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‘Operating is the easy part’: Surgeons’ decision-making processes and responses to parental requests for elective paediatric appearance-altering facial surgery

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Summary Some parents request elective appearance-altering facial surgery for their children for cosmetic, psychological and/or social reasons. These operations have attracted controversy in the bioethics literature. They are also the subject of professional guidance documents internationally, which leave much to individual practitioners’ discretion. Despite their controversial nature, very little is known about surgeons’ practices and decision-making processes regarding these operations. Individual semi-structured interviews were conducted by 22 plastic surgeons and oral and maxillofacial surgeons in Australia to explore their descriptions of the types of parental requests they receive for these operations, their decision-making processes and their responses to these requests. Interviews were audio-recorded, transcribed and analysed using inductive content analysis. Surgeons reported parents often request these operations to

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alleviate or prevent teasing and associated psychosocial distress. However, surgeons expressed concern some parents may be requesting surgery to further their own interests, rather than their child's. Surgeons reported considering multiple factors when making decisions about the ethical justifiability of facilitating these parental requests, including children's wishes about surgery, the severity of the facial difference, the child's growth stage and parents' reasons for requesting. Although most surgeons appeared comfortable denying parental requests when they believe surgery is not in the child's best interests, some indicated they will acquiesce if parents persist. This study provides insights into surgeons' practices and decision-making processes regarding elective paediatric appearance-altering facial surgery requested by parents. It also highlights implications for clinical practice and education, and identifies areas warranting further research.

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Introduction

At least one in every 700 children born worldwide is born with a defined facial difference, such as a cleft lip.¹ Indications for operating on children with facial difference may be, as in cleft lip and palate, both functional and aesthetic. When surgical aims are functional, decisions about surgery are broadly non-controversial. When surgical aims are purely aesthetic, however, such as in otoplasty, surgical risks must be balanced against often poorly defined psychosocial benefits and the ethics of surgery are more open to question.²

Elective paediatric appearance-altering procedures have consequently been debated within the bioethics literature.³ The main ethical arguments put forward for these procedures are that they may reduce appearance-related social stigma, such as teasing, and, therefore, *alleviate* consequent psychological distress, such as poor self-esteem. It has also been argued that such operations may be justified if they *prevent* similar issues occurring in the future.^{2,4}

Several authors, however, have questioned these ethical justifications. They argue that there is minimal methodologically rigorous outcome data supporting claims that the psychosocial benefits of these procedures outweigh their physical risks, such as surgical and anaesthetic complications.⁵ It has even been suggested that surgery may lead to unexpected psychosocial harm, in that some children may later interpret surgery as a form of parental rejection.⁶ Others have questioned whether these procedures, if performed before children can meaningfully participate in decision-making, unjustly violate children's rights to bodily integrity⁷ and an open future⁸ or whether altering appearance might negatively affect the child's identity.^{9,10} Other authors have argued that it would be better to change society's negative attitudes towards and treatment of individuals with visible differences, rather than children's appearances.¹¹

These ethical arguments are particularly acute in facial-altering procedures. It has been claimed that facial differences are more susceptible to social stigma than other appearance differences^{2,12} because of their visibility and the important role of the face in public identification and social interaction.^{13,14} It has also been argued that faces are more closely linked to personal identity than other body parts, raising the risk that surgery may have unforeseen effects on identity.^{15,16}

Several medical associations have issued professional guidance documents regarding appearance-altering procedures for minors.¹⁷⁻¹⁹ These documents do not adopt concrete positions, leaving much to surgeons' discretion. Surprisingly little is known, however, about how surgeons make decisions around parental requests for appearance-changing surgery on children. This study sought to address this important gap. Previous studies are generally hypothetical²⁰⁻²² and therefore may not represent clinicians' actual decision-making and/or have employed survey methodology,^{4,23} limiting the ability to explore clinicians' decision-making and practices in depth. This study involved qualitative interviews with plastic and oral and maxillofacial surgeons who operate on children, exploring the types of parental requests for facial-altering operations surgeons receive, ethical and other factors surgeons consider when responding to these requests and how surgeons respond when they have ethical concerns. The findings may act as an important starting point for developing or refining professional guidance documents in the future, working towards practical, evidence-based recommendations to guide clinical decision-making that may benefit children, families and clinicians.

