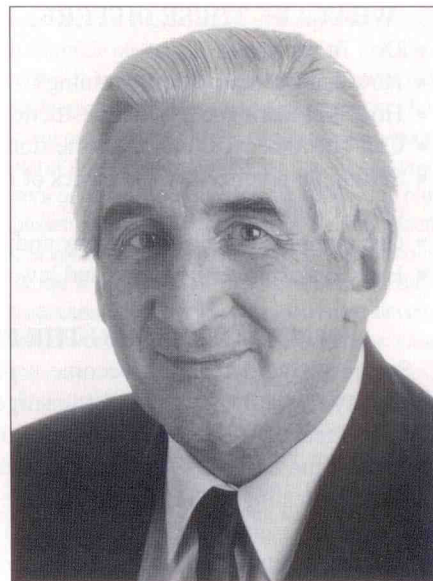


Becoming an expert aesthetic plastic surgeon: An exercise in stress control

Devenir un expert en chirurgie esthétique : Un exercice de contrôle du stress



Jean-Paul Bossé MD FRCS

Professor of Surgery, University of Montreal, Montreal, Quebec

Past General-Secretary, International Confederation for Plastic and Reconstructive Surgery

In this age of government regulated medicine, those aspects of medicine escaping government takeover are becoming increasingly attractive to our individualistic minds. More doctors are looking towards medical practices like osteopathy, acupuncture, industrial and medico-legal expertise, and of course, aesthetic medicine and surgery.

As plastic surgeons we lead the way out of confining regulations and unionized labour by setting up private clinics and office surgery. By doing so we regain the financial controls we lost to state medicine. It was only a matter of time before other groups would try to get in through the back door to share the benefits of free enterprise and higher incomes. We should not be surprised at this burgeoning of unrelated competitors. They are here to stay, they have credentials and our only alternative is to be positive about it. We have to hope that most of the people in related specialties will keep to their own turf and that only a few will try to step on ours. For those we have to make sure that they offer a proper quality of service. We must allow them fair competition but at the same time try to outdo them by maintaining our superiority. This is what I predict to be THE STRESS OF THE FUTURE.

The younger members of our specialty must confront this challenge by adequately facing the different stresses they will encounter going up the stepladder to success.

I will try to address the different stresses we all have to go through from the beginning of our quest, to its pinnacle, and weave in some personal thoughts that I have harvested throughout my career.

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WHAT ARE THESE DIFFERENT STRESSES?

- Do I fit the profile?
- How can I get good basic training?
- How do I learn and practise aesthetic surgery?
- Can I become an expert from the start?
- Setting up practice and the basics of office organization are very important questions.
- Can complications have a happy ending?
- How to sleep over litigation and law suits.

STRESS OF FITTING THE PROFILE

So, you have decided to become a plastic surgeon and eventually feel attracted to aesthetic surgery for many good motives. I feel that it is essential, before you get into the field, to identify the attributes indispensable for this trade. Since you will be dealing with people who have an image problem you should present a clean look with no disturbing visible deformity. Beauty is certainly not a requirement to become a plastic surgeon but your appearance must be pleasant. You must inspire confidence in your artistic capabilities by dressing properly, and not too eccentrically.

Your behaviour from the outset must inspire warmth, confidence and understanding. Since you are facing patients who come to you with problems which disturb them emotionally, your first task will be to relieve tension. Therefore, you will need to allow psychological transference, not unlike a psychologist or a priest. People listening to your introductory comments must find in you a person in whom they want to confide.

Failure to listen to what the patients have to say to what they think is wrong with their appearance and to why they want something done or changed in their appearance, is the most frequent complaint I hear from unsatisfied patients. They went to a surgeon, had the feeling of being a number, and were rushed into the consultation, the surgeon being routinely technical, impersonal, and with a presentation that could almost come from a prerecorded tape. Remember that the correction the patient is seeking is not always what is obvious to you. At times, you will be surprised. Early in my surgical residency a relative of mine was troubled by acne scars and wanted a correction. I organized a visit to one of our well-known local plastic surgeons. No sooner had the patient entered the office when the surgeon began telling her how wise a decision she had made to have her nose shortened and how good she would look with her new nose. When the doctor stopped for breath, my relative saw a chance to tell him that her problem was acne scars, and that she wanted advice on a possible dermabrasion. Eventually the quid pro quo was straightened out. The patient had a quite acceptable correction of her acne scars, plus a nice shorter nose free of charge because, realizing his mistake, the surgeon had reiterated his original offer for free, learning the hard way to listen first.

