The Physician's Duty to Screen Patients for Elective Surgery

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Elective surgery is surgery that is not immediately required.[1] It is planned for the convenience of the patient,[2] and is dependent upon the desire of the patient as well as the mutual agreement of the patient and physician.[3] Cosmetic surgery, abortion, sterilization and sex change operations can all be forms of elective surgery.[4] The demand for various types of elective surgery is greatly increasing.[5] The demand for cosmetic or aesthetic surgery has increased by more than six thousand percent since 1946.[6] The demand for abortion[7] and elective steriliza-

1. TABER'S CYCLOPEDIC MEDICAL DICTIONARY E-12 (13th ed. 1977); DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 499 (25th ed. 1974).

2. TABER'S CYCLOPEDIC MEDICAL DICTIONARY, *supra* note 1, at E-12.

3. *Id.*

4. Cosmetic surgery is elective surgery to improve appearance. Wright & Wright, *A Psychological Study of Patients Undergoing Cosmetic Surgery*, 101 ARCH. OTOL. 145 (1975). Surgical sterilization may also be elective. For a discussion of vasectomies, see Lombard, *Vasectomy*, 10 SUFFOLK U. L. REV. 25 (1975). Discussing elective sterilization generally, see Note, *Elective Sterilization*, 113 U. PA. L. REV. 415 (1965). Although sex change operations may be subject to the preliminary critical evaluation and final approval of medical boards, *see* Money & Schwartz, *Public Opinion and Social Issues in Transsexualism: A Case in Medical Sociology*, in TRANSSEXUALISM AND SEX REASSIGNMENT 261, 273-75 (R. Green & J. Money eds. 1969), they too are elective in that the patient chooses to undergo surgery that is not immediately required and then proceeds to persuade a physician to perform the procedure. Knorr, Wolf, & Meyer, *Psychiatric Evaluation of Male Transsexuals for Surgery*, in *id.* at 271, 273. A woman's decision to have an abortion may also be elective. Consulting with her physician, a woman must weigh mental, emotional, and physical factors in deciding whether to have a child. Roe v. Wade, 410 U.S. 113, 155 (1973). Unless the mother's health is in danger, an abortion is not immediately necessary, but rather, is a product of choice.

5. Uhlman, *Incidence of Vasectomies Refused and Reasons for Refusal*, 89 PUB. HEALTH RPT. 447-49 (1974); Ziegler, Rodgers, & Kriegsman, *Effects of Vasectomy on Psychological Functioning*, 28 PSYCHOS. MED. 50 (1966); *see About the Boom in Plastic Surgery*, U.S. NEWS & WORLD REP., Sept. 16, 1974, at 67. In the western United States, in 1960, approximately seven percent of the husbands of fertile wives had had a vasectomy. Ziegler, Rodgers & Kriegsman, *supra*, at 50.

6. *About the Boom in Plastic Surgery*, U.S. NEWS & WORLD REP., Sept. 16, 1974, at 67. With the nose-job (rhinoplasty) and face-lift (rytidectomy) by far the most popular surgical procedures, the number of operations performed for cosmetic reasons has bounded from approximately 15,000 in 1946 to one million in 1972. *Id.*

7. *See* Tietze, *Legal Abortions in the United States: Rates and Ratios by Race and Age, 1972-1974*, 9 FAM. PLANN. PERSP., Feb. 1977, at 12. "Prior to 1970, relatively few women were able to obtain legal abortions in the United States . . . ." *Id.* Between 1972 and 1974, however, 2,229,070

tion[8] is also rapidly climbing. Despite the rising popularity of elective surgery, doctors realize that not everyone who requests surgery is psychologically fit to be treated.[9]

The term "psychologically fit" includes patients who are merely neurotic.[10] Neurotic patients are quite common, and often have a very good prognosis.[11] Nevertheless, some patients present psychological problems sensitive enough to warrant a surgeon's close scrutiny. A plastic surgeon should keep in mind a list of danger signs that may alert him to the possible unsuitability of a patient to undergo surgery.[12] For instance, excessive pressure by family members to have surgery, vague reasons for desiring surgery, unrealistic expectations of the results of surgery,[13] and indications of psychotic or schizophrenic personality[14] are all danger signs. Physicians performing abortions[15] and elective sterilizations[16] should beware of similar signals that make surgery inadvisable.

Elective surgery differs from other kinds of surgery in that usually it is the patient who prompts the physician to perform the operation.[17] Because a request for elective surgery is the product of individual preference, such a request can be indicative of underlying psychological conditions.[18] The actual motivations of patients desiring elective surgery are not always apparent. Doctors prefer that the motivation for

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legal abortions were reported. *Id.; see also* Schwartz, *The Impact of Voluntary Abortion on American Obstetrics and Gynecology*, 42 MT. SINAI J. MED. 468 (1975).

8. Ziegler, Rodgers & Kriegsman, *supra* note 5, at 50; Uhlman, *supra* note 5, at 448.

9. Snider, *Psychiatrist Warns Cosmetic Surgeons*, SCI. DIG., Aug. 1973, at 48.

10. One who is neurotic may have internal conflicts, but contact with reality is maintained. TABER'S CYCLOPEDIC MEDICAL DICTIONARY N-21 (13th ed. 1977). Although neurotic patients may exhibit extreme anxiousness, such patients are often excellent candidates for surgery. Wright & Wright, *supra* note 4, at 148-49. Everyone is a little neurotic. *Id.* at 145.

11. Wright & Wright, *supra* note 4, at 148. As one man asked a surgeon: "in this neurotic world would you expect me to be normal—what do you think I am . . . crazy?" Aronoff, *The Psychiatric Aspects of Phinoplasty*, in 1 PLASTIC AND RECONSTRUCTIVE SURGERY OF THE FACE AND NECK, 97 (J. Conley & J. Dickinson eds. 1972).

12. *See The other face of plastic surgery: The Disappointed Patient*, SCI. DIG. Apr. 1971, at 16, 17. *See also* discussion notes 25-26 *infra; The Plastic-Surgery Boom*, NEWSWEEK, Jan. 13, 1977, at 73.

13. Reich, *Factors Influencing Patient Satisfaction with the Results of Aesthetic Plastic Surgery*, 55 PLAS. & RECONST. SURG. 5, 9 (1975). *See also* Peterson & Topazian, *Psychological considerations in corrective maxillary and midfacial surgery*, 34 J. ORAL SURG. 157, 161-62 (1976); *The other face of plastic surgery: The Disappointed Patient*. SCI. DIG., Apr. 1971, at 16, 17.

14. Jefferson, *The Psychiatric Assessment of Candidates for Cosmetic Surgery*, 68 J. OF NATL. MED. ASSOC. 411, 416 (1976); Wright & Wright, *supra* note 4, at 148.

15. *See* text & notes 89 & 90 *infra.*

16. *See* text & notes 62 & 70 *infra.*

17. *See* Wright & Wright, *supra* note 4, at 145. Oftentimes, the request by the patient for surgery becomes a blatant demand. L. WILLIAMS, HOW TO AVOID UNNECESSARY SURGERY 89 (1971).

18. *See* Wright & Wright, *supra* note 4, at 151. *See generally* Goin, Burgoyne, & Goin, *Face-Lift Operations: The Patient's Secret Motivations and Reactions to Informed Consent*, 58 PLAS. & RECONST. SURG. 273 (1976); Lombard, *supra* note 4, at 34 n.64. See text at notes 39, 100, 106 *infra.*

surgery be based on healthy internalized desires.[19] However, the artful patient may conceal unhealthy reasons for wanting surgery by giving the appearance that his desires are sound.[20] When a patient seeking cosmetic surgery has great deformities the surgeon can fairly assume that the patient's motivation for surgery is rational and healthy.[21] In other instances, however, there is a significant risk[22] that the patient will have, or be vulnerable to, psychological problems that will be caused, or aggravated to a dangerous extent,[23] by surgery. In some cases the aggravation of these problems could lead to suicide.[24]

The purpose of this Note is to analyze the duty owed by a surgeon to his patient when the patient requests a form of elective surgery. Although cosmetic surgery, voluntary sterilization, sex change operations, and abortions will be discussed, cosmetic surgery and voluntary sterili-

19. Internal motivations are preferable to external motivations. Peterson & Topazian, *supra* note 13, at 157, 161-62. An internal, healthy motivation is one whereby the patient freely and rationally makes an independent decision. In cosmetic surgery, such a motivation is shown when the patient claims that surgery is desired because he wishes to improve his own appearance. Wright & Wright, *supra* note 4, at 151. An unhealthy, external motivation is characterized by unrealistic expectations or coercion by third parties. Such a motivation is shown when a patient requests surgery because a relative wants the surgery performed. *Id.; see* Peterson & Topazian, *supra* note 13 at 161; *see generally* text & note 79 *infra*.

20. Although some physicians believe that after a few appropriate questions, a patient will reveal his or her true motivation for wanting surgery, Book, *Psychiatric Assessments for Rhinoplasty*, 94 ARCH. OTOL. 51 (1971); Peterson & Topazian, *supra* note 13, at 157, 161, others believe that some patients are far too sophisticated to reveal their hidden motivations during a simple diagnostic examination. MacGregor & Schaffner, *Screening Patients for Nasal Plastic Operations: Some Sociologic and Psychiatric Considerations*, 12 PSYCHOSOM. MED. 277, 278 (1950); Money & Schwartz, *supra* note 4, at 273 (patients requesting sex change are often highly intelligent and try to make a good impression on the physician); Wright & Wright, *supra* note 4, at 146. Regardless of patients' abilities to conceal underlying motivations, however, a physician should make reasonable inquiries in order to spot danger signs widely recognized in the practice of surgery. See discussion notes 100, 106 *infra*.

21. Updegraff & Menninger, *Some Psycho-Analytic Aspects of Plastic Surgery*, 25 AM. J. SURG. 554, 554 (1934). Because gross deformities and other severe problems often have the best prognoses, *see Psychiatrist Warns Cosmetic Surgeons*, SCI. DIG., Aug. 1973, at 49, in these cases reasonable care usually requires less concern with danger signs that caution against surgery. *The other face of plastic surgery: The Disappointed Patient*, SCI. DIG., Apr. 1971, at 16, 17.

22. One surgeon claims that only a small group of patients, those at the end of the spectrum, are actually psychologically unfit for cosmetic nasal surgery. Book, *supra* note 20, at 52. Nevertheless, "some patients are patently psychoneurotic." Pickering, *Socio-economic considerations of aesthetic surgery*, in 4 SYMPOSIUM ON AESTHETIC SURGERY OF THE FACE, EYELID, BREAST 7 (Masters & Lewis eds. 1972). An estimate is that 10% of male and female elective sterilization patients, Wolf, *Legal and Psychiatric Aspects of Voluntary Sterilization*, 3 J. FAM. L. 103, 110, 117 (1963), and 5% to 10% of cosmetic surgery patients should not be operated upon. Interview with Plastic Surgeon Dr. Morton Aronoff, in Tucson (Jan. 2, 1978) (Doctor Aronoff is not related to the Aronoff cited note 11, *supra*). *See also* Kurtzberg, Safar & Mandell, *Plastic Surgery in Corrections*, FEDERAL PROBATION, Sept. 1969, at 44, 46 (less than five percent of those requesting plastic surgery are psychologically unfit). Almost all surgeons agree, however, that the proportions are significant enough to require screening of patients. *See* Book, *supra* note 20, at 51; Macgregor & Schaffner, *supra* note 20, at 277; Peterson & Topazian, *supra* note 13 at 157; Wright & Wright, *supra* note 4, at 145.

