Aesthetic Surgery Practice: Another Nigersaurus?

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The dinosaur Nigersaurus wandered the earth 110 million years ago. Its shovel-shaped mouth, which contained 50 rows of teeth, was uniquely adapted for the purpose of eating massive quantities of grass as it ambled along, head constantly to the ground, perhaps consuming as much as a football field worth of “munchies” in a day. Unfortunately, as the climate changed, the specific grasses to which it had become uniquely adapted were replaced by different vegetation. Nigersaurus did not adapt along with its environment and thereby became extinct.

Although this story may not seem relevant at first, I propose that this is a situation—one of failure to adapt and subsequent extinction—in which the independent plastic surgeon (or independent groups of plastic surgeons) whose practice exclusively or primarily comprises aesthetic surgery may soon find himself or herself.

The downturn in the economy, along with certain medical insurance issues, has accelerated a dynamic that has been evolving for several years in the medical community. “Strength in numbers” has become the byword. Multispecialty medical groups have rapidly expanded across the United States, in many cases forcing the independent practitioner to join them. For example, a urologist who has served a community well might be informed by a dependent practitioner to join them. For example, a urologist across the United States, in many cases forcing the independent practitioner to join them. For example, a urologist across the United States, in many cases forcing the independent practitioner to join them. For example, a urologist across the United States, in many cases forcing the independent practitioner to join them.

The subsequent extinction—in which the independent plastic surgeon becomes part of a multispecialty group—has been evolving for several years in the medical community. “Strength in numbers” has become the byword. Multispecialty medical groups have rapidly expanded across the United States, in many cases forcing the independent practitioner to join them. For example, a urologist who has served a community well might be informed by a dependent practitioner to join them. For example, a urologist across the United States, in many cases forcing the independent practitioner to join them.
“work in progress,” the situation is more problematic. For these surgeons, a considerable expenditure of both time and money will likely be necessary in establishing a successful aesthetic practice. To that end, an aggressive advertising campaign (local newspapers and magazines, Internet, local television) as well as appropriate public relations to brand the practice and maintain a community presence is mandatory. This is an expensive but necessary undertaking; otherwise, the aesthetic plastic surgeon with an immature practice will indeed go the way of the Nigersaurus.

Besides the more immediate financial impact of these dynamics, there is another consequence that is more insidious. Traditionally, cosmetic practices have an intrinsic value. As the practice grows, so does its worth. Toward the end of their career, successful practitioners of the past could consider taking in a young partner or selling the practice prior to retirement. However, with an uncertain future looming, these practices cannot possibly be worth what they once were, and the possibility of a “buy in” or “buy out” becomes less feasible.

The dilemma is equally problematic for the young plastic surgeon finishing his or her residency. The choices are to (1) attempt to establish a solo practice in general plastic surgery while building a cosmetic practice; (2) join a group practice where the established partners are willing to provide aesthetic cases; (3) pursue a full-time academic practice with little likelihood of establishing an aesthetic practice; (4) accept a part-time academic appointment, allowing other time to establish an aesthetic practice using the cache of the institution and the largesse of more senior members of the staff who have established aesthetic practices; or (5) join a multispecialty group.

If the young plastic surgeon is determined to go it alone, he must look carefully at the demographics of the community in which he intends to practice. He must research the potential aesthetic population, the competition, and especially the existence of multispecialty group practices that already have a plastic surgeon. His dilemma is compounded by the harsh reality that when he begins practice—when he rents office space, hires personnel, purchases equipment and supplies, and pays malpractice insurance—he is already considerably in debt from his medical school days (to the tune of $156,456 on average in 2009, according to the Association of American Medical Colleges).

While the first option—a group aesthetic practice—is more attractive under these circumstances, the issues cited above make joining one a less attractive and viable option than in prior years. The uncertain future cannot help but make senior partners less generous in their offerings, while also making the young plastic surgeon wary of a commitment. The “investment” in the young plastic surgeon is less likely to yield returns, and in turn, the financial incentives to join the group will be reduced. The consequences of becoming a full-time academic are obvious. It is certainly possible to become a part-time academic since the modest income provided would help the young plastic surgeon defray some start-up expenses and pay malpractice insurance. However, these opportunities are few and far between and cannot accommodate the large number of plastic surgeons looking to start an aesthetic practice after residency.

The incentive to join a multispecialty or hospital-based group therefore looms large. In many ways, it is an ideal environment for young plastic surgeons. They will be guaranteed a salary, malpractice insurance is paid, and they have ready-made office space with clerical staff and a patient coordinator. Of the various options available, this one would appear to be the most appealing for the majority of young plastic surgeons. Currently, such positions are limited but will likely become increasingly available as multispecialty groups continue to grow.

Aesthetic surgery will continue to evolve in many positive ways, but clearly the patient experience will change. In fact, I am certain that the way most of us currently practice aesthetic surgery will reach an end in the near future. It is just a matter of time. We must anticipate this “climate change” and adapt accordingly, lest we face extinction. For those of us of a certain age, who are likely to keep doing what we’re used to doing, no matter what, “Long live Nigersaurus.”

Disclosures

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REFERENCES
