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Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

Madhubanti Sadhya

Abstract

Cosmetic surgeries and enhancements may be defined as interventions to augment some feature, function or physical attribute in addition to what is considered vital for the preservation of physical health. These surgeries are unique in the sense that they seldom seek to remedy any ailment that interferes with the functioning of a healthy body. Patients voluntarily undergo cosmetic procedures that target the improvement or enhancement of physical appearance of an otherwise ‘normal and healthy’ bodily feature. But like all other medical procedures, cosmetic surgeons take prior consent from their patients before initiating any procedure. This article deals with the role and importance of consent in cosmetic procedures. Four important issues have been addressed in this article: Evolution of consent, its importance in medical practice and the relation between patient autonomy and consent. How are cosmetic surgeries different from traditional therapeutic procedures? Is there a higher threshold of disclosure of risks and available alternatives before seeking informed consent from a patient of cosmetic surgery than in other therapeutic procedures? What are the problems encountered by cosmetic surgeons in relation to informed consent? The article ends with the conclusion that a separate and special category of informed consent for elective or optional cosmetic surgeries must be contextualised which imposes on the surgeon a broader duty of disclosure, than what is associated with medically necessary surgeries.

Keywords: cosmetic surgery, informed consent, real consent, medical negligence, autonomy, patient

INTRODUCTION TO THE CONCEPT OF CONSENT IN MEDICAL TREATMENT

Etymologically, the word ‘consent’ owes its origin to the French term ‘consentir’ which means to agree or comply and from the Latin ‘consentire’ implying to ‘feel
together’. In today’s times a well informed and mentally capacitated patient may be of the opinion that securing his consent before undergoing any major or minor procedure is an imperative that the doctor or the hospital concerned cannot do without. But, this was not always the norm. Medicine for a greater period of time was practiced in a paternalistic fashion, especially owing to the position that the profession wielded in society. Dr. Robert Veatch\(^1\) has even gone on record to state that “the old Hippocratic ethic saw the patient as a weak, debilitated, childlike victim, incapable of functioning as a real moral agent.”\(^2\) When a patient visited a doctor with his ailment, his complaints were noted down, his disease diagnosed either through clinical investigations or otherwise, and medication or further course of treatment advised. Although doctors did explain to the patients the nature of their ailments, purely medical considerations that defined what is in the best interest for the patient’s recovery steered their viewpoints and decisions. Differing perspectives of the patients were more often than not written off, and they were expected to follow the recommendations and advice given to them. Opposition to the line of treatment suggested was not entertained and customarily disapproved by the doctors.\(^3\)

India has been a seat of paternalism in the field of health care for a greater part of history, and even up until the early days of the twenty first century. If truth be told, the bulk of the Indian population lives below the poverty line with little or no understanding of medical science. They place doctors on the same pedestal as God and surrender themselves completely to the good sense and authority of clinicians if some medical tragedy befalls them. Around two decades back, the process of medical consent-taking in India was usually treated as a formality. Patients were presented with elaborate details that they failed to grasp but, nevertheless, assented to the procedure by signing the consent form or placing their thumb impressions. Under such circumstances, many

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1 Professor Emeritus of Medical Ethics at Georgetown and Senior Research Scholar at the Kennedy Institute of Ethics.

2 Steven H Miles, ‘Hippocrates and informed consent’ (2009) 374 The Lancet 1322

3 K.S. Jacob, ‘Informed consent and India’ (2014) 27 The National Medical Journal Of India 35
Indian doctors assumed a paternalistic stance and perceived the idea of taking informed consent as a futile and time consuming exercise that directly impeded their duties towards patients and, sometimes, even intimidated them enough to decline life saving treatments. The doctors were of the view that when they had decided what was in the best interest of their patients who had no qualms about the treatment suggested, obtaining informed consent was a perfunctory routine practice of little importance.  

**PATIENT’S AUTONOMY AND CONSENT**

Obtaining valid consent from the patient before commencing medical treatment is a vital prerequisite that medical professionals cannot afford to avoid today. Consent is said to be ‘valid’ when it has been given by a person who is legally competent to give consent and when the consent given is an informed one. Consent is perhaps the only concept that touches all facets of health care services. The requirement of taking consent stems from the patient’s legal and ethical right of self-autonomy. The right of autonomy, often described as the ‘right of self-determination, the right to privacy, liberty and the right to be let alone,’ clothes a ‘competent’ patient with the legal right to accept or decline the treatment offered by a doctor. It authorizes him to assess his best interests without incurring any liability, either moral or legal, to defend or justify his choice. Despite its wide amplitude, a patient’s autonomy is subject to two limitations: first, a doctor cannot be compelled to treat the patient in a manner that contravenes his clinical assessment of the patient’s condition and is in blatant disregard of what he considers to be in the best interest of the patient, and second, fuelled by an urge to commit suicide, a patient cannot coerce a doctor to prescribe a course of treatment that would ultimately lead to his death and make the doctor complicit to the crime.

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Consent and patient’s autonomy became the quintessence of ethical medical practice following the Nuremberg Trials of 1947. The trials brought to light the brutality of the medical experiments that were carried out by Nazi doctors in the garb of scientific research, and necessitated the laying down of ten basic principles. These basic tenets came to be known as the Nuremberg Code of 1947 and mandated the recording of voluntary and informed consent from human subjects.7 This was followed by another set of principles - Ethical Principles for Medical Research Involving Human Subjects, popularly known as the Helsinki Declaration, adopted by the 18th General Assembly of the World Medical Association. The Declaration of Helsinki, as amended in October 2013,8 contains detailed provisions on informed consent and specifically lays down that no individual who is competent to give informed consent shall be made a subject of medical research unless he or she freely consents to it.9

Schloendorff v. Society of New York Hospital,10 decided by the Court of Appeals of New York in the year 1914 was the first case which gave legal recognition to the concept of patient’s autonomy and established a legally competent adult’s right to refuse medical treatment. In this case, a surgeon who had failed to obtain consent from the patient before conducting hysterectomy had to face charges of assault and was held liable in damages by Benjamin Cardozo J. who observed that every adult of sound mind has the privilege to decide what shall be done to his body.11

INFORMED CONSENT

The expression ‘informed consent’ was voiced for the first time by Justice Cardozo in the 1957 medical malpractice suit of Salgo v. Leland Stanford Jr.
Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

In this case, the plaintiff, who became paraplegic following a procedure of aortography which was intended to locate a block in his abdominal aorta, alleged that his physician had not disclosed to him the potential risks of the procedure before he was made to undergo the same. The Court ruled that it was the duty of the physician to disclose to the patient “all the facts which mutually affect his rights and interests and of the surgical risk, hazard and danger, if any....” Any fact that a physician withholds which, in turn, incapacitates the patient to give an intelligent and sound consent to the proposed treatment makes the physician liable for non-disclosure.13

Informed consent is a relatively new concept in India that gained prominence after the enactment of the Consumer Protection Act, 1986, especially subsequent to the landmark judgment of the Supreme Court in Indian Medical Association v. V.P. Shantha and Ors14 which brought the medical profession and its services within the purview of the Act. Nowadays, the two most prominent stakeholders of the medical profession, the doctors and the patients, are becoming more conscious about this idea, and patients are well armed with information concerning their rights vis-à-vis the medical services and treatment they avail of.15 The wave of consumerism and commercialization that has engulfed India’s health care services, particularly in the private sector in the recent decades, has empowered patients to have a say in their treatment choices and is symbolic of the shift from the paternalistic approach to medicine to a more patient-centric model.16 Thus, in this backdrop, it can be safely said that the entire discourse on consent has become relevant today, particularly from the viewpoint of medical practitioners, because any doctor who treats a patient without securing his valid consent may be held liable under civil or criminal law.

