patient also may try to conceal or explain away past procedures to avoid arousing suspicion in the doctor.\textsuperscript{92} The physician should emphasize the importance of candor when taking the patient’s medical history, and should use the opportunity to inquire into the patient’s motivations for and satisfaction with any past cosmetic work as well.

(e) \textit{Demographic characteristics}. Individuals with BDD statistically tend to share certain demographic or dispositional traits. For instance, individuals with BDD are likely to suffer from increased levels of depression, anxiety, and hostility compared to

\textsuperscript{88} Fukushima, supra note 4.
\textsuperscript{89} Crerand, supra note 1, at 171.
\textsuperscript{90} Id.
\textsuperscript{91} Id.
\textsuperscript{92} Fukushima, supra note 4.
persons free from the disorder. Additionally, compared to the general cosmetic surgery population, patients with BDD are significantly younger at the time of the cosmetic procedure, suggesting that “[t]he younger age might be a clue to look for a BDD diagnosis in candidates for cosmetic surgery with minimal defect in appearance.”

Although the mere fact of a patient’s youth or a history of depression does not necessitate a full psychological evaluation, if it appears in conjunction with other indicators of BDD or psychiatric disorder, the cautious cosmetic surgeon will be careful to chart how she arrived at her treatment decision in order to avoid problems in any future litigation.

As discussed, the prudent physician will want to—indeed, may have a legal or ethical duty to—probe further into the psychological status of patients who display any of these signals. While some evidence of BDD symptoms need not automatically preclude the individual from obtaining the desired surgery, the surgeon should make note in the patient’s medical record of any contraindications to the procedure that she observes during consultation, along with an explanation of her eventual course of action, whether it be surgery or psychiatric referral. Although this extra recordkeeping effort may seem excessive, evidence of incomplete or altered medical records is a common but preventable reason that defendant doctors lose or are forced to settle malpractice cases.

Furthermore, memories fade over time, so written documentation will assist the surgeon in justifying her treatment decisions and demonstrating that she arrived at them through the careful exercise of her professional medical judgment. Finally, recording any observable symptoms of possible BDD, even if they are insufficiently robust to preclude surgery, will assist future doctors that the patient may approach in their own determinations of whether cosmetic surgery is appropriate.

3. Informed Consent:

93 Crerand, supra note 1, at 171.
94 Tignol, supra note 32, at 522.
95 See, e.g., 44 AM. JUR. TRIALS 317, Forensic Document Examination in Medical Malpractice Cases (2007) (“The consequences of altered medical records for the physician or other health care provider are generally disastrous…. The [individual] who alters the records will frequently see the outcome of the proceeding that the alteration was intended to control determined in favor of the patient despite the presence of other credible evidence that supports the health care provider's legal and factual defenses.”).
As elaborated below, the case law regarding proper informed consent has focused on the physician’s disclosure of the risks inherent to the operation and alternative procedures that the plastic surgery candidate might undertake (for example, the relative merits of a “tummy tuck” as compared to liposuction of the stomach). However, to the prudent doctor will also want to make it policy to discuss the following:

(a) *Whether the patient has exercised all other non-surgical options.* These alternatives may range from the basics of diet, exercise, and the use of make-up, to more complicated beauty procedures such as trying Botox before undergoing a face lift. While the patient need not always prove to the doctor that surgery is a last resort, the doctor should feel confident that the patient has thoroughly thought through the surgical decision and has given serious consideration to less invasive ways of managing the perceived flaw. By exploring the candidate’s past attempts to improve this aspect of her appearance, the doctor may also be able to gauge whether her efforts have become obsessive, indicating possible BDD.

(b) *If the surgery is wholly irreversible in nature, or if future surgeries may be needed.* For instance, individuals generally need to receive Botox injections every three to six months to maintain the results, and collagen injections to the lips last only two to four months. Furthermore, breast implants often harden, rupture, or leak, with as many as 70 percent needing to be replaced after 10 years. Patients often assume a breast augmentation will last forever; a responsible plastic surgeon will inform the prospective patient of the statistics for implant replacement in general and, if available, for her own practice. Even seemingly obvious statements like the fact that the results of liposuction will not be maintained unless the patient’s diet and exercise habits are sufficient may need to be disclosed in the exercise of caution. When providing cosmetic work to an

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96 See infra Section 2.A.
100 One study found that weight gain after a liposuction procedure was three times more likely in patients who failed to eat a healthy diet, and four times more likely in those who failed to exercise. See Rod J.
individual with BDD, there is always an increased risk that the patient will continue to view the treated body part as flawed after the procedure is complete. If the patient was not made aware of all of the potential ways that even a properly executed surgery could actually detract from rather than improve her physical appearance, as well as all the necessary steps she must take to heal properly and to maintain the results, she may blame the cosmetic surgeon for her continued unhappiness with her appearance and argue that she would not have undergone surgery if she had known about these possibilities beforehand.

(c) The surgeon’s policy on corrective surgery. Even if the operation is a technical success, some cosmetic surgeons will offer a reduced fee to provide additional work if the patient is dissatisfied with the aesthetic results. Discussing this matter reminds the patient that perfection is not guaranteed. Moreover, the patient’s reaction to the possibility that the surgery might not achieve her imagined ideal could tip off the doctor to the presence of underlying mental illness. Finally, doctors should be cautious but not dismissive of patients who do seek “corrective” operations when their complaints seem objectively unjustified; if the flaw is an imagined one, the patient will never be satisfied with the outcome, no matter how many surgical attempts the doctor makes to “fix” the patient’s concern.

After making these disclosures and providing the patient with an opportunity to ask additional questions, the doctor should have the patient sign a written document acknowledging that the doctor discussed these matters (which, to a reasonable extent, should be specified on the form) and addressed the patient’s unique concerns, and affirming the patient’s voluntary consent to undergo the procedure. If the patient did raise any special issues during the disclosure process, the doctor also should be sure to record this in her notes and to indicate how she handled it.

As a final point, the authors of one study have brought up the interesting question of how to handle patients who have extreme distress about an objective aesthetic

problem. As they note, the potential therapeutic effects of plastic surgery on such individuals has not been studied.\footnote{Sarwer, supra note 49, at 1644.} From a legal perspective, the prudent doctor should take many of the same precautions she would with a BDD patient whose flaws are imagined or grossly exaggerated. In particular, the surgeon should refer the patient to a mental health professional who will confirm the patient’s competency and psychological stability before the surgeon agrees to operate, and who will follow up with the patient postoperatively.

Part Two: Potential Causes of Action for Aggrieved BDD Patients

Depending on the jurisdiction and the factual circumstances of the case, the various potential causes of action that an aggrieved BDD patient could bring against her plastic surgeon may overlap or preempt each other. For instance, if the doctor ignored obvious symptoms of the disorder while explaining the risks of surgery, it could constitute a general breach of due care or a more specific failure to obtain informed consent to the operation. The resulting cause of action could sound in battery, negligent nondisclosure, or medical malpractice, depending on the state’s common law and the plaintiff’s theory of the case. Each of several potential causes of action is discussed separately here for the sake of clarity, although occasional references to other claims occur when they help to elucidate distinctions or possible litigation strategies. Both trial lawyers and physicians should be aware of how each theory of liability would be presented to a jury, although not every claim will have a common law or statutory basis in each state.

Part Two thus begins with a discussion of the law of negligent nondisclosure and informed consent doctrine. Negligent nondisclosure refers specifically to the physician’s failure to provide the patient with adequate information prior to the operation, while the concept of informed consent may be broader, encompassing not only the doctor’s failure to disclose but also the patient’s legal incapacity to consent as well. Judicial opinions and
academic literature sometimes conflate the two; this article considers them in the same section but emphasizes that general informed consent doctrine can raise issues outside the scope of negligent nondisclosure. The second section of this part discusses the tort of battery. Depending on the jurisdiction, this cause of action may be available where the physician objectively provided the patient with sufficient information about surgical risks but the patient lacked the legal capacity to consent to them, or where the physician failed to comply with the disclosure requirements of informed consent doctrine such that even otherwise competent consent constitutes no consent at all.

Next, the third section analyzes the potential claim of breach of fiduciary duty. The fiduciary nature of the doctor/patient relationship gives rise to many of the physician obligations that can form the basis for independent causes of action, most notably informed consent. However, some jurisdictions may allow breach of fiduciary duty to be brought as a separate claim when the nature of the cosmetic surgeon’s wrongdoing does not perfectly conform to other more specific grounds for liability. Finally, the last section in Part Two discusses contract law in the context of cosmetic surgery. With the advent of computerized imaging software, the increase in direct-to-consumer advertising for cosmetic procedures, and the fact that cosmetic surgery resembles a traditional commercial transaction far more than any other type of medical service, lawsuits for breach of contract against plastic surgeons seem increasingly likely. Although any patient could argue that she bargained and paid for a specific aesthetic result that was not subsequently obtained, BDD patients are more likely to be dissatisfied with the outcome of their surgeries and to seek revenge in the form of litigation against their doctors.

The discussion of the various potential causes of action that a cosmetic surgeon might face may seem intimidating to medical practitioners, perhaps even inducing some to practice defensive medicine in order to reduce the odds of a future lawsuit. While it is important that doctors are aware of and act in accordance with their legal obligations, however, the factual circumstances from which the malpractice charges described herein can stem should not be surprising. A common theme throughout all of them is that, in order to be viable, there must be evidence that the cosmetic surgeon abused or neglected her basic duty of care to her patient, whether due to greed or carelessness. A cosmetic surgeon who makes an effort to screen her patients for signs of BDD, who is willing to
turn them away or refer them to psychiatric counseling even if doing so means wasted time and loss of income, and who is candid with them throughout this entire process, will rarely be found of wrongdoing.

A. Negligent Nondisclosure and Informed Consent

1. The Law of Informed Consent

   (a) Common law traditions. Depending on the jurisdiction, cosmetic surgeons will be subject to one of two legal standards for informed consent. Some states require doctors to disclose information that a “reasonable medical practitioner,” either in the particular locality or under a general nationwide standard, would provide to the patient under the same circumstances. Other states mandate that the doctor disclose information that a “reasonable patient” would want to know. Although there are variations in statutory and case law between states, generally a doctor must inform the patient of all material or reasonably foreseeable risks, the nature of the proposed treatment, possible alternative treatments, and the probable consequences of refusing treatment altogether. Cosmetic surgery is elective, of course, so patients will suffer no physical harm if they decide not to undergo any procedure. There is, however, some judicial precedent for requiring doctors to explain other options that could produce results similar to those of the requested procedure even in the context of plastic surgery. Even scholars who question the “idealist” conception of informed consent, and who argue for an emphasis on efficiency from the physician’s perspective and differential

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103 *Id.*
104 *Id.* at 916-17.
105 See, e.g., *Lynn G.*, 272 A.D.2d at 40 (holding that a “triable issue” was raised by the plaintiff’s assertion that the defendant doctor “never discussed any options other than a mini or full abdominoplasty” and by the plaintiff’s expert’s opinion that the doctor “should have suggested a suction-assisted lipectomy as a less invasive alternative”).
106 “[I]dealists tend to define informed consent law’s pivotal concepts—materiality of risk, disclosure, alternatives, and causation—broadly and subjectively from the perspective of the individual patient rather than that of the professional, while defining the law’s exceptions to the duty narrowly.” Schuck, *supra* note 102, at 903.
obligations between various medical specialties, recognize that elective cosmetic surgery implicates special concerns that may necessitate heightened disclosure.107

The charge of negligent nondisclosure or failure to obtain informed consent centers on communications prior to the surgery, rather than the circumstances of the operation itself.108 There is no cause of action for negligent nondisclosure unless (1) the unrevealed risk that should have been made known actually materializes, and (2) there is a causal connection between the failure to adequately divulge the risk and the harm to the patient, as demonstrated by a jury finding that a reasonable person in the patient’s position would have decided against the treatment if the risk had been revealed.109 Thus, the plaintiff in informed consent cases has two burdens to overcome. First, she must demonstrate that the risk that was not disclosed also was the particular harm that she suffered. Second, she must show that if the doctor had disclosed the risks, she would not have submitted to the procedure.110 Generally, the second prong is evaluated under an objective, rather than subjective standard, asking what decision a reasonable person in plaintiff’s position would have made if adequately informed of all significant risks.111

