Cosmetic surgery for children and adolescents. Deontological and bioethical remarks

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Abstract

The only interventions deemed ethically acceptable are those that serve the “objective interest” of the minors involved from the standpoint of and conducive to sound mental health and balance in a patient’s teenage years; by the same token, disproportionate interventions (e.g. overly invasive or pointlessly risky), or all those deemed unsuitable with regards to a poor cost-benefit ratio are viewed as unacceptable.

In the process of considering the best interest of the minors involved, a wide array of factors come into play, such as: age, maturity, psychological and emotional conditions, motivations put forth by the underage patient, the opportunity to procrastinate the operation: parents, who are naturally entitled to give consent to the surgical procedures, and physicians are primarily liable to safeguard and act in the minor’s best interest.

The authors attempt to lay out how medical science has evolved over the past century, and aim to set forth an array of considerations centered on cosmetic surgery for adolescents. Clin Ter 2017; 168(6):e415-420. doi: 10.7417/CT.2017.2044

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Introduction

Over the past century, scientific and technological advancements have profoundly changed the world of medicine, suffice it to mention the rate of progress in transplants (1,2), the discovery of stem-cells (3) and new psychoactive substances capable of improving learning abilities or memory (4). Technology has produced ever more reliable tools and devices, which have enabled doctors to quickly diagnose diseases (5), but which have also given rise to ethical issues and especially conscientious objection practices (6) as far as medically assisted procreation procedures are concerned (7-11), as well as end of life treatments (12-13). In 21st century medicine is characterized by an extremely high degree of specialization (14) and by a great deal of contradictions. too: on the one hand, predictive medicine makes it possible to find out about possible illnesses, on the other hand hospital-acquired infections (15) and uncontrollable adverse events in delivery rooms (16-18) continue to take lives. Another distinctive trait of 21st century medicine is that it is no longer limited to restoring health and curing diseases, but it can make wishes come true and has the stated goal to improve one’s looks, as is the case with cosmetic surgery.

In today’s society, the urge to look well in terms of physical appearance seems to be gradually outweighing the inner self and inherent human worth of an individual.

Such a trend is particularly detectable in youths, who in the pre-pubescent age often present entrenched dissatisfaction with their looks and physical attributes. Their requests to undergo cosmetic surgery are often grounded in a stated goal to attain “ideal” physical beauty which is propagated and spread through the media, which is widely thought of as a means to assert oneself socially (19-20).

Therefore, it is not necessarily easy to discern to what extent such dissatisfaction is due to age-related issues as opposed to real, blatant physical flaws.

For such reasons, the Italian National Bioethics Committee has seen fit to enhance awareness among cosmetic surgery professionals as to the hazards that their messages may convey, setting up paragons of physical beauty that might lead youngsters to reject what they see in the mirror (21).

In light of such unintended consequences, it would be advisable to introduce legislation guidelines barring the conveyance of similar ambiguous messages, which might cause minors to reject their own image, as well as lead to social self-marginalization, especially in TV time slots when a vast audience of adolescents might be watching.

Researchers concur that cosmetic surgery may be instrumental in improving an individual’s social and working life, as well as emotional interactions, especially in patients negatively affected, from a psychological standpoint, by their real or perceived physical flaws.
For all of the above-mentioned reasons, Italian lawmakers have effectively barred mammoplasty from being performed on underage girls for mere aesthetic reasons, with the sole exception of serious congenital malformations; such law is specifically crafted in order to prevent such surgery from being performed on adolescent girls who are still in process of physical development that might give rise to a natural growth of the mammary glands, which in turn might lead the girl to a different perception and awareness as to the real need to undergo such surgery (22).

In the light of these societal changes, new reflections arise about how far the lawfulness of surgical treatment with aesthetic purposes arrives. The purpose of this paper is to analyze the ethical and legal aspects of performing plastic surgery on minors, through the examination of the legislation and the ethics committees’ statements, focusing on informed consent and the legitimacy of these treatments on minors with disabilities.

