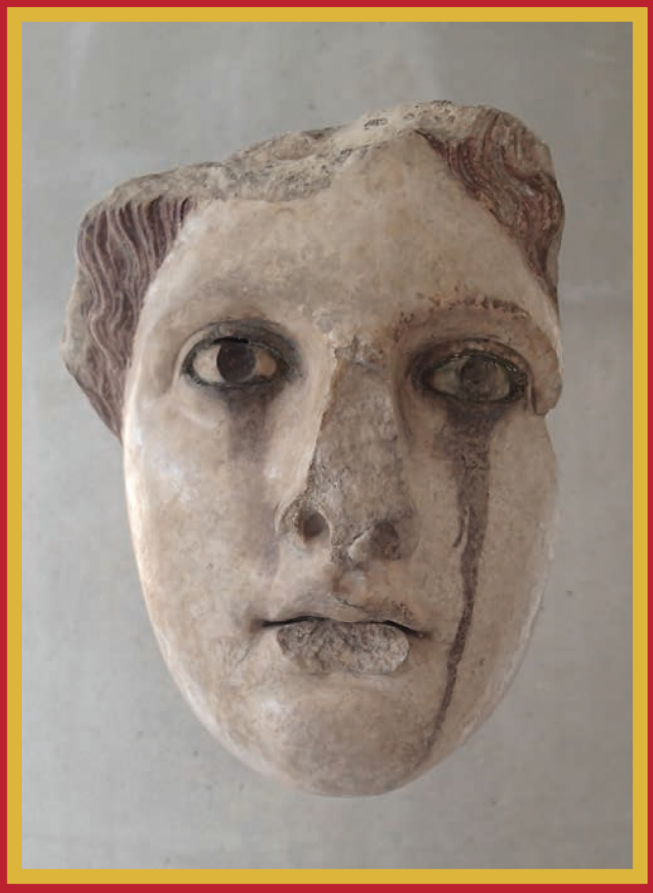
The Unfavorable Result in PLASTIC SURGERY

Avoidance and Treatment

Fourth Edition



Mimis N. Cohen and Seth R. Thaller

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3267 illustrations

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Library of Congress Cataloging-in-Publication Data

Names: Cohen, Mimis, editor. | Thaller, Seth, editor.
Title: Unfavorable results in plastic surgery : avoidance and treatment /
Mimis Cohen MD, FACS, FAAP, Professor and Chief, Division of Plastic,
Reconstructive and Cosmetic Surgery, Director Craniofacial Center,
University of Illinois, Chicago, IL, Seth Thaller, MD, Professor and Chief
University of Miami Division of Plastic Surgery, Miami, FL.
Description: 4th [edition]. | New York : Thieme, [2018] | Includes bibliographical references and index.
Identifiers: LCCN 2017030614 (print) | LCCN 2017032596 (ebook) | ISBN
9781626237636 (e book) | ISBN 9781626236745 (print : alk. paper) | ISBN
9781626237636 (ebook)
Subjects: LCSH: Surgery, Plastic--Complications.
Classification: LCC RD118.7 (ebook) | LCC RD118.7 .U54 2018 (print) | DDC 617.9/52--dc23
LC record available at https://lccn.loc.gov/2017030614

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+55 21 3172-2297 / +55 21 3172-1896

Cover design: Thieme Publishing Group
Typesetting by Debra Clark, Chris Lane, Susan Trail, and Ditech Processing Solutions

Printed in China by Everbest Printing Co. 5 4 3 2 1

ISBN 978-1-62623-674-5

Also available as an e-book:
eISBN 978-1-62623-763-6

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Dedicated to the memory of Robert M. Goldwyn (1930–2010), world-renowned plastic surgeon, outstanding teacher, respected mentor, and a great friend.

This book is dedicated to my wonderful wife Andrea, who has been standing by my side and supporting my academic career for over 35 years, and to my daughter Saranna, the light of my life.

Mimis N. Cohen, MD, FACS, FAAP

To my wife Pat who has always been there for me and will continue to be for the foreseeable future. She will always guide our lives. My parents Jack and Phyllis, who have left an indelible footprint on my journey. My children, Steven Cody and Alexandra Lee, who have added so much light and joy to our days.

Seth R. Thaller, MD, DMD, FACS

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Preface

Errare humanum est, preseverare diabolicum
To err is human, but to persist (in mistake) is diabolical (stupid).
Lucius Annaeus Seneca (c. 4 BC–65 AD)

The first edition of this book was published in 1972. At that time, acknowledgment and reporting of complications were frowned upon due to pride and ignorance but mainly because of fear of litigation. Twelve years later, in 1984, the second edition was published, followed by the third edition in 2001. Recognizing the overwhelming advances in our specialty and the increased importance and acceptance of patient safety in everyone's practice, Bob and I started developing plans for a fourth edition a few years later. Unfortunately these plans were interrupted due to Bob's serious illness, which led to his untimely death in 2010.

Despite the plethora of great publications related to our specialty published during the last decade, there was a recognized void in comprehensive coverage of the topic of avoidance of unfavorable results and management of complications. Yet I was reluctant to go forward with the next edition without Bob's presence and guidance, concerned that I might not be able to do justice to his monumental endeavor. As the idea was maturing in my mind, I discussed my thoughts with my good friend Seth Thaller. He offered valuable advice and suggestions and encouraged me to go forward with the project. He also enthusiastically agreed to serve as co-editor for the fourth edition.

We agreed to dedicate the book to the memory of Dr. Robert Goldwyn, who conceived the text and edited the three previous editions, and to retain the universally, highly praised format of the book with chapters focusing primarily on avoiding unfavorable results or complications and on how to manage and treat them if they do occur. Each chapter, as in the previous editions, was to be followed by a discussion by an expert who would highlight and provide counterpoints to further elucidate successful management of untoward conditions.

