Interspecialty Battles: Who Should Perform Cosmetic Surgery?

In day-to-day life, we see many examples of rivalries. We see Republicans fight Democrats, Dolphins fight Redskins, Yankees fight Red Sox, and American Idol contestants fight each other for the final spot. Friendly rivalries can be fun and spur competition, but unfriendly rivalries can be negative, hurtful, and affect business and patient care. Doctors are far from immune to rivalries and turf battles. At any given time in any given hospital boardroom, orthopedists are fighting with neurosurgeons about spine cases, cardiothoracic surgeons are fighting with radiologists about invasive procedures, and plastic surgeons are fighting with a myriad of specialists about cosmetic procedures. These fights sometimes spill out of the boardroom to state legislature, which fortunately sees them as what they really are, turf wars. Interspecialty battles have existed from the beginning of medicine and surgery and will probably be eternal.

One of the most commonly fought battles in medicine and surgery has focused on who should perform cosmetic surgery. Each doctor has his or her own litany of reasons why they are qualified to perform cosmetic surgery and why others are not. Too often, the public gets caught in the middle. Many times I have heard that dermatologists are not surgeons and that they have no business performing aesthetic procedures. I have heard specialists disparage ear, nose, and throat (ENT) specialists by saying they have no business in the cosmetic arena. People in my specialty, oral and maxillofacial surgery, are called dentists and some people do not believe we should perform cosmetic facial surgery. So, who is qualified to be called a cosmetic surgeon? Quite simply, a cosmetic surgeon is a surgeon who limits his or her practice to cosmetic surgery, or one which cosmetic surgery constitutes a major part of their practice.

Does a plastic surgeon have better outcomes than a dermatologist? Does an ENT specialist have less complications than an oral and maxillofacial surgeon? The answer to that question, like all other competency issues, is simple. There are excellent dermatologic cosmetic surgeons and there are some plastic surgeons who are not competent in aesthetic surgery. Competence boils down to training, experience, outcomes, and patient care. There are great and not so great cosmetic surgeons in all specialties. Cosmetic surgery is not plastic surgery; however, plastic surgery is a specialty that can encompass cosmetic surgery. Many plastic surgeons are well trained in cosmetic surgery and many others are less trained than many of their competing specialties. A recent article in *Plastic and Reconstructive Surgery* surveyed plastic surgery program directors and concluded that many plastic surgeons do not receive enough experience in cosmetic procedures during their residency training.[1] This survey examined results taken from program directors and surgery residents at all 89 plastic surgery residency programs in the United States and concluded that many plastic surgery residency programs offer inadequate or nonexistent training in cosmetic procedures. In many programs, cosmetic surgery exposure may last only 3 to 4 months. Of the surveyed senior residents, 51% reported that they are not satisfied with their cosmetic surgery training. Of that group, a surprisingly large percentage of respondents were uncomfortable performing a range of cosmetic procedures. For years, plastic surgery organizations have told the media that only their members are capable of performing cosmetic surgery. In reality, a neophyte plastic surgeon may take his or her board exams and not get tested in cosmetic surgery at all.

Jeff Frentzen, editor of *Plastic Surgery Practice*, stated in a recent editorial that[2]

> It is worth noting the stated standards for cosmetic surgery requirements in plastic surgery residency programs. The RRC (Residency Review Committee), which is a subset of the ACGME (Accreditation Council for Graduate Medical Education), control residency standards and criteria.
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> These organizations claim that a plastic surgery resident is stamped trained in cosmetic surgery after he or she is involved in approximately 40 cosmetic surgery cases during residency. However, these graduates enter a highly competitive marketplace where many "real" cosmetic surgeons have hundreds—perhaps thousands—of cosmetic procedures under their belts.
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> The "40 procedures" requirement is intellectually dishonest. There are plastic surgeons coming out of their residency who may have never done a rhinoplasty. Half of all residency program directors advise their graduates to get postgraduate training in cosmetic surgery fellowships as soon as possible.

