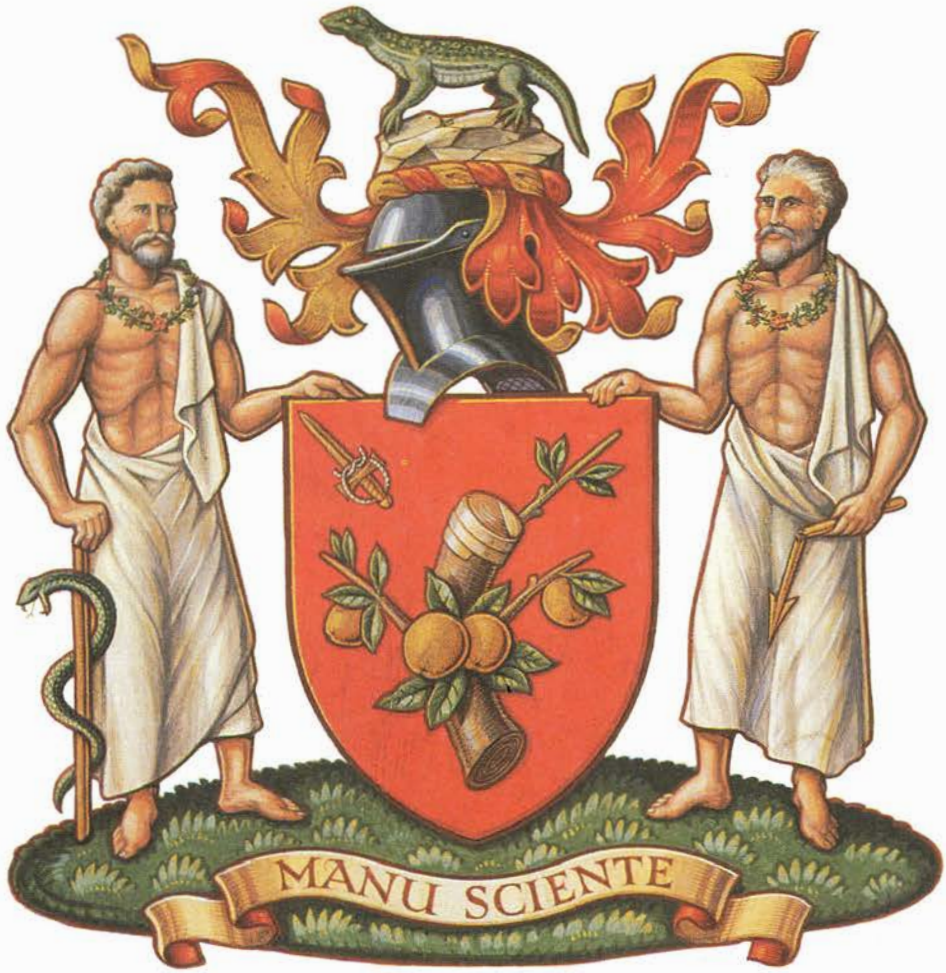
The History of the

British Association of Plastic Surgeons

The First Forty Years



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JAN 1987

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The History of the

British Association of Plastic Surgeons

The First Forty Years

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Edited by the Honorary Archivist and distributed to
all Members and Associate Members of the British Association of Plastic Surgeons

Churchill Livingstone

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Foreword by the President of the Association

Forty years' existence of an Association may not seem long enough to consider writing its history, but the rapid development of plastic surgery over these years makes it appropriate to put facts on record before they are forgotten.

The dictionary defines history as "an account of an event, or a knowledge of past events, or a past of more than uncommon interest". The history of the British Association of Plastic Surgeons surely fulfils all three definitions. The account of the event which saw the birth of the Association is a fitting introduction to the sections relating past events written by those who were there. It is thus a living history and as such must be of more than passing interest to all who work in the specialty. It also records the debt we owe to those who have gone before and led the way.

Special thanks are due to our archivist, Mr A. F. Wallace, for the enthusiasm and dedication he has shown in bringing an idea to reality.

Anne B. Sutherland
London, November 1987

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Editor's notes

This history has been commissioned by the Council of the Association to celebrate the 40th birthday of the British Association of Plastic Surgeons in November 1986. The idea of writing a history is not new and Members of the Association have been involved in earlier attempts to produce such a work, but felt that many of the personalities and events involved were too close for comfort—that it would be impossible to write dispassionately and fairly.