Methods

Study design and sample

This qualitative study involved individual semi-structured interviews with 22 surgeons who perform elective appearance-altering facial surgery on children. Purposive sampling²⁴ identified plastic and oral and maxillofacial surgeons in Australia with relevant experience.

Participants were recruited using three methods: (1) via the Australian Society of Plastic Surgeons, (2) directly via their publicly available contact details, and (3) snowballing, where participants suggested colleagues who may be interested in participating. In line with qualitative research methods, our sample size was not intended to be statistically representative of the broader surgeon population but rather to generate rich data addressing our aims.^{25,26} Participant recruitment occurred simultaneously with data collection and analysis, and continued until data saturation occurred (i.e., when little or no new data addressing the aims were generated through data analysis).^{24,25}

Table 1 Participant information.

	Number and percentage of participants
Surgical specialty	
Plastic Surgery	18 (82%)
Oral and Maxillofacial Surgery	4 (18%)
Sex	
Male	18 (82%)
Female	4 (18%)
Experience as a fully qualified specialist surgeon	
Less than 5 years	3 (14%)
Between 5 and 9 years	6 (27%)
Between 10 and 14 years	1 (4.5%)
Between 15 and 19 years	2 (9.1%)
20 years or more	10 (46%)
Employed at a children's hospital?	
Yes	12 (55%)
No	10 (45%)
Total number of surgeons interviewed	22

This study received ethics approval from the University of Melbourne Human Research Ethics Committee (ID: 1238870). Written informed consent was obtained from participants for in-person interviews, and written and/or verbal consent for telephone interviews.

Data collection

Surgeons participated in individual semi-structured interviews, 14 in person and eight via telephone. A semi-structured interview guide was used, with open-ended questions regarding (1) types of requests surgeons receive from parents, (2) how surgeons make decisions about the ethical justifiability of performing surgery, and (3) how surgeons respond to parental requests. Interview length ranged from 17 to 107 min (mean: 42 min).

Data analysis

Interviews were audio-recorded and transcribed with participants' permission, using pseudonyms to protect confidentiality. Transcripts were analysed using inductive content analysis, which involves sorting data into common content categories.²⁷ Unlike traditional content analysis, content categories in inductive content analysis are not pre-determined but generated from the data.²⁸

The analysis involved open coding of transcripts, followed by sorting transcript sections labelled with similar codes into broad content categories. Once saturated with data, these categories were divided into more nuanced subcategories.²⁷

Results

Twenty-two surgeons were interviewed (Table 1), including 18 plastic surgeons and four oral and maxillofacial surgeons. Surgeons reported performing a range of appearance-altering facial surgery on children (Table 2), with otoplasty

the most common. Representative quotes are reported in Table 3 and additional quotes are referred to in the text where relevant.

Types of parental requests

According to surgeons, parents request appearance-altering facial surgery for three main reasons: (1) concern for the child's *current* psychosocial wellbeing; (2) concern for the child's *future* psychosocial wellbeing; and (3) reasons surgeons believed were motivated by parents' concern for their *own* psychosocial wellbeing, rather than their child's (see Table 3 for representative quotes).

Surgeons' decision-making

Surgeons reported considering four main factors when making decisions about the ethical justifiability of agreeing to parental requests: (1) child's wishes, (2) severity of the facial difference, (3) child's growth stage, and (4) parents' reasons for requesting. The frequency of these factors is shown in Figure 1.

Child's wishes

All surgeons reported considering children's wishes about surgery, where children were able to express these. While many surgeons required active *wanting* from the child before they would consider operating, some required this for some operations (e.g., otoplasty and cleft revision) but not others (e.g., primary cleft lip surgery and surgery for facial palsy). One surgeon (Surgeon 16) hypothesised this is not due to functional concerns, but rather because some facial conditions are viewed as 'deformities' requiring early intervention while others are perceived as mere 'differences'.

