

*SPECIAL TOPIC*

# Cosmetic Surgery: The Genesis and Evolution of a Specialty

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In the mid 1960s, a group of visionaries gave birth to 2 organizations, one of which would eventually turn into what we know today as the American Academy of Cosmetic Surgery...but the journey to this place and time has not been easy.

The 1960s was a time in history when no institution existed for teaching the unique skills and insights that set “cosmetic surgeons” apart from reconstructive surgeons. However, following the truism, “necessity is the mother of invention,” Drs Jack Anderson, Wally Berman, Jan Beekhuis, Bill Wright, Ira Tresley, Richard Farrior, and John Dickinson Benito Rish, and a half dozen other facial surgeons created not 1—but 2—organizations.

One was the American Association of Cosmetic Surgeons, heretofore referred to in this presentation as “The Cosmetic Association.” The other was the American Academy of Facial Plastic and Reconstructive Surgery, heretofore referred to as “The Facial Academy.” As you will come to see, the creation and evolution of the American Academy of Cosmetic Surgery arose out of both of these grassroots organizations.

The founders’ intent was to create a specialty devoted to cosmetic surgery and to do it in a staged manner. Attention would first be directed to the Facial Academy. Once the numbers of cosmetically oriented members justified doing so, the founders of the 2 sister organizations intended to take the Cosmetic Association off the shelf and have it represent a multidisciplinary assembly of “elite” surgeons, each of whom possessed uncontestable credentials in

appearance-enhancing surgery, strategically modeled after the membership requirements of the prestigious American College of Surgeons.

Shortly after the Caribbean meeting in 1964, the group of founders was joined by a dynamic young plastic surgeon from Boston, Mass, Richard Corliss Webster, an independent thinker who was born and reared on the Mason/Dixon line. Webster was the protégé of the famed dental, oral, and plastic surgeon, Dr V. J. Kazanjian.

From personal experience, Dr Webster knew that although his own specialty (plastic surgery) had originally expressed interest in creating a multispecialty organization, after the aesthetic society was formed, plastic surgical leaders rejected the idea of cross-specialty teaching. On the other hand, the founding fathers of the Facial Academy and its sister organization, the Cosmetic Association, embraced the idea.

So, the founders went to work. It took a little more than 10 years for the Facial Academy to initiate its 1000th member. The roster comprised otolaryngologists, dermatologists, oculoplastic surgeons, oral and maxillofacial surgeons, and a handful of plastic surgeons.

Then, an unanticipated change in policy occurred. With a push from academic otolaryngology, a new wave of facial surgeons jockeyed themselves into positions of authority within the Facial Academy.

Yielding to pressures being applied at home (from university-based plastic surgeons and from others within the American Board of Medical Specialties), academically affiliated members of the Facial Academy’s governing board moved to change its membership criteria, effectively excluding dermatologists and oral surgeons.

Seeing the handwriting on the wall, Richard Webster (who had served as one of the Facial Academy’s presidents) threatened to resign. In the early 1980s, a

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handful of past and present officers met in a suite at the Breakers Hotel in Palm Beach, Fla, and came up with an alternate plan. We would jump-start the American Association of Cosmetic Surgeons. Rather than creating a society of elitists, it would become the “Big Tent” under which cosmetic surgeons from a variety of specialties could share information and knowledge. The Facial Academy, on the other hand, would effectively become the plastic and reconstructive surgery arm of Otolaryngology.

A letter, cosigned by Dr Webster and the most respected head and neck surgeon in the world (Dr John Conley of New York City, NY), was mailed out to doctors from across the appearance-enhancement spectrum, inviting them to join the American Association of Cosmetic Surgeons. Appropriately, Richard Webster became President. He was followed by Blu Stough, a dermatologist from Hot Springs, Ark. The next President was facial plastic surgeon, Trent Smith from Columbus, Ohio, who was followed by Dr Robert Wood, a plastic surgeon from Houston, Tex.

Then, at the age of 37, I became the Association’s fifth president. Three of the first 5 presidents of the Cosmetic Association had been—or presently were—officers and directors of the Facial Academy. I point this out only to demonstrate the close working relationship that once existed between the leadership of the 2 organizations.

