GUEST EDITORIALS

MISCONCEPTIONS REGARDING ELECTIVE PLASTIC SURGERY IN THE BLACK PATIENT

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There are some misconceptions in the medical and lay literature by a large number of surgeons regarding elective plastic surgery in black patients. Generally, it is felt that operating upon blacks is more hazardous and the results are unpredictable. Specifically, the problems of scarring, keloid formation, pigmentary changes, and psychological/sociological adaptation are given as reasons for not performing elective surgery on blacks.

As a black plastic surgeon whose patient population is predominantly black, I feel obligated to present a more realistic approach to the concerns of both surgeon and patient when considering elective surgery for black patients. One area of concern revolves around keloid formation and I shall address my attention, briefly, to this subject as it relates to plastic surgery.

By definition, a keloid is a benign tumor that grows beyond the boundaries of the original scar. It usually does not improve with time. This is unlike a hypertrophic scar that remains within the confines of the original injury and usually *does* improve with time. Both may present with the same symptoms of burning, itching, and stinging.

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Keloids can occur in anyone. The statistics regarding keloids state that the ratio of keloid formation ranges from 5:1 to 10-15:1 (blacks:whites).

In this instance black may mean one of African or of Mediterranean area extraction, ie, Greek, Italian, Israeli—and darker vs fair skinned, blue eyes, etc. The shade of coloration of the skin is apparently not significant. The darker skin does not mean that keloid formation chances are greater.

The propensity to form keloids does, at times, run in families, although no definitive inheritance pattern has been determined. By the time a patient has reached adulthood, the tendency to form keloids should be obvious. In short, if you form keloids, you do—if you have not formed them by adulthood, you probably will not.

The etiology of keloid formation is any break in the skin (the epidermis). Most patients have had some form of skin trauma (abrasions, pierced ears, lacerations, or surgery) by the time they are adults. If not, then a test incision could be done. Therefore, a history and brief physical examination is usually all that is needed to rule out the possibility of keloid formation.

The problem of hyper, hypo, or mottled repigmentation encountered with dermabrasion or sand papering is more unpredictable. The medical literature states that dermabrasion either should not be performed, or approached with great caution in darker skinned patients.

Again, the darkness of coloration is not the major factor. The risks of possible repigmentary alterations should be weighed against the cosmetic improvement. If dermabrasion is performed, it should be done more superficially and repeated if necessary. Scarring is a probable outcome of *no* greater proportion in blacks than in non-blacks.

Elective surgery on blacks may have both sociological and psychological implications for the patient and subjective misconceptions by the surgeon. The criteria for patient selection should be the same as for the non-black. The self image of the patient is the primary consideration. The black patient is not asking to look "white" when inquiring about rhinoplasty—he is seeking the same changes a Caucasian patient would be seeking. This holds true for any cosmetic surgical procedure the patient inquires about.

The socialization process of blacks in accepting surgically done cosmetic changes in friends and family is in its infancy, and the patient should be prepared to deal with the negative pressures imposed by his/her friends, family, and peers. These pressures do change, however, as blacks learn and understand more about their heritage and gain better acceptance of themselves as individuals.

Black patients are sometimes reluctant to discuss their feelings and desires with Caucasian surgeons for fear they will be misinterpreted. Only through education of the patient and the surgeon will this stumbling block be overcome.

With very few exceptions, elective plastic surgery can be performed on blacks in the same manner and using the same criteria of patient selection as for non-blacks, and with the same expected results.

THE RECERTIFICATION PROCESS

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In 1976, the American Board of Medical Specialties unanimously endorsed the principle of recertification as a means of re-evaluating the academic capacity and clinical fitness of certified physicians and surgeons. Several medical boards, namely, those of internal medicine, obstetrics-gynecology, pediatrics, plastic surgery, and family practice, have implemented this concept. The American Board of Surgery was established in 1937 so as to certify the competence of an individual who fulfilled the minimum requirements for examination and successfully passed the latter. Such persons certified by the Board are known as Diplomates.

In this era of consumerism, the public and government are united in inducing the medical community to regulate and control its own membership. The American public wants and deserves high quality surgical care at reasonable costs.

Historically and currently, all responsible and ethical physicians and surgeons are committed to voluntary methods for the individual specialist to demonstrate to the public, peers, governing authorities, and him/herself that he or she possesses the education, knowledge, and qualifications considered necessary for high quality specialty practice.

Medical practice has become specialty oriented, ranging from the new specialty of family practice through innumerable specialties and subspecialties. In 1937, the procedures for certification by the American Board of Surgery were formulated and implemented. Certification was a plausible designation for those individuals who had successfully completed *all* requirements. However, during the past ten years the concerns and tactics of organized medicine—malpractice, public medical education and awareness, the Professional Standards Review Organization (PSRO), and government regulations—have promulgated the concept of recertification. It is my opinion that recertification and relicensure should become mandatory requirements to provide tangible professional evidence that all categories of medical practitioners have acquired professional standards for high quality medical and surgical practice.

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