Jeanette Kohl, Dominic Olariu

Face Matters. Facial Surgery from the Inside

Interview with Prof. Dr. med. Dr. dent. Rainer Schmelzeisen

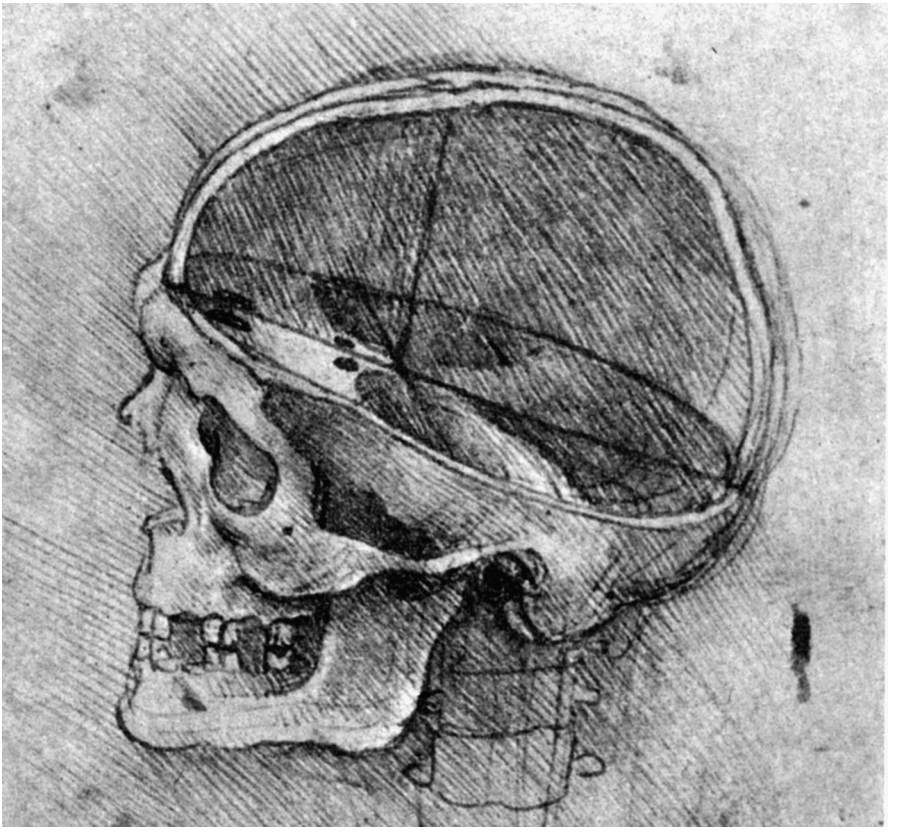
Professor Schmelzeisen is Chair of the Department of Oral and Maxillofacial Surgery at the University Clinic of Freiburg, Germany and a Fellow of the Royal College of Surgeons, London. Apart from being one of the world's top specialists in reconstructive and tumor surgery of the face he is also president of the Gottfried Benn Society and a practicing artist.

The interview was conducted by Jeanette Kohl with questions from Jeanette Kohl and Dominic Olariu.

J. K. *French art historian and cultural philosopher Georges Didi-Huberman in his book* Être crâne *(Being Skull) describes the anatomist's and surgeon's work as an ‹anatomical excavation,› as an intrusion into foreign zones and paradoxical places.*[1] *For him the skull, even though a locked system, in that sense is an open space, a place of unpredictabilities and challenges. Does this viewpoint coincide in some way with your experience as a surgeon working within the skull?*

R. S. Naturally, it is ideal for a surgeon if there are no unforeseen situations whatsoever. A prerequisite to work on or within the skull is that you have exact anatomical knowledge and a certain amount of experience with the intricate spaces behind the face that you will need to reach and work in. The skull is symmetrical, to a certain extent it mirrors itself, so there are reference values and quite exact dates for the distances between different locations and for the appropriate routes of access. There are of course age related differences – for example between children and adults – that create variations with which the experienced surgeon is familiar. Surgery in my field and specialty usually approaches the skull-base from below, either from the visceral cranium or from the neck. In both places, the anatomy is complex, with vital nerve pathways and vessels. And then of course accidents and tumors can alter the anatomy. One important experience actually correlates to Didi-Huberman's non-medical interpretation of the skull is the fact that, yes, you run into deviant anatomies; but even then, when working in areas that are extremely hard to reach or show anomalies, you still have to create an open space where you can do the work.

J. K. *In his seminal study* The Work of Art in the Age of Mechanical Reproduction *of 1936, Walter Benjamin compares the surgeon's work with that of a cameraman: «Magician and surgeon act like painter and cameraman. The painter, while working, observes a natural distance from the subject; whereas the cameraman, on the other hand, penetrates deep into the subject's tissue.»*[2] *How would you describe the relation of distance and closeness the surgeon experiences when working on and behind the human face?*



1 Leonardo da Vinci, *Section of a Skull*, ca. 1489, ink on black chalk, 18,7 × 13,5 cm, Windsor Castle, Royal Library, detail.

