Contrasting contemporary plastic surgery training with that in the late 20th century: 'thirteen years a slave'

BY JAMES D FRAME

The past

Was I a slave? Absolutely not. I loved every minute of my training. I had the choice of career pathway as a young surgeon, but I was hypnotised by enthusiasm and a desire to help people with major injury, deformity and disability. I have had many mentors, colleagues and friends in this career and all have enthused competitive ambition, original thought and tremendous support for my research projects. I am over 40 years a doctor, 13 years a trainee surgeon, and nearly 30 years a consultant plastic surgeon in a leading UK plastic surgery hub. I trained in general surgery, orthopaedics, paediatrics, urology, vascular, cardiothoracic and plastic surgery. There is little that I had neither seen nor done within that era.

'Time expired' senior registrars at over 42 years of age were often the link pin of surgical units and I was very lucky to be appointed as a consultant plastic surgeon at the youthful age of 37, my senior registrar position being replaced by two new senior registrar jobs! After that my hair went grey!

It was the senior registrars' job to train the registrars, who in turn trained the senior house officers (SHOs). There was plenty of surgical experience for all. Consultants were often out of date and behind with the rapid advances developing during these golden years of the specialty, especially in the field of free tissue transfer and were largely sidelined for on call emergencies and the major reconstructions. The least onerous on-calls were one in three, but I worked one in one in many training posts, including as senior registrar and loved it. I don't believe we were dangerously tired –it did not affect our health and contrary to current opinion I didn't see any evidence of medical disasters associated with working hard, as a team. We were not given a day off in lieu of a night on call, or a chance to go to the cinema or take our kids and much appreciated long-suffering wives on regular holidays, or we would lose links of togetherness within the team and the consultant's magic reference and phone call that would set up the next six-month or two-year rotation at another training unit.

The more units we trained in the better known we were within a very tight community of plastic surgeons but, more importantly, we saw different approaches to solving the same problem. We loved working and being part of a team and we were given the freedom to operate all night to catch up and clear all the day's emergencies with exceptionally qualified and dedicated staff. Rarely were locum surgeons involved and never at grades above SHO. There were no cancellations of routine lists and no staff shortages.

I never witnessed bullying but consultants were always revered and respected by medical and administrative staff alike. Saturday morning teaching rounds were the norm and you didn't go home until your consultant's patients were sorted out. You did not hand over routine work to colleagues so that you could get off on time. Medicine was a true vocation and you had to be dedicated.

The simple chance to have a quiet drink together at the end of the day or a team curry on-call bonded us. There were staff social clubs, complimentary tea and cakes for all in the doctors' mess, and even a half pint of beer at dinner, paid from an endowment from a retired consultant. Pretty fearsome matrons had to be avoided at times, but otherwise they were the senior staff who provided discipline. The consultants joined the social gatherings and often entertained their 'firms' at home or at Twickenham, having fun and learning gossip, but always leaving parties at an appropriate time having discretely analysed the personalities of the trainees. It was up to the senior registrar to invoke discipline or direct juniors to perform better at work. Having spent years longer in training than contemporaries in other surgical specialties and having to swallow hard and retrain for up to 18 months as post-fellowship SHOs learning basics of wound care, healing and tissue handling skills I now know why. In those days it was not mandatory to spend time doing an irrelevant MS in general surgery to be a plastic surgeon. Those that did have a Masters may have by-passed six months as an SHO in plastic surgery, but actually those months were when you learned how to deal with wounds and care for burn injury. There was far more relevant research to be done in this field and you were not aware of this until you were in post.

The environment was also 'publish or perish'. The SHO clinics provided continuity of care for the surgical procedures that you had seen in theatres, days and weeks earlier. Time was spent helping in the nurses dressing stations. Free flaps and major changes in patient reconstruction, congenital deformity, limb replantation, tendon repair and burn care were on the way and there was no time to spend on a higher degree. That being said, the experienced clinician can see where targeted research can offer advances to knowledge and ultimately help the patient, but a higher degree should not be used to solely fast track career promotion, it should be based on talent and work ethos.

It has taken me all these years, now as an academic professor myself, and with well over 100 publications, book chapters and even books, to realise the importance of academia and how to be a better and more tempered surgeon. It is the beauty of academia – "You think and reflect upon that which you do. You reap what you sow". The reasons to publish are to discover and question what you do in a constructive way. Publishing a paper means you must have read around the subject, analysed the data and then formed an opinion based upon fact. That paper will be reviewed

in a constructive fashion by others. You have to be able to defend your principles and practices. At times there can be antagonistic orchestrated criticism and careers have been put on the line. What finer an example than that of a well-known and highly respected, later professor of plastic surgery, who presented a factual study on paediatric burn injury as an SHO at a British Burns Association (BBA) meeting in the 1980's and the Executive Committee of the BBA, consisting of peri–retired burns consultants, heard and disliked enough to collectively and aggressively try to suppress and destroy his career in the UK. He was right and they were wrong! There are other examples where stifling research produced by innovative junior doctors has forced them to emigrate and work in the USA or Australia, but they then fortunately went on to become world leaders in the field of burn injury and intensive care.

