BAPS TO BAPRAS

The History of the Association

1986–2016

BAPRAS

British Association of Plastic
Reconstructive and Aesthetic Surgeons

Edited by A Roger Green

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to
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and Aesthetic Surgeons

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Dedicated to the memory of Antony Wallace
1928–2015

who started the Archive
Honorary Archivist
1981 to 1993

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Acronyms

ABCP	Academy of British Cosmetic Practice
ABS	Association of Breast Surgeons
ALERT	All Africa Leprosy Rehabilitation and Training Center
AO	Arbeitsgemeinschaft für Osteosynthesefragen
ASiT	Association of Surgeons in Training
ASPS	American Society of Plastic Surgeons
BAAPS	British Association of Aesthetic Plastic Surgeons
BAD	British Association of Dermatologists
BAHNO	British Association of Head and Neck Oncologists
BAPS	British Association of Plastic Surgeons
BAPRAS	British Association of Plastic, Reconstructive and Aesthetic Surgeons
BESS	British Elbow and Shoulder Society
BFIRST	British Foundation for International Reconstructive Surgery and Training
BOA	British Orthopaedic Association
BSSH	British Society for Surgery of the Hand
CCT	Certificate of Completion of Training
CCST	Certificate of Completion of Surgical Training
CESR	Certificate of Eligibility for Specialist Registration
CMO	Chief Medical Officer
CoRSU	Comprehensive Rehabilitation Services in Uganda
COSECSA	College of Surgeons of East Central and Southern Africa
CPRD	Clinical Practice Research Datalink
CSPSS	Combined Services Plastic Surgery Society
CSIC	Cosmetic Surgery Interface Committee
DoH	Department of Health
DfID	Department for International Development
e-LPRAS	e-Learning for Plastic Reconstructive and Aesthetic Surgery
ESPRAS	European Society of Plastic Reconstructive and Aesthetic Surgeons
FILACP	La Federación Iberolatinoamericana de Cirugía Plástica
FSSA	Federation of Surgical Specialty Associations
GOSH	Great Ormond Street Hospital
HES	Hospital Event Statistics
IAPS	Irish Association of Plastic Surgeons
ICOBRA	International Collaboration of Breast Registry Activities
ICOPLAST	International Confederation of Plastic Surgery Societies
ICRC	International Committee of the Red Cross
IPRAS	International Confederation of Plastic Reconstructive and Aesthetic Surgery
ISCP	Intercollegiate Surgical Curriculum Programme

JCHST	Joint Committee on Higher Surgical Training
MALPACS	Malayan Association of Plastic Surgery
MDDUS	Medical and Dental Defence Union of Scotland
MDHU	Military Defence Hospital Unit
MDU	Medical Defence Union
MERLIN	Medical Emergency Relief International
MPS	Medical Protection Society
MSF	Médecins Sans Frontières
MTAS	Medical Training Application System
MMC	Modernising Medical Careers
NCPOD	The National Confidential Enquiry into Patient Outcome and Death
NHSLA	NHS Litigation Authority
OMFS	Oral and Maxillofacial Society
OPSA	Overseas Plastic Surgery Appeal
OTSC	Overseas Training and Service Committee
PAPS	Pakistan Association of Plastic Surgeons
PLASTA	Plastic Surgery Trainees Association
PMETB	Postgraduate Medical Education Training Board
PSAHSC	Professional Standards Authority for Health and Social Care
PRASIS	Plastic, Reconstructive and Aesthetic Surgeons Indemnity Scheme
RACS	Royal Australasian College of Surgeons
RBSPS	Royal Belgian Society of Plastic Surgeons
RCDM	Royal Centre for Defence Medicine
RCS	Royal College of Surgeons of England
RSTN	Research Surgery Trials Network
SAC	Specialist Advisory Committee
SRTC	Senior Registrars Travelling Club
STA	Specialist Training Authority
THET	Tropical Health and Education Trust
TIG	Training Interface Group

Contents

BUCKINGHAM PALACE

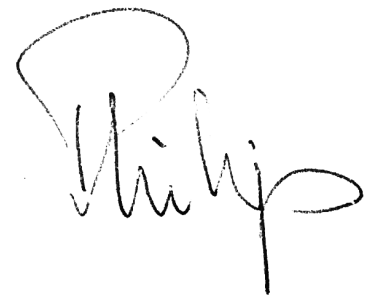
Plastic surgery, as a separate branch of surgery, is a relatively recent specialty, but its development has been dramatic. The story of its emergence as a specialty has been told in the publication of the *First Forty Years* of the Association in 1986. Like every other branch of medical care, progress since then has accelerated and it is this progress that is the subject of this volume. It also tells the story of the emergence of the re-named British Association of Plastic, Reconstructive and Aesthetic Surgeons.

Improvement in capacities and techniques in medical specialties do not happen on their own. It is a gradual process of building on the work of predecessors and making use of developments in equipment and procedures. This book makes it clear that the growth in the delivery of plastic surgery services is largely due to the work of senior staff in producing appropriate training programmes for young surgeons wishing to take up the specialty and its latest techniques. It also records their work, in their own time, to organise and provide help and training in other countries.

This book tells the story of how plastic surgery and reconstructive surgery has improved the lives of many thousands of patients and none more so that for members of the armed services.

I very much welcome the publication of this book as a record of the invaluable contribution of this specialty to human well-being.

HRH The Duke of Edinburgh KG. KT



Editor's notes

In 1986 Antony Wallace edited *The History of the British Association of Plastic Surgeons: The First Forty Years* to coincide with the 40th anniversary of the founding of BAPS. There have been many changes in the delivery of healthcare since that time, which have affected the basic structure, delivery of service and training not just in surgery but throughout all branches of medicine. For the 70th anniversary of the Association, Council felt that it would be appropriate to record the processes of changes from 1986 to 2016 for future reference.

During this period, the public perception of plastic surgery had become very much weighted toward cosmetic surgery, ignoring our primary remit of reconstruction. It was felt important to highlight the importance of both, and to confirm their place within the work of the Association. The most noticeable development has been to include both 'reconstructive' and 'aesthetic' within the title of the Association, and with it BAPS became BAPRAS. Reflecting this change, and many others, the constitution has been brought up to date. This has not only improved the running of the Association, but also allowed the inclusion of colleagues from other reconstructive surgical disciplines. The Association has played a vital role in responding to developments in the regulatory landscape of the profession. In particular, the significant shortening of training time prompted the careful construction of a structured training programme and the development of the intercollegiate examination to assess trainee competence.

The Association plays a unique and important role in the development of surgery in the UK. Through the persistent efforts of colleagues at a local level the value of plastic surgery has been increasingly recognised by NHS management. This has led to an increase in the numbers of units and consultants, which in turn has swelled the numbers of our members.

I have been privileged to witness, at close hand, the enormous efforts made both by the Association centrally and the consultant body nationally to respond to the ever-increasing numbers of changes, restraints and edicts that we have been required to address. I have asked a number of those colleagues who have been involved in the development of the Association through these years to contribute to this account. They have been extremely generous in devoting time, despite their ever-increasing clinical workloads, to record their recollections. The merit of these various chapters is to the exclusive credit of their efforts. I am extremely grateful to them all.

Inevitably there will always be omissions that some feel should have been included, and some will disagree with one or other of their recollections. There is also a certain amount of overlap in the various chapters; however, I felt that comments from several different authors would only help to describe these topics more broadly.

I am particularly pleased that a history of the Archives has been documented by Brian Morgan, himself the Archivist for 15 years, in order to record the immense efforts of Tony Wallace, to whom this book is dedicated.

I would like to thank all those who have contributed, as well as David Maisels and Brian Morgan, both of whom were involved in the production of the first book, for reading through a draft, and in particular Gemma Adlington and Ruth Neave, for their help in accumulating and checking information, and for proof reading. It would, of course, have been impossible to edit this publication without the immense help and the encyclopedic memory of Helen Roberts. Donald Sammut kindly designed and produced the painting for the front cover. John Carr in the Photographic Department of the RCS has been of great assistance in finding many of the photographs, and he has kindly give his permission for their inclusion. Finally, I am immensely grateful to Matt Whitaker, from Polymath Publishing, who has been very patient in steering me through the intricacies of the process of publishing.

A Roger Green FRCS
Honorary Archivist
November 2016

From BAPS to BAPRAS

Background

There was always a certain disquiet between the plastic surgical and the aesthetic or cosmetic surgical elements in the structure of the British Association of Plastic Surgeons (BAPS).

This was partially evidenced by the formation of a British Society of Aesthetic Plastic Surgeons in 1979, later rebranded as the British Association of Aesthetic Plastic Surgeons (BAAPS).

In 1993 Roy Sanders, who was the President of BAPS at that time, presented a very strong argument at the AGM that BAPS should consider a name change to BAPRAS. The climate was unfavourable and, to quote Roy Sanders, the title got a 'resounding drubbing' and was rejected (see Appendix).

There was a different atmosphere on BAPS Council in 2003 when Martin Milling was President and I was Vice President. Simon Kay, as the new Editor of the *British Journal of Plastic Surgery* (*BJPS*) had achieved a change of name and rebranding of the journal, which was now to be named the *Journal of Plastic Reconstructive and Aesthetic Surgery* (*JPRAS*), a wholly less parochial and more international name for the future. This did not go unnoticed by Council, and murmurings for a similar change for the Association began to gain hearing.

Action

In my presidential section in the April 2004 newsletter to all BAPS members, I suggested that the debate on a name change to BAPRAS should be started and I welcomed all comments. This reflected the majority view of BAPS Council at the time and in particular the view of the officers at the time, Martin Milling, Chris Walker, Chris Caddy and Chris Khoo. Needless to say I received a letter of support from Roy Sanders.

The support for change was consolidated at the 2004 summer Council meeting in Dublin, and on 9 September I circulated a memo to all members both by email and letter with the main reasons why we felt BAPS should become BAPRAS.

They were:

1. The success of the journal name change and rebranding.
2. The discussions with the NHS Modernisation Agency and its *Action On* programme clearly demonstrated that the name 'British Association of Plastic Surgeons' did not accurately reflect what we were doing. It was appreciated however that losing 'plastic' would be inadvisable and to include 'reconstructive' was necessary.
3. An international perspective suggested that the majority of plastic surgical associations worldwide included plastic, reconstructive and aesthetic in their titles.
4. Ongoing confusion between the British Association of Paediatric Surgeons (BAPS) and the British Association of Plastic Surgeons (BAPS) would come to an end.

With the September letter there were two questions:

- Firstly, do you agree with changing the name of BAPS to BAPRAS?
- Secondly, if you do not agree, what name do you suggest or would you prefer no change?

Replies would form the basis for further discussion at the Council meeting in London at the end of September.

Results of the September 2004 poll

There were 112 replies.

- 79 agreed on a change from BAPS to BAPRAS.
- 14 were against.
- 19 suggested another name, the 'British Association of Plastic and Reconstructive Surgeons' being most popular.

Preparing for debate

It was essential that any name change would be made with due regard to views of the membership and the constitution. Constitutional issues were combed through by Roger Green and website and domain issues were dealt with by Per Hall. In my presidential letter of 11 October 2004 to

The First BAPRAS Council 2006

the membership I outlined the reasons for changing the name of the Association and enclosed published articles by Brian Sommerlad and Rod Rohrich, dealing with the direction of plastic surgery in the UK and USA respectively. Members were informed that the AGM on 2 December 2004 would present an opportunity to debate and vote upon the name change. Proxy votes were circulated before the meeting.

There seemed to be few objections to 'plastic' and 'reconstructive' being included in the new name. The main problem appeared to be the inclusion of the word 'aesthetic'. This encouraged me to write my personal view in 11 October letter as follows:

> 'Aesthetic: The use of this word recognises the thread of artistry that extends throughout our specialty. We must take back this word to the mother association. We have failed to grasp the fact that many of our BAPS members practise aesthetic surgery almost exclusively and many others have more than a passing interest in it. If we are to become teachers of aesthetic/cosmetic surgery we should have it enshrined in our title.'

The AGM debate on 2 December 2004

The BAPS AGM took place in the Royal College of Surgeons headquarters in London. The minutes record 72 members as being present. After the committee reports the President, Michael Earley, tabled an amendment to the constitution (which had been previously circulated) concerning the change of name of the Association from BAPS to BAPRAS. Those present were informed that a discussion would follow and then the vote taken. A quorum constituted 20 full members and a majority vote was required for a decision.

Adam Searle, President of BAAPS, made a presentation representing the 'no' vote. A spirited and vigorous debate ensued after which a vote was recorded.

- 88 were in favour of change from BAPS to BAPRAS.
- 37 were against it.
- The President personally abstained.

It was therefore decided that the amended constitution would be forwarded to the members for approval. This would be done prior to the December 2005 AGM.

Consolidation

The following year saw the details of the change of name being ironed out under the guidance of Chris Khoo. The AGM of 2005 saw the approval of the constitutional amendment required to move from BAPS to BAPRAS.

On 11 July 2006, with Bob Page as President, BAPRAS was officially launched and the website overhauled to reflect the new branding. The salamander was incorporated into the logo.

The following year BAPRAS had its first foreign outing in Deauville, France, hosted by its new President, Chris Walker, and BAPS became history.

Appendix

Throughout 1993 councils of both BAPS and BAAPS had discussed the possibility of a merger of the two associations.

The minutes of the 1993 AGM record that a proposal was put to the meeting by the President Roy Sanders that 'the Constitution be changed to enable the formation of a new Association,

The British Association of Plastic Reconstructive and Aesthetic Surgeons.' The Vice President Phil Sykes seconded the motion.

Peter Davis proposed an amendment to this that 'This meeting supports the concept of a union between BAPS and BAAPS, and recommends the establishment of a working party to advise both Associations on a Memorandum and Articles of a new Association'. David Harris, President of BAAPS, seconded this amendment.

> '[A]t the end of a lively and wide ranging discussion' a further amendment was put forward by Mike Timmons and seconded by Brian Sommerlad that 'the change of name of the Association be taken as separate issue from the other amendments and the original proposal'.

This last amendment was carried by 42 votes to 20. The amendment of Peter Davis was carried by 48 to 10.

Roy Sanders recollects that, 'when eventually the name was changed in 2006 I saw Andrew Batchelor, who had supported the change ten years previously. He said "it took ten years". So it did.'

The salamander

Background

As Michael Earley has described in the preceding chapter, the change of our name in July 2006 from BAPS to BAPRAS came eighteen months after the decision to do so was taken in principle by the Association at its Annual General Meeting in December 2004. In the intervening period there was much work for the officers of the Association and its Secretariat to prepare for the change. This was a great deal more than a simple change of title for our Association; it reflected a wish by the members to be viewed differently, to demonstrate to others the whole scope of our specialty and to emphasise that our Association embraced all aspects of it. It was also an opportunity to make changes to the way that the Association was governed and to be more inclusive in its membership rules and how it conducted itself.

As the last Honorary Secretary of BAPS and the first of BAPRAS it fell to me to support Chris Khoo and Bob Page – Presidents in 2005 and 2006 respectively – in managing the transition. One of the major tasks for the officers was the drafting of and then getting agreement to a new constitution, but there were many more mundane tasks such as changing all the stationery and bank accounts and even the sign on the office door. Helen Roberts and her team worked tirelessly and with great efficiency to make sure this all happened smoothly.

Council recognised that to be successful, a change of this magnitude required careful and effective communication to our members – not all of whom were in support – but also to wider stakeholders, including the media and the public. The change also provided an opportunity to reposition the specialty and the Association. This drew on the thinking that had emerged during the NHS Modernisation Agency's *Action On* programme for plastic surgery, chaired energetically by Dr Catriona King. One aspect of that programme was a facilitated workshop at Henley Business School which had developed a framework for how the Association should think about and portray itself.

Communications

After some debate, BAPS Council determined that we would need external professional support if we were to manage the communications well and make the best of the opportunity the name change afforded us. This was not universally held and for some there was anxiety about the perception of using 'spin doctors', and whether this would be an appropriate use of the financial resources of the Association. Those of us who were accountable for actually making the transition happen recognised that the Association was well placed for maintaining the status quo but did not have sufficient capacity or expertise to prosecute such a change effectively. It was something of a relief therefore when Council agreed that we should appoint an external communication company to help and guide us. After a tendering process, BAPS appointed Forster Communications as our advisors, initially on a one-year contract. This proved an excellent choice: Forster not only brought considerable expertise, having developed a number of health-related campaigns for the NHS and its partners, but also demonstrated strong ethical values in the way they worked. As a beneficial by-product this meant we reflected on our own ethical and environmental behaviours.

Forster was briefed to help us ensure that the 'brand' of BAPRAS would be understood by stakeholders and members and reflect the values of the Association. They were also to develop a communications plan for the newly named Association that explained the reasons for and the significance of the change. In doing so, Forster was asked to help deal with any potential confusion or conflict with the brand of BAAPS, most of whose members were also members of BAPS/BAPRAS. Forster's final task was to establish a communications office to react to media enquiries but also proactively promote those aspects of plastic surgery that in our view did not get sufficient media coverage at that time.

Our identity

In advance of the July 2006 'go live' date, Forster spent time discussing with officers, Council members, Secretariat and some general members to learn about our specialty before producing a new visual identity for BAPRAS. As might be expected, there were at least as many views as there were Council members when first I presented the initial proposals to Council. It was not straightforward to balance the wishes of 'modernisers' with those of 'traditionalists' and the debate at times was lively and passionate. There was a recognition, however, that the purpose of the change of name was, in part, to update the image of the Association and so, after a number of iterations, common ground was found.

It was noticed on our arms that there was a lizard-like creature sitting on a stone at its top. The full details of the grant of arms made to the Association in 1955 may be found in the history of

the first forty years of BAPS. Suffice to say that Garter, Clarenceux and Norroy & Ulster [Heralds to College of Arms] determined that our Arms would feature '[...] and for the Crest On a Wreath of the Colours upon a rock a lizard proper as the same are in the Margin hereof more plainly depicted.'[1]

In his article, Wallace proposes that the lizard standing on a rock was selected 'because of its ability to regenerate its tail when that part had been lost, the ideal if so-far-unachievable technique for the replacement of lost tissue in plastic surgery'. Whilst this may be the reason, it was argued at Council that the Garter Arms' 'lizard proper' may in fact have been intended to represent a salamander, which had mythological attributes that were relevant to our specialty as well as sharing the ability to regenerate tissues.

Salamanders

Salamanders have much in common in appearance with lizards, with a longer slender body, a blunt snout, four short limbs that are at right angles to the thorax and a long tail (see image below). Importantly, although often confused by non-experts, lizards are reptiles whereas salamanders are amphibians. There is some controversy about the taxonomy of salamanders but most biologists now classify the many different families of salamander as being in the order Urodela. Salamanders range in size from just a couple of centimetres long to the Chinese giant salamander which can reach 1.8 metres in length and weigh the same as an adult human! Most salamanders are between 10 and 20cm in length.

Salamandra salamandra, the fire salamander

1 Wallace AB. 'Grant of Arms' *in* The History of the British Association of Plastic Surgeons, the First Forty Years. Churchill Livingstone: London; 1967.

An important characteristic of a salamander, highly relevant to plastic surgery, is that not only can it regenerate a tail, most commonly lost during a predator attack, but it can also regrow entire limbs and elements of its eyes including the retina and lens. There is much interest in studying how this regeneration is achieved and the factors that switch regeneration into scar formation instead.[2]

Salamanders in folklore

In addition to their real ability to regenerate, salamanders have been ascribed fantastic attributes throughout history, many of which relate to fire and flames. Aristotle and Pliny reported that salamanders could extinguish flames by the coolness of their skin.[3] Throughout mediaeval times, and more recently, linkages with fire persist and it is thought that this stems from the predilection of the salamander for living in rotting logs from which, when the log was brought in for the fire, the salamander would appear. Leonardo da Vinci considered that salamanders got their energy not from food but from fire 'in which it constantly renews its scaly skin'.[4] Several authorities considered that the fire-resistant attributes of salamanders could be transferred to man through using 'their wool' to weave garments. William Caxton describing this in 1481 'This Salemander berithe wulle, of which is made a cloth and gyrdles that may not brenne in the fyre'.[5]

The BAPRAS logo

With these real and imaginary attributes and the link to the original crest, it was decided to adopt the salamander rather than the lizard as the logomark for BAPRAS. Many different versions were drawn and considered and I recall an entertaining and protracted debate at Council with Simon Kay about the number of digits there should be (it varies between front and rear limbs and different salamander families) and whether there should be webbing (there should not). We settled on the stylised version that has four digits on the front limbs and five on the rear (see image on page 27). The colour (Pantone 221) of the salamander logomark was chosen because of its associations with royalty (the RCS and our patron) and for its sense of authority. The choice of typefaces for the logotype were intended to strike a balance between our history and authority and our wish to appear forward looking and modern. This was reflected also in the choice of text colour, Pantone Warm Grey 10. These devices were protected for the Association

2 Yun MH, Gates PB, Brockes JP. Sustained ERK Activation Underlies Reprogramming in Regeneration-Competent Salamander Cells and Distinguishes Them from Their Mammalian Counterparts. Stem Cell Reports 2014;3: 15–23. DOI: http://dx.doi.org/10.1016/j.stemcr.2014.05.009

3 Bostock J, Riley HT (eds.) Pliny the Elder, The Natural History. Book 10, Chapter 86. London: Taylor and Francis; 1855.

4 Richter JP (ed.) Humorous Writings: The Notebooks of Leonardo da Vinci. Book XX. 1880.

5 White TH. The book of Beasts: Being a Translation from a Latin Bestiary of the Twelfth Century. Dover Publications NY; 1984. pp183-4.

BAPRAS

British Association of Plastic
Reconstructive and Aesthetic Surgeons

The BAPRAS logo agreed by Council. Designed by The Forster Company

The Association crest in its warm grey format. Original designed by the College of Arms. Note the lizard-like creature at its top.

in law and clear and detailed guidelines were created to ensure appropriate usage of the logotype and logomarks, as well as how to develop sub-brands and how to display them on different types of printed and online materials. These are available from the Association.[6]

The crest

For some members there was anxiety about moving away from the existing crest, certainly until the new BAPRAS identity was established. This was seen most in more senior members who had grown up with and had strong emotional attachment to the crest that had adorned their journal and the BAPS letterhead for 50 years. It was important however not to dilute the impact of the new visual identity, and the messages it conveyed about BAPRAS, with such a strong link to our past and to BAPS. It was agreed quickly that the solution would be to retain the crest device but to use it without colour: printing it in Pantone Warm Grey 10 to complement our logotype (see image above right). The corporate guidelines state 'The BAPRAS crest should be used until such a time when the new BAPRAS identity is established. It has been retained to bridge the transition from old to new identity. It supports the new logo it does not overpower it. The crest will only ever appear in warm grey. It never appears in full colour. On stationery, the crest will appear on the bottom right, on all other usage it will appear on the reverse of literature with the address sign-off.'

6 http://www.bapras.org.uk/docs/default-source/Member-Brand-and-Media-Documents/members-guidelines-interactive-pdf.pdf?sfvrsn=2 (accessed 30 July 2016)

Attitudinal survey

Another outcome of the name change was a decision by Council to conduct an independent review of the membership to discover what they thought about the Association, what they wanted from it and what they thought were the challenges facing the speciality. A market research consultancy (the Dream Mill) was engaged to do this and they held several small group meetings with members across the UK with invited members, as well as administering a detailed questionnaire for all members during the late summer of 2006. This produced rich data which Council considered at its meeting in December 2006. Some key findings were:

- The benefits of membership of BAPRAS considered to be most important were that it provided professional legitimacy, belief in the profession and the ability to keep up to date professionally.
- Future strategic planning should include increasing public perception and understanding of plastic surgery, setting standards in education and training and improving the understanding of plastic surgery in the NHS (colleagues, managers and influencers).
- That the greatest threat to the specialty was fragmentation and future NHS cuts.
- That the general understanding of plastic surgery among the public and NHS decision makers was low.
- That there was a need for information campaigns with all audiences, especially the public and NHS managers.
- The views of the performance of Council was mixed, with London-based members being most critical (interesting in the context of a perception that the Association was too London-centric).
- The move to geographical Council membership was welcomed and that its committees should invite expertise from outside the Association if required.
- Members wanted a printed bulletin three times a year and an e-bulletin every other month.
- There was strong support for PR assistance and various engagement mechanisms were suggested.
- Members wanted to see more effort to raise the profile of plastic surgery in the undergraduate medical curriculum.
- There was strong support for the charitable activities proposed by BAPRAS, especially public education, research and development and rewarding outstanding achievements.
- Younger members were less satisfied with their Association than those over 50 years of age and there was a need to ensure that the needs of younger colleagues were met.

The website

By December 2007 it was apparent that the website of the Association was not meeting our needs, and I advised Council that we should tender for a new supplier. A budget was approved

and the work to redevelop the site began. Every page of content was reviewed (there were over three hundred) and a number of members worked valiantly with a lay copy-editor to ensure the content was not only factually correct but written in language accessible to the public. The new visual identity was embedded throughout the site and extra functionality added for the launch in 2009. A careful decision was made by the website group that we would commission drawings and not photographic images to illustrate the information, to ensure clarity and a consistent style.

Press office

Forster ran our new press office with great professionalism. In general, most media enquiries coming into the office related to cosmetic surgery and so a strategy of generating pro-active stories to highlight the range and breadth of our specialty was developed. In the 5 years from 2005, more than 500 media enquiries were responded to and 294 pieces of media coverage were generated, including national newspapers, major magazines and national TV. A live interview on the *Today* programme about the impact of cosmetic surgery tourism on the NHS was particularly daunting but successful in raising awareness of this important issue. In total, 12 members underwent media training to speak on our behalf and a booklet on media guidance was produced for members. Forster were always prepared to advise us when not to respond or comment to an emerging story.

Communications Officer

The expanded focus on active communication placed a considerable burden on the Honorary Secretary role because of the need for quick decision-making and response to stories in print and broadcast media if we were to ensure our voice was heard. Council therefore decided that a new post of Communications Officer should be created to work alongside the President and Hon Secretary, supported by Forster and the Secretariat and guided by a Communications Committee. The inaugural appointment commenced in 2008 for a three-year term.

The BAPRAS constitution

A constitution is a body of fundamental principles or established precedents according to which an organisation is acknowledged to be governed. The change of the name from BAPS to BAPRAS 2005 presented an opportunity to develop a new constitution that met the needs of the rebranded Association. Proposals for change emerged out of a membership survey in 2006, and discussions ensued in Council about how best BAPRAS could serve its members.

The first constitution of BAPS was drafted over three days in April and May 1944. It was commendably short, and consisted of just five principles (see Appendix).

Our starting point was the October 1991 iteration of the constitution. The document was divided into an initial 'Memorandum of Association' followed by a more comprehensive 'Articles of Association' together making up the constitution. This had evolved by 2005 into a 36-page A5 booklet bound in red card, and routinely appended to the annual 'Members and Associates' Booklet'.

In October 2007 the President wrote to all members proposing a number of changes that were to be discussed and debated at a series of AGMs and EGMs over the ensuing year or so.

The objects of the Association

One thing that was undisputed was the objects of BAPRAS.

'The Objects of the Association are:

a. to relieve sickness and to protect and preserve public health by the promotion and development of plastic surgery; and
b. to advance education in the field of plastic surgery.'