Surgeons gave various reasons why they deem children's wishes ethically important. Some reasons were consequentialist, relating to the potentially negative consequences

Table 2 Appearance-altering facial surgery surgeons reported performing on children.

Surgeons who reported performing: ^a	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
Appearance-altering facial surgery:																							
Otoplasty (17 surgeons)																							
Orthognathic surgery (5 surgeons)																							
Craniofacial surgery (6 surgeons)																							
Cleft surgery (10 surgeons)																							
Rhinoplasty (7 surgeons)																							
Surgery for facial trauma (7 surgeons)																							
Scar revision (7 surgeons)																							
Mole removal (10 surgeons)																							
Birthmark removal (8 surgeons)																							
Cyst removal (2 surgeons)																							
Surgery for facial palsy (1 surgeon)																							
Tongue reduction (Beckwith-Wiedemann syndrome) (2 surgeons)																							

^aSurgeons 1-18 = Plastic Surgeons; Surgeons 19-22 = Oral and Maxillofacial Surgeons

Table 3 Categories of parental reasons for requesting elective paediatric appearance-altering facial surgery, as reported by surgeons.

Category	Reported by	Example quote
Child-related		
(1) Child-related (current) ^a	20 surgeons (91%)	'it's usually driven by the child to be honest, after the age of six...because they are so tormented at school' (Surgeon 13, Plastic Surgeon).
(2) Child-related (future) ^b	20 surgeons (91%)	'they [parents] have identified a problem...which they think the child will be mercilessly teased about, which will ruin their self-esteem, and they want to fix it before it's a problem' (Surgeon 7, Plastic Surgeon).
Parent-related^c	7 surgeons (32%)	'sometimes we'll see kids who are one or two years old and they've got a birthmark on their face or something and the parents are kind of embarrassed about it, or the parents don't like the attention it causes for <i>them</i> ...the motivation for operation is to benefit the parent... <i>they're</i> embarrassed... <i>they</i> feel socially stigmatised...and they'll say things, like "everyone stares at the kid and me in the checkout line and people come up to me and ask me what's wrong with my kid's face" and all this sort of stuff and it really, really, really distresses the parent' (Surgeon 14, Plastic Surgeon, original emphasis).

^a Parental request aims to *alleviate* existing appearance-related psychosocial issues (e.g., teasing, poor self-esteem and self-consciousness) the child is *currently* experiencing.

^b Parental request aims to *prevent* potential appearance-related psychosocial issues the child may or may not experience in the *future*.

^c Parental request does not appear to be motivated by concern for the child's current or future psychosocial well-being, but rather by parental concern for their own interests.

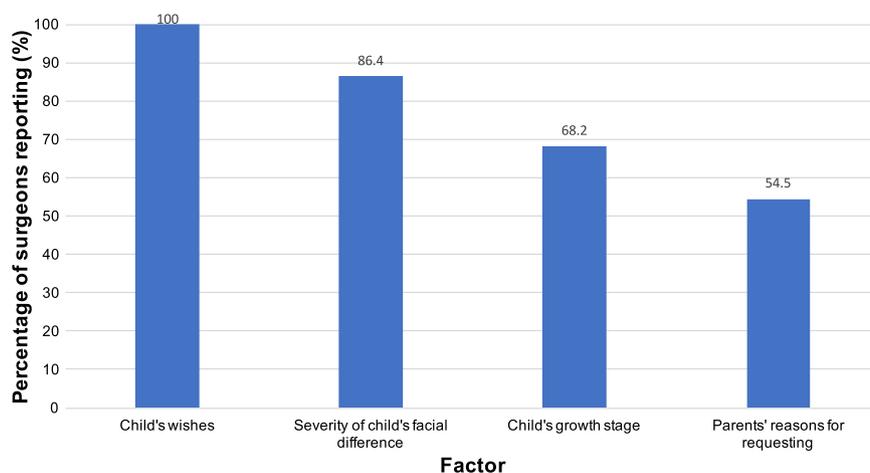


Figure 1 Main factors considered by surgeons in their decision-making.

of operating on unwilling children. For example, many surgeons noted that unwilling children may not cooperate with post-operative care, potentially compromising surgical outcome. Other surgeons appealed to factors apart from consequences, such as the importance of respecting children's developing autonomy.