As the Canterbury opinion notes, there is at least a theoretical distinction between a physician’s “duty to disclose” and a patient’s “informed consent.” While the former clearly focuses on the doctor’s “performance of an obligation,” the latter tends to “imply that what is decisive is the degree of the patient’s comprehension.”112 The Canterbury opinion, which has been foundational to much future informed consent jurisprudence, is careful to emphasize that “the physician discharges the duty when he makes a reasonable effort to convey sufficient information, although the patient, without fault of the physician, may not fully grasp it.”113 To the extent this is valid, then, undisclosed and

107 Id. at 955 (“[T]he risk-benefit ratio is more controversial, the choice is highly personal and private and does not directly affect others, and the dialogic opportunities are relatively great.”).
108 “A claim against a physician for negligence based on lack of informed consent is separate from a claim based on negligence in medical treatment…. A physician can be liable for failure to obtain informed consent before treatment without being negligent in the actual treatment of the patient.” Sherwood v. Danbury Hospital, 896 A.2d 777, 788 (Conn. 2006) (citing 61 AM. JUR. 2D 267, Physicians, Surgeons, Etc., § 152 (2002)).
110 Schuck, supra note 102, at 918-19.
111 Id. at 919.
112 Canterbury, 464 F.2d at 780.
113 Id.
non-obvious mental illness arguably should not subject a physician to liability, even if the ultimate effect is that the patient does not consent to the treatment’s risks with an ideal level of comprehension. Once again, the difficulty is determining whether a cosmetic surgeon—someone whose specialty is clearly distinct from psychiatry—ought to be able to detect an undisclosed (and sometimes actively concealed) psychiatric disorder in someone who is seeking an elective aesthetic alteration to her appearance.

(b) **Body Dysmorphic Disorder and Competency.** Although members of the profession should have a general awareness of BDD due to its disproportionate prevalence in cosmetic surgery clientele, its defining symptom will be present to some degree in every individual that plastic surgeons see: namely, dissatisfaction with a particular part of the body that is sufficiently intense to justify to the individual the payment of a large sum of money to permanently alter it. Moreover, in the case of optional treatments, there seems to be a heavy presumption in favor of both the doctor’s ability to suitably communicate her evaluation of the risks and benefits of the elective procedure, and the patient’s ability to understand this discussion.\(^\text{114}\) Since “it must be the exceptional patient who cannot comprehend such an explanation at least in a rough way,”\(^\text{115}\) it appears that the physician can discharge her disclosure duty even in the absence of perfect patient comprehension.

However, the very foundation of informed consent law seems to take for granted that the patient will be legally competent to consent. This leads to contradictions and inconsistencies in the standards by which informed consent must be evaluated when the plaintiff’s general competence is questionable. On the one hand, the law seems to place a burden on the physician to explore the peculiarities of each patient’s needs and motivations for the operation, and to proceed accordingly. The doctor is in a unique “position to identify particular dangers,” since she has “knowledge of, or ability to learn, [the] patient’s background and current condition.”\(^\text{116}\) On the other hand, the “scope of

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\(^{114}\) *Id.* at 782, n.27.

\(^{115}\) *Id.*

\(^{116}\) *Id.* at 787.
the standard is not subjective as to either the physician or the patient”\textsuperscript{117} in many jurisdictions. Yet, even under this objective analysis, the physician must give “due regard for the patient’s informational needs and with suitable leeway for the physician’s situation.”\textsuperscript{118} The focus of this so-called objective standard is thus often formulated with respect to “a reasonable person in what the physician knows or should know to be the patient’s position.”\textsuperscript{119}

The resultant problem in the context of body dysmorphic cosmetic surgery candidates, of course, is whether the “patient’s position” should be construed to include the patient’s mental disorder. If so, the standard is by definition impossible: a person in this “situation,” with a diagnosable mental illness, cannot be reasonable in the normal sense of the word, particularly when the context requires the patient to make judgments that so heavily implicate the body image insecurities and distortions that characterize BDD. Further complication stems from the issue of whether the doctor “should know” that the patient might have BDD, even if the patient’s medical records contain no direct indication of the disorder. It would be unfair to expect a plastic surgeon to have a psychologist’s expertise in perceiving any cognitive impairment that could, at a later date, be argued to have negated competency to consent at the time of the consultation or operation.

As discussed, given the frequency with which BDD occurs in the cosmetic surgery population, doctors ought to examine the prospective patient’s surgical and psychiatric histories, and to inquire into the patient’s expectations, body image, and so forth, in order to identify the most severe body dysmorphic situations and to require psychiatric counseling and special approval before proceeding with any operation. Beyond the ethical appeal of such an obligation, it comports with general informed consent and medical malpractice legal doctrine. While a physician “obviously cannot divulge any [risks] of which he may be unaware,” meaning that “[n]ondisclosure of an unknown risk does not, strictly speaking, present a problem in terms of the duty to disclose,” the full scope of a physician’s duties is much broader, indicating that such

\textsuperscript{117} Id.
\textsuperscript{118} Id.
\textsuperscript{119} Id.
failure to disclose “very well might pose problems in terms of the physician’s duties to have known of it and to have acted accordingly.”

The general rule thus seems to be that fulfilling the legal duty-to-disclose requirements is necessary but not sufficient to securing the patient’s consent to an operation or other treatment. Before the consent can be efficacious, it “must be free from imposition upon the patient,” and the physician must have “first elucidate[d] the options and the perils for the patient’s edification.” While failure to so inform the patient may subject the doctor to liability, it does not exhaust the doctor’s responsibilities. Formalistic compliance with disclosure obligations may not shield the doctor from common-law battery charges if it is found that the therapy was not authorized by the patient. Therefore, even if the doctor is able to escape negligent nondisclosure liability for technical compliance under an objective informed consent standard, she may still be vulnerable to a malpractice or battery suit if there is evidence that the patient was incapable of competently consenting to the procedure at all.

2. Policies Underlying Informed Consent

According to one scholar, Professor Peter Schuck, informed consent in the medical context implicates the policy justifications and goals of both contract and tort law. Specifically, informed consent should advance the contract ideals of individual autonomy, economic efficiency, and independence from state power, while fostering the moralistic tort law concepts of fault and duty. Professor Schuck believes that to best achieve these objectives, the definition of proper informed consent in a given situation must be “contextualized” in a way that accounts for (1) the marginal cost-effectiveness of increased doctor/patient dialogue; (2) the way risks are characterized and

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120 Id.
121 Id. at 783.
122 Id. at 782-83; see also infra Section 2.B.
123 Schuck, supra note 102, at 900-01.
124 Id. at 902.
communicated to different patients; (3) the circumstances in which the consent is elicited; and (4) the opinions of all parties as to what informed consent ought to entail.125

(a) Individual bodily autonomy. Professor Schuck also discusses several arguments as to why robust disclosure rules may be necessary in the medical context. First and most fundamentally is the principle of autonomy, which holds that a mature individual has a basic right to self-determination, especially in the private and intimate context of her own bodily integrity.126 The autonomy argument would seem to favor allowing mature individuals to undergo even extreme forms or excessive amounts of plastic surgery as long as they were fully apprised of the possible physical and psychological repercussions beforehand. However, there is a philosophical distinction between the “negative right” to be free from unwanted interference or coercion, and the “positive right” to do or receive something.127 Many scholars, particularly those in the libertarian tradition, find negative rights to be more normatively justifiable.128

In the context of plastic surgery that is unnecessary or performed on dubious candidates, this theoretical framework could pull either way. On the one hand, the law of informed consent can be construed as a prohibition against subjecting a person to unwanted or misunderstood surgical procedures. In the absence of a contractual agreement otherwise, there would be no positive right to any form of cosmetic surgery, only a negative right to be free from having another person operate on one’s own body. Moreover, doctors would have a corresponding autonomy right to not be forced to perform surgical procedures, including elective ones for which they believe the benefits do not outweigh the risks, even if those benefits and risks are self-centered, such as the income they would gain from performing the service or their fear of being sued at a later date.

On the other hand, one could argue that if both the patient and the doctor were competent and willing, they should be able to proceed with whatever type of plastic

125 Id. at 905-06.
126 Id. at 924-26.
128 See, e.g., Tibor R. Machan, The Perils of Positive Rights, 51 The Freeman: Ideas on Liberty 49 (2001) (arguing that America’s political system is founded on a theory of negative natural rights, and that positive rights are suspect because they tend to “trump freedom”).
surgery they agree on, free from governmental, organizational, or societal constraints. While a pure libertarian philosophy would support the latter position, American case law has consistently recognized that sometimes broader public interests can trump personal autonomy.\footnote{See, e.g., Roe v. Wade, 410 U.S. 113 (1973) (women’s right to abortion not unqualified due to countervailing state interests “in safeguarding health, in maintaining medical standards, and in protecting potential life”); Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) (societal interest in upholding a certain quality of life within the community can outweigh the right to privacy in some circumstances); Rutherford v. United States, 616 F.2d 455 (10th Cir. 1980) (governmental interest in protecting public health outweighs individuals right to select whatever medication she desires to treat a disease).} Thus, it is unclear whether the autonomy argument is independently sufficient to sustain a right to any cosmetic procedure the candidate may desire, or if instead medical boards or legislatures should be able to flatly prohibit certain procedures on certain members of the public.

(b) Doctor/patient conflicts of interest. A second argument in support of informed consent in the healthcare context is that the doctor and patient may have a conflict of interest, particularly when care is provided on a fee-for-service basis.\footnote{Id.} Demanding disclosure requirements help to constrain the physician’s incentive to unilaterally increase the quantity and complexity of the procedures she performs, because she is legally obligated to make sure the patient understands the relative merits and risks of her recommendations.\footnote{Id.} This rationale seems to be particularly relevant to plastic surgeons’ practices. Since health insurance generally will not cover non-reconstructive aesthetic surgeries, the patient will pay the doctor directly and out-of-pocket. Additional procedures mean additional income. As a result, the cosmetic surgeon may be more inclined to downplay the drawbacks of the proposed operation, knowing that the patient has no urgent medical reason to assume the risks of surgery. She may also be motivated to overstate her abilities and the potential results the patient can expect, and to recommend “complementary” procedures and other parts of the body the patient might want to change.\footnote{The concept of complementary plastic surgery procedures is not unprecedented or categorically unethical. For instance, some doctors will suggest chin implants to their rhinoplasty patients in order to improve the person’s entire side profile. See generally Travis T. Tollefson & Jonathan M. Sykes, Computer Imaging Software for Profile Photograph Analysis, 9 ARCH. FACIAL PLAST. SURG. 113 (2007) (discussing the use of computer imaging software to improve facial symmetry in patients who received both rhinoplasty and chin surgery). The two procedures are at least rationally related to a desired aesthetic improvement.}
A concept of informed consent that mandated the actual comprehension and rational evaluation of disclosed risks and foreseeable results would frequently preclude body dysmorphic patients from receiving much of the surgery they seek, since their illness distorts their ability to make these types of judgments about their bodies. Of course, such an individualized standard would be inefficient for the physician and nearly impossible to enforce. However, even the less demanding informed disclosure requirements under an objective standard will help to modify the behavior of candidates for multiple cosmetic procedures and the doctors who would perform them, both of which populations are particularly vulnerable to the repercussions of these types of conflicts of interest.

