



Key strategies to avoid litigation, poor outcomes

Use extreme caution when evaluating smokers for surgery

Smoking is the nemesis of plastic surgeons, greatly increasing the likelihood of a poor outcome with many procedures. But patients who smoke don't have to be turned away as long as you are extremely cautious and counsel the patient appropriately. Key strategies, say experienced surgeons, include insisting on a period of cessation and never taking the patient's word about smoking habits.

Plastic surgeons all learn about the hazards of smoking patients – that the nicotine causes blood vessels to constrict and impair circulation – and that healing can be poor in procedures including face lifts, abdominoplasties, and breast augmentations where circulation is crucial to a good result.

In one recent retrospective study, researchers found there is no question that smoking results in impaired wound healing and poor surgical results.¹ The researchers compared outcomes in 155 smokers, 76 ex-smokers, and 517 non-smokers who received postmastectomy breast reconstructions during a 10-year period. Ex-smokers were defined as those who had quit smoking at least three weeks before surgery, so that would include many patients who follow doctor's orders to stop smoking around the time of the procedure.

There was evidence that the surgeons changed their technique in response to the smoking. Transverse rectus abdominis musculocutaneous (TRAM) flap surgery was performed significantly less often in smokers (24.5%) than in ex-smokers (30.3%) or non-smokers (39.1%). Tissue expansion followed by implant was performed in 112 smokers (72.3%), 50 ex-smokers (65.8%), and 304 non-smokers (58.8%).

The overall complication rate in smokers was 39.4%, compared with 25% in ex-smokers and 25.9% in non-smokers, which the researchers report is statistically significant. Mastectomy flap necrosis developed in 12 smokers (7.7%), two ex-smokers (2.6%), and eight non-smokers (1.5%). Among patients receiving TRAM flaps, fat necrosis developed in 10 smokers (26.3%), two ex-smokers (8.7%), and 17 non-smokers (8.4%). Abdominal wall necrosis was more common in smokers (7.9%) than in ex-smokers (4.3%) or non-smokers (1%).

"Complications were significantly more frequent in smokers. Mastectomy flap necrosis was significantly more frequent in smokers, regardless of the type of reconstruction. Breast reconstruction should be done with caution in smokers," the

Inside This Month...

- *Study shows wide variation in how surgeons handle smokers. Research suggests there is no clear consensus among plastic surgeons on how to treat smokers Page 14*
- *Consent form explains risks and requirements for smokers. Anthony Griffin, MD, FACS, counsels his patients carefully about the risks of smoking and plastic surgery Page 14*
- *Surgeon offers protocol on plastic surgery patients who smoke. Boris M. Ackerman, MD, a plastic surgeon specializing in facial rejuvenation with endoscopy, laser liposculpture and breast surgery, offers his own protocol for working with patients who smoke Page 15*
- *Malpractice insurer wary of patients who smoke. One of the foremost malpractice insurers in the country isn't crazy about you operating on patients who smoke ... Page 16*
- *Set yourself apart with 'branding,' more than just marketing. Branding is the most misunderstood concept in marketing. Even many marketing professionals do not fully understand the concept. So what is it and how can it help you? Page 18*
- *Expand your practice: Monday Night Football is an opportunity to market to more men. If you're looking for a way to market more effectively to men in your practice area, here's an idea: Host a Monday Night Football evening at a local bar Page 21*
- *Saying 'I'm Sorry' is sometimes a good way to stay out of court. If you're not fresh out of medical school, chances are good that you were taught to avoid saying you're sorry to a patient who is unhappy with her results of surgery. But in recent years there has been a movement to change that approach as a way of avoiding lawsuits Page 21*
- *Validate the patient's feelings, consider an outright apology. Whether you actually apologize or not, you should talk sincerely with an unhappy patient. Page 23*

researchers report. "Ex-smokers had complication rates similar to those of non-smokers."