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13 154 Cal.App.2d 579.
14 1995 SCC (6) 651.
16 Koley (n 11) 112
Although several attempts have been made to define ‘informed consent,’ one of the most comprehensive definitions of the term can be found in the book titled *Principles of Biomedical Ethics* authored by Tom Beauchamp, where informed consent has been defined by dividing its constituent elements into two components: the information component and the consent component. Beauchamp notes that the legal, regulatory, philosophical, medical and psychological writers seem to favour the division of informed consent into five essential constituents or ‘building blocks,’ namely, (1) competence, (2) disclosure, (3) understanding, (4) voluntariness and (5) consent which must co-exist for the consent to be informed. The information component consists of the disclosure of information to the patient which, in turn, allows him to comprehend what has been disclosed to him. The consent component comprises of a decision that the patient makes of his own volition and the ensuing authorization to proceed with the treatment or otherwise that follows. Thus, as per this definition, informed consent to a medical intervention is given when one is competent to act, has full disclosure of the proposed treatment, comprehends the information that has been disclosed, acts voluntarily on one’s free will and gives assent to the intervention.17

The Supreme Court of India extensively dealt with the concept of ‘consent’ in medical treatment in *Samira Kohli v. Dr. Prabha Manchanda and Anr*18 and went ahead to note that although the expression ‘informed consent’ is repeatedly used, it is an American concept which has no existence in English Law, and although it enshrines within itself the basic requirements that qualify an approval to be consent, its emphasis is on the doctor’s responsibility to make known to the patient the vital information to obtain his consent. On the other hand, consent in the United Kingdom is defined from the perspective of the patient and is considered to be ‘real’ and valid when (i) it is given by the patient voluntarily; (ii) the patient has the competence to give consent; and (iii) the patient has the

17 Tom L. Beauchamp, *Principles of Biomedical Ethics* (Tom L. Beauchamp and James F. Childress ed., 5th edn, Oxford University Press 2001)

18 Appeal (civil) 1949 of 2004; 2008(1) SCALE 442.
least amount of adequate details about the nature of the medical intervention to which he is consenting.19

From a plain reading of the judgment of the aforementioned case, it becomes clear that the Supreme Court of India endorsed the UK approach of ‘real consent.’ The Court stated that keeping in mind the ground realities in the medical and healthcare situation in India, where the majority of the citizens requiring medical attention are incapable of understanding medical terms, concepts, and treatment procedures, the ‘reasonably prudent patient test’ developed by the United States Courts of Appeals, District of Columbia Circuit in Canterbury v. Spence,20 which required the doctor to acquaint the patient with all the material risks in the proposed treatment before eliciting consent, was not suitable for India. The Apex Court sided with the concept of ‘real consent’ developed by the House of Lords, first in Bolam v. Friern Hospital Management Committee21 and later adopted in Sidaway v. Bethlem Royal Hospital Governors & Ors,22 where the majority were of the view that a doctor’s duty of disclosing the intrinsic risks in the line of treatment proposed by him was the same as the test applicable to ascertain the liability of the doctor in any diagnosis or treatment, namely, that the doctor was required to act in accordance with the practice that was acknowledged as appropriate by a responsible body of medical men of the time in question.23 The Supreme Court, however, hinted at the possibility of adopting the ‘reasonably prudent patient test’ in India in the days to come with the increase in awareness amongst the public of patient’s rights.24

The Apex Court went on to elaborate the idea of real consent, when it noted that the patient must be given all the adequate information25 that one requires

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22 [1985] 1 All ER 643.
24 ibid. para 33.
25 The Supreme Court in para 32 of the said judgement noted that, “The ‘adequate information’ to be furnished by the doctor (or a member of his team) who treats the
in order to reach a proper decision, but the doctor is under no duty to warn the patient of remote risks. The doctor is expected to inform the patient of only such risks which are recognized, rather than those complications which are a rarity or highly remote that may intimidate the patient. In advising a patient to undergo an operation, the Supreme Court, therefore, observed that the doctor is required to act in the way in which a competent surgeon (in this case a gynecologist) employing reasonable skill and care in comparable circumstances would have done. The Court gave a good amount of scope to the doctors in allowing them to decide the quantum of information that should be disclosed to the patient, keeping in view the patient’s personality, the questions he/she asks and his view of how much of the information the patient is capable of comprehending.26

In the *Samira Kohli* judgment, the Court impliedly renounced the practice of taking an all-encompassing consent in medical treatment when it noted that consent which has been given for a particular treatment or procedure cannot be used and will not be held to be valid for conducting some other procedure. Even if the subsequent surgery or procedure is aimed at benefiting the patient or even if it saves time and prevents future medical expenses or relieves the patient from future sufferings, these facts would not absolve the doctor from liability in an action in tort for negligence or assault and battery, if the same are carried out without obtaining valid consent. The subsequent procedures conducted without securing consent would, nevertheless, be valid if they are performed to safeguard the life or preserve the health of an unconscious patient and delaying the procedure to seek consent would be unreasonable, and if the subsequent procedure becomes indispensable during the course of the surgery. If there is prior contemplation, a diagnostic procedure which later necessitates

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patient should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment, or not. This means that the Doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment.

26 (2008) 2SCC 1 para 34.
Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

an operative procedure can both be conducted with a valid consent for the former.  

WHAT ARE COSMETIC SURGERIES?

Cosmetic surgery, often termed as aesthetic or beauty surgery, is not a modern phenomena. The birth of such surgeries can be traced back to the early sixth or seventh century B.C. when the Indian physician Susruta in his book Susruta-Samhita - the first known historical book to report reconstructive surgery had described the first reconstruction of the nose and ear.  