STRESS OF TRAINING

So you have the physical and psychological profile and you have a very creative mind; therefore, you decide to go ahead and enter plastic surgery training! Your next stress will

be the choice of training centre. Some are better than others, and not everybody can get into the better ones. Remember, the training you receive will be through your own achievements, regardless of the training facilities. If your training centre has limitations, use what it can offer and plan for postgraduate training to supplement these shortcomings. Your first aim is to become a plastic surgeon with as wide an exposure as possible.

If you want to be able to master the stress from without that will come from the competition of other specialties, you need to have more than fair knowledge of all related specialties, like ophthalmology, ear, nose and throat, dentistry, head and neck surgery, and orthopedics. You need to learn and master the intricacies and subtleties of the so-called grey zone problems, principally those of the face and the neck, if you are aiming to undertake aesthetic cases later.

My suggestion is to find a centre for postgraduate studies in this country or abroad which favours and specializes in related surgical problems like eyelid reconstruction, functional nasal disturbances, maxillofacial surgery, head and neck reconstruction, and facial nerve surgery. With this kind of knowledge, you will be prepared to face the so called stress from without.

No doubt your biggest challenge of the '90s will be to face the competition from other specialties. You will need more than your background to outdo them. To do so, you will have to address what I call the stress within. The most efficient way to counter this threat from within is to first start practice with the material that you have learned and the techniques with which you are familiar. It may take two or three years before you become confident in your capabilities and gain assurance in your skill. Once you have that you can start thinking aesthetic. Remember that imperfections in this field of surgery are not well tolerated, and that you have to perform almost to perfection from the very beginning. You almost have to become an expert before you start.

You must not only know the techniques of the recognized experts which you have witnessed a few times live or on videos. You must also learn the little tricks of the trade. They come only with experience and enable you to achieve predictably good results. But before anything, you need a firm knowledge of the tissues that you will be working with. So, when you think aesthetic, first think anatomy. Go back to the laboratory and go over the structures. Practice on cadavers provides a very secure way, an almost easy way, to learn and develop technique. This is the basis of training in aesthetic surgery. It is not yet readily available in all centres, but with a bit of perseverance, I am sure that all young trainees could manage to go through this preliminary, and necessary, step.

Specific training in aesthetic surgery is still a problem not completely solved, but many centres are gradually responding to the surge of this new field and improving their structure to allow young plastic surgeons a better exposure and much needed experience. The difficulty is that all this teaching has to be done in private facilities which have to bear the inherent financial burden of teaching. But a formal full-time fellowship is not the only avenue. For example, some of your senior colleagues would be happy to have you as an assistant in their

clinic on a part-time basis. This is probably the best way to learn the little tricks. You could also ask a more experienced colleague to come and assist you for your first few aesthetic procedures. This would allow you a good night's sleep before and after. If you repeat this a few times, eventually you will be qualified to do it on your own. In the same line of thought, we have come up with a project of part-time fellowship that would combine both active practice and training. This part-time fellowship would apply to young plastic surgeons who are in their second or third year of active practice and who are not in a position to leave, even temporarily, their busy office. The person entering this type of course could work his regular surgical schedule the first days of the week and, for example, spend Friday and Saturday at an approved fellowship training facility like a well-established clinic or, in our project, a private hospital. During his stay at the hospital, the trainee would have consultation and follow-up clinics. He would operate on patients who, for financial considerations, would have accepted the concept of supervised or tutored surgery. The young surgeon would also be welcome to bring his own patients to operate on under guidance of recognized teachers. The fellowship would also include anatomy sessions, videos, lectures, etc. Funding of such a project would come from the trainees themselves, from the technical operating fees paid by the patients, and from a foundation which is being set up. Certification at the end is also a possible consideration. The project has already been presented to and endorsed by the Quebec Association of Plastic Surgeons. It has also received approval from the Faculty of Medicine of the University of Montreal. This project, if no other difficulties occur, will start in the very near future.

Following these suggestions will greatly decrease stress from within and build the confidence and skill that is needed to become an expert aesthetic surgeon. Remember that the career of a young practitioner is not embedded in concrete. Opportunities might appear that will make profound changes in your surgical life. Unless you are aiming for academia with full or part-time engagements, do not embark on long term endeavours that might tie you down. Accept short term engagements until your horizon becomes clear. Whatever your decision, you must not fall into the trap of high financial commitments from the very beginning, because to do so implies high expenses that will have to be supported by a high practice income. You will only work yourself to exhaustion, become less selective in patients and be forced to get involved in the field of aesthetic surgery before you are ready for it.

