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***Review Article***

# The First Guardian: The General Practitioner's Pivotal Role in Navigating Aesthetic Surgery Requests in Morocco: An Ethical, Supportive, and Vigilant Framework

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**Abstract**

In Morocco, the confluence of globalized beauty standards, social media proliferation, and a growing medical aesthetics market places the general practitioner (GP) at a critical but ill-defined crossroads. This integrative literature review synthesizes evidence from 2010–2025 to theorize the GP's role beyond a simple gatekeeper. We propose a conceptual framework positioning the GP as the "First Guardian", an ethical navigator responsible for patient assessment, expectation management, and vigilant safety screening. The synthesis reveals that while the demand for aesthetic procedures is well documented, primary care lacks structured protocols for managing these requests. Key concepts include the GP's function in medical vigilance (screening for contraindications), psychological vigilance (particularly for Body Dysmorphic Disorder (BDD)), and supportive counseling within a culturally competent, shared decision-making model. A significant gap exists in validated, GP appropriate screening tools for the Moroccan context. The review identifies three core debates: the medical necessity of elective aesthetics, the tension between patient autonomy and non-maleficence, and the challenges of navigating an under regulated market. We present an integrative framework, the Aesthetic Surgery Navigation Model (ASNM), that operationalizes the GP's role across five phases: Elicit, Evaluate, Educate, Escort, and Endorse/Follow up. A research agenda is proposed to empirically test this framework, develop localized assessment tools, and map referral pathways, ultimately empowering Moroccan GPs to safeguard patient wellbeing in the evolving landscape of aesthetic medicine.

## 1. Introduction

The global aesthetic medicine market has undergone exponential expansion, with emerging markets in the Middle East and North Africa (MENA) region reflecting this trajectory through rising demand for both surgical and non-invasive procedures. In Morocco, this growth is evidenced by increased patient inquiries in private clinics and a socio professional shift where aesthetic practices are increasingly integrated into medical and dental scopes, driven by globalized beauty ideals and amplified by social media platforms [1, 2]. This burgeoning demand, however, intersects with a primary care context that remains largely unprepared for its unique clinical and ethical nuances. Moroccan GPs, often the first and most trusted medical contact for patients, encounter aesthetic requests without the benefit of structured guidelines, leading to a critical gap in patient care [3, 4].

The legislative framework in Morocco, particularly Law n° 131 13, governs the practice of plastic and aesthetic surgery, mandating physician qualifications and oversight by the National Medical Council [5]. However, gaps in dedicated legislation for the rapidly expanding

field of non-surgical aesthetics, coupled with variable regulatory enforcement, expose both patients and referring GPs to potential liability [5]. This ambiguity places the GP in a position of profound responsibility without a clear roadmap.

This review posits that the GP must transcend the simplistic function of a referral gatekeeper to become an essential navigator and first line evaluator. Acting within an ethical, supportive, and vigilant framework, the GP is pivotal in conducting assessments, managing patient expectations, screening for contraindications and underlying psychological pathologies, and guiding patients towards safe, ethical, and satisfying care pathways. The Moroccan context adds specific layers: rapidly evolving beauty ideals that negotiate global trends with local identity [1], the enduring role of the GP as a trusted family confidant [3], and the need for cultural competence in navigating sensitive discussions about appearance.

This review aims to delineate this multifaceted role by synthesizing existing literature and proposing a conceptual framework. The core thesis is that the GP serves as the primary guardian of patient wellbeing, acting as a filter (screening for medical/psychological risk), a counselor (managing expectations and exploring alternatives), and a sentinel (upholding ethical standards and ensuring patient safety).

### Research Questions (RQs)

1. **RQ1:** What is the current scope of aesthetic surgery requests in Morocco, and what are the documented medical, psychological, and social characteristics of patients seeking these procedures?
2. **RQ2:** What are the core components of an effective, ethical, and supportive framework for GPs to manage aesthetic surgery requests, drawing on international best practices and the specific Moroccan context?
3. **RQ3:** What are the key barriers and facilitators for Moroccan GPs in implementing a structured approach to pre operative assessment, referral, and post operative care for aesthetic patients?
4. **RQ4:** How can the roles of medical vigilance, psychological screening (especially for BDD), and patient education be integrated into a coherent, practical model for primary care?

## 2. Approach and Corpus Description

This review employs an integrative/narrative approach with a concept centric synthesis. Given the heterogeneous nature of the evidence, spanning primary care, plastic surgery, psychiatry, and health policy, an integrative review is most appropriate for building theory and mapping debates across diverse methodologies [6]. A pure systematic review with meta-analysis would be premature due to the paucity of interventional or high-quality comparative studies specifically addressing the GP's role in this domain.

### 2.1. Search Strategy and Corpus Assembly

The corpus was assembled through an iterative, multi stage process. The foundational core included key references on the Moroccan context [1, 2, 5], global trends [7, 8], psychological aspects of aesthetic surgery [9–11], and the GP's role [3, 4, 12]. This core was then systematically expanded.

- **Databases/Venues:** PubMed, ScienceDirect, Thieme Connect, Google Scholar, and the library catalogues of major academic publishers (Springer, Elsevier, MDPI) were searched.
- **Search Strings and Keywords:** Search strings combined terms from three conceptual blocks using Boolean operators (AND, OR).
- **Population/Provider:** "general practitioner," "family physician," "primary care," "family medicine."
- **Intervention/Context:** "aesthetic surgery," "cosmetic surgery," "plastic surgery," "non surgical aesthetic," "botulinum toxin," "dermal fillers," "patient request," "referral."
- **Outcome/Concept:** "body dysmorphic disorder (BDD)," "psychological assessment," "patient selection," "informed consent," "shared decision making," "ethical framework," "post operative complications," "patient satisfaction," "Morocco," "North Africa."

#### Inclusion/Exclusion Logic

**Included:** Peer reviewed original research, systematic reviews, narrative reviews, clinical guidelines, and professional consensus statements published between January 2010 and December 2025. Seminal foundational works (e.g., on BDD criteria) published prior to 2010 were included to frame core concepts. English, French, and German language publications were considered.

