Pearls and Pitfalls in Cosmetic Oculoplastic Surgery

Second Edition

Morris E. Hartstein
Guy G. Massry
John B. Holds
Editors

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Foreword

I like this textbook. It has more pearls than Captain Hook could have imagined in his pirate quests. The first edition of *Pearls and Pitfalls in Cosmetic Surgery* was published in 2008. Six years later, there have been updates in the many aspects of cosmetic oculopastic surgery and this textbook captures those changes. Like its predecessor, it is still packed with important details of cosmetic oculoplastic surgery and is still authored by the masters and authorities of this discipline. Whereas the first book had 172 chapters, the second edition has expanded to 209 chapters.

What is a pearl? Not only a beautiful jewel, but, pertaining to surgery, a tip and update that we might not know about and that a master surgeon can pass on to us to improve our ability to do a procedure. Whereas most textbooks go into long great detail to do a procedure, this book guides us in short, succinct chapters through the most important points of the procedure. (It has been my recent experience that the trend in medical meetings is to steer away from long, laborious lectures and toward short lectures on tips and updates of procedures.) Harstein, Holds, and Massry are encompassing this trend in their new textbook.

What is a pitfall? I believe this is a kind word describing the potential complications that we can trip into. So, in addition to the thousands of pearls in this textbook, the master authors also in their short, succinct chapters, inform us how to avoid the many potential downfalls and traps of these procedures so that we might get a more perfect result when we do the operation.

The textbook could be titled *Pearls and Pitfalls of Cosmetic Oculofacial Plastic Surgery*, rather than oculoplastic surgery. There are many chapters that go beyond the eyelid area, including endoscopic forehead and browlifts, rhytidectomies, facial fillers, facial botulinum toxin, and facial laser resurfacing.

All the specialists that do cosmetic oculofacial plastic surgery will enhance their surgical results by reading this textbook. It is a must.

IL, USA — Allen M. Putterman, MD

Foreword (From 1st Edition)

Learning oculofacial surgery is a lot like learning to dance. In the beginning, the dance student is consumed with where to put his or her feet. For these new students (or for the rhythmically challenged), dancing is characterized by the struggle to step their feet in imaginary numbered shoeprints, 1–2–3–4, and they barely hear the music. In surgery, the beginning surgeon is preoccupied with steps as well. Their focus is on the mechanical process. Proscribed steps create the paradigm for performing the surgery.

With time, the dance student moves on to the next stage. He does not have to think as much about where he is putting his feet, and can start to listen to the music and feel the rhythm. The advanced surgeon begins to internalize the steps of surgery so that instead of a preoccupation with the next maneuver, she can start to individualize the surgery to the patient and employ flexibility in the face of unique problems.

The master dancer makes no conscious effort to move his feet; his feet move him. He does not concentrate on rhythm; the rhythm of the music becomes part of him. Freed from the intellectual exercise of dancing and from the technical requirements of keeping time, he is free to break from the restraints of the proscribed steps and invent a new dance as he goes along.

The master surgeon enjoys a similar freedom. The focus is not on maneuvers and, in fact, the surgeon might be temporarily taken aback if asked to explain the mechanical details of what he is doing. Instead, the thought process is conceptual. The surgeon is visualizing a result, is sensitive to the nuances of the patient's individual anatomy, and is always making adjustments to address the unique requirements presented by the case at hand. By approaching the operation conceptually, and having effortless command of anatomy and technique, the master surgeon is freed from the constraints of proscribed operations, and is able to invent new surgeries.

In this book, a high octane collection of master surgeons provide a work that reflects the scope of ophthalmic plastic surgery. There is material here for every type of student. The beginner will appreciate step-by-step instructions and clear anatomic diagrams. The advanced surgeon will be drawn to the delightful tricks and peals that are sprinkled liberally throughout the text. The master surgeon (and the aspiring master) will recognize that they are seeking the same thing that the authors are seeking, and they will be stimulated to continue to search for better treatments and surgeries. The obvious hard work that went into the preparation of this book will pay off handsomely when its

readers improve their ability to take care of their patients, and particularly when they are inspired to continue their own journey toward mastery of our discipline.