We were fortunate to meet Ms. Sue Hodgson. She was fully aware of the success of the previous editions and promised to work closely with us for the preparation of an outstanding publication. Sue agreed to support our plans to fully modernize the book into a two-volume format. It would be highlighted with full-color printing throughout, a bespoke artwork program especially created for the new edition by the Publisher, and the addition of numerous videos in a complementary e-book version.

Because of how highly specialized plastic surgery has become, it has become apparent we would need the participation of more experts. So we invited several renowned authorities to serve as associate editors in the section related to their respective areas of excellence. They actively participated in the planning and organization of the content, the selection of an international group of highly qualified and respected authors, and the critical review of the manuscripts.

Safety in surgical practice is no longer a formality. It has been incorporated into everyday clinical practice, education, and board certification. Thus following the current trends we expanded the section on legal and safety issues to include valuable information for the established practitioner as well as the novice starting a practice. This section is followed by presentation of cutting-edge information and an updated list of the most commonly encountered topics in everyday practice and beyond, recognizing that it would be impossible to include all plastic surgery–related topics in one publication.

The book has been designed for quick and easy reference with color-coded sections, summary boxes, and lists of potential complications. It is extensively illustrated with more than 3,200 photographs and illustrations and comes with a bundled e-book version so that the information can be accessed while on the road or in the operating room. More than 100 videos are also included with technical pearls and recommendations for avoiding and treating unfavorable results and complications.

Although overall this is a very different book from the previous editions, it maintains intact the philosophy of those editions as established by Dr. Goldwyn. We hope that our readers will be pleased with the outcome and regularly employ the knowledge to improve patient care.

Mimis N. Cohen, MD, FACS, FAAP

Preface to the First Edition

By its focus on unfavorable results, this text differs from most books on plastic and reconstructive surgery because it is devoted solely to the unpleasant realities of our specialty. It contains information that we would like to obtain at meetings and in articles but seldom do.

Although medicine has evolved to a point at which it acknowledges mistakes, a certain amount of hush-hush remains. Formerly, pride and ignorance were the cause of this reticence; now fear of litigation is also a factor. In many ways this book makes plastic surgeons less vulnerable to adverse legal proceedings, not only because its information should upgrade our skills but also because it confronts and confirms our fallibility. These pages strongly document the fact that the ideal result is not always achieved. A successful result is what most of us, if fortunate, are likely to attain. The patient and surgeon will fare better if each understands and accepts the risk and unpredictability of any procedure. The vagaries of the human condition are largely responsible for this unpredictability, and that is one reason why medicine remains an art, no matter what its scientific accretion.

In this text the term *unfavorable result* refers to a sequela of treatment which the patient, the surgeon, or both consider undesirable. Admittedly, what is desirable varies according to individual standards and preferences. We painfully remember the occasional patient dissatisfied with what we judged a superior result. Yet, if we are honest, we should also recollect the many who have been delighted with something far less than perfect, sometimes to the point of making us feel a twinge of guilt.

The situations selected for discussion here are those which most discerning patients and surgeons would consider unfavorable.

One might object to the word *result* in the title because of its implied finality. In defense I would say that not all results are necessarily final, except for death, and even this point may be argued by some. Moreover, many chapters nicely demonstrate that what we would consider a "bad result" need not be the end stage if we have sufficient persistence and ingenuity.

An unfavorable result includes more than what *complication* connotes. All complications are unfavorable results, but not all unfavorable results are complications in the usual sense of the word. For example, a patient with a wound infection after rhinoplasty would undoubtedly be listed among the weekly complications of a surgical service. If this same patient had an uneventful postoperative course but a year later bore the flarednostril stigma, she would have an unfavorable result (not necessarily irrevocable) but not a complication. Yet, for the surgeon as well as the patient, this unhappy outcome would cause considerable distress, even more than might arise from a complication that has not left permanent damage—such as a penicillin reaction or a momentary cardiac arrhythmia.

Complications and unfavorable results have here been considered together in order to present maximal information about clinical pitfalls. The contributing authors have not had an easy task; aside from the usual rigors of writing for a compulsive editor, each has had to review his experience without blinders but with candor and completeness This form of self-examination is masochistic and unpopular. But we all would acknowledge the truth of the maxim, "Mistakes are often the best teachers." In that regard, this book is extremely ambitious and moderately naive: it assumes that we can learn from the mistakes of others—not a well-established human faculty.

Dealing with a large variety of problems, these pages should contain something for everybody in different stages of the learning and practice of plastic and reconstructive surgery. Since no single volume of such a nature can be all-inclusive, there are lacunae—not too conspicuous, it is hoped, or too numerous.

The book should also stimulate a review of our thought processes in treating a patient. One will soon realize what complex measures he takes, consciously and unconsciously, to avoid an unwanted outcome in achieving the surgical objective. This chess player's mentality is discernible at every step in the therapy, from the first encounter to the last good-bye.

R.M.G.

Preface to the Second Edition

It is not enough to have carried out an operation skillfully: it is just as important to foresee and to prevent the complications that may follow it.

Dominique-Jean Larrey

…The best surgeon, like the best general, is he who makes the fewest mistakes.

Astley Paston Cooper

More than a decade has passed since the first edition of this book was published. During this interval, significant events have occurred in plastic surgery. One immediately thinks of the now routine application of microsurgery to reimplantation and transplantation, the burgeoning numbers of craniofacial procedures, and the common use of musculocutaneous flaps. Our specialty has become so specialized that the general plastic surgeon is extinct. I know no one who in fact or fantasy does with equal skill and frequency craniofacial operations, microsurgery, repair of clefts and hypospadias, head and neck work, cosmetic procedures, and hand cases. Because of the breadth and depth of plastic surgery, no single volume could realistically include every possible undesirable outcome, with its prevention and treatment.

