MANAGING INFORMATION IN PLASTIC SURGERY PROCEDURES

CARLO ROSSELLO

Abstract: Information management has become a critical aspect of surgical procedures with important legal implications. Recent figures indicate a trend in aesthetic procedures where patients’ expectations exceed the reasonably attainable results. Because the quality of the results in elective surgery is ultimately assessed by the patient, a dramatic increase in medical malpractice claims has been observed. Among common plastic surgery procedures, aesthetic procedures on the female breasts are the ones that generate the highest rate of medical malpractice claims and further court cases. In the author’s opinion many of these claims can be avoided by carefully managing the information and the informative procedures. This involves assessing the patient’s motivation and following an appropriate code of practice. The paper provides practical considerations and guidelines to help reduce the risk of malpractice claims after elective surgery. The paper will mainly refer to breast surgery which is identified as the leading determinant of such claims.

Keywords: Information Management, Claims prevention, Informed consent, Plastic surgery

1. INTRODUCTION

A careful analysis of litigation and insurance claims in the field of aesthetic surgery shows that a large proportion of them, easily over 50%, could have been avoided if preventive measures had been taken to effectively select and inform the patient prior to the surgical procedure. Further research into this issue, in fact indicates that very few of these claims are determined by actual malpractice or by poor surgical technique; most typically they have to do with an unrealistic mis-match between the patient’s expectations and the results obtained, even when the surgical procedures have been successfully carried out. The most evident cases of this type can are observed in relation to elective surgeries on the breasts, especially in relation to breast augmentation. Because of the social impact and the psychological implications that the shape and the size of the breasts typically have on women’s lives, any aesthetic procedure aimed at improving the current appearance of the breasts carries a high risk of patient dissatisfaction with the final result. Ultimately it is the patient’s judgement in relation to their expectations to determine whether even a successful procedure with high quality results will be a cause for litigation to be considered for a possible case of malpractice. It is the author’s argument that careful selection of the patients and proper information of same can go a long way in preventing trouble after the procedure.

2. THE INFORMATIVE PROCESS

Because aesthetic procedures are entirely elective, it is the duty of the surgeon to provide the patient with full information on the risks and effects of the procedure, prior to performing it. The information should also cover the alternatives available, for instance alternative treatment as well as no treatment at all. The appropriate code of practice requires the surgeon to anticipate possible questions by offering the information in full without pointing the patient in any direction that she doesn’t explicitly choose. Legally, the patient has to make the decision and should not be rushed into signing and informed consent without the opportunity to carefully evaluate the risks and benefits of the procedure, and possibly seek a second or a third opinion from other surgeons. Familiarizing the patient with the procedure is key to enabling an informed decision on their part. While the format and the number of copies required may vary, it is necessary that copies of an informed consent are obtained and kept for the records of the surgeon and those of the clinic or hospital where the procedure is going to be performed, according to the local legislation. Along with the information which is strictly related to the procedure, the surgeon should endeavour to build realistic expectations and discourage wrongly motivated patients. This is especially applicable to the treatment of minors, under the age of 18, where
2. The surgeon frequently fails to make sure that the patient clearly understands who is financially responsible for what in case of an untoward result or repeat surgery. The only interest the medical malpractice carrier has is to see that responsibilities are documented in writing before the surgery and not afterward.

3. It is not what the surgeon says, but how he or she says it that guides the patient into accepting the surgeon's preference. It is a mistake to refer to capsular contracture as a "complication." It is not a complication; it is an inherent risk. There is a difference. If the patient refuses to accept the concept of inherent surgical risk, that in itself is a red flag that should cause the surgeon to rethink his or her decision.

3. CENTRAL RULE OF COMMUNICATION BETWEEN DOCTORS AND PATIENTS

Traditionally, the relationship between doctors and patients existed in a world that Jay Katz has described as "silent." Katz equates this silence with the attitudes of paternalism that governed how doctor and patients interacted. Medical paternalism has been in large part replaced with a respect for the patient's autonomy. Katz argues that this transition has entailed dialogue between doctor and patient. Central to this transition, according to Katz, is the legal doctrine of informed consent. For Katz, the doctrine of informed consent indicates that trust between doctor and patient is central, and that "trust must be earned through conversation."