**Excluded:** Case reports, opinion pieces without substantive evidence, conference abstracts, and studies focused solely on surgical technique without reference to patient selection or primary care interface.

**Stopping Criteria:** Search saturation was considered reached when repeated searches across databases yielded no new, unique concepts relevant to the research questions.

### 2.2. Expected Blind Spots

This review has several inherent limitations. First, there is a language bias; while French and German sources were included, the search was predominantly English centric, potentially missing relevant literature published in other languages. Second, there is a publication bias towards high impact journals, which may underrepresent the realities of aesthetic practice in less resourced or non-academic clinical settings. Third, the Morocco specific evidence base is nascent [1, 2, 5]; consequently, much of the clinical framework is synthesized from international literature and must be cautiously extrapolated. Fourth, grey literature, including national health ministry reports and professional society guidelines (which may be crucial for understanding the local regulatory landscape), was not systematically searched.

## 3. Concept Matrix and Organizing Schema

We structured the review using a framework that links key ideas to relevant studies, their methods, main findings, and limits. This framework guides the sections, following the patient's journey, from understanding needs, through medical and psychological assessment, to education, referral, and follow up, considering Morocco's legal and cultural context.

### 3.1. Demand, Motivations, and the Evolving Patient Profile

The literature examining demand and motivations for aesthetic procedures draws upon diverse methodologies including cross sectional surveys, qualitative thematic analysis, and epidemiological trend analyses. Foundational work by Rami and El Amrani (2026) provides Morocco specific insights into evolving beauty ideals [1], while Triana and colleagues' (2024) 14 years analysis of International Society of Aesthetic Plastic Surgery (ISAPS) data establishes global procedure trends [7]. Barone et al. (2024) contribute qualitative evidence on social media's role in shaping patient expectations [8], and a 2025 qualitative study on rhytidectomy patients identified six key motivational domains including desire for self-control over aging (53.4%) and social adversity concerns (6.9%) [12]. The canonical claim emerging from this corpus is unequivocal: demand for aesthetic procedures is rising globally and in Morocco, driven predominantly by social media exposure and evolving cultural norms [1, 7, 8]. Motivations are consistently found to be multifactorial, encompassing aesthetic desires, psychosocial factors, and identity related negotiations [1, 8, 12, 13]. However, these findings carry important boundary conditions. Motivational studies are often retrospective and subject to recall bias. Critically, the cultural specificity of motivations within the Moroccan context, particularly how globalized beauty standards interact with local, ethnic, and familial notions of attractiveness, remains significantly under explored, representing a substantial gap in the evidence base [1].

### 3.2. Body Dysmorphic Disorder: Prevalence, Diagnosis, and Screening Imperatives

The evidence base for Body Dysmorphic Disorder (BDD) in aesthetic populations is robust, drawing from diagnostic criteria synthesis [9], prevalence studies in cosmetic surgery settings [10], systematic reviews [11], and clinical practice recommendations for primary care [14]. The canonical finding is unequivocal: BDD prevalence in cosmetic surgery settings is alarmingly high, estimated between 13% and 20%, with even higher rates in rhinoplasty cohorts [9, 11]. The condition constitutes a major contraindication to aesthetic procedures, as surgical intervention in untreated BDD consistently exacerbates symptoms and leads to poor outcomes [9, 10]. The literature further establishes that general practitioners, through their long-term therapeutic relationships with patients, occupy a uniquely advantageous position for initial screening [14]. The DSM 5 TR criteria remain the diagnostic gold standard: preoccupation with perceived defects, repetitive behaviors in response to concerns, and clinically significant distress or impairment [9]. However, significant boundary conditions temper these findings. While screening tools such as the Body Dysmorphic Disorder Questionnaire (BDDQ) are well validated in specialist settings, they remain markedly underutilized in primary care [9, 14]. Furthermore, BDD diagnosis requires nuanced clinical judgment, and poor insight; a core feature of the disorder; frequently complicates detection [9]. The feasibility, acceptability, and predictive validity of these tools in time constrained Moroccan GP consultations have not been established.

### 3.3. Medical Vigilance and Pre-Operative Risk Assessment

The literature on medical vigilance draws primarily from expert consensus, textbook chapters on complication avoidance, and clinical practice guidelines [15, 16]. Rohrich (2021) articulates the foundational principle that patient safety must remain paramount in plastic surgery [15], while Hartstein and colleagues (2020) provide detailed, procedure specific guidance on complication prevention [17]. The canonical claim is well established: comprehensive pre-operative screening for systemic risk factors, including uncontrolled diabetes mellitus, hypertension, coagulopathies, active smoking, and autoimmune conditions, is essential to minimize surgical morbidity and optimize outcomes [15, 18]. The evidence supporting individual risk factors is robust and derived from decades of surgical outcomes research. Yet a critical boundary condition emerges when considering the GP's specific role: the evidence linking GP led screening protocols directly to reduced complication rates remains largely inferential rather than causal [3, 4]. No randomized controlled trials have tested whether structured GP screening, compared to usual care, improves surgical outcomes. The GP's unique contribution; contextualizing risks within the patient's longitudinal health record; is conceptually compelling but empirically unvalidated.

### 3.4. Psychological Assessment Tools and Their Clinical Applicability

Recent methodological advances have produced validated instruments for psychological assessment in aesthetic populations [19, 20]. Smearman and Faulkner (2025) review existing tools in the context of plastic surgery [19], while Căiță and colleagues (2024) introduce and validate the Bee Cosmetic Surgery Scale (BCSS), a novel instrument assessing psychopathological, psychosocial, and decision-making factors involved in accepting cosmetic procedures [20]. The canonical finding is that reliable, multidimensional assessment of psychological readiness is possible using these validated tools [19, 20]. The BCSS, for example, demonstrates good psychometric properties in assessing constructs relevant to surgical decision making [20]. However, the boundary conditions here are particularly salient for this review. Most existing tools are designed for specialist administration by surgeons or psychologists, not for primary care settings [19, 20]. Their feasibility in a time constrained GP consultation, typically lasting 15 20 minutes, is unknown. Their acceptability to Moroccan patients, and their predictive validity for post-surgical satisfaction in this cultural context, remain entirely unexplored. This represents a critical translational gap between specialist psychological assessment and primary care implementation.