23. *See* discussion note 121 *infra; see also* text & notes 48, 49, 79 *infra*.

24. Arnoff, *supra* note 11, at 98; Wright & Wright, *supra* note 4, at 148-49. Throughout this Note the terms "psychological problems" and "psychological harm" will be used interchangeably with such terms as "emotional harm" and "mental harm" and are meant to refer to psychiatric disorders. *See generally* Schwartz, *Neurosis Following Trauma,* TRAUMA, Dec. 1959, at 31, 32 (using the terms interchangeably).

zation will be emphasized. After a brief view of the nature of the problem, consideration will be given to patients' decision-making processes and the subconscious motives of patients requesting elective surgery. The physician's duty to screen patients will be discussed within the framework of general tort law. This entails an examination of the scope of a surgeon's duty to consult and interview patients with special attention given to the interview itself. Specific cases will be discussed to reveal the nature of psychological harm that can result from elective surgery, followed by suggested standards of care to avoid the harm. Finally, the topic of informed consent will be explored.

NATURE OF THE PROBLEM

Many physicians realize the risk of performing elective surgery on psychologically unfit persons and, therefore, recommend a diagnostic process of screening.[25] Screening can most effectively be achieved by cooperation between the surgeons who will perform the operation and psychiatrists[26] who are able to examine and interview the patients to best determine the advisability of surgery.[27] Screening is, therefore, equivalent to examining a patient to determine whether he is psychologically "fit" for surgery. The strong correlation between preoperative psychological problems and adverse postoperative effects[28] has prompted many physicians to make at least general inquiries of their patients and respond to signals of unhealthy personality[29] by denying surgery. "[O]ne of the hallmarks of a good plastic surgeon is the care with which he screens his prospective patients. The best surgeons will quickly reject anyone who doesn't actually have an obvious defect to correct."[30]

25. Screening may involve a routine psychological assessment by the patient's surgeon in order to avoid surgery where it would be hazardous to the mental well-being of the patient. Wright & Wright, *supra* note 4, at 145. Rather than acting "merely as an instrument to carry out an operation at the whim of a patient," the surgeon should be alert to factors that indicate psychological problems and should "refer doubtful cases to a psychiatrist for evaluation." MacGregor & Schaffner, *supra* note 20, at 290.

26. MacGregor & Schaffner, *supra* note 20, at 290 (recommending that the alert physician refer cases to psychiatrists to avoid hazards); Wolf, *Legal and Psychiatric Aspects of Voluntary Sterilization*, 3 J. FAM. L. 103, 122-23 (1963) (recommending a psychiatrist's approval of sterilizations); *see* Wright & Wright, *supra* note 4, at 145 (cosmetic surgery); Note, *supra* note 4, at 422 n.20 (recommending that some patients be referred to psychiatrists).

"For example, an experienced psychologic investigator as a member of a team studying candidates for plastic surgery would be equipped to gather and help evaluate the sociologic and psychologic data pertaining to the patient. In addition he can serve as a liason between the surgeon and the patient." MacGregor & Schaffner, *supra* note 20, at 290.

27. MacGregor & Schaffner, supra note 20, at 290.

28. *See* Reich, *supra* note 13, at 5 (concluding that unfavorable intrafamilial attitudes and an unstable personality are key factors in predicting adverse postoperative effects); *accord* Wright & Wright, *supra* note 4, at 145.

29. See text & note 106 *supra*.

30. *The Plastic-Surgery Boom*, NEWSWEEK, Jan. 24, 1977, at 74. The careful surgeon watches for signs of unhappy marriage, masochistic personality, and coercion by others. *Id.* For examples

In addition to screening, physicians should disclose the risks of psychological harm that elective surgery may present[31] and should recommend psychiatric help rather than surgery in doubtful cases.[32] Performance of elective surgery when the patient's real problem is psychological should be viewed as evidence of misdiagnosis[33] and unnecessary surgery.[34] Although it would be too burdensome for surgeons to refer all patients to psychiatrists,[35] it is reasonable to require surgeons to diagnose a patient's problem as either physical or psychological and to respond to clues of psychological disturbances.[36] To accomplish this, surgeons must be aware of the elements that influence patients to request surgery.

THE PATIENT'S DECISION-MAKING PROCESS AND MOTIVATIONS FOR SURGERY

The major means of evaluating a patient for possible psychiatric dangers is a "full probing of his motivation."[37] Ideally, a surgeon

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of cases where surgery was either denied by the physician or decided against by both patient and doctor, see discussion, note 132 *infra*.

31. According to one court, "all risks potentially affecting the decision must be unmasked." Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). In defining the scope of the risk, the court adopted a reasonableness standard. The physician must inform the patient of all risks that a reasonable person in what the physician knows or should know to be the patient's position would attach significance in deciding on the proposed therapy. *Id.* at 787. See text & notes 166-207 *infra*.

32. *See* Peterson & Topazian, *supra* note 13, at 162.

33. A physician must make a careful and skillful diagnosis of his or her patient. Golonka v. Gatewood, 199 Neb. 216, —, 257 N.W.2d 403, 408-09 (1977). Although an erroneous diagnosis is not conclusive proof of negligence, Clark v. United States, 402 F.2d 950, 953 (4th Cir. 1968), a failure to adequately examine a patient in order to formulate an accurate diagnosis is negligent medical treatment. Hicks v. United States, 368 F.2d 626, 630 (4th Cir. 1966).

34. "The fact, for example, that 150 psychiatric patients should have had a total of 496 courses of medical treatment and 244 courses of surgical treatments . . . prior to the time that their illness was diagnosed as psychiatric in nature is a startling and disturbing report." L. WILLIAMS, *supra* note 7, at 90. The surgeons should have advised these patients that the requested elective surgery was unnecessary. *See id.* at 91.

Because a physician must disclose to his patient the likelihood that a particular procedure will fail to cure the patient's problem, Rahn v. United States, 222 F. Supp. 775, 780 (S.D. Ga. 1963), physicians performing elective surgery who perceive that the patient's real problem is psychological should advise of the futility of surgery.

35. *See* Pickering, *supra* note 22, at 7.

36. The failure of a physician to make a skillful and careful diagnosis of his patient renders him liable for injury sustained by the patient. *See* Hicks v. United States, 368 F.2d 626, 630 (4th Cir. 1966) (physician liable for death proximately caused by failure to conduct tests necessary for a proper diagnosis); R. LONG, THE PHYSICIAN AND THE LAW 3 (3d ed. 1968). The physician must diagnose his patient with the same duty of care he uses in the actual treatment of the patient. *See generally* Golonka v. Gatewood, 199 Neb. 216, 221-22, 257 N.W.2d 403, 408-09 (1977); Note, *Unnecessary Surgery: Doctor and Hospital Liability*, 61 GEO. L.J. 807, 810 (1973). "A surgeon or general practitioner who notices that his patient may be unconsciously fabricating symptoms should be under a duty to refer the patient for a psychological consultation before . . . performing [surgery]." *Id.* at 813.

37. Aronoff, *supra* note 11, at 97. The degree of probing required depends on the type of surgery involved. When cosmetic surgery is at issue, the probing can be accomplished by well-placed questions. See text at notes 99-113 *infra*. Questions should focus upon the decision-making process of the patient and inquire into family relationships, marital relations, support shown by friends and relatives, and the freedom and independence of decision by the patient. See text at

should "get the patient to state his motivation and expectations"[38] concerning the requested therapy. However, in many cases, to merely ask a patient to state his motivation and expectations is insufficient. A study of twenty cosmetic surgery patients shows that the reasons initially given for desiring surgery are frequently misleading or inaccurate.[39] If a surgeon fails to probe into the patient's personality he may eventually perform surgery that is psychologically hazardous.[40] The necessity for at least minimal preoperative evaluations of both personality and motivations for surgery will be discussed in the contexts of cosmetic surgery, elective sterilization, and elective abortion.

Cosmetic Surgery

In a study of ninety cosmetic surgery patients that used both psychological interviews and the Minnesota Multiphasic Personality Inventory Test (MMPI),[41] significant differences were noted between the cosmetic surgery group and a control group of non-cosmetic surgery

notes 50 & 52 *infra. See generally Noses Out of Joint: Detecting Psychologically Unfit Patients for Plastic Surgery*, NEWSWEEK, May 22, 1967, at 112. Lack of support by family members and friends is a negative signal that should warn the surgeon of potential problems. Reich, *supra* note 13, at 9; Wright & Wright, *supra* note 4, at 149. A lack of freedom of decision is also a negative factor. Peterson & Topazian, *supra* note 13, at 161. *See generally The Plastic-Surgery Boom*, NEWSWEEK, Jan. 24, 1977, at 73.

In the case of elective sterilization, these same factors are relevant, but the physician must be even more thorough in his approach because of the permanency of the decision, *see Sterilization: now it's simpler, safer*, GOOD HOUSEKEEPING, Jan. 1978, at 163 (suggesting that new methods may increase the success of sterilization "reversals" in women), the direct relationship of sterilization to the family and its members, and the messages of studies that suggest definite adverse postoperative effects. See discussion note 82 *infra*. Because sterilization is often a cause or instigating factor in marital and familial friction, see text at notes 60, 76 & 79 *infra*, a complete psychiatric interview of both the husband and wife has been recommended. *See* Wolf, *supra* note 26, at 116. It is recommended that physicians performing sterilizations first consider the patient's family and social relationships. *Id.* at 111-12; see text at note 63 *infra*.

Preoperative evaluation of abortion patients should focus upon age, independence of decision, family and personal relationships, and the degree of support by others. Bracken, Hachamovitch, & Grossman, *The Decision to Abort and Psychological Sequelae*, 158 J. NERV. & MENTAL DIS. 154, 160-61 (1974). See text at notes 89-93 *infra*.

38. Wright & Wright, *supra* note 4, at 150.

39. Goin, Burgoyne, & Goin, *supra* note 18, at 274. Of the 20 subjects studied, 12 gave preoperative reasons that differed from the postoperative reasons for wanting the surgery. *Id.* at 275. Two admitted they felt that their improved appearance would find them a job. *Id.* This is usually a sign of healthy motivation. *The other face of plastic surgery: The Disappointed Patient*, 69 SCI. DIG., Apr. 1971, at 16, 17. Three admitted that the surgery was in response to marital problems. This is often a strong negative signal. Reich, *supra* note 13, at 9; Wright & Wright, *supra* note 4, at 148. It follows that the assessment of what motivates a patient to request elective surgery cannot easily be made. *But see* Book, *supra* note 20, at 51 (indicating that such an assessment can be easily undertaken).

Although a surgeon should not be expected to determine with precise accuracy what motivates his patients, he should make reasonable inquiries that tend to elicit responses which are indicative of either healthy or unhealthy motivation. See discussion note 106 *infra*.

40. *See* Wright & Wright, *supra* note 4, at 148, discussing how a psychiatric consultation "could have" avoided a psychotic break in a patient.