The remainder of the constitution was potentially subject to change.

The proposed changes

The membership was given more detail of the changes prior to the December 2007 AGM. There were three main areas of proposed change:

- The structure of BAPRAS Council.
- The development of geographical 'constituencies' for Council members.
- Changes to the requirements for membership and the various categories.

BAPRAS Council

It was proposed that we move to having 13 Council members, elected by their local consultants, and two Council members elected nationally. The idea being that, by having a locally elected regional member, BAPRAS members would better feel that they had a voice in the Association.

Geographical constituencies

The proposed constituencies divided England into 10 regions largely corresponding with NHS administrative areas. There would then be one member each for Scotland, Wales and Ireland.

Membership categories

It was proposed to broaden the membership, and to accept that in future individuals who might otherwise be considered for full membership may not hold NHS consultant posts. It was proposed to encourage and increase membership applications from medical students, trainees and colleagues from allied reconstructive surgical specialties.

The December 2007 AGM

These proposals were taken to the AGM in order to get approval in principle for these changes so the Ethical, Constitutional and Professional Standards Subcommittee could then go ahead with the process of drafting these changes and establishing the detail. The changes to Council and its new geographical membership were uncontroversial. However, the concept of inviting consultants from other specialties into membership of the Association was met with disquiet from the AGM. It was evident that many members did not realise that we already had an allied associate membership category that included such colleagues, and that such a membership

category had been part of the original 1944 constitution. In view of the reservations expressed from the floor it was agreed that any vote would be deferred and we would bring a more detailed proposal to the summer EGM and put it to the vote at that stage.

The July 2008 EGM

At this stage the term 'interspecialty member' had been coined for those from allied reconstructive specialties who wished to join BAPRAS. It was made clear that:

- Such members would have to use the prefix 'interspecialty' when referring to their BAPRAS membership.
- Their applications must be supported by two referees who worked with them in reconstructive surgery, a full member of the Association who could confirm first-hand knowledge of their multidisciplinary involvement with plastic surgery and a reference from their 'host' specialty association confirming their good standing within that association.
- Their application must go to a general meeting for a vote.

These conditions made application for membership more stringent than the former category of allied associates, who could be elected on the say of Council alone. However, at this point it was being proposed that interspecialty members would have full voting rights, something that allied associates did not have. This clause would prove a major sticking point as the process went on.

Once again these proposals provoked heated debate. Scenarios of surgeons from other specialties completely taking over BAPRAS from plastic surgeons were projected.

The constitution rewrite

By the autumn of 2008 it had become clear that we were embarking on an extensive rewrite of the constitution, quite apart from having to resolve the issue of membership categories in a manner acceptable to the membership as a whole. There followed a series of emails, meetings and iterations as the document evolved. There was nothing further to bring back to the December 2008 AGM since the constitution remained a work in progress.

The two-year presidency

As we were rewriting the document we considered the proposal that BAPRAS move to having a two-year presidential term instead of the previous one-year presidency. It was felt that one year

was not really enough time to have a worthwhile influence on BAPRAS itself, and insufficient time to spend on other representative bodies. It was suggested that the President elect serve as vice President for the year prior to their presidency and then again for their year as immediate past President. This was to enable continuity in the presidential roles. Council was in favour of this change and it was put to, and supported at, the July 2009 EGM.

The December 2009 AGM

By the winter of 2009 the entire constitution had been rewritten and was put to the vote. The majority of the changes were supported without reservations. However the matter of interspecialty membership once again proved controversial. This issue divided the membership. There were those who saw the way forward for plastic surgery as embracing those in allied reconstructive specialties and encouraging them into the BAPRAS camp. Others took the contrary view that we should close the doors, eject allied associates and make BAPRAS membership just for plastic surgeons. There was a strongly expressed fear that other specialties might take over BAPRAS entirely, and that these surgeons would take the work of plastic surgeons. The motion to introduce the category of interspecialty membership was withdrawn.

A new constitution

So by December 2009 we had a new constitution with a two-year presidency that would commence in 2013. We had revised membership categories to invite medical students to join, to include trainees both on training programs and not. We would elect Council members on a regional basis, and these Council members would represent their local constituents. We had tightened up the mechanisms by which membership might be suspended or terminated. However, we still had not resolved the issue of interspecialty membership. We had 24 allied associates who no longer had a membership category to sit in. This situation could not remain.

Interspecialty membership

The proposal to have interspecialty members had not been supported, so we had to revisit the rights associated with such a category of membership. It was agreed to go back to an AGM with a revised version of interspecialty membership in which such members would not be notified of, and could not attend general meetings of, the Association, and would not have voting rights. All interspecialty members would have to be surgeons. This was a watered-down version of the original proposal, but it was felt that it did address the genuine concerns expressed at previous general meetings. The version of interspecialty membership arrived at was more difficult to attain

than allied associateship had been, and carried with it no extra rights. Nevertheless it was felt that this more closely represented the position of the Association's members.

The December 2010 AGM

At the 2010 winter BAPRAS scientific meeting there was a debate on the subject 'Should surgeons from other specialties be permitted to join BAPRAS?'. The following day, three motions were put to the AGM:

Motion 1:

That the category of Allied Associate (Section 13) be removed and we no longer admit surgeons from other specialties into BAPRAS membership.

If this motion is carried, motion 3 is redundant and we can move on to motion 2; if it is not carried motion 2 is redundant and we can move on to motion 3.

If we pass motion 1 we have to decide what to do with the current surgical Allied Associates. We can leave them in 'limbo' as former Allied Associates, collect their fees and keep them as members. Alternatively we can simply terminate their membership, hence motion 2.

Motion 2:

That current surgical Allied Associates are informed that they are no longer eligible for BAPRAS membership as we no longer have a membership category into which they fit, and that their membership is terminated.

If motion 1 is not carried and we agree to continue to accept members from other surgical specialties we need to find a membership category in which to put them, hence motion 3. This reintroduces the separate category of Interspecialty Member. This is essentially a 'beefed-up' version of the former category of Allied Associate, but including only surgeons. Applicants must be involved in multidisciplinary practice with plastic surgeons. Their Full Member sponsors must vouch that this is the case. All applications must go through the process of scrutiny by Professional Standards Committee and Council. Names will be then put forward to a General Meeting for election by the membership. One of the Full Member sponsors must be present at this meeting or the application will not be considered. Interspecialty Members do not have voting rights, they cannot attend General Meetings, they cannot be elected to Council or to the position of Officer.

Motion 3:

That the category of Allied Associate (section 13) be removed and the category of Interspecialty Member be introduced as shown in 13 below:

13 Interspecialty members		
(1)	Any person who:	
	(a)	Is engaged in multidisciplinary practice in reconstructive surgery, and has his name included in the Specialist Register of the General Medical Council in any of the surgical specialties other than plastic surgery (SAC-defined or ophthalmology); and
	(b)	is considered by the Council in its absolute discretion to be suitable to become an Interspecialty Member; and
	(c)	has been sponsored by two Full Members who must vouch, from personal experience, for their active involvement in multidisciplinary care in collaboration with plastic surgeons; and
	(d)	has been recommended for Interspecialty Membership by the Council,
	shall be eligible to be appointed an Interspecialty Member by resolution passed by a majority of not less than two-thirds of such Members as (being entitled to do so) voting in person or by proxy at a General Meeting. A separate resolution shall be passed in respect of each person recommended for Interspecialty Membership by the Council. At least one of the Full Member sponsors must be present at the General Meeting at which the candidate's application is considered.	
(2)	The names of candidates for Interspecialty Membership shall be submitted to the Honorary Secretary not later than 3 months before the next General Meeting for recommendation as an Interspecialty Member.	
(3)	Interspecialty Members shall be entitled:	
	(a)	to receive notice of and to attend Scientific and Clinical Meetings of the Association; and
	(b)	to have their names and addresses held by the Association and published in the Association's Handbook or whatever medium is currently accepted by the Association.
(4)	Interspecialty Members shall not be entitled to receive notice of, to attend or to vote at General Meetings whether in person or by proxy.	
(5)	Interspecialty Members shall not be eligible:	
	(a)	To be elected or co-opted Members of Council; or
	(b)	To be elected Officers.
(6)	Interspecialty Members shall be bound to pay annual subscriptions in accordance with Article 14.	
(7)	An Interspecialty Member will no longer be eligible to be an Interspecialty Member if he ceases at any time to fall within the criteria set out in Article 13(1).	

'After some discussion the membership voted on the motions as follows:

- Motion 1: 20 voted in favour, 32 against, the motion therefore was defeated.
- Motion 2: as motion 1 was defeated, this was not discussed.
- Motion 3: 35 voted in favour, 18 against, there were 6 abstentions.'

Lessons learnt

Plastic surgery has enjoyed tremendous growth in its size and influence in the past 30 years. This has been in part due to more sophisticated techniques, but also because we have joined multidisciplinary teams. We have worked on joint guidance with other specialties, we have moved from isolated regional units into teaching hospitals becoming an integral part of surgical teams, and we have set up joint training programmes. Many of us will recall the initial suspicion with which we were viewed when presenting ourselves as willing servants to help other specialists when they were in trouble, or when we began to set up satellite services in hospitals not previously served by plastic surgery. Now we work with these individuals in an atmosphere of mutual respect and regard them as valued colleagues and friends. We know that plastic and reconstructive surgery thrives when it works together with other specialists.

Yet there remains, amongst some, a suspicion of colleagues who might be perceived as out to take 'our work'. Much of this, I am sure, results from an altruistic intention to protect patients from individuals who lack the skills and experience to meet the standards we expect from plastic surgical colleagues. It must be stated, however, that this may result from a fear that other specialists might learn our skills and take our private patients. Also that others might intrude into the field of aesthetic surgery, which we might wish to call 'ours'.

While some might regard such fears as irrational there is a substantial body of opinion within our specialty that we are under threat. The lesson that I have taken from this episode is that BAPRAS as an organisation has a duty to respect this view, and represent those members who take such a position.

I would like to bring you back to May 1944, when the grandfathers of BAPRAS were drafting an outline of what BAPS should look like. Allow me to quote:

> 'Associate Membership should be open to qualified members of the medical and dental professions. It would be desirable to encourage membership from the specialties of anaesthetics, neurosurgery, all aspects of dental surgery, ear nose and throat, ophthalmic surgery, orthopaedic surgery and radiology'.

Disclaimer

The content of this chapter is a collation of my recollection of events during my time as Honorary Secretary of BAPRAS between 2008 and 2010. It is referenced by some contemporary documents that I have retained. It is intended as my reflection on events, and I can give no guarantee as to the total accuracy of what is written. Any views expressed are my own and not those of BAPRAS.

Appendix

The original BAPS constitution

J N Barron, From : *The History of the British Association of Plastic Surgeons – The First Forty Years*. AF Wallace (Ed) Churchill Livingstone 1986. p14.

'[…] and a constitution?

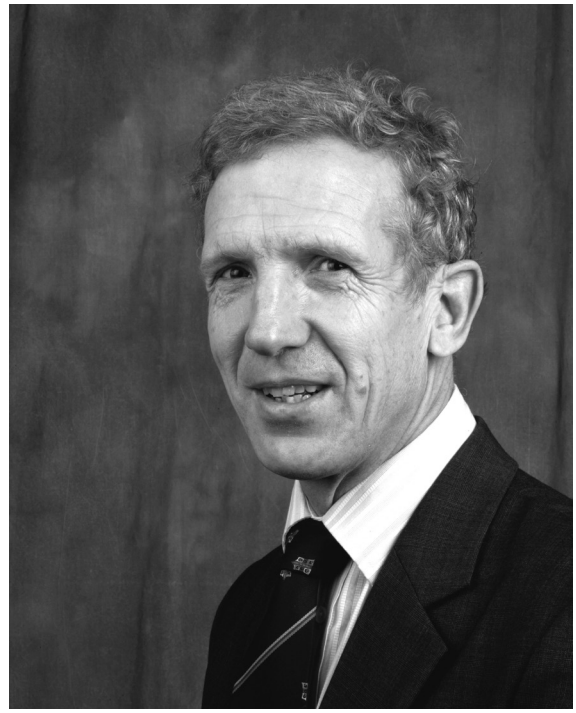
Having decided on a name, our attention was drawn to the consideration of a constitution, and it was here that we realised that we suffered from serious political inexpertise! Many hours of discussion ensued and we opted finally for the simplest and most flexible formula which would be capable of modification as the years passed and the Association expanded. The principles were as follows:

1. The Association should be constituted so that it could control and safeguard the interests of surgeons practising in the specialty and that it should direct the development of the specialty along sound and progressive lines.
2. The Association should foster and co-ordinate study and research in this ever-widening branch of surgery and it should provide machinery for the dissemination of knowledge among its members and in the profession as a whole.
3. As a focal point for the Association, facilities should be sought at the Royal College of Surgeons in London.
4. The executive body should be a committee of seven members with a President, Vice President, Secretary, Treasurer as *ex officio* members. There should be at least one member from Scotland, the North, the Midlands and the South.
5. Membership. Full membership should be open only to British subjects who pursue and intend to pursue plastic surgery as their primary surgical occupation. Full members shall have trained at a centre recognised by the Association.

   Associate membership should be open to qualified members of the medical and dental professions. It would be desirable to encourage membership from the specialties of anaesthetics, neurosurgery, all aspects of dental surgery, ear, nose and throat, ophthalmic surgery, orthopaedic surgery and radiology.'

The first two-year President

It was at the BAPRAS Extraordinary General Meeting in Oxford in 2011 that I first heard of the decision that the presidential term of office would be for two years. The successful candidate would serve as Deputy President during 2012, take up the post as President for 2013 and 2014 and then serve as Deputy President for 2015 to assist the incoming President. The expectation behind the move to a two-year post was that more continuity would lead to more achievement. In writing this reflection I have no doubt that this aspiration was achieved. The myriad of changes (both nationally and internationally) meant that relationships developed in the first 12 months were essential as the groups and meetings never solve anything within the first year.



Graeme Perks: The first two-year President

I had no previous experience of BAPRAS committee work when I took up post as Deputy President, and was very grateful for the enormous support of Rick Milner during his presidency and the other officers, Tim Goodacre, Joe O'Donoghue and Paul McArthur.

The sacrifices required to perform my duties effectively were soon apparent, as Tuesday featured regularly for meetings and this was the day I had free from the NHS for work in the private sector. I decided that it was easier to relinquish private practice for the duration than try to fit it in around the new commitments, which were greater than I could have imagined.

I had asked to work part-time but my Chief Executive declined, so I remained Head of Service in Nottingham for the two-year term. This seriously curtailed my national plans and I failed to achieve one of my intended aims, which was to travel around to the many departments in the country. I only managed to visit the departments in Odstock, Salisbury, Wexham Park and the East Anglian meeting during my time. Subsequent presidents will have even less flexibility in the increasingly rigid 'service delivery' driven NHS. It is possible that NHS trusts will demand reimbursement for time spent on Association business in future

An indication of the scope of my commitments in the first part of 2013 is shown in table 1 on page 48.

National representation

The President attends four FSSA meetings a year and four meetings of the Council of the RCS, coupled with Surgical Senate meetings.

I raised a dispute with ENT-UK President Valerie Lund whom I had come to know through time spent together at FSSA meetings. I challenged her about their use of 'facial plastic surgery' description and a planned new 'FPS-UK' website. I was reassured that this will now never happen!

I managed to attend the Scottish BAPRAS meeting in Dunkeld in both years as President. This allows the President the opportunity to meet many trainees and consultants for a Q&A session on the Thursday and then enjoy a superb scientific day on the Friday

Advanced educational course meetings

I attended three out of four of the faculty dinners for the courses in Manchester, and gave an opening address at the lower limb course. This was a welcome opportunity to thank the organisers for the great efforts that they put into each course, and thank the international and UK visitors for supporting BAPRAS.

The Combined Services Plastic Surgery Society

I attended both annual meetings of the CSPSS, the first in 2013 at the Army Air Corps in Middle Wallop and in 2014 at the naval training establishment HMS Excellent, Portsmouth. The latter was hosted on board HMS Bristol, a destroyer converted for educational purposes. This was another great opportunity as BAPRAS President to thank those many people whom I would not

Presidents' Dinner: Cabinet War Rooms 2012

otherwise meet, for the inspiring work that is done by military members of our specialty under exceptional circumstances. The standard of presentations was outstanding and the research presented by UK trainees working for 2014 international guest Lt Col Mike Davis from the USA most impressive.

National issues

The GMC

The GMC Chief Executive Niall Dickson and his team received Amanda Powell-Smith (Forster) and myself in January to discuss the specialist register and the misuse of the term plastic surgeon and plastic surgery by those not on their specialist register. They acknowledged that the specialist register gives the only objective evidence of training. After this meeting I was able to write to all full members and encourage them to use the phrase 'GMC specialist register in plastic surgery' on their websites in a prominent position.

Training interface fellowships

BAPRAS has been the specialty that has contributed extensively to the establishment of interface training in cleft, hand, head and neck and oncoplastic breast surgery. The total failure to secure a

single plastic surgery trainee to the oncoplastic fellowships (9 were available) and a similar lack in head and neck caused great disquiet, which required redress. I met Kieran Horgan, ABS President, for coffee late one evening in Leeds to discuss the balance of the interview process, where we acknowledged the importance of equity. Steering group meetings for the two specialties were held with the postgraduate dean at RCS in London with strong representation from BAPRAS. Three places on the breast oncoplastic reconstructive interface fellowship were guaranteed, while for head and neck surgery one place for plastic surgery was guaranteed for a trial period.

Moh's surgery

Efforts by some dermatologists to set up a 'Moh's College' were aborted with the support of Professor Chris Bunker, President of BAD, and a Moh's guidelines group established instead. After much diplomacy, and with his backing, I was able to secure representation on the group as 'plastic surgery/Moh's surgeons' rather than 'reconstructive surgeons', which had been the initial invitation. The inaugural meeting was attended by Hamid Tehrani and Howard Peach, who reported positive feedback, which is encouraging for the future collaboration, with BAD acknowledging parity of the BAPRAS Moh's surgeons.

Surgeon-specific outcome data

Surgeon-specific outcome data was the focus of the RCSEd 'President's meeting' in March 2013 at which I spoke on outcome measures. In recognition of the dearth of sound data, Anita Hazari, very ably supported by Richard Cole, most successfully developed and launched the national flap outcome database in collaboration with Dendrite. This was offered altruistically to ABS and BAHNO as a benefit to those groups.

The Reconstructive Surgery Trials Network (RSTN)

It was a great pleasure to help Abhilash Jain, the inaugural Director of this joint venture between the Royal College of Surgeons of England, the British Society for Surgery of the Hand (BSSH) and BAPRAS. Abhi (most ably assisted by Matt Gardner and many other members) has put plastic surgery research on a level never before seen in the specialty, to praise from the RCS and the envy of other specialties. The RSTN now organises a session annually the BAPRAS winter scientific meeting, as well as their own meeting in June.

The Cosmetic Surgery Interspeciality Committee (CSIC)

This was the result of the Keogh report into cosmetic surgery, delegated by the government to the RCS to organise. I served as the BAPRAS representative on this multi-specialty group with the GMC and Department of Health along with representatives of the private sector who provide cosmetic surgery, as well as lay representation. The recommendations made at the end of 2015 will go some way to improve patient safety in this sphere.

International representation

ICOBRA (International Collaboration of Breast Registry Activities)

BAPRAS and the DoH are partners in this international collaboration, established by the Australian Society of Plastic Surgeons. The Clinical Practice Research Datalink (CPRD) is leading the development of the pilot and subsequent UK Breast Implant Registry under the leadership of Stephen Mulgrew, not as a BAPRAS trainee member, but as the CPRD expert. I continue as BAPRAS representative.

IPRAS/ICOPLAST

I attended the IPRAS 2013 meeting in Santiago, Chile, as BAPRAS representative along with Chris Khoo. Ill feeling about poor financial management, cronyism and opaque auditing surfaced in the national delegates' session. Little did any of us realise that we were witnesses to the beginning of the end for that organisation.

BAPRAS Council, along with national country members from North and South America, Ireland, Australia and New Zealand, agreed to withhold our dues, and more countries followed suit. The 2015 IPRAS meeting that was due to be held in China was cancelled, and the planned subsequent meeting in Vienna was shelved in the absence of any IPRAS funds.

After two years as President, one as deputy President and a further year on in 2016 (after international discussions which I attended at ASPS San Diego 2013, ESPRAS Edinburgh 2014, ASPS Chicago 2014, RBSPS/BAPRAS Bruges 2015, and finally FILACP 2016 Punta del Este) a new international collaboration, ICOPLAST, was born. Having made personal friendships afforded by the two-year Presidency, I was able to bring consistency to the meetings, and was asked to be one of two European representatives on the inaugural ICOPLAST Board of Directors.

ASPS Chicago 2014

The Global Leaders Forum and an extraordinary meeting of the IPRAS Board were the political highlights of this trip, which has led to decisions about our IPRAS membership as noted above. Australia was the guest nation and they had the most spectacular video presentation relating to the history of our specialty from their perspective. I met many USA, UK and international trainees trying to help build useful lasting future contacts. ASPS President Bob Murphy has been a great supporter of BAPRAS, attending the IAPS/BAPRAS winter meeting in Dublin last year and then ESPRAS in Edinburgh. I hope that we can continue to build on this for mutual benefit

IAPS/BAPRAS

The BAPRAS winter meeting 2013 was a joint meeting with the Irish Association of Plastic Surgeons in Dublin on 27–29 November. Despite some initial misgivings from some, who questioned the wisdom of a winter meeting away from London, it was a great success. Many friendships were rekindled or strengthened, and new ones formed. Making one of the four meetings held during a President's two-year term a joint meeting was acknowledged to be healthy for the Association, and at the request of the Belgian RSBPS a joint meeting was held in Bruges in 2015. Plans are already being made for a joint meeting with the Finnish society in Helsinki in 2017.

ESPRAS

The 2014 ESPRAS meeting in Edinburgh was the biggest event that BAPRAS has ever hosted, with 865 delegates from 62 countries – fractionally more than the International Congress held in London in 1959. I wish to record thanks to Chris Khoo (who won the bid to host the event) and Joe O'Donoghue who were the brains behind the scientific programme of the conference, while Helen Roberts and Gemma Adlington in the BAPRAS Secretariat provided the additional energy to keep the organisation on track. There were a great many highlights of the scientific programme and social events, and many new relationships were begun with visitors from around the international plastic surgery community. Thanks to all the chairpersons at all the scientific meetings, and to John Scott who, with invaluable help from RCSEd, ran a superb surgical skills masterclass, where 245 delegates were registered.

One of the enormous benefits of a two-year Presidency was the ability to develop contacts and network with surgeons from other countries. This has led to invitations to several of their association meetings and resulted in widening of BAPRAS influence, and the ability to develop a global position to the benefit of all.

The Pakistan Association of Plastic Surgeons (PAPS) invited me to Multan for PAPSCON 2014. I had the privilege of being the first BAPRAS President to attend one of their meetings. As many of us appreciate, the demands on plastic surgeons (where the ratio of surgeons to patients far outweighs our 1:80,000 aspiration) are almost incomprehensible to one who has not witnessed a presentation of their work. The volume and complexity of pathology and the expertise brought to bear by our Pakistani colleagues left me feeling very small.

The Malaysian Association of Plastic Aesthetic and Craniomaxillofacial Surgeons invited me to Kuala Lumpur, again as their first BAPRAS presidential guest. Once again I received most generous hospitality, met new colleagues, made very useful contacts and shared much goodwill. There were discussions about the FRCS international exam, which had raised anxieties regarding equivalence among UK trainees. However, the GMC has stated that successful candidates would not be eligible to apply for registration in the UK. An FRCSEd international exam in plastic surgery was held in Penang 2015.

I represented BAPRAS at the ICOBRA meeting in Singapore held in conjunction with the RACS annual scientific congress, which they shared with the Royal Australasian Society of Anaesthetists. The joint congress was huge, with all surgical specialties represented, plus excellent faculty and national speakers. As a fellow of the RACS and former Melbourne trainee it was great to meet old friends and colleagues. I spoke at one of the Australian Society of Plastic Surgeons sessions, visited the Women's and Children's Hospital, Singapore, and had lunch with some of the Singaporean trainees, which was a great opportunity to hear about the pressures of training elsewhere.

It has been a very busy time, but I have been given generous support from all directions (in particular Helen Roberts, BAPRAS Secretariat Manager, and her team) to help me complete the first ever two-year term as President. It has been a great privilege and an enormous pleasure to contribute in a small way to the future of plastic surgery. I have no doubt that the extended appointment made for a more satisfying personal experience and hopefully (as described above) more durable benefits for the Association, our patients and members.

Table 1: BAPRAS President's Diary March–June 2013

7 March	BAPRAS committees RCSEd Edinburgh
8 March	RCSEd President's meeting Presenting 'Outcome measures' in Plastic Surgery
Congress meeting to plan ESPRAS meeting Edinburgh	
20 March	RCS surgeon specific outcomes London
27 March	RCS commissioning London
3 April	East Anglian meeting
11 April	FSSA Dublin
13 April	ICOBRA Oxford Rod Cooter/WE Correa/Tim Goodacre
14 April	Advanced Course Dinner Manchester
17 April	CEO Harley Medical Group telephone conversation (Lidl carpark Newark)
21 April	ASPS 2013 Melbourne Australia invited speaker (no cost)
9 May	IAPS/BAPRAS planning for winter joint meeting Dublin
15 May	BAPRAS media training London
20 May	JPRAS strategy meeting London/ meet President of BAD
21–22 May	ABS Manchester invited speaker (no cost)
23 May	BAPRAS committee
June	Medical Protection Society Leeds
12 June	Communications Teleconference
14 June	FSSA Edinburgh

Presidents 1986–2016

The British Association of Plastic Surgeons

1986 Mr David O Maisels, FRCS
1987 Miss Anne B Sutherland, FRCSEd
1988 Mr Hugh G Brown, TD QHS FRCS DL
1989 Mr Ronald W Hiles, OBE FRCS
1990 Mr John Colville, FRCSEd FRCSI
1991 Mr Antony CH Watson, FRCSEd
1992 Professor William H Reid, FRCS FRCSEd FRCSG
1993 Professor Roy Sanders, FRCS
1994 Mr Philip J Sykes, OBE FRCS
1995 Mr Magdy N Saad, FRCS FRCSEd
1996 Mr Timothy M Milward, FRCS
1997 Mr Brian DG Morgan, FRCS
1998 Mr Brian C Sommerlad, FRCS
1999 Mr Alan G Leonard, FRCSEd FRCS
2000 Mr Douglas S Murray, FRCS FRCSEd
2001 Mr David S Soutar, FRCSEd FRCSG
2002 Mr Michael D Brough, FRCS
2003 Mr Martin A P Milling, OBE FRCS FRCSEd
2004 Professor Michael J Earley, FRCSI FRCS(Plast)
2005 Mr Christopher TK Khoo, FRCS
2006 Mr Robert E Page, FRCS

The British Association of Plastic, Reconstructive and Aesthetic Surgeons

2006 Mr Robert E Page, FRCS
2007 Mr Christopher C Walker, FRCS
2008 Mr A Roger Green, FRCS
2009 Professor Simon PJ Kay, FRCS(Plast)
2010 Mr Eric Freedlander, FRCE(Plast) FRCSEd
2011 Mr Timothy EE Goodacre, FRCS
2012 Mr Richard H Milner, FRCS(Plast)
2013–14 Mr A Graeme B Perks, FRACS(Plast) FRCS(Plast)
2015–16 Mr Nigel SG Mercer, FRCS

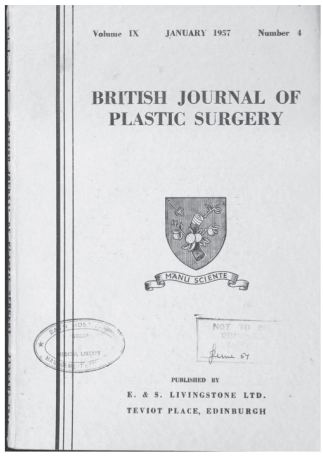
From *BJPS* to *JPRAS*

I write this as I return from a meeting of the Australian Society of Plastic Surgeons, where among other things I presented on the future of publishing in plastic surgery. The dystopian content of my talk met with some surprise, evinced when Dan Kennedy in the chair thanked me with 'Well! We certainly weren't expecting that.'