Diagnosis for the plastic surgeon includes deciding whether the patient is an appropriate candidate for the intervention that the surgeon envisions. The plastic surgeon should understand clearly the patient's motivation for surgery, her expectations as well as her subconscious desires, before undertaking an elective operation. Getting to know the patient before surgery is essential to screen out those patients with unrealistic expectations. If the patient is seeking what is psychologically or physically unattainable through surgery, the operation is a certain failure even if it is a technical success. The doctor, in this situation, may become the target of the patient's blame and anger. An extreme example of unrealistic expectations has been termed "dysmorphophobia," a phenomenon in which the patient suffer from a subjective feeling of ugliness despite a normal appearance or a minimal cosmetic defect. It is essential for the surgeon to identify these traits preoperatively.

While the plastic surgeon is not required to diagnose a particular psychiatric illness in a patient, sensitive communication before surgery will allow him to identify a "high risk" patient for whom further psychological evaluation may be required.

4. PATIENT SELECTION

The aesthetic surgeon bears an enormous responsibility in trying to advise the augmentation candidate who has clearly unattainable or simply wrong expectations.

Many plastic surgeons, seriously concerned with providing the prospective patient with full disclosure, often fail in three important respects:

1. Disclosure procedures during consultation and how they are conducted are again the physician's to make in whichever fashion he or she finds comfortable. The surgeon must inform the patient of:

   a. The choice of implants available with their advantages and disadvantages. The surgeon's preferred choice of technique in the particular case and reasons for it. The truth: regardless of how inconspicuous, there will be a scar. The surgeon is under obligation to explain that how the patient heals is part of her genetic package and there is nothing the physician can do about it.

   b. The surgeon frequently fails to make sure
There are basically two categories that make the patient an unlikely candidate for elective aesthetic surgery. The first one is anatomic unsuitability. The second is psychological inadequacy. As far as psychological inadequacy, different kinds of patients can be identified according to their typical behavior:

- The excessively demanding patient who brings with him or her photographs, drawings, and exact architectural specifications. Such patients should be managed with great caution because they show very little flexibility in accepting any degree of failure on the part of the surgeon to deliver exactly what they anticipated.

- There are patients with great expectations, who have an extremely unrealistic and idealized, but vague conception of what elective aesthetic surgery is going to do for them. These patients obviously have a very unrealistic concept of where their surgical journey is taking them and have great difficulty in accepting the fact that any major surgical procedure carries inherent risk.

- The secretive patients are patients who wish to convert their surgery into a "secret" and request all kinds of elaborate precautions to prevent anyone from knowing what they are doing.

- The youthful or immature patient (age has no relationship to maturity) usually has excessively romantic expectations and a highly unrealistic concept of what the surgery will achieve.

- Particularly in the case of a minor. If there is disapproval, not uncommonly, errors in communication or less than optimal results immediately produce an automatic reaction, which not only deepens the guilt of the patient but also the dissatisfaction and the likelihood of filing a claim.

5. CONCLUSIONS

Only by cultivating the absolutely crucial elements of patient rapport will surgeons be able to stay one step ahead of the plaintiff's attorney. To obtain patient satisfaction and thus avoid exposure to liability claims in breast augmentation, the plastic surgeon must take pains to exert not only his or her surgical competence but also his or her medical-legal awareness. There is an association between the doctor’s interpersonal and communicative skills and the incidence of litigation. Communication is essential to building a bond between doctor and patient. First of all, if the patient is to be engaged as a partner in decision-making, she must be appropriately informed. Communication continues to be a central part of relationship-building, even when medical problems or complications arise. Maintaining this relationship and keeping communication flowing are core features of effective risk management. If the patient feels that the doctor has turned his back or become distant, the patient will look for someone else to trust. Communication between doctor and patient has been termed a "key" to malpractice claim prevention. A lawsuit, from this perspective, indicates a poor relationship. The doctor-patient relationship, when healthy, constitutes a substantial emotional barrier for the patient to consider seeking legal advice.

REFERENCES

Glass R: The physician-patient relationship: JAMA focuses on the center of medicine. JAMA

C ROSSELLO: MANAGING INFORMAITON IN PLASTIC SURGERY PROCEDURES
275:147, 1996
Pechansky R, Macnee C: Initiation of medical malpractice suits: A conceptualization to test. Med Care 32:813-831, 1994
Press I: Predisposition to file claims. Law Med and Health Care 12:53-64, 1984