CA, USA Robert Alan Goldberg, MD

Preface

The goal of this book is to help surgeons perform more efficient, productive, and successful surgeries. By sharing our varied experiences acquired through years of practice, we hope this book will provide insights that can enhance surgical outcomes. In compiling this text, we solicited contributions from experts in cosmetic oculoplastic surgery as well as surgeons from other related fields such as facial plastic surgery, plastic surgery, and dermatology. The book is divided into 12 parts, which cover the spectrum of oculofacial procedures. Each section is divided into concise chapters focusing on just one aspect of a given procedure. Within these short chapters, each contributor offers tips on how to achieve optimal results. For example, the section on upper lid blepharoplasty is subdivided as follows:

- Preoperative evaluation
- Incision planning
- Procedure pearls
- Adjunctive procedures
- Wound closure and postoperative care

There are also multiple presentations on the same aspect of a procedure to provide different points of view and approaches. We greatly appreciate the various experts who have shared their experiences.

In this second edition of the book, we have updated chapters where necessary as well as added nearly 50 new chapters to reflect the constantly evolving field of oculofacial plastic surgery.

We are indebted to Rebekah Amos at Springer for all of her support and assistance and the tireless efforts of Michael D. Sova (Developmental Editor) in keeping track of the multitude of moving parts in preparing this manuscript.

Zerifin, Israel — Morris E. Hartstein, MD, FACS
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Editors

Dr. Morris Hartstein completed his undergraduate studies at Columbia University, attended the Albert Einstein College of Medicine, interned at Bellevue Hospital and did his residency at New York University School of Medicine. He completed a fellowship in Ophthalmic Plastic Surgery at Harvard's Massachusetts Eye and Ear Infirmary and at Tuft's New England Eye Center. He was Associate Professor of Ophthalmology and Plastic Surgery and the Director of Ophthalmic Plastic Surgery at Saint Louis University Eye Institute. He is currently Director of Ophthalmic Plastic Surgery at Assaf Harofeh Medical Center, Tel Aviv Sackler School of Medicine, and in private practice. Dr. Hartstein has published over 75 scientific articles and book chapters and has delivered over 200 presentations. He is a regular instructor at the annual meetings of the American Academy of Ophthalmology and the American Society of Ophthalmic Plastic and Reconstructive Surgery. Dr. Hartstein continues to direct a cadaver dissection course annually at Saint Louis University, which is attended by physicians from all over the world. He has previously edited the first edition of *Pearls and Pitfalls of Cosmetic Oculoplastic Surgery and Midfacial Rejuvenation*.

Dr. John B. Holds completed his medical degree at UT Southwestern in Dallas Texas, ophthalmology residency at the Cullen Eye Institute, Baylor College of Medicine, and ophthalmic plastic surgery fellowship training at the University of Utah. After years as a full-time faculty member at UT Galveston and Saint Louis University, he has been in private practice in St. Louis Missouri for the past 20 years. Dr. Holds is the Program Director for the St. Louis combined oculofacial surgery fellowship, and has published over 100 peer-reviewed publications, and over 50 book chapters and other communications. Dr. Holds is a frequent lecturer on topics of subspecialty interest at national and international meetings and has directed and instructed at over 75 CME anatomy workshops over the past 23 years. He was also on the committee responsible for the American Academy of Ophthalmology Basic Clinical Science Course volume 7, *Orbit, Eyelids and Lacrimal System,* for 11 years, chairing the committee for 6 years through two revisions of the textbook. Importantly, Dr. Holds was lucky to join Drs. Hartstein and Massry as an editor through the two editions of *Pearls and Pitfalls in Cosmetic Oculoplastic Surgery.*