So having looked forward let me look back, and having just read the nicely written summary of the name change of the Association by Michael Earley, I realise that my recollections may be completely fallible. Unlike Michael I have not kept details of emails and the only documents I retained were related to controversies probably best referenced elliptically here. Instead I hope the reader will bear with a less structured, highly personal view that is intended to be reflective and as honest as a 65-year-old cerebrum can allow. Instead of dealing with single issues, such as our journal, I find several are bound together and since I was an initiator of both good and bad, now might be the only time I can explain them, invested as I am in the common conceit of any author that someone somewhere one day will be interested.

I had been a Council member for some years, serving in various roles and offices before standing for President. Some considerable committee experience had already been gained as Council member and President of the British Society for Surgery of the Hand and I believe I came to BAPS with a sound insight into how slowly specialty organisations change. A brief summary may help explain my hopes for BAPS at the time.

At the BSSH I had had an agenda, in cahoots with Phil Sykes, to start the foundation of hand surgery as a specialty that was being obstructed by the fact that no one could define 'hand surgeon'. On a walk beside a Birmingham canal Phil and I hit on the idea of providing three key building blocks to forge hand surgeons, who then would be irrefutably recognisable as such and could so be accredited by whatever agency one chose. In other words we proposed to define hand surgeons as those who had received education and training in hand surgery and has passed an exam at the end of that training. These building blocks therefore were top-sliced clinical training, comprehensive educational course (which became the Manchester international courses), and an exam (which became the diploma). The first two were achieved before I left BSSH politics and focused on BAPS and the final one was



seen to fruition by the competent stewardship of Vivien Lees. One last contribution to BSSH Council had been to see through a rewriting of the constitution.

I now had an appetite for change or reform and in BAPS and the *British Journal of Plastic Surgery* there was ample scope. More to the point there were some agreeable fellow travellers with a fortuitous complementary skill set amongst them. These included (but are not confined to) Chris Walker, in many ways the ideal chairman, Roger Green, the epitome of sense and probity, Chris Khoo, the consummate diplomat and negotiator, Michael Earley, whose enthusiasm and humorous cynicism charmed so many, and Hamish Laing, smart, waspish and so clear thinking. David Coleman also stands in the role of Honorary Secretary as a logical, modest man of high integrity and dogged capacity for detailed work.

When I took on the editorship of the journal my publishing knowledge had been confined to a textbook and my own writings. I had three aims: to widen its appeal, to increase the quality and to expand the content. Only one of these was wholly successful in my time but I do believe the other two were on the way when I handed over. These aims were addressed in a modernising agenda that axed the solely British editorial board, and changed the name (in stages so as not to shock some venerable beasts watching us from the sunny uplands of retirement) by transitioning through *BJPS* to the radically new *JPRAS*. This name was the acronym for the registered name of *Journal of Plastic Reconstructive and Aesthetic Surgery*. Change like this could not have happened without the support and detail provided by Chris Hammond of Elsevier, who saw us through the start-all-over-again loss of impact factor and many other technicalities. Nor could it have been achieved without the support of Council.

This name change was crucial to abandoning the potentially toxic restraint of 'British' in the title, and supplanting it with the strapline 'An International Journal of Surgical Reconstruction'. Most controversial of all was including 'Aesthetic' in the title, and this remains subject to criticism from some. However, it is also central to what happened next, and was a subject on which I felt some personal zeal. I believed that if we did not pull aesthetic back into our mainstream then the activities of the purely cosmetic surgery practitioners would finally divide their work away from our specialty, and each parent surgical area of endeavour would then spawn its own narrow-focus cosmetic surgeons.

In retrospect I still believe that to be in one umbrella specialty is wiser and more likely to lead to quality assurance and excellence in training. There were other perfectly plausible and possibly correct contrary views to be respected. Perhaps time will tell which one was correct, although as Chou En-lai, when asked in 1972 whether the French revolution had overall resulted in good, said: 'It is too early to tell'. It may always be too early to tell for us. Understanding the complexities of aesthetic indications for surgery eludes many other specialties and even some of our own surgeons, and will I predict be crucial in future negotiations with regulators who comprehend our specialty poorly.

We then made the office of *JPRAS* electronic and paperless, hugely improving turnaround times for articles and peer reviews, and meaning the office could be anywhere in the country or indeed the world. Our next Editor was to be based in Hong Kong, much to my delight. I felt the journal now truly internationalised and that the mission was accomplished. BAPS (becoming BAPRAS, not surprisingly a change I enthusiastically endorsed and promoted) continued to gain a large revenue from the publication of *JPRAS*, which went from strength to strength and garnered better status, higher impact factor and improved circulation. Mindful of that I was keen to acquire the *European Journal of Plastic Surgery*, which was owned by Springer. I felt this would be a useful partner to *JPRAS*, either sitting alongside as a content repository (a concept derided by some, but now vindicated by *PRS Open* and other spin-off journals that help deal with content overload and remain lucrative) or eventually merging with us and so bringing many European societies to our publications. Sadly, despite the astonishingly good terms we secured for this transition over a ten-year timescale, this proved a leap too far for some Council and board members and was abandoned. I regret that missed opportunity for us even now.

As a Council member, officer and then President I had three main enthusiasms, each of which was directed to consolidate our specialty and make it inclusive and to try to prevent areas of special surgery being hived off to single-interest groups. It was for that reason I continued to promote with others the Association's name change to include aesthetic. I also moved to rewrite our archaic constitution, seeking to make it more fit for governance and accountability (among other things introducing a disciplinary mechanism for members and officers: a timely move as it transpired), and writing into it another membership category so that those many allied surgical disciplines whose reconstructive surgeons were outside their own mainstream specialty would find a home in our association. These interspecialty members (such as ophthalmic plastic surgeons, breast surgeons, etc) would enrich our Association and in return their skills would derive from and contribute to the greater community of reconstructive and aesthetic surgery as whole. This tree of hope has been slow to fruit, but if it does, then beneath its great arbour will be a perfect place for all who care more about the surgery than the politics to dwell.

David Coleman, Roger Green and I fashioned the new constitution in various meetings around the country. Each contributed hard work and congenial collegiality and each had their own gift.

Roger so gently restrained my headier ideas that I scarcely noticed while David kept all of us on-topic and consistent. It was a propitious team I believe and my final wish, which passed both these censors and astonishingly got through Council and the AGM, was to create a two-term Presidency. I found that one year was simply not enough, and my own year had been less productive than I might have wished because it was spent in part testing out our new constitution and defining some important future roles.

I apologise to the reader of the future who has no idea who I am nor who the preceding dramatis personae are. There is a definite tendency for surgeons who rise within their organisation, whether it be a royal college or a humble specialty association, to think and behave as if they are global statespersons, and their every deliberation of enormous importance. This hubris is easily punctured by the nemesis of retirement. Little conceits like those written here are not historical documents and are probably full of errors of omission and inclusion, but may be of interest to a small few survivors for a few years yet. I hope plastic and reconstructive surgery survives as a discipline despite the depredations others would visit upon it. We believed and we tried. Floreat BAPRAS.

The Secretariat

How interesting that the excellent account on the BAPS Secretariat by Mary Hamilton in *The First Forty Years* ends with pondering about the future location of the Secretariat. Now, once again, this is being discussed in connection with the proposed 'Project 2020'. The RCS has taken the decision to refurbish the interior of the College, with the result that the joint Secretariat of BAPRAS/BSSH/BFIRST/BESS and PRASIS will be decamped to temporary accommodation until that work is completed. Who knows at this point if we will ever return?

Twenty-seven years ago BAPS and BSSH separated from the combined office that we shared with the BOA. At that time there were four members of staff employed to run the two associations. Now, in 2016, there are eight staff, some part-time, to manage the demanding work of the four organisations.

Linda Sizer was awarded honorary membership of BAPRAS in 2014 having completed 25 years of loyal service as Finance Manager. In 2002, under the presidency of Michael Brough, BAPS donated half a million pounds toward the founding of the extremely successful Healing Foundation (see chapter 15), which continues to flourish today. However, this brought financial hardship to BAPS, which Linda managed with her usual quiet efficiency. A radical streamlining of activities was needed, which has to this day has proved a useful exercise. Linda is replaced by Shreena Dholakia.

Judy Richards serves as Finance Co-ordinator, ever loyal and a stickler to the last penny since May 2001; Angela Rausch carried out a number of roles as Administration Coordinator from 2000 to 2016. Jo Hall, a geologist, works for two days a week, efficiently managing the Council and Committee meetings plus BESS, who have been housed within the office since 2014 when Jo began her role. Sharon Ross, a Canadian, happily wishes everyone 'a nice day', has managed workforce planning and BSSH audit since 2010.

Gemma Adlington has very successfully, and with terrifying efficiency, run BAPRAS events since 2009, and is now ably assisted by Kavita Prashkar, who joined the team in 2014 to help with events – initially to cover maternity leave, but thankfully now on a permanent basis – allowing

Left to right: Linda Sizer, Helen Roberts, Shreena Dholakia, Gemma Addlington, Brian Morgan, Sharon Ross, Kavita Prashkar, Judy Richards, Angela Rausch

Helen Roberts

Gemma more time to concentrate on communications. I have been privileged to hold the position of Head of the Secretariat for 28 years.

The small turnover of staff is testament to the membership, who treat us like royalty. The terms and conditions of employment we enjoy are excellent. We are a happy team who work well together. I was privileged to receive a comment by a past President who said, 'it is like walking into a happy family'.

We are lucky to be housed in beautiful spacious modernised offices on the third floor of the RCS, and in 1999 the accommodation underwent an extension and refit. However, it is only with the diligence of officers and Council members that the staff are able to keep up to date with the ever-changing

rules and regulations occurring within health provision. We have been kept on our toes with the management of these new challenges.

Computers

Our software is frequently updated to reflect the demands of the work and hardware is updated every three years. SAGE accounting software was introduced a number of years ago to manage the huge number of invoices that we process.

With the expansion of plastic surgery provision has come a huge increase in our membership, and an increase in the complexity of the management of the two Association meetings held each year.

'Bespoke Software' manage the ever-more-complex abstract and registration systems for up to 800 attendees over the two meetings. A tailor-made membership system manages the 945 members (we hope to reach 1,000 by the end of 2016). Spreadsheets hold extensive information. Emails dominate the working day (partly because everyone copies each other in to everything). The landline telephones *do* ring less. But do all these advances in technology help a busy office? The demand for more detailed information is mandatory, but the computer is only as good as the person entering the text.

A 'clear desk' policy was introduced in 2014, which is working well, and we are working towards a paperless office.

My motto is 'respond, do not react'. Think it, but keep smiling. The BAPRAS Secretariat is the front of house and the show goes on. But the show goes on behind the scenes too! Some of our most treasured members have glorious nicknames. Those who cause disquiet are rarely forgotten.

So long as the show looks perfect on the outside and the human errors are quietly corrected, all is well. Dummy medals have been presented when we forgot to order the real thing. A very distinguished past President kindly agreed to deliver a prestigious Edinburgh college lecture in the English college, which was kindly chaired by the President of the Edinburgh college, looking rather splendid in his presidential gown. He announced quite sternly that the lecture would not proceed without the lecturer donning an Edinburgh college gown. Edinburgh is a long way from London, and the lecture was due to commence in five minutes. Unexpectedly, an Edinburgh college gown was spotted near the John Hunter statue, being worn by a previous BAPRAS President. He looked somewhat bewildered when it was hastily ripped off his back but, sensing something was very amiss, he quietly walked into the gowning room picked up an English gown, allowing the Edinburgh college gown to be placed on the lecturer and the procession to start on

time. All was well. When the procession left the lecture theatre, the President whispered, 'I was only joking about the Edinburgh college gown, but jolly well done'. I duly nodded.

Belvoir Castle

Our summer meeting dinner was to be a splendid occasion, held at the beautiful Belvoir Castle venue. Such a shame, then, that we were stopped by a military guard at the foot of the castle drive, and told we could not go any further. It transpired that a military dinner was being held, which included entertainment from the Royal Marines band 'Beating Retreat'. The castle had been double booked. Instead of arriving through the beautiful entrance hall with fire lit, we scrambled through the wreckage of empty champagne bottles in the makeshift kitchen area of the double-booked drinks reception. Such was the chaos that to appease our guests the Duchess of Rutland kindly undertook a personal tour of the state rooms. The Chinese contingent at the meeting praised us for the impressive military spectacle that we had arranged, claiming it was the best part of the evening. The President and I smiled sweetly.

Gleneagles

A warm, picturesque evening was spent drinking champagne on the terrace for an extended hour owing to two large fridges having broken down that afternoon, and all the starters and deserts having to be thrown away. The chef insisted on a changed menu, which also needed to be printed. Not everyone appreciated some of the rugby songs on the return coach trip to Edinburgh!

Public Relations

2005 saw the employment of Forster Communications, who very successfully raised the profile of the Association and of British plastic surgery. After open competition, Portland succeeded Forster in 2016. Interestingly, BSSH employed Forster in early 2016.

Royal Visits

Roy Sanders recollects the visit of our patron, The Duke of Edinburgh, at the winter meeting in 1993:

> 'I had a passing acquaintance with the private secretary to Prince Philip so wrote to him asking whether there was any possibility that our members might benefit from a visit

by our patron just once during the duration of their professional career. An immediate acceptance was received.

'In order to maximise the exposure I invited HRH to chair the AGM. He accepted, but the palace demanded that any proceedings be scripted and approved prior to the meeting. So, we had to send in for approval the reports of the President, and the several committees, and there was to be no discussion.

'The meeting being concluded, the members and spouses and staff hastily proceeded to the main hall where Helen had organised everyone in prearranged groups with a leader to present them. As we walked toward the Edward Lumley Hall, Prince Philip caught sight of the assembled throng and appeared not to have been briefed that he was to meet us all, though it had been previously agreed. He said 'do I really have to meet all those people?' I affirmed that this was hoped for and he acceded.

'Afterwards we walked to the door of the College where HRH, his private secretary and I stood, to my astonishment, chatting for about twenty minutes on a variety of subjects from plastic surgery, to carriage driving, to hunting, to development of surgery in developing countries. He left in his personal 'black cab' (which was actually green in colour).'

We were honoured that Prince Philip also came to the Association dinner in 2002 during the Presidency of Mr Michael Brough. Confirmation of this event was received in July 2002, on the day of his 60th birthday, and he was notified at the summer meeting Association dinner on a

HRH Prince Philip with Roy Sanders

Left to right: Michael Brough, RCS President Sir Peter Morris, HRH Prince Philip, Gus McGrouther

Everyone knows who controls the strings. Courtesy of Roy Sanders

boat sailing down the Thames to the sound of the greatest plastic surgery band of all time, 'Tuck That' – the guitarist looking very fit and handsome in a bandana.

While Michael was overjoyed at this forthcoming prestigious event, the office was not as happy with the increase in work that ensued. Much correspondence and liaison with Buckingham Palace was involved. Sniffer dogs toured the lecture theatre and we efficiently managed to then lock the AV staff inside and lost the key. A replacement key was found as the patron arrived, and we hustled 300 people rapidly into their seats. Gus McGrouther delivered a thought-provoking McIndoe Lecture entitled *The Redefinition of Plastic Surgery*, before guests sat down to a splendid dinner in the Edward Lumley Hall. Prince Philip delivered an excellent speech, written himself. The great and good of British surgery had a charming evening.

Michael had enjoyed extending invitations to all and sundry right up until 5pm on the day of the event, at which time he was banned from the office to allow the seating plan to be finalised, resulting in the local printing company staying open late especially to print 500 copies.They were still warm when they were distributed. The Secretariat staff collapsed with exhaustion at 1am.

I type this the day after I received a text from the current President on his departure from the Buckingham Palace Garden Party, which he had attended with Barbara Jemec. Both of them enjoyed being presented to our patron.

British plastic surgery and the many wonderful people associated with it have been a huge part of my life and my career. I hope I am around enjoying retirement to read the next 30 years published in 2046, when I will be 89!

Professional standards

Introduction

The past 30 years have seen unprecedented changes in society, both in the United Kingdom and throughout the world. That these should have affected the practice of medicine profoundly perhaps goes without saying. When reflecting on such change, it must first be understood that any historical summary will at best be but part of the whole truth, and will also inevitably reflect the perspective of those now charged with recording events. Hindsight is a superb mechanism for distorting the reality of circumstances that confronted those responsible for leading organisations and professions, and the decisions that were made. Thus this short piece is an attempt to summarise simply a few of the affairs that have dominated the thinking of BAPRAS over the past three decades, and show how difficult it has been for our small Association to represent fully the maintenance of the highest standard of practice possible in the UK and – where we have influence – beyond our borders.

Background

Alongside enormous global events, the British medical establishment was beset by major enquiries into specific affairs that were to change the face of practice for ever. The implications of Shipman's crimes, the Alder Hey body parts investigation, and most importantly of all, the outcome of Ian Kennedy's report into Bristol paediatric cardiac surgical services were all to shift the focus of healthcare provision irrevocably. These much-needed changes urged a wholly patient-orientated system that rejected the established paternalistic approach characteristic of so many service providers – the consultant establishment not the least among them. Accountability, monitoring and measurement of performance and outcomes, structured training and the introduction of new techniques or ideas, and true empowerment of patients extending to far more than informed consent were accompanied by cogent demands for better health service management and increased expenditure. There thus began a sea-change in UK health service provision that has generated a system that has little resemblance to that instituted after 1948 – the system in which I was trained and which had more in common to that portrayed in the highly popular film *Doctor in the House* than anything our medical students of today would recognise.

This veritable avalanche of change brought with it the need for clinicians across all service sectors to embrace a change of culture that would include a great expansion in numbers of consultants and impose regulatory processes that would beggar the belief of previous generations. Of course, our forebears were subject to the rules imposed by the GMC and NHS at its inception, but so long as they maintained a rigorous divide between NHS and private practice, and adhered closely to the prohibition of the '5 As' (alcohol, addiction, advertising, adultery and 'asylum') they had considerable liberty to practice as best suited them. Transgression of any of those areas, of course, would bring the full weight of the GMC to bear – as was felt by the unfortunate leaders of BAPS in the early 1960s when the inadvertent distribution of membership lists to the public and press led to a major investigation that could have meant erasure from the register of seven senior London members (see chapter 11 of the previous BAPS history book for a fascinating description of this episode).

The subject of how the practice of plastic surgery should be delivered became ever more important. Medical litigation was on the increase and surgical decisions were being challenged. Chris Ward, when chairman of the Ethical and Constitutional Committee in 1993, as part of his MA thesis, wrote eight essays on ethics relating to the practice of plastic surgery. These were printed in a single volume and covered such subjects as consent, rationing, teaching, advertising and the legal aspect of foetal surgery.

The leadership of the royal colleges (which have always retained much statutory responsibility for medical standard setting and examination within UK law under Privy Council authority) and the designated specialty associations had to come to terms with a never-ending stream of new processes. Inevitably that was in addition to the usual steady influx of matters requiring attention. The structure of BAPS Council and its officers would become increasingly stretched throughout the coming decades. Even such a simple matter as increased membership brought with it a commensurate added workload not only to the Secretariat, but also for those attempting to lead the Association in simply having an adequate grasp on what was happening and where. Alongside these national changes, the government was engaged in a string of reorganisations, which required support and information from the specialty associations.

In this light, it is almost impossible to adequately track the changes that have been made in BAPS/BAPRAS during the past years that have enabled plastic surgery not only to flourish in our nation, but also to serve first and foremost the interests of patients, alongside representing the interests of our members. Instead this short chapter will now touch on several of the more important initiatives that have transformed the Association into its current shape, and hopefully have left it equipped and able to negotiate yet further changes ahead. The Ethical and Constitutional (E&C) Committee of BAPS was the principal group that dealt with such overarching matters, while the Service and Development Committee engaged with the ever-pressing demands of a changing health service along with the remarkable developments in plastic surgical techniques at the end of the 20th century.

A change of name and profile

BAPS had, for several years, been contemplating including the word 'aesthetic' in its title in order to represent better the spectrum of work rightly within the remit of the membership. BAAPS had been formed in the early 1980s as a subspecialty group in order properly to reflect and develop the burgeoning field of cosmetic surgery with a firm grasp on best practice and the highest standards. However, the pace of change surrounding the whole specialty created an urgent feeling that the external profile of the Association needed to change. In 1993 the E&C committee minuted:

> 'Given the uncertainty about the precise nature of any relationship between BAPS and BAAPS, no immediate changes are anticipated (in the constitution) with the exception of the introduction of the word 'aesthetic' within the title of the Association.'

The matter was not pursued with a great deal of vigour until the early part of this century, as has been discussed in chapter 1.

Constitutional change

All organisations require a formal description of their rationale for existence and remit for activity, and clear detail of their structure and operating processes. BAPS had been founded in times that many might look back to with a degree of longing for the relative simplicity and tacit assumptions that were enshrined in the founding articles. Society had moved on however, and by the early 90s, the E&C committee had welcomed a thorough revision of the constitution written by the then-chairman Michael Black.

In the first decade of the new century it became evident once again that numerous aspects of the constitution were not fit for purpose, and that among other matters, they left the Association vulnerable to serious legal challenge and financial risk. The intricacies and difficulties that were encountered in achieving this are described in detail in chapter 3.

The need for a carefully defined code of practice had become more urgent in the light of changes in GMC regulation. The whole area of advertising had changed dramatically, and this had a direct effect on what could be included on curriculum vitae. Social media promotion of activities was also developing, and the degree of liberalisation of information flow into the public domain was creating some degree of tension within the membership of BAPRAS.

Incidences of operations being offered as prizes in competitions in magazines that would potentially be read by vulnerable individuals, distasteful advertisements for practices – with which

some members were closely involved – and conflicts of interest between members and commercial organisations were all felt to be matters that could bring the Association into disrepute and reflect very poor standards to the wider patient group it stands to defend.

The new code, introduced in 2012–13, gave BAPRAS a well-defined framework for practice that would be expected of all members. It has generated much debate. A balance had to be achieved between defending the best interests of the public at large (including standard setting, development of services, advisory work and so forth), and representing the best interests of the members of the Association. Within the UK statutory structure, BAPRAS is recognised as being the definitive representative body for plastic surgery. However, as it is a voluntary membership organisation, its members understandably expect a significant degree of attention to be devoted toward their support and wellbeing. It can frequently appear that the efforts required to fulfill the many statutory requests from the Department of Health and others for information or guidance are irrelevant to the membership. However, much that has been done to develop plastic surgery in the past decades relates directly to initiatives created and supported by BAPRAS – including major national audits of outcomes, the establishment of the register of major flap procedures, the development of patient advisory booklets and website pages and the running of major training courses and meetings.

Coding and plastic surgery

Another defining aspect of late-20th-century management of organisations has been the intense focus on using measurable factors in processes as a means of determining performance and supporting subsequent improvement through change. Surgery, and our specialty within it, has not been immune to such drives, and the need to measure what we do, who does it and where it is done has assumed a great degree of urgency. (Perhaps regrettably, the old dictum attributed to Voltaire – 'not everything that matters can be measured and not everything that can be measured matters' – has mostly been forgotten in this onslaught of management by numbers, which may be fuelled largely by the prevalence of computing power).

For our work to be measured reliably, it is imperative to have accurate and appropriately determined codes not only for pathology (which is comprehensively addressed by the WHO International Classification of Diseases) but also the procedures – codes for which have historically lagged far behind contemporary practice. Several BAPS/BAPRAS members have laboured long and hard over past decades to attempt to reform the coding of procedures within our specialty. The most lasting impact of such effort has been the revised 'Lexicon of Codes' that was generated during the presidency of Simon Kay, and which was adopted in the first national database of procedures – termed the eLogbook – developed jointly by the four royal colleges of surgery.

This work followed several iterations of procedure recording that had been developed to manage the need for evaluation of the activity of trainee surgeons by the specialty advisory committee in the 1990s. The common agreement that most procedures are now adequately described in the eLogbook output has helped document activity better, but much remains to be done to harmonise our data with that collected by the DoH in England and Wales as Hospital Episodes Statistics data – on which much future funding and attribution of work depends.

Membership debate

As seen in David Coleman's chapter on the changes in the constitution, toil and tears have been expended on the subject of membership of our Association for as long as any can recall. Tension arises from the honorable objective of maintaining standards of surgical care by ensuring a certain standard of achievement and standing before entry to the group, alongside the need to avoid creating an exclusive 'in-crowd' club that refuses to acknowledge diversity in acceptable practice. Membership categories have evolved over the years to ensure that full members of BAPRAS have reached a standard that assumes the right to independent practice in the UK, along with carefully determined requirements devised to ensure that such membership can be understood by the public as trustworthy and acceptable. The Association has never had any remit to 'police' the specialty for incompetence or poor practice or behaviour. Such activity falls squarely within the realm of the GMC and hospital authorities. However, when any individual is sanctioned by one or other of those, the Association is obliged to act appropriately to ensure that membership is not perpetuated unthinkingly, so that the public can be sure that membership indicates a certain level of ability.

Medical indemnity

Perhaps one of the most significant changes within surgical practice over the period covered by this article is the sea change in litigation that has followed, as surely as night follows day, the profound loss of trust in the medical profession. This escalation of litigation became evident in the 1980s (and was described by the BMA at the time as 'astronomic') and led to the introduction of a scheme within the NHS to cover indemnity costs for cases within its remit and related to NHS employee activity. That in itself followed a major climb-down by the medical profession, which had hitherto refused such proposals for fear of loss of professional independence. The NHS Litigation Authority scheme came into force on 1 January 1990, and delivered what must now be seen as an essential protection for NHS practitioners whose defence subscriptions would otherwise have been punitively high.

However, the inexorable rise in accusations of clinical negligence, along with a concurrent rise in practitioners being referred to the GMC regulatory body for fitness-to-practise allegations, led to a surge in demand for support from the long-established medical protection mutual societies – the MPS, MDU, and MDDUS. While only dealing with cases from private practice and personal regulatory authority concerns, these organisations began to have major problems managing the cost of case settlement and management.

In a short period of time, these so-called 'mutuals' began to reorganise their structure of indemnity provision, and this reorganisation was most evident in the introduction of differential fees for specialty areas with grossly different litigation risks. It is not difficult to imagine why plastic surgery (more particularly the aesthetic elements) should have found itself towards the top of the risk evaluation for both number and cost of cases. Alongside these new fees, the MDU withdrew from most international markets to focus entirely on the UK and Ireland – and latterly even withdrew wholly from the Irish market as well. The MPS remained international but made significant changes to its management of the market.

