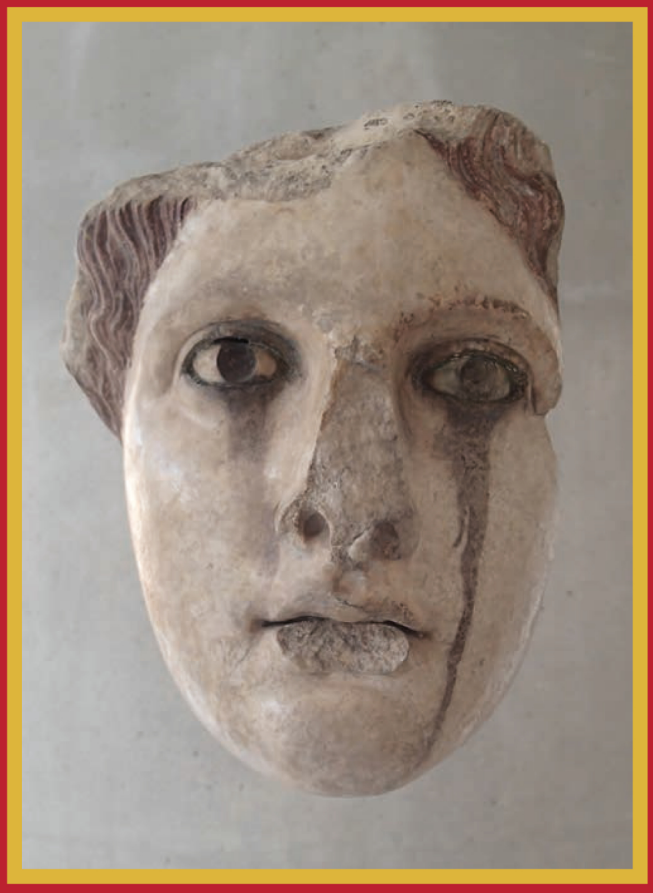
The Unfavorable Result in PLASTIC SURGERY

Avoidance and Treatment

Fourth Edition



Mimis N. Cohen and Seth R. Thaller

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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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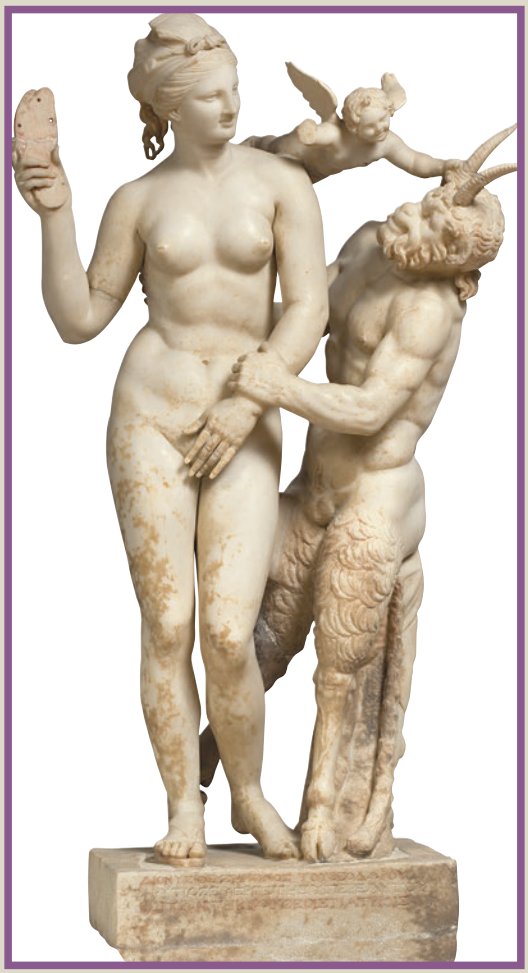

Aphrodite and Pan from the House of the Poseidoniasts of Beirut, Island of Delos Greece.
(National Archaeological Museum, Athens, Greece. ©Hellenic Ministry of Culture
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CHAPTER
1

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,

regardless of who the surgeon is or how long he or she has been in practice, things can go wrong; the mighty also fail and fall.

Avoiding the Reality

Because most of the results are favorable, surgeons instinctively turn away from an adverse outcome, but the sooner they accept it, the better they can manage it. I was once in a colleague's office when a patient complained of asymmetry of her nipples after breast reduction. The problem was obvious to me, but the other plastic surgeon tried to convince the patient that she was wrong. In my opinion, he compounded the injury by insulting her intelligence. Most patients and their friends or family are capable of judging a scar that is thick (hypertrophic or keloid) or a tip that is bulbous. Trying to talk the patient out of a problem may succeed for a few hours, but ultimately it will fail. It will make the patient angrier and less willing to follow advice. If there is anything that can drive a patient to another plastic surgeon or to an attorney, it is distorting reality.

Blaming the Patient or Becoming Angry at the Patient

To accuse the patient of producing an unfavorable result usually is unjustified. Although a patient can, by not following instructions (such as smoking after a breast reduction), cause an adverse result, usually it is the surgeon or the circumstances of the operation that are to blame. The surgeon should not then accuse the patient of causing the poor result. This creates animosity between the patient and surgeon. Instead the surgeon should recognize the reality and work together with the patient to correct it.

Not uncommonly, surgeons become angry at patients when something goes wrong. Although that is understandable as an expression of the surgeon's frustration, it is unacceptable professional behavior.

A plastic surgeon I knew very well used to accuse her patients of "poor eating habits and nutrition" whenever a wound healed unsatisfactorily. One patient, whom I saw in consultation, was incensed by this kind of treatment. She happened to be an Olympic skier with an excellent diet.

When a patient is angry and the surgeon retaliates in kind, both regress together. The patient becomes angrier because he or she becomes more fearful to be in the presence and hands of a surgeon who has lost control. At the moment when the patient is looking to the surgeon for guidance and maturity, it is devastating to have the healer decompensate. This makes a difficult situation worse.

On a few occasions, I have said to a patient, "I know that you are angry and I also would be if I were in your position. However, it is important that we work together. I need your support, also, to get through this and I can assure you that I will be there for you."

Being Distant or Unavailable

The surgeon should not erect a barrier against the patient; instead the surgeon should be available at all times. An unfavorable result may actually be an opportunity to deepen the relationship and sometimes can be converted from a potentially miserable disaster into a satisfying experience. Over the years, several of my patients who developed postoperative problems and were managed with a modicum of decency actually became enthusiastic supporters and subsequently referred other patients. Everyone in the office should be instructed that a patient with an unfavorable result has direct and immediate access. I give patients my personal telephone number to make them feel more secure. This actually results in fewer telephone calls. If a surgeon becomes hard to reach, an easy-to-reach attorney will quickly be on the scene. Medicolegal considerations aside, it is unfair to the patient for the surgeon to become unavailable after an operation has been performed, even if it has not turned out as either the surgeon or the patient expected. Anyone would certainly resent this attitude if, for example, a carpenter came to their home, performed a task, did not produce the expected outcome, and then would not respond to telephone calls.

Many years ago, a colleague referred a patient from the West Coast who was going to school in Boston and on whom he had operated, after which the rotation flap became necrotic in the lower leg. The patient required débridement and subsequent skin grafting. During the course of her hospitalization, the doctor was in town for a meeting but failed to see the patient in the hospital. The patient, as well as her family, knew that he was in town, and although they forgave him for the complication, they never excused his refusal to see the patient in follow-up. I was not surprised to learn that a court battle ensued.

Failing to Structure a Treatment Plan

No patient, especially a dissatisfied one, should be left uninformed. No matter what the situation, the surgeon can always structure a plan, even if he or she cannot give specifics. For example, for a patient whose flap has become necrotic, the surgeon can say, "I want to see you in the office at least twice a week so that I can remove the dead tissue. How large the wound becomes through this process will determine whether a skin graft will be necessary. I wish I could tell you that precisely now, but I cannot. However, I assure you that you will know everything that I am thinking at the time of your visit."

Precise details are not necessary, but the surgeon should offer the security that any patient, especially one in distress, craves. That sense of security would be destroyed if the surgeon were to tell the same patient, "I am really not sure what will happen. I guess I should see you frequently. We can set up some schedule over the next 2 or 3 weeks. You might need a skin graft, but you might not. I will let you know

when I think that it is necessary, but for now, my secretaries will be in touch with you, and you should keep in touch with us."