Unlike 15 years ago, unfavorable results are now discussed openly both in meetings and in print. This change from the hush-hush of the past has come as the plastic surgeon's susceptibility to malpractice suits has increased. Although at first thought one might consider this phenomenon a paradox, it is not. The explanation is the cogency of reality and the necessity for a profession and those it serves to deal with events as they are. It is preferable that a surgeon and a patient comprehend the reality before operation; then any complication will have been anticipated if not expected. When the realization first comes postoperatively, it is unsettling, even astonishing, leaving the patient feeling betrayed and angry and the surgeon bewildered and defensive.

It was said that the greatness of Caesar lay in his "not expecting the plum tree to give forth peaches." That not every treatment culminates in success is so well known that it seems unnecessary to mention. Yet it is surprising how frequently this surgeon manages to expect the next operation to give a perfect result. Depending on the observer's vantage point, this attitude has been called optimistic, vain, grandiose, arrogant, stupid, or negligent, or a combination thereof.

This book, then, is devoted to the unpleasant side of our specialty. It is part of our professional life but not all of it, no more than a funeral is the story of a life. Death, disease, and displeasure are realities, however, with which all humans must contend. For most of our lives, we surgeons meet these unwanted circumstances more often in others but, alas, we find them ultimately in ourselves. Wherever initiative or chance leads us, we will eventually encounter reality. Enlarging the surgeon's perception of reality is a major objective of these pages. I have long pleaded that we report our professional acts, operative or not, in terms of the entire spectrum: best, average, and worst results, the last being the focus of this book. Without adequate information, we shall engender within ourselves fanciful expectations that we will transmit unknowingly to our patients.

R.M.G.

Preface to the Third Edition

This third edition comes 28 years after the first and 16 years after the second. During those intervals, significant advances occurred in plastic surgery and in all medical disciplines. We now can do more for patients. Yet inevitably, unfavorable results, minor and major, still occur. This edition, like its predecessors, concerns these unpleasant realities.

When I was gathering material about complications for the first edition, I reported my own and enlisted others to do the same. A few senior plastic surgeons advised me to desist because they feared the medicolegal repercussions for our specialty and the personal consequences for myself if my name were to be forever linked to bad outcomes. Fortunately, perhaps miraculously, these predictions have proven false. In fact, attorneys for defendants have used this information to demonstrate to juries that a complication for which their client has been charged with negligence has been well described. Patients still come to me despite a reputation built partially on failed procedures, luckily not all mine.

By custom, this preface should have been written by both editors, Mimis Cohen and myself. As the (considerably) senior editor, I prevailed on him to let me author it because I wasted to praise and thank him for this constant enthusiasm, his prodigious work, and his sage counsel. If I had not enlisted him – and if he had not graciously agreed – this third edition would likely not have appeared. In this endeavor, as in my entire professional life, I have been blessed and am truly grateful.

We both appreciate more than we can express the labors of the contributing authors and discussants whose book this really is. We also want to thank the highly skilled professionals at Lippincott Williams & Wilkins who helped make this book possible, including Beth Barry, Joanne Bersin, Tony DeGeorge, Penny Bice, and Allison Risko.

Robert M. Goldwyn, MD

Acknowledgments

Compiling a textbook involving the full breadth of our specialty and including an array of formidable authors can be a daunting challenge. Add to this the task of compiling and organizing an outstanding international team of experts committed to re-create and/or update the third edition of an iconic and novel opus conceived by such an outstanding individual as Dr. Robert Goldwyn, proved to be a mammoth, truly herculean effort. We hope we have been able to successfully reinvigorate Dr. Goldwyn's landmark contribution, *The Unfavorable Results in Plastic Surgery: Avoidance and Treatment*, and we would like to briefly recognize all the individuals who were instrumental in the completion of this project.

In order to achieve the best possible outcome, we enlisted the participation of highly qualified and talented experts in their field to serve as associate editors for each of the sections of the book. They provided us with invaluable advice regarding titles of chapters and prospective authors. Each submitted excellent contributions within their sections but also reviewed most of their section's manuscripts and revised them, as needed. We are grateful to Dr. David Birnbach for his participation in the section of Legal and Safety Issues; Dr. Linda Philips for General Problems; Dr. James Stuzin for Aesthetic Surgery; Drs. Joseph Serletti and Joshua Fosnot for The Breast; Drs. Pravin Patel and Peter Taub for Pediatric and Craniofacial Surgery; Dr. Lawrence Gottlieb for Reconstructive Surgery of the Head and Neck, Body, and Lower Extremity and Burns; and Drs. David Netscher and Zubin Panthaki for Hand and Upper Extremity. We would have never been able to successfully complete this project without their phenomenal contributions.

Our colleagues and renown experts, drawn both nationally and internationally, volunteered to participate as contributing authors or discussants. They prepared exceptional chapters that required thoughtful insight into the specific aspects of plastic surgery, namely unfavorable results. Delving into what can be a deeply personal and sensitive subject requires deep soul searching and courage. They shared their extensive experience and insight on the prevention, recognition, and management of unfavorable results. In addition, many furnished technical videos to further complement the educational value of their contributions. We deeply appreciate their involvement and their time and effort in accomplishing our goals.

Our office assistants, Erin McGinn and Teresa Shipman, helped keep us on track. They coordinated and participated in the numerous conference calls through the course of development, and they actively participated in the preparation of lists, correspondence with authors and the publisher, confirmation of assignments, and the overall smooth interaction with our publisher.

We are indebted to the archeologists and staff of the National Archeological Museum in Athens, The Acropolis Museum in Athens, and the museums in Corinth, Herakleion, and Delos for the guidance and assistance in the selection of representative artwork to complement this publication.

