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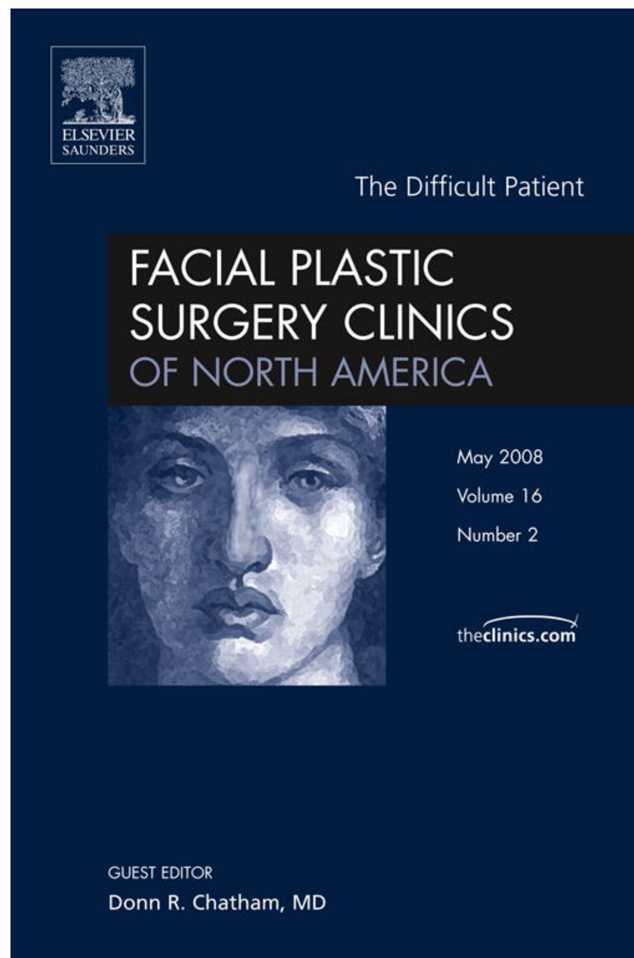

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What Makes a Patient Unhappy

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Cosmetic surgery differs from nearly every other medical and surgical discipline in that we are dealing in "want" rather than "need." Patients rarely require the services we offer. It therefore behooves us to be especially cognizant of discussing fully the procedures that we are planning, including a full discussion of limitations and risk. One can easily understand how patients feel when they do not achieve the results they expected. They already have paid a significant amount with no guarantee of results. Imagine how you feel when you make a purchase or have a repair done only to experience an unsatisfactory outcome. Generally, our first response is to ask for our money back or to complain that the service should have been done right the first time. Why should we expect our patients to feel any differently?

This issue is becoming increasingly important because of the dramatic change in the field of cosmetic surgery over the past 25 years. In an earlier era, cosmetic surgery was relatively uncommon, and when patients sought our services, it was a very slow and deliberate decision based on a great deal of introspection. Furthermore, our patients came from the more traditional routes of referral—patient or physician recommendation or personal reputation.

All this has changed. Cosmetic surgery has come into vogue. It often is touted as "beauty surgery" leading to the expectation that we can make average people look beautiful. Patients are led to believe that we can make them they can look just like the celebrities who have become models of the results of cosmetic surgery.

These unrealistic expectations are augmented by the competition that has arisen in the field. Because of decreasing reimbursement in general medicine, many doctors are looking to supplement their practices and income by offering cosmetic services. Increasing numbers of dermatologists are emphasizing skin care and laser and laser-like services in their practices. More and more surgical specialists are delving into cosmetic surgery, often without adequate training and experience. Facelifting now has become a franchised business, with entrepreneurs hiring surgeons of varying backgrounds who work on a salary or commission, with the company obtaining the patients.