Additionally, the American Society of Plastic Surgeons recently underscored the risk of complications from nicotine by revising its suggested informed consent forms to include the risk of second-hand smoke. In addition to a thorough warning about how smoking can increase the risk of

Study shows wide variation in how surgeons handle smokers

Research by **Rod J. Rohrich, MD, FACS**, chairman of the Department of Plastic Surgery at the University of Texas Southwestern Medical Center at Dallas, suggests there is no clear consensus among plastic surgeons on how to treat smokers.¹

Using information supplied by 955 plastic surgeons, Rohrich concluded that 60% of plastic surgeons "routinely perform a less than optimal procedure on their patients who smoke." The survey measured willingness to perform various operative procedures on patients who smoke and types of smoking cessation aids offered. Of those physicians who require patients to quit smoking before surgery, only 16.7% would perform a nicotine test if they suspected noncompliance.

"Interestingly, 28.6% of the physicians responding admit to a smoking history, whereas only 1.5% continue to smoke, compared with the national smoking rate of almost 25%," Rohrich writes. "Physicians who are previous smokers are less likely to offer smoking cessation aids than those who have never smoked, and the proportion not offering aids increases as the amount of previous smoking increases."

Rohrich concludes that a wide range of opinions exist on which elective surgical procedures should be performed on patients who smoke, but he also says your own smoking history may influence the decision.

Reference

1. Rohrich RJ, Coberly DM, Krueger JK, et al. Planning elective operations on patients who smoke: survey of North American plastic surgeons. *Plast Reconstr Surg* 2002; 109(1):350-355.

complications, the form asks patients to acknowledge that they understand second-hand smoke can lead to the same problems.

Don't have to turn away all smokers

The effects of smoking are clear, but how to handle the patient who smokes is not so clear sometimes. Do you just turn away all patients who smoke and want a face lift?

That's not necessary, says **Anthony Griffin, MD, FACS**, a plastic surgeon in Beverly Hills, CA. Griffin is experienced with operating on patients who smoke, and he says they do not have to be ruled out automatically, even for the most sensitive procedures like face lifts. But they do require a careful, tough love response from the physician, he says.

Griffin generally tries to avoid patients who smoke, but he will operate if they agree to his strict conditions. Patients must agree to stop smoking for a period of approximately one month before and

Consent form explains risks and requirements for smokers

Anthony Griffin, MD, FACS, Beverly Hills, CA, counsels his patients carefully about the risks of smoking and plastic surgery. This excerpt from the consent form used in his office explains the potential for problems:

"Smoking has been shown to clearly increase the risks of poor wound healing and tissue death by damaging the blood vessels within the tissues, decreasing the oxygen carrying capacity of the blood, and filling the tissue with the noxious chemicals. The side effects of smoking last for years after stopping and surgical complications are more frequent even years after cessation.

"You are advised that smoking during the 1-2 week pre-operative periods will seriously imperil the outcome of your surgery. You should agree to refrain from smoking during that time period. **YOU MUST ACCEPT THE INCREASED RISKS ASSOCIATED WITH CURRENTLY SMOKING OR HAVING BEEN A SMOKER.**"

Plastic Surgery Practice Advisor™ is published monthly by National Health Information, LLC, 1123 Zonolite Rd., Suite 17, Atlanta, GA 30306-2016.

Telephone: (800) 597-6300 or (404) 607-9500. E-mail: nhi@nhionline.net Website: www.nhionline.net

POSTMASTER: Send address changes to Plastic Surgery Practice Advisor, P.O. 15429, Atlanta, GA 30333-0429.

Editor: Greg Freeman Associate Publisher: Lynn Yoffee President: David Schwartz

Subscription rates: USA, one year (12 issues): \$367. USA possessions and Canada: \$377. Other international subscriptions: \$387. Back issues: \$30 each.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other forms of professional advice are offered for general guidance only; competent counsel should be sought for specific situations. Copyright © 2005 by National Health Information, LLC. All rights reserved. Any reproduction, distribution, or translation without express written permission is strictly prohibited. Plastic Surgery Practice Advisor™ is a trademark of National Health Information.

one month after surgery, Griffin says. If they will not agree to cessation, Griffin refuses to operate on them.