Throughout the 1990s and following decade, subscriptions for private practitioners in plastic surgery undertaking cosmetic work had reached staggering levels. These truly related to the absolute cost of such indemnification, and reflected similar changes in some other specialties (such as obstetrics and spinal neurosurgery) where the expenditure almost exceeded income from a practice.

As the situation deteriorated, a group of senior members associated with BAPRAS approached Council to see how the Association might assist the membership with this difficult situation. As a purely voluntary organisation under charitable articles, BAPRAS is not permitted to become engaged as a representative body for employment or financial negotiations, and (increasingly) has to set clear boundaries within which it can offer advice and support best practice. As such, the Professional Standards Committee (PSC) was not able to deliver a structured review of available indemnity providers with comment on their respective benefits and disadvantages, as some members had requested. The Association was even prevented from holding a head-to-head debate at the winter meeting between the main established providers and representatives of a nascent new organisation being formed to deal specifically with plastic surgical indemnity. This was due to the strict rules applying to company law and presentations of services within a commercially sensitive context.

Following robust debate among the PSC and within Council, BAPRAS agreed to adopt a broadly supportive stance towards the formation of PRASIS – a new indemnity company established by two former employees of the MPS and chaired by Council member Mark Henley. Several other Council members and a past BAPRAS President, Eric Freedlander, also joined the board of PRASIS, which nevertheless remained, wholly independent and with a firm 'Chinese wall'

between it and BAPRAS. PRASIS aimed to use a carefully directed focus on the specialty alone, along with an ethos that furthered a significant reduction in fees for evidence of proper training and good continuing practice – acknowledging the feelings that many members had voiced in favour of some form of 'no claims discount'. PRASIS remains an established company, with Mark Henley, who is finishing the term of his office at the end of 2016, having devoted enormous energy in its development.

The indemnity conundrum in the UK remains enormous, however, and fees continue to be almost prohibitively high for many with small to medium-sized private practices. No-fault compensation schemes remain unpopular with the mutual societies who are considering this problem, since they are seen to be frequently unsupportive of individuals and still need the option of litigation for claimants with genuine needs to be supported. The solution promoted by the mutuals is for robust governmental action to address the levels of settlement with robust statutory change across all areas of healthcare. Whether this is taken up in the near future is in doubt, but until it does, ever more members will find it impossible to run private practice at a sensible margin, and the NHS will continue to suffer the disastrous financial consequences of massive crown indemnity provision. BAPRAS has attempted to warn members of the dangers inherent in running to low-cost insurance providers (which are legally acceptable within GMC regulations) and especially of taking 'claims made' policies, which carry a greater risk of lack of cover at the time a claim is actually filed.

Complaints

Along with the increase in litigation from patients towards surgeons, medical practices throughout the world have seen a rise in complaints from and towards surgeons and provider institutions, between individuals and trainers, and relating to just about any matter that generates dissatisfaction. BAPRAS has not been immune to such feelings, and the Code of Practice was developed to establish something of a framework for setting standards that the public could realistically expect of high-quality plastic surgeons. While always difficult to enforce, these have been helpful when complaints have arisen about dreadful advertising, misuse of titles by self-promoting members and the encroachment of invidious financial methods into the promotion of aspects of surgical practice.

The Association has also encountered several highly complex areas of complaint that were managed without additional cost to the membership under the terms of a charitable association insurance policy that Christopher Walker presciently arranged and negotiated while he was Treasurer and President. Along with skilled support from our legal advisers and accountants, BAPRAS has weathered many a storm and remained able to support patients and members in promoting the best care over the past few decades. We are grateful for those mentioned

and many others whose thoughtful management and wisdom has enabled such a course to be steered.

PIP implants and cosmetic surgical regulation

The final episode to mention in this chapter will be well known to all those in plastic surgical practice worldwide in the past decade. A French businessman developed and heavily promoted a silicone gel breast implant range under the brand 'Poly Implant Prothèse' from 1991. After suffering some loss of market share, he changed his use of medical grade silicone filler to a similar but industrial-grade product in 2001. With sharp market practices and sales promotion, the PIP implants were used throughout the world in large numbers, but with time, major deficiencies in the product became evident. These were an especially high rupture rate of the shell, and an unusual appearance of the filling material when ruptured implants were explored.

Towards the close of 2011, the extent of use of these faulty devices became known, along with a torrent of complaints from patients who were suffering from a diverse range of symptoms and signs. The media furore erupted just after Christmas of 2011, and raged unabated for the following year. I had extensive discussions with the Medical Director of the NHS, Sir Bruce Keogh, at that time, and he rapidly put together an expert advisory group to manage the crisis. Available evidence on the extent of implant use in the UK was very poor, as well any valid scientific data on outcomes or complications. Toxicology was also poorly understood, and the advisory group convened had the highest level of expertise available across all disciplines at the time.

In the midst of the crisis, the French regulatory authorities issued advice to all women who had had such devices implanted to have them removed. Keogh's group elected to spend longer accruing whatever data could be obtained on the devices, and together with superb statistical assistance from Professor David Spiegelhalter managed to establish a more accurate picture of the extent of the problem that had emanated from any other country addressing the problem. Along with the best toxicological advice available, all associations working alongside the government group were able to offer important reassurance and detailed advice to affected women.

I worked alongside the incoming President, Richard Milner, on the Keogh group to draft detailed advice for patients, GPs and our membership. Alongside what has been an exceptionally long process for dealing properly with a major public health crisis, the woeful lack of proper governance of the burgeoning cosmetic surgical 'industry' exposed major failings on the part of of the government as well as unscrupulous practices amongst providers. The demise of the ill-fated BAPS breast implant registry some time ago (it was badly designed and unable to manage data properly, which eventually necessitated the destruction of the entire dataset) left the nation

with no handle on what was being done, and where and by whom. In addition, a major attempt to establish some more robust regulation of cosmetic surgery a decade previously by BAPS and BAAPS leaders had sadly come to naught.

Keogh, with Simon Withey from BAAPS, then established a smaller group representing all of plastic surgery. That group reported their review in 2013, and the government endorsed all the recommendations in early 2014. Keogh's report recommended the following:

- The Royal College of Surgeons of England was to set up an interspecialty committee to ensure standards for cosmetic surgery and to work with the General Medical Council on a code of ethical conduct.
- Health Education England were to lead a review of training for providers of some non-surgical procedures, such as botulinum toxin and dermal filler injections.
- A breast implant registry should be created to reassure women that if problems arise they can be contacted, kept informed and called in for treatment if necessary.

Throughout these protracted deliberations, BAPRAS has been closely involved – most recently with the close support of the first two-year Presidents Graeme Perks (2013–14) and Nigel Mercer (2015–16). The outworking of each of the proposals is hotly awaited. As of writing, it would appear that some form of credentialing for cosmetic practice will be established as mandatory within the foreseeable future. A trial implant registry has already been established although implementation has already been watered down somewhat by the refusal to make compliance mandatory.

This whole episode, unfinished business as yet, serves to illustrate the complexity that good, robust, but fair regulation presents to all involved in crafting it. It also emphasises the necessity for close cooperation between the professions that establish and maintain standards of best practice, and the government that has the wherewithal to enact enforcing legislation. Such matters will not be the last, and future generations of specialty association leaders will require ever-more-detailed professional guidance and training if a better route is to be established for best patient care and surgical life.

Concluding note

A chapter on how BAPS/BAPRAS has worked to maintain and develop professional standards over the past 30-plus years would be only half complete without mention of the immeasurable contribution that Helen Roberts has made to the specialty in the UK and Ireland. From her initial nominal role as 'Secretariat Manager', Helen has exercised extraordinary care and diligence as she worked alongside numerous presidents and officers bringing with them assorted ideas

and enthusiasms, as well as the potential to wreak havoc. In reality she has been the CEO and chief overseer of the wellbeing of our Association – and also of individual members through countless deliberations, crises and achievements. The impact of such personal care can never be counted or detailed, but is frankly priceless to a degree of which most members will never have any cognisance whatsoever. By way of this note, I want to offer my personal thanks to Helen, as well as speak on behalf of members and colleagues past and present, for all she has done to make our national organisation one of integrity, great care and authority, and on that is internationally respected. Trust and reliability are the result of long hard work and can be destroyed in an instant. For your close attention to the banana skins as well as supporting your leaders and Council for so long, Helen: we salute you.

Towards the regulation of cosmetic surgery

The Royal College of Surgeons Cosmetic Interspecialty Committee has defined cosmetic surgery as 'Operations or other procedures that revise or change the appearance, colour, texture, structure, or position of bodily features, to achieve what patients perceive to be more desirable'.

The 2014 *Government Response to the Review of the Regulation of Cosmetic Interventions*[1] by Sir Bruce Keogh stated that cosmetic interventions were a booming business in the UK, worth £2.3 billion in 2010 and estimated to rise to £3.6 billion by 2015.

Sir Benjamin Rank observed in 1971 that although the line of demarcation between normal and abnormal is not clear cut, the techniques of aesthetic surgery should be skilfully and artistically applied to selected patients. 'This is a field of high scientific, technical, artistic and personal expertise. It is a realm of difficult decisions and great responsibility to all plastic surgeons if it is not to become the province of the market place'. He could not have foreseen that there would be a surgical marketplace of this magnitude, supported by an industry, and driven by commercial pressures.

Specialist training and registration

Cosmetic surgery is not a recognised surgical specialty under Schedule II of the European Specialist Medical Qualifications Order, 1995.

There is currently no UK specialist qualification in cosmetic surgery, and there are no proposals to establish a training scheme leading to a new specialist Certificate of Completion of Training (CCT), although the General Medical Council has stated: 'Doctors undertaking cosmetic

1 Department of Health. *Government Response to the Review of the Regulation of Cosmetic Interventions*. DoH; 2014.

procedures must be competent to do so, and a list of such doctors with confirmed competencies should be maintained by a responsible body', though it did not define *which* responsible body.

Attempts to secure formal recognition for a distinct specialty, with a structure for training, assessment and infrastructure, governed by a specialty advisory committee, have failed because of the need to change primary legislation, and the cost of introducing such change.

In 2005 the Postgraduate Medical Education Training Board (PMETB) assumed the roles previously carried out by the Specialist Training Authority (STA) under the provisions of the General and Specialist Medical Practice Order 2003, which specified the categories of doctors eligible for entry to the Specialist Register. Surgeons seeking specialist registration had to demonstrate that their past specialist training and/or qualifications met the present standards required for the award of a CCT.

UK legislation affecting cosmetic provision

The fifth report of the Health Select Committee on the regulation of private and other independent healthcare, published in 1999, and the Care Standards Act 2000 affected cosmetic provision.

Standard A 4.2 stipulated that:

> All practitioners working independently in private practice must be on the Specialist Register of the GMC, or if undertaking cosmetic surgery before 1 April 2002, have completed basic medical/surgical training, had specialist training in procedures provided, maintain records and undertake regular patient satisfaction surveys.

Standard A 26.1 further stated that:

> Surgeons performing cosmetic surgery procedures must belong to a relevant professional organisation, which provides continuing medical education and adheres to the principles of the GMC's *Good Medical Practice*.

Practitioners entitled to practise cosmetic surgery

The Care Standards Act 2000 granted entitlement to perform cosmetic surgery to three groups of surgeons:

1. Surgeons who have completed recognised training and passed the Intercollegiate Specialty Fellowship Examination (PMETB).
2. European surgeons who hold the CESR (Certificate of Eligibility for Specialist Registration) (GMC).
3. Surgeons who were practising cosmetic surgery in the UK before 1 April 2002.

An original provision in the first draft included the requirement that practitioners should also be members of a professional association such as the British Association of Plastic Surgeons (BAPS) or the British Association of Aesthetic Plastic Surgeons (BAAPS).

The act was challenged in the European court by some 60 practitioners who did not possess CCT, CESR or specialist regulation (as in groups 1 and 2) but who were in established cosmetic surgery practice on the grounds that they would otherwise have been unfairly deprived of a living. They were allowed to continue in practice (group 3). A list of all practitioners was to be held by the GMC.

That successful legal challenge made authorised bodies, such as colleges and the GMC, reluctant to hold lists of authorised practitioners for fear of legal challenges.

Cosmetic surgery providers

The Care Quality Commission was charged with registering and inspecting independent clinics and hospitals providing cosmetic surgery, or providing treatments using lasers and intense pulsed light, in order to help ensure that patients were treated safely and to reduce the risk of poor practice. It was made a criminal offence to carry out regulated activities without being registered, and providers who failed to register would be open to prosecution. In addition, consultants with hospital practising privileges working purely privately without any NHS affiliation were personally affected, whether working as sole traders, in partnership, or as a limited company.

Compliance of providers

The effectiveness of current regulation was reviewed in the 2010 NCEPOD report *Cosmetic Surgery: On the Face of It* (on which two directors of the Academy of British Cosmetic Practice [ABCP] served as advisors).

It investigated policies surrounding advertising and consent, the structure and case-mix of teams providing cosmetic surgery, the number and types of procedures performed, postoperative follow-up policies, facilities and protocols, patient records, and clinical audit.

A significant finding was that only 32% of 212 providers responded to requests for audit returns, despite their legal obligation to do so. Thus, the regulations that existed were not effective and had not been enforced.

Standards and safety

In 2001 Sir Liam Donaldson, Chief Medical Officer, raised concerns about quality standards, variable surgical outcomes and the safety of patients undergoing cosmetic surgery. He also highlighted again the lack of formal cosmetic surgery training in the UK. The Cosmetic Surgery Interspecialty Committee (CSIC) was established, initially under the chairmanship of Sir John Temple, then under Professor John Lowry. The committee found that cosmetic procedures were delivered by a variety of providers, that there was a lack of regulation of practitioners and premises, and that most independent sector care was delivered unsupervised.

Following the publication of the report by the Healthcare Commission, *The Provision of Cosmetic Surgery in England,* and the report of the expert group on the regulation of cosmetic surgery[2] in January 2005, it was recommended that there should be:

- Enhanced standards for professional development and accountability.
- Regulation of non-surgical cosmetic procedures.
- Improved public education.

In responding to both reports, on the day that they were launched, Sir Liam Donaldson accepted all the recommendations and committed to ensuring proper protection for the safety of patients by improving training, regulation and information. The Department of Health committed to:

- Ensuring that facilities where botulinum toxins are injected were licensed with the Healthcare Commission and therefore subject to its regulations.
- Ensuring that all cosmetic surgeons and nurses provided details of their qualifications, registration, membership of professional organisations, and other medical training and education to potential and actual patients.
- Ensuring consistent enforcement of current legislation and regulation governing the use of lasers and that every facility defined in the legislation should be registered with the Healthcare Commission. Laser procedures should be overseen by a doctor and conducted by appropriately trained and qualified practitioners.

2 Department of Health. *Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer*. DoH; 2005.

- Ensuring that the General Medical Council improved the recording and classification of data about complaints so that comparisons can be made between different medical specialties and procedures.
- Reviewing the need and scope for additional regulation of aesthetic fillers and in particular any that contain human tissue, with the Medicines and Healthcare products Regulatory Agency taking into account any forthcoming proposals from the European Commission for the regulation of tissue engineered products.

The Department of Health developed, with support, a comprehensive cosmetic surgery information website, but the other recommendations did not achieve implementation by 2005, as intended.

Implementation

The CSIC was asked to advise on education, training and assessment, national minimum standards, the benchmarking of overseas and peripatetic practitioners, and new technologies. Their report, *Procedure Specific Accreditation and Benchmarking of Practitioners: A Proposed Framework*, was published in February 2007.

It was intended that training in cosmetic surgery procedures was to be implemented through the Joint Committee of Higher Surgical Training, the specialist advisory committees in the recognised surgical specialties and ophthalmology, the intercollegiate specialty boards, postgraduate deans, the Cosmetic Surgery Interface Group, and the Royal College of Surgeons of England Aesthetic Surgery Project Group, and the cosmetic surgery tutor (funded jointly by the RCS and BAPRAS).

However, it became clear that government funding for a new regulatory structure for cosmetic surgery would not be forthcoming, nor would there be parliamentary time for a change in primary legislation to recognise a new specialty of cosmetic surgery, and to put in place a statutory system for regulation of the delivery of cosmetic procedures. A private member's bill, the Cosmetic Surgery (Minimum Standards) Bill 2013, was put forward by Ann Clwyd MP, but without support it failed to progress beyond its first reading.

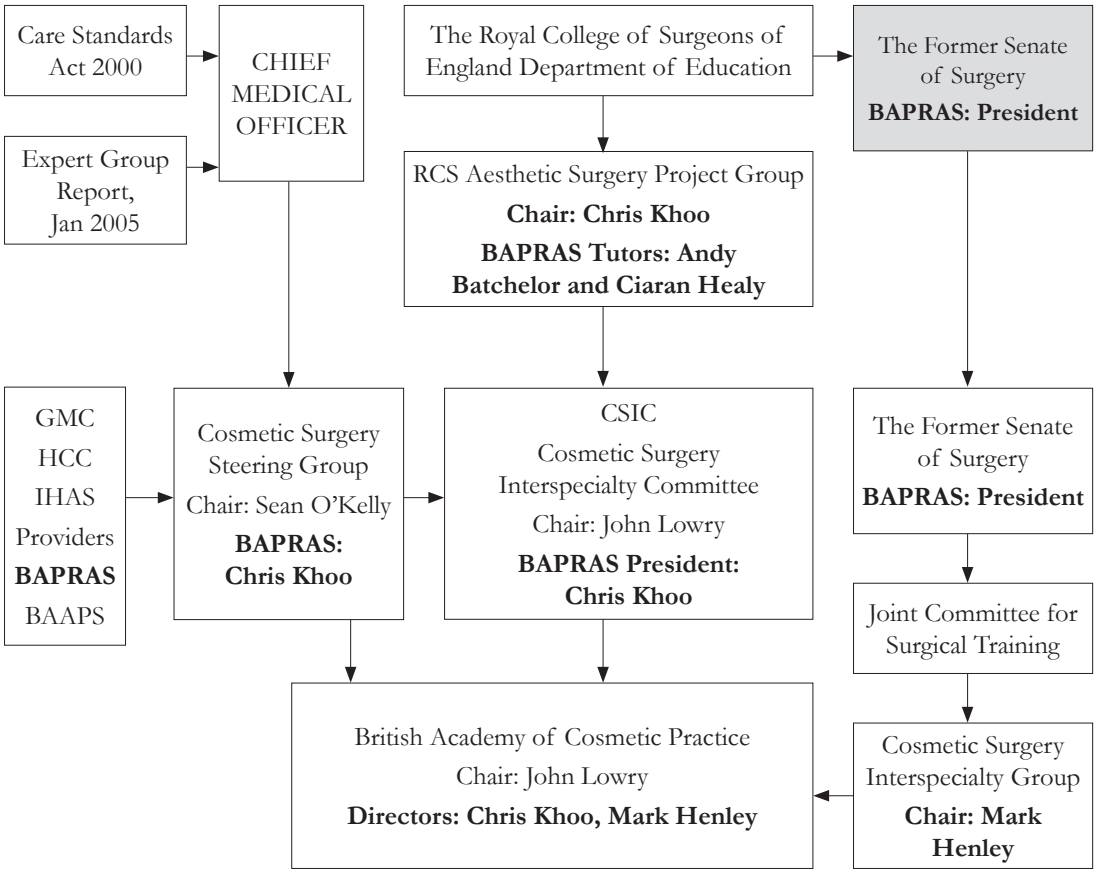
Sets of guidelines have, in the meantime, been issued: The Royal College of Surgeons' *Professional Standards for Cosmetic Practice*[3] in 2013, and the Independent Healthcare Advisory Services' *Good Medical Practice in Cosmetic Surgery*[4] in 2014.

3 The Royal College of Surgeons of England. *Professional Standards for Cosmetic Practice*. London: RCS; 2013.
4 Independent Healthcare Advisory Services. *Good Medical Practice in Cosmetic Surgery*. London: IHAS; 2014.

Attempts at regulation

Despite Sir Liam Donaldson's acceptance of all the recommendations in the 2005 reports, no firm progress was made towards implementing formal regulation of surgical and non-surgical cosmetic treatments. An advisory group, the Cosmetic Surgery Steering Group, was set up to report to the CMO twice a year on progress towards implementation, and to provide advice and evidence on what further action might be needed in the future to secure improved patient safety. The group had a role in liaison, advice, support, overview and strategic planning. It had a role working with the regulators to promote best practice and in supporting robust mechanisms for dealing with malpractice. BAPRAS was represented.

In an attempt to put the 2005 recommendations into action, initiatives included liaison with the Department of Health, the regulators, the colleges, and – through the Independent Healthcare Advisory Service – the commercial providers. There were discussions with PMETB and the GMC about the feasibility of formal accreditation, but after a pilot study this was not found to be a viable option. There were many stakeholders in 2005 in the field of potential cosmetic regulation:



It was recognised that funding constraints, coupled with the lack of willingness to introduce primary legislation to recognise and set up training, assessment and an accreditation structure for a new surgical specialty of cosmetic surgery would mean that formal regulation would be hard, if not impossible, to achieve. It was therefore proposed by the original Cosmetic Surgery Interspecialty Committee and the steering group that a new self-funding voluntary body might be set up to bring together cosmetic practitioners.

The Academy of British Cosmetic Practice

The Academy of British Cosmetic Practice (ABCP) was inaugurated to promote safe and effective cosmetic procedures and was supported by and administered from the offices of BAPRAS at the Royal College of Surgeons. Other founder members are set out in the Appendix. (The British Association of Aesthetic Plastic Surgeons [BAAPS] was initially a founder member but subsequently withdrew.)

The academy set out to:

- Have four chapters of membership for those working in professional cosmetic practice: specialist physicians, specialist surgeons, dentists and nurses.
- Hold a register of members to be admitted to the respective chapters depending on professional qualifications and training.
- Ensure that medical members would comply with professional standards of practice through the self-regulation mechanism then envisaged under the aegis of the Professional Standards Authority for Health and Social Care (PSAHSC).
- Ensure that medical members would undergo annual appraisal of their cosmetic practice, supported by a validated log of clinical activity and evidence of patient satisfaction.

Preliminary arrangements were put in place to make application to the Council for Healthcare Regulatory Excellence (CHRE) for accreditation as the voluntary regulator in the field of cosmetic practice, subject to the Health and Social Care Bill and PSAHSC

The further development of ABCP was overtaken by events relating to the PIP breast implant crisis and the lack of determination by the administration to implement formal organisation of cosmetic treatments, though guidelines for surgical treatments have been issued by the new Royal College of Surgeons Cosmetic Surgery Interspecialty Committee, and for non-surgical treatments by Health Education England, with involvement of and advice from members of the ABCP board.

Formal regulation

Members of BAPRAS have been effective in working personally to advance the cause of cosmetic regulation, through involvement in the expert advisory group of the Department of Health and cosmetic surgery steering committees, the Royal College of Surgeons Aesthetic Surgery Project Group and its Cosmetic Surgery Interspecialty Committees, and BAPRAS Cosmetic Surgery and Independent Healthcare Committees. BAPRAS presidents and officers have had a voice on the councils of the royal colleges, the former Senate, the Surgical Forum and academic bodies such as the Intercollegiate Board, the Joint Committee for Surgical Training, and the SAC, and had been working with other specialist bodies such as the Association of Breast Surgeons and the British Association of Surgical Oncology. The Association has been a supporter of the Academy of British Cosmetic Practice in its attempts to bring together all providers of surgical and non-surgical cosmetic treatments.

While regulation has not been fully achieved, the safety of patients and the attainment of consistently good surgical outcomes remain at the heart of the objectives of BAPRAS in this 'field of high scientific, technical, artistic and personal expertise', as we face difficult decisions with a sense of great responsibility, as Sir Benjamin Rank counselled fully 45 years ago.

From the Editor

This complicated chapter reflects the difficulties and the numerous disappointments that have dogged all attempts by BAPRAS to achieve formal regulation of practitioners providing cosmetic surgery. The diagram of the organisation of UK cosmetic surgery shows the inordinate number of committees (and acronyms) that have been set up in an attempt to resolve the problem. It also shows the immense hard work undertaken by the author to promote a change that might protect the public from inappropriate practitioners.

Appendix

ACADEMY *of* BRITISH COSMETIC PRACTICE

At the British Association of Plastic, Reconstructive and Aesthetic Surgeons
The Royal College of Surgeons, 35–43 Lincoln's Inn Fields, London WC2A 3PE

Board members

Chair: Christopher Khoo
The British Association of Plastic, Reconstructive and Aesthetic Surgeons

Vice Chair: Nairn Wilson CBE
Joint Committee for Postgraduate Training in Dentistry

Secretary: Paul Johnson
British Association of Oral and Maxillofacial Surgeons

Richard Barlow
British Association of Dermatologists, British Cosmetic Dermatology Group

Naresh Joshi
Royal College of Ophthalmologists
British Oculoplastic Surgical Society

Mark Henley
Joint Committee on Surgical Training

Timothy Woolford
ENT UK

Elizabeth Bardolph
Co-opted Nursing Representative

Lay members

Brendan Eley
Chief Executive, the Healing Foundation

Jerry Read
Consultant, Primary Care Commissioning

Registrar: Helen Roberts
Secretariat Manager, the British Association of Plastic, Reconstructive and Aesthetic Surgeons

Consultant expansion

Although plastic surgery remains a relatively small surgical specialty compared with general surgery and orthopaedics, in the last 30 years there has been a very significant increase in consultant numbers across the country. Perhaps considered surprising by those working in 1986, this increase could never have been anticipated by the founding members of BAPS. The increase has been due to several factors.

Before 1989

Prior to the late 1980s district health authorities decided when hospitals could appoint consultants. They were responsible for the process of advertising and interviewing for consultant posts as well as for the issuing of contracts of appointment. Prior to 1989 these health authorities generally did not consider plastic surgery to be a priority and so around the country plastic surgery departments tended to be largely static in terms of numbers of consultant staff. Although unpopular to broadcast, there was at times an unspoken belief that private practice flourished in an economy where demand outstripped supply, and that new posts in a department could mean more competition for what private practice there was. With district and regional health authorities holding the purse strings, hospitals were not encouraged to seek more work. The incentive was lacking. This was about to change.

The 1989 white paper

In 1988, after an unusually difficult time answering questions on problems affecting the health service, Prime Minister Margaret Thatcher announced on the television programme *Panorama* a widespread NHS review. In 1989 the government produced a white paper that was to radically alter the way in which health services could be delivered. The white paper, *Working for patients (NHS reforms)*,[1] proposed a split between purchasers and providers of care, the establishment

1 HM Government. *Working for patients*. London: The Stationery Office; 1989.

of GP fundholders, and a state-financed internal market. In 1990 the National Health Service and Community Care Act became law. As far as the hospital service was concerned the most important change was the plan to introduce a degree of independence to the way that hospitals were run. This was by allowing the establishment of NHS hospital trusts. With the introduction of the internal market those hospitals allowed to become trusts and with responsibility for their own budget had the freedom to actively pursue more activity, competing with others and gaining more income. In turn a trust could appoint new staff, including consultants, if successful delivery of their contracts required this. A new era of consultant expansion had begun.

