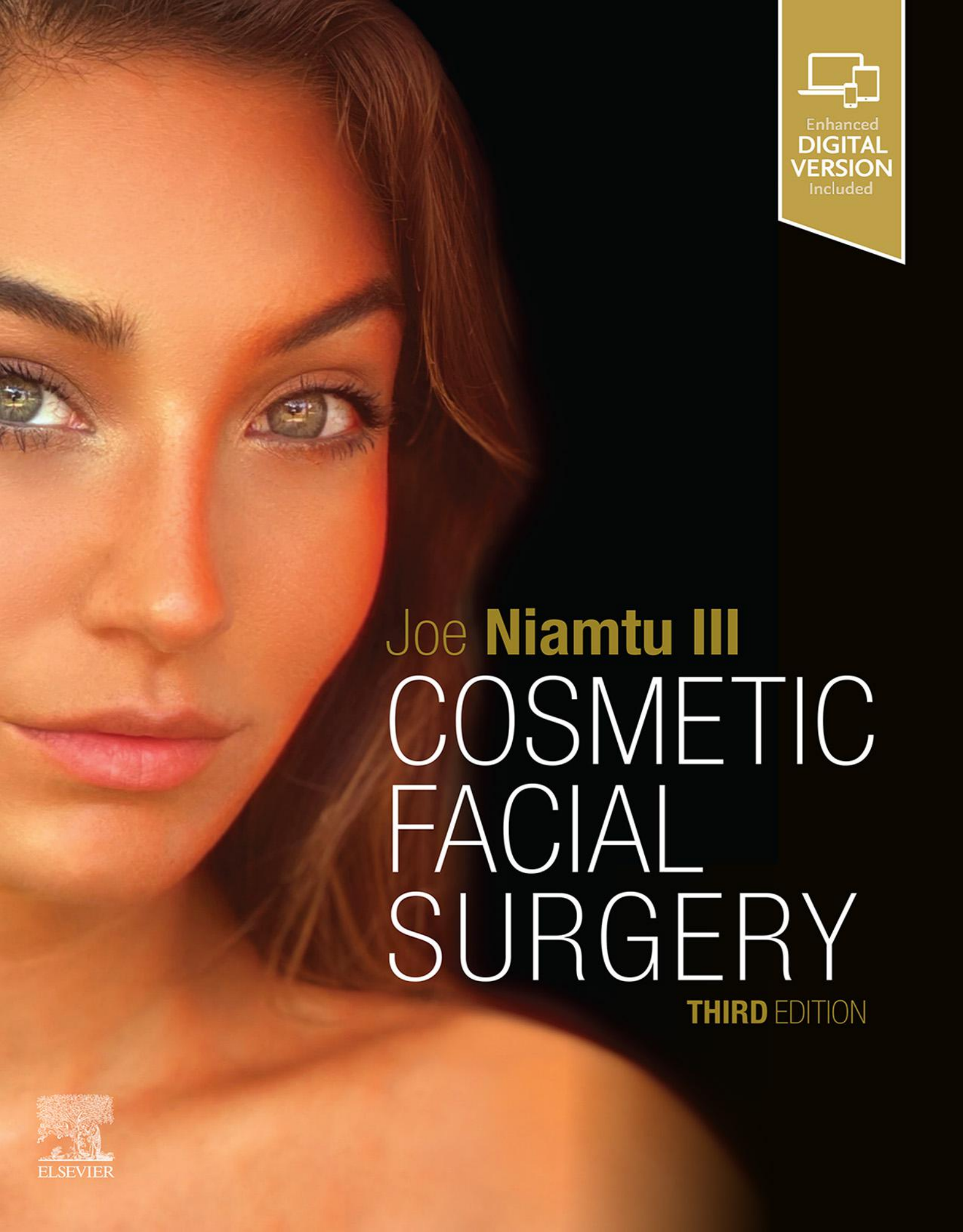
Enhanced
DIGITAL
VERSION
Included
Joe Niamtu III
COSMETIC
FACIAL
SURGERY
THIRD EDITION
ELSEVIER

eBooks for Practicing Clinicians

ELSEVIER

Any screen. Any time. Anywhere.

Activate the eBook version
of this title at no additional charge.

Elsevier eBooks for Practicing Clinicians gives you the power to browse and search content, view enhanced images, highlight and take notes—both online and offline.

Unlock your eBook today.

1. Visit **expertconsult.inkling.com/redeem**
2. Scratch box below to reveal your code
3. Type code into "Enter Code" box
4. Click "Redeem"
5. Log in or Sign up
6. Go to "My Library"

It's that easy!

Place Peel Off Sticker Here

For technical assistance:
email expertconsult.help@elsevier.com
call 1-800-401-9962 (inside the US)
call +1-314-447-8300 (outside the US)

COSMETIC FACIAL SURGERY

This page intentionally left blank

EDITION **3**

COSMETIC FACIAL SURGERY

JOE NIAMTU, III, DMD

MEDICAL DIRECTOR, NIAMTU COSMETIC FACIAL SURGERY
DIPLOMAT, AMERICAN BOARD OF COSMETIC FACIAL SURGERY
DIPLOMAT, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
ASSOCIATE PROFESSOR OF ORAL AND MAXILLOFACIAL SURGERY, VIRGINIA COMMONWEALTH UNIVERSITY
RICHMOND, VIRGINIA
USA

For additional online content, visit ExpertConsult.com

ELSEVIER

Edinburgh London New York Oxford Philadelphia St Louis Sydney Toronto 2023

Elsevier
1600 John F. Kennedy Blvd.
Ste 1800
Philadelphia, PA 19103-2899

COSMETIC FACIAL SURGERY, THIRD EDITION ISBN: 978-0-323-79519-7

Content Strategist: Belinda Kuhn
Content Development Specialist: Andrae Akeh
Publishing Services Manager: Deepthi Unni
Project Manager: Radjan Lourde Selvanadin
Design Direction: Patrick C. Ferguson.
Cover photo courtesy of Tara Colquitt, MSMI

Printed in India
Last digit is the print number: 9 8 7 6 5 4 3 2 1

Contents

VIDEOS

Chapter 1

1. The Patient

Chapter 2

1. Short video on facial aging factors

Chapter 3

1. Platysmaplasty and Single Side Facelift
2. Platysmaplasty Model
3. Short Scar Facelift Part 1
4. Short Scar Facelift Part 2
5. Facelift Markings and Tumescent Anesthesia Infiltration
6. SMAS Plication
7. Deep Plane Incisions and Skin Flap Narrated
8. Deep Plane Dissection and Suspension
9. Zygomaticus Major and Facial Nerve
10. Flap Tailoring and Inset
11. Ultralift

Chapter 4

1. Transfollicular Brow and Forehead lift
2. Endoscopic Brow Lift Release and Stability

Chapter 5

1. Upper and Lower Laser Blepharoplasty with TCA Lower Lid Peel
2. Upper Scalpel Blepharoplasty with Lower Laser Assisted Transconjunctival Blepharoplasty
3. Single Suture Simplified Canthopexy
4. Subciliary Approach to Lower Lid Blepharoplasty

Chapter 6

1. External Approach Chin Implant and Open Rhinoplasty
2. Bulbous Tip – Cephalic Turm-In
3. Bulbous Tip – Overlap Technique
4. Bulbous Tip – Re-Curvature of Nostrils
5. Bulbous Tip – Setting the Tip with Columellar Strut

Chapter 7

1. Chin Implant Submental (Extraoral) approach with Facelift

Chapter 8

1. Case 1 Mustarde and Davis Otoplasty
2. Mini Davis Conchal Bowl Reduction

Chapter 9

1. Neuromodulators: What's in the Pipeline for the USA by Dr. Steve Fagien
2. Botox Injections to Platysmal Bands
3. Botox Injection to Bunny Lines, Lip, Lower Lids, Glabella and Lateral Canthus
4. Botox to Lip Lines
5. Dysport Injection to Masseter Muscles
6. Microbotox by Dr. Sam Lam

Chapter 10

1. Olympic Ring Technique for Cheek Injection
2. Implant Trace Technique for Cheek Injection
3. Dissolving Filler with Hyaluronidase
4. Cannula Eye Lift Introduction
5. Will Cannula Tear Trough Technique be Effective?
6. Tear Trough Filler with Cannula
7. Non-Surgical Rhinoplasty Lecture
8. Filler Injections to Nose, Cheeks and Temples
9. PDO Threads Lifting
10. Thread Lifting for Filler Patients
11. PDO Thread Removal
12. Ultrasound and Facial Fillers

Chapter 11

1. Subnasal Lip Lift

Chapter 13

1. Fractional CO_2 to neck and Traditional CO_2 Laser to Face
2. Candela Core CO_2 Laser for Facial Resurfacing

Chapter 14

1. TCA Chemical Peel
2. Obagi Blue Peel

Chapter 15

1. Nanofat Treatment
2. Fat Transfer to Face

This page intentionally left blank

How to Read This Book

As the author of this book, I have recruited internationally known coauthors to enhance this text. There are many ways to perform similar procedures, and all readers should use discretion and never perform any procedure without the proper training, facility, and follow-up. Also, a general rule is that no doctor should perform a procedure for which he or she would be unable to manage postoperative complications.

Over the past decade, I have been told by doctors from all over the world that my book is "easy to read." That is a huge compliment, and my writing style is designed for just that. Let's face it, textbooks are not the most interesting reads. Having said that, I remember reading cosmetic surgery textbooks with passion and excitement in the early days of my career. My readings were absorbed like a sponge. My goal is to present safe and relevant commentary and techniques in a simplified manner. The chapters in the book are arranged by four main categories:

1. Diagnosis
2. Treatment and Postoperative Care
3. Case Presentations
4. Complications

In writing a textbook on cosmetic surgery, the author is charged with being able to satisfy a broad audience that includes beginners, intermediaries, and experts. With this comes an ethical responsibility to present relevant information that is hopefully evidence based, time tested, and will provide a blueprint for the discussed procedures.

All doctors have two main responsibilities when it comes to performing surgery. The first is patient safety, and this should never ever be compromised. The second is predictable outcomes. To excel and remain competitive in cosmetic surgery, natural results are paramount. I tell my patients that for me to look good, they have to look good. I also tell them, "It is your face, but my reputation." No surgeon should ever perform a procedure for which he or she is not properly trained or unable to manage their potential complications. Never do a procedure that you would not do on a family member, and walk before you run. Begin smaller, easier cases, and progress commensurate your skill level. Putting one's enthusiasm before their skill set can lead to patient injury and lawsuits.

It is important to remember that the descriptions in this book represent a typical way to perform a procedure. This may be how I do it or how another author does it, but by no means is it the final word on how any given procedure is performed. If you asked 100 surgeons to write a chapter on the same topic, you would probably have 100 different chapters. My goal is recall on my 35 years of facial surgery and experience—the good, the bad, and the ugly—and to distill this down to diagnosis and procedures that are safe and predictable. Faithful readers of my books will notice that some of my techniques have changed from one edition to another. Like many of my motivated colleagues, I am always trying to refine my craft, again, based on patient safety and predictable outcomes. Prudent surgeons find what works best in their hands regardless of surgical fads or trends. Changes in techniques should be conservative, well thought out, and never "experimental." My advice is to pay more attention to what works for you and worry less about what others do. Remember, the bottom line is always happy patients with natural results.

This page intentionally left blank

Foreword

In 2008, I had the honor of being asked to write a textbook on cosmetic facial surgery for Elsevier, the largest and premier medical textbook publisher in the world. This was a huge honor, but a task of awesome proportion. Cosmetic facial surgery is my passion, and before the first book I had written some small "clinics" books, a respectable amount of peer-reviewed journal articles, and a ton of topical cosmetic articles for various specialty magazines, newsletters, and websites. I was not sure even where or how to begin, but I knew I had a deadline, so one day on a plane on the way to a cosmetic surgery meeting I penciled down a table of contents. This was the start of what would become the first edition of my textbook, *Cosmetic Facial Surgery*. I had to write this entire book with the exception of a single chapter from scratch, literally typing every word, sometimes working for up to 11 hours a day for months. I also had to take several thousand pictures and make numerous videos to accompany the book. With sore hands from typing and the sacrifice of many personal and family hours, it was completed and published in 2010. The book proved to be very successful with international multispecialty readership and was also translated to Spanish.

The shelf life of a textbook is approximately 5 years. It takes at least 1 year to write the book. When the book is released, if it is successful, you have to start thinking about the next edition after 2 to 3 years. The biggest challenge in writing a new edition of a textbook is that it must be significantly different from previous editions. All of us have fallen prey to buying what appeared to be a new edition only to get it home and see pretty much the same book that we already had on our shelves. I promised the publisher that my content for the third edition would be significantly different from the second edition, which was published in 2017.

When the second edition was released (along with the electronic edition), it proved to be even more successful than the first edition, which made me very proud. Although many cosmetic surgery textbooks are written every year, getting a third edition published is unusual. There were some extremely popular cosmetic and plastic surgery textbooks by world-renowned authors that never made it to a second edition, let alone a third.

I literally got goosebumps when Belinda Kuhn, my Elsevier project manager, contacted me and asked me to author the first two editions and again a smaller text dedicated to facelift surgery. *The Art and Science of Facelift Surgery: A video Atlas* was published in 2019.

As stated, being asked to write a third edition of any textbook in this day and age of digital study and reading is a distinct honor. I was excited but had immediate flashbacks of the many hours ahead of writing, photographing, making videos, and striving for new and relevant materials.

So, it is with great pleasure and honor that I present the third edition of *Cosmetic Facial Surgery*. I want to sincerely thank the thousands of people all over the world who have purchased my textbook, and it is my honor to assist in your journey of cosmetic facial surgery.

Enjoy the book. Always be a teacher, and always be a student.

Sincerely,
JOE NIAMTU, III, DMD
Cosmetic Facial Surgery
Richmond, Virginia

This page intentionally left blank

List of Contributors

The editor(s) would like to acknowledge and offer grateful thanks for the input of all contributors who enhanced this third edition.

List of Contributors

The editor(s) would like to acknowledge and offer grateful thanks for the input of all previous editions' contributors, without whom this new edition would not have been possible.

Abraham Pathak, MD
Aesthetic Plastic Surgeon in Private Practice, New York, NY, USA.
Attending in the Department of Plastic Surgery at Lenox Hill Hospital and Manhattan Eye, Ear, and Throat Hospital
Assistant Attending in Plastic Surgery at NYU Langone Health
USA

Darrick E. Antell, MD, DMD, FACS
Assistant Clinical Professor of Plastic Surgery
Icahn School of Medicine at Mt. Sinai
New York, New York
USA

Pamela J. Schell Werschler, PsyD, MSN, ARNP, DNC
Werschler Aesthetics
3rd and Sherman Medical Plaza
Spokane, Washington
USA

Jonathan M. Sykes, MD
Professor Emeritus
Facial Plastic Surgery
UC Davis Medical Center
Past President
American Academy of Facial Plastic and Reconstructive Surgery
Beverly Hills, California
USA

Gaurav Bharti, MD, FACS
Owner Partner HKB Cosmetic Surgery
Owner Partner K&B Management
Charlotte, North Carolina
USA

L. Mike Nayak, MD
Private Practice
Nayak Plastic Surgery
St. Louis, Missouri
USA

Zachary Willis, MD
Willis Cosmetic Surgery
Saint Louis, Missouri
USA

Angelo Cuzalina, MD, DDS
Tulsa Surgical Arts
Tulsa, Oklahoma
USA

Nicole A. Langelier, MD, MBE
Oculofacial Plastic Surgery
Virginia Eye Institute
Richmond, Virginia
USA

Richard Gentile, MD
Gentile Plastic and Aesthetic Laser Center
Youngstown, Ohio
USA

Julie Ann Woodward, MD
Professor of Ophthalmology
Chief, Oculoplastics Ophthalmology
Professor in Dermatology
Duke University School of Medicine
Durham, North Carolina
USA

John B. Holds, MD, FACS
Clinical Professor of Ophthalmology and Otolaryngology/Head and Neck Surgery, Saint Louis
University School of Medicine
St. Louis, Missouri
USA
Ophthalmic Plastic and Cosmetic Surgery, Inc.
Des Peres, Missouri
USA

Albert Carlotti, MD
Private Practice
Scottsdale, Arizona
USA

Barry Eppley, MD
Eppley Plastic Surgery
Carmel, Indiana
USA

Brian B. Farrell, DDS, MD, FACS
Private Practice/Director of Fellowship Program
Carolinas Center for Oral and Facial Surgery
Charlotte, North Carolina
USA
Assistant Clinical Professor
Department of Oral and Maxillofacial Surgery
Louisiana State University Health Science Center
New Orleans, Louisiana
USA

Peter Dennis, DMD, MD
Fellow
Carolinas Center for Oral and Facial Surgery
Charlotte, North Carolina
USA

Steven Fagien, MD, FACS
Cosmetic Oculoplastic Surgery
Private Practice
Boca Raton, Florida
USA

Samuel M. Lam, MD, FACS, FISHRS
Drector, Lam Facial Plastics
Plano, Texas
USA

Sheila Barbarino, MD, FAAO, FAACS, FACS
Barbarino Surgical Arts
USA

Brett Kotlus, MD, MS, FACS
Cosmetic Oculoplastic Surgery
Private Practice

New York, New York
USA

Alexander Z. Rivkin, MD
Assistant Clinical Professor
David Geffen, UCLA School of Medicine
Owner
RIVKIN Aesthetics
Los Angeles, California
USA

Suneel Chilukuri, MD
Founder, Refresh Dermatology
Associate Clinical Professor, Baylor College of Medicine
Houston, Texas
USA

Radhika Trivedi, MD, MPH
Refresh Dermatology
Houston, Texas
USA

Kian Karimi, MD
Facial Plastic Surgeon
Rejuva Medical Aesthetics
Los Angeles, California
USA

Steven F. Weiner, MD
Aesthetic Clinique
Santa Rosa Beach, Florida
USA

Lisa Espinoza, MD
Owner, La Chele Medical Aesthetics
Newhope, Newtown
Upper Dublin Pennsylvania
USA

Ryan Diepenbrock, DMD
President, American Board of Facial Cosmetic Surgery at American Board of Facial Cosmetic Surgery Inc.
Owner of Diepenbrock Facial Cosmetic Surgery
Fort Wayne, Indiana
USA

Nabil Fakih, MD, MSc, FFPS
Chief of Department of Facial Plastic and Cranio-Maxillo-Facial Surgery
Fakih Hospital, Khaizaran Main Street
Saksakiyeh
Lebanon

Mohammad Banki, MD, DMD, FACS
Assistant Clinical Professor of Surgery
Warren Alpert Medical School of Brown University
Artistic Contours
Warwick, Rhode Island
USA

Elie M. Ferneini, MD, DMD, MHS, MBA, FACS
Partner, Greater Waterbury OMS
Medical Director, Beau Visage Med Spa
Cheshire, Connecticut
USA
Associate Clinical Professor
Department of Surgery
Frank H Netter MD School of Medicine, Quinnipiac University
North Haven, Connecticut
USA
Associate Clinical Professor
Division of Oral and Maxillofacial Surgery
University of Connecticut School of Dental Medicine
Farmington, Connecticut
USA

Suzan Obagi, MD
Associate Professor of Dermatology
Associate Professor of Plastic Surgery
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania
USA

Rania Agha, MD, FAAD
Assistant Clinical Professor
Department of Dermatology
The University of Illinois at Chicago and Jesse Brown VA Medical Center
President and Medical Director, Summit Dermatology and Aesthetic Surgery
Chicago, Illinois
USA

Abdul Nassimizadeh, MBCHB, BMedSci, MRCS (ENT)
University Hospital Birmingham
United Kingdom

Alexandra Reivitis
Physicians Assistant Student
Northeastern University
Boston, Massachusetts
USA

Morris Hartstein, MD
Director Ophthalmic Plastic Surgery
Assaf Harofeh Medical Center
Tel Aviv University, Sackler School of Medicine
Zerifin
Israel

Jean Carruthers, MD
Clinical Professor, Department of Ophthalmology
Fellow, American Society of Ophthalmic Plastic and Reconstructive Surgery
University of British Columbia
Vancouver, British Columbia, Canada
Diplomat Board of American Board of Cosmetic Surgery
Past President, Canadian Society for Dermatologic Surgery

Alastair Carruthers, MD
Clinical Professor, Department of Dermatology and Skin Science
University of British Columbia
Vancouver, British Columbia
Canada
Past President, American Society for Dermatologic Surgery
Past President, Canadian Dermatology Association
Past President, Canadian Society for Dermatologic Surgery

Ting Song Lim, MD
Medical Director, Clique Clinic
Kuala Lumpur

Soheila Rostami, MD, FAACS
Associate Professor at George Washington University Hospital
Assistant Professor at Howard University Hospital
Rostami Oculofacial Plastic Consultants
Reston, Virginia
USA

Shino Bay Aguilera, MD
Cosmetic Dermatologist
Fort Lauderdale, Florida
USA

Postscript

After signing contracts and aligning chapter authors, I got down to work in January 2020. I distinctly remember typing away on the first chapter with the network news playing in the background when they mentioned a new virus had originated, and the first case appeared in the United States. It did not seem too urgent, as we have seen swine flu, SARS, and other fast-spreading worldwide viruses.

Bang….It hit the world like an asteroid and changed everything in a matter of weeks. Soon, hand sanitizer, toilet paper, and surgical masks were impossible to find. My thriving practice, along with all other elective surgical practices throughout the country, were shuttered for 5 weeks. This gave me time to concentrate on writing, but the time passed quickly. I was amazed at how fast and hard my practice bounced back. I believe there were many reasons. First, people had time on their hands because they were laid off or working from home and not traveling. Second, many people were wearing masks and could hide some surgical procedures. Third, people were not going on vacations, trips, or class reunions and had elective money to spend on themselves. Finally, the "Zoom Effect" was a real thing. People were looking at themselves on the continual Zoom and related virtual interactions and saw themselves from an often-unflattering angle and position. This, I believe, in many cases was the proverbial straw that broke the camel's back. "I am not working. I am not going anywhere. I am not spending money on anything else. I am looking old. I will do something for me."

