It is impossible to summarise a detailed presentation from an expert within a few paragraphs, but by way of a very brief overview or recap*, the key points were these:

- Prof. Veale highlighted how little research and data there is into how many patients seeking aesthetic surgery suffer from psychological vulnerabilities, including BDD. Therefore his views and comments were based on his experience in practice and as an expert, and some limited reported studies, rather than on numerous peer-reviewed publications based on large-scale studies. The focus of his presentation was BDD.
- Patients seeking aesthetic surgery might suffer from a range of psychiatric conditions ranging from Mania (rare) through to personality disorder and BDD. The labels for personality disorders are not exact and may overlap. Prof. Veale suggested that the personality disorders to look out for in particular include:
    - Borderline/emotionally unstable personality – these patients are very impulsive and may self harm in other ways. Their moods go up and down frequently. They experience self-hatred and fear of abandonment;
    - Histrionic personalities (highly dramatic);
    - Narcassistic personalities.
- Prof. Veale's view is that around 10% of outpatients from cosmetic surgery have BDD, compared with around 2% of the general population.
- Prof Veale's view is that the categories of patients who are likely to have higher rates of dissatisfaction with a cosmetic procedure are:
    - Male, single, young patients,
    - Those with a personality disorder,
    - Patients seeking procedures to change their appearance (e.g. rhinoplasty) rather than to restore a previous appearance,
    - Patients with an unrealistic expectation of the psychosocial outcome,
    - Patients where there is a large discrepancy between their subjective concern and an objective assessment of the 'deformity',
    - Patients with a history of being dissatisfied with the outcome of previous procedures, even where the objective outcome seemed acceptable,
    - Patients seeking to emulate the appearance of a celebrity,
    - Those with psychiatric contra-indications.
- Prof. Veale explained that BDD can be diagnosed by a suitably qualified psychiatrist, and the diagnostic criteria includes the patient having a preoccupation with perceived defects or flaws that are not noticeable or appears only slight to others. BDD is associated with repetitive behaviours, like looking in mirrors, touching their skin, reassurance seeking. The patient will be significantly distressed by their appearance, causing interference in their life. It is not an eating disorder – the focus is on their face often or a body part – it is not about being fat or the shape of their body. Also, it is not vanity – BDD patients hate themselves and are not narcissistic. They tend to feel defined by the feature or perceived deformity that defines them.
- By contrast, Prof Veale explained that patients who seek repeated cosmetic surgery do not necessarily have BDD. Some patients seek to extensively change their appearance over time and are happy with the results. Similarly, patients who are seeking an extreme beauty ideal (e.g. seeking much more lip filler than normal to achieve an extremely full lip shape) do not necessarily have BDD.

- Unfortunately, BDD can be difficult to identify in patients seeking cosmetic procedures. There seems to be a low level of awareness of the condition, and also patients can be secretive about their BDD symptoms to avoid the perceived stigma associated with it.
- Prof. Veal confirmed that there are treatments available for BDD. He emphasised that the treatments are not always successful and that the condition is quite difficult to treat. Mild BDD can be treated with Cognitive Behavioural Therapy (CBT) and moderate to severe BDD can be treated with CBT and Selective Serotonin Reuptake Inhibitors (SSRI) therapy. However, an example of successful treatment is where a patient is asked to draw a self-portrait featuring their perceived 'defect' such as a perceived very large nose (larger than it appears in real life), and then to draw another after treatment. Where the second self-portrait accurately represents the size of the nose, then the therapy has worked as a sort of "psychological rhinoplasty."
- Prof. Veal considered whether patients with BDD should have surgical cosmetic procedures. His expert view on balance is that they should not, but emphasised that his view is necessarily somewhat tentative because there is insufficient data about how BDD patients fare following psychological therapy only, surgical intervention only, or a combination of both. He suggested that it may be that BDD patients with very localised concerns might have as good an outcome (in terms of satisfaction) from surgical intervention as patients without BDD.
- Unfortunately it is difficult to be sure about the additional risks (including to their mental health) faced by patients with BDD (diagnosed or otherwise) who are seeking cosmetic surgery. Prof. Veale explained that there is a lack of research in this area. But in his opinion, BDD makes the patient's satisfaction with the surgery outcome unpredictable. Even if the patient is satisfied with the outcome of that particular surgery, the symptoms of BDD may persist and the focus of the preoccupation may change to another part of the body or face. A patient with BDD may also find that their symptoms of preoccupation with their appearance are worse after surgery.

