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Patient Expectations and Error Tolerance in Plastic Surgery

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Abstract

Background: Plastic surgery holds a unique position among surgical specialties, as clinical success is intrinsically linked to the patient's subjective perception. This subjectivity creates significant professional and medicolegal vulnerability. The objective of this article is to analyze the impact of patient expectations on the perception of surgical outcomes and the prevention of litigation.

Methods: A critical narrative review of contemporary literature was conducted through systematic searches in indexed databases (PubMed, Google Scholar, SciELO). The review evaluated literature focused on patient satisfaction, physician-patient communication, outcome measurement, and medicolegal aspects in aesthetic surgery.

Discussion: Postoperative dissatisfaction frequently stems from a negative disconfirmation between idealized expectations—often exacerbated by social media and marketing—and biological reality. Conflict prevention relies on the "Three Cs" model (Communication, Consent, and Complications) and the consolidation of the therapeutic alliance. The integration of Patient-Reported Outcome Measures (PROMs such as BREAST-Q and FACE-Q), the timely detection of psychiatric contraindications like Body Dysmorphic Disorder (BDD), and the identification of high-risk litigation profiles (SIMON and FATIMA acronyms) constitute fundamental clinical strategies. Furthermore, the participation of surgical residents demands absolute transparency in the informed consent process.

Conclusion: Technical excellence is insufficient without the proper management of expectations. The plastic surgeon must implement rigorous preoperative assessments and empathetic communication to reconcile surgical limitations with the patient's biopsychosocial well-being.

Keywords: Plastic surgery; Patient satisfaction; Informed consent; Body dysmorphic disorder; Clinical ethics

Background

Plastic surgery occupies a distinct niche within surgical specialties, given that—unlike other disciplines where success is defined by quantifiable parameters—the efficacy of an aesthetic intervention is fundamentally tied to the patient's subjective perception [1,2]. This inherent subjectivity places the plastic surgeon's practice within an environment of heightened professional and legal vulnerability, heavily dependent on postoperative patient satisfaction [1,3]. Plastic surgery residency involves not only mastering surgical technique but also managing the patient's psychosocial expectations and developing communication skills necessary for a successful long-term clinical outcome. The specialty must routinely navigate challenges such as a steep learning curve, establishing realistic aesthetic goals, managing body dysmorphia, and mitigating the influence of social media [3,4]. This article addresses how expectations influence the perception of surgical outcomes and errors, examining preoperative communication, patient satisfaction, litigation, and the measurement of subjective outcomes. Therefore, the purpose of this review is to analyze the influence of preoperative expectations on patient satisfaction,

while evaluating the utility of clinical communication, informed consent, and Patient-Reported Outcome Measures (PROMs) in preventing litigation within plastic surgery.

Methods

This study was designed as a critical narrative review, utilizing a systematic approach for the selection and synthesis of evidence. A literature search was performed across PubMed, Google Scholar, and indexed databases. Given the heterogeneous nature of this research topic, a narrative review format was selected to allow the integration of multidisciplinary concepts that could not be adequately captured under restrictive systematic review criteria.

Discussion

The Expectancy Disconfirmation Theory

The Expectancy Disconfirmation Theory posits that an individual's degree of satisfaction is not solely related to the objective quality of the service or product received, but rather to the discrepancy between pre-event expectations and the post-event experience. Originally developed to analyze service management, this framework was subsequently extrapolated to healthcare delivery [5,6]. In a surgical context, if the outcome exceeds the patient's preoperative expectations, a positive disconfirmation is achieved, which correlates with high rates of clinical satisfaction. If the outcome matches initial expectations, it results in neutral confirmation or expected satisfaction. Conversely, the primary clinical risk lies in negative disconfirmation, wherein the outcome—regardless of whether it is technically flawless from a surgical standpoint—fails to meet the patient's idealized expectations. This discrepancy creates profound dissatisfaction, markedly lowering the patient's tolerance for minor complications, natural asymmetries, or expected surgical scarring [5,7]. Patient satisfaction is also heavily influenced by past experiences and social conditioning. Extraneous life stressors, such as recent divorces, social pressure, or low self-esteem, impose an emotional burden on the procedure that complicates postoperative satisfaction. In these cases, the surgical intervention cannot achieve the desired biopsychosocial well-being, ultimately leading to negative disconfirmation [5,7,8].