Dr. Guy Massry was born in Israel and raised in Los Angeles, California. He received his undergraduate and medical degree at the University of Southern California (USC) and then his ophthalmology and ophthalmic plastic training in St. Louis, MO, and New York, before returning to Beverly Hills where he is in full-time practice. Dr. Massry is a fellowship co-preceptor for an AAFPRS approved facial plastic surgery fellowship, which is currently training its sixth fellow. Dr. Massry has published over 75 manuscripts and book chapters, is a frequent guest lecturer at various symposia throughout the country and has edited three textbooks focusing on aesthetic oculoplastic surgery. The most recent text titled *Master Techniques in Blepharoplasty and Periorbital Rejuvenation* has been well received and is the first such text which is truly multi-disciplinary in nature with contributions from the four core aesthetic subspecialties (plastic surgery, facial plastic surgery, oculoplastic surgery and dermatology). Dr. Massry is also a reviewer for various scientific journals and sits on the editorial board (while serving as section editor of aesthetic citations), for his society's specialty journal: the journal of *Ophthalmic Plastic and Reconstructive Surgery* (OPRS).

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Part I

Preoperative Evaluation

Preoperative Evaluation of the Cosmetic Patient

1

Jemshed A. Khan

First and foremost, the surgeon should elicit from the patient those specific topographic facial features that the patient wants to have improved. Patients often express concern that their periocular facial features are communicating unintended signals such as disapproval (glabellar frown lines), tiredness (lower eyelid fat pad herniation or upper eyelid ptosis), worry or ageing (crow's feet). The face, as an organ of communication, is malfunctioning (Khan 2001).

After eliciting and documenting the patient's concerns and taking photographs, the surgeon can evaluate the facial features for the anatomic basis of the patient's concerns. Patient's concerns are often related to familial, gravitational, or age-related facial changes.

Patients who cannot accept a "marked definite and noticeable improvement" as opposed to a "perfect result" may be considered poor candidates for aesthetic surgery. Informed consent includes discussing with the patient the risks, consequences, benefits, and alternatives of surgery as well as a signed document.

Finally, keep in mind that properly informed patients will not and should not always choose the surgical option that most effectively addresses their physical concerns. Other considerations factor in, including cost, invasiveness, surgical risk, location and visibility of surgical incisions, recovery times, postoperative morbidity, and procedure length. The goal is not to invariably create the best aesthetic improvement, but rather to educate the patient to the point where the patient can select the procedures which best meet their aesthetic goals while at the same time considering financial and psychological constraints, tolerance for surgical risk, and desires regarding rapidity of recovery (Figs. 1.1, 1.2, 1.3 and 1.4).

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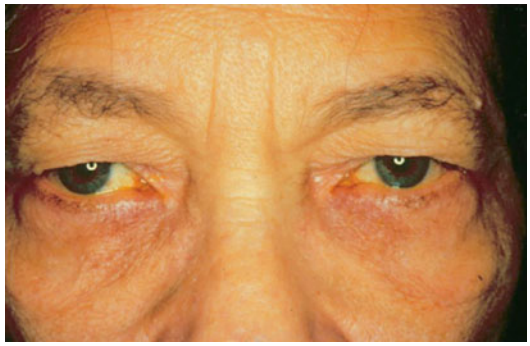

Fig. 1.1 Preoperative appearance of upper eyelid dermatochalasis communicates unintended facial signals of anger, skepticism, or disapproval

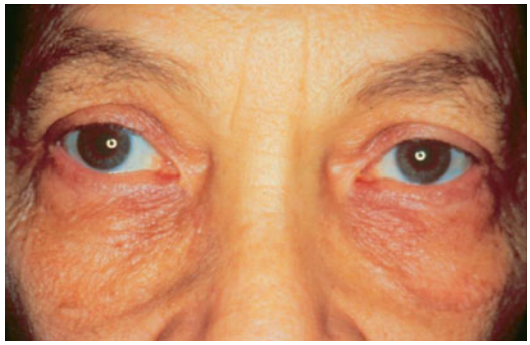

Fig. 1.2 Postoperative appearance communicates a more neutral and friendly appearance

