# Absolutes, Beliefs, and Preferences

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In January of 2002, my pastor and close friend Dr. Ed Dobson gave a message on absolutes, beliefs, and preferences. This message not only affected my spiritual growth but has absolutely transformed how I look at life. I have applied this message not only to my personal life but also to our seven-surgeon plastic surgery practice to help deal with any contentious issues, particularly difficult personal or career conflicts.

In Ed's message, he noted that not all truth is equally important and described three separate levels of faith: absolutes, beliefs, and preferences. An *absolute* is a basic conviction that holds all believers together. Absolutes are the essential, basic, fundamental, and foundational principles that hold, in this instance, Christians together, such as the nature of God and who we believe the person of Christ to be. An absolute truth is a gun-to-your-head, pull-the-trigger conviction that you would stand for. A *belief,* however, is not at the level of an absolute and is not an absolute necessity, but is the next level of importance. It is based on our understanding of the Bible or, in this instance, the practice of plastic surgery and how we put it into practice. His example was baptism. Do you believe in sprinkling or submersion? If someone put a gun to his head about a belief, as Ed said, "Whoa! Whatever way you want it dude, sprinkle or dunk." A *preference* is the third level of your conviction. It is not at the level of a belief and certainly not an absolute. It may be cultural or just a style. The example he used was clothing or music in the church. Do you wear a suit or casual clothes? Do you prefer hymns or praise and worship music? At the end of the day, beliefs may be important, but preferences really do not matter all that much.

He went on to say how interesting it is that, even in the church setting, it is rare to have conflict or controversy over an absolute. Turmoil always seems to surround a belief or a preference, and "a lot of time is wasted arguing and getting bent out of shape over beliefs or preferences." Churches have even split over what style of music should be played! Ed also shared how common and easy it is to elevate a preference or a belief to the level of an absolute. Wow! Have you ever experienced this? It is so easy to judge others or a specific approach if it differs from your own at any of these levels. "He is not one of us. He does not wear our label." Sound familiar? I, for one, have been guilty of this.

In the practice of surgery and medicine, what we do is based more on science and on outcomes data than on faith. How we practice plastic surgery should be based on basic principles and fundamentals, or absolutes, versus just what we may think or prefer. Do not get me wrong. There is certainly room for beliefs and preferences in our practices, but there are also, or should be, basic foundational principles for each patient we treat and each procedure we perform. For example, I learned in my training that I should leave 25 mm of skin between the lid margin and lower brow. If I take more skin than this, there is a high chance of producing lagophthalmos and significant complications. This maximum skin resection, when it comes to blepharoplasty, would be an absolute.

I was taught in my training and, painfully, in practice not to elevate random skin flaps in smokers and to limit full face lifts and full abdominoplasty to nonsmokers. Not performing major skin flap elevation in smokers would be an absolute. My practice is mainly cosmetic breast surgery. Applying this approach to breast augmentation has been extremely helpful. A few absolutes for me when it comes to breast augmentation would be basing the implant selection on breast base width and compliance, adequate coverage over the implant, and a precise, meticulously bloodless pocket. Some examples of beliefs would be the incisional approach or pocket position if coverage is not an issue. An example of a preference would be having the patient wear a brassiere and use ice postoperatively, or placing Steri-Strips vertically or transversely. These beliefs and preferences may be important, but they are not absolutes from the standpoint of the ultimate result of minimizing future complications and limiting revisional surgery.

Just as a certain set of absolutes holds believers together in a certain faith, what can we learn and apply to our specialty or certain areas of controversy?

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First, if we cannot or do not agree on an absolute, we should "agree to disagree" and understand that we will not be in the same camp or see things in the same way. One of the most disappointing trends in our society and even at national meetings is the increasingly personal or group attacks that are at odds with a presenter's approach. When not agreeing with an absolute, each surgeon owes it to him- or herself to ask whether the absolute is based on science or merely anecdotal before dismissing it.

Second, just as Ed Dobson warned, we all must be extremely careful not to elevate a belief or a preference to the level of an absolute. In plastic surgery, this is so very easy to do. Surgeons have developed personal techniques, approaches, or procedures or may have certain beliefs that we do every day. We may be very passionate about many of these, but they may not be absolutes. How many disputes or heated disagreements are actually because one colleague has elevated a specific belief or even a preference to the level of an absolute? I have found that recognizing what level we are discussing can be extremely helpful in these situations, if the parties can in fact remove the emotional aspect of the disagreement and discuss things objectively. In addition, discussing beliefs with colleagues requires humility and kindness.

Third, we should investigate and subsequently agree on what we truly know are the absolutes. It is much easier and quite frankly much more fun to talk about techniques and methods versus principles and absolutes. In fact, our world in general is trending away from absolutes altogether. We are taught that there are always two sides to everything. I would argue there may be two ways to view certain events (beliefs or preferences), but when it comes to foundational principles (absolutes), there is an ultimate "truth." Further, studies have shown that after about 5 years, it is very difficult for physicians to change, to look at things in a new way. If we have elevated or substituted our beliefs or preferences, either consciously or not, it is difficult to look at a procedure or approach that we have used for a long time in a new or fresh way.

One example of this is the use of the newer anatomic breast implants. The informed consent and patient education, patient evaluation, surgical techniques, and results are different from those used for smooth, round saline devices. If a surgeon does not approach using these implants as a new procedure and tries to apply older techniques, the outcomes will be, at best, suboptimal. Just as an endoscopic brow lift is different from an open approach, a superficial musculoaponeurotic system face lift is different from a skin-only approach, and open rhinoplasty is different from closed. The informed consent, evaluation, surgical techniques, and results are very different. It is very difficult to go back and evaluate principles, particularly when we have been performing a specific procedure for a long time. However, we should all revisit the absolutes, particularly the procedures we perform most often.

Fourth, when it comes to a belief or a preference, there is not just "one best way." There are trade-offs, good things and bad things about every technique, approach, device, belief, and preference that we utilize. We need to recognize and openly and honestly discuss these trade-offs with our colleagues and our patients. There are many different styles and techniques that we all need to recognize. This is the specific area where individualism, personal approach, and techniques come into play. We can also agree to disagree in this realm. We also need to be brutally honest and self-reflective, review our own results and data critically, and, again, be humble and kind.

Fifth, we do not lose our artistry if we adhere to the absolutes. At a recent Inamed Academy, one of the speakers eloquently noted that da Vinci based his drawings and art on his "divine proportions," that is, on measurements and science. This is certainly a "both/and" situation and not an "either/or." We can base our artistic results on scientific measurements and principles. I believe we inherently know this to be true. I sure would rather have a face or breast as drawn by da Vinci versus Dali or Picasso. Wouldn't you?

My hope is that, in the future, we as plastic surgeons, particularly those in leadership roles, will focus on our patients and how we can personally achieve and help our fellow plastic surgeons obtain the best long-term results with the lowest complication rates. I hope that we critically review, in a new and fresh way, the way we practice and perform specific procedures of our own as well as those of our colleagues and do so with the utmost honesty and humility, remaining focused on our patients and their optimal outcomes. I also trust you will find this concept of *absolutes-beliefs-preferences* as powerful and helpful as I have. I am sure many of you will have other applications to both your personal life and practices. I would love to hear your positive feedback, or you could just agree to disagree.

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