As the Cosmetic Association’s President, one of my first initiatives was to create a *Journal of Cosmetic Surgery*. Published by EBSCO Media, the *Journal* was well received, but we were ahead of our time, and in those days, paid advertisements and grants were hard to come by. So after 2 years, the publisher decided to shelve the *Journal*. However, the specialty of “cosmetic surgery” had driven a stake in the medical landscape, and its *Journal* would be revived after a critical merger that is to be addressed in another section of this article. Shortly thereafter, another cosmetic surgery association (The American Society of Cosmetic Surgery) picked up on the idea of a journal devoted to cosmetic surgery.

In the early years, facial and cosmetic surgeons were hammered by a nationally coordinated smear campaign orchestrated by general plastic surgery organizations. In response to the plastic surgeons’ clever twist on “board certification,” a group of California-based surgeons—led by Drs Richard Aronsohn and Robert Franklin—incorporated the American Board of Cosmetic Surgery. On another front,

I persuaded the Facial Academy and the Cosmetic Association to support my efforts in organizing the National Council for the Medicine, Surgery, and Dentistry of Appearance. Representatives from the various appearance-enhancing disciplines, including psychiatry, held a series of meetings in Chicago, Ill. The plastic surgery societies were invited to attend, but refused.

As the Council’s elected chairman, I was able to share—with other professionals—materials obtained by the Federal Trade Commission during its investigation of anticompetitive practices on the part of the American Society of Plastic and Reconstructive Surgeons (ASPRS).

A Machiavellian-like “Cold War” strategy employing “guerilla warfare” described how plastic surgeons intended to conduct a “Cold War,” during which they would “stall, frustrate, and destroy” physicians and surgeons identified as competitors. The document launching the “Cold War” was crafted in 1964 and was later retrieved by the Federal Trade Commission from the files of the ASPRS executive offices in Chicago.

From a handwritten note above its title, it came to be known as *the Inter-Group Conflict Document*. And the fact that plastic surgery organizations were found to be following the class warfare tactics it contained convinced the Federal Trade Commission that the document represented a strategy.

The “Cold War” eventually became a heated war. So much so that—in addition to the FTC—the US Congress became involved, calling all sides before a congressional hearing. The hearing provided a forum whereby a team of facial and cosmetic surgeons provided evidence of anticompetitive and unlawful tactics being used against us.

Drs Frank Kamer, Ted Cook, Robert Simons, Regan Thomas, and I made our case. The Federal Trade Commission issued a “consent decree,” which meant that the US federal government found evidence of unlawful, anticompetitive practices.

The next skirmish in the “Inter-Group Conflict” followed the publishing of an article that was constructed by Dr Jack Anderson and myself, entitled, “An Old Specialty Puts on a New Face ... and Head ... and Neck.”

The article was published in the *Journal of The Southern Medical Association* under Jack’s name. It was intended to inform the medical world that Otolaryngology had evolved beyond “Ear, Nose, and Throat.”

and had appropriately added the term “Head and Neck Surgery” to its name. With the assistance of publicist, Al Walter, Jack, and I spelled out the reasons why the name change was timely and appropriate.

Afterward, I consolidated the original article into a 1-page summary that was published in the *Medical Journal of the State of Alabama*. Then, I sent my abbreviated version to key individuals around the United States, asking them to submit it to their own state’s medical journal.

One of the first to do so was Dr Bill Silver of Atlanta, Ga. The article apparently infuriated members of the Georgia Society of Plastic Surgery, who immediately fired off a stinging retort in the same journal. Their response was entitled, “Things Are Never What They Seem, Skim Milk Masquerades as Cream.” The vitriolic rebuttal identified general plastic surgeons as “cream” and referred to Dr Jack Anderson, members of the American Academy of Facial Plastic and Reconstructive Surgery, and members of the American Association of Cosmetic Surgeons as “skim milk.”

The plastic surgeon’s attack on the “good names” of those identified solidified an already good relationship between the Facial Academy and the Cosmetic Association. The 2 organizations joined forces to right yet another wrong. A lawsuit for slander and libel was filed in the state of Georgia. The Facial Academy agreed to pay all expenses for the 3 plaintiffs: Dr Anderson, the American Academy of Facial Plastic Surgery, and the American Association of Cosmetic Surgeons.

As the sitting Secretary of the Facial Academy and a former President of the Cosmetic Association, I testified at trial, explaining to the judge and jury the fallacious charges levied against the qualifications of members of the 2 organizations and one of my mentors, Dr Anderson. Another one of this Academy’s former presidents, Dr Bill Beeson, participated in the demonstration.

