Scientific Forum

The Patient’s Right to Self-determination: Complexities of Informed Consent

There is a seemingly endless variety of information available to educate patients about aesthetic plastic surgery and other cosmetic treatments, ranging from Web sites to surgical videos. As a result, a patient often arrives for the first consultation with unrealistic expectations as well as misconceptions about the risks associated with cosmetic surgery. In order to make informed decisions that are both personally and medically appropriate, the patient must truly understand the risks and benefits of the available treatment options.

The process of informed consent is an opportunity for the plastic surgeon to build a relationship of respect and trust with the patient. At the same time, it fulfills one of the physician’s most important responsibilities—ensuring that patients are given information that enables them to make informed choices about their health care.

First and foremost, the doctor-patient relationship must be an ethical one. A physician must respect the patient’s right to self-determination and provide the patient with the information needed to make a rational decision. Understanding risk is a crucial step in this decision-making process, and effectively communicating risk is a complex task. One of the most basic questions in informed consent is whether it is necessary to address all conceivable risks, only those that occur frequently, or only those of recognized importance. Whether a risk is material is a function of its severity and the frequency of its occurrence. It is unrealistic to expect physicians to discuss with their patients every risk of a proposed treatment, no matter how small or remote.

There are 5 basic dimensions of risk, which should be explained to patients to facilitate informed consent.

1. What are the pertinent undesirable outcomes? Do these relate to surgery (eg, infection, bleeding, scarring) or to a medical device (in the case of breast implants, for instance, capsular contracture, rippling, deflation)? Is additional advisory information (eg, on breast implants and mammography) needed?
2. How permanent is the potential undesirable outcome? Its possible severity, remedy, and permanence are all factors affecting the patient’s decision.
3. When might the unwanted outcome occur? Negative outcomes may occur in the perioperative period or later (eg, capsular contracture around a breast implant, late deflation). Patients often think of future risks and immediate risks differently.
4. What is the probability of the unwanted outcome? Quantifying risk for patients remains a challenge in informed consent, but the growing body of clinical and scientific literature concerning many aesthetic procedures is an invaluable educational resource. For example, in the case of saline-filled breast implants, we can now pro-
vide data from several well-designed studies showing the incidence of implant deflation over a given period.

5. How significant is the unwanted outcome to the patient? Patients will inevitably rate subjective "badness" differently. However, some patients have difficulty relating to statistical data, and they may underestimate or overestimate the significance of a particular risk. It is important for the physician to facilitate an accurate perception of objective data.

Patients may misinterpret risk information on the basis of personal values, biases, and media influences. They may be subject to anchoring bias, in which they estimate their risks on the basis of familiar risks (e.g., a family member developed deep venous thrombosis after abdominoplasty). Patients may overestimate a risk factor that has achieved notoriety in the media (e.g., autoimmune disease alleged to have been caused by breast implants). Compression bias involves the overestimation of small risks and the underestimation of large risks. Miscalibration of confidence ("This will never happen to me") leads to an assessment of risk that is less than realistic.

One of the greatest challenges in informed consent is helping patients understand the meaning of statistics on a personal level. A patient may face a given treatment with the reassuring advice that the chances of a serious complication are only 1 in 100, but if the complication occurs, its incidence is 100% for that patient. Simply altering the scale in which risk is placed can alter the patient’s perception of risk.

Helping patients understand risk may require a multifaceted approach. After describing an undesirable outcome, the physician might explain the frequency of the outcome using several methods, such as qualitative terms, statistical expressions, graphs, and examples from everyday life. A comprehensive strategy accommodates patients with diverse preferences and learning styles.

Consent forms do have value, inasmuch as they establish that the patient had an opportunity to read the information contained within. If a complication does arise and the consent form included a description of that particular risk that was adequate for the patient to have made an informed decision, it will be of help in a physician’s defense in a lawsuit.

A well-written informed consent document has tremendous educational value. Conversely, a document written in legalese that looks like a laundry list of potential complications may be viewed by patients as a medical Miranda advisory. The message from a poorly written consent document is clear: the physician is more interested in protection from liability than communication with patients.

The best approach is to treat patients as people and to be sensitive and compassionate. Most of all, it is imperative to communicate openly with patients, keeping in mind that informed consent is a process during which you can learn about your patient’s decision-making style. Do not press patients to decide quickly. Do not make them feel that you do not have time for them. If you do, regardless of how much information they are given, you will have lost the opportunity to use the informed consent process as a way to develop the best kind of doctor-patient relationship.