Cosmetic and plastic surgeons: what’s the difference?

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The term ‘surgeon’ and the title ‘Mr’ originated in England in 1815 following a dispute between general practitioners and a group of more highly trained hospital surgeons. In the 1800s, for the first time, qualified medical practitioners started to provide formal qualifications and letters after their names and the title ‘Member of the Royal College of Surgeons’ (that is, ‘MRCS’) became universally applied across all practitioners.

Hospital surgeons, however, were unhappy that general practitioners used the same letters and qualifications, even calling themselves ‘surgeons’, without having had the same level of training. They responded by referring to themselves as ‘pure’ surgeons—a reference to their greater surgical skill and depth of training and an appointment at a hospital. As a group they also charted new professional territory based on ethical considerations, focusing on the wellbeing of the patient as well as a new level of professionalism in surgical medicine, thereby distancing themselves from the unscientific practices of blood-letting and the ‘barber surgeons’. They also ceased dispensing drugs and practicing midwifery.1 Out of 8000 practitioners who held the MRCS in England in 1834, there were just 200 ‘pure’ surgeons.2

Professional life for this group was initially difficult. They had chosen to deliberately abandon some of the more lucrative parts of their previous careers in order to pursue an ethical practice based on surgery and science. In time, however, broader society came to hold this small group in high regard. They were respected for following a higher ethical code and their dedication to a profession that focused on patient wellbeing rather than simply the provision of a service.
In 1843, a new charter changed the Royal College of Surgeons of London into the Royal College of Surgeons of England and this provided this small group of ‘pure’ surgeons with an opportunity to introduce the new rank of ‘fellow’ (or FRCS). This title became the hallmark of the ‘pure’ surgeon and was firmly linked to the convention of addressing such surgeons as ‘Mr’.¹,³

Discussion today around the difference between cosmetic surgeons and plastic surgeons should likewise address issues such as the level of ethics and professionalism that applies in each case. But a question we should ask is whether a ‘cosmetic surgeon’ is so fundamentally different that a lesser standard of surgical training, ethics and professionalism applies.

The Australian Society of Plastic Surgeons defines cosmetic surgery as ‘any invasive procedure where the primary procedure is to achieve what the patient perceives to be more desirable appearance where the procedure involves changes to bodily features that have a normal appearance on presentation to the doctor.’¹ In contrast, surgery with the goal of achieving a normal appearance, where the bodily features at presentation do not have a normal appearance due to congenital defects, developmental abnormalities, trauma, infection tumours or disease, does not constitute cosmetic surgery and is best described as restoration or ‘reconstruction of the whole’.⁴

The most important difference between cosmetic surgery and reconstructive surgery is therefore a patient’s appearance, relative to normal, at presentation. That difference essentially relates to the purpose of the patient in seeking the procedure. However, in terms of the science, the training, the ethical code of the medical practitioner performing the surgery, and the professionalism of the practitioner, there should be the same standards for both cosmetic and reconstructive surgery.

Surgical techniques are shared extensively across reconstructive and cosmetic surgery and any practitioner working in this field should be expected to possess the full armamentarium of surgical techniques to achieve the best outcome for his or her patient.

It is often said that the hallmark of a master reconstructive surgeon is a beautiful cosmetic result. This is clearly apparent in the field of breast reconstruction after cancer but could equally be applied to facial cancer surgery reconstruction or hand reconstruction after trauma. Yet it could also be applied to cosmetic breast surgery. It is the outcome that is critical.

Sadly, as in the early 1800s, we still have practitioners that are not equal who are now working in the area of cosmetic surgery. Some are clearly highly qualified, well trained, have a depth of understanding of surgical anatomy, are proficient at surgical planning and know how to salvage an unforeseen or rapidly deteriorating situation quickly, with expertise and with minimum harm to the patient. Some, however, are not.

Specialist plastic surgeons should be seen as occupying the high ground of cosmetic surgery. They undergo a minimum of an extra five years of full-time, supervised, accredited and licensed training, with many spending significantly longer due to the competitive selection process into accredited training. In 2017 the average age of a fellow graduating from the Royal Australasian College of Surgeons was 39—that is, 21 years after entering medical school at 18. By comparison, there are many so-called ‘cosmetic surgeons’ who are medical practitioners but who have done little more than a weekend course in a plastic surgery technique.

Plastic surgery is the only training in cosmetic surgery that is accredited by the Australian Medical Council (AMC), the national body that oversees and accredits all official surgical training in Australia. Graduates of this intensive training can be recognised by the letters FRACS—fellows of the Royal Australasian College of Surgeons—and are extensively trained in the full spectrum of reconstructive through to cosmetic surgery.

‘Specialist plastic surgeon’ is the only AMC-recognised title that a practitioner can use in the area of plastic surgery in Australia. Many other practitioners use terms such as ‘facial plastic surgeon’, ‘oculoplastic surgeon’, ‘aesthetic surgeon’, ‘specialist cosmetic surgeon’ or just ‘cosmetic surgery’.
surgeon’ but none of these are related to AMC-accredited training in plastic surgery. And yet—to an unknowing consumer searching online—all these terms appear to have equal billing.

Is this part of the recent societal shift toward the simplification of complex scientific phenomena and the emergence of untrained individuals or groups to provide opinions on scientific facts? This itself is an incongruous concept but it is perhaps part of a general devaluation of expertise and a desire to give equal weight to alternative viewpoints irrespective of a particular argument’s underlying scientific validity or a proponent’s depth of scientific understanding.

Cosmetic surgery has become fashionable—an accessory even—and an apparently integral part of the modern millennial beauty regime. But cosmetic surgery is not trivial. It comes with real risk and, as illustrated recently in Sydney with the tragic death of a beauty clinic owner and the unilateral permanent blindness inflicted on a young girl in a beauty parlour, any cosmetic procedure can be dangerous in the wrong hands. Relevant state and federal authorities are only now coming to realise that cosmetic surgery is real surgery and that un- or inadequately-trained practitioners pose a significant risk to patients and public health.

While governments are moving to tighten regulation around cosmetic surgery, unfortunately, in the interim, there is little to protect the public from unscrupulous or untrained practitioners. Consequently, it falls back on prospective patients to conduct their own research into the training of a practitioner, the licensing of a facility and the capacity of a ‘surgeon’ to be able to perform the surgery proposed.

It seems we haven’t moved so far from 1815 after all.

Disclosure
The authors have no financial or commercial conflicts of interest to disclose.

References
4 Nicola R Dean FRACS, PhD. Personal communication to the Australian Society of Plastic Surgeons Executive, August 2017. Working paper on defining cosmetic surgery.