R. S. There are different dimensions to this comparison. Closeness and understanding come into play even before the operation takes place, in discussing the possibilities and risks of a surgical intervention with the patient. It is important to develop a clear sense for the patient's needs and fears: You have to literally look behind his face. During the actual surgery on the other hand, it is important to create an emotional distance, which leaves a neutral environment for maximal concentration despite the physical proximity. In conventional surgery, a high level of such physical immediacy is involved – you actually penetrate someone's open face or skull with your hands. Something I would call tactile intelligence comes into play, an almost ‹blind› understanding through your hands – the German word be-greifen explains this phenomenon aptly. You actually feel, even through the gloves, what is there, if resisting or giving way. It is an act of coordinating tactility with surgical tools and with your analytical knowledge. To a certain extent, microscopy and endoscopy, the surgeon's camera tools, modify this immediacy. Working with these tools needs to be learned from scratch, in particular as it involves a decoupling of eye and hands; and it creates a whole different experience for the surgeon. Robot assisted interventions are yet

another story because they totally remove the surgeon from the patient, spatially and physically. In a Benjaminian sense, yes, the cameraman who penetrates ‹the real› through his lens, through that filter, in order to ‹reach› it, comes close to what the facial surgeon does.

J. K. *A cult movie from the 1960s describes* The Loneliness of the Long Distance Runner.[3] *How does the facial surgeon handle this loneliness when confronted with life and death decisions?*

R. S. During surgery, hardly anything can be postponed. The main goal of a surgical procedure is usually reached through a fixed sequence of ratable and interrelated steps. Sometimes it can be necessary to skip certain steps, to vary them or to take detours, yet hardly anything can be deferred.

It is part of our task to discuss the surgical procedures with the patient, to explain what kind of decisions might be necessary in different situations in order to follow the aim and a positive outcome of the operation. In case of unforeseen events, intra-operative decisions will be made in the interest of the patient. I guess that even in team effort it means that with responsibility comes a certain amount of ... solitude.

J. K. *One of the most influential and fascinating definitions of the face as a cultural and social phenomenon is in Gilles Deleuze's and Felix Guattari's milestone publication* A Thousand Plateaus. Capitalism and Schizophrenia *of 1972.*[4] *The authors understand the face as a ‹strong organization,› a pattern of perception related to evolutionary history, psychology, politics and media, between image and the imaginary. How does, on the other hand, the surgeon as the intruder define the entity ‹face›? Is it an organ?*

R. S. A face is a skin surface with a high density of units for sensory perception. In regards to the publication by Deleuze/Guattari: From my point of view, which necessarily differs from theirs, it is on the contrary a hard fact – though its perception might very well be an ‹invention› influenced by familiar patterns, wishes, desires and different patterns of intention. However, it has many unique functions but it is not an organ, which is defined as a tissue-structure with functions inside of the body.

J. K. *Are there any binding ethical principles in facial surgery, that is: Where do you set limits? We are thinking of a case like Michael Jackson, who knowingly and gradually underwent procedures that would ultimately not only change his facial features but would also eliminate his ethnicity and blur his gender identity – certainly a case that equally exemplifies psychological borderlines. What do you think about this?*

R. S. If you ask me personally, every surgeon should determine these limits for himself and in consultation with the patient. In our profession, one should act according to one's conscience, one's level of experience and abilities. The surgeon – in particular in the case of non vital aesthetic interventions – of course wants to meet the patient's expectations and ideas as precisely as possible; yet he also should realistically reject what he thinks are exaggerated expectations or absurd wishes. There is of course a fine line, and individual judgment is required. Psychological components are most difficult in the case of facial transplants. Those patients need intensive psychological care. They not only have to adapt to the face of someone else, they have to live with the face of someone dead. Such a paradoxical ‹living