From the beginning, we wish to acknowledge the foresight and perseverance of our Editor Sue Hodgson. Even though the name of the publisher changed not once, twice, but three times, this never swayed our fearless leader. She continued pushing forward to completion. Her efforts and guidance were truly exceptional. We would also like to thank Developmental Editor Kathleen Sartori who kept the project moving and took care of the many details. A special thank you to our Art Director Brenda Bunch, our copyeditor Kelly Mabie, and the entire production team in St. Louis and New York. Their expertise and dedication to publishing attractive and accurate books are second-to-none.

We must not forget to acknowledge our patients. They allow each of us, as plastic surgeons, to practice our specialty every day. Their trust in us as makes going to work each day a pleasure and not a mundane task. The knowledge gained from them and the content from the book *The Unfavorable Result in Plastic Surgery* will hopefully benefit many more patients in the generations to come.

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Cover Image: "Head of Goddess." Courtesy Acropolis Museum, Athens, Greece. Photo: Socrates Mavromatis. © Acropolis Museum, Athens, Greece.

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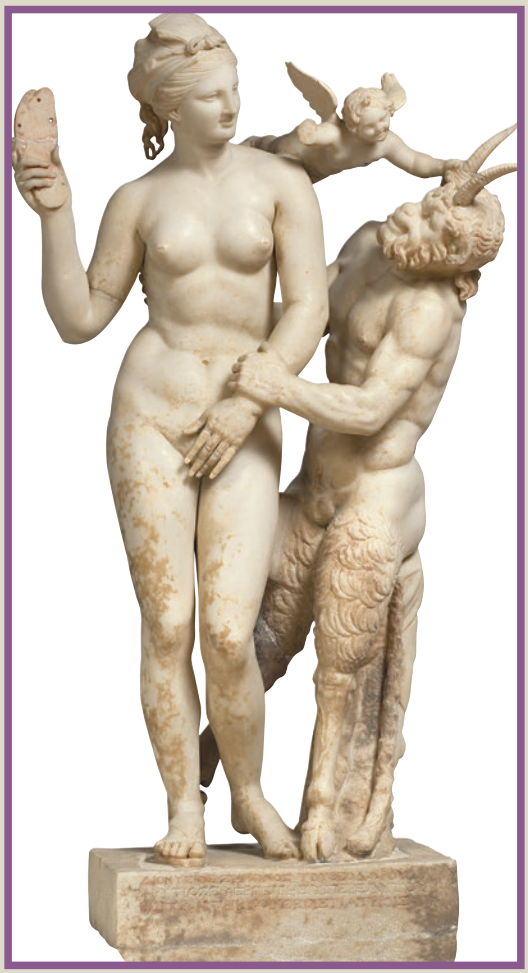

Aphrodite and Pan from the House of the Poseidoniasts of Beirut, Island of Delos Greece.
(National Archaeological Museum, Athens, Greece. ©Hellenic Ministry of Culture
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CHAPTER
1

Why We Fail

Robert M. Goldwyn

Men are men, they needs must err.
—Euripides, Hippolytus

The ancients were right: to err is human. No patient and no surgeon can live a full life without being the victim or perpetrator of an error. This fact does not condone mistakes but recognizes their reality. The genesis of human fallibility has been variously ascribed to Original Sin, divine retribution, arrested evolution, astral mismatch, capricious fare, simple chance, malice, and poor judgment. Whatever the cause or causes, the effect can be the same: despair and defeat.

After a failure, most of us seek an explanation. Paré's philosophy, "I dress and God heals," may be valid for many medical situations, but not all. Should God be blamed for a poorly designed flap? We tend to externalize responsibility: To look heavenward is easier than to look inward.

Oscar Wilde, however, recognized a basic truth: "There is a luxury in self-reproach. When we blame ourselves we feel that no one else has a right to blame us."

The title of this chapter, "Why We Fail," was chosen with care. Originally I called it "Why Things Go Wrong," but that would imply that an unfavorable result occurs because we are helpless victims of circumstances. Responsibility for actions is the cornerstone of Judeo-Christian religion. The burden on the individual is unrelenting. In our Western culture, the development of which has been intimately related to science, it is unacceptable to say only that "something happened." We are compelled to probe why it occurred, although the explanation may not be obvious. For example, if on a wintry day someone falls, the easy answer might be that it was because of the ice. Indeed, that may be true, but the real cause might have been that the person was in poor health or was not wearing proper shoes or was rushing because he had risen too late from poor planning or laziness.

The purpose of this book is not just to name specific complications and unfavorable results. The reader should become aware of the more subtle conditions and factors that predispose to failure. These situations constitute what might be called the *matrix of mistakes*. To improve, the surgeon, like any other erring human being, must not only recognize and correct the mistake but, if possible, identify its cause and avoid it in the future. Admittedly, to be able to do this requires the talents of a Sherlock Holmes and a Sigmund Freud. Only by taking an unswerving look at ourselves during the course of treating patients can we find the critical points where errors commonly arise.

Preoperative

Incomplete Initial History and Hasty Physical Examination

The initial consultation can be either the moment of truth or the moment of deception. The most common cause of selecting the wrong patient, making the wrong diagnosis, or recommending the wrong treatment is not spending enough time with that patient. An assembly-line approach in the office invites disaster.

Hazards are inherent in different stages of our professional life. Success, for example, does not always make for continued success. On the contrary, it may confer defeat because of false security. When one begins a practice, one tries to establish a name. Later, the name by itself may come to represent the skills and care that the doctor once had but consciously or unconsciously no longer exercises. The doctor may become sloppy, and the patient is the victim. The

traps and trappings of a flourishing practice replace sound judgment and hard work. The surgeon may hire someone to take the history and even to talk to the patient about what to expect from the procedure and how to pay for it. The doctor may do the physical examination but in a superficial manner. Trying to operate on more patients may transform a physician into a policeman directing the medical traffic in the office. Under these circumstances, it is not hard to imagine how an error might occur.