### 3.5. The GP Patient Relationship and Communication Dynamics

The therapeutic alliance between general practitioner and patient constitutes a foundational concept in the literature [3, 12, 14, 21]. Qualitative interview studies [12], ethical analyses [21], and clinical practice recommendations [14] converge on a shared conclusion: a nonjudgmental, trusting relationship is essential for uncovering patients' true motivations and managing expectations around aesthetic

procedures [3, 12, 14, 21]. The literature further establishes that GPs must continuously balance respect for patient autonomy with their professional duty of care, a tension that becomes particularly acute when patients request procedures the physician considers unnecessary or potentially harmful [21]. The boundary conditions here are striking. Despite the centrality of this relationship, research specifically examining how aesthetic requests are discussed in primary care consultations is virtually absent [3, 4]. The conversational dynamics, the specific communication strategies GPs employ, and the ways patients experience these discussions remain unstudied. In the Moroccan cultural context, where hierarchical dynamics and family involvement may shape medical consultations differently than in Western settings, this gap is particularly consequential [1, 3].

### 3.6. Referral Pathways and Shared Decision Making

The literature on referral practices and shared decision-making draws from surveys of primary care providers [22] and descriptions of patient decision aids (PDAs) developed for aesthetic procedures [4, 19]. The canonical finding reveals significant inconsistency in GP referral practices, with providers' perceptions of plastic surgery substantially influencing their referral patterns [22]. Structured referral letters that include relevant medical history, medications, and with patient consent concise psychological summaries can enhance inter-professional communication [19, 22]. PDAs, such as those developed for breast augmentation, have been shown to improve patient knowledge and support shared decision making [4]. The boundary conditions, however, are substantial. The effectiveness of PDAs in the Moroccan healthcare system has not been studied [3, 4]. The specific content, format, and communication channels that would optimize GP surgeon collaboration in Morocco are unknown. Furthermore, the assumption that better-informed patients make better decisions, while intuitively appealing, requires validation in this context [4, 21].

### 3.7. Post operative Care and Complication Management

The GP's post operative role is addressed in literature reviews on complication management [16], systematic reviews of psychosocial outcomes [13], and clinical guidance on post procedural care [18]. The claim holds that GPs can appropriately manage minor sequelae such as expected swelling and bruising, provide essential psychosocial support during the vulnerable recovery period, and address "post operative dysphoria" [13, 16, 18]. Equally important, they must recognize red flags; infection, hematoma, venous thromboembolism, or vascular compromise; that warrant urgent specialist re-referral [16, 18]. The boundary conditions here are concerning. Much of this evidence base is dated, with some foundational studies now over three decades old [16]. There is a notable lack of contemporary, evidence-based algorithms to help GPs distinguish normal post procedure recovery from true complications [18]. For emerging treatments and novel technologies, this guidance gap is even more pronounced.

### 3.8. Legal and Regulatory Context in Morocco

The Moroccan specific evidence base comprises legal analysis [5] and cross-sectional survey data from dental practice [2]. The core finding establishes that Law n° 131 13 provides a foundational framework governing plastic and aesthetic surgery, requiring physician qualifications and oversight by the National Medical Council [5]. However, significant gaps remain, particularly in legislation specifically addressing the rapidly expanding field of non-surgical aesthetics [2, 5]. GPs face potential liability in referrals without clear regulatory guidance [5]. The boundary conditions here are perhaps the most significant for this review: the practical interpretation and enforcement of these laws in everyday clinical practice are poorly documented. How Moroccan GPs actually navigate this regulatory ambiguity, what informal norms have developed, and what medicolegal concerns most affect their clinical decision making remain empirically unexamined [2, 3, 5].

## 4. Synthesis: The GP as "First Guardian: A Concept Centric Analysis

### 4.1. The Evolving Demand: From Elective Choice to Complex Psychosocial Need

The literature robustly supports the notion that the demand for aesthetic procedures is no longer a niche phenomenon [1, 7, 8]. Triana et al.'s 14-year analysis of ISAPS data confirms a global shift towards minimally invasive procedures, which now constitute over 50% of the market [7]. This trend is mirrored in Morocco, where a cross sectional survey of dentists revealed that 33.1% receive regular patient requests for aesthetic treatments, signaling a mainstreaming of these desires within general healthcare interactions [2].

Critically, the motivations behind these requests are more complex than simple vanity [1, 8, 12, 13]. A 2025 qualitative study on patients seeking rhytidectomy identified six key motivational domains, including a "desire for self-control over aging" (53.4%) and "social adversity concerns" (6.9%), demonstrating that psychosocial factors are integral to the decision-making process [12]. This aligns with Barone et al.'s observation that social media cultivates a "patient as consumer" mindset, distorting beauty ideals and fueling desires to conform to digitally enhanced standards [8]. For the Moroccan GP, this means that a request for, say, rhinoplasty, must be understood as a potential expression of deeper identity related negotiations, between globalized beauty standards and local, ethnic, or familial notions of attractiveness [1]. The GP's first task is therefore hermeneutic: to interpret the narrative behind the request [3, 12].

### 4.2. Medical Vigilance: Screening for Physiological Safety

The GP's role in ensuring patient safety begins with a comprehensive medical evaluation [3, 4, 15]. This is not merely a pro forma checklist but a critical risk stratification exercise. Expert consensus, as summarized by Rohrich [15] and detailed in textbooks on complication avoidance [17, 18], mandates screening for systemic risk factors that are well documented to increase surgical morbidity [15, 18].
These include:

**Metabolic and Cardiovascular:** Uncontrolled diabetes mellitus, hypertension, and a history of thromboembolic events [15, 16].