With the blessing of Council, a small committee of friends, convened by the Honorary Archivist of the Association, met informally and took the first definitive steps to launch this undertaking, at the Rose and Crown Hotel, Salisbury, on March 30th 1985 and then lunched together—John Barron, Ivor Broomhead, Charles Chapman, Brian Morgan, Tom Patterson, Michael Tempest and Tony Wallace. They met again in Salisbury on January 18th 1986, with the addition of Denis Bodenham. An enlarged committee including David Maisels, Tony Watson and John Watson met in the Robin Brook Centre of St Bartholomew's Hospital, London, on June 28th 1986 where lunch was served.

Any historical record, in certain respects, cannot help being incomplete, possibly inaccurate and to some extent prejudiced by the memory of the authors. These failings can appear even in an autobiography! The merit of the various chapters stands to the exclusive credit of the authors; the deficiencies that are unavoidable in this kind of work are not deliberate but stem from the real difficulty of keeping within the brief of writing a history of the Association rather than a comprehensive commentary on the history of plastic surgery in Great Britain. As Charles Chapman, who has contributed so much to the Association's archives, has written, "This volume is about the history of the British Association of Plastic Surgeons but without the brief history of the development of the specialty in the United Kingdom it would be bare bones indeed. In an age where television and satellite communications encourage the formation of associations and societies of persons with similar interests almost overnight, the birth of the British Association of Plastic Surgeons 40 years ago must seem to many to have been delayed unduly. The formation of the Association did not result from any particular technical breakthrough, indeed it can be said that it was born through a process of logical evolution greatly stimulated by the two World Wars. Developments elsewhere in the world, where charlatans were tolerated more easily, may even have delayed its formation in a conservative British society in which conventional professional progress was, and still is, the hallmark of medical respectability. The foundations of the specialty in the United Kingdom were laid in the 19th century by notable, if isolated, achievements of British surgeons in the realm of reconstructive surgery." History before 1914 has been excluded since its relevant innovations are world-wide.

All the plastic surgeons who have contributed to this volume are Members of our Association. Mary Hamilton of the Joint Secretariat in the Royal College of Surgeons of England is well known to us all. Brenda Lamb, when she wrote her chapter, was the "Matron" (despite reorganisations!) of St Andrew's Hospital, Billericay. Norman Rowe is one of the most distinguished oral surgeons in the UK, a highly respected author of authoritative surgical texts, and in the early years of our Association was an Associate Member and regular attender and speaker at our meetings.

The Editor has avoided duplication of information as far as possible and has used his prerogative to introduce additional material in certain chapters where it fits best and in such a way as to escape identification! Information and illustrations have been taken from the archives of the Association, the collection of which started in earnest in 1980. This history should be read in conjunction with the continuing series of histories of the plastic surgery units in the UK, the first of which appeared in the *British Journal of Plastic Surgery* in January 1985, and perhaps with a more general history of the specialty such as was published in 1977, 1982 and 1986. In this history the *British Journal of Plastic Surgery* is usually referred to as the Journal.

The Association can take justifiable pride in the many effects which it has had on the development of the specialty in the past 40 years. It has provided the main forum in the UK for the interchange of ideas and the dissemination of surgical advances. Throughout its existence the Association has been particularly circumspect in ethical matters and the good standing of the specialty owes much to the strength of the BAPS Council. Very strict rules

have been followed, undoubtedly, in many cases, to the considerable financial detriment of Members.

Without the organisational drive of Council and the Presidents, contributions made by Members could well have been scattered and lost but in, for example, burn care, facial fractures, hand surgery, microsurgery, cosmetic surgery and the treatment of congenital deformities, the Association provided the only effective platform for many years. Each of these sub-specialties now has its own specialised society, with many of the members of those societies also Members of BAPS. The history of the Association is linked so intimately with that of the specialty that it would be impossible to separate the two.