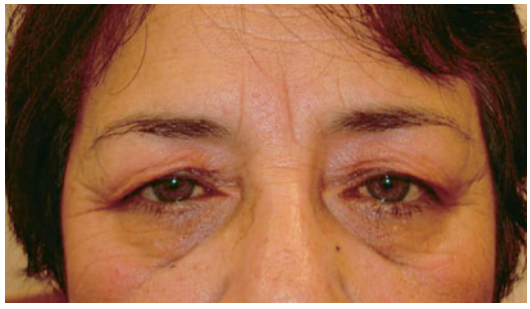

Fig. 1.3 Note the tired unfriendly facial expression due to upper eyelid dermatochalasis

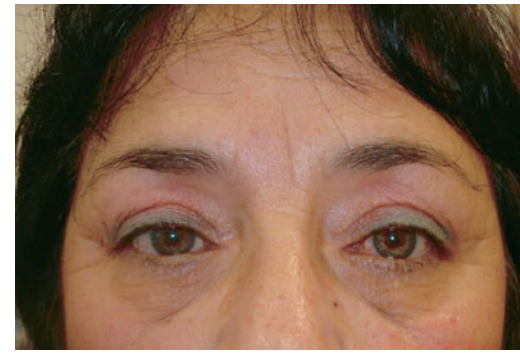

Fig. 1.4 Note the improvement of facial appearance and signaling following upper eyelid blepharoplasty

Reference

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Evaluation of the Cosmetic Patient

2

Rona Z. Silkiss

The Eightfold Path to Patient Happiness

1. Manage the balance of power.
2. Listen to the patient.
3. Ensure appropriate patient motivation.
4. Determine realistic surgical goals.
5. Screen out the difficult patient.
6. Conduct thorough informed consent.
7. Avoid surgical overcorrection.
8. Create an aesthetic environment.

Manage the Balance of Power Between Doctor and Patient

The relationship between the doctor and patient must be bilateral and balanced. Both the patient and surgeon must be willing to walk away from the "contract" that exists prior to surgery if signs of imbalance exist. If the balance of power lies too heavily with either the patient or the surgeon, the potential for an unhappy patient is high.

The patient must take responsibility for the initial objectives of the cosmetic surgery. In order for the surgeon to meet the patient's expectations, they must be established by the patient to himself or herself preoperatively. There must be an established metric for surgical success. If there is no defined endpoint, vague dissatisfaction or even litigation is a possible outcome.

Additionally, the decision to recommend surgery by the surgeon should not be based on whether you "can" perform surgery, but whether you "should." Patients may be asking for reassurance and may not be ready for surgery either physically or emotionally. A patient may be reacting to the increasing pressure of early surgery perpetuated by the media. Cosmetic surgery procedures may change the patient's perception of self and lead to an unhappy patient. A patient may already be unhappy and be sublimating this into a "surgical fix."

In general, surgeons may advertise but should avoid "selling" their services. A patient will appreciate honesty. Surgical integrity will be rewarded many times over. What is rare and withheld is valued more highly.

Listen to Your Patient Before Surgery (or You Will Surely Have to Listen to Them After)

In the course of a consultation with a patient, surgeons should specifically ask patients what they wish to achieve. Ask to see old photographs and remind the patient of his or her youthful configuration. Allow the patient to bring in photos of the desired or anticipated outcome.

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The contrast between target and actual configuration serves as the basis of a discussion about what surgery can and cannot provide. This defines the "envelope of the possible" for the patient. Remind the patient that "perfection is not part of the equation" for results no matter how perfect the surgery or procedure.

