

Plastic Surgery: Technique or Discipline?

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The definition of “plastic surgery” has been subject to a variety of interpretations. To the practitioner who has completed formal training in plastic surgery, it is defined and inherently recognized as a specialty that encompasses a vast body of knowledge and that requires a comprehension of fundamental principles and concepts that allows one to plan and execute a particular operation. In other words, it represents a *discipline*. To the practitioner who has not completed formal training in plastic surgery, it is often defined literally as the ability to mold or create. In other words, it represents a *technique*. These varying interpretations are creating a milieu for surgeons who have not completed a formal residency in plastic surgery to impinge on the specialty with the effect of misleading patients and creating a foundation for poor outcomes. The purpose of this editorial is to educate individuals who are of the opinion that plastic surgery is a technique that can be performed by anyone.

The timeliness of this editorial is in response to the noticeable increase in the number of practitioners who are interested in performing operations that are inherently within the domain of plastic surgery. Many of these practitioners are board certified in specialties other than plastic surgery, and all of them have one denominator in common: none of them have completed a residency in plastic surgery as defined by the American Board of Medical Specialties.¹ This phenomenon is not new, especially among the specialties somewhat related to plastic surgery in which there is some degree of technical overlap. This editorial is not directed at practitioners of those specialties, because many of the fundamental concepts and principles that are used to solve complex problems are similar. This editorial is directed to practitioners within specialties that are completely unrelated to plastic surgery in terms of training requirements and practice

profile. It is recognized that the number of individuals who violate the boundaries of their specialty is small; however, they do exist, and they are making their interests and intentions known. Although there are a number of operations that are vulnerable to encroachment, the focus of this editorial is on reconstructive and aesthetic surgery of the breast.

I have had the experience of dealing with this unpleasant issue regarding boundaries on several occasions. I will elaborate on three. At a recent national symposium, I was approached by a surgeon who was interested in learning how to perform certain cosmetic and reconstructive operations related to the breast. He asked if I would be agreeable and allow him to spend 1 or 2 weeks with me in the operating room. When asked why women in need of reconstructive breast surgery were not referred to a plastic surgeon, the response was that there were no plastic surgeons in the community. This practitioner believed that women within his community would be better served by him providing services that were not currently available. While his intention may have been genuine, I had serious reservations and declined the request, based on the fact that this surgeon had not received formal training in plastic surgery and was therefore not qualified to perform it. It was clear, however, that he felt otherwise and proceeded to convey that the “techniques” would be relatively easy to learn and perform.

In another example, I was contacted by an attorney to see whether I would be willing to review a legal case for the defense involving a board-certified physician who had performed a reduction mammoplasty. The patient decided to litigate because of complications and a poor outcome. Further questioning revealed that this board-certified physician was a dermatologist who had additional certification from the American Board of Cosmetic Surgery.² I explained to the attorney that it would be difficult to defend this case, because it was performed by a dermatologist who had not received formal training in plastic surgery and that the American Board of Cosmetic Surgery was not a board that was recognized by the American Board of Medical Specialties.

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Finally, I was asked my opinion on whether a board-certified surgeon should be granted hospital and operating room privileges to perform reduction mammoplasty. This individual had no formal training in plastic surgery. Although this surgeon claimed comfort with the technique, I opined that this surgeon should not be granted privileges for four reasons: first, this individual had not completed a formal residency in plastic surgery; second, this surgeon was not properly trained in the management of complications following reduction mammoplasty; third, the likelihood of a poor outcome and malpractice litigation was increased because of the lack of formal training; and finally, there were other board-certified plastic surgeons in the community who could provide this service.

Circumstances such as these lead to some very important questions, which were the impetus for preparing this editorial. Given that plastic surgery is defined as a body of knowledge, can anyone learn to perform plastic surgery, or does it require formal training? Should restrictions be placed on physicians or specialties that wish to perform plastic surgery, or should anyone with a doctorate in medicine or another discipline be allowed to perform it? Should there be a governing body that oversees and regulates the activities of individuals and specialties, or should a free market philosophy prevail? The answers to some of these questions are at present undefined, variable, controversial, and warrant discussion.

The practice of plastic surgery is based on two fundamental and essential requirements: an understanding of the principles and concepts inherent to the specialty and the technical ability of the surgeon to perform a particular operation. To master these elements, the minimum requirement is the completion of an accredited residency in plastic surgery. During the early phases of the plastic surgery residency, residents are instructed and guided on the technical and conceptual aspects of a particular operation. Emphasis is placed on preoperative evaluation, indications for surgery, and postoperative management. As the educational process continues, through reading, didactic lectures, operative experience, and patient management, the resident begins to acquire an understanding of the principles and concepts that are fundamental to plastic surgery and becomes more adept in the planning and execution of particular operations. Thus, the technical exercise becomes less demanding and the real challenge becomes how to solve the problem. This educational process usually takes 2 to 3 years to complete.

All specialties have their unique characteristics that define their purpose. It would be foolish for a plastic surgeon to perform a tonsillectomy without completing a residency in otolaryngology or to perform dental procedures without graduating from dental school. Patient care is optimized when physicians respect the boundaries of their specialty training and do not perform operations in which they have not received formal training. Malpractice issues are the focus of many discussion groups within virtually all specialties. Why should we as boundary-abiding individuals and organizations fuel the malpractice crisis by tolerating the activities of nonqualified individuals who perform procedures that are outside the realm of their specialty? It is my opinion that the minimum requirement for "standard of care" should be board certification.

This leads to the ultimate question: what can we do about this? The unfortunate reality is that it is difficult to dictate or regulate what a physician does in his or her own private office or operating room. Given that even the best surgeons will have an occasional complication, the legal system will eventually track down those individuals who are performing operations for which they have not received proper training. Fortunately, hospitals in the United States have credentialing committees that will grant certain privileges to surgeons and monitor their surgical activities. It is prudent for hospitals and chiefs of services to grant privileges to perform operations that are within the domain of the surgeon's specialty training. Surgeons who have not completed a residency or fellowship in plastic surgery should not be granted privileges to perform procedures that are within the domain of plastic surgery.

In conclusion, physicians who choose to perform procedures for which they have not received proper training, as defined by the Accreditation Council for Graduate Medical Education,³ are potentially establishing a foundation for medical-legal liability. The hospitals that grant privileges to physicians to perform procedures in which they have not received formal training are, in my opinion, subject to medical-legal liability. In a community where there are surgeons who have completed a residency in plastic surgery, patients should be referred appropriately. In a community where there are no plastic surgeons, patients should be referred to a nearby community where there are plastic surgeons. There is no justification for a physician or surgeon who has not completed a residency in plastic surgery to perform operations that are outside the realm of their specialty.

Although we as plastic surgeons should continue to teach our specialty, we should also protect it by ensuring that it is performed properly. Individuals who have not completed a formal residency in plastic surgery are wise to heed this adage: learn the trade, not the tricks of the trade.

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DISCLOSURE

The author has no financial interest in any of the products, devices, or drugs mentioned in this article.

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