2 Michael Jackson after facial surgeries.

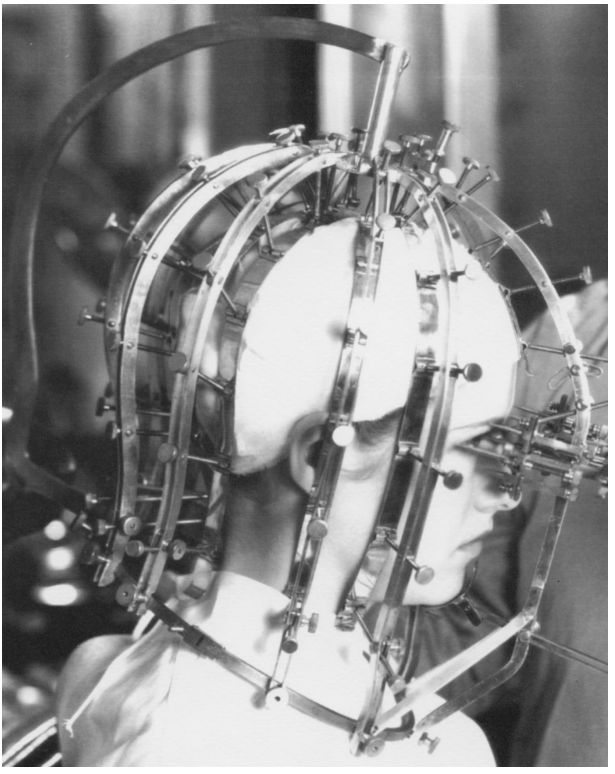
presence› of a formerly dead face through transplantation also asks a lot from the relatives of both the dead and the living person.

J. K. *Do you specifically refuse any particular forms of facial interventions?*

R. S. I refuse procedures that I assume will mutilate or do not correspond to someone's individuality and personality. After surgery, a patient should be able to recognize his face and feel a familiarity. I think I draw the line rather strictly. It is of course no problem to tighten the skin or improve the jawline, yet when a patient asks to change his face randomly just to make him more beautiful with any operation I become very hesitant, indeed. There are patients who bring cut outs of movie stars from magazines, often times with own drawings or written remarks in order to instruct the surgeon. They want to look like Tom Cruise or Demi Moore. In such cases, I usually recommend they consult a psychiatrist.

J. K. *This phenomenon of desired assimilation to an ideal, a star or a super-hero also raises the question of how significant gender differences are. Is there something like a trend towards approximation between male and female? Do men, for example, more often utter the wish to have softer features or does the trend go towards a prominent He-Man chin?*

R. S. There is a strong trend towards aesthetic surgery for men in general. We also see an increasing demand among males for eyelid reconstruction (blepharoplasty) in order to look younger, fresher, more present. Entire facelifts are also becoming more popular with men, in particular minimal invasive biolifts. Here in Freiburg, we have only had one or two patients asking for a feminization of the male face. American male patients, for example, often understand a prominent and strong jaw-line not only as a gender specific feature but also as particularly ‹American,› almost as a ‹national› genetic trait. In Japan, on the other hand, one of the most frequent requests of women is the Caucasian eye-lid, which is commonly perceived as more attractive. More specific gender related aspects emerge in cases of sex transformation. In addition to adequate psychological counseling aesthetic surgery may contribute in a significant way to the patient's new self-esteem and to feeling comfortable with their new gender and the related aesthetic clichés. In female to male sex changes it may be indicated to render the chin more prominent and to adapt the angles of the jaws. We often use pre-formed implants made of biomaterials to remodel the jawline and the forehead around the eyebrows. We also have to decide whether osteo-



3 *Max Factor ‹Beauty Calibrator,›* 1932, a pseudo-scientific device to correct facial flaws with pancake make-up.

tomies of existing bone structures, augmentations or abrasions of bone with or without soft tissue work and if artificial materials give the most benefit.

J. K. *What is the most frequent request in aesthetic surgery and what are the common reasons behind it?*

R. S. One of the most popular wishes is the treatment of wrinkles by injection. It is an easy procedure with a high rate of satisfactory results and few possible side effects. As far as surgery is concerned, it is again blepharoplasty, where the surgeon in an outpatient procedure usually achieves very satisfactory results. The lower lid is a little more complicated than the upper one. Secondly, there is a lot of demand for simple face-lifts, mini-lifts, followed by more extensive lifts, which include tightening of the skin, aponeurosis and fasciae.

J. K. *In all of these procedures aiming at beautification, what role does the ‹average› play? Are faces commonly perceived as beautiful defined by average values, as many empirical studies suggest, or are there other individual factors at work, too? And, in relation to this, do you personally notice any shifts or changes in the concepts of beauty and in the wishes of patients who try to get closer to such ‹ideals›?*

R. S. In surgery average per se is not bad, it is what we are used to see, it relates to cultural standards of acceptance. As far as my profession is concerned and the actual work on and with a patient's face, it is largely in the sur-

geon's hands, literally, to choose the appropriate procedures and techniques to achieve the desired result. There definitely is something like an average in our own procedures and interventions for which each surgeon then has his or her own slight modifications. As for the individuality of the surgeon's work, this is largely a question of technique and if someone prefers more or less radical forms of surgery and how they are combined, for example just tissue modifications or tissue and underlying bone surgery. This indeed depends on the surgeon's own preference, style, and judgment as well as on the patient's wishes and how far they want to go. As for me, I tend to think that often times less is more and that it is crucial to design the outcomes of surgery in a way that maintains type and personality.