Document and Demonstrate

Photograph the patient during the consultation and demonstrate preoperative asymmetry. Patients may not be aware of their own preoperative asymmetry. In contrast, with certainty, they will be aware of any postoperative asymmetry. Preoperative awareness and documentation may prevent the patient from ascribing their underlying preoperative asymmetry to the surgery or surgeon.

Ensure Appropriate Patient Motivation

Often patients will be motivated to seek cosmetic surgery in the event of a recent job loss, divorce, or life crisis. It is critical that the surgeon assess the patients' motivation for surgery to decide if they are appropriate surgical candidates. Do not give the patient the opportunity to transfer his or her unhappiness to the recent surgery or surgeon. It may be useful to advise the patient to return after an interval of time when life circumstances have become more stable.

A patient's surgical goals should be appropriate and self-generated. The patient must be personally committed to the surgery and accept the risks of surgery and the physical alteration. Patients may be seeking reassurance from a consultant that surgery is optional at a particular point in time. Reassurance alone may be the best medicine. A patient trying to reestablish his or her own self-esteem, advised to postpone surgical intervention, may be your most grateful and happy patient.

Determine Realistic Surgical Goals

Both the surgeon and patient must be realistic. The surgeon needs a clear understanding of what a technique can optimally and usually provides. He or she needs to communicate this knowledge to patients so that their expectations can be adjusted to an informed reality. In advising patients, do not assume that the patient shares your personal aesthetic or style. Be aware of misguided surgical goals such as:

1. An attempt by the patient to match a distant image ideal (celebrity)
2. An attempt by the patient to achieve arbitrary standards of perfection through more surgery
3. An attempt by the patient to heal psychological pain by body alteration or wounding

Misguided surgical goals may lead the patient "driving to imperfection." This is a situation where the patient's fervent desire to achieve an impossible ideal may lead to surgical outcomes that are quite the opposite of beauty.

Screen Out the Difficult Patient

Learn to recognize the warning signs of a difficult patient. This is a limited list of signs of the potentially difficult patient:

1. The patient's chief complaint is one concerning prior surgeons.
2. The patient has already received multiple procedures and is still not satisfied.
3. The patient manifests an obsessive/compulsive approach to small or invisible suboptimalities. This may be demonstrated by overt self-intolerance or disdain or overly detailed, lengthy questions or email prior to considering the procedure.
4. The patient complains of pain or an abnormal feeling related to the cosmetic concern.
5. The patient continues to critically self-evaluate and primp in the mirror, despite your initiation of a conversation.
6. The patient appears to have an unrealistic expectation for the surgical outcome.

7. The patient refuses to "hear" the limitations of surgery and reiterates a desired outcome despite your explanation regarding the improbability or impossibility of same.
8. The patient displays an inappropriate level of familiarity or flattery, especially during the initial consultation.
9. The patient is inappropriately aggressive or hostile during the consultation or is inappropriately demanding or demeaning to the office staff.
10. The patient consultation takes an unusually lengthy period of time, making the surgeon uncomfortable with the degree of self-absorption and detail demanded.
11. There is excessive "negotiating" about price, location, or insurance prior to surgery.
12. Repeated cancelation of the surgical date.
13. Insistence by the cosmetic patient that "their friend's surgery was covered by insurance."
14. The patient seeks urgent or emergent cosmetic surgery unrealistically close to an important social event such as a wedding or reunion.
15. Your intuition informs you that this patient is likely to be difficult, yet your ego struggles with your desire to "fix the problem" other surgeons have been unable to correct, leading to your own internal tension and turmoil.

Determine whether a potentially difficult patient is someone for whom you wish to care in the event of a problem. The consultation is the honeymoon phase. The relationship is unlikely to get easier. Ask whether the patient will later insist, should there be a suboptimal outcome in his mind, that he or she was not given alternatives and appropriate time to make an informed decision or that the surgeon "rushed" to operate.

