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Patient Dissatisfaction With Results of Technically Satisfactory Surgery[1]

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Abstract. In many instances, successful cosmetic surgery may be followed by dissatisfaction by the patient. This results from many factors, broadly classified into three categories: those attributable to the patient; those attributable to the surgeon; and those resulting from interaction between the surgeon and the patient. Careful preoperative evaluation and detailed explanations of sequelae and expected results can help avoid some of these problems.

Key words: Patient expectations—Postoperative results—Sociological medicine—Psychological factors

Assuming that surgical comptence is not the issue, what are some of the causes of patient dissatisfaction with the results of their operations? For the purpose of this discussion, I have placed these causes roughly into three categories: (a) those attributable to the patient; (b) those attributable to the surgeon; and (c) those attributable to interaction between surgeon and patient.

Those attributable to the patient include:

1. Patient has multiple or serious psychological problems.
2. Patient expects surgery to solve life's difficulties.

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3. Patient's expectations for aesthetic results are unrealistic (objectively and/or subjectively).
4. Patient has surgery as a result of external pressures (i.e., to please someone else) or has acted on impulse.
5. Patient is dependent on others for self-esteem (would be influenced by negative responses from others postoperatively).

Those attributable to the surgeon include:

1. Hasty evaluation of patient.
2. Failure to prepare patient fully regarding procedure and what to expect.
3. Minimizing what is involved.
4. Operative design according to what surgeon thinks best (without consulting patient or ascertaining his or her expectations and wishes).
5. Refusal of surgeon and secretary-nurse to listen empathetically to patient's problems or complaints postoperatively.

Those attributable to interaction between surgeon and patient include:

1. Personality conflicts.
2. Poor communication.

Although the scope of this paper does not permit discussion of each item listed above, I would like to point out that, of the various reasons for ending up with a dissatisfied patient despite successful surgery, the most basic one is traceable to the surgeon's initial failure to interview and carefully evaluate the patient, or to have an evaluation done by a professional skilled in this area. Once the patient is accepted, the possibility of dissatisfaction again arises if the surgeon designs the operation according to what he or she thinks best, without consulting the patient or ascertaining his or her expectations or wishes.

Ethnic Considerations

Like architects who go on building buildings that have no relation to the people who live in them, some surgeons, in their zeal to achieve anatomic perfection, go on building noses and faces that may bear no relationship to the persons who must live with them. Overlooked is that what may be aesthetically ideal for one person may not be so for another, and also that there are ethnic and cultural variations in concepts of what is the ideal.

Following is a case in point. A 29-year-old woman requested a rhinoplasty for the correction of a conspicuous retroussé nasal tip. She was tired of being teased about her "Bob Hope nose." From the surgeon's point of view, the results were excellent. But when the patient saw her nose she began to cry and later went into a depression. Although pleased with the modified tip, she had not expected the elimination of a slight dorsal concavity. She was of Irish descent and extremely proud of her heritage. Equating Irishness with a turned-up nose, she had tacitly valued the dorsal curvature. The surgeon's creation of what he perceived as the "best" aesthetic effect—that is, a straight dorsum—destroyed what the patient valued, her Irish identity [1].

Body Image

There are other occasions when patients' displeasure and protests about results seem to defy any rational explanation. To impartial judges, the changed nose or altered face has definitely improved the patient's appearance. Yet the patient is unhappy. Such individuals are generally written off as "problem" patients or as emotionally disturbed. To these particular patients, however, the perception of others is irrelevant. The issue is how the patient perceives her or himself, a perception that is directly related to body image.

The role played by the body image in patients' dissatisfaction with adequate surgical results has received little or no systematic study. An elusive and complex concept, it is nevertheless one that deserves more attention. At the risk of oversimplification, the body image may be defined as the sum total of conscious and unconscious attitudes we have toward our own bodies and their functioning. It is an image that begins in early childhood and is influenced during development both by experience and the behavior and attitudes of others toward us [5]. Because of its significant role in identity and expression of individuality, a central area of focus for the body image is the face. When there is a discrepancy between body image and real appearance as a result of physical modification or alteration (whether it spoils or enhances the appearance), it can have an unsettling, if not a deep, impact on a person's psychological equilibrium [3]. This is not caused entirely by the change in appearance per se but by the meaning it has in the life structure of the individual and by the fact that, when a person looks different, the world starts reacting to her or him differently, while inside that person feels the same.

We can readily understand the meaning the change has for those whose faces are damaged or made unsightly; their sense of loss and reactions of grief, depression, and anger seem natural. However, we are not prepared for adverse reactions in instances where cosmetic improvement is achieved. Nevertheless, more than is generally recognized, alterations in appearnce can generate feelings of disorientation and disturbance in the body image. Moreover, as with those who are severely disfigured, some patients take years to integrate the alteration into their body image; others never do. For such individuals, surgery becomes a metaphor for a profound transformation—hence, their complaints about identity and the discrepancy between appearance and reality of oneself and the world.

Thus, we have the case of Jack M., age 27, who is still asking "Who am I?" and wondering what he would look like had he never had a rhinoplasty. At age 14, he underwent surgery for breathing difficulties. Although his nose detracted from an otherwise pleasant face, he was not prepared for the rhinoplasty his parents had arranged for him. "I expected to see the same nose," he said, "and when I saw myself my mind was blown. The nose looked great." Prior to his surgery, a girl to whom he was greatly attracted had treated him with total indifference. "Suddenly she was pursuing me. Her sudden reaction demanded a different reaction than the one I previously had—one of extreme shyness. I had to appear different toward her, yet inside I wasn't. This feeling that you're

a different person because the world starts reacting differently to you, while inside you feel the same, creates a discrepancy between appearance and reality and sets up a conflict between oneself and the world. When I look in the mirror I'm not sure it's me, and I wonder what I would really look like. This leitmotif, i.e., the difference between appearance and reality, has lasted all my life."