The Impact of Commercialized Imagery

Presently, patient expectations are closely intertwined with digital marketing and social media platforms. Research indicates that patient behavior is strongly associated with the idealized imagery presented in advertising campaigns. Furthermore, advertisements promoting surgical procedures rarely present explicit information regarding medical risks. This lack of risk disclosure, combined with the presentation of "perfection" via edited "before and after" photographs, perpetuates an unrealistic perception of plastic surgery. Patients rely on these sources during their information-seeking phase, developing unrealistic projections that the surgeon is expected to replicate in the operating room [8,9].

The Physician-Patient Relationship: A Fundamental Pillar

The technical skill of the surgeon accounts for only a portion of the overall success of a procedure; communication failures constitute the predominant factor driving litigation and postoperative discontent. Forging a strong therapeutic alliance with the patient mitigates the negative impact of potential adverse outcomes [1,5,10]. Consequently, the "Three Cs" model has been developed for the prevention of legal issues, based on: Effective Communication, Informed Consent, and Management of Complications.

- **Effective Communication**: The surgeon's interpersonal approach correlates directly with final patient satisfaction scores. Patients place high value on empathy, a willingness to answer fundamental questions, and the quantity and quality of time dedicated to them during the preoperative phase. For example, when the surgeon clearly communicates that the purpose of a rhinoplasty is not to replicate another person's features but to harmonize the individual's existing facial traits, realistic goals are successfully established [5,11].
- **Informed Consent (IC):** This document represents the legal and ethical manifestation of patient autonomy. The nature of the intervention must be articulated clearly, detailing not only the benefits but also the associated risks and the expected course of postoperative rehabilitation. A thoroughly educated patient will experience a more compliant recovery process and exhibits a decreased propensity for litigation [5,11,12,13].
- **Management of Complications:** A patient's psychological response to adverse events is significantly influenced by their preoperative preparation. When potential complications are discussed transparently and proactively prior to surgery, patient distress and anxiety are markedly reduced if those outcomes occur [5,6,13].

Integration of the Resident in Training

The integration of physicians-in-training within academic medical centers adds complexity to the physician-patient relationship. Bioethical standards dictate that patients must be adequately informed regarding the specific role of the plastic surgery resident in their operative care. Studies indicate that only approximately half of patients are fully aware of resident participation in their procedures. While the majority of patients accept the involvement of a resident as a surgical assistant, a large portion would reject the resident acting as the primary surgeon. Consequently, the

inclusion of plastic surgery residents introduces complexity to patient dynamics and can elevate dissatisfaction, driven primarily by patient biases regarding the surgeon's trainee status [13,14].

Objective Measurement of Subjective Outcomes

For plastic surgeons, the ultimate priority extends beyond achieving technical precision in the operating theater to measurably improving patient quality of life. Accordingly, Patient-Reported Outcome Measures (PROMs), such as the BREAST-Q and FACE-Q instruments, have become fundamental pillars of contemporary clinical practice [15,16]. These scientifically validated questionnaires provide a standardized approach to quantifying deeply subjective domains: personal satisfaction, psychosocial well-being, physical function, and self-image perception before and after aesthetic or reconstructive breast and facial procedures. By integrating BREAST-Q and FACE-Q metrics, specialists move away from evaluating surgical success solely through clinical visual assessment [17,18,19]. Concurrently, these tools provide direct patient feedback, allowing surgeons to refine operative techniques, establish more realistic preoperative expectations, and ensure that each procedure yields a meaningful benefit to the patient [17,18,20].