The scope for increased activity

In the last 30 years plastic surgery procedures in some areas of work have become more complex and therefore more labour intensive. Reconstructive surgery is now frequently carried out in a multidisciplinary team environment with other specialties. Examples of this collaborative work include head and neck reconstructive procedures, breast reconstruction, and reconstruction following lower limb trauma. Microsurgical free flap reconstruction has become the norm in many areas and this has required increased manpower at consultant level.

First-wave trusts

Free from local health authority control, NHS trusts seized the opportunity to determine where and how they wished to increase their activity and workload. As a first-wave NHS trust, the Northern General Hospital in Sheffield became one of the first in the country to pursue its own business plans. If the hospital management agreed with these plans, departments were allowed to advertise for new posts. A fifth plastic surgery consultant post was thus given the go-ahead and the long process of increasing the number of consultants began. From three consultants when the author of this chapter took up post the department has grown to thirteen. This scenario has been repeated around the country as more hospitals became trusts. As it became clear in which areas of the specialty plastic surgeons could increase their work, departments have grown and developed as their income increased.

NHS targets

Even with enthusiastic surgeons and enlightened management there would inevitably have come a time when a business plan based solely on bringing in more work (at times at the expense of competitors) would run out of steam. Fledgling consultant expansion was however given a boost that has lasted until the present day through the adoption of targets within the health service – including the hospital service. When these were first introduced the target was that a

patient should spend no longer than two years on a waiting list before they had to be given a date for surgery. This was then reduced to 18 months, then 12 months. In 2012 the government introduced the target of a maximum 18-week wait for consultant-led treatment. Government-introduced waiting times for cancer treatment also dropped dramatically.

These targets enabled plastic surgery clinical directors to produce plans indicating that these constantly shortening waiting times for treatment (in our specialty's case treatment usually meant surgery) could not be met without an increase in consultant numbers. Because hospitals faced financial penalties if waiting time targets were missed, hospital managers came on board to implement so-called target-driven service delivery, and so expansion of consultant numbers has continued.

Consultant-delivered service

In recent years the government has made it clear that a consultant-delivered service should be the model for the future, rather than a service where treatment was delivered to patients by consultants or by junior staff. This has affected both outpatient clinics and surgery. In outpatient clinics consultants are now expected to see all new referrals, as well as patients with follow-up appointments. Surgical lists previously performed by junior staff have become increasingly uncommon, with more and more lists – both inpatient and outpatient – being carried out on a regularly scheduled basis by consultants. As part of this trend registrar training posts have generally declined in number following a long period of expansion. It was predicted that 30 of the new training posts that had been created in England in 2007 would be lost from 2012 onwards.

How the numbers have grown

All these factors above have resulted in a steady increase in consultant numbers. In the early 1980s there were a little over 100 consultants in the UK. By 2015 that number had grown to over 430. BAPS and now BAPRAS have recommended that there should be 1 plastic surgery consultant per 100,000 population. This requires a continuing increase in manpower. Some regions of the country are now close to this ratio – including London, the north east, Yorkshire and the Humber – but others such as the south east, East Midlands and north west remain closer to 1:200,000 population.

Workforce survey

Our specialty until recent years has struggled with the fact that very little accurate data had been collected at a national level to describe our specialty in terms of numbers of consultants and

trainees. More women were entering the workforce in plastic surgery and those considering part-time work were believed to be on the increase. The number of consultants with subspecialty interests in the different areas of the specialty was unknown. To address this, the first national survey of the specialty in the UK was undertaken in 2010. A questionnaire was sent to each unit where a linkperson had been identified. A 100% return was achieved, due in no small way to the hard work put in by the Workforce Project Coordinator, Sharon Ross, who had been appointed to collect and analyse the returns. The annual survey has continued with every unit participating and has allowed strategically important information to be gathered and collated. This will play an increasing role in negotiations with trusts and commissioning groups as the specialty continues to expand.

Information that is now collected from all the plastic surgery units across the UK includes the following:

- Consultant numbers (headcount and full time equivalents)
- Gender and age breakdown
- Subspecialty interests
- Geographical distribution of posts by region
- Programmed activities worked
- Retirement projections

Information is also collected regarding specialty doctors and trainees.

The next 30 years

In 1990, when first-wave trusts were introduced, the newly established chief executive in the author's trust was under the impression that plastic surgery was unlikely to expand and more likely to contract in terms of activity and manpower. Events certainly proved him wrong. In 2016 the NHS finds itself in severe financial difficulties. Budgets in all specialties will be stretched. Efficiency savings continue to be asked for. However, as the public has become more aware of its rights under the NHS constitution, an ever-higher standard of treatment will be expected from plastic surgeons. Patients will expect more and more of this treatment to be provided directly by consultants. Hospital league tables are becoming more familiar to us all. Performance will be scrutinised in a way not known by our predecessors. Seven-day working is currently high on the government's agenda. Our specialty may not always welcome all these developments, but if we can appreciate that they can be turned to our advantage in driving expansion, then consultant numbers will continue to increase over the next thirty years.

Appendix: Extracts from 'The Way Forward'

BAPS worked closely with NHS Modernisation Agency to provide a comprehensive update on the work of plastic surgeons and the manpower and resources required for the delivery of a plastic surgery service. This culminated in the publication by BAPS in 2003 of a 32-page document *The Way Forward*.

'Executive Summary

The last document on the plastic surgery service within the National Health Service was published in 1994. This document has been compiled to reflect the many changes in the NHS and in the specialty since that time.

The manner in which the service is delivered to patients and the accountability of those delivering that service has radically altered in recent years. The training of surgeons of the future has become much more structured and the trend towards a consultant-based rather than a consultant-led service continues.

The following recommendations are made to improve the service and to provide high quality and efficient treatment for patients throughout the British Isles.

The plastic surgery service should be provided as a managed care network based on the hub and spoke principle.

There should be three levels of regional hub units: regional (approximately 20 consultants); large sub-regional (approximately ten consultants); and small sub-regional (approximately five consultants)

There should be at least an outpatient service to every district general hospital giving locally based universal access to plastic surgery.

There should be one consultant per 100,000 to 125,000 population, which would require at least a doubling of present numbers as well as an increase in medical, nursing and other supporting staff.

Every medical student should be aware of the scope and principles of plastic surgery.

Research in the specialty should be supported, as much of the research originating within the specialty benefits all surgical disciplines.

Plastic Surgery Service Configuration

Plastic, reconstructive and aesthetic surgery should be provided as a managed care network based on the hub and spoke principle as defined in the *Independent Review of the Special Services in London* (HMSO June 1993).

A central hub unit should be based in either a teaching hospital or a large acute hospital. It would be the main base for the work of each consultant. It would contain inpatient beds and theatre facilities and would be the focal point for training juniors. Consultants would visit the spoke unit hospitals for outpatients, and sometimes carry out day surgery work there.

The size of the central hub unit would vary.

A regional unit may have up to twenty consultants. The work may include:

- Comprehensive hand service (trauma, congenital, degenerative)
- Cleft lip and palate service/craniofacial unit
- Burns unit
- Paediatric unit
- Sarcoma service
- Highly specialist work, such as facial palsy

A large sub-regional unit may have up to ten consultants. The work may include:

- Hand trauma service
- Head and neck reconstructive service
- Lower limb acute trauma service

A small sub-regional unit may have up to five consultants. The work may include:

- Breast reconstructive surgery
- Skin cancer with sentinel node service
- Wound management problems, pressure sores
- Normalisation and improvement of appearance, eg deviated nose, prominent ears

The district general hospital (DGH) serving a population of 200,000 to 300,000 was recognised as the basis for emergency and elective services in 1999 by the Joint Consultants Committee (JCC) in the document *Organisation of Acute General Hospital Services*. Each DGH should be serviced by a plastic surgeon with at least a weekly outpatient clinic, where new patients and

follow up patients who had been treated at the hub unit would be seen. The surgeon would be available to visit and advise on any inpatient and may carry out day surgery at this hospital.

Manpower

Consultants

Currently in the UK, there is approximately one consultant plastic surgeon for 280,000 population. It is recommended that there should be at least one per 125,000. (The Senate of The Colleges of Surgeons as quoted in *The Surgical Workforce in the New NHS* have estimated that there should be one per 100,000)

- It is recommended that a one in five on call rota is the most onerous acceptable for providing emergency cover at a single site.
- Accepting the above indicators approximately 600 consultant plastic surgeons are required for the UK.
- A BAPS review in 2000 showed that there were 228 consultant plastic surgeons, 24 non-consultant career posts and 173 specialist registrars. There are less than half the number of consultants currently in post to meet existing needs.
- There are increasing demands for consultant-based service provision including emergency care, teaching and training. Even more consultants will therefore be needed.
- There is an urgent need for consultant numbers in plastic surgery to increase. The current deficit has implications for training of the required future specialists. This training may be compromised by the European Working Time Directive (EWTD) and New Deal for Junior Doctors.

Specialist Registrars

- There are currently 170 SpRs throughout the UK.
- It is recommended there should be 300.
- While SpRs would be committed to plastic surgery there would be scope for them to work in related specialty fields in years five and six.

SHOs and HOs

- There are currently approximately 200 in the UK.
- These posts are popular and there is considerable scope for greater integration in rotations with other surgical specialities.'

There is an urgent need for consultant numbers in plastic surgery to increase.

Resources

Beds

Seven Day Beds

The number of inpatient beds required at the central (hub) unit depends on casemix and the availability of five day and day facilities. Four protected beds per consultant should be a minimum.

Five Day Beds

The efficiency of usage of a five day facility is dependent on the timing of the theatre list during the week. If the list is at the start of the week more complex cases can be operated upon. Five day beds are particularly useful in plastic surgery and at least two per operating session should be available.

Day (or 24 hour) Beds

These are extremely useful in plastic surgery. Over 100,000 operations were carried out using day beds and minor day care facilities in the UK in 2001/02.

Day Care Minor (Ambulatory)

The majority of skin cancers can be removed under local anaesthetic using this facility.

Theatres

Due to the large number of major complex surgery procedures carried out it is recommended that each consultant has one all day operating list each week. In addition to this, each consultant should have one other list which may be a day surgery unit list. Dedicated theatre time must be constantly available for the treatment of emergency cases.'

BAPS service review: Plastic Surgery Cases operated 2001/02

Emergencies 64,796 : Elective 65,850: Day Cases 101,139: Total 231,785

Subsequently the NHS Modernisation Agency Action on Plastic Surgery published *Information for Commissioners of Plastic Surgery Services* to provide guidance on priorities for the commissioning and delivery of plastic surgery services.

Education

The development of the plastic surgery curriculum

By Vivien Lees

The curriculum defines what we do as plastic surgeons and the areas that we ultimately include in our practices. When I was a trainee, the only curriculum or syllabus was a short printed list of topic areas that showed what we needed to cover for our FRCS(Plast) examination. Nothing more formal existed.

Years later, when already a member of the specialist advisory committee (SAC), I happened to overhear a conversation at a professional dinner where two non-plastic surgeons were commenting on our 'weak curriculum'. Suffice to say, I was not best pleased to hear this and was also mindful of the huge efforts that my predecessors had just expended to generate the first version of the Intercollegiate Surgical Curriculum Programme (ISCP) at the time of Modernising Medical Careers.[1] This had been a particularly difficult task in our own speciality, given the sheer breadth of subject matter that had to be covered. Nonetheless, it seemed to me at the time that there was some truth in the comment.

There was a developing gap between what was expected of the newly appointed consultant and what would normally be achieved by the time of CCT (Certificate of Completion of Training). In other words, having fulfilled all the requirements made of them, trainees could still find themselves lacking in certain skills and indeed areas of specialist knowledge. Curricula are usually written from the early years, with more being added for each successive year until the period of training ends. My idea was to reverse this approach and to start with what was wanted of the newly appointed consultant, be this of a specialised or a more generalist nature, and then to work back sequentially towards the early registrar years. It seemed to me this would make clearer what needed to be taught at the beginning of training. In addition, I, and others, felt that there was an over-reliance on fellowships abroad in the final stages of training to generate surgical experience that should have been gained within the UK programmes.

1 Department of Health, Scottish Executive, DHSSPS Northern Ireland, Welsh Assembly Government. *Modernising Medical Careers: the next steps? the future shape of foundation, specialist and general practice training programmes*. London: Department of Health; 2004.

It was agreed that we would use a modular programme that allowed for some optional elements and the development of bespoke practices within the specialty. This approach was quite favoured within educational circles for a wide variety of qualifications, not just surgery. To date the other surgical specialties have not used this approach, but are gradually moving towards this manageable format.

The GMC is legally responsible for the regulation of a specialty, setting the standards for specialty training and providing quality assurance of the delivery of specialty care.[2] I had already been working on the hand surgery curriculum and, having presented our first iteration of this to them, it became clear that the modular format found favour.

However, they wanted it to be applied not just to one section of training, but to the whole of plastic surgery. The workload quadrupled overnight. There was no room for discussion so a team was assembled from within our SAC, and expertise enlisted widely from our professional base to cover the entirety of the specialty. In multiple telephone conference calls we scoped, developed and refined each syllabus area module. The inclusion of patient input was a helpful requirement of the GMC and we were fortunate to have the Changing Faces group work with us. Their organisation has emphasised the importance of the plastic surgery community gaining additional knowledge and skills in the psychosocial aspects of the work we do, to better help our patients.

The curriculum for the final years (ST7 and ST8) was published and went live in August 2012. This is effectively the curriculum for subspecialty development in the two years following success in the FRCS(Plast) examination and corresponds to trainees taking national and international fellowships.

Attention then turned to the next phase of the exercise, which was the intermediate years curriculum (ST3–6 inclusive). It became clear that it was important to do this in concert with the intercollegiate examination board for plastic surgery, to ensure that this curriculum dovetailed with what we as a specialty deemed every plastic surgeon should know and be able to do. This part of the curriculum is effectively the syllabus for FRCS(Plast) and went live in August 2013.

There is more work to be done with the early years curriculum prior to current recruitment to specialty at the national selection interviews. I am pleased to hear of plans for the convergence of the various training interface groups (TIGs). The hand surgery curriculum is already shared and formally adopted by the orthopaedic surgeons, and I believe our curriculum development will be used as the basis for discussion in other specialties and further development of some of those areas, including breast, cleft and head and neck. At the present time, we are the only specialty to have an effective and clearly articulated aesthetic curriculum, which can, if needed, be shared with the relevant modules in our sister specialties. Future developments will include

2 GMC. *Standards for curricula and assessment systems*. GMC; 2010.

some modification around the proposals within *Shape of Training,*[3] as well as the development of the higher profile of trauma work, which again is clearly expressed within specific modules of the different subspecialty areas

Developing an educational foundation

By Joe O'Donoghue

In 2007, the year after the adoption of the new name for the Association, the then-President, Chris Walker, mooted the idea that BAPRAS should consider establishing an educational foundation.

After much discussion at various Council meetings during that year it was agreed that the Educational and Research Committee that was already in existence should be given the task of bringing this idea to fruition.

It was agreed that all educational events should be self-funding and self-supporting. As the new committee Chairman, I held a consultation process with the membership, following which a blended career-long learning approach was felt by the Committee to be the best way that BAPRAS could contribute to the education of fellow professionals from undergraduate to retirement.

It was recognised that plastic surgery was disappearing from the undergraduate curriculum and it was therefore agreed that a series of undergraduate courses be established to increase the exposure of medical students to the speciality. Chris Davis organised the first series of courses in 2008. These proved to be immensely popular and their value was demonstrated in a pedagogic research paper published in *JPRAS*.[4] These courses are still very popular (despite being held at weekends!). They are held in rotation around the country once every nine months, run by consultants and registrars.

At the same time it was recognised there was a dearth of CPD courses covering all aspects of the speciality for trainees and for consultants. With the prospect of revalidation looming, it was agreed that a new series of advanced educational courses be established and held twice yearly. These have been held at the Manchester Conference Centre since 2008 and have been very well attended. The courses are didactic in nature and are aimed at senior trainees and consultants covering all the main subspecialties within plastic surgery. The faculties have consisted of very high-quality UK-based consultants as well some of the best known plastic surgery researchers and educators from Europe, North America and Australasia.

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3 Greenaway D. *The Shape of Training Review: Securing the Future of Excellent Patient Care*. GMC; 2013.

4 Davis C, O'Donoghue J, McPhail J, Green AR. How to improve plastic surgery knowledge, skills and career interest in undergraduates in one day. *Journal of Plastic, Reconstructive and Aesthetic Surgery* 2010; **63:** 1,677–1,681.

In response to the the increasing numbers of nurse specialists, courses have been established for them in skin cancer and oncoplastic breast surgery. More recently these have been run alongside the advanced educational courses, which has allowed for greater educational interaction between the specialist nurses and the surgeons. These courses have also proved to be very successful.

With a new curriculum being developed by the then-Chair of the SAC, Vivien Lees, it was quickly realised that trainees in the middle years preparing for the intercollegiate examination lacked easy access to online educational material. Prior to the new curriculum being approved, funding was obtained from the e-Learning for Healthcare Project at the Department of Health to establish a remote learning tool for trainees in the early years of the speciality. Sarah Pape was appointed as the project lead and *eLPRAS* is now the largest online learning resource in plastic surgery in the world.

In 2010, BAPRAS, represented by Chris Khoo, won the bid in Rhodes to host the 12th quadrennial ESPRAS congress. This was hosted at the Royal College of Surgeons of Edinburgh and the Edinburgh International Conference Centre in July 2014. A major theme of the congress was education, and a week-long series of surgical skills courses at the College was organised by John Scott. Leading faculty members from around the globe contributed to this innovative idea, and the courses were oversubscribed.

Although an educational foundation has yet to be formalised, the building blocks have been in place since 2006. This has more recently included the recognition that research is so important to the speciality that it should have its own committee structure. It was therefore separated from the Educational Committee in 2012.

SRTC to PLASTA

The Senior Registrar's Travelling Club (SRTC) had been established in 1972 and had grown steadily as the numbers of plastic surgery trainees increased. In 1987, there were 18 senior registrars (SRs) recognised in the UK (though there were some 'jobbing' registrars). Senior registrars had trained first in general surgery before obtaining the FRCS, and then, in their final years of surgical training, had completed years as a senior house officer (SHO)and registrar in plastic surgery, before a competitive appointment to senior registrar. This post was not typically an endless contract – the trainee might spend two to three years in post, though some spent longer, prior to obtaining a consultant post. The SRTC would meet on a twice-yearly basis for two to three days, usually over a weekend, and at a different unit each time.

The meetings remained free to attend, and in later years were often supported by sponsorship. Attendance grew steadily from 10 SRs in the earlier periods to more than 30 attendees in the later years. The primary purpose of the meetings was educational, covering topics relevant to pre-consultant trainees, including practical tips on how to become a consultant, how to set up private practice and medico-legal aspects of practice. There were often live demonstrations of operations, performed by a consultant in the hosting unit, covering a wide range of operations both in NHS and private practice. These included demonstrations of complex reconstructions such as free functional muscle transfer and of aesthetic surgery such as rhinoplasty and breast surgery.

There continued to be a substantial social component to the meetings with activities such as clay pigeon shooting at Mount Vernon, white water rafting in Nottingham, horse riding in Dublin, tank driving in Norwich, golfing, sailing and go-karting. Occasionally there were also visits to attractions close to the host unit such as the kissing the Blarney Stone in Ireland, visiting the Black Museum in Scotland Yard, and visiting the Swann-Morton factory and a snuff tobacco factory. The evening dinners varied from formal black tie dinners to more casual surroundings, and usually featured mandatory speeches, jokes and general banter.

The meetings provided not only an educational component but also a forum for senior registrars to network, get to know each other, catch up, share troubles or have a good moan. Ideas on

research projects, notes and tips on fellowships abroad were exchanged. The meetings represented an opportunity to visit the various units in the UK and to gauge future job prospects around the country. Likewise, consultants from hosting units could meet potential future colleagues and candidates.

Changes in training and their impact on the SRTC/PLASTA

The history of the SRTC cannot be told without making reference to the many changes in training. In an effort to improve workforce planning, national training numbers were introduced in the summer of 1989, and these were were attached to senior registrar posts.

The FRCS(Plast) examination was first held in Glasgow in 1986 and was voluntary at its inception. Despite initial apprehension from the SRTC, FRCS(Plast) gained wide acceptance and was made mandatory for CCST in 1993, making plastic surgery the second surgical specialty to do so after orthopaedic surgery. The Ian McGregor Medal was introduced in 1993, and awarded for outstanding performance at the FRCS(Plast) examination.

Surgical training as a whole continued to face challenges with the introduction of the 72-hour working week by the Joint Committee on Higher Surgical Training (UK & Ireland) (JCHST) in 1991. The SRTC contributed to the debate on the potential detrimental impact on training, the need for changes in work practice and the expansion of the 'middle tier' to enable rota designs that would be compliant with the new working hour limit. In addition, there was a recognised increased in service demand, which helped fuel an increase in the number of trainees.

The end of the SR role was heralded by Calman's continuum of training report in 1993[1] and its gradual introduction in 1995. Plastic surgery training would see an introduction of a 'run-through' six-year program along with the new 'specialist registrar' grade (SpR). The SRTC voiced concern and urged caution about implementation of the new training scheme, and continued to provide trainee perspective to the matter. The senior registrar grade was slowly phased out, and in 1996 Ian Whitworth was the last to be appointed to a post at East Grinstead.

SRTC to PLASTA

With the changes in training and increasing numbers of plastic surgery trainees in the late 1990s and early 2000s, the role of the SRTC changed to accommodate the new SpR grade. SRTC membership changed to include SpRs on years five and six, the last two years of training, which

1 Calman K. *Hospital Doctors: Training for the Future*. London: DoH; 1993.

was thought to reflect the previous SR grade. The SRTC continued to organise regular meetings and champion the interests of trainees by providing feedback for the evolving FRCS(Plast) examination, the maintenance of adequate study budgets and leave, and speaking against plans to restrict private practice until after a consultant had been seven years in post. The organisation also helped BAPS with the early plans for a website, and helped them establish an email database of plastic surgery registrars.

As early as March 1996, suggestions had been made to change the nature and the name of the organisation – with the Association of Plastic Surgeons in Training (APST) being very popular. There was also a suggestion in 1997 that there might be a membership subscription for SRTC (£120), but this was never implemented.

It was not until the meeting in December 2003, that the Plastic Surgery Trainees Association (PLASTA) was formally introduced. It would have wider scope to include and represent the interests of trainees at all levels, totalling 150 members at the time. Election onto the committee remained reserved for trainees with a national training number. With the increased membership, the twice-yearly meeting format of SRTC would be unmanageable, and was replaced with a single annual general meeting to be held in conjunction with winter BAPS meetings. PLASTA would only make slight modifications to the existing SRTC logo, keeping the overall design the same.

This transition from SRTC to PLASTA was necessary owing to the changing nature of plastic surgery training, and the loss of the senior registrar training grade. The expansion of trainee numbers led to a loss of informality and some would say camaraderie. The trainee organisation evolved from representing the interests of trainees at the end of their training to encompass trainees at all grades. The issues that required representation were also increasingly wide and varied – from the selection process into the specialty, the challenges and changes to training, exam structure, and the challenges facing post-CCT fellows – requiring formal responses and more professional representation in committees within BAPRAS and external organisations or bodies. With this increase in responsibility there was an increased need for accountability, transparency and democratisation.

With the rise of ubiquitous access to the internet, the PLASTA website was established in 2003, separate from the BAPS website, and remains the mainstay of communication with the PLASTA membership. Email was not as widely used or accessed at the time, and thus the PLASTA online forum was established to allow fast two-way communication between the membership and committee.

PLASTA involvement in medico-politics would increase, as further changes were afoot with the introduction of the European Working Time Directive (EWTD) in 2003 and its gradual implementation over the subsequent years. Not only were trainee numbers increased further

to cope with the new working-hour limits, more changes were planned for the structure and delivery of training in the form of Modernising Medical Careers (MMC) in 2005, preceded by the publication of the Tooke report. Among the changes introduced was the change from CCST to CCT and the failed Medical Training Application System (MTAS) in 2007. PLASTA, with the support of the then newly formed BAPRAS, proved a strong unified voice, speaking against the flawed aspects of MMC and MTAS in conjunction with other organisations. PLASTA worked to resolve the issues around MTAS and secured additional interviews to mitigate the problems that had arisen. During this time online forums provided an outlet for frank discussion and means of quick communication to its 950 listed members (this included all registrars, and senior house officers who were interested in the specialty).

Post-MTAS, PLASTA would continue to play an important role in the inception and implementation of the central interview process for national selection into plastic surgery at ST3 level under the leadership of Wendy Reid, then Lead Dean for plastic surgery. PLASTA also provided the trainee perspective in other important initiatives such as the BAPRAS advanced education courses, ISCP, TIG fellowships and e-LPRAS. PLASTA produced workforce surveys in 2009 and 2011, and a formal 2011 report of trainee numbers and career intentions, to inform and aid in workforce planning in plastic surgery.

Recurring challenges

Through the years, there have been repeated themes and issues that have been managed by successive generations of trainees. As far back as records began, there have been problems with workforce planning and it remains a concern for trainees, with previous reports of a 'bulge' in registrar numbers, mentions of 'stuck' registrars or 'lost tribes', and inadequate consultant jobs all referred to throughout the period of this review. A formal solution to training in aesthetic surgery also remains elusive, with formal discussions on 'inadequate cosmetic training' and the BAAPS training scheme as far back as 1987, to modern day credentialing of cosmetic surgery as outlined by the GMC and CSIC recommendations. Changes to working time restriction (both the 72-hour limit in 1991, then the 48-hour limit in 2003 as per EWTD) repeatedly necessitated increases in the workforce and the way trainee surgeons work. Some would comment that this led to the loss of the 'surgical firm' and the introduction of shift working. New training schemes continue to bring challenges to each successive generation, with 'Continuum of Training', Modernising Medical Careers and more recently Shape of Training. However, these challenges bring forward new methods and concepts such as simulation training and competency based training. Also as patient and employer expectations change, there have been repeated references to increasing the consultant workload, increasing service provision, reduced training time and the erosion of the role of plastic surgery in interface specialties.

SRTC/PLASTA and BAPS/BAPRAS

SRTC/PLASTA has always existed as an independent and separate entity to BAPS/BAPRAS, though they continue to work in close concert. The trainee organisation has always been grateful for the support and guidance provided by BAPRAS Council, who have been forward-thinking and inclusive of trainee views. Presidents of BAPS/BAPRAS would regularly attend and address trainees at the SRTC meetings.

The BAPS trainee membership category was introduced in October 1988. Prior to 1993, an SRTC representative (usually the secretary) had been invited to give verbal reports annually at BAPS Council and was only present for the duration of the report. Topics ranged from reports on SRTC meetings (including numbers), SR visiting schemes and travelling fellowships, comments on the 'new' FRCS structure, and BAPS SHO training schemes and the overseas training diploma scheme.

Increasingly, BAPS Council recognised the need for a trainee voice on Council. In 1993, under the leadership of its then-President Roy Sanders, Ian Taggart became the first senior registrar to have an official seat on BAPS Council. Trainees would increase their involvement in other committees such as the Growth and Development Subcommittee, the Education and Research Subcommittee, the Career Structure Subcommittee and the Editorial Committee of *JPRAS*.