(c) Power and information imbalances. A final argument in favor of strong informed consent laws in the healthcare sector is that imbalances in information and bargaining power are inherent to the doctor/patient relationship, but disclosure obligations and dialogue can remedy some of this inequity.\textsuperscript{133} Regardless of whether knowledge and power disparities are as pervasive and pernicious in modern medicine in general as this argument implies,\textsuperscript{134} plastic surgery in BDD patients raises a sufficient number of unique issues that it deserves a particularized analysis. Since health insurance will not cover purely cosmetic operations, the prospective patient will be able to choose a doctor without worrying about staying within an HMO’s network, since she will have to cover all costs herself anyway. This, in combination with the fact that the surgeries are wholly elective and not urgent, gives the patient more mobility to move between doctors until she is fully satisfied. Of course, this freedom of choice may be constrained by market supply: even in the absence of a legal prohibition, there may be a shortage of doctors who are willing to risk medical board censure, reputational backlash, or potential personal ethical discomfort, to operate on a candidate who, despite her protestations that

objective. A surgeon who advises the patient that she could also alter a totally separate body part about which the patient has not complained (bringing up breast augmentation during a facelift consultation, for example) is clearly more ethically questionable.\textsuperscript{133}\textsuperscript{134} Notably, the cause of action for breach of fiduciary duty, discussed infra 2.C, is predicated on the proposition that such imbalances do exist and give rise to special obligations of loyalty and honesty that the physician must fulfill.
she consciously and competently is choosing the procedure, may have a mental illness that distorts her perception of her appearance before and after the surgery.

Furthermore, prospective patients for cosmetic surgery may be more knowledgeable about their options than traditional healthcare consumers whose need for treatment arises from an unanticipated accident or disease. The decision to seek out a particular doctor for a particular procedure indicates at least a minimal level of independent research into the process. The wealth of information on the internet about even the rarest procedures also allows the surgery candidate to personally inform herself about relevant facts and risks beforehand, and to ask intelligent questions during the consultation itself. While some body dysmorphic patients may be more impulsive about requesting surgery, others will have agonized over the body part, researched surgical options, and saved up money for years, hoping that the procedure will finally align their self-image with what an objective observer would perceive.

The barrier to achieving a truly informed decision in either case often is not that the person does not know or understand the disclosures in a technical sense, but rather that her mental conditions compels her toward surgery in a way that arguably renders her unable to evaluate their options the way the average rational healthcare consumer would. As a result, although requiring certain disclosures may be desirable for other reasons, it is unclear how much informed consent laws work to restore the doctor/patient balance of power in the cosmetic surgery context, particularly with BDD patients.

The *Canterbury* case also attributes the need for informed consent policies to information asymmetries between doctor and patient. “True” consent entails an “informed exercise of a choice,” and the average patient “ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision.”

Although, as mentioned, the advent of the internet has helped to narrow this information gap, not every patient has ready access to or familiarity with how to use the internet, it can be difficult for the lay person to distinguish between legitimate online medical advice and biased or misinformed websites, and even thorough personal research cannot substitute for years of medical training and professional experience.

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135 *Canterbury*, 464 F.2d at 780.
A body dysmorphic patient who has been through multiple procedures, or who has obsessively researched the precise methodology of different types of alterations that could be performed on her “flawed” body part, may have greater factual knowledge, if not rational understanding, of the operative process than the average patient. A prudent plastic surgeon whose patient can recite the risks associated with a given procedure should not assume that she is therefore exempt from meeting all appropriate disclosure and consent requirements, however. A plastic surgery “addict” may have discovered that displaying her familiarity with the risks of surgery and the informed consent process can be an effective way to assuage a doctor’s latent concerns about lawsuits and thus make the doctor more inclined to perform an operation without fully investigating the patient’s surgical history or psychological profile.

Generally, however, a BDD patient will more closely align with the ordinary seeker of plastic surgery with respect to technical knowledge of the medical sciences. Even those BDD sufferers who engage in addictive or manipulative behavior, moreover, may not have heard of their disorder or be aware of how distorted their self-perception is, particularly if they have not yet begun psychotherapy. Furthermore, the fact that a BDD patient may have had multiple operations does not imply that she will remember all the attendant risks to surgery in general with perfect clarity, nor will the necessary disclosures for one procedure perfectly correspond to another. As a result, where the prospective patient already has undergone multiple cosmetic procedures, not only should the surgeon be sure to disclose all the information she would with someone having a cosmetic operation for the first time, she should also be on heightened alert to the presence of potential BDD symptomology and the necessary discussions or referrals that would follow therefrom.

3. Assumption of Risk

When a malpractice plaintiff has voluntarily undergone extreme, extensive, or unnecessary cosmetic procedures that she later regrets, the jury may not be very sympathetic to her complaints. Instead, the jurors seem likely to believe that the patient assumed the risks of the surgery, including the risk that she would later regret doing it at
all, as long as there is evidence in the record that the doctor adequately informed the
patient in a way that an average reasonable person would understand. However, to the
extent that the plaintiff can demonstrate the doctor’s subjective awareness of the plaintiff’s
mental condition and the resultant increased probability of disappointment, the
jury—whether motivated by prior case law or by its own collective sense of justice—may
impose a more stringent duty on the doctor, effectively obligating her to go beyond
formalistic compliance with the law to ensure that the patient does in fact have the legal
capacity as well as the necessary information to properly consent to assuming the
procedure’s risks.

Professor Schuck discusses a series of lawsuits against cigarette manufacturers to
infer “a set of public perceptions about the conditions under which genuine consent—
consent conceived as legally, and perhaps morally, compelling—can be imputed to
individuals.”136 Under certain conditions, juries refuse to “override… individual choices
in pursuit of public health goals,” and thus are willing to find that the plaintiff consented
to assuming a particular risk.137 Specifically, Schuck argues that in the suits against
cigarette manufacturers, juries implicitly found and based their verdicts on the following
facts: (1) at the time of consumption, the individuals were adequately informed of the
relevant risks; (2) “widespread public discussion… and growing social stigma further
signaled this risk”; (3) the plaintiffs’ choice to assume these risks was voluntary, rather
than compelled by addiction; (4) plaintiffs had rejected viable alternatives to the harm-
causing activity for which they were now suing; and (5) they “received something of
value—namely, physical and psychological satisfaction—in return for their choice.”138

All of these factors are likely to be present in litigation over plastic surgery on
BDD patients as well. Specifically, (1) even minimal or formalistic physician
compliance with informed consent obligations should put a reasonably prudent patient on
notice that surgery is not risk-free; (2) public discussion, debate, and controversy over
“extreme makeovers” has brought these matters into public consciousness;139 (3) the urge

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136 Schuck, supra note 102, at 953.
137 Id.
138 Id.
139 On the ABC reality TV show “Extreme Makeover,” for example, participants are treated by a team of
plastic surgeons, dermatologists, cosmetic dentists, hair and makeup artists, dieticians, stylists and personal
for plastic surgery, even when accompanied by a BDD diagnosis, may seem to a jury to be more analogous to a cigarette use (which requires an affirmative act, with a time lapse between the urge and the completion of that act, allowing for reevaluation and resistance of the compulsion) than more severe forms of mental illness like schizophrenia, where the behavioral manifestations (delusions, hallucinations, erratic speech and thought processes) are more severe and appear to be less within the individual’s control; (4) most people will choose less drastic alternatives to surgery if they want to change their appearance to better suit their aesthetic preferences; and (5) those who do elect the pain and expense of cosmetic surgery are frequently perceived to have done so in order to gain the benefit of appeasing their own vanity or winning increased social or sexual approval and desirability.

Sufferers of BDD seem, at least superficially, to battle a greatly amplified form of the insecurity that most people feel about certain physical flaws, both real and imagined. Jurors who do not fully understand or who are not sympathetic to the disorder may label the plaintiff as vain and wonder why she did not simply resort to using make-up, changing her clothing style, or intensifying her exercise program like most people would do. Opposing counsel could capitalize on such biases by emphasizing these alternatives to surgical procedures. If not properly rebutted, such arguments may lead the jury to conclude that the plaintiff was irresponsible for not limiting herself to less permanent forms of physical alteration. As in cigarette litigation and other assumption of risk contexts, then, juries facing these types of plastic surgery cases may “favor using tort law to emphasize individuals’ right” to partake in risky behavior like elective surgery and “their corresponding blameworthiness and financial responsibility for the resulting harms they risk.”

trainers to completely transform their appearance. The subjects recuperate in a ritzy “Makeover Mansion,” and the show’s producers arrange for a spectacular unveiling, often incorporating footage of the participant achieving a lifelong dream (such as being swooned over at her high school reunion or accompanying a famous singer on the violin). See The Extreme Makeover official website, http://abc.go.com/primetime/extrememakeover/show.html (last visited Dec. 6, 2007). The message that certain susceptible viewers may garner from watching is that extreme plastic surgery is completely safe, glamorous, and a key step to improving other areas of one’s life.

See DSM-IV-TR, supra note 1, at 298.

Schuck, supra note 102, at 953 (noting a similar jury propensity in recreational risk contexts).
4. The Case of *Lynn G v. Hugo*

The New York case of *Lynn G v. Hugo*\(^{142}\) sparked a wave of concern among plastic surgeons that they would face increasing vulnerability to charges of failure to obtain informed consent from former patients who, dissatisfied with past surgical results, would claim to have had BDD at the time of the operation. Since *Lynn G* is the only case to date to directly address the legal implications of BDD on informed consent, it is discussed in detail here to illustrate possible future directions of the law in other jurisdictions. The case also demonstrates how other legal concepts and potential causes of action—such as the duty of due care and the tort of battery—intersect with informed consent jurisprudence.

Over the course of several years, the plaintiff in *Lynn G.* had nearly 50 professional visits with the defendant Dr. Hugo, who had performed a wide range of elective cosmetic procedures on her, including eyelid surgery, liposuction on several parts of her body and face, eyebrow tattooing, and Botox injections.\(^{143}\) At issue in the lawsuit were the results of an aggressive course of liposuction and a breast lift, followed by further liposuction and an abdominoplasty (commonly known as a “tummy tuck”) nine months later.\(^{144}\) Dissatisfied with the final appearance of her stomach, particularly the scarring thereon, she alleged, *inter alia*, that she had been incapable of giving informed consent because she had body dysmorphic disorder.\(^{145}\) The plaintiff’s theory was that because the doctor was aware that she had been receiving psychiatric treatment for depression, and because she also had an “unusually high demand for surgical correction of slight or imagined defects,” the doctor should have recognized “the presence of a mental disorder that fueled her demand for unnecessary surgery and prevented her from assessing the risks and benefits of such surgery.” Under such circumstances, she argued that due care required at minimum that the doctor consult with a mental health specialist before performing additional invasive procedures.\(^{146}\)

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\(^{143}\) *Id.* at 39.

\(^{144}\) *Id.*

\(^{145}\) *Id.*

\(^{146}\) *Id.*
Even in the absence of coercion or pressure from the physician, “lack of informed consent can also be predicated on the doctor’s failure to disclose a complete range of options,” since the patient cannot accurately assess the relative risks and benefits of a given procedure if she is not aware of reasonable alternatives beyond inaction.\textsuperscript{147} The court found no reason to subject elective cosmetic surgery to any less stringent of a standard: “Though the patient’s identification of the problem… may be motivated by subjective vanity rather than objective physical impairment, once the patient has decided that this feature is a problem that needs to be corrected, … the choice of treatment and the expected outcomes are governed by objective medical principles.”\textsuperscript{148} Dialogue between doctor and patient about alternative surgical and non-surgical methods for managing the perceived flaw will be especially crucial if the doctor suspects that the patient may have a mild incidence of BDD. Even if the patient’s mental disorder is not so severe as to preclude her from surgery, her body image distortions may induce her to desire a more aggressive surgical approach than is warranted. Indeed, when there is evidence that the patient’s judgment may be impaired, simply presenting an array of options and alternatives to the proposed surgery and allowing the patient to choose among them, without any medical advice about “whether one procedure is better than another or better than doing nothing at all,”\textsuperscript{149} may be insufficient to comport with the duty of due care. The surgeon may also have a duty to actively dissuade the patient from undergoing the procedure, or to encourage the patient to seek psychotherapy first, irrespective of whether the surgeon eventually agrees to perform the operation.\textsuperscript{150}

Over time, the body dysmorphic cosmetic surgery addict may visit a number of plastic surgeons, either because she wishes to receive services from specialists in a variety of different techniques on many different parts of her body, or because she hopes