**Hematological:** Coagulopathies or use of anticoagulant/antiplatelet medications [15, 17].

**Integumentary and Lifestyle:** Active smoking (a major risk factor for wound healing and necrosis), poor skin quality, and a history of keloid scarring [15, 16, 18].
**Immunological:** Autoimmune diseases, which may be contraindications for certain procedures or increase infection risk [15, 17].

While the evidence linking GP led screening to reduced complication rates is largely inferential [3, 4], it is a cornerstone of preoperative care in any surgical specialty [15, 16]. The GP's unique contribution is the ability to contextualize these risks within the patient's longitudinal health record, identifying subtle, long-term conditions that a surgeon seeing the patient for the first time might miss [3, 14].

### 4.3. Psychological Vigilance: The Imperative of BDD Screening

The most critical, and perhaps most challenging, aspect of the GP's role is psychological assessment, with Body Dysmorphic Disorder (BDD) being the paramount concern [9, 11, 14]. BDD is a psychiatric condition characterized by a preoccupation with perceived flaws in appearance that are not observable or appear slight to others, leading to significant distress and functional impairment [9]. The prevalence of BDD in cosmetic surgery settings is alarmingly high, estimated between 13% and 20%, and is even higher in rhinoplasty cohorts ($\sim$ 20%) [9, 11]. Performing aesthetic procedures on individuals with untreated BDD is contraindicated, as it almost universally leads to patient dissatisfaction, exacerbation of symptoms, and significant medicolegal risk for the surgeon [9, 10].

A German practice paper explicitly identifies the GP as playing a "key role in diagnosis and treatment" of BDD due to the often long standing relationship of trust with their patients [14]. This positions the GP as an ideal first line screener. However, BDD is underdiagnosed due to patient shame and lack of physician training [9, 14].

#### What the literature supports?

**Prevalence:** BDD is common (2-3% in the general population, much higher in aesthetic settings) and associated with high rates of suicidal ideation and attempts [9].

**Diagnosis:** The DSM 5 TR criteria are the gold standard: preoccupation with perceived defect(s); repetitive behaviors (e.g., mirror checking, camouflaging, reassurance seeking) in response to the concerns; clinically significant distress or impairment [9].

**GP's Potential:** GPs can leverage the therapeutic alliance to conduct targeted, sensitive screening [14].

#### What is synthesis/interpretation?

A Pragmatic Screening Approach for the GP: Given time constraints, a full diagnostic interview is impractical. A brief, two question screening approach, adapted from the BDD Questionnaire (BDDQ), could be feasible:

1. "Are you very worried about a physical feature, to the point where you think about it a lot and wish you could change it?"
2. "Does this concern interfere with your life, for example, do you avoid social situations or does it make it hard to work or be with friends?"
3. "Yes" to both warrants a more detailed assessment or a referral to a mental health professional before any aesthetic referral is made [9, 14].

### 4.4. The Educational Imperative: Managing Expectations and Preventing Regret

The GP is uniquely positioned to counteract the pervasive commercial messaging that portrays aesthetic procedures as risk free, quick fixes [3, 4, 8]. This educational role has two primary components.

First, correcting misinformation and exploring alternatives. Patients may be unaware of legitimate non-surgical alternatives to a requested surgery, or vice versa [4]. The GP can provide unbiased information, helping the patient understand that a "face lift" request might be addressed initially with a combination of laser resurfacing, fillers, and neuromodulators, a discussion that should be free from the financial incentives that might influence a commercial provider [4].

Second, discussing realistic outcomes and risks. This includes not only physical risks (infection, scarring, nerve injury, anesthesia complications) but also the possibility of psychological outcomes like "post operative dysphoria"—a transient period of depression or anxiety following surgery as the patient adjusts to their new appearance and recovers from the physical stress of the procedure [13]. The GP's forewarning can normalize this experience and prepare the patient's support system [3, 13].

### 4.5. The Referral as a Therapeutic Act: Shared Decision Making and Communication

The referral letter should not be a perfunctory administrative task but a continuation of the therapeutic process [3, 19, 22]. It is an act of communication between two physicians with the patient's best interest at heart. Alharbi et al. found that primary care providers' perceptions of plastic surgery significantly influence their referral patterns, highlighting the need for better inter specialty understanding [22].

A ”rational referral” from a GP should include:

1. **Concise Medical Summary:** Relevant history, medications, allergies, and risk factors [3, 22].
2. **Psychological Status (with consent):** A note on motivation and expectations. For example: ”Patient’s motivation appears rooted in self-improvement post weight loss, and expectations seem realistic.” Or, for a more complex case: ”Patient expresses some dissatisfaction with previous procedures; please assess for possible BDD.” This alerts the surgeon without breaching trust, fostering a collaborative approach to patient safety [19, 22].
3. **Patient’s Questions:** The GP can help the patient formulate a list of questions for the surgeon (e.g., about the surgeon’s experience, complication rates, revision policies, and the ability to see before and after photos of patients with similar anatomy) [3, 4]. This empowers the patient and promotes shared decision making [21].

### 4.6. The Post Operative Continuum: From Red Flags to Reassurance

The GP’s involvement extends beyond the referral [3, 4, 18]. Post operatively, the GP is often the first point of contact for patient concerns [13, 16]. This requires a dual competency:

**Recognizing Red Flags:** The GP must be able to distinguish between normal sequelae (swelling, bruising, soreness) and true complications that require immediate surgical re-referral, such as signs of infection (erythema, pus, fever), expanding hematoma, unilateral pain and swelling suggestive of deep vein thrombosis (DVT), or signs of vascular compromise (e.g., skin blanching or necrosis after filler injection) [17, 18].

**Providing Psychosocial Support:** The recovery period is a vulnerable time. The GP can offer reassurance, validate the patient’s emotional experience, and manage ”post operative dysphoria” or disappointment if the immediate results do not match idealized expectations [13]. This continuity of care is a unique and invaluable asset of the primary care setting [3, 14].