Present-day PLASTA

Today, PLASTA continues to be a source of guidance and help for trainees in plastic surgery as well as aspiring young surgeons, doctors and medical students who are looking to enter the field. The evolution of plastic surgery training is relentless as standards are constantly scrutinised and improved upon to maintain the high quality of the CCT. Still free to join, for all trainees regardless of training level, PLASTA is a resource for information on meetings, courses, jobs (both trainee and consultant level) and opportunities. It aims to help trainees navigate the changing landscape of training and also represent their interests in matters that affect both their current training and future consultant practice.

Communication continues to be a challenge, as PLASTA aims to provide relevant and timely information to the trainee group with a wide variety of subspecialty interests. PLASTA currently provides monthly communication by email to all subscribed members listed on the website. Increasingly, it also uses social media such as Twitter and Facebook. It remains an independent organisation, but works in close concert with BAPRAS. The committee consists of trainees holding national training numbers and has grown in number as the involvement and reach of the organisation has increased.

The current committee consists of:

President	Hawys Lloyd-Hughes
General Secretary and Treasurer	Andreas Shiatis
Education representative	Rachel Clancy
Events and Sponsorship Secretary	James Wokes and Lindsay Shanks
SAC representative	Sherilyn Tay
Research representative	To be advertised
TIG/Fellowship and Global Surgery representative	Richard Thomson
Intercollegiate Board representative	Alexandra Molina
ASiT representative	Ian King

PLASTA continues to represent trainees in plastic surgery on various committees, including:

BAPRAS: Council, Education Committee, Research Committee, Professional Standards Committee, Microsurgery Committee
RSTN (Research Surgery Trials Network)
BFIRST, BSSH and ASiT
Plastic Surgery Specialty Advisory Committee

PLASTA has also contributed to other important initiatives such as the Cosmetic Surgery Interspecialty Committee and through the Royal College of Surgeons of England, has commented on the implementation of *Shape of Training*.

PLASTA currently runs many successful courses aimed at providing pertinent information relating training in the speciality. Among them:

The ST3 Plastics Interview Course

A course that started in 2015 and is held at Chelsea and Westminster Hospital. It provides simulated interview practice, including portfolio advice and personalised feedback, and is run by trainees and consultants familiar with the interview process.

The Imperial PLASTA FRCS(Plast) Course

This course was first introduced in 2015, with experienced consultants providing valuable insight into difficult topics and viva practice.

The Plastic Surgery Trainee Study Day (in conjunction with BAPRAS)

A recent addition to meetings organised by PLASTA, the first trainee day was held in May 2016, providing a forum for trainees to receive help and advice on many aspects of training including information on fellowships (national TIG and overseas fellowships), with talks by both successful candidates and prominent consultants, the FRCS(Plast) examination, with both structure and tips for passing the exam, and a range of peri-CCT topics such as medical reporting, the NHS and cosmetic practice.

Despite having minimal financial support from advertising and collaborations PLASTA provides some financial incentives such as discount on external courses.

PLASTA believes in recognising excellence in plastic surgery training. In 2015, the first PLASTA Golden Scalpel Trainer Award was awarded to Donal Dewar of Leeds Teaching Hospitals for his outstanding contribution to teaching. All nominations were received from trainees and then voted on by the membership. The award will now be awarded annually to continue to foster good training practices.

Looking back and then to the future

Over the last 30 years, the trainee organisation for plastic surgery has changed beyond recognition in response to changes in the way plastic surgeons are trained, the expansion of the speciality, the unforeseen challenges to the medical profession as a whole and the relentless advancement in medicine. But in the natural order of things, everything changes. It has grown from a meeting of a small group of enthusiastic senior trainees to an organisation representing a large and varied body of trainees at any level. PLASTA continues to exist to help trainees and to be a voice for them in various forums and committees, and it hopes to shape and inspire the plastic surgeons of the future.

Secretaries of SRTC

1987 Norman Waterhouse
1989 Simon Knight
1990 Tim Goodacre
1991 Rob Ratcliffe
1992 Ian Taggart
1993 Ian Taggart (on Council)
1994 Peter Hodgkinson

1995 Ken Dunn
1996 David Orr
1997 Ian Whitworth
1998 James McDiarmid
1999 John Scott
2001 Rob Dunn

Presidents of PLASTA

2003 Andy Hart
2005 Vivek Sivarajan
2008 Sofaine Rimouche
2011 Tassi Halka
2012 Adrian Murphy
2015 Hawes Lloyd-Hughes

BAPRAS abroad

It is impossible for me to do justice to all who have contributed to the development of reconstructive surgery abroad within this one chapter. It would take a whole book; in fact it would probably take several books.

Over the last 30 years, BAPRAS members have been involved in a wealth of projects overseas, operating, training and teaching, forging friendships and making a difference to local patients and to our overseas colleagues. Some have relocated their whole families for months, some for years, some have made annual trips to the same place year after year and some have founded national and international organisations to help spread the teachings of plastic reconstructive surgery.

The Overseas Doctors Certification Scheme

This scheme was started in 1987 in order to give surgeons from overseas the opportunity to come to Britain to work in designated units for one year as a senior house officer (SHO) followed by two years, in a different unit, as a registrar. The object was that they would then return home with a BAPS Certificate of Training and be able to pass on their knowledge to local surgeons. The first intake of seven trainees began in July 1987. The scheme initially worked very well but in the mid-1990s, with the onset of Calman training, the development of national training numbers, changes to Home Office immigration rules and because only half the trainees returned home, with some gaining consultant posts in Britain, there were no further intakes after March 1998.

The BAPS Overseas Interest Group (initially the Overseas Aid Group)

In 1996 BAPS Council felt that it would be appropriate to document the work being done by members working abroad. The inaugural meeting of the BAPS Overseas Aid Group met in London on 5 December 1996. Ron Hiles was in the chair, Tim Goodacre was the minute secretary and Howard Stevenson and Charles Viva were also present. Their brief from Council was '… to

gain some knowledge about the various projects involving BAPS surgeons abroad, and reflecting Council's interest in contributing financially to the development of such projects'.

It was felt that Jack Mustarde and Stewart Watson should be invited to join the group. A survey of members would be conducted by questionnaire and the results followed up by telephone.

A second meeting on 24 January 1997 discussed appropriate means of providing assistance to surgeons, and how a rapid response to disasters might be organised. At this meeting it was thought that a less patronising name would be the BAPS Overseas Interest Group (OIG).

A mission statement was written (see appendix), which is as apt today as it was then.

The OIG supported a number of projects over the years, including the Overseas Doctors Certification Scheme. The BAPS/BAPRAS fellowship programme was started, and numerous applications were made to the Home Office to allow surgeons from abroad to come to the UK in order to gain valuable training. Collaboration and connections were forged with the East and West African colleges, Tropical Health amd Education Trust (THET) and Department for International Development (DfID).

Waseem Saeed with patients at the Sumatra earthquake in 2009

The emphasis of BAPRAS overseas involvement has increasingly been on integration with the local surgeons and their communities and furthering locally relevant knowledge. Workshops have been arranged, units established and fellows from abroad have been welcomed in the UK units for weeks or months, as well as attending training courses and gaining targeted training which they can use in their home countries. Without a doubt we have profited from our experiences abroad: it is a two-way communication.

No one ever comes back unmoved; everyone is richer for the experience and humbled by it.

The British Foundation for International Reconstructive Surgery and Training (BFIRST)

In 2012 BFIRST (bfirst.org.uk) was founded as the official overseas charity for BAPRAS.

BFIRST works on an invitational basis from overseas nations and the educational approach is based on discerning the local need by analysing the case mix, designing a unique curriculum for the country and delivering consultant-led training. The Pareto principle is employed in analysing which factors are causing 80% of the problems; BFIRST then presents the host nation with curricula in their chosen subspecialty, from which they in turn can choose relevant chapters, reflecting their local need.

The training is consultant-delivered, but trainees are accompanying us on trips and are a vital asset in logistics, public relations and administrative tasks and we hope by involving them early in their careers to encourage a lifelong responsible involvement in training. By seeing the problems faced abroad they will have a chance to tailor their UK and specialist fellowship training to provide the expert relevant teaching as consultants in resource-poor countries in due course.

The individual progress of the local surgeon is charted using the CanMed[1] assessments, the visiting surgeons are assessed by their hosts, and, using a constant measurable feedback, the training is optimised to deliver the ultimate goal of an independent, self-sufficient unit that no longer needs our input.

BFIRST fellows continue to come to the UK in their chosen subspecialties and make new friends who can then be invited back to their countries. We have funded fellows from Bangladesh, Nepal, Nigeria, Pakistan, Sri Lanka, Iraq, Uzbekistan, Georgia, Ethiopia, Iran, Ghana and more.

With BFIRST, it is hoped that there will, at last, be an official channel to archive, coordinate and

1 The Royal College of Physicians and Surgeons of Canada. *CanMEDS Physician Competency Framework*. RCPSC; 2015.

recognise the different efforts of BAPRAS members for the work they are doing in the many developing countries in the world. Some projects will be directly sponsored by BFIRST but others, already in existence, are offered the chance of being affiliated with BFIRST, in order to share existing expertise and connections.

Africa

Jack Mustarde founded what today has become ReSurge Africa (resurgeafrica.com) after visiting Ghana in 1992. He built and equipped a 73-bed reconstructive plastic surgery and burns centre, with two operating theatres and outpatient consulting rooms, a lecture room and offices in Korle-Bu Teaching Hospital (KBTH), Accra. He also built 32 flats to accommodate nurses working in the centre. Both of these buildings were entirely financed by the charity and, upon completion, were presented to the Ministry of Health in Ghana.

Arthur Morris has been working in KBTH and Komfo Anokye Hospital, Kumasi, since 1994 under the auspices of Jack Mustarde's project.

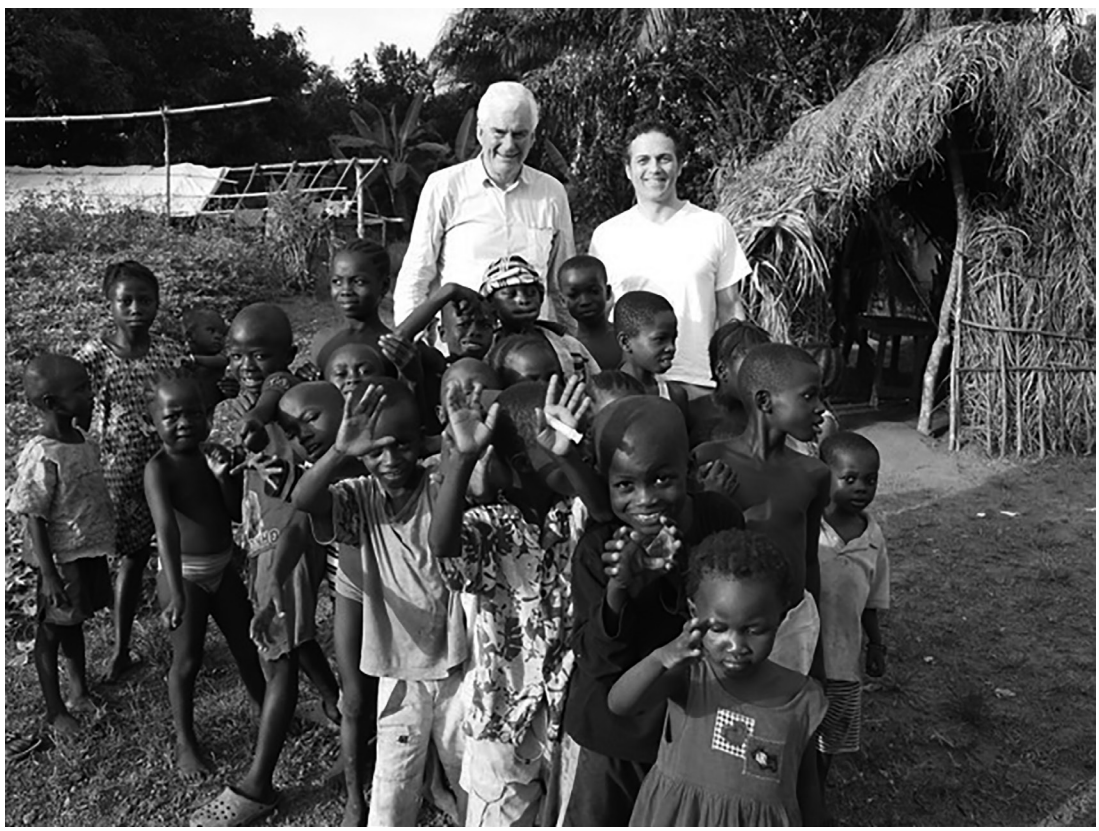
In March 1996, Professor Mustarde had asked him to 'Take Kumasi under his wing' and with introductions to the hospital administrative staff, the department of surgery, Professor Hiadzi and Dr Pius Agbenorku, a young Ghanaian consultant plastic surgeon, he helped to establish a plastic and reconstructive surgery service there. Using a Rotary International matching grant to spearhead funding, the project trained six nurses in Dundee, who returned to work in the newly built Burn Intensive Care Unit, which opened on 1 February 2001, with a similar unit opening in the A&E department in 2004.

The training ReSurge Africa provides in reconstructive plastic surgery follows a specific pattern: the trainees pass their west African fellowship and are then offered a year or so working in an established unit elsewhere (Canniesburn in the UK, Coimbatore in India with Professor Raja Sabapathy, or Groote Schuur Hospital in South Africa). Opoku Ampomah who now leads the Accra centre in KBTH, and others, have also passed the FRCS(Plast) in London.

Now 24 years later there are 15 fully trained Ghanaian plastic surgeons working in the two centres in Accra and Kumasi. Some were trained in the UK, but many were also trained locally by visiting surgeons, notably Chris Bainbridge, who lived in Accra for six months at the beginning of the project and visited again later. Other surgeons who visited to give training included Hiroshi Nikishawa, Patricia Eady, David Dunaway, Margaret Strick, Mike Green, Tony Watson, Barbara Jemec, Catina Bernardis, Ciaran Healy, Odhran Shelley (present Chairman of ReSurge Africa), Ronnie Slater and especially Stuart Watson, who was also involved in the Malawi Burns project and taught on numerous courses, especially on flaps.

Martyn Webster has been instrumental in this achievement in Ghana. He worked tirelessly alongside Jack for many years and was the Chairman, now the Director, of ReSurge Africa.

Since 2009 'papa' Webster, as he is know locally, together with consultant plastic surgeon Albert Paintsil from the KBTH, expanded ReSurge Africa's reach to Sierra Leone, to the Holy Spirit Hospital in Makeni, and funded the training of two Sierra Leoneans at KBTH. Without Martyn, the project would not be where it is today.



Martyn Webster with Scott Brown (an anaesthetist from Oregon) and fans, in Makeni, Sierra Leone

Jimmy James has for years been heavily involved in the East African surgical college. His connection with overseas plastic surgery began with leprosy and reconstructive surgery in Ethiopia at ALERT Addis Ababa in 1973/74, followed by the East African Flying Doctor Service (AMREF). He was appointed Consultant Leprosy and Reconstructive Surgeon with AMREF in Nairobi for four years before returning to the UK, but subsequently worked every year abroad on leave. In 1996 he resigned from the NHS and went to Blantyre, Malawi, as Senior Lecturer in Surgery to run the burns unit (which he helped set up with Howard Stevenson). After five years

there, he became the first Secretary General of the College of Surgeons of East Central and Southern Africa (COSECSA), which accredits suitable training establishments in the region for the membership and fellowship examinations in the various specialties including, plastic surgery.

Howard Stevenson founded the Malawi Burns Trust — which was set up 20 years ago by Ann Gloag, CEO of Stagecoach, following a serious bus crash — and established a 24-bed burns unit in Blantyre Hospital, Malawi. The unit is now locally led with annual input from the UK. Howard also served as the Chair on the BAPRAS Overseas Committee from 2000 to 2002 and is a trustee of BFIRST.

Andrew Hodges and his wife Sarah both worked as doctors in general surgery and anaesthesia at a Church Mission Society (CMS) mission hospital in Kagando, west Uganda between 1992 and 1998, before returning to the UK for Andrew to train as a plastic surgeon and Sarah as an anaesthetist. Towards the end of their time in Uganda, they undertook a comprehensive tour of the country, offering cleft surgery to hundreds of children and adults.

They founded the charity Interface Uganda (www.interfaceuganda.org) in 2001 and returned to Uganda in 2004 to work jointly in the government service at Mulago (Makerere University Hospital) and Mengo (the oldest mission hospital in all of East and Southern Africa). Subsequently, they helped design and open the Comprehensive Rehabilitation Services in Uganda (CoRSU) Hospital in Kampala, which specialises in reconstructive orthopaedic and plastic surgery and rehabilitative care. They continue to work on training programmes for medical staff from Uganda and beyond at CoRSU and Kagando Hospital, in collaboration with Mbarara University Hospital (in south western Uganda), Ghent University and Vancouver University Hospital.

The postgraduate training program in plastic surgery began in 2009 and the first two students graduated in 2012.

Marc Swan is a trustee of Interface Uganda and has developed strong links with the country since first visiting in 2008 – including teaching on the cleft module of the masters programme in plastic surgery based at Mbarara University and CoRSU Hospital, Kampala. He has worked for six months at the Red Cross Children's Hospital in Cape Town and has taught at the Guwahati Comprehensive Cleft Care Centre in Assam, India.

Vik Deveraj has also been working with Interface Uganda since 2001 – not just in Uganda, but also the Democratic Republic of Congo and Rwanda.

Bill Towny visited Uganda at CoRSU in 2015 to teach the module on head and neck in the plastic surgery training rotation.

Tim Goodacre and his wife Kate went to Tanzania in 1983 to work in a mission hospital at Mvumi, near Dodoma in mid-Tanzania. They returned in 1985 for Tim to train in plastic surgery at Mount Vernon Hospital, but Tim maintained his close links with East Africa and beyond. He lectured on developing world surgery on the the Diploma in Tropical Medicine and Hygiene (DTM&H) course at the London School of Hygiene and Tropical Medicine for eight years and in 1992 was invited to visit Uganda with Professor Eldryd Parry's International Health Consortium. He has been an enthusiastic supporter of the plastic surgical capacity-building programme at what is now CoRSU and travelled extensively to support training links, including particular friendships in Pakistan and Palestine.

Tim was included by Ron Hiles in the very first BAPS Overseas Service Subcommittee, and subsequently took over as Chair of the then BAPS Overseas Committee. He now chairs Interface Uganda, is a surgical advisor to the Semiliki Trust and has been a trustee of BFIRST.

David Dunaway started his overseas work in KBTH, Accra, Ghana, and now regularly trains Ethiopian surgeons with Facing Africa (www.facingafrica.org), treating noma in Addis Ababa, with Neil Bulstrode, Hiroshi Nishikawa, Paul Wilson and LeRoux Fourie, with Mark Liddington and Daniel Saleh joining the team in October 2016.

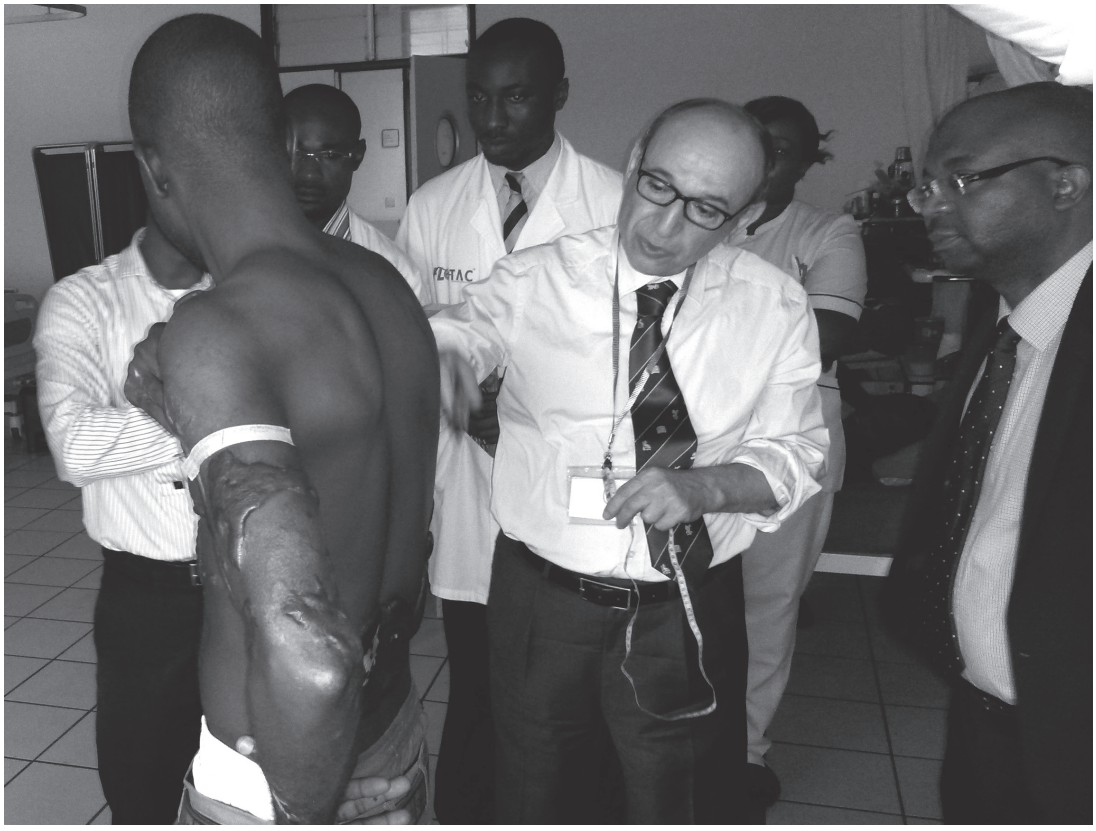
LeRoux Fourie started working with Facing Africa in 2004 in Sokoto, Nigeria, in collaboration with the Dutch Noma Foundation. Since 2007 the team has been operating in Addis Ababa, Ethiopia.

BFIRST fellow and local surgeon **Rashed Ibrahim** arranged the first Nigerian-led burns course in Abuja in October 2015, with Naguib El-Muttardi and David Barnes, in collaboration with the Nigerian Association of Plastic, Reconstructive and Aesthetic Surgery, the Nigerian Burn Injury Society and BFIRST (see image on following page).

Mike Timmons went on assessment missions for UKMed/ODA/DFID to Rwanda and Kenya in the 1990s, and more recently with Tony Redmond and UKMed.

Drew Flemming visits Zimbabwe on an annual basis, with the help of Farida Ali, Mo Akhavani, Jameel Moledina and Alex Molina. He works closely with Professor Godfrey Muguti, Chief of Surgery at the University of Zimbabwe. Two of the local registrars have now been mentored in the unit and have passed the COSECSA plastic surgery exam. St George's Hospital in London is currently hosting one of these senior trainees for a year through the International Medical Graduate Sponsorship Scheme with the Royal College of Surgeons of Edinburgh.

Michael Earley has been working tirelessly with Operation Smile (www.operationsmile.org.uk) since 2003, founding the branch in Ireland with David Orr, who also set up the plastic surgery



Naguib El Muttardi with Abdulrasheed Ibrahim, Abuja, Nigeria, October 2015

centre in Jimma, Ethiopia, with **Per Hall**. Per has been visiting the University Hospital in Jimma with Operation Smile since 2006. Initially working with cleft lip and palate and burns reconstructions, he has supported the university in establishing their own plastic surgery training curriculum and is mentoring three Ethiopian general surgeons as they train outside Ethiopia in Taiwan, India and South Africa. They will return as fully trained plastic, reconstructive, cleft and microsurgeons, thereby establishing a self-sustaining service for south east Ethiopia, serving a population of 15 million people.

Duncan Atherton has worked with Operation Smile in Ethiopia, Cambodia and Madagascar and continues with Norman Waterhouse in Nicaragua and Peru.

Tony Barabas spent four months volunteering in Cape Town working in the Red Cross Children's Hospital and the Groote Schuur Hospital, dealing with children with burns and congenital hand problems.

Ruth Lester and colleagues in Zanzibar

Ruth Lester works with Interplast Holland (www.interplastholland.nl) and the Zanzibar government in Mnazi Mmoja Hospital in Stone Town, reconstructing burns, general plastic surgery and hypospadias including urethral fistulae.

Asia

Ron Hiles has worked with burns, especially victims of acid burns, in Bangladesh since 1982, as well as working in India and Cambodia for more than 25 years. He was the lead surgeon in Acid Survivors Trust International (www.acidviolence.org), as well as treating cleft lip and palate in Peru. He was awarded an OBE in 2004 for his services to Bangladesh.

Ron had the vision to inaugurate the first wholly dedicated subcommittee for overseas interests within BAPS, and tirelessly supported that group for more than 20 years.

The micro-surgical faculty at the Jinna Hospital, Lahore, 2015. The unit employs over 520 full-time people for 4 dedicated plastic surgery theatres and a burns ITU. Picture by Umraz Khan.

Umraz Khan is the visiting professor to the Allama Iqbal Medical School in Lahore and runs annual BAPRAS badged courses in microsurgery, which have been part of the postgraduate curriculum in the Jinna Hospital, Lahore, for the last 10 years. The 75-bed centre includes a burns ITU and five theatres offering replantations services, and is a respected centre for microsurgery. He has been greatly helped by **Omar Ahmad**, **Rizwan Alvi**, **Azhar Iqbal** and **Tuabin Rashid**.

Facing the World (facingtheworld.net) was founded by the late **Martin Kelly** and **Norman Waterhouse** in 2002. After working with several charities providing reconstructive surgery abroad and finding conditions that were not possible to treat locally, Kelly and Waterhouse founded Facing the World to provide surgery in London for the affected children. Their work spanned Ethiopia, Afghanistan, Ghana, Sri Lanka and especially Vietnam and is today continued by Niall Kirkpatrick, Simon Eccles and Richard Young. Facing the World today provides surgery in London for children with cranio-facial problems, but also provides training for Vietnamese doctors in London and in Da Nang.

Wee Lam is the present Chairman of BFIRST and has been teaching hand surgery at the Children's Surgical Centre (CSC) in Phnom Penh, Cambodia, since 2012, enabling their

independent practice in brachial plexus explorations including nerve transfers. **Greg O'Toole** has been visiting CSC as a hand and ear reconstructive surgeon during the same time. In Cambodia, BFIRST collaborates with our (now) Singaporean colleagues **Vaikunthan Rajaratnam**, **Gus McGrouther** and **Andrew Yam**.

Wee has written the first hand curriculum for BFIRST and has arranged for Simon Kay and Grainne Bourke to work in the VietDuc University Hospital with Dr Ha, teaching congenital hand and brachial plexus surgery, including vascular malformations, as the next BFIRST project.

Bran Sivakumar is teaching congenital hand surgery at the Lady Ridgeway Hospital in Sri Lanka and **Neil Bulstrode** is providing the training in surgery for vascular malformations with interventional radiologist **Alex Barnacle** in collaboration with local surgeon **Romesh Gunasekera** for BFIRST. The Lady Ridgeway paediatric hospital in Colombo is a 4,000-bed paediatric hospital with a catchment area covering nearly all of Sri Lanka.