There are some scholars who are of the view that it was in the period of Renaissance, towards the end of the sixteenth century, that surgeons began to articulate their views on aesthetic or beauty surgery. The fifteenth century ended with the outbreak of epidemic syphilis which had stigmatizing effects on the affected populace. Ottoman Hilderbrand (1858-1927), a reconstructive surgeon and a noted historian of aesthetic surgery, traced a relationship between this disease of an unaesthetic nature and the emergence of aesthetic surgery. The latter decades of the nineteenth century witnessed the birth of modern aesthetic surgery in Europe, particularly in Germany, France and the United Kingdom and in the United States of America. The colonial and post-colonial era saw the growth and spread of this branch of surgery, treading the path of globalization and economic expansion, under the hegemony of Western medical theory and practice to continents of South America, Africa and Asia. The twenty first century has witnessed an unprecedented number of cosmetic and aesthetic surgeries being performed all over the world. As per the International Society of Aesthetic Plastic Surgery (ISAPS) global statistics on aesthetic/cosmetic procedures released in December, 2019, more than 23 million (23,266,374)

28 Dimitrije Panfilov, Cosmetic Surgery Today (Thieme 2005)
cosmetic surgeries and procedures were performed the world over.\textsuperscript{31} India ranked fifth in the total number of procedures performed, accounting for 895,896 procedures, preceded by USA, Brazil, Mexico and Germany.\textsuperscript{32}

The Clinical Congress of the American Medical Association held in the year 1974 in Portland defined the term cosmetic surgery as “that surgery which is done to revise or change the texture, configuration or relationship with contiguous structures of any feature of the human body which would be considered by the average prudent observer to be within the broad range of “normal” and an acceptable variation for age and ethnic origin; and, in addition, is performed for a condition which is judged by competent medical opinion to be without potential for jeopardy to physical or mental health.”\textsuperscript{33}

Although the terms ‘cosmetic surgery’ and ‘plastic surgery’ are used interchangeably, they are different from one another. Plastic surgery derives its name from the term ‘plastic’ which stems from the Greek word ‘plasso’ meaning to mould or shape. It involves the restructuring or enhancement of appearance, form or function of parts of the body by resection, transplantation or implantation. Plastic surgery, thus, includes within its folds reconstruction of defects, especially those acquired due to trauma, or burn injuries, removal or replacement of congenital deformities, or damaged or amputated parts of the body, etc. Thus, cosmetic or aesthetic surgery which seems to focus more on the aesthetic or visual quotient of appearance is a part of the broader discipline of plastic surgery.\textsuperscript{34}


\textsuperscript{33} Panfilov (n 28)1

\textsuperscript{34} ibid. See also, Sara Goering, ‘The Ethics of Making the Body Beautiful: Lessons from Cosmetic Surgery for a Future of Cosmetic Genetics,’ (2015) 13 The Center for the Study of Ethics in Society 1
Cosmetic surgeries and procedures can primarily be divided into two categories: firstly, procedures which are minimally invasive, that are carried out on the surface of the skin and can be done in a very short span of time, without the involvement of any surgical procedure; such as laser hair removal treatment and skin resurfacing, and secondly, surgeries which are akin to traditional surgeries and are carried out in a hospital or clinical setting that require the patient to be sedated or anesthetized.

An illustrative list of cosmetic procedures on the face would include cheek implant, chin augmentation (mentoplasty), ear pinback (octoplasty), eyelid tightening (blepharoplasty), face-lift (rhytidectomy), nose reconstruction (rhinoplasty) and forehead lift; collagen and fat injections to enhance sunken facial features; hair transplantation; scar revision and removal of birthmarks; skin resurfacing, etc. Some of the common cosmetic surgeries which are carried out on the bodies of patients include arm lift (brachioplasty), breast augmentation, breast implant removal, breast reduction (mammaplasty), breast tightening (mastopexy); buttock and thigh lift; calf and other implants; liposuction; male breast reduction (gynecomastia); penile enlargement and implant; transgender surgery which changes the form of primary and secondary sexual characteristics; tummy tuck (abdominoplasty), etc.

**CONSENT IN COSMETIC SURGERIES AND PROCEDURES**

In India, cosmetic and aesthetic surgeries are not governed under any specific legislation, and hence, the common law and other statutory provisions as applicable to other branches of medicine are also applicable to this field. It is important to bear in mind that, like in other fields of medicine, a cosmetic surgeon may have to face litigations in case of his negligence in treatment or on other grounds discussed in the article. Therefore, it is extremely crucial for the cosmetic surgeon to be aware of the legal aspects involved in aesthetic surgeries.

35 Gilman (n 29) 6,7
36 ibid

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There is no denying the fact that there are certain peculiarities of cosmetic surgeries and enhancements which sets them apart from the traditional and mainstream medical interventions. Since the relationship between a cosmetic surgeon and his patient is different from that of a traditional doctor-patient relationship, there are certain legal and ethical issues that cannot and must not be ignored, securing informed consent from the patient being one of them. Despite its uniqueness, the fact that cosmetic surgery involves the performance of some kind of surgical interventions on individuals for the sake of improving appearance is indisputable, and hence, the requirement of taking consent before starting the procedures is very pertinent. Cosmetic procedures are one of the best examples of consumer driven medicine, that patients pursue not out of need, but to fulfill some ‘want’ that they have with respect to their physical features that they wish to get altered or augmented. Hence, if the outcome of the procedure or surgery fails to fulfill the expectations of the patient, in all likelihood a case may be instituted against the doctor for negligence. This makes effective communication and consultation between the doctor and patient one of the most crucial elements to avoid litigation. One of the fundamental duties of the doctor is to inform the patient of all relevant information relating to the procedure, the pre-procedure requirements, inherent risks, alternatives and post-operative care, etc., before commencing any surgery, and this gets legal sanctity in the procedure of taking informed consent through the consent form.

**IMPORTANCE OF CONSENT IN COSMETIC SURGERIES AND PROCEDURES AND REMEDIES AVAILABLE TO PATIENTS**

Taking of informed consent before any procedure is primarily important for two reasons; firstly, it upholds the patient’s autonomy, and secondly, it safeguards the doctor from future legal tangles. Moreover, the principle of informed consent prevents physicians from downplaying the risks of surgery or exaggerating the possible outcomes of the surgery. The need to take informed consent also ensures that there are no ‘information imbalance or asymmetry’ between the patient and the physician.37 The need of obtaining consent from patients before commencing any cosmetic treatment becomes further pronounced for cosmetic surgeons. Every surgery and intervention, whether major or minor, comes

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37 Kristen Nugent, ‘Cosmetic Surgery on Patients with Body Dysmorphic Disorder: Cutting the Tie That Binds’ (2009) 28 Developments in Mental Health Law 77
with its share of risks which in some treatment procedures although remote, cannot be written off altogether. If any of these medical hazards are realized in the course of the operation or during further course of treatment, the consent taken from the patient, whether express or implied, acts as a valid defence in law for the doctor. Under the Indian law, this defence is available to the doctors under Section 88 of the Indian Penal Code, 1860, which provides that no harm done to a person would be considered to be an offence if it is done for the benefit of the person concerned, in good faith, and with the person’s express or implied consent to suffer the harm. Thus, Section 88 grants legal protection to the doctor against criminal action for any treatment or surgery undertaken in good faith for the benefit of the patient who has signified express or implied consent for the medical intervention, even if some harm results from it. The applicability of this section to medical professionals is further exemplified by the illustration appended to the section which states a doctor, despite being aware that a particular operation is likely to cause the death of the patient, would not be liable of committing any offence if he treats the patient in good faith for the benefit the patient, provided it is done with the consent of the patient. The protection afforded to medical professionals by Section 88 of the Indian Penal Code, 1860, has also been affirmed by the Supreme Court in Kusum Sharma and Ors. v. Batra Hospital and Medical Research Centre and Ors.