Failing to Consult

Another aspect of managing a dissatisfied patient is proper use of a consultant. Most patients want to remain with the original physician, but it can comfort the patient, as well as the surgeon, to get another opinion, especially if it is warranted. The surgeon must learn to sense when a patient wishes a consultation and should not make the patient jump hurdles to obtain one; however, the patient should not feel tossed off or shunted, but *directed* to the other physician. I usually dictate a letter in the patient's presence stating what the problem is and that I would like the consulting surgeon's advice, which can be discussed freely with the patient.

Occasionally, a surgeon may sense that a patient does not feel that he or she should pay for "the surgeon's mistake." I believe surgeons should consent to see patients for colleagues at no charge to maintain the delicate balance between the unhappy individual and a hard-pressed physician. However, if the referring physician believes that a patient should be charged for the consultation, he or she should inform the consulting surgeon of this and offer to pay for it personally. Most surgeons likely would not allow a colleague to do so, but this practice has precedence and does not imply that the referring surgeon is guilty of any wrongdoing. If the patient chooses to continue his or her care under another doctor, either the consultant or someone else, the patient should not be made to feel guilty. In similar situations, I have made sure that I knew when the patient was going into the hospital and have even called the patient in the hospital or at home afterward. The patient thus realizes that I am truly interested in his or her well-being, and the doctor who has cared for the patient also welcomes my support and does not feel that he or she has lost a professional friend.

Many patients have told me that when they suggested to another doctor a "second opinion," the response was hostile. A recent patient who had loss of skin behind the ear after a facelift relayed that the surgeon said that he never wanted to see the patient back if she went to someone else. That behavior is puerile and irrational, because the patient was a reasonable individual, justifiably concerned about her face. Fortunately, time and dressing changes resulted in a satisfactory outcome.

The patient may require a consultation with a psychiatrist or a psychotherapist if he or she becomes depressed and seems unable to handle the stress. This should be suggested sooner rather than later. Sometimes obtaining agreement from the patient is difficult. In this situation, the primary care physician may be helpful.

Ignoring Pain

Some patients reveal their unhappiness by complaining of pain long beyond the time that would seem appropriate. People vary greatly in their pain tolerance, and it is impossible to know how much pain another person is having or should have. Chronic pain after an aesthetic operation usually signifies a depressed and displeased patient. A busy plastic surgeon, if not vigilant, may prescribe medication just to stop the patient's calls. However, such medication should be left in the province of an expert such as a psychiatrist or pain specialist.

Those patients who have puzzling persistent pain requiring analgesics and allegedly preventing their return to work after reconstruction, on the other hand, should lead the surgeon to suspect malingering for secondary gain emotionally and financially. Depression also is a possibility, and here again the surgeon should make an effort to enlist a therapist to determine the dynamics of the behavior and to offer an effective treatment.

Neglecting the Support System

A dissatisfied patient, like most human beings in difficulty, needs support. I find it helpful to involve the close and relevant members of the family and friends, even showing some of them how to change dressings if wound breakdown has occurred. The referring doctor should be informed to enlist his or her help.

Most people like to hide an embarrassing situation. Although that is instinctual, it is unwise for surgeons. That something has gone wrong with an operation mirrors life: bad things happen. If the surgeon has a secretive way of dealing with a problem, the patient will sense the shame of it and will become even more unwilling to deal with the reality. As the sense of the surgeon's guilt increases, so does patient anxiety.

Increasing the Financial Burden

When considering the management of an unfavorable result, the financial aspects are important. For patients who had reconstructive surgery, the cost of treating a complication usually is borne at least in part by insurance. This is not the case when things go wrong after a cosmetic operation. In these cases, the patient must pay the entire bill. If the surgeon has his or her own operating room, the patient need not be charged for its use. However, many plastic surgeons do not have such a facility and depend on the hospital's resources. I stipulate in my consent form that a patient undergoing cosmetic surgery is responsible not only for the expense of that operation, but also for those associated with any complication that will involve the hospital. Although I would not charge a patient for revision after an aesthetic procedure, I cannot assume the additional expenses of the hospital. On occasion, the surgeon may sense that another financial stress for an individual would be unfair and inappropriate. Some attorneys advise billing a patient for any work to relieve a complication because not doing so would imply guilt. Others contend that not charging the patient and noting in the record this has been done to lighten the patient's financial load is an acceptable alternative in a

trying situation and, rather than implying guilt, denotes compassion, something a jury might readily understand. This is a difficult decision, so surgeons facing a revision or poor result should consult with their malpractice insurance company.

One colleague had a patient whose umbilicus was off-center after an abdominoplasty. He charged her for its relocation. The patient did not mind paying for the hospital but was irate that the surgeon made additional money from a mistake that he made. Again, most people would not tolerate that kind of business practice from a carpenter, plumber, or painter. They are professionals, too, who make mistakes, but customers expect them to rectify the errors without added cost.

It is perhaps too simple to say that surgeons should treat the patient, satisfied or dissatisfied, as they would want to be treated. In so doing, Emerson's words should be comforting:

> Bad times. . .are occasions a good learner would not miss.

When the Dissatisfied Patient Is Somebody Else's Patient

A consultant who sees a patient with an unfavorable result arising from the work of another surgeon is in a singular position to do considerable good or irrevocable harm. Although in this situation, as in any other medical circumstance, the first obligation is the patient, a surgeon also can help or try to help the other doctor.

The first step is to obtain as objective a history as possible. Exclamations of disbelief at the patient's story or the other surgeon's behavior should be assiduously avoided. A patient who is angry and distraught may provide too brief a history because he or she wishes something done immediately to correct the undesirable result. The patient may be impatient with the consultant for laboriously trying to gather the sequence; however, securing a full account is crucial.

I always inform the patient that I wish to get in touch with the other doctor to improve his or her care. If the patient does not allow this, I am reluctant to continue treatment.

The following are typical statements from patients whom I have seen in consultation:

> "I went to him because he was supposedly tops in his field. How could he have done this?"
>
> "He never told me this could happen. I was in and out of his office 1-2-3."

In reply to the first statement, I usually am able to truthfully say that I have had the same kind of problem or that this is not an unheard-of difficulty. To the second statement with its implication that the patient was not properly informed, I have found it beneficial to say nothing and to hear the other side of the story.

As part of the history, the surgeon should ask the patient about his or her general health and professional and family life, just as would be asked if the patient had presented for the initial procedure. The surgeon should ask the patient about relationships with the spouse, parents, and employer; whether the patient is now abnormally depressed; and how he or she has reacted to previous operations.

When a patient expresses anger at another physician, the surgeon should not agree with this assessment; instead the surgeon should tell the patient, "I can understand that you are angry. I am sure Dr. – is upset also. No good doctor wants to have an unhappy patient. I can tell you that I wish all my patients had wonderful results, but that is not true. Perhaps he is seeing one of my patients as I am seeing you now."

The physical examination usually is less of a problem than the history, because the examination is more objective. The patient is almost eager to show the scars that "shouldn't be there," the breasts that "don't match," the nose that "looks awful," the tendon graft that "doesn't work." For the consultant, the pitfall is being so absorbed in the local problem that he or she neglects the patient in totality. A consultant might fail to notice, for example, how scars have healed from past operations; or he or she might not detect systemic disease, such as a malfunctioning thyroid. During the examination, the surgeon should avoid expressing distress at the results of previous surgery. The patient will be alert to any sign of how bad the consultant feels the problem is or how badly he or she thinks the other surgeon performed.

The patient should be asked to return to the consulting room for a proper discussion. Most likely the patient feels the other doctor is not spending enough time with him or her and would not want another opinion on the fly no matter how impressive the consultant's credentials.

This is the most difficult part of the consultation—literally, "the moment of truth." I have found it best to give the patient as honest an appraisal of his or her problem as is possible, but to do so with warmth and empathy and to avoid any pejorative statements. I begin simply, "Mrs. –, as you know, you have had a breast reduction and your problem is that the scars are more noticeable than you want. It is true, also, as you said, that the breasts are not symmetrical. I am sure that for both you and Dr. –, this has been very distressing, because you both know that he would have wanted the best for you." Having structured the problem, the surgeon can proceed to the treatment, which, for the patient, is the most important derivative of the consultation: "Now, Mrs. –, we would all agree that we have to decide what to do. Looking backward is not productive and can be very upsetting." The consultant should give a candid but not condemning evaluation. Patients fear conspiracy among doctors; they believe that physicians will protect the worst actions of the most incompetent to maintain the solidarity of their guild. Unfortunately, in some instances, this is not mere paranoia.

A practical matter must resolved at this point: Who now is responsible for the patient's future care? Sometimes the patient will settle the matter by refusing to return to the for-

mer doctor. However, frequently the surgeon who arranged the consultation will continue to care for the patient.