## 5. Methods and Measurement Appraisal

The field’s literature is characterized by methodological heterogeneity.

**Theoretical/Empirical Balance:** The evidence base is heavily weighted towards descriptive epidemiology (e.g., procedure trends [1, 2, 7]) and qualitative exploration of motivations [8, 12]. There is a notable lack of interventional studies [3, 4]. For instance, no randomized controlled trials have tested the efficacy of a specific GP led screening protocol on downstream patient satisfaction or complication rates.

**Measurement Validity:** The construct of ”patient motivation” is increasingly well measured using validated scales like the new Bee Cosmetic Surgery Scale (BCSS), which assesses psychopathological, psychosocial, and decision-making factors [20]. However, the validity of these tools in a primary care setting, administered by a GP rather than a surgeon or psychologist, remains unproven [3, 19]. The measurement of BDD is robust, with well validated instruments (BDDQ, DSM 5 TR criteria) [9, 11].

**Causal Identification:** The literature is weak on causal claims. While we know that BDD is associated with poor post-surgical outcomes [9, 10], we cannot claim that screening by a GP causes improved outcomes, as this link has not been empirically tested [3, 14]. Similarly, the relationship between social media exposure and the decision to seek surgery is correlational, not causal [8].

**External Validity and Dataset Bias:** Much of the high-quality evidence comes from Western, high-income countries (US, Europe) [7, 11]. The external validity of these findings to the Moroccan context is a major concern [1, 3]. Moroccan datasets are small and nascent [1, 2], limiting generalizability. There is also a potential bias in patient samples, which are often drawn from single private clinics, potentially excluding patients from lower socioeconomic backgrounds who may seek care elsewhere.

## 6. Debates and Fault Lines

### Debate 1: The ”Medical Necessity” of Aesthetic Surgery

**Position A (Restrictive):** Aesthetic surgery is purely elective, a matter of consumer choice, and lies outside the core domain of ”medical” care. The GP’s role is therefore minimal, to refer upon request, as there is no ”illness” to treat [5].

**Position B (Expansive):** The psychosocial impact of appearance related dissatisfaction can be profound, affecting mental health, social functioning, and quality of life. Therefore, addressing these concerns through safe, ethical means is a legitimate part of healthcare [13, 23].

**Synthesis & Missing Evidence:** This debate hinges on how we define health (the WHO definition includes ”social wellbeing”). What is missing is longitudinal data from the Moroccan context on the health related quality of life outcomes of patients who do and do not undergo aesthetic procedures, stratified by preexisting psychological status. Such data could help GPs and policymakers understand the true ”medical” impact of these interventions [1, 3, 23].

### Debate 2: Autonomy vs. Non-Maleficence

**Position A (Prioritize Autonomy):** A well informed, mentally competent patient has the right to make choices about their own body, even if the GP perceives the request as unnecessary. The GP’s role is to inform, not to paternalistically block access [21].

**Position B (Prioritize Non-Maleficence):** The GP has a primary duty to "first, do no harm." Given the high rates of BDD and post-surgical regret, the GP must act as a firm gatekeeper, potentially denying referral to protect the patient from harm [9, 10].

**Synthesis & Missing Evidence:** This is a classic ethical tension. The resolution lies in the quality of the assessment. A robust psychological evaluation can identify patients for whom the principle of non-maleficence must take precedence (e.g., those with active BDD) [9, 11]. For others, supporting their autonomous choice is appropriate [21]. What is missing is a decision-making algorithm that helps GPs weigh these principles in real time, based on quantifiable risk factors [3, 14].

### Debate 3: Navigating the Unregulated Market

**Position A (GP as Passive Informant):** The GP's responsibility ends with providing a list of board-certified surgeons. It is the patient's responsibility to verify credentials and choose a safe provider [3].

**Position B (GP as Active Sentinel):** In a market with variable regulation, especially for non-surgical providers [2, 5], the GP has an ethical duty to actively guide patients away from unsafe practitioners and to inquire about the planned facility and practitioner's qualifications [5].

**Synthesis & Missing Evidence:** This debate highlights the gap between ideal practice and real world constraints. A GP cannot be expected to vet every practitioner. However, they can empower the patient with the right questions to ask [3, 4]. What is missing is a publicly available, GP endorsed registry of qualified, board-certified plastic surgeons and accredited facilities in Morocco, which would transform the GP's role from passive informant to active guide [5].

## 7. Integrative Framework: The Aesthetic Surgery Navigation Model (ASNM)

### 7.1. Overview and Rationale

The synthesis presented in the preceding sections reveals a critical disconnect between the evidence base and clinical practice. While the literature robustly documents the rising demand for aesthetic procedures [2, 7**?** ], the high prevalence of psychological contraindications [9, 10], and the GP's unique position as first medical contact [3, 14], no coherent framework exists to translate these findings into actionable primary care practice. The Aesthetic Surgery Navigation Model (ASNM) is proposed to address this gap, serving as the conceptual output of this review, designed to operationalize the "First Guardian" role for Moroccan general practitioners.

What is being proposed here is not merely a descriptive account of current practices, but a prescriptive model grounded in the synthesized evidence. The model is deliberately structured as a circular, patient centered process to emphasize that this is not a linear, onetime event but an iterative continuum of care that may cycle back as patient circumstances, understanding, or requests evolve. The term "navigation" is intentional: it positions the GP not as a gatekeeper controlling access, but as a guide helping patients traverse a complex, often commercialized, and potentially hazardous path [3, 4]. This framing preserves patient autonomy and the therapeutic alliance while fulfilling the physician's duty of care [21].