Besides this, the doctrine of informed consent protects a patient from any unjustifiable touch. In such situations, a patient can only contend that he or she had no prior intimation of the nature of touch or the treatment provided to succeed in such a case. Under civil law, the patient may institute a suit against the cosmetic surgeon in tort for trespass to person or the tort of negligence. In some cases, the cosmetic surgeon may even be criminally held liable for assault or battery. Battery has been traditionally defined as an act of directly causing, either intentionally or by negligence, physical contact with another person without obtaining the person’s consent. The burden of proof in cases of battery is lower than a case of medical negligence where the patient is obligated

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39 (2010 3 SCC 480).
40 Nandimath (n5)344
to prove that – (i) the doctor owed a duty of care to the patient, (ii) the doctor breached the said duty and (iii) the patient suffered consequent harm due to the breach of the doctor’s duty. In a case of battery, the patient need not prove that the touch that was not consented for resulted in any harm or injury. So long as the physical touch and the contact by the surgeon is non-consensual, the patient has high chances of prevailing in a case of battery instituted against the surgeon.\(^4^1\) Claims of battery are usually made in conjunction with claims of medical negligence and may be made in cases where the surgeon performs in the course of the surgery something which had not been discussed prior to the commencement of treatment, for instance, inserting a different type of chin implant without prior discussion.\(^4^2\)

Through its decision in *Indian Medical Association v. V.P. Shantha*,\(^4^3\) the Supreme Court has brought patients within the purview of the Consumer Protection Act, 1986, as ‘consumers’ of medical ‘service.’ Since the enactment of this Act, the consumer courts, or the quasi-judicial bodies established under this Act equipped with the powers of a civil court, have been the preferred forum for filing complaints of medical negligence, since these courts assure expeditious redressal of grievances, with simpler procedural formalities than those mandated by the civil courts. The Act has been recently superseded and repealed by the Consumer Protection Act, 2019, which defines consumer of service as any person who hires or avails of any service for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment.\(^4^4\) Thus, by this definition, any patient who avails of the services of a doctor may file a complaint before the appropriate consumer forum.\(^4^5\) The legal heirs and representatives of the deceased consumer and the

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43 1995 (6) SCC 651

44 Section 2(7)(ii) of the Consumer Protection Act, 2019

45 The consumer forum where the complaint would be filed is determined by the pecuniary jurisdiction of each forum and the value of the goods or services paid as consideration.
parents or legal guardians of a minor consumer of service are also recognized as ‘complainants’ under the Act.

There is no explicit mention of medical negligence under the Consumer Protection Act, 2019. A complainant, who wishes to seek remedy under the Act or make a claim of compensation for the negligent act of the service provider must file a complaint claiming ‘deficiency in service.’ ‘Deficiency’ in relation to any service has been defined as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance of service, where the quality, nature and manner of performance have been stipulated under any law in force or specifically taken up for performance by the service provider in pursuance of a contract or otherwise. The Supreme Court has clarified that a charge of deficiency in service leveled against a medical practitioner under the Consumer Protection Act would be decided by applying the same test comprising of the three elements of ‘duty, breach of duty and harm suffered by the patient’ to decide a claim of damages for the tort of negligence in a civil court. In addition to this precedent that has been followed in assessing cases of medical negligence filed before the consumer courts, the Consumer Protection Act of 2019 Act has expanded the definition of deficiency in service by including within its purview any act of negligence or omission or commission by the service provider which causes loss or injury to the consumer. Thus, any

47 Section 2 (11), Consumer Protection Act, 2019.
48 Indian Medical Association v. V.P. Shantha and Ors 1995 (6) SCC 651
act of negligence committed by the doctor that causes harm to the patient has been statutorily recognized as ‘deficiency’ in service.

In addition, where a doctor’s failure to take adequate care results in harm to the patient, the consumer courts, particularly the National Commission, has held in a number of cases\(^49\) that failure to take informed consent, perfunctorily taking consent from the patient without explaining the details of the procedure or non-disclosure of adequate information about the procedure results in deficiency in service, since it robs patients of the opportunity to exercise their choice with respect to their treatment decisions. The importance of informed consent in medical interventions has been further enhanced by the Consumer Protection Act, 2019, which has also included deliberate withholding of relevant information from the consumer by the service provider within the definition of ‘deficiency’ in service.\(^50\)

The law does not make any distinction between therapeutic and elective aesthetic surgeries while making remedies available to patients who have suffered due to the negligence of the treating doctor or hospital. The field of cosmetic surgery is replete with cases of alleged medical negligence, most of which are instituted before the Consumer Commissions established under the Consumer Protection Act. In addition to invasive surgical cosmetic procedures like liposuction\(^51\) or hair transplantation,\(^52\) patients who have undergone non-

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50 Section 2 (11), Consumer Protection Act, 2019.


invasive procedures such as laser skin treatment or laser hair removal\(^{53}\) have also instituted complaints alleging deficiency in service under the Act and have been awarded compensation if the allegations against the doctor were proved.

If the service rendered by a doctor comes within the purview of contract of service, theoretically speaking, doctors can also attract civil liability for breach of contract. Courts in India have seldom held doctors liable for the breach of contractual obligations, although several decisions of the Supreme Court have recognized the contractual relationship shared by a doctor with his patient and have noted that the former has to compensate the latter under the law of tort, and/ or contract, if any harm is suffered for any negligent act or omission.\(^{54}\)

The field of cosmetic surgery is highly commercialized with patients demanding a result that exactly mirrors the image they had in mind. Therefore, it would not be wrong to contend that for cosmetic procedures where the relationship between the doctor and patient is more transactional than therapeutic surgeries, the doctor should be liable to compensate the patient for failing to deliver the result that had been expressly consented to for breach of contract.