This experience has been testament to the resilience of cosmetic surgery and how important patients feelings about the way they look and feel are. In a time of abject doom and gloom, looking better and upping one's self-esteem was a sensible investment.

JOE NIAMTU, III, DMD

This page intentionally left blank

Dedication

During the writing of this text I lost my younger brother James Niamtu and my father Joseph Niamtu, Jr. My brother was taken way to soon and was a consummate teacher. My father survived the great depression and World War II and lived to the age of 97. He (and my late mother), inspired me to work hard, never quit, take care of those who cannot take care of themselves, be humble and have fun.

This page intentionally left blank

Chapter 1

Diagnosis of the Cosmetic Facial Surgery Patient

The Art of the Consult and the Office Patient Experience

Joe Niamtu, Pam Werschler, and Jon Sykes

Cosmetic surgery is a very unique specialty as it is totally elective. No one needs cosmetic facial surgery! Very few surgeons begin their journey as "strictly cosmetic surgeons." Having a total cosmetic surgery practice is actually pretty rare as many "cosmetic surgeons" perform other procedures based on their background training. For instance, plastic surgeons may also deal with burns, trauma, and reconstruction; facial plastic surgeons may also treat skin cancer and perform ear, nose, and throat procedures; oral and maxillofacial surgeons may also deal with TMJ disorder and wisdom teeth; dermatologists may also treat acne and perform general dermatology; and ophthalmologists may also treat cataracts and perform corneal surgery. Some practitioners love this mix, and others only perform the noncosmetic procedures because they have to. If a surgeon is interested in transitioning to a totally cosmetic surgery practice, he or she will eventually drop the ancillary procedures and progress to total cosmetics. I, personally, have limited my practice to cosmetic facial surgery since 2004, and there are certainly pluses and minuses to this. First of all, I love cosmetic facial surgery. It is my passion, and I love going to work, so this specialization has been awesome for me. A relative drawback is that elective cosmetic surgery demand can fluctuate with the economy. Having said that, my business did not change during the 2008 recession or the COVID-19 pandemic (with the exception of a brief statewide shutdown). I explain to residents interested in a cosmetic surgery practice that the highs are high, and the lows are low. This chapter will elucidate this statement numerous times. Other surgeons will list negatives as having to deal with the sometimes fickle, unpredictable, body dysmorphic, demanding, litigious, and elective patients with unrealistic expectations. Like any job, there are positives and negatives, but most successful cosmetic surgeons I know love what they do, and the positives greatly outweigh the negatives.

The cosmetic surgery patient is truly different from many patients we experience in residency or in specialty practice. The biggest difference is that they are elective patients seeking an upper-class luxury. When treating a patient for trauma or malignancy, they are frequently grateful for your skills as they are emergent. Cosmetic surgery patients, on the other hand, are totally elective and pay a great deal of money for services they do not actually "need." Fortunately, the vast majority of these patients have a positive outcome and are happy with their treatment. Many cosmetic surgery patients may also have significant biopsychosocial implications that complicate normal interaction. Some of these patients have unrealistic expectations, some are body dysmorphic, and others desire surgery for the wrong reasons. In this case, they may be unhappy with a perfectly acceptable surgical result. This is when things can become problematic. One of the best ways to become a great cosmetic surgeon is to choose the right patients and avoid the wrong ones. This is a skill that usually takes decades to master and will be addressed later in this chapter.

There is no more important aspect of the cosmetic surgery experience than the initial patient consult. As they say, "you never get a second chance to make a first impression." First impressions in this day and age may be through websites and social media, which may or may not convey the true pulse of the practice. The next "first impression" occurs when the patient phones the office to make an appointment. Unfortunately, this is where a lot of patients are lost. Having personable, friendly, energetic staff answering the phone can be one of your best referral sources. I have had many patients tell me they actually saw three other surgeons, but the professionalism and attitude of my staff persuaded them to come to my office. Many barriers between the initial phone call and the operating room can be eliminated by an astute front desk person. A compassionate receptionist can alleviate many patient apprehensions and bring the patient into the office. In my office, we refer to the "front desk" employees as *patient service representatives*.

An exceptional patient service representative knows how to "answer the phone with a smile" and make patients feel comfortable. The first question they ask is the caller's name, and they use it frequently throughout the conversation as everyone likes to hear their own name. A great front desk person can convert a question into a consult. If a patient calls to inquire "how much

do you charge for Botox?" a poor employee with tell them "$11" and the conversation is over. An exceptional employee will ask the patient their name. The patient answers, "Anne." The representative says, "Thanks for calling Anne, have you ever had Botox before? Did you know Dr. Niamtu is in the top 3% of Botox providers in the country and teaches Botox techniques to other surgeons? He also uses special techniques to make the procedure painless. Can we make you an evaluation appointment?" This great patient service representative has now converted a patient with a question into a patient with an appointment. Great patient service representatives are priceless, and poor ones can run your business into the ground.

Our patient service representatives are familiar with every procedure we perform and can discuss them accurately with prospective patients. We have all patient service representatives spend time in the operating room observing procedures, and we also cross-train all of our surgical assistants to answer the phones and make appointments. This cross-training allows all employees to appreciate the work of their peers and also means that they fill in if needed.

Fig. 1.1 The very tastefully done reception room at Tulsa Surgical Arts. (*Photo courtesy Angelo Cuzalina, MD.*)

The Physical Plant

If you perform cosmetic surgery, you must have an office that is similar to your competitors. It is not uncommon for cosmetic surgery patients to seek multiple consultations. Patients are likely to see your competitors, and if the competitor's office grossly outshines yours, you are already at a disadvantage. Having said this, a poor surgeon with a great office will not succeed, but cleanliness and presentation can go a long way. Always remember that these are elective patients seeking upper-class luxury surgery. They shop at high-end stores, stay at high-end hotels, and go on high-end vacations. They are used to being pampered and being in pleasant surroundings. The cosmetic surgery office must be set up with this in mind. Having said this, many of my patients are middle class or blue collar, but they are spending outside of their means and expect the same environment as do wealthier patients. Figures 1.1–1.5 show well-done cosmetic surgery spaces.

Fig. 1.2 A treatment room at Tulsa Surgical Arts. (*Photo courtesy Angelo Cuzalina, MD.*)

The cosmetic surgery office should be clean, pleasant, and in most practices decorated to accommodate female patients, as the majority of cosmetic patients are women. Consider your experience at a very high-class hotel, and try to duplicate it in your business. Concierge care is a new buzzword, but most successful practices have known these secrets for decades. The entire goal is to get the patient's attention. They should come and go with positive impressions. They must realize that you are special and "do it differently." Having a patient greeter, providing drinks and snacks, assisting patients with paperwork, and having educational materials available underline your commitment to patient service. Conveniences such as available computers or iPads and wireless connection and charging stations are all amenities appreciated if not expected by potential cosmetic patients.

Fig. 1.3 The contemporary front desk at Spokane Dermatology. (*Photo courtesy Phil Werschler, MD, and Pam Werschler, PSY.D, MSN, ARNP, DNC.*)

If you are looking for a model of what to do, consider Las Vegas casinos. They totally have it right. They know how to treat their high rollers to keep them coming back. Cosmetic surgery patients

are also high rollers, and successful practices know how to make them feel special. Everything is clean and bright, and they have beautiful furnishings, great smells, a comfortable temperature, and extremely friendly staff. Everyone likes to feel special. It is like a vacation or holiday. If you figure out how to make your patients feel special, you will be way ahead of the pack.

The surgeon and/or staff should regularly sit in the reception room and observe all of the senses. Does everything look good, smell good, and sound good? Are the magazines current? Is the space spotless? Every several years, our administrator has a "secret shopper" who comes to the office to evaluate the entire experience. This can be very eye-opening as we sometimes fail to see the negative things around us. Fish cannot see water because they are in it! Many practice management specialists say that there should be no magazines in the office and only promotional material about services offered. Personally, I think patients need some diversion. Every single patient has seen my website and marketing before arriving. Sometimes it is nice just to chill and not feel you are getting "sold" at every angle. First-time cosmetic patients are usually nervous, so I want them to feel as relaxed as possible. They can use our computers, watch TV, read a variety of magazines, or have drinks and snacks, which about 99% do. The COVID-19 pandemic has shattered traditional patient service, but it will return with vigor.

One of the goals of a well-run office is to not make people wait for long periods. In my office, we have five evaluation and treatment rooms and a relatively small reception room. My goal is to move the patient from the reception room to an evaluation room as soon as possible. No one likes to wait, but the wait seems shorter if you break up the experience and keep the patient busy. Once they get to the evaluation room, they have the company of a staff member and also can watch TV or review our website while waiting for the surgeon. One of the biggest simple innovations of the past decade has been the development of affordable, high-quality widescreen TVs. We have 15 in our office and use them for many purposes including recreation, patient education, anesthesia monitoring, and teaching. If a doctor is running behind, it is a great courtesy to call patients and let them know. Most are relieved as they too usually run late.

Fig. 1.4 Patients love bright and open spaces such as the Avani Spa at Nayak Plastic Surgery. (*Photo courtesy Mike Nayak, MD.*)

Office Accreditation

In the 1970s, an uncomplicated facelift required a 4.5-day hospital stay. There have been huge paradigm shifts in hospital stays for all surgical procedures, and currently most cosmetic surgeries are not performed in the hospital environment. There are numerous reasons for this including exorbitant hospital costs, risk for nosocomial infections, lack of insurance coverage for cosmetic surgery, a need to reschedule surgeries because of emergencies or other surgeons running behind, and lack of privacy for elective cosmetic procedures.

Having a fully accredited surgery center in one's office offsets the need to operate in a hospital and all of the negatives associated with it. It gives the surgeon total control of the operating environment. There are no other surgeons to run late or bump your case. Surgery is much more cost-effective compared with hospitals. Safety is usually enhanced because the same people do the same job all day every day, which eliminates shift changes and

Fig. 1.5 Patients expect contemporary spalike spaces. (*Photo courtesy Joe Niamtu, III, DMD.*)

related problems. There is no worry about infections from other patients. Because cosmetic procedures are usually very personal and discrete, patients can come and go without exposure to scores of employees who work in a hospital environment. Also, small offices usually have one or two anesthesia providers who work on a continual basis, and this prevents surprises that can occur with random anesthesia providers. Finally, convenience for the doctor, staff, and patient is unparalleled. I spent a lot of time driving back and forth from the hospital before I had an office surgery center, and now my operating room is just several steps away.

Office accreditation is not a panacea and has relative drawbacks. First and foremost, the surgeon is the captain of the ship, and every good and bad thing falls on his or her shoulders. If an emergency occurs in the hospital environment, there are dozens of trained personnel immediately available. In your office, it is you and your staff. For this reason, the surgeon must use discretion as to which cases are not suitable for the office surgery center. I never take a chance, and I cancel cases 5–6 times per year because the patient has a medical condition that may put them at risk. As I have stated many times, a big part of having a good reputation and being safe is choosing the right patients. Never take a chance with a patient's health. We do not operate on American Society of Anesthesiology (ASA) class III patients. Significant comorbidities can ruin lives.

One of the best things I have ever done in my professional career was having my office and surgery center accredited. I have hundreds of colleagues who will echo the same remarks. Many surgeons are hesitant to pursue this because of the perceived extra work and expense. Also, many surgeons mistakenly believe they must physically rebuild their facility. In reality, bona fide accreditation is attainable for the average practitioner and facility if the surgeon and staff are willing to rise to the requirements. The biggest misconception is that accreditation is a bricks-and-mortar undertaking, when in reality it is actually more about policies and governance (Fig. 1.6).

The basis of accreditation is to ensure a safe, efficient, and accountable facility to better serve patients, surgeons, and staff by meeting or exceeding nationally recognized standards. In effect, you are making your office function as a small hospital. This definitely ups the ante for work and paperwork and is not something to be taken as casual. In short, it is a lot of work, mostly paperwork, but it unequivocally will make you a better and safer surgeon with a better and safer staff, facility, and patient experience.

The most common organizations for outpatient office ambulatory surgery center accreditation are the Accreditation Association for Ambulatory Health Care (www.AAAHC.org), the Joint Commission on Accreditation of Healthcare Organizations (www.jointcommission.org), and the American Association for Accreditation of Ambulatory Surgery Facilities (www.AAAASF.org).

Examples of changes to routine office protocols include required dictation of all surgical operative reports, quality review studies for sterilization, rehearsal of a malignant hyperthermia scenario, infection prevention and reporting, studies for patient waiting times, peer chart review, impaired physician and operating room fire rehearsals, and credentialing all users of the operating facility. Again, this is all very paperwork intense. Trying to become accredited on your own can be a task of awesome proportions. I highly recommend that any practice that is interested in becoming accredited seek the services of professional accreditation consultants. It is not excessively expensive, and they coach the office and staff through every step of the way, including a mock accreditation site visit. Although I know doctors who have become accredited without a consultant, I can speak from experience that the consultant route is much easier on the doctor and staff. Finally, one drawback to accreditation is the fallacy that the surgeon must do all the work. In actuality, the staff does 90% of the work and recordkeeping, and the surgeon is the team leader. Having one nurse or exceptional employee to handle all of the accreditation work makes this task very straightforward. Because accreditation comes in 3-year cycles with office inspections, having a stable employee who will be there for a long time is preferable.

Fig. 1.6 The author showing some of the numerous manuals of policies, procedures, documentation, and governance for accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC).

Cosmetic Surgery Staffing

I have always said that a surgeon can be no better than the sum of his or her staff. In elective surgery, there is no doubt that a great staff will enhance the experience, and a poor or apathetic staff will drive patients away. Choosing the correct staff is never happenstance and takes years for the average doctor to figure out. Cosmetic surgery is very different than many specialties as it is an upper-class luxury of mostly female patients and totally elective. Your staff must understand and relate to the biopsychosocial needs of this clientele. Some of my best cosmetic staff were not trained in surgery but rather worked at high-end women's stores. They know how to talk to and sell to upper-class women. Some of my best front desk representatives previously worked at hotels or travel agencies. Again, they are used to catering to people who have elective money to spend and value exceptional service.

When it comes to building a great staff, the word *team* says it all (Fig. 1.7). We have a cosmetic team in my office, and we all represent exceptional patient service with optimal safety and predictable and reproducible outcomes. No team becomes good by happenstance. Any winning team in any sport takes hours and

Fig. 1.7 The author and his cosmetic team. These people make going to work and doing my job a pleasure. They make me look forward to Monday.

Fig. 1.8 Consistent branding is important in conveying the team concept.

hours of practice and working together. A cosmetic team is no different. Each "player" must have a distinct job description and also understand the job of other team members. This can achieve synergy. This is when the total is greater than the sum of the parts. Success is greatly simplified when you build a great team with everyone on the same page. This entire text could deal with staffing, but needless to say, we want team players who are "win-win" people. They represent health and beauty and should look the part. They should radiate happiness, warmth, and compassion and should be able to make conversation with anyone at any time. In interviews, I look for bubbly conversationalists with a great smile. Their demeanor is much more important than their job experience. I want to hire a "people" person. The job of my staff is to make me look good, and they do an excellent job.

Germane to the team concept is consistent use of logos, trademarks, photos, etc. for all office and marketing materials. This includes scrub logos (see Fig. 1.7), printed materials (Fig. 1.8), and promotional items (Fig. 1.9).

Fig. 1.9 Consistent branding also should extend to promotional items used in the practice.

The Art of the Consult

Cosmetic surgery is my passion, and like many of my colleagues, I love to operate. If we could all go to our offices and simply operate, life would be perfect, but to have surgery you must have consultations, postoperative visits, and follow-up visits. As enjoyable as time in the operating room can be, the profession becomes complex after the surgery.

The cosmetic consultation is usually the first face-to-face meeting with the cosmetic team and the surgeon. It is an extremely important appointment, and making the best impression is paramount because many patients will see multiple providers. Because most consultations begin on the phone, the front desk patient service representative can be a great adjunct. They can set the stage for great patient service, explain what will happen at the consult and obtain information in advance from the patient.

Patients must be impressed from the time they enter the parking lot, and the doctor and team must make sure that everything is in order. Are you easy to find? Is the traffic negotiable? Is it easy to park? Are the grounds and building clean and classy? All of these small elements serve to add to a final analysis and choice on the part of the patient.

When patients walk in our door, they are greeted personally, and our staff signs them in, serves them snacks and/or drinks (almost everyone wants some), and makes small talk. If we are running behind, patients are informed and kept up to date. It is not appropriate to make a new consult patient wait; it sends a very bad signal, so it is important to schedule new patients during predictable times when the office does not run over. If you are running behind, you can give the patient something to do. Getting them from the reception room to a consult room breaks up the wait.

The patient should be escorted from the lobby to the consult room by the person who will be assisting the doctor at the consult. Furthermore, the same person should accompany the patient

throughout the entire surgical experience. This one-on-one bonding is extremely powerful at building relationships. The prospective patient should see smiles and positive energy from every employee. Once in the consult room, the patient needs something to do if there will be a wait. Having informational literature or, better yet, having the patient spend time on your website obtaining information about perspective procedures that will be discussed is a great occupier. Many surgeons have videos discussing procedures, and this is a great time to use them.

In my current practice, the assistant takes the patient to the consult room to begin the process. In the last edition of this text, I recommended using a specific cosmetic surgery coordinator to perform all cosmetic consultations. Although there are some positives with this type of consultation model, it is difficult for a single person to be available for all consultations. As a result of this bottleneck in my practice, we reverted to having all of our nurses and surgical assistants perform consultations. There are numerous advantages to this. First and foremost, five or six people are able to perform consultations, so you eliminate the bottleneck of a single cosmetic coordinator. In addition, the surgical assistants are actually present at the cosmetic surgery and are well versed in each procedure. Some of my assistants are better suited to consult with older patients, while others are more aligned with millennials. It is up to the leader of each practice to decide who is capable of performing quality consultations, but it is a huge convenience in efficiency and cross-training for all of your staff to be proficient in performing consultations.

We do have a dedicated employee who performs all scheduling for surgeries. This staff member wears dress clothes and meets patients in a formal business office after the clinical consultation. The scheduler is much more than a "scheduler" as she has a lot to do with proceeding the patient to the booking phase for surgery. She has the ability to further bond with the patient and to follow up with undecided patients. This staff member also hands out formal branded material pertaining to formalized fee estimates and the surgical experience.

In terms of the consultation suite, this room should be the fanciest one in your office and should have a comfortable temperature and pleasant smell. Aromatherapy is a powerful stimulation of the senses. The first order at hand is for the assistant to bond with the patient by making small talk and relaxing the patient (Fig. 1.10).

As a sidebar, when patients are serious about having a large procedure or are considering multiple procedures, it is frequently helpful to have their spouse at the consult. So often, the spouse (usually the husband) may have considerable concerns about the need for surgery, the finances, and other questions. In addition, the spouse will most likely be the caregiver, and it is important to know what will happen.

For many patients, meeting a new doctor makes them very nervous. With cosmetic patients, they not only must meet a stranger, but must show them and tell them about their biggest physical insecurities. Many patients have problems with aging and do not handle it well. This apprehension can add up to a patient who is perspiring by the time the doctor examines them. The best thing the staff can do before the surgeon enters the room is to relax the patient. It is also very important for the staff to compliment the surgeon. They can make the doctor look good in advance so the doctor does not sound arrogant. People want to know that they are seeing a compassionate, experienced, and popular surgeon, and your staff can really help with this. Although patients are here to discuss cosmetic surgery, having your staff discuss pro bono or community work impresses them and lets them know you are compassionate.

The assistant will also ask the patient what they wish to discuss and can make cursory suggestions such as, "I believe Dr. Niamtu will want to discuss eyelid surgery, cheek implants, and a facelift with you." She will then open our website on the widescreen TV and walk the patient through the specific procedure pages to discuss what we do and how we do it. She will also show the patient before and after photos of relative cases. This interaction is important as it gives the patient an idea of what the doctor will discuss, provides information on the procedures, and can shorten the surgeon's consultation time. Having awards, publications, and similar accolades in plain view can be very impressive to patients (Fig. 1.11).

Fig. 1.10 A bubbly conversationalist is a great attribute for the staff performing the consult. The ability to interact, relax, relate, and bond with the prospective patient is extremely important.

Fig. 1.11 Patients love to see good things about their doctors, and, in turn, they frequently brag about them to their inner circle. Showcasing academic publications, awards, accreditations, and community service is great free marketing.

Meeting the Surgeon

When the staff consultation is completed, the surgeon enters the room and introduces himself or herself. I always shake hands with the patient (pre–COVID-19) and introduce myself by my first name. I believe friendly communicative contact puts patients at ease and subliminally enhances the doctor–patient relationship. Showcasing a friendly, smiling, and energetic persona and engaging in small talk with the patient before getting to the cosmetic problems is time well spent. As stated, patients are frequently nervous. To relax them, I may ask about what they do for a living, their hobbies, how they heard about our office, how they are enjoying their summer, and so on. Again, putting a patient at ease is an art form. If the patient states that they love playing tennis (or whatever topic), we note that in the patient record, and next time we can ask, "How is the tennis game?" Patients are always impressed that we remembered. The world is full of arrogant, stuffy physicians. A smiling, energetic, down-to-earth surgeon is an attention getter.

Most of our patients register online and are asked to list their cosmetic facial concerns in advance and bring a list with them. Nervous patients often forget to ask key questions.