I do not believe it medically wise or ethically correct to force patients to return to a doctor whom they no longer trust or like, regardless of whether this attitude is founded. Plastic surgeons who provide consultations must be willing to assume responsibility for difficult situations. The fear of losing respect or trying to avoid a lawsuit should not lead the consultant to refuse to treat the patient. As a practical matter, a patient who is refused by a second or third surgeon is likely to seek redress through an attorney.

At some point in the consultation, the fact should be reiterated that in surgery, as in all of life, perfection is the aim but rarely the attainment. Consulting surgeons must emphasize again that they also have results that are not excellent and patients who are dissatisfied. In indicating the limitations of their own talents, however, they must not make the patient feel that he or she has been so deformed as to be beyond help. This is a delicate balance to achieve. Occasionally, nothing further can be done from a surgical point of view, but the surgeon should be willing to continue to see the patient and to support him or her during this difficult period. This is not the time to be cool, distant, or insensitive.

The consultant should be sufficiently mature not to use the patient's misery to denigrate a colleague or to plump his or her own ego. The golden rule is eminently pertinent here. Because all who operate are bound to have failures, rejoicing secretly in someone else's professional misfortune is immature and shortsighted.

A consultant who is able to help a patient in trouble also helps a family and a colleague. Few situations in medicine demand greater sense and sensibility but yield more satisfaction.

Reference

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CHAPTER
3

Psychological Aspects of Cosmetic Surgery and Minimally Invasive Treatments

David B. Sarwer and Heather M. Polonsky

The last two decades have witnessed a dramatic increase in the number of persons who undergo cosmetic surgical and nonsurgical treatments to enhance their appearance. Even before this increase, plastic surgeons have long been interested in the psychological characteristics of individuals who choose to undergo these procedures as well as the psychological changes surgeons commonly observe postoperatively. The earliest reports in this literature from decades ago characterized most persons seeking surgery as suffering from mood or anxiety disorders, schizophrenia, or personality disorders. These early reports, however, have not been confirmed by more contemporary research studies nor clinical impressions of plastic surgeons. More recent investigations of patients have focused on psychopathology, but also motivations for surgery. Body image dissatisfaction is believed to be one of the strongest motivations for surgery. For some patients, however, this dissatisfaction may be extreme and suggestive of the presence of body dysmorphic disorder or other forms of psychopathology. These conditions are likely of greatest relevance to plastic surgeons because of their likely association with poor postoperative outcomes. They are also the conditions in which plastic surgeons will most commonly ask patients to undergo a consultation with a mental health professional before surgery.

This chapter begins with an overview of the literature on psychological aspects of cosmetic surgery, including a discussion of the sociocultural factors that have contributed to the popularity of cosmetic surgery, as well as the psychological factors that motivate individual patients. The psychiatric conditions most commonly seen in cosmetic surgery patients are also detailed. The research in these areas is used to provide recommendations on the psychological assessment of new patients who present for cosmetic medical treatments.

The Popularity of Cosmetic Surgery

Over the past 2 decades, cosmetic surgical and minimally invasive treatments have exploded in popularity. There likely are a number of potential explanations for the dramatic increase[1–4]:

- Technologic advances have made many of the surgical treatments safer.
- More general advances in medicine have decreased the length of most postoperative recovery periods.
- Minimally invasive treatments have even less associated risk and recovery time, as well as lower relative cost, both of which fuel their appeal to patients.
- Cosmetic procedures, unlike other forms of medicine, readily lend themselves to direct-to-consumer advertisements in a variety of outlets such as city and regional magazines, billboards, and bus stop advertisements. Their banner advertisements on websites and other forms of mass media, as well as the entertainment industry, have all contributed to the growth of cosmetic surgery.
- Cosmetic surgery has long been a very popular topic for women's (and men's) beauty magazines, which often tout the latest advances in the field, and the last decade has witnessed unprecedented coverage of cosmetic surgery on television—from informative health programs to reality-based patient contests, as well as surgeon-focused shows.
- A growing number of celebrities now publically reveal their experiences with cosmetic surgery, something not seen in Hollywood decades ago.

For all of these reasons, it is safe to say that cosmetic surgery is a cornerstone of popular culture. These more overt cultural influences play against a backdrop of relentless images of physical perfection depicted in magazines, television programs, movies, and the Internet. The end result is that consumers cannot help but be exposed to depictions of physical beauty, with cosmetic surgery depicted as an acceptable step on that path to perfection.

In addition to its representation in the media, there are other potential explanations for the growth of cosmetic surgery. Evolutionary theories of physical attractiveness, which suggest that physical characteristics representing reproductive potential are the ones considered most physically attractive, have been applied to cosmetic surgery.[3] Many surgical and minimally invasive treatments performed on the face are undertaken to help an individual look more youthful or enhance facial symmetry; both of these traits are well-established markers of facial attractiveness. At the same time, procedures such as liposuction and abdominoplasty can decrease an individual's waist-to-hip ratio—another marker of reproductive potential.

Social psychological research on the importance of physical appearance in daily life can also be used to understand the growth of cosmetic surgery. Over the past several decades, this body of research has suggested that individuals who are more physically attractive are believed to have a number of more positive personality traits, which may afford them preferential treatment in a range of social situations across the life span, such as opportunities for promotions at work, as well as the development of friendships and romantic relationships in the personal sphere.[3] Thus whether we like to acknowledge it or not, physical appearance does seem to matter.

Whereas decades ago an individual's interest in improving his or her appearance may have been seen as being symptomatic of excessive vanity, narcissism, or other deep-seeded psychopathology, today it also can be seen as a more adaptive and potentially psychologically healthy behavior strategy, akin to other self-improvement strategies, such as eating a healthy diet and exercising regularly.[5]

Preoperative Psychosocial Characteristics of Cosmetic Surgery Patients

A now-sizable body of research has investigated the psychosocial characteristics of persons who present for cosmetic surgery. The following discussion provides an overview of patients' motivations and expectations for surgery, as well as the most common forms of psychopathology likely seen by mental health professionals asked to consult on candidates for cosmetic procedures.

Motivations for Surgery: Body Image Dissatisfaction

Patients present for cosmetic procedures with a variety of motivations and expectations regarding the impact of surgery on their lives. Motivations for surgery have been described as internal or external.[6,7] Although both patients and surgeons may struggle to articulate or identify specific motivations for surgery, patients with internal motivations (e.g., desire to improve one's self-confidence) rather than external motivations (e.g., undergoing surgery to obtain a romantic partner) are believed to be more likely to have their postoperative expectations met.[8]

Body image dissatisfaction is considered to be a primary motivation for cosmetic surgery and other appearance-enhancing behaviors.[4,5,9–12] The past several decades have witnessed an increased interest in body image, with much of the study of cosmetic surgery patients over the past 20 years focusing on this construct.[2,9,13] In its simplest form, body image refers to an individual's perceptions, thoughts, and feelings about his or her body.[14] Cash and Smolak[15] refer to body image as "the psychological experience of embodiment." Although both these definitions provide more detail and nuance to the concept of body image, recognizing how an individual's body image can affect his or her quality of life and other psychological factors, neither addresses the ways in which body image can influence behaviors, such as the desire to have cosmetic surgery.

Because of its relationship with quality of life and self-esteem, body image, and more specifically body image dissatisfaction, has often been examined in relation to eating disorders and obesity.[10,16] Although body image dissatisfaction is often positively associated with body weight, people across genders, age groups, and ethnicities suffer from body image dissatisfaction regardless of their body weight.[12,13] This suggests that how one perceives his or her body may have little to do with how someone actually looks.[15] Nevertheless, body image dissatisfaction is associated with numerous appearance-enhancing behaviors, including dieting, physical activity, and fashion and cosmetic purchases.[10] Thus it should come as no surprise that individuals with body dissatisfaction may also turn to cosmetic surgery.

Numerous studies of cosmetic surgery patients have found that patients report heightened body image dissatisfaction preoperatively.[17–22] For example, breast augmentation candidates report greater dissatisfaction with their breasts compared with other small-breasted women who do not seek breast augmentation.[23,24] Similarly, individuals who seek body contouring surgery after the massive weight losses seen with bariatric surgery typically report heightened dissatisfaction with their bodies.[25] Although the weight loss is associated with improvements in body image, many patients report great unhappiness with the loose, hanging skin of their abdomens, thighs, breasts, and arms.[25] For ex-

ample, 91% of adolescents who had undergone bariatric surgery reported feeling unattractive because of their excess skin.[25]

Nevertheless, though some degree of body image dissatisfaction is believed to be a prerequisite to cosmetic surgery, these feelings may also be representative of several forms of formal, severe psychopathology.