The jury saw through the author’s malignant attempts to discredit our 2 specialties in the eyes of our peers and returned a guilty verdict against the plastic surgeons. But the jury did more. It awarded the largest judgment in history against a medical organization, specifically, the Georgia Society of Plastic Surgeons, and the 2 local doctors who identified themselves as authors of the “Skim Milk” article. The court ordered the plastic surgeons to pay a total of \$1.5 million in punitive damages—\$1000 each to the Facial

Academy and the Cosmetic Association, and the rest to Dr Anderson. But Jack Anderson never intended to keep the money for himself. He quickly turned around and donated his portion of the judgment to the Education Foundation of the Facial Academy for the purpose of establishing a certifying board for Facial Plastic Surgery.

More than the money, the verdict sent a message throughout the land. Assertions that only 1 group of doctors possesses the talents and knowledge to perform appearance-enhancing surgery are not only false and misleading, they are unlawful.

The greater message that came out of the suit was that facial and cosmetic surgeons would no longer tolerate maliciously engendered attacks on our good names. And any individual—or any organization—that engages in such nefarious practices could expect to pay a dear price.

With case law coming down on the side of facial and cosmetic surgery, plastic surgeons around America backed off slanderous attacks and vitriolic campaigning. But the “Cold War” did not end in an Atlanta courtroom. The battles to limit how surgeons can identify themselves in the public arena continue, as witnessed by attempts to prevent the American Board of Cosmetic Surgery from obtaining “equivalency” status in California.

In the mid 1970s, another important development occurred in the creation of the Cosmetic Academy. Liposuction—a new cosmetic surgical procedure—was gaining widespread appeal in Europe, although on this side of the Atlantic, few surgeons were familiar with it.

According to Philadelphia, Pa, plastic and cosmetic surgeon, Dr Richard Dolski, Yves-Gerard Illouz, a French gynecologist, began to remove fat from the human body with suction-assisted techniques. The technique was learned by Fred Berkowitz from Newport Beach, Calif, who traveled to Paris, France, to observe Illouz, Fournier, and Ottei—3 European pioneers. Upon his return to the United States, Dolski, Michael Elam, and Ottei organized a workshop on liposuction at The Graduate Hospital in Philadelphia. Dolski’s surgical demonstrations marked the first organized teaching of liposuction to America surgeons.

Shortly thereafter, Dolski and his colleague, Dr Julius Newman (along with several colleagues), created a Liposuction Society and began to attract other cosmetic surgeons into their newly formed organization, including one, Dr Richard C. Webster.

To avoid duplication of efforts and further division among cosmetic surgeons, Dr Webster and Dr Newman

decided to approach the governing boards of the Association of Cosmetic Surgeons, the American Society of Cosmetic Surgery, and the Liposuction Society to initiate merger talks. In 1985, the merger was consummated, giving birth to the American Academy of Cosmetic Surgery.

All the while, a separate—yet related—organization, the American Board of Cosmetic Surgery, grew in numbers and in credibility. Fellowships in cosmetic surgery began to be offered by an eclectic group of instructors.

Dr Richard Webster devoted the remainder of his professional life to promoting the Academy (and the certifying Board) of Cosmetic Surgery, embracing the “Big Tent” policies that both exhibit. And it is appropriate that this Academy remembers Dr Webster as I do. I knew Richard Webster. Richard was not only my teacher and colleague, he was my friend. He was a brilliant strategist and a relentless competitor—one on whose side you’d want to be in battle, or in the courtroom.

Today, Richard’s vision is shared by many of us—the vision that someday, all the specialties involved in appearance-enhancing surgery will recognize our shared heritage and realize that we have much more in common than not.

Clearly, a specialty of cosmetic surgery is—as Victor Hugo—once said, “... an idea whose time has come.” Appearance-enhancing procedures are more popular than ever, with no end in sight. This presents both opportunities and challenges to this Academy and its members.

Before I came to Phoenix, Ariz, to deliver this address, I reflected on how other fledgling organizations evolved into formidable competitors. At the risk of stepping on toes, I’d like to share a series of strategic growth and development “ideas” with you. Having accumulated a patchwork of scars from the various cosmetic surgery battlefields, I feel qualified to engage in philosophical ruminations.