No matter how well the surgeon plans the day, often there is not enough time for an adequate history and physical examination. It is better to inform the patient of that fact and to invite him or her back, at no charge, for proper evaluation. Most patients will appreciate honesty and thoroughness and will not mind the inconvenience of having to make another appointment. Just as the major cause of automobile accidents is driving at excessive speed for existing conditions, so the major cause of error in a physician's office is seeing too many patients too hastily. Some physicians truly believe that it is their duty to help as many patients as possible. Others, less nobly motivated, realize that more patients mean greater income. High aspirations and income are not in themselves objectionable, but too often the patient becomes the casualty. Perhaps for most physicians, seeing an excessive number of patients results not from design but from inadvertence, the inevitable outcome of the "fit her in somewhere" philosophy. The surgeon and his or her staff over the years gradually may become stretched beyond their capacity.

That most plastic surgeons do aesthetic surgery may predispose them to regard their procedures as just skin deep. Because cosmetic patients usually are in good health, the surgeon may not believe that a thorough physical examination is crucial, the assumption being that, whatever the procedure, the patient will come through unscathed except for local scarring. The surgeon may not inquire about systemic illnesses, past operations and emotional reactions to them, drug sensitivities, smoking history, and so forth. Furthermore, because the patient for aesthetic surgery has a focus, such as the nose or breast, the surgeon may limit his or her attention to one segment of the patient. In fact, it would be considered odd and inappropriate if the plastic surgeon did a pelvic examination on a 40-year-old woman desiring a facelift. However, in viewing the patient narrowly, the plastic surgeon may forget that he or she is a physician with the duty to think of that individual globally and not only regionally. The patient may reinforce the plastic surgeon's superficial approach because he or she does not want to believe that a rhinoplasty, for example, is a real operation with true hazards.

Operating for the Wrong Reasons

The decision to operate should be made for medical or surgical reasons with regard to the patient and not for the surgeon's ambition, convenience, pride, or fiscal needs. If a surgeon cannot improve a situation, it should be left alone. If the surgeon believes that he or she cannot give a patient the result he or she expects, either consciously or unconsciously, that surgeon should not undertake that operation.[1,2] Selecting the proper patient and giving him or her the proper operation are the ultimate objectives of the initial consultation.[3] As plastic surgeons, we justifiably place great reliance on technique, but a well-executed procedure does not necessarily produce a happy patient. This is particularly so in aesthetic surgery, where psychological factors may predominate over anatomic ones.

Certain types of patients should raise the surgeon's antennae and threshold for operating: those who write an excessively long letter to arrange the initial consultation, therein revealing an obsessive and perhaps neurotic nature; those who are rude or pushy, who want to be treated as an exception, or who have a high degree of self-entitlement; those who are unkempt or dirty and therefore may be severely disturbed and need a psychiatrist rather than a plastic surgeon; those who praise you excessively and denigrate your colleagues; those who give a false history or are indecisive or vague about what they wish to have done; those who have a minimal deformity but maximal concern; those who refuse to conform to the surgeon's usual regimen in such matters as undressing or being photographed; those who have shopped for the "right" plastic surgeon and have come to you as the fourth or fifth on the list; those who are the compulsive seekers and bearers of multiple operations; those who acquiesce to have an operation to please someone else, such as a disinterested husband or an overbearing parent; those who are paranoid or visibly depressed; those who are in psychotherapy without having obtained the approval of their therapist, without the surgeon having communicated with their therapist, and without the surgeon having obtained the approval of their therapist; older male patients who seek a rhinoplasty to resolve sexual inadequacy; "special" patients who are so important socially that they do not want to be bound by the usual conventions of medical care; and, finally, patients who the surgeon simply dislike upon meeting.[4]

The reality is that surgeons vary in their intuition. However, in reviewing my own experience and in speaking to many plastic surgeons who had dissatisfied patients, I have found that we too often disregarded our presentiments. When we have more than an inkling that a patient for elective surgery will be too difficult emotionally for us to manage, saying no at the initial consultation is better than inviting the patient back for additional appraisals and bending over backward, literally contorting our judgment, to give him or her another opportunity for an operation that should not be done, at least not by us. Sometimes a member of our staff will voice uneasiness about a patient because of an incident that should alert us to potential disaster. Ignoring this information may cause considerable regret later.

Not Seeking a Consultation

Surgeons should periodically objectively assess their own abilities. If a procedure requires a skill that a surgeon does not possess, the surgeon should offer a referral or at least

a consultation. Plastic surgeons have criticized other surgeons for venturing beyond their competence. They should not do the same. The era of the omnificent plastic surgeon has ended. The patient is gravely endangered, as is the surgeon, by the undertaking of an unfamiliar procedure. Specialized plastic surgeons offer a sufficient variety of skills to make referral not only possible but mandatory. Because most plastic and reconstructive surgery is elective, the opportunity to guide the patient to the right physician is available.

Sometimes a surgeon builds a reputation in a particular area, such as maxillofacial surgery, but, in truth, with time, he or she seldom performs those procedures. The surgeon may be unwilling to relinquish them and to admit to having a practice that is more "aesthetic" than "traumatic." He or she may prefer to retain the self-image of a young prowler of the emergency room and a "healer," occasionally performing an operation that preserves this image, but it soon harms the surgeon's reputation and, more important, injures the patient. For many plastic surgeons, there is an inevitable shift in what they focus on over the years. In my own career, I performed a considerable amount of hand surgery when I was first in practice, but this work decreased as other procedures came to predominate. I recall my discomfort when I first made the hard decision of referring a patient who needed a tendon graft to someone who was doing this operation every week rather than, as in my case, about once every 2 months. A good rule is that a surgeon and patient should feel comfortable with one another; whenever this rule is transgressed, error and rancor are more likely to result. I have yet to meet a patient who has not respected a physician more for having admitted his or her limitations. Pretending prowess where none exists is wrong medically, ethically, and legally.