J. K. *In regards to the different stages of life, can one say that there is a preferred or ‹ideal› age? Do people usually find themselves physically more attractive when they are 20, 30, or 40 and is there a frequent point of reference for ideals and wishes of how to look, like: «I want to have the face I had when I was 30?»*

R. S. Interesting question. My observation is that older patients in their 40s and 50s often times find themselves in a basic way more attractive than younger ones. I guess in the process of aging you get used to your own face and its flaws, which increases acceptance. These patients often come see me because they want to look fresher. Younger people often have more diffuse but also more urgent and drastic ideas of actually changing their face. Physical attractiveness and conformity to ideals of beauty and perfection as they are disseminated through the mass media play a much important role in the age group around 20 and 30.

J. K. *What are the fundamental differences between aesthetics surgeries and reconstructive surgeries after accidents and tumors? And in the case of trauma surgery, what do you reconstruct: the face as it was before, an average, or even an improved face?*

R. S. ‹Aesthetic› surgery aims to optimize the face as it is. Accident and trauma patients hope to look similar to how they did before the accident or disease. However, there are some rare cases in which for example during a fracture treatment the crease of the upper lid can be used to perform blepharoplasty to improve the look of the eye. This can only be done if the patient is not in an immediate emergency situation and able to make clear decisions. In the case of extreme facial injuries we usually aim to reconstruct the face as good as we can to make it look ‹normal,› that means acceptable and presentable, the German term ansehnlich expresses this appropriately.

Some facial tumors require a removal of tissue plus bone, which changes the look of a face drastically. Here, we have developed reconstructive techniques where skin, muscle and bone material from other parts of the body are transferred to the face to substitute the loss. There are areas of similar skin color and texture like the skin above the shoulder blade that can be used for the face. These can be reanastomosed microvascularly under the operation microscope, meaning that a certain area of skin is transplanted including the arteries and veins, which are then connected with existing vessels on the neck in order to keep the transplanted area alive. You can

4 Repairing War's Ravages: Renovating facial injuries, 1914–18, London, Imperial War Museum.

imagine that in such cases even an approximation to what we would call ‹aesthetic normality› is a huge success. Also, we must explain to the patient that the initial appearance is not the final result yet. There is always swelling and sometimes soft tissue excess that will be reduced over time or will have to be surgically removed in smaller procedures.

J. K. *Let us come back to the hand: What role does it play in times of high tech medicine and highly predetermined surgical routines?*

R. S. Even with high tech appliances and instruments the tactile perception of tissue plays an important role – next to the eye. There is a notion that some surgeons have a better sense for bones, others for soft tissue. Some specializations are based on these particular abilities. It is a lot about the balance and the relation between bones and tissue. In the area of the face it is especially important to balance pros and cons of for example a profile changing intervention, such as orthodontic relocations of the upper and lower jaw or chin. Is a correction of the tissue enough or does the jaw have to be moved into another position? As I said before, it is one of the great challenges of a facial surgeon to be able to understand with his eyes and hands, in a tactile manner. With your hands you feel the texture of the tissue, its flexibility, movablity. You have to palpate and grasp the mobility of bones against tissue, bones against bones. Robot assisted systems can transfer movements from a workstation to the operation table with a high precision and advanced features such as tremor control. Yet what's missing is the tactile element, everything ‹feels the same.› This still needs to be refined. However, the surgeon's like the boxer's hands are irreplaceable tools. I think it was Muhammed Ali who described the hand as the most quick-footed embodiment of human intelligence. I really like this paradoxical simile.

J. K. *If the hand is that important, one would expect that there is also something like an ‹individual handwriting› or a signature a certain surgeon leaves behind. Is it possible to identify a particular surgeon or a school by the outcomes of facial surgery? In Art History, Giovanni Morelli in the 19th century established a method or technique of identifying certain artists by a minute diagnosis of minor details, such as the form of the earlobes and nasal wings of sculptures. Is there anything like that in your discipline?*

R. S. I do not know of anyone who has tried to identify individual surgeons by their techniques and the resulting outcomes in a systematic way, although this would be quite interesting. To some degree, some clinics prefer specific techniques that correlate to certain results. For example, there are different incision techniques for cleft lip and palate situations or in trauma approaches as well as in aesthetic surgery, which result in specific forms of scars. So I guess you can say there is something like ‹different schools,› but the procedures at present are much less dogmatic than in the past.

J. K. *By implication, could one say that every surgeon wants to be invisible, disappearing behind his finished masterpiece?*

R. S. I like that idea! To be invisible, yes, just like the accesses for surgery and the scars. To cut along one's natural lines and creases, parallel to the skin's stretching lines, under the hair, behind the lower lid, in the crease of the upper lid, from inside the oral cavity – to leave no marks, no traces, ideally. The main goal sure is to perform surgery that no one notices.