Through its committees and sub-committees and their reports, sound guidance, backed by the authority of Council, has been given to its Members. The *British Journal of Plastic Surgery* is its favourite child. The Association has maintained a controlling interest in training facilities and standards, and these have been followed in the various units. Such Regional Plastic Surgery Units have withstood much political buffeting and have become strong. Formal training has also benefited greatly from the tri-annual meetings run by the British Post-Graduate Medical Federation, which were first held in September 1980. The content of each meeting is organised by Members of the Association and the courses' excellence has stimulated the Association itself to play a more effective part in training.

Council, the authors and the Editor, trust that this account of the BAPS will be read and enjoyed both abroad and in the United Kingdom. It is presented "warts and all". It may help future generations of plastic surgeons to understand how and why their seniors moulded plastic and reconstructive surgery into the distinctive British shape that has had such world-wide influence. At a time when big international conferences are a major "growth" industry, it is well to be reminded (Chapters 10 and 12) how straightforward it can be to organise them inexpensively and so to enjoy them even more!

In addition to the great forbearance of the authors and "Salisbury Committee" members identified, the Editor is particularly grateful to the present and immediate past Editors of the Journal, Tony Watson and Michael Tempest, for their detailed advice and assistance given so generously and to Mrs Helen Stein for preparing the final draft of this History for the publishers.

Antony F. Wallace
Honorary Archivist to the Association
December 1986

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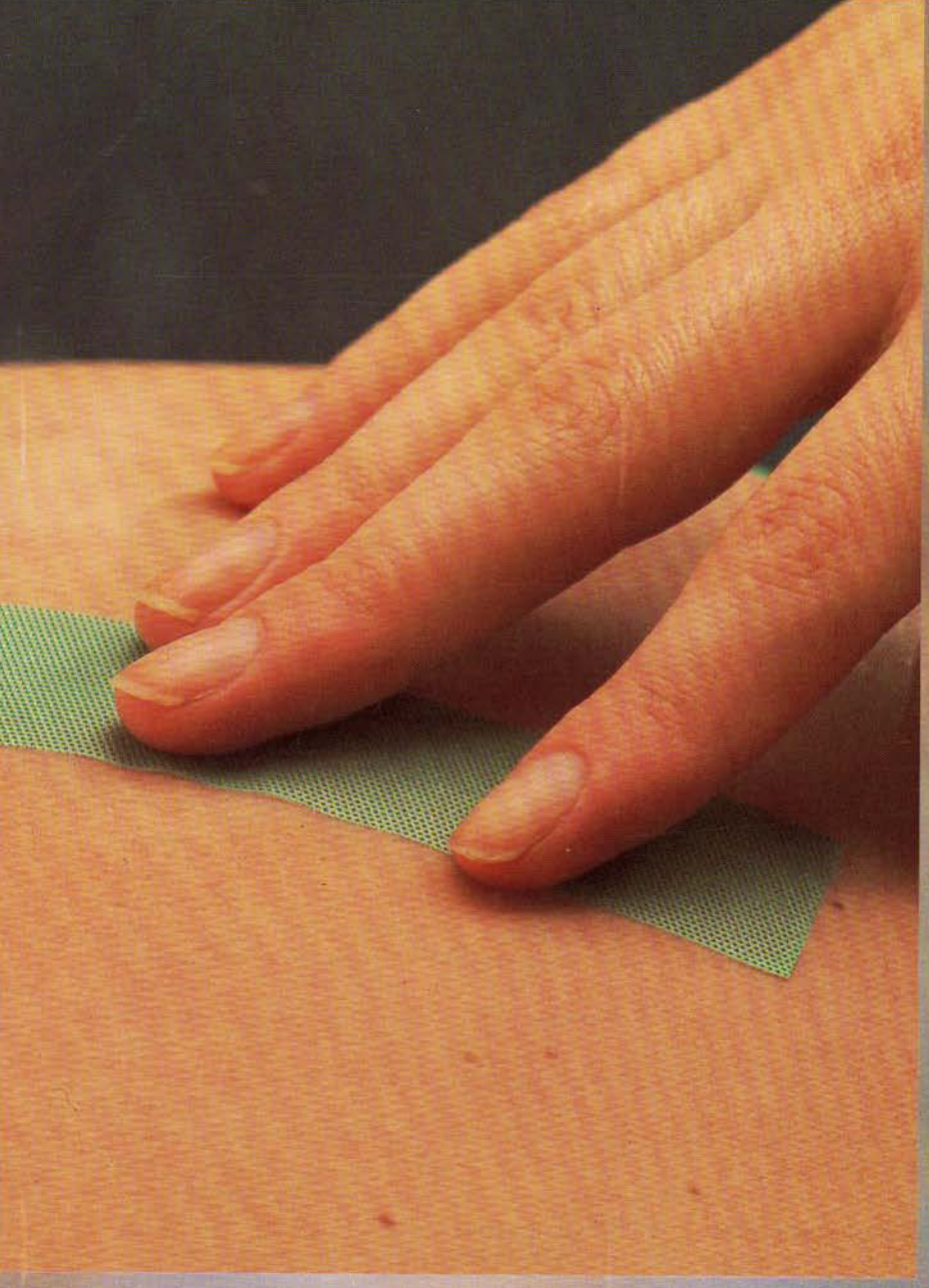
Contents



