A Greater Expertise

Ending the one-stop, full-service cosmetic surgery practice is better for both patients and physicians

by Richard L. Anderson, MD, FACS

I have been fortunate to be part of the golden years in oculoplastic surgery. I believe in getting the best possible training and trying to find a niche where you can be the best. So, after completing an ophthalmology residency, I took not one but two fellowships in oculoplastic/facial plastic surgery. Most oculoplastic surgeons, at the time, were ophthalmologists who did part-time oculoplastics. The oculoplastic cases were confined to the eyelids; eg, ptosis, entropion, ectropion, dacryocystorhinostomy, and blepharoplasty. The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) was formed in 1969 by several surgeons with an interest in oculoplastic surgery and several fellowship programs were started. When I finished my training and returned to the staff as an assistant professor at the University of Iowa, Iowa City, in 1976, I was the first full-time oculoplastic surgeon at a university.

When I joined the faculty at the University of Iowa, a general plastic surgery department did not exist. Each specialty did its own plastic surgery and several had their own plastic subspecialist. Working together with the other subspecialists gave me an excellent opportunity to train residents and fellows. Turf battles were minimal, and expertise and experience in subspecialty areas developed rapidly. I became professor and chief of the oculoplastic division and developed the largest volume and fellowship training program in the country by 1982.

In 1984, I moved to Salt Lake City as professor and chief of oculoplastic and facial cosmetic surgery at the University of Utah in addition to running a private practice. In 1999, I went into private practice full time and started the Center for Facial Appearances. In Salt Lake City, I have worked closely with plastic surgeons and craniofacial surgeons who provide valuable expertise in craniofacial work and extensive head and neck reconstruction.

I was fortunate to work with and learn from excellent colleagues in ophthalmology; ears, nose, and throat; neurosurgery; dermatology; and plastic surgery. I find that most of the true experts in cosmetic surgery have subspecialized and focused on what they do best. The era of plastic surgeons who specialize in everything is gone forever.

In my 3 decades in oculoplastic surgery, I have seen the field grow from a few interested ophthalmologists starting ASOPRS to an organization with more than 500 members who specialize in oculoplastic/facial plastic surgery. Most limit their practices to this specialty. Subspecialties of oculoplastic surgery such as orbital surgery, lacrimal surgery, eyelid malpositions, and facial cosmetic surgery, have evolved. I feel that it is a mistake for oculoplastic surgeons to despecialize and do general plastic surgery.

I believe the upper eyelids are a continuum with the brows and the lower eyelids with the cheeks and midface. I have several colleagues who started as general plastic surgeons and specialize in oculoplastic surgery with great expertise. I believe that in plastic surgery, it is more important where you finish than where you begin. It is the responsibility of referring physicians and patients to seek out the best-qualified physicians and care for their patients and themselves. It is the responsibility of physicians to do only procedures in which they are well-trained and qualified. My conscience would not allow me to do procedures that I know can be done better by others.

In general, more training and experience in an area provides greater expertise. There is no substitute for hands-on experience. The average oculoplastic surgeon spends 4 years in medical school, 1 year in surgical internship, 3 to 4 years in eye and eyelid surgery, and 2 years specializing in oculoplastic/facial plastic (surgery around the eyelids and face). Thus 5 or 6 years of training are spent in the critical area of eyelid and facial plastic surgery. I doubt that any other specialty spends more than 5 to 6 weeks of training in eyelid surgery. I think it is critical for surgeons to provide excellent preoperative evaluation of the structures to be operated on and to manage the potential complications of surgery. The majority of complications in eyelid surgery are related to the eye. These range from dry eye to visual decrease. Nowhere on the body does the skin and deeper structures provide such important movement protection and cosmesis as on the eyelids. Understanding the physiology of the eyelids requires understanding the physiology of the eye. It is the same for the nose, teeth, brain, and other specialty areas. I do not perform rhinoplasty because I believe that only an expert on noses should perform rhinoplasty; only a dentist or oral surgeon should perform teeth surgery; and only a neurosurgeon should operate on the brain, even though these structures are all part of the head.

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After training in oculoplastic/facial plastic surgery, I have had no desire to perform plastic surgery on other parts of the body. It is perplexing to me why some oculoplastic/facial plastic surgeons want to be general plastic surgeons and why plastic surgeons, dermatologists, and even dentists want to be oculoplastic surgeons. Some may

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blame this on the present day economic woes of medicine. Others adhere to the current philosophy that physicians must be a one-stop, full-service cosmetic surgeon and do everything. I strongly disagree. I have a thriving cosmetic practice based on doing only those procedures I know I am trained to perform better than my colleagues. I am honest with my patients and tell them I feel other physicians perform cosmetic noses better than I do. Today's cosmetic consumers are better informed than in the past and understand that no one plastic surgeon can be the best in all areas. They respect surgeons who specialize and will only do what they do best. Most patients want specialized types of cosmetic surgery with more rapid rehabilitation than in the past. The one-stop cosmetic surgery physician and patient are hopefully gone forever.

The transition from doing mainly reconstructive surgery to doing mainly cosmetic surgery over the past 3 decades would have been psychologically impossible for me if I had tried to be an expert in everything. I believe that the level of responsibility to our patients and ourselves is much greater when doing cosmetic surgery. Cosmetic surgery is the only area where we operate on well patients. I can only accept the risks of a complication from cosmetic surgery with the belief that I am the best to perform that procedure with the fewest risks. I could not enjoy my practice and sleep at night otherwise. ■

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