### 7.2. Phase 1: Elicit

This initial phase is deceptively simple but conceptually foundational. The patient presents with an aesthetic request, a statement that, on the surface, appears to be about a procedure but, as the motivational literature demonstrates, often encodes deeper psychosocial concerns [1, 8, 13]. A 2025 qualitative study on patients seeking rhytidectomy identified six key motivational domains, including "desire for self-control over aging" (53.4%) and "social adversity concerns" (6.9%), demonstrating that psychosocial factors are integral to the decision-making process from the outset [12]. Barone et al. (2024) further establish that social media cultivates a "patient as consumer" mindset, distorting beauty ideals and fueling desires to conform to digitally enhanced standards [8].

The GP's task at this stage is purely receptive: to create a nonjudgmental space that invites the patient's narrative. Dirhoussi et al. (2025) found that understanding patient expectations during initial plastic surgery consultations requires active, open-ended listening [12]. The "elicit" framing is deliberate, it implies drawing forth, not simply hearing. Using open ended questions such as "What change are you hoping this procedure will bring to your life?" or "Can you tell me the story behind your request?" allows exploration of the narrative, not merely the technical demand [3, 12]. In the Moroccan context, where the GP often serves as a trusted family confidant [3], this phase leverages an existing therapeutic relationship that specialist consultants cannot replicate.

### 7.3. Phase 2: Evaluate

This is the core diagnostic and risk stratification phase, comprising three parallel streams of assessment grounded in the evidence reviewed in Sections 4.2 and 4.3. The GP must conduct these evaluations simultaneously, recognizing that medical, psychological, and social factors interact in complex ways to determine patient suitability.

A. **Medical Vigilance:** Drawing on Rohrich's (2021) foundational principle that patient safety must remain paramount in plastic surgery [15], and Hartstein and colleagues' (2020) detailed guidance on complication avoidance [17], this involves systematic screening for organic contraindications. The evidence mandates evaluation of: metabolic and cardiovascular status (uncontrolled diabetes mellitus, hypertension, history of thromboembolic events); hematological factors (coagulopathies, anticoagulant medications); integumentary and lifestyle factors (active smoking, a major risk factor for wound healing and necrosis, poor skin quality, history of keloid scarring); and immunological status (autoimmune diseases that may contraindicate certain procedures or increase infection risk) [15, 18]. While the evidence linking GP led screening protocols directly to reduced complication rates remains inferential rather than causal [3, 4], this comprehensive assessment represents the standard of preoperative care in any surgical specialty [15]. The GP's unique contribution

lies in contextualizing these risks within the patient's longitudinal health record, identifying subtle, long-term conditions that a surgeon seeing the patient for the first time might miss [3, 14].

B. **Psychological Vigilance:** This is the most critical and challenging component, and the evidence for its importance is unequivocal. Body Dysmorphic Disorder (BDD) prevalence in cosmetic surgery settings is estimated between 13% and 20%, with even higher rates in rhinoplasty cohorts [9, 11]. Performing aesthetic procedures on individuals with untreated BDD is contraindicated, as it consistently leads to patient dissatisfaction, exacerbation of symptoms, and significant medicolegal risk [9, 10]. Rück et al. (2024) further note that BDD is associated with high rates of suicidal ideation ($\sim$ 80% lifetime) and attempts [9].

   Based on this evidence, we argue for targeted screening using either validated instruments where feasible or, more pragmatically, brief approaches adapted from the BDD Questionnaire (BDDQ) [9, 14]. A two question screening approach could be feasible in time constrained consultations:

   - "Are you very worried about a physical feature, to the point where you think about it a lot and wish you could change it?"
   - "Does this concern interfere with your life—for example, do you avoid social situations or does it make it hard to work or be with friends?"
   - A "yes" to both warrants a more detailed assessment or referral to mental health services before any aesthetic referral proceeds [9, 14]. Watzke and colleagues (2020) explicitly identify the GP as playing a "key role in diagnosis and treatment" of BDD due to the often-long-standing relationship of trust with their patients [14], positioning primary care as the ideal setting for this initial screening.

C. **Social Assessment:** This stream, informed by the motivational literature [1, 8, 13] and studies on patient decision making [4, 20], explores the patient's support system, external pressures, and practical circumstances. The GP must assess whether the patient faces pressure from partners, peers, or workplace ageism; whether financial constraints might drive them toward cut price, high risk providers operating outside accredited facilities; and whether adequate social support exists for the post operative recovery period [3, 5]. This is where the GP's longitudinal knowledge of the patient's life context becomes an irreplaceable asset, enabling nuanced judgment that no cross sectional specialist consultation can achieve [3, 14].

### 7.4. Phase 3: Educate

This phase translates assessment into action through shared decision making—a process that respects patient autonomy while fulfilling the physician's duty to inform [21]. Drawing on Corduff's (2023) exploration of surgical versus non-surgical choices [4] and the broader literature on informed consent [13, 21], the GP's educational role has two complementary components.

First, correcting misinformation and exploring alternatives. Patients frequently present with misconceptions propagated by commercial messaging that portrays aesthetic procedures as risk free, quick fixes [4, 8]. The evidence establishes that patients may be unaware of legitimate non surgical alternatives to requested surgeries, or vice versa [4]. The GP can provide unbiased information, helping the patient understand that a "face lift" request might be addressed initially with a combination of laser resurfacing, fillers, and neuromodulators—a discussion free from the financial incentives that might influence a commercial provider [4]. This educational function is particularly critical in the Moroccan context, where regulatory gaps for non-surgical procedures create variable quality and safety standards [2, 5].

Second, discussing realistic outcomes and risks. This encompasses not only physical risks; infection, scarring, nerve injury, anesthesia complications, and procedure specific adverse events [15, 18]; but also psychological outcomes. Honigman and colleagues' (2004) systematic review established that "post operative dysphoria"; a transient period of depression or anxiety following surgery as the patient adjusts to their new appearance and recovers from the physical stress of the procedure; is a common experience [13]. The GP's forewarning can normalize this experience, prepare the patient's support system, and potentially reduce distress when it occurs [3, 13]. The evidence supporting this phase is largely qualitative and consensus based rather than experimental, but the ethical imperative for informed decision making is clear and well established in the literature on patient autonomy [21].