The most important instrument used in the consult is a hand mirror. I ask patients to tell me what bothers them when they look in the mirror at home and what they would like to change. I ask them to show me in the hand mirror. At this point, I always begin with a compliment like "you have a great jawline" or whatever positive feature you can start the conversation with. Because you are going to be discussing negatives, it is best to begin with a positive. Occasionally a patient will say, "Doctor, what do you think I need?" The novice surgeon should never fall into this trap. It is imperative that the patient take ownership of what bothers them or what they would like to change. Patients who cannot communicate their cosmetic problems may have other underlying problems. Some patients are embarrassed to discuss the topic and need some prodding. The other problem with answering the question "What do you think I need" is that the surgeon may suggest a problem that the patient does not see and offend the patient.

Some practice management experts say that you should not hand a woman a mirror as it is offensive to make her look at her flaws. I do not agree with this. Every single patient looks in the mirror at home, and most of them pull their facial skin back. The mirror (and now the cell phone) is where the rubber meets the road. An alternative to using a mirror is to take several photos of the patient just before the consult and project the images on the widescreen monitor. This can have significant impact on showing patients their aging changes. Also giving the patient a copy of the photos to take home can go a long way in having them realize their aging problems, especially in the lateral view, which no patient likes to see. A simpler means of avoiding the mirror is to use a tablet to take front, three-quarter, and side views and share them with the patient.

Although I marketed one of the original digital imaging systems in the 1990s, I am not a fan of surgical predictions. First, they are time-consuming. Having the doctor or staff play around with digital surgery can waste precious patient time. At one time, digital imaging would help promote a doctor or sell a case, but today I feel that it is blasé. Secondly, it is simply a digital cartoon. You can make any patient look good, but not necessarily produce that result. The accuracy is often suspect and can also give the patient a false hope of what to expect. Having said this, some of my colleagues love surgical predictions and feel that it truly enhances their consults.

The best way to discuss cosmetic deficiencies is to make the consult an educational experience. I explain to patients that I will discuss their entire head and neck in terms of diagnosis and potential treatments. This does not mean that I feel they need all of the discussed procedures, but they are possible options.

The most orderly means of systematically discussing facial aging and potential treatment is to explain to the patient that the face is divided into thirds and that we will discuss the upper, middle, and lower third, and then discuss the skin as a separate unit. During this discussion, the surgeon should never assume, for example, that the patient understands the difference between brow aging and eyelid aging. The best thing is to stay elementary when explaining diagnosis and treatment. Many patients have never heard of cheek implants or understand what a browlift or facelift does. If the patient is put off by discussion of multiple procedures and I sense the conversation going that way, I consider this patient more conservative and stay closer to their main concerns as opposed to additional options. As I talk with the patient, I include my assistant in the discussion. I may say, "Mrs. Smith, I think you are a great candidate for laser skin resurfacing; don't you agree, Jenny?" (Fig. 1.12). This adds a second opinion to the discussion, puts the patient at ease, and reinforces my diagnosis. This also implies a team approach. My assistant continually records the consultation discussion and prepares a form that lists the discussed procedures and their respective fees to give to the patient when they leave.

Fig. 1.12 The surgeon and staff should work together in consultation to help reinforce that you are a team and that you value the knowledge and experience of your staff. In most cases, it is the staff that will be bonding with the patient. Using the same staff member throughout the entire experience helps give the patient consistency.

I prefer to do my cosmetic facial consults in a plush, contemporary dental chair that can also double as a treatment platform for injectables or minor procedures. In almost every consult, I recline the chair and have the patient elevate their chin and look in the hand mirror (Figs. 1.13 and 1.14). This takes gravity out of the equation and provides a surprisingly accurate estimation for a facelift, browlift, or cheek implants. I have done this for years, and it goes a long way to help the patient understand and preview a potential result. At this point in my career, I feel that telling patients that their appearance when reclined is an accurate prediction of a facelift and neck lift.

A very important concept is not to assume that any patient really has an appreciation as to what any procedure is or does. We do surgery all day, every day, but they may do it once in their lifetime. It is our job to clearly define the correct diagnosis and explain in an elemental way what procedures are available and what each one will and will not do. The more "props" you have on hand, the easier it is to convey how procedures are performed. In this digital age, the standard for consultations includes animations, videos, and photos. The best place in the world for me to get all of this is from my own website. Our standard protocol is to have the assistant open our website on a widescreen TV in the consult room (Fig. 1.15). Then, the staff member will review the procedures that interest the patient. While on the web page, they can view and discuss procedural examples, animations, surgical videos, and thousands of before-and-after images. The consult should definitely be an educational experience, and I think this is a great way to do it.

Fig. 1.13 A contemporary dental chair is comfortable for consults and useful for showing patients approximate results for various procedures such as facelifts, browlifts, and cheek implants. The right patient images are shown upright and supine, illustrating a prediction.

Fig. 1.14 I have the patient look in a hand mirror while we discuss what bothers them and elucidate other aging changes. This is an educational experience for most patients. Reclining the patient provides a predictive perspective for facelift, browlift, or cheek implants.

Fig. 1.15 Using my website on a widescreen TV has been the most efficient way for me and my staff to truly educate the patient during consultation.

I feel the best way to perform a consultation is to tell the patient, "Today we are going do a full examination and discuss what aging changes you have and what nonsurgical and surgical options are available." I further explain that "cosmetic surgery is totally elective and just because I point out some aging or discuss a procedure, it does not mean that you need or want that procedure." I further explain that the list of procedures is a "menu, and they can "order" only the procedures that interest them.

It is very important for the staff and surgeon not to appear "pushy" in terms of having surgery. No patient likes a high-pressure sales pitch. There are many aggressive offices out there that push too hard, and it is very apparent to the patient. I make a point to tell the patient that I do not care what procedures they do or do not do. I love doing surgery, and if the procedure is good for the patient, it is good for me. I may make suggestions, but if I see that a patient is very conservative or resistant to multiple procedures, I immediately refrain from discussing a comprehensive treatment plan. Of utmost importance is to address the patient's primary concern first. If a patient presents and says, "I hate my neck," then you would not begin the conversation about their eyelids. Stay focused on what is important to the patient, and other areas can be addressed after their major concern is thoroughly discussed. As stated, patients are frequently nervous, and the office has a lot of information to present, so it is easy to confuse the patient or skip over important details. The best way to avoid this is to do the same thing in the same order at every consult.

I frequently use myself as an example saying, "When I look in the mirror, I see a big bald head, so I would love to have hair." That usually brings out a giggle, and then they relax and tell me what bothers them. I must say, as I have gotten older and now have some early jowling and neck skin, I can use myself as a model to discuss aging, which helps the conversation because I "feel their pain." Light, self-deprecating humor can be an ice breaker. Once I address the main problem, I tell the patient we are going to do an educational aging analysis in a specific order, addressing four distinct areas. The areas to be discussed are the upper face, middle face, lower face, and skin. I then repeat the list to make sure the patient understands the order.

While the patient looks in the mirror or at a picture, I point out aging problems in the following areas:

- Brow and forehead complex
- Upper eyelids
- Lower eyelids
- Cheeks and nose
- Lower face and neck
- Skin

After I discuss each area, I present nonsurgical and surgical options, and my staff records the procedures and the appropriate fee. Once we discuss all problem areas, I tell the patient that we will build a personalized "cosmetic menu" that is unique for every patient, and that some patients order everything on the menu and others may order only one item. I reinforce that they should only consider procedures that are important to them and not let our list influence their decisions. By this time, we have also discussed their health history, recovery window, and budget. My average patient is a candidate for 3 *L*s and a *C*. This translates to lift, lids, laser, and cheeks. These are the most commonly combined cosmetic procedures in my practice.

At this point, I tell the patient that "I have done all the talking," and I ask for their input and sit back and listen. Once again, I review their "menu" and then tell them that my staff will discuss further details (e.g., finances, scheduling) when I leave. Before leaving the room, I personally hand each patient my business card with my personal cell phone number and email. Most patients are quite surprised by this as many doctors hide from their patients. I tell my patients if they cannot call their surgeon, then they chose the wrong surgeon. This availability has a large impact on a patient choosing a surgeon. I shake the patient's hand, thank them for coming, ask how they heard about our office, and once again ask if there are any further questions. The average time for the consult is 45–60 minutes, and the actual face time with me is about 20 minutes.

Some key points for the surgeon and patient at consultation include health, psychological stability, recovery, and budget.

Health

The patient must be in adequate health for the planned procedure. Although most patients are candidates for some type of rhytidectomy procedure, it is not uncommon that they have systemic problems such as hypertension, cardiovascular disease, diabetes, hyperlipidemia, arthritis, osteoporosis, and other comorbidities. Patients are living longer and taking more medications, so their medical status may be complex. Most of these patients are candidates for cosmetic surgery if their diseases are controlled and/or medically managed. Patients taking anticoagulants or medications that affect platelet function present special problems and may require intense medical management. The more problems a patient has, the riskier the surgery and anesthesia will be. There comes a point at which the risk associated with surgery outweighs the benefits of looking younger. In and of itself, age is not a contraindication to facelift surgery. I have treated 85-year-old patients who were healthier than some of my 50-year-old patients. However, older patients may have decreased function or not

tolerate extended surgeries and recoveries as well as younger patients, and the treatment plan must be tempered. We must always keep in mind that we are providing elective surgery. No patient has ever died because they did not have a facelift, but some have died because they did. It is not uncommon for older and sometimes sick patients to have nonelective surgical procedures such as joint replacement or cataract surgery. This instills a mindset that any senior patient can have surgery, even with multiple comorbidities. Because of this, many patients assume that they can have facelift surgery, regardless of physical condition. In an elective practice, most cosmetic facial surgery is performed in an accredited ambulatory office surgery center. An office death or severe complication can be a devastating setback that can taint the reputation of an elective surgeon, not to mention the loss for the family and related malpractice actions. I have always said, "The best surgeons are always a little bit scared." This means that many of their surgical decisions are somewhat based on "what can go wrong." This can be a good limiter and ensures a double-check to stay safe with surgery and anesthesia. It is not uncommon for sick patients to want to have surgery. It is also not uncommon for them to become angry if they are turned down because of health risks. As difficult as it is to turn down a surgical patient, smart surgeons know how and when to say no.

All of my facelift patients are required to have a history and physical examination from their primary care physician and any indicated laboratory tests or consults. Patients with hypertension or cardiac history receive an electrocardiogram. Cardiac consultation and echocardiogram or stress testing is performed when indicated.

For all patients, it is imperative to have a written document from their physician stating that the patient is stable and cleared to undergo elective anesthesia and surgery. In the event of anesthesia or surgery problems, this omission is one of the first things a plaintiff's attorney would seek.

Smoking, alcohol, and drug abuse are lifestyle factors that could influence surgery and anesthesia. Smoking is a particularly common factor encountered. Some surgeons refuse to operate on smokers. I practice in Richmond, Virginia, where tobacco forged the state economy for centuries. Altria (formerly Phillip Morris) is headquartered here, and the state has the second lowest tax rate in the country for cigarettes. Smoking is common.

About 10 years ago I did an informal survey of my facelift cohort. Of approximately 800 patients, 8.5% were admitted cigarette smokers, and this is not an absolute to facelift surgery in my practice. Of further note, the Centers for Disease Control and Prevention states that 18.1% of adults in the United States smoke cigarettes, and 14.5% of them are female. I have performed several hundred facelift surgeries on smokers. In my experience, there is no significant difference between smokers and nonsmokers in the incidence of major complications such as flap breakdown. Over the years, I have had several cases of significant skin breakdown in patients who smoked, but I also have seen this in nonsmokers. All smokers underreport their usage, and the most common answer when queried is "I smoke a pack a day." I have numerous colleagues who refuse to operate on smokers. They actually perform salivary nicotine tests on the day of surgery and cancel surgery if the patient tests positive. I do not do this, but I may be more surgically conservative with a smoker. When a surgeon demands that a patient quit smoking, many will agree and simply lie about quitting. In addition, having a normal recovery after elective cosmetic surgery is often difficult. Trying to have a normal recovery in the midst of nicotine withdrawal can be extremely challenging for the patient, surgeon, and staff. Obviously, extremely heavy smokers (two to four packs per day) are prone to increased anesthetic morbidity, decreased healing, and increased complications, so all surgeons must decide when to operate and when not to operate.

Psychological Stability

Psychological imbalance or body dysmorphic disorder (BDD) may not be a huge problem in a patient seeking lip filler or neurotoxin treatment, but with a facelift, it can provide extreme challenges and malpractice actions. All novice surgeons should be familiar with the warning signs of potentially problematic patients.

Recovery

Patients must be able to take time away from work or play commensurate with the procedure(s) being performed. Everyone is busy, and with more women in the workplace, it is difficult to balance cosmetic surgery and work. One of the biggest mistakes a surgeon can make is to downplay a recovery. If you tell a patient they will recover in 1 week and it takes 2 weeks, they can become furious. If you tell a patient it takes 3 weeks and they recover in 2 weeks, you can be a hero. Many aspects of surgery, such as incisions, sutures, anesthesia, bandages, and so forth, can be objectively and accurately described. Recovery, on the other hand, is very subjective. On several occasions, I have performed the same procedure on identical twins, and one twin had a great recovery while the other had unusual swelling and bruising. It is impossible to guarantee precise recovery, and the surgeon must rely on the mean recovery time for a procedure or procedures. I tell facelift and laser patients that the average patient can return to work or social situations in 2 weeks. I explain that on the bell curve, some patients may look great at 9 days, and others may still be bruised at 3 weeks. The surgeon should always err on the high side; if the patient is given a range of 6–14 days, 6 days is the only number they will remember. All of this must be covered in the consent and presurgical material issued to the patient. I give patients the option of a Thursday surgery, which gives them a weekend, a full workweek, and another weekend to recover. This is sufficient for selected surgeries, but I tell them that no surgeon can guarantee a specific recovery. If they are having a facelift before a big event, such as a child's wedding, a reunion, or an important vacation, I suggest 4–6 weeks for recovery. I also explain that the recovery process in actuality takes about 90 days, and they will see positive changes throughout this period.

Budget

Patients must have adequate finances for the procedure(s). Cosmetic surgery is expensive, and I tell my patients that it is a good long-term investment. Some patients desire cosmetic surgery, but in reality they cannot afford it. In normal circumstances,

there is significant stress for the patient when having cosmetic surgery. Add the stress of a poor financial situation, and this may put some patients over the edge. In addition, patients who cannot afford a procedure tend to skimp on details that are important, such as not purchasing expensive antivirals or antibiotics, or using private duty nurses. If the financial stress causes family problems, the experience can turn into a negative one. Some patients should simply postpone surgery until they can afford it; otherwise they may ask the surgeon to compromise throughout the surgical experience. Offering alternate financing options to patients is helpful but occasionally enables them to do something that is impractical at this point in their life. Although senior surgeons with excellent reputations often command extreme fees for facelifts, most parts of the country have similar fees for a facelift. Some surgeons will discount secondary procedures such as facial implants or laser skin resurfacing when performed simultaneously with a facelift.

Although I did not charge for consults for years, as we became busier, I instituted a $75 consultation fee that is applicable to any product or service. I initially worried about this as many other surgeons in my area do not have a consultation fee. Most professional practice managers will tell you that your time is worth money, and you should charge for that, but when you are beginning a practice most people will take all comers. Most surgeons fear that the consultation fee may limit patients coming to the practice. Although I am sure that I lose an occasional patient because of the fee, I can say from experience that this has not limited patients because I am more productive. This is because having a consultation fee has eliminated many "tire kickers" (patients who are curious but not serious about having cosmetic surgery). It has greatly improved our schedule to concentrate on more serious patients. Since the last edition of this text, I have raised the consultation fee to $125 for in-town patients and $225 for out-of-town patients, and my practice continues to get busier. The consultation fee is applicable to injectables, skin care, and scheduled surgeries. Some of my colleagues do not allow the consultation fee to be redeemed for services. My personal recommendation to those starting a practice is not to charge a consultation fee because you need all the exposure you can get.

When I leave the consultation room, the assistant sits down again and continues the conversation with the patient. My assistant provides handwritten fee estimates to our cosmetic scheduler, who, in turn, provides a formalized printout for the patient. The patient is passed from the assistant to the scheduler and meets with the scheduler in her business office, away from the clinical space. The scheduler discusses finances and provides literature about payment plans (if asked) and gives the patient a professionally made presurgical packet that contains comprehensive information about our office, our doctor, and the presurgical experience (Figs. 1.16 and 1.17). This will also include forms for medical clearance, caregivers, and lodging (if pertinent). Like many other mature practices, my practice involves many out-of-town patients who will require an increased level of communication as they will be coming from another city and staying for a specified time after their surgery. These patients not only need more planning but more TLC as many are going through this experience without family present.

Fig. 1.16 After the clinical consultation with the doctor and surgical staff, the patient meets with our cosmetic scheduler. This is a more formal and business-oriented part of the consultation.

We encourage patients to carefully study our website in relation to their anticipated procedures as it is a great educational tool. Serious patients are given information about required preoperative history and physical and laboratory tests so they can begin planning their surgery.

Before patients leave the consult room, we also ask about their skin care regimens, and many will show interest and purchase products at the appointment (Fig. 1.18). I do not have a spa or aesthetician in my office, but for surgeons who do, this is an excellent time to promote these services and tour these spaces.

Finally, when a new patient leaves the office, we want them to remember us. We give all new surgical consults a gift bag with small logo gifts, office brochures, and product information (Fig. 1.19).

Before the patient leaves the office, the assistant gives them a tour of our surgical facility if time permits and we do not have patients in the surgery center. We discuss all the attributes of having a fully accredited surgery center and explain that all of our facilities, equipment, procedures, and emergency equipment are the same as those at local hospitals (Fig. 1.20).

On the same day as the consult, we send a personal note card thanking the patient for coming to the office and invite them to contact us with further questions or assistance. If we do not hear from the patient in 6 to 8 weeks, a "tickle" letter is sent to remind them that we are at their service for questions or concerns, and the staff member who participated in the evaluation calls the patient to see if there are any questions she may answer.

Patient Screening

Choosing the correct patient can have everything to do with the success or failure of a case. A patient with a positive attitude and realistic goals and expectations can make the cosmetic facial experience a joy. Patients who do not understand the procedure, are uncooperative, or have unrealistic goals and expectations can present significant clinical and legal problems. A frequently quoted sentence is that "1% of your patients will cause 99% of your problems," and it is so true. One of the keys to happiness and balance in a

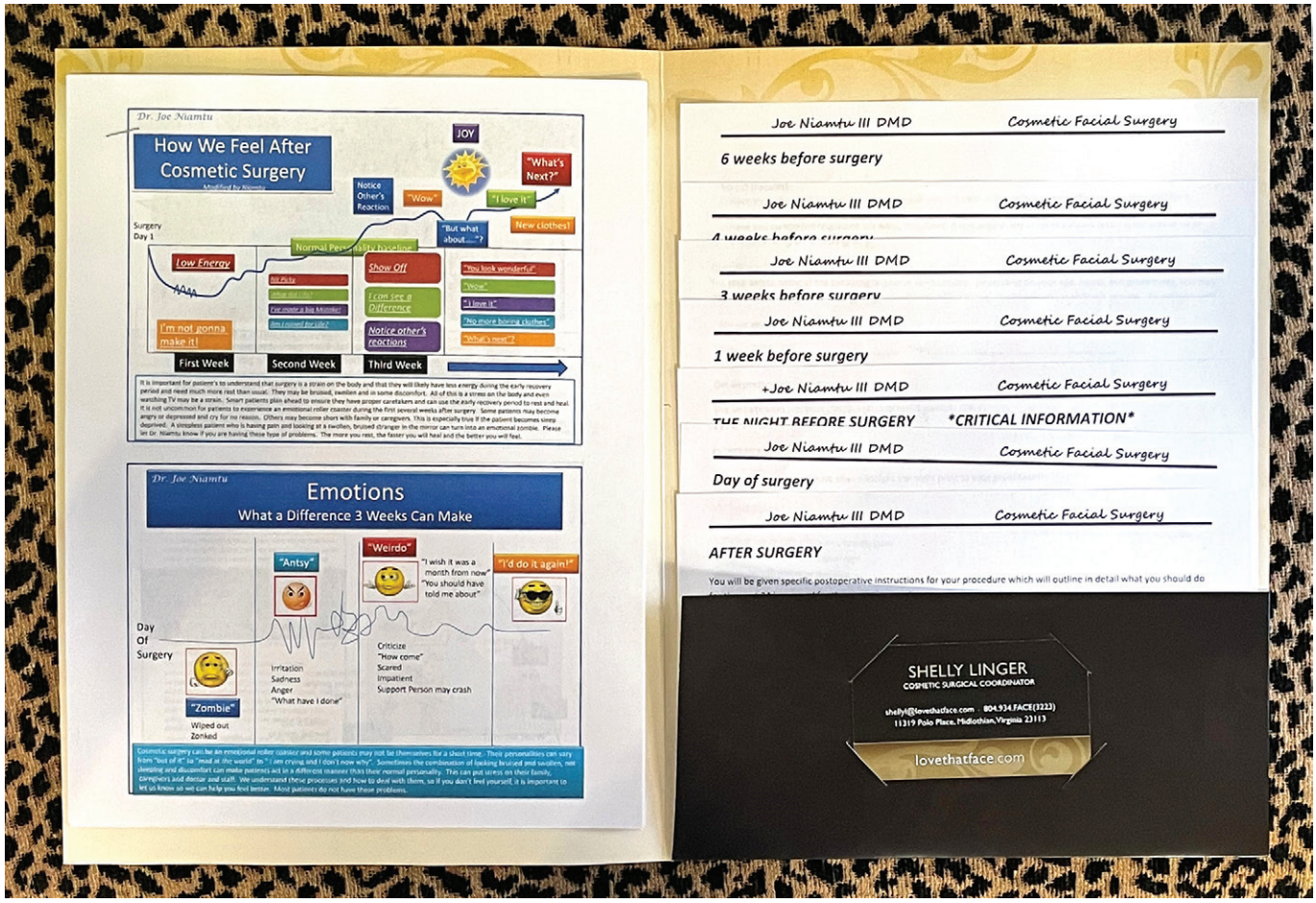

Fig. 1.17 A portion of the presurgical packet the patient receives at the end of the consultation appointment.