A Poorly Informed Patient

If a patient and his or her family do not understand the when, why, or what of a procedure, trouble will follow—not only from the medicolegal standpoint but from the total therapeutic aspect. A patient may actively dislike an objectively good result if he or she did not comprehend the pain, time, and cost involved, as well as the nature of the scars and the limitations of the procedure. Sometimes the patient does not know what the surgeon has in mind because the surgeon does not really know. He or she may not have taken the time to plan the treatment properly. In aesthetic surgery, the fact that a patient has prepaid and has signed an informed consent does not necessarily mean that he or she has completely understood and, more important, remembered what the doctor has said. But even under the best of circumstances, when the patient is intelligent and the surgeon painstaking in his or her explanation, verbally, in writing, and perhaps even with the aid of audiovisual materials, the recall by the patient is modest. What chance does a patient or surgeon have under less than ideal circumstances, if the information is too scanty and too rapidly presented?

Finances

Financial considerations are difficult for both surgeons and patients to navigate. Certainly medicine involves more than finances, but when misunderstandings occur in this realm, the relationship between the patient and the surgeon is doomed. The payment of a bill by a patient who is unhappy or dissatisfied is a common impetus for him or her to seek an attorney. This does not necessarily mean that patients who sue for malpractice are only those who have been stressed or distressed by a bill. However, paying someone for services whose quality is doubtful, either subjectively or objectively, is disturbing, at the very least. It is imperative that the financial aspects are clearly stated, understood, and remembered by the patient and the surgeon before any procedure is undertaken. Prepayment for the surgery may solve many but not all of these problems. Prepayment has the additional advantage of having the patient indicate a commitment. If he or she feels a conflict about the operation, it is likely to come to the fore at the time of writing a check. Should the surgeon detect vacillation, he or she should welcome this opportunity for learning that a patient is not a good candidate for the procedure and should tell the patient to wait until he or she is more certain. I never charge a patient for an operation that I have not done because the patient canceled. I do not want to coerce someone unwilling to submit to surgery.

Intraoperative

A Poorly Planned or Poorly Performed Operation

Although bad preoperative and postoperative management can destroy a good operation, a bad operation can rarely be transformed into a good one by bedside attentions. This is true particularly in plastic and reconstructive surgery, in which the results depend directly although not totally upon technique.

The operating room should not be the first place a surgeon performs a procedure. The surgeon should walk through the surgery mentally within the 12 hours or so before the operation if the case is elective. Considerations such as the design of the flap, the type of immobilization, and the availability of blood and proper equipment should not be left to happenstance. The ability to improvise may lend a virtuoso quality to surgical performance, but it should never replace tactical thinking. A surprising and distressing number of surgeons do not start thinking about the case until they take up the knife.

No operation is truly minor. It has been said that a "minor operation" is what happens to someone else. Every surgeon and patient should be wary of the "simple case." Underestimating a procedure can lead to a surgical "nightmare." How apt the Russian proverb: "More drown in the puddles than in the sea."

Subtle factors may ruin a good result. For example, a surgeon may be stimulated to try something that he or she ordinarily would not do to impress a new resident or a visiting surgeon. Alternatively, surgeons may not give a particular operation their full effort because they are battling the clock—another case, a meeting, patients in the office, a dinner party at home. The fourth operation on a surgeon's schedule should be done with the same high standards as the first. If the patient is in satisfactory condition, no procedure should be terminated until it has been executed as well as possible. Boredom, fatigue, or the press of a schedule should not compromise judgment or quality. A result that looks just fair at the end of the operation generally will look worse in the office. If that final glance discloses a remediable fault, the surgeon must heed that assessment. A few more minutes can make a startling difference. Time spent then is more worthwhile than excuses and explanations later. Stitches are not sacred: they can and should be removed and replaced until the desired result is achieved. Michelangelo wisely commented: "Trivials make perfection but perfection is not trivial."

A good surgeon is not necessarily someone whose hands move fast but someone whose brain keeps ahead of the next step in the procedure. He or she does not repeat unnecessarily.

When I was a resident and rotated onto the anesthesia service, it soon became apparent to me from the other end of the table how easy it was to distinguish the excellent surgeons from those who were only good or fair. The distinction was not based on digital dexterity but on planning and judgment. The best do not waste time. Although an operation should not be a tense affair, it certainly is not a social event. Those who unnecessarily prolong a procedure are usually surgeons who have smaller practices and want to savor each minute or, to be exact, each hour of the session.

Like any professional, a surgeon who is committed to doing an excellent job must concentrate and avoid distractions that can result in disaster. Every operation poses the risk of a suboptimal outcome, complications, and even patient death.

Surgeons must be attentive to many things and not just to what they are physically doing. They must be alert to possible breaks in asepsis; must check all solutions before using them; must be sure that the patient has been properly placed on the operating table with all bony prominences padded; must check that alternating pneumatic boots on the legs, if used, are functioning even before the patient is given anesthesia; must communicate with the anesthesiologist about vital signs. If surgeons have a cavalier approach to their duties, other surgical personnel will adopt a similar attitude. Patients trust the surgeons to whom they have committed themselves. That responsibility deserves the surgeon's best.

Although the surgeon is in charge and must oversee the activities of many, he or she should do this without becoming a martinet. Creating an uncomfortable and fearful environment is inimical to success. Others in the operating room should not be afraid to speak or to advise when they see something that could be improved.

Postoperative

Concluding the Case with the Operation

In reality, the operation is not over until the patient is discharged from the surgeon's care. The hit-and-run technique has no place in surgery. The patient and his or her problems should not fade from the surgeon's consciousness as soon as the dressing is applied.

