Avoiding the Unhappy Patient by Building Rapport in the Internet Age

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Abstract

The dynamics of the doctor–patient relationship has been complicated as more patients seem to expect perfection in this age of selfies and Internet postings. The preoperative patient interview is critical to recognize both body language clues and subtle but apparent red flags to avoid rhinoplasty on potentially unhappy patients. This interview should include routine use of a body dysmorphic disorder screening questionnaire since legions of these patients are undiagnosed prior to surgery and few, if any, are ever satisfied with even an excellent surgical result. These patients need diagnosis and psychological intervention—not surgery. Rapport is critical to patient and surgeon's satisfaction; therefore, it is valuable to practice the ABC's of rapport building: 1) active listening, (2) positive body language, and (3) candor.

Keywords
- aesthetic surgery
- doctor–patient relationship
- communication

In most cultures, there is a powerful desire for appearing attractive and remaining youthful. Success in rhinoplasty, and plastic surgery in general, relies on excellent surgery and patient rapport, while managing the patients' expectations.

Modern technological trends have affected the medical practice of plastic surgery more profoundly than in any other field of medicine with surgery occurring in greater numbers and at younger ages than ever before. These technological advances created an unprecedented demand for aesthetic procedures, but contemporary tools—especially the Internet and iPhones—have complicated the doctor–patient relationship by seemingly increasing demands for perfection. In addition, "selfies" and smartphone photographs distort the patient's image, often making the patient feel self-conscious about the appearance distortion.

In 2016, a study by the American Academy of Facial Plastic and Reconstructive Surgery identified 13% of surgeons surveyed had patients who wanted "to look better in selfies." By 2017, only 1 year later, 55% of surgeons reported having patients who expressed a desire "to look better in selfies."[1]

Present-day access to information seems unfettered even at kindergarten age, as the young are exposed to appearance-enhancing procedures through the lens of the Internet, television, and social media sites at younger ages.[2] In addition, children are learning that dissatisfaction with their appearance can be changed in the "blink of an eye," magically by plastic surgery; just as they learn that almost anything else can be obtained by pushing a button. The idea of instant gratification grasped, comprehended, enacted. The very common practice of posting "selfies" while announcing daily activities focuses attention to facial features which potentially heighten people's insecurities about their external appearance, providing fodder for the increasingly common appearance-based bullying.[3] High-tech speed challenges society's ability to legislate safe usage parameters while daring us to realize the ultimate effects of evolving technology on society's psyche.

With rhinoplasty patients, "selfies" and social media postings play an inordinate role in driving patients toward aesthetic surgery while dictating acceptability of results. Communication among rhinoplasty patients through "online chatter" is correspondingly commanding the "expected perfect" result. Some patients are no longer satisfied with a pleasing profile in a mirror or on a printed photograph, but the nose must also "look good" on that extremely magnified and distorted digital image. Appearance-based bullying has

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become epidemic in the current milieu, apparently associated with social media photographic postings.

Despite the technological advancements of modernity which have accelerated the aesthetic practice, it is the classical positive rapport between surgeon and patient which is critical and correlates well with positive patient outcomes. Positive rapport continues as the foundation upon which compassionate care is delivered. Our Internet age of instantaneous mass connectivity, instant gratification, and "selfie-centered" living necessitates, now more than ever, our tenacious commitment to the patient's needs along with a dose of what are realistic goals in any particular case.

The primary purpose of this article is to highlight both the undeniable challenges affecting our interaction with the aesthetic patient and the timeless techniques for establishing excellent patient rapport. First and primarily, knowing the importance and techniques of rapport building because no matter the result, if good rapport has not been established, an unhappy patient is the likely result. Unhappy people are capable of revenge by way of:

1. Verbal abuse
2. Internet slander
3. Legal attacks
4. Physical attacks/including murder

The preoperative interview[4] is irreplaceable in assisting the surgeon in determining the potentially unhappy postoperative patient. Clearly body language and other nonverbal communication impact a patient's judgment. Ambady et al[5] noted that patients make judgments not only from body language but also from our tone of voice. In one study, surgeons (65 orthopaedic and general surgeons) judged to have an unconcerned voice tone had a documented history of two or more medical malpractice claims against them, while surgeons judged to possess a warm concerned tone had a zero-malpractice history.[5] During the preoperative interview, it is imperative that surgeons judge a patient's psychology and suitability for surgery. For example, use open-ended questions to determine appropriateness for surgery:

1. What bothers you the most about your nose?
2. How often do you think about your appearance: daily, seconds, minutes, or hours?
3. Can you show me, (as you hand a mirror and Q-tip to the patient), what exactly is it that you dislike about your nose?
4. Why do you want the operation?
5. Why now?
6. How will it change your life?
7. Who is important in your life?
8. Do you have any questions?