Fig. 1.18 Many patients want to jump start their treatment and have an immediate interest in skin care. Skin care products are displayed in several sites in the author's office.

Fig. 1.19 Giving new patients a gift bag with branded items and information is a nice way to make them remember you.

surgeon's professional life is the ability to "avoid the problematic patient." Unfortunately, there is no quantifiable way to do this, and sometimes we are fooled. The surgeon and staff must continually be on the lookout for patients who exhibit "red flags" for potential problems. The best reason for a patient to have cosmetic surgery is to look as good as they can for their age. When I hear this, I know I have a potentially great patient. Patients who are attempting to look like someone else, get a job promotion, follow a social media trend, or save a failing relationship may be poor surgical choices. Problematic patients include those shown in Box 1.1.

Fig. 1.20 One of the author's operating suites and postanesthetic suites. Patients feel very confident when they see a modern, safe, well-equipped facility. Giving them a personal tour shows our commitment to excellence.

Box 1.1 Potential Red Flags that can signal potential problematic patients

Surgeons should proceed with caution with a patient who exhibits the following warning signs:

- Demands guaranteed results
- Must be seen and have surgery immediately or as soon as possible
- Is not liked by the surgeon or staff
- Exhibits body dysmorphic disorder or psychiatric conditions
- Wants to look like a celebrity
- Wants to "look young" or "take 20 years off"
- Is overly narcissistic or immature
- Is unfriendly or impersonal
- Does not make eye contact
- Does not listen and does all of the talking
- Does not "get it" and asks the same questions over and over
- Is too busy or important for surgery
- Does not want photos taken or demands unusual anonymity
- Is not telling the spouse or family about the surgery or true extent of the procedures
- Berates pervious surgeons and compliments you
- Cannot decide on a surgical plan
- Is overly impulsive; wants to book surgery immediately
- Has unrealistic expectations
- Knows more about the procedure than the surgeon
- Requests specific operative techniques
- Is obsessed with online cosmetic surgery patient sites and social media
- Has many selfies on mobile devices
- Is addicted to cosmetic surgery
- Overreacts to small flaws or minor aging
- Complains about or wants to negotiate fees
- Wants surgery for the wrong reasons, such as a job promotion or pending divorce
- Has a resistant spouse
- Has consulted with "all of the leading specialists"
- Cannot stop physical activity or exercising
- Refuses caregivers
- Sends too many email questions
- Cannot afford the surgery
- Has transportation problems
- Will not come to the office for consults
- Is nice to the doctor but rude to the staff

The Internet and social media are wonderful things, and they have changed my practice from a local to an international cosmetic facial surgery center. Although I am honored to accept out-of-town patients, social media can also bring some uniquely problematic ones. I frequently meet with younger patients who request cosmetic procedures generally performed on much older individuals. Many of these patients are heavily involved with Internet cosmetic surgery such as cosmetic surgery bulletin boards and social media sites. Also potentially problematic are younger patients who have already had numerous cosmetic procedures despite their age. Some of these patients are clearly addicted to cosmetic surgery, and many have components of BDD. They are seeking rejuvenation for the wrong reasons, and once you operate on them, you "own" their result. If they are unhappy, which they have a strong potential to be, they will frequently retaliate with actions that can put your reputation, brand, and practice at risk. Younger Internet male patients can be a specific problem, especially those who forward photos of male models they want to emulate. Much has been written about SIMON, which is an acronym for *single immature male overly narcissistic*. These initials can really be a setup for poor experiences. These younger patients are very Internet savvy, and if they are not happy with an outcome, they can assassinate your practice on physician rating sites.

One of the hardest things, especially for novice practitioners who are not busy, is to say no to a patient who is sitting in front of you, wants surgery, and can pay for it. All the surgeon has to say is, "I do not think I can achieve your goals and make you happy." Following this advice can save novice surgeons from very stressful and unhappy experiences. Much is written about having questionable patients see a psychiatrist before accepting their case. Personally, I never do this. First, if I am worried enough about a patient's psychological status to have them evaluated, I already know that they are not a good fit for my practice. Second, this can be very offensive to a patient and is just not in my interest. Good cosmetic surgeons know how to say no and do it frequently. It is important to remember that having good and predictable outcomes and a great reputation has a lot to do with operating on the right patients.

Preoperative Appointment

When patients schedule a surgical appointment, they are required to pay a nonrefundable deposit. This screens out insincere patients and discourages broken surgical appointments. The preoperative appointment is scheduled at least 2 weeks before the surgery date. At this appointment, we conduct the informed consent process and ensure that the proper laboratory tests, history, physical examination, and anesthesia information are in order. This appointment also gives the patient additional time to ask questions and the surgeon a final time to examine and document the patient. A lot of time can be saved and repetition can be minimized by having patients review postoperative instructions and sign consents online before this appointment. The informed consent process can be a very unnerving experience for the patient. Reviewing four to five lengthy consent documents that discuss significant complications can cause apprehension. I explain to every patient that it is perfectly normal to be worried about the things mentioned in the consent. I also tell them that I feel that statistically they put themselves in more peril driving to my office than having surgery at my office. I never try to minimize or downplay consents but do emphasize that severe complications are extremely rare and that if problems occur after their surgery, we will stand by them throughout the process (Fig. 1.21). Obviously, a staff member must participate as a witness in the process. Although we sometimes take presurgical photographs at this appointment, this is usually delayed until the day of surgery, when the patient will not be wearing makeup.

At this preoperative appointment, the remainder of the surgical and anesthetic fee is due. Many surgeons bill for the anesthesia and pass this on to the anesthesiologist. Although there is nothing wrong with this, it appears on the surgical bottom line and makes your surgical fees appear higher. By having the anesthesiologist bill separately for their services, the actual surgical fee has less impact.

We prefer to have the patient's caregiver present at this appointment. The first 20–30 minutes of the preoperative appointment are spent with the surgical coordinator or surgical nurse. They review all of the consents, surgical details, and postoperative instructions. Again, caregivers must really understand their upcoming role. At this point, I enter the room and review all of the information and questions or concerns. I also perform and document a formal physical examination. I cannot stress the importance of accurate documentation at this appointment. Any problems, asymmetries, abnormal anatomy, or other issues must be documented at this time and the patient informed. "Before" photos can be taken at this appointment, although most female patients will present with makeup. Although many surgeons have a dedicated photography room, I feel it is too much of a bottleneck, and I prefer having the ability to take accurate standardized clinical photographs in any room in our office. This is achieved by using a black photographic cloth on a frame mounted to the door, which slides up or down to accommodate patient height (Fig. 1.22).

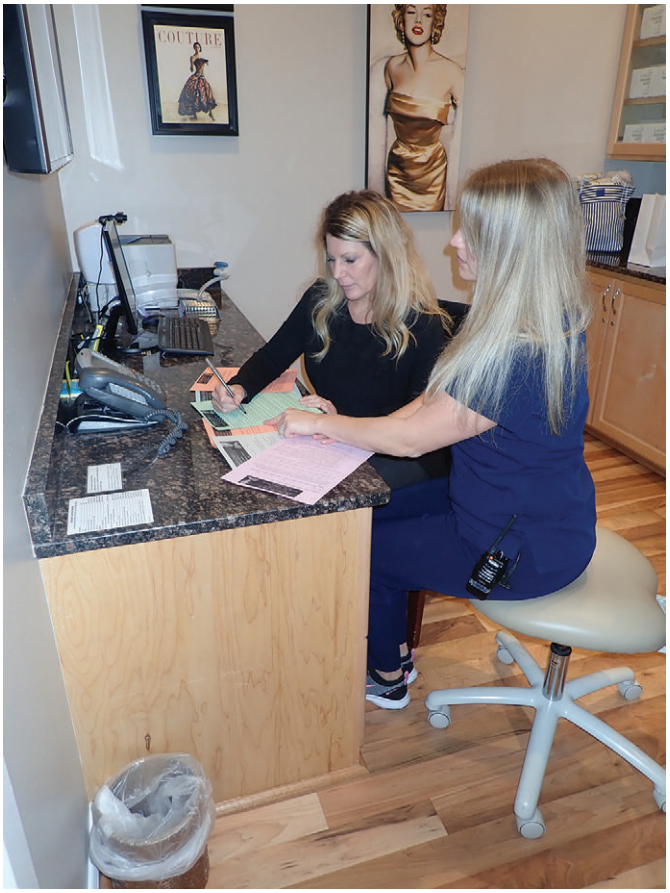

Fig. 1.21 It is important for the doctor and staff to review the informed consent with the patient and answer all questions well in advance of the surgery.

Patients are given their prescriptions, preoperative instructions, surgical instructions, and postoperative instructions at this appointment. Out-of-town patients or those without caregivers are offered the option of private-duty assistants or nurses and transportation if needed.

The Day of Surgery

When the patient arrives at the office, NPO status is verified and vital signs are taken. The surgeon greets the patient, takes preoperative photos (I actually take my own photos), and performs the

Fig. 1.22 Having a photographic background on the back of each door enables professional and controlled photos in any room and negates the need for and congestion in a centralized photographic suite.

surgical markings. Patients are usually nervous, and I always maintain an upbeat bubbly attitude. I tell the patient that I am very excited to be their surgeon and that everything will be fine.

In our practice, the anesthesiologist meets with the patient on the morning of the surgery. If there are any significant medical or anesthetic concerns, a meeting would have been scheduled several weeks earlier, but the anesthesia evaluation is performed on the morning of the surgery for routine cases on healthy patients.

At this point, the patient changes into a hospital gown. It is very important to give these patients a warm robe and to keep them out of the hustle and bustle of the office. Nervous patients in skimpy gowns and cold rooms with a lot of activity is not the environment you want. Remember that we do this every day and can be immune to the comfort and privacy required.

The Intraoperative Period

The intraoperative period is very busy, and errors can occur during this period. The room is kept warm and quiet during the anesthetic induction. The very first thing that occurs when the surgeon enters the operating suite is a formal time out. A standardized form is projected on the widescreen TV in the room, and all personnel in the room stop while the circulating nurse reviews the patient, their medical history, allergies, specific surgical sites, and proposed

Fig. 1.23 An official time out is taken to ensure that the entire staff is aware of procedures, surgical sites, and patient history.

procedures. Any specifics relating to the surgery such as lid ptosis, asymmetries, or previous surgeries are also mentioned (Fig. 1.23). I also personally mark the patient's cricothyroid ligament in the rare event that an emergency airway would be required during the surgery. In 30 years, this has not happened, but it is a preventive intervention.

Every surgeon and staff member should understand the stressful situation of waiting for a loved one who is having surgery. At this time, the patient's family frets and fears bad things happening, and they must updated and reassured. We encourage relatives and caregivers not to stay in the office, but if they desire to, we keep them in a segregated small family waiting room that is stocked with beverages and snacks and has a widescreen TV and Internet access. The circulator also personally updates the family or caregiver in the middle of the case to let them know that everything is going well.

The Postsurgical Period

After completing the surgical procedure(s), we transfer the patient to the postanesthesia suite. This is also a vulnerable time for medical errors as many things are going on. The operating room is being cleaned, instruments are being washed, and preparations are being made to see afternoon patients. It is imperative that a qualified, dedicated staff member stay by the patient's side and monitor their vital signs until they leave the office (Fig. 1.24). Many tragic stories exist about unattended or poorly attended recovery patients. After the patient is coherent, the caregiver is brought back to the recovery suite. It is important that family members and caregivers are prepared to see their spouse or family member bruised, battered, bleeding, and burnt. This will prevent fainting so the caregiver can be strong for the patient. Although I will keep a patient in my office for 23 hours on rare occasions, some surgeons have in-office suites for the patient to stay (Fig. 1.25). The patient is discharged and stays at the office suite as a courtesy or pays for the privilege. This can be a great setup for the patient as there is no need to

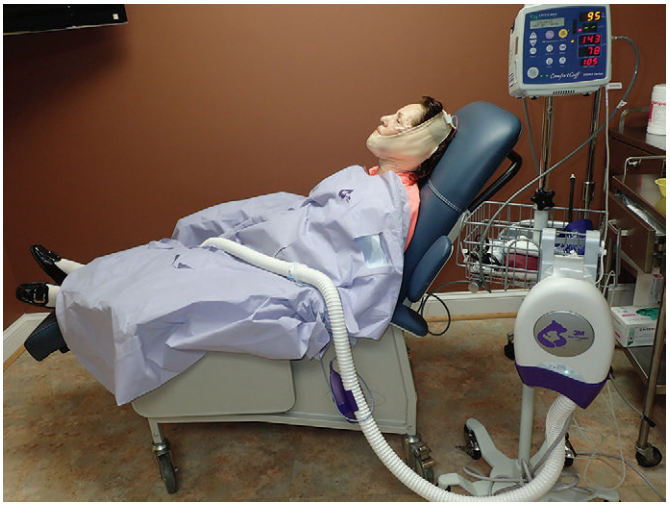

Fig. 1.24 The recovery period is a critical time for patient safety and staff communications. Proper monitoring and staff are essential. Keeping the patient comfortable, warm, pain free, and normotensive are basic goals.

Fig. 1.25 Having an in-office recovery suite is an advantage for the surgeon and patient. Shown here is one of the in-office recovery suites at Tulsa Surgical Arts. (*Photo courtesy Angelo Cuzalina, MD.*)

travel and return to the office. It also is an advantage for the surgeon to have the patient on the premises should they need emergent treatment.

An ambulatory outpatient anesthesia recovery unit is very different from a hospital postanesthesia recovery unit with an entire shift of nurses and ancillary staff attending. It is imperative that no patient is ever discharged without proper stability of vital signs and mentation. A recovery scale must be used and documented. A caregiver who has been properly instructed previously is a huge asset for patient management. The caregiver is given my cell phone number and told that I or one of my staff will check in with them later in the evening. Germain to this conversation is to be prepared in the event that the patient has a postsurgical hematoma or complication. The office must have an emergency plan for "return to operating room." You will need available staff, clean instruments, anesthesia support, and medications. If you are not prepared for this, you are putting your patient and yourself at risk. Be prepared!

Patient Recovery and Biopsychosocial Implications

Getting a patient "in the door," completing the preoperative phase, and finishing the surgery are generally considered to be the bulk of the surgical experience. As every surgeon is aware, this is often only the beginning, and sometimes the recovery process is the most complex phase of the entire doctor–patient experience. Although some patients understand, are prepared, and breeze through their recovery, others are ill-prepared, misinformed, and struggle to maintain a normal balance of life. In extreme cases, these patients may require psychological assistance or other intervention to prevent mental decompensation. Patients with a straightforward, uncomplicated recovery are a pleasure, and patients who become entwined in a web of complicating physical and mental factors can suck the energy and spirit out of the surgeon, the staff, and the family or caregiver.

Why do some patients fare much better than others in healing, recovery, accepting the temporary disability, and returning to normal life? There is no single answer other than the complexities of unique constitutions for every individual. Simply put, some patients have more drama than others. This does not only apply to surgery, but I believe that if one could follow a complex recovery patient throughout life before and after surgery, they would see these complexities extend to other psychosocial aspects of the patient's life. This may include trouble with interpersonal relationships, manipulating spouses, problems interacting with their children's teachers or neighbors, and other similar situations that categorize individuals as "high maintenance."

These individuals may create an accelerated problematic environment that includes problems, symptoms, and reactions that are beyond the mean for an average patient for the given procedure. Suddenly their cosmetic recovery becomes abominable. The patient may wallow in self-pity or experience unimaginable pain. They may fear that something is terribly wrong or become totally physically incapacitated or unable to sleep, eat, or drink. Some patients simply do not handle pain, swelling, or recovery well and have a terrible recovery, although they are totally normal before and after they heal. It is typical for this type of patient to troll the Internet to discover scores of things that "went wrong" with their surgery. Other patients, however, may exhibit intentional problems in an effort to extract pity from the doctor and/or family, manipulate relationships, or induce retribution. An example of this dichotomy is a patient who undergoes a facelift, blepharoplasty, full-face laser treatment, and cheek implants. She recovers quickly in the office surgery center, goes home, and presents the next morning bruised and swollen, but smiling and joking about her appearance. She is sipping on orange juice and eating snacks from the waiting room. Her husband is supportive and has been a good caregiver. This patient has a positive attitude and wants to make sure she does all she can do to hasten her recovery. Another patient who is the same age with the same frame, health, and so on has the exact same procedures as the first patient. However, this patient is crying in pain immediately on anesthesia recovery and begs for pain medicine. She is worried that she may not have enough pain medicine from her preoperative prescription. She stays in recovery

twice as long as normal for her procedure. Her husband begins calling the office soon after they arrive home, and she has uncontrollable pain and is crying in the background. Her husband is confused because she told him that she was get just getting a little tune-up. The surgeon's cell phone rings numerous times during the night as the patient is still in pain and does not know how to perform her recovery care despite having been given comprehensive instructions and handouts 1 week earlier. The patient presents the next morning for follow up and cannot get out of the car without assistance. The patient asks for an emesis basin and for the room lights to be turned off. She has the demeanor of a multisystem trauma patient and will not make eye contact or engage in discussion. She still complains of severe pain, is sorry she had the procedure, and states that we did not tell her it would "be like this."

The differences between the two patients are notable. The first patient makes surgery fun, and the second patient makes the surgeon wonder why he or she chose this profession. Not every patient who acts like the second patient has psychological problems; some are merely fragile and have lower pain thresholds. More often than not, however, a distinct pattern is seen in this type of patient. Sometimes the surgeon and staff can settle the patient down and get them back on track. Other times it may require some TLC and the surgeon explaining to the patient that what she is experiencing can happen and that the doctor and staff will support her. Some patients need increased pain control and sleep medications. The mix of pain, swelling, sleep deprivation, and fear can put some patients into an acute psychosis. Even strong and "normal" patients can become emotional, especially female patients who may have spontaneous crying episodes and when asked what is wrong, they honestly say, "I don't know." Emotions can sometimes run rampant with the combination of surgery, swelling, bruising, and medications. Male patients are not exempt from such behavior, but with my practice being 85% female, I obviously see what is commensurate with my gender population. To combat the problematic patient, I spend significant time in the preoperative consultation discussing the good, bad, and ugly aspects of recovery with the patient. I tell them (as does my staff) that they probably will not like me for several days and that they may ride an emotional roller coaster in the immediate and sometimes extended recovery period. I also provide them with the following graphics that discuss the various predictable and (and sometimes unpredictable) stages of recovery. I have seen facsimiles of these charts around for years, and I am unaware of the original author. I made significant modifications to this idea and present them in the following graphics (Figs. 1.26–1.31).

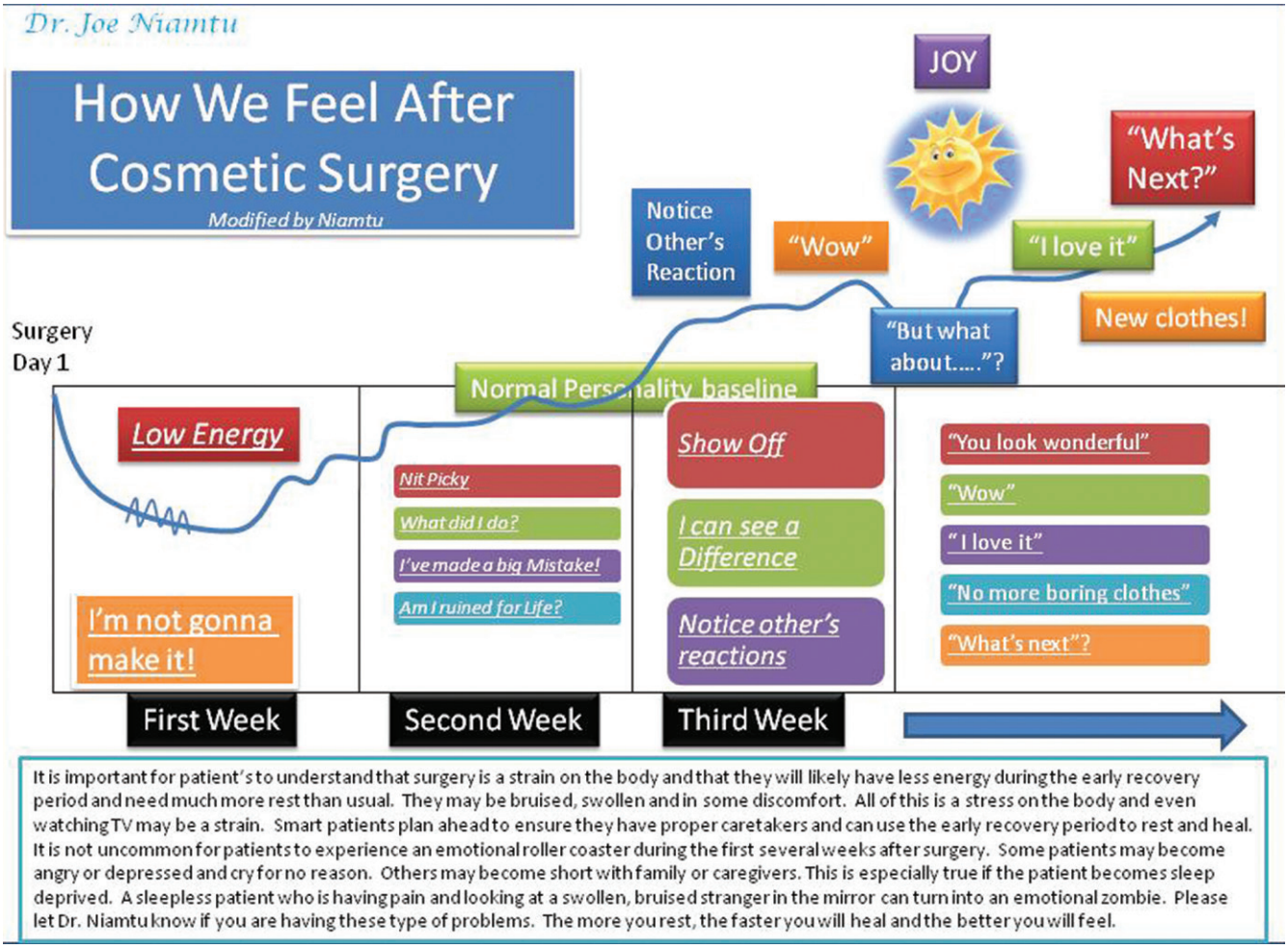

Fig. 1.26 The various phases that patients experience after cosmetic surgery.