Should aesthetic or cosmetic surgeons try to screen for BDD and other psychological vulnerabilities?

The legal Bolam test (applicable in the UK) states that surgeons must act to the standard of a reasonable group of surgeons of the same specialism in the same circumstances. In the event of a litigated compensation claim, this would be decided on a case by case basis on the basis of the factual and expert evidence.

There might be some specific situations where a surgeon could prove that there is a reasonable group of surgeons who would not carry out any psychiatric screening. But it seems that the wider trend is that surgeons should be carrying out some form of psychiatric screening of their patients as a matter of course.

For example, the 2016 GMC *Guidance for Cosmetic Interventions* confirmed that surgeons must consider the psychological needs of their patients. The 2016 RCS *Professional Standards for Cosmetic Surgery* states that surgeons must 'make attempts' to identify the psychologically vulnerable patients. In October 2019 the CQC sent an open letter to independent cosmetic surgery providers stating that, '*clinicians must have a system in place to assess a patient's psychological state*'.

In the future, it will be harder for surgeons to defend claims for psychological injury following aesthetic plastic surgery if there was insufficient psychiatric screening (or the screening was insufficiently documented).

Also, even where a surgeon can satisfy the Bolam test and show that there is a reasonable group of surgeons who would not carry out any psychiatric screening, the Bolitho legal test gives the court an opportunity to find that the surgeon was nevertheless negligent. The court can decide whether the practice of that purportedly reasonable group of surgeons stands up to logical scrutiny. In other words, even if you can show that lots of other surgeons do not carry out any psychological screening for prospective cosmetic surgery patients, there would always be a risk that a court would nevertheless find that this was irrational given the known (albeit difficult to quantify) risks of carrying out cosmetic surgery on a patient with an underlying psychiatric condition such as BDD.

On balance, therefore, Incision Members should probably be carrying out some form of screening on all prospective patients to give them the best prospect of being able to demonstrate that they are complying with all their duties.

Screening vs diagnosis

Very few specialist aesthetic plastic surgeons will have a dual qualification in psychiatry. All GMC regulated surgeons have an obligation to refrain from providing care if they are not competent to provide it. Aesthetic plastic surgeons should be reassured that they are not obliged to actually diagnose (let alone try to treat) psychological vulnerabilities in their patients. Only an appropriately trained mental health professional could fully assess or diagnose the patient's psychological vulnerabilities.

Interaction with Montgomery informed consent

The 2015 leading case on informed consent (*Montgomery*) made it clear that patients need to be informed of all risks that are material to that individual patient. All aesthetic plastic surgeons are highly experienced in explaining the potential physical complications and side effects of surgery (infection, asymmetry, need for revision surgery etc). But it may be that not all aesthetic plastic surgeons are doing enough to explain the potential for mental health/psychological complications.

The risk of mental health consequences or outright psychological injury could be 'material' to many patients, but for patients with existing psychological vulnerabilities, they could be absolutely key to the question of whether aesthetic plastic surgery is actually in their best interests overall. Without express advice on this aspect, they are unlikely to be able to give properly informed consent to the surgery. A lack of informed consent can in itself give rise to a compensation claim, even where the surgery was performed perfectly.

Another aspect of 'materiality' is how prevalent a particular risk is. Prof. Veale has explained why the lack of relevant research and data makes it difficult to say with any precision what additional risks are faced by patients with BDD (diagnosed or otherwise) who have cosmetic surgery. But Prof. Veale estimates that around 10% of patients seeking cosmetic surgery may have BDD. This is very significant, because it implies that is statistically likely that a surgeon will be consulting with a number of patients each week who have BDD. When you consider how many of your prospective patients may have BDD, and also the fact that patients are often secretive about their symptoms making screening harder, the likely conclusion is that surgeons should routinely be including information about BDD and the risks associated with it as part of their patient consultation and consenting process. That way any patients whose BDD is not picked up by screening, nevertheless have a better prospect of being adequately consented for their intended surgery.

