EDITORIAL

Should Cosmetic Surgery Be Limited to Selected Specialties?

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Although name calling has become a national pastime (as you saw if you were paying attention to the recent national election), there ought to be no room for ad hominem attacks in professional discourse. Yet recently, *Plastic Surgery Practice* ran an article by Dr Grant Stevens discussing his opinion of "core" cosmetic surgery providers,[1] which claimed that only a limited number of specialists are qualified to perform cosmetic surgery, an argument that has often been made within the plastic surgery community.[2] Although Dr Stevens has made many contributions to cosmetic surgery, the statements and opinions within the article are not the product of rational investigation. Instead, they are simply aimed at limiting who should do cosmetic surgery based solely on specific limited specialties.

There is no question that all surgeons owe the public safe treatment with predictable outcomes, but so many variables affect this that a physician's original specialty training cannot be the exclusive determinant. No specialty "owns" the face or body, and no specialty owns cosmetic surgery. The word "core" has taken on a new meaning in the discussion of cosmetic surgery qualifications. All of a sudden, a group of self-appointed (if not self-anointed) leaders in several specialties, most visibly plastic surgery, are making the argument, and even trying to legislate their own specialists as the only ones qualified for cosmetic surgery procedures. These specialties are trying to convince each other (and those who will listen) that they hold the keys to the cosmetic universe.

As a plastic surgeon (J.A.P.) and an oral maxillofacial surgeon (J.N.), we sit on editorial boards and publish within the fields of several specialty organizations, and we share podiums with other specialists. By and large, most plastic surgeons are very talented people and do some amazing things, but one cannot say that just because they have completed a plastic surgery residency and passed a board exam that they are singularly qualified to perform cosmetic surgery. After World War II, the field of plastic surgery arose out of the combined fields of general surgery, oral maxillofacial surgery, and trauma surgery. Early cosmetic surgeons included dermatologists, general surgeons, otolaryngologists, dental surgeons, and even orthopedic surgeons.[3] Until the mid-1980s, plastic surgeons even disparaged the field of cosmetic surgery as frivolous. As recently as 2003, this issue of cosmetic surgery domain and the multispecialty origins of plastic surgery were addressed by Norman Cole in the Upchurch lecture, which is well worth rereading today.[4] Richard Webster, a plastic surgeon, participated in the founding of the American Academy of Cosmetic Surgery (AACS) precisely because he was unable to present his cosmetic work within the field of plastic surgery. His ideal of cosmetic surgeons from many surgical specialties teaching and learning from each other remains a hallmark of the AACS to this day.

As education and technology progress, many specialties continue to incorporate cosmetic surgery procedures into their core training. Please note that the word "core" is used here as it relates to what is taught to the average resident in the average specialty program. This use of core is a quantifiable and proper reference that implies that dermatologists; ear, nose, and throat (ENT) specialists; oral and maxillofacial specialists; and ophthalmologists began teaching and performing cosmetic procedures during their residency programs. My (J.N.) personal experience of having a practice limited to cosmetic facial surgery stems from such a situation. I practice in a town with a well-known oral and maxillofacial surgery residency program, and in the early 1990s, I noticed that cosmetic facial procedures were being taught in contemporary oral and

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maxillofacial programs. These procedures also became part of the oral and maxillofacial surgery board exams and were covered by malpractice carriers. Hence, over the past 15 years, cosmetic facial surgery has become part of core oral and maxillofacial surgery training in many programs. This same set of circumstances has occurred with dermatology, ENT, ophthalmology, and other specialties.

History repeats itself, and throughout human civilization, when competition, the flow of dollars, and customers have become threatened, people do harsh things to maintain or regain control. Although Dr Stevens and many others in the self-satisfied "core" group claiming control of cosmetic surgery are now bragging about their special skills and training, the actual history of inter-specialty cooperation has not been as positive. Editorials, state legislative sessions, and hospital board room and credentialing committee meetings on plastic surgery reveal a long-standing attempt by plastic surgery specialists to limit those who may perform face-lifts, liposuction, or breast cosmetic surgery. The literature documenting professional political attacks on cosmetic surgery by organized plastic surgery is brimming with examples of plastic surgeons previously criticizing every single specialty they are currently embracing as "core family members." One of the most notorious litigations involved a suit between ENT/facial plastic surgery physicians with the AACS, against organized plastic surgery, in which a federal investigation found that the plastics group was guilty of defamation and restraint of trade.[5] Following is an excerpt from an article in which Dr Galen McCullough addressed the issue of cosmetic surgery as a specialty[5]:

> As the Council's elected chairman, I was able to share—with other professionals—materials obtained by the Federal Trade Commission during its investigation of anticompetitive practices on the part of the American Society of Plastic and Reconstructive Surgeons (ASPRS).
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> A Machiavellian-like "Cold War" strategy employing "guerilla warfare" described how plastic surgeons intended to conduct a "Cold War," during which they would "stall, frustrate, and destroy" physicians and surgeons identified as competitors. The document launching the "Cold War" was crafted in 1964 and was later retrieved by the Federal Trade Commission from the files of the ASPRS executive offices in Chicago.
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> From a handwritten note above its title, it came to be known as the *Inter-Group Conflict Document.* And the fact that plastic surgery organizations were found to be following the class warfare tactics it contained convinced the Federal Trade Commission that the document represented a strategy.
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> The "Cold War" eventually became a heated war. So much so that—in addition to the FTC—the US Congress became involved, calling all sides before a congressional hearing. The hearing provided a forum whereby a team of facial and cosmetic surgeons provided evidence of anticompetitive and unlawful tactics being used against us.

