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Cosmetic surgery on children

Professional and legal obligations in Australia

Background

Public awareness and concern about cosmetic surgery on children is increasing. Nationally and internationally questions have been raised by the media and government bodies about the appropriateness of children undergoing cosmetic surgery. Considering the rates of cosmetic surgery in comparable Western societies, it seems likely that the number of physicians in Australia who will deal with a request for cosmetic surgery for a child will continue to increase. This is a sensitive issue and it is essential that physicians understand the professional and legal obligations that arise when cosmetic surgery is proposed for a child.

Objective

This article reviews the current professional and legal obligations that physicians have to competent and incompetent children for whom cosmetic surgery has been requested.

Discussion

A case study is used to highlight the factors that Australian primary care physicians must consider before referring and conducting cosmetic surgery on children.

Keywords: children; plastic surgery; law; professional standards

Concerns have arisen both internationally and nationally about the ethics and practice of children undergoing cosmetic surgery.¹ While Australia lacks reliable data on the prevalence of cosmetic surgery on children,¹ there is evidence to suggest that an alarming proportion (31%) of young Australians report dissatisfaction with their bodies.² It is also known that body image dissatisfaction frequently motivates the decision to have cosmetic surgery.³

It seems likely that there is a demand for cosmetic surgery for children in Australia. In the United States of America in 2009, over 36 000 cosmetic procedures were performed on children (including rhinoplasty, breast augmentation and

reduction, otoplasty, liposuction, abdominoplasty and genioplasty).⁴

Given the concerns raised, the likely incidence and demand for such procedures and the current inquiry into cosmetic surgery by the Australian Health Ministers Advisory Council,⁵ it is a good time to provide physicians with a review of the medical and legal obligations owed to child patients when deciding whether to refer for or provide cosmetic surgery.

Generally, surgery for children is governed by what is in the child's 'best interests'. Therefore, physicians must understand what this entails and how a best interest 'test' should be applied in practice. To assist physicians in making sound medicolegal decisions we review Australian professional policy and law, and use a case study to highlight factors that must be considered before conducting cosmetic surgery on children.

Cosmetic surgery

We define 'cosmetic surgery' as procedures undertaken by a qualified medical practitioner to revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient's appearance or self esteem.⁶ This definition encompasses procedures not uncommon in young children – such as otoplasty – but also more controversial procedures such as cosmetic breast surgery and liposuction.

Professional guidelines

Limited professional guidance about cosmetic surgery on children exists for Australian physicians. No relevant policy has been published by The Royal Australian College of General Practitioners or a similar surgical body

such as the Royal Australian College of Surgeons or Australian Society of Plastic Surgeons. Nationally, the Australian Medical Association position statement on body image and health⁷ states that patients under 18 years of age should not have procedures to ‘modify or enhance physical appearance’, unless it is in their ‘medical and or psychological interests’. How this is to be determined in relation to cosmetic surgery is not explained.

New South Wales Medical Council guidelines advise that cosmetic surgery on a child is subject to a ‘cooling off’ period of 3 months following initial consultation,⁶ after which a further consultation is required before proceeding. The Medical Board of Australia’s medical practice guidelines⁸ only include general guidance on treatment of children.

While failure to follow guidelines can result in disciplinary action affecting registration, we know of no cases of an Australian practitioner being disciplined for conducting cosmetic surgery on a child.

Law in Australia (except Queensland)

Physicians must consider legal duties as well as professional obligations. While the law is easy to state, its practical application can present challenges.

Competent children

Australian law generally respects the competent child’s autonomy by allowing them to consent to medical treatment. Where a child has ‘sufficient understanding and intelligence to enable him or her to understand fully what is proposed’, that child is considered competent and is able to consent to medical procedures.⁹ There is a lack of clear judicial guidance on what is required to satisfy this test. However, together with medical opinion about a child’s capacity, factors likely to be relevant include the child’s:¹⁰

- age
- understanding of the nature and consequences of the proposed treatment, including the physical and emotional consequences in the short and long term
- maturity, including intellect and life experience
- ability to understand wider consequences of

the decision, including the effect on other people, and moral and family issues

- psychiatric, psychological and emotional state.