41. The MMPI is a self-administered personality inventory test which scores a subject's personality against nine clinical scales. High scores in any of these scales can be evidence of abnormal personality. The scales cover problems such as paranoia, immaturity, depression, psychopathic behavior, and schizophrenia. *See* Wright & Wright, *supra* note 4, at 146. The

patients.[42] The MMPI results for the cosmetic surgery group showed that these patients were less typical of the low-risk patient than was the control group.[43] The test results suggested that cosmetic surgery patients were less "open" with others, more disregarding of social mores, more prone to be self-centered and self-critical, and more prone to have paranoid schizophrenic symptoms.[44] In addition, the cosmetic surgery group was more restless, less satisfied with social and family relationships,[45] and less able to express realistic motivations for desiring surgery than the control group.[46]

The physicians conducting this test interpreted the data to denote a need for special care in counseling and screening patients for cosmetic surgery in order to avoid possible postoperative psychological problems.[47] Numerous case histories supported their belief. One patient who had unrealistic expectations regarding surgery and whose MMPI score suggested the presence of a psychotic disorder, suffered a mental breakdown that could have been avoided by preoperative psychiatric consultation.[48]

That the entire decision-making process of the cosmetic surgery patient should be thoroughly analyzed is illustrated by another case where a patient suffered acute anxiety after such surgery.[49] This patient had failed to obtain her husband's cooperation and consent to the surgery, and became emotionally upset at her husband's displeasure with the surgical results.[50] Although her MMPI score suggested difficulty with interpersonal relationships, her presurgical counseling did not explore this issue.[51] In retrospect, it is clear that decisions freely made with the participation of all family members can provide added assurance to the physician that his patient is a healthy candidate for surgery.[52]

Oftentimes, patients for cosmetic surgery will blame their personal troubles on such simple problems as a nasal deformity.[53] The imperfect nose serves as a psychological "crutch";[54] when the nose is oper-

MMPI is particularly useful because "fakers" can be identified. *See* Caldwell, *Courtroom Use of Psychological Testing*, 1 TRAUMA, Apr. 1960, at 111, 138.

42. Wright & Wright, *supra* note 4, at 147. The MMPI was administered prior to surgery.
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.* at 146.
47. *Id.* at 148.
48. *Id.*
49. *Id.* at 149.
50. *Id.*
51. *Id.*
52. *Id. But see* discussion note 19 *supra*.
53. Aronoff, *supra* note 11, at 97-98. *See also* text & note 56 *infra*.
54. Aronoff, *supra* note 11, at 97-98.

ated upon and personal problems fail to disappear, the patient may suffer emotional disturbances that were foreseeable to the careful physician.[55] To avoid potential problems, surgeons must determine whether the expectations of patients are realistic. Hopes and aspirations of new careers that are supposed to sprout from the correction of minor physical infirmities should alert physicians to the vulnerability of their patients to postoperative psychological problems.[56] Surgeons must always warn that miracles cannot be expected.[57]

Elective Sterilization

The decision-making processes of patients electing sterilization also require exploration. This is especially true because of the rapidly growing popularity of such operations.[58] Patients frequently desire sterilization for transitory or irrational motives giving little consideration to the real consequences of the operation.[59] Sterilizations are sometimes requested in an attempt to improve an unhappy marriage, punish a spouse,[60] or achieve self-punishment or psychological self-destruction.[61] A study of physicians' reasons for declining to perform sterilizations at the election of the patient indicates that fear of psychological side effects and pre-existing psychological problems are primary concerns.[62] These surgeons consider the following as relevant in assessing the patient's motivation and the advisability of the operation: (1) marital problems; (2) the presence of coercion by the other spouse; (3) age; (4) number of children; (5) patient's knowledge of the consequences; and (6) the harmony of the couple's decision.[63] An inquiry into these factors might necessitate an interview with both spouses.

Studies of the psychological effects of sterilization support the contention that careful patient screening is required. In a study of 293 women who had been sterilized, significant psychiatric disadvantages were noted in forty percent of the cases.[64] The most prevalent disadvantages related to disturbed bodily integrity and unfulfilled motherhood drives.[65] The disadvantages of the operation outweighed the

55. *Id.*
56. A patient who placed the blame for his life's dismal course upon the shape of his nose, and who expected his life to greatly change after surgery, was discouraged from proceeding. MacGregor & Schaffner, *supra* note 20 at 284.
57. *About the Boom in Plastic Surgery*, U.S. NEWS & WORLD REP., Sept. 16, 1974, at 67.
58. *See* Uhlman, *supra* note 5, at 449; discussion *supra* note 5.
59. Note, *supra* note 4, at 418.
60. *Id.*
61. Lombard, *supra* note 4, at 34 n.64.
62. Uhlman, *supra* note 5, at 449.
63. *Id.*
64. *See* Wolf, *supra* note 26, at 109-10 (citing a reported study).
65. The psychiatric problems brought on by sterilization related largely to unsatisfied motherhood drives and disturbed bodily integrity which is "the basis of our self-esteem." *Id.* at 111-

advantages in ten percent of the cases.[66] The study concluded that sterilization touched upon many concerns of both individuals and society, and that in a given case, the individual patient, her family, and social relationships must be looked into as precisely as possible.[67]

A preoperative evaluation of the individual is also important in the context of male sterilization. A study of twenty-two vasectomy patients concluded that male sterilization is a procedure accompanied with psychological risks and that it should always be preceded by thorough psychiatric examinations of both the subject and, if married, his wife.[68] Although it is reasonable to require surgeons to screen patients by asking penetrating questions,[69] the suggestion that "thorough psychiatric examinations" be made is much too rigorous. Reasonable inquiries pertaining to marital relations, the number of children the man has, and the degree of freedom of decision, should be made.[70] In general, when the patient already has children[71] and makes his decision free of coercion (subtle or blatant) from others,[72] the prospects are healthy.

A third study reported that usually less than ten percent of vasectomy patients express definite and permanent regret, but that this percentage is significantly larger for samples of patients with pre-existing psychiatric conditions.[73] Post-operative regret was found to be largely due to unhappy marital relations, too few children, and pressure by a third person for consent to the operation.[74] If the physicians had carefully screened these patients and warned of the dangers of postoperative problems caused by an imprudent decision to undergo surgery there may never have been consent to surgery.

The great importance of the patient's decision-making process in elective sterilization and the harm that can possibly result from the failure to properly screen patients is demonstrated by a study of eighty-

112. The psychiatric impact of the unsatisfied motherhood drive can occur long after the sterilization when the initial reasons and motivations for wanting the operation grow weak, and the desire for more children grows strong. *Id.* at 111. The disturbance of bodily integrity is a result of feelings of inadequacy and weakness often accompanied by strong sexual disturbances. It is a feeling of being dirty, lame, heavy, " 'corroded, ripped apart,' etc." *Id.* at 112.

66. *Id.* at 110.

67. *Id.* at 111, 112.

68. *Id.* at 116.

69. See note 106 *infra*.

70. *See* Wolf, *supra* note 26, at 117-18 (citing a reported study). Another study found that some men request vasectomy after much persuasion by emotionally sick wives who desire to harm their husbands. *Id.* at 117. Another finding was that some men request vasectomy as an act of self-punishment. *Id.* Carefully placed questions regarding motivation and expectations of the patient could help reveal these problems and enable the surgeon to refuse surgery until more healthy prospects were evident. *See generally* Uhlman, *supra* note 5, at 449.

71. Note, *supra* note 4, at 421 (discussing interviews with physicians).

72. *See* Uhlman, *supra* note 5, at 449.

73. Wolf, *supra* note 26, at 117.

74. *Id.*

three vasectomy patients who later required psychiatric care.[75] In greater than fourteen percent of these cases, the operation played a precipitating role in disturbing psychological functioning and the disruption of marital harmony.[76] Because the operation was the predominant cause of emotional and marital upset, as opposed to more individual causative factors,[77] it is fair to conclude that the operation was a "but for" cause of the ultimate consequences.[78] One patient, previously an alcoholic, was persuaded by his wife to have a vasectomy that he did not want. Within one month following the operation, and apparently as a result thereof, he again became an alcoholic and had to be hospitalized for severe paranoia. His wife divorced him within a year.[79] Another patient consented to a vasectomy to regain his wife's affection. After the operation, sexual strife continued, however, and the husband developed a paranoid schizophrenic illness, the vasectomy being the focal point of his problems.[80] Subsequently, his wife filed for divorce.[81] Careful preoperative interviews with both the husband and wife may have averted these tragedies.

The actual benefit of preoperative counseling and the potential for reduction in adverse postoperative psychiatric effects is demonstrated by two additional studies.[82] Both of these studies conclude that vasec-

75. Johnson, *Social and Psychological Effects of Vasectomy,* 121 AMER. J. PSYCH. 482 (1964).
76. *Id.* at 485.
77. *Id.*
78. See text & notes 150-64 *infra*.
79. Johnson, *supra* note 75 at 484.
80. *Id.*
81. *Id.*
82. Ziegler, Rodgers, & Kriegsman, *Effect of Vasectomy on Psychological Functioning*, 28 PSYCHOSOM. MED. 50 (1966); Ziegler, Rodgers, & Prentiss, *Psychosocial Response to Vasectomy*, 21 ARCH. GEN. PSYCH. 46 (1969). The first study consisted of a comparison of two groups of vasectomy patients, groups A and B. Group A was observed and compared with observations made of group B at a prior time. Group B consisted of 46 vasectomy patients who were given both preoperative and postoperative Minnesota Multiphasic Personality Inventory Tests (MMPI, see note 41 *supra*). Ziegler, Rodgers, & Kriegsman, *supra* at 51. Despite a unanimous expression of satisfaction with the results of the surgery by the patients, the MMPI showed adverse psychological impacts. *Id.* at 51. The patients' expression of satisfaction was conclusively deemed to be a simple defense mechanism designed to minimize regret. *Id.* at 60.

Group A consisted of 22 couples where the male elected vasectomy. *Id.* at 62. These couples were tested preoperatively and postoperatively, but unlike the 46 men in Group B, the Group A patients had considerable contact with the research team and had greater opportunities for discussion between husband, wife, and physician. *Id.* at 59. Intimate concerns and life histories were discussed. *Id.* The postoperative results showed that this more extensive interviewing process helped reduce adverse psychological effects. *Id.* at 60. This first study concluded that although vasectomy characteristically can cause personal anxiety and marital friction, more intensive interviewing and testing procedures can ameliorate such adverse effects. *Id.* at 62.

The second study involved 37 couples who completed a four year study program. Ziegler, Rodgers, & Prentiss, *supra* at 47. The couples were carefully selected, and had a great deal of contact with the study team and physicians. The postoperative results indicated that the procedures utilized buffered these couples from adverse psychological change. *Id.* at 52. The study concluded

> that if a man, his wife, and a physician conclude that vasectomy is a desirable contraceptive method for the couple and if the couple has adequate opportunity to discuss all implications of the procedure with an informed person, the ultimate effect of vasectomy

tomy has definite effects on psychological functioning and marital adjustment, but that such effects can be ameliorated by preoperative interviews that afford the patient an opportunity to discuss with the physician and spouse all of the implications of the operation.[83] In both studies, patients who were carefully screened, who had much personal interaction with both the physician and spouse, and who consequently were "open" in discussing intimate matters, showed superior postoperative adjustment in comparison to groups where such thorough screening and personal contact were absent.[84] The most recent study notes that because the patients were prescreened[85] and selected for having "rational reasons for vasectomy and for having a stable family situation [they] were buffered from notable adverse reactions and psychological change after vasectomy . . . ."[86] Screening clearly can prevent a vasectomy from upsetting the psychological state of patients who have pre-existing emotional problems.