### 7.5. Phase 4: Escort

This phase operationalizes the referral as a therapeutic act, not an administrative task. Alharbi and colleagues (2019) found that primary care providers' perceptions of plastic surgery significantly influence their referral patterns, highlighting both the need for better inter specialty understanding and the opportunity for structured communication to improve patient care [22]. Smearman and Faulkner (2025) further emphasize the importance of systematic pre-operative assessment in optimizing surgical outcomes [19].

Based on this evidence, we propose a structured approach to the referral process. The GP formulates a rational referral letter that includes: concise medical summary (relevant history, medications, allergies, identified risk factors); psychological status, with explicit patient consent (e.g., "Patient's motivation appears rooted in self-improvement post weight loss, and expectations seem realistic," or for complex cases, "Patient expresses some dissatisfaction with previous procedures; please assess for possible BDD"); and any additional contextual information that might aid the surgeon's assessment [3, 19, 22]. This communication alerts the surgeon without breaching trust, fostering a collaborative approach to patient safety [22].

Critically, the GP also provides the patient with a "question list" for the surgeon [3, 4], empowering them to inquire about the surgeon's experience with the specific procedure, complication rates, revision policies, and the ability to see before and after photos of patients with similar anatomy and skin type [4]. This transforms the patient from passive recipient to active participant in their care, operationalizing the principles of shared decision making [21]. The GP may also normalize seeking a second opinion, reinforcing that careful consideration, not haste, characterizes wise decision making in this domain [3].

### 7.6. Phase 5: Endorse/Follow up

The final phase acknowledges that the GP's responsibility continues post operatively. Truswell (2020) provides comprehensive guidance on managing complications and supporting patients through the recovery process [18], while Dillerud and Bunaes (1989), despite their vintage,

established foundational principles for distinguishing normal sequelae from true complications [16]. Based on this literature, the follow up phase involves two parallel tracks.

First, recognizing red flags that require immediate surgical re referral. The GP must distinguish between normal post procedure experiences (expected swelling, bruising, soreness, transient dysphoria) and true complications: signs of infection (erythema, purulent discharge, fever); expanding hematoma; unilateral pain and swelling suggestive of deep vein thrombosis; or signs of vascular compromise (skin blanching, necrosis, or sudden visual changes after filler injection) [17, 18]. The evidence supports that timely recognition and appropriate referral of these complications significantly improves outcomes [15, 18].

Second, providing psychosocial support during the vulnerable recovery period. The GP can offer reassurance, validate the patient's emotional experience, and manage disappointment when immediate results do not match idealized expectations [13]. This continuity of care, the patient returning to a trusted physician who knows their history and can contextualize their current experience, is the GP's unique contribution to the aesthetic journey, distinguishing primary care from the episodic, procedure focused specialist consultation [3, 14].

**Crucially, this phase acknowledges circularity:** Post operative experiences may generate new questions, concerns, or requests that restart the cycle. A patient satisfied with one procedure may return with a new request; a patient experiencing unexpected outcomes may need re-evaluation and re-education. This circularity reflects the reality of continuous, relationship based primary care [3, 14].

### 7.7. Theoretical Propositions and Empirical Implications

The ASNM is not merely descriptive; it generates testable propositions that could guide future research and clinical validation. These propositions flow directly from the synthesized evidence and address the gaps identified throughout this review.

**Proposition 1:** Implementation of the ASNM in Moroccan primary care will lead to higher rates of BDD identification compared to usual care. This proposition directly tests the psychological vigilance component against the current baseline, addressing the documented underdiagnosis of BDD in clinical settings [9, 14]. A cluster randomized controlled trial comparing ASNM trained GPs to controls, with blinded diagnostic interviews as the gold standard, could provide causal evidence for the model's effectiveness.

**Proposition 2:** Patients who undergo the ASNM process will report higher levels of preparedness and lower levels of post operative decisional regret. This tests the cumulative effect of the educational and shared decision-making components [4, 21]. A prospective cohort study following patients from initial consultation through six months post procedure, using validated measures of decision regret and preparation for decision making, could establish whether the model improves patient reported outcomes.

**Proposition 3:** The quality of the GP surgeon referral letter; as a proxy for inter-professional communication; is positively correlated with patient satisfaction and the surgeon's ability to provide appropriate care. This proposition, drawn from Alharbi et al. (2019) and Smearman and Faulkner (2025), tests whether the "escort" phase actually improves outcomes [19, 22]. A content analysis of referral letters linked to surgical and patient reported outcomes could identify which elements of communication most strongly predict favorable results.

**Proposition 4:** GPs trained in the ASNM will report higher confidence and lower anxiety in managing aesthetic requests compared to untrained colleagues. This tests the model's impact on provider outcomes, addressing the documented lack of structured guidance that leaves GPs uncertain how to respond to these consultations [3, 4].

### 7.8. Model Limitations and Boundary Conditions

Transparency about the framework's limitations is essential. First, the ASNM is conceptually derived from the synthesized literature, not empirically validated. Its feasibility, acceptability, and effectiveness in actual Moroccan primary care settings remain untested, a gap the research agenda in Section 8 is explicitly designed to address.

Second, the model assumes a level of GP training and confidence in psychological assessment that may not currently exist. The BDD screening component, in particular, requires communication skills and psychiatric knowledge that may necessitate targeted continuing medical education before implementation [9, 14].

Third, the model does not specify how time constrained GPs should prioritize among the five phases when consultation length is limited. In practice, GPs seeing 30 40 patients daily cannot conduct comprehensive five phase assessments for every aesthetic request. The model should be understood as an ideal framework to guide clinical reasoning, not a rigid protocol to be applied indiscriminately [3]. Clinical judgment must determine when abbreviated assessment is appropriate and when full evaluation is essential.

Fourth, the model's applicability may vary across different types of aesthetic requests. A request for minimally invasive treatment (botulinum toxin, fillers) may warrant different assessment intensity than a request for major surgical intervention (abdominoplasty, rhinoplasty) [4]. The evidence base does not currently support procedure specific guidelines, representing another gap for future research.