There are several psychiatric syndromes associated with difficult patients. The two most common are narcissism and body dysmorphic syndrome.

Narcissism is a condition in which the individual expresses an extreme need to be the center of attention. They make an inappropriate attempt to control the social environment. The etiology of narcissism is an underlying deep insecurity. Patients that are narcissistic may have a strong negative reaction to a surgeon's unwillingness to operate on them. They may view this as a personal rejection and may be inappropriately harsh in their response to the surgeon.

Body dysmorphic syndrome is manifested by an inaccurate or inappropriate assessment of body appearance. Patients manifest severe distress regarding their physical appearance despite numerous cosmetic procedures, irrespective of their actual appearance.

Surgery does not cure either of these psychiatric conditions. The experiment has been done again and again and again. There is no need to repeat the experiment.

As a surgeon, you are not obligated to care for a cosmetic patient whom you view as litigious, threatening, or difficult or for whom you believe the surgery is unlikely to satisfy—independent of result.

Conduct a Thorough Informed Consent

It is critical that the operative surgeon obtain a thorough informed consent prior to surgery. In addition to the specifics of the procedure, the consent discussion must emphasize that "function trumps form" every time. The potential risks and suboptimalities of surgery should be discussed openly. The most common risk is "expectation risk," and this should be discussed explicitly. Patients need to be reminded that "perfection is not part of the equation" for surgery, and if they will be satisfied with improvement, they will likely be happy. If they are seeking perfection, they will not be happy.

During the patient consultation and consent, the patient should be educated regarding the aesthetic surgeon's understanding of rejuvenation. In years past, more surgery, more excavation, and more hollowness or tautness were considered the standard of care and sometimes even proof of getting "one's money's worth" in surgery. This

provided patients with an unnatural, obvious, surgical alteration leading one to look "lost in time." In contrast, the current understanding of rejuvenation emphasizes that fullness is a sign of youth and that youthful individuals are not taut, hollow, or skeletonized. Additionally, youthful individuals are not overly frozen, plump, or exaggerated in configuration.

It is important to remind patients that form follows function and that a maximally aesthetic result will follow from the appropriate management of the target tissue. These tissues should not be overcorrected. Aesthetic results are always relative to age and native configuration. Patients and surgeons need to keep the correction in context to the patient's age, ethnicity, and natural appearance and physiognomy in youth.

Create an Aesthetic Environment

As an aesthetic surgeon, it is beneficial to create an environment in the office which expresses your ability to understand the nature of aesthetics. One should develop a clean, comfortable space with current décor. There should be health and fashion magazines in the patient lounge. Although the medical profession may receive its cosmetic information from peer-reviewed scientific journals, your patients are receiving their information and misinformation from mass media. The surgeon should be somewhat familiar with the current "lore or buzz" in the media.

The aesthetic environment should extend to the operating room. Here, the surgeon should provide for a calm, controlled, relaxing experience. "Handesthesia" goes a long way to reassuring an anxious patient during a procedure.

Patients always like to receive something more than expected. Send your patients home with sunglasses, gel packs, ointment, etc. Make the postoperative period easy. Send patients home with their postoperative medication or prescriptions, a postoperative appointment, and easy-to-read, explicit instructions. Ensure comfortable suture removal.

Be explicit about your revision policy in advance. Make certain this policy is well known to your staff to avoid unnecessary confusion or conflict. Finally, and above all, be available, affable, and able to follow through in resolving patient issues before and after a procedure.

The ultimate secret to a happy patient is communication, expectation management, and informed surgical and procedural judgment. Perhaps "The Eightfold Path to Patient Happiness" can help guide your way.