An important decision that deserves a mention in this regard is *Sullivan v. O’Connor*\(^{55}\) decided by the Supreme Judicial Court of Massachusetts. A professional entertainer consulted a plastic surgeon to undergo rhinoplasty to augment the shape of her nose. The doctor took photographs of her nose and drew on the image to depict the change that the procedure would bring about. However, after two surgeries, the patient’s nose looked worse off than before, and the disfigurement suffered was apparently permanent that further corrective surgery failed to remedy. The patient alleged breach of contractual obligation of the surgeon for his failure to enhance her beauty through the surgery and negligence in performing the surgery. The jury found the surgeon

\(^{53}\) Prashant Sahu v. Chairman and Managing Director, Kaya Ltd. (CC/211/2017 Gurgaon District Consumer Disputes Redressal Forum, decided on 16 March, 2020)


guilty of breach of contract and awarded $13,500 in damages. The Court in this case deduced an express contract to have been entered into by the parties through the drawings that were made on the photograph. The illustration made by the doctor was seen as an irrevocable promise of the outcome of surgery which he failed to deliver and had, hence, breached the contract. Unlike cases of negligence which necessarily require proof of harm, in an allegation of breach of contract, failure to reach the desired result that had been consented to, could be enough to hold the doctor liable. In Sullivan, although the outcome of the surgery was not as anticipated, the plaintiff had failed to establish that her botched up nose had adversely affected her employment as an entertainer.56

Medical professionals in India are yet to be charged solely for the breach of contractual obligations, but it is worth noting that the theory of contractual liability broadens the doctor’s burden by making him accountable to fulfill every aspect of the surgery result he had expressly consented to deliver. The day does not seem far when courts may allow patients to recover damages from doctors, especially if the doctor has used aggressive promotion tactics or relied on computer imagery to convince the patient of the proposed outcome that led him to consent to the cosmetic procedure.57

**STEPS TO SECURE CONSENT IN COSMETIC SURGERIES AND PROCEDURES**

The foregoing discussions on the liability that a doctor can attract under civil and criminal law for not recording consent further reinforces the importance of consent in medical practice. The first part of the article has already pointed out the factors that are taken into account before a patient is said to have given an informed consent or a real and valid consent to a medical procedure or treatment. Cosmetic surgeries and enhancements being unique for reasons already hinted at require certain supplementary conditions to be fulfilled

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Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

before an informed consent is secured by the cosmetic surgeon. The steps that should be involved in securing consent in cosmetic surgeries have been discussed hereunder.

COUNSELLING:

A counseling session between the cosmetic surgeon and the prospective patient is indispensable. Providing adequate information to the patients that enable them to take an informed decision is of utmost importance in cosmetic surgeries. The amount of information to be revealed also depends upon the patient profile and what a ‘prudent patient’ would want to know. Usually, in the course of counseling the following information must be shared - the condition the client has, or the alterations or enhancements the client seeks; modes of treatment or alternatives available; the proposed procedure; the number of sittings required; duration and approximate cost of such treatment; expected results; instructions to be followed before or after treatment; possible side effects, complications or health hazards, medical risks;58 possible consequences if post-operative advice is not followed, etc.59 If the surgical procedure to be undertaken, alternatives available and the risks are explained audio-visually or by some other health professional other than the cosmetic surgeon, the surgeon still owes a duty to the patient to meet him or her personally to ascertain that the patient has adequate knowledge about the procedure.60

PRE-PROCEDURE INVESTIGATIONS:

Before providing informed consent, patients undergoing cosmetic procedures are often made to undergo pre-procedure investigations. Some scholars are

59 Mark Gorney, ‘Medical Liability in Plastic and Reconstructive Surgery’ in Maria Siemionow, Marita Eisenmann-Klein (eds.) Plastic and Reconstructive Surgery (Springer 2010)
of the view that in addition to the medical history of the patient, a detailed account of the cosmetic procedures that have been undertaken in the past and the level of satisfaction derived from the same should be enquired. This can help the surgeon to gauge the expectations that the patient has from the proposed treatment. Besides the medical history of the patient, the social background of the patient, including occupation, is very pertinent.  

PHOTO-DOCUMENTATION:

Photo-documentation has become extremely pertinent in cosmetic procedures, which not only acts as a valid legal document, but also helps patients assess the outcome of surgery. Photographs help to increase patient satisfaction, since they allow patients to appreciate the change they have undergone and to ascertain whether they have received the treatment they had assented to. They also safeguard doctors if certain aberrations or scars which were present prior to the surgery are attributed to the procedure undergone by the patient.  

REQUISITES OF VALID CONSENT:

For the consent to be valid in cosmetic surgeries and enhancements, the following three conditions must be fulfilled: it should be given by a person who is legally competent to give consent, that is to say the person must have attained the age of majority and must be of sound mind and capable of appreciating what he or she is consenting to. In the case of minors, consent must be given by the parents, and in the case of teenagers (13-18 years), consent of both the teenager and the parent should be taken; the consent must have been given voluntarily; and it must be given after the patient has all the adequate details about the condition, need for undergoing the procedure, other modalities of the proposed procedure, duration of the procedure, number of sittings, expected

results; pre-operative and post-operative instructions and precautions that must be followed and possible side effects, etc. Besides these requirements, it must also be seen that the consent has been well documented. It must be in written form and signed by both the doctor and the patient or parent/guardian in the case of minors. The consent form should include a statement which in essence expresses that the surgical procedure was explained to the patient and risks and complications, viable alternatives and their risks and complications were discussed and that all questions were answered. It must be simple, comprehensible and in the language that is understood by the patient. It is always preferable to have a witness in cases of cosmetic surgeries. It is also important to obtain consent a day or two prior to the procedure, which should be recorded by the treating doctor. It should not be obtained on the date of the surgery or several days before the surgery. The General Medical Council in the United Kingdom\(^\text{63}\) and the Medical Board of Australia\(^\text{64}\) have recommended cooling off periods for cosmetic surgeries – that is, an interval of time after consultation before the decision to undergo the procedure is taken or the procedure is undergone. This period allows patients to weigh the options presented by the surgeon and not take a hasty decision. While this practice is yet to be formally adopted in India, professional associations of aesthetic and plastic surgeons in India recommend to their members to provide cooling off periods to their patients. If consent is provided for one procedure, the doctor cannot undertake any procedure in addition to the procedure consented to or in place of it, which may or may not bear the same results. Moreover, if a patient has consented to a particular surgery or enhancement to be conducted by one doctor, some other doctor cannot do the surgery. Furthermore, if some new procedure or equipment is being used, there must be a mention of it in the consent form.\(^\text{65}\)


\(^{65}\) Rao (n 41) 172
HOW ARE COSMETIC SURGERIES DIFFERENT FROM OTHER SURGERIES?