Listen to the patient's answers and observe body language for clues to their psychological state. Have the "significant other" present and include someone from your staff. Always discuss the goals, risks, complications and options to surgery, including possible use of fillers. Regarding revision surgery, always inform the patient, prior to performing any operation, that there is a chance that another procedure may be required because surgeons cannot control healing, nature or scar formation. We suggest preparing the patient for the possibility of a second operation before doing the first operation.

Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) is a significant and debilitating psychological disorder that requires identification and medical/psychiatric care—rather than surgery—since many if not most of these patients are unhappy after surgery. The American Psychiatric Association's Diagnostic and Statistical Manual, fifth edition defines BDD as excessive concern with a slight or perceived defect impairing daily life and is classified under obsessive compulsive disorders. Many of these patients are seriously impaired and harbor suicidal ideation.

Astounding as it is, 84% of patients with BDD are diagnosed only AFTER surgery![6] In a 2011 European study, of the 226 patients presenting ($n = 226$) for an evaluation of nasal aesthetic (cosmetic) deformities, ~33% of the patients had moderate-to-severe symptoms of BDD.[7] While BDD occurs in ~1 to 3% of the general population worldwide, in some estimates as many as 50% of these patients seek cosmetic surgery sometime during their lives. Postoperatively, these patients frequently radiate unhappiness no matter what the surgical result. It is indispensable to work with a psychiatrist interested in cosmetic and BDD patients.

Thus, it is crucial to identify and diagnose a BDD patient before surgery for two important reasons. First, these patients almost always are dissatisfied postoperatively posing a potent potential risk of aggressive physical, Internet or legal action. Second, and most importantly, many of these patients can benefit from a trial (which may require 3 months) of selective serotonin reuptake inhibitor drugs (►**Table 1**) using larger than recommended dosages for depression and for that reason these patients need monitoring by physicians (psychiatrists) experienced in using these medications. Many (over 50%) of these BDD patients will benefit from this medical treatment alone without psychotherapy or cognitive behavioral therapy and will no longer desire or require any type of surgery.[8–11]

Words are important, especially for psychiatric referral. As a suggestion, the following words were useful in over 40 years of practice: "Surgery is both a physical and an emotional trauma, and I'm concerned about your ability to manage the emotional trauma. If you were a member of my family, I would like you to see someone who helps with emotions, one of our psychologists or psychiatrists; especially if a 3-4-month trial of medication alone can avoid surgery and help you feel better while improving your life. Is that okay with you?" Always ask permission.

Table 1 Alphabetical listing of selective serotonin reuptake inhibitor drugs

Citalopram (Celexa)
Escitalopram (Lexapro)
Fluoxetine (Prozac)
Paroxetine (Paxil, Pexeva)
Sertraline (Zoloft)
Vilazodone (Viibryd)

Since 1970, routine use of the psychological screening test, the Minnesota Multiphasic Personality Inventory, in many thousands of patients, has been extremely utilitarian; however, it was not designed to identify BDD. After missing some of these BDD patients, a specific method for identifying possible BDD surgical candidates was sought. Three decades of dedicated ground-breaking research into BDD have been pioneered by psychiatrist Katharine Phillips, MD, including articles, books, and a specific BDD screening test questionnaire.[8–12] Lekakis et al[13] used a modified short questionnaire with seven items (►**Table 2**) and considered it positive for BDD if the patient was concerned about their appearance (with answer to question 1 yes) and preoccupied with these concerns (answer to question 2 yes) causing "… at least moderate distress or impairment in different domains of daily life…" (with positive answers to questions 3 or 4 or 5 or 6, or a yes answer to question 7). They reported a sensitivity of 89.6% and specificity of 81.4%; of course, "borderline" cases of BDD or patients suspected of deliberate deception should be referred for further evaluation by a mental health professional.

A comprehensive diagnostic and sophisticated management approach to BDD is extensively covered in the recent 2017 book titled *Body Dysmorphic Disorder: Advances in Research and Clinical Practice,* edited by Phillips.[9] Surgeons who suspect that a patient has BDD should dissuade the patient from having surgery. Phillips suggests not to "reject" patients who may feel very intense shame about their symptoms, but it is imperative to inform these patients that effective treatments do exist that can be delivered by mental health professionals for their condition. Referral is indicated for both accurate diagnosis and treatment, recognizing that proper medication can be very effective in significantly reducing their suffering from this serious and debilitating mental disorder. Many patients are successfully treated and can live fulfilling and productive lives.[9] It is never in the patient's best interest to minimize their concerns about their symptoms. After evaluation by a mental health professional, it is wise to share those findings with the patient.

