Section I

Complications Prevention Essentials

I

1 General Approach: The Consultation—Patient Evaluation

Eric T. Carniol

Summary
The preoperative stage of a surgeon-patient relationship is important in order to assess physical and psychological candidacy for a procedure and establish realistic expectations. Surgeons must be prepared to deny treatments to patients who are not candidates as well as build trust with patients with whom they would like to continue with treatment. The surgeon-operated patient relationship is permanent, and both parties must understand and willingly enter into this relationship.

Keywords: consultation, preoperative planning, preoperative assessment, psychological evaluation

1.1 Introduction

The goal of minimally invasive facial rejuvenation or aesthetic/cosmetic procedures is to enrich a patient's life by improving a perceived flaw in function or appearance. The initial consultation is important in avoiding and minimizing complications from procedures. This first meeting between the physician and new patient is an important opportunity to establish a strong enduring relationship. For the physician, it is imperative to identify the patient's goals and aspirations and to determine the appropriate potential procedure or procedures. For the patient, it is imperative to express those goals and establish realistic expectations. Patient selection is of paramount importance, and the issues related to patient selection can be challenging. There are four main components. First, how likely is the identified procedure(s) going to yield the change that the patient is seeking? The answer to this and other related issues will be discussed in the chapters that follow. The second component is patient selection. The third component is procedure execution, and the final component is any care, if appropriate, that is required after the procedure.

Patients today can do extensive research on both a desired procedure and their potential physician. It is important for the physician to recognize that the patient will probably present with a fair amount of information about the procedure being requested. This comes with additional challenges, as some of the information may not be accurate or may not be applicable to the patient or their concerns. The physician should be prepared to discuss the risks, benefits, and alternatives to the procedure in addition to respectfully addressing any misinformation that the patient may have acquired from their own research. It is important to demonstrate expertise when addressing any misinformation.

Many patients seek multiple opinions and consultations prior to deciding upon a physician and procedure; therefore, during this time, it is imperative for the physician to ensure that she/he engages the patient in a physician–patient relationship. As the aphorism goes, "The preoperative period is finite. The postoperative period is infinite."

Once goals and expectations are identified, discussed, and agreed upon, the physician should pursue a structured conversation regarding the remainder of the treatment experience. A well-described and adapted structured discussion is the R-DOS model, adapted from Daniel Sullivan, founder of "The Strategic Coach."[1]

The first question (The R-Factor) is "If we were to meet here in one year and look back over the year, what would have happened, both personally and professionally, for you to be satisfied with your progress in life?" While the answer usually has little to do with the requested procedure or displeasing bodily feature, the answer will reflect whether the physician and the patient will have an ongoing relationship that will last at least one year. The answer, as with all answers, is important to note as precisely as possible. This allows the physician to utilize the patient's own language, a process known as reflective listening.[2] If a potential patient has difficulty answering this question, it is worth asking if they anticipate that the procedure being discussed has the potential to change their future. This may be the situation for a patient with a significant deformity or problem. However, for a more frequent, relatively straightforward cosmetic procedure, it is unlikely that the procedure will change their future. Patients who anticipate that a relatively small cosmetic procedure will change their lives expect too much from the procedure and may become unhappy with the outcome when their life does not change. Therefore, these patients should be avoided.

The second question relates to the patient's perceived risks of the procedure. "When thinking about [the procedure/body part], what specific questions or concerns do you have?" Writing down these questions also imparts to the patient that you are listening and that you are attentive to their concerns. These questions also give the physician an insight into the emotionality that the procedure or the disliked feature plays on the psyche of the patient. The concerns or questionsare the only negative part of the interaction. The physician should go over every question with the patient for completeness. Once addressed, the discussion can be (permanently) shifted to the positive.

Opportunities: Once the concerns have been addressed, attention in the conversation can be moved to the future. "Pretend that it is one year in the future and that you have had the successful procedure, what will that do for you?" Although this question can seem similar to the R-Factor, it instead shifts the patient's focus to the future, once the procedure and the recovery are finished.

Strengths: Many times, patients have already addressed their personal strengths in the consultation. However, this is the time to address strengths specifically and continue to build on them. "What are your strengths and how will this procedure build on them?"

The R-DOS conversation allows the physician to gain key insight into the patient. By assessing these, the physician can decide whether a patient is a candidate for surgery. There are some patients who are unable to provide quality responses to these questions, or are so apprehensive about these questions that they will refuse.

If the patient is unable to imagine their future and their place in it, they may also be unable to imagine their postprocedure recovery and may have increased difficulty adjusting to their postoperative result. Some prospective patients may also describe secondary gains from surgery such as change in social stature, renewal of love or attention from a significant other, or maintenance/attainment of a job. These responses help the physician identify a potentially unhappy patient. The physician may also determine that the prospective patient is not someone with whom they would like to engage in a permanent physician-operated patient relationship.

This conversation can help a patient frame their surgery as not just an outcome or a good that is purchased, and instead as an experience that they will use to continue to improve their life. After going through the R-DOS conversation, patients have increased engagement and higher rates of conversion to and satisfaction from their procedure.

1.2 Assessment of Expectations

Management of expectations is also important in order to obtain a happy patient. If a patient's expectations are greater than what is usually attainable from a procedure or even what a given procedure can achieve, there is no way to please the patient.

For example, a patient in her fifties who comes in requesting facial rejuvenation and shows you a photo of a celebrity in her twenties probably will not be able to look like the celebrity. As well, a patient with a prominent nose and thick skin should not expect a petite ultra-defined nose after a rhinoplasty as their soft tissue envelope may not contract down after the procedure.