\textsuperscript{147} Id. at 40.
\textsuperscript{148} Id. at 40–41.
\textsuperscript{149} Id. at 42.
\textsuperscript{150} It may seem counterintuitive that a cosmetic surgeon may try to convince the patient not to undergo the operation, or to require counseling prior to and following the operation, but then to agree to provide the surgical service anyway. However, the doctor may believe that the patient’s rights of self-determination and bodily autonomy are paramount. Thus, provided the patient falls within the class of BDD sufferers whose symptoms are relatively mild and manageable and for whom there is a medical consensus that cosmetic surgery is not automatically contraindicated, a surgeon may believe as a matter of principle that she should not interfere with the patient’s choice, even if she disagrees with it. Of course, the doctor retains the right to flatly refuse the patient in accordance with her best medical judgment.
that by spreading the operations across a number of different doctors she will avoid arousing suspicion in any of them that her pursuit of surgery has reached an unhealthy extreme. The lower court opinion in *Lynn G* instructed doctors that the fact that other surgeons have treated the patient at one point does not relieve any single doctor of her duty of due care—including the duties to adequately inform and to obtain competent consent—when rendering their particular services to the patient.151

The *Lynn G* court was careful to delimit the bounds of an argument that a particular mental illness can nullify the patient’s ability to make a competent informed consent. Claims that depression makes one incapable of entering into a contract, or that BDD renders one incompetent to give informed consent to healthcare in general, would apparently be dismissed as unreasonable.152 Likewise, the court would find excessive the imposition of “a general rule requiring pre-operative psychiatric referral of all plastic surgery candidates,” or even of just the candidates who have been treated for depression in the past.153 The plaintiff’s argument was found to be reasonable because it was limited to the effects of one particular type of disorder—namely, BDD, which results in “irrationally exaggerated perceptions of [one’s] bodily imperfections”—on the ability to evaluate the appropriateness of a particular type of treatment, namely elective cosmetic surgery.154 For cosmetic operations, where “there is no medical need for the operation and only the patient’s subjective aesthetic opinion determines her view of whether surgery is to be undertaken, a physician should have some responsibility to provide objective guidance to a patient whose capacity for self-assessment is clearly disordered.”155

Indeed, the court displayed an air of moral disgust at the doctor’s “almost complete lack of curiosity about his patient’s mental state.”156 When the doctor is on notice that the patient has a history of mental illness (in this case, depression and anxiety), and the surrounding circumstances suggest an abnormal desire for surgery, a court could impose on the doctor the legal responsibility of “consult[ing] a mental health

151 *Lynn G*, 272 A.D.2d at 41.
152 *Id.*
153 *Id.*
154 *Id.* at 41-42.
155 *Id.* at 42.
156 *Id.*
professional for advice about how to proceed, or otherwise attempt[ing] to explore [the] patient’s psychiatric history, once her behavior raise[s] warning signals that her judgment [is] impaired.” The lower court in Lynn G also seemed to expect that a plastic surgeon will “be cognizant of an established psychiatric condition [BDD] that affects body image and could impair a patient’s ability properly to appraise and consent to cosmetic surgery.” As awareness of body dysmorphic disorder becomes more prevalent both in the public and in the medical professions, plastic surgeons who remain ignorant of its symptomology or willfully blind to its manifestations within their patient population are likely to expose themselves to liability for breach of a duty, whether of general due care or the more specific attainment of competent informed consent.

While the lower court credited the plaintiff’s argument that BDD could effectively negate her legal ability to consent to plastic surgery and was willing to impose a duty on cosmetic surgeons to be alert to this possibility and to structure their practice accordingly, the dissenting opinion and the reversal of the ruling in New York’s Court of Appeals demonstrate a different way of approaching the problem. Since these types of medical malpractice suits are a matter of state law, jurisdictions across the country could consider adopting either approach. Here, the higher court found that the doctor made a prima facie showing of informed consent by introducing evidence that he had advised the plaintiff of the risks, including the risk of the unsightly scarring about which the plaintiff complained, associated with the procedures, and that she had executed a consent form acknowledging her understanding of these risks. Moreover, there was evidence that the doctor did not deviate from the standard of acceptable medical care by not referring her to a psychiatrist; as a defense expert testified, the plaintiff’s medical record and her use of antidepressant medication were insufficient to alert the defendant to her potential BDD. Importantly, however, the holding in favor of the defendant seems to turn on the fact that the record was devoid of evidence that the plaintiff actually “suffered from BDD at the time of her surgeries, or that her ability to consent was impaired by any

157 Id. at 42-43.
158 Id. at 43.
160 Id. at 251.
mental disorder.”161 The opinion classifies BDD as one of the “major psychiatric disorders” that can impair one’s ability to consent,162 suggesting that the court might find that stronger evidence of BDD negates consent and renders the surgeon liable for resulting harms.

If this is indeed the implication of the opinion, then cosmetic surgeons may have a special duty to make psychiatric referrals before operating on certain patients. The dissent in the lower court cautioned against the “pronouncement of such a blanket rule, imposed under threat of a malpractice lawsuit if not complied with,” which it believed represented “an unacceptable form of judicial legislation by creating a subclass of both surgeons and patients who would require psychiatric guidance before undertaking surgery.”163 Of particular concern were the potentially substantial costs of compliance with such a requirement, the imposition of which was said to be beyond the competence of the courts.164 Similarly, the lower court found that malpractice liability will be inappropriate where there is no evidence of coercion, pressure, or deception inducing the plaintiff to submit to an elective procedure.165 This policy comports with principle of individual autonomy, bestowing on the individual both the right to undergo medically unnecessary surgery and the responsibility to deal with the consequences of that choice, assuming the treating doctor has provided adequate information beforehand.

B. Battery

Traditionally, a cause of action for battery in the medical context was founded on the principle that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in

161 Id.
162 Id.
163 Lynn G, 272 A.D.2d at 48.
164 Id. at 48-49.
165 Id. at 49-50.
Each state has its own rules regarding the factual circumstances under which a battery claim could be viable, and those under which the law requires the plaintiff to assert a claim of negligent nondisclosure or medical malpractice instead. In some jurisdictions, a charge that the defendant never obtained the plaintiff’s informed consent results in a battery cause of action, effectively superseding any possible negligent nondisclosure claim. One approach, for instance, is the multi-step analysis described by the court in Cardwell v. Bechtol, where either the patient’s legal incapacity to consent to surgery generally or the doctor’s failure to provide sufficient information under informed consent doctrine could result in a battery. A similar approach might be taken for patients with BDD who submit to plastic surgery operations.

Specifically, where battery charges are allowed in this context, the jury must first decide the question of fact of whether, based on the totality of the circumstances including the individual’s experience, education, degree of maturity or judgment, and conduct and demeanor at the time of the incident, the individual had the capacity to consent to the medical treatment at all. The burden would be on the body dysmorphic plaintiff to prove that at the time she consented to the surgery, she had a diagnosable case of BDD that the doctor should have recognized. If believed, the burden would then shift to the defendant doctor to explain why, given the surrounding circumstances at the time of the consultation and operation, a reasonable physician would have considered the plaintiff competent to consent and would have performed the procedure. If the doctor is unable to meet this burden, a battery charge will hold.

If, however, the evidence shows that the person did in fact have the capacity to consent generally, notwithstanding her actual or alleged BDD, “then the question becomes whether the consent given was effective because it was based upon adequate

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167 724 S.W.2d 739 (Tenn. 1987). At issue in this case was a potential “mature minor” exception to the parental consent rule, which is predicated in part on the policy that it would be unfair to hold a physician liable for battery because of what amounts to a technicality of age, when the minor has given the physician every reason to believe she is competent and capable of consenting to medical procedures. In this sense “mature minors” may be analogous to cosmetic surgery candidates with BDD, who also may appear to be competent and capable of consenting to a procedure generally, but for whom the law wishes to impose a presumption that they are rationally incapable of appreciating “the nature of the treatment and its risks and probable consequences,” Id. at 748, in the context of cosmetic operations.
168 Id.
information on which to make the decision to submit to treatment.” If not, battery is again the appropriate cause of action. In other words, the failure to obtain informed consent is deemed equivalent to the failure to obtain any consent at all. While the common law in many jurisdictions has evolved such that this would be designated a negligent nondisclosure claim, there is both historical and contemporary precedent for treating it as the tort of battery as well. Finally, once the defendant doctor has survived these two potential grounds for liability under battery, “the question becomes whether the defendant subsequently did anything negligent in the administration of the treatment for which consent was obtained.” This is the traditional medical negligence claim.

Thus, if BDD so distorts an individual’s perception of her body that her ability to competently consent to cosmetic alterations is nullified under the law, the operating surgeon becomes exposed to a significantly increased risk of liability. In contrast to malpractice claims, in a battery action, “a patient need not prove that the physician deviated from either the applicable standard for disclosure or the standard for performance of the operation. Accordingly, an operation undertaken without any consent (battery) even if perfectly performed with good medical results may entitle a plaintiff to… damages.” Once it is established that her mental disorder rendered her incompetent to consent, and thus the doctor attained no consent at all, the plaintiff patient would only have to prove that there was a touching—an element made obvious by the fact of the surgery itself. Even perfectly executed procedures, where the doctor displayed the utmost skill and care, would be actionable. This would nearly amount to a theory of strict liability for surgeons who operate on BDD patients. While BDD sufferers deserve protection from unscrupulous doctors who would capitalize on their patients’ insecurities and perceived flaws to market additional procedures and boost their income, strict

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169 Id. at 751.
170 Id.
171 See, e.g., Tonelli v. Khanna, 569 A.2d 282, 285 (N.J. Super. Ct. App. Div. 1990) (“The battery theory applies where the surgery was completely unauthorized as, for instance, where the plaintiff did not consent to the particular medical treatment provided…. Where the surgery was authorized but the consent was uninformed, negligence applies rather than battery.” (citing treatises and cases)).
172 Cardwell, 724 S.W.2d at 751.
liability would have a chilling effect on the industry, restricting the availability of services even to those people who want them for the “right” reasons.\footnote{174 The American Society of Plastic Surgeons identifies two categories of patients for whom permanent surgical alteration of their physical appearance is an appropriate choice: patients who have a strong self-image in general but who are bothered by a particular physical characteristic, and patients who have an actual “physical defect or cosmetic flaw that has diminished their self-esteem over time.” See THE AMERICAN SOCIETY OF PLASTIC SURGEONS (ASPS), PSYCHOLOGICAL ASPECTS: YOUR SELF-IMAGE AND PLASTIC SURGERY (2007), available at http://www.plasticsurgery.org/patients_consumers/planning_surgery/psychological_aspects.cfm.}

Moreover, to win a case of negligent nondisclosure—which would be unavailable or unnecessary in jurisdictions following the \textit{Cardwell} court’s logic—the plaintiff has to convince the judge and jury (1) that a reasonable physician would disclose (or, depending on the jurisdiction, a reasonably prudent patient would want to know) that, among other risks, patients with body dysmorphic disorder often remain dissatisfied with their appearance following cosmetic surgery, and (2) that a reasonable patient in this particular plaintiff’s situation would not have undergone the procedure upon hearing these warnings. Similarly, if the doctor did inform the patient of all the necessary risks in accordance with the relevant standard of care, then the plaintiff will have to produce, and the factfinder will have to credit, expert testimony indicating that the surgeon deviated from the minimum standard of care in performance of the surgery, which in turn resulted in an objectively unsatisfactory outcome.\footnote{175 See, e.g., Folse v. Anderson, 202 So.2d 404, 409 (La. App. 1967) (finding no inference of negligence when patient remained dissatisfied with the appearance of his nose following surgery, and noting that the physician has a duty not to exercise “the highest degree of skill and care possible,” but rather only that “degree of skill ordinarily employed… by members of his profession in good standing…, and to use reasonable care and diligence”).} For a patient whose complaint is simply that she does not like the results of the procedure, these burdens are a substantially higher barrier to recovery compared to what she would need to prove under a battery claim.

