Trends for the future in aesthetic surgical education

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There is a growing recognition among members of the plastic surgery community, both in Canada and the United States, that there must be a change in the approach to training future plastic surgeons to better prepare them to handle the burgeoning variety of plastic surgical procedures. In Canada, two years of training in general surgery precede plastic surgical training, and it is currently under consideration to lengthen the experience in plastic surgery to three years. In the United States, the traditional training process for plastic surgery has recently been reviewed and evaluated by a coalition including the American Board of Plastic Surgery (ABPS), the Residency Review Committee for Plastic Surgery (RRC) and the Association of Academic Chairmen of Plastic Surgery (AACPS), with input from various specialty societies. This critical evaluation has led to the following conclusions:

- Traditional training in general surgery as a prerequisite to plastic surgical training is probably not as appropriate as it once was, even for those individuals desiring a career in academia.
- Aesthetic surgery and reconstructive surgery are integral to the specialty of plastic surgery and, as such, both deserve significant emphasis within the basic residency.

Two years is an insufficient length of time in which to train a plastic surgeon adequately without the need for postgraduate fellowship training. However, subspecialization within plastic surgery will continue to be attractive to some trainees, and certain areas of special interest may best be taught in fellowship-type, post-residency programs. These areas may include hand surgery, craniomaxillofacial surgery and burns; the time required could be variable for each. An individual pursuing such fellowship training would likely seek only a single fellowship.

The training program director must exercise greater control over the entire educational experience of the resident. Not all training programs have sufficient clinical material or dedicated faculty to prepare the resident adequately in all aspects of the specialty. Therefore, training must be individualized to a much greater extent, requiring the program direc-

tor to take an active role in creating special opportunities for off-site training. In many cases, this may be facilitated with the assistance of various subspecialty societies.

An organization of various interested boards and societies within the specialty has an important role to play in analyzing and resolving issues affecting plastic surgery. The informal Council of Plastic Surgical Organizations (COPSO) is acting as such a nonpartisan body to examine problems facing the specialty and potential solutions.

It can no longer be denied that aesthetic surgical concepts are applicable to every phase of plastic surgical training, and it is essential that the philosophy of enhanced form be brought to the consciousness of the young surgeon throughout his or her training. The resident must understand that it is no longer acceptable to treat any defect or deformity without attention to an aesthetic as well as a functioning goal. No longer can a child with Crouzon's disease simply be 'fixed' or a biscuit-type flap be used for hand repair. While the restoration of function is paramount, the aesthetic component of any plastic surgical procedure must be given proper attention.

Although aesthetic surgery is absolutely integral to a basic plastic surgical education, it is a fact that the quality of aesthetic training varies greatly among residencies. Training opportunities in aesthetic surgery often are not as accessible to the large, superspecialized university centre as they are to the free-standing facility or small private hospital. How do we ensure the availability of appropriate aesthetic surgical training to all plastic surgery residents, and what minimum standards should be set for resident experience in aesthetic surgery?

AVAILABILITY OF TRAINING

Recently, the American Society for Aesthetic Plastic Surgery established an ad hoc committee for aesthetic training. The charge of this committee is to work with representatives of the American Society of Plastic and Reconstructive Surgeons, the RRC, AACPS and ABPS to develop recommendations for aesthetic training standards in both the basic residency and at the postgraduate level. In exploring this issue, we learned that there is a high level of dissatisfaction among residents due to a perceived lack of opportunity for more extensive aesthetic training. A survey of program directors revealed that at least half are receptive to the suggestion that residents should receive greater exposure to aesthetic sur-

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TABLE 1
AACPS suggested minimum levels of aesthetic experience in plastic surgical residencies

Category	Resident operated	Total
Facial	8	13
Facelift and/or browlift		
Reshaping		
Liposuction (independent procedure)		
Osteotomies and osteotomies		
Autogenous, homologous or alloplastic implants		
Chemical peel/dermabrasion		
Eyelid	5	12
Blepharoplasty		
Orbital modification and repositioning		
Micropigmentation (tattooing)		
Ear	1	3
Repositioning		
Reshaping		
Nasal	4	9
Reshaping		
Augmenting		
Breast	6	12
Augmentation		
Mastopexy		
Trunk and extremities	7	15
Reshaping		
Total	31	64

Recommended to the Association of Academic Chairmen of Plastic Surgery (AACPS) by Committee on Aesthetic Training, Fritz E Barton Jr, Chairman, May 9, 1993

gery. At the same time, a survey of plastic surgeons who are members of the Aesthetic Society indicated that more than half of these respondents would be willing to work with program directors to provide more opportunities for residents. Their commitment might include providing rotations for residents, contributing their time, providing access to their facilities and involving residents in the treatment of their patients.

Most importantly, the consensus among residents, program directors and representatives of the boards and specialty societies is that extensive training in aesthetic surgery must not be relegated to a post-residency fellowship but, instead, must be an integral part of basic residency training. Given this consensus, what criteria need to be applied to ensure adequate exposure to aesthetic surgical training in the residency?

Dr Fritz Barton and the AACPS Committee on Aesthetic Training reviewed data from the plastic surgical operative log submitted by trainees to the RRC. They recommended that an ideal experience in aesthetic surgery would be presented by the 70th percentile of the total number of reported clinic procedures. Furthermore, they established the 30th percentile as the minimally acceptable experience (Table 1).

Obviously, a certain distribution of cases in various categories is implicit in these numbers. In some instances, there may be equivalent procedures that encompass similar operative techniques and anatomical principles as an aesthetic procedure, for example, a parotidectomy and a facelift. Additionally, some credit could be earned for the performance of half of a bilateral procedure. Cadaveric dissection and didactic teaching would also contribute credit. Finally, certain cognitive as well as technical experience must be included, such as the involvement of the resident in the preoperative assessment and postoperative care of patients.

The American Society for Aesthetic Plastic Surgery is committed to furthering the development of these concepts, as well as providing tangible support to the efforts to enhance aesthetic training of plastic surgery residents. As part of this commitment, the society has:

- waived the registration fee for residents to attend the annual scientific meeting;
- continued the program of permitting residents to attend teaching courses free of charge, provided they are willing to assist the instructor as a course monitor;
- established an award to honour training programs that exhibit exceptional attention to aesthetic surgical education;
- expanded the society's travelling professor program, making available two outstanding plastic surgeons for visits to various teaching programs to conduct rounds, clinics and give lectures to residents;
- initiated a new project to assist program directors in making opportunities for aesthetic training available to residents, with the cooperation of society members in the same geographic area.

These initiatives by the Aesthetic Society, and by other representatives of the specialty, underscore a growing recognition of the fundamental importance of aesthetic training to the basic plastic surgical residency. Aesthetic surgery, once considered by many as frivolous or superfluous, has at last been recognized as a cornerstone of plastic surgical training. This realization, followed by appropriate steps to increase aesthetic training for residents, will undoubtedly lead to a new and exciting era for the plastic surgical specialty in which enhanced function and form will be considered the inseparable elements of every successful surgical outcome.