CASE REPORT

An analysis of 1361 aesthetic procedures from 2000 to 2005 in a large regional plastic surgery unit: implications for cosmetic surgery training

Iain S. Whitaker*, Lyndon Mason, D.E. Boyce, M.A.C.S. Cooper

Welsh Centre for Burns and Plastic Surgery, The Morriston Hospital, Swansea, UK

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Summary  One of the challenges facing our profession is the adequate training of plastic surgeons in the subspeciality of aesthetic surgery, in addition to covering the rest of the large curriculum. The UK’s Chief Medical Officer, Professor Sir Liam Donaldson, has recently called for better training for doctors, better information for patients, and a tougher regulatory structure for private cosmetic surgery. In this study, we show that the training of cosmetic procedures in our unit has risen steadily over the 6 year period studied. As part of our commitment to improving training, our unit has recently organised a 3 month block solely dedicated to aesthetic surgery, allowing increasing exposure to cosmetic clinics and theatre sessions. It is clear that as a group, we must continue to develop robust training schemes to produce plastic surgeons able to cope with the demands of 21st Century healthcare, and ensure that the public does not fall prey to practitioners in unregulated clinics.

As plastic surgeons in the United Kingdom, we must safeguard the highest standards in our diverse and challenging specialty. Plastic surgery is a complex and varied specialty, with highly competitive entry standards, procedures often transcending the anatomic boundaries which define and limit other specialties. One of the challenges facing our profession is the adequate training of plastic surgeons in the subspecialty of aesthetic surgery, in addition to covering the rest of the large curriculum. Other specialties such as otolaryngology and maxillofacial surgery are already showing great interest in aesthetic surgery training and are developing robust training schemes. There has been concern amongst plastic surgery trainees in the UK that trainee exposure to aesthetic surgery has reduced in recent years. It was perceived that due to the funding restrictions put in place to cope with the demands and challenges of the modern day National Health Service,

* Corresponding author. 8 Avonlea Road, Sale, Cheshire M33 4HZ, UK. Tel.: +44 161 962 7563.
E-mail address: iainwhitaker@fastmail.fm (I.S. Whitaker).
aesthetic procedures were being carried out in the private sector, or on ‘initiative lists’ in local treatment centres. This study aims to allay such fears, and highlight the importance of continued robust aesthetic surgery training for plastic surgery trainees in the UK.

Methods

All procedures carried out at the Welsh Centre for Burns and Plastic Surgery are logged into a versatile piece of computer software (ORAC) designed by one of the current consultant plastic surgeons. The computer records of all plastic surgical procedures carried out from 1 January 2000 to 31 December 2005 were analysed (n = 99,651).

Procedures were coded according to the BAPS (British Association of Plastic Surgeons) and SAC (Specialist Advisory Committee) guidelines. One thousand three hundred and sixty one (1361) were for purely aesthetic reasons.

Results

In total, over the 6 year study period, the unit performed a total of 99,651 procedures, of which 1361 were for purely aesthetic reasons. In contrast to the belief of trainees, the number of aesthetic procedures shows an increasing trend (Fig. 1). The most common procedures carried out in the unit were breast augmentations and breast reductions (Fig. 2). A plastic surgery trainee had involvement in all the operations, either assisting, or scrubbed supervised.

Discussion

This simple study shows that current fears of decreasing exposure to aesthetic surgery in the NHS are unfounded. However, we must not conclude that the future of aesthetic surgery training in the UK is guaranteed or indeed appropriate. We must be pro-active as a community in seeking out training opportunities, and maintaining standards. The Royal College of Surgeons of England has several courses dedicated to aesthetic surgery, and the British Association of Plastic Surgeons runs instructional courses covering the aesthetic surgery curriculum. With the shortening of junior doctors’ hours to keep in line with the European Working Time Directive, there is the opportunity to assist consultants in their aesthetic work, with their prior agreement as advised by Nicolle. In addition to seeking out clinical training opportunities, trainees can take advantage of surgical simulators, training models and fresh cadaver dissection courses.

The UK’s Chief Medical Officer, Professor Sir Liam Donaldson, has recently called for better training for doctors, better information for patients and a tougher regulatory structure for private cosmetic surgery. As part of our commitment to improving training, our unit has recently organised a 3 month block solely dedicated to aesthetic surgery. This will allow increased exposure to cosmetic clinics and theatre sessions. It is important to note that there are only 12 SAC-approved aesthetic fellowships available in the UK per annum, the entry for which is highly competitive. These are suitable for post-FRCS (Plast) specialist training.

In the current National Health Service, it is unlikely that we will ever match the American model outlined by Wanzel and Fish suggesting that aesthetic surgery training should comprise 12.2% of a plastic surgery training programme.

It is clear we must continue to develop our training schemes to produce plastic surgeons able to cope with the demands of 21st Century healthcare, and ensure that the public does not fall prey to practitioners in unregulated clinics.

References

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