Competition also has led to heavy marketing. Patients are shown examples of excellent results either in print or on the Web, leading patients to believe that these results are typical. This effect is compounded: even if the patient chooses to have the operation performed by a surgeon who had not made these implied claims, the expectation still exists. The new television "reality" shows have had a major effect in raising expectations. We have

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observed a major shift in our practice, with patients requesting multiple major procedures at one time and often requesting combinations of procedures that would increase operating time significantly and raise the risks of infection, bleeding, and anesthesia complications to unacceptable levels.

The consultation

The consultation with a patient sets the stage for everything that follows. Unfortunately, in a busy practice, this area is the first that gets short changed. We may depend on our staff to do much of the consultation or perhaps overutilize commercial pamphlets or videos. This pitfall is especially likely when you are doing the same procedure over and over. Nevertheless, this is your best opportunity to avoid subsequent dissatisfaction. The consultation is just as important as the surgery when it comes to satisfying your patients.

How you communicate with the patient is of utmost importance, and many surgeons never learn the importance of verbal and nonverbal communication. Diogenes said that "speech is the image of actions," and we must realize that what we say and how we say it will affect profoundly the relationship that we establish with the patient. A full discussion of verbal and nonverbal communication is beyond the scope of this article, but some points deserve comment.

Some of these skills can be learned, but others are simply reflective of your basic attitude. If you are truly interested in your patient, this will generally show through, as will the opposite. Patients often can detect when you are simply going through the motions. We all have our individual approaches, and no particular way is more correct than another, but if you are truly concerned about your patients, they will usually sense it and they will appreciate it.

Your overall posture can make a great difference. How do you seat your patients? A large desk between you and patients creates a barrier. It can be more comforting when you sit next to the patient or across a smaller table. The use of comfortable chairs or a sofa can make a difference. Eye contact can be important. If you are constantly making notes or writing during the discussion, the patient easily can interpret that activity as a lack of interest. Leaning forward also denotes your interest in the patient, whereas an overly erect or backward posture suggests indifference.

Your facial expressions are of the utmost importance. A pleasant smile suggests interest and empathy; frowning can send the message of disbelief. Crossing your arms in front of you may suggest a barrier, whereas opening them can give an impression of overall openness. Many experts in communication suggest "mirroring" as a tool for positive communication. Mirroring is nothing more than mimicking the posture and movements of the individual with whom you are trying to communicate. While mirroring may be effective, one must be careful not to overdo it to the point that it looks phony.

Communication is a two-way street. While you want to impress prospective patients favorably, you are also evaluating them. While we all want our patients to choose us to do their surgery, it is more important to select patients with whom you feel you will be able to work well. As much as you may feel that a patient can benefit from a surgical procedure, it is even more important to assess whether you are the best person to offer that service. In this sense, I'm not only talking about your technical ability to do the operation—although that is important, but whether you are the best person to deal with a particular patient. We'll talk more about that in the next section. As to the former issue—whether you are the best person to do the operation—is difficult to quantify.

Obviously, we all gain experience, and hopefully become better surgeons because of it. Everyone has to start somewhere. Only you can determine whether you have sufficient experience in a given procedure. If you are trying something new, be honest about it. Tell the patient why you propose this procedure, how you learned it, and how much experience you have. If it's just a variation of a technique that you have been using, that is far different from a totally new procedure that you heard about at a meeting or read in a journal. We'll come back to this later, when we discuss the operation itself.

Avoiding the problem patient

There are some types of people that can be a tip-off to possible trouble. These are some things you might notice in evaluating your potential patient.

- **Obsessive-compulsive behavior**
- **More doctor shopping than would be expected for second opinion**
- **Urgent demand for immediate surgery, suggesting that surgery is being undertaken without due consideration**
- **Extreme flattery**
- **History of litigation**
- **Unclean appearance**
- **Unreasonable or unrealistic expectations**

Of course these suggestions are just guidelines. There are always exceptions. For example, in West Texas, where I live, it is common even for wealthy patients to come in off the ranch in old jeans and

a work shirt, wearing scuffed boots. But in general, keeping these tips in mind can help you avoid trouble.