Three important factors must be considered when setting up an office.

First, AMBIENCE. Your surroundings must reflect your creativity and artistic trend. You can choose to buy inexpensive wall decorations and some original furniture, but it may be better to adorn your walls with the work of young talented artists who may be only too glad to let you have their work or exhibits free in return for the exposure you provide.

Your second most important asset is your SECRETARY, probably the most valuable long term investment, because a

very skilled person will be able to build the confidence that you need around you, and extinguish the fires. This person will become your organizer and your marketing agent. This, of course, requires some soul searching from the very beginning.

The last asset is what I call your CONSULTATION TOOLS. Simple verbal explanations no longer suffice in today's world. You will be expected to provide each of your patients with reading material pertinent to their problem. Such material is readily available from both the Canadian and American Societies. You might feel, at the beginning, that it is too expensive but this is a worthwhile investment. You will greatly enhance confidence if you explain things carefully to your patients using diagrams from books and/or slides. Patients usually like to see some examples of corrections. You will have to show them pre- and postoperative pictures or slides, even if they are not yours. Not all will want to see complications, even if they want them explained in degree of severity and frequency. Some patients will appreciate videos and will want to feel implant material. Basic consultation tools are a very well illustrated book, a carousel slide projector and a video system. You must, from the very beginning, have a good photographic setup and be very rigorous in taking preoperative photographs. Hopefully these will stay confidential and never be used, but you never know when they might become needed.

STRESS OF COMPLICATIONS

No matter how experienced or gifted a surgeon you are, you will have some complications or imperfections, and, hopefully not too often, some unsatisfactory or bad results. You will have to live through these complications and survive them positively, controlling the inevitable stress that it will impose. You can reduce that stress by careful first consultations. You must first sit back and listen, and find out the patient's expectations. Sort out the emotionally disturbed, the masochists, the hysterical, and the compulsive perfectionists, because these people, otherwise normal, will tolerate poorly the stress of postoperative negative events. Insist on discussing details at length and showing them slides of complications. Some will probably shy away from the operation. You will find that many patients will come to you having been thoroughly briefed, by friendly neighbours and envious friends, on all the negative aspects. They will not be deterred easily and will accept the inherent 'risque' of surgery.

One of my patients was a chain smoker, and when I asked her, prior to surgery, to stop smoking, she answered that I had done two of her smoking friends and they had not obeyed and had kept on smoking without problems. Well, she did have a problem, but she coped with it philosophically.

It helps to reassure patients about the financial implications of complications and secondary surgery. Personally, I feel that a fee for a service, up to a point, includes secondary procedures, at least in the immediate postoperative period. It would certainly not apply to a facelift or breast revision after five years. Patients should be made aware that they would be expected to pay hospital and anaesthetic expenses. You

might also decide to charge them a technical/surgical fee for revision. There is nothing wrong in doing this but you must always remember that a satisfied patient will eventually bring you five potential new patients who will amply cover the cost of surgical revisions.

Once you realize that there is a complication, show restraint in your emotions. Don't look too surprised or defensive. Give a plausible explanation of what is happening, the outcome, and always give a time frame for the problem to be corrected. Show compassion, be reassuring and available. I always give my weekend location and phone number to these patients rather than let them have to look for a resident or another colleague at the hospital who is not properly briefed in the case. Never make negative comments such as "I do not understand" or "I have never seen this." If you feel that things are not going as they should, or if you are puzzled by a case, do not wait too long before asking for help. Suggest a second opinion and make sure it is a friendly colleague.

If you see someone else's complications, please choose your words properly. These patients are very worried and anxious for proper answers. Whatever your feelings about the case, keep them to yourself, because you do not know all the details of a case when you see these patients for the first time. In most instances, I do not even ask for the surgeon's name unless the patient wants to give it freely. Patients at first are reluctant to give the name of their surgeon. It is their guilty feeling, and you should respect it. If it should become pertinent information, you could easily get it through the hospital chart.