Elective Abortion

The importance of preoperative evaluation is also clear in the case of abortion. Although it has been said that moderate to severe psychiatric problems following abortion are very rare,[87] the issue is far from being resolved.[88] Common postoperative reactions to abortion are guilt, self-reproach, depression, and psychiatric disturbances.[89] When the patient is young, coerced, or persuaded by a close friend or relative to have an abortion, the risk of harm is higher than average.[90] Just as the presurgical decision-making process is vital in the context of cosmetic surgery and vasectomy, the preabortion decision-making process is also vital and must be considered in order to understand psychological reactions to abortion.[91] To minimize the risk of adverse psychological effects, the patient, as well as her family and her partner, should be the focus of the physician's screening process.[92] Moreover, the degree of support by others for the patient's decision can influence her post-

on psychological functioning and marital adjustment will, on the average . . . [be more favorable than if such precautions are not taken].

Id. at 53.

83. *See* discussion at note 82 *supra*.

84. Ziegler, Rodgers & Prentiss, *supra* note 82, at 52; *see* discussion note 82 *supra*.

85. Ziegler, Rodgers & Prentiss, *supra* note 82, at 52-53.

86. *Id.* at 52.

87. Kummer, *Post-Abortion Psychiatric Illness—A Myth?*, 119 AM. J. PSYCH. 980, 982 (1963).

88. *See* White, *Induced Abortions: A Survey of Their Psychiatric Implications, Complications, and Indications*, 24 TEX. REP. BIOL. & MED. 531 (1966).

89. Bracken, Hachamovitch, & Grossman, *supra* note 37, at 154.

90. *Id.* at 155.

91. *Id.*

92. *Id.*

abortion emotional adjustment.[93] "Only when the decision to abort has been made with a rational and realistic appraisal of all that such a decision involves, will women and men be free of any risk of possible psychological reactions to induced abortions."[94]

Unlike elective sterilization, however, the postoperative effects of abortion are not so predictably adverse. Although a study of eighty-four legally aborted women found that greater than twelve percent suffered definite impairment of mental health,[95] other studies found that psychological problems are more rare.[96] Happiness and relief are more prevalent than sadness and other adverse emotional feelings,[97] but abortion can still be a significant factor in causing adverse psychological effects. Because it is recognized that the pre-abortion decision-making process is important in predicting or avoiding post-abortion psychological problems, it must be conceded that careful counseling and screening should be conducted by physicians before performing abortions.

The literature concerning the psychological effects of cosmetic surgery, elective sterilization, and abortion contains common themes. Authorities stress the need for careful consideration of patient motivation to ensure that the ultimate decision to undergo surgery is based upon realistic appraisals of personal need, and upon support and consent of family members who contribute to the patient's overall personality and adjustment.[98] The preoperative interview is an ideal means by which to take such a precaution.

The Interview

In screening patients for elective surgery, a physician cannot be expected to conduct extensive personality tests on his patients.[99] Physicians should, however, have a duty to remain sensitive to characteristics of patients that indicate widely recognized irrational

93. *Id.* at 160.
94. *Id.*
95. White, *supra* note 88, at 534.
96. *See id.* at 535.
97. Adler, *Emotional Responses of Women Following Therapeutic Abortion*, 45 AM. J. ORTHO. 446, 453 (1975).
98. MacGregor & Schaffner, *supra* note 20, at 290; *see* text & notes 51, 52, 63, 67, 68, 70, 79, 92 *supra*.
99. Psychiatric or psychological consultation, though essential for psychotic cases, is impractical as a routine screening process. Such consultations are expensive, inconvenient, and time-consuming; furthermore, they often put the real problem patient on his guard as he is most likely to recognize and manipulate his way through the screening process. "[W]hat seems to be needed is a simplified, fairly stereotyped counseling routine that would encourage the patient to communicate forthrightly and would allow a high degree of protection even to the more inexperienced surgeon." Wright & Wright, *supra* note 4, at 150.

motivations.[100] In determining the nature of a patient's motivation for elective surgery, the interview is the key data-gathering device.[101] Many surgeons performing elective surgery recommend that the pa-

100. *See* MacGregor & Schaffner, *supra* note 20, at 289. Common motivating social factors inducing patients to request cosmetic surgery are the desire:

1. To correct a deformity which is felt to be a handicap to economic and social achievement;
2. To conform to cultural standards of physical beauty;
3. To eliminate a deviant physical trait which evokes ridicule and/or other negative reactions which serve as barriers to satisfactory social interaction;
4. To gain social approval by improving one's appearance and thereby raise one's own self-concept;
5. To eliminate a socially perceptible trait which patients feel may produce false or negative pre-judgments of their personality or character;
6. To attain group membership by conforming to requirements of external appearance;
7. To reduce social visibility in order to cross caste or class lines;
8. To change one's physical traits to avoid racial or cultural stereotyping.

The most common psychological motives found among patients requesting nasal plastic operations, were the following:

1. The wish to alter one's personality by changing one's appearance;
2. The belief that plastic surgery can correct psychologic difficulties and psychosomatic manifestations;
3. The wish to alleviate feelings of inferiority by removing defects which others had criticized;
4. The extreme narcissistic need to be admired, loved, "popular";
5. The hope of bettering interpersonal relationships by improving external features which have been considered social handicaps;
6. The wish to avoid anxiety-producing insights or the unconscious denial of deeper psychologic disturbances, by fixation upon an external physical feature;
7. The wish to eliminate a physical feature similar to that of a rejecting or rejected parent;
8. The unconscious hope of insuring greater dependency upon others, by submitting to an operation;
10. The unconscious utilization of a physical defect in order to shift responsibility for failure in life;
11. The wish to change one's previous identity in order to "begin a new life."

Id. Obviously, some of the goals of patients, as reflected by the motivations listed above, will never be achieved by surgery. That a patient is obviously motivated by a particular factor may serve to warn the physician of possible postoperative adverse effects and create a duty, in certain instances, to conduct thorough and open interviews so that the patient has an opportunity to better evaluate the advisability of surgery. Clinical experiences have proven that many of the above motivations, in conjunction with other factors discovered during the interviewing procedure, should serve to warn the physician that surgery is not a wise choice. *See* Jefferson, *The Psychiatric Assessment of Candidates for Cosmetic Surgery*, 68 J. NAT'L. MED. ASSOC. 411, 416 (1976) (discussing the negative implications of prior mental health problems). A "narcissistic" motivation has resulted in postoperative feelings of depression and threats of suicide. Wright & Wright, *supra* note 4, at 150. The hope of improving interpersonal relationships can also be a high risk motivation. Jefferson, *supra* at 414; *see* Aronoff, *supra* note 11, at 97. A motivation that shifts blame for personal failure upon simple physical defects is also unhealthy. *See* Aronoff, *supra* note 11, at 97. While the desire to eliminate ugly physical features or regain a youthful appearance is a healthy motivation, the desire to erase one's racial heritage or attain sexual potency through cosmetic surgery is an unhealthy motivation. *See* Jefferson, *supra* note 14, at 413-14. Many motivations that are otherwise healthy, may be unhealthy when past psychological problems have been characteristic of the patient. *Id.* at 416. The Michigan Court of Appeals has stated, in dicta, that when there is "any history of mental disorder that the defendant [physician] was aware of," a duty exists on the part of the physician to take reasonable precautions to avoid harm that is a consequence of such disorder. Lanczki v. Providence Hospital, 77 Mich. App. 732, 736, 258 N.W.2d 238, 240 (1977).

101. Knorr, Wolff, & Meyer, *supra* note 4, at 271. *See also* Peterson & Topazian, *supra* note 13, at 158; Reich, *supra* note 13 at 8, 9; Wright & Wright, *supra* note 4, at 145 (also utilizing the Minnesota Multiphasic Personality Inventory Test).

tient be interviewed twice.[102] The patient for cosmetic surgery should be questioned to determine the following: (1) what it is he desires; (2) the realism of his expectations; (3) his ability to accept an imperfect result; and (4) his physical and psychological background.[103]

Cosmetic surgery should not be conducted at the whim of the individual.[104] The surgeon has a duty to determine whether the patient has a psychotic disorder, an inadequate personality, or decisional discrepancies.[105] "[D]angerous symptomatology can be spotted by unrealistic responses to a few well-placed questions."[106] The surgeon must be

102. Peterson & Topazian, *supra* note 13, at 158; Reich, *supra* note 13, at 9; Wright & Wright, *supra* note 4 at 151 (discussing a pre-counseling and counseling interview). The surgeon should never acceed to demands to hurry the scheduling of surgery. Pickering, *supra* note 22, at 7. The scheduling of two interviews facilitates a more thorough discussion with the patient of his reasons for requesting surgery, Reich, *supra* note 13, at 9, and affords ample opportunity to discuss the operation with the spouse or other relevant individuals. Wright & Wright, *supra* note 4, at 151.

103. Reich, *supra* note 13, at 9; *see* discussion notes 19 & 20 *supra*; see discussion note 106 *infra*. Many different criteria have been proposed to aid the analysis of a patient's suitability for various forms of elective surgery. For example, in deciding whether an individual should have a sex change operation, physicians may ask, "1. Is the patient psychotic? 2. Is the patient authentically motivated? 3. Will the patient undergo a sociocultural crisis? 4. Is the patient a candidate for psychotheraphy?" Knorr, Wolf, & Meyer, *supra* note 4, at 275. To answer these questions, the physician must interview the patient, determine whether the patient can distinguish between reality and delusion, determine whether the patient has actually "lived" in the role of the other sex, and decide whether surgery or psychotherapy is the true solution to the patient's problem. *Id.* at 276-79. "[I]t was simply assumed that, according to the traditions of medicine, the experts would make the decision concerning the diagnosis, suitability, and acceptance of applicants for surgery. Therefore, sex reassignment may not be obtained as a whim or caprice of individual choice . . . ." Money & Schwartz, *supra* note 4, at 261.

104. MacGregor & Schaffner, *supra* note 20, at 290.

105. Wright & Wright, *supra* note 4, at 148, 151. The failure to make reasonable inquiries prior to surgery can lead to great postoperative mental frustration and grief. *Id.* at 148; MacGregor & Schaffner, *supra* note 20, at 290.

106. Wright & Wright, *supra* note 4, at 151. The following are examples of appropriate questions and favorable and unfavorable answers proposed for the context of cosmetic surgery:

1. *What specifically would you like for me to do for you?*
   HEALTHY ANSWER: "Remove the hump on my nose," or "make my nose smaller."
   UNHEALTHY ANSWER: "Doctor, you tell me; I know that whatever you do or say will be best."
2. *Why do you want this done?*
   HEALTHY ANSWER: "I want to look better."
   UNHEALTHY ANSWER: "Mother said I'd look better," or "I want it to help me to get along better with my friends."

See note 73 *supra*; see discussion *infra*.

