Aesthetic Breast Surgery: Consulting for the Future—Proposals for Improving Doctor–Patient Interactions

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Many significant advances and refinements in breast augmentation have been realized over the past 15 years including improvements in technique, better implant selection processes, and perhaps most importantly, availability of better implants. Concordant with the elevation of this most basic of aesthetic breast procedures is the level of sophistication required to perform the procedure successfully. Gone are the days where a plastic surgery “hobbyist” could generate the types of results demanded by the current patient clientele, and with good reason. The previous model of one operation fits all simply does not reflect the wide variety of patient presentations seen currently. In fact, one of the most difficult aspects of the breast augmentation procedure relates to the handling of the small but significant asymmetries presented by nearly every breast augmentation patient. Clearly, this is an operation that can and should be performed only by those with the training and skills to carry out the procedure in a way that maximizes the aesthetic result and minimizes the potential complications.

It is with this in mind that the survey reported by Heden and colleagues is noteworthy because it underscores the need for well-trained and highly qualified plastic surgeons to bring the same level of expertise to the consultation process as they do to the procedure. Clearly, for the modern patient, a simple 10-min consultation designed to say hello, get a quick photograph, choose an implant, and schedule the surgery is woefully inadequate. In this advanced information age, patients will be much better informed and aware of the various options available to them. If the patient senses in any way that her need for information or

her desires for the surgical outcome are being sacrificed for the sake of time, she will most likely seek treatment elsewhere.

To build an optimal level of trust with the patient, the entire consultation process must be crafted to meet the needs of each individual. To this end, the recommendations noted in the paper by Heden and colleagues merit careful consideration. From the time the patient contacts the office, the process of trust building must begin. This process includes knowledgeable front desk personnel, a caring nursing staff, helpful billers and schedulers, and sufficient individual time with the surgeon for a healthy doctor–patient relationship to be built. This time is optimally spent developing a history, performing an exam, going through an organized implant selection process, and taking photographs. The implant selection process must include an examination of the breast with regard to the base diameter, the soft tissue thickness medially and laterally, the breast height, and laxity of the soft tissue framework.

After these factors have been determined, the patient’s desires regarding her size is established by a series of questions, and the projection of the implant is determined. This entire process is explained to the patient so she can play a significant role in the final implant selection, thus significantly minimizing postoperative discontent over implant choice.

It is entirely appropriate to use well-trained ancillary staff to assist in the education process, but the overall impression must be that the physician is in charge and looking out for the best interest of the patient. In this fashion, a level of trust is built with the patient that will keep her in the physician’s office through to the successful completion of the procedure and beyond. Heden and colleagues are to be congratulated for summarizing these important concepts.

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