Preoperative Patient Counseling for Cosmetic Blepharoplasty

3

William P. Chen

Cosmetic blepharoplasty is one of the most popular forms of aesthetic surgery of the face. The surgical outcome is intimately related to the interaction of the upper eyelids with the forehead and brows, as well as the lower eyelids, lateral canthi, and the midface and cheek's topography. Therefore, in any discussion and examination of a patient with regard to this form of surgery, an astute clinician should be attentive to the entire face and not confine his or her attention to the superficial upper and lower eyelid skin layers. This awareness of surrounding as well as deeper structures will ultimately yield much better surgical outcome and a happier patient.

In my first office consultation with new patients, I listen first to their complaints and mentally classify the complaints into relative orders (like items on a wish list) including those that can be improved upon versus transient improvement or no improvement at all. I then assess what degree of enthusiasm or tolerance to surgery they possess base on their feedback. Ultimately, the surgeon and the patient need to mutually agree on what is comfortable, beneficial, and worthwhile for the patient to undertake. This may include financial matters, time commitment as to postoperative healing course, as well as overall general medical conditions that may have a bearing on the type of surgery and anesthesia recommended.

I always try to encourage patients to speak their mind, even if they may be embarrassed, and I try to facilitate this in an environment free of stress. Very often, patients may be overly self-conscious about an issue that matters very little to anyone they interact with, or one may need to point out an extreme condition that needs to be corrected before the aesthetic outcome can be achieved, for example, involutional ptosis in conjunction with upper eyelid hooding. It is important to customize individual aspects of your particular technique for that patient. For example, I have not performed two exactly identical procedures among any of my patients who came to me to have Asian blepharoplasty.

After an adequate prioritization of goals with the patient, I then explain what the procedure involves before, during, and after the surgery and what is expected of the patient.

In the office chart for the patient, I jot down particular aspects of their preexistent facial structure (like ptosis, ectropion, entropion, lateral canthal dehiscence, thinning of levator and aponeurosis, forehead brow overaction, prominent sulcus), what was mentioned to them (e.g., one upper lid margin is a millimeter lower than the other, one eye has a more prominent sulcus), what were the patient's response and preferences (high crease, low crease, shape of crease selected as well as skin texture and preexistent thinning of

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lower lid skin and telangiectatic blood vessels observed), as well as whether I have told the patient the likelihood their stated preference can be achieved. If a patient has thick dry skin, an oily complexion, superficial furuncles, or rosacea, these are all noted onto my plan of management for this patient.

If a patient seems extremely nervous, I try to call them the night before the procedure to make sure all is well. On the day of surgery in the preoperative area, I greet the patient again and reiterate the goal(s) of the surgery. If there is any discrepancy between what I told them and what they think and expect of the surgery, I will always defer the surgery until another day, although this is extremely rare.

Suggested Reading

Chen WPD, Khan JA, editors. Color atlas of cosmetic oculofacial surgery, (with DVD, 2nd ed). Philadelphia: Saunders; 2010.

Part II

Anesthesia

Cosmetic Oculofacial Pearls to Live By

4

Kenneth D. Steinsapir

> Only the paranoid survive. Andy Grove, Founder of Intel

When I was a medical student, I marveled at the speed of a particular attending plastic surgeon when he performed facelifts. He premarked the entire skin excision and removed the skin en bloc with Mayo scissors on each side as a big strip. He closed the face by whipping the skin edges together with a running suture in lightning speed. His facelifts were complete in about an hour. As a student, I thought this was absolutely amazing: a marvel. It was not until I was in practice on my own and saw his patients well after they had healed that I realized that my professor did an absolutely horrible facelift! My message here is that without perspective, very little of what we do has meaning. You might think what you do and what you have been taught are great. However, exposure to another surgeon's technique may cause you to rethink favorite methods long ingrained since early training. It is important to look for new approaches and understand what changes are worthwhile, perhaps essential, and what changes contribute very little. Separating what you come across in your journey as a surgeon is how one evolves into a better surgeon.

