Future development of plastic and reconstructive surgery in Australasia

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Plastic surgery has always been a specialty that pushes boundaries and drives the development of both new techniques and new technologies. Our specialty is limited by blood supply, not anatomic boundaries, using the application of fundamental principles to address novel clinical problems rather than simply one of a set number of procedures.

Our lack of limitation by anatomic site leads plastic surgeons to develop practices that crossover with many other specialties: head and neck otolaryngology, orthopaedic hand surgery, breast oncoplastic surgery, oral and maxillofacial surgery and even cosmetic surgery. As the experience of these sister specialties advances they adopt the approaches and techniques developed by plastic and reconstructive surgeons as they extend their scope of practice, as demonstrated by the increasing use of micro-vascular surgery by other disciplines.

This expansion of skills by other specialties is entirely appropriate and predictable, however, more often than not, it is viewed as an existential threat to plastic surgery. Other specialties extend their scope of practice in the absence of plastic surgeons. It is our very lack of availability and presence that drives the expansion of skills by other specialties. The future of plastic surgery, in my view, should be one of expansion and growth but to achieve this, and avoid becoming less relevant, it will take both significant engagement and cultural change.

In Australasia, plastic surgery services are almost all siloed in metropolitan centres. In Aotearoa New Zealand plastic surgeons are only resident in seven cities and towns—mainly linked to the traditional training units. Otolaryngology and urology, however—specialties of similar size—are found in 14–16 regional centres and general surgery and orthopaedic surgery in every town that provides surgical care. Yet people in all those towns still develop skin cancer, have traumatic hand and limb injuries, require breast reconstruction and indeed, if the milk solid payout is good, elect to have aesthetic surgery. Even in metropolitan centres plastic surgery is often siloed in one or two hospitals and has little or no regular...
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presence in other major hospitals, including some trauma centres.

Historically, plastic surgery services outside key centres have been provided by visiting services or mandating that patients travel to the centre. This ‘hub and spoke’ model keeps planning control central, and outreach services are often inconsistent or limited. This model is not patient focused and can act as a driver for the provision of ‘reconstructive’ surgery locally by non-plastic surgeons. In New Zealand more than half of all public hospital discharges for reconstructive procedures were not provided by plastic surgeons. There is a significant pressure—from patients and funders—to provide services closer to home.

The ‘hub and node’ model—whereby services are based in smaller centres but supported from larger centres for advanced practice, tertiary care and clinical governance—builds services in a patient focused way. New Zealand has recently seen the development of two nascent plastic surgery units in key regional cities which have developed from previous visiting services. The presence and availability of plastic surgeons have supported their growth and the vitality of these units reflects this. These new nodes have both retained strong links with ‘parent’ centres but plan and provide for the needs of their local populations.

New Zealand is entering a significant period of change regarding the provision of publicly funded healthcare with the planned devolution of 20 local district health boards into a single national health service—‘Health NZ’. The new structure, while still opaque, is an ideal opportunity to develop regional and national services supported with a centralised funding structure and a vision of national equitable care. It remains to be seen how much change can be achieved. The development of local/regional plastic surgery services also fits well with the Royal Australasian College of Surgeons (RACS) bi-national rural and regional health equity strategy. The central tenets of the strategy are selection, training and sustaining a rural/regional surgical workforce across all sub-specialties. For the provision of future plastic surgical care to benefit from either of these initiatives it is crucial that there is engagement and participation across the profession. The plastic surgery workforce, like all health workforces, has suffered from a failure to align workforce requirements, training and employment opportunities.

Finally, for broad plastic surgery services to develop, there also needs to be cultural change within the profession. Plastic surgeons have always praised and promoted advanced skills and experience. Most new fellows spend valuable post-fellowship time gaining and honing skills in niche areas. This, however, reinforces a future practice in large centres. Likewise, a cultural and commercial pressure to work solely in aesthetic surgery also drives urban practice. We have not always promoted, recognized, nor often modelled, generalist practice across both reconstructive and non-reconstructive plastic surgery. This needs to change. Palmerston North and Bendigo don’t need trans-cranial paediatric plastic surgeons but they do need practitioners experienced in the diagnosis and management of facial trauma. Regional and generalist positions need to be established and these roles supported and promoted for the value they provide populations who currently are not well served with access to plastic surgery.

Plastic and reconstructive surgery continues to have an enormous amount to offer in terms of surgical skills, a tissue-based approach to the pathology and the advancement of surgical science. But plastic surgeons and plastic surgery services must be visible, accessible and available for patients both in regions and across metropolitan centres if the specialty is to remain relevant. For our patients, equity of outcome requires equity of access.

References


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