Cosmetic surgery in minors

In the case such as a minor requesting plastic surgery, the underlying ethical, legal and psychological implications are all the more relevant. It is well documented how some physical conditions and flaws may give rise to severe psychological unease and distress and thus take up considerable significance which might pressure the minor to seek surgery.

It is therefore essential to figure out to what extent such decisions can be prompted by external pressure, including media-induced perceptions (23). Having prefaced that, it is worth bearing in mind that any surgery, barred emergency cases, cannot take place without patient’s consent. Such a principle holds true for underage patients as well.

The enforcement of any minor’s rights is carried out by his or her parents, or any party exercising tutelage over him or her, until the legal age of majority has been attained.

Consequently, given how the minor is in no condition to give a legally binding consent, such an informed consent needs to be granted by his parents, as exercising tutelage over him or her.

Nevertheless, a minor’s role in reaching such an informed consent is pivotal.

In such respect, it is worth noting how the Charter of Fundamental Rights of the European Union (24) states that minors can freely express their opinions on such matters as those relevant and affecting them as to their age and maturity (art. 84). By the same token, the Oviedo Convention (25) states in article 6 that “Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorization of his or her representative or an authority or a person or body provided for by law. The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.”

According to the Italian National Bioethics Committee, “it is unlikely to consider the concept of informed consent or dissent before the age of 7. At a later stage, once the child has further explored his or her motivations, comparing them to other people’s actions and views, it is conceivable to consider his or her informed consent, or dissent, coupled with the parents”. Upon attaining the age of 12, in adolescent age, such a concept can be taken into account with progressively greater awareness.

As a matter of fact, such assessment needs to be made on a case-by-case basis, since a minor’s cognitive skills may greatly vary “in relation to individual development and the degree of complexity that a given situation involving a minor may carry” (26-27).

The relevance of a minor’s involvement in healthcare-related choices affecting him or her also surfaces in the “Charter on the rights of hospitalized children”, laid out by four major Italian hospitals. Such a document states, in Articles 7 and 8, that “a child-patient is entitled to be informed as to the procedures he or she is due to undergo, in such a language that is both understandable and befitting his or her stage of development and maturity. Child-patients are entitled to freely voice their opinions pertaining to any issue that might impact them. Such opinions “must be taken into account, considering the child’s age and maturity” and that “children have a right to get involved in the decision-making process producing informed consent or dissent towards the medical procedures they are set to undergo”(28).

The above-mentioned guidelines acknowledge the growing relevance of a child-patient’s opinion in proportion to their age and level of maturity and awareness. Nonetheless, no law entitles minors to decide independently, therefore they, however discerning and clear-sighted they may be, cannot legally grant or deny consent to any medical or surgical procedure without their parents’ involvement.

Parents serve as “mediators” of their child’s will, but they function as guarantors and safeguards as well, therefore they need to make reasonably sure that the motives at the root of any intervention not be swayed by unrealistic or far-fetched expectations, possibly dictated by unattainable standards of beauty (29).

Parents’ decisions, as mentioned before, cannot carry absolute weight, but rather need to be reconciled with the children’s, in keeping with the consistent furtherance of the child’s personality.

If, for instance, in order for some plastic surgery to be performed on a minor the parents’ consent turns out to be necessary, it would be up to the minor to express his or her wish to undergo such a procedure, having been made aware of any potential benefits which might stem from it, as well as of its limits (30).

Information in cosmetic surgery on minors

In most cases, cosmetic surgery is not necessary. It is generally aimed at fixing aesthetic flaws and, as such, it needs to be informed on thoroughly and exhaustively as to what extent it might result in significant improvement in that respect (31-32). Italian Supreme Court states that in case of aesthetic surgery the informed consent must be even more detailed than that for other treatments, because the patient is healthy and he is not asking for a life-saving or urgent procedure (33).
Comprehensive debate and counseling are therefore absolutely necessary, which may lay bare the real motivations prompting the minor to choose to undergo cosmetic surgery.

Such discussions should bring to the table any alternative or further measure or treatment, with respect to cosmetic surgery, which could be instrumental in dealing with and possibly overcoming any state of distress or anxiety that children may face.

It is well established how at the basis of any medical decision lies the need of healthcare professionals to provide as thorough and accurate an information as possible in terms of contents and practices, which encompasses every aspect of the surgery at hand, formulated in such a way as to be suitable and consistent with an individual’s comprehension skills and their mental state (34).

Information pertaining to minors is even more crucial. As a matter of fact, the Italian Code of Medical Deontology states that every physician must provide underage patients with all elements “for them to understand their health condition and all diagnostic and therapeutic treatments due to be undertaken with the purpose of getting them involved in the decision-making process” (art. 33), and “it must take into proper consideration the minors’ opinions throughout the decision-making process affecting them” (art. 34) (35-36).

Such communication and counseling procedures are key in assessing the appropriateness of any intervention, factoring in the patient’s expectations, the risk-benefit ratio, not merely from a clinical standpoint: such a choice, for all of its peculiarities highlighted here, should be geared towards the child’s best interest.

One needs to consider how a child-patient is still devoid of his or her fully developed decision-making skills, and is going through a phase of abrupt, fast development, which makes it necessary to estimate possible benefits stemming from the intervention, not only at the current juncture, but over the long term too.

That’s why, in addition to the clinical aspect, it is just as important to take under advisement the emotional one, by means of an exhaustive evaluation of the patient’s maturity and decision-making skills, in order to establish just how much weight his or her will should carry.

Such interactions can go a long way in assessing an underage patient’s expectations as to the physical change as well as enhancing awareness of the limits inherent in cosmetic surgery and the risks and complications involved.

In light of such considerations, a postponement of the surgery should not be ruled out, to a later stage at which the patients may have gained a higher degree of maturity and awareness.

Therefore, if a doctor views a minor-patient as capable of self-determination, any possible discrepancy between the minor’s choice and his or her parents’ or tutor’s compels the physician to try and bridge the gap, through psychological counseling.

Later on, once acknowledged the different positions as irreconcilable with no shared decision possible, the healthcare professional must bring the case to the attention of the courts.

Along the same lines, the Italian National Bioethics Committee asserts that there are limits to the suitability of cosmetic surgery interventions, unless they meet the standards of objective interest of the patient from the standpoints of physical health, mental balance of the adolescent age and carves in stone the principle of “unacceptability” of disproportionate surgical procedures, namely overly invasive ones or needlessly risky and ill-suited as far as the intended benefits hoped for by the patient go.

It is therefore essential to abide by the principle of “proportionality”, i.e. the assessment of any intervention’s suitability and advisability, based on a risk-benefit ratio, and as related to the minor’s psycho-physical conditions, the functionality of the organs involved as well as the results being pursued by the patient (37).

On the other hand, psychological vulnerability and instability on the part of the minor, who is in the midst of a process of identity development, may sway his or her capacity to make a decision with regards to a surgical procedure which should be totally devoid of any external pressure and conditioning, that is absolutely aware (38).

The American Society for Aesthetic Plastic Surgery has laid out a set of guidelines to assess teenagers requesting cosmetic surgery and their “suitability” in terms of physical development and degree of maturity attained, which is the prospective patients’ ability to a) properly assess the benefits and limits of the procedure, b) hold reasonable expectations, c) properly understand the risks that the surgery entails as well as the set of post-operative limitations (39).

**Cosmetic surgery for minors with Down syndrome**

Preliminary information before aesthetic surgery operations aimed at improving unsatisfactory facial features needs to be particularly straightforward, for the sake of clarity.

A surgeon needs to act even more cautiously when asked to intervene on Down syndrome sufferers, given their condition of double weakness, as minors with Down syndrome.

