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Make sure they're seeking surgery for the right reasons

Teenagers can be suitable for surgery, but proceed carefully

When a teenager walks in to your office for a consultation, you must shift gears from the typical talk you have with an adult patient. Teenagers can be suitable candidates for surgery, but they bring special concerns and require a different, more intense screening process.

According to American Society of Plastic Surgeons (ASPS) statistics, more than 331,000 cosmetic plastic surgery procedures were performed on people age 18 or younger in 2003.

Joseph K. Williams, MD, chief of plastic and reconstructive surgery at Children's Healthcare of Atlanta, says he has seen an increase in the number of teenagers in his office.

"There is no doubt that we are seeing a significant increase in the number of teenagers seeking elective plastic surgery," he says. "This is probably related in some part to the media presence of plastic surgery, societal expectations regarding appearance and the need for quick gratification."

Williams also suggests that as plastic surgery procedures are experienced by more people in everyday life, that option becomes more acceptable and available to their children. For teenagers seeking breast reduction, the motivation often comes from a very active lifestyle. Williams says most teenagers in his practice are seeking rhinoplasty and breast reduction, with a few more desiring breast augmentation.

Though there is an undeniable increase in teenagers seeking plastic surgery, it's not as if you have to brace for a mob of high school kids rushing your office. There has been an increase certainly, but not a huge trend suggesting that young patients are diving in without giving the procedure some thought, says ASPS president **Scott Spear**, MD, chief of plastic surgery at Georgetown University in Washington, DC.

"Contrary to popular belief, people 18 and younger make up only 4% of all cosmetic plastic surgery procedures," Spear says. "Although the numbers have increased over the years, teens continue to be a small percentage of the plastic surgery population."

But that doesn't mean you should let your guard down. Even if the sheer numbers of teenaged patients are not increasing all that much, each young patient still presents particular challenges for the plastic surgeon. They require special attention, say surgeons experienced in working with them.

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You must consult with both parents and teen

Williams says the secret to success with teenaged patients is including both parents and patient in the entire pre-operative process. All aspects of the postop course and restriction of activities should be clearly outlined. Encourage conversation so that the parents can bring up any concerns or point out issues that the teenager has not considered. Ideally, the parents should feel free to speak up and augment your explanation instead of listening quietly. For instance, a parent might realize that their daughter won't be able to go horseback riding for some time after surgery and that she hadn't considered how much she would miss that activity.

"This is even more important than in the adult patient," Williams says. "One should also be mindful of the fact that young ladies are often very shy, and every effort should be made during the visit and examination to make them comfortable."

The indications that a patient is not right for surgery are similar to those you watch for in adults, but Williams says teens may require a higher level of suspicion and a little more searching when you see any of these signs:

- The patient is hesitant regarding the surgery.
- The patient is unclear what he/she is looking for.
- There is disagreement between patient and parent or between parents regarding the surgery.
- There are other issues that should be addressed, such as a poor self-image, that should not be the basis for wanting the surgery.

Counseling may be warranted

Michael Bruck, MD, director of plastic surgery at JUVA Medi-Spa in New York, often requires teenaged patients to meet with a therapist before he will agree to operate. While he screens young patients with the same criteria he uses for adults, Bruck also assesses two more factors with teenagers: Do they have the emotional maturity to make a rational decision, and do they have the ability to understand what the procedure really means for them?

Bruck assesses those factors in his own consultation with young patients, but he sometimes refers them to a therapist for more counseling to determine whether the teenager's concerns are rooted in the temporary, though intense, angst that young people will eventually outgrow.

"While in my adult population I almost never suggest counseling, sometimes I do with teenagers because they may need to speak with someone who is really removed from the situation," he explains. "Between parents and children especially, there can be emotions that cloud the child's judgment."

Bruck is most likely to require counseling for a teenaged patient when he or she does not seem to be seriously considering what Bruck says about the surgery. Any indication that the young patient has "tunnel vision" about getting the surgery and the potential results will prompt Bruck to send the patient for counseling. He also will require counseling if the parent seems to be pushing the child into surgery -- a major warning sign that the patient is not a suitable candidate. The alternative to counseling, he says, is refusing to operate.

"Sometimes, if that patient is able to talk more in depth with someone who is professionally trained in that area, we can conclude that the patient really is a suitable candidate," he says. "With teenagers there can be many layers you have to get through before you hear the real motivation behind wanting surgery."

Bruck refers those teenaged patients to a child psychiatrist he has worked with for years. He notes that a psychologist or experienced therapist would be fine also, but he or she should be familiar with the pertinent issues in plastic surgery and your philosophy towards teenage patients.

Technical approach may not vary much

In general, surgeons say, the technical approach to surgery differs little from teenage to adult. But how you care for the teenage patient post-op might require a little more finesse, Williams says.