Several surgeons also described how they attempt to ascertain children's wishes regarding surgery. Some reported relying on parents to convey these, particularly if the child was shy. Others reported asking children directly, using closed-ended (e.g. 'do you want me to fix your ears?', Surgeon 1) or open-ended questions (e.g., 'what do you perceive to be a problem, if any, and what would you like me to do?', Surgeon 20). These surgeons emphasised the importance of hearing from children directly, and advocated for children if parents interrupted.

Most surgeons stated they refuse to operate when the child declines or appears ambivalent about surgery. Surgeons reported this often surprises parents, some who view the child's role in decision-making differently (e.g., 'a lot of parents make the comment that "I thought it would be just like her tonsils, where she didn't have any say in it"', Surgeon 1).

Severity of the facial difference

Surgeons regarded the severity of the facial difference as relevant for three main reasons. First, some stated the facial difference must be noticeable enough to warrant surgery and its risks. Second, some viewed psychosocial distress associated with a relatively minor facial difference as a possible sign of body dysmorphia, more appropriate for psychological intervention. Finally, many surgeons regarded the severity of the facial difference as predicting the child's future wishes, claiming children with more noticeable facial differences are more likely to want surgery.

Child's growth stage

Surgeons noted that operating before a facial feature has attained its adult size may interfere with its future growth. Consequently, many surgeons recommended delaying surgery until after the facial feature has fully grown. An additional concern was that future growth may lead to relapse or other complications, necessitating further surgery.

While many surgeons stated that in some cases, delaying surgery until growth completion is more likely to lead to better *physical* outcomes, some recognised this may compromise the child's psychosocial wellbeing. These surgeons reported making exceptions and operating earlier if the child was experiencing appearance-related psychosocial distress, even though they knew further surgery may be required.

Parents' reasons

Half of the surgeons reported considering whether parents are requesting surgery for the 'right' reasons, and most felt that 'wrong' reasons were those related to *parents'* own benefit, rather than the child's. In these cases, surgeons were concerned that children may be exposed to risk for no compensating benefit.

There was considerably more disagreement among surgeons regarding the ethical justifiability of facilitating *preventative* parental requests aimed at avoiding future problems. While some surgeons facilitated these requests, providing parents' decisions were fully informed, most surgeons believed surgery in these circumstances was less ethically justifiable than operating on children who are experiencing psychosocial distress. Reasons given for this included: parents' concerns about future teasing may not eventuate, children may be teased for other characteristics, and teasing should be regarded as a normal (though unfortunate) part of childhood.

Surgeons' refusals of parental requests

Some surgeons also described *how* they refuse parental requests in cases where they do not believe surgery is in the child's best interests. Surgeons emphasised the importance of leaving the 'door open' for parents and children to return. For example, in cases where they refused to operate because the child appeared unwilling, many surgeons reported they tell parents and/or children to come back 'when' or (less commonly) 'if' the child wants surgery.

Most surgeons appeared comfortable denying parental requests and indicated they would not be talked into performing surgery they did not believe to be in the child's best

interests (e.g., ‘the more they get uppity...the higher my rejection rate’, Surgeon 4). Conversely, other surgeons appeared less comfortable and stated they would acquiesce if parents persist (e.g., ‘there are some parents who are quite keen to have otoplasty done before they start at school, which means you end up doing it on them when they’re four to five years of age, and sometimes I don’t think that’s the best time’, Surgeon 9).

Discussion

Elective surgery in children, particularly surgery whose sole aim is to alter appearance, involves a range of ethical issues not encountered in adult surgical practice. This study has found that while surgeons are generally aware of these issues, they manage them in different ways. Understanding the nature of these issues is important to prepare surgeons for paediatric practice.

