IN RESPONSE TO: Plastic surgery and aesthetic medicine: specialties and specialists *By Prof Andrew Burd*

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I read with great interest the article 'Plastic surgery and aesthetic medicine: specialties and specialists' by Professor Andrew Burd published in the Feb/Mar issue of *PMFA News*.

Prof Burd brings up many valid points about the specialty of plastic surgery and the future of the specialty with regards to specialisation in aesthetic medicine and surgery not just in Hong Kong and mainland China but around the globe.

As Prof Burd has pointed out very rightly, completion of training in plastic and reconstructive surgery does not equate that a practitioner has competency in aesthetic medicine / surgery. This is due to the emphasis of training in public hospitals which is heavily slanted toward reconstructive surgery. Very few plastic surgery units in the world actually offer hands on training under guidance for elective aesthetic surgery.

Prof Burd also comments on the monopoly within the specialty of plastic surgery where some plastic surgeons are trying to give the impression that only those from the specialty are qualified to perform aesthetic surgery. This is indeed very true.

I do however believe that plastic and reconstructive surgery provides the best training background for any aspiring aesthetic surgeon as the trainee will be exposed to a wide variety of subspecialties within the specialty and gain competency in burns management, microsurgery, breast reconstruction, cleft and craniofacial surgery,lower limb trauma cover and management, hand surgery and wound care. Plastic surgery is one of the last bastions of general surgery where the practitioners are not con ned to any particular anatomical area. But this is also a double edged sword where the specialty has been encroached on by other specialties providing cross coverage. For example, hand surgery is now predominantly orthopaedic based in many parts of the world, breast surgeons elect to undertake their own reconstruction, maxillofacial surgeons also provide cleft care and deal with facial trauma, ENT surgeons perform rhinoplasty, and urologists treat hypospadias and other urogenital reconstruction. When plastic surgeons leave public service, they are often still inexperienced in aesthetic surgery. Some attempt to be a part-time hospitalist and a part-time aesthetic surgeon.

The truth being told is many aesthetic and plastic surgeons do not learn their trade in the public hospitals. And when they decide to focus on private practice there is a discord of what is being taught in surgical training and what they are demanded of in private practice. However, many plastic surgeons are very intelligent and adaptable. Given their lengthy broad based training and knowledge of anatomy and surgical skill set; a significant number successfully undertake aesthetic surgery with good results.

Many plastic surgeons learn aesthetic surgery via several routes if their core residency programme has no significant component of aesthetic surgery training. One is by partnering with a senior surgeon experienced in aesthetic surgery who is also willing to show the ropes to the neophyte aesthetic surgeon. With intense competition in the marketplace, this option is not always a viable one. The second route is to undertake a fellowship in aesthetic surgery, generally lasting anywhere from three to 12 months, where the trainee may learn the trade by assisting and rotating with different consultants. These fellowships, although beneficial, do not offer hands-on operative experience as the clientele are private paying patients. A third option is to attend as many congresses, workshops, courses as possible and to observe aesthetic surgeons overseas before attempting to perform the cases oneself. The latter is often how many older generation plastic surgeons obtained experience in aesthetic surgery. It is a trade secret that many a plastic surgeon will perform their first breast implant on a private paying patient.

The learning curve in aesthetic surgery is steep regardless of what specialty one comes from. The notion of 10,000 hours to achieve mastery holds true here. While I do agree that many specialties are capable of performing aesthetic surgery, and should be allowed to, there also has to be a governing body to regulate cosmetic surgery. Many maxillofacial and ENT surgeons perform facial aesthetic surgery. Oculoplastic surgeons perform periorbital aesthetic work. Breast surgeons perform breast augmentation surgery and reduction mamaplasties. However, there has to be a credentialing system in place.

Speaking to many plastic surgeons and being in the specialty myself, market competition has driven many plastic surgeons to be critical of other swpecialties. Many aesthetic organisations have sprung up and offer 'board certification' in aesthetic medicine and even aesthetic surgery. These organisations do provide quality teaching and CME but we have to acknowledge that they are also business and market-driven. Some GPs and internists have taken short courses and suddenly become 'board certified in cosmetic surgery' in as little as three months having no basic surgical training to begin with. Some really talented or 'special' (as Prof Burd terms it) physicians do good work and build a solid aesthetic practice. But how can the public be assured that all non traditional-route aesthetic surgeons are 'special'?

Therein lies the dilemma – should the plastic surgeons 'regulate' the cosmetic industry or would they be biased and self-serving? Or should the industry be 'self regulated'? Are all 'aesthetic surgeons' created equal?

Prof Burd's article highlighted the wording of 'crisis' in Chinese characters – danger and opportunity; the very tenet of yin and yang. Plastic surgery units can use this opportunity to implement formal aesthetic surgery training with a core logbook of procedures within its curriculum and not treat aesthetic surgery as a stepchild. Plastic surgeons have to remember that before attempting to regulate other specialties within the realm of aesthetic medicine / surgery they first have to regulate themselves successfully.