Aesthetic Medicine: A Professional Perspective

By Associate Professor Goh Lee Gan

MEANING OF AESTHETIC MEDICINE/SURGERY

There is presently no universally accepted definition for aesthetic medicine/surgery. There are also synonyms like cosmetic surgery and plastic surgery. Broadly, aesthetic medicine/surgery can range from simple cosmetic dermatological and hair procedures, to body enhancement surgery, to claims of reversal of the ageing process. It can be seen to be made up of three parameters[2]:

- performed to reshape normal structures of the body;
- initiated by the patient and not on medical need, and
- excludes reconstructive surgery.

Reconstructive surgery has been defined as surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease. It is generally performed to improve functions, but may also be done to approximate a normal appearance (AMA, 1989)[3]. Plastic surgery is surgery that encompasses both cosmetic surgery and reconstructive surgery (American Society of Plastic Surgeons)[4].

In practice, there are "gray areas" of the procedures, which can either be reconstructive or cosmetic, depending on each patient's situation. For example, eyelid surgery (blepharoplasty) – a procedure normally performed to achieve cosmetic improvement – may also be done if the eyelids are drooping severely and obscuring a patient's vision[3].

AESTHETIC MEDICINE/SURGERY COMPARED WITH CONVENTIONAL MEDICINE

Conventional medicine has at least four characteristics. These are:

- Goals of medicine are treatment and prevention.
- Scientific- and evidence-based medicine approach is the basis for intervention.
- Professionalism of provider focuses on competency and informed consent.
- Overlap is complementary rather than competitive amongst different healthcare providers.

How does aesthetic medicine/surgery fit into this framework?

Goals of medicine

Medicine has been defined as "The science of diagnosing, treating, or preventing disease and other damage to the body or mind"[6]. Aesthetic medicine/surgery stands apart in that they are procedures to reshape normal structures of the body to improve the patient's appearance and self-esteem. Here, the basic problem is not abnormal structures per se, but rather, the patient is dissatisfied with the beauty aspects of the body part and seeks the help of the healthcare provider to improve it. In this respect, it is unconventional.

To reconcile this phenomenon with conventional goals of medicine, we will need a broader definition of health, namely, the WHO definition that includes not only physical but also social and mental dimensions of health. There is also the need to be clear that the patient does not have a dysmorphic body disorder[7,8,9], and that he or she is not a young person whose growth and development will be affected by the aesthetic procedure[10]. The focus in aesthetic medicine/surgery is on treating normal structures to improve the appearance and self-esteem. Patient and safety must remain as the number one consideration. Where there is no disease to begin with, the burden to "first, do no harm" will be truly, the most onerous (Markey, 2004)[11].

Scientific- and evidence-based approach

Allopathic medicine or the Western medicine that we know of is based on the scientific- and evidence-based medicine approach. Much of aesthetic medicine/surgery is based on the knowledge and research in reconstruction surgery, ENT surgery, dermatology, pharmacology and pharmaceuticals. The application of such knowledge in aesthetic medicine/surgery will be technically acceptable. There are areas however, where the evidence-based medicine is still weak, for example, mesotherapy and cellulite treatment. Further research and development are needed before such techniques can be adopted as conventional treatment.

Professionalism – provider competency and informed consent

This is presently not uniform because the definition and scope of work, and therefore knowledge base and adequate formal training, are still in a flux. Given such a state then, informed consent becomes difficult. This needs to be resolved by the medical profession through consensus and self-regulation.

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Overlap amongst providers

Some overlap is inevitable amongst healthcare providers. In the case of aesthetic medicine/surgery, there is an overlap between plastic surgeons, dermatologists, general practitioners, nurses, dental surgeons, and other healthcare providers like ENT surgeons, head and neck surgeons on the one hand, and cosmetologists or beauticians on the other. Such overlap should be complementary rather than competitive.

Over time, the pricing mechanism, difficulty of the procedures, and patient safety factors will distribute the turf, but this can be speeded through discussion in a multi-disciplinary body like the Cosmetic Surgery Interspecialty Committee in the United Kingdom. A similar body that Singapore could consider setting up would be an Aesthetic Medicine/Surgery Interspecialty Committee. Such a body could also define the training, facilities, patient safety, patient education and empowerment for the primary care level and specialist level of practice.