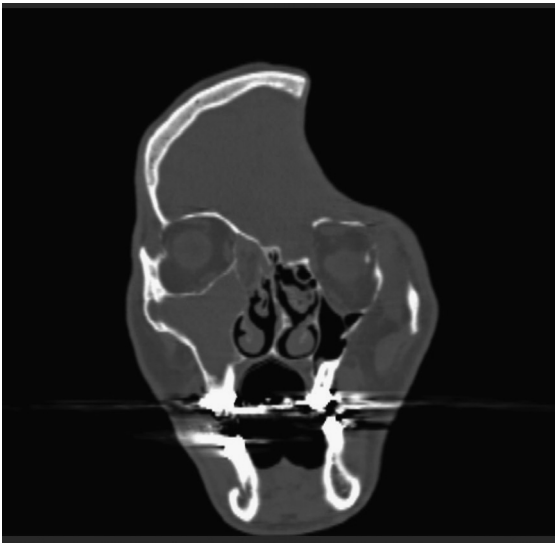
J. K. *In what ways have new imaging technologies changed the field and the actual work of the surgeon?*

R. S. Imaging and data processing technologies, such as high resolution CT, MR PET scans and combinations as well as navigation aided procedures and intraoperative 3D imaging have contributed largely to improve planning and preparation. We can simulate surgical interventions on the screen and get a much better impression of the expected outcomes. We are also able to perform segmentations of bones on the screen and perform virtual surgeries in order to ponder the possibilities of different accesses more precisely. Preformed implants can be virtually inserted into the orbital cavity with high precision to anticipate the accuracy of position and fit. During surgery, navigation procedures allow for highly accurate determinations of anatomical positions. The 3D CT image is on the screen while infrared cameras capture the exact position of surgical instruments, like the instrumental approach procedure in an airplane. We are thus able to visualize and see the precise position of an instrument working for example on the extremely intricate and complex skullbase. This certainly facilitates precision work in difficult areas.

J. K. *When Leonardo da Vinci was working on his anatomical drawings he invented a new kind of anatomy atlas. What do you think: Will software produced for digital imaging in facial surgery at some point in the future be used for computer and video games or in movie editing?*

R. S. I think there is a lot of potential for this. Today, the equivalent of his work would probably be a virtual atlas of head and neck anatomy in 3D.

J. K. *To come back to the relation of face and psyche, which of course has an intrinsic quality: What are your experiences with changes in personality after drastic facial interventions? It is pretty obvious that certain complexes and a low self-es-*



5 CT-Scan of patient suffering from massive bone loss, orbital fracture and soft tissue injury following trauma.

teem can be improved through ‹better looks.› Is it possible that the ‹transformation› of one's face results in profound personality changes? In other words: Can a person with a changed face literally jump of out their skin?

R. S. Personality changes with looks, and looks change the personality – at least to a certain degree. Patients with so-called profile changing interventions often times behave and appear much more self-confident. They dress differently, more boldly, and women use different and more pronounced make-up. There is an interesting study by my colleague Knut A. Grötz in Wiesbaden. He showed images of patients with profile irregularities to a group of human resource managers; all kinds of irregularities such as protruding upper or lower jaw, prominent chin, retro-positioned – before and after surgery. The result is hardly surprising but telling: The managers generally preferred the candidates after surgery and judged them as more intelligent and energetic, in some cases they even thought that they were more honest. But to come back to your second question: I do not believe that people can jump out of their skin – it is more: «New skin for the old ceremony,» as Leonard Cohen put it. An aesthetically enhanced, refreshed face usually provokes positive reactions in those looking at that face, and these positive signals in return boost the person's self-esteem.

J. K. *How would you define the role the mirror plays? We are thinking of moments of self-confrontation after facial surgery.*

R. S. The first look into the mirror is still a crucial moment for the patient. Some really shine with joy while others are even moved to tears. For patients with a tumor history or significant facial injuries the point of time needs to be chosen carefully, and they might need company. I vividly remember the case of a little Russian girl who had been bitten by a dog and lost large parts of her cheek. In the aftermath of the incident she completely avoided mirrors. After we had performed surgery she became curious to see how

she looked and asked for a mirror herself. And she was very happy to see her face. Honestly, these can be very touching moments. Especially patients with a poor prognosis and for example malignant tumors have a special and intricate relation to mirrors. «Facing death, who would not hesitate in front of mirrors» – to paraphrase Paul Celan.