One of the primary differences between mainstream medical surgeries and cosmetic surgical or non-surgical interventions is that cosmetic procedures are ‘elective’ or discretionary or voluntary in nature in contrast to ‘non-elective’ procedures like, for instance, a surgery for the removal of a ruptured appendicitis, where a patient has little scope for exercising choice but has to undergo treatment. There are very remote chances of death from cosmetic or aesthetic surgeries, and the success of these procedures is judged by the patients and not the doctors who undertake them. Patients who undergo aesthetic or cosmetic surgery are rarely referred to as patients, primarily because they are not unwell per se and are often addressed as ‘clients.’66 A fundamental question which has often confounded surgeons is whether cosmetic surgery even falls within the purview of healthcare, since some are of the opinion that the practice of cosmetic surgery falls beyond the scope of traditional medicine.67

Cosmetic surgeries and enhancements have been customarily defined as interventions intended to augment some feature, function or physical attribute in addition to what is considered vital or basic for the preservation of health.68 The traditional practice of medicine has centered around pathological findings that mark out the nature, origin, progress, and cause of disease. This style of combating or remedying the condition of an ailing person concentrates on the cause of the ailment and the medication or therapy that would restore the vigour and bring the patient back to health. Enhancement procedures and surgeries on the other hand may or may not have a deficiency or disease as a starting point of reference that needs to be cured. The focal point of such surgeries lies in innovation, and enhancement of appearance and capabilities.69

66 Gilman (n 29) 4, 5
67 Avinash De Sousa, ‘Concerns about cosmetic surgery’ (2007) 4 Indian Journal of Medical Ethics 171
69 ibid 696
When a cosmetic surgeon performs a cosmetic surgery, individuals who are otherwise in good health undergo procedures that may give rise to medical hazards, side effects and complications, the end result of which may be beneficial for the persons in question but are, debatably, non-therapeutic. The patient has a say in the line of treatment selected, and all decisions pertaining to the procedure are made in concurrence with the patient, since being subjected to the surgery or ‘going under the knife’ is the prerogative of the patient. The interaction between the cosmetic surgeon and his/her patient is unique in such surgeries, since the recipient has to be provided a level playing field to be able to freely articulate the expectations from such interventions.70

Since cosmetic surgeries primarily deal with aesthetics or features that appeal to the eye, their success or failure is dependent on whether the patient perceives the results to have matched his or her expectations.71 This emphasis on patient’s subjective opinion finds resonance in the fact that it is not uncommon to find patients who are often dissatisfied with the outcome of a cosmetic procedure that was otherwise successful in a technical sense. In such circumstances, even if a cosmetic surgeon is not held liable under civil or criminal law, the procedure would still not be deemed to be a success.72 At times, the dissatisfaction of patients may stem from insufficient consultations with the doctor prior to surgery, which could result in mistaken presumptions about the results of surgery. Such dissatisfaction may be further heightened in patients with body dysmorphic disorders (BDD)73 - whose estimations and anticipation about the

73 Body dysmorphic disorder is a mental disorder where individuals are fanatical about physical frailties which may have either been imagined or blown out of proportion.
proposed treatment and its outcome are skewed even before the preliminary doctor-patient consultation.\textsuperscript{74}

Another difference that sets cosmetic surgeries apart from other therapeutic interventions is that the cost incurred to undergo these surgeries are usually quite high, and they are seldom covered under medical insurance. Besides this, in other medical procedures like surgeries for curing cancer, serious heart ailments or other high risk procedures like neurosurgery, patients are often willing to accept some medical risk including death in extreme circumstances. But, in cosmetic surgeries, patients allow no room for complications or mishaps. \textsuperscript{75}

A person undergoing cosmetic surgery has a self-image and may have been triggered to undergo the procedure for a variety of reasons that could range from social media influences, peer pressure, societal pressure and employment demands to racial discrimination. Patients undergoing cosmetic surgery may have their own whims, fancies and expectations that are often difficult to fulfill. Cosmetic surgeries are often undergone for reasons that are highly superfluous. For instance, in 2008, the American Society of Plastic Surgeons identified two groups of patients who were most inclined to surgically alter their appearances - first, patients who had a strong self-image in general, but were troubled by a particular physical characteristic, and second, patients who had low self esteem owing to some physical imperfection or cosmetic flaw.\textsuperscript{76}

**PROBLEMS ENCOUNTERED BY DOCTORS AND PATIENTS IN RELATION TO INFORMED CONSENT IN COSMETIC SURGERIES:**

Since cosmetic surgery is unique and is at variance from mainstream medical practice for several reasons already outlined in the article, there are certain specific problems that cosmetic surgeons and patients face in the consent procedure, some of which have been discussed hereunder.

\textsuperscript{74} Nugent (n 36) 80
\textsuperscript{75} Rao (n 41)876
\textsuperscript{76} Nugent (n 36) 79
Patient selection, informed consent and legal liability of the cosmetic surgeon: ‘Patient selection,’ as the name suggests, is the exercise that cosmetic surgeons engage in to select patients they would operate upon or render their services to. Patient selection is another distinctive feature of cosmetic surgery which sets it apart from other medical interventions. Since the patients voluntarily elect to undergo such surgeries and do not have any ailment that needs to be treated, the surgeons have the ultimate say in deciding whether or not the patient in question is appropriate and fit to undergo the procedure. Thus, in a way, the surgeon selects the patient and not vice-versa. In order to gauge the patients’ suitability to undergo the cosmetic treatment, the surgeons have to evaluate the patients psychologically besides physically evaluating them. As has already been hinted at, some individuals are stimulated by emotional or psychiatric gains to undergo cosmetic surgeries. Therefore, it is extremely important for the cosmetic/aesthetic surgeons to have a thorough consultation and dialogue with prospective patients in order to gauge whether they suffer from any kind of psychiatric disorders, including body dysmorphic disorder, mood disorder, personality disorders, etc. On one hand, these surgeries may have a positive impact on persons who undergo them, and on the other hand, the psychological and emotional distress that urge patients to undergo these procedures may get aggravated post surgery, which could persuade them to institute legal action against their doctors.

Since the ability to provide informed consent for surgery is related to the mental make-up of the patient, the competency to give consent comes within the purview of the general medico-legal guidelines of securing consent. This requires surgeons undertaking cosmetic procedures to give additional attention to the patient’s capacity to consent, because the issue of pre-existing

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77 Joshua B. Hyman and Robert T. Grant, ‘Evaluation of the Patient for Cosmetic Surgery,’ in Robert Grant, Constance Chen (eds.) Cosmetic Surgery (McGraw Hill Professional 2010). The authors in the book have further pointed out that there are certain cosmetic surgery patients who exhibit ‘danger signs’ and must, therefore, be dealt with very carefully. Some of the danger signs that the authors have noted down that may be a sign of the patient suffering from psychological issues are: delusional distortion of body image, unclear motives for undergoing surgery, unrealistic expectations regarding changes in their daily lives as a result of the surgery, present adversities linked to their physical appearances, history of seeing physicians and being dissatisfied with them, bringing photographs of film stars with the expectation of having similar features, taking multiple opinions, etc.
psychological disorders is often brought up in medical malpractice suits.\(^78\) An action for battery against the surgeon may be instituted if there is a lack of informed consent owing to the incapacity or incompetence of the patient to give consent. A patient would be considered competent to give consent when he or she is capable of taking a decision after evaluating the potential outcomes of the surgical or non-surgical intervention. There may be situations when the patient may make an irrational choice; one that is at odds with what the cosmetic surgeon perceives to be in the best interest of the patient. This does not necessarily prove that the patient is incompetent. However, patients who are severely troubled by their psychological problems may be found incompetent to give an informed consent if their emotional state prevents them from taking decisions or communicating their consent or accepting the fact that they are in need of psychological help.\(^79\) Thus, ascertaining the physical and psychological suitability of the patient to receive cosmetic treatment and to give an informed consent becomes an uphill task for the cosmetic surgeon.