Where a physician considers these factors and is satisfied the child is competent, the child’s consent is sufficient and the surgery requested can proceed (unless there is legislation to the contrary). Of course, some physicians may not offer cosmetic procedures based on their personal values, ethics, or their perception of what constitutes ‘good medical practice’.⁸

Incompetent children

If surgery is considered for a child who is incompetent (eg. due to young age or immaturity), generally that child’s parents can legally provide consent.⁹ However, parents’ power is not unlimited; they must act in the best interests of their child.⁹ Therefore, when parents present with a young child requesting cosmetic surgery there is a legal and professional obligation to consider whether parents can lawfully consent on behalf of their child. This requires an assessment of whether the proposed procedure is in the child’s best interests.

How the legal test of ‘best interests’ is satisfied in individual circumstances is, again, not clear cut. In part this is to allow a desirable measure of flexibility. A child’s best interests does however, include a child’s medical, psychological and social interests. The courts also make clear that, while not determinative, the views of the child should be sought and taken into account.¹¹ However, the possibility that a child may be influenced by parents or others to undergo a particular procedure should also be considered.¹²

Relevant factors to take into account when considering the best interests of a child for whom cosmetic surgery is proposed will include the existing evidence and opinion regarding:

- surgical outcomes (including risks, poor results and side effects) compared with not having the surgery
- the child’s current psychological state and social issues (if any), and the likely psychological impact of having and not having the surgery

- the child’s expressed views (if any) and consideration of the influence of parents’ wishes on those
- whether the procedure can, or should, be postponed until the child is older.

Case study

Consider the best interests test in this example.

Parents of a boy, 5 years of age (legally incompetent), request a referral for otoplasty from their general practitioner because they fear teasing once the child starts school. The boy has obviously protruding ears and a history of moderate to severe asthma requiring hospitalisation and a previous paediatric intensive care unit admission. The child’s mother had prominent ears and suffered teasing as a child until having otoplasty. She is enthusiastic about having the child’s ears ‘fixed’. The child seems unaware of the protruberance of his ears.

Otoplasty, a procedure which seeks to reduce the protruberance of the ears, can (and often is) carried out on children from the age of 4 years.¹³ It is often assumed that otoplasty will definitely benefit the individual child; the justification being that it will prevent the child from being teased or from suffering embarrassment.^{3,12} However, such an assumption may not be correct.

Otoplasty is carried out for a range of indications, including:

- a child’s own dissatisfaction and self consciousness
- peer teasing or bullying,¹⁴ and
- prevention of anticipated self consciousness or social problems in a child (often before starting school).^{15,16}

Up to 90% of children who undergo otoplasties for the reasons identified in the first two categories report reductions in bullying, as well as improvements in happiness and self confidence following successful otoplasty.^{14,15} There is however, no clear evidence regarding the role of prophylactic otoplasty.

There is no relationship between objective severity of ear protuberance and an individual child’s level of distress or the age at which such distress develops (if it does at all).¹⁴ This begs the question whether parents or treating doctors can predict if, or when, a child will suffer psychological harm. The best interests test dictates that the

needs of each child be addressed individually, not the desires of parents or treating surgeons. While the majority of surgeons, parents and psychologists would only consider otoplasty after a child has voiced concerns,¹⁷ anecdotally in Australia and in our experience, prophylactic otoplasty is not an uncommon request.

A subgroup of children exists in whom marked preoperative social isolation and distress is unimproved despite objective improvement in prominence of ears.¹⁴ So, while it may appear that most children will psychologically benefit from such surgery, this cannot be guaranteed for all children.