Red Flags

It is warranted to be cognizant of situations or behaviors called red flags (preoperative warnings) for the potentially unhappy patient after surgery by declining or postponing surgery for many of these patients. It may be helpful to say something like, "I don't think I can achieve what you are looking for by my surgery." These red flags are modified from Vuyk and Zijlker[14] and from the recent comprehensive book by Constantian[15] to include:

1. Poor rapport
2. Minor or nonexistent defect (BDD)
3. Demanding personality
4. Perfectionistic attitude
5. Impulsiveness
6. Vagueness regarding goals
7. Litigation history

Table 2 Body dysmorphic disorder questionnaire–aesthetic surgery

1. Are you very worried about your appearance in any way?	Y	N			
2. Do these concerns preoccupy you? That is, do you think about it a lot and do you wish you could worry about it less?	Y	N			
3. Did these concerns cause you a lot of distress, torment, or pain? (Circle the best answer)	1	2	3	4	5
	No	Mild, not too disturbing	Disturbing but manageable	Severe, very disturbing	Extreme disabling
4. Did these concerns cause you impairment in social, occupational, or other important areas of functioning? (Circle the best answer)	1	2	3	4	5
	No	Mild, not too disturbing	Moderate disturbing but still manageable	Severe very disturbing	Extreme disabling
5. Did these concerns often significantly interfere with your social life? (Circle the best answer)	1	2	3	4	5
	No	Mild, not too disturbing	Disturbing but still manageable	Severe, very disturbing	Extreme disabling
6. Did these concerns often significantly interfere with your schoolwork, job, or ability to function in your role? (Circle the best answer)	1	2	3	4	5
	No	Mild, not too disturbing	Moderate, disturbing but still manageable	Severe, very disturbing	Disabling
7. Are there things you avoid because of these concerns?	Y	N			

Source: From Lekakis et al,[13] used with permission.

8. Demanding personality
9. Emotional crisis
   (a) Death in family
   (b) Divorce (family strife)
   (c) Loss of job
   (d) Loss of lover
   (e) School failure
   (f) Childhood abuse and neglect

Constantian[15] suggests that one revealing question that could be asked during the preoperative interview would be, "Tell me about your childhood."

Rapport Building

One reason many patients are so unhappy with their physicians is the absence of good rapport between patient and surgeon. In one study of medical malpractice cases using transcripts of plaintiff discovery depositions ($n = 45$ patients and reviewing 3,787 transcript pages), 71% of the patients cited, "problematic relationship issues"—essentially *"poor rapport"* [italics ours])—as one of the main reasons for suing the doctor.[16] If you have not established "good" patient rapport, it is wise to decline performing the surgery.

Techniques for establishing positive rapport can be summarized as the ABCs of rapport building:

A. Active listening

In the childhood, "telephone game" a written phrase is then whispered into a child's ear who then repeats the phrase passing it onto the next child and so forth until all have heard the phrase. Usually the final phrase is totally different than the original phrase. This is an example of passive listening. Active listening is repeating back what's heard so the patient understands that you unambiguously understand what was just said. Active listening facilitates accuracy and ensures the patient has been heard.

B. Body language is considered optimal when the surgeon is:

1. Sitting facing the patient
2. Using an open posture (without crossed arms or legs)
3. Leaning toward the patient
4. Maintaining eye contact with the patient

All this optimal body language occurs within the context of a relaxed friendly atmosphere.

C. Candor—always be honest!

So, the ABCs of rapport building include:

(a) Active listening
(b) Body language
(c) Candor

Conclusion

Recent technological advances, especially the Internet, have complicated the dynamics of the doctor–patient relationship. More patients seek cosmetic surgery; patients are inundated with images of themselves through "selfies," and a satisfactory outcome becomes more elusive as the patients struggle to find perfection through the distorted and magnified lens of the "selfie"; it is therefore more critical than ever to refocus attention on the time-honored preoperative interview as the bed rock skill critical to establish patient suitability for and satisfaction with aesthetic procedures, especially rhinoplasty. The wise surgeon must be cognizant of both body language cues and the subtle but apparent red flags to avoid potentially unhappy patients. Routine use of a screening questionnaire may assist in identifying BDD patients preoperatively. Finally, practice rapport building—(1) active Listening, (2) positive body language, and (3) candor—since positive rapport is fundamental to both patient and physician satisfaction.

Conflict of Interest
None.

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