3. *Why do you want the operation at this time?*
   HEALTHY ANSWER: "I've saved the money."
   UNHEALTHY ANSWER: There is often a long pause, followed by an answer that does not really state the reason. For example: "I just suddenly decided I wanted it."
4. *Why have you chosen me?*
   HEALTHY ANSWER: "I like the results you have obtained on my friends."
   UNHEALTHY ANSWER: "Because you are the greatest surgeon in the world."

Id. In evaluating answers to questions during the interviewing sessions, the surgeon should beware of the following answers or complaints:

1. Confused, vague, or unconvincing explanations for requesting plastic [or other] surgery;
2. Complaints about physical problem or defect not justified by actual appearance;
3. Patient's expectation of results from plastic surgery is excessive or obscure;
4. Patient's answer indicates pressure from family, friends, medical advisors, or others, rather than a strong desire on the part of the patient;

wary of great enthusiasm,[107] vague or excessive expectations on the part of the patient,[108] personal stress,[109] and paranoid personalities.[110] A surgeon should also consider the relevance of relatives and other individuals who influence the patient's decision-making, and the degree of support for the decision that they may provide.[111]

When interviews reveal present or potential deep-seated psychological disturbances, the surgeon may be forewarned of the patient's need for psychiatric help.[112] In such a case, the physician should candidly confront his patient, and suggest that he make arrangements for psychiatric consultations prior to surgery.[113]

A LEGAL DUTY TO SCREEN AND INFORMED CONSENT

The duty of surgeons to screen patients for elective surgery has its roots in the fiduciary relationship existing between the physician and patient,[114] and the physician's duty to perform careful and skillful examinations.[115] If a surgeon uses ordinary care[116] in achieving a diagno-

5. Patient's history reveals a series of previous operations in elective surgery that proved unsuccessful;
6. Patient's answers reveal that he places responsibility for difficulties in life on external factors rather than realizing his own role in them;
7. Patient's answers reveal that his request for surgery is based upon a desire to mutilate himself or is a manifestation of another psychiatric disturbance which will trigger emotional upset following surgery.

See MacGregor & Schaffner, *supra* note 20, at 289-90.

Reasonable inquiries should also be made of patients requesting to be sterilized. See text at notes 63, 67 *supra*. A physician should attempt to minimize the risk of subsequent psychological harm by first asking how many children the patient has. If the patient has no children, the potential for future adverse psychological effects is higher than usual. Note, *supra* note 4, at 421; Wolf, *supra* note 26, at 103. Other relevant inquiries pertain to the age of the patient and his previous record of mental health. *Id.* at 122.

107. Reich, *supra* note 13, at 11.

108. Peterson & Topazian, *supra* note 13, at 162.

109. *See* Book, *supra* note 20, at 54.

110. *Id.*

111. See text at notes 50, 52, 63, 82 *supra*.

112. *See* MacGregor & Schafner, *supra* note 20, at 290.

113. Book, *supra* note 20, at 54. *But see* text at notes 206-07 *infra*. An example of a tactful approach is: "Look, you seem to be having an awful lot of problems in your life right now. . . . I can make arrangements for you to see a psychiatrist I know." *Id.* Another approach to suggesting psychiatric help is first to work out details such as fees, hospitalization, and the duration of the postoperative period, and then "introduce the concept of the surgery being done for the patient's happiness as well as appearance." Aronoff, *supra* note 11, at 97. Then psychiatric care can be suggested.

114. The physician-patient relationship is a fiducial one. Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Emmett v. Eastern Dispensary & Cas. Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967). Fiduciary relationships involve great confidence in one who is bound to act in the interest of another. Neagle v. McMullen, 334 Ill. 168, 175-76, 165 N.E. 605, 608 (1929). The physician must exhibit conduct characteristic of reasonable care and diligence. He must act in good faith, and make reasonable disclosures to his patient if he knows that the treatment requested by the patient is not necessary or beneficial. R. LONG, *supra* note 36, at 6.

115. *See* Hicks v. United States, 368 F.2d 626, 630 (4th Cir. 1966). Golonka v. Gatewood, 199 Neb. 216, 225, 257 N.W.2d, 403, 408-09 (1977).

116. The majority rule is that "ordinary care" is a standard determined by reference to the procedures and customs followed by physicians practicing in the particular community. *See* Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir.), *cert. denied* 409 U.S. 1064 (1972); Sawyer v.

sis he is free from liability—even for an erroneous diagnosis.[117] In the case of elective surgery, the physician should "diagnose" his patient, to determine the cause of a particular complaint or of the patient's poor health, and to determine whether the patient is fit or unfit for surgery on the basis of an evaluation of the patient's decision-making processes.[118]

The foregoing discussion is another way of saying that the duty of physicians to screen patients for elective surgery is a duty founded upon the application of general principles of negligence. The crux of negligence lies in the foresight of harm,[119] and the foreseeability of harm can, in certain circumstances, create a duty to take reasonable precautions to avoid the harm.[120]

The foreseeability of emotional harm resulting from elective surgery when screening is not conducted is well documented by the research of physicians.[121] In the case of cosmetic surgery, "[b]ecause

Methodist Hospital of Memphis, 383 F. Supp. 563, 565 (W.D. Tenn. 1974). In Arizona a community standard is statutorily required. *See* ARIZ. REV. STAT. ANN. § 12-563(1) (Supp. 1977).

Where the community standard is lacking, however, a standard set by law is appropriate. *See* Canterbury v. Spence, 464 F.2d at 783-84. "Respect for the patient's right of self-determination . . . demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 784. *See also* cases cited note 171 *infra*.

117. Hicks v. United States, 368 F.2d 626, 630 (4th Cir. 1966).

118. Although the term "diagnosis" usually refers to an attempt to discover the source of a patient's ills, *see* BLACK'S LAW DICTIONARY 540 (Rev. 4th. ed. 1968), in the context of elective surgery the term should connote the process of evaluating a patient's fitness for surgery. For a discussion of relevant factors in making this determination, see discussion note 101, 104, & 107 *supra*.

119. *See* Paul v. Holcomb, 8 Ariz. App. 22, 24, 442 P.2d 559, 561 (1968); Berg v. General Motors Corp., 87 Wash. 2d 584, 592-93, 555 P.2d 818, 822 (1976); Rose v. Nevitt, 56 Wash. 2d 882, 884, 355 P.2d 776, 777 (1960); Thompson v. Green Mountain Power Corp., 120 Vt. 478, 483, 144 A.2d 786, 789 (1958).

120. *See* Paul v. Holcomb, 8 Ariz. App. 22, 24, 442 P.2d 559, 561 (1968); W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 31, at 146 (4th ed. 1971).

121. *See* Jefferson, *supra* note 14, at 411-13 (1976). Patients for cosmetic surgery present a risk because they are less typical of the "good" or low risk patient. Probably a little less than 10% of patients requesting cosmetic surgery are unfit because of unhealthy motivations. Interview with Dr. Morton Aronoff, Plastic Surgeon, in Tucson, Arizona (Jan. 2, 1978). Women requesting sterilization present a risk because at least one study concluded that significant psychiatric disadvantages exist in 40% of these cases. See text & notes 64, 66 *supra*. Although less than 10% of vasectomy patients express permanent regret, the percentage increases when pre-existing psychiatric conditions are a factor. *See* text at note 64 *supra*. A study of vasectomy patients who later required psychiatric care indicates that the operation had adverse psychiatric effects in 14% of the cases. *See* text & notes 76, 82 *supra*. Studies of vasectomy patients show that screening actually can reduce adverse psychological effects. *See* note 82 *supra*. Although conflicting conclusions exist regarding the postoperative effects of abortion, 12% of the women evaluated in one study showed definite impairment of mental health. *See* text at note 95 *supra*.

For examples of the harm that can follow elective surgery, consider the following case histories:

A. A patient wanting plastic surgery on her nose disclosed that because of her nose her husband and children didn't love her, and that her pupils in school did not respect her. Her physician, sensing emotional problems, refused to perform the surgery unless she had a psychiatric interview. Rather than have the interview, she obtained the surgery elsewhere and eventually committed suicide. Aronoff, *supra* note 11, at 97-98. Apparently, the repairing of her nose removed an excuse for her unsuccessful social life; having no more excuses, she ended her life. *Id.* An interesting point raised by this example is that in order to protect patients, all surgeons must use screening methods as a matter of course. Perhaps the surgeon that eventually performed the

appearance is so laminated to psychological cohesion, it becomes all the more critical for the cosmetic surgeon to assess his patient" for psychological stability.[122] In the course of this assessment, facts may appear that substantiate the physician's initial concern for postoperative psychological harm. For instance, a patient who expresses a desire to accentuate ethnic characteristics by having her nose flattened and hair kinked may pose a risk of postoperative psychiatric problems because of inner instability with respect to social identity.[123] Other clues that make psychiatric problems foreseeable are plentiful and well-documented in the literature.[124]

Research has led many physicians to recognize the utility of screening and to advocate its adoption as a standard practice.[125] This recognition provides other physicians with constructive knowledge of the harm that can result by a failure to screen. This constructive notice is a necessary element of both foreseeability and duty because knowledge of danger is essential to the creation of a legal duty to take precaution.[126] To establish a definite duty to screen, however, three variables must be considered: (1) probability of harm; (2) gravity of harm; and (3) burden of adequate precautions.[127] These factors help determine how a reasonable and prudent physician would act under like circum-

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cosmetic surgery in this case was negligent in not taking precuations. For an example dealing with vasectomy, *see* text & note 207 *infra*.

B. A surgeon-patient interview was marked by vague and childish requests for plastic surgery. Despite preliminary warnings from personality test scores, the patient was scheduled for surgery. After receiving the requested surgery, the patient became suicidal and required psychological counseling. The surgery was apparently a precipitating factor. Wright & Wright, *supra* note 4, at 150.

C. Alleging that he was not competent to consent to a vasectomy, a minor sued his physician claiming, among other things, psychological damage due to his inability to procreate. Smith v. Seibly, 72 Wash. 2d 16, 17, 431 P.2d 719, 721 (1967). The issue of a physician's duty to ask questions in hope of avoiding postoperative mental distress was not mentioned in the opinion of the court. See text & note 205 *infra*.

D. A patient who desired to overcome his impotency by having a nasal deformity corrected developed an acute schizophrenic crisis following surgery. Aronoff, *supra* note 11, at 97.

E. A fashion model, later considered "schizophrenic," desired surgery for apparently minor reasons. Following surgery, she became upset, hostile, and engaged in abusive hypothesizing. The patient claimed that the surgeon had planted a piece of his penis in her chin. The surgeon's retort was that he "had none to spare." Aronoff, *supra* note 11, at 98. Although this example is perhaps more humorous than illustrative, it is indicative of postoperative complaints that could possibly have been avoided by proper screening. For other case histories, see text at notes 48, 50 & 79 *supra*.

122. Jefferson, *supra* note 14, at 411.

123. *Id.* at 413-14.

124. See note 100 *supra*.

125. Jefferson, *supra* note 14, at 412. Although a complicated analysis of each patient is not expected, certain principles are basic to effective screening. See text & notes 99-113 *supra*. *See also* Wright & Wright, *supra* note 4, at 151; MacGregor & Schaffner, *supra* note 20, at 288-90.

126. *See* Thompson v. Green Mountain Power Corp., 120 Vt. 478, 483, 144 A.2d 786, 789 (1958); *accord*, Ross v. United States, 365 F. Supp. 1138, 1142 (D. Vt. 1972).