SCOPE AND PLACE OF AESTHETIC MEDICINE/SURGERY

The scope of aesthetic medicine/surgery is fairly wide. However, it can be regarded as synonymous with cosmetic surgery. As such, the procedures can be grouped into two broad categories: (1) those requiring application of the skills of the trained surgeon, operating theatre and anaesthesia services; and (2) those which are minimally invasive and can be done as office procedures by primary care doctors. (See Table 1.)

Table 1. Scope of Aesthetic Medicine/Surgery

Cosmetic surgical procedures

- Cosmetic breast surgery – breast enlargement, breast uplift (mastopexy), breast reduction, inverted nipple correction
- Body reshaping – abdominoplasty (tummy tuck), liposuction, thigh and buttock lift, upper arm lift
- Facial surgery – brow lift, cheek implant (malar augmentation), chin augmentation (mentoplasty), dermabrasion, ear surgery (otoplasty), eyelid surgery (blepharoplasty), facelift (rhytidectomy), forehead lift, lip augmentation (other than injectable materials)

Cosmetic minimally invasive procedures

- Botox – anti-wrinkle treatment
- Chemical peels
- Laser hair removal, laser skin resurfacing, laser and intense pulsed light (IPL) therapies for scars and skin blemishes, laser treatment for lines and wrinkles, laser treatment for vascular birthmarks, laser treatment of leg veins
- Soft tissue fillers – calcium hydroxylapatite (Radiesse), collagen, fat, hyaluronic acid (Hylaform, Restylane)
- Sclerotherapy
- Others – fat transfer (liposculpture), microdermabrasion, mole removal, scar revision, tattoo removal, split earlobe repair

The turf that belongs to the beautician should be left to the beautician. Aesthetic medicine/surgery should therefore exclude beauty or grooming activities that have no structural impact on body tissue, ear or body piercing or tattooing.

Overlapping healthcare providers include plastic surgeons, dermatologists, general practitioners, dental surgeons, other specialists like ENT surgeons, head and neck surgeons, and also nurses[1].

In the United Kingdom, the problem of overlap is resolved by the Cosmetic Surgery Interspecialty Committee. A similar body can be set up in Singapore. The plastic surgeons, ENT surgeons, head and neck surgeons, and dental surgeon can take care of the first category of procedures relevant to their area of training. The general practitioners and dermatologists can take care of the second category of procedures. In this way, there will be complementary overlap of work rather than competitive overlap of the different healthcare providers.

GOOD MEDICAL PRACTICE PRINCIPLES

Providers of aesthetic medicine/surgery will be expected to abide by the seven principles of good medical practice[12] as defined by the General Medical Council in the United Kingdom. (See Table 2.)

Table 2. Good Medical Practice as defined by the General Medical Council

1. **Good clinical care:** (1) Providing a good standard of practice and care, (2) Decisions about access to medical care, (3) Treatment in emergencies
2. **Maintaining good medical practice:** (1) Keeping up to date, (2) Maintaining your performance
3. **Teaching and training, appraising and assessing:** (1) Making assessments and providing references, (2) Teaching and training
4. **Relationships with patients:** (1) Obtaining consent, (2) Respecting confidentiality, (3) Maintaining trust, (4) Good communication, (5) Ending professional relationships with patients, (6) Dealing with problems in professional practice, (7) Conduct or performance of colleagues, (8) Complaints and formal inquiries, (8) Indemnity insurance
5. **Working with colleagues:** (1) Treating colleagues fairly, (2) Working in teams, (3) Leading teams, (4) Arranging cover, (5) Taking up appointments, (6) Sharing information with colleagues, (7) Delegation and referral
6. **Probity:** (1) Providing information about your services, (2) Writing reports, giving evidence and signing documents, (3) Research, (4) Financial and commercial dealings, (5) Conflicts of interest (6) Financial interests in hospitals, nursing homes and other medical organisations
7. **Health:** If your health may put patients at risk

Source: General Medical Council UK, 2001

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CONCLUSIONS

Aesthetic medicine/surgery differs from conventional medicine in that it is focused on improving normal structures and the patient's self esteem. Its growing demand hinges on well-being being regarded as more than just the absence of abnormality in structure or function. To practise it professionally, ethically, and with patient safety and accountability, there is a need to apply the principles of conventional medicine, and define what aesthetic medicine/surgery should include and exclude as its practice.

An aesthetic medicine/surgery interspecialty committee can define the work, necessary training and competency that each level of practitioners will need in order to practise safely. The seven principles of Good Medical Practice defined by the General Medical Council in UK in 2001 form a good basis for defining the expected standards. ■

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