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27th November, 1964.

Dear Air Vice Marshal,

I am replying to your letter of 9th November to Squadron Leader Checketts.

There is, you will be glad to hear, no need for further paper work on the matter!

His Royal Highness has readily agreed to become the first Patron of the British Association of Plastic Surgeons and the deed is now done.

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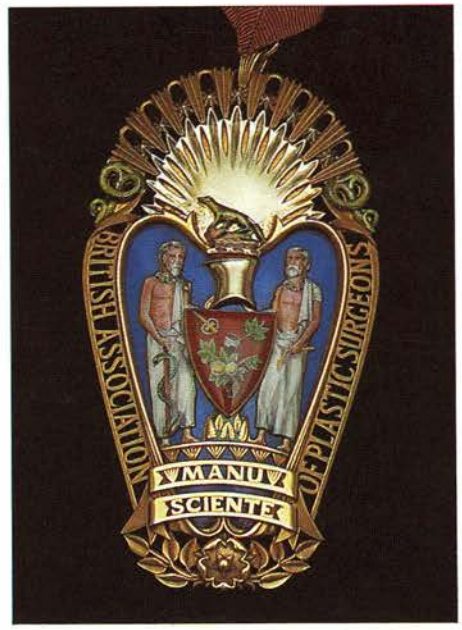
Yours Sincerely,