For the 21st century, consumer names and labels matter. A name or brand affects the choices that buyers make. So, let us look at cosmetic surgery from outside in, as a potential consumer might. If a group of doctors brand themselves as “surgeons” and then proceed to offer “nonsurgical” treatments and procedures, the public becomes confused. Equally important, the organization weakens its argument for a rightful seat at the table of venerable surgical specialties.

One of the world’s most prestigious surgical societies is the aforementioned American College of Surgeons

(ACS). In keeping with its name/brand, the ACS limits its membership to doctors who only perform surgery. I know for a fact that the College has denied membership to doctors who perform surgery and engage in medical therapies. The ACS takes the position that to be considered a “specialist,” a doctor must focus on whatever it is that he or she claims to be. To do more—or less—makes the doctor a generalist.

Here’s another question to ponder. Do temporary injectable therapies and superficial skin polishing procedures qualify as “cosmetic surgery,” or should these procedures be considered “cosmetic nonsurgery”?

In the eyes of both the public and medical colleagues, it is counterproductive to brand oneself a “surgeon” and—at the same time—offer “nonsurgical” procedures. In like manner, it could be counterproductive for an organization to identify itself as a “surgical” organization and offer courses and seminars teaching “nonsurgical” treatments.

In the spirit of consistency, I’ve expressed these same sentiments to my facial surgery colleagues, both verbally and in the *Archives of Facial Plastic Surgery*.<sup>1</sup> I have raised these issues only in the best interest of everyone who hears or reads my words.

At this stage in life, I see things from a rather unique vantage point. From the shoulders of the giants that I’ve been fortunate to know, I see cosmetic surgery as it has been, as it is, and as it can be.

As I gaze over the horizon before us, I see a bright future, provided that members of this Academy are willing to do the following things:

- Tell your story often and with conviction. Make those who don’t want to hear this Academy’s story hear it anyway.
- Make your case for “equivalency” with indisputable facts, incomparable clinical outcomes, and the best legal representation that is available.
- Refuse to accept pejorative labels that antagonists would hang around your necks.
- Reach out to clear-thinking leaders of other societies and organizations that share common interests. If there is a way to get along with others in the appearance-enhancing professions, find it and nurture it.
- Be smart, be committed, aim high, and act wisely.
- Work within the scope of your training and experience.
- Refuse to be seduced by the sirens of “change,” which would lure you toward the boneheaps of history.

- In all matters, let your conscience be your guide. Consider the consequences of the procedures and techniques that you advocate and/or offer to your patients.
- Be honest in evaluating the quality of your work.
- Do not claim to be that which you are not, nor undertake procedures for which you may not yet be qualified.
- Focus on procedures that not only are safe and effective, but that spend your patients' money wisely. Patients will respect you for it and will repay the favor, a thousand times over.
- Investigate the safety and efficacy of so called "new" technology and procedures. Before you use them on your patients, be certain that you'd offer the same procedures to a member of your family, or have them done on yourself.
- Hear the advice of one who has been tested in the crucibles of cosmetic surgery for almost 4 decades: Different is not necessarily better. And "change" has consequences. It takes 5–7 years before a "new" technique, technology, or ideology can be said to be better than what is already available. Many doctors can attest to the fact that "too good to be true" machines, procedures, devices, and promises are just that—"too good to be true"; that "no down time" means no lasting result; and that there's always a "new and improved version" of the equipment you already own.
- One colleague recently told me that he had a million dollars of equipment (that proved to be *ineffective*) stored in a closet in his office. A million dollars is a lot of money. So, be wise and investigate the science behind emerging technology and the character and veracity of the people behind the "too-good-to-be-true" claims.
- Be leery of commercialized, assembly line, and "one-size-fits-all" surgical procedures with seductive-sounding names. Before you invest your money and reputation in trendy procedures or equipment, investigate the science behind the claims, and consider the long-term consequences.
- Keep in mind that a doctor who is trying to be a "Jack of All Trades" is not the "Master" of any of the services he or she offers.
- Look at the broad field of cosmetic medicine and surgery. Decide what you do best. If surgery is what you do best—be a cosmetic surgeon. If cosmetic medicine and nonsurgery are what you do best—be a cosmetic physician. Then, do what you do best as well

as—or better—than your competitors, irrespective of the certificates hanging on their walls.

- And, once you have mastered the procedures that you do best, in the most professional manner possible, refuse to be characterized as anything less than you are—a competent and caring "specialist" in cosmetic surgery.