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GUEST EDITORIAL

The purpose of this editorial is not to disparage plastic surgery. There are many plastic surgeons who are leaders in cosmetic surgery. Many dermatologists, ENT specialists, oral and maxillofacial surgeons, obstetricians, gynecologists, general surgeons, and ophthalmologists perform excellent cosmetic surgery.

The belief that people should only seek cosmetic surgery from a board-certified plastic surgeon is sometimes taken seriously by patients and media. It comes off as self-serving, thinly veiled, and unfounded rhetoric. This is similar to saying that a Mercedes is the only safe car and that nobody should drive a Lexus, which is nonsense. It all boils down to training, competency, outcomes, and patient care.

As a board-certified oral and maxillofacial surgeon, I have treated complex orbital facial fractures for many years. No one cared when I was treating an indigent patient who had severe orbital trauma at midnight on Christmas Eve. However, when I wanted to take some skin off the eyelid of an elective-paying patient, I was suddenly just a dentist. I have seen the same irrational reasoning with spectacular Mohs surgeons. Although Mohs surgeons can take the face apart, some competing specialists believe they should not be allowed to make elective cosmetic incisions. There are highly trained ENT specialists who encompass some of the most complex head and neck cases, but some competing specialists believe they should not be allowed to perform face-lift surgery.

Do not misunderstand my message because I do not believe any doctor should be allowed to perform cosmetic procedures if they cannot document experience. On the contrary, I think that the bar should be set high and that any doctor, regardless of specialty, needs to present documentation of continuing medical education, cadaver courses, preceptorships, and case logs before being declared competent. Some specialists now receive this in their core training and others perform cosmetic fellowships. This is a good thing. However, there needs to be an alternate pathway for older practitioners that cannot merely put their life on hold and perform a fellowship. The alternate pathway is frequently criticized by competing specialties as weekend courses and used against those surgeons in pursuit of contemporary practice. In reality, many excellent existing cosmetic surgeons did not receive core training in new technologies, such as lasers and endoscopic brow lift. They learned these procedures sitting next to many of us at weekend courses.

Cosmetic surgery has experienced an exponential growth in the last decade and, in my opinion, the largest contributing factor in this growth has been the merging of numerous specialties into the melting pot of cosmetic surgery. Dermatology, the ENT specialty, ophthalmology, oral maxillofacial surgery, and numerous other specialties brought their expertise to the common table of cosmetic surgery. The techniques, research, and experience from these specialties has helped fuel cosmetic surgery. To argue that any single specialty should be in control of cosmetic surgery is no longer a valid argument. When I hear someone say that dermatologists have no business performing cosmetic surgery, it always pleases me to remind them that tumescent anesthesia and lasers were basically pioneered by dermatologists. There are many more examples involving other contributing specialties.

I was once told that because I am not a physician, I am not qualified to perform cosmetic facial surgery. My argument included the fact that I performed a hospital internship, and 4-year hospital residency, and rotated through all major medical and surgical services alongside my physician colleagues. Furthermore, are pediatricians, psychiatrists, and internists better qualified than me to operate on the face even though they have the title of physician? My biggest argument is that every practitioner has the obligation to offer his or her patients the latest advances in his or her specialty. Cosmetic facial surgery is taught in oral maxillofacial residency programs, is part of our boards, and is covered by malpractice insurance. Many other specialties have the same arguments and qualifications.

I recently saw a patient who told me that she first went to another medical office because she believed the media hype that only a board-certified plastic surgeon should perform cosmetic surgery. When she had the procedure performed, she was treated by a nurse. There goes that argument.

Turf wars will likely never end and we must all embrace the idea of cosmetic surgery diversity. We must all realize that we are not the only game on the block and respect other specialists who perform competent cosmetic surgery. It is fine for doctors to root for their own team, but always keep in mind that the trenches are full of competent practitioners from diverse branches of health care that are striving to learn and perform competent cosmetic surgery.

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References

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