"The secret to happiness with patients this age is less external dressings and quicker time to resume normal activities. I have found that much more negotiating occurs throughout this period

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with teenagers than adults, who tend to accept the post-op course as outlined in the initial clinic visits," Williams says. "Do not compromise your results by shortening the post-operative period."

From a psychosocial standpoint, Williams says teenaged patients may fall into two extremes. The patient is either very ambivalent about the results or prematurely concerned about

Five rules for working with teenagers

Joseph K. Williams, MD, chief of plastic and reconstructive surgery at Children's Healthcare of Atlanta, has plenty of experience with younger patients, and he says any qualified plastic surgeon can take on younger patients if they follow important guidelines.

Many of the criteria that surgeons use for adult patients can be used in the teenage group, he says, but you may have to go the extra mile with minors to make sure you have properly screened and educated the patient.

For starters, Williams says, it is important to create a comfortable professional relationship and create very good lines of communication. That might be a challenge with a moody teenager whose parents are thrilled to get more than a few words at a time. However, Williams says it is imperative that clear communication be established with both parents and the patient.

All parties should be present at all visits and be involved in all data sharing, discussions, and decision making (especially the patient).

"A warning light should go on if there is disagreement among the participants about having the procedure. That situation should be avoided," he says. "Certainly the patient should be enthusiastic about the procedure. I must be convinced that the patient is mature enough to appreciate the gravity of the decision and consequences."

Williams cautions that teenagers are different from older patients in two important ways, and you must consider these points when screening and preparing them for surgery:

Teenage fact 1: They desire instant gratification so much that it can blind them to other concerns. They will listen intently when you describe how you can help them, but they never hear the part about the post-op course or potential complications.

Teenage fact 2: They desire specific results, much more than the typical patient. Whereas the older patient may speak in general terms about looking better, or feeling better, or being more comfortable, the teenage patient may expect a very specific result such as looking good in particular type of dress for the prom. The surgeon must listen for this kind of expectation and explain what is and is not reasonable.

Williams offers these five rules for working with teenagers seeking plastic surgery:

1. Never present a sales pitch. Emphasize the potential complications. There should be a focus on the reality that this is a surgical procedure. Downplay any preconceived notions that the results are quick, easy, and guaranteed.

2. Repeat until the information gets through. Review and re-review the post operative course including specific details about scars, bruising, dressings, restriction of activities, timing of socialization, and any other concerns. It is critical that all salient points be understood by the patient and parents regarding these things. It is also critical to emphasize the physical changes that will occur with the operation. Despite a lengthy discussion, often the patient is surprised by the change. Williams uses several tools including imaging, careful explanation of the changes in a mirror, and presizing for breast surgery.

3. Explain what may happen later. The surgeon should emphasize the impact the surgery will have on the patient because of the many years left in their lives and changes such as pregnancy and weight gain that may affect the results. The teenage body is much more dynamic than an adult body, and the effects of these changes on the patient should be explained. Specifically with breast augmentations, the patient should understand that the implants have a limited life span and could create a deformity when removed.

4. Get the patient to state the goal of surgery. The specific desires of the patient should be stated verbally. Teenage patients may be ambivalent about the specific results they are looking for (while some can be overly specific). That ambivalence should be a red flag for the surgeon, signaling that the patient could be unhappy with the results no matter how successful the surgery. Reasonable expectations are a priority with all patients, but even more so when counseling the teenage patient.

5. Give the patient and parents plenty of time to think about what you've said. Williams always emphasizes that a decision is not required immediately. The operation is available at any time and all parties must be comfortable with the decision. "It is rare that I will have the patients schedule a surgery without a second visit to allow time to digest the conversation," he says.

the results in the early post-operative phase. In the former group, it is important to prompt an answer with very specific questions after surgery. "Do you like it?" usually will not be helpful. More specific questions like "Is the change as noticeable as you expected?" or "Do the breasts look equal to you now?" might be more useful.

In the latter group, a lot of reassuring and reminding about what to expect is important. Parents are often helpful with either group because they know their children and will ask appropriate questions or help the patient through the post-op course. The surgeon and parents must battle the desire for instant gratification.

Different motivations for teenagers

Spear says teenagers who want to have plastic surgery usually have different motivations and goals than adults. They often have plastic surgery to improve physical characteristics they feel are awkward or flawed, that if left uncorrected may affect them well into adulthood. Teens tend to have plastic surgery to fit in with peers, to look similar, while adults tend to have plastic surgery to stand out from others.

Common physical characteristics or concerns teenagers wish to correct include nose reshaping, protruding ears, overly large breasts, asymmetrical breasts, and severe acne and scarring. Teens frequently gain self esteem and confidence when their physical problems are corrected. In fact, successful plastic surgery may reverse the social withdrawal that so often accompanies teens who feel different, Spear says.