And if they do agree to stop smoking for the procedure, Griffin verifies that pledge with a urine test to detect nicotine. If the test indicates nicotine usage in the prohibited period, the surgery is canceled.

Significantly impairs healing

Min S. Ahn, MD, a facial plastic surgeon and medical director of the Aesthetic Wellness Center in Worcester, MA, also advises a very cautious approach to patients who smoke. Studies have shown that patients who smoke have 7.5% risk of skin loss after face lifting, compared to only 2.7% for non-smokers, he notes. Nicotine and carbon monoxide also impair oxygenation to the tissues, reducing blood delivery.

Even if patients stop smoking around the time of surgery, smoking causes persistent microvascular disease that does not abate in one month, Ahn says. So the patient who smokes is always a higher risk even if she stops smoking for a month before and after surgery. A period of cessation does mitigate the risk from other smoking effects.

Some surgeons modify their techniques, particularly with facelifts, if the patient smokes. Ahn says he will sometimes try to avoid raising a long skin flap on smokers so as to minimize the disruption of blood flow. The deep plane face lift often produces the best results for patients who smoke, he suggests.

Boris M. Ackerman, MD, a plastic surgeon specializing in facial rejuvenation with endoscopy, laser liposculpture and breast surgery in Newport Beach, CA, also advocates caution with smokers but says he rarely changes his surgical technique for them. Like others, he requires patients to abstain before and after surgery, but he is reluctant to change what he considers the best way to do a particular procedure just because the patient smokes.

"I'd rather not do a procedure on a smoker than change my technique in a way that produces an inferior result," he says.

Ackerman does have one requirement for smokers that is not so common: All patients who smoke are required to go for hyperbaric oxygen treatment twice a day for two or three days after surgery. He also sees those patients daily for the first few days, up to a week.

With some patients who smoke, Ackerman also uses applications of dimethyl sulfoxide (DMSO) to promote healing. He says that with his protocol for patients who smoke, he has never had flap loss with tummy tucks, breast augmentations

or face lifts. (See below for more on his protocol.)

Don't trust patients to tell you the truth

Because the risks of a bad outcome are so great with patients who smoke, Griffin says surgeons must be very strict in enforcing the conditions under which they will operate. Unfortunately, he says, you cannot trust patients to tell you the truth about their smoking habit. Patients probably know already that smoking may disqualify them from the surgery they want, so they are motivated to lie or downplay how much they smoke. And on top of that, smoking is seen by many as socially unacceptable and generally unhealthy and unwise, so people may be reluctant to admit to the habit.

Griffin says surgeons must screen patients carefully by asking about smoking habits, but you also should be skeptical.

"Smoking is like addiction to alcohol or eating or anything else. You can't trust them to be honest

Surgeon offers protocol on plastic surgery patients who smoke

Boris M. Ackerman, MD, a plastic surgeon specializing in facial rejuvenation with endoscopy, laser liposculpture and breast surgery in Newport Beach, CA, offers this protocol for working with patients who smoke:

- **Get a good history.** How many packs per day? For how many years?
- **Find out about cessation experiences.** Have they quit before? How many times? For how long? What have they used to quit?
- **Decide what type of surgery may be appropriate.** Some procedures may be out of the question for patients who can't stop smoking, and some may be okay if the patient can stop around the time of surgery. The particular surgical technique may have to be altered.
- **Insist that the patient stop smoking for three to four weeks before and after surgery.** Discuss strategies for cessation with the patient. Get a feel for how motivated the patient is to stop smoking and how much you can trust him or her to comply with your instructions.
- **Refer the patient to the appropriate help.** Nicotine patches can be helpful if they are discontinued a month before surgery. Selective serotonin re-uptake inhibitors also might be useful.
- **Patients must agree to hyperbaric oxygen treatment for the two or three days after surgery.** Ackerman believes the hyperbaric treatment aids in healing and reduces the negative effects of smoking.

about their habits," he says. "Ultimately as the surgeon you are taking responsibility for that patient, and the outcome will always be on your shoulders. It's like Reagan used to say, "Trust but verify."