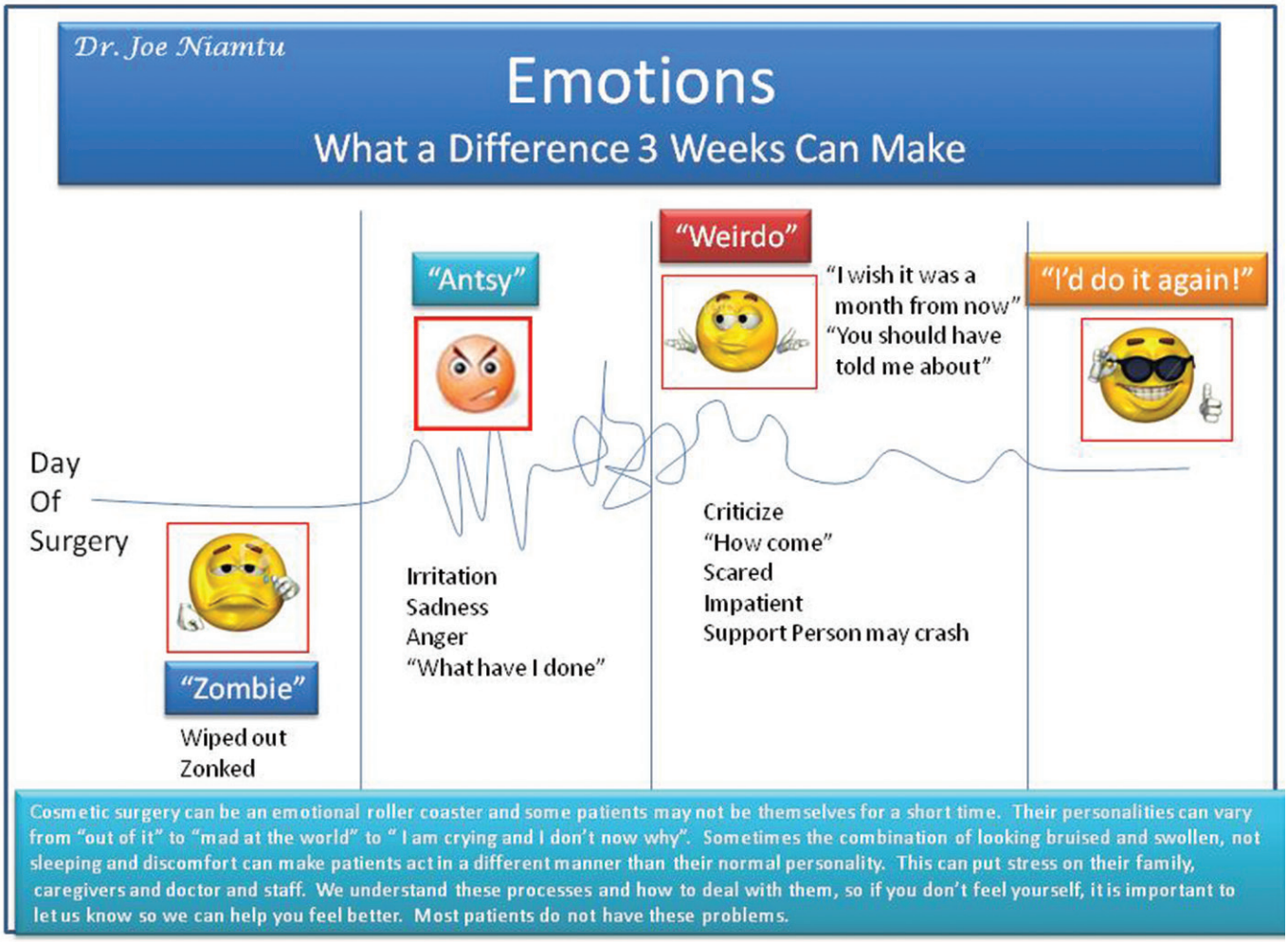

Fig. 1.27 The emotional roller coaster that patients may experience.

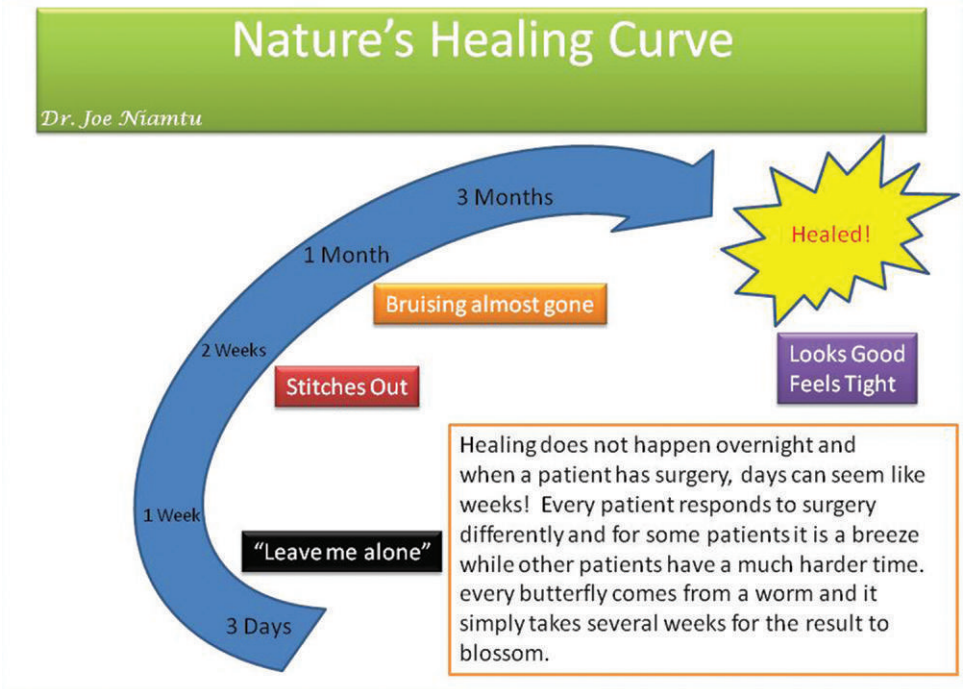

Fig. 1.28 Nature's healing curve.

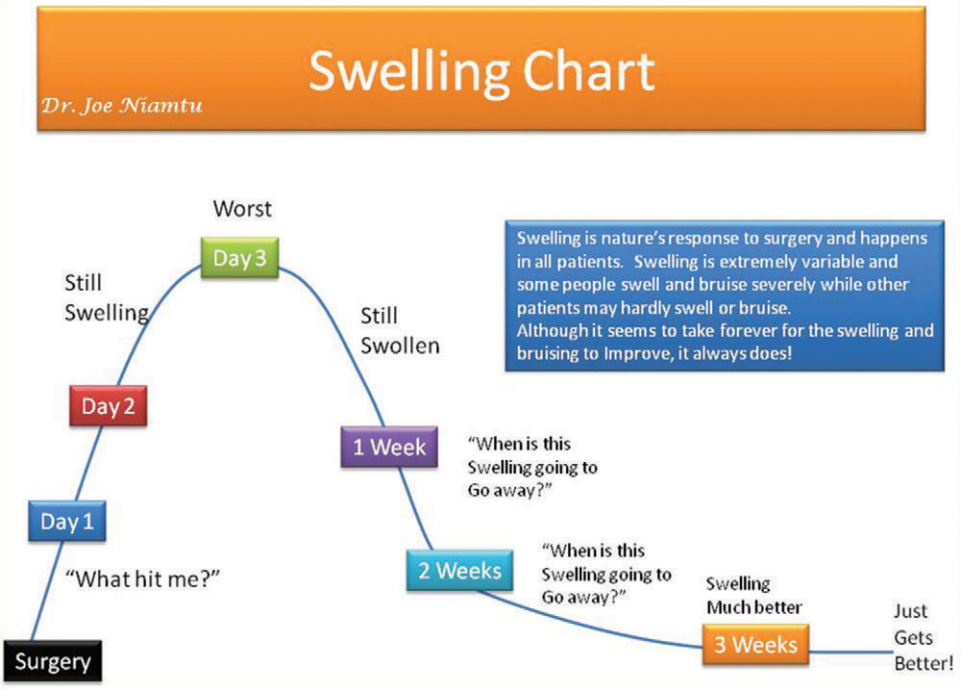

Fig. 1.29 Swelling phases after cosmetic surgery.

It is important for patient's to understand that surgery is a strain on the body and that they will likely have less energy during the early recovery period and need much more rest than usual. They may be bruised, swollen and in some discomfort. All of this is a stress on the body and even watching TV may be a strain. Smart patients plan ahead to ensure they have proper caretakers and can use the early recovery period to rest and heal.
Rest and relaxation is essential for proper healing. The immediate post op period is not a time to clean your garage or work in your garden! Severe complications can occur from post operative over exertion which can complicate and affect the final result. The surgeon is responsible for the surgery and the patient is responsible for the recovery. If the patient does not follow instructions, the best surgeon in the world cannot get the desired result.
Use this opportunity to be a queen or king and be catered to. Enjoy your recovery! Rest and relax, watch those movies you never have time for. Do not perform functions that will increase your blood pressure or promote bleeding. Drink plenty of fluids and protein. A high protein shake several times a day will help insure proper surgical nutrition. Taking a single multi vitamin each day is also a good idea. Sleep like a baby! The more you rest the more you heal.

Fig. 1.30 The rest, relax, and recover attributes after cosmetic surgery.

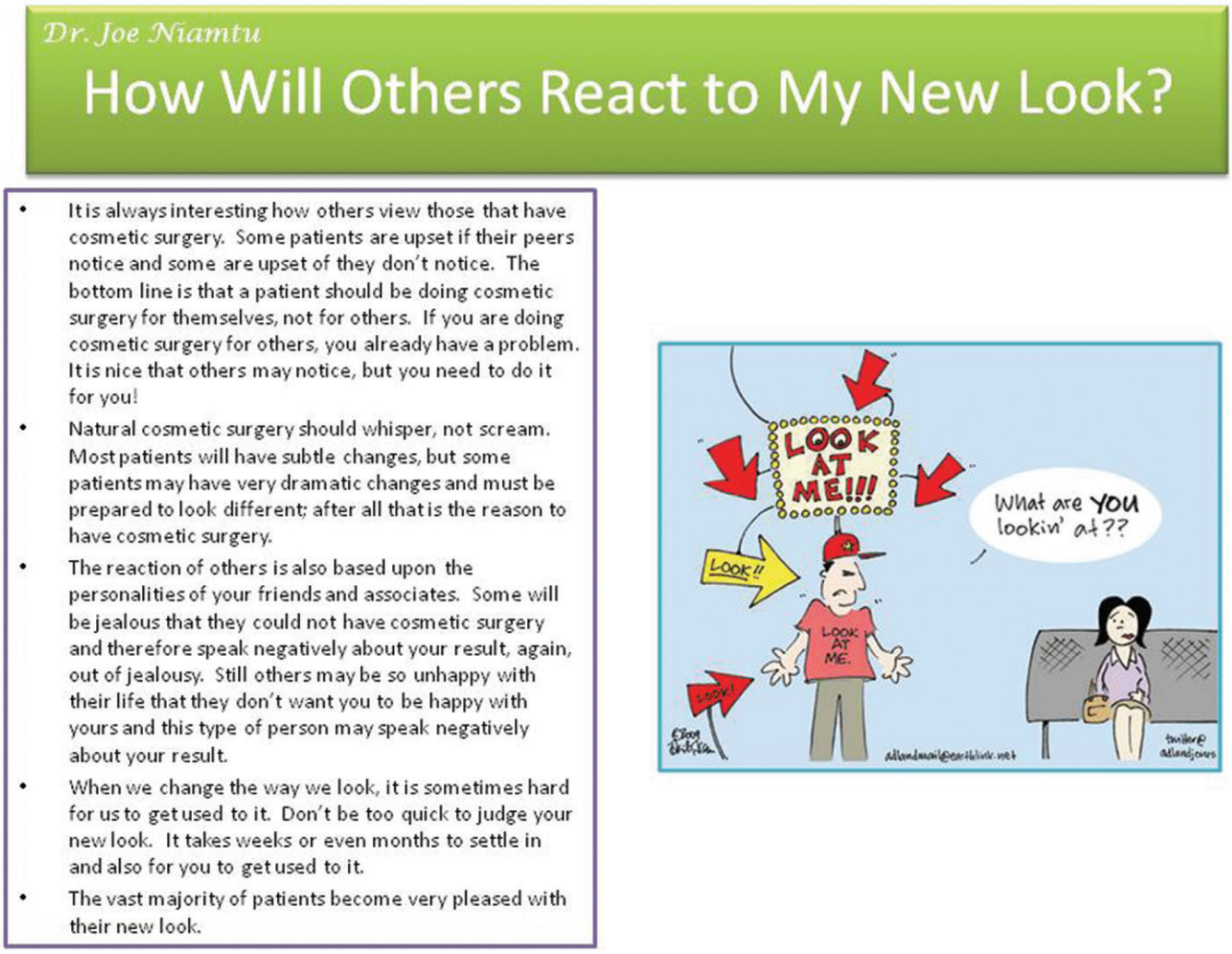

Fig. 1.31 How others will react to a patient who has had cosmetic surgery is a common concern. Some patients fear that everyone will notice, and others fear that no one will notice.

Dealing with the Unhappy Patient

Most of this chapter has been about making patients happy, but every cosmetic surgeon will have unhappy patients from time to time. This may be because of a complication, an unanticipated outcome, or a patient who simply had an unrealistic expectation. A mad or unhappy patient can upset your world from several aspects. First, most cosmetic surgeons truly care about their patients, outcomes, and reputation and take it personally when things do not go well. Second, elective cosmetic surgery is fertile ground for lawsuits. Even though physicians win the vast majority of lawsuits, it can be a humiliating, time-consuming, expensive, and stressful ordeal. The best to way to stay out of a lawsuit is to make every aspect of the patient experience protect the practice. Poor documentation is one of the frequent conditions that lead to suits. Although it is time-consuming, accurate documentation is imperative, and this is where your staff can really assist. Your informed consent process should be very broad, and these documents should be dynamic. By this, I mean that informed consent forms must be continually updated to protect the practice. Each time you feel that your consent form has everything covered, some patient finds a new way to say they were not aware of a given situation. Updating your consent forms helps protect you. You must go out of your way to think of the most unusual situations that could arise and reflect them in your consent forms. As stated, numerous times in this chapter, if you or your staff see red flags with a given patient, do not operate on them. Choosing the right patients has a lot to do with success.

There are two types of unhappy patients: those who have a complication or problem and those who have a normal course or result but are unreasonable. We will first discuss patients who have a normal course or result but are unreasonable. Some patients will never be happy. They may decide to have a facelift and think it will transform their entire life and being. These are frequently patients with low self-esteem or with other problems such as poor interpersonal relationships, relationship stress, obesity, and so on. They go through the entire surgical process, have an acceptable outcome, and still do not like themselves when they look in the mirror. This is not your problem; it is theirs. But in their mind, it is your problem. To get through this, you must make it "your problem." Sometimes all these patients want or

need is some attention. This is not a case for a coarse or defensive attitude, but rather a time to bring these patients in at the end of the day and spend time with them letting them vent. As we will discuss later in this chapter, this is a time for the doctor to be "small" in the room. This is when compassionate staff members are invaluable. They can bond with these patients and hold their hand, literally and figuratively. It is also important that the patient record includes a place to document whether the patient is happy or unhappy at the time of their visit. I have had cases in which an unreasonable patient became unhappy several months down the road and claimed they were never satisfied with the treatment or result. It is extremely valuable (especially if the case involves legal proceedings) to be able to review the record and show the patient that the documentation shows they were happy at the past six appointments. I know some surgeons that actually have a place on the record for the patient to state their satisfaction level and actually sign the chart. This obviously would carry even more weight.

If an unreasonable patient turns sour, at some point you must review the informed consents with them and point out the preoperative discussions of what their surgical procedure will and will not do. I have regular preoperative consent forms in my office, but for every operation, there is also a consent for "What your procedure won't do." This is important as some patients may think a facelift will lift their brows or fix wrinkles around their lips, for example. Also, if I have a case that may portend a revision, I discuss this with the patient in the presurgical period. An example may be a bariatric surgery patient with extreme submental skin or a laser patient with extensive wrinkling or acne scars. I add a section to the consent form stating that their situation is more extensive than the average patient and that a secondary procedure may be necessary at the expense of the patient. I do this in writing and several times in verbal conversations, preferably in the presence of their spouse. Actually, all my consent forms have a paragraph that clearly states, "Surgery is not an exact science and the result is subject to many variables, some beyond the control of the surgeon or patient. In these cases, a revision may be necessary and additional surgical and anesthetic fees will be applicable." This is not ironclad, but it does set the stage for postsurgical conversations. As stated, in cases that may need obvious retreatment, I use this paragraph and the "What your surgery won't do" section. The bottom line is to make your policy clear *before* the surgery. When dealing with an unrealistic patient, showing them this consent can back them off. Some patients may be very unhappy at first, but after significant communication and passage of time, they often settle down. The worst thing you can do with these patients is to be arrogant. Arrogant surgeons are sued, so you must be "small" in the room. If the surgeon is not a good communicator and mediator, they should use a staff member who is proficient in these skills. Some of these patients simply realize that their facelift did not "make them pretty" or change their life, and they have buyer's remorse from the expenditure. This is especially true with patients who could not afford the surgery and now have debt. Other scenarios include a spouse who is unhappy or friends who "can't see any difference." Most patients are reasonable, but every surgeon will encounter some who are not.

The single most important question for the surgeon to ask this type of patient is "What can I do to make you happy?" Sometimes the answer may be, "Just listen to me." Sometimes the answer may be to revise a part of the surgery, and other times the answer may be to refund the surgical fee.

There is no universal answer, and it is dependent on the situation. If a patient has a facelift but still has some residual submental skin or jowl, a small submental skin excision or jowl liposuction under local anesthesia may make them happy. Some will agree to pay for a revision, and others may be adamant against it. Some surgeons refuse to revise anything without payment, but I always provide some options. First, you can have a compromised result that is the surgeon's "fault" such as skin or fat excess. In some cases, the problem may be the patient's fault, such as not taking care of laser wounds or burning the face postrhytidectomy with a heating pad. Finally, you have postoperative problems that are no one's fault and just "Mother Nature," such as infections, untoward reactions, and so on. If I truly feel that my result could have or should have been better, I usually redo it with no charge or ask the patient to cover the cost of general anesthesia if required and a "materials fee." I performed 109 facelifts during the past calendar year, and I probably had to perform 4–5 revisions, some small with local anesthesia and others larger requiring general anesthesia. I did not charge some of these patients to keep them happy, while others paid a revision fee if they were receptive. I am probably pretty "wimpy" when it comes to digging my heels in and requiring an unhappy patient to pay for a revision. I say this, even though my consent that the patient signed clearly states that it is the patient's responsibility. If I feel that their problem is not a result of the surgery, I will simply have the staff tell them what our fee is for the revision, and if they are unhappy, I ask them, "What do you feel is fair for this extra surgery?" Sometimes they may provide a figure, and other times they remain insistent on paying nothing. For revision surgery, I never argue over money. In the end, all any surgeon has is their brand and reputation. You must do your best to keep all patients happy. Sometimes it will cost you some money, but to me this is simply a form of marketing. I tell all patients numerous times in the presurgical communications that in terms of result "It is your face, but it is my reputation, and if you do not look good, I do not look good." The key is to convert an unhappy patient to a happy patient, get the negativity out of your practice, and move on to happier patients.

Some patients will ask for a total refund, and this can get tricky. No surgeon wants to perform a 4-hour surgical case and end up refunding the fee. In today's social media environment, an unhappy patient can literally punish a surgeon (deserved or not) on doctor rating sites. Patients know this, and if you run across a vindictive patient, they can quickly tarnish your great reputation. Some of these patients are very unbalanced and will spend much of their time defaming you. Consumers are used to getting full refunds from many stores and services and do not think surgery should be any different. Doctors can take the hard line, and if they feel that it is out of the question, they can refuse and pass the information on to their lawyer. I have seen some physicians refuse to refund a single penny, but after 1 week out of their office sitting in depositions, they realize that a refund is not a bad deal. Remember, it

does not cost anything for a patient to sue you. Some will initiate this process knowing that it is a good bargaining chip for a settlement. If communication comes to the point of a patient requesting a refund, I will usually try to achieve a compromise. Again, I may ask them "What do you think is fair?" Sometimes they surprise you with a reasonable amount. If they hold out for a full refund, then the surgeon must make a decision. My advice is to just get it done and move on. As I stated earlier, in cosmetic surgery, the highs are very high, and the lows can be very low.