Formal Psychopathology

As mentioned previously, preoperative psychopathology among patients is a primary focus of cosmetic surgery research. The first studies of this issue, conducted decades ago, relied heavily on clinical interviews of cosmetic surgery candidates and described them as having high rates of psychopathology, including mood and anxiety disorders, as well as personality disorders.[26–29] All of these conditions were believed to be associated with poor postoperative psychological outcomes. More recently, studies have included the use of standardized psychometric measures rather than or in addition to clinical interviews of prospective patients; these studies typically have found less psychopathology.[23,24,30,31] Both sets of studies suffer from methodological problems that have made interpretation of these conflicting findings difficult.[4,5,20,32] Thus the rate of psychopathology among cosmetic surgery patients remains poorly understood and, perhaps more importantly, the relationship between preoperative psychopathology and postoperative outcomes is largely unknown.

Given the number and diversity of individuals who now seek cosmetic surgery, all of the psychiatric diagnoses can likely be found within the patient population. However, three disorders in particular—body dysmorphic disorder, eating disorders, and depression—warrant the greatest attention from plastic surgeons and the mental health professionals asked to consult on a patient's psychological appropriateness for surgery.

Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) is defined as a preoccupation with a slight or imagined defect in appearance that leads to substantial distress or impairment in social, occupational, or other areas of functioning.[33] The disorder often develops in adolescence, as individuals become more aware of and concerned with their physical appearance and attractiveness.[34]

Although not introduced into the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* until the third edition in 1987, cosmetic surgery literature included descriptions of "minimal deformity" and "insatiable" patients as early as the 1960s, and dermatology literature described case reports of patients with "dysmorphophobia" and "dermatological nondisease" in the 1980s.[35,36] Like contemporary BDD patients, these individuals sought procedures to improve slight or imagined defects and were often dissatisfied with their results postoperatively.[4] Although the incidence rate of BDD in the general population is believed to be between 1 and 2%, a number of studies conducted throughout the world have found that 5 to 15% of cosmetic surgery patients appear to have some form of the disorder.[4] Although persons with BDD typically report concerns with their skin, hair, and nose, any body part can become a source of preoccupation.[4,37,38]

Persons with BDD commonly seek cosmetic medical treatments as a means of improving their perceived defects.[37,39–41] In a survey of 289 patients, Phillips and colleagues[40] found that 76.4% of patients with BDD sought cosmetic or dermatologic treatment, with other studies finding similar results.[39,42] A more recent survey of 234 patients visiting a facial plastic and reconstructive surgery clinic found that 13.1% of patients undergoing cosmetic surgery and 1.8% of patients undergoing reconstructive surgery who visited the clinic over a 4-month span had BDD.[37] The most common procedures sought by patients with BDD are surgeries like rhinoplasty, breast augmentation, and liposuction, as well as minimally invasive procedures such as collagen injections, microdermabrasion, and dental repairs.[39–41]

In light of cosmetic surgery's inherent objective to enhance physical features that to some may be considered perfectly normal, it is often difficult to distinguish patients with BBD from other patients who seek cosmetic surgery. As noted previously, many cosmetic surgery patients present with body image dissatisfaction preoperatively. Thus determining the degree of a patient's dissatisfaction with body image, and the subsequent distress caused, is essential in discriminating between patients with and without BDD.[4] For some patients the degree of distress can be so severe that it causes them to revert to previous habits of self-injury.

In a survey of 25 patients with BDD who had undergone 46 cosmetic procedures, researchers found that 9 patients were so distressed by their appearance that they performed "do-it-yourself" procedures in an attempt to enhance their appearance and rid themselves of their perceived deformity.[43] Examples of these extreme measures included a man who was so obsessed with his skin that he used sandpaper to remove scars and smooth his skin, and a woman who used a knife to cut out fat from her thighs.[43] Although these extreme cases of self-performed cosmetic procedures are rare, it is likely that other patients use less severe, but equally unsuccessful, measures to improve their appearance.

In contrast to most cosmetic surgery patients, individuals with BDD are typically dissatisfied with the outcome of such treatments.[42] Although a handful of studies suggest cosmetic surgery can result in positive outcomes for patients with BDD, these findings are limited, because the studies focused on specific procedures and patients with mild to moderate BDD symptoms.[38,44] Aside from the aforementioned few, and methodologically limited, studies, most evidence to date suggests that cosmetic procedures and treatments are inadvisable for patients with BDD.[4] Two retrospective stud-

ies have found that greater than 90% of persons with BDD report either no change or a worsening in their BDD symptoms after cosmetic treatments.[39,45] Similarly, a prospective study of 166 cosmetic rhinoplasty patients found that BDD symptom scores were inversely related to postoperative satisfaction and quality of life 3 and 12 months after surgery.[46] Of even greater concern, studies have documented high rates of suicidal ideation, suicide attempts, and self-harm behaviors (e.g., "do-it-yourself" surgery) among patients with BDD.[43,47]

There are also reports of patients with BDD who have threatened to sue or physically harm their treatment providers.[48,49] For example, in 2000 the New York Supreme Court, Appellate Division, saw a malpractice case in which a cosmetic surgery patient suffering from BBD sued her surgeon for malpractice, claiming her BDD symptomology prevented her from providing informed consent, her surgeon failed to inform her of other treatment options, and that the surgeon was negligent in his performance of the surgery.[50] In a recent survey of 260 American Society for Dermatologic Surgery (ASDS) members,[49] 30 surgeons reported being threatened by a patient with BDD, 24 reported a legal threat, and 6 reported a physical threat. In light of these issues, a growing consensus has developed that cosmetic medical treatments should be contraindicated for persons with BDD.[4,10,20,51,52] Encouragingly, many surgeons refuse to perform procedures on patients who they believe to have BDD.[39,40,48] Although screening methods for BDD vary, several groups have suggested the use of both the Body Dysmorphic Disorder Questionnaire (BDDQ) and direct questions about BDD symptoms.[4,37]

Eating Disorders

Given the disproportionate amount of concern that patients with eating disorders place on their appearance, these disorders may be more common among those who seek cosmetic surgery. Patients with eating disorders may erroneously believe that surgery will improve their intense dissatisfaction with their bodies. Eating disorders may be a particular concern for women (and men) who seek body contouring procedures, including liposuction, abdominoplasty, and even breast augmentation. Patients may mistakenly believe that these procedures can reshape their bodies in a way that restrictive eating or maladaptive compensatory behaviors cannot. Women who present for cosmetic breast augmentation are typically below average weight and report greater exercise compared with physically similar women not seeking breast augmentation, both of which also may be suggestive of eating psychopathology.[20,22–24,27–29] Unfortunately, the study of the relationship between eating disorders and other cosmetic procedures has been limited to small case series.

Depression

The presence of major depression or other mood disorders also warrants particular attention. At least one study has suggested that approximately 20% of persons presenting for cosmetic surgery are engaged in mental health treatment, most typically the use of an antidepressant or other psychiatric medication.[53] Compared with other cosmetic surgery patients and women from the general population, women considering breast augmentation or those with breast implants have been found to report a higher rate of outpatient psychotherapy, psychopharmacologic treatments, and psychiatric hospitalizations.[24,53,54] Although these studies suggest that the rate of psychopathology may be higher among patients with breast implants, the investigations provided no information on the specific psychiatric diagnoses of these women.

Of even greater concern is the association between cosmetic surgery and suicide. Seven epidemiologic studies investigating the relationship between silicone gel–filled breast implants and all-cause mortality have found an association between cosmetic breast implants and suicide.[55] For example, using medical records from 13,488 cosmetic breast implant patients and 3,936 other cosmetic surgery patients, cosmetic breast implant patients experienced a higher mortality rate than the other cosmetic surgery procedure patients (relative risk 1.27; 95% confidence interval [CI] 1.0–1.6), noting higher numbers of brain cancer (N = 13; standardized mortality ratio [SMR] 2.25), respiratory cancer (N = 32; SMR 3.03), and suicide (N = 19; SMR 4.24) deaths.[56] Overall, results from these six studies indicate that the suicide rate among cosmetic breast implant patients is two to three times higher than estimated rates in the general population, with a total 126 patients committing suicide postoperatively across the studies.[55]

Although specific reasons for this phenomenon have not been widely studied, explanations of the relationship between breast implants and suicide have primarily focused on the preoperative psychosocial status and functioning of the women.[2,55,57,58] Women who undergo breast augmentation have been shown to have a number of distinguishing demographic characteristics. Not only are they more likely to report more lifetime sexual partners and a greater use of oral contraceptives, but they also tend to be younger at the time of their first pregnancy and have a history of terminated pregnancies. In addition, these women are more likely to use alcohol and tobacco and, as noted previously, have a below-average body weight. Many of these characteristics alone are risk factors for suicide.