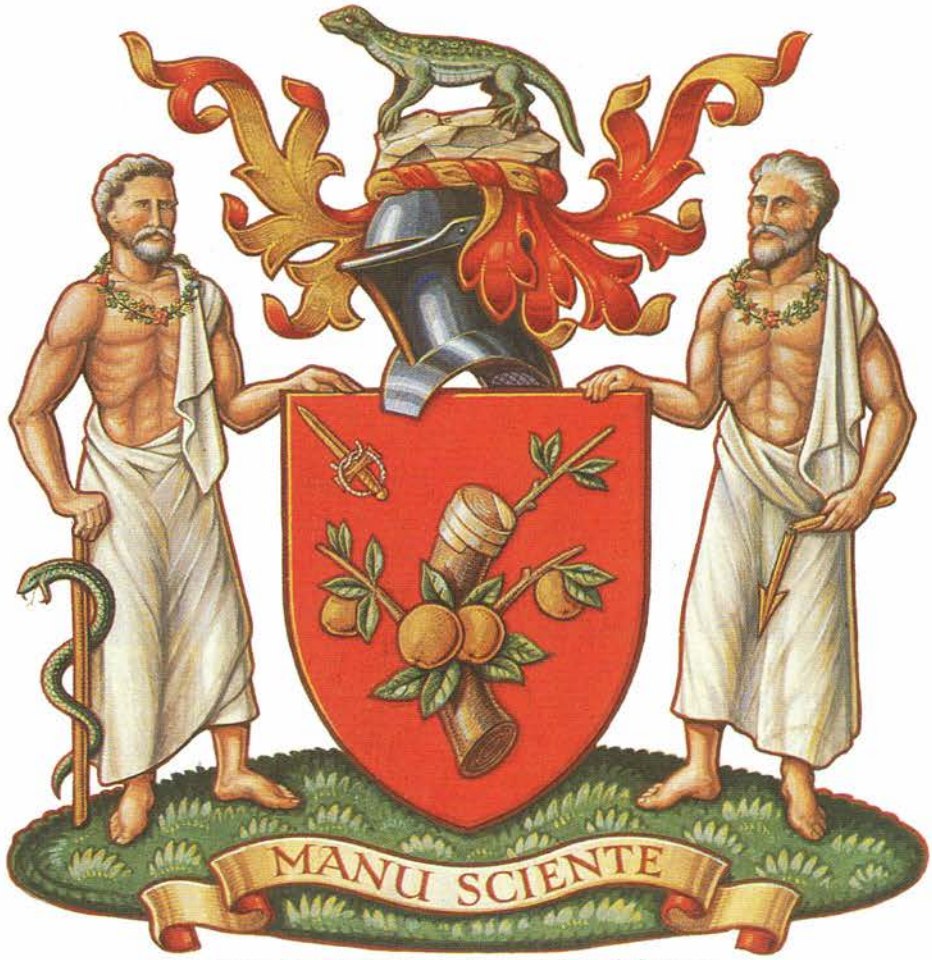
Christopher Bonham-Carter

Air Vice-Marshal G. H. Morley, C.B.E.

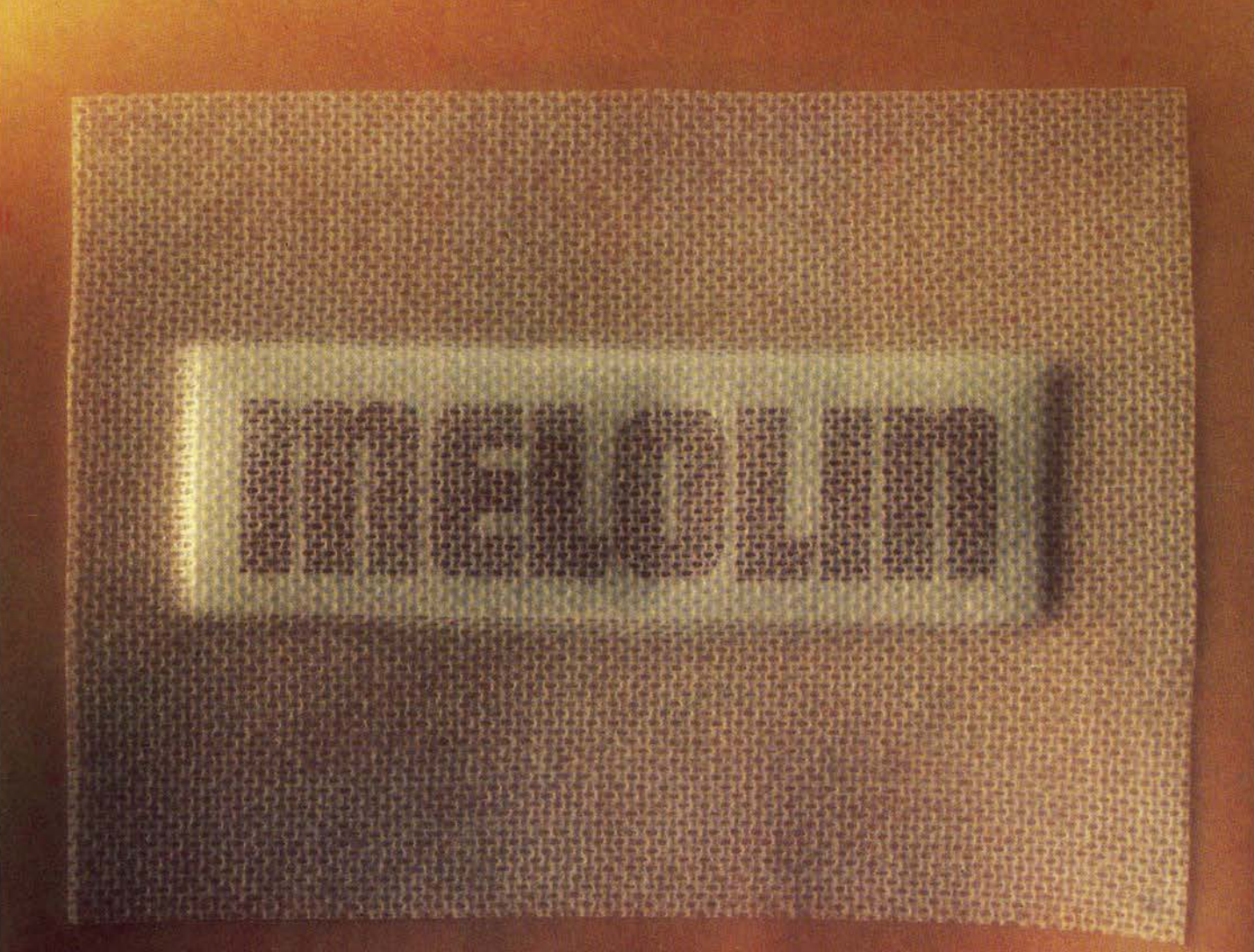
A letter from Buckingham Palace to Air Vice-Marshal G. H. Morley.



