

Discussion: Plastic Surgery Chief Resident Clinics: The Current State of Affairs

Alexander T. Nguyen, M.D.

Jeffrey E. Janis, M.D.

Dallas, Texas

In their report, “Plastic Surgery Chief Resident Clinics: The Current State of Affairs,” Neaman et al. present a summary of the survey responses from program directors and chief residents designed to characterize “chief clinics” and their importance and relevance to plastic surgery training. Chief clinics are an important aspect in addressing perceived deficiencies of plastic surgery training, especially cosmetic surgery, as shown by survey results in 2006 by Morrison et al.¹ and in 2010 by Kenkel.² These authors present some interesting data that, considered together with the prior surveys on resident cosmetic surgery education, raise several poignant topics for discussion.

First, we commend the authors for obtaining representation from 85 percent of current programs—no small feat for a survey methodology that usually obtains far lower response rates than what was obtained in this study. Some of the surveys, though, were incomplete in that some questions were unanswered when returned to the authors. It would be interesting to know whether the incomplete surveys had similarities among the questions not answered. Unfortunately, the inclusion of these incomplete surveys in the study’s results somewhat confuses full reporting, potential accuracy, and completeness of the data set.

It would be intriguing to see demographic data presented by geographic location of the programs. This may reveal associations or biases based on location, patient subpopulations, or even procedures performed. For instance, obesity is an epidemic across the country, but it is more prevalent in some areas of the country than in others. It is plausible that breast and body contouring, and body contouring after massive weight loss, may constitute a greater proportion of the surgical causes in some areas of the country compared with others. Furthermore, median income per capita

can also influence the volume of patients seen in these clinics, particularly if they are predominantly cosmetic in nature. It would be interesting to see the survey data stratified by location and demographic factors to help define differences between different programs’ clinic experiences further, which may help explain disparities in responses reported by the survey.

The authors state that they had similar response rates between cosmetic and reconstructive clinics. One important point that should be noted is that not all clinics are created equal. Specifically, the quality and quantity of cosmetic and reconstructive experiences can vary widely. This fact makes it difficult to compare these clinics against each other, especially with respect to referral patterns, fee-for-service, and procedures performed. Although the chief clinic experience, irrespective of cosmetic versus reconstructive emphasis, is still valuable, it is still difficult to interpret the data because of this fact.

The reported data, although useful, could perhaps be even more beneficial if they were stratified by resident responses versus program director responses, giving more clarity in assessing results and comparing perceptions between residents and program directors. It has been shown that opinions between the two groups can vary significantly.¹ For example, the impression of patient risk in this survey was reported using a combined perspective of both the residents and program directors. However, residents and program directors have very different experiences and access to objective data, and subsequently have unequal qualifications and/or perspectives to make such impressions.

Perceived weaknesses in training, both from a resident perspective and a program director perspective, may also have been included in this survey, further legitimizing the need for such chief clinics. This is evident by the fact that other cos-

From the Department of Plastic Surgery, University of Texas Southwestern Medical Center.

Received for publication March 29, 2010; accepted March 30, 2010.

Copyright ©2010 by the American Society of Plastic Surgeons

DOI: 10.1097/PRS.0b013e3181e07a44

Disclosure: *The authors have no financial interest to declare in relation to the content of this Discussion or of the associated article.*

metic organizations exploit the findings of Morrison et al. that plastic surgery training may be deficient in cosmetic procedures.³

The authors' results raise several important issues that should be emphasized and highlighted. For instance, it was reported in this survey that two-thirds of clinics do not prescreen patients. Although one could argue that being able to determine who is and is not a surgical candidate is a valuable objective of the chief clinic experience, an alternative perspective could be that it is not necessary to use clinic time to see patients who are not surgical candidates. For instance, at the University of Texas Southwestern, we do not perform elective surgery on active smokers because of well-documented increases in complication rates. Therefore, these patients are not appointed to the clinic based on prescreening results. The same might be said for uncontrolled comorbidities and morbid obesity. The prescreening process, therefore, can lend itself to a more efficient resident experience, as all patients appointed to the clinic ostensibly are potential surgical candidates, assuming the prescreening process is accurate and that patients give honest answers to the prescreening questionnaire.

The authors also report that 54 percent do not accept certain patients because they do not offer the procedure requested. It would be interesting to note which procedures, in particular, were not offered and reasons why, especially taking the survey by Morrison et al. into account that documents resident "discomfort" with certain procedures such as rhinoplasty, face lifts, and noninvasive techniques.¹ If it were determined that these types of procedures were the ones not offered in chief clinics, one could conclude that the chief clinic experience should be modified to address this perception and increase resident experience and confidence in performing these procedures.

Like the authors, we were very concerned by responses from three program directors and that 20 residents stated that they had "complete autonomy." The definition of complete autonomy should be standardized or clarified in future surveys to ensure that Accreditation Council for Graduate Medical Education rules are not being violated.

Another worrisome result from the survey was that 6 percent of the residents surveyed reported no feedback on performance and 10 percent received no education in billing and coding. It is obvious that addressing and rectifying these differences would most definitely enhance the residents' experience in chief clinics.

The authors conclude that the chief clinics are an opportunity for residents to perform cosmetic surgery with increased autonomy. We could not agree more. There is no substitute for true hands-on experience under direct faculty supervision. This includes training in minimally invasive and nonsurgical techniques, which continues to be a reported deficiency in training.^{1,2} A resident clinic also allows for development of the unique interpersonal skills necessary in the management of the preoperative and postoperative cosmetic patient, which can represent one of the most challenging patient subpopulations to treat, if not the most.⁴

The authors suggest the need to increase the numbers of required index cases. Although this may represent one possible solution, an alternative may be that a certain percentage of the residency review committee-mandated cosmetic surgery requirements be satisfied directly through chief clinics, thereby representing a true intensive experience in cosmetic surgery that emphasizes not only the operative procedures themselves, but the continuum of care in taking care of these patients, which would represent a rich educational experience.

In summary, we commend the authors on reporting their results, which emphasize the importance of chief clinics, and the conclusion that their utility is undeniable. If fact, chief resident clinics, cosmetic or reconstructive, should be a compulsory component of any training program, as they afford graduated levels of responsibility, longitudinal patient care experiences, and supervised autonomy in this complex patient population. Chief resident clinics are an excellent opportunity for graduating residents to further develop surgical maturity while still having the safety net of attending physician supervision.

Jeffrey E. Janis, M.D.

Department of Plastic Surgery
University of Texas Southwestern Medical Center
Dallas, Texas 75390-9132
jeffrey.janis@utsouthwestern.edu

REFERENCES

1. Morrison CM, Rotemberg SC, Moreira-Gonzalez A, Zins JE. A survey of cosmetic surgery training in plastic surgery programs in the United States. *Plast Reconstr Surg*. 2008;122:1570-1578.
2. Kenkel J. Paper presented at the 2010 Annual Association of Academic Chairmen of Plastic Surgery Meeting, San Antonio, Texas, March 21, 2010.
3. American Board of Plastic Surgery. Available at: <http://www.americanboardcosmeticsurgery.org/How-We-Help/cosmetic-surgery-vs-plastic-surgery.html>. Accessed March 21, 2010.
4. Rohrich RJ. The importance of cosmetic plastic surgery education: An evolution. *Plast Reconstr Surg*. 2000;105:741-742.