At present, the most intuitively consistent explanation of the relationship between cosmetic breast implants and suicide appears to be the presence of preexisting psychopathology before implantation. However, only one of the epidemiologic studies provided any information on the psychiatric history of the women studied; it documented a higher rate of previous psychiatric hospitalizations among women with breast implants, compared with both women who received other cosmetic procedures and women who underwent breast reduction.[54] Among women in the general population, a history of psychiatric hospitalizations is one of the strongest predictors of suicide.[59–61] Unfortunately, Jacob-

sen and colleagues[54] did not report information on diagnosis, history of illness, or other psychiatric treatments for the women in their sample.

Psychosocial Status after Cosmetic Surgery

Despite the aforementioned concerns regarding the psychosocial status of some patients, most cosmetic surgery patients report satisfaction with their postoperative result in the first few years after surgery.[16,31,62,63] Studies suggest that most women report improvements in body image within the first 2 years after cosmetic surgery.[31,64–66] In a systematic review of 16 articles, Imadojemu and colleagues[67] found that cosmetic procedures can improve numerous psychosocial domains. Specifically, the articles reviewed reported improvements in quality of life, body image, and self-esteem among a variety of different cosmetic procedures including Botox injections, laser resurfacing, rhinoplasty, rhytidectomy, and blepharoplasty.[67] Despite these encouraging findings, it is important to note that this evidence is limited, because many of these studies contained methodologic issues that call into question the validity of the findings.[67]

An issue that has received surprisingly little attention is the relationship between postoperative complications and psychosocial outcomes after surgery. Intuitively, postoperative satisfaction and the psychological benefits associated with cosmetic surgery may be negatively impacted by the occurrence of a postoperative complication.[8] At least one study found that breast augmentation patients who experienced postoperative complications reported less favorable changes in body image in the first 2 years after surgery.[65] Unfortunately little else is known about these relationships.

Preoperative Psychological Assessment of Cosmetic Surgery Patients

Despite these mental health issues, cosmetic surgeons typically do not require all patients to undergo a mental health evaluation before cosmetic surgery. In the competitive marketplace of cosmetic medicine, such a policy would likely drive patients to other practices almost immediately. More importantly, given the lack of current evidence suggesting a relationship between preoperative psychosocial status and postoperative outcomes, recommendations for such routine evaluations is not warranted. Rather, cosmetic surgeons, like all medical professionals, should assess and screen for the presence of psychopathology as part of a taking of a medical history and completion of physical examination.

When screening for psychopathology, surgeons should focus on three main things[68]:

1. Motivations and expectations
2. Appearance and body image concerns
3. Psychiatric status and history

Assessing presurgery motivations can be as simple as asking patients why they want the procedure. Typically internally motivated patients (e.g., those who seek to improve their self-esteem or body image) fare better than externally motivated individuals (e.g., those who hope to save their marriage or get a coveted promotion), so understanding patients' underlying motivations can help frame further discussion about the procedure. Similarly, knowing whether patients' postoperative expectations are surgical, psychological, or social in nature provides surgeons the opportunity to correct any misconceptions or unrealistic expectations regarding the procedure's likely outcome. Research has demonstrated that patients who are internally motivated and have realistic expectations tend to fare better than externally motivated patients. Although studies suggest patients are regarded as more attractive after their cosmetic procedure, no current evidence suggests that social relationships will improve after surgery. Ensuring patients understand what is and is not likely to change postoperatively can help prevent unmet expectations and grievances. Evaluating patients' body image concerns is also an important component of the psychological assessment, because patients who suffer from BDD are less likely to experience improvements in their symptoms. Questions that reveal the degree to which patients are dissatisfied with their bodies and the extent to which these negative feelings affect their daily life can unveil potential BDD symptomatology.

Surgeons also should gather information regarding a patients' psychiatric history and status. Although this information is reported on most standard medical history forms, probing deeper with a one-on-one interview allows clinicians to better observe the patient's behavior, demeanor, and ability to interact with office staff. Studies suggest that 19% of cosmetic surgery patients report a mental health history, which often includes a variety of mood and eating disorders.[53] Surgeons should take note of these issues and refer patients of concern to mental health professionals before surgery.

Unfortunately, most plastic surgeons (or their delegates) likely skip this psychological screening portion of the assessment and, as a result, fail to identify patients who may exhibit symptoms of psychopathology. For example, a survey of 260 ASDS members found that although three quarters of surgeons reported asking patients about their motivations (76.7%) and expectations (76.4%) for surgery, less than two thirds (60%) asked about mental health history during the physical exam, and only one fifth consulted with a mental health provider regarding a patient's mental health status.[49]

Encouragingly, most patients interested in cosmetic medical treatments are believed to be psychologically appropriate for such treatments.[2,3,69] These patients typically have specific appearance concerns, internal motivations, and realistic postoperative expectations. Thus most patients do

not need a psychological evaluation before undergoing a cosmetic treatment.

Patients who display symptoms of psychopathology during their initial consultation for cosmetic medical treatment, as well as those with a history of psychopathology, are most likely to be referred to a mental health professional. Many of the early descriptions of cosmetic surgery patients are complete with elaborate interpretations of the role of unconscious conflicts and poor parental relationships in the decision to seek surgery. There is no evidence, however, to suggest that such interpretations are necessarily valid or useful in determining patients' appropriateness for surgery.[5,20] Thus a detailed assessment of patients' parental relationships and decades old historical experiences is unlikely to provide useful information to either the mental health professional or referring surgeon in determining appropriateness for surgery. Rather, a more straightforward evaluation of patients' current functioning, as found in a more general cognitive-behavioral assessment, is recommended.[70]

A trusted mental health professional can be a valuable consultant to a plastic surgery practice. This mental health professional should have a good understanding of the psychological aspects of cosmetic surgery, as well as knowledge of disorders with a body image component, such as BDD and eating disorders. In most cases, the mental health professional will be called upon to assess a patient's psychological appropriateness for a procedure at a given point in time. The mental health professional also may be asked to join in the care of a patient postoperatively. This is most likely to occur if the patient is dissatisfied with an objectively successful outcome or if the patient experiences a significant postoperative complication.

Cosmetic surgery patients may react to a referral to a mental health professional with anger and defensiveness, believing that they will only feel better if they look better, and therefore may refuse to go to the consultation. To increase the likelihood that the patient will accept the referral, it should be treated like a referral to any other health professional. The patient should be informed of the specific areas of concern and the reason for the referral, and this information also should be shared with the mental health professional.

Psychiatric History and Status

The assessment of the patient's psychiatric history and current status should be the central part of the consultation with a new patient. With the exception of BDD, no conclusive data exist regarding the prevalence of psychiatric diagnoses among persons who seek or undergo cosmetic surgery. As noted previously, all of the major psychiatric diagnoses can likely be found in this patient population. Particular attention should be paid to disorders with a body image component, such as eating disorders and somatoform disorders, and to mood and anxiety disorders. The presence of these disorders, however, may not be an absolute contraindication for cosmetic surgery. In the absence of sound data on the relationship between psychopathology and surgical outcome, appropriateness for surgery should be made on a case-by-case basis.

As discussed previously, approximately 20% of patients who seek cosmetic medical treatment report using a psychiatric medication at the time of treatment.[53] Patients who receive these medications from a primary care physician often do not experience complete relief from their symptoms. Therefore a psychopharmacologic evaluation should be considered if symptoms do not appear to be well controlled. If patients are in treatment with a mental health professional, the surgeon should contact this professional and, if necessary, discuss their appropriateness for cosmetic treatment.

Physical Appearance and Body Image

Potential patients should be able to articulate specific concerns about their appearance that are readily visible to the treating surgeon; patients who are markedly distressed about slight defects that are not easily apparent may have BDD. Because the judgment of an appearance defect as "slight or imagined" is highly subjective, the nature of the appearance defect may be difficult to assess. What a lay person regards as a slight defect, well within the range of normal, may, to the trained cosmetic surgeon, be a defect that is observable and easily correctable. As a result, the degree of emotional distress and impairment, rather than the specific nature of the defect, may be more accurate indicators of BDD in these patients.[10,11,24,58,71–73]

In addition, the degree and psychosocial consequences of dissatisfaction should also be assessed. Asking about the amount of time spent thinking about a feature or the activities missed or avoided may indicate the degree of distress and impairment a person is experiencing and may help determine the presence of BDD.