The alternative approach, which has become more popular as courts decide that they are unwilling to subject doctors to such expansive potential liability, is to eliminate or greatly restrict the availability of a battery claim when it is based on a failure to obtain informed consent. In \textit{Kinikin v. Heupel},\footnote{176 305 N.W.2d 589 (Minn. 1981).} for instance, the doctor performed an adenomammectomy on the patient, which he explained was the prophylactic removal of fibrocystic breast tissue, but which she thought would be a cosmetic reduction in the size...
of her breasts.\textsuperscript{177} When she was displeased with the extent of the tissue removal and resultant scarring and deformity in appearance, she sued the doctor.\textsuperscript{178} The court distinguished between battery, a touching “of a substantially different nature and character from that to which the patient consented,”\textsuperscript{179} and negligent nondisclosure, when the physician fails to disclose information that a reasonable person in the patient’s position would attach significance to in formulating her treatment decisions.\textsuperscript{180} The court noted that although inadequately informed consent is essentially “no consent at all, and hence a battery,” the charge of battery “connotes an intentional invasion of another’s rights, [and] an aura of moral fault attaches….”\textsuperscript{181} Thus it concluded that battery is more appropriate in the context of touching of a “substantially and obviously different kind,” such as an operation on the wrong body part, whereas submitting only negligent nondisclosure charges to the jury would be preferable in the case at hand.\textsuperscript{182}

It is difficult, however, to know how such a jurisdiction would classify a case in which the plaintiff was suffering from a mental disorder at the time of disclosure and purported consent that hindered her ability to accurately evaluate the attendant risks and to make an informed treatment decision. This situation is distinct from a doctor’s failure to describe or explain the relevant risks at all. It seems that if the surgeon did disclose the proper information that would be relevant to a reasonable patient (an objective rather than subjective standard), the negligent nondisclosure claim would be without merit. The only remaining issue would be whether the doctor knew (or perhaps should have known) that the patient was unable to and in fact did not offer competent consent to any procedure at all. Even where a party lacks the capacity to consent to a contractual agreement, the court may distinguish the capacity to assume a risk under tort law and hold that the BDD patient was capable of the latter.\textsuperscript{183} Although these may seem like difficult barriers to

\textsuperscript{177} Id. at 592-93.
\textsuperscript{178} Id.
\textsuperscript{179} Id. at 593 (internal citations and quotations omitted).
\textsuperscript{180} Id. at 594.
\textsuperscript{181} Id. at 593.
\textsuperscript{182} Id.
\textsuperscript{183} In \textit{Lacey v. Laird}, for example, a teenage girl below the age of majority, set up an appointment to have plastic surgery on her nose after seeing an advertisement for the doctor in the phonebook. 139 N.E.2d 25, 26 (Ohio 1956). After the operation, she sued the doctor under an assault and battery claim, contending that because she was a minor and her parents had not consented to the procedure, the surgeon should be
bringing a valid case under either claim, no doctor would dare to perform these surgeries otherwise because the threat of lawsuits from former patients claiming they were incompetent at the time of the operation would constantly be looming. However, in jurisdictions where battery claims would be available to BDD patients, cosmetic surgeons may want to take extra measures to ensure that every patient’s assumption of the risks of and agreement to submit to surgery are legally binding.

C. Fiduciary Duty and the Duty of Due Care

1. The Duty of Due Care:

Another area in which a physician’s legal duty to challenge a potentially disordered patient about the appropriateness of the surgery, or even to actively dissuade her from pursuing it, could arise under a simple due care analysis. The Canterbury court noted that beyond the physician’s legal duty of proficiency in diagnosis and therapy, she “is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it.”184 Due care also requires the physician to alert the patient to symptoms of bodily abnormality that she perceives; to inform the patient when she “confront[s] an ailment which does not respond to [her] ministrations”; to instruct the patient “as to any precautionary therapy he should seek in the future”; and to “advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued.”185 All of these components of due care could be construed as legal limitations on the cosmetic surgeon’s ability to operate on someone who appears to have body dysmorphic disorder. Specifically, they suggest respectively that the physician must alert the patient if the patient’s complaints indicate a distorted view of her body; must inform the patient that performing surgery when the flaws are

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184 Canterbury, 464 F.2d at 781.
185 Id.
imagined or grossly exaggerated by the patient will not fix the problem; and must instruct or advise the patient to pursue psychotherapy and to resolve her body image issues before undergoing any permanent or dangerous operations.

The inference that these aspects of due care may obligate the physician to refuse to perform the patient’s desired elective procedure is not negated by the Canterbury opinion’s statement that “it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.”186 Although the “context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken,”187 the factual circumstances upon which the opinion is based, in conjunction with medical malpractice jurisprudence in general, suggest that the patient’s decision-making right extends only to her ability to refuse treatment. Although there may be some procedures that are so deeply connected to privacy or autonomy that the patient should be able to pursue them even contrary to medical opinion,188 elective aesthetic surgery does not implicate any such fundamental rights that would justify state coercion of medical practitioners.

186 Id.
187 Id.
188 An abortion is the most obvious example of a medical procedure that a woman has the legal right to receive, despite any concerns from her doctor that she might later regret the choice. See Roe v. Wade, 410 U.S. 113, 153 (1973) (“The right of privacy… is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent…..”). But see Gonzales v. Carhart, 127 S.Ct. 1610, 1634 (2007) (“The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, [how a “partial-birth abortion” is performed]…. It is a reasonable inference that a necessary effect of the regulation and the knowledge it conveys will be to encourage some women to carry the infant to full term….”). See also Carhart, 127 S.Ct. at 1648-49 (Ginsberg, J., dissenting) (“[T]he Court invokes an antiabortion shibboleth for which it concededly has no reliable evidence: Women who have abortions come to regret their choices, and consequently suffer from ‘[s]evere depression and loss of esteem.’ … [T]he Court deprives women of the right to make an autonomous choice, even at the expense of their safety.”). Similarly, the Supreme Court may soon hear arguments in a case brought forth by the Abigail Alliance organization as to whether a terminally ill patient’s “right to privacy” and “right to life” imply a right to unapproved and potentially toxic, but also potentially beneficial, pharmaceuticals, notwithstanding the objections of the FDA and drug industry representatives. See Brief of Appellants, Abigail Alliance for Better Access to Developmental Drugs v. Crawford, 495 F.3d 695 (D.C. Cir. 2007), 2005 WL 1826286 (“The regulations giving the FDA final say over such a profoundly important and personal issue violate the fundamental right of these patients to basic autonomy and privacy.”).
2. **Fiduciary Duty**

More expansive surgeon obligations to the BDD patient may also stem from the “fiducial qualities of the physician-patient relationship.”

Although the *Canterbury* court mentions the doctor’s fiduciary duty to patients only briefly, it takes the duty’s existence as a given, obligating the physician to reveal to the patient that which furthers the patient’s best interest. The legal concept of a fiduciary relationship is grounded in the laws of trusts and of agency, but it now extends to a variety of professional spheres such as lawyers to their clients, corporate officers to their shareholders, and financial advisors and brokers to their clients. Physicians and their patients are analogous to these groups with respect to the physicians’ specialized expertise, the application of professional judgment and discretion in their work, the difficulty for patients of effectively questioning or monitoring their performance, and the consequent importance of securing a relationship built on dependence, reliance, and trust. This is reaffirmed by a number of codes and ethical mandates propounded under various state and national laws, as well as by professional organizations, which emphasize that any conflict between the patient’s welfare and the doctor’s economic interest must be resolved in favor of the patient.

Some scholars, although conceding that doctors play a role similar to that of traditional fiduciaries and that these doctors hold themselves out as fiduciaries in their ethical guidelines, maintain that “the law holds doctors accountable as fiduciaries only in restricted situations.” Even to the extent this is true, however, the situations in which the fiduciary duty is weakened appear to be those where the doctor’s loyalty is divided

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189 *Canterbury*, 464 F.2d at 782 (citing Emmett v. E. Dispensary & Cas. Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967) (internal punctuation omitted).
190 Id.
192 Id. at 243-46; see also Adams v. Ison, 249 S.W.2d 791 (Ky. 1952) (“[T]he patient must necessarily place great reliance, faith and confidence in the professional word, advice and acts of his doctor. It is the physicians’ duty to act with the utmost good faith and to speak fairly and truthfully at the peril of being held liable for damages for fraud and deceit.”).
194 Id. at 242.
between the patient and another group involved in the procurement and payment of healthcare (such as a hospital or a managed care organization), rather than between the patient and the doctor’s own pecuniary interests. Accordingly, to the extent that a plaintiff can argue that a cosmetic surgeon put her own financial concerns ahead of her patient’s wellbeing by performing an unjustifiable procedure on a candidate with BDD, the cause of action for breach of fiduciary duty would seem to be unhindered. A situation where the doctor’s greed or carelessness alters her medical judgment is distinguishable from financial conflicts of interest with third parties, which judicial precedent—or more accurately, lack thereof—suggests is generally outside the scope of any fiduciary duty under medical malpractice law.

Beyond academia, while some courts reject the notion outright that a physician could be sued for breach of a fiduciary duty, regardless of the extent to which the doctor/patient relationship resembles a fiduciary one, other jurisdictions are more flexible and have expanded fiduciary doctrine to provide aggrieved patients with an additional potential cause of action. The physician’s fiduciary duty “is predicated on the proposition that the physician has special knowledge and skill in diagnosing and treating diseases and injuries and that the patient has sought and obtained the services of the physician because of this expertise,” requiring the physician “to exercise the utmost good faith in dealing with his or her patient.” The courts may specify particular obligations that stem from the doctor’s fiduciary responsibility, including the duties (1) to fully inform the patient of her condition; (2) to provide continuity of care; (3) to obtain informed consent; and (4) to make referrals to a specialist if needed.

Under this rationale, and in the context of a plastic surgeon’s fiduciary duties to a BDD patient, the surgeon could potentially face liability (1) if she failed to inform the patient that she suspected the presence of a psychiatric condition that could interfere with

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195 Id.
196 Id. at 249.
197 Carson v. Fine, 123 Wash.2d 206, 218 (1994). In Carson, a case addressing the issue of whether a treating physician who testifies as an expert witness against her patient in a malpractice case (here, stating the opinion that a previous doctor was not negligent or substandard in her care) violates the doctor/patient privilege, both the majority opinion and the dissent labeled and discussed the doctor/patient relationship as fiduciary in nature.
198 Id.
the patient’s satisfaction with the cosmetic results and overall health and wellbeing; (2) if she did not either follow up with the patient postoperatively herself or enlist a mental health professional to provide continuing treatment; (3) if she did not or could not obtain the patient’s informed consent, whether due to the patient’s competency issues or the doctor’s own reluctance to fully and forcefully disclose the risks that patients with even mild manifestations of BDD would face in undergoing an elective operation; or (4) if she did not refer the patient to a psychiatric professional upon perceiving symptoms of BDD, and then continue to consult with this specialist before performing any procedure.

The special privileges afforded to the doctor/patient relationship are judicial and legislative recognition of the importance of the fiduciary duty, which “is broader than the statutorily defined code of confidentiality and includes a duty to act consistent with the best interests of the patient.”199 Once the doctor/patient relationship is established, there arises an implied promise that “the physician will refrain from acting in a way that is inconsistent with the good faith required of a fiduciary. The patient should… be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.”200 The somewhat paternalistic implication of this rationale is that a doctor who agrees to render her services to a BDD patient for whom a cosmetic operation is contraindicated—even if motivated by a desire to uphold the patient’s bodily autonomy and freedom to change her appearance, and absent any evidence that potential personal or economic gain impaired the doctor’s medical judgment—may be deemed to have not acted in the patient’s best interest and thus may be liable for breach of her fiduciary obligations.

Furthermore, not only must the physician inform the patient if she “cannot accomplish a cure,” but her fiduciary duty also mandates that she advise the patient if “the treatment adopted will probably be of no benefit.”201 A cosmetic surgeon who is familiar with the literature on BDD should know that patients suffering from the disorder usually are unsatisfied with the results of cosmetic procedures and experience no

199 Id. at 228 (Johnson, J., dissenting). The dissent in Carson not only acknowledged the existence of a fiduciary relationship between doctors and patients, but imputed even more importance to it than the majority did.