Careful observations, detailed orders, and clear instructions are critical, especially with the ascendancy of ambulatory surgery. If a patient is admitted, the surgeon should be fully aware of the hospital course and should not abrogate the responsibility to residents. The surgeon should know, for example, about unusual pain, vomiting, or other important incidents or complaints. The surgeon should be fully aware of the patient's medications, blood pressure, pulse, and temperature. Standards of care should not go down with the setting sun. If a dressing or splint warrants removal, it should be done as quickly at night as during the day. The "wait for the morning" attitude is unacceptable for managing patients.

Surgeons should take an active part in follow-up and not assign accountability to others in the office. The surgeon must assess how the wound is healing and be available to listen to the patient's fears and anxieties. The office atmosphere must not intimidate a patient into silence. If a postoperative situation presents problems beyond a surgeon's skills or knowledge, a consultation should be offered before the patient asks or a tragedy occurs—not just to keep the surgeon "clean" medicolegally but, more important, to ensure the patient receives the best treatment.

Surgeons must fight the tendency to become fair-weather doctors, attentive and helpful when all goes well but distant and punitive when a complication develops. A patient who has to bear an unwanted result usually feels isolated and angry, and often guilty. Such a patient should be encouraged to express his or her sentiments without fear of reprisal. Unconsciously, the patient might think of his or her complication as divine retribution for the self-indulgence of an elective procedure, especially a cosmetic one, that friends and family considered unnecessary. The physician's responsibility is to guide the patient through this difficult period with genuine sympathy. This is certainly not the occasion for rancor and desultory care (see Chapter 2).

Inadequate Follow-Up

A surgeon who fails to continue to observe his or her patient for an adequate period will lose a valuable chance to learn. In contrast, a surgeon who believes in extended observation will behold many things, sometimes wondrous, occasionally painful, always instructive. A revised scar that

initially looked disappointing will have improved miraculously after a year. The reverse also is true. The rhinoplasty that appeared "just perfect" at 6 months may develop many imperfections. It is always tempting to quit while ahead—discharge the facelift patient, for example, after a few months, when he or she is feeling rejuvenated and grateful. If surgeons truly wish to improve their techniques and to understand their patients' reactions to their operations, however, they should follow them for longer than several weeks and in many instances, such as after augmentation mammaplasty, for many years. During this period, the surgeon must be genuinely committed to objective evaluation and resist the temptation to fit the facts to an old thinking mold. There is a difference between 20 years of experiences and 20 years of 1-year experiences.

The Iron Man (Woman) Delusion

No surgeon—no human being—is invincible. An operation is a series of interdigitating sequential acts, whose quality depends on the soma and psyche of the surgeon as well as of the patient. An overworked, overstressed surgeon does himself or herself little good and may do the patient considerable harm. As an athlete must stay in peak shape, it seems logical for surgeons to try to keep fit physically and emotionally for their daily performance. Although surgeons should not shirk their tasks, they must take time to replenish. Periodic vacations or a day enjoying a favorite pastime are beneficial. A professional life is a marathon, not a sprint.

Chance

No surgeon, even the most careful, skillful, and knowledgeable, can control every variable in a patient's treatment. A passage from Ecclesiastes is pertinent: ". . .time and chance happeneth to them all." From that perspective, it is remarkable that most outcomes are good and most patients are satisfied. However, the unusual and unexpected can occur. A patient in the hospital may not receive the right medication or may develop a sensitivity to it; a patient with a recent rhinoplasty may injure the nose. The scenarios are infinite. Although the surgeon is not responsible for these capricious turns of fate, he or she must deal with them appropriately and with equanimity.

Conclusion

The recognition of certain prime factors in failure should make surgeons less willing to accept an unfavorable result as an event related only to the patient or emanating only from chance. In many instances, although not all, its genesis lies with the surgeon, with his or her treatment style. Although surgeons cannot always assume total responsibility for an unwanted outcome, they must not delude themselves into thinking that they had no part in the occurrence of any complication. No matter how attentive surgeons are, fallibility and unpredictability mark the human condition, and mistakes will occur. Of this sad reality, Hippocrates observed:

> Mistakes, no less than benefits, witness to the existence of the art, for what benefited did so because correctly administered, and what harmed did so because incorrectly administered. Now, where correctness and incorrectness each have a defined limit, surely there must be an art. For absence of art I take to be absence of correctness and of incorrectness, but where both are present art cannot be absent.
>
> —The Art, V (W.H.S. Jones, translator)

Humans are not self-correcting computers. Our capacity to learn is present but not always used. An error, although painful and unwanted, nevertheless presents a unique opportunity for self-betterment.

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CHAPTER 2

The Dissatisfied Patient

Robert M. Goldwyn

A dissatisfied patient is an unfortunate, stressful reality that can be prevented only by retiring from practice. Because this is an impractical alternative, surgeons must seek more practical and fulfilling ways to manage an unhappy patient after surgery. Although uncommon, an unsatisfied patient has an enormous negative emotional impact. It is thus important to address the management of dissatisfied patients in a discussion of unfavorable results.[1]

Background

Physicians seek to help others and to obtain their approbation. It is terribly distressing to have to deal with a person one has not only failed to help, but possibly has made worse; who, instead of being grateful, is hostile; and who, instead of applauding the surgeon's motives and talents, openly accuses him or her of greed and incompetence and may actually seek legal redress.

A plastic surgical residency, like most other educational experiences, does not usually equip surgeons to manage the unpleasant side of the profession. Residents only address the results of somebody else's efforts, and even when they advance to having their own patients, they are looking forward to the time when the rotation ends and they can begin their own practice. However, as practicing professionals, surgeons are ultimately responsible for results.

Plastic surgeons often practice in high population areas and are usually unknown to the patient before the initial consultation, have only brief contact with the patient, and project an image of wealth. Statistically, most plastic surgeons are at the upper end of the socioeconomic ladder and are portrayed by the media as delighting in displaying their wealth as well as their talents.

