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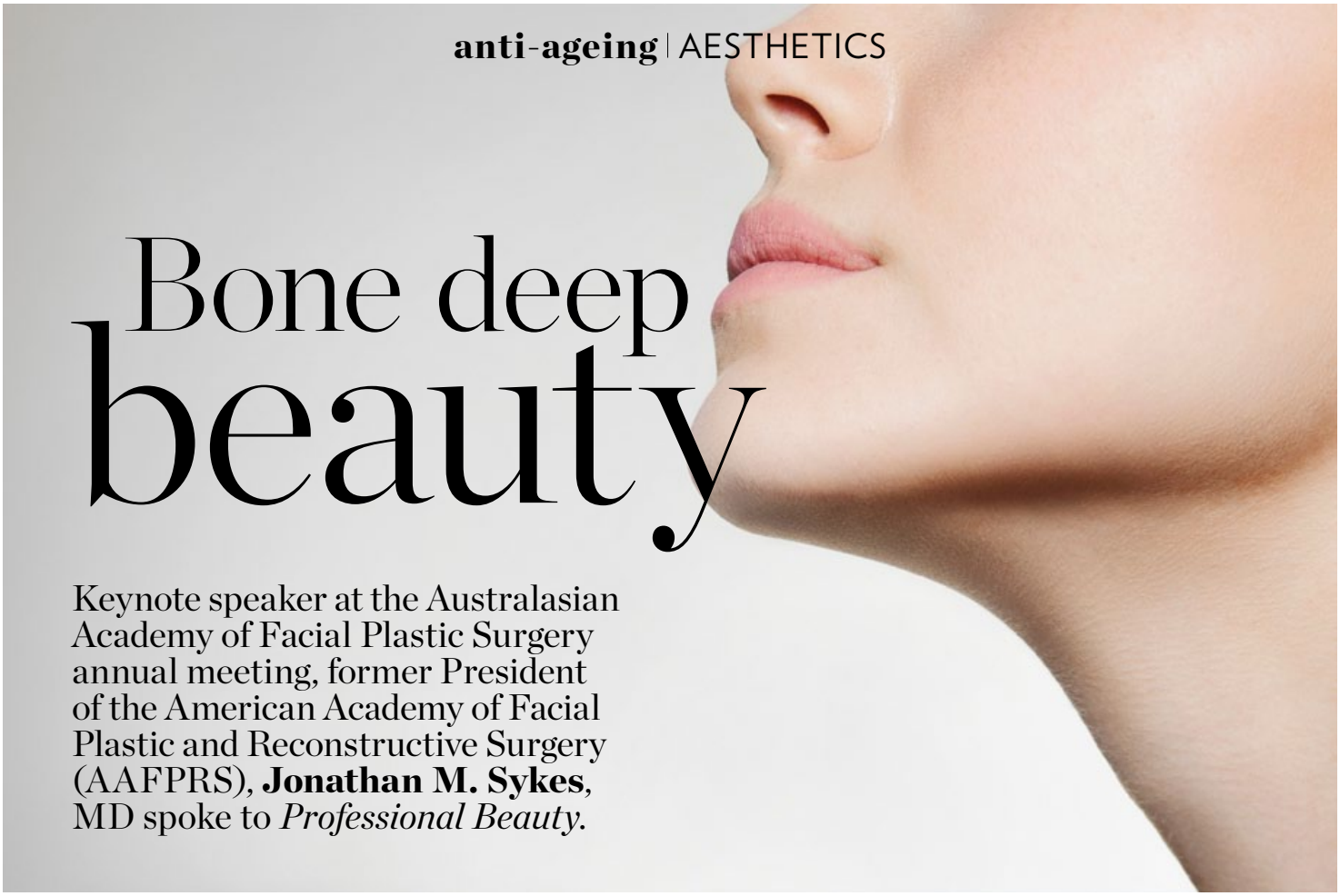

Bone deep beauty

Keynote speaker at the Australasian Academy of Facial Plastic Surgery annual meeting, former President of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), **Jonathan M. Sykes**, MD spoke to *Professional Beauty*.

BACKGROUND: Deciding on a career in facial plastic surgery was a progressive thing, a ferreting-out of what I liked at Medical School. Ultimately I liked doing surgery and seeing the change in appearance in what I did. I liked being able to operate on someone's face and see the change in form in the patient so that there is a direct reward; it's different than giving a patient a medicine. I liked the three-dimensionality, applying anatomy to form and changing the external form and also function. Specifically in my practice, patients are not always aesthetic; I do congenital-cleft lip and palate and cranio-facial surgery on children, moving jaws around – that's the most wonderful surgery; where form and function are both improved and occur together.