Donald Sammut in Katmandu, Nepal, November 2009

Donald Sammut travelled with Médecins Sans Frontières (MSF) to work and teach in Sarajevo in 1994. He later set up the leprosy surgery programme in Anandwan, Maharashtra, central India, assisted by **David Evans**, which ran from 1999 to 2007, the leprosy and teaching project in Anandaban Leprosy hospital, Kathmandu (2008–2011), and the leprosy and hand surgery programme in Lalgadh Hospital, Janatpur, Nepal from 2011 to date, as well as the being the tutor in hand surgery in Kirtipur Hospital, Kathmandu, since 2012. He treats leprosy, burn contractures, congenital hands and some general plastic surgical problems, teaching local and UK surgeons. He has set up the charity Working Hands (www.workinghandscharity.org) to run this project.

Vivien Lees and **Andy Batchelor** continued the work of Donald Sammut in Anandwan, and included cleft lip and palate and burns, as well as continuing the hand surgery programme as Hands for Life (www.handsforlifesd.org). The project has run annually since 2000. The surgical group works with local physiotherapists and doctors so that they can take care of rehabilitation and longer-term aftercare. Cases include Hansen's disease (leprosy), with tendon transfers forming the

main focus, foot drop correction, lagophthalmos correction, burns contracture reconstruction and children's hand disorders. **Adam Goodwin** is now taking the programme forward.

Bruce Richard spent two years in Nepal as a leprosy reconstructive surgeon (1983–85) then, after completing middle registrar training in plastic surgery, returned in 1989 for a further nine years, working primarily in the Western Regional Hospital and setting up a department for plastic and reconstructive surgery for the government of Nepal in Pokhara. He trained seven Nepalese surgeons in trauma, burns and plastic surgery and his two main colleagues remain to this day in these roles. Four BAPRAS senior registrars visited him for cleft and tendon transfer learning opportunities. He now visits Nepal occasionally as an ad-hoc educator for the postgraduate plastic surgery programme.

Peter Budny has for the past 10 years worked to provide free plastic surgery to children in Pakistan born with cleft lip and palate.

Patricia Eadie was invited by Martyn Webster to spend a week teaching in Accra and Kumasi in 2005, went with Friends of Albania in 2006, and has visited the Children's Hospital No2 in Ho Chi Minh City, Vietnam (from 2007 to 2012). There, she collaborated with local surgeon Dr Tam, teaching and performing paediatric plastic surgery with an emphasis on congenital hand surgery.

Nick Hart founded the Overseas Plastic Surgery Appeal (OPSA, opsacharity.com) in 1998 and works in Gujrat, Pakistan, providing cleft lip and palate, burns and general plastic surgery services with Muhammed Riaz and Chris Hill. OPSA provides training for trainees from the UK and Pakistan. The Cleft Hospital won the Smile Train Global Leader Award for 2015.

Raj Ragoowansi is working with Mission Nehemiah, a church-based charity helping civil war victims in Sri Lanka. The charity has equipped one laminar flow theatre in Vavunya General Hospital with a microscope as well as micro and plastic surgery instruments. They treat mainly post-trauma deformity – including burn contractures, tendon and nerve reconstruction – but also congenital abnormalities. The postoperative follow-up is carried out by local general surgery and orthopaedic teams via Skype.

Muhammed Riaz worked voluntarily as a plastic surgeon in Nishtar Hospital, Multan, Pakistan, between 1999 and 2001 and established the burn and plastic surgery unit, which has now developed into a standalone hospital that he still supports by annual visits. He has worked with Nick Hart in OPSA since 2004. He has also made inroads to establish a breast reconstruction service in Gujrat.

Brian Sommerlad has worked regularly with cleft teams in Bangladesh, Sri Lanka and Uganda for more than 15 years. More recently, he has established links with cleft teams in Egypt, several

countries in South America, Iran and the Kurdish region of Iraq. He visits at least annually, sometimes with other team members if requested by the local team. Brian served as the Chair on the BAPS Overseas Service and Development Subcommittee from 2006 to 2009 and instigated the BAPS/BAPRAS Overseas Fellowships (now BFIRST Fellowships). These allow surgeons to visit UK units for six weeks on an observational fellowship in their subspeciality of choice.

Brian was on the Medical Advisory Board of Smile Train for many years. In 2007, he co-founded CLEFT (www.cleft.org.uk), a cleft lip and palate charity that funds cleft research and supports teams in several lower-income countries. The charity does not fund operating visits by teams from the UK, but aims to support local clinicians in developing sustainable services. Their current priority project is to help colleagues in Dhaka Medical College Hospital to establish the first comprehensive, interdisciplinary cleft and craniofacial centre in Bangladesh.

Sarah Tucker spent two years in Nepal dividing her time between a mission hospital for reconstructive surgery and rehabilitation – the Green Pastures Rehabilitation Centre – and the local government hospital the Western Regional Hospital, both in Pokhara. She recently organised the BAPRAS response following the earthquake in Nepal, where she also led a mission in 2015. She is the Vice Chair of BFIRST.

Chris Ward was a major force in the Sri Lanka project for cleft lip and palate, which was organised through orthodontist Michael Mars (from 1984 to 2005) at GOSH. The project took full cleft teams to Galle on three occasions and published growth studies on their data. Surgeons came from Oslo and London, and among them were Chris Ward, Jimmy James, Henrik Borchgrevink, David James, Peter Saxby and Norman Waterhouse.

Oliver Fenton has for the past four years visited Chitrakoot in Uttar Pradesh, India, operating cleft lip and palate and burns with **Claudia Malic**, a British-trained consultant now working in Ottawa, who helped Oliver Fenton in Romania for many years (see below), before joining him in Chitrakoot in Utter Pradesh to provide surgery for cleft lip and palate (see above). She is a trustee in the Chitrakoot charity (www.chitrakootuk.org) and was a trustee of BFIRST from 2012 to 2015. She now leads the BFIRST project on burns in the Medical College Hospital Dhaka together with Andy Williams, who has also been instrumental in burns education in Pakistan. Oliver visited the paediatric hospital in Brasov in Romania every year since 1990 to perform cleft lip and palate surgery, which led to the local surgeons themselves now being proficient in the surgery.

Europe

Graeme Perks has worked in Tbilisi, Georgia, with James Heaney. Graeme established links between BAPRAS and the Azarbaijan, Armenian and Georgian plastic surgery societies.

Nigel Mercer provided cleft and burn surgery in St Petersburg in the early 1990s with Derek Gordon in the regional children's hospital, under a scheme organised by RedKidz. He has furthermore been a Smile Train partner to Plovdiv in Bulgaria, visiting Professor Youri Anastassov. Professor Anastassov works closely with the charity the European Cleft Organisation (ECO, www.europeancleft.org), of which Nigel is a director. The ECO gives practical training in the care of babies with cleft lip and palate, who might otherwise be orphaned. At present Nigel is helping Dr Ningwen Zhu, a plastic surgeon in Shanghai, to set up a cleft unit.

Jack McCann started the Friends of Albania programme, in 2005, and he continued to work clinically in Albania once or twice a year until 2013. More recently he has set up a microsurgery laboratory and has to date trained 36 surgeons from Albania and neighbouring Macedonia and Kosovo in microsurgical techniques.

The Middle East

Naveen Cavale has visited the Shifa Hospital in Gaza on a number of occasions with Tim Goodacre to treat and train surgeons in the management of lower limb injuries through IDEALS (www.ideals.org.uk) and MAP (www.map-uk.org).

Ali Juma provided reconstructive surgery in Syria in 2016 as part of the LEAP Global Missions project (www.leapmissions.org).

Latin America

Norma Timoney has worked for years with Ron Hiles through PazHolandesa (www.pazholandesa.com) in Peru for cleft lip and palate and was instrumental in writing BFIRST's constitution.

International disaster response

Waseem Saeed provided acute reconstructive surgery after earthquakes in Pakistan 2005, China 2008, Indonesia 2009 and Haiti 2010, campaigning for plastic surgeons to be integral members of

A hospital pharmacy in Haiti earthquake of 2010.
Photo reproduced with permission from Anthony Roberts.

relief teams throughout this time. In 2010 he presented a case to DfID that led to the formation of the UK Register. Since then he has been on the faculty at the Global Risk Forum Emergency Surgery Workshops in 2011 and 2013, helping to shape future emergency responses. In 2015 he participated in the joint AO Foundation–ICRC collaboration as an invited expert to develop global guidelines for disaster limb injury. He teaches the plastic surgery component of the *Surgical Training for Austere Environments* course at the Royal College of Surgeons and is a member of the ICRC (www.icrc.org).

Anthony Roberts was a medical officer in Lesotho, South Africa, and the Republic of Rhodesia in 1973/74. He worked in the Athens Petroleum Refinery Disaster relief Team in 1992 and was a member of the medical aid teams to Bosnia (Operation Phoenix) in 1994, 1996 and 2001. He joined the disaster relief teams in Azerbaijan from 1998 to 2000, and helped provide post-war relief in Kosovo in 2001 and 2007. Anthony went to Haiti with BAPRAS and Merlin after the earthquake in 2010, and to the Philippines as part of the UK International Emergency Register

team after the typhoon in 2013. He went with Save the Children as a fire disaster assessor in South Sudan in 2015. Among his many other activities he spent 12 years as a visiting professor to the Chinese University in Hong Kong from 1992, and from 1995 taught the Egyptian military for many years on burns and hand surgery.

Colin Rayner was the visiting professor to El-Azar University, Cairo, and the University of the West Indies, Jamaica, and the British Council representative and visiting professor to the government of Jordan (1984–1994). In 1989 he was a member of the Anglo–Irish relief team to Russia at the time of the Ufa train disaster. From 1991 to present (2016) he has been the visiting professor to the Urals cancer centre, the south Urals medical hospitals and the medical school in Chelyabinsk, Russia, and the visiting professor to the Donetsk Mining Institute, Ukraine.

Clive Reid assisted with reconstructive surgery in Sarajevo during the war in the 1990s.

James Clover went to the Haiti earthquake in 2010 with the BAPRAS-organised response and has written several papers on the data collected, which clearly show the benefits of a combined ortho-plastic approach in earthquakes. He maintains ortho-plastic limb salvage as a focus for the UK international emergency response team, whom he joined in Nepal in 2015.

Sian Falder provided support in the 2005 earthquake in Pakistan with Azhar Iqbal and Rizwan Alvi, and has been a part of the Alder Hey international link with Kanti Hospital in Nepal since 2008. Sian hosts overseas fellows annually and as part of Interburns (interburns.org) has visited Bangladesh many times. She has edited a comprehensive training manual *Essential Burn Care* – a full-colour manual specifically designed to be contextual for resource-poor environments. She was also a member of BAPRAS overseas committee for many years and she continues to be a prolific writer on the subject of plastic surgery provision overseas.

Remo Papini went to Nepal (2009–2011) to teach burns with Sian Falder through the Alder Hey and later Interburns and was part of the BAPRAS response to the Haiti earthquake in 2010. He now lives and works in Australia.

Stewart Watson worked with the South Manchester Accident Team after the Armenian earthquake of 1988 (where it was not possible to operate, patients were taken to Iran), in the Iranian earthquake of 2003 and in the Chelyabinsk rail disaster at Ufa 2009 on behalf of BAPS, along with Colin Rayner, John Settle and an Irish burns and plastics team. Individually these surgeons re-visited Chelyabinsk and brought children over to the UK for surgery. He also participated in two government-initiated hospital visits to Sarajevo during the civil war, along with Tony Redmond and lately worked with British Society for Surgery of the Hand (BSSH) in the upper limb project in Makeni, Sierra Leone.

Ankur Pandya is the current Deputy Chief Medical Officer and Director of Quality Assurance for Operation Smile (www.operationsmile.org.uk), positions he has held since 2010. He was the Regional Medical Officer for Europe, the Middle East and Africa (2007–2010) and since 2007 has been on operating surgical missions to many different countries. He set up a course called *Burns Understanding Resuscitation, Nursing and Surgery* (*BURNS*) on which he has taught in four countries. He is active with the Swinfen Trust as a consultant in telemedicine to the third world and is currently engaged in a project with Portsmouth University to disseminate surgical training through the medium of simulation and virtual reality.

In 1990 **Charles Viva** formed the British affiliate of Interplast UK (now ReSurge UK), which has recently visited Uganda, Kashmir, Islamabad and Quetta, providing burns surgery and cleft lip and palate.

Tom Potokar worked for MSF on surgical programmes in Rwanda and Madya Pradesh, India, in 1999, undertook assessment on behalf of DfID in Nairobi after the bomb blast in 1998, and led the Welsh surgical team on a reconstructive surgical mission in north west Pakistan after the earthquake. He set up a link with the burns centre in Indore, India in 2004, which gradually expanded the international work of Interburns (International Network for Training, Education and Research in Burns) in 2006 (www.interburns.org). Interburns is a leading global NGO providing contextualised training and education in burn care and prevention for resource-poor environments. He developed international consensus standards for burns services in low- and middle-income countries and a comprehensive integrated approach to quality, improvement and capacity building in burn care and prevention.

Interburns have ongoing programmes in Nepal and Bangladesh (which are funded by DfID), Ghana, the West Bank and Ethiopia, and have run training programs in Côte d'Ivoire, Malawi, Tanzania, India and Pakistan, as well as a well-established training centre in India and prospective training centres in Nepal and Ghana. Interburns also provides a training program for MSF and has been asked by the WHO to deliver a training programme on burn management for Syria.

During his time on the BAPRAS Overseas Committee Tom managed to publish *Repair and Reconstruction: Injury, Deformity and Disease*, a journal specifically aimed at the problems and solutions in reconstructive surgery in poorer countries, which owing to lack of funding sadly only ran for two editions.

He contributed to the WHO five-year plan for burn care and prevention and sits on the WHO Global Alliance for Care of the Injured, chairing the education and training sub-committee as well as the Global Initiative for Emergency and Essential Surgical Care.

The Right Honourable Lord Bernie Ribeiro, patron, Barbara Jemec, founder, Tim Goodacre, board member and Wee Lam, current Chairman at the BFIRST launch in November 2014 at the Royal College of Surgeons of England in London.

Barbara Jemec visited KBTH, Accra, in Ghana annually between 2004 and 2008, either with Martyn Webster, by herself or bringing her own team, and worked in Bolivia (in 2008 and 2009) and Mali with Interplast US (in 2010). In 2010 she organised and coordinated the BAPRAS orthoplastic response to the Haiti earthquake with Merlin. It saw James Clover, Shehan Hettiaratchy, Sanjib Majumder, Remo Papini, Sahan Rannan-Eliya and Anthony Roberts working with our orthopaedic, maxillofacial and anaesthetic colleagues during the immediate aftermath of the disaster.

While on the BSSH Council she initiated their Overseas Committee (which is still active) and in collaboration with ReSurge Africa she set up the BSSH project in the Holy Spirit Hospital, Makeni, Sierra Leone, which was only curtailed by the Ebola outbreak in 2015. It saw Ian Grant, Sanjib Majumbder, Stewart Watson, Martyn Webster, Albert Paintsil, David Gateley, Brian Fu, Juling Ong, Vinod Kumar, Nanak Sarhadi, Oliver Harley, Dave Bell, Sohail Akhtar, Yvette Goodwin, Richard Pinder, Barbara Jemec and our orthopaedic counterparts all provide an orthoplastic reconstructive surgery service and training of the local staff, mostly in upper limb surgery.

As the Chairman of the BAPRAS Overseas Committee she founded BFIRST in 2012, and was the Chairman from 2012 to 2015.

She is now the lead for the BFIRST hand surgical project at the Dhaka Medical College Hospital in Bangladesh, which she visited for the first time in 2016, after being invited by previous BFIRST fellow Tanveer Ahmed.

It is to be hoped that BAPRAS will continue to bring together the efforts of so many brilliant surgeons and teachers in order to teach reconstructive surgery to the resource-poor world to allow them to practise at an independent level.

Appendix

The British Overseas Interest Group Mission Statement

Reconstructive plastic surgical partnership with the world

The Association is dedicated to the development and support of high quality reconstructive plastic surgery services to the poor of the world, by encouraging and facilitating experienced members to help with service needs and training overseas, with a view to an ultimately sustainable and autonomous service within the limits of the infrastructure and resources of the country concerned.

The Association also supports the provision of emergency reconstructive surgical services, wherever required, in the event of a natural or man-made disaster. Collaboration and co-ordination with other professional organisations, aid agencies and governmental groups is welcomed.

This goal is to be achieved

a. by partnership with those overseas doctors who are identified as being committed to improving the welfare and health of the poor,
b. by supporting arrangements for volunteer UK members to train those overseas doctors in or near their own practice environment, in reconstructive surgical skills and the appropriate application of acquired skills to local needs by supplementing in-situ based training, where appropriate by grants and scholarships for selected overseas doctors for short periods of study and further training in the UK to equip them better to serve the particular need.

Plastic surgery in the UK armed forces 1986–2016

The last historical review of UK military plastic surgery[1] had been prepared about the same time as *The History of the British Association of Plastic Surgeons – the First Forty Years* and concluded with a look to the future. It stated; 'Plastic surgery, once considered to be the surgery of late reconstruction, is an acute surgical specialty' – articulating a desire for plastic surgeons to carry out the debridement and early coverage of wounds, and not having to wait for days or weeks before they could embark on reconstruction. Have we, in Her Majesty's Armed Forces, come any closer to that vision in the last 30 years?

In 1986 the focus was on the Cold War, with forces essentially structured to act as a deterring defensive block at NATO's eastern European front. There were still military hospitals both in the UK and overseas. These were based on the requirements of each service and provided in-patient facilities, with most of the workload generated by service personnel suffering from 'normal' illnesses and non-combat injuries. There was an element of the hospital's activity that was provided to the surrounding civilian population. Over the years the military plastic surgery departments had developed and changed with influence on and from the NHS. The role to act as receiving hospitals in times of war was intermittently realised during outbreaks of significant armed conflict, such as had been seen in the Falklands. What was often not appreciated was the steady flow of a background number of patients being repatriated following combat injury from Northern Ireland and various small-scale military engagements around the world.

The Royal Navy (RN) provided plastic surgery at its main shore bases, the Royal Naval Hospital, Haslar, and Royal Naval Hospital, Plymouth. The army had Queen Elizabeth Military Hospital, Woolwich. The Royal Air Force (RAF) had Princess Mary's Royal Air Force Hospital, Halton. Bruce McDermott headed the unit at Woolwich and, until Peter Chapman had finished his training in 1989, was supported by the RN and RAF with Charles Chapman and Tony Attwood

1 Brown RF, Chapman CW, McDermott BC. The continuing story of Plastic Surgery in Britain's Armed Services. *Brit J Plast Surg* 1989; **42:** 700–709

respectively. Ronnie Brown was at Halton. These were purpose-built modern burn facilities able to deliver acute critical care, as well as plastic surgery wards and theatre suites. Nurses from all three services received specialist burns and plastic surgery training. The capability existed to deliver contemporaneous high-quality care.

Burns and plastic surgery seemed to have a secure place in the armed forces. Numbers of surgeons were small when compared to general and orthopaedic surgery, and it was still seen as having its main role in late reconstruction based in the UK. Plastic surgery was not part of the core surgical capability for deployment in support of operations but would form specialist teams if it was deemed that large numbers of burn or head and neck injuries might be expected.

Surgical training at this time still placed an emphasis on gaining generalist skills. The leaders of military surgery were predominantly from general surgery backgrounds. They had control of training up until entry into higher specialist training and each service had its own policy as to the number of specialists required. Not all aspiring plastic surgeons were permitted to embark on their chosen specialty and several left to train as civilians. The RN did not place anyone into plastic surgery training for a period and the Army and RAF anticipated only needing very small numbers.

Following 1989, as the Soviet Bloc collapsed, an opportunity for a 'swords to ploughshares' peace dividend was anticipated. The 'options for change' defence review from the government in 1990 gave a clear indication of intent to very significantly reduce the size of the armed forces.

In August 1990 Iraq invaded Kuwait and the UK became part of the international coalition aimed at liberating Kuwait under United Nations Security Council resolutions. A significant UK force was deployed with the expectation of a high risk of burn injuries, given the armoured nature of the planned ground offensive. A need was seen for a burns and plastic surgery capability within the medical support to Operation GRANBY. Peter Chapman was initially deployed to a forward location. A larger field hospital was established at Riyadh in Saudi Arabia that was to include a burns team and this was joined by Charles Volkers, a reservist. Two trainees in plastic surgery, Godwin Scerri and Tim Burge, were also deployed to support the two consultants. The casualty numbers were lower than anticipated, in particular only a small number of burns, and the plastic surgery units in the UK military hospitals were not heavily used.

Instability in post-Tito Yugoslavia resulted in a succession of conflicts in the Balkans during the 1990s and UK armed forces were deployed as part of a NATO force under United Nations authority. The plans for medical support did not perceive a requirement to deploy burns and plastic surgery expertise. The expectation that all surgeons in the military retain some generalist skills, however, resulted in plastic surgeons being deployed to general surgical posts throughout the conflict up until 2002. This approach also led to junior plastic surgery trainees being given opportunities for generalist training; for example, a number were sent to South Africa for trauma surgery experience.

It could be argued that these new conflicts demonstrated that there was no evidence to suggest that the post-Cold War world was more stable. The government still pressed on with the planned reduction in the scale of the armed forces and in 1994 produced *Front Line First: The Defence Costs Study*.[2] This aimed to develop smaller but more agile and better-equipped forces and to reduce the size of managerial and supporting functions. Medical support was not spared, and a policy of greater interaction with the NHS was pursued. More emphasis was to be placed on a defence medical service rather than single-service control of medicine. One tri-service hospital was to be formed at the Haslar site, to be called Royal Hospital Haslar. This would be managed and staffed by the military. Woolwich and Halton were to close. Military staff were also to be placed in NHS hospitals where they would work under NHS management but maintain a degree of military identity. In addition to Haslar, these Ministry of Defence hospital units were established at Derriford Hospital, Plymouth (RN led), Frimley Park and Northallerton (both army led) and Peterborough (RAF led).

Derriford had a long-established civilian plastic surgery unit but none of the other military defence hospital units (MDHUs) provided plastic surgery services, nor had plans to develop them. Haslar would, therefore, succeed Woolwich as the centre of gravity for military plastic surgery and a state-of-the-art burns unit and theatre suite were built within the hospital. The service at Woolwich had been named the Mountbatten Plastic Surgery Unit and this was transferred to the Haslar service.

Significant change to a system is often a catalyst for individuals to reassess their personal circumstances. This, along with some normal retirements, meant that, as Woolwich shut in 1995, there was a period during which there were no serving consultant plastic surgeons in the regular armed forces. The realisation that numbers of plastic surgery trainees had been miscalculated came too late to prevent this, but corrections had been made and gradually consultants came off the top.

Godwin Scerri (RAF) had been accredited as a consultant in early 1996 and immediately became the lead for the specialty as Defence Consultant Adviser in Burns and Plastic Surgery, taking up his post at Royal Hospital Haslar. He was joined later that year by Tim Burge (army) after his accreditation. Andy Malyon, Nick Bennett (both army) and Ankur Pandya (RAF) also arrived at Haslar over the next few years.

The reserve forces have structurally been meant to provide personnel in support of large-scale or enduring operations and for the medical services they are numerically significant. There had previously been several plastic surgeons who had served in their professional role as reservists and others who had undertaken reserve service in a non-medical capacity. In the late 1990s only

2 Todd T. *Front Line First: The Defence Costs Study.* MOD; 1994.

The Combined Services Plastic Surgery Society Conference in 2014, aboard the HMS Bristol

Alan Kay, Shehan Hettiaratchy and David Wilson were engaged as surgeons within the reserves, and not specifically as plastic surgeons. Alan Kay transferred to regular service in 2002 but remained as a consultant placed in Bristol for a time.

The UK armed forces remained busy, although in lower-threat environments. Injuries were less common and the plastic surgery unit at Haslar mainly provided a civilian-style service to the local population. The burns unit there was not used and the experienced nursing staff were relocated to work in other critical care environments. In September 2000 some UK soldiers were injured during Operation BARRAS, a hostage rescue mission in Sierra Leone. They were repatriated to Haslar for their reconstruction.

NHS changes around this time included a rationalisation of burn services and a move towards centralisation of trauma services. A need was seen for a centre of excellence for research and clinical delivery of military medicine and it was envisaged this would need to be in a large university teaching hospital that had the appropriate specialties to allow it to become a trauma centre, including burns. A formal bidding process resulted in University Hospitals Birmingham being chosen to host the Royal Centre for Defence Medicine (RCDM), which opened in 2001 and was granted its royal title in 2002. Policy changed and all UK armed forces personnel who required evacuation back to the UK for in-patient treatment of injury or illness would be brought back to Birmingham. It was the NHS that had the responsibility for delivery of care but the RCDM provided additional specialist expertise, manpower and military welfare.

September 2001 brought '9/11' and the start of a significant period of combat operations. Initial operations against Al-Qaeda and the Taliban in Afghanistan generated few UK casualties. Surgical teams deployed did not include a plastic surgeon. There was no military plastic surgeon at RCDM and the civilian department provided the reconstructive expertise.

The force deployed for the invasion of Iraq in 2003, Operation TELIC, was large and medical support included two field hospitals plus the RN's primary casualty-receiving facility on RFA Argus. Armoured fighting was again to be a major feature, with the potential for burn injuries, so plastic surgery was to be included. Andy Malyon and Nick Bennett deployed to the field hospitals, taking the RN's senior trainee, Rory Rickard, with them. Alan Kay took on a more generalist trauma surgery role in a smaller surgical team. The RN still had no consultant plastic surgeon so

Ankur Pandya was deployed aboard RFA Argus. As the planning developed it became clear that distributing the two army consultants across two field hospitals was not as effective as if they were working together. All of the burns and plastic surgery land assets were therefore centralised to a single unit. Using historical precedent this was named 56 Independent Burns Team and included anaesthetists, nurses, and physiotherapists. UK combat injuries were again lighter than expected, but several Iraqi civilians who had sustained burns were brought to the facility. A total of 114 procedures were performed over about 6 weeks, of which 81 were burn related. What became apparent was the beneficial effect of having plastic surgeons present to assist in general wound management and surgical debridement. This was, however, viewed as only a 'nice to have' capability with the inference that deployed plastic surgery offered little for UK casualties who would receive their reconstruction back in the UK. Ankur Pandya was similarly busy afloat, with local civilians providing most of the surgical challenges.

With no drive or support from other surgical specialties to maintain a plastic surgery presence beyond the initial invasion phase, and the still-small number of consultants, no plans were made to retain the capability in Iraq. A sizable UK force remained until 2009 supported by a surgical team without plastic surgery. A greater number of casualties were sustained later in the campaign. Some plastic surgery trainees were deployed, but in a more generalist surgical and supervised capacity.

Activity in Afghanistan had dropped, as the main focus had moved to Iraq. It was then decided that the UK would undertake a new significant role in Helmand Province, southern Afghanistan, starting in April 2006 as part of Operation HERRICK. Historical attitudes to surgical provision persisted and no thought was given to including plastic surgery. A field hospital was established in the UK's main operating base named Camp Bastion, initially manned by a single surgical team of two surgeons. One of the two was Alan Kay, who was working in a general surgical role. Over the next couple of years, the intensity of conflict increased, with ever-growing casualty rates. There was also an increasing requirement to provide definitive surgical care to the Afghan police, army and civilians.