Clearly, not every teenager seeking plastic surgery is well suited for an operation. Guidelines from the ASPS say that teens must demonstrate emotional maturity and an understanding of the limitations of plastic surgery. In addition, certain milestones in growth and physical maturity must be achieved before undergoing plastic surgery.

Other than the guidelines for breast augmentation, the ASPS has no formal position on plastic surgery for teenagers. But the society does offer three criteria that can reassure you the patient is a suitable candidate for surgery:

- *The teenager initiates the request.* While parental support is essential, the teenager's own desire for plastic surgery must be clearly expressed and repeated over a period of time.
- *The teenager has realistic goals.* The young person must appreciate both the benefits and limitations of plastic surgery, avoiding unrealistic expectations about life changes that will occur as a result of the procedure.
- *The teenager has sufficient maturity.* Teenagers must be able to tolerate the discomfort and temporary disfigurement of a surgical procedure. Plastic surgery is not recommended for teens who are prone to mood swings or erratic behavior, who are abusing drugs and/or alcohol, or who are being treated for clinical depression or other mental illness.

Williams agrees with those guidelines and offers his own tips for working with teenagers. (See the article on p. 27.) In general, he says, he approaches teenagers with much more skepticism than the typical adult he sees in a first consultation.

"There is a sense that I have to reluctantly be convinced that the surgery is appropriate for the patient," he says.

Some procedures prompt special concern

Certain procedures elicit concern when the patient is a minor or a young adult, particularly those that are considered "vanity" procedures and not corrective. Breast augmentation on teenaged girls has come under fire in recent years, with some critics saying minors are too young to make an informed decision about augmentation and that their bodies should not be altered while they are still developing.

Those concerns led the ASPS to adopt a policy that is consistent with the U.S. Food and Drug Administration's (FDA) approval of saline filled breast implants for women at least 18 years old. The ASPS policy statement gives background on what it calls the "controversial" issue of teenage breast augmentation as well as information on patient selection, informed consent, provider qualifications and recommendations. (The policy is available to ASPS members online at www.asps.org.)

Valerie Ablaza, MD, FACS, of the Plastic Surgery Group in Montclair, NJ, says the policy is a good response to concerns that teenagers are seeking cosmetic enhancements that should be delayed until they are more mature. She notes that those teenaged patients are in the minority, however, with most seeking treatment for asymmetric breasts, gynecomastia, and similar problems. A strict approach to purely cosmetic procedures is justified with young patients because of their lack of maturity, she says.

"They don't have the big picture yet. They get tattoos and body piercing because they don't look very far down the road and think about whether that's what they really want in life," Ablaza says. "As plastic surgeons we shouldn't encourage them to make hasty decisions about their appearance at this stage in life."

Gregory A. Buford, MD, of the Center for Plastic and Aesthetic Surgery in Englewood, CO, says he has seen more young women seeking breast augmentation and he will consider the procedure on patients under 18. The age is still key; a 17-year-old girl could be a reasonable candidate, but a 14-year-old would not, he says.

He recently performed a breast augmentation on a 17-year-old, but only after a year of consultation and having developed a good rapport with her. Buford had previously performed augmentations on several of her family members, and that relationship helped him understand that the underlying motivations of the girl were solid.

"Her mother paid for half of it but made her pay for the other half, which I thought was a very valid, motivating force," he says. "She had to really think about it and assess why she was doing this, while she was saving the money for it."

18 is common for augmentation

The ASPS policy details various reconstructive abnormalities that may require augmentation, including congenital defects, trauma or disease. It also explains the challenge that teenagers seeking cosmetic breast augmentation can pose to plastic surgeons.

While Spear emphasizes that plastic surgeons are not doing a great deal of augmentation

Common plastic surgery procedures for teens include rhinoplasty, otoplasty

The American Society of Plastic Surgeons (ASPS) provides this breakdown of the most common procedures performed on young patients:

• **Rhinoplasty**: Plastic surgery may be performed on the nose to straighten the bridge, remove an unsightly hump, reshape the tip or open breathing passages. Ordinarily this is not performed until the nose reaches its adult size -- about age 15 or 16 in girls and a year later in boys. In the event of a prior injury or obstruction to breathing, insurance may cover a portion of the procedure. According to ASPS statistics, rhinoplasty was performed on 42,513 patients age 18 or younger in 2003. The procedure made up more than 50% of all cosmetic surgical procedures performed on this age group.

• **Otoplasty:** Surgical correction of protruding ears may be performed any time after the age of five. Otoplasty made up 2% percent of all cosmetic surgical procedures performed on this age group in 2003, with more than 16,000 procedures. Insurance reimbursement for otoplasty is possible, but typically occurs in extreme cases.

• **Correction of breast asymmetry**: The surgeon may choose to correct the difference by reducing the larger breast, augmenting the smaller, or both. Insurance reimbursement is occasionally possible with this procedure.