127. *See* Mills v. Charles Roberts Air Cond. Appliances, 93 Ariz. 176, 178-79, 379 P.2d 455, 457 (1963); Seifert v. Owen, 10 Ariz. App. 483, 485, 460 P.2d 19, 21 (1969). *See also* United States v. Carroll Towing Co., 159 F.2d 169, 173 (2d Cir. 1947).

stances.[128] When the burden of taking a precaution is small, and the probability and gravity of harm is great, a legal duty to take the precaution exists.[129] In the case of cosmetic surgery and elective sterilization, the probability of harm may be small statistically, but the burden of making reasonable inquiries and referring doubtful cases to psychologists or psychiatrists to avoid substantial harm is negligible.[130] Therefore, failure to take these precautions is imprudent and unreasonable.

One physician states that he "cannot stress enough the need for the cosmetic surgeon to confront the patient about his fantasies and expectation[s]" regarding the proposed surgery.[131] In many instances, such a confrontation or evaluation will reveal that the patient's real problem is psychological, and that the requested surgery is unnecessary.[132]

In the case of cosmetic and other elective surgery, underlying psychological considerations always exist,[133] and it is the surgeon's responsibility to deal with both the psychological and physical manifestations.[134] To perform surgery without so much as a preliminary diagnosis of the patient's emotional fitness for surgery is negligent,[135] and reduces the physician's role to that of a mere instrument of the whims of patients.[136]

The duty of a physician to be sensitive to the mental and emotional state of his patient is particularly clear in the context of abortion. Referring to a woman's decision whether or not to have an abortion, Justice Blackmun in *Roe v. Wade*[137] said:

Psychological harm may be imminent. Mental and physical health

128. Mills v. Charles Roberts Air Cond. Appliances, 93 Ariz. 176, 178, 379 P.2d 455, 457 (1963).

129. Smith v. Arbough's Restaurant, Inc., 469 F.2d 97, 107 (D.C. Cir. 1972), *cert. denied*, 412 U.S. 939 (1973); United States v. Carroll Towing Co., 159 F.2d 169, 173 (2d Cir. 1947); Conway v. O'Brien, 111 F.2d 611, 612 (2d Cir. 1940), *rev'd on other grounds*, 312 U.S. 492 (1941); Gulf Refining Co. v. Williams, 183 Miss. 723, 733, 185 So. 234, 236 (1938). Chicago, B & Q.R.R. Co. v. Krayenbuhl, 65 Neb. 889, 903-05, 91 N.W. 880, 882-83 (1902). For an example of weighing the burden of precautions against the probability and gravity of harm, see Mills v. Charles Roberts Air Cond. Appliances, 93 Ariz. 176, 379 P.2d 455 (1963), discussing the "utility in having a coffee-grinder in a store . . . compared with the probability that children would injure their fingers in it." *Id.* at 179, 379 P.2d at 457.

130. The burden of reasonable inquiries and adequate screening is not great. *See* Jefferson supra note 14, at 412; Peterson & Topazian, *supra* note 13, at 157; Wright & Wright *supra* note 4, at 151.

131. Jefferson, *supra* note 14, at 414.

132. After recognizing that a famous movie star's request for cosmetic surgery was the product of psychological problems, therapy was suggested and the star rescinded her request for surgery. *Id.* at 413. A boy's preoccupation with the supposed deformities of his nose led physicians to suspect underlying psychological problems and they discouraged the boy's efforts to obtain cosmetic surgery. MacGregor & Schaffner, *supra* note 20, at 283-84.

133. Wright & Wright, *supra* note 4, at 151.

134. *Id.*

135. It is the surgeon's duty to conduct a careful and skillful diagnosis. Golonka v. Gatewood, 199 Neb. 216, 225, 257 N.W.2d 403, 408-09 (1977). In elective surgery, this diagnosis should focus upon emotional fitness. See text & notes 100, 106 *supra*.

136. *See generally* MacGregor & Schaffner, *supra* note 20, at 290.

137. 410 U.S. 113 (1973).

> may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. . . . All these are factors the woman and her responsible physician will consider in consultation.[138]

This statement was made to emphasize the need for a decision to be made by the patient and physician unhindered by state regulation that interferes with the patient's right of privacy.[139] The statement focuses upon the pregnant woman's mental health, and recognizes the duty of a responsible physician to remain attuned to the psychological needs of the patient, regardless of whether his final decision is to perform or not perform the abortion. If a physician has reason to believe that the possible mental harm to the patient outweighs other considerations, he should refuse to perform the abortion. In *Doe v. Bolton*,[140] Justice Blackmun said that "medical judgment may be exercised in light of all factors—physical, emotional, psychological and familial . . . ."[141]

These pronouncements can be interpreted as signifying the importance the judiciary places on the screening of abortion patients to determine beforehand whether a patient will likely be satisfied, physically and psychologically, with her decision.[142] Although the Supreme Court in *Doe v. Bolton* held that an abortion review committee at a state hospital violated the patient's constitutional rights because it unduly burdened the patient's choice to have an abortion,[143] the Court did not rule out restrictions on abortions imposed by private physicians who are interested in the general well-being of their patients. To the contrary, the Court stated that physicians can use their good judgment, and refrain from performing abortions if they feel they have reason to do so.[144] Therefore, although a state may not constitutionally impose broad limitations upon the right of a patient to seek an abortion, it is entirely possible that a physician would be negligent in not imposing his own limitations.[145] Beyond a flat refusal to perform the abortion, a

138. *Id.* at 153.
139. *Id.* at 153-55.
140. 410 U.S. 179 (1973).
141. *Id.* at 192.
142. Marcin & Marcin, *The Physician's Decision-Making Role in Abortion Cases*, 35 JURIST 66, 69 (1975).
143. 410 U.S. 179, 198 (1973).
144. *Id.* at 197-98. One possible reason would be the foreseeability of mental and emotional harm to the woman.
145. One of the reasons that the United States Supreme Court held in *Doe v. Bolton* that a state-imposed abortion review committee violated the Constitution was that the "patient's rights and needs . . . have already been medically delineated and substantiated by her personal physician." 410 U.S. at 198. This indicates great confidence in the medical profession. However, in some instances, a patient for elective surgery will simply shop around; some physicians may notice factors that negate surgery, but eventually, the patient will have the surgery performed. See text & note 207 *infra; see also* Aronoff, *supra* note 11, at 97-98 (after having been refused surgery by one physician, patient had surgery performed elsewhere and eventually committed suicide).

physician could condition the operation upon the patient's informed consent to the risks involved,[146] including the risk of post-operative psychological harm.

Imposing a legal duty upon physicians performing certain kinds of elective surgery to screen patients and deal individually with those who exhibit psychological problems is consistent with theories of tort law concerning medical malpractice. When a physician whose expertise lies in other areas of medicine discovers through careful screening that his patient exhibits a definite need for psychological counseling, such physician is under no duty to take affirmative steps to cure the patient;[147] however, the physician must at least refer the patient to a specialist for counseling before proceeding with treatment.[148] By analogy, because psychological factors are at the root of many requests for elective surgery,[149] the physician should further inquire into patient motivation to assure that psychological problems are not imminent.

Breach of Duty as the Cause of Psychological Harm

In addition to proof of a duty to screen, an injured plaintiff seeking redress in an action for negligence must prove a reasonably close relationship between the physician's omission and the ultimate injury.[150] In other words, the physician's breach of duty must be the proximate cause of the patient's injury.[151] Proximate cause consists of cause in fact and a legal limitation.[152] Although it is stated that a cause in fact is an event that brings about results that would not have occurred "but

146. See text & notes 165-207 *infra*.

147. Brandt v. Grubin, 131 N.J. Super, 182, 190, 329 A.2d 82, 86 (1974).

148. *See id.* at 193-94, 329 A.2d at 84-86. In *Brandt*, the plaintiff's expert witness argued that the defendant was negligent in not seeing "to it that the patient got psychiatric consultation and evaluation before making any recommendations whatsoever. To simply . . . tell the patient to get psychiatric help was clearly inadequate. . . ." *Id.* at 186, 329 A.2d at 85. The court rejected the argument that the physician must see to it that the psychiatric attention is received, but apparently agreed that there is a duty to refer patients for psychiatric counseling. *Id.*

149. See notes 18 & 100 *supra*.

150. *See* Pacht v. Morris, 107 Ariz. 392, 394, 489 P.2d 29, 31 (1971). This necessary element of a cause of action for negligence is called "proximate cause." *Id.*; W. PROSSER, J. WADE, V. SCHWARTZ, CASES AND MATERIAL ON TORTS 146 (6th ed. 1976).

151. W. PROSSER, J. WADE, V. SCHWARTZ, *supra* note 150 at 146.

152. The cause in fact requirement is usually satisfied when the defendant's conduct is a substantial factor in producing the plaintiff's injury. Steinhauser v. Hertz Corp., 421 F.2d 1169, 1172 (2d Cir. 1970); Anderson v. Minneapolis St. P. & S. St. M.R.R., 146 Minn. 430, 179 N.W. 45 (1920); W. PROSSER, *supra* note 120, § 41, at 240. The "legal limitation" requirement is one imposed by social policy. *In re* Kinsman Transit Co., 338 F.2d 708, 725 (2d Cir. 1964), *cert. denied*, 380 U.S. 944 (1965); W. PROSSER, *supra* note 120, § 43, at 257. This policy determines whether, under the circumstances, the defendant should be liable. It is a policy based partly upon the foreseeability of harm. W. PROSSER, *supra* note 120, § 43, at 257-58. "It is all a question of expediency . . . of fair judgment, always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind." Palsgraf v. Long Island R.R., 248 N.Y. 339, 354, 162 N.E. 99, 104 (1928). *See generally* Green, *Proximate Cause in Texas Negligence Law*, 28 TEX. L. REV. 471 (1959); Probert, *Causation in the Negligence Jargon*, 18 U. FLA. L. REV. 369 (1965); Prosser, *Proximate Cause in California*, 38 CAL. L. REV. 309 (1950).

for" the event,[153] the courts generally accept as a cause in fact those events that are material elements[154] or substantial factors[155] in bringing about particular results.

That a failure to screen can cause or aggravate psychological harm is evidenced by the following statement referring to a patient's adverse postoperative experience: "Had more information been available, the surgeon might conceivably have . . . averted such eventualities."[156] Since a "cause" includes substantial or material factors contributing to the ultimate injury, a patient-plaintiff suing for postoperative psychological harm need not claim that he had no pre-existing problems or vulnerabilities;[157] he need only prove that regardless of his previous mental state, the physician's conduct has been a precipitating and substantial factor that has triggered new problems.[158] For example, a child who previously had propensities toward schizophrenia may sue the driver of an automobile whose negligence is a substantial factor precipitating an acute form of schizophrenia.[159] Similarly, a patient who becomes schizophrenic following elective surgery,[160] where the physician negligently failed to screen, should be able to sue the physician provided his condition has been aggravated by surgery.

There are two reasons why such a suit may be successful. First, there is ample literature and evidence establishing foreseeability of harm and thus a duty to screen.[161] Second, a physician could not de-

153. *See* Tennessee Trailways, Inc. v. Ervin, 222 Tenn. 523, 527, 438 S.W.2d 733, 735 (1969); *see generally* Strachan, *Scope and Application of the "But For" Causal Test*, 33 MOD. L. REV. 386 (1970).

