The plastic surgery consultation

When I started practising plastic surgery 21 years ago, I did not give much thought to the patient consultation. I assumed it was easy and that surgery was the hard part. I have since changed my opinion. Surgery is the easier part and it is the consultation which can be hard.

The concept of informed consent changed everything. We now need to assess every patient and make a reasonable prediction as to the outcome of surgery; we also need to explain the operation and the risks that are involved, in a manner that enables the patient to absorb and understand this information. Only then do we make the decision about whether to proceed with surgery or not.

I have learned a few things about consultations since I started. Those who have no trouble doing consultations do not need to read this. I still have trouble.

It is the people themselves that make consultation interesting. You never know who is going to come through your door. Every person is different. We need to diagnose their condition, examine them, explain the situation to them clearly and sometimes operate on them, guiding them through the surgical experience and then on the road to recovery. The consultation sets the stage for all of this.

The consultation is the most important visit and almost all of the decisions can be made without delay. First, some basic principles. I bring the patient into the consulting room and we both sit while I read the patient's name, getting help with pronunciation if necessary. At this time I have already started to observe how the patient sits and acts. I never say anything that I would not want repeated elsewhere; your consulting room is private but don't count on it. Also, even though an explanation is clear and direct, it can be completely misunderstood. So repeat, recheck, slow down and never go ahead until the patient understands what is being said.

I try to get the patient to talk and then I listen to their story. This is probably the most important lesson in consultations. Most people want to talk and many have the diagnosis worked out already. It is critical not to interrupt them, otherwise you may not hear the whole story. I think it blocks the patient's story and the quiet reflection necessary in any consultation.

Next is the physical examination. This avoids talking about something the patient does not have, and puts you on track for the proper diagnosis. Diagnosis is half the treatment and this is also the perfect time to listen to the heart and lungs and decide on the best anesthesia. Plastic surgeons are fortunate since we can do so much under local anesthesia. Furthermore, the newer short-acting drugs, such as midazolam, propofol and fentanyl, have really improved what we can do and increased the number of people we can do it to, with impressive and fast postoperative recoveries.

Everything I have said so far is simple. Explaining the operation is trickier. Most of us do this in a way that is often

far too complex, at least I used to. I now try to speak slowly and repeat myself even more slowly if there is any sign of a lack of comprehension in the patient's eyes. I try to avoid using technical or medical words as much as possible. It is all too easy to use words like "symmetrical", when it's far easier to say "the same on both sides" and be sure that the patient has understood. This cannot always be done, however, and for diseases that have no simple name, I write it down so the patient can learn it.

If the patient looks like he or she is scared during the consultation, it is best not to simply reassure them but to say "You look quite afraid, please tell me what you are afraid of".

It is better for any concerns to be aired at this time rather than after the operation, when it may be too late. I learned this lesson when a mother brought her young son for an otoplasty. She looked terrified, but he did not. Before this I had always taken the reassuring approach, only to be subsequently frustrated when I could not settle the patient down. But this time I asked the mother why she looked upset. She replied: "My son's best friend died when having his tonsils out, and I'm terrified of the anesthetic." She would not have told me this if I had not asked. So I decided to do the operation under local anesthesia; the boy was fine and everyone was happy.

Once I have decided what to do (and it is usually easy to decide), the next duty is to tell the patient. If, during this process, the patient shows any sign that he or she has had enough and is not understanding what I am saying, then I

stop. There is no use transmitting when nobody is receiving. It is best to pause to see what is on the patient's mind. Sometimes they have had enough and cannot absorb any more information, and sometimes they might pose a tough question such as "Doctor, would you do this on your wife?".

The informed consent is supposed to be most complete in elective operations and less so in emergencies. Many patients have never heard of consent and think that I am trying to scare them for some reason. So I explain to them first what a consent is. I say: "This is just information you need to know to make a decision".

It is a little scary to some, particularly those from other countries because for the first time perhaps they realize that they have to participate and that I am not going to make all the decisions for them. This is also particularly threatening for those without complexity in their mental make-up, since simplicity is so reassuring.

I find the best approach is to say: "The informed consent is to tell you what you need to know about this operation. Please let me tell you all the way through and I'm sure I'll tell you much more than you thought. Leave your questions until I'm through because otherwise I might leave out something important". I then go through the whole operation and mainly talk about what the patient wants to know: when to arrive for the operation, how long recovery may be, what pain can be expected, what pills are used to relieve it and how to call me after surgery if there are any concerns. This way it is easy to bring up the subject of complications and how both the patient and I can try to prevent them. It is important to make it clear that the patient and surgeon are "working together" to "try" to achieve the best result. Never "guarantee" a result. In fact, the word "guarantee" should be avoided altogether during the consultation.

When I have finished explaining everything to the patient, I sit back, relax and listen to any questions they may have. This is the best time to assess the type of person the patient is. There are several publications on this particular area of patient appraisal. The Gorney scale is useful; it is also helpful

to mark where the patient fits on an optimist-pessimist scale and a vague-specific scale. Many assessments will change as you see the patient handle stress. The main value of this exercise is to force yourself to make decisions about the patient and to see him or her as an individual and not an operation.

At this time, I also write the booking information on the patient's chart, indicating whether the patient can book now or if they need further time or information before deciding. This avoids having the patient booked for an appointment before he or she is ready.

The final step in the consultation is to summarize the whole procedure in one short paragraph on the patient's chart. I find this extremely useful when looking at the chart six months later and I need a reminder of what was decided at that time. It also serves as a prompt to call the patient in to review their progress. I also dictate the hospital history, making sure to send a copy to the referring doctor. It is imperative to keep all parties informed. With all this useful information on the patient's chart, I make sure to take it to the operating room when doing the operation.

This is my own personal approach to the plastic surgery consultation, and I fully appreciate that there are many other ways of tackling this important aspect of our work. As long as we speak openly with our patients and we are human and understanding, especially if we have been a surgical patient ourselves, we can carry out consultations that are useful to both patients and surgeons. But always be prepared to expand and experiment with this process, keeping what works and leaving out what does not.

John R Taylor, Toronto

Note: If you have your own favourite approach to patient consultations, either write a letter or prepare an editorial. We would be pleased to hear from you on this or any other matter that relates to the field of plastic surgery – The Editor.