Improving outcomes for patients can only follow from advances in technique and advances in science. Well informed young surgeons carry fresh ideas. They must be encouraged to become leaders in their field of interest, given time to undertake funded research, publish and lecture globally. For their part they have to deliver or move over. That BBA Executive Committee have long since gone, but are we any further on? Unfortunately there are too many in high positions keen to invoke their own opinions of political correctness upon all of us. This is the Halligan's phenomenom, and results in the acceptance of mediocrity as the norm. It is also manifest within the Dunning Kruger Syndrome where those that speak the loudest may not be the ones to follow or take advice from [1].

The present

21st century structured plastic surgery rotations are, in my opinion, not an advance and in my opinion they have destroyed the competitive nature of training. Once on a programme a trainee is pretty unlikely to be removed. The supporters of the current structure argue that weeding out of the poor surgical trainees happens at a much earlier stage and gives them time to adjust their career pathway, but actually this should have been pretty obvious during pre-registration jobs. It is not a race to be a consultant and I think a prolonged training programme that incorporates an interdisciplinary approach would be more valuable. Working to a senior level in multiple specialties gives a much wider experience and confidence to make appropriate cross referrals. A return to the old days!

Many potentially excellent candidates are put off applying for training programmes because they are told it is a difficult career pathway and it is a shortage specialty – hardly – it is more likely they see the commitment required and want an easier life!

There are more women in medical school than men and with a larger numbers of training posts and fellowships available it is vital that the best candidates go forward regardless of gender. Informal inter-consultant discussions about potential appointments are not seen as politically correct nowadays. Appointments are apparently without bias now and made using a mathematical game of points and a computer literate glossy application. Hardly a selection of surgical talent! With fewer competitive interviews and fewer references from geographically remote units to determine who moves on in their career, there is no incentive for the trainee to research and produce papers, only to fill in their log books! There should be no concern about shortages of consultant appointment especially with early retirements and resignations as plastic surgeons move at much earlier ages into private practice. More importantly though is the demise of the specialty as other specialties take over previously protected fields such as breast surgery, cleft lip and palate, head and neck reconstruction, paediatric and hand surgery. In fact there are not enough trainees to take up posts in some parts of the country. This stifles innovation and ultimately prevents improvement in patient outcomes – period!

The number of peer reviewed publications included within the curriculum vitaes of the 'modern' newly accredited plastic surgeons seeking consultant appointments can be counted on one hand in most instances. There are at least five times more consultants per unit and the same magnification of junior plastic surgeons per unit than in 1990 within considerably more geographical units, probably with similar patient numbers per annum, so juniors cannot possibly be getting the exposure and responsibilities that they had in the late 20th century. Consultants in 2019 have a much larger hands on presence in trauma than in the 1990s and if they are called in they will prefer to speed through the case themselves rather than teach in the early hours of the morning.

Trainees today seem to have had easier lives, including on calls, and now can become consultants by the age of about 32 years. Some have undergone a protracted route or came into the specialty late for other reasons but six years of training is, in my view, insufficient even if the surgeon stays within a very limited scope of NHS practice. Clearly they are far less experienced than those that have gone before and I am not convinced that they should be called consultants at the age of 32. In my opinion they need continued mentoring from senior colleagues for a least a further five years before calling them consultants in the NHS. Income-generating private practice should not be allowed until then. They should be salaried appropriately within their NHS appointment to this 'Associate Consultant' grade. During this five years they would be expected to undergo specialist training and accreditation in aesthetic surgery especially if they wish to do aesthetic surgery in private practice.

The senior hierarchy within training is now unclear. More time off, with less clinical exposure and disaffected consultants indifferent to training juniors, means that trainees will find it difficult to gain a special interest in research and therefore are less likely to be motivated to publish. Time off creates a lackadaisical approach to a career where you expect everything to be done for you and your career handed to you on a plate. This is the future for Generation Z. There is no evidence that patients are better off today than they were 30 years ago, in fact it is likely the opposite. Trainees have little opportunity for original thought and there is a general loss of team spirit with dissolution of the old 'firm' structure. This will not advance the specialty. A prime example is that of abdominoplasty. The NHS persistently and dogmatically teaches surgeons to remove skin and close the wound around two drains as in a DIEP flap. This operation has been around for nearly 30 years [2]. In private practice these same NHS surgeons are encouraged by the Royal College of Surgeons to add these cases into their log books for 'the new licence' to perform aesthetic surgery of the abdomen. In practice, cosmetic abdominoplasty is not the same procedure. Closure of these wounds may involve wide undermining, the Scarpa's fascia is destroyed in the lower abdomen, there is no narrowing of the waistline or elevation or thinning of mons pubis and nearly always there is a reliance on drains, unless they have the courage to rely on quilting the bed to try and avoid seroma. Now we know that the complication rate from this approach is greater than 20% [3]. The 'modified Brazilian abdominoplasty' has a complication rate less than 1%, faster rehabilitation and a better cosmetic outcome [4]. The answer to why these surgeons are prepared to use the same old procedure in the private sector is probably ignorance of the advances in aesthetic surgery which are not taught within the NHS nor examined at FRCS(Plast). Very

