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How Do Unreasonable Patients Impact Our Practice?

PATIENT SELECTION FOR PLASTIC SURGEON

You are listening to ReachMD, the Channel for Medical Professionals. Welcome to The Clinician's Roundtable. I am your host, Dr. Michael Epstein, board certified plastic surgeon. Our guest is Dr. Peter Adamson, Professor of Otolaryngology/Head and Neck Surgery and head of Facial Plastic and Reconstructive Surgery at the University of Toronto. Dr. Adamson is recognized as an international leader in facial plastic surgery.

DR. MICHAEL EPSTEIN:

Welcome Dr. Adamson.

DR. PETER ADAMSON:

Thank you Michael. It is a pleasure to be with you.

DR. MICHAEL EPSTEIN:

Lets get right into it. Why don't we talk about, you know, what are some of the typical problem patients that you see in your practice, Dr. Adamson?

DR. PETER ADAMSON:

Well, let me emphasize that most patients are not difficult patients. Most of them are really are, if not very good, at least good and satisfactory, but there is a small percentage perhaps 5 to 15% that are not good candidates and certainly we don't want to proceed with them both for their best interest and obviously some times the surgeon's to. We see many different type of patients. One type of patient we have actually put a name on the syndrome we call up the goldilocks syndrome and these are the kinds of patients that come in and they are just not happy unless everything is just right. They are perfectionist. They are little bit related to obsessive-compulsive disorders, but everyone of you who is a doctor practicing clinical medicine has had these patients where you spend your 5 or 10 minutes maybe in a followup visit for any postsurgical reason and everything seems to be okay and just as you are ready to go out the door and say we will see you again in 3 months or whatever they say oh by the way or but what about this and everything has been fine. They don't bring up any complaints or unhappiness until sort of the every end. Then when you look at any aesthetic problem if aesthetic

surgery the defect or deformity is usually within the limits of normal. It is part of the normal asymmetries which we all have in our faces and we call the goldilocks syndrome because it has to be just right. Nothing can be just little bit hot or little bit cold. So they are interesting and they can be challenging to make them happy at the end of the day. Another type of patient that we will all see more of because we live in an increasingly multicultural world is the cross cultural patient and in particular I have seen more of these patients in the younger group who are for example studying in America at university. They are from different culture in the Middle East or far east for example and they become quite culturized to North American ways and for example they might like to have a rhinoplasty to remove out the big bump or make their nose a little bit more elegant, but when you talk to them and say well have you spoken to your family about this who is back home, well no, they really don't think they will need to speak to them but they are going to get it done and they will tell them afterwards. Now sometimes in some cultures particularly if they are particularly patriarchal, if the patriarch or indeed the matriarch then sees this result and feels that person has tried to alter their racial or cultural characteristics then they can become very upset and these patients won't always have the ego strength to withstand the dissatisfaction of their family members and if there is any reason at all to be concerned about the result then that will be transferred to the surgeon. So I think it is really important with individuals who are seeking changes if they are not of, you know, North American culture to be sure that what they are asking for is something that either suits their culture, their racial characteristics or if it is going to be a little bit different you really need to make sure they are good candidate for and they are going to have equal strength and family support to do so. And the final type of patient that we see is titled exhaustive surgeon syndrome and this has been described for some time and this is the patient who comes in and you speak with them and they virtually all we seen are the doctors and they will tell you this. They will say, well, doctor you are the first one who really understands my problems and I am so glad that I found you and sometimes they will even send you flowers the next day saying how terrific it was to meet you and looking forward to working with you and then when you do the operation afterwards, well, all of a sudden it is not quite right what you have done as well and then you become the next surgeon who has let them down and they will draw on you and draw on you by coming in and being dissatisfied and finally they will just disappear into the night as well and you know they have gone to another surgeon. I once had a patient come in and gave me a typewritten list of 113 surgeons whom she had seen for her facial concerns and I was number 114 and so you can imagine that I did not perform any surgery on that patient or I would have just been another in exceptionally long list of exhaustive surgeons.

DR. MICHAEL EPSTEIN:

Who would you classify, if you can give me sort of a bullet point list, would make a good surgical candidate, sort of putting the contraindications sort of in the reverse?

DR. PETER ADAMSON:

A good candidate has a very specific object of complaint about facial feature that you yourself as a surgeon see and agree with. Furthermore, when they describe how they would like it improved you realize that you can objectively surgically achieve that result for them. Next bullet is that if you achieve that for them remember who wants to have surgery, this is just a tool that if you do that they are going to have a psychological gratification in whatever form they are seeking and they are going to have harmony between their spirit and their facial appearance and harmony of course is beauty and furthermore that they are physically and psychologically fit so they are a good candidate for surgery and that if there might be some kind of complication or less than ideal result you recognize and they recognize they have the ego strength to accept the small risks that are real but small and accept the small risk that if there is a problem they can handle it. If all those things line up then you probably have a very good candidate.

DR. MICHAEL EPSTEIN:

I would imagine that the real key here is to identify the problems as early as possible. Do you have any specific tips on how you would go about doing this?