As in other studies, our findings indicate that parents request surgery not just to alleviate existing appearance-related psychosocial distress but also to prevent it occurring in the future.^{29–32} We also report that several surgeons believed that some parents who request surgery are driven by their own interests, rather than their children’s. Although such parent-related requests have been speculated about,³⁰ they have not previously been documented. This may be because parents are not willing to disclose this or because they are not even aware of their motivations. The ability to explore such issues in an open-ended manner is a distinct advantage of qualitative research methodologies over survey-based methods, where outcomes are typically pre-defined.³¹

Surgeons reported weighing multiple factors in their decision-making, including children’s wishes about surgery, the severity of the facial difference, growth stage and parents’ reasons for requesting surgery. Of particular interest is our finding that many surgeons reported they are more likely to facilitate parental requests when facial differences are more significant on the grounds that children with more noticeable facial differences are more likely to experience psychosocial distress and want surgery in the future. Although surgeons’ assessments of the severity of the facial difference may be regarded as a proxy for objective assessment, the psychology literature has consistently found that the objective severity of an individual’s visible difference is not necessarily correlated with the degree of appearance-related psychosocial distress (if any) experienced by the individual.^{29,30,33,34} Rather, psychosocial factors such as social skills and self-confidence have been shown to more reliably predict psychosocial adjustment than the severity of the facial difference.^{35,36} It is also possible that a child, if given the choice, might decide that surgery is not worth the risks, even if they are experiencing psychosocial distress. Surgeons may be overestimating the predictive value of the objective (or surgeon-determined) severity of visible difference. The more relevant therapeutic issue is the patient’s own assessment of their visible difference and its impact (if any).

Our findings demonstrate that surgeons deny some parental requests for surgery on ethical grounds. Moreover, they do so for reasons that are congruent with accepted

principles in paediatric bioethics, such as by recognising their fiduciary duty to act in their paediatric patients’ best interests.³⁷ Most surgeons who believed operating was not in the child’s best interests reported carefully explaining their reasoning to parents and remaining firm if parents persisted. However, some surgeons reported that denying parental requests is challenging and indicated they may operate if parents insist. This suggests there may be a need for institutions to support surgeons in acting on their ethical decisions and for training bodies to assist surgeons to develop strategies to resist parental pressure.

This study has limitations that should be considered when interpreting our results and analysis. One limitation is its relatively small sample size, meaning the decision-making processes and practices of the surgeon participants may not represent those of the broader surgeon population. However, qualitative research does not aim to be statistically representative but rather to generate rich data addressing the study aims.^{25,26} By including surgeons who work in various settings, we obtained diverse perspectives. Given the lack of qualitative research on this topic, additional research with surgeons in other countries would be worthwhile to ascertain whether their decision-making processes and practices are similar or different to those of our surgeon participants.

A second limitation is that discussion of one procedure, otoplasty, predominated in the interview data, ahead of more complex appearance-altering surgery, such as craniofacial surgery, where ethical concerns may be more pressing. Our interview questions were not specific to otoplasty, but it was the procedure which the highest proportion of participants (17/22) performed. Although surgeons also discussed ethical aspects of many other facial surgeries (Table 2), many of the quotes on ethical aspects of surgery, such as the importance of respecting children’s wishes, were made in the context of otoplasty. Asking surgeons specifically about other craniofacial differences would be worthwhile in future studies.

A third limitation is that surgeons’ descriptions of parents’ reasons may not be accurate. Further qualitative research is needed to obtain parents’ first-hand accounts of why they want these operations for their children. Most importantly, as the individuals are directly affected by these decisions, empirical research with children about their own experiences of surgical discussions and/or undergoing these operations is crucial, as is research on patient-reported outcomes of facial surgery.

Implications

Although there is currently insufficient evidence to produce concrete recommendations for clinical practice, our findings provide an interesting starting point for further discussion and future development of recommendations. Our findings lead us to highlight six specific implications for practice, three for individual surgeons and three for professional bodies. These implications are listed in Table 4 and described below.

First, it would be preferable for surgeons who perform appearance-altering surgery on children to do so in a setting that offers a range of options for managing

Table 4 Implications for individual surgeons and professional bodies.**Implications for individual surgeons**

- (1) It would be preferable to work in a setting where a range of treatments, including non-surgical, is available for children experiencing appearance-related psychosocial distress.
- (2) It is important for surgeons to consider improving their skills in ascertaining children's wishes regarding their appearance and surgery, including by asking appropriate open-ended questions.
- (3) It is important for surgeons to consciously prioritise children's interests and wishes, and be prepared to refuse to operate if it is not in the best interests of the child.

