Commentary

Commentary on: Why Should Young Aesthetic Plastic Surgeons Care About Aesthetic Medicine?

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The authors make the logical argument that nonsurgical procedures, what they call “Aesthetic Medicine,” are an essential component of a young plastic surgeon’s cosmetic surgery practice. Few could argue credibly to the contrary, but, for the sake of discussion, I will take issue with some of the assumptions and some of the semantics.

The primary argument in favor of offering cosmetic nonsurgery, as well as cosmetic surgery, in my opinion, is that the practitioner who offers the entire spectrum of treatment can more effectively make the case that a particular therapeutic recommendation is based on what is best for the patient, and not on the capabilities and credentials of the provider; a dermatologist cannot offer the same spectrum of treatment and, “if you have a hammer, the whole world looks like a nail.”

However, depending on nonsurgical treatments for revenue comes at a price, so to speak—potentially a high price. Nonsurgical procedures are offered by individuals with far less training than a surgeon certified by the American Board of Plastic Surgery or the American Board of Otolaryngology, and marketing nonsurgical procedures puts one in competition with a much larger number of practitioners. Can a plastic surgeon really state that he/she is better at nonsurgical fat reduction than a general surgeon? Better at skin care than a dermatologist? Better at Botox than a well-trained, experienced nurse injector? Cosmetic surgery is what separates a plastic surgeon from other surgeons, other physicians, and nonphysician providers. If surgery is not maintained as our core, we will lose any claim to superiority. If we give up cosmetic surgery as our main thrust, a few talented entrepreneurs among us may do well for a while, but what does the future hold for plastic surgery? Won’t we lose facelifting like we lost rhinoplasty?

Secondly, I take issue with the contention that the authors’ “Five Principles of Aesthetic Medicine” are “all centered on patient care.” In fact, 3 of the 5—patient acquisition, patient retention, and patient conversion—are centered on the surgeon’s wallet. I simply make the point that building a practice is not necessarily the same as taking good care of patients, and it is important to analyze what we do to achieve better results and what we do to develop a busier practice. I also take issue with the statement that “it is important to offer diverse services with a range of price points for patient acquisition.” That may be true, but it is, again, a commercial consideration, not a patient-care consideration. The authors also use “career” synonymously with “building a practice.” “Career,” I believe, refers to one’s profession and has nothing to do with whether one gets rich doing it.

Thirdly, the concept that nonsurgical treatments are a gateway to a practice where patients will return for more coveted surgical procedures is not necessarily a real phenomenon, particularly in a competitive, urban area, where sophisticated patients seek “the best.” When I first started...
to practice in New York City I had patients who would come to me for injectables, presumably because I had time on my hands and could pamper them, and then they went to Sherrell Aston and Dan Baker for their facelifts! It wasn’t until I had some happy postoperative patients walking around that I began to develop a surgical practice. I would certainly not suggest that nonsurgical treatments are bad but the best practice-builder that I know of is a collection of happy surgical patients. And surgical patients can’t get happy unless they have had surgery! Surgery is also a more productive use of a surgeon’s time than nonsurgical treatments (unless one does the latter on a large scale).

Fourthly, unfortunately the authors’ statement about the rise of American Society for Aesthetic Plastic Surgery (ASAPS)–sponsored fellowships is also inaccurate. At the present time there are only 25 fellowship positions annually endorsed by ASAPS. Therefore, only 12.5% of the approximately 200 graduates of plastic surgery training programs each year can gain one of those fellowships. If diplomats of the American Board of Plastic Surgery are to hold on to cosmetic surgery, we need to train more post-residency fellows and train them better. If I could change one thing about our specialty, that would be it.

Finally, semantics. Although I am devoted to ASAPS, I do not like the word “aesthetics” when applied to surgery, nonsurgical procedures, or to surgeons. What is an “aesthetic plastic surgeon”? A plastic surgeon who looks good? I am not totally stupid; we know what it means—but does the public? Aesthetic medicine? Aesthetic surgery? Do you think those terms resonate with patients? I personally like the term “cosmetic surgery” because it is the most descriptive and the least pretentious. “Aesthetic” makes us sound like snobs. My opinion.

The authors make utterly legitimate points but hopefully the devil’s advocate position above offers some useful further thoughts for discussion.

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