Motivations and Expectations

The treating surgeon should also inquire about patients' motivations and expectations for cosmetic treatment. In assessing patients' motivations for surgery, the surgeon may want to begin by asking, "When did you first think about changing your appearance?" Similarly, it may be instructive to ask, "What other things have you done to improve your appearance?" In addition to providing important clinical information, these questions also may reveal the presence of some obsessive or delusional thinking, as well as bizarre or compulsive behaviors, related to physical appearance. It is not uncommon for cosmetic surgery patients to report that they have tried several do-it-yourself treatments, such as those found on the Internet, in an attempt to improve their appearance—many of which may be unhelpful and potentially dangerous.[43]

Patients should be asked how romantic partners, family members, and close friends feel about the decision to change a physical feature. Although these individuals likely influence patients' decision-making process, their role may

not be as great as intuitively believed. Breast augmentation patients reported that their decision to seek surgery was influenced more by their own feelings about their appearance than by the thoughts of their romantic partners.[23,65] Nevertheless, patients who seek treatment specifically to please a current partner or attract a new one are less likely to be satisfied with their postoperative outcomes. Thus the surgeon should inquire about patients' general expectations about how the change in appearance, which may be rather subtle and potentially unnoticed by others, will influence their lives. There is no current evidence suggesting that cosmetic procedures directly affect interpersonal relationships. Therefore patients should be reminded that predicting how others will respond to their changed appearance is impossible. Some patients may find that few people notice the change in their appearance, while others may believe that everyone seems to notice them. Although some patients may find this attention pleasurable, others may find it uncomfortable. To assess this issue, patients should be asked how they anticipate their lives will be different after surgery. The experience of unmet postoperative expectations is another possible explanation of the relationship between cosmetic breast augmentation and suicide.[9,55] Some women may present for breast augmentation surgery with unrealistic expectations about the effect that the procedure will have on their romantic relationships or daily functioning. When these expectations are not met, they may become despondent, depressed, and potentially suicidal.

Postoperative Psychological Issues

Patients also may experience psychological issues postoperatively. Most patients likely experience some type of adjustment reaction to the surgical procedure or postoperative recovery and experience the "postoperative blues" for a few days. Clinical experience suggests that this may be common among very busy individuals who, a week or two after surgery, have experienced some return of energy and stamina, but may not be ready to return to full-time work and may be growing anxious while feeling 80 to 90% of full strength. Others may report dissatisfaction with a technically successful procedure (from the surgeon's perspective). This can be suggestive of BDD. Still others may experience an exacerbation of several forms of psychopathology (including depression, eating disorders, or BDD) that was not identified preoperatively.

Patients in each of these examples may benefit from a referral to a mental health professional, who often can undertake a more formal assessment of psychopathology and provide psychotherapy to address the dissatisfaction or psychopathology. The availability of a mental health professional with interest in working in collaboration with a plastic surgeon can be a valuable resource to the surgeon. The surgeon must make referrals to mental health professionals with thoughtfulness and empathy. Efforts should be made to destigmatize the referral and, at the same time, communicate to the patient that the surgeon is not abandoning care of the patient.

Conclusion

Plastic surgeons have long been interested in the psychosocial functioning of their patients. The earliest writings in this area, well before the tremendous growth of the specialty, generally suggested that patients were highly psychopathological. As cosmetic procedures have become more common and culturally accepted, this perception has changed. Individuals who present for cosmetic procedures are not seen with the same degree of suspiciousness as they previously were. Furthermore, most of the more contemporary research has suggested that there are relatively few differences between individuals who seek cosmetic procedures and those who do not. The most consistent difference seems to be increased body image dissatisfaction, which is the catalyst for a cosmetic treatment. Encouragingly, many patients report improvements in their body image after a cosmetic treatment. However, a small yet significant percentage of patients appear to have BDD. Others likely have eating disorders or depression. All three conditions should be evaluated by surgeons preoperatively. Psychosocial functioning also should be monitored postoperatively, because patients can experience an exacerbation of these symptoms, sometimes with dramatically unfavorable results, such as threats of legal action, physical harm, or suicidal behavior. These outcomes underscore the importance of the surgeon being mindful of psychosocial status and functioning throughout the continuum of care for cosmetic patients.

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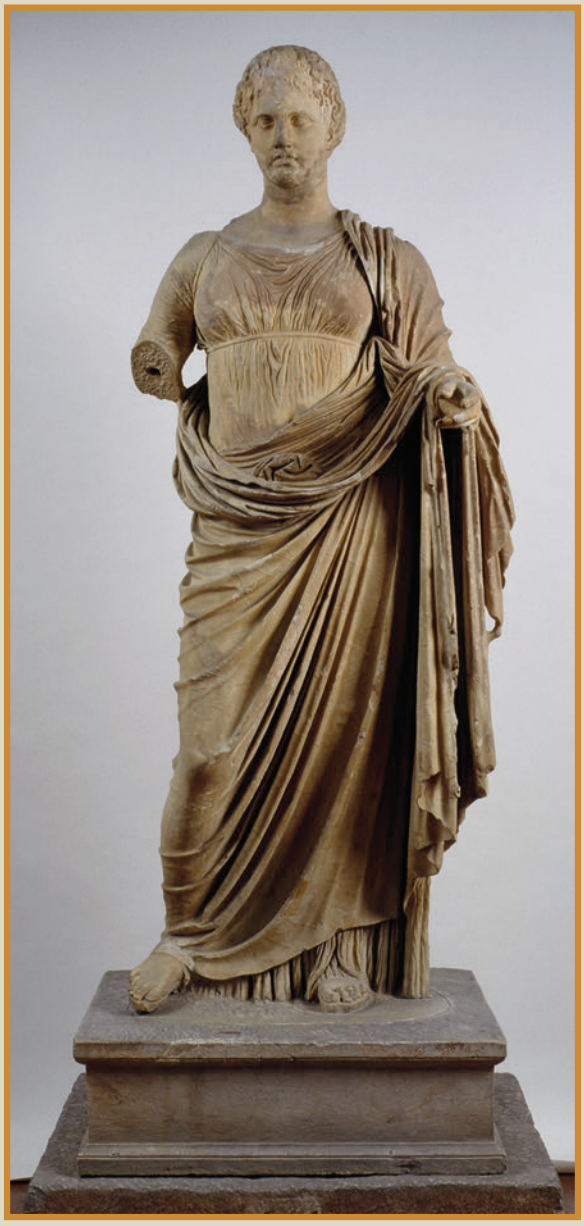
SECTION II

Legal and Safety Issues



Statue of Themis (goddess of justice) from the temple of Nemesis in Rhamnous, Greece c. 300 BC. (National Archaeological Museum, Athens, Greece. © Hellenic Ministry of Culture and Sports/Archeological Receipts Fund. Photo: Klaus Valtin von Eickstedt.)

CHAPTER 4

Ethics and Plastic Surgery Practice

Kenneth W. Goodman and David J. Birnbach

Biomedical ethics guide physicians in making the challenging moral decisions associated with delivering appropriate health care. Each specialty has a unique set of ethical issues, yet they all follow one or more guiding frameworks for contemporary medical practice.[1] In this chapter, we address the complexities of biomedical ethics specifically associated with the practice of plastic surgery. Fields of medicine associated with aesthetics are being fueled by increased consumer demand, in part because of the effects of the media and a society that is greatly concerned with image and appearance.[2] The specialty of plastic surgery requires a particularly mindful approach so that professionalism and the physician–patient relationship are held in high regard and the patient is free from exploitation. Unlike many other physicians, plastic surgeons can provide aesthetic changes or other physical alterations that may be deemed unnecessary for proper physiologic function. Furthermore, there is a level of subjectivity involved in the decisions related to whether plastic surgery should be provided. These issues are the focus of this discussion.

In general, *biomedical ethics* can be defined as the study of morality in medicine, and this morality concerns both character and behavior.[3] One guiding framework for contemporary medical practice has been crafted as four principles bridging low-level morality with high-level morality. Published in the *Principles of Biomedical Ethics,* Beauchamp and Childress[3] established respect for autonomy, beneficence, nonmaleficence, and justice as the core values underpinning modern medical and surgical practice.

Respect for autonomy is reflected in medical practice through the consent process. This is not merely obtained by just getting a signature on a preprinted form; the surgeon must explain all the associated risks of surgery, particularly when, as in plastic surgery, the patient is not necessarily experiencing an illness. Beneficence-based clinical judgment identifies the moral obligation to act in the best interest of the patient.[4] This is complex in plastic surgery, where identifying the best interest is often a subjective determination. Nonmaleficence protects the patient from harm and negligence. In plastic surgery, the challenge may lie in a patient's expectations or complications, sometimes because of existing medical conditions. The concept of justice requires that access to care be equitable. Because most aesthetic procedures are elective, the ability to pay and the sale of services is an especially complex matter.