In view of the body image phenomenon and the anxiety-provoking distortions that may be produced in a patient postoperatively, unanticipated and unwanted changes should be studiously avoided. Although their intentions are good, surgeons who are tempted to play God, to make modifications according to their assessment of what are "artistic" results, may find themselves with patients who suddenly become a problem.

For example, Miss J., 32 years old, full-bodied and handsome, came to the clinic with a complaint about the cosmetic results of a rhinoplasty she had had elsewhere. To our surgeons, the results appeared good. In fact, her nose approximated what is commonly judged as "the ideal." Because they believed the patient to be "a neurotic," she was referred to me for an evaluation. Miss J., of Czechoslovakian-Jewish origin, had been in the United States only a few years. Troubled by severe breathing difficulties, she accepted the recommendation of her physician to have a submucous resection. On the morning of her operation, the surgeon casually suggested that while he was at it he could remove the slight dorsal hump on her nose to make it "nice and straight." Such an idea had never entered her mind, but in her anxiety about the forthcoming surgery she agreed, with the specification that no other changes be made. "I like it as it is." Postoperatively, she was shocked when she saw that the surgeon, in addition to removing the hump, had narrowed the nasal bridge and shortened and lifted the tip of her nose as well. (Preoperative photographs showed a well-shaped aquiline nose.) The patient's protests were dismissed as "unrealistic." And, adding insult to injury, the surgeon charged her an additional fee for cosmetic work.

Following this event, Miss J. became depressed. She stopped dating and sought the help of a psychiatrist. She claimed that the change in her nose and expression had undermined her sense of security and provoked anxiety attacks. "I was always proud of my face, and confident," she said, "and I felt myself sensuous and sexy looking. All this is gone. I look hard and stern, and I don't feel attractive. By itself it's not a bad job, but I'm a big person, I have big breasts, and this nose doesn't fit my face. I'm obsessed and angered, and I have sorrow for the loss of myself—my identity."

Secondary Scars

Another source of patients' dissatisfaction that has received little systematic study is the matter of secondary scars, i.e., scars that have been surgically induced in adjacent or distal body areas in the process of correcting a primary defect. In seeking plastic surgery for a particular imperfection, the average person is either unaware of or has not considered the possibility of residual

scars. Despite the words *incision, skin grafts, donor sites,* and the like, the notion exists that surgical scars are invisible or, if not, can later be eradicated.

For some patients, the distress caused by scarring may equal, if not surpass, that generated by the original defect. Even though the surgeon considers the primary correction on which he or she has concentrated to be satisfactory—an opinion that may well be shared by the patient—the effect of unexpected but unavoidable scars on other parts of the body may be such as to cancel out the psychological benefits that were achieved by the initial procedure.

In our society, negative reactions to unsightly body scars are universal, and today, with the fading taboos about nudity, such imperfections take on an added significance. Some patients who are not satisfied with the aesthetic outcome of the initial correction view a secondary imperfection as an extension of their original problem, and others as substituting one blemish for another. Patients who seek surgery because of attributed difficulties that are more imagined than real may transfer their preoccupation from the original defect to the secondary "mutilation" or use it as an additional cause of unhappiness. Regardless of age or sex, negative reactions are more likely to be pronounced in those individuals who are perfectionists or have narcissistic tendencies. For such a patient, a scar that is hardly perceptible can become a source of inordinate concern.

In my work, I have found that resentment about surgical sequelae is usually aggravated by, but more often has its origin, in the fact that they are unexpected. Even if patients are forewarned by the surgeon, they may not be prepared for the extent or the appearance of the defect. Patients frequently fail to hear what the doctor tells them, and ambiguous or nonspecific statements such as "there may be some residual scarring" make no impression at the time. When unpleasantly surprised postoperatively, they tend to feel misled and direct their anger toward the surgeon. The surgeon's assurance that the scar is not very big or will not show under one's clothes is often cold comfort to the one who has it. One young man who had acquired scars on his chest and neck in the course of surgery for his malformed ear referred to these as "obnoxious body blemishes," which to him were violations of his body and worse, he said, than having an imperfect ear. He was so ashamed of these scars that it was necessary for his parents to seek psychological help for him. While this is an extreme reaction, a lasting bitterness is not unusual.

I have found that the ability to accept unavoidable scarring is highly correlated with the degree to which the patient has been realistically and psychologically prepared. In order to avoid or mitigate untoward reactions, it is incumbent upon the surgeon to explain in careful detail, insofar as can be anticipated, what may be expected. Such information will give the patient an opportunity to weigh the alternatives and make a decision [2, 4].

References

1. Macgregor FC: Selection of cosmetic surgery patients: Social and psychological considerations. Surg Clin North Am **51**: 289, 1971.

2. Macgregor FC: Ear deformities: Social and psychological implications. Clin Plast Surg **5:** 347, 1978
3. Macgregor FC: After Plastic Surgery; Adaptation and Adjustment. Praeger Publishers: New York, 1979, pp 22–24
4. Macgregor FC: Social and psychological considerations in aesthetic plastic surgery: Old trends and new. In Rees TD (ed): Aesthetic Plastic Surgery. WB Saunders: Philadelphia, 1980, vol 1, pp 33–34
5. Schilder P: The Appearance and Image of the Human Body. International Universities Press: New York, 1950