At RCDM, the combined UK casualties from both Iraq and Afghanistan were generating a significant burden. A solitary RAF orthopaedic surgeon, Ian Sargeant, was providing the military surgical input and had developed new surgical strategies along with the civilian head of trauma, Keith Porter. In 2007, an army plastic surgeon, Steve Jeffery, who had been appointed initially to Newcastle, moved to RCDM as part of the burn service. A senior army burns nurse, John Clark, also arrived. It soon became appreciated that the complex blast injuries being seen had a similar systemic effect as a burn injury and required the same expertise of care as a large burn. It was also apparent that completeness of initial surgical debridement at Bastion was difficult for those not used to seeing such massive tissue destruction.

56 Independent Burns Team, Operation TELIC, 2003

In June 2008, Alan Kay visited Camp Bastion while in Afghanistan on a different task. There was now a larger surgical team with two operating tables, yet still no plastic surgeon. There was a local civilian teenager with a large burn injury and no surgical expertise to manage her. Extensive debridements on combat wounds were being performed with no real appreciation of future reconstructive options. The case to deploy plastic surgeons was made, but not supported. Godwin Scerri, who was still Defence Consultant Adviser, then visited Bastion along with the lead for general surgery. He strongly recommended the deployment of the specialty and, although his insistence on establishing a post for a plastic surgeon was rejected, it was agreed that a plastic surgeon could deploy in place of a surgical trainee as a trial.

In autumn 2008 Simon Heppell, an army plastic surgeon who had been appointed to Haslar, was deployed to Camp Bastion as the first official plastic surgeon. He was followed by a series of plastic surgeons, and their performance demonstrated the true ability of the specialty, not just to perform the reconstruction, but also to provide expertise in wound management right from the initial debridement. At this stage Rory Rickard had been appointed to Derriford to become first consultant plastic surgeon to the RN since the retirement of Charles Chapman. Tania Cubison (army) was appointed to East Grinstead and Demetrius Evriviades (RAF) was to follow soon at RCDM. It took until the summer of 2009 to convert the trial into a permanent established post. This remained filled until Bastion shut in October 2014 with consultants doing eight-week stints of duty.

In August 2009 Alan Kay was appointed as Defence Consultant Adviser to succeed Godwin Scerri. It was becoming increasingly obvious that the complexity and volume of injuries being evacuated back to RCDM were over-stretching the system. He moved himself from Bristol to RCDM and set about developing a larger military plastic surgery capability. Initially this involved temporarily moving consultants from other units for short-term periods and using senior trainees. Over the next couple of years James Baden, Mark Foster (both army) and Wian Van Niekerk (RAF) became consultants at RCDM. Dominic Ayers (RN) had been appointed in Bristol, Chris Taylor (army) went to Derriford, Graham Lawton (army) to Imperial, London, and Jason Smith (RN) to Haslar. The majority of these new consultants had spent time at Camp Bastion as trainees. All would be deployed there as consultants, most more than once, as would the existing consultants and Shehan Hettiaratchy (army reserve).

With a plastic surgeon at Bastion and a now robust team at RCDM, the full benefits of the specialty in the management of complex combat injury could be realised. A strong link with the military orthopaedic consultants allowed the development of a true orthoplastic team and there was significant cooperation with the maxillofacial surgeons.

The military burns and plastic surgery nurses at RCDM took over as overall coordinators of patient care, as well as delivering their clinical skills. They would be present in theatres and were instrumental in developing a method of topical negative pressure dressing for deep cavity ballistic wounds. This role was translated to Camp Bastion and the single burns and plastic surgery nurse who had been deployed was the busiest in the hospital, effectively being available to carry out dressings 24 hours a day.

Similarly, there was only ever a single plastic surgery consultant at any one time at Bastion. At its busiest there were six or seven general surgeons and five or six orthopaedic surgeons. An audit of the surgical workload showed the single plastic surgeon was doing virtually as much operating as the other specialties, with about 40% of cases having the plastic surgeon scrubbed.

The official number of plastic surgeons required for defence had remained fixed at six for quite a while. It was recognised that with few reservists and the increasing use of plastic surgeons, this number was inadequate. Recruitment was allowed to increase, albeit it by use of unfilled liability from other areas rather than an official increase. A formal review to set the manpower requirements, to be achieved by 2020, was undertaken and reported in 2013. This was heralded as a great success for plastic surgery in that it increased the number to 14 (2 RN, 10 army, 2 RAF), but unfortunately was actually a reduction when compared to established consultants plus the surgeons we had already been allowed to put into training.

Royal Hospital Haslar has closed and the services have moved to the Queen Alexandra Hospital, Portsmouth, including the Mountbatten Plastic Surgery Unit.

The recognition of a role for plastic surgery in the acute management of injury has gradually permeated through defence and into the civilian world of trauma care. Although the BOA/BAPRAS recommendations for severe lower limb injuries have been around since the early 1990s, entrenched views doubting a need for plastic surgery remain, mainly in units not doing complex limb reconstruction. Likewise, there are still military surgeons around who contest the place of plastic surgery in the deployed setting. At the end of Operation HERRICK the view was that UK armed forces would never again fight in a conflict where we had such a secure footing as to be able to build and run a hospital as at Camp Bastion. The excellent clinical result achieved could not be repeated and we would have to get used to working to lower standards in smaller tented facilities. Plastic surgery was not seen by some as having a place in constrained facilities. Fortunately the consensus is moving towards acknowledging the skill set of plastic surgeons and how this can enhance the care from the outset. The majority of deployed medical treatment facilities with a surgical team now include a plastic surgeon along with an orthopaedic and general surgeon, even in more austere environments. There is no reason why the clinical excellence cannot be maintained.

A consultant appointment with an interest in acute trauma management has also become a desired goal for some plastic surgeons in the civilian setting. The workload of complex trauma reconstruction at RCDM generated a fellowship scheme, which is still running, and individuals were able to gain experience in clinical leadership within the major trauma service. The 2015 report on major trauma workforce sustainability by the Royal College of Surgeons of England[3] sees plastic surgeons as well placed to take on the major trauma consultant role.

Although there had always been meetings of the military plastic surgeons, it was decided in 2007 to formalise an annual conference and the Combined Services Plastic Surgery Society was formed. This has grown into a healthy forum for presentations of research, invited international speakers, cross-specialty cooperation and a strong social element.

There are several academic departments within the defence medical service, and plastic surgery has been a key driving force behind the Academic Department of Military Surgery and Trauma. This is led by the Defence Professor of Surgery – the modern title for the ancient position of Professor of Military Surgery. From its inception, the department has had at least two of the five senior lecturer posts filled by plastic surgeons and in 2014 Rory Rickard was made the Defence Professor of Surgery. We have firm links with research programmes at the United States Army Institute for Surgical Research, San Antonio, Texas. Major Robert Staruch is currently a Fulbright Scholar at Harvard.

3 RCS. *Major Trauma Workforce Sustainability*. London: RCS; 2015.

Since the end of Operation HERRICK, plastic surgeons have deployed on exercise with nearly all levels of surgical support and operationally to Sierra Leone as part of the response to Ebola (Operation GRITROCK), and to Pakistan (Operation PANAKA). There is strong demand from junior military doctors wanting to enter plastic surgery training. Our training pipeline is already over-full. There have been several enquiries from those interested in joining the reserves and it looks as if the numbers there will increase.

We have gained credibility in the eyes of our military and civilian peers as deploying surgeons involved in the immediate care of trauma and have put ourselves very close to the vision expressed by our predecessors in military plastic surgery.

Godwin Scerri, Andy Malyon, Nick Bennett, Demetrius Evriviades, Dominic Ayers and Wian Van Niekerk have, for various reasons, decided to leave the armed forces.

Remaining are:

Army consultants

Colonel Alan Kay (RCDM)
Lieutenant Colonel James Baden (RCDM)
Lieutenant Colonel Tania Cubison (East Grinstead)
Lieutenant Colonel Mark Foster (RCDM)
Lieutenant Colonel Simon Heppell (Portsmouth)
Lieutenant Colonel Steve Jeffery (RCDM)
Lieutenant Colonel Graham Lawton (Imperial, London)
Lieutenant Colonel Niall Martin (Chelmsford)
Lieutenant Colonel Chris Taylor (Derriford)

Army trainees

Major Rachel Howes
Major Johann Jeevaratnam
Major Robert Staruch
Major Rachael Thomas
Major Matt Wordsworth
Major Guang Hua Yip

RAF consultant

Wing Commander Ankur Pandya (Portsmouth)

RAF trainee

Squadron Leader George Wheble

Royal Navy consultants

Surgeon Captain Rory Rickard (Derriford)
Surgeon Commander Jason Smith (Portsmouth)

Royal Navy trainee

Surgeon Lieutenant Commander Anton Fries

The BAPRAS Archive

Antony F Wallace. BAPS Honorary Archivist 1981–1988

The BAPS Archive dates back to April 1981 when Antony Wallace, then the Secretary of BAPS, and Maurice Kinmonth, the President, discussed the idea. Kinmonth wrote to all the ex-Presidents asking for photos, dinner menus and records of outings and social events that had occurred during their year of presidency. Tony Wallace had kindly agreed to act as official archivist and material began to accumulate. At the winter meetings of 1981 to 85, Wallace organised small exhibitions, which spurred memories and enabled him to collect more. A visit to Lady Gillies produced a wealth of photographs and, importantly, she was able to detail events and put names to photographs. Meanwhile Wallace researched the available history of plastic surgery and in 1982 published his book *Progress of Plastic Surgery*.[1]

The recording of the histories of the UK plastic surgery units was a task dear to Wallace's heart. He approached each unit and persuaded a senior figure there to write the story. These were then published one by one in the *BJPS*. He didn't quite achieve all of them but 21 were completed and provide a wonderful record of plastic surgery service in the post-war years.

John Barron and Wallace conceived the idea of writing a history of the first 40 years of BAPS. There was a memorable meeting in the *Rose and Crown Hotel*, looking out on Salisbury Cathedral, in March 1985. This led, after a deal of cajoling and persuasion, to the publication of a booklet in 1986.

1 Wallace AF. *The Progress of Plastic Surgery. An Introductory History*. Willem A. Meeuws; 1982.

In July 1987 at the summer meeting in Edinburgh Wallace suffered a cerebro-vascular mishap, which left him with a dense stroke. This forced him to retire from clinical surgery but his faculties remained acute and with two helpers, Charles Chapman and David Elliot, and the secretaries Joy, Linda, and Tracy, the collection and cataloguing continued. In 1996 David Ross, who had a History of Medicine diploma, was made Assistant Archivist; however, the pressure of clinical duties got in the way of his participation. 1998 saw the appointment of Phil Sykes and Brian Morgan, both previous presidents. Phil was engaged in writing a book on the history of plastic surgery[2] with his co-author Paolo Santoni-Rugiu, which was published in 2007. Phil had retired to Cumbria so regular supervision of the collection was difficult, and he resigned in 2000.

Brian oversaw the continual growth of the archive through donations, which included a large number of documents relating to John Barron (via Magdy Saad) and Pomfret Kilner. He also contributed his considerable expertise to the curators employed to catalogue the collection, while facilitating loans of instruments and artwork for exhibitions. He has continues to champion the place of art in the practice of plastic surgery as advocated by Gillies himself.

Brian continued to the end of 2014, which was a busy year because of the centenary of the First World War and the birth of British plastic surgery. The Wallace Archive has been fortunate in the appointment of Roger Green, a past President and Secretary of the Association, as an enthusiastic replacement. Technically an archivist only deals with paper records and possibly photographs – whereas ours has surgical instruments and other artifacts, making it a collection. It is too late to change the name so it remains an archive.

Many boxes of surgical instruments, papers and photographs were kept in Wallace's shared consulting rooms in Portland Place. It was not until 2003 that the collection was rehoused in the storeroom of the BAPS office at the Royal College of Surgeons in Lincoln's Inn Fields. It was in 2005 that the Antony Wallace Archive was officially opened in the presence of Wallace

Queen Mary's Hospital, Sidcup, was the hospital custom built for the treatment of facial injuries in the First World War. Here, Harold Gillies and Commonwealth surgeons carried out their pioneering work. Plastic and reconstructive surgery ceased there in 1925 and it became a general hospital. Andrew Bamji, a consultant rheumatologist, discovered the old records, which were about to be destroyed, and set up an archive in the postgraduate centre at Sidcup. He was able to locate a great deal of material, records, papers, photographs and artifacts relating to surgery in the First World War, including the records of the New Zealand patients. Dr Bamji founded the Gillies Archive and a very successful website. Sadly the archive was closed by the management in 2011, as the result of hospital reorganisation. The patient records were transferred to the Archive of the Royal College of Surgeons and the papers, photographs and artifacts to the BAPRAS

2 Santoni-Rugiu P, Sykes PJ. *A History of Plastic Surgery*. Springer; 2007.

The George II silver beer tankard presented by BAPS to Harold Gillies in 1953 as a mark of esteem

Archive (these artifacts included a silver tankard originally presented to Gillies by BAPS). Dr Bamji was made the BAPRAS Gillies Archivist and an honorary member of the Association.

Sir Harold Gillies' granddaughter, Susie Winter, moved to New Zealand (the family home) in 2003 and donated much of Gillies, correspondence and photographs to BAPRAS Archive. These included a fascinating correspondence between Sir Harold Gillies and Ralph Millard while they were writing their wonderful book The *Principles and Art of Plastic Surgery*,[3] which was eventually published in 1957. Some of Millard's letters were written from Vietnam where he was on active service. The papers give some insight into the extraordinary character of Gillies. There is an amusing letter written to Gus Aufrich at the time of the International Congress in 1959 when Rainsford Mowlem was president. 'I want to apologise for my "terrible" behaviour at the Garrick Club, by the time the news of it got to Mowlem he was so frightened of me that he thought I might take my trousers off at the main dinner'. Gillies had invented a coat hanger that enabled one to hang a jacket before the trousers and had spectacularly demonstrated its use.

The presence of the BAPRAS collection in the Royal College of Surgeons has enabled a close cooperation between the RCS museums and the BAPRAS Archive. For the first time it was possible to have a paid employee, a curator, shared with the College. The first was Zoe Brealey, who photographed, catalogued and marked our collection of surgical instruments. The digitised information was then made available on the internet as a part of the RCS's *Surgicat*. This included our set of nasal instruments once owned by Jacques Joseph, the German master of cosmetic nasal surgery. A Dr Kohn had looked after the instruments for Joseph in Karlsbad in the mid-1930s. He then came to England, as a general surgeon in Bath, and gave the instruments to plastic surgeon Emlyn Lewis in thanks for treatment he had received. Wallace subsequently purchased these from Lewis's daughter.

Another of achievements Zoe made was to digitise and catalogue our wonderful collection of 2,700 drawings by Dickie (Diana) Orpen, (the daughter of Sir William Orpen). At the outset

3 Gillies HD, Millard RD. *The Principles and Art of Plastic Surgery*. Little and Brown; 1957.

The Coleman Ladd mask. Anna Coleman Ladd worked in Paris during the Second World War making casts of the faces of badly disfigured soldiers. Their features would be sculpted onto clay, which could be used to make a facial prosthesis of galvanised copper, which subsequently would be painted to match the skin tones of the patient. This exhibit is thought to be one of the last complete masks in existence.

of the Second World War Rainsford Mowlem had been given the task of setting up a plastic surgery unit at Hill End Hospital in St Albans to cover the northern sector of London and the home counties. The artist, Dickie Orpen, spent the years from 1942 to the end of the war in the operating theatre with Mowlem, drawing and recording the surgery. It is a remarkable artistic achievement and all the drawings are now available to be viewed in the Archive and also on *Surgicat*. The artistic fraternity has shown interest in her drawings and an exhibition was mounted at the Camberwell School of Art in 2008, and at the Royal College of Surgeons in 2009, curated by Brian Morgan and Jeanne Woodcraft

The next of our shared curators was Kristin Hussey. Kristin catalogued the 16mm film from Roehampton Hospital and arranged for the BBC to digitise them. Some of the treatments of burns sequences were so ghastly that the BBC team could only work in short bursts, allowing time to recover! The cataloguing of over 400 Hennell photos was also quite distressing for Kristin. Percy Hennell was a photographer who had perfected a new system of printing photographs in vibrant and lasting colour, a rare accomplishment at the time. During the Second World War he travelled around the plastic surgery units, including the RAF hospitals, recording the injuries and their reconstruction.

The 2014 ESPRAS meeting in Edinburgh gave Brian and Kristin an opportunity to arrange the exhibition *A Strange New Art – Plastic Surgery and the First World War*, describing the birth of modern plastic surgery. The exhibition was so successful that it was repeated in Bruges in 2015 and then invited to the American Association of Plastic Surgeons meeting in Boston in the autumn of the same year.

The next incumbent of the shared post appointed in 2014, Ruth Neave, has continued the large task of cataloguing all our records and making the information available on *Surgicat*. This has resulted in many recent requests to visit the Archives, particularly by undergraduates for their dissertations, and also for PhD theses and by historians. We have also been included in a number of television broadcasts.

What of the future? Space and storage is at a premium and there will be a great upheaval if the RCS goes ahead with a proposed rebuild. Many of our plastic surgery units were built in WW2 and are now being redeveloped or closed so we need to be vigilant that material of historic interest is not lost. Obituaries are rarely written and published now so people who have contributed to the development of our specialty will be forgotten. Our electronic age allows wonderful access to information and our printed journals are becoming obsolete, but there is a danger that information is lost into the ether. A final plea, therefore: please think of the instrument you invented or the photograph at the bottom drawer of your desk and let the archive know!

Contributions to exhibitions:

How we are: Photographing Britain
Tate Britain, London, 2007

War and Medicine
Wellcome Collection, London, 2008
Deutsche Hygiene Museum, Dresden, 2009
Canadian War Museum, Ottawa, 2011

Dickie Orpen – Surgeon's Artist
Camberwell College of Art, 2008
Royal College of Surgeons, England, 2009

Superhuman
Wellcome Collection, London, 2012

Saving Lives
Imperial War Museum North, Manchester, 2012

War Art and Surgery
Royal College of Surgeons, England, 2014

'A Strange New Art', Plastic Surgery and the First World War
ESPRAS Congress Edinburgh, July 2014
RBSPS Bruges, July 2015
American Association of Plastic Surgery, Boston 2015
Finnish Association of Plastic Surgeons, Helsinki, 2017

Unit history publications:

Aberdeen	*BJPS* (1995) 48; 254–257
Armed Forces	*BJPS* (1989) 42; 700–709
Billericay	*BJPS* (1985) 38; 423–425
Cork	*BJPS* (1988) 41; 206–208
Dublin	*BJPS* (1988) 41; 200–205
East Grinstead	*BJPS* (1988) 41; 422–440
Gloucester	*BJPS* (1985) 38; 55–69
Hull	*BJPS* (1995) 48; 112–113
Leeds	*BJPS* (1989) 42; 107–113
Liverpool	*BJPS* (1996) 49; 328–331
Manchester	*BJPS* (1985) 38; 177–186
Mount Vernon	*BJPS* (1988) 41; 83–91
Northern Ireland	*BJPS* (1989) 42; 235–239
Nottingham	*BJPS* (1987) 40; 653–654
Oxford	*BJPS* (1989) 42; 349–352
Sheffield	*BJPS* (1986) 39; 559–564
Shotley Bridge	*BJPS* (1989) 39; 422–431
Stoke Mandeville	*BJPS* (1986) 39; 85–95
Tayside	*BJPS* (1990) 43; 226–231
West Midlands	*BJPS* (1987) 40; 317–322
Wexham	*BJPS* (1987) 40; 655–656

The Scar Free Foundation

Today, the Scar Free Foundation (formerly the Healing Foundation) is the most active medical research charity in the area of reconstructive surgery, wound healing and disfigurement. The charity oversees a busy research programme in cleft, burns, tissue regeneration medicine, hand surgery, the psychology of disfigurement, aesthetic treatments and more. In 2016 the charity took one of its most significant steps, rebranding to The Scar Free Foundation under the refreshed vision of 'A World Without Scarring' and a bold new mission: 'to achieve scar free healing within a generation and transform the lives of those affected by disfiguring conditions'. A pioneering research strategy has been published and a major fundraising drive is underway to provide the £24 million needed over the next five years to kick start a globally significant programme of work that will have far-reaching implications for those who live with scarring or disfigurement.

The Scar Free Foundation was established by BAPRAS, registering as an independent charity in 1999. The genesis of the charity was in the King's Cross Station Fire of November 1987 and the subsequent Phoenix Appeal, which was led by Michael Brough and Gus McGrouther based at University College London. They knew that in order to take reconstructive surgical research into the 21st century a national, concerted and collaborative focus was required, with an ambitious vision of the future. The then British Association of Plastic Surgeons (BAPS) agreed to set up the charity and generously funded the essential start-up costs.

Marion Allford Associates (MAA), a leading consultancy in the voluntary sector, was commissioned to assist and to recommend how the charity should be formed and structured.

It was recognised that BAPS could not and should not do this alone and other professional bodies agreed to join the initiative. These included BAAPS, the BBA, the BSSH, and the Craniofacial Society of Great Britain and Ireland. It was this commitment and particularly the inclusion of the British Psychological Society which set the new charity apart from the regional and unit-based research organisations that preceded it and never quite broke out of their area of focus.

Early work identified that the charity should be patient/beneficiary orientated and confirmed the importance of a multidisciplinary approach. After much soul searching, the name of the new charity was confirmed as the Healing Foundation.

The Countess of Wessex and Brendan Eley with Simon Weston. Photograph courtesy of the Scar Free Foundation

MAA provided an Acting Director (Jacqueline Krarup) to take the plans forward, producing a corporate plan for the charity and establishing three working parties to plan its key activities: the Medical Research Working Party (chaired by Sir Kenneth Calman, former Chief Medical Officer), the Communications Panel (chaired by Lord Chadlington of Dean, founder of PR specialists Shandwick International Plc) and the Fundraising Intelligence Panel (chaired by The Hon Charles Martyn Hempell, a director of Deutsche Asset Management). However, the major coup was the appointment of Chris Patten (now Lord Patten of Barnes) to become Chairman of the new charity. The introduction to Chris Patten was brokered by plastic surgeon, Brian Morgan, who had known the family for many years.

The next important step was the appointment of John Hart CBE as the first Director of the Healing Foundation in February 1999. Work continued, with the charity formally registered in December 1999 and the agreement of the armed forces, police and fire services to become involved with the initiative. The main focus however, was on the development of the case for support for the charity, the establishment of the eminent Research Council and subsequently the vital research strategy, with an agreed list of major projects to be funded.

The Countess of Wessex with a young cleft patient. Photograph courtesy of the Scar Free Foundation

At the same time work started on developing the fundraising strategy. John Hart was working with the help of senior supporters to identify and recruit the Appeal Chairman and Brendan Eley joined the organisation in December 2001 as the Appeal Director to set up the fundraising function.

The second major coup was the appointment of Sir David Jones, Chairman of NEXT, as the Appeal Chairman. He made a major personal commitment and brought on board a team of high-level business leaders to support his fundraising for the initial target of £12 million. After what had been a long gestation period, the Healing Foundation's Appeal was launched at the Tower of London in 2003.

The Healing Foundation's first appeal was successful, raising the funds necessary to establish the charity's first national programme of research investments. These included:

- A major patient information research project undertaken by the Picker Institute Europe to assess the content and construction of high-quality patient information within the disfigurement sphere (grant value, £170,000 over three years).
- The establishment of the Appearance Research Collective, a UK-wide collaboration of clinical and health psychologists, led by Professor Nichola Rumsey at the Centre for Appearance Research at the University of the West of England, investigating coping and resilience among those affected by disfiguring conditions (grant value, £500,000 over three years).
- The Chair of Tissue Regeneration at the Healing Foundation Centre at the University of Manchester. This group numbered some 40 researchers investigating wound healing and tissue regeneration in a range of animal models (including tadpoles, mice and drosophila). The centre enjoyed significant publication successes including a paper in *Nature* (grant value, £5 million over 10 years with approximately £7.3 million matched by the University of Manchester).

The Countess of Wessex at the launch of the Scar Free Foundation. Photograph courtesy of the Scar Free Foundation

- The Cleft Collective. A nationally networked programme of clinical research in cleft and craniofacial anomalies at the University of Manchester, and a cleft gene bank and cohort study centred at the University of Bristol in partnership with the University of the West of England. Investigating the causes, long-term outcomes and best treatments for children born with cleft, this represented the largest single investment in cleft research ever seen in the UK (grant value, £5 million over five years with significant matched funding from host partners).
- The Burns Collective. Driven from two sites, the Children's Burns Research Centre – at the universities of Bristol, Bath, Cardiff and the West of England – and the Centre for Burn Injury Studies – at the University of Birmingham in partnership with the Queen Elizabeth Hospital, the Birmingham Children's Hospital and the Royal Centre for Defence Medicine. This collaborative research programme is interrogating an array of burns research topics from acute care, the systemic response to major burns, the epidemiology of secondary burns in children and a pioneering scalds prevention programme (grant value, £3.7 million over five years).

- The BSSH Centre for Evidence Based Hand Surgery at the University of Nottingham (£500,000 over five years).
- An ongoing programme of fellowships, bursaries and student elective awards totalling more than £1 million over 12 years.

In 2015, the foundation undertook a detailed assessment of previous research work and future priorities. Driven by the 'big questions' posed by BAPRAS and other member associations, a clear ambition to achieve scar-free healing within a generation had emerged. The goal is to initiate and lead a scientific and clinical research programme to deliver new scar-free treatment options for the future but also provide better understanding and improved treatments, both clinical and psychological, for those affected by disfiguring conditions today. In July 2016, the charity formally changed to become the Scar Free Foundation and a detailed scar free strategy was published. The strategy, authored by an advisory group of eminent research academics and clinicians, sets out the research themes and collaborative, networked drive necessary to achieve scar-free healing, delivered through new clinical treatments, within a generation.

The inspiration behind the Scar Free Foundation was the late Michael Brough and BAPRAS was the driving force. From the formation of the Phoenix Appeal through the success of the Healing Foundation and now the exciting ambition of the Scar Free Foundation, BAPRAS should be proud of the enormous contribution that has been made so far. Proud not just of the multiple return on our original investment and the impressive track record of high-quality patient-relevant research, but proud too of an organisation in the Scar Free Foundation to both frame and achieve world-changing surgical and clinical advances.

BAPS to BAPRAS: The History of the Association 1986–2016 records the past 30 years of this organisation, and follows the previous book, *The History of the British Association of Plastic Surgeons: The First Forty Years.*

This history includes perspectives from members, ex-Presidents and associates of BAPRAS and related societies, and traces the history of both the society and the specialty of plastic surgery over the past 30 years.

> "This book is a timely update on the development of the specialty of plastic surgery over the last thirty years, following on from *The First Forty Years* by Antony Wallace in 1986. Now, as we approach the seventieth anniversary of the Association, this book covers the name change of the Association from BAPS to BAPRAS and gives the reasoning behind such a move, now already ten years ago. Chapters have been written by those closely involved in the evolution of those changes and they are to be congratulated on this excellent record of the immense progress that has been made by all those involved in our specialty."
>
> Nigel Mercer, President of BAPRAS 2015–16

BAPRAS

British Association of Plastic
Reconstructive and Aesthetic Surgeons

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