DR. PETER ADAMSON:

The first thing that we do and I think everyone should do is let the patient speak. We all know for many studies that, you know, I think the timeframe varies, but it is something like between 17 and 28 seconds after a patient sits down in a chair and starts to tell their story the doctor interrupts them and starts to talk. So it really is important after initial chitchat for a minute or so to get the patient comfortable. I always say please tell me your story about whatever it is and then as much as I can I sit back and listen for 2 or 3 minutes. So the patient really rounds out what needs to be said and then you can go back and fill in the details that you require. We do a full functional inquiry just like we would for a patient who is coming in with, you know, gallbladder disease or any other significant medical condition. In that way, I think you establish rapport with the patient and get to understand them. Once that's done and you have examined the patient well, then I think you start to get a good idea as to whether or not you are going to be able to achieve, you know, what they are seeking.

DR. MICHAEL EPSTEIN:

If you have just joined us, you are listening to The Clinician's Roundtable on ReachMD. I am your host, Dr. Michael Epstein. Our guest today is Dr. Peter Adamson, Professor of Otorhinolaryngology/Head and Neck Surgery and head of Facial Plastic and Reconstructive Surgery at the University of Toronto. We have been identifying some of the key early identifying factors for the problem plastic surgical patient. Dr. Adamson obviously is focusing on the facial plastic surgery, but we can extrapolate the body as well from any of these things.

DR. MICHAEL EPSTEIN:

Dr. Adamson, do you have anybody else in your practice interviewing the patient or do you have a questionnaire that you give the patient?

DR. PETER ADAMSON:

We do have a questionnaire which is a fairly straightforward medical questionnaire, but we don't have anyone them as such, but what is very important is there is an informal interview which begins with our front office manager who takes the phone calls and I do stress that we call her and treat her as the front office manager, not as a receptionist, and I very much listen to what she has to say about how patients interact with her on the phone and her sense of people. She has the authority in our practice not even to book or schedule a patient for a consultation if she feels that they are "off" and might be difficult or she might put the patient out a little bit longer period of time just so that we get a better sense of things and then of course, I am very fortunate to have a clinical fellow. He always sees the patient on our second visit to go over all the details of surgery and discussing risks and complications, etc. so he gets feel for the patient and then our patient consultant also interviews that patient as well as our nurse. So, we work as a team and if anyone expresses reservations then we do have a huddle and say what's our sense of this patient. How do we manage this?

DR. MICHAEL EPSTEIN:

Just several checkpoints along the way. Lets switch gears for a second because I think one of the more interesting thing that we haven't discussed is the effects of these difficult patients on our practices.

DR. PETER ADAMSON:

Well, these patients can be very, very trying and it is the old 80:20 rule, hopefully in this kind of patients about 95:5 rule that, you know,

5% of your patients cause you 95% of your grief. I think the first thing is that we surgeons are all, you know, trained and brought up to be, you know, somewhat perfectionist in our own way and we always expect ourselves to do things right and so when we do have an unhappy patient or problem we first of all have to deal with our own sense of failure, whether it is realistic or not realistic, if something I think it is intrinsic to being a surgeon if somehow we failed whether in just doing this patient when we should not have or in fact, you know, we don't always get perfect results. Lets face it, we don't always get a home run. As long as we get the first base or second base that is terrific, but once in a while in spite of our best efforts we do not do well. So we have to deal with our own psychological feelings about it and the first thing of course is sometimes anger and rejection then we have to overcome that and by, you know, utilizing some of the tools we have been discussing about we need to take a proactive professional approach so that we can say this is a problem, we have to be honest with ourselves, identify it, and accept it and rather than rejecting that patient we have to embrace them. That means more visits to the office which is something we don't really want to do when we have an unhappy patient. It also can be very hard on your office staff because these patients can take up an inordinate amount of time on the telephone whether it is complaining or wanting to get specific appointments because they now expect to be treated especially and your office staff can feel very traumatized psychologically sometimes by these patients. Then there comes the whole issue of, you know, is it a real problem that there might be a suit about it. Of course, we all recognize that there can be many suits even if there is no really good medical basis, but that does not mean that you won't get a writ and so you have to start to do all of the medical legal things and whether it is talking to your insurance carrier, making sure you note everything exceptionally well in the chart. These things take your time and your energy and when these patients come in to the office they can of course be disruptive just to you, they are challenging, or if they are really unhappy and making a nuisance of themselves which is very rare, but it is not completely unheard of. One of my colleagues had a fellow in front of his office for 3 months with a sandwich board walking around saying what a terrible doctor he was and he needed to get a court order to have this individual, you know, removed from the premises. So we have these patients. If we have any unhappy patient we have a look at them as the very last patient at the end of day, so I feel even though I am tired at the end of the day I have time to manage them and they don't feel rushed which is an important thing for these patients. So, yes I think they can be very demanding in many ways in our practice and that's why we try so hard to avoid them and make sure that our patients are going to be happy.

DR. MICHAEL EPSTEIN:

That was terrific and I would like to thank our guest, Dr. Peter Adamson who have really hit some great issues and helped us sort of deciphering which patients potentially be difficult. We have been talking about key issues and patient selection for plastic surgeons. I am Dr. Michael Epstein. You have been listening to The Clinician's Roundtable on ReachMD XM157, the Channel for Medical Professionals. Be sure to visit our website at ReachMD.com featuring on demand podcast of our entire library. For comments and questions, please call us toll free at (888 MD-XM157) and thank you for listening.

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