Especially worth emphasizing is the flatterer who comes in saying that you are so good that you can achieve the result desired, even though deep down inside, you realize that the request is somewhat unrealistic. When you hear, "Oh doctor, everyone knows that you're the best, and I know you can make my nose look just right," it may be just the time to cut and run.

Avoiding these potentially problem patients is not easy. When first starting out, you are driven by the desire not to "lose the case." Later, your motivation changes to your desire to avoid taking patients who are likely to be dissatisfied. Some of these selection techniques become almost second nature, even though you are never always right. One of the best things about experience is that it lets you get by with greater ignorance!

Discussing the operation

In attending conferences and medical meetings, I never cease to be amazed at how often I hear speakers talk about what the patient needs. As stated at the beginning of this article, no one *needs* anything that we offer. We deal in *want* rather than *need*. I like to think that my primary goal is to make my patient feel better about himself or herself. After all, how you feel you look to others is as important, or perhaps more important, than how you actually appear. In many ways, it is unfortunate that we live in a society that is so appearance oriented, but we don't make these rules; we just respond to them.

A surgeon who believes that he or she is the one who should determine what is done is more likely to conduct a consultation by advising the patient on what should be done. Far better, in my opinion, is to spend time listening to the patient to try to determine what really is of concern to the patient.

I cannot tell you how often I have seen a patient and have my eye drawn immediately to a given area, expecting the patient to seek correction of that issue. Perhaps the patient may have a large, unattractive nose. The temptation, of course, would be to begin discussing rhinoplasty. The patient, however, may be perfectly happy with the nose and be concerned instead about the eyelids. Reacting on the basis of our own individual impression could lead us down the wrong course, at best, and at worst could distress the patient by bringing up an issue that initially was of no concern.

This issue seems to come up most often in rhinoplasty patients who have a receding chin. All of us recognize the importance of total facial balance and harmony. I recently had a patient with just such an appearance. I gently tried to steer toward considering a chin implant by suggesting that such a procedure would help put her nose in greater harmony with her face. No such luck! She was quite happy with her chin and only wanted the nose reduced. We went ahead with a rhinoplasty, and as you would expect, the result, although good on its own terms, was less than ideal because of the receding chin. Nevertheless, she was happy.

Would she ultimately have been happier if I had pushed for the chin implant? Perhaps, but if she did not get the result she expected, she might have been justifiably unhappy with me for pushing her in a direction she did not wish to go. It always is easier to deal with a less than optimal result when the patient knows that the you were doing something that he or she had requested rather than something you had suggested.

Limitations of surgery

As important as it is to give patients an idea of what you hope to accomplish, it's even more important to stress what you can't. By its very nature, this article deals more with concepts than specifics, but a few examples help emphasize this point.

How often have you done a facelift or blepharoplasty, only to have the patient come back and say that one side is different from the other? You look at the patient, and you do see that there is some difference. Then you go back to the patient's preoperative photos and notice that the difference actually existed before surgery.

You to explain that pre-existing condition to the patient, but by then it may be too late. The patient has fixed in his or her mind that something is not quite right. In my own practice, I would often hear the patient say, "Why did you let your Fellow do one side?"

It doesn't take long before you realize the importance of pointing out these asymmetries before surgery. One of my former Fellows told me of a saying that might be worth framing and putting on the wall in front of one's desk: "What you tell a patient before surgery is an explanation. What you tell them afterwards is an excuse."

Another example relates to facelift surgery. Sure, we all know that our facelifts are the best and last longer than anyone else's, but the truth be known, we realize that facelifting is, at best, an imperfect operation, because it does nothing to stop the normal progression of aging. Because aging is not a linear progression, but instead occurs irregularly, we simply cannot predict how it will occur and, therefore, how long a facelift will last. Better to stress these limitations beforehand than to wait for the patient to come back dissatisfied because

your facelift did not last the 12 years you said it would.

We try to address this with a positive spin. During the consultation, we point out these limitations. At the same time, we recommend that our patients consider coming back every couple of years for a mini-tuck to be done under local anesthesia. This simple procedure requires virtually no downtime afterwards. We even give the patient a "gift certificate" that offers a discount if they elect to have the procedure within 2 years of the original operation.