Another aspect of informed consent is the need to make clear what alternative treatments are available. Prof. Veale has highlighted that where BDD treatment is successful it can remove the need for surgery at all because the patient no longer has a distorted and negative perception of the feature that had been causing them concern. If a "psychological rhinoplasty" (or equivalent for other procedures) is a possible alternative treatment, then the patient needs to know this before they can decide whether they wish to accept the risks associated with invasive surgery.

Incision Members have access to detailed guidance notes on *Montgomery* informed consent, and it would be worthwhile revisiting them with this issue in mind. [Nathasha – perhaps insert links to the full "Patient Consent Short Series Parts 1-4" that I first wrote for you in early 2019?]

What screening steps should surgeons take?

This is a complex question! Most aesthetic plastic surgeons would need advice and guidance from an appropriately qualified specialist on how to design and implement an effective (yet efficient) screening system to identify patients with psychological vulnerabilities. A well-designed process will need to take into account:

- the diverse range of conditions or incidents that can leave a patient with psychological vulnerabilities, and
- the fact that some patients lack insight into their own psychological vulnerabilities, and some may actively seek to hide them, and
- the surgeon's particular practice, including what sort of procedures they provide and through which private hospital or clinic group.

If a potential psychological vulnerability is known or identified through screening, it is often appropriate for the patient to obtain a detailed mental health assessment before the procedure so that the mental health professional can assist in identifying the risk of psychological complications for that particular patient. Only once the patient understands those risks can they give informed consent to them (or decide not to go ahead).

With that in mind, all surgeons should have a good referral network so that they can promptly identify and refer patients for mental health assessments before they can continue on the path towards surgery.

Happily, Prof. Veale (who would likely be a valuable addition to your referral network) has provided guidance for Incision insureds on screening for BDD specifically, and in summary his guidance and recommendations in relation to BDD are as follows:

- Use a specially designed screening questionnaire for BDD such as the one being developed by Prof. Veale and colleages, called "Cosmetic Procedures Screening Questionnaire" (COPS). The screening questionnaire is freely available for use, and can be downloaded here COPS Part 1 (kcl.ac.uk). Information notes on how to use and interpret the patient's responses can be found here 33_COPS_for_BDD_2011_short.pdf (kcl.ac.uk) Development of a Cosmetic Procedure Screening Questionnaire (COPS) for Body Dysmorphic Disorder - Research Portal, King's College, London (kcl.ac.uk)
- As you will see from the COPS questionnaire, the advice of Prof. Veale and his colleagues is that you should include the following questions in your standard patient health questionnaire to help screen and assess for BDD:

    - What concerns do you have about your appearance? How noticeable do you think it is? [*The aim is to assess whether there is a discrepancy between perceived appearance and their actual appearance*.]
    - On a typical day, how many hours a day is your appearance at forefront of your mind? [*Anything more than an hour a day (2 hours for adolescents) is a concern*]
    - Do you find that your concerns about your appearance preoccupy you? Do you ruminate or brood over them?
    - Do you find that you have to check your appearance a lot? For example looking in mirrors a lot.
    - Do you find that you carry out other actions often such as comparing your present appearance with old photos, checking/touching/inspecting/measuring the feature of concern, and explaining to others why you consider the defect exists?
    - Do you find your appearance distressing/shameful?
    - Do your concerns about your appearance interfere with your ability to study/work?
    - Do your concerns about your appearance interfere in dating/your relationship/your social life?
    - Do you have multiple concerns about your appearance [*Need to give space for the patient to list all the concerns – multiple concerns are potentially an indicator of BDD*]
- Reassure patients that screening for psychiatric vulnerabilities is a normal and essential part of the process, and try to reduce any stigma that the patient may feel is associated with psychological vulnerabilities.
- When you meet the patient in person, be alert to other indicators of BDD in their dress or mannerisms. These can include: Wearing a hat, sunglasses, baggy clothes, scarf inappropriately; Visible body piercings or tattoos to distract attention from their perceived defect; Heavily made up; Head shaven because they are trying to not have their hair symmetrical; Long hair to hide their face; Sitting in a particular way to hide their worst side; Difficult to make eye contact; Scars from skin picking; Evidence of previous attempts at 'do it yourself' surgery.
- When you consult with the patient, ask questions to assess their motivation for the procedure. Why do they want this procedure now? What are their expectations? Are they asking for impossible things (e.g. "I want a completely flat stomach with no scars", "I want my ethnicity completely disguised")? Are they seeking perfection or having a feature that matches a celebrity? You could also ask the patient to do a self-portrait (artistic ability does not matter!) to understand how they see themselves and what they would like to achieve after a procedure.
- If you consider that you need to refer a patient to a mental health practitioner ("MHP") to assess whether they have BDD or some other form of psychological vulnerability, Prof. Veale's tips are:
    - Make it clear to patient that a referral is commonplace (remember the 10% BDD statistic mentioned above), and they are not being singled out.
    - Do provided good information for the MHP – the more you provide the better
    - Set out your own questions for the MHP – don't just ask generically for 'an opinion'. However, if you cannot be specific but just have a sense that something isn’t right, then you can say so
    - Talk to the MHP about their experience of cosmetic procedures. Some may not be as familiar with the scarring implications do common procedures, or technical challenges of achieving the result a patient is asking for. The best practice in some psycho dermatology clinics is to have MHP in the clinic.