A surgeon who repairs a cleft lip, performs postmastectomy reconstruction, or restores craniofacial structures after an accident may be confident that he or she is eliminating a defect or restoring a body part to a baseline level of function or appearance. These types of reconstructive surgery raise the typical ethical issues related to access, consent, and the surgeon–patient relationship. On the other hand, cosmetic surgery has as its primary ethical challenge the fact that such service may not be accessible to all patients because of economic, social, or geographic limitations. In these cases, an unfavorable outcome is typically limited to incomplete restoration of function, increased pain, infection, or physician error. Although the results may not be as aesthetically appealing as the patient expected, they will typically be an improvement over the presurgical appearance.

On the other hand, plastic surgeons who perform the more common elective surgeries such as blepharoplasty, rhytidectomy, rhinoplasty, abdominoplasty, augmentation mammoplasty, or body contouring procedures (to name a few) may be doing so to improve a patient's sense of personal aesthetics. Although there may be an unfavorable result or some form of error that impairs a function or degrades an appearance, an ethical and reputable plastic surgeon will engage in conversations with the patient regarding the potential risks and will receive informed consent.

In considering the use of plastic surgery as a panacea for personal and relationship issues or other social pressures, the plastic surgeon may face an ethical dilemma. Therefore

these patients should undergo a very thorough preoperative assessment.[3] Ultimately, however, if the patient has been properly evaluated and provides a solid rationale (even if it is just to look better), the plastic surgeon has fulfilled the ethical obligation.

Ethical Foundations and Practical Tools

The foundations of full disclosure and valid consent can be especially challenging in plastic surgery. Valid consent entails three components (**Box 4.1**).

These criteria evolved over decades of debate and analysis regarding human subject research and clinical practice. They are universally accepted and have come to shape the laws governing research and practice. This is as it should be; ethics precedes the law to establish the criteria legislators use in determining what behaviors are permitted, required, or forbidden. The three criteria for valid consent are jointly required: It would be a mistake to regard the consent process as valid if one were to inform an incapacitated patient of risks, benefits, and alternatives or to allow a family member to exert undue pressure on an informed and capacitated patient. For this reason, the term "valid consent" is preferable by many to "informed consent," which highlights only one of the three criteria; indeed, the lack of capacity or voluntariness *invalidates* the consent of a patient who has received adequate information. Note also that these are the same criteria for "valid refusal," such that if a capacitated, informed, and free-acting patient refuses treatment, that refusal should generally be honored.

The literature on each of these three criteria is vast and analyzes best practices in the event of failure of any of the three criteria. Generally, if a patient has received inadequate information, the surgeon should communicate better and ensure that such communication is part of a process and not a single event that concludes with the signing of a legal consent document; if a patient is being pressured or coerced into receiving or refusing a procedure, the surgeon must reassure the patient that the choice is his or hers and try to assist in eliminating the source of the inducement; and, if a patient lacks capacity, either functionally or by legal criteria, the surgeon must seek the help of a surrogate or proxy.

Box 4.1 Three Components of Consent

1. Adequate information so a typical patient can make a reasoned decision whether to proceed
2. Cognitive capacity or, generally, the ability to understand and appreciate that information
3. Voluntariness, or freedom from beguilement, undue pressure, or even coercion

This last is often the most difficult to manage, and it is especially tricky in the case of cosmetic procedures. In ordinary, nonemergency reconstructive procedures, the consent process is usually straightforward. The surgeon informs the patient of known risks, anticipated benefits, and alternative procedures; highlights anything distinctive about the procedure or the products to be used (the use of fillers or dressings with biological materials—i.e., synthetic mesh); and makes it easy for the patient to ask questions. In both noncosmetic and cosmetic procedures, there are two overarching challenges: Demonstration of technical proficiency to the best of one's ability and patient satisfaction with the resulting appearance. Assuming the surgeon's proficiency, a lack of error, and the fact that the valid consent process was clear about risks, the patient may have few options if the desired result is not achieved, except perhaps a corrective procedure.

In both cosmetic and noncosmetic cases, however, patient dissatisfaction regarding aesthetics is much more difficult to address and manage. In cosmetic surgery, the challenge of such dissatisfaction rises to an extraordinary level—so much so that in seeking to prevent "unfavorable results," the tools and requirements of valid consent are stretched to the limit; indeed, in some cases, the consent process may not be up to the task. There are two reasons for this. The first is that the procedure was not medically necessary in the first place. The second is unrealistic expectations; in some cases, even patients with adequate capacity to consent to surgery have very poor insight.

Cosmetic surgery has long posed ethical challenges and indeed been subjected to criticism and sometimes regarded as a peripheral medical practice[5]:

> Although increasingly popular, cosmetic surgery is a most unusual medical practice. Invasive surgical operations performed on healthy bodies for the sake of improving appearance lie far outside the core domain of medicine as a profession dedicated to saving lives, healing, and promoting health. These cosmetic procedures are not medically indicated for a diagnosable medical condition. Yet they pose risks, cause side effects, and are subject to complications . . .

This negative perception of elective aesthetic surgery has been blamed in part on the media and the "flashy" behavior of some aesthetic plastic surgeons.[6] Nonetheless, many plastic surgeons enjoy favorable reputations and stake their professional name on building good relationships with patients and performing appropriate surgeries as determined by the surgeon with their patient. In the end, the work of a plastic surgeon is in plain sight, so surgeons serve their own self-interest by governing themselves accordingly.

Even with a comprehensive disclosure of surgical risks—including the possibility of aesthetic disappointment—as part of the valid consent process, some patients will be dissatisfied. Most cosmetic surgeons have had the experience of performing a near-perfect rhinoplasty or breast augmentation but nonetheless ultimately having a disappointed pa-

Box 4.2 Preoperative Discussion

A thoughtful surgeon should assess the following:

- Purpose for surgery: Is the proposed surgery realistic? Does the patient seem competent to make the decision to have surgery?
- Degree of deformity: Is the deformity noticeable? Are the patient's expectations for correction appropriate?
- Level of physical maturity: Will the patient grow out of the deformity?
- Social costs: Does the patient suffer socially because of the problem?
- Patient–parent decision: Are the parents of a child or adolescent supportive of the surgery? Are the parents pushing for the surgery against the patient's desires?
- Postoperative patient attitude: Will the patient be able to adhere to a postoperative regimen?

tient. Such frustrations can in principle be mitigated or reduced by careful preoperative discussions[7] (**Box 4.2**).

The question of "social costs" or social suffering must also be addressed, because such suffering is commonly cited as a motivation by patients and a justification by surgeons—especially in the case of minors, as signaled by this preoperative consent checklist. There are instances of noses so large or breasts so asymmetrical that a case can be made for their correction, even if the noses or breasts function normally. Such a case can even be made when there is no function at all. Consider this personal anecdote[8]:

> When does one not have a belly button? I once had a patient who didn't as a result of very severe and extensive burns in childhood. When I met him he was 15, and he was bent at the hip, his collar bone touching the contralateral knee, such were the retractions. The boy was bent, folded, and he fought like hell to have a life. Of course he was poor, of course he came from the countryside. He was evacuated to my hospital, and the plastic surgeons swung into action; there was work for everybody—but in about two years the boy was unfolded, ironed out, grew about 30 centimeters, and I was invited to his last operation. After the ceremony of Z-plastying his last abdominal retraction, which would give him a flat abdomen, instead of a ridged horror, the surgeon was closing and he asked me if I thought he should make him a belly button. No big deal, just a cushion stitch. I said yes; everybody else said no: he was already 9 hours under on his umpteenth intervention, and even 5 minutes was too much. "Yes," I insisted: finish the job, give him parity with the rest of the human race. Would you know it? It was the thing he thanked us for. Not standing, not walking, not sex, not having an ordinary life. He wore cropped tops and chased all the nurses, now that he was equal.

This anecdote suggests that the desire for cosmetic surgery and subsequent result can both overstate the definition of medical necessity and understate the measure of personal happiness that can accompany the remedy of a physical disfigurement regardless of cause.

However, caution is recommended before a surgical intervention to improve appearance. Although peers can be cruel, fitting in socially has significant advantages, and life is sometimes unkind, such observations will not always—and should perhaps rarely—be used as justification for a surgical intervention. Ultimately, psychological suffering is not always best addressed surgically. Furthermore, what may be best for one patient might not be best, appropriate, or even permissible for others in a similar situation. The distinction among surgical options for any patient must be drawn carefully and based on the following uncontroversial criteria, based on the list of presurgical questions to be asked by the plastic surgeon:

- Medical or psychological need
- Likelihood of success
- Availability of less-invasive alternatives

From an ethical perspective, all three should be considered. It would, for instance, be problematic to undertake an aesthetic procedure with little or no chance of success, or if a minor change in lifestyle could potentially accomplish the same thing.