If a patient is disappointed with the initial result, we suggest that, if they wait a few months and have the mini-tuck, the problem will likely be rectified. The secret is that we have already paved the way by discussing this follow-up procedure both verbally and in writing. We are not springing something new on them.

Risks and complications

It is common for patients to tell you that they don't want to hear about problems or complications. It is tempting to take them at their word and avoid discussing the unpleasant part. After all, it is much more pleasant to talk about the good part and, besides, we really don't see those problems very much anyhow.

Do not be lulled into acquiescing. It is just such a patient who will complain afterwards, when experiencing a complication, they really wouldn't have had the operation if they knew such a thing could occur. Rather, it is far more important to stress that complications can occur. After all, if they never occurred, there would be no reason to discuss them. It is unfortunate that, even when stressing risks, patients rarely remember much of what you say during the consultation. Whether it's because patients are somewhat nervous during the consultation or simply do not want to hear the bad side, it is well recognized that patients forget much of what you tell them.

It's very understandable. Years ago, my wife had a serious medical problem and I can remember sitting through the consultation. I was so worried that when, I discussion, her doctor asked if I had any questions, I can clearly remember responding, "I don't really remember anything you said!"

Of course one would expect that a cosmetic consultation would not be quite so stressful, but the lesson is clear. We simply cannot expect our patients to remember everything we tell them.

It is very helpful to supplement your consultation with written handouts. Ideally, these handouts should be written by you, but if you don't have any, the commercial preparations are better than nothing.

After every new consultation, I send the patient a letter in which I summarize my findings and recommendations. Any important limitations that I discussed are also mentioned. I include a standard paragraph advising the patient to read the information provided during the consultation and to contact us with any questions.

Included in the written information is a copy of the operative consent form that they will be asked to sign at the time of surgery. We want them to have this information before they even schedule the operation.

Not only is this good patient relations, it is also good risk management.

Use a video or PowerPoint presentation

There are some procedures we do over and over again. Even though there may be some differences with each patient, going through the same discussion can become tedious. Over the years, I have made PowerPoint presentations for the operations that I do most frequently.

After examining the patient and talking with them, during which time I determine that they may be a good candidate for the desired procedure, I bring them back to my office where I go through the slide talk.

Facelifting is an example. In this presentation I schematically go through the technique, anticipated recovery, and potential risks and complications. The talk then covers combined laser resurfacing, because many patients have these procedures combined. Finally, the presentation emphasizes the office philosophy regarding the secondary mini-tuck discussed in the previous section on the limitations of surgery. The last slide always asks the patient for questions.

Make no mistake, this presentation is no substitute for your personal discussion, but it does help to keep me on track and make sure that I cover the issues that need to be discussed. I usually try to add some cartoons to keep the presentation from being too stuffy, and of course the slides are only a guideline. Each discussion is geared to the individual patient.

One word of caution: these discussions should not turn into a lecture. Always include pauses and gestures that let your patient know that you are also seeking their input. After all, that's what a consultation really is—a discussion rather than a discourse!

Bring your dog to work

When we are in our office or at our clinic, we are in our element. We are, or should be, entirely

comfortable. Patients, on the other hand, are entirely out of their element. They probably are uncomfortable even admitting that they are considering surgery to alter their appearance. I think we tend to forget this, since most of us consider cosmetic surgery to be such a natural thing to undergo.

Anything that you can do to make your patients feel more comfortable will pay dividends in the long run, especially when things do not turn out exactly as you or your patient had hoped or expected. Remember, if your patients really like you, they generally are not going to want you to feel disappointed and are less likely to complain about minor imperfections or failings.

The opposite is generally true also. If patients see you as unconcerned about them personally, they are more likely to complain or to feel that you did less than your best for them.