AGEING: The composite of our face, what we show to the public, is thought of as how our skin looks, but it's much less about how our skin looks and more where our bones are and that's where beauty is created. Beauty is bone deep, generally, not skin deep. The most beautiful people in the world have the most beautiful bones.

As we age, what changes most is the soft tissue on top of the bone and the total amount of fat in our face. More fat on our face improves our appearance as we age. As patients age, our bones remodel slightly a little and our soft tissue contracts.

PATIENTS: Practitioners have more and more fillers available so for me it has to do with what the patient wants and is able to go through. If a patient is already going to surgery and has more gravity needs, I'll tend to use autologous fat (their own fat) to improve facial volume; if a patient is non-surgical, then I might use off-the-shelf fillers. There are plenty of people who get fillers and at a later date decide to have some minimal surgery and fat transfer, which can eventually lead to larger surgery and more fat transfer.

While there are certain things that can only be fixed by plastic surgery, we have expanded the role of what minimally invasive procedures and off-the-shelf fillers do. One of the good things is we now have more options open to practitioners; the bad thing is the limitation of the eyes and brain of the practitioner. We tend to see things we're able to fix; if we're 'fillers' and all we tend to perform is filling, then surgery is never seen as necessary, and if a practitioner doesn't perform fillers, they tend to see fillers as not permanent. In reality, there is a role for each of them.

Meetings with clients will often concentrate on 'how do I do this?' My feeling is, as a teacher for many years, 'how do I analyse this?' and how do these other things I do fit into what I see. How do I maximise the beauty of this face?

All the things we do have inherent limitations and surgery, on top of this, is invasive. With an implant you are limited by the size of the implant, where you can put the implant, and potential complications of the surgery. The natural tendency is to think that autologous (the patient's 'own') material is good, non-autologous material bad, but as surgeons we have to look at all the parameters for the person; what it costs, the level of invasiveness, the chance for complications, the patient's body structure and how comfortable it is to make a decision on what is best to do. The practitioner has to be honest with themselves and their patient; this is our most difficult thing to do because we don't see it as dishonesty — we see it

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BIAS: Patients tend to come in thinking they know what they want and ought to have so they have an inherent prejudice. Doctors also have inherent prejudices; namely, practitioners are biased to use things that make them money with small effort. Where it becomes problematic is when the patient has an expectation that they’re getting the result they saw on the internet or on television without knowing that the procedure was performed on the ideal candidate.

Patients often think they can be educated online which often means they come in and say, ‘I want this’. When I do the consultation I try to change the patient’s perspective to ‘what am I trying to achieve’ and ‘what is your goal’ rather than what procedure they should have. In an ideal world, you’d have people trained in every procedure and the doctor with no bias of ‘this is easier for me’ or ‘this makes me more money’. In reality, doctors are normal people and they are motivated by various factors of success. The way to combat this is that doctors try to do things as unbiased as possible, try to forget their overheads when evaluating patients, try to analyse the patient not in terms of what they do, but what they see. Then there’s the patient, who needs to go into consultations as unprejudiced as possible.

SOCIAL VIEWS: Stigma is a very personal thing. Some patients are very open, they will go into chat rooms; sometimes that openness is behind a barrier, sometimes they don’t want their identity revealed or they go on television and talk about their experiences. Overall there is now less stigma associated with facial plastic surgery. It’s not that it no longer exists but there is also a cultural element. When I go to South America to do surgery there is less of a stigma for a patient to openly discuss their facial plastic surgery procedure, you go to a café and see somebody with a nose cast on and nobody thinks twice about it — in the US that tends not to happen. It’s cultural and often deeply personal.

EVIDENCE-BASED MEDICINE: In facial plastic surgery, new is always associated with good. However, it’s not about new technology, it’s about the working technology and the evidence. We’re trying to get more evidence based results in plastic surgery but there are some areas where this is extremely difficult. We can take two different technical produces and see if one works better, but no two patients are identical. If I did one side of a patient’s face with one technique and the other side another way that might give us some important data as to which technique is more effective. Unfortunately very few people would sign up for using two different techniques. Societies are trying to introduce more and more evidence-based medicine onto the podium. It’s a growing area in facial plastic surgery, but still there are some inherent flaws in it. The idea behind evidence is to reduce bias for the practitioner; not ‘I think this works’ but quantitative or other analysis that delivers parameters of results.

SUCCESS: How do we measure success in facial plastic surgery? We don’t have a great rating system like television and so we must look at patient satisfaction. In order to have a successful outcome in plastic surgery you need four things: Choose your patient carefully; choose the surgeries/procedures well; technically do the surgeries well; and help your patient heal well. ■

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