few full-time private plastic surgeons sit on national committees and none are allowed to be examiners for the FRCS(Plast) despite aesthetic surgery being incorporated into the examination curriculum.

The NHS foots the bill for successful litigation and major complications in an NHS setting can easily be swept under the carpet. Not so in the private sector where big rises in medicolegal fees penalise the surgeon, even when only reporting a potential claim that may need to be defended or settled with no fault compensation.

The future

The concept of a part-time consultant or sub-consultant grade to accommodate those with outside commitments other than in private practice is sound in principle and helps talented part-time plastic surgeons fulfill a career, but in my view, if these part-time jobs are set up to allow an income-generating private practice for the individual, there has to be penalty and different privileges. Those fully committed to the NHS should be paid appropriately – probably double the present salary in recognition of dedication and commitment. This should also include a high salary for the proposed 'associate consultant grade', probably starting at the present consultant salary. For those NHS surgeons who are more than doubling their NHS salaries by working 'part time' in private practice and also sharing the kudos of an NHS appointment, they should either not take, or reduce their NHS salary, rather like it was before the inception of the NHS and into the late 20th century. Private practice pays well enough to forego an NHS salary especially in the latter years of practice.

What we actually need to advance plastic surgery are responsible, committed and talented surgeons freed from the severe stranglehold of administration and political correctness, ethical committee obstructions and delays. Harold Gillies would not have started the modern Plastic Surgery era if current regulations were in force [5].

Where is the future? Medical ethical committees are responsible for approving studies involving patient confidentiality, safety and legality to research, but sometimes they are obstructive, opinionated and frankly difficult. The benefit versus risk assessment for a research project is sometimes obvious to all yet still hoops need to be negotiated over a protracted time and time is valuable. The UK is far more stringent than many competitor countries and we may, therefore, be shooting ourselves in the foot if this leads to lost translational commercial interests. Unfortunately the need to progress through a laborious ethics submission is expensive and time consuming, and committee decisions may result in the need for further scrutiny and delay, stifling innovation and progress, particularly if a trainee has only a short window of attachment and exposure to a surgeon's practice. There needs to be a better fast track system and I think an ethics submission should receive a 'chairman's action' more frequently. This is a logical common sense approach if a time restricted study that demonstrates no obvious risk to patient or society, is being assessed. Chairman's action releases a project and enthuses researchers rather as it was in the good old days, to play hard and work harder, be a team, respect the patient, but always look to improve appearance of patients with deformity and disfigurement, after restoring function of course. Think to future fields of research such as robotics, which will undoubtedly make current surgeons' roles obsolete, or cellular level tissue restoration or regeneration, so replacing post injury defects with identical tissues and avoiding reconstructions that are merely fillers without form or aesthetica. A less fettered approach to academia is the answer and plastic surgeons should be supported and encouraged to responsibly reintroduce this into our clinical practices to help maintain the UK as an influential international leader.

References

1. Kruger J, Dunning D. (1999). Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology* 1999;**77(6)**:1121–34.
2. Arya R, Healy C, Frame JD, Ramakrishnan V. 21 year follow up of a DIEP (deep inferior epigastric perforator) flap: a tale of a 'nultiple'. *J Plast Reconstr Aesthet Surg* 2014;**67**:1436-9.
3. Stewart KJ, Stewart DA, Coghlan B, et al. Complications of 278 consecutive abdominoplasties. *J Plast Reconstr Aesthet Surg* 2006;**59**:1152-5.
4. Mossaad BM. Improving the waistline with the modified Brazilian abdominoplasty. In: Frame J, Bagheri S, Smith D, Khan H. *Aesthetic Surgery Techniques - A Case based Approach.* 2018; Elsevier; Chapter 31:239-46.
5. Petty R. *Plastic Surgery: its Origins. The Life and Works of Sir Harold Gillies, 1882-1960.* 2013; Richard Petty.

AUTHOR

James D Frame FRCS(Plast),

Consultant Plastic Surgeon; President UKAAPS; Professor of Aesthetic Plastic Surgery; The School of Medicine, Anglia Ruskin University, Chelmsford, Essex.

Declaration of competing interests: None declared.