As far as the desire on the part of an adult to modify his or her body is not unacceptable, a different issue arises when parents want their children to go through such procedures (aimed at improving facial features typically ascribed to children with Down syndrome) by virtue of their suffering from such a syndrome (40).

The main factors prompting parents to make such a decision are the desire to “neutralize or minimize as much as possible the manifestation of abnormality they see on their children’s faces” as well as the urge to “reduce the social stigma and stave off any reaction leading to rejection, even more so in those social settings where the culture of integration may be underdeveloped”. In this vein, it needs to be carefully weighed whether to make minors with Down syndrome, who are naturally incapacitated to understand and give their informed consent due to their condition, undergo such surgical procedures.

In this respect, two different scenarios usually surface: if the cosmetic surgery is therapeutic in nature, as it aims for a functional improvement through the resolution or attenuation of disabling physical issues (e.g. macroglossia or nasal nostril stenosis which may compromise the patient’s ability
to breathe, etc…), then the parents’ consent is completely legitimate, given the existence of precise clinical prescriptions towards the surgery, thus preserving the principle of beneficence (41).

If, on the other hand, the surgery is solely aimed at an aesthetic goal, the surgeon should turn down the parents’ request, since the operation has no functional usefulness and it could only be performed with the patient’s informed consent.

In fact, if, as stated before, the therapeutic aim of cosmetic surgery targets the patient’s psychological welfare, it is apparent how such a procedure could only be administered if the individual declared unequivocally how his or her physical flaws were negatively affecting him or her psychologically; such a request cannot come exclusively from the parents.

As a matter of fact, some physical abnormal traits, such as epicanthal folds may abate as the child grows up, and some other flaws, such as tongue protrusion can be improved with simple exercises (42).

The tongue is a mobile, very vascularized organ, and surgery may give rise to complications such as infection and airway obstruction (43-44).

Over the course of the operation, taste buds are partially removed, and this may bring about taste defects.

Furthermore, only rarely is phonation positively affected, whereas clinical studies have registered even a worsening of it in 10% of cases (45-46).

The National Bioethics Committee claims that even those operations seeking to meet functional needs should be cautiously planned out, given “their complexity and painfulness, their not solutional nature, and the fact that several physical traits and flaws may abate as age progresses”.

As far as Down syndrome children are concerned, the wish to improve their facial features rests with the parents; the surgery is not based on the presumptive will of the child-patient, and it has a steep price in terms of physical pain, with no guarantee that the results hoped for will be attained or the patient’s quality of life will be enhanced, attenuating the facial features commonly associated with Down syndrome children.

The issue of cosmetic surgery being performed on Down syndrome patients should also be dealt with without overlooking the possible problems arising from anesthesia, post-operative course and the need for hospitalization itself, given the frailty of Down syndrome children, or more broadly of any minor who is hospitalized in an institution, removed from his family setting, also considering the fact that children and adolescents constitute a particularly vulnerable group, since “still in the process of developing an awareness of their bodies, time, future, with no ability to acknowledge the importance of their being hospitalized and related procedures”.

Other issues to be weighed are the pain endured by patients in the aftermath of such invasive procedures, the possibility that the prosthetics might move from their implants, the need for further surgery as the child grows up. Therefore, in such cases, regardless of the parents’ knowledge of these data, their consent is not enough to view cosmetic surgery on a Down syndrome child as suitable. In fact, the principle of beneficence makes it clear how attempting surgery is to be considered as last resort, i.e. when it is not feasible to achieve the same functional results in any other way.

The principle of proportionality turns out to be pivotal, that is the proper evaluation of suitability and desirability of similar procedures based on a thorough cost-benefit ratio, as related to the psychological and physical conditions of the child patient, the functionality of the organs involved and the results expected by each individual patient.

In conclusion, the issue of the suitability of surgical procedures should be sorted out on a case by case basis (46).

Final remarks and conclusions

The crux of the matter is the concept that acceptance of one’s disabilities is not necessarily bound to bodily alteration, but rather to personal recognition and validation, best exemplified in the relationship with and acceptance of one’s existential condition.