One point of great importance is to *never* refund any money without a legal document and release. This may vary from state to state, but my refund release states that we are making a refund in the interest of patient relations and admit no wrongdoing. It also clearly states that by accepting the refund, the patient will waive all legal action and agree not to defame the surgeon or practice in any form of verbal and written media. I must say that there have been instances in my career when I was actually relieved to trade a refund for a signed patient release to dismiss a problematic patient and move on. Although a patient may sign a release, they probably could still proceed with legal action, but I have never seen this. I probably provide some form of refund every 1 or 2 years in the interest of patient relations. When I go back and look at a list of these patients, 100% of them had some of the red flags I listed earlier in this chapter. Although it may be difficult to turn away a patient, it is really important not to accept patients who exhibit these trends or behaviors.

Another scenario is the situation in which a complication occurs that may not be your fault, but it is nonetheless a bad situation. A post-facelift hematoma, skin necrosis, or infection are examples. Complications that patients may perceive as the surgeon's fault could include nerve damage, poor scars, unnatural vectors of tension, hairline changes, or pixie earlobes. Regardless of whose fault it is, the surgeon may be faced with a significant complication. Sometimes bad things happen to good surgeons and patients. The key to handling these types of situations is to devote your complete attention to these patients and get them through their problem. The first matter of business is to maintain the patient's confidence and keep them in the practice. No surgeon wants his or her complication to end up in someone else's office, especially if it is a hostile competitor, which unfortunately is not uncommon in cosmetic surgery circles. The key to retaining the patient with complications is confidence and communication. Apologizing for the problem (without admitting fault) can go a long way. "Mrs. Smith, I treated you with the same care I would provide my own family, and I am very sorry this problem occurred and has inconvenienced you. I promise to do everything in my power to get through this problem and will not let you down." As long as a patient feels that you are contrite and will stand by them, they will most frequently stay the course.

There are some special considerations for patients who experience complications. The foremost factors are communication and hand holding. These patients must be seen frequently for complication management. They must be seen when the surgeon and staff can spend adequate time with them in a calm and unrushed environment. I like to see these patients at the end of the day as the last patient. This keeps them from mixing with your other patients, gives them privacy, and I can spend adequate time with them because the day is over. Of equal importance is not to complicate communication by having numerous staff members deal with this patient. The most understanding and compassionate staff member in the office should be the only other person who tends to the patient. I prefer to have a single staff member stick with every patient throughout their entire surgical journey as this creates a bonding that is preferable when complications occur. In a situation such as skin necrosis after a facelift, many wound care appointments will be required. These patients must feel that they are your only patient. Frequent phone calls from the surgeon and staff are also helpful when appropriate, and these patients, of course, have my personal cell phone number and email. It is also important to have the exact same level of communication with the patient's spouse. Remember, keeping these people confident that you can heal them is the key. From time to time I have also done small things to compensate these patients for their inconvenience such as free Botox or products. If done in a sincere manner, it is not viewed by the patient as a "bribe."

If you face a complication that is not clear, a second opinion or specialty referral must be made in the early phase. Many lawsuits occur for failure to refer or failure to refer at an early enough period. A friendly consult or second opinion is a much better option than having a patient leave your practice and end up with a hostile competitor. If a referral is needed, the question of "Who will pay for this appointment or treatment?" will frequently arise. This can be a sticky situation, and there is no correct answer. Sometimes the surgeon is best served if the unhappy patient does not incur additional fees. I have done it both ways, picking up the tab or having the patient be responsible. Usually, most colleagues (who experience this with their own patients) are sensitive to this and will assist with little or no fee. In the event that a surgeon does not want to pay the referral expense, I would suggest speaking with their legal counsel first.

Over my career, I have steered some typical and atypical complications through the tight straights of healing, consultation, and recovery. These patients are usually grateful for the care and attention and stay as happy patients of the practice. Some cases will leave your care, and this occasionally happens to all surgeons. The best thing you can do is to learn from these situations and make your practice better. Remember, all surgeons have complications, and the key is to learn from them.

When you speak with colleagues about complications, their conversation frequently starts out by saying "I have this crazy patient." This may be so, and at some time all doctors will have some "crazy" patients. We surgeons strive so much to be perfect that we are sometimes insulted or defensive when accused of doing something wrong. With complications or problematic patients, the surgeon must look in the mirror, examine the entire situation, and be honest with themselves and their staff about what went wrong and how the doctor or staff could have avoided this situation or how it could be averted in the future.

Dealing With Online Reviews

Online doctor review sites are relatively new to seasoned practitioners and the standard for younger physicians. For surgeons who

have been in practice, this has been a paradigm shift and game changer. Positive reviews can greatly enhance one's practice, and negative ones can keep patients away. The biggest miscarriage of this system is that anonymous or false reviews are accepted, and anyone can say anything, whether it is true or false. Great reviews can come from your sister, and vile reviews can come from your competitor's receptionist. There is simply no control. The best thing a surgeon can do is to have many positive reviews to offset any potential negative reviews that may ensue. However, it would look very suspicious if a surgeon has only several reviews with a negative review followed by five positive reviews the next day. The key is to run your practice in a manner to encourage positive reviews. You staff can be very helpful with this as patients will often verbally complement the office, staff, and surgeon. This is a great time for a staff member to tell the patient that their comments are so gracious, and we work hard for this type of satisfaction. If the staff member further explains that by posting these comments of satisfaction online the office is greatly assisted, many patients are happy to do so. Having a professionally printed "thanks for being a great patient" card with instructions on how and where to post online reviews will also make it easier for happy patients to share their experiences. Just remember, it is a lot easier to bury a negative comment when you have a long history of positive comments.

From time to time, even the most caring and efficient offices will have negative reviews, whether they are warranted or contrived. If you feel that a negative review is contrived, hateful, or otherwise unwarrantedly offensive, some sites will review or remove the review. Asking for this is always a first step. If you have a negative review, the first thing the surgeon and staff should do is look in the mirror. Although hard to take, sometimes the negative review is accurate. Perhaps your wait times are excessive, it may be difficult to find parking at your office, or you have a rude staff member. Progressive offices will use these comments to make their experiences better and hence generate more positive reviews. The best thing a surgeon can do to respond to a negative review is to be humble, apologize, and ask the patient to call the surgeon personally to discuss the problem. This makes the doctor and office look sincere. The worst thing you can do is engage in a pompous online battle with an already unhappy patient. Bullying in the digital world is not accepted. The surgeon also must be extremely careful not to violate the Health Insurance Portability and Accountability Act (HIPAA) guidelines in discussing a patient's care. You want to come off as the good person, and it goes a long way as most people fully realize that some negative reviews are normal and that many are unwarranted.

Conclusion

Cosmetic surgery is an elective upper-class luxury, and we serve a patient population that is accustomed to having excellent service and an industry that perpetuates it. Clinical competence is obviously the biggest factor in the equation of success, but it can be totally overshadowed by a poorly run office or an arrogant physician. It is said that excellence is a journey and not a destination. This means that you can never actually achieve excellence as even the best things can be improved. If you and your team strive to continually improve all aspects of patient care, safety, and satisfaction, you truly can have an excellent office. Cosmetic surgery is a tremendously fulfilling practice, and I have a passion for it. I love going to work, and I love the interaction with my team and patients. Continually striving to make it all better is pleasure.

Management of the Difficult Patient

Jonathan Sykes

The goal of any elective cosmetic surgical is a happy, satisfied patient. Achieving this goal requires the following:

- Careful patient selection
- Well-chosen procedure(s)
- Meticulous performance of the surgery
- Empathetic postoperative care

On the surface, completing a cosmetic surgery to improve the appearance and function of a patient seems simple. However, as any experienced plastic surgeon knows, postoperative patient satisfaction is complex and multifaceted.

The successful plastic surgeon (or any surgical specialty that performs cosmetic procedures) realizes that the goals and motivations of plastic surgery patients are complex and that understanding these goals is requisite for patient satisfaction. For this reason, the surgeon should spend time and effort on selecting patients who are likely to have proper expectations regarding surgical outcomes. The key is to deselect patients who likely will be impossible to satisfy or present with dangerous personalities and to learn to effectively communicate with and manage the others.

Dissatisfaction after cosmetic surgery results in distress for both the patient and surgeon. Even though a relatively small percentage of cosmetic surgery patients are truly dissatisfied with their results, these few patients usually occupy a large amount of the surgeon's time and energy. Learning to deal with patient dissatisfaction after cosmetic surgery requires significant psychological and communication skills by the surgeon.

Patient Selection

The first step to obtaining a successful outcome in facial plastic surgery is to carefully select the patient. The decision of when not to operate is rarely discussed in surgical training and requires the surgeon's judgment and experience. Although patient selection may seem like an easy task, various factors can obscure the process. The surgeon's financial motivation, ego, and ineffective communication styles can contribute to poor decision-making when deciding who to operate on and who to avoid. Successful patient selection requires that the surgeon listen to specific patient desires and expectations. To understand the patient's motivations for surgery, the surgeon must ask open-ended questions and allow the patient to expose their psychological tendencies.

The key skill the surgeon must possess is to be an *educated listener*. On the surface, the importance of being a good listener seems intuitive and easy to accomplish. However, many physicians

seem intent in describing who they are and what they intend to do, rather than finding out who the patient is and what they want. Using open-ended questions during the initial consultation can help unveil the patient's psychological tendencies. For example, "How much time do you spend thinking about your appearance in a day?" or "How does your dissatisfaction with your appearance affect or disrupt the quality of your life?" Less than ideal patients are often able to hide their personality flaws to gain the surgeon's understanding of his or her reasons for surgery. Furthermore, the true character of the difficult patient often manifests in the postoperative healing process.

Dealing with the Difficult Patient During the Consultation

Aesthetic surgery is elective in almost all instances; therefore if a patient is not a suitable candidate for medical or psychological reasons, the surgeon is tasked with refusing surgery to a potential patient. The task of denying surgery to a patient who seemingly desires the procedure can seem problematic. Surgeons are wired to help people and to "fix" things, and the prospect of refusing a patient who wants what you do seems contrary to natural instincts. Refusing services can be a sensitive issue as the surgeon may be confident that a procedure will objectively improve the patient's appearance.

An additional issue that often obscures the judgment of surgeons is money. The surgeon benefits financially only when surgery is paid for and performed, and refusing the patient can be economically impactful. Although an unhappy patient often creates a large amount of economic and emotional distress to the surgeon and the practice, many surgeons are blinded by the potential positive economic impact of each patient, and their bias can cloud their judgment.

If concerns regarding a patient's ability to psychologically tolerate aesthetic surgery are raised during the initial preoperative consultation, the first option for management is to schedule a second consultation. This allows both the patient and surgeon to reevaluate the situation and address lingering questions or concerns from the initial encounter. If the surgeon's concerns are alleviated by the second consultation, then surgery can be scheduled with greater confidence that the outcome will be satisfactory to the patient. However, if the patient continues to exhibit difficult or dangerous personality characteristics, then the second consultation was of great value in that it provided additional evidence to support the decision to avoid surgery in a potentially problematic patient.

Managing Dissatisfaction in Plastic Surgery Patients

Despite all efforts to screen patients preoperatively for realistic surgical expectations and emotional health to withstand the psychological stresses of surgery, patients can be disappointed with the outcomes of surgery. Dissatisfaction after cosmetic surgery results in distress for both the patient and surgeon. Although the incidence of patient dissatisfaction after cosmetic surgery is low, the amount of time and energy spent on an unhappy patient is often much greater than the time required for most other patients. Learning to deal with patient dissatisfaction after cosmetic surgery requires a unique skill set by the surgeon.

To effectively manage an unhappy cosmetic surgery patient, the surgeon must have a strategic plan that involves listening to the patient and making the patient feel understood and accepted. Surgeons want happy and satisfied patients. When a patient is less than satisfied with their surgical outcome, the surgeon often feels that they have done a bad job. This can affect the surgeon's self-esteem. It is common for the surgeon to feel attacked and to become defensive about the surgical result. In general, surgeons want to help people and to be appreciated for their efforts and skill. Much of the surgeon's self-worth is wrapped up in their perfecting (or trying to perfect) their craft and being acknowledged for their experience. Being criticized for their failings does not feel good.

It is important for the surgeon to recognize an unhappy patient, listen to the patient, and have a strategy geared to make the patient feel understood and accepted. This will diffuse anger from the patient, promote or regain trust, and provide possible remedies to achieve patient satisfaction. Developing a strategy to manage an angry, dissatisfied patient is as important as making a diagnosis or performing the surgery well.

The Importance of Listening

Communication is essential in the management of dissatisfaction in the postoperative cosmetic surgery patient, and the key to effective communication is *listening*. It is important that the patient feels listened to, understood, and accepted. The surgeon should avoid the temptation to rush to "fix" the problem. Providing a fix will obscure the surgeon's ability to listen and will make the patient feel unheard.

There are several techniques for optimizing listening skills that can demonstrate empathy and strengthen the physician-patient relationship. Listening with curiosity and genuine interest will help the surgeon better understand the etiology of the patient's concerns. It is also important to give the patient adequate time and space to express their concerns freely; listening in silence provides this opportunity. The surgeon should use *reflective listening* to allow the patient to feel understood and that the surgeon is truly listening. This involves paraphrasing what the patient says back to them. Phrases such as, "If I could summarize what I am hearing…" or "It sounds like you are saying…" followed by "Is this correct?" or "Have I properly characterized your complaints?" can be helpful in these conversations. Additionally, follow-up questions such as, "Have I correctly characterized your complaints?" can further demonstrate empathy and strengthen the physician-patient connection. It is difficult to a patient to hold on to anger if the patient feels as though the surgeon is listening and empathetic.

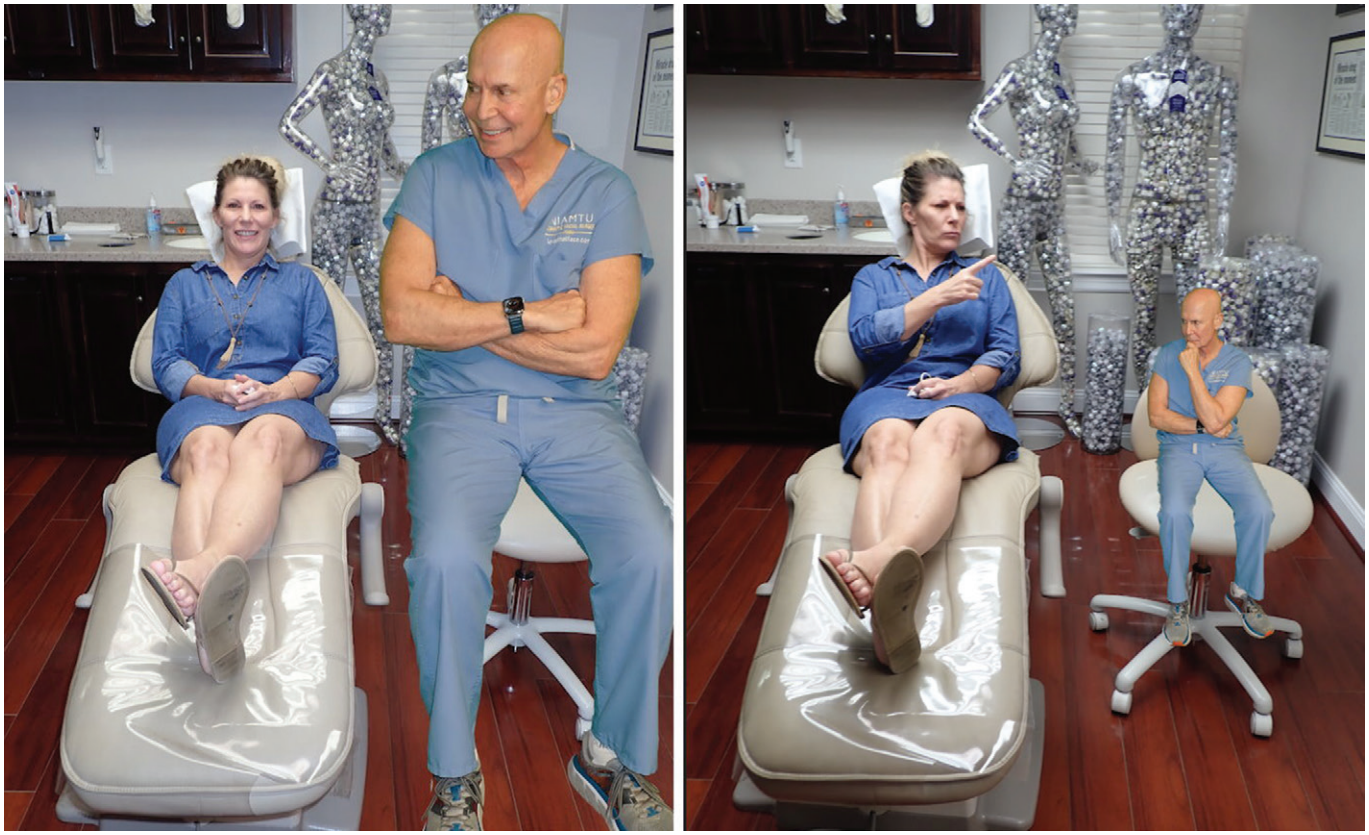

Fig. 1.32 The *left image* is a metaphor for the surgeon's stature, posture, and personality in the preoperative period in which they are confident and self-assured ("big" in the room). The *right image* conveys an unhappy patient and the surgeon's role as an empathetic, effective, and calm listener who is not defensive ("small" in the room).

Fig. 1.33 The "hand-on-the-door" communication is a poor way to interact with any patient but can truly offend a dissatisfied patient who feels that the arrogant doctor is in a rush to leave the conversation.

Stature and Position: Get "Small" in the Room

It requires a different skill set for the surgeon to be effective preoperatively versus postoperatively. Preoperatively, the surgeon must be confident and be an educator. Before any treatment, the surgeon should be self-assured and have a definitive perioperative treatment plan ("big" in the room; Fig. 1.32). Postoperatively, when a patient is upset about the cosmetic surgery outcome, the surgeon should not be logical and should not be confident. The surgeon should be empathetic and kind ("small" in the room; see Fig. 1.32). It is advisable that the surgeon sits low in the room (preferably in a chair lower than the one the patient is sitting in). It is also advisable that the surgeon sits away from the door so the patient does not feel as though the surgeon is rushed or in a hurry. It is imperative to avoid the "hand-on-the-door" phenomenon (Fig. 1.33). Although it is difficult to receive criticism for a less-than-optimal surgical result, the surgeon should stay calm and avoid the temptation to be defensive regarding the surgical outcome.

Finding a Satisfactory Solution

After carefully listening and understanding the problem, the surgeon should ask if it is reasonable to suggest a management plan. Asking a question such as, "Would it be reasonable to suggest possible solutions?" is a safe method to transition into a treatment plan. Even though the possibilities for problem solving are the same as with the "find-it and fix-it" method, reflective listening and request for permission from the patient to treat the problem feel different to the patient. It is also acceptable for the surgeon to express

disappointment in the surgical result. This must be done without fostering any blame on the patient for the result.

In rare cases, when the physician-patient relationship is poor and the patient dissatisfaction persists, it is appropriate to consult with risk-management specialists and the physician's liability carrier. This will provide the surgeon with legal protection. If the patient asks for a refund of surgical fees, this can be performed in selective cases, but it should only be done after consulting legal advice and after the patient signs a complete release of liability.

Summary

Managing patient dissatisfaction after cosmetic surgery is difficult and stressful for the surgeon. It requires a wide skill set including the ability to listen carefully and empathize with the patient. The surgeon must have a strategic plan that includes listening first and eventually suggesting a solution. Regaining lost trust is essential. The keys to success in plastic surgery are as follows:

- Careful patient selection
- Appropriate setting of expectations
- Honest communication of goals and limitations
- Reflective listening
- Getting "small" in the room
- Avoiding the "hand-on-the-door" phenomenon postoperatively
- Jointly arriving at a possible solution for the unhappy patient

If these principles are followed, patient dissatisfaction can usually be avoided or, at least, can be properly managed.

The Unhappy Patient: Addressing the Inevitable

Jeff Segal, MD, JD, and Coleman Topalu

"I expected you to make me better. You made me worse. I'm thinking about speaking to an attorney. Also, I want the whole world to know so they can be forewarned." Yikes!

Doctors want to treat as many patients as reasonably possible. Our careers are long. But if you practice long enough, you'll treat *them*. Who? Angry patients. It is unfortunate, but doctors can do a lot to de-escalate these conflicts. This article shares general tips.

First and foremost, find out what the patient wants from you. If their request is reasonable, do your best to accommodate them. Although you may have an answer, it is imperative to consult others in your practice as your staff have likely interacted with this patient and can provide valuable input.

Gather clues to why this patient may be unhappy, and then pick up the phone. Just call the patient. Ask them directly to explain the challenge. If the patient perceives that you care, they will likely reciprocate. The bar is low. Most patients do not expect a call from their doctor. Surprise them. While you are at it, be generous with providing your cell phone number. All patients appreciate this courtesy. The vast majority of patients respect the boundary implied when you entrust them with your cell phone number.

The next step is to prevent patient conflict from taking root by managing patient expectations up front. Storm clouds gather when a patient's expectations are not met. You, the doctor, can manage these expectations by providing information that sets the patient's expectations accordingly. In setting reasonable expectations specific to the "big four"—recovery time, outcomes, risks, and money—you crush conflict before it manifests.

But sometimes doctors do everything right, and patients still become incensed. What then?

If the patient cannot be pacified, consider transferring care to a different doctor. Doing this correctly can result in multiple positive outcomes. Doing this incorrectly likely will result in an abandonment charge propelled by an even angrier patient. Consult qualified medico-legal counsel before acting rashly.

Here is another critical warning: Keep the conflict offline.