For years, until shortly before her recent death, I brought my dog, Amelia, to work with me. Granted, initially it was just because U loved to have her with me. She was a beautiful and amazingly friendly and well-behaved Doberman. It didn't take me long to realize, however, Amelia was one of the best and most effective staff members at putting patients at ease.

It was so common for patients to sit and pet her as we talked. Often patients asked for her before they went into surgery, or after surgery as they recovered in one of our overnight suites. After Amelia died, I received an outpouring of sympathy from patients asking where she was.

Now I'm a real dog lover, so Amelia served another purpose. I figured that if people were put off by her presence, they were not the right type of patients for me. It rarely happened, but I firmly believe that she saved me from some potentially troublesome patients. It all goes back to the point that we all have different styles and relate to different types of people. When you first start out, you want every potential patient to choose you. As you gain more experience, you learn that some patients are simply better off with other surgeons, and you are better off without them.

Other articles in this issue emphasize how to deal with the dissatisfied patient. I'm more concerned with avoiding the situation in the first place. Sure, we're not 100% successful, but anything that increases the percentage is well worthwhile.

The operation: do what you do best

It always is exciting to go to a meeting and hear about all the new procedures. Speaker after speaker presents glowing reports backed by excellent preoperative and postoperative pictures. Of course, that same speaker probably has presented previously some other new and exciting procedure that he abandoned after a short while. All of us who speak at meetings have an interest in teaching, but we also have our egos to satisfy. Frankly, we're not too interested in talking about something that did not work out very well.

Consider also that there is always someone from the lay press at that meeting who is anxious to write about the latest and greatest technique. This, in turn, leads to patients coming into your office asking if you do the latest totally noninvasive, incisionless, long-lasting facelift as seen on television and described in all the women's magazines. Of course you don't want to admit that you are behind the times, and you did see that presentation at the latest meeting.

When placed in this position, try to remember that there is rarely anything truly new under the sun. As you develop experience in a technique, you move towards being a master of that procedure. Not everyone is as adept at every technique. A good example follows: I have long had an interest in the extended subperiosteal coronal lift. I believe that it is the best way to produce a long-lasting improvement in the mid-face area. I have been doing the operation for a long time, and I've gotten pretty good at it. My patients are pleased with the results, even though it leaves a long scar across the top of the head.

I have heard many presentations that describe a similar operation done with an endoscope. Supposedly, the surgeons who do this procedure can do the same thing with a number of shorter incisions and no scar across the top of the head. Sounds great, but if I were to undertake that procedure, I would be going to the bottom of the learning curve. It might take me years to develop the skills that would allow me to do the endoscopic operation and achieve the results that I get with the open operation that I have been doing for so long.

When patients ask me about new procedures, my comment often is "Yes, I've heard about this, but I don't have any experience in the technique. It's still pretty new and I'm reluctant to try it. If you are interested, I can refer you to someone who is doing it." Rarely do patients take me up on the offer, and if they do, I still feel I'm better off and I'm doing the patient a service. Occasionally, I have had patients who do accept the referral and then come back to me later when they want other surgery. They appreciate my honesty. After all, you cannot be an expert at everything.

Opportunistic surgery

One of the principles that has guided me over the years is a concept that I call opportunistic surgery.

I actually learned this concept from Dr. Jan Beekhuis, one of the pioneers in facial plastic surgery. Dr. Beekhuis did not use this term, but he practiced the concept. In opportunistic surgery we start with a surgical plan, but we always have a fall-back position. It's really nothing more than the fundamental principle of "first, do no harm."

For example, when I do a facelift, it is normally an extensive biplane procedure. I really believe in the importance of extensive subcutaneous dissection combined with a second submusculofascial dissection, resulting in a strong musculofascial flap that provides the major lift of the operation. However, if for any reason, the dissection is not going well, I will not hesitate to alter my plan and simply do a single deep-plane dissection. I may not feel that I'm getting quite the lift, but safety first. It doesn't happen often, but it is always in the back of my mind.