J. K. *About the future of the face and facial surgery: What is the role and impact of naturalness or rather ‹artlessness› and (how) are we getting closer to the ideal of a face that underwent aesthetic surgery yet looks completely natural?*

R. S. Like most methods and techniques in medicine and aesthetic surgery, certain procedures in an earlier phase may be applied up to the limits of feasibility. With time, we usually experience a return to a ‹healthy› dimension of what's doable. I rely upon this. As you know my credo is adequacy and reasonableness – of the procedures and in regards to the human individual. I believe that we will see a steadily increasing number of aesthetic surgeries yet with less excessiveness – as you brought up the example of Michael Jackson earlier. New biotechnologies will probably bring about further improvements in looking ‹natural› after surgery – but honestly, a 60year old will not look like a 20year old, at least not in the near future. We might be pretty good already, but we don't work miracles.

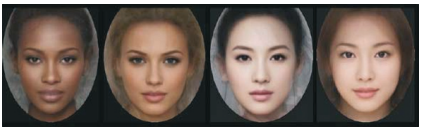
J. K. *Do changed faces change our perception of beauty? In other words: Does aesthetic surgery actively change or manipulate a society's wishful thinking about what beauty is?*

R. S. This is a question with far reaching implications and one hard to answer. I think that surgically changed, beautified faces certainly alter our ideals of beauty, but in both directions. They define new visual standards, standards of presumed perfection, yet they also might give impulses for a return to the ‹origins,› which could be a quest for more natural beauty. Who knows, maybe we will see such a backlash in the future. I have certain patients who come in at regular intervals for smaller procedures and I think we are able to keep up a natural as opposed to an operated look. It is really more about the charisma that you work on, from the inside and from the outside, if necessary.

J. K. *Do you see the problem that certain ‹faces› and a level of beauty will only be affordable for the happy few while the average person will not be able to afford any of this, while at the same time the desire for surgical beautification is spurred by the media? Or will there be more ‹open access,› also financially, that is: plastic surgery for everyone?*

R. S. I guess we already see this ‹open access› happening, in particular in the US. However, I think that the desire for and the awareness of beauty is generally increasing in the more prosperous societies. This does not only concern the desire for a particular or a particularly beautiful face; it is about shaping our environments in a much more beauty- and design-conscious way. Aesthetic oral and maxillofacial surgery is just part of this larger phenomenon of increased aesthetic attention and ‹styling.› Related to this is the strong quest for youth and a youthful appearance, the fight against aging, its downsides and its stigmata. We will see what the future brings on this front.

J. K. *To what extent are the dynamics of aging and the related visible changes predictable for faces that underwent surgery?*



6 From left to right, composite ‹most attractive faces› of black, white, Chinese and Japanese women.

R. S. Generally, the dynamics should remain the same as before surgery yet there is an altered tissue ratio due to scarring after surgery and the refixation of subdermal tissues.

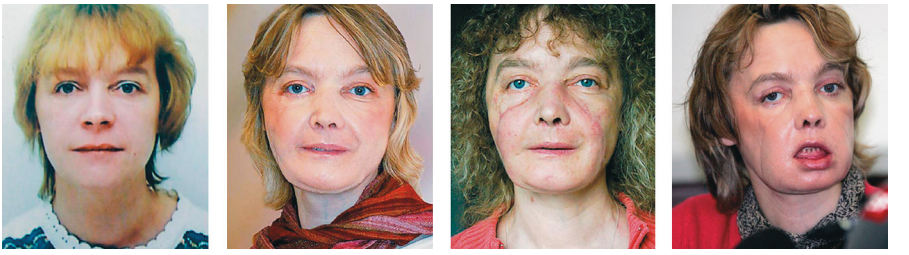
J. K. *Without asking you for an ethical statement about facial transplants that in the past years have caused quite a stir in the media: Is the pioneer work by Bernard Devauchelle and others really such a quantum leap for your discipline and mankind? And which accomplishments of the last 25 years in your field do you admire most?*

R. S. Operations of the kind Devauchelle conducted are surgical and logistical masterpieces and ideally a minutely orchestrated cooperation between different individuals and disciplines. What comes with it are of course far reaching ethical questions about living with someone else's face, for patients as well as relatives and friends. We spoke about this earlier in the interview. These are very delicate ventures. If they work out in the end – then that's extremely gratifying. Currently, there are debates about ‹reconstruction vs. transplantation,› how much actually can and should be reconstructed and when it makes sense to transplant. The great achievement of Professor Devauchelle has probably raised more questions than it has answered, but that's a good thing.

In my view, other remarkable advancements are the more everyday possibilities for osteotomies in the craniomaxillofacial area such as putting maxilla and mandible in a new position after osteotomies with reliable fracture healing. Really important for my work as a maxillofacial surgeon are recent developments in the use of pre-formed implants made from bioinert materials such as titanium meshes in the orbit and the mandible.