154. *See* Steinhauser v. Hertz Corp., 421 F.2d 1169, 1172 (2d Cir. 1970); Anderson v. Minneapolis St.P. & S.St. M.R.R., 146 Minn. 430, 439, 179 N.W. 45, 48 (1920).

155. "[I]n order for something which is a cause in fact to be a legal cause . . . it shall have been a substantial factor in bringing about the harm." Krauss v. Greenbarg, 137 F.2d 569, 572 (3d Cir. 1943); *accord*, Eazor Express, Inc. v. International Bro. Team., etc., 520 F.2d 952, 967 (3d. Cir. 1975); Anderson v. Minneapolis, St. P. & S.St. M.R.R., 146 Minn. 430, 439, 179 N.W. 45, 48 (1920).

156. MacGregor & Schaffner, *supra* note 20, at 290.

157. Steinhauser v. Hertz Corp., 421 F.2d 1169, 1172 (2d Cir. 1970) (recovery would be permitted if plaintiff's schizophrenia were shown to be precipitated by defendant's negligence although plaintiff had previous signs of potential schizophrenia); Evans v. S.J. Groves & Sons Co., 315 F.2d 335, 347 (2d Cir. 1963) (prior ear disease is not a bar to recovery for injury which is triggered by blow to head); McCahill v. New York Transp. Co., 201 N.Y. 221, 224, 94 N.E. 616, 618 (1911) (negligence causing death of respondent's intestate is actionable for "hastening" the onset of delirium tremens although such a condition may have otherwise developed).

158. See cases cited note 157 *supra*.

159. Steinhauser v. Hertz. Corp., 421 F.2d 1169, 1172 (2d Cir. 1970).

160. Schizophrenia, a disorder characterized by disturbances of thinking, mood and concepts of reality, TABER'S CYCLOPEDIC MEDICAL DICTIONARY S-18 (13th ed. 1977), is a very frequent psychiatric problem among patients for elective surgery. *See* Aronoff, *supra* note 11, at 97 (patient desiring to become "potent" by having nose job developed acute schizophrenia postsurgically); Johnson, *supra* note 75, at 484-85 (patients developed schizophrenia after having vasectomies). The most frequent psychiatric problem found among patients for cosmetic surgery is paranoid schizophrenia. Jefferson, *supra* note 14, at 416. One such patient accused his doctor of being a F.B.I. agent and murdered him in his own office. *Id.*

161. See discussion note 121 *supra*.

fend by stating that the specific harm to the plaintiff's mental stability was unforeseeable. This reasoning is an adjunct of the principle that negligent defendants take the plaintiff as they find him.[162] Just as one who injures a man with an eggshell skull is not entitled to defend by claiming the unforeseeability of the plaintiff's vulnerable physique,[163] a physician cannot defend by claiming that the patient's particular vulnerability to psychological problems was unforeseeable.

In the case of psychological harm following elective surgery, the patient-plaintiff can argue that had the physician either refused surgery, or warned of the imminent risks of psychological harm, thereby better educating the patient as to the advisability of surgery, the surgery would never have been performed.[164] The latter alternative of warning the patient of the risk of postoperative psychological harm will be discussed in the section that follows.

Informed Consent

Informed consent is consent to therapy made with knowledge of the options available and the risks of each.[165] Although a total absence of "consent" may give rise to an action for battery,[166] a lack of informed consent is more appropriately an issue of negligence.[167] The duty of physicians to fully disclose risks and options is incident to the fiduciary relationship between physician and patient,[168] and is intended to enable the patient to rationally accept or reject the proposed treatment.[169] The physician, in protecting the interests of his patient, must communicate information to the patient when reasonable care so requires,[170] and must advise the patient "of any risks to his well-being

162. When a plaintiff sustains personal injuries, the defendant need not be able to foresee the extent of such injuries; he need only foresee the general category of risk to which he subjects the plaintiff. *In re* Kinsman Transit Co., 338 F.2d 708, 723-24 (2d Cir. 1964), *cert. denied*, 380 U.S. 944 (1965). *See* Thompson v. Lupons, 135 Conn. 236, 239, 62 A.2d 861, 863 (1948) (overweight woman required a longer than usual recovery period); Ominsky v. Charles Weinhagen & Co., 113 Minn. 422, 423-24, 129 N.W. 845, 846 (1911) (woman lost hair due to fright); *see* cases cited note 157 *supra*.

163. Dulieu v. White & Sons, 2 K.B. 669, 679 (1901).

164. If a surgeon uses his judgment, and refuses surgery on the basis of information acquired from careful screening, no problem of liability will arise. *Cf.* Doe v. Bolton, 410 U.S. 179, 197-98 (1973) (a physician may refuse to perform an abortion). However, the physician should have the option of obtaining a patient's informed consent to surgery based on the disclosure of risks of psychological harm. See text & note 173 *infra*.

165. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1636 (1974).

166. Cobbs v. Grant, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). *But see* ARIZ. REV. STAT. ANN. § 12-562(B) (1977) (eliminating battery as a cause of action in medical malpractice cases).

167. Cobbs v. Grant, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

168. R. LONG, *supra* note 36, at 45; Note, *supra* note 165, at 1637-38.

169. R. LONG, *supra* note 36, at 45.

170. Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 240-43, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

which the contemplated therapy may involve."[171] The duty to inform is an offshoot of the maxim: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[172] Only with knowledge of options and risks can a patient truly choose his own destiny.

Physicians performing elective surgery cannot avoid their duty to carefully screen patients to determine whether the patient's problem is basically psychological and whether the patient is emotionally fit for surgery.[173] However, when physicians detect danger signs during the screening process there should be an option of either refusing to perform the surgery or obtaining the patient's informed consent based upon disclosure of risks of psychological harm.

It should be stressed that patients who have psychological problems or who are vulnerable to such problems generally are not incompetent to give consent to surgery.[174] To be incompetent, more than a peculiar personality or psychological instability must exist; it must be shown that the patient is not of sound mind[175] or is insane by "clear, cogent and convincing evidence."[176] He must be unable to distinguish between right and wrong or to comprehend the nature and consequences of his actions.[177] However, because the determination of whether a patient is competent to give consent is a "question of fact to be determined from the circumstances of each individual case,"[178] it is possible that severe psychological problems could render an individual incompetent to consent to surgery.[179] In such a case, the value of

171. Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *see* Miller v. Kennedy, 11 Wash. App. 272, 284-86, 522 P.2d 852, 863 (1974).

172. Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914); *accord*, Karp v. Cooley, 493 F.2d 408, 419 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *In re* Long Island Jewish-Hillside Med. Center, 73 Misc. 2d 395, 397, 342 N.Y.S.2d 356, 359 (Sup. Ct. 1973).

173. Part of the surgeon's duty to diagnose includes reasonable efforts to determine whether the patient's problem is physical or psychological, and whether the patient's motivation is healthy. For a discussion of reasonable care in detecting the patient's underlying problem, see text & notes 114-18; discussion note 100 *supra*.

174. When a patient is "vulnerable" to possible postoperative psychological harm, such as great depression or forms of schizophrenia, see discussion note 161 *supra*, it can hardly be said that, at the time of surgery, the patient was not mentally competent to give consent to surgery. Similarly, mild forms of psychiatric problems, which may be aggravated by surgery, are not evidence that can overcome by "clear, cogent and convincing evidence" the presumption of a patient's sanity. *See* Grannum v. Berard, 70 Wash. 2d 304, 307, 422 P.2d 812, 814 (1967).

175. Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). *See also In re* Long Island Jewish-Hillside Medical Center, 73 Misc. 2d 395, 397, 342 N.Y.S.2d 356, 359 (Sup. Ct. 1973); Oklahoma Natural Gas Corp. v. Lay, 175 Okl. 75, 76, 51 P.2d 580, 582 (1935) (there must exist a privation of reasoning faculties).

176. Grannum v. Berard, 70 Wash. 2d 304, 307, 422 P.2d 812, 814 (1967). *See also* Page v. Prudential Life Ins. Co., 12 Wash. 2d 101, 109, 120 P.2d 527, 531 (1942).

177. *See* Johnson v. Maine & New Brunswick Insurance Co., 83 Me. 182, 186, 22 A. 107, 108 (1891) (insanity signifies unsoundness of mind or derangement of the intellect).

178. *Id.*

179. Although this Note will not attempt to define the characteristics of the "incompetent" patient who is incapable of giving consent to surgery, it should be noted, as an example, that some pre-existing psychotic behavior that may be indicative of potential postoperative problems, *see*

screening is profound because such patients can be identified and the careful surgeon will refuse surgery.

Assuming a competent patient, the scope of disclosure required of physicians extends to all material dangers inherently involved in each therapy.[180] It has already been noted that in the case of elective surgery, psychological considerations are material and inherent to the decision whether to operate.[181] However, the duty to disclose has limitations. There is no duty to disclose obvious risks.[182] Nor is there usually a general duty to inform the patient of all known risks,[183] or risks not recognized in the community as worthy of disclosure.[184]

When physicians who are requested to perform elective surgery have reason to believe that there is a risk of psychological harm, reasonable care should require disclosure of such risks.[185] These risks, like risks of physical injury inherent in various medical therapies, can be substantial, and where disclosure would have influenced the patient to

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Wright & Wright, *supra* note 4, at 148, is not reliable evidence of incompetence. Certain types of psychoses have little or no effect on intellectual functioning. *See* TABER'S CYCLOPEDIC MEDICAL DICTIONARY P-162 (13th ed. 1977). Furthermore, many of the pre-existing psychological conditions that surgeons recognize as warning signals in elective surgery—depression, tension, fear and paranoia—are only marginally relevant to sanity. *See generally* Wright & Wright, *supra* note 4, at 146. No one would contend that an emotionally upset man who desires to have a vasectomy to please his estranged wife and convince her to return is insane or is of unsound mind. *See generally* Johnson, *supra* note 75, at 484. Likewise, no one would contend that a woman whose emotional upset concerning a nasal deformity was insane for expressing the belief that her nose was the cause of her low social esteem. *See* Aronoff, *supra* note 11, at 97.

180. Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 240-43, 502 P.2d 1, 10-11, 104 Cal. Rptr. 505, 514 (1972).

181. See text & note 19 *supra; see generally* discussion note 121 *supra*. Individuals who seek cosmetic surgery always have psychological considerations. Wright & Wright, *supra* note 4, at 151.

182. *See* Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 630 (1970).

183. In Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965), the Arizona Court of Appeals rejected the notion of a duty to disclose all recognized risks: "This is too great a penalty to inflict upon a surgeon seeking to do no harm. And because of the emotional frailties of the human species, we do not believe such a rigid rule is in the best interests of society." *Id.* at 370, 409 P.2d at 86. *But see* Hales v. Pittman, 118 Ariz. 305, 576 P.2d 493 (1978). Although this statement may be valid as a general proposition, it clearly does not bar a suit in which the issue relates to the duty to disclose risks of psychological harm following elective surgery. Such harm is foreseeable, and is a "probable result" when the patient's decision-making is oftentimes irrational. See text & notes 100 & 121 *supra*.