Finally, the ASNM is GP centric by design, reflecting this review's scope. It does not detail the parallel responsibilities of plastic surgeons, anesthesiologists, or mental health professionals, nor does it specify how these various providers should coordinate care. A truly integrated care pathway would require elaboration of these inter professional interfaces [6, 22].

### 7.9. Summary: The "First Guardian" Operationalized

The Aesthetic Surgery Navigation Model operationalizes the "First Guardian" thesis that has guided this review. By structuring the GP's role into five sequential phases, Elicit, Evaluate, Educate, Escort, and Endorse/Follow up, it provides cognitive scaffolding for clinical decision making where previously only ambiguity existed [3, 4]. It reconciles the tension between patient autonomy and non-maleficence by locating both within a structured assessment process: autonomy is respected in patients deemed appropriate candidates after comprehensive evaluation [21], while non-maleficence guides the management of those with identified medical or psychological risks [9, 10]. It clarifies the GP's legal and ethical position by making explicit what constitutes appropriate pre-referral assessment, potentially reducing liability

exposure in an under regulated market [5]. Most importantly, it centers the patient's journey within the continuity of primary care, ensuring that the pursuit of aesthetic enhancement does not occur in isolation from holistic medical oversight [3, 14]. The GP, as First Guardian, does not block the path but illuminates it, identifies its hazards, and accompanies the patient along the way.

## 8. Gaps and Research Agenda

The following concrete gaps, if addressed, would significantly advance the field.

1. **Gap:** Prevalence of BDD and other psychiatric comorbidities in Moroccan aesthetic patients.
    - **Proposed Study:** A multi-center, cross sectional study in GP practices and plastic surgery clinics in major Moroccan cities (Casablanca, Rabat, Marrakech) using a validated Arabic/Darija version of the BDDQ to establish baseline prevalence [1, 9, 11].
2. **Gap:** Lack of a culturally adapted, GP friendly psychological screening tool.
    - **Proposed Study:** A mixed methods study to adapt and validate an existing tool (e.g., the BCSS or a short form BDDQ) for the Moroccan primary care context, assessing its feasibility (time to administer), acceptability (to patients and GPs), and predictive validity for post-surgical satisfaction [9, 14, 19, 20].
3. **Gap:** Absence of data on GP knowledge, attitudes, and practices (KAP) regarding aesthetic requests.
    - **Proposed Study:** A national KAP survey of Moroccan GPs to map current practices, identify training needs, and assess their confidence in managing BDD and other psychological aspects [3, 4, 14].
4. **Gap:** Unclear referral pathways and quality of communication between GPs and surgeons.
    - **Proposed Study:** A qualitative interview study with both GPs and plastic surgeons to understand the barriers and facilitators to effective communication, followed by a co design workshop to develop a standardized referral template [19, 22].
5. **Gap:** Lack of evaluated educational interventions for GPs.
    - **Proposed Study:** A cluster randomized controlled trial of a Continuing Medical Education (CME) module based on the ASNM. The intervention group would receive training on BDD screening, shared decision making, and ethical referral. The primary outcome would be the proportion of patients with identified psychological risk factors prior to surgery [3, 9, 14].
6. **Gap:** No data on the post operative role of GPs and patient experiences of complications.
    - **Proposed Study:** A prospective cohort study following patients from GP referral through to 6 months post procedure, tracking the incidence of minor and major complications, the type of follow up care received (from GP vs. surgeon), and patient satisfaction with the overall care continuum [13, 16, 18].
7. **Gap:** Ethical and legal ambiguities for GPs in a partially regulated market.
    - **Proposed Study:** A legal and ethical analysis combined with Delphi consensus methodology involving medico legal experts, GP representatives, and plastic surgeons to develop a national guidance document on GP responsibilities in aesthetic referrals [2, 5, 21].

## 9. Limitations

This review has several limitations. First, its conceptual and integrative nature means it is designed for theory building, not for providing definitive clinical effect sizes [6]. Second, the scarcity of primary data from Morocco means that much of the proposed framework is extrapolated from international literature, and its applicability must be validated locally [1, 3]. Third, the review is GP centric; it does not deeply explore the perspectives of plastic surgeons, nurses, or other allied health professionals, which are crucial for a truly integrated care pathway [6, 22]. Fourth, the synthesis regarding the practical implementation of screening tools and decision aids in a resource constrained Moroccan GP practice is speculative and requires empirical testing [3, 14]. Finally, while we attempted to be systematic, the search strategy may have missed relevant literature in non-indexed regional journals or grey literature.

## 10. Conclusion

The Moroccan general practitioner stands at the frontline of a rapidly evolving medical and social phenomenon [1, 3]. The request for aesthetic enhancement is no longer a rarity but an increasingly common component of primary care consultations [2, 3]. This review has synthesized the available evidence to argue that the GP's role must be re conceptualized from that of a passive gatekeeper to an active, ethical, and supportive "First Guardian" [3, 4, 14]. Through a structured framework of medical vigilance [15, 18], psychological screening (with a focus on BDD) [9, 11], patient education [4, 13], and rational referral [19, 22], the GP is uniquely positioned to safeguard patient wellbeing. The proposed Aesthetic Surgery Navigation Model (ASNM) offers a practical, concept centric guide for this endeavor.

To empower GPs in this vital function, a concerted Call to Action is necessary:

1. Integrate foundational modules on aesthetic medicine psychology, ethics, and basic procedural awareness into Moroccan GP continuing medical education (CME) programs [3, 4, 14].
2. Foster formal collaboration and communication channels between national GP and Plastic Surgery societies to establish shared guidelines and referral protocols [5, 22].
3. Encourage research, within the Moroccan context, on patient satisfaction and complication rates correlated with GP led pre operative assessment models [1, 3, 13].

By embracing this multifaceted role, the GP truly becomes the first guardian of patient welfare in the complex and alluring pursuit of aesthetic enhancement.

### Article Information

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