• **Breast augmentation:** Many teenagers who want breast augmentation have one breast that is larger than the other -- sometimes a full cup size or more in difference. Although waiting may prolong the physical awkwardness, it is advisable to delay surgery until breast growth ceases in order to achieve the best result. Breast augmentation made up less than 5% of the total number of cosmetic surgical procedures performed on this age group in 2003, with 3,841 procedures.

• **Breast reduction:** Surgical reduction of very large breasts can overcome both physical and psychological burdens for a teenage girl. In fact, many teenagers suffer ongoing back pain due to overly large breasts. Again, although the waiting may prolong the psychological awkwardness, it is advisable to delay surgery until breast growth ceases in order to achieve the best result. Insurance reimbursement is often possible with this procedure. In 2003, 16,085 patients age 18 or younger had breast reductions, accounting for 15% percent of all breast reductions performed in 2003.

• **Acne and acne scar treatment:** Acne eruptions may be brought under control by the proper use of modern prescription drugs. In addition to supervising the use of these medications, plastic surgeons may improve acne scars by smoothing the skin with a laser or dermabrasion. In 2003, nearly 3,000 dermabrasion procedures were performed on patients age 18 or younger. Treatments for other acne-related skin problems include microdermabrasion and chemical peels. In 2003, more than 74,000 microdermabrasion procedures were performed on patients 18 or younger, accounting for 29% of all cosmetic minimally invasive procedures for this age group. Chemical peels made up almost 50% of cosmetic minimally invasive procedures in this age group, with 126,327 procedures performed in 2003.

• **Correction of enlarged breasts in boys**: Teenage boys with gynecomastia are often eager to undergo plastic surgery. Surgical correction, accomplished in a variety of ways, is occasionally covered by insurance. Gynecomastia accounted for almost 4% of cosmetic surgical procedures for patients age 18 or younger in 2003, totaling more than 3,000 procedures.

with young patients, he says the ASPS leadership felt "a responsibility to more than just quietly comply with the FDA. We want our members and the public to see how strongly we feel about teenage cosmetic breast augmentation."

The policy specifically recommends that adolescent candidates for purely cosmetic breast augmentation should be at least 18 years old. The procedure should be delayed until the patient has sufficient emotional and physical maturity to make an informed decision about cosmetic breast augmentation, according to the policy.

Like most plastic surgeons, Bruck says he will not perform a breast augmentation for cosmetic purposes on a patient under 18. He is not comfortable with a teenager's ability to consider the impact of the surgery, and a young girl's breasts may still be developing when she seeks surgery, he says. A young patient seeking augmentation for asymmetry or other legitimate reasons is a different matter, he notes.

Make sure they know about pain

Ablaza is more comfortable with a teenaged patient who has expressed a desire for surgery over some length of time, maybe several years of complaining that her breasts are too large. And she watches for any sign that the parent is blaming the child's depression or other problems on her breast size.

"The more I can determine that she has a valid reason for wanting the surgery, and she's felt that way for a long time and will repeatedly voice that desire, the more I can be sure that this procedure is appropriate," Ablaza says. "I make a point of talking to young patients privately, without the parents present, so I can hear what they really think, not what they want their parents to hear."

Liposuction also raises questions with teenagers, Bruck says. If a young patient seeks liposuction for weight loss, Bruck says no. But if a girl has pockets of fat that will not respond to a weight loss regimen, he will consider the surgery.

"The same issue applies with adults, but you might see more teenagers seeking liposuction for the wrong reasons," he says.

Ablaza also notes that teenagers need more counseling about the consequences of surgery. Unlike older patients, the teenager has less familiarity with health care issues and less life experience regarding pain and recovery.

"They haven't been through childbirth, most of them have never had any surgery or trauma. The worst they've experienced is having a tooth pulled," she says. "You have to make sure they understand that this will hurt, there will be pain they may not have experienced before, and it will take a while to heal."

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Listen to your staff

Difficult patients best handled with firm approach, including dismissal

No matter how experienced and skilled you are as a surgeon, you are bound to run into a patient once in a while who just can't be made happy no matter what you do -- the patient who is unhappy with the surgery results, resentful of the billing amount, angry with someone's comments, or miffed about the way she was treated by staff.

How you handle these difficult patients can determine whether the dispute is a brief interlude or a disruptive, never ending argument or an expensive court case.

A well run practice can minimize the number of "difficult" patients through good screening and attentiveness by the surgeon and staff, but you can't avoid them all, says **Robert M. Freund**, MD, FACS, a plastic surgeon in New York.

"No matter how experienced you are, working with a difficult patient is a challenge," he says. "Part of it is that I, as a surgeon, have a need to be appreciated, and when the patient is dissatisfied and if I know I did good work, you immediately face a situation with emotions rising. It's my job as the surgeon to recognize that and not let it get out of control."