- Phone MHP if things are difficult to put in a letter, particularly if the information might upset the patient if disclosed in writing later
- Don’t refer a patient who is intimidating or threatening without discussing with MHP first.
- Don’t position MHP as a 'gatekeeper' to future surgical treatment by saying things like 'if the MHP approves, we can go ahead with surgery'. In other words, don't automatically add someone to your surgical list just because they have 'passed' a MHP assessment.
- Liaising with the patient's GP is good practice, assuming that the patient consents for the GP to be involved.

To that excellent guidance we would add:

- Consider the patient's answers to the screening questions carefully. Be alert to suspiciously negative responses, as well as positive responses. For example if the patient denies that the feature in question causes them any distress at all, that is a red flag because they are either lacking in insight (if it does not bother them at all, then why seek surgery), or they are being truthful and the impetus for seeking surgery comes from elsewhere (e.g. inappropriate pressure from a partner).

<u>What advice should be given in order to obtain informed consent?</u>

This is a very difficult question, especially because of the lack of reliable research and data as Prof. Veale has highlighted.

We would suggest that it would be worthwhile including a generic section in your patient information literature on the risks of surgery for patients with underlying psychiatric vulnerabilities, regardless of whether they are diagnosed or not. This can explain that it is presently unknown how many patients who seek cosmetic surgery also have a psychiatric vulnerability (explaining what that term means), and that it is also presently unknown what additional risks to their mental health these patients face. However, the summary can explain that experts do believe that patients who have unaddressed psychiatric vulnerabilities may be at greater risk of dissatisfaction with their procedures (even if the outcome is objectively good), or that the surgery will exacerbate or change their mental health symptoms.

The patient information leaflet can go on to gently explain that for this reason it is essential that all patients engage properly and honestly with the psychiatric screening questions. If the screening identifies a potential concern, then this is not a diagnosis of a mental health or personality disorder, it simply means that some further assessments need to be carried out to understand the overall risks of the procedure for that individual patient.

Emphasise that a screening questionnaire cannot identify all concerns, and there will always be a risk that an underlying psychiatric vulnerability is not picked up and assessed further. Therefore even if the screening does not highlight any concerns, the patient should only go ahead with the procedure if they understand and accept the risk that they may have an undiagnosed psychiatric vulnerability that may affect their subjective satisfaction with the outcome, even where the objective outcome is good. It may also affect their emotional resilience in the face of clinical complications.

To try to address any stigma the patient may perceive around these issues, you could include a short statement to the effect that you endeavour to be an ally for people experiencing psychological vulnerabilities of any kind, and that if any potential concerns arise from the screening questions, then they will be treated with kindness and compassion and will be given advice that is in their best interests as a patient.

The purpose of this generic information in a patient information leaflet is to give you a prospect of being able to argue that the patient gave informed consent to mental health risks even where no concerns arise from the screening questionnaire.

If the screening questionnaire raises concerns, you can carry on with a consultation about the requested procedure, but you need to make it clear that you cannot finalise your consultation or give all the necessary advice or decide with the patient whether to go ahead with surgery until after a MHP has assessed the patient. Make records about the patient's wishes and your clinical advice in the normal way.

