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THE LEGAL FRAME

Plastic reconstructive and esthetic surgery and tobacco, a legal approach

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Summary Tobacco is a supplementary surgical risk factor to which some of our patients expose themselves. A patient who smokes incurs a heightened risk of medical accident. This is now accepted scientific knowledge, and no currently practicing plastic surgeon can be unaware of the close connection between smoking and postoperative cutaneous healing complications. On this subject, surgeons are invested with a duty to advise. And when a patient continues to smoke, a physician can refuse to operate, except in the event of an emergency. In some cases, however, he can go ahead with the operation, provided that his analysis of the risk/benefit highlights the interest of the surgery for the patient, whatever may be the tobacco-related complications. It is nonetheless necessary that the latter be preliminary informed and that he or she knowingly accept the risk.

Tobacco consumption represents a supplementary surgical risk factor to which many of our patients subject themselves. Operative risk, anesthesia risk and vascular risk are all increased in a patient who smokes. The deleterious consequences of tobacco use on postoperative skin healing in plastic and esthetic surgery are well-known. How can the notion of ''smoking patient'' be considered in cases of medical accident, whether or not it be due to malpractice? How does this notion affect the approach of a legal expert in his analysis of the harm, the causality and the accountability relative to tobacco? As it is now certain that no surgeon can be unaware of the close relationship between smoking and postoperative skin healing difficulties, the duty to advise is inescapable (1). It is equally necessary to define a reasonable and pragmatic legal approach to a public health problem. While some of us wish to see the arrival of a tobacco-free generation [1], one of out of three adults in France is still smoking. Legal action taken against surgeons by smokers having suffered postoperative harm is a frequent occurrence and necessitates separate and specific legal analysis (2).

The duty to advise a smoking patient

It is now an established scientific fact; tobacco use is a surgical and anesthetic risk factor. Learned societies have organized consensus conferences [2], and for many years they have been producing publications and putting forth recommendations [3]. The French health ministry and

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official agencies such as the Institut National de Veille sanitaire have likewise been providing information on the dangers of tobacco in a peri-operative context [4].

The postoperative complications related to tobacco are widely known and have been regularly detailed in published articles [5] dealing with general as well as plastic surgery [6]. According to Delay (2005), breast reconstruction using lower abdominal flap is contraindicated in smoking patients because of impaired microcirculation and increased risk of flap necrosis [7]. In a more recent article, Robert showed smoking to be associated with hypertrophic scarring following breast reduction operations [8].

From the initial examination onwards, a surgeon questions a patient on possible operative risk factors, whether they be general (diabetes, high blood pressure, immune pathology, anticoagulant therapy...) or local (scar, limb revascularization difficulties...). It would appear obvious that tobacco impregnation is a known risk factor, and that if a patient fails to be questioned on the subject, the surgeon has committed a serious error of omission. It is henceforth impossible not to be aware of the relationship between tobacco consumption and postoperative healing problems, and once this risk factor is forgotten, and the patient is allowed to believe that continued smoking will be inconsequential (cessation has not been considered during the examination), the surgeon is rendered liable and may be sued for malpractice if things go wrong. A plaintiff can cite as grounds for legal action the surgeon's failure to inform and advise with regard to the need to stop smoking during the peri-operative period. Indeed, plaintiffs often mention failure to provide timely advice or guidance on this point as a reason to sue, as occurred in a case of postoperative necrosis following lipectomy in a female smoker. In the conclusions to her presentation, the claimant stated that the surgeon had not ''provided sufficient information given the double risk entailed first by the preceding interventions, which prevented the scar from being positioned on the bikini line, and second her smoking, which augmented the risk of necrosis'' [9]. Since the Hédreul decree concerning the delivery of patient information and the law of 4 March 2002, the burden of proof is the physician's, which means that it is up to him to prove that he has informed the patient on the imperativeness of his or her quitting.

If the patient states that he is a non-smoker, the surgeon has fulfilled his obligation; it is not his duty to verify the accuracy of the statement; all he has to do is note in the relevant file that the patient does not smoke.

If a notion of tobacco addiction is present, it requires detailed evaluation of actual consumption in terms of cigarettes a day and packs a year. It matters to be apprised of the degree of dependency: ''Have you already managed to stop smoking? Will you be able to stop in view of undergoing an operation?'' The above-mentioned evaluation is an essential preliminary to the advice the surgeon has subsequently got to give the patient. Above and beyond a patient's basic right to be informed [10], the duty to advise is a contemporary surgeon's obligation [11]. The patient must be advised to stop smoking, and the intervention postponed from 6 to 8 weeks. The surgeon must explain to the patient that the intervention shall not take place immediately, inform her on smoking-related risks and, finally, in the event that cessation appears difficult to achieve, refer her to a colleague specialized in tobacco addiction.

Only an emergency response, that is to say a necessary, indispensable and inevitable intervention, renders rapid and immediate surgery allowable without awaiting the beneficial effects of smoking cessation on microcirculation. Urgency is often a fact exonerating the surgeon from liability, especially as concerns delivery of information and informed consent, but also and perforce as regards smoking cessation. On the other hand, if intervention as an emergency response is likely to associate repair and reconstruction during the same operation, only the time devoted to the rapid repair necessitated by the emergency shall relieve the surgeon of legal responsibility, and it is consequently preferable that the smoker's reconstruction procedure be postponed. For example, emergency repair of a mutilated thumb in a smoking patient does not pose a problem of liability in the case of tobacco-linked damage. But when the repair is associated with reconstruction by means of emergency pollicisation [12], there will ensue not only the ethical problems revolving around information and consent [13], but also, were something to go wrong, the liability entailed by rapid programming, without awaiting the benefits due to smoking cessation, of non-urgent reconstruction surgery.

For all cosmetic surgery, there exists a minimum time lapse, which a practitioner is bound to observe between delivery of a medical fee quotation and occurrence of a possible intervention [14]. In France, this legal obligation remains in force for fifteen days minimum [15], and there can be no derogation or exemption, even at the request of the person involved. The mandatory delay enables surgeons to explain to smoking patients that in certain cases (in cosmetic surgery, for example), there not only exists the aforementioned minimum legal time lapse prior to an operation, but also that the time lapse is lengthened in some specific cases, particularly when tobacco is a factor.

If the patient agrees to smoking cessation, is it necessary to verify, prior to the operation, that he or she has indeed stopped? Should the nicotine content in urine be systematically monitored when the patients says (but cannot otherwise prove) that he has ''quit''? In our opinion this should not be mandatory; after all, a practitioner's relationship with a patient is a ''care agreement'' predicated on mutual trust. However, when the surgeon decides to institute a urine nicotine test and the result is positive, this means that as regards smoking cessation, the patient has told him a lie. In that case, a unilateral breach of a morally binding contract has occurred, and the surgeon can legitimately refuse to perform the operation. But if, in spite of everything, the surgeon still agrees to carry out the procedure, he renders himself liable in the event of failure; from a magistrate's standpoint, he will have gone ahead with the operation with full knowledge of the risk involved (positive nicotinuria) for the health of a patient to whom he had preliminarily explained the dangers of tobacco use and whom he had advised to stop.

After the duty to advise, the refusal to treat

When a patient cannot or will not stop smoking, then the surgeon can refuse to carry out an operation.

If this is so, some may fear the establishment of ''anti-smoker'' discrimination, as was the case in Great Britain