Ideally a surgeon should screen out those patients who will be dissatisfied no matter what, but some still slip through, he says. To watch for those potentially difficult patients, Freund advises paying attention to your staff. If the patient is giving off signals that she is going to be difficult and unhappy after surgery, your staff will know it before you, he says.

"They overhear things and they can pick up a lot from the way the patient acts outside your presence. They're on their best behavior when they're talking with the surgeon," Freund says. "The times I've really been burned by a difficult patient is when I ignored the concerns of my staff."

Do what you can to make them happy

If there is a legitimate reason for the patient to be unhappy, Freund says the obvious course of action is to make the situation right. But the patient with an unfounded complaint, or the patient who can't be satisfied no matter how you try to address the concern, can become a serious disruption to your practice.

Freund recalls a recent patient on whom he performed a rhinoplasty, with results he calls undeniably good. No one would look at the patient and see a flaw, he says, but she complained vehemently that the nostrils were too wide. He explained that if he made the nostrils any narrower she couldn't breathe, but the patient continued complaining so much that she was becoming a distraction to him and his staff.

Freund stuck to his position that he could not alter the nostrils any more without damaging her, but he did agree to an injection that might narrow the nostrils a bit more.

"I try to satisfy my patients without hurting them," he says. "Once you try to do exactly what they want, against your better judgment, that's when you can hurt them. It can be hard to say no when you're trying so hard to make them happy, but you have dig in your heels sometimes."

The patient was not satisfied with Freund's efforts and demanded her money back, but he ignored that claim and she eventually just left the practice. Freund worried briefly about whether she might sue, but then he thought, "What's she going to sue me for? She has a perfect nose."

Avoid arguments when possible

Another strategy is to defuse the potential dispute up front. For instance, Freund tries to avoid blaming a bad outcome on the patient even when it really is the patient's fault, because that often encourages the patient to be defensive and argumentative.

"I never tell the patient that she developed a hematoma because she went swimming two days after a face lift and that's her fault," he says. "I may say that I should have been clearer and more forceful and explained that no exercise really means no exercise."

Patients who are even more difficult, those who exhibit mental instability or an aggressive nature, may require a more determined response from the doctor. At that point, you may need to completely sever the relationship. This is also known as "firing" the patient.

Insurers will provide guidelines on the best way to sever ties with a patient, but they all focus on the need to state clearly that you will no longer be his or her physician and that you will assist in referring the patient on to another doctor for ongoing care.

With plastic surgery, the process is a bit easier because there is little concern about ongoing care, Freund says. Never sever the relationship while you are continuing post-op care or providing other medical treatment, he suggests.

"I send them a letter terminating the relationship, without getting into any of the dispute that led to it, and I tell them that if they want further care from a plastic surgeon they can seek a referral from our local medical society," he says. "I make sure that prior to that point I've gone out of my way to try to make the patient happy."

When to say goodbye

So when do you know you've done enough and it's time to end it? Freund says he usually goes about six months too long trying to make the patient happy, but then he realizes the effort is taking too much of an emotional toll on him and his staff, and they're never going to make the patient happy. Freund uses these points to assess when enough is enough:

- *Have you done all you can to address the patient's concerns?* If there is a legitimate complaint, you should do everything in your power to correct the problem. But in some situations, you will do everything you can and the patient still will be unhappy. That's a good sign it's time to say goodbye.

And if the patient had no legitimate concern to begin with, were you accommodating anyway? Did you try to work with the patient and assuage the concerns?

- *Has the difficulty gone on for months and months?* Sometimes a patient will get over her anger if you let a little time pass and provide some extra TLC. Sometimes not. If the dispute is dragging on and on despite your best efforts, you have to conclude that it's time to cut your losses.
- *Is the patient disrupting your practice?* If the unhappy patient is haranguing your staff, demanding more and more of your time, or criticizing you in front of other patients, you should draw the line. As long as you've tried to make the patient happy, you should not tolerate a disruption to your practice.

Cover yourself when firing the patient

Elbert Cheng, MD, of The Center for Facial Rejuvenation in Los Gatos, CA, recently had to fire a patient and he says it was entirely necessary. The patient had been to multiple surgeons in the past and had a history of manic depres-

sion. Red flags for trouble, right? But Cheng thought that it was safe to provide a simple, non-invasive filler material for her lips.

Two weeks later, the patient complained of swelling and demanded her money back. Cheng's policy is that he never gives money back, though he will do anything necessary to fix a problem.

"For her it just became a money issue and she didn't want anything else," he says.

Cheng contacted his malpractice insurance carrier, which provided him with guidelines for terminating the relationship and reminded him not to alter the patient record in any way, even in a well-intentioned effort to clarify. Instead, Cheng created a second file to document the chronological explanation of events, along with his own thoughts about what happened and why it was necessary to terminate the relationship.