If the outcome of the MHP assessment is that the patient does not have BDD or some other psychological vulnerability, so the MHP has no clinical objection to surgery, you still have a responsibility to do a follow up assessment to make sure that the patient's expectations are still realistic and that they will benefit from surgery and are willing to give informed consent to all the risks. It would be very difficult to 'pre-approve' them for surgery subject to a MHP assessment, because the issues discussed with the MHP could have changed their wishes in terms of what they want and what risks they are willing to accept, compared with your initial consultation with them.

If the outcome of the MHP assessment is that the patient does have some mild BDD or some other mild psychological vulnerability, but the MHP has no overall objection to surgery going ahead, then you and the MHP need to work together to make sure the patient has the best advice available about the risks (to their mental health) of going ahead with surgery. This is perhaps the most difficult situation of all. If the patient has mild BDD or other mild psychological vulnerability, then you have to advise about the 'known unknown' that their condition could affect their satisfaction with the result of surgery, but without being able to be precise about the likelihood or nature of those risks. It is unlikely to be unethical to go ahead with surgery, the difficulty will be in ensuring that the patient can give informed consent to the psychiatric risks as well as the physical risks of surgery. You will need to weigh up whether you are confident in your skills and experience to be able to guide the patient (with the assistance of the MHP) through these discussions. If not, then it is necessary for you to refer the patient to a colleague who is better equipped to advise and operate on patients with a known (albeit mild) BDD or psychological vulnerability.

If the MHP has a clinical objection to surgery then it would be extremely difficult from a professional ethics perspective to justify going ahead with surgery. If the patient tries to insist on going ahead, you can only refer them to another surgeon or back to their GP for advice.

How can I politely turn away patients?

Some patients may refuse to engage in a psychiatric screening process, or the results of that screening may raise concerns and may it inappropriate to go ahead (or at least not until a proper psychiatric evaluation has been carried out by a suitably qualified MHP such as Prof. Veale).

If you have concerns about a particular patient and have decided not to accept them for treatment, then you need to communicate your decision in a polite and patient-centric way and signpost them to the next steps they need to take. For example you can set out your advice in your normal clinic letter, and conclude that letter by explaining politely that you cannot be certain that you are the right surgeon to meet that patient's needs, and you recommend that they seek treatment elsewhere and wish them well. You can offer to refer them on to another surgeon or a MHP if they wish.

What about insurance?

Your Incision indemnity includes cover for claims brought by private patients, and also for the cost of legal representation in the event of a GMC referral, Inquest or police investigation (regardless of whether the care was NHS or private).

It would be prudent to contact the Incision medico-legal helpline to discuss whether a precautionary notification to your insurers is also necessary in the following situations:

- A patient complains about your attempts to screen them for psychological vulnerabilities, or your refusal to take them on as a patient and treat them;
- You have carried out surgery on a patient already, and they are highly dissatisfied with an objectively good outcome, or you have other reasons to suspect that they may have BDD or some other psychological vulnerability. There is a risk of a claim here, for example because the patient's unrealistic expectations will impel them to try to seek compensation even where they have no meritorious complaint, or alternatively because they could argue that they were insufficiently screened for psychological vulnerabilities, and could not give informed consent to the mental health risks they were running by going ahead with surgery;
- A patient threatens to refer you to the GMC or contact the police for any reason even if it seems completely unmeritorious (or if you are contacted by the GMC or the police if that is your first knowledge of the issue);
- If a patient dies of any cause related to your surgery, or by suicide, after having had cosmetic surgery with you. There will likely be an Inquest, and you could be made an "Interested Person" in that Inquest depending on the circumstances;
- A patient complains about you contacting their GP or another healthcare professional about them – either about whether you had their consent to contact the GP or about the content of the information you provided to them.

A notification will not always be necessary, but assessing whether there is the potential for a claim, regulatory proceedings and Inquest or a police investigation will always depend on the specific facts. The Incision team is highly experienced in identifying the matters that need to be notified.

Perhaps more importantly, contacting the Incision medico-legal team as soon as you can foresee a problem means that you will get medico-legal support (and formal legal advice and representation, within the terms of your Incision insurances) at the time you need it, if and when matters progress. This will give you the best possible prospect of getting through the difficulties with your professional reputation (and sanity) intact, and with expert and sympathetic advice and support every step of the way.

Incision members can reach the Incision medico-legal helpline at medicolegal@incisionindemnity.com, and 0333 010 2826.

* The summary of Prof. Veale's webinar provided in this guidance note has not been separately approved by him, so any errors are those of the author.