The average patient seeking aesthetic surgery comes with the belief that perfection is just around the corner. Some surgeons within the specialty, coupled with the media, have reinforced this false reality. Although it is true that most patients will be satisfied and that the surgical results will be exemplary, this obviously is not true for every patient and every outcome.

The Patient

As mentioned, some patients arrive with inflated expectations and unrealistic beliefs of the prowess of the plastic surgeon. However, many come distrustful of medicine in general and of any doctor in particular. A few patients are openly hostile and have the attitude "show me what you can do." Unlike when I first began practice, patients today pointedly ask about the surgeon's training, experience, capability, and even previous malpractice suits. The latter information is available online in many states.

Many patients have been referred by primary physicians whose incomes are generally less than those of plastic surgeons, especially those doing a preponderance of aesthetic operations. If something does go wrong, the family physician may not be the most understanding or helpful because of his or her resentment about the disparity in the financial rewards or personal views about aesthetic surgery in general.

Why Is the Patient Dissatisfied?

The first task of the surgeon is to determine why the patient is unhappy. Typically the patient allows no ambiguity by voicing a strong, unequivocal statement of the complaint, but if this is not forthcoming, the surgeon should be alert to veiled discontent—a sullenness, an irritability, or some form of passive-aggressive behavior, such as the patient not keeping appointments or not paying the bill if payment expectations were not clearly outlined before the operation.

In some respects, it seems easier to let the patient leave the office, content to avoid the confrontation. Sooner or later, however, the unpleasantness will appear and must be faced. The surgeon must not become so unreceptive that the patient's resentment festers and reaches the proportions of a lethal abscess. Before this occurs, a helpful comment might be, "You don't seem too happy today. What is troubling you?"

Some patients seem more unhappy than they prove to be. Once they have expressed their concerns, sometimes after having been asked, they may respond more positively than anticipated. This becomes a good foundation on which to build the ensuing discussion and management. For many patients, dissatisfaction disappears with reassurance that circumstances are justified. For example, someone who is concerned about swelling 2 weeks after blepharoplasty can be told that the swelling will subside as healing progresses over the next several weeks or months. A patient may worry about the bulkiness of a recently turned flap. Here, too, reassurance about the progressive flattening will be comforting, particularly because it is true. Surgeons must keep in mind that one never reassures a patient if reality dictates otherwise.

Occasionally, postoperative unhappiness centers on minimal or nonexistent factors. In this situation, the surgeon must determine "why this now?" Is the person depressed and feeling guilty about having an elective operation or about something else? Has there been a recent loss, such as a divorce or death? I had a 35-year-old married woman as a patient who had a very good result after a rhinoplasty and chin implant but seemed depressed a few weeks later. She then told me her girlfriend next door had "kept away" and finally confessed to my patient that she feared rejection because she thought that my patient, now better looking, would need her less. Occasionally the culprit in postoperative depression of a mild sort is a primary care physician, who may have made a comment such as, "You went through all this to look like that?"—perhaps because the patient did not consult him or her about the surgery or because of resentment of what the physician considers an excessive fee for something that is not life-threatening.

Several patients have revealed after aesthetic surgery that female friends have rejected them because they believe that the patient is now a threat to them because their spouse might find the patient more attractive. A more insidious situation is a spouse or lover who may have enjoyed the personal dominance that resulted from the patient's feelings of inferiority about a disliked feature. After surgical correction, the partner may become less secure about the leverage he or she formerly possessed. For example, after a breast reconstruction, a patient left her husband who was having affairs because he thought that, with her deformity, she would be lucky to have him and was not in a position to object to his other activities. One cannot save a marriage through plastic surgery, but sometimes the procedure may prompt a divorce.

A patient who complains legitimately about an undesirable result, for example, infection, asymmetry, or bad scarring, deserves prompt, appropriate attention. A valid complaint merits respect and empathy. A patient who has had aesthetic surgery may have sought it against the advice of family, friends, and other physicians and may have paid a large fee. When something goes wrong, he or she may feel foolish, ashamed, guilty, and, not unexpectedly, angry. The patient may believe that this complication is divine recompense for vanity that led him or her to risking his or her health for something "frivolous" that now has become a distinct liability.

Mismanaging a Dissatisfied Patient

The following comments from my patients emphasize the importance of properly managing dissatisfaction.

> "He [another plastic surgeon] always tries to minimize the problem. He hasn't really been honest with me. I don't want to go back to him even though he said he would do it over for nothing. I don't trust him. Suppose he makes a mistake again. But if I go to someone else, it will cost a lot of money and I can't afford it. I already paid him $8,000 and for what [facelift]?"
>
> "I am bringing my wife here to see you for a second opinion. It would have helped if Dr. [–] had suggested it. He never would. His ego could fill a ballroom."
>
> "He expects me to like him after all I have been through. He is lucky that I won't sue him and I really might. I have trouble enough seeing him for this hole in my face [concavity after liposuction]. He avoids me like the plague. Maybe an attorney can get to him."
>
> "He was there for the money but he is not there for me now. All I get to talk to is his nurse [secretary]. He really doesn't give a damn."
>
> "If I really thought this would have happened, I wouldn't have had it done. Every time I see her, she tries to talk me into thinking that it [noticeable ectropion] will go away with time. It has already been 10 months. She won't admit that she goofed. I can't get a word in edgewise with her."
>
> "I thought that with your reputation, this wouldn't have happened."
>
> "My boyfriend hasn't come near me since the operation. I really can't blame him. This big hole [skin loss after abdominoplasty] would disgust me, too."

Aesthetic patients generally are well informed, often have sought more than one consultation, and, even though they have been informed about the possibility of a complication, have not been prepared emotionally to accept it.

A complication is even harder to accept if the patient went to a surgeon with a well-known reputation. However,