In the New York case of *Lynn v. Hugo*,\(^80\) the plaintiff instituted a case against her former doctor on the allegation of failing to take her informed consent. Mrs. Lynn G. brought a malpractice suit against her former plastic surgeon, Dr. Norman Hugo, on the basis of two abdominal plastic surgeries performed by him in February and November 1993. In February 1993, Dr. Hugo performed a liposuction of the abdomen, flanks, thighs and knees, and a bilateral mastopexy, followed by an inner thigh liposuction and a full abdominoplasty in November 1993. Prior to these surgical treatments, Mrs. G had paid nearly 50 professional visits to Dr. Hugo and had undergone a number of elective procedures, such as eyelid surgery, facial liposuctions, removal of skin growths, wrinkle removal and tattoos on her eyebrows. After undergoing the abdominoplasty in November, Mrs. Lynn was unhappy with the unsightly scar

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\(^78\) David B. Sarwer, ‘Plastic Surgery in Children and Adolescents’ in J. Kevin Thompson, Linda Smolak (eds.) *Body Image, Eating Disorders, and Obesity in Youth: Assessment, Prevention, and Treatment* (American Psychological Association 2001)

\(^79\) Verwey and Carstens (n 52) 445

Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

on her abdomen, which prodded her to institute a case of medical malpractice against Dr. Hugo based on his failure to obtain informed consent. Her first allegation was that Dr. Hugo had not advised her to undergo less intrusive alternatives to a full abdominoplasty, especially keeping in mind the fact that she had already undergone liposuction in that area just a few months earlier. Her second allegation was that she was incapable of giving informed consent because she had Body Dysmorphic Disorder, and Dr. Hugo was aware of the fact that, between 1986 and 1990, Mrs. Lynn had been under psychiatric treatment. It was her further contention that her psychiatric history coupled with her unusually high demand for surgical correction should have cautioned the defendant of her mental ailment which fed her demand for excessive surgeries and prohibited her from appreciating the associated risks and benefits. At the least, she expected that the defendant should have consulted a mental health professional before performing the second surgical procedure on her. After much litigation, the case was dismissed by the Court of Appeals of New York in 2001, since there was no evidence that the patient was suffering from Body Dysmorphic Disorder at the time of the surgery or that she was incapable of making an informed decision. The Appellate Court also held that the defendant had informed the patient about the risks associated with the surgery and that the patient had consented to these risks in writing.81

Disclosure of the ‘rarest of the rare’ risks: When the plea of lack of informed consent is taken by a patient, the law requires the patient to prove that a complication or risk which was not explained to the patient did in fact occur and that the patient would not have undergone the surgery if informed of that particular risk or complication. Cosmetic surgeries are fraught with risks. This poses some amount of difficulty for cosmetic surgeons, since they are required to inform the patient of the ‘rarest of the rare’ risks involved in the surgery. This is not an easy task because a cosmetic surgeon may not always be in a position to apprise the patient about all the possible reactions and side effects that a particular surgery may give rise to.

81 Lynn v. Hugo 752 N.E.2d 250, 251 (N.Y. 2001)
In *Martelli v. Reardon*, the defendant doctor had to pay the plaintiff damages to the tune of $738,100 for the lack of informed consent. In June 1995, the plaintiff had a facelift and the surgical reconstruction of an eye-lid. After undergoing the procedures, the plaintiff developed permanent numbness behind the right ear extending to the angle of the jawbone and chronic facial pain which included sensations of shock over the right side of her face. Plaintiff alleged *inter alia* the lack of informed consent. Defendant claimed he was aware of the foreseeable risks, but had not disclosed the same to the plaintiff because the complications which arose were extremely rare.

The Canadian law on the subject of informed consent is very interesting, and it requires physicians to inform patients if a particular procedure they intend to undergo is merely elective and not medically necessary, as such information enables the patient to postpone or forego the treatment. In *White v. Turner*, the landmark case on the issue of disclosure, the court held that, when an operation is optional, risks that are negligible must also be disclosed to patients. In another case, an attractive young woman underwent a rhinoplasty to reduce the size of her nose, and the defendant surgeon failed to mention the risk of scarring which was about 10 percent. Unfortunately, the risk was realized, and the plaintiff’s nose was left with a scar and indentation, which subsequent surgery would not be able to remedy. The plaintiff instituted an action of negligence against the defendant, based, *inter alia*, on the fact that he had failed to inform her of the risks involved. The court held that surgeries performed for purely cosmetic purpose carry with themselves the requirement of a very high degree of risk disclosure.

82 New York County (NY) Supreme Court, Index No. 12414/97
83 Shiffman (n 43)218
84 (1981) 15CCLT 81(Ont.)
86 Verwey and Carstens (n 51) 650
In *Veena Sethi v. Dr. J.B. Ratti*, the Delhi Consumer Disputes Redressal Commission found the doctor guilty of deficiency in service for not giving adequate details about the procedure to the patient, for his failure to inform about the after-effects of surgery and the subsequent corrective treatment that would be necessary to remove the scars and rectify disfigurement suffered in the arms. The patient had decided to undergo liposuction at the doctor’s clinic after seeing an advertisement in a local daily. The complainant was assured that she would lose 50kg to 60 kg of weight the very same day. After the procedure, the complainant found that there were long cuts and scars in both her arms and that she had undergone lipoplasty although the advertisement mentioned liposuction. The State Commission found the doctor guilty of medical negligence, since the complainant suffered due to the false representation of the doctor who had been negligent in conducting the procedure. The State Commission ordered the doctor to pay a compensation of fifty thousand rupees to the patient for the deficiency in service.

Although, in therapeutic medical surgeries, it is often felt that minor or remote risks need not be informed to the patients for fear that they may decline to give consent to a procedure that could cure them of their ailment, the same cannot be done in cases of cosmetic or aesthetic surgeries. This is primarily because a minor aberration in the expected result may be of no consequence to one patient, but it may be highly relevant to another. For instance, a slight scarring on the skin after a nose reconstruction surgery may be of great importance to an actress, but it may not be so for a home maker.