Implications for professional bodies

- (1) It would be beneficial for professional bodies to educate surgeons on how to manage parental requests for surgery, provide specific training in ethics and autonomy in paediatrics, and provide training on how surgeons can respectfully decline to operate.
- (2) Development of guidelines and standards for decision-making for appearance-altering surgery in children may be beneficial.
- (3) Additional research on the relative benefits of surgery and psychosocial treatment in children with facial differences would be helpful.

appearance-related psychosocial distress. This may involve collaboration with professionals who offer interventions such as social skills workshops and counselling.³⁸ Surgery, while effective in some cases, may not be the only option available to children and parents for alleviating distress, and alternatives may be less invasive and less risky.

Second, it is important for surgeons to further their skills in seeking and considering children's wishes regarding surgery. The importance of including children in healthcare decision-making has been increasingly recognised in the literature, particularly for elective procedures.³⁹ Surgeons may wish to consider how their approaches to ascertaining children's wishes may affect children's feelings about their appearance. Although most surgeons in our study recognised the importance of hearing from children directly, some reported asking children whether they want their facial difference 'fixed'. Children may interpret such questions as suggesting their facial difference is a 'problem' in need of 'fixing'. In our view, an open-ended approach is preferable as it allows children to better direct these conversations.

Third, prioritizing children's wishes and interests is important. Parents' wishes are not ethically determinative, and refusing to operate is ethically right if surgery is not believed to be in the child's best interests. If parents' concerns seem mainly self-related, they may benefit from psychosocial support to assist them in addressing their anxieties regarding their child's facial difference.

Our findings also have important implications for professional bodies, particularly when developing or revising professional guidance documents and education for surgeons and trainees. First, including specific content on how to elicit children's wishes and recognise parent-related reasons motivating requests for surgery as part of plastic and oral and maxillofacial surgery training may be helpful. Some surgeons may find it challenging to refuse parental requests for surgery, even when they feel that surgery may not be appropriate, and specific techniques such as mock consultations could be used to develop communication skills which will be valuable throughout practicing life. Including specific training about ethics and autonomy in paediatrics would also be beneficial.

Second, existing guidelines¹⁷⁻¹⁹ could be revised so that they address specific issues such as distinguishing between preventative and alleviative parental requests, a major factor influencing our surgeon participants' decisions. Setting appropriate standards may also provide support for surgeons who feel pressured to perform surgery they are not comfortable with, and undermine the notion that 'if I don't do it, someone else will', which may lead some surgeons into inappropriate practice. Guidelines could also encourage use of alternative treatment strategies and promote development of networks of providers offering these treatments.

Finally, further research into the relative benefits of surgical and nonsurgical approaches to manage appearance difference is worthwhile. Most surgeons strongly believe that surgery improves children's quality of life, but the evidence base for this belief needs strengthening. There is a lack of knowledge regarding whether these benefits could be achieved by other means or strengthened by delivering surgery in a more structured psychosocial context.

Conclusion

This study provides the most detailed account to date of surgeons' decision-making processes regarding the ethical justifiability of facilitating parental requests for elective paediatric appearance-altering facial surgery. Our findings have led us to highlight important implications for clinical practice, surgical training and professional guidance that consider the nuances of clinical practice and are hopefully of greater relevance to healthcare professionals, policy makers and bioethicists.

Authorship statement

- Participated in study design: Lauren Notini, Lynn Gillam, Merle Spriggs, Anthony Penington.
- Conducted and transcribed interviews: Lauren Notini.
- Participated in data analysis: Lauren Notini, Lynn Gillam, Merle Spriggs, Anthony Penington.

- Wrote first draft of paper: Lauren Notini.
- Participated in the writing of the paper: Lauren Notini, Lynn Gillam, Merle Spriggs, Anthony Penington.

Conflict of interest

None.

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