In the same article,[5] Dr McCullough discusses another case where a defamatory article from a Georgia plastic surgeon led to the largest judgment at that time against a medical organization:

> The plastic surgeon's attack on the "good names" of those identified solidified an already good relationship between the Facial Academy and the Cosmetic Association. The 2 organizations joined forces to right yet another wrong. A lawsuit for slander and libel was filed in the state of Georgia. The Facial Academy agreed to pay all expenses for the 3 plaintiffs: Dr Anderson, the American Academy of Facial Plastic Surgery, and the American Association of Cosmetic Surgery.
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> As the sitting Secretary of the Facial Academy and a former President of the Cosmetic Association, I testified at trial, explaining to the judge and jury the fallacious charges levied against the qualifications of members of the 2 organizations and one of my mentors, Dr Anderson. Another one of this Academy's former presidents, Dr Bill Beeson, participated in the demonstration.
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> The jury saw through the author's malignant attempts to discredit our 2 specialties in the eyes of our peers and returned a guilty verdict against the plastic surgeons. But the jury did more. It awarded the largest judgment in history against a medical organization, specifically, the Georgia Society of Plastic Surgeons, and the 2 local doctors who identified themselves as authors of the "Skim Milk" article. The court ordered the plastic surgeons to pay a total of $1.5 million in punitive damages—$ 1000 each to the Facial Academy and the Cosmetic Association, and the rest to Dr Anderson. But Jack Anderson never intended to keep the money for himself. He quickly turned around and donated his portion of the judgment to the Education Foundation of the Facial Academy for the purpose of establishing a certifying board for Facial Plastic Surgery.
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> More than the money, the verdict sent a message throughout the land. Assertions that only 1 group of

> doctors possesses the talents and knowledge to perform appearance-enhancing surgery are not only false and misleading, they are unlawful.

Other materials are available to show that organized plastic surgery has also spoken out against other specialties that are now being embracing as core specialties. It is amazing that over the past decade one of organized plastic surgery's top legislative agendas has been to fight the advance of cosmetic facial surgery by single-degree oral and maxillofacial surgeons.[6] With all the pressing issues facing their profession, and medicine in general, it is hard to believe they would fear and/or attempt to limit the competition of a group that spends more time in residency training on the face than their own residents! Was that really among the top issues affecting organized plastic surgery? Hardly. It was and is all about turf war, and unfortunately, it is being passed off as "public protection." For the record, the patients have remained safe.

Most major trauma centers split facial trauma cases between plastic surgery, oral and maxillofacial, and ENT specialties. Based on our experience performing bilateral temperomandibular joint replacement and LeFort osteotomies at the cranial base (J.N.) and microsurgery and craniofacial surgery (J.A.P.), we know these procedures are more challenging that most common soft-tissue cosmetic procedures. It is amazing that organized plastic surgery tries to discount and cloud the training of board-certified, residency-trained oral and maxillofacial surgeons, gynecologic surgeons, or general surgeons when in fact they know full well their claims to the high ground of "patient safety" are unsubstantiated. In the 2011 article mentioned earlier,[1] Dr Stevens is quoted as referring to "dentists doing breast surgery and liposuction." There is no state in the United States, however, that allows any general dentist to perform breast surgery or liposuction. Oral and maxillofacial surgeons with medical degrees and multiple years of general surgery and cosmetic fellowships may perform these surgeries, but how is this any different from dermatologists or ENT/facial plastic surgery physicians who perform the same? Single-degree oral maxillofacial surgeons perform 5 years of hospital internship and residency and rotate through all the major medical and surgical services. Most single-degree oral and maxillofacial surgeons operate above the collar bone—and do more of it than most other specialists. For instance, one of us (J.N.) performs 2 face-lifts a week on average, has extremely busy practice in which surgeries and minimally invasive procedures are performed, and is the largest solo provider of Botox in Virginia. This is just one example from one specialty. In other fields, dermatology, otolaryngology, and oculoplastic surgeons all have their own examples.

What is currently happening is an attempt by organized plastic surgery to stop cosmetic educational advancement. Many other specialties have contributed to and advanced the cosmetic field. False propaganda will not stop other fields from continuing to work in and promote cosmetic surgery.

The newly self-defined core specialties include, according to Dr Stevens[1] and Jonathan Sykes,[7] dermatoplastic, oculoplastic, and facial plastic surgery. The implication that practitioners in these fields are the only trained, competent cosmetic surgeons is without merit. Simply adding the word "plastic" to the subspecialty doesn't change the nature of a practitioner's training, experience, or expertise, and it is the actual training, experience, and expertise that define cosmetic surgery. If these so-called core cosmetic surgeons, in addition to calling themselves dermatoplastic, facial plastic, or oculoplastic, begin doing breast and body contouring surgery, will they still be acceptable partners with the plastic surgeons? If they have the fellowship training to educate them in these procedures, will they still be compatible with plastic surgery?