**Risk tolerant attitudes of cosmetic surgeons and its consequence on patients:**
Patients, especially women, are often influenced by cultural norms and societal perceptions that fuel their desires to attain a body which conforms to the definition of beauty ordained by society. Similarly, surgeons who operate upon patients are very much a part of the same social and cultural fabric. Their

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88 Rao (n 41) 877
discernment of female beauty within the same cultural mould might direct them to be more tolerant to high risk surgeries or to even downplay the risks involved, which they would otherwise be more conscious of in the absence of such predefined norms of beauty. Thus, the risk tolerant attitudes of cosmetic surgeons may affect the patient’s ability to make informed decisions, since they would not be adequately informed of the risks and complications of the surgeries they are consenting to, even though they may formally put their signatures in the consent forms. This may subsequently lead to disastrous consequences if complications do arise, because after giving an informed consent, a patient may find it difficult to prevail in a case instituted against the cosmetic surgeon.

**Cosmetic surgery on minor patients:** Cosmetic surgeons have to be doubly sure about securing valid consent before operating upon any minor patient. In India, the age for giving valid consent to medical treatment is 18 years and, thus, before treating a minor, the cosmetic surgeon must obtain consent from the parent or guardian. In some of the western countries, the concept of a “mature minor,” i.e., a minor who is mature enough to understand the repercussions of the medical procedures he undergoes, is well recognized, although the same has not gained acceptance in India. Cosmetic surgeons must be extra cautious in dealing with patients who, although minors, may represent themselves to have attained majority, since the onus of ascertaining whether the patient is a minor or a major is on the doctor. The argument gaining momentum in the West, especially in America, is that children should not be exposed to cosmetic surgery unless it is found to be medically necessary. Cosmetic surgeries on minors suffering from cognitive disabilities bring in further ethical considerations for cosmetic surgeons. For children with disabilities, the cosmetic surgery undertaken may be psychologically beneficial for the parents, like, for instance, facial plastic surgery on children suffering from down syndrome may ultimately benefit the parents who would like the world to perceive their children as ‘normal,’ but the children operated upon may never be in a position to appreciate the advantages of such surgery. In such circumstances, whether a cosmetic surgeon

Role of Consent in Cosmetic Surgeries and Enhancements: A Comparative Analysis

should look into the risks and benefits associated with the surgery from the perspective of children or their parents before securing their informed consent is a question worth looking into.90

Some of the issues related to consent that are faced by patients and doctors and the differences between traditional therapeutic medical treatment and aesthetic surgeries, as pointed out herein before, merit additional safeguards for the doctor as well as the patient for increased disclosure and informed consent requirements.

CONCLUSION

Cosmetic surgeries and enhancements are one of a kind for more reasons than one. The purposes for which people undergo cosmetic surgeries are diverse. While a pathological test may reveal that a person is suffering from hyperthyroidism or that one has high or low blood sugar, it is extremely difficult to ascertain what makes an individual aesthetically beautiful or what ensures that they have attained the ideal weight. Such norms and standards that individuals set for themselves are highly subjective, which makes it a herculean task for cosmetic surgeons to ascertain what a patient hopes to achieve by a particular cosmetic or aesthetic intervention. Securing valid consent is a sine qua non in all medical surgeries and procedures. Cosmetic surgeries and procedures are no exception. From the standpoint of the doctor, a valid consent acts as a valid defence and prevents legal complications that may arise in case the patient alleges that he or she was subjected to treatment without consent. A patient, also, stands to benefit from a valid consent. Since the consent form is supposed to include all the details about the intended treatment or surgery, any deviation from the same can be brought to the attention of the doctor, and legal remedy may be sought. The importance ascribed to consent in cosmetic procedures is further magnified when the liability that a doctor can attract for treating a patient without consent is considered.

One must also be conscious of the issues associated with the securing and giving of informed consent in cosmetic surgeries, both from the perspective of doctors and patients and efforts must be made to remedy the same. For the differences that exist between cosmetic surgeries and therapeutic medical interventions there is a heightened need for prior communication and consultation between the doctor and patient, pre-procedure investigations, photo-documentation and the recording of consent that is well-documented, before the commencement of the procedure.

Adequate information disclosure that allows a patient to make an informed choice is an unassailable element of the consent procedure. So far, the Bolam Test of English import has been adopted by Indian Courts in assessing standards of information and risk disclosure in cases of alleged medical negligence, which requires doctors to adopt a paternalistic stance and give patients the minimum level of information required to consent to treatment. There has been a change in this standard in the United Kingdom post the decision of the Supreme Court in Montgomery v. Lanarkshire Health Board.91 This case departs from the standard laid down by the House of Lords in Bolam and enjoins upon the doctors to give details of all “material and significant” risks associated with any suggested line of treatment or the alternatives proposed before securing consent.92 This shift demands an approach to be adopted by medical professionals that requires them to consider information disclosure from the standpoint of a reasonable and prudent patient - a patient centered approach, initially espoused by the United States Courts of Appeals, District of Columbia Circuit in the case of Canterbury v. Spence.93

In India, doctors have been held guilty of deficiency in service for failing to make adequate disclosures to patients before taking consent. In cosmetic procedures, information and risk disclosure assumes great importance since

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91 [2015] UKSC 11
93 1972 [464] Federal Reporter 2d. 772
patients may choose to not undergo a purely elective surgery if they find that the risks far outweigh the benefits they would derive from it. On the other hand, even if they decide to undergo an otherwise risky procedure, patients have the right to be informed of all consequences that their bodies are likely to face. Cosmetic surgeries also present unique challenges to doctors, since patient autonomy largely governs the practice and drives it and leaves little room for information imbalance between the parties. Moreover, patients of cosmetic surgeries squarely fall within the purview of the Consumer Protection Act, 2019, which has granted statutory recognition to information disclosure by the service provider by identifying deliberate withholding of relevant information from the consumer as a ground for deficiency in service.

In *Samira Kohli v. Dr. Prabha Manchandha,* the Supreme Court acknowledged the shift towards the disclosure standards laid down in Canterbury, but continued to apply the *Bolam* test taking into account the ground realities in India where the overwhelming majority continues to be ignorant about medical science and treatment alternatives. Elective cosmetic procedures are voluntarily opted for by patients to alter the outward show of an otherwise ‘normal’ bodily feature. They are usually better informed about the procedure they want to undergo, unlike patients who submit themselves to the doctor’s judgement to treat ailments they are afflicted with that often surface with no prior warning. With the commercialization of the medical field in India, a move towards greater information disclosure for all medical procedures is required, but the need is further heightened for the field of cosmetic surgery, and this should be formally recognized by the legislature as law, to safeguard the interests of both patients and doctors.

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94 *(2008)2 SCC1.*