It follows that a major surgical intervention should not be scheduled until a patient has at least considered appropriate counseling. If a patient rejects counseling, that can be a sign of either a well-adjusted person who knows what he or she wants, or alternatively someone setting himself or herself up for precisely the kind of unfavorable result that is feared. Simply stated, to be patient-centered does not consist in doing everything a patient asks, because some capacitated patients might make requests that are irrational or potentially dangerous.

This concept evolves into an even more complex area of concern: the development of the field of "elective medicine," which involves performing numerous types of body modifications outside what is considered conventional. The intentional modification of one's appearance now goes beyond tattooing and piercing and includes subdermal implants to simulate horns and provide other embellishments. Other

body modifications include penile beading and ribs, extraocular implants, and "flesh pocketing" to hold jewelry. No peer-reviewed medical literature discusses these phenomena, but a number of other sources, such as Wikipedia, are available.[9] An online search of images for surgical body modification illustrates forked tongues, pointed ears, and a cell-cultivated ear attached to an arm. It is unclear whether any of these modifications were performed by licensed plastic surgeons. According to CNN,[10] one surgeon has documented some of these and reports one kind of procedure he is commonly asked to repair: gauge earrings that function to gradually dilate an ear piercing, often to extraordinary size.

Requests for some corrections are closely tethered to fashion and culture, if not counterculture: "The perception of female genital beauty is very much culturally dependent. For example, in Japan the so-called 'butterfly' appearance is greatly admired. In Western society, protruding inner labia are considered less attractive, whereas in parts of Africa, the inner labia are deliberately stretched from a young age. There are also fringe groups in Western society, who stretch different parts of the genitalia."[11] Nonetheless, the considerable difference between genital mutilation—widely and correctly condemned and prohibited in the West—and the kinds of vulvovaginal alterations increasingly requested in Europe and North America throws in stark relief this particular challenge.[12,13]

The evolution of labiaplasty provides a good example of healthy people with no dysfunction seeking surgical alterations. Although some requests for labiaplasty are said to be motivated by discomfort during sports and coitus, there is insufficient epidemiologic data to document the incidence and prevalence of such requests, or surgeons' responses to them.[14] What we do have is cautious and reasoned guidance regarding what has been unhappily called the "quest for the 'perfect' vagina,"[15] namely the highly regarded opinion from the American College of Obstetricians and Gynecologists[16]:

> So-called 'vaginal rejuvenation,' 'designer vaginoplasty,' 'revirgination,' and 'G-spot amplification' are vaginal surgical procedures being offered by some practitioners. These procedures are not medically indicated, and the safety and effectiveness of these procedures have not been documented. Clinicians who receive requests from patients for such procedures should discuss with the patient the reason for her request and perform an evaluation for any physical signs or symptoms that may indicate the need for surgical intervention. Women should be informed about the lack of data supporting the efficacy of these procedures and their potential complications, including infection, altered sensation, dyspareunia, adhesions, and scarring.

By comparison, if an informed, voluntarily acting and capacitated patient declines chemotherapy, participation in a research study, or aggressive end-of-life care, the patient's refusal must be honored; indeed, it would likely and generally be unethical to force a patient in any such instances. However, if a patient requests an antibiotic for a viral infection, an opiate for recreational purposes, or horn-shaped structures with flashing lights to be implanted in his forehead, these voluntary, autonomous requests do not impose any sort of duty or obligation on a physician or surgeon. Even if this patient were to argue that he would be distressed or unfulfilled if his doctor did not grant these requests, it would be irresponsible to grant them. Indeed, it would be unprofessional to grant such requests, because they are outside the established boundaries of surgery and medicine. This is not to suggest that a surgeon who objects to such requests is demonstrating paternalism or overriding the patient's right to self-determination or autonomy. It is rather to remind all physicians that their status, by virtue of special education and training, longstanding professional values, and social oversight in the form of licensing and accreditation, requires the exercise of informed professional judgment. Such judgment is a filter through which patient requests must be transmitted.

This does not suggest that a standard rhinoplasty or breast augmentation is generally to be regarded as inappropriate. Rather, thoughtful surgeons should take steps to encourage patients seeking such procedures to consider that their desire is culturally shaped and conditioned; that there is, in fact, nothing wrong with them; that they might very well, on careful introspection, come to regard the proposed surgical intervention as unnecessary; and that behavioral counseling can be useful in coming to acquire a better perspective on their desire to be surgically altered. Cosmetic surgeons should consider developing information sheets that make these points, include references to professional or lay resources that address them, and advise that making time for reflection sacrifices nothing and might lead to a different decision.

Children, Advertising, and Promotion

Circumstances exist in which the plastic surgeon should simply decline to do as asked. Although different societies regard adulthood as commencing at different ages, there is no disagreement on the criteria for valid consent. Minors are universally and accurately regarded as lacking capacity to enter into contracts, vote, or consent to elective medical procedures or biomedical research. Minors are unable to understand some information crucial to the consent process, are easily influenced, and have diminished ability to weigh risks, potential benefits, and medicosurgical alternatives.[17] More important, the bodies and brains of children and adolescents undergo swift and significant development, and any cosmetic surgical intervention carries the risk of long-term outcomes far worse than not performing the surgery. In recognition of this, the Food and Drug Administration has not approved, and the American Society of Plastic Surgery has not endorsed, the use of breast implants in patients younger than 18 years.[18]

That a culture permits, let alone encourages, adolescents to receive cosmetic alteration is itself a poor justification for a surgeon to acquiesce to some of the more extreme of the

requested procedures. Fashion and culture change. The values that undergird the profession of plastic surgery do not. Indeed, some requests for surgical alteration might in fact be based on conditions with physiologic or pathologic causes, as in the case of gynecomastia, for instance, and this might in conjunction with psychological factors provide adequate warrant for surgery.[19] Such warrant is generally, however, exceptional. For these reasons, purely elective cosmetic or aesthetic surgery on children should be a very rare exception.[20]

In all cases, decisions whether to undertake such surgery should be based on professional standards and the best interests of patients, not on the financial interests of the surgeon. Plastic surgery has been commercialized, perhaps in part to serve such interests.[21] It might be hypothesized and perhaps assumed that the marketing and advertising of cosmetic procedures are intended to improve public health or even the happiness of individuals dissatisfied with their appearance. Advertising drives demand, and demand increases business. Yet the practice of advertising and marketing is now more common for all medical specialties. All physicians should consider the delivery of care as a professional privilege and not as a purely commercial enterprise, even if demand for cosmetic surgery can be increased through advertising.

The issues of marketing and advertising are shaped both by ethical and professional standards. Regarding ethics, the values of self-effacement, patient-centeredness, and social commitment, including public health, should guide medical practice. With respect to professionalism, because of a surgeon's special training, accreditation, and licensing, the professional must disregard profit-motivated commerce.[22] This is not to argue that physicians may not earn a handsome living; however, such a living, being based on the misfortunes of the sick, injured, or disfigured, should be acquired by excellent practice and not because of boastful self-promotion (sometimes by those with dubious qualifications) that trades in human insecurity and frailty. Such values and standards are the insights of physicians themselves and not lawyers, ethicists, or legislators; that is, these values and standards are and should be seen as internal to the profession.

Conclusion

The history of plastic surgery dates to well before Hippocrates. An ancient and noble profession, it has dramatically improved the lives of countless people through practice and advocacy. Physicians will continue to face ethical dilemmas and will need to come to terms with novel challenges ranging from stem cell–based therapies to increasing numbers of cases of gender reassignment.[23–25] These challenges and temptations rarely pose "ethical dilemmas." An ethical dilemma is a situation in which no matter what one does, one does something wrong. Many ethical challenges are difficult, but difficulty, and perhaps even the need for occasional sacrifice, does not qualify as a dilemma. Plastic surgeons should have ample resources and professional touchstones to guide practice.

The foundations of valid consent, the legitimacy of arguments for cosmetic surgery, reasoned limits to certain kinds of procedures, and cornerstone of professional integrity addressed in this chapter are important ethical considerations. The profession's ancient history regularly elicits restatements of core values, and they bear close attention. Lejour's vision is laudable[26]:

> I would like to see reconstructive and cosmetic surgery practiced only by well-trained surgeons with high ethical standards, concerned with the service to their patients more than with money and self-promotion.

Such ideals should be the goal of all physicians, and they should be held in particularly high regard to guide and protect the profession of plastic surgery.

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