I think that this is a safer way of looking at things compared to the attitude that, regardless of the situation, I'm capable of seeing this through and carrying out the more extensive dissection. That attitude may make sense in life-saving surgery, but not in totally elective cosmetic surgery.

By keeping this concept of opportunistic surgery in mind, I think you are also keeping the welfare of your patient at the forefront. As I stated previously, most of the time you will be able to carry out your initial plan. In the rare cases when you cannot, your patient will be more satisfied than if you pushed ahead, only to have the operation complicated by slower recovery and a complication that might have been avoided. Don't let your ego get in the way of your patient's welfare.

Postoperative care

Fortunately, most patients recover from cosmetic surgery without significant difficulty. On the other hand, I have noticed that little problems seem to be of more concern than in other aspects of surgery. Of course this concern is to be expected. As always, it is best to warn the patients about these problems. Pain probably is the most common issue. So often we tell our patients that pain will not be severe, even though we know that some patients will hurt much more than others. Why not mention that difference in pain experience? Ask your patient what pain experience he or she has had. Preoperative discussion of pain, numbness, bruising, or generalized discomfort can go a long way toward avoiding postoperative dissatisfaction.

On the other hand, a preoperative discussion is no excuse for not following up promptly when patients complain, even if you are sure it is an anticipated issue. Your availability when patients have concerns is one of the best defenses against patient dissatisfaction. If all looks well, reassure the patient, but be sure you don't discourage them from calling again if necessary.

I think this is one of the most difficult balances in postsurgical care. Our clinical nature combined with the natural defensiveness fostered by our litigious climate can make it difficult to reassure a patient when one knows that a bit of redness in the incision line is probably insignificant but could be a harbinger of infection. Somehow, we need to be reassuring but remain vigilant.

Once, many years ago, I asked the late Dr. Jules Newman, one of the early pioneers in the field of cosmetic surgery, what he told his patients about complications after cosmetic surgery. His answer, although overly simplistic, is memorable: "Nothing will go wrong, but if it does, I'll fix it!" Of course, I'm not advocating you avoid discussing risk, but I feel the positive attitude is what is important here.

If something does need to be revised, this always poses a challenge in regard to your obtaining the patient's satisfaction. It seems that, no matter how much you discuss limitations and complications, patients expect everything to go just right the first time.

Saying " I'm sorry" does no harm. We tend to be very defensive because of the litigious nature of medicine, but saying you're is sorry is not an admission that you did something wrong. I also believe that one should try in every way to avoid adding to the patient's expense, as much as you can. Of course, there will be cases in which patients will need laboratory services, wound care, or outside consultation, and these situations must be individualized, but do remember that cosmetic surgery is expensive, and patients do not anticipate extra charges.

If you don't share this overall philosophy, at least spell out to your patients what they might be responsible for in the event of a complication or unexpected result.

When patients are unhappy with a result, we all tend to get a bit defensive. This is the time to swallow your pride. After all, regardless of what you or anyone else thinks about the result, if the patient is not happy, the operation is not a success. Our major goal as cosmetic surgeons is to make patients feel good about themselves.

Do not argue with the patient over the result. If you think you have achieved the best possible result, an apology on your part may serve the purpose: "I know you're unhappy, and I wish I could have done more to please you, but I don't honestly know what more I can do to help you achieve the result you expected."

Sometimes it is helpful to ask patients what they would like you to do. This question gives patients a chance to express themselves and clues you into what they are seeking. If they want you to fix it, and you can, that might be the answer. But what if you don't feel it advisable to do more surgery?

Summary

Most patients who seek cosmetic surgery are happy, or at least satisfied, with our work. That part is what makes it so much fun. When patients are dissatisfied, we tend to suffer as much as the patients do. Working to keep our patients happy begins at the moment they contact our office and continues throughout the treatment process.

Patient selection will help to avoid dissatisfied patients, but once you accept the patient for treatment, the patient is fully your responsibility until that treatment program is complete.

By doing what you do best and doing it to your best ability, combined with an ongoing interest and concern for your patient, dissatisfied patients should be the exception rather than the norm.