1.3 Assessment for Body Dysmorphic Disorder

Care must be taken with patients with body dysmorphic disorder. Although early studies demonstrated increased rate of this disorder in men, more recent research demonstrates that this purported increased risk may not be present.[3] Patients with body dysmorphic disorder often have other psychiatric comorbidities. In one study, more than 75% had a lifetime history of major depression, 30% history of obsessive compulsive disorder, 25 to 30% history of substance abuse, and 7 to 14% history of an eating disorder. More than half of these patients fulfilled criteria for at least one personality disorder.[4]

In patients with body dysmorphic disorder, it is important to recognize that cosmetic procedures do not usually improve symptoms, and can often worsen them.[5] For patients with concern for previous psychopathology, open-ended questions about body image and perceived appearance can often be helpful, as well as degree of dissatisfaction compared to the physician's measure. Assessment of appropriate motivations is also important as otherwise discussed in this chapter.

1.4 Accurate History Taking

It is important to ask patients about their medical history in different ways. Patients can be intentionally or unintentionally forgetful about medical comorbidities. Intake questions that are specific about particular organ systems are more effective in obtaining accurate histories. As well, separate

questions on prescription and over-the-counter medications, vitamins and other supplements can also serve as a valuable resource to determine other disease processes that are ongoing. It can be frustrating for the physician to find out, just prior to a procedure, about a portion of the patient's medical history that was not previously disclosed. Particularly, history of infectious diseases, such as HIV and hepatitis C, should be asked specifically. In some states, patients are mandatory reporters of their viral status but this should not be solely relied upon, as many patients are unaware of their viral status.

Today, as the cultural and political landscape shifts about marijuana and related products, it is also important to question patients on this in addition to alcohol and other drug use. Recent research has demonstrated that certain marijuana-related products can alter patient's pain tolerance, with some patients requiring increased dosages of anesthesia during surgery and also increased postoperative narcotic requirements.[6]

Patient's support systems can be very important during the immediate preoperative, postoperative, and the long-term postoperative periods. Having emotional backing prior to undergoing a procedure can decrease preoperative stress and allow the patient to focus on instructions for example, easing the recovery period. After a procedure, patients who have less support are more likely to have challenges associated with their recovery. They are at greater risk of being noncompliant, and therefore may be more likely to encounter postprocedure problems, exacerbate postoperative symptoms, and possibly delay recovery resulting in suboptimal outcomes. Finally, encouragement from a patient's support system can aid the transition to their new, rejuvenated appearance.

1.5 Preoperative Counseling

The preprocedure period is an important time to counsel patients on the postprocedure course. If a physician discusses with a patient a potential complication that they could have before surgery, it is *counseling*. However, a discussion with a patient about an issue that they are having after a procedure is a *complication*.

For more major procedures, after the consultation an additional preprocedure appointment can be beneficial to confirm the treatment plan, expectations, and discuss postoperative recovery. The interval between the two visits is important for both the patient and the physician to decide that they wish to proceed with the procedure. During this interval, the physician can also elicit feedback from staff on their interaction with the patient. Often a patient can "put on a show" for the physician, but may be completely different toward staff, potentially cluing the physician to an underlying personality or other psychiatric disorder.[2]

At the preoperative visit, we review the indications, contraindications, procedure itself, risks, and recovery from surgery. One key area of risk to focus on during this period is the probability of revision. This inherent risk of surgery can be a difficult discussion with patients, as many physicians believe that this discussion pierces the veil of confidence. However, by addressing it with the patient (and documenting this discussion), physicians can more effectively manage the patient's expectations. Even for a surgery with a 5% revision rate, for 5% who fall in that subset of patients, 100% of them are having a revision. As well, there is some percentage of patients within the 95% who are not totally satisfied with the outcome, but not dissatisfied enough to undergo the revision surgery. Therefore, the physician must also anticipate that any given patient could be in the dissatisfied/revision group. If a patient does experience such an issue, then the follow-up for the patient will be at a much higher frequency than that of a patient who does well. Therefore, the physician must be prepared for spending significant portions of time with the patient postoperatively.

For some patients who are not psychologically ready for a procedure, a psychiatrist, psychologist, or counselor can be very helpful. Such patients may over the course of therapy become ready for the procedure, or acknowledge that they are not ready. It is important for the physician to partner with the patient and the mental health team. Any patient who returns for surgery after counseling should allow the physician to discuss the patient directly with the counselor.

1.6 Conclusion

The preoperative evaluation (the consultation and the preoperative planning meeting) is an important area for physicians to carefully select patients for a procedure. Overall, most patients will do well and be happy with a given procedure. However, it is the physician's responsibility to do her/his best to wean out the patients who are significantly more at risk of poor outcomes. The physician should never be fearful of saying no to a patient, as the physician-operated patient relationship is permanent.

References

[1] Constantinides M. The rhinoplasty consultation and the business of rhinoplasty. Facial Plast Surg Clin North Am. 2009; 17 (1):1–5, v

[2] Sykes J, Javidnia H. A contemporary review of the management of the difficult patient. JAMA Facial Plast Surg. 2013; 15 (2):81–84

[3] Daines SM, Mobley SR. Considerations in male aging face consultation: psychologic aspects. Facial Plast Surg Clin North Am. 2008; 16(3):281–287, v

[4] Phillips KA, McElroy SL. Personality disorders and traits in patients with body dysmorphic disorder. Compr Psychiatry. 2000; 41(4):229–236

[5] Crerand CE, Phillips KA, Menard W, Fay C. Nonpsychiatric medical treatment of body dysmorphic disorder. Psychosomatics. 2005; 46(6):549–555

[6] Huson HB, Granados TM, Rasko Y. Surgical considerations of marijuana use in elective procedures. Heliyon. 2018; 4(9): e00779