Clearly, a specialty devoted entirely to cosmetic surgery is "an idea whose time has come." And no one specialty or course of study has a monopoly on surgical skills and clinical judgment. Not only has the idea come, it is here to stay, and so is the professional organization that protects its members' right to compete in the marketplace.

Be emboldened by the words of Edmund Burke: "He that wrestles with us strengthens our nerves, and sharpens our skill. Therefore, our antagonist is our helper."

Rather than feeling resentment toward our antagonists, we should be grateful to them, for it is our antagonists who are responsible for the genesis and evolution of this specialty and *The Journal* in which this monologue is published. It is our antagonists who are responsible for the Academy, Foundation, Certifying Board, and postgraduate fellowships that represent this specialty's interest and further its dream.

Be encouraged by the words of Martin Luther King, who dreamed of the day "when a man would be judged by the content of his character." This should be the dream of every surgeon: to be judged by his or her character, the manner in which he or she cares for patients, and the quality of work that emanates from his or her hands, and not the label placed upon him or her by others.

As we stand on the precipice of the next era in the history of this Academy, let us reflect on an instructional scene from an ancient Greek epic—entitled *The Civil War*.

Anxious to see the size of an enemy army that waited just over the horizon, Didacus Stella, the Greek general, said to one of his captains, "Put the dwarfs on the shoulders of the giants. From such a lofty position, dwarfs can see farther over the horizon than giants."

So my colleagues, the lesson that calls out from an ancient Greek battlefield is this: If, today, we are able to see farther and more clearly into a future of our own making, it is due neither to the greatness of our own size, nor to the keenness of our own eyes, but because we are borne aloft by that giant mass of knowledge and wisdom passed down to us by the giants who have gone before.

My coach (when I played football for the University of Alabama, Tuscaloosa, Ala) was the legendary Coach Paul “Bear” Bryant. When he was laid to rest, Bryant-coached teams had won more football games than any major college teams in history.

Coach Bryant attributed his success to the following motto: “If you believe in yourself and have dedication and pride... and never quit, you’ll be a winner. The price of victory is high, but so are the rewards.”

In cosmetic surgery, a lot of people have paid a dear price for the victories that, today, give us the right to practice our art and sit at the table with other venerable specialties.

The American Academy of Cosmetic Surgery (AACS) has achieved full membership in the American Medical Association (AMA). Within the AMA, the academy has membership in the section on counsel on plastic and oral maxillofacial surgery. It sits on this counsel as equal partners with the American Society of Plastic Surgery and the American Academy of Facial Plastic and Reconstructive Surgery. There is no second-class citizenship when the AMA comes to recognize the AACS in the provision of cosmetic surgery to the American public.

But the “Cold War” still exists. It is unfortunate that in the formation of the Physicians Aesthetic Coalition (created to “promote patient safety in cosmetic medicine and aesthetic surgery through public and physician education initiatives”), the AACS was not included. From everything I have witnessed, I am convinced that the AACS is as concerned about patient safety as any organization in American medicine.

If it is truly “patient safety” that the founding members of the Physicians Aesthetic Coalition—the American Society for Aesthetic Plastic Surgery (ASAPS), the American Academy of Facial Plastic and Reconstructive

Surgery (AAFPRS), the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS), and the American Society for Dermatologic Surgery (ASDS)—seek, it would be wise to reach out to all organizations whose members provide cosmetic medicine and surgery to the public. Otherwise, the initiative appears to be self-serving and politically motivated, rather than consumer protection oriented.

Knowing what I know about this Academy and its new leadership, I feel sure that the AACS will do whatever it takes to rise to the occasion and convince any unbiased tribunal that it is deserving of the public’s trust and its colleagues’ respect. I know this because I am a seasoned veteran of the plastic surgery “Cold War,” when the American Academy (and Board) of Facial Plastic Surgery was looked upon as the “out group.” The AAFPRS and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS) refused to be denied, and so must the AACS. The reason is this: “though the price of victory is high, so are the rewards.”

Thank you for the opportunity to share my thoughts on the genesis, evolution, and future of the honorable specialty of cosmetic surgery.

#### **Acknowledgment**

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#### **Reference**

1. McCollough EG. Minimally invasive—minimally effective: The paradigm shift toward mediocrity in facial plastic surgery. *Arch Facial Plast Surg*. 2007; 9(4):293–294.