If the patient posts online, the argument becomes publicly accessible. The public (existing and future patients) will be drawn to the conflict if the incensed patient makes enough noise. The subject of angry patients cannot be discussed without addressing refund requests. If the patient has requested a refund for a modest amount of money, it may be best to refund the money, with some critical caveats:

- The patient cannot return for more cash later.
- The patient cannot take the cash and blast you online.
- Before the said refund is tendered, these constraints must be memorialized in writing in a formal release that is signed by the patient.

If the patient threatens to injure your business (e.g., posting a defamatory review online), the game changes. The patient has threatened an action that will likely satisfy the definition of criminal extortion. And what if the patient has defamed you online? Even if it looks like you will prevail on paper, we do not advocate suing patients. This is because an angry patient under the gun of litigation (for example, charging defamation) will lash out. They may contact the media and warn their friends and family to stay far away from your practice.

Proving defamation (at least according to the law) is difficult. An angry human cannot be dismissed as easily as a traffic ticket. If you take the patient to court, you will likely see them more often than you will see your own family. We are not kidding. When should a physician involve the law? If the patient makes threats of violence, the physician should call the police.

In closing, when de-escalating patient conflict, keep the following points in mind:

- When meeting a patient for the first time, identify the patient's key concerns, and set expectations accordingly. Discuss recovery time, potential risks, potential outcomes, and the anticipated cost of care.
- If the patient is already upset, contact them and determine the origin of the problem. If the patient cannot be pacified, take responsibility for transferring care to another physician.

- Next, keep debates offline at all costs. If the patient requests a refund, consider honoring the request *if the amount is reasonable and the patient signs documentation* that satisfies critical conditions.
- Litigate sparingly. Propelling litigation against a patient will likely propel you, your patient, and your practice into the spotlight.
- Most importantly, understand that these challenges represent a mundane reality that every physician must address. An angry patient does not make you a bad physician; it makes you a human being.

The Patient-Provider Relationship: Insights into Patient Happiness and Subsequent Satisfaction in an Aesthetic Practice

Pamela J. Schell Werschler

My interest on the subject of human happiness has been a long-standing educational journey and a subsequent durable passion of mine. As to the history of how this began, while I was finishing my doctorate in health psychology some years ago, a movement in modern psychology was initiated by the president of the American Psychological Association (APA), Dr. Martin Seligman PhD. Dr. Seligman's suggestion to focus on the positive aspects of a person and their strengths, rather than their weaknesses, has now grown into a vast scientific area of study called *positive psychology*. This area and new facet of psychology fascinated me. This was in part because I spent the first 18 years of my career working as a registered nurse in an acute psychiatric facility with very sick patients. Focus on the positive instead of the negative aspects of an individual was an epiphany for me and my fellow practitioners.

Positive psychology has been in mainstream practice for approximately 20 years. As a result, most of us have experienced the benefits and have been positively affected through the studies run under the positive psychology umbrella. Today, the basic tenets of positive psychology are used in a variety of settings, including our health care practices. Positive psychology can be used to understand employee engagement, enhance career fulfillment, improve job satisfaction, develop employee wellness programs, maintain employee retention, ensure positive communication in the workplace, participate in mindfulness practices at work, market our practices to patients, and many more areas; the list goes on and on.

Consequently, you may be asking how this is pertinent to your aesthetic practice. From my perspective as a practitioner in the field of aesthetic medicine for the past 18 years, understanding the tenets of positive psychology can make your aesthetic practice stand out from other practices and make your patients feel more engaged, appreciated, and subsequently, less likely to move on to another practice. Patient satisfaction and overall happiness with your practice is paramount to the success of an aesthetic practice. This topic is addressed somewhat in the aesthetic literature, but not in a comprehensive research-based means, leaving practitioners with little direction.

Here is my condensed version for how to increase overall patient happiness and subsequent patient satisfaction using what we have learned from positive psychology. We will start with what happens with negative thinking, which we carry through to a negative experience with or in your office. Humans demonstrate a natural bias to be affected by negative events more than positive ones. In fact, it takes five positive events to overcome one negative event, and this ratio has held true through numerous studies on this topic over many years. Research also demonstrates that a single negative event can have long-term consequences on a person's self-esteem and sense of well-being. This demonstrates the importance of attempting to ensure that every patient or potential patient has a positive encounter with or in your office at every visit or during any communication with your practice.

Beyond basic politeness, not making patients wait long to see you, incredible customer service, a clean and attractive office, and excellent aesthetic talents, what could make a visit better for your patient? I believe that understanding from a psychological perspective what people value and what makes them happy is what is missing.

The science behind positive psychology has extensively studied the strengths held by everyone and has identified 24 single character strengths. Character strengths are positive traits that we all possess and present in our everyday thoughts, feelings, and behaviors. Accordingly, we all possess these traits as humans, but they are expressed more in some individuals and less in others. Consequently, we all possess each of the 24 character strengths, but we possess each strength to different degrees, giving each of us a truly unique character profile. This is an important fact to understand as you will discover the differences in what female patients will want and what male patients will want from you as an aesthetic provider, and it is not just a quality aesthetic procedure.

As a side note, before we review research done on gender differences in men and women, I am in no way implying or portraying any gender bias in this discussion. We have taken the steps to have our practice confirmed as LGBTQIA+-friendly, and we fully appreciate gender differences and gender fluidity at our practice. Here, I am only referring to males and females in regard to the research I am referencing that has been conducted in positive psychology.

The research tells us that the most common character strengths for women were honesty, kindness, love, gratitude, and fairness. Life satisfaction for women was predicted by the appreciation of beauty and excellence, love for other women, gratitude, hope, and zest. Conversely, life satisfaction for men was predicted by fairness, creativity, perspective, and humor. This gives us some pause for thought. How can we treat the whole person sitting in our chair (not just erase wrinkles, laser off brown spots, or make beautiful lips)? What can we really do to make our patients happier with increased satisfaction with our practices? Think about all of the

incredible research done on this topic, and apply it to your everyday practice.

All providers understand the person sitting in their aesthetic chair is a whole person. They may have had an argument with their partner before seeing you, gotten a speeding ticket, been fired from a job and feel they should not be in your office spending money, and so on. You as a provider are bringing all of your life experiences into the patient-provider relationship as well. When you enter the room, bring your best *mindfulness* techniques (another concept from positive psychology) to the forefront, and practice being in the here and now. The patient in your chair is the most important thing, so you should give them your complete attention. Modulate your expressions if you are having a bad day; science has taught us that we can read an expression sometimes in as little as 17 milliseconds.

Another negative aspect of being an aesthetic provider is the fact that much of what we do can be painful to some degree. Now is the time to pull out what you have just learned from positive psychology about the most important contributors to life satisfaction for women and men. As stated earlier, values are different for each unique person, so be sure to discuss with your patient what may be important to them. While I am seeing patients and considering what I know from positive psychology, I truly ask myself, "What would I want if I were the patient at this moment?" and "Where can I go from here to make this experience better?"

If I am treating a female patient, now is the time to consider what may be most important to her—appreciation of beauty and excellence, love for other women, gratitude, hope, and zest. First, I appreciate that she is here to see me. I always thank them for trusting me. Conveying a sense of gratitude and positive energy and being in the moment will convey zest. Not enough can be said about making your patient see the beauty that they naturally possess; we all have something about us that is incredibly beautiful. It is also important to ask your patient what they think their best feature is. This is important because most of the appointment will focus on features they do not like about themselves, and this will aid in the appreciation of their natural beauty. As a provider, you can convey an appreciation for excellence through careful assessment and listening to the patient and understanding what they want from their visit. A sense of warmth and personal connection is important as well. This is imperative because, as humans, we are driven to have a connection with our surroundings and the people in them. On forming this connection, you can deliver excellent aesthetic service. Explain what you are doing, leave your ego out of the room, and never make your patient feel ugly. For male patients, the same ideas exist. Considering that life satisfaction for men is predicted by fairness, creativity, perspective, and humor, I would gear my assessment and conversation to a more teaching perspective and use appropriate humor during the appointment.

Furthermore, I never do something that will not benefit the patient just so they will spend money. In this way, I develop a sense of trust with me and our practice. Try to always remember personal things about your patients to let them know they are important to you. Many times I have heard a patient say they left a practice because they were made to feel ugly or that the provider was so egotistical that it overwhelmed the visit. Without patients, a practice cannot exist. As a result, providers should treat patients with respect and remember that it takes five positive experiences to overcome one negative experience. These concepts are important to build into your practice to make it a successful one that stands apart from other aesthetic practices.

Interestingly, one of the major aesthetic pharmaceutical companies, Merz Aesthetics, has embraced some of these positive psychology concepts in their international campaign across the Asia Pacific—the Merz Aesthetics Serendipity Journey (www.myserendipityjourney.com). The concept of the Serendipity Journey is that women can be beautiful on the inside and outside, and they can enhance their best features through this realization. The Serendipity Journey explores feeling empowered to be the best version of oneself through enhancement in balance with the rest of one's features through aesthetic treatments and by embracing self-confidence and self-happiness. It also encourages being the best version of oneself by embracing one's unique individuality without conforming to societal standards. I appreciate this message immensely and find that it can be a powerful message for all of us to embrace.

My last words of wisdom mirror what Dr. Niamtu stated regarding a problem patient. Specifically, it is certainly wise and prudent to say "I have nothing here that will benefit you" if you do not feel comfortable treating a patient. In addition, I do not like to present aesthetic patient evaluation questionnaires in the room with a patient. However, if you would like to use one of the available aesthetic patient evaluation questionnaires, memorize the questions on the ones you like, ask the patient in the course of the patient evaluation, and document the answers. In this way, the patient will not feel like they are performing a psychological examination and feel devalued or demeaned.

Another word of wisdom comes from my incredible husband, Dr. Wm. Philip Werschler MD. Early in my almost 20-year aesthetic career, he told me to "never be a hero, you're not saving lives here, it's aesthetic medicine," and these words still ring true for me today.

Also, it is important to always appreciate the opportunity to learn! When you think you know everything there is to know about aesthetic medicine and have nothing left to learn, you are wrong, and this mindset could lead to negative outcomes. The top international Key Opinion Leaders in aesthetic medicine are always discussing new techniques and are hungry to learn from each other. I learn something new at least once a week from either my own experiences, reading journals, discussing things at work and with my husband, or talking to colleagues. Aesthetic medicine is one of the most rapidly growing industries. In closing, best of luck, enjoy your patients, and enjoy yourself. An aesthetic practice can truly be a life-changing miraculous journey for not only your patients but also for you. Have fun, and be happy!

Figures 1.34–1.36 show scenes for the offices of Drs Philip and Pam Werschler.

Fig. 1.34 Understanding the positive attributes of the aesthetic patient and tailoring their experience is imperative for practice growth and job satisfaction. (*Photo courtesy Phil Werschler, MD, and Pam Werschler, PSY.D, MSN, ARNP, DNC.*)

Fig. 1.35 Aesthetic patients are pampered and expect bright, clean, contemporary spaces. W Aesthetics Premier Medical Spa reception room. (*Photo courtesy Phil Werschler, MD, and Pam Werschler, PSY.D, MSN, ARNP, DNC.*)

Fig. 1.36 Showcasing and branding one's work online and providing copies for the patient is a great way to stand out as excellent in aesthetics. (*Photo courtesy Phil Werschler, MD, and Pam Werschler, PSY.D, MSN, ARNP, DNC.*)

Suggested Readings

American Psychiatric Association. (1994). (DSM-IV). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: American Psychiatric Association.

An, P. G., Rabatin, J. S., Manwell, L. B., et al. (2009). Burden of difficult encounters in primary care: data from the minimizing error, maximizing outcomes study. *Arch Intern Med*, *169*, 410.

Capone, R. B., & Sykes, J. M. (2012). *Complications in Facial Plastic Surgery*. New York: Thiem Medical Publishers.

Crutcher, J. E., & Bass, M. J. (1980). The difficult patient and the troubled physician. *J Fam Pract*, *11*, 933.

Ferrando, S. J., & Okoli, U. (2009). Personality disorders: understanding and managing the difficult patient in neurology practice. *Semin Neurol*, *29*, 266.

Gladwell, M. (2005). *Blink: The Power of Thinking without Thinking*. New York: Little, Brown, and Company.

Goldberg, P. E. (2000). The physician-patient relationship: three psychodynamic concepts that can be applied to primary care. *Arch Fam Med*, *9*, 1164.

Hahn, S. R. (2001). Physical symptoms and physician-experienced difficulty in the physician-patient relationship. *Ann Intern Med*, *134*, 897.

Hahn, S. R., Kroenke, K., Spitzer, R. L., et al. (1996). The difficult patient: prevalence, psychopathology, and functional impairment. *J Gen Intern Med*, *11*, 1.

Krebs, E. E., Garrett, J. M., & Konrad, T. R. (2006). The difficult doctor? Characteristics of physicians who report frustration with patients: an analysis of survey data. *BMC Health Serv Res*, *6*, 128.

Macdonald, M. (2003). Seeing the cage: stigma and its potential to inform the concept of the difficult patient. *Clin Nurse Spec*, *17*, 305.

Peteet, J. R., Meyer, F. L., & Miovic, M. K. (2011). Possibly impossible patients: management of difficult behavior in oncology outpatients. *J Oncol Pract*, *7*, 242.

Simon, J. R., Dwyer, J., & Goldfrank, L. R. (1999). The difficult patient. *Emerg Med Clin North Am*, *17*, 353.

Smith, R. C. (1984). Teaching interviewing skills to medical students: the issue of 'countertransference'. *J Med Educ*, *59*, 582.

Smith, R. C. (2002). *Patient-Centered Interviewing: An Evidence-Based Method* (2nd ed.). Philadelphia: Lippincott Williams and Wilkins.

Sykes, J. M. (2008). Patient selection in facial plastic surgery. *Facial Plast Surg Clin North Am*, *16*, 173–176.

Sykes, J. M. (2009). Managing the psychological aspects of plastic surgery patients. *Curr Opin Otolaryngol Head Neck Surg*, *17*(4), 321–325.

Wetterneck, T. B., Linzer, M., McMurray, J. E., et al. (2002). Worklife and satisfaction of general internists. *Arch Intern Med*, *162*, 649.

Chapter 2

The Aging Face

Joe Niamtu, Abraham Pathak, and Derick Antel

This chapter provides a comprehensive discussion of facial aging. It is important that the reader also note that specific anatomic aging changes are also discussed in individual chapters within this text.

"Aging is a privilege denied to many," Dr. Niamtu often tells patients who are unhappy with their aging. However, what is not denied to the cosmetic surgeon is dealing with this patient population daily. Perhaps equally important is how the patient is "handling" their aging. A 60-year-old patient who wants to look 30 is unreasonable, while a 60-year-old patient who wants to look as good as they can for 60, is very reasonable. A big part in a surgeon having favorable outcomes is picking the right patients. Cosmetic facial surgery has become very popular in our culture, and body dysmorphic disorder (BDD) is very prevalent. A normal and balanced cosmetic surgery patient can be a pleasure to work with. However, a patient with BDD can be a nightmare both clinically and legally. This type of patient cannot accept aging, and their entire psyche revolves around narcissism and pathologic body image and well-being. Acquiring the ability to avoid this type of patient is a true skill.

Aging is a physiologic process of the body in response to the passage of time. Since the beginning of time, people have sought treatments to retard or reverse aging, to no avail. Aging can be accelerated by both intrinsic and extrinsic factors, and it cannot be stopped or reversed, but its effects can be mitigated.

Despite being a universal process, a complete knowledge of facial aging continues to elude us. The evolution of numerous theories and anatomic observations have continually increased our understanding of the morphologic aging process.

Lambros recently broadened the visual understanding of facial aging with his comprehensive 54-year three-dimensional population study. Building on our shared registration of changes over time, his landmark-based three-dimensional comparative image analysis revealed sex-independent spatial changes, including narrowing of the eyelid aperture, retrusion of the nasal alae into the cheek with thinning of the upper lip unit accentuating the nasolabial crease, and gradual definition of the jowl fat pad over time (Fig. 2.1). Changes do not occur solely along the surface planes of the face, but at right angles, speaking to the multidimensionality of facial aging.

It is imperative that cosmetic surgeons fully understand the pathophysiology of aging. Accounting for these changes and educating patients about aging helps them appreciate the process and basis for rejuvenation. Most textbook descriptions of facial aging are very mechanical and relate to loss of volume and support. Although these are important factors to recognize in aging reversal through cosmetic surgery, various other intrinsic factors also play a role in aging.

As most cosmetic facial surgery patients are female, the nuances of metabolic aging influences are significant. Menopause produces decreased estrogen levels with elevated androgen levels, which contribute to epidermal and dermal changes. The decrease in basal metabolic rates (in men and women) facilitates weight gain and fat distribution in unwanted places such as the thighs, abdomen, hip, buttocks, face, and neck. Add the effects of childbearing to the skin and muscle and it is easy to understand the aging process in females. Subcutaneous fat also decreases, which affects the support of the skin. The face and neck are rich in glandular structures, which are less frequently discussed in volume loss but are probably moderate contributors. Skeletal muscles can undergo 50% atrophy with aging, and osteoporosis plays a key role in bone resorption, as the majority of women in their fifth decade are osteoporotic. Osteoporotic changes also occur in males and contribute to facial skeletal and dental resorption in both sexes. As the facial skeleton shrinks, even more soft tissue support is lost (Fig. 2.2). Bone in the aging face is more prone to resorption in specific areas such as the orbital rims, maxilla and piriform regions, and anterior mandibular and pre-jowl regions (Fig. 2.3). In addition, ligamentous attachments from bone to soft tissue tether the overlying soft tissue and contribute to hollowing when bone loss drags down the soft tissue anatomy.

One unique factor to facial aging is that in most cultures the face is exposed. Clothes can mask somatic aging, but the face, neck, and hands give it away.

As with all other theories or processes, surgeons and anatomists argue about what exactly happens during aging. Although most surgeons agree that atrophy, ligamentous laxity, and ptosis are causative factors, others argue against this. It is universally agreed, however, that aging is a gradual process of structural weakening,

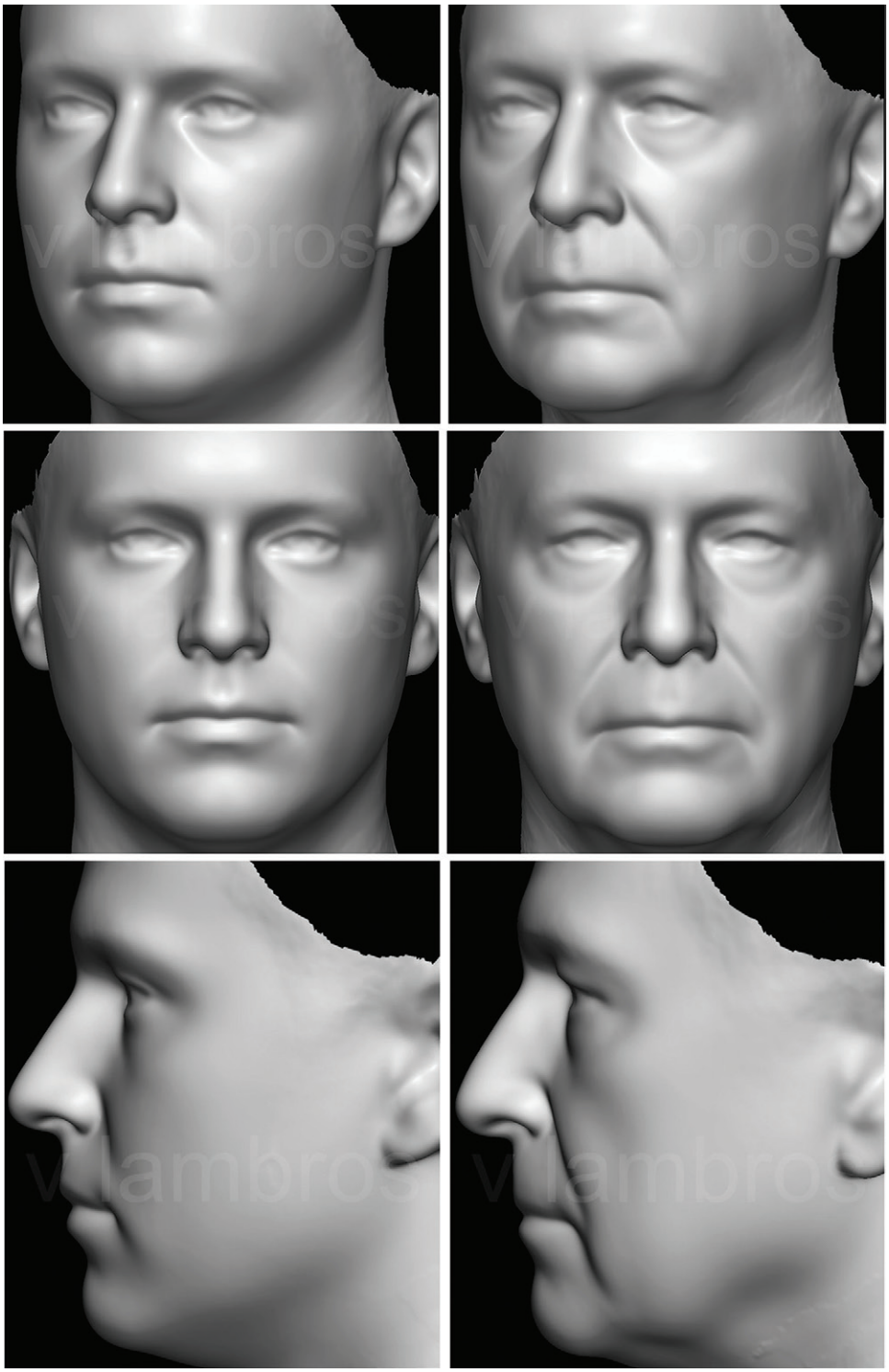

Fig. 2.1 Comparative image transitions of the average young and old male face showing the spatial changes of narrowing of the eyelid aperture, retrusion of nasal alae into the cheek with a thinning upper lip unit accentuating the nasolabial crease, and demarcation of the jowl fat pad. *(Reprinted with permission from Val Lambros, MD.)*

and its clinical effects begin in the third decade and progress throughout an individual's lifetime. Aging can be described as a process of deflation similar in the transition from a grape to a raisin (Fig. 2.4).