J. K. *It seems that in the long history of facial surgery some of the most remarkable achievements were made in times of war, when extreme facial injuries occurred in large numbers, in particular during both World Wars. Obviously, these developments have shifted – despite many wars still taking place worldwide – into the prosperous societies.*

R. S. Historically, this is indeed true. Otto Dix's images spring to mind, illustrating the pandemonium of World War I. Pure necessity caused huge leaps in the advancement of plastic surgery. For someone who has not seen any of these extreme wounds it is hard to imagine the horror nurses and doctors were facing during the wars. The movie The English Patient deals with one of these cases. Also, for the treatment of such a wide range of facial injuries it was very helpful to possess both the skills and knowledge of a surgeon and of an orthodontic – a combination that led to the common double medical license as DDS (Dr. dent.) and MD (Dr. med.) in maxillofacial surgery. Some of the techniques and principles for medical procedures developed during the wars are still practiced in the treatment of gunshot injuries and severe car accidents.



7 Isabelle Dinoire, patient who received the first facial transplant in the history of maxillofacial surgery, before (left) and after surgery in 2005.

J. K. *During and after World War I there was a rather unique collaboration between a renowned British art professor, Henry Tonks, and the Queens Hospital in Sidcup, England. In a series of hauntingly expressive watercolor portraits, Tonks documented the horror of faces destroyed, burnt, shot through and deformed by war injuries. The patients, however, reacted utterly positive when they were confronted with Tonks' portraits. They reported that the artworks encouraged them. The simple fact that someone dared to look into their faces, not just briefly and reluctantly, but openly and with compassion and interest, in order to turn them into works of art, gave them hope. To be confronted with the ruins of what once had been their face in a work of art had a consoling effect and was easier than looking into a mirror. To us, the story seems significant as a possible future model for a fruitful alliance between the arts and reconstructive surgery. What do you think?*

R. S. Artworks like these certainly contribute to some extent to a ‹normalization› of the horror of defacement. However, it will always be a shock to look into a deformed face like the ones we see here. Our definitions of what is normal and what is beautiful are turned upside down. I do find the idea intriguing that art may function as a sort of buffer or filter that makes such horrors more acceptable than, let's say, the immediate look into the mirror. In terms of psychological support it seems a good point of departure. An idea, we should pursue. Surgeons certainly benefit from a second, non-medical opinion by a person who is unbiased when looking at faces, someone who does not automatically ponder surgical possibilities or restrictions in outcome, someone who compares faces unbiased with what is regarded as normal, or beautiful, or both.

J. K. *Which leads us to the question of medical education. Wouldn't it be worthwhile to educate future facial surgeons in disciplines like classical aesthetics, art history, and psychology?*

R. S. What we are doing here at my clinic are interdisciplinary consultation hours with psychologists and psychiatrists for patients with severe facial injuries. If I may articulate a vision: It would be great to involve several additional disciplines for patient treatment, such as make-up artists, actors, artists, personal trainers. As for university education, yes, I agree, from an intellectual perspective the opening up of our discipline towards art history, the history of aesthetics and the history of the own discipline would be highly desirable as part of the education of young scientists and physi-

8 Henry Tonks, *Watercolor Portraits of Patients with War Related Facial Injuries Treated at the Queen Mary's Hospital, Sidcup*, 1916–1918, London, The Royal College of Surgeons.

cians, in particular but not only if they want to specialize in aesthetic surgery. If this is in any way feasible within the current system and its tight curriculum is another question.

J. K. *Will genetic engineering have a significant impact on facial surgery and are there already significant points of contact?*

