Crossing Surgical Borders: Where are We, Where are We Going and Can We Find the Way?

There has been intense debate nowadays on what surgical procedures a speciality must do or must not do, particularly among dermatosurgeons, plastic surgeons, oculoplastic and maxillofacial surgeons. Now, dentists and gynaecologists have jumped the fray with each specialist treading on another's toes. Should dermatosurgeons do blepharoplasty or leave it to the oculoplastic surgeon, should plastic surgeons do chemical peels, vitiligo surgery and non-invasive or minimally invasive lasers or let it be the domain of dermatologists? Should maxillofacial surgeons do hair transplant, should dentists do botulinum toxin injections? Who should do liposuction and who should do non-invasive body contouring? Should gynaecologists do aesthetic treatment and should dermatosurgeons and plastic surgeons do non-invasive vaginal tightening or leave it to the gynaecologist? Which speciality is best for facial cancer surgery; the dermatosurgeon, Mohs surgeon, plastic surgeon, maxillofacial surgeon or the cancer surgeon? This blurring of surgical borders is causing confusion and heartburn, especially when it comes to teaching and training. Have we lost the wisdom in our quest for money and knowledge?

The main reason for this confusion is the evolution of medicine and surgery. The introduction of minimally invasive procedures has forced everyone to change. Patients want least invasive procedures, with minimal downtime. Technological advances in machines such as lasers, radiofrequency and therapeutic ultrasound make aesthetic rejuvenation simpler. Procedures such as soft tissue fillers for face, lip and nose contouring, botulinum toxin for wrinkle reduction and follicular unit extraction in hair transplant make aesthetic surgery easier and accessible to learn and master, irrespective of basic training. This paradigm shift in aesthetic medicine and surgery has led to blurring of borders.

New data released by the American Society of Plastic Surgeons show a shift in the types of procedures patients have chosen, with minimally invasive procedures such as botulinum toxin Type A (up 1% from 2014 and 759% since 2000), soft tissue fillers (up 6% from 2014 and 274% since 2000), chemical peels (up 5% from 2014 and 14% since 2000), laser hair removal (unchanged from 2014, but up 52% since 2000) and microdermabrasion (down 9% from 2014 and 8% since 2000) showing a steep rise, while traditional plastic surgery procedures such as breast augmentation, liposuction, nose reshaping and eyelid surgery showing a gradual decline from 2000.[1] Hawks in associations cry for regulations and restrictions, while the doves want to settle for a middle path. Can associations dictate what another speciality should do or not do? Can we stop the march of knowledge crossing over to another speciality? What seems wrong today may be right tomorrow.

On the flip side, this across the border learning has led to increased interdisciplinary crosstalk among doctors, which of course will benefit the patient. Joint conferences like AESTHETICS, IMCAS and DASIL between dermatosurgeons, plastic surgeons and oculoplastic surgeons are becoming very popular and each wants to learn from the other. Today, with increasing circulation of knowledge, the identities of each speciality are blurring and fragmenting and can no longer be put back the same old way. We have to learn and at the same time teach new things.

This issue of the journal has three such articles, local facial flaps for reconstruction of cutaneous malignancies[2] by a plastic surgery unit, outcome of flap surgeries in a dermatosurgical unit[3] and laser ear piercing by a plastic surgeon[4] and many such in the past issues. A past editor of the journal gives his views on this dilemma of teaching other specialities.[5]

Do we know the way ahead or are we lost? Can we find the way? Our predicament is somewhat similar to Alice in Wonderland.[6] To quote Lewis Carroll in Alice in Wonderland, Alice asks,

'Would you tell me, please, which way I ought to go from here?'

'That depends a good deal on where you want to get to,' said the Cat.

'I don't much care where—' said Alice.

'Then it doesn't matter which way you go,' said the Cat.

'—so long as I get SOMEWHERE,' Alice added as an explanation.

'Oh, you're sure to do that,' said the Cat, 'if you only walk long enough'.

In this era of information overload, we are lost, but we are making good time. We are getting somewhere. The

path is for us to choose and decide. Let new paths show the way.

In the end, I conclude by saying that as different specialities we have to travel together, navigate the differences, continue the cross talk, teach and train well and find the path to best benefit the patient.

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Access this article online

Quick Response Code:

Website: www.jcasonline.com

DOI: 10.4103/0974-2077.197027

How to cite this article: Khunger N. Crossing surgical borders: Where are we, where are we going and can we find the way?. J Cutan Aesthet Surg 2016;9:213-4.