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In the following pages, I will share with you a few practice pearls that I hope will aid in developing one's perspective. What is certain is there are no absolute truths. Surgical practice includes much that is subjective: the stuff of art. What works in your hands does so not just because of mastery of technique but also mastery of a particular style of interacting with your patients. Our practices are very much shaped by who we are as surgeons, who we choose to offer surgery, and who we ultimately decline to accept as surgery patients.

Carefully Speak and Listen to Your Patients

Unfortunately, we sometimes fail at this most basic task. Remember open-ended questions from medical school? Another way to think about an open-ended question is being open minded. If your goal is to close your patient on blepharoplasty, it can be awfully hard to hear that the person in your exam chair is really just interested in cosmetic botulinum toxin or filler services. Sometimes this type of approach works out beautifully. You need to decide what type of practice you are running. Pressuring your potential patients to do what you want might work especially if you have a potent narcissistic personality. However, not every patient will be happy with such an approach.

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Practicing in Beverly Hills, I am personally not comfortable with pressuring patients to do what I think is best. I have adopted a style of listening as carefully as I can to the patient to determine if they even make sense to me. Generally, they will tell you precisely what they are looking for, if you listen carefully enough. Their analysis might not be right, but they usually will annunciate a concept of what they are looking for. Recently, I saw a 40-year-old man who told me that he was not happy with his upper eyelids. He did have a heavy upper eyelid fold and prominent herniated medial orbital fat pads in the upper eyelids. I was thinking that he would be a very good candidate for upper eyelid surgery. No, that was not what was bothering him. What concerned him was the cord-like appearance of the superior limb of the medial canthal tendon as it inserted into the medial canthus. I agreed with him that his was a bit more visible than most, but there really was no surgery that could help this. Imagine discovering this misunderstanding after performing upper blepharoplasty? Malpractice insurance carriers tell us that lack of communication is the cause of most malpractice lawsuits. Listening carefully and speaking carefully to your patient begins with your very first question: What can I do for you?

Be Honest with Yourself and Your Patients Without Being Mortally Wounded

I personally feel I am immediately in trouble with the patient who vaguely waves their hand over their face and asks "what do you think I need?" As previously noted, our business is subjective. Do not pretend to read your patients' mind by being baited into answering this question. I tell these individuals that I really need to know what their concerns are and then I am happy to give my opinion. It should not be your goal to exploit the insecurity of your patient by telling them such things as, "those are the worst lower eyelids I have ever seen." Preying on such insecurities is coercive, unethical, and morally reprehensible.

There is truth to the concern that you will be the next target for the patient sitting in front of you who is bad-mouthing a colleague. It is not necessary to deny that the patient is having an issue or that the issue was caused by a surgery. Surgeries have risks including the risk of the unexpected outcome, the risk of the disappointing outcome, and the risk of the expected but disappointing outcome. No surgeon picks up a scalpel with the intention of doing a bad job. It does not really help you to ask a patient the following: "Dr. Jones did what to you!!?" On the other hand, I think it is important to understand that well-intentioned and, generally, well-trained surgeons get into trouble. Are you any more or less likely to repeat the mistakes of the prior surgeons? I do a fair amount of fixing the eyelid work of other surgeons. It is not uncommon for me to see someone who has had 2, 3, 4, 5, or more surgeries for the same issue by well-meaning and often well-known surgeons. In many cases, each revisional procedure contributed its own complications to the situation. It is irrational to assume that you will not be the next surgeon to be bad-mouthed by this patient unless you have some insight that the prior well-meaning and well-qualified surgeons did not have. If you are not certain that you possess this needed insight, be honest. Declining to offer service will save you and the patient unnecessary trauma.

Be Wary of Vendors Bearing $200,000 Machines

The medical industry understands something about surgeons: we find expensive shiny machines with bells and whistles irresistible. It is not just our patients who blindly believe that any device with a laser is better. Sure, in some cases it is actually true. Refractive surgery is on such example. The jury is still out on "laser eyelid surgery" versus using a scalpel to make the eyelid incision. Similarly, it is unclear that laser-assisted