The letter to the patient gave Cheng's patient two weeks in which he would still care for any medical problems and suggested that she should contact the local medical association to find a physician for future care. "After two weeks from the receipt of this letter, you are no longer a patient of this practice," the letter explained.

The patient continued contacting Cheng to demand her money back and refused to pay the remaining amount due, so Cheng says he plans to pursue the case in small claims court.

"I really hate terminating a relationship with a patient, and I don't do it often, but sometimes you realize that there is nothing you can do with this patient," he says. "I will work hard to make a patient happy, but I won't just roll over and let difficult patients have whatever they want when they are not in the right."

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How to set yourself apart from the 'nip and tuck' latecomers

Public relations promotes your practice via third-party endorsement

Public relations, marketing -- it's all the same thing, right? Getting your name out in front of people, drumming up business for your practice, making the phone ring.

Actually, public relations (PR) and marketing are not the same thing at all, and a successful plastic surgery practice must employ both to keep patients coming in the door. Though they are different, they are closely related and intertwined, explains **Nan Andrews Amish**, a management consultant in health care and economics who serves on the faculty at the University of San Francisco.

In a nutshell, Amish says, marketing is the overall effort to promote your practice, but the term "marketing" usually refers to the efforts you do on your own including paid advertising and seminars. PR, however, refers to efforts to get *others* to promote your practice.

In other words, it's marketing when you say "we have a great plastic surgery practice," but it's PR when the local television news program calls your practice "a leading provider of plastic surgery in our community."

Amish says examples of PR include your local newspaper writing a story about a plastic surgeon who spends two weeks in a third-world or war-torn country, repairing cleft lips of native children, or providing something as simple as antibiotics and hygiene training to community leaders.

"PR provides great visibility for your practice, but it comes from a third party. It's not self promoting," Amish says. "It's like when you get a good referral from a patient, but this is a referral in the media."

Look for PR opportunities

Plastic surgeons tend to be pretty good at marketing and advertising, Amish says, but PR can pose more of a challenge. There are plenty of opportunities for PR, however, including things you might already be doing and just aren't getting any media attention for. If you volunteer to do surgery on a low-income victim of a birth defect or accident, make sure it is written up as a human interest story in the paper -- focusing on the victim or the medical issue, but mentioning you and your practice.

On a small scale, you might handle that effort yourself. But for a larger, more effective PR campaign, you might want the help of a professional. **Katherine M. Rothman**, president of KMR Communications, a public relations firm in New York, says PR professionals help plastic surgeons create campaigns that focus on new trends, techniques, controversies, safety issues in a respective sub-specialty, or any host of topics deemed press worthy by a publicist and media representative.

"Essentially, a PR campaign works by taking information the consumer needs and wants to know and presenting it in the form of actual stories related to your sub-specialty," she says. "Ensuing media exposure in outlets such as *Men's Fitness*, *Vogue* magazine or programs like the "Today Show" have a huge impact on prospec-

tive patients' medical choices. It serves to reinforce that a physician is the expert in his or her field. In addition, it lends a cachet and seal of approval that cannot be achieved even by an aggressive ad campaign."

Some disadvantages to PR

Rothman notes that PR is not a perfect strategy. There are disadvantages, such as being unable to control the content, the timing or the visual appearance of your message. Those disadvantages are outweighed by the credibility that PR brings when a third party promotes your practice, she says.

Some surgeons think they don't have to make any concerted effort with PR because their good work will speak for itself. Rothman says that belief, unfortunately, is naive.

"It is a reality that prospective patients give more credence to a write-up in *Vogue* or *Allure* than they do a doctor s training or contributions to scholarly papers," she says. "But doctors who do use PR must remember not to compromise their ethics in the quest for media coverage. This means steering clear of media outlets inappropriate because of their content or editorial slant, conducting one's self appropriately with the media, and not compromising philosophical beliefs to satisfy an editor or a particular story."

Charitable work yields results for practice

Eugenio A. Aguilar, MD, a plastic surgeon in Houston, TX, considers PR an important part of his practice. One of Aguilar's passions is providing care for victims of congenital microtia, in which children are born without ears, and he uses PR to help gain attention for that problem and indirectly to promote his own practice.

"PR has helped develop a lot of goodwill in the community for the kids and in turn it has helped my practice," he says. "We use PR to get word out about the disease, but at the same time people are hearing about me as a plastic surgeon and our practice in general."

About 25% of Aguilar's practice is children with microtia, but the rest includes breast augmentation, face lifts, liposuction -- the whole realm of plastic surgery. Aguilar's work with microtia patients in Houston led to contacts with television producers that eventually led to him being included in an episode of ABC television's "Extreme Makeover" series.

"That, in turn, generated great response for my practice in the Houston area," he says. "It's funny how these things come around. You do something that gets a little attention and that leads to something else, and before you know it you're getting a tremendous benefit for your practice."