I once saw a patient with a wound and nipple necrosis who was six weeks post-reduction. She was very distressed and was urgently seeking advice. She first mentioned that I had performed a very successful breast reduction on her 20 years before. Then, in the last few years she had experienced progressive regrowth of her breast tissue, as can happen in the pre-menopause period, with recurrence of back problems. She was referred by her gynecologist to a younger colleague who apparently was using a new and quite predictable technique, almost complication free, which was later explained as the inferior base pedicle technique. In the immediate postoperative period she could readily see that something abnormal was going on. Both nipples were pitch-black as was the skin in some areas. When this started to open it became evident that she had infection following necrosis. The surgeon was less than sympathetic and told her that she was to blame because of her smoking habit, and for having worn too tight a bra. Following this, she was shifted for debridement to another plastic surgeon in another centre. Two successive operations were required to bring things under control, but the wounds were still left open. She was told that she would eventually have to have reconstruction of her breast by extensive tissue transfer involving a risky microsurgical technique. The patient then became frantic and decided to come back to me. The patient was not in a state of mind to accept any kind of reconstructive procedure. I felt that the best course of action would be to adopt a 'wait and see' period, and she accepted this advice. After six months it became evident that very simple reshaping of the breast and nipple reconstruction

was all that she needed. Only then did the patient begin to be inquisitive about the turn of events, and was less than convinced that her smoking was responsible for it. She suspected that something else had happened, and I suggested that the best way for her to find out was to contact the College of Physicians. Before deciding upon his surgical technique, the surgeon should have asked first for the operative report of the initial operation to find out what kind of pedicle had been used. In this case, it was a Strombeck natural pedicle. If you choose to do an inferior based pedicle, smoker or non-smoker, you are bound to have some circulatory problems.

This case is a good example of poor patient management. The first surgeon certainly was negligent in not inquiring, prior to surgery, about the operation that had been done 20 years before. In the postoperative period, he became defensive and blamed the patient for smoking rather than finding a more plausible explanation. He finally showed indifference by transferring the patient to another colleague for treatment with not even a phone call or postoperative visit of compassion. The second surgeon was attentive but definitely overreacted in suggesting to a distressed patient that she would require extensive surgery to correct her problem rather than letting matters cool down and dealing with a serene patient. Patient management comes with experience, and my suggestion to you is that you should benefit from your senior colleagues by sitting with them a few times in consultation to learn the innuendos, especially if you have decided to take up cosmetic surgery. You need to develop that sixth sense of perception that is called 'Comprehension of Human Behaviour'. This is the essence of good surgical practice, because this continual effort to master technique, as well as patient behaviour, will become your best asset against another major stress that you will have to face eventually, that of medical-legal litigation.

STRESS OF LITIGATION

No matter how careful you are with your surgery and patient management, you will eventually face, rightly or wrongly, legal threats from unsatisfied patients, and eventually lawsuits. Patients will often be steered into that path by compassionate souls who feel that the patients have been wronged and should be compensated or because they sense an easy profit. If you sense this situation review your chart and make sure that it is complete and accurate. Jot down the pertinent facts and rationale to support your behaviour and, above all, be truthful. Remember that all your documents will be scrutinized by some of your colleagues, and that you will have to support scientifically what you have written in your chart. If you have made a mistake, admit it, and show how you have tried to correct it. After all, you are only mortal, and therefore you will not be legally judged on an error, a distraction or an oversight but rather on your management of the events. Do not try and buy peace with a refund. Suggest a second opinion from a knowledgeable colleague or even suggest that the patient make a formal complaint to your own College of Physicians. Most people will not do it, and you should not be apprehensive about a College inquiry. It is a

bother of course. They will ask for your chart and files. You might even be summoned, but if you are confident that you have done well, you do not have to fear the outcome, and you may save your patient the expense, and yourself the burden, of a lawsuit.

No matter how confident you are that you have done no wrong, when you receive a lawsuit, you become the accused, the so-called defendant. At first, all your emotions will set in. Your self-esteem will be challenged; somebody out there will try to demonstrate, with arguments, that you are not the best and that you have done something wrong. A feeling of self-dejection might appear. You will become 'mad as hell' at the apparent injustice. Doubts will set in: "Am I sure that I chose the right technique, that I was not negligent or hasty?" or "Was I ignorant in missing the first sign of a complication? Could it have been prevented?" Be aware of these natural early reactions. Dominate your stress by, first, making sure that all your charts and files are in order, the operative report is done and accurate and that you have your preoperative photos. Immediately record the details of the events, including your preoperative discussions with the patient. Think of small details pertaining to the interview: appearance, posture, personality, presence of a witness through the consultation. Describe how you explained the technique, the complications and the results. Six to 10 years later this may prove quite valuable information against the inevitable affirmation of the patient that you did not explain the specifics. When it comes down to your word against the patient's about the informed consent, you will be glad to have all this on paper. If you have done something wrong, it will probably be settled out of court. If you did no wrong, the claimant may eventually drop the charges, usually because they cannot find an expert on their side.

If you go to court be calm and factual. Remember, you are only a witness, not an expert. And whatever the outcome, you have now become a full-fledged, experienced aesthetic plastic surgeon.