That advice applies from the initial screening all the way through to the time of surgery. Griffin says you should put on your detective hat as soon as you meet a new patient.

"When they come in the office, you can smell the smoke on some of them," he says. "But they also have tricks to try to hide it, like spraying their clothes with Febreze to mask the smell. If you're looking for the signs you can usually tell a smoker regardless of how they answer the question."

Patients may try to evade testing

Griffin does not always tell patients that he includes a nicotine screen as part of the preoperative testing because some patients are so savvy and determined to get the procedure that they will try to thwart the test.

"They might even try to submit someone else's urine. It's like a drug test in some ways, very similar in the way people will try to get around it," he says.

The extreme diligence is necessary because the effects of nicotine around the time of surgery can be dramatic, leading to very poor outcomes for which the patient may sue. Griffin says it is sometimes tempting, especially for younger physicians just building their practices, to let their guard down and take the patient's word that they have stopped smoking, or to even go ahead and operate on a patient with nicotine in her system.

"They come in with a lot of money, they're paying you cash, and it's tempting to just believe them at face value," he says. "But you can really get burned by doing that. If they're smoking, you're just asking for trouble."

The higher the risks from smoking, the more skeptical and dogmatic you should be about enforcing your rules, Griffin says. With some procedures, like liposuction or rhinoplasty, smoking may pose such a small risk that you can cut someone some slack with their smoking habits. But with others in which the risk is very high -- face lifts, redo breast with mastopexy, redo augmentation with

Malpractice insurer wary of patients who smoke

One of the foremost malpractice insurers in the country isn't crazy about you operating on patients who smoke. The advice offered by the insurer should make plastic surgeons pause before operating on anyone with a history of smoking.

Mark Gorney, MD, FACS, is a clinical professor emeritus of plastic surgery at Stanford University in California and a founding member of The Doctors Company, an insurer in Napa, CA. He is well known as an expert in plastic surgery malpractice risks and authored a paper on the company's web site that spells out the insurer's concerns about smoking. (See the full article at www.thedoctors.com/risk/specialty/plasticsurgery/J3246.asp.)

Gorney makes these points:

- A recent review of malpractice claims revealed three cases that involved wide-tissue undermining procedures, such as facelift and breast surgery, where the patients were heavy smokers. The patients suffered sloughs or sloppy healing, which in turn caused poor scars that could have been predicted preoperatively.

"These cases reflect a continual flow of totally avoidable claims that are directly linked to smoking," Gorney writes. "If a patient is a heavy smoker [one pack a day or more], surgery should be declined or postponed, or the plastic surgeon should carefully document that the patient was warned of the possible complications of continued smoking."

- Gorney advises that if a patient agrees to a no-smoking period before surgery, the procedure should be postponed for a minimum of two weeks, preferably one month. Patients should sign a document stating that they have not smoked for the specified period and will not smoke for the same length of time postoperatively, he says.

- One of The Doctors Company's cases involved a 35-year-old patient who contacted a plastic surgeon seeking breast reduction surgery. The plastic surgeon performed a bilateral breast reduction without incident but during a follow-up visit noted a full thickness necrotic area on the patient's right breast. The surgeon performed a debridement of the patient's left nipple and conducted a skin graft from the right groin to the right breast, continuing to monitor the patient and providing antibiotics and dressing changes. Almost three months after the surgery, the patient developed drainage and inflammation of the left breast. The surgeon noted that the patient was noncompliant with postoperative instructions to cease smoking during the recovery period.

The patient sued and claimed surgical damage to circulation in her areolar-nipple-complex area.

"This case was defensible because the surgeon properly documented that the patient was a smoker and that appropriate pre- and postoperative instructions had been given for her to refrain from smoking one month prior to surgery and during recovery," Gorney writes. "The patient's complications appeared related to her failure to comply with the instructions."

Editor's Note: Contact Mark Gorney at (800) 421-2368.