The article in which Dr Stevens was interviewed tries to make villains of practitioners of such specialties as obstetrics/gynecology and even general dentists who may be doing injectables in their practice.[1] This sounds like the saying "the enemy of my enemy is my friend." The claim that only plastic surgeons and those they refer to as their "core" colleagues are qualified to provide safe treatment with predictable outcomes is simply silly. In addition, some cosmetic courses, which exclude certain specialists from faculty participation, do not hesitate to take tuition from those same specialists as students. Dr Stevens mentions that in his early days his nurse performed his collagen injections.[1] A recent meeting for Merz Pharmaceuticals in Dallas included a broad group of practitioners as part of an expert injector group. A presenter from the United Kingdom stated that general dentists and nurses perform much of the neurotoxin and filler procedures in his country. This sparked much controversial discourse and talk about how these injectors were not in the "core." What is amusing is the fact that most of the people who were doing the criticizing employ nurses in their practice to perform injections! You can't have it both ways.

Dr Efrain Gonzales responded to Dr Steven's article by stating that he "has a dream for the day when surgeons are judged by their outcomes and not their original specialty training."[8] This was the fundamental principle of Dr Ernest Amory Codman (1869–1940). Dr Codman, considered a radical in his time, first proposed keeping data on surgical outcomes as a quality measure in 1900.[9] He believed data regarding surgical outcomes (the "End Result Idea") should play an important role in determining a surgeon's stature. Expelled from Massachusetts General Hospital (MGH), Dr Codman opened a 12-bed hospital of his own in 1911, to demonstrate the value of this idea. He openly published data on his own outcomes, and those of his hospital. By 1916, MGH and several other hospitals initiated the End Result Idea, which led to the birth of the contemporary morbidity and mortality conference and outcomes research. Results matter, and the subsequent reappointment of Dr Codman to MGH in 1929 proved the value of his idea. Dr Codman was the founding chairman of the American College of Surgeons committee for hospital standardization; he had a long and distinguished career and was widely recognized as a dissident force in surgery.[10] It is certainly appropriate to consider outcomes of cosmetic surgery to be a greater evidence of competence than simply training background.

There is an old principle that there are win-win people and win-lose people. Win-win people succeed on their own merits, accomplishments, and progress; they never berate their competition and don't spew negative energy. They realize that, no matter what others say, if they do a consistent good job, they will be on top. Win-lose people, however, are the exact opposite. For them to win someone else has to lose. They are the insecure types that continually bash their competition and disseminate nontruths in hopes of confusing the media and public. They fear that others that may be as good or better than they are, and their world is sad. Life is too short for negative energy. It is great to be proud of one's specialty, and there will always be collegial favoritism, but that should not require bashing other specialties

Open-minded people who see the world as it is, and not as a threat to their existence, will appreciate individual contributions from all specialties. Judge people by what they do and how they do it, not by preconceived prejudices that are aimed only at defamation based on economics. Codman's idea of the End Result as a measure of excellence provides an excellent standard to apply. The tired excuse that some practitioners are "only out to protect the patient" is irrational. The irrational attacks by some plastic surgeons against competing cosmetic surgeons, focus attention on the occasional outlying bad apple, when they ignore their own errant colleagues. In 2011, the *Today Show* (and all other major news outlets) surprisingly ran a piece about a patient whose face was damaged from eyelid surgery by a board-certified plastic surgeon from New Jersey.[11–13] I (J.N.) really felt sorry for the physician because his name and location and were mentioned in the story, and there may have been another side to the situation. What is notable is that cosmetic bulletin boards, blogs, and plastic surgery Web sites were totally silent on the incident. Fatalities or malpractice by nonplastic surgeons is frequently cited as evidence that only plastic surgeons should be performing such procedures. Bad outcomes can be found for all types of physicians.

Finally, we should ask, what are the core specialties? Use of the term "core" to create a specific limited group overlooks the wide variability in training, education, and experience that are found not only within an individual specialty residency but also between residencies in the same field. The Accreditation Council for Graduate Medical Education currently identifies core competencies as including the following 6 specific areas:

1. Patient care
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice.

These competencies apply across all fields, regardless of specialization. Specialized training refers to unique knowledge and skills but the approach to the 6 core competencies should be identical across all specialties. The specific knowledge required to become a cosmetic surgeon is not owned by any one group of practitioners but is something learned as part of surgery residency, regardless of specialty, and enhanced by fellowship training or other postgraduate education, continuing education, and experience.

Going forward, the American Board of Cosmetic Surgery is moving toward the recognition that cosmetic surgery cannot be divided into simply face, body, or dermatology but encompasses the whole human being. We can only hope that our colleagues in cosmetic surgery, whether plastic surgeons,

otolaryngologists, ophthalmologists, or others, will come to understand that our field is not fragmented but made whole by our common interests.

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