200 Id. at 231 (quoting Petrillo v. Syntex Labs., Inc., 148 Ill.App.3d 581, 594 (1986)).

201 Tvedt v. Haugen, 294 N.W. 183, 187 (N.D. 1940).
alleviation of their BDD symptoms. In this sense, performing the operation would be “of no benefit” to the BDD surgical candidate, and failure to inform the individual of such would make the physician “guilty of a breach of duty.”

Clearly, the fiduciary duties of a cosmetic surgeon to her patient overlap with a number of other statutory, judicially, and professionally defined responsibilities. While, as demonstrated, under the common law of some states the failure to comport with these standards constitutes a breach of fiduciary duty for which the plaintiff patient may have an independent cause of action, in other jurisdictions these fiduciary responsibilities are incorporated into other claims. For example, the fiduciary duty underlies the learned intermediary doctrine, which imposes on physicians the responsibility for informing their patients of the risks and benefits of a particular drug or therapy, and supervising its use. The implications of the fiduciary duty in this context, and the rationale of the learned intermediary doctrine as a whole, are analogous to the responsibility imposed on cosmetic surgeons to monitor potential patients for signs of BDD and to treat them accordingly.

Specifically, the learned intermediary doctrine recognizes that “not all patients are alike and it is the physician who best knows the patient.” This aspect of their fiduciary relationship is predicated on the proposition that “the patient seeks out and obtains the physician’s services because the physician possesses special knowledge and skill,” and as a result “both parties envision that the patient will rely on the judgment and expertise of the physician.” Similarly, rather than a blanket mandate of psychological testing for all cosmetic surgery candidates, a proper policy would recognize that the cosmetic surgeon is in the best position to assess the patient’s needs during consultation, to weigh the physical and psychological risks and benefits of surgery, and to come to a mutual decision with the patient about whether an elective aesthetic procedure is an appropriate

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202 Id.
203 See, e.g., Spoor v. Serota, 852 P.2d 1292, 1294 (Colo. App. 1992) (“[A] fiduciary duty… includes, among other things, a duty to exercise reasonable care and skill on behalf of the client. That same duty is imposed upon physicians under negligence theories…. [Thus,] assertion of a claim for breach of fiduciary duty against [the doctor] would have been duplicative….”).
205 Id.
206 Id. at 879.
choice. Dereliction of these duties would be, by analogy, a betrayal of the fiduciary relationship in the same way a failure to act as a learned intermediary would be. In either situation, each jurisdiction must decide whether these types of deviations from fiduciary responsibility should constitute independent claims, should be incorporated into a generalized breach of fiduciary duty claim, or possibly both.

Some courts explicitly label the physician’s relationship to her patient as a fiduciary one, but refuse to construe breach of fiduciary duty as a separate and distinct cause of action from medical malpractice or failure to obtain informed consent. Some of these courts fear that, were they to hold otherwise, they would undermine every legislative effort to put special constraints on medical malpractice claims, since they would be pled as a breach of fiduciary duty whenever the plaintiff wanted to avoid having to show actual injury or to circumvent the statute of limitations. For example, in some jurisdictions, fraud and deceit claims relating to preoperative disclosures are subsumed within the doctrine of informed consent. In one case, where the patient agreed to liposuction and abdominoplasty after the doctor falsely represented that he was a board-certified plastic surgeon without clarifying that he was only certified in facial plastic surgery, the court found that “the patient’s basic right to determine what is done to her body and the physician’s fiduciary duty to make that right meaningful by supplying the patient with enough information to enable her to make informed decisions” were violated under informed consent doctrine. Accordingly, even if the jurisdiction does not recognize an independent cause of action for breach of fiduciary duty in the doctor/patient relationship, a surgeon who does not act in the BDD patient’s best interest

\[\text{Id. at 171.}\]


\[\text{Id. Welch}^{210} \text{ involved both the physician’s express statements about his credentials, as well as advertising brochures that he disseminated to the public and on which the plaintiff relied, which allegedly contained demonstrably false or misrepresentative assertions of fact. Id.}\]
may be held liable under other medical malpractice claims into which the fiduciary duty has been incorporated.\textsuperscript{211}

C. Breach of Contract

1. Contract Law and Cosmetic Surgery

In the absence of an explicit contract, promise, or guarantee warranting a particular result, courts are unlikely to hold a physician who operated in accordance with reasonable care and basic skill responsible for the patient’s unhappiness with the outcome of the surgery.\textsuperscript{212} The courts have consistently held that a physician or surgeon “is not an insurer or guarantor of results, in the absence of express agreement,” and that “in the absence of such a special and peculiar contract, the fact that treatment has resulted unfavorably does not even raise a presumption of want of proper care, skill, or diligence.”\textsuperscript{213}

Despite the general rule stating that by commencing the physician/patient relationship the doctor does not guarantee a cure absent an express warranty to the contrary, cosmetic surgery would appear to be a more opportune area than other medical specialties for a dissatisfied patient to bring charges sounding in contract law. The

\textsuperscript{211} See also Sherwood v. Danbury Hospital, 896 A.2d 777, 797 (Conn. 2006) (“[P]rofessional negligence alone does not give rise automatically to a claim for breach of fiduciary duty. Thus not every instance of professional negligence results in a breach of a fiduciary duty. Professional negligence implicates a duty of care, while breach of a fiduciary duty implicates a duty of loyalty and honesty.” (internal punctuation and citations omitted)).

\textsuperscript{212} See, e.g., Bush v. St. Paul Fire & Marine Ins. Co., 264 So.2d 717, 721 (La. App. 1972) (finding no liability for necrosis on left cheek following a lower face lift in the absence of demonstrable medical negligence or pre-operative warranty of results); Kutzgar v. Yarborough, 381 So.2d 1260, 1261 (La. App. 1980) (plaintiff’s theory that leaflet describing process and potential results of hair plug transplants constituted a doctor/patient contract was “not unreasonable,” but no physician liability for patient’s dissatisfaction because the writings did not purport to be their entire contract and because the leaflet’s language contained no promises or misrepresentations).

\textsuperscript{213} Folse v. Anderson, 202 So.2d 404, 410 (La. App. 1967) (citing 70 C.J.S. Physicians and Surgeons § 57, and 41 AM. JUR., Physicians and Surgeons § 104); see also Chatellier v. Ochsner Foundation Hospital, 348 So.2d 110 (La. App. 1997) (holding that since the doctor had not entered into a specific contract for the desired result, nor had he made any guarantees or promises about the nose’s final appearance, he would not be forced to act as an insurer of the results of the treatment afforded to the patient).
surgical candidate approaches the cosmetic surgeon out of desire rather than necessity for a certain procedure, and enters into the transaction in the pursuit of obtaining a particular aesthetic result rather than in the hopes of alleviating pain or curing a medically identifiable ailment. Although the courts generally are “unenthusiastic or skeptical about contract theory” in this context, since given “the uncertainties of medical science and the variations in the physical and psychological conditions off individual patients, doctors can seldom in good faith promise specific results,” many jurisdictions will hold an alleged contract enforceable when there is clear proof of its existence.\footnote{Sullivan v. O’Connor, 296 N.E.2d 183, 185-86 (1973).}

However, body dysmorphic patients may be more inclined to hear “[s]tatements of opinion by the physician with some optimistic coloring… [and] transform such statements into firm promises in their own minds, especially when they have been disappointed in the event, and testify in that sense to sympathetic juries.”\footnote{Id. at 186.}

If the surgeon does in fact make express warranties about the final results of the procedure, the patient may be able to sue under a breach of contract claim. In \textit{Frank v. Maliniak},\footnote{232 A.D. 278 (N.Y.A.D. 1931).} the plaintiff sought the defendant plastic surgeon’s services to repair a botched rhinoplasty that had caused paraffin to filter from the tip of her nose into her cheeks, causing unsightly bumps.\footnote{Id. at 279.} The doctor explicitly promised that he would perform the operations in a manner such that no incisions would be made on her face and she would have no external scarring.\footnote{Id. at 278.} During the fifth corrective operation, however, he breached this agreement and made two cuts on each side of the plaintiff’s mouth.

Although the court found no proof of any lack of skill or negligence, the plaintiff had a viable cause of action for breach of contract, since the cutting constituted “an infraction of the express agreement.”\footnote{Id. at 279.} The plaintiff “became entitled to all the damages the proximately flowed from that act.”\footnote{Id. at 280.}

Many modern cases have refused to find that doctors have breached any implied warranties to perform their services in a workmanlike manner, in accordance with the
widely recognized rule that no such warranties arise when the service requires the exercise of professional medical judgment.\textsuperscript{221} Medical negligence claims, which involve a culpable failure of this judgment, would encompass such allegations anyway.\textsuperscript{222} However, knowing misrepresentations and express warranties “do not fall within the ambit of the plain meaning of negligence,” which in one jurisdiction allowed a patient harmed as a result of such assertions to recover under the state’s Deceptive Trade Practices Act.\textsuperscript{223} The patient in this case, who was unhappy with the results of her breast augmentation, was permitted to bring charges against the doctor who had encouraged her to select a nude model from a Playboy magazine and had expressly promised her that he could make her breasts look the same way, and who also had affirmatively stated that there would be no problems with respect to scarring and other possible complications.\textsuperscript{224}

Given the high percentage of individuals presenting for cosmetic surgery who have BDD, telling a patient that she can surgically achieve the same look as a model in a magazine or a celebrity, or even using computerized digital imaging software is a risky proposition. Not even the best surgeon can make a patient appear identical to the predictive virtual image, and the BDD patient’s distorted perspective will focus on any deviations from the aesthetic ideal she had hoped to achieve. An embittered patient could seize on what she interpreted as a guarantee of perfection and complete satisfaction to initiate litigation against the surgeon. Some cosmetic surgeons may be understandably reluctant to give up the use of computer-imaging software, often perceived as a powerful but ultimately harmless marketing or explanatory tool. However, even if the physician clarifies that the technology is meant to show a hypothetical estimation of what the results could look like or that a reference to a celebrity is meant only for comparative purposes, and reaffirms that the patient’s outcome will be different and tailored to suit her unique bone structure, the unrealistic expectations such images or statements may create in a significant portion of the surgeon’s clientele may make it too much of a potential liability to be worthwhile.

\textsuperscript{221} See, e.g., Rhodes v. Sorokolit, 846 S.W.2d 618, 620 (Tex. App. 1993).
\textsuperscript{222} Id.
\textsuperscript{223} Id. at 621.
\textsuperscript{224} Id. at 620.
This raises the related issue of whether and to what extent consumer advertisements for cosmetic procedures can form the basis of a specific contractual relationship between patient and doctor from which the dissatisfied patient can recover damages. Practitioners have expressed concern about the use of advertising in the industry, suggesting that “cosmetic surgery is moving progressively further away from the field of medicine to become a purely commercial activity,” where “non-medical criteria are influencing operative decisions.” This reinforces the potential applicability of contract theory in cosmetic surgery cases, particularly when the plaintiff may have trouble recovering on other grounds and particularly if the cosmetic surgeon advertised or engaged in puffery during consultation in a manner that certain vulnerable individuals (such as surgical candidates with BDD) would be likely to interpret as an express guarantee of satisfaction or of a certain result.

Although allowing these charges to be brought too easily will interfere with doctors’ practices and their ability to communicate with the many other patients who will never initiate lawsuits, and may frighten them into practicing defensive medicine, perhaps increased caution and conservatism is necessary given the increased probability that cosmetic surgeons face of dealing with a mentally ill candidate for an elective operation. Moreover, completely prohibiting these claims could expose the public “to the enticements of charlatans,” a potentiality that is especially problematic if an under-qualified doctor makes grandiose claims or promises to a patient who is desperate to believe them. Bringing forth a contract claim rather than a tort or malpractice claim may also give the plaintiff the advantage of a longer statute of limitations, depending on the laws of the particular jurisdiction. Furthermore, a contract claim can be brought even in the absence of evidence of negligence in performing the operation, since “it is hardly a defence [sic] to a breach of contract that the promisor acted innocently and without negligence.”