Aguilar notes that PR regarding any charitable work can be especially helpful in building a good image for your practice. In particular, it can set you apart from the new breed of cosmetic surgeons who are setting up shop in every strip mall.

"This kind of work helps show plastic surgeons as caring and concerned about more than just getting every dollar possible. It sets us apart from the 'nip and tuck' people," he says. "That's always going to be good if you can shore up your image that way."

Aguilar's annual budget for PR costs less than 10% of his total revenue, about $50,000 a year. He notes that in the last year, he has spent almost nothing on advertising because he has benefitted so much from PR. To increase awareness about microtia, Aguilar founded the Craniofacial Foundation of Houston and he sponsors an annual golf tournament to benefit the foundation. The local media cover the tournament, and Aguilar is interviewed extensively on television, radio and in the newspaper.

"Invariably when I'm being interviewed, questions come up about cosmetic surgery as well," he says. "My radio time especially has been productive, because the host and the callers will want to bring up other plastic surgery topics as we discuss microtia."

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CRNA sedation may be good option sometimes, but can be problematic too

Research is suggesting that IV sedation with local anesthesia can be used safely for plastic surgery procedures in the office when administered by a certified registered nurse anesthetist (CRNA), but experts on the topic warn that surgeons still must exercise caution when selecting the proper mode of care for office surgery.

The question of proper anesthesia delivery in the office setting remains a difficult one, says **Phillip C. Haeck,** MD, a surgeon in Seattle and the editor of *Plastic Surgery News* for the American Society of Plastic Surgeons (ASPS). While there is reason to consider IV sedation with a CRNA in some circumstances, Haeck says, the decision should never be made lightly or for the wrong reasons. No matter what practical advantages might come with using a CRNA, patient safety must be paramount.

"I've had personal experience both ways and the right CRNA can be very effective," he says. "And I've had experience with an anesthesiologist providing anesthesia that was inappropriate for an outpatient setting. It's not as important whether you use a CRNA or an anesthesiologist as it is for them to give the appropriate level of anesthesia for an office-based setting."

The key, Haeck says, is to match the experience of the person doing the anesthesia to the appropriate setting.

"A CRNA who has never worked outside of the hospital may have difficulty adjusting to the need for a rapid recovery in a physician's office, and the same is true for anesthesiologists," he explains. "You have to look at their experience with surgery in an office setting, where the anesthesia must be lighter to facilitate a faster trip home."

Airway management can improve safety

One surgeon who has researched the topic suggests that to maximize patient safety the CRNA should always maintain the airway no matter what form of anesthesia is used.

Peter J. Capizzi, MD, a plastic surgeon in Huntersville, NC, has studied the question and he tells *Plastic Surgery Practice Advisor* that surgeons can be confident using a CRNA as long as they ensure certain standards are met. Chief among these, he says, is that the patient's airway should be maintained during the procedure even though the IV sedation does not require airway management.

Maintaining the airway is necessary to maximize safety, Capizzi says. When the laryngeal mask airway (LMA) is in place already, the CRNA is better able to respond quickly and effectively to any difficulty during surgery, he explains.

All of Capizzi's patients have a breathing tube, no matter what kind of anesthesia is used. Some don't like the idea, especially if they've heard about being able to undergo surgery without general anesthesia, but Capizzi stresses the need for caution.

"No patient likes to hear they're going to have a tube in their throat, but they have to understand that it's for their safety," he says. "People can go to the local strip mall and have surgery with someone who calls themselves a plastic surgeon, but then if they get an overdose of medication and there's no airway control, that's a big problem."

Airway not a panacea

Haeck cautions that, while he agrees with the basic idea of airway management during IV sedation, it is not a simple cure for all that can go wrong. And in some ways, it may complicate the whole question of whether to use general anesthesia or IV sedation.

"I think it's generally a good idea, but a lot of anesthesiologists will say that once you have an LMA in place and using propofol, you're essentially doing general anesthesia," he explains. "So then one needs to match the credentialing level for the facility to the type of anesthesia that is being provided."

If a CRNA is using propofol in a level B facility, for instance, that is an incorrect usage, Haeck notes. The drug is very close to being a general anesthetic, he says.

"You would have to be prepared to maintain and monitor the patient, and recover them, as if they had had general anesthesia," he says. "So an airway can be an extra measure of safety, but it's not as simple as saying that if you have an airway in the patient, then the CRNA can do whatever he wants."

Half use CRNAs for anesthesia

According to the ASPS, 56.5% of plastic surgeons use CRNAs to administer anesthesia care in an office-based surgery setting some or all of the time. Physician anesthesiologists provide similar services. Forty-three percent of plastic surgeons exclusively use physician anesthesiologists to administer anesthesia care in an office-based surgery setting.