In light of an Italian National Bioethics Committee’s opinion, there do not seem to be any founded ethical reasons apt to justify, towards any Down syndrome sufferer, any treatment other than the conventional ones usually carried out on minors or mentally disabled individuals who, insofar as unfit to exercise those personal rights which are vested upon them, may not be made to undergo any medical treatment barring health-preserving ones.

The valid alternative is then to acknowledge these children’s dignity and humanity beyond their disabilities but, first and foremost, to carry out a thorough assessment as to the effectiveness of any feasible solution by means of a strict cost-benefit ratio evaluation with only the minor’s best interest in mind.

Cosmetic surgery is no solution to these children’s issues. The decision, on the part of the parents, to surgically alter a child’s facial features gives rise to positive consequences in terms of benefits, but adverse ones in terms of costs for the parents, the child and the surgeon him/herself.

The child might end up feeling more accepted by his peers, hence gaining psychological benefit from that, while at the same time bearing the burden of more invasive procedures and correlated post operative risks, with the considerable suffering that might ensue.

Parents might gain psychological relief too, arising from the sight of their child’s improved appearance, more akin to “normalcy” and from witnessing how their child may be better accepted by his peers, having become more similar to them; at the same time, they are exposed to significant psychological distress, stemming from their child’s suffering.

The surgeon might be satisfied with fulfilling the parents’ wish, and in case of a successful procedure, with his contribution to the child’s life improvement.

The burden on the surgeon, from the deontological standpoint, is his awareness of having performed surgery without valid patient’s consent, and without a real therapeutic purpose.

The rational which compels parents of Down syndrome youths to weigh cosmetic surgery for their child is understandable, and starts when the child is born, since their consciousness that their child will never be like the other children breeds anguish and despair.

They think about their child’s future when they will no
longer be by his or her side, since, provided that national legislations of all countries are geared to safeguard the disabled, they realize that within society, those deemed to be different are often discriminated against.

Parents of children with Down syndrome, in good faith or out of desperation, consider surgically altering a child’s features embody something wrong with the environmental context they inhabit.

Society must provide them with the proper support and to that end a key role is played by healthcare professionals (pediatrician, pediatriic neuropsychiatrist, psychologist, physiotherapist, speech-language pathologist).

Such clinicians should advise the parents and answer their requests, such as those pertaining to cosmetic surgery.

Significant help may come from those families who have lived through the same experiences, e.g. the several associations comprised of Down syndrome children and families.

Among these, many have grown to become well-established realities, relying on outstanding organizational structures and the ability to constitute relevant sources of information and education for parents, children, professional operators and everyone else who has the best interest and future of Down syndrome sufferers at heart.

After more than 30 years since the first operations, there is no scientific paper and data to bear out the theory that surgically changing a child’s features might increase the likelihood of successful social integration or bring about an improvement of their cognitive skills.

By virtue of that, it is not suitable to recommend any complex and painful surgical procedure which, in all likelihood, will not yield the results it is meant to. In fact, there is no scientific evidence suggesting that a surgical modification of children’s facial features will help them blend in the social fabric.

On the contrary, according to several scholars (47), it would appear that a child, in the aftermath of a physically altering operation, might go through an identity crisis because, looking at him/herself in the mirror, fails to recognize his or her own face.

The fallout from that is on the one hand, the child might feel estranged from his or her own image and end up rejecting it, and on the other hand he or she might feel rejected by his or her parents as well. In similar cases, the surgery, far from resulting beneficial, might engender additional issues. Altering one’s appearance does not diminish the risk of being marginalized for the disabled, because the real hurdle does not reside only in their looks. In point of actual fact, Down syndrome entails mental retardation which may be of medium or high severity, and such a disability persists, improved looks notwithstanding. Most parents have come to realize the futility of such surgeries, which have been performed extremely rarely, anywhere in the world (48).

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