Consideration must also be given to the risks of such an operation: general anaesthetic; haematoma (1.4–2.2%) and infection (up to 2.4%); which can lead to perichondritis, cartilage necrosis and poor cosmetic results (up to 11.1%).¹⁸

It is vital that when an incompetent child presents for an otoplasty, an individualised assessment of the child's interests be conducted. The best interests test is likely to be more easily satisfied where children are aware of their prominent ears and request that something be done;¹² however, underlying psychological issues should be investigated and addressed. Despite current practice, it appears

more difficult to legally justify pre-emptive otoplasty on children who are not aware of, or suffer no distress from, their physical appearance. In the *Case study*, exposing this child to the risks of a general anaesthetic and operation for no tangible benefit appears to not be in his best interests based on the available evidence.

Law in Queensland

Queensland is the only state in Australia that has legislation governing cosmetic surgery in children. Following a review into cosmetic surgery in children,¹ changes to the law were introduced in 2008¹⁹ to make it an offence to perform a cosmetic procedure on a child (ie. those under the age of 18 years) (*Table 1*). However, the *Public Health Act 2005* (Qld) section 213B,²⁰ as well as the amended legislation,¹⁹ offer a defence: no offence will be committed where a person 'believes, on grounds that are reasonable in the circumstances, that performance of the procedure is in the best interests of the child'.²¹ To rely on this, physicians must be able to demonstrate that their belief developed after considering the:

- views of the child (including the reasons the procedure is wanted), taking into account the child's maturity and understanding of

the procedure, its risks, limitations and consequences

- views of the parent, including whether the parent supports the procedure
- child's physical and psychological health
- timing of the procedure, including whether waiting until the child is an adult is preferable.

Consequently, Queensland physicians faced with a competent child can no longer simply rely on that child's consent to cosmetic surgery. Instead, they must believe the cosmetic procedure is in the best interests of the child. Cockburn and Madden²¹ note that practitioners following good medical practice may already be fulfilling these obligations. However, some suggest physicians may need to consult with colleagues or medical defence organisations to test the reasonableness of their beliefs.²²

Conclusion

Primary care physicians can expect to encounter increasing demands for referral and surgery from the paediatric population. Currently, the inconsistent legal approach and the lack of clear guidance on how to apply the different legal tests mean that more professional direction is needed. In that respect, the pending Australian Health Ministers Advisory Council report is

Table 1. Definition of 'cosmetic procedure' in Queensland legislation²⁰

Procedures included in the definition	Procedures excluded from definition
<ul style="list-style-type: none"> • Abdominoplasty • Blepharoplasty • Brachioplasty • Foreheadplasty • Liposuction or liposculpture • Rhytidectomy • Thighplasty • Torsoplasty • Resurfacing of the skin by removal of the epidermis and penetration of the papillary dermis • Insertion of facial contour implants • Mammoplasty • Genioplasty • Insertion of permanent injectable fillers • Rhinoplasty • Porcelain veneer of teeth 	<ul style="list-style-type: none"> • Otoplasty • Circumcision of the penis • Reshaping of hand or foot that is polydactyl or syndactyl • Correction of disfiguring scarring resulting from a medical condition, illness or trauma • Removal of a: <ul style="list-style-type: none"> – skin tag – tattoo – naevus that is disfiguring, melanotic or interferes with the function of part of the body • Where these procedures are carried out to correct a deformity, congenital abnormality or the physical effect of a medical condition, illness or trauma: <ul style="list-style-type: none"> – mammoplasty – genioplasty – rhinoplasty – craniofacial, orthognathic or otolaryngological surgery (where it is part of a plan to treat a child)

timely; media reports indicate that the draft report makes some recommendations regarding children requesting surgery for nonmedical reasons.²³ It is hoped that the final report will act as a catalyst for uniform laws or professional guidelines to be developed regarding when children can appropriately receive cosmetic surgery.

Finally, physicians need to understand that their current professional and legal obligations require them to undertake individualised assessments of children. Whether referring or intending to operate on a child, physicians are reminded that it would be unwise to assume that cosmetic surgery will always be in a child's best interests.

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