Capizzi notes that IV sedation with local anesthesia has been criticized for not being as safe as general anesthesia in an office-based setting, but his recent research suggests that CRNAs and plastic surgeons can provide patients with safe and effective anesthesia care in an office-based setting if proper precautions are followed.[1] In that study, physicians analyzed 3,615 consecutive patients who had office-based plastic surgery procedures with IV sedation and local anesthesia. Ninety-six percent of patients had cosmetic procedures and four percent had reconstructive procedures.

More than 890 patients had multiple procedures during the same surgery. Less than one percent of the surgeries lasted for more than six hours. Liposuction was the procedure most frequently performed, followed by breast augmentation, eyelid surgery, and facelift. Not one patient in 4,778 consecutive procedures had major complications.

To ensure all procedures were performed safely, patients received a preoperative evaluation by the plastic surgeon and the CRNA at which time questions relating to the surgery and anesthesia were answered. Postoperative moni-

toring of the heart and blood pressure were mandatory. In addition, all patients were required to remain for a minimum of one hour in the recovery room with a designated registered nurse. The operating plastic surgeon was on the premises at all times during recovery.

Verify licensure, ACLS training

Though he is confident that IV sedation with CRNAs can be safe, Capizzi notes that the issue is not cut and dried when it comes to legal and regulatory issues. Your own state's standard of care must be considered in order to avoid the choice of anesthesia becoming an issue during a malpractice case.

Each patient's condition must be considered carefully when deciding on a course of anesthesia, Capizzi says, and you should take a hard look at the qualifications of CRNAs available to you. If the patient is low risk and you are confident that the CRNA is skilled and experienced, IV sedation can be a reasonable option for many cases, he says.

"Make sure the CRNA is board certified, current and up to date on all requirements," he says.

Haeck endorses that advice, but he adds an important point: Make sure the CRNA is licensed in your state. Don't make the mistake of assuming that he or she is licensed just because all the other credentials are in order.

"I have seen several cases now in which the CRNAs did not have a valid license but the surgeon hired them anyway," Haeck says. "Because they are in high demand and tend to travel to lots of different clinics, they can sneak in under the radar screen. That has led to several disasters, because it is the surgeon's responsibility to verify the licensure."

In addition, Haeck notes that either the surgeon or the CRNA must have advanced cardiac life support (ACLS) training.

"If the surgeon does not have ACLS training, he should not have a CRNA who doesn't have it either," he says. "Somebody in the room must have ACLS."

In addition, it is important to make sure that the CRNA is comfortable providing the type of care you're seeking for the patient. Not all CRNAs will be comfortable with all types and levels of anesthesia, he notes.

"If the CRNA says he's uncomfortable with twilight, for instance, you can get different concentrations of the medication during the procedure and the patient may be deeply somnolent sometimes and almost awake at other times," he says. "It's best to stick with what the CRNA is very comfortable providing."

Switch to CRNAs scary but successful

Ben H. Lee, MD, a plastic surgeon in Englewood, CO, says his recent experience affirms that CRNAs can provide a safe alternative to anesthesiologists. He recently switched from operating in a hospital to an office setting. He previously believed that operating in a hospital, or at least an ambulatory surgery center, with an anesthesiologist was the only safe option. But about a year ago he switched to a practice that does exclusively office-based surgery.

"I thought there was no way this could work," he says. "But it's worked out fine."

Lee now uses a CRNA and says he has been pleased with the results. He actually has had fewer complications, which he attributes partly to the office staff being familiar and comfortable with the forms of anesthesia in use at the practice.

"I do breast augmentation with IV sedation and local. Patients come out with less nausea and better pain control in the postoperative period," Lee says. "There's less bleeding during the procedure because the adrenaline in the local anesthetic solution cuts the bleeding, and that means there is less pain postop."

The CRNAs' experience in an office setting makes all the difference, he says. His comfort level also is assuaged by the fact that his office is about a block away from the hospital. Lee is confident that, in a worst case scenario, he could get the patient to the hospital emergency department by calling 911 faster than he could have gotten an emergency consult if operating in the hospital.

Though Lee doesn't follow Capizzi's policy of having all patients intubated as a precaution, he says he worries less about that issue than some surgeons might because he has experience in emergency medicine and intubation. Plus, he says, many CRNAs these days were trained in the military and are skilled in emergency intubation.

"There's always room for debate, but when I can use sedation instead of general anesthesia, it's almost always a better option," Lee says. "It's like night and day for my augmentation patients. They wake up almost smiling and giggling sometimes, and you don't see that after general anesthesia."

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Reference

1. Bitar G, Mullis W, Jacobs W, et al. Safety and efficacy of office-based surgery with monitored anesthesia care/sedation in 4778 consecutive plastic surgery procedures. *Plast Reconstr Surg* 2003; 111:150-6.

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