

because of the sincerely held views of a minority⁶ (Marplan Poll commissioned by Middlesex Polytechnic, 1985) who oppose work designed to promote healthy life and avoid untreatable crippling disease.

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- 1 Department of Health and Social Security. *Human fertilization and embryology: a framework for legislation*. London: HMSO, 1987. (Cmd 259.)
- 2 Committee of Inquiry into Human Fertilization and Embryology. *Report*. London: HMSO, 1984. (Warnock report.)
- 3 Anonymous. BMA response to DHSS consultation document "Legislation on human infertility services and embryo research." *Br Med J* 1987;294:1303-5.
- 4 Chen C. Pregnancy after human oocyte cryopreservation. *Lancet* 1986;i:884-6.
- 5 Hooper M, Hardy K, Handyside A, Hunter S, Monk M. HPRT deficient (Lesch-Nyhan) mouse embryos derived from germline colonization by cultured cells. *Nature* 1987;326:292-5.
- 6 Templeton AA, Glasier A, Angell RR, Aitken RJ. What potential donors think. *Lancet* 1984;i:1080-1.

Plastic surgery: a specialty on its knees

Britain has not nearly enough plastic surgeons. One consequence is that the National Health Service is offering a service in plastic surgery that is effectively emergencies only. Another consequence is that private clinics for cosmetic surgery have proliferated, and some supply a substandard service. Why has this shortage of plastic surgeons arisen and what can be done?

The British Association of Plastic Surgeons reported in 1976 that Britain had 78 consultant plastic surgeons for 54.5 million people.¹ The association recommended to the Department of Health and Social Security, which accepted the advice, that there should be one plastic surgeon for every 250 000 people—that is, 217. The next 10 years saw an increase to 112, still half the desirable number. Britain has proportionately fewer plastic surgeons than any other member of the European Economic Community and fewer than many third world countries. (The dangerously low number of plastic surgeons was illustrated by the Bradford football stadium fire: 13 consultants and senior registrars treated 257 patients. Thus for two weeks 10% of all British plastic surgeons were tied up (D T Sharpe, personal communication)).

Since the 1976 report the demand for plastic surgery has risen enormously. Many new surgical techniques, such as breast reconstruction and microvascular surgery, have been introduced and demand for cosmetic surgery has risen massively. Thus a second review by the British Association of Plastic Surgeons in May 1986 showed that patients waiting for plastic surgery had risen from 30 670 in 1976 to 43 075 in 1986.² About four fifths of patients wait over a month for urgent admissions, and two thirds over 12 months for non-urgent surgery. The average plastic surgeon's waiting list has increased from 393 patients in 1975 to 463 in 1986. (Orthopaedic waiting lists are notoriously long, yet the average orthopaedic surgeon has only 202 patients on his list.) In the year since the report waiting lists have grown as undertaking elective surgery is becoming increasingly difficult in the contracting hospital service.

One reason for the shortage of plastic surgeons is that during the second world war plastic surgery expanded by developing centres in specialised units divorced from other medical specialties. Subsequently plastic surgeons have been reluctant to leave these centres and join the mainstream of

medicine. Thus 15 years ago when oral surgery and orthopaedics expanded greatly plastic surgery remained static.

Some authorities have, however, increased their number of plastic surgeons: for instance, the North West Thames Regional Health Authority has in the past year seen an expansion from 5.4 to 7.9 whole time equivalent plastic surgeons for a population of 3.5 million. In 10 years' time it plans to have 10 whole time equivalents. This compares with the South West Thames Regional Health Authority, which has similar financial problems, but has only 2.3 whole time plastic surgeons for 3.2 million people and no plans for expansion.

Emergency surgery and surgery for cancer are still comprehensively provided by the NHS, although the delay in treatment in some cases is long. The wait for reconstructive surgery is now generally unacceptable and likely to get worse. Many operations in plastic surgery are thus done by other specialists, and some of the subspecialties of plastic surgery may be lost. Ultimately only cosmetic surgery may be left to plastic surgeons. In my view, the specialty is also failing in its commitment to teaching and research, which can lead only to a decline in the standards of British plastic surgery and eventually British surgery itself.

Cosmetic surgery is available on the NHS in theory if it is clinically indicated either because of a functional problem (such as excess of skin in the upper eyelid limiting the visual fields) or psychological distress. Most patients requesting cosmetic surgery have an underlying anxiety, and the plastic surgeon has discretion on which patients he accepts for treatment on the NHS and the degree of priority each is given. In truth, almost all cosmetic operations are given low priority and join the long waiting list; probably many patients now being placed on the waiting list for cosmetic surgery will never receive it. Perhaps the DHSS must declare that some operations—for example, removing tattoos, repairing split earlobes, breast augmentation, facelifts, abdominal reductions, and fat aspiration—are no longer available on the NHS. This is a line taken by the private health insurance companies and followed by state funded medical provision in Canada and Australia.

The failure of the NHS to provide an adequate service has led to a huge increase in private clinics undertaking cosmetic surgery, and such is the demand that a recent advertisement in the *BMJ* offered a salary of up to £150 000 a year for a surgeon to work in a cosmetic clinic. With all clinics and hospitals now able to advertise packages for specific cosmetic surgery operations we must be concerned, specifically about the unrealistic advertising, the sometimes poor selection of patients, the absence of truly informed consent, and the inability of some of the surgeons to manage the postoperative complications. Policing of these clinics is urgently required.

Clearly, however, the public wants cosmetic surgery and is willing to pay for it. One solution to the shortage of plastic surgeons would thus be for health authorities to employ plastic surgeons on a more part time contract. This might mean that areas of the country that have no plastic surgeon could then have one.

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- 1 Cobbett JR. *A review of plastic surgery in the United Kingdom*. British Association of Plastic Surgeons. Evidence to the Royal Commission of the National Health Service. London: British Association of Plastic Surgeons, 1976.
- 2 Lendrum J, Broomhead IW, Sommerlad BC, Milward TM, Morgan A. *Report of the growth and development sub-committee of council. Recommendations for increasing the specialty*. London: British Association of Plastic Surgeons, 1986.