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225 Dr. J.P. Meningaud et al., supra note 26, at 248; see also Welch v. Edds, discussed supra notes 209-10 and accompanying text, where the surgeon’s deceptive advertisements were considered part of the physician’s disclosures to the patient sufficient to violate informed consent doctrine.

226 Sullivan, 296 N.E.2d at 186.

227 Id.

228 Id. at 186 n.2.

229 Id. at 187.
2. Advantages of a Contract Suit

If the factfinder determines that the cosmetic surgeon did make a contractual promise to the plaintiff, the issue of whether or not the patient is otherwise deemed to have been competent to offer informed consent or to contract with the doctor for specific results is immaterial to the surgeon’s liability. If the patient was competent despite her BDD and the jurisdiction allows for recovery under contracts for medical or cosmetic services, then the particular agreement should be treated like any other commercial transaction. If, in contrast, the patient’s BDD rendered her incompetent to contract, the majority rule is that the contract itself “is not void but at most voidable at the insistence of the alleged incompetent.”230 Obviously the patient will have no incentive to avoid the contract, and her mental illness at the time of entering into the agreement with the doctor will not provide the doctor any defense.

Despite the longer statute of limitations and the lack of an expert testimony requirement, recovering under a contract claim will frequently require a strained interpretation of the surrounding facts and will be a cause of action of last resort when battery, lack of informed consent, breach of fiduciary duty, and medical negligence charges have failed. If, however, the court believes that the patient could have reasonably interpreted the doctor’s statements during consultation or the doctor’s advertising methods and materials (either separately or in conjunction) as a promise to attain a certain result, the court may allow the patient to recover damages.

Such appears to have been the situation in *Lovely v. Percy*,231 where the court rendered summary judgment against the plaintiff on her claims of fraud and medical malpractice against her plastic surgeon, but ruled that she presented evidence creating a genuine issue of material fact as to whether she entered into an oral contract.232 Specifically, the plaintiff claimed that she told the doctor that she wanted her breast size increased to a 34C cup, and that the surgeon told her that he would be able to accomplish

230 RICHARD A. LORD, 5 WILLISTON ON CONTRACTS § 10:3 (4th ed. 2007).
231 826 N.E.2d 909 (Ohio App. 2005).
232 Id. at 910.
this goal.\textsuperscript{233} The surgeon in this case seemed to have taken all the requisite standard precautions to avoid liability: he averred to the court that he only told the plaintiff her breasts would “most likely” be between a B and C cup postoperatively but never gave any assurance or guarantee; he had her initial each page of a six-page informed consent document and sign a disclaimer stating that no guarantee had been given as to the results that may be obtained; and he had her sign an additional consent to the operation on the day of the surgery which also stated that no guarantees had been given as to outcome.\textsuperscript{234}

Nonetheless, the court discounted the value of the consent forms, stating that it was doubtful that they constituted the entire contract between the parties, particularly since neither contract contained an integration clause indicating the parties’ intent that the forms were to comprise their entire agreement.\textsuperscript{235} The court affirmed its acceptance of the rule that “a doctor and patient can enter into a satisfaction contract that is separate and distinct from the primary contract between a doctor and patient for medical care,” and that “showing a breach of a satisfaction contract does not require, or involve, a demonstration of medical malpractice.”\textsuperscript{236} While any patient, regardless of her psychological profile, could bring similar allegations of an oral agreement against her doctor, the potentiality should be of special concern to cosmetic surgeons dealing with BDD patients. This subset of the surgical population may be more likely to misinterpret a physician’s opinion or generalized explanation as a guarantee that their perceived flaws will be “fixed,” and consistently have been proven to be more likely to find fault with their outcomes and more litigious against the doctor who performed the operation.\textsuperscript{237}

3. Measure of Damages

Assuming, then, that the common law of the jurisdiction and the factual circumstances of the case do permit the aggrieved BDD patient to recover damages from the surgeon under contract law, the question becomes under what theory the plaintiff’s

\begin{itemize}
  \item \textsuperscript{233} \textit{id.} at 910-11.
  \item \textsuperscript{234} \textit{id.} at 911.
  \item \textsuperscript{235} \textit{id.} at 913.
  \item \textsuperscript{236} \textit{id.}
  \item \textsuperscript{237} Crerand, \textit{supra} note 1, at 175.
\end{itemize}
amount of compensation should be measured. If the doctor’s promise is treated like an ordinary commercial promise, then the standard measure of recovery is either compensatory damages (also known as “expectancy damages,” an amount meant to put the plaintiff in the position she would have been in if the doctor had fulfilled the original promise) or restitution damages (an amount that will restore to the plaintiff any benefit she had conferred upon the defendant under the breached contract).\footnote{Id. at 186.} To calculate expectancy damages, some courts have suggested that the jury estimate and award to the plaintiff the difference between the value of the surgical results as promised and the result actually obtained.\footnote{Id.}

The difficulty with such a formula in the context of cosmetic surgery is that the relevant body part is functionally healthy, and aesthetic value is a subjective matter. Particularly when the patient suffers from BDD, the outcome of the operation could accord with what the surgeon believes the patient had requested and the surgeon wanted to achieve, but still appear unsatisfactory to the patient. Unlike most surgeries, where success or failure is objectively assessable, a positive outcome in cosmetic surgery depends on the patient/client’s ultimate happiness. If the patient’s BDD is sufficiently severe and her perspective substantially distorted, a physician who promises to make the patient’s nose look smaller or her stomach look flatter may have contracted to do the impossible, at least so far as the patient will be able to perceive it. Although “before and after” photos may prove to a factfinder that the physician did fulfill her part of the bargain and accomplished a physical alteration that would be noticeable and acceptable to an objective observer, the surgeon still will be forced to deal with the burden of potential litigation. Moreover, assigning a monetary value to the subjective concept of beauty seems more difficult than placing a value on the functional characteristics of a body part, since the latter can be measured and verified, whereas the former is dependent on the varying opinions of each party to the case and the individual jurors.

\footnote{As the court noted, “[t]he same formula would apply, although the dollar result would be less, if the operation had neither worsened nor improved the condition” at issue. Id.}
Reliance damages may also be available if the court believes that a more lenient and plaintiff-friendly measure of damages should be applied. This formulation is meant to restore the plaintiff to the position she occupied before entering into the agreement, and requires compensation for any detriment (including, according to some, any suffering or distress resulting from the breach) incurred in reliance on the agreement. The rationale in these cases would be that the body dysmorphic patient underwent the pain and expense of a surgical procedure in order to obtain a particular physical result and personal satisfaction therewith; and “that suffering is wasted if the treatment fails” to result in her attaining the body ideal for which she contracted and which the physician promised.

Part Three: State Licensure Board Action

As this article has suggested, there is no single theory of liability that perfectly and consistently fits a doctor’s failure to adequately investigate potential BDD in a cosmetic surgery candidate. However, it works a legal and ethical injustice if such a doctor is able to repeatedly take advantage of such patients’ mental disorders for personal financial gain. To the extent that the court system in ill-equipped to control such physicians, administrative proceedings run by a team of medical professional peers are a viable alternative. The threat of sanctions from the state medical licensure board should constrain the majority of opportunistic surgeon behavior, and those doctors who do violate their legal and ethical obligations to BDD patients will be subject to the suspension or revocation of their medical licenses, their membership in professional organizations, and their hospital privileges in order to prevent them from harming future patients.

The BDD patient who regrets her operation, however, may want a more personal form of redress—namely, monetary compensation under a tort or contract cause of}

\[240 Id. at 187.\]
\[241 Id. at 187, 189.\]
\[242 Id.\]
action. Moreover, placing the greater part of the burden of oversight on entities outside of the judiciary is subject to several criticisms, not least of which is the question of whether the medical industry is able to adequately police itself, particularly in a specialty where the operations are all elective and monetary incentives can have an especially strong pull. This section of the article discusses these and other issues related to the feasibility and effectiveness of using state licensure boards to prevent or punish physician negligence toward cosmetic surgery candidates with BDD, either as the sole or primary means of redress, or in conjunction with patient-initiated actions in the legal system.

A. State Medical Board Hearing Procedure and Judicial Review

Rather than allowing a judge or jury to assess a claim of medical negligence for failure to adequately address BDD in a cosmetic surgery patient, the matter could be handled internally through state medical licensure and disciplinary boards. In this case, medical professionals would examine the circumstances of the doctor/patient consultation and the surgery, and decide—perhaps with less emotional bias than a lay jury would have—whether the facts demonstrate that the surgeon’s behavior deviated from acceptable medical standards of care. Although the outcome of such hearings would be reviewable through the traditional legal system, the courts tend to defer to the medical boards’ guilty verdicts and punishment decisions in most cases, using the “no rational basis” standard of review typically applied to administrative proceedings.243 Given the special vulnerability of BDD patients in these circumstances, the increased monetary incentives generally presented to cosmetic surgeons, and the fact that these procedures are elective and serve no functional medical purpose, however, some of the judicial deference that might otherwise be shown to the profession’s ability to adequately police itself could be reduced.

The processes through which one jurisdiction’s medical boards and courts determined whether individuals who identified as transsexual had been negligently

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243 See, e.g., French’s Estate v. Fed. Energy Regulatory Comm’n, 603 F.2d 1158, 1163 (5th Cir. 1979) (“[T]he scope of our review is limited to ascertaining whether there is a rational basis for the agency’s determination….”).
designated appropriate candidates for gender reassignment surgery provide an example of how similar issues might be dealt with for BDD patients. In the Reisner case, the court reviewed the actions of the Office of Professional Medical Conduct (the “OPMC”), which had investigated and evaluated allegations of gross negligence, incompetence, and medical misconduct against a psychiatrist who had approved a number of individuals for gender reassignment surgery. According to the OPMC, the psychiatrist fell below acceptable medical standards due to (1) his failure to conduct sufficiently thorough psychiatric evaluations that documented his patients’ emotional and behavioral needs and psychological histories; (2) his recommendation of gender reassignment surgeries in the absence of adequate medical and psychiatric evidence; and (3) his inadequate provision of necessary postoperative follow-up care for the individuals who did receive surgery. In these circumstances, it was within the scope of the OPMC’s statutorily granted authority to determine the physician’s guilt or innocence and the penalty to impose on him, by considering transcripts, exhibits, expert testimony, and other proffered evidence similar to the way a trial court would have done.

Such an administrative determination will not be overturned provided that it is supported by substantial evidence within the entire record and is not otherwise “arbitrary, capricious, or unreasonable.” Arguably, this deferential standard of administrative review promotes efficiency by sustaining verdicts reached outside of the court system by professionals who are most familiar with a discreet subject matter, while at the same time affording defendant doctors protection from discriminatory treatment or unmerited sanctions. Likewise, courts will only set aside the punishment imposed by an administrative body if it is “so disproportionate to the offense… as to be shocking to one’s sense of fairness.” Thus, in Reisner, the court found that suspending the doctor’s medical license was justified due to the doctor’s approval of “patients for irreversible surgery without having adequately evaluated” them.

245 Id. at 25.
246 Id.
247 Id. at 27.
248 Id. at 28.
249 Id. at 31 (internal quotations omitted).
250 Id. at 30-31.
The fact that the doctor is being judged by her colleagues and peers could pull in either direction. On the one hand, a medical board panel may be more sympathetic to the difficulties of making medical judgments, and so less likely to punish someone they consider “one of our own.” On the other hand, other cosmetic surgeons may want to legitimize their own practice by sanctioning or suspending the licenses of predatory doctors who seem more interested in making money than in helping their patients. There also might be latent resentment from doctors of other specialties who perceive cosmetic surgeons as greedy and superficial, less interested in pursuing patient health and public welfare than their own financial wellbeing. Administrative proceedings may limit the ability of the aggrieved patient to tell her story and to receive compensation, but at least they can prevent the doctor from similarly taking advantage of BDD patients in the future. Finally, a wider range of punishment is available through administrative hearings; rather than simply awarding the plaintiff damages, the costs of which may be covered by malpractice insurance anyway, the board can determine whether the doctor’s medical license should be suspended or revoked, the doctor’s practice should be supervised for a given period of time, the doctor must complete awareness classes or additional training, or some other form of restitution or remediation is in order.

B. Benefits and Drawbacks of Licensure Board Hearings

Substantial debate surrounds the issue of whether state medical licensure boards are able to adequately police matters of “unprofessional conduct”—which depending on the state may be defined to include physical or sexual abuse of a patient, inadequate recordkeeping, failure to recognize common symptoms of an ailment, and performance of services beyond the scope of one’s license—as well as the negligence, incompetence, or lack of professionalism that would be associated with performing a cosmetic procedure on a patient severely incapacitated by BDD.251 In the past, a majority of board proceedings against physicians did not involve the quality of clinical care directly, but

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rather focused on narcotics violations and substance abuse problems. However, this has changed in recent years, with state boards giving increasing emphasis to sanctioning negligence and deviations from practice standards.

Investigating and disciplining cosmetic surgeons who inappropriately operate on BDD patients seems to fall within the mission of medical boards to protect the public from incompetent professionals and to rehabilitate or remove those physicians who harm patients or who do not conform to appropriate standards of care. These state entities have the ability to require that the recalcitrant surgeon receive additional education or training on identifying and handling patients with BDD; to monitor the surgeon’s practice; to fine, reprimand, or take other punitive action against the surgeon; or to revoke, suspend, or restrict the surgeon’s medical license. This ability to tailor the severity of the punishment to the physician’s culpability, and to take corrective actions that will reeducate the doctor and protect future patients rather than simply compensating a single injured patient who decided to bring suit, is one of the great advantages of medical board regulation over the judicial system. There is evidence, moreover, that the harshness of the punishment is in fact related to the extensiveness of the doctor’s misconduct, resulting in a proportion of “severe” sanctions ranging from 21 to 39 percent of the total, and the proportion of “medium” ranging from 17 to 36 percent. However, the “startlingly” high rate of repeat offenders processed through the state board system demonstrates that a subset of doctors display behavioral issues that current internal disciplinary mechanisms are not adequately controlling: physicians who had received mild sanctions in the first of 2 five-year time period were 12 times more likely to be sanctioned in the subsequent five-

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252 Id. at 875.
253 Id. at 876.
254 Id. at 870. The authors classify three levels of punishment involving actions for cause, based on the harshness of the penalty:
- The “severe” category encompasses disciplinary actions that result in a revocation, suspension, surrender, or mandatory retirement of a license or the loss of privileges afforded by that license. The “medium” category includes actions that resulted in probation, limitation, or conditions on a medical license or a restriction of license privileges. The “mild” category covers other prejudicial actions, general reprimands or license modifications, such as requirements that doctors complete risk-management programs or undergo monitoring for substance abuse.
255 Id. at 873.
year time block compared to physicians who had received no sanctions initially.\textsuperscript{256}

Furthermore, more than 20 percent of doctors who received a medium or severe sanction in the first period were sanctioned against in the second period.\textsuperscript{257}

Such findings could be interpreted as indicating that medical boards are unable to properly rehabilitate, control, or remove incompetent or unprofessional doctors. However, “\textsuperscript{258}If the threat of board sanctions strongly influences the behavior of many physicians, deterring them from engaging in questionable conduct, the subset of physicians identified for sanctioning will be distinctive: those low-quality physicians who are the least responsive to regulatory incentives.” If the medical board is diligent about continual monitoring of these doctors, moreover, they are more likely to be caught than the average doctor if they deviate from proper practices again.

Furthermore, it is not clear that the legal system is the superior alternative. The same study showed that physicians who were punished by the judicial malpractice system in the first of two time periods have higher than average claim experience in the second, and that the relative risks tend to increase in accordance with the severity of the initial sanction.\textsuperscript{259} Since the legal system and medical boards often address different issues and deal with different physicians,\textsuperscript{260} both seem to be necessary to handle the problem of cosmetic surgery on body dysmorphic patients. A series of lawsuits against a particular doctor by former clients alleging that they should not have been operated on because of their severe BDD may indicate to the state medical board that the surgeon’s clinical practice and patient screening mechanisms need further examination. However, proper self-regulation within the medical profession requires board intervention even in the absence of any litigation, and the existence of a malpractice claim against the surgeon does not automatically imply that she also should be subject to board disciplinary action, even if she eventually decides to settle the case.

\textsuperscript{256} Id. at 877. The researchers divided the data into 2 five-year time periods: 1994-1998 (“period A”) and 1999-2002 (“period B”). Id. at 876-77. Less than 1 percent of physicians who did not receive any sanctions in period A were sanctioned in any form during period B. Id. at 877.

\textsuperscript{257} Id.

\textsuperscript{258} Id. at 882.

\textsuperscript{259} Id. at 880-81.

\textsuperscript{260} Id. at 881 (“[O]nly 8 percent of physicians with very high claims experience had complaints filed against them with the medical board, less than one-half of which led to a medium or severe sanction.”).
Scholars and public officials have criticized medical boards for their failure to aggressively identify physician competency problems and to respond to the doctors in these cases with uniform and significant punishment.\textsuperscript{261} However, the alternative of judicial regulation and oversight only through privately initiated medical malpractice lawsuits is also flawed, among other reasons due to the civil justice system’s inconsistencies in identifying and compensating practitioner negligence.\textsuperscript{262} Moreover, in recent decades, “more nonphysicians have become board members, the public has more closely monitored disciplinary outcomes, and funding has increased.”\textsuperscript{263} This has alleviated some of the concerns about lax supervision between fellow doctors and by public officials, and about insufficient resources to properly investigate allegations of impropriety.\textsuperscript{264}

Indeed, some legal and medical scholars and practitioners believe that medical boards wield too much potential power over physicians’ careers and lives and thus should face higher evidentiary burdens before being able to take action.\textsuperscript{265} They have argued that the potential sanctions imposed by state licensure boards threaten a magnitude of harm that is greater than what a doctor would face if she had to make a medical malpractice payment and report it to the National Practitioner Data Bank, since internal misconduct proceedings can cost thousands of dollars in legal fees, may not be covered by insurance, and can end the physician’s career by revoking her license.\textsuperscript{266} The standard of proof is also lower than the “reasonable doubt” burden that would be in place in a criminal trial, although it is equally or more favorable compared to what a physician would face in a civil case: approximately three-quarters of the states maintain a “preponderance of the evidence” standard for medical board hearings, while the other quarter utilize a stricter “clear and convincing evidence” standard.\textsuperscript{267}

\textsuperscript{261} Id. at 870.
\textsuperscript{262} Id. at 871.
\textsuperscript{263} Id. at 872 (internal citations omitted).
\textsuperscript{264} Id. at 871-72.
\textsuperscript{266} Id. at 109.
\textsuperscript{267} Id. at 110-11.
Notwithstanding speculation that physicians, who still constitute the majority of medical board members, will be sympathetic to their colleagues’ explanations or excuses for substandard behavior and will be reluctant to severely punish them, the boards face significant pressure from the media, government officials, and public interests groups to secure convictions.268 Moreover, some have suggested that precisely because the panel members are mostly other doctors who are familiar with the system, they will know that other medical professionals must have first investigated the physician’s conduct and determined that it was unprofessional before taking it to hearing, thus creating a predisposition to find against the doctor.269 Therefore, as discussed above, the fact that medical board hearings will be run mostly by the cosmetic surgeon’s peers does not necessarily pull in her favor.

Finally, the legal system has an additional interest in supervising or regulating cosmetic surgery because any licensed medical doctor can advertise as a cosmetic surgeon and perform cosmetic procedures, even without board certification and with only minimal training or experience.270 Whereas cosmetic surgeons accredited by the most highly regarded plastic surgery board, the American Society of Plastic Surgeons, must complete five years of general surgery training with at least two years focused specifically on plastic surgery, must adhere to a strict code of ethics, and must fulfill continuing education requirements,271 doctors specialized in unrelated areas are not restricted from marketing and providing cosmetic procedures, provided they do not actively mislead patients about their credentials (or lack thereof). Presumably, the potentially large increase in income from entering cosmetic surgery practice entices many of these doctors to stray from their original specialty, suggesting that some may lack the experience to recognize BDD candidates or the self-control to turn them away. This is a system with which licensure boards generally will not interfere unless and until direct

268 Id. at 124 (describing statistical reports judging and ranking the various state boards by the number of convictions each secures in proportion to the number of physicians over which it has jurisdiction).
269 Id. at 126 (quoting Frank M. Zeder, Defending Doctors in Disciplinary Proceedings, 10 ARIZ. ATT’Y 22, 27 (2004)).
271 Id.
harm results. Given this historically permissive attitude, the added oversight of the legal system can provide an extra measure of protection.

Considering these factors and interests in the aggregate, it appears that both state medical board proceedings and privately initiated lawsuits are necessary to handle the problem of cosmetic surgeons providing unjustifiable treatment to patients with BDD. The involvement of state boards will help to more sharply delineate the appropriate standard of care in these circumstances, which will result in the more rapid dismissal of frivolous patient-initiated civil actions. At the same time, repeated lawsuits against the same cosmetic surgeon for performing procedures on patients with diagnosable cases of BDD will alert licensure boards that more serious internal investigation and punishment may be required. Although both systems are imperfect and are subject to abuses, the relative strengths of each balance out the weaknesses of the other, making it less likely that an incompetent or delinquent surgeon will be able to continue her harmful practices unnoticed.

Conclusion

This article combined the knowledge and perspectives of three disciplines—law, medicine, and psychiatry—in order to analyze and formulate appropriate policies and procedures for addressing the problem of patients with body dysmorphic disorder who seek cosmetic surgery. The chief objective was to establish an appropriate balance between, on the one hand, upholding patients’ bodily autonomy and supporting cosmetic surgeons’ need to run their businesses without inefficiencies and unnecessary fear of legal or regulatory sanctions, and on the other hand, protecting patients with BDD from doctors who would ignore or take advantage of the patients’ mental disorder to provide unwarranted cosmetic procedures.

The first part of this article discussed the diagnostic criteria for BDD, and then placed the disorder in the broader context of a burgeoning industry for elective operations
and an increasing body of evidence suggesting that the population of individuals who receive cosmetic surgery often have special mental health issues. Since research indicates that body dysmorphic disorder is a contraindication for cosmetic surgery, Part One also provided examples of how doctors can recognize the disorder during preoperative consultations and take appropriate measures to avoid legal liability.

Part Two examined four potential causes of action that an aggrieved cosmetic surgery patient might assert against her doctor if she were unsatisfied with the results of her operation and came to believe that body dysmorphic disorder interfered with her judgment. Specifically, this section explained the factual circumstances and rationale under which charges of negligent nondisclosure, battery, breach of fiduciary duty, and breach of contract could be argued. The importance of maintaining a relationship grounded in candid doctor/patient communication (with complete and accurate medical records thereof) was a pervading principle with regards to avoiding malpractice liability under any claim: the cosmetic surgeon must properly screen her patients for BDD during preoperative consultations by observing their behavior and encouraging them to honestly answer her questions and to ask her their own, and she must be completely forthright about risks and benefits of the proposed operation, including any information she knows relates to a given patient’s particular circumstances. The cosmetic surgeon must be willing to turn down candidates whose self-image is significantly distorted, and may want to solicit the opinion of a mental health professional in borderline cases before proceeding.

The final part of the article considered the merits of state medical board disciplinary proceedings both relative to and in conjunction with private patient-initiated civil actions. Acknowledging both the advantages of licensure board regulation (such as its ability to more finely tailor sanctions to particular circumstances), as well as its drawbacks (such as the potential for board member physicians to be too lenient toward their peers), Part Three determined that regulatory investigations and hearings of recalcitrant doctors will generally be an effective way of controlling the problem, but that civil malpractice lawsuits should remain available to plaintiff patients. Cases of egregious cosmetic surgeon misconduct are likely to be relatively rare, but when the evidence clearly demonstrates that a doctor performed an elective operation on an
individual with BDD, with negligent or willful disregard for that patient’s long-term psychological wellbeing, adequate redress will likely entail both direct compensation to the particular victim and licensure action to protect the welfare of future patients.