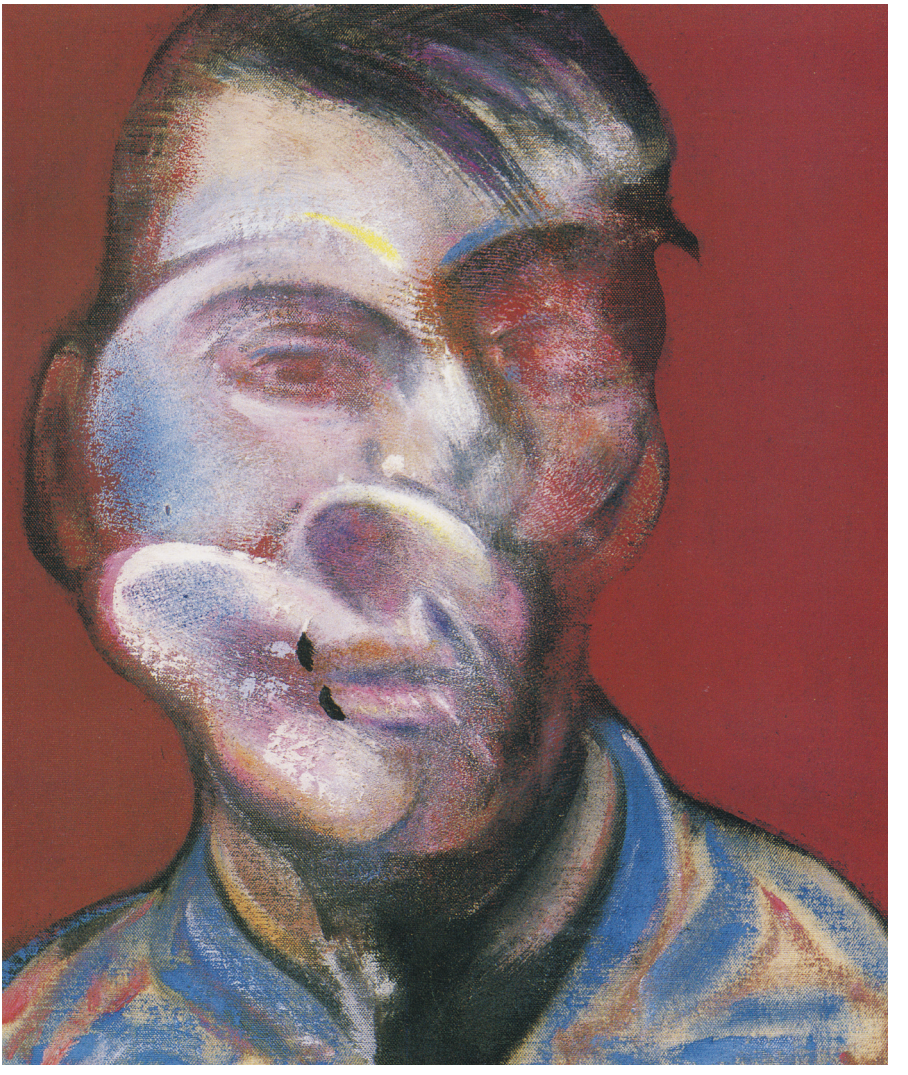
R. S. As of now, I am afraid, to a much lesser extent than we wish for.

J. K. *Is the future of the face Caucasian?*

R. S. So far, subtle ethnic blends are often perceived as the most beautiful. I do not see this changing significantly in the near future and in a globalized world.

J. K. *Let us return to Walter Benjamin, who writes: «The audacities of the cameraman do indeed invite comparison with those of the surgical operator. [...] What elaborate sequences of the most delicate muscular acrobatics are not in fact required of anyone seeking to repair or rescue the human body?»*[5] *Is the facial surgeon to some extent an ‹artist› – or more of a precision worker?*

R. S. The facial surgeon is a very conscious physician in the first place who ideally thinks and feels with the patient and accompanies him for a certain time – with the intention to heal. He also is a ‹repairman› who fixes human bodies, as Benjamin puts it, and may even save lives. Ideally he is a ‹repairman› with a certain amount of technical skills, experience and a good choice of materials, techniques and the right instruments and realistic goals. That's already a lot. If he also is an attentive listener and diagnostician, if he can ‹think through his hands› during surgical procedures and has quick reflexes and a certain amount of intuition – all the better. That makes a ‹whole,› well rounded representative of his species. Creativity is a surplus, but the space for experiments is really limited during surgery. Yet I believe that every excellent surgeon has a passion for what he is doing, and



9 Francis Bacon, *Three Studies for Self-Portrait*, 1973, oil on canvas, 35,5 × 30,5 cm, London, Marlborough Fine Art, detail.

he is doing it for a purpose. The result is a highly visible and subtle work of surgery, which is on display for everyone. He works for the patient he is working on and who is going to be the first observer and critic of what he has done. So, yes, maybe there are parallels with an artist's work.

J. K. *We know that besides your passion for facial surgery you also have a passion for the arts. What is your favorite face in a work of art? A face that represents something extraordinary or strikes a chord in you?*

R. S. My favorite face is part of a triptych of self-portraits by Francis Bacon of 1973. The face, like the ‹self,› is a complex thing.

Annotations

1 Georges Didi-Huberman, *Être crâne. Lieu, contact, pensée, sculpture,* Paris 2000.
2 Walter Benjamin, «The Work of Art in the Age of Mechanical Reproduction,» in: Walter Benjamin, *One-Way Street and other Writings*, trans. J.A. Underwood, introd. by Amit Chaudhuri, London/New York 2009, p. 228–259, here p. 248.
3 Tony Richardson, *The Loneliness of the Long Distance Runner,* movie, 104:00, 1962.
4 Gilles Deleuze and Felix Guattari, *A Thousand Plateaus. Capitalism and Schizophrenia*, trans. and foreword Brian Massumi, London 2004 (cop. Minneapolis 1987).
5 Benjamin 2009 (as in note 2), p. 276.