Commentary on: Cosmetic Surgery Training in Canadian Plastic Surgery Residencies: Are We Training Competent Surgeons?

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In “Cosmetic Surgery Training in Canadian Plastic Surgery Residencies: Are We Training Competent Surgeons?” Chivers et al discuss the results from a survey of Canadian senior plastic surgery residents assessing their perceptions regarding the quality of their cosmetic surgery training. This mirrors in design our 2 recent publications regarding plastic surgery resident cosmetic training in the United States. The results and conclusions of these articles are also quite similar.

As stated by the authors, major dichotomies face plastic surgery residents and educators in both Canada and the United States: (1) Major advances in plastic surgery over the past 20 years have led to greater levels of sophistication, requiring increased time and effort to gain the necessary knowledge base and technical skills. Yet recent restrictions on resident work hours have reduced training time, so, paradoxically, there are less training hours in the day. (2) Although plastic surgery residencies have increasingly been concentrated in academic centers, the focus of cosmetic surgery has mostly moved outside these centers. This makes the resident cosmetic surgery experience, at times, less than ideal.

Dealing with the flight of cosmetic surgery to private outpatient facilities is not an easy task for residency program directors. How does the department match the convenience, the privacy, and the inviting atmosphere of the private surgicenter? Can the academic plastic surgeon be as clinically productive as the private practice surgeon, given his or her many nonclinical mandated responsibilities? Can the academic plastic surgeon command a salary that approaches the private practice cosmetic surgeon? How does the program attract and retain plastic surgeons who focus on cosmetic surgery? It’s the rare breed of surgeon who is willing to practice cosmetic surgery in the academic setting, bypassing financial and nonfinancial rewards.

In comparing and contrasting the current Canadian survey described in this article and the US surveys mentioned above, many of the findings were similar, but differences did appear. First, the Canadian investigators queried a more uniform group of senior residents because all Canadian residencies are integrated, whereas the US residents were from both independent and integrated programs. Second, although both Canadian and US residents felt that the resident clinic was important and the majority of US programs had resident clinics, it was unclear from the current article how many of the Canadian programs had resident clinics. The article merely stated that 17% of the Canadian programs had cosmetic clinics in which there were 30 or more cases. Third, although the majority of US residents felt prepared to incorporate cosmetic surgery into their practice, less than 20% of Canadian senior residents felt similarly. Also, Canadian senior residents felt that their elective cosmetic rotation was the most valuable portion of their training, whereas US residents felt that their resident clinic was most valuable. Last, US residents are required to perform minimum numbers of operations in critical cosmetic areas (“index cases”: facelift, rhinoplasty, blepharoplasty, etc) as the “surgeon” to satisfy Residency Review Committee standards. Canadian residents have no such requirements.

How these perceived differences figure into training is difficult or impossible to ascertain. Perhaps a better exercise would be to describe what the ideal aesthetic resident training might look like. One might suggest components of the following: (1) a uniform, core didactic cosmetic curriculum for all residencies to follow; (2) a focused cosmetic rotation in both the junior and senior years of training, allowing for graded responsibilities; (3) organized cadaver dissection or simulations in the head, neck, and torso; and (4) a resident cosmetic clinic with staff oversight where not only case numbers but case diversity (minimum index cases) are mandated and outcomes and complications are formally reviewed and reported.

Of course, it is important to realize that all of these reports—including this commentary—were written with a
cosmetic surgery “centric” point of view. Cosmetic surgery training cannot be viewed in isolation. This is only one of many areas the plastic surgery resident needs to master. Increased time spent in one subspecialty detracts from time spent elsewhere. Although the current authors correctly note that US plastic surgery programs have responded to this issue by increasing the length of their independent program from 2 to 3 years and mandating that their integrated residencies be 6 years in duration, Canadian residencies may, in fact, be ahead of the curve, since all Canadian programs are integrated.

All aspects of education involve choices. There are many residents who perhaps may prefer to spend less rather than more time in the cosmetic sphere and who plan to perform little or no cosmetic surgery when they finish training. This is consistent with the findings in this study, since the current authors found that although 70% of Canadian residents had elective rotations, only 30% used this time for cosmetic surgery. Similarly, another publication found that recent plastic surgery graduates rated cosmetic surgery fourth behind hand, breast, and microsurgery as areas in which they desired more training. With this in mind, perhaps a good answer to this problem is to formalize the Canadian elective to a 3-month “mini-fellowship” toward the end of the plastic surgery residency, allowing each resident to gain further sophistication in his or her specific area of interest once he or she has successfully completed minimum numbers of index cases.

So what is a program director to do when he or she cannot meet specified cosmetic surgery standards mandated by the Residency Review Committee or the Royal College of Physicians and Surgeons of Canada? There may be significant impediments to developing a cosmetic clinic from an institutional or medical-legal standpoint. Case volumes may preclude offering adequate numbers or diversity of cases. As stated in the current study, the value of affiliating with a plastic surgeon who performs a significant amount of cosmetic surgery and is interested in education is the best option.

Now, we would like to offer some predictions: despite the importance of cosmetic surgery to our specialty, postgraduate cosmetic fellowships will decrease in number in the future because of financial constraints. Resident cosmetic surgery clinics will increase and ultimately become a mandated part of plastic surgery training. Rotations with plastic surgeons focusing on cosmetic surgery outside the academic centers will increase. Plastic surgery residency training will be increasingly responsive to the needs of young practicing plastic surgeons and, therefore, the specialty will monitor its own preeminence in the cosmetic field.

Finally, we would like to caution that we should beware of what we wish for. Although what we describe is the ideal situation, our training programs in reality will have difficulty meeting the ideals. These worthwhile discussions should act as a springboard for discourse aired in a public forum for the benefit of all, but our competition can and, on occasion, will use this information to denigrate our training. We must take the high road by continuing to analyze, critique, objectify, and establish best practices in order to, above all, produce the best product imaginable. This “high tide” will lift all boats, and our patients will ultimately benefit most. We sincerely hope that this will be our legacy.

Disclosures

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REFERENCES