The President's Badge.



The Arms of the British Association of Plastic Surgeons.



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Two World Wars and the years between

The dictum that war is the best school for surgeons had a special significance for plastic surgery during World War I, 1914 to 1918. Until then facial "reconstruction" had been by artificial methods using materials such as celluloid plates and wax injections. Skin flaps had been used but no sound principles had been laid down. Gillies changed this, and put reconstructive surgery on a sound basis on which others could build. He recognised that missing tissue had to be replaced by similar tissue—skin by skin and bone by bone. Trench warfare and the horrific facial injuries which it produced led to a new race of surgeons.

Born in Dunedin, New Zealand, in 1882, the youngest of a family of eight children, Gillies was four years old when his father died. At the age of eight he was sent to a preparatory school, Lindley Lodge near Rugby. Four years later he returned to New Zealand to enter Wanganui College, but returned to Gonville and Caius College, Cambridge in 1901. At school he had been captain of the cricket eleven. He developed a love of fly fishing from his brother Bob. At the university he became a rowing blue and a half-blue for golf. His nickname of "Giles" dates from his university days. While still at university he reached the semi-finals of the Amateur Golf Championship at St Andrews.

Moving to St Bartholomew's Hospital, London for his clinical training he played first violin in the hospital musical society. After graduation and a period as house surgeon at St Bartholomew's, he gained his FRCS in 1910 and became assistant to Sir Milsom Rees, the senior ENT surgeon at St Bartholomew's.

At the outbreak of war in 1914 Gillies was 32. He volunteered to serve with the Red Cross and in late January 1915 was sent to France as a general surgeon. It is interesting to speculate about the principal reasons for his subsequent development of a special interest in facial injuries, perhaps being an "ENT man" had something to do with it. In Boulogne he came into contact with Charles Auguste Valadier who was working on jaw injuries in Wimereux. Varaztad H. Kazanjian was attached to a British General Hospital at Camiers and Gillies's close association with these two men no doubt played a part in his developing interest in maxillo-facial injuries. An American dental surgeon working in Paris lent Gillies a book on jaw wounds by Lindemann, of Germany, and suggested that Gillies should take up this sort of work. C. B. Heald, a close friend from Cambridge and medical student days, met Gillies in Boulogne and mentioned that a Canadian medical officer had expressed surprise that the British appeared to have done nothing about plastic surgery for their casualties. Finally, there was the impression made on him by the French surgeon, Hippolyte Morestin, whom he visited in Paris at the Val-de-Grâce Military Hospital. After watching Morestin operating Gillies himself wrote, ". . . I felt that this was the one job in the world that I wanted to do".*

The story from then on is better known—how Gillies (now transferred to the RAMC) managed to interest the Army authorities in the treatment and repair of face and jaw injuries and, with the backing of Sir William Arbuthnot Lane, was put in charge of a special unit set up in the Cambridge Military Hospital in Aldershot in early 1916. It was to this hospital, and to other far smaller hospitals provided with the help of the Order of St John and the British Red Cross Society, that the casualties of the campaign in France were now evacuated in rapidly increasing numbers. From the battle of the Somme alone (July 1916) 2,000 casualties were referred to Gillies.

* This statement is of such historical importance that it reappears later—Editor.

The Order of St John and the British Red Cross Society

The Priory in Clerkenwell, the headquarters of the Order in England, was founded in 1140. