INTRODUCTION

From the 1940's to the 1960's, most patients seeking cosmetic surgery were referred for psychiatric evaluation, as it was felt "essentially every patient seeking cosmetic surgery...(has a) psychiatric problem..." (1). Depression was the most commonly diagnosed problem, and it was felt to be exacerbated by aesthetic surgery (2).

Today, cultural norms have expanded, and what was once considered socially abnormal may now be acceptable. It is recognized more than half of all patients undergoing surgery of any kind develop postoperative transient depression, and this is no longer seen as abnormal (3). The number and types of people requesting aesthetic surgery is also expanding, and the percentage of people in this population with recognized psychiatric illnesses is lower (4).

The demand for aesthetic surgery continues to grow, and an objective means of assessing the patient is required. This paper will discuss the preoperative evaluation of the surgical patient, including patient selection and facial analysis.

THE SURGEON'S ROLE

The surgeon plays the roles of physician, therapist, psychiatrist and artist. Role confusion and disillusionment, both by physician and patient, are increasing. Yet it is known that properly selected patients usually expect less of their surgeon than the surgeon expects of themself. Surgeons who successfully choose patients tend to have three characteristics. First, they recognize their role is no longer sacrosanct yet they are able to maintain the principle role of leader. Second, they approach problems affirmatively and assertively. Third - and most importantly- they have a clear understanding of the patient's motivation before the operation proceeds (5).

First and foremost the surgeon must understand the motivation of the patient. The patient may mask their true desires, applying a "cover reason" for surgery. They may request
one surgery, when truly desiring another. Occasionally, the patient suffers from a psychiatric illness. Such circumstances demand the surgeon understand what is not said. This requires the surgeon know the patient, including a complete history and physical exam with emphasis on social and family history.

The role of leader should not be relinquished by the surgeon, yet the surgeon is no longer sacrosanct in our society. This requires a more subtle leadership, which relies on communication, including informing the patient of what is and is not possible. Importantly, the surgeon should not voice any opinion until the patient has fully explained their desires. This avoids projection of the surgeon's wishes onto the patient, which may be a problem in the manipulative patient.

**PATIENT SELECTION**

The goals of aesthetic surgery are a satisfied patient and surgeon. The perception of a successful outcome are often different between the two. The patient may be satisfied whereas the surgeon may find fault, and visa versa.

Deciding an acceptable outcome should be jointly established by the surgeon and the patient *prior to any surgical procedure*. Failure to do so may result in misunderstandings and dissatisfied parties. Preoperative communication may include family members, if approved by the patient, as they often serve as good reminders of any preoperative agreements. It is now known the most frequently expressed dissatisfaction by a patient is the physician's lack of communication prior to treatment (6).

The selection of a patient for cosmetic surgery begins with the initial interview. It is the surgeon's responsibility to screen all patients and, in the end, all problems are due to either poor patient selection or technical error. The initial interview should be concerned with proper patient selection. The purpose is to uncover the patient's fears and wishes and to assess whether these issues will lead to future problems. If an underlying problem is discovered, an operation should not be posed as a cure.

**PSYCHOLOGIC CONDITIONS**

The aesthetic surgeon should recognize six pathologic conditions that should be addressed by a psychiatrist prior to any surgical procedure (5).

*The neurotic patient:* The neurotic patient is characterized by excessive worry, anxiety and somatic complaints. These neurosis serve as a defense mechanism, and attempting to address these characteristics in a flippant manner results in a defensive, unhappy patient. These patients usually ask numerous, often repetetive, questions which often require detailed and technical explanations. They often obsess about possible postoperative complications, which they usually are aware of in detail. Their questions are often a "cover" for the need for reassurance.
Properly counseled, neurotic patients often make excellent surgical candidates. Their preoperative concerns are usually unfounded, and they are often happy with results. The important part in this patient selection is to identify the problem preoperatively and properly address all issues, including possible psychologic evaluation.

_The psychotic patient:_ The most commonly seen psychotic disorder is schizophrenia. These patients have disorganized thoughts, flight of ideas and are incapable of introspection. They are usually emotionless and humorless. The paranoid schizophrenic also incorporates thoughts of persecution and selfish behavior. Dr. Vasquez Anon performed a rhinoplasty on one of these patients and grew tired of the excessive demands postoperatively and refused to see the patient. The patient killed Dr. Anon. This has been repeated on at least two other occasions.

If a patient appears paranoid, suspicions should be raised and a psychiatric evaluation ordered. If one chooses to operate on the paranoid patient, meticulous postoperative care should be anticipated.

_Personality Disorders:_ Personality disorders manifest as behavior problems, rather than psychotic or neurotic problems. Unfortunately, these patients are often able to disguise their personalities, making diagnoses difficult. An uneasy feeling often overcomes the surgeon, but the reason for the feeling is difficult to pinpoint.

Commonly seen personality disorders include the narcissistic patient and the "splitter". The narcissistic patient is usually regal and elegant in appearance, and often obsessed with subtle- even imperceptible - physical flaws. Their opinions of themselves are often grandiose, and they are sometimes "name droppers." They suffer from poor ego formation and self esteem, and are prone to postoperative depression and dissatisfaction. Psychiatric evaluation is warranted. Several other personality disorders use "splitting" as a personality trait. "Splitting" refers to lumping people into "us versus them" categories. Examples include idealizing the current physician while denigrating former physicians. The same is often true for feelings about family members and friends. Manipulation is usually prevalent in this population, and these patients may occasionally dress inappropriately and be excessively flirtatious. Likewise, these patients require preoperative psychiatric evaluation.

_The surgery addict:_ Addictive personality types, such as those with substance abuse, can likewise be "addicted" to surgery. They repeatedly request surgical procedures - often revisions - of subtle or absent physical flaws. An extension is the patient with Munchausen's Disease, where unnecessary procedures are repeatedly requested - and sometimes granted - on family members. These patients tend to "doctor shop" and are almost uniformly unhappy with prior procedures and physicians. These patients mandate psychotherapy.

_The malingering:_ The malingeringer fakes symptoms and illnesses. The motive is usually monetary, either from a presumed injury or through malpractice insurance from the physician. Like the personality disorder, this condition usually makes the physician
uncomfortable for an unknown reason. Usual findings during examination include complaints that are grossly out of character with physical findings.

*The depressed/manic patient:* The depressed patient complains of minimal joy in things they formerly found pleasing (*anhedonia*). They either have difficulty sleeping despite being tired, or sleep excessively with little sensation of rest. They complain of poor energy and motivation. Depression may be part of a grief reaction and therefore transient, or part of an underlying pathologic process. An adequate social and family history may discern between the two. The manic patient usually has flight of ideas, pressured speech and is disheveled in appearance. They more rarely present for aesthetic surgery than the depressed patient. Psychologic evaluation is required of both.

**PATIENT REJECTION**

Physicians do not commonly reject patients outright. They are usually referred to another physician or a repeat consultation session is scheduled. The patient may find another surgeon whom they prefer, or they may become tired of the apparent indecision by the surgeon and seek treatment elsewhere. Another common tactic is to schedule an initial consultation which is free of charge, but charge for additional consultations.

**THE DISSATISFIED/LITIGINOUS PATIENT**

Despite a seemingly meticulous preoperative evaluation there are dissatisfied patients. The first impulse of the surgeon is a defensive one, but this should be avoided. Defensive posturing on the surgeon's part leads the patient to feel abandoned and unappreciated. The unappreciated and abandoned patient is more likely to be litigious. It is of little use to argue with a patient regarding surgical outcome, as this usually leads to feeling of isolation.

The physician must listen to these patients patiently and in their entirety. Listening does not imply agreement, but is often therapeutic. If the surgeon feels the patient is correct in their concern, the surgeon should be forthright, and if necessary, offer revision surgery. If the surgeon does not feel revision is warranted, return visits at regular intervals may be scheduled. These patients concerns and dissatisfaction often resolve with time (7).

**CONCLUSION**

Preventing patient dissatisfaction depends upon proper patient selection. The selection process begins with the initial interview. Any patient that makes the surgeon uncomfortable should at the minimum have surgery delayed, and perhaps referred for psychiatric evaluation. The most commonly diagnosed psychologic conditions which should make the surgeon concerned include: neurotic disorders, personality disorders, psychotic disorders, depression/mania and the malingerer.
REFERENCES