Epidemiology and Clinical Impact of Body Dysmorphic Disorder

Body Dysmorphic Disorder (BDD) represents a severe contraindication for aesthetic surgery. Characterized by an obsessive, intrusive, and disproportionate preoccupation with slight or entirely imagined physical flaws, BDD profoundly alters the risk-benefit ratio of any surgical intervention [21,22]. Patients diagnosed with BDD exhibit exceptionally low rates of postoperative satisfaction. Following corrective surgeries such as rhinoplasties, breast procedures, or liposuction, BDD symptoms typically exacerbate rather than subside, often shifting to a new anatomical focus. Consequently, the patient may develop marked hostility toward the surgical team, perceiving that the perceived defect was worsened due to "medical negligence." [22]. In the current era, the pervasiveness of social media has altered body image perceptions globally. Visually driven applications such as Instagram and TikTok foster a false standard of physical perfection through digital filtering tools that modify facial architecture [23]’ Exposure to this altered aesthetics establishes new beauty thresholds that are anatomically unfeasible. Plastic surgeons note an exponential increase in consultations where patients present digitally modified images of themselves. These unrealistic expectations generate cognitive distortions, complicating surgical decision-making in young, psychologically vulnerable patients [22,24,25]. Addressing this challenge requires the surgeon to dedicate sufficient time during preoperative consultations to deconstruct the false realities promoted by social media and mass media, re-educating the patient on the complex, imperfect nature of human anatomy to establish realistic objectives and achieve higher postoperative satisfaction [25].

Complaints, Litigation, and Patient Selection

Despite clinical advancements, plastic surgery operates within a highly litigious environment, with lawsuits related to aesthetic procedures steadily increasing. For this reason, evaluating the patient's psychiatric and psychological profile during the preoperative phase is mandatory before proceeding with any intervention. Furthermore, the triggers for litigation are largely preventable through rigorous informed consent and proactive postoperative care [26]. To address this challenge, the scientific community has developed screening tools to identify high-risk personality profiles prone to initiating legal action. Patient selection remains a critical clinical tool that must be utilized systematically [27]. The acronym SIMON (Single, Immature, Male, Obsessive, Narcissistic) is utilized to identify individuals who demonstrate exceedingly high expectations and demands that exceed technical limitations. However, SIMON focuses exclusively on male patients, whereas the majority of plastic surgery patients are female [27,28]. To address this gap, a new profile was postulated: FATIMA, which identifies female patients (F) with a clinical history of anxiolytic or antidepressant use (A), body tattoos (T), implants (I), middle age (M), and ready access to legal assistance (A). These tools are not intended to institutionalize discriminatory practices, but rather to provide surgeons with an early warning system [27,29,30]. When encountering a patient with these characteristics, the surgeon must exercise meticulous care during the preoperative evaluation, request psychiatric consultations, execute a comprehensive informed consent process, and, if the patient is deemed unsuitable for surgery, decline to perform the procedure [28].

Conclusion

The evolution of modern plastic surgery presents an escalating array of challenges, routinely confronting practitioners with complex ethical and clinical dilemmas. Technical perfection in the operating room no longer guarantees clinical success; currently, surgical outcomes are inextricably linked to the psyche of patients who are continuously exposed to unachievable aesthetic standards [10,16]. To successfully navigate this environment of legal vulnerability, the surgeon must transcend the traditional technical role and act as an active manager of patient expectations. This shift necessitates rigorous preoperative screenings to filter high-risk profiles, the systematic implementation of objective metrics (PROMs), and an informed consent process grounded in empathy and transparent

communication [20]. In conclusion, true excellence in plastic surgery is not achieved solely by minimizing physical scarring, but by forging a resilient therapeutic alliance that successfully reconciles the biological limitations of medicine with the patient's biopsychosocial well-being.

Administrative Disclosures

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