Babies and toddlers have full rounded faces with full convex contours. This is, in part, from the small skeleton supporting the generous fat compartments in infancy. Adolescence includes rapid but disharmonious growth of bone, cartilage, muscle, and fat, which produces a sometimes-awkward appearance in the preteen years. Through the teen years, puberty produces secondary sexual characteristics including rapid growth phases, which produce hereditary but predictable and distinguishable facial changes. Middle

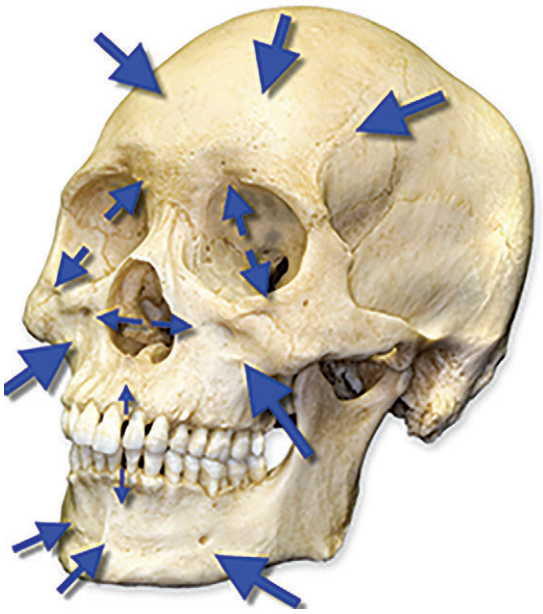

Fig. 2.2 Osseous resorption accounts for many aging changes. Common regions of bony atrophy *(arrows)* cause loss of support for overlying soft tissue anatomy.

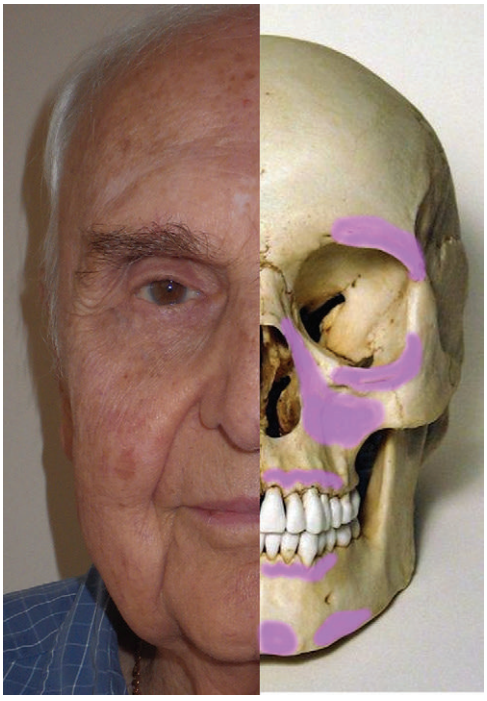

Fig. 2.3 Images showing soft tissue volume loss and descent secondary, in part, to underlying bony atrophic aging changes.

Fig. 2.4 The youthful grape transforming to an aging raisin symbolizes skin aging and volume loss over time. Both intrinsic and extrinsic changes affect aging. Note that the grape is drinking water and using sun protection, while the raisin is smoking, drinking alcohol, and not using sun protection.

age brings the onset of aging changes that progress until death (see later). The cycle of aging is such that infants have large orbits and smaller maxillae, which make their midfacial characteristics resemble an aged person. As the midfacial skeleton grows, the infant takes on the midface of youth. Continued aging produces widening of the orbits with simultaneous maxillary and piriform resorption, which makes the aged person resemble an infant. This is truly the cycle of life. Although some parts of the facial skeleton resorb with age, some areas such as the mandible enlarge, underlining the multifactorial and dynamic changes that contribute to the aging facial skeleton.

The youthful face is tapered like an upside-down egg because of the distinct volume and tight tissue retention (Fig. 2.5). The aging face is more of a reverse taper, similar to a right-side-up egg, because of the descent of volume and fat compartment changes (see Fig. 2.5).

Aging changes are not only caused by volume loss and support changes but are also caused by intrinsic and extrinsic factors (Box 2.1).

It is interesting that biologic aging can sometimes exceed chronologic aging, and we all know 45-year-olds who look 60 years old or the inverse. Fig. 2.6 shows a career truck driver with obvious accelerated actinic damage on the driver's side that is exposed to more sun and wind. Fig. 2.7 shows a 65-year-old female with both hereditary and acquired aging (intrinsic and extrinsic). Lifestyle and hereditary factors are significant contributors to the aging equation. Some aging factors are controllable, while others are not. Studies of monozygotic twins have revealed that aging is affected greatly by environmental and lifestyle factors, as measured by physical appearance. The factors that exert the greatest influence seem to be substance or alcohol abuse, sun exposure, and emotional distress. These aging changes are shown with supporting images in the various procedure chapters. An excellent description of cutaneous aging is presented in Chapter 12.

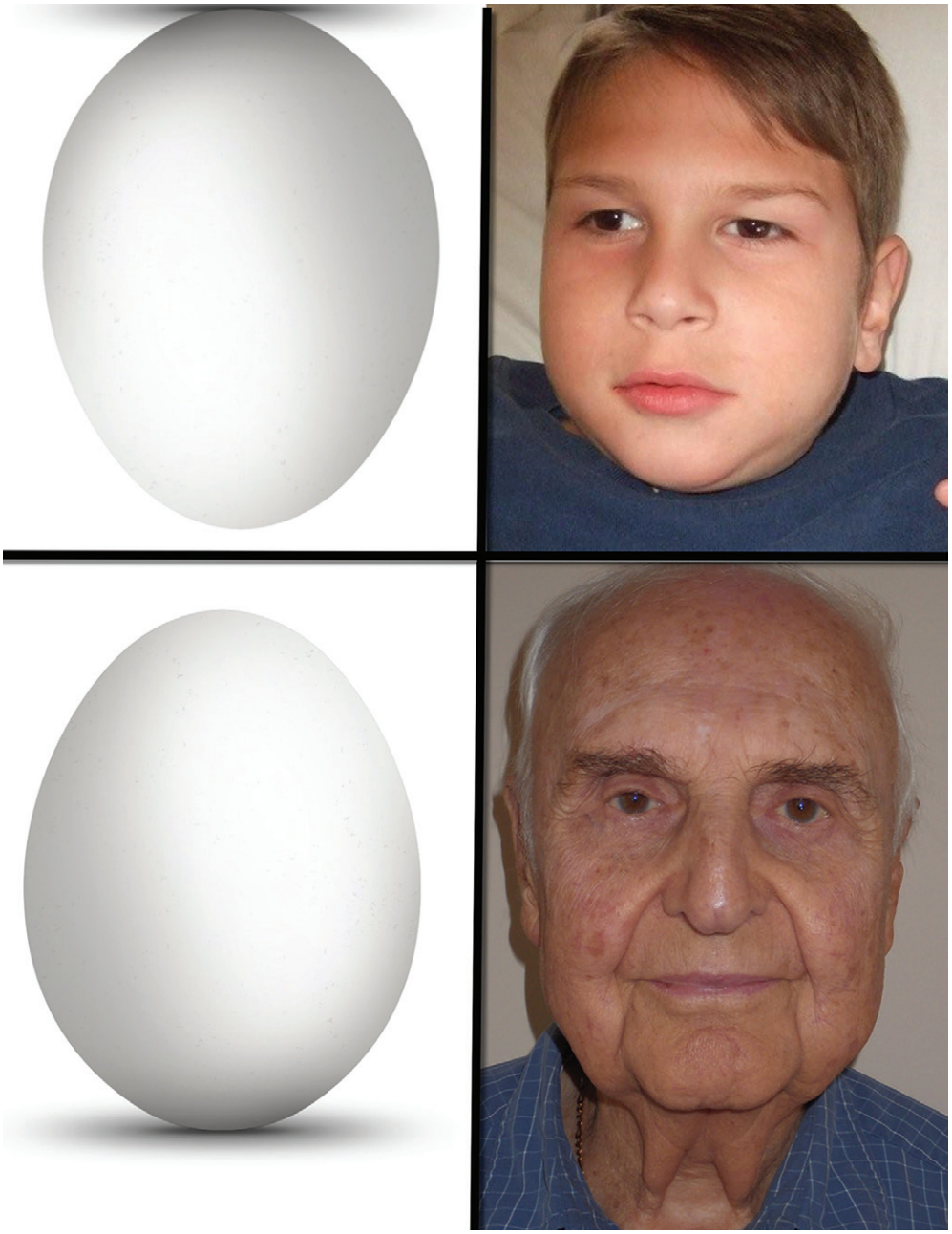

Fig. 2.5 A young, youthful face is tapered toward the jawline, similar to an upside-down egg *(top)*. An 80-year-old patient with a squared-off lower face similar to a right-side-up egg *(bottom)*.

Box 2.1 Comprehensive aging factors

Intrinsic aging factors	Extrinsic aging factors
Cellular senescence	Ultraviolet radiation
Decreased proliferative capacity	Environmental factors (e.g., ozone)
Decreased cellular DNA repair capacity	Tobacco use
Chromosomal abnormalities	Ethanol abuse
Hormone reduction	Gravitational effects
Gene mutation	Elasticity changes
Hard, soft, and dental structure loss	Emotional stress

In a previous text published by Niamtu, Tom Faerber contributed to a section on facial aging that details a study in which he obtained CT scans on his 9-year-old daughter, 42-year-old wife, and 75-year-old mother-in-law to compare aging changes. Particularly notable is that the youthful face is convex, while the aging face is concave as a result of fat atrophy, muscle atrophy, gravitational changes, and ptotic changes (Figs. 2.8–2.10). A pattern of muscle atrophy was demonstrated in the masseter and buccinators muscles in the oldest family member. The parotid gland maintained its volume, whereas the surrounding perimuscular and subcutaneous fat showed atrophy. Fat and muscle atrophy in the temporal, buccal, and malar regions were also seen and

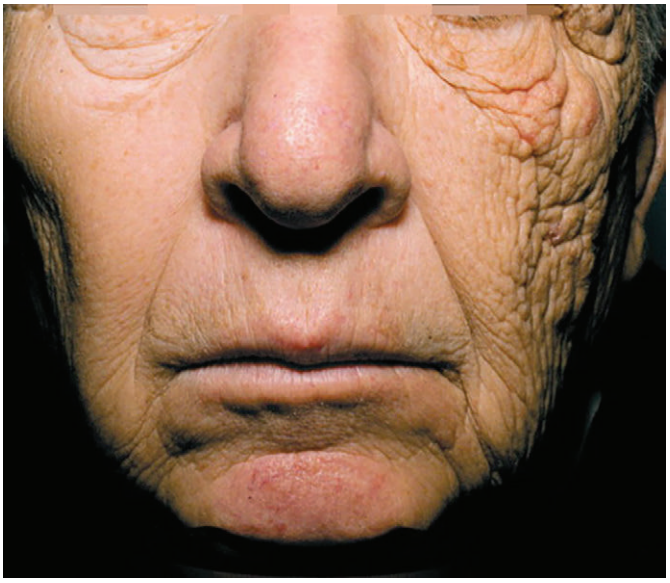

Fig. 2.6 Unilateral advance skin actinic damage is shown on a career truck driver whose left side faced the window.

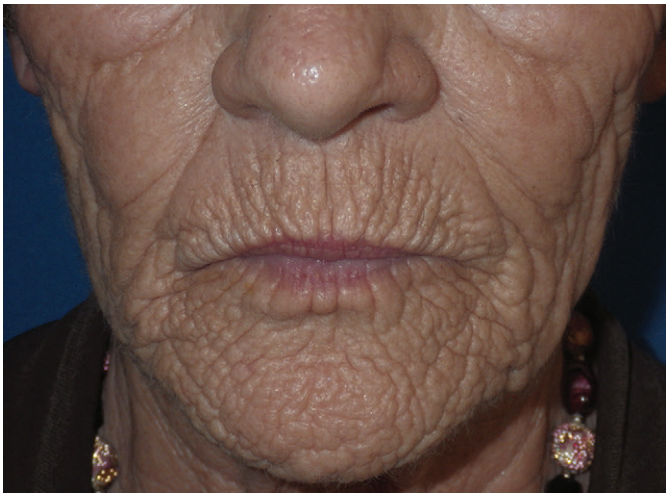

Fig. 2.7 A 65-year-old female patient with advanced skin aging, likely from sun damage and genetic predisposition.

contributed to concavities in the regions that develop with age, as evidenced in the progressive CT scans. This evidence-based data show facial aging transformations from convex to concave. Although osseous volume loss is a big component of midfacial aging, some studies show that osseous volume increases in the lower face.

Once thought to be a continuous structure anatomically, Rohrich and Pessa revealed that the subcutaneous fat of the face is highly compartmentalized with vascularized fibrous septal boundaries separating individual facial fat compartments (Figs. 2.11 and 2.12).

The nasolabial fat and jowl fat are separate distinct compartments. The periorbital fat is divided into superior, inferior, and lateral compartments. The malar fat is divided into the medial, middle, and a larger lateral temporal-cheek fat spanning the height of the face from the cervical subcutaneous fat to the lateral-most compartment of the forehead. The forehead similarly has three compartments with the central, middle, and lateral temporal-cheek fat. Some compartments, such as the periorbital and malar fat pads, tend to deflate earlier in middle age, while others deflate later in life. In the youthful face, the transition between these subcutaneous compartments is smooth, whereas variable deflation among compartments in the aging face render distinguishable abrupt contour changes. This volumetric understanding of facial aging continues to elicit interest and influence the techniques employed in facial rejuvenation today.

Regional Facial Aging

The most logical means of addressing facial aging and rejuvenation is to start at the top and work downward in an orderly progression during the consultation and discuss the diagnosis and treatment of each unit.

Skin

The most plentiful facial tissue is skin. It serves as the canvas of the face, revealing the deflation and atrophic changes of the various underlying components. Like the exposed hands, it rarely gets respite from the ravaging effects of the environment. Extrinsic factors such as sun exposure, stress, and smoking can accelerate the effects of aging.

Contributing to exogenous skin aging is the decrease in skin functions that occur with age. These changes include decreases in cell replacement, injury response, barrier function, sensory perception, immune and vascular responsiveness, thermoregulation, sweat production, sebum production, and vitamin D production. As normal regulatory pathways become dysfunctional with age, both the rejuvenation and healing processes of the skin are impaired. Recent studies have pointed to dysfunction of the hypoxia-inducible factor (HIF)-1α regulatory pathway as a primary contributor to the decline of both processes. The dermis is thicker on the areas of the face that are less mobile (e.g., forehead and nose) and thinner on the areas of the face with increased movement (e.g., lower eyelids).

Genetic contributions to skin aging result in numerous biochemical, histologic, and physiologic changes. These changes include a reduction of vascularity, increased dermal/epidermal thickness, collagen changes, proteoglycan and dermal cellularity, and loss of elastic fibers.

However, studies of monozygotic twins have highlighted the importance of external factors on the aging of the skin. Originally researched by Dr. Darrick Antell, studies on identical twins have shown the effect of personal lifestyle choices and habits, with smoking and sun exposure attributing the greatest degree of discordance in visible aging between genetically identical twins (Fig. 2.13).

Smoking-associated differences are usually seen in the middle and lower thirds of the face, with fewer attributable differences seen in the upper face. However, photodamage, the aging changes

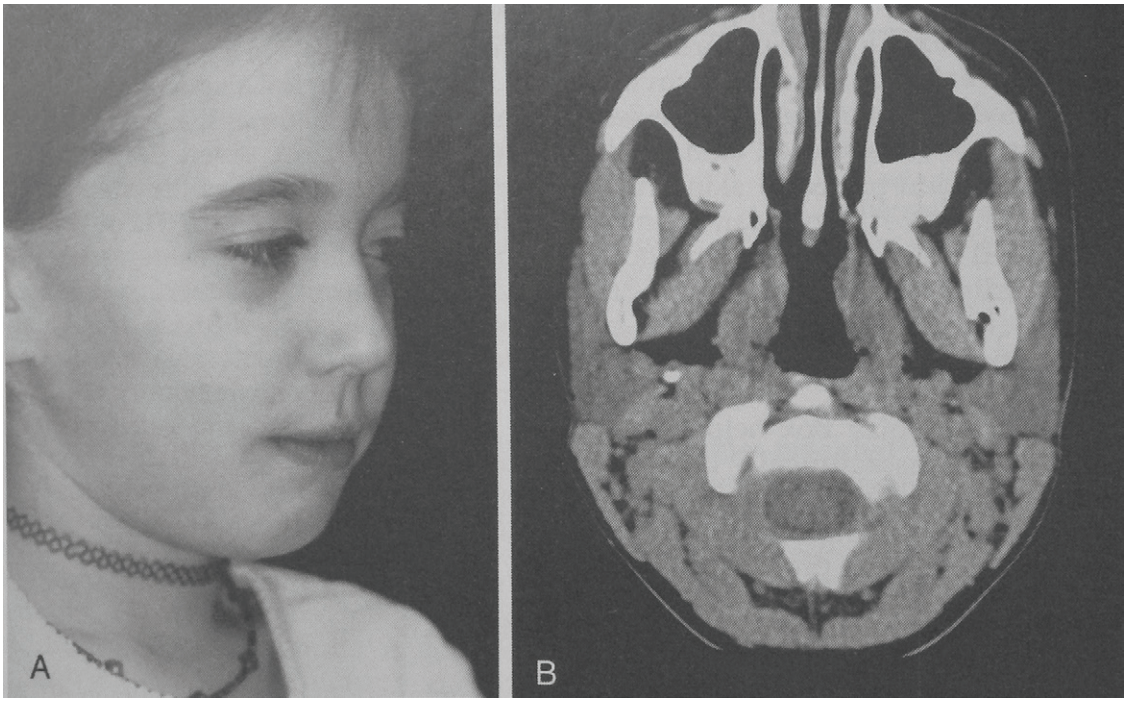

Fig. 2.8 CT scan showing the facial anatomy of a 9-year-old female patient.

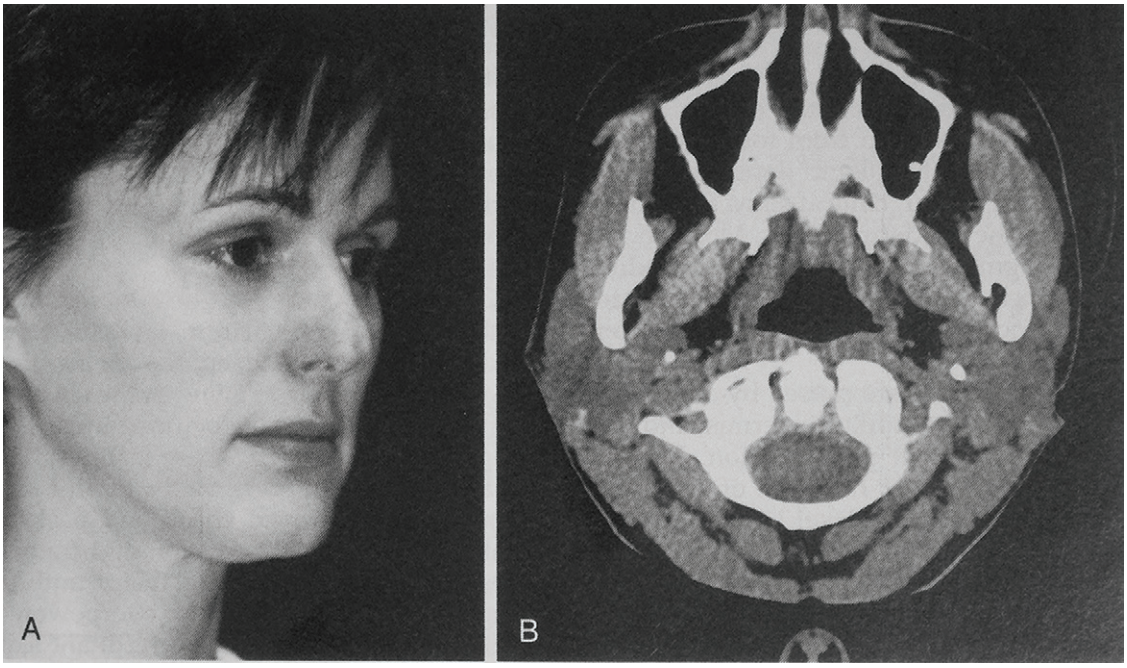

Fig. 2.9 CT scan showing the facial anatomy of a 42-year-old female patient.

of the skin from chronic ultraviolet (UV) light exposure, is more pervasive and affects all areas of chronic exposure. Cumulative photodamage can be seen in almost every patient by comparing the sun-exposed and sun-protected areas of skin. The most obvious clinical cutaneous aging changes include markedly increased skin roughness, mottled hyperpigmentation, loss of elasticity, wrinkling, and sallowness.

Photoaging causes functional and anatomic modifications in the exposed regions. Ultraviolet B (UVB) radiation produces direct damage on the DNA of skin cells and also modulates the activity of cytokines and adhesion molecules. Ultraviolet A (UVA) radiation initiates the formation of reactive oxygen species (ROS), which also damage nuclear and mitochondrial DNA and activate matrix metalloproteinases (MMPs).