For a discussion of a recent shift in Arizona law on disclosure and informed consent, see "The Physician's Duty to Disclose Risks of Treatment," 20 ARIZ. L. REV. — (1979).

184. DiFilippo v. Preston, 53 Del. 539, 543, 173 A.2d 333, 336 (1961); Note, *supra* note 165, at 1637. In Arizona, the community standard is defined by statute. The standard is "that degree of care . . . expected of a reasonable, prudent health care provider in the profession or class to which he belongs within the state acting in the same or similar circumstances. . . ." ARIZ. REV. STAT. ANN. § 12-563(1) (Supp. 1977).

185. See discussion note 192 *infra*.

186. Because one of the essential elements of negligence is a causal connection between the unreasonable conduct and the resulting injury, W. PROSSER, *supra* note 120, § 30, at 143, it must be shown that screening and disclosure of the risks of surgery would have induced the patient-plaintiff to decide against the proposed treatment. Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 194

refuse surgery,[186] nondisclosure is negligence.[187] When dealing with vasectomy patients, surgeons should warn of the risks of postoperative schizophrenia and paranoia that can result when the patient's motivation is unhealthy.[188] Surgeons should also warn of the risks of adverse psychological functioning and decreased marital happiness and harmony.[189] When dealing with female patients electing sterilization, physicians should warn of the risks of adverse psychiatric effects due largely to the unsatisfied motherhood drive.[190] In the case of cosmetic surgery, the surgeon should warn of the adverse psychiatric effects that are prevalent when the patient has unrealistic expectations.[191] These adverse effects include schizophrenia[192] and depression.[193]

Although community standards have long been significant in de-

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Cal. Rptr. 505, 515 (1972). Careful screening and disclosure frequently influences the patient against surgery. *See* Smith v. Seibly, 72 Wash. 2d 16, 18, 431 P.2d 719, 721 (1967) (patient initially refused a vasectomy because family doctor noted marital difficulties); Jefferson, *supra* note 14, at 414; MacGregor & Schaffner, *supra* note 20, at 284 (patient with exaggerated complaints concerning his nose was discouraged from having surgery).

187. In order to establish a cause of action for negligence, however, the patient-plaintiff must prove actual loss or damage characterized by substantial symptoms that are capable of objective determination. *In re* United States, 418 F.2d 264, 269 (1st Cir. 1969); D'Ambra v. United States, 396 F. Supp. 1180, 1183 (D.R.I. 1973); Owens v. Childrens Memorial Hosp., 347 F. Supp. 663, 666-67 (D. Neb. 1972).

In dealing with actions where emotional disturbances comprise the bulk of the alleged damages, courts attempt to ferret out fraudulent claims by requiring proof of actual physical consequences. W. PROSSER, *supra* note 120, § 54, at 328-29 and cases cited therein. The definition of "physical" however, is quite broad. Physical harm is harm that is substantial and manifested by objective symptomatology. Wallace v. Coca-Cola Bottling Plants Inc., 269 A.2d 117 (Me. 1970). By this definition, recovery can be had for negligent action causing nervous disorders or mental suffering. *In re* United States, 418 F.2d 264, 269 (1st Cir. 1969).

> In the light of advances which have been made by medical science and the improvement in investigatory techniques . . ., we adopt the rule that in those cases where it is established by a fair preponderance of the evidence there is a proximate causal relationship between an act of negligence and reasonably foreseeable mental and emotional suffering by a reasonably foreseeable plaintiff, such proven damages are compensable even though there is no discernable trauma from external causes. The mental and emotional suffering, to be compensable, must be substantial and manifested by objective symptomatology.

Wallace v. Coca-Cola Bottling Plants Inc., 269 A.2d 117, 121 (Me. 1970). In determining whether or not a substantial nervous disorder has resulted, the attorney for the plaintiff should introduce evidence of changes in personality and working habits, and the amount of treatment required. *See* Note, *Torts—Expanding the Concept of Recovery for Mental and Emotional Injury*, 76 W. VA. L. REV. 176, 187 (1974). The plaintiff should introduce expert testimony concerning adverse psychological changes in his personality that have been caused by surgery. Both the testimony of experts such as psychiatrists and psychologists, and the results of objective tests such as the Minnesota Multiphasic Personality Inventory Test, see discussion note 41 *supra*, should be admissible. *See* United States v. Riggleman, 411 F.2d 1190, 1191 (4th Cir. 1969) (allowing the introduction of expert testimony and results of psychological tests). *See also* Hidden v. Mutual Life Ins. Co., 217 F.2d 818, 821 (4th Cir. 1954).

188. Johnson, *supra* note 75, at 484-85. See text & note 80 *supra*.

189. *See* Ziegler, Rodgers, & Prentiss, *supra* note 82, at 46; Ziegler, Rodgers, & Kriegsman, *supra* note 84, at 62. See text & notes 81-83 *supra*.

190. Wolf, *supra* note 26, at 112. See text & note 65 *supra*.

191. A key factor in predicting the postoperative psychiatric problems is the patient's expectations. Reich, *supra* note 13, at 7.

192. For examples of postoperative schizophrenia, see Wright & Wright, *supra* note 4, at 148; Aronoff, *supra* note 11, at 97.

193. For examples of postoperative depression, see Wright & Wright, *supra* note 4, at 150; Aronoff, *supra* note 11, at 98 (patient committed suicide within eight months following surgery).

fining acceptable conduct within the medical profession,[194] there is a trend toward a general standard of reasonable care.[195] Courts following this trend demand that specific information be communicated to the patient when the "exigencies of reasonable care call for it."[196] Consistent with this trend, disclosure of the risks of psychological harm caused by elective surgery should be mandatory when reasonable diligence so requires.[197]

In addition to patient screening, if a physician chooses to use a standard consent form, it is advisable to adapt the form to the needs of elective surgery. In *Sard v. Hardy*,[198] a case involving elective sterilization, the defendant-physician received a favorable verdict on the issue of negligence in performing an unsuccessful operation. The topic of psychological harm following elective surgery was not an issue, but the consent form[199] used in that case is an example of one that is deficient in numerous respects. In elective surgery of the type discussed in this Note, the patient's decision-making, motivation, expectations, and relationships with others are all vital considerations in determining whether to perform the surgery.[200] Yet the consent form in *Sard*

194. *See* Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Note, *supra* note 165, at 1637.

195. Note, *supra* note 165, at 1639. *See* Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); Small v. Gifford, 133 Vt. 552, 557, 349 A.2d 703, 705 (1975); Hellig v. Carey, 83 Wash. 2d 514, 519, 519 P.2d 981, 983 (1974); Miller v. Kennedy, 11 Wash. App. 272, 284-86, 522 P.2d 852, 863 (1974). This trend was explained in Small v. Gifford, 133 Vt. 552, 349 A.2d 703 (1975) where the court, dealing with a malpractice suit in elective surgery, concluded that the "medical community's practice as a standard by which the sufficiency of the information furnished is measured is unduly restrictive." *Id.* at 557, 349 A.2d at 706. In *Small*, the plaintiff contracted hepatitis as a consequence of surgery and sued an anesthesiologist for not disclosing such a risk. The court rejected the defendant's reference to community standards regarding the disclosure of risks. *Id.*

196. Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

> The duty to warn and to advise of alternatives does not arise from and is not limited by the custom of physicians in the locality. Rather, it exists as a matter of law if: 1) the risk of injury inherent in the treatment is material, 2) there are feasible alternative courses available, and 3) the patient can be advised of the risks and alternatives without detriment to his well-being.

Miller v. Kennedy, 11 Wash. App. 272, 284-86, 522 P.2d 852, 863 (1974); *accord*, Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972). Abandoning the community standard where such standard is unreasonable, *see* Hellig v. Carey, 83 Wash. 2d 514, 517-19, 519 P.2d 981, 983 (1974).

In the context of elective surgery, the factors listed above are relevant because the risk of psychological harm is material. See discussion note 121 *supra*. Because the surgery is "elective," there are the alternatives of either having psychotherapy for a problem that is psychiatric in nature, or having no surgery at all.

197. Although prevailing medical practice may provide a useful benchmark by which to judge conduct in a specific case, prevailing practice "does not itself define the standard." Canterbury v. Spence, 464 F.2d 772, 784-85 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). *See also* Hellig v. Carey, 83 Wash. 2d 514, 517-19, 519 P.2d 981, 983 (1974).

198. 34 Md. App. 217, 367 A.2d 525 (1977).

199. *Id.* at 235 n.5, 367 A.2d at 535 n.5.

200. For discussions of the various factors that should be considered in evaluating a patient's request for surgery, see text & notes 52, 63, 67, 70, 90, 92, 94, 103, 105-08 *supra*.

sought mainly to ensure that the patient understood what sterilization is, and that the consent given was voluntary.[201] In order to ensure that the patient understands the risks—both physical and psychological—of elective surgery, the form should inquire into the patient's motivation for requesting surgery as well as the role that friends and family members have played in the decision. As previously stated, requests for sterilization may represent irrational attempts to repair failing marriages.[202] Even in cosmetic surgery, it is recommended that parents or spouses be present during counseling interviews in order to avoid decisional problems and facilitate an exploration of patient motivation.[203] Although the presence of parents and spouses should not be required, a careful physician should ensure that the patient has adequately considered the role that they play in the patient's satisfaction with the results of surgery. In obtaining a patient's consent to sterilization, a consent form should make clear that the patient has carefully evaluated his desires regarding procreation.[204] It is not enough merely to have the patient sign a form that states that procreation will no longer be possible following sterilization.

In *Smith v. Seibly*,[205] a minor patient who consented to a vasectomy was denied relief against his physician when he contested the validity of his consent and sued for psychological damage as a result of his inability to procreate. The court based its decision upon a finding that the consent was valid,[206] but the adequacy of the screening process employed by the physician was not discussed. Interestingly, however, the first physician the plaintiff saw refused to perform the requested vasectomy on the grounds that the plaintiff had unstable marital relations.[207] It is possible that the physician who ultimately performed the vasectomy was negligent in not taking precautions similar to those of the first physician and by failing to obtain consent based upon knowledge of the risk of psychological harm that exists when a patient fails to consider thoroughly the implications of his decision.

CONCLUSION

Elective surgery is different from other forms of surgery because subjective desire, rather than objective need, is the usual motivator.

201. Sard v. Hardy, 34 Md. App. 217, 235 n.5, 367 A.2d 525, 535 n.5 (1977).
202. See text at note 60 *supra*.
203. Wright & Wright, *supra* note 4, at 151.
204. See text at note 70 *supra*.
205. 72 Wash. 2d 16, 431 P.2d 719 (1967). See discussion note 121 *supra*.
206. *Id.* at 20-22, 431 P.2d at 723-24.
207. *Id.* at 17, 431 P.2d at 721. After having been refused the operation by the family physician, the plaintiff sought and found another physician to perform the operation. *Id.* See also text at note 63 *supra*.

According to a significant number of studies, when the patient's motivation and expectations are irrational, a failure to carefully screen patients may lead to postoperative psychological harm. A surgeon confronted with a high risk patient should either refuse surgery, or disclose the risk of psychological harm involved. To require less of surgeons is to allow patients to enter operating rooms without regard to foreseeable and substantial consequences. Although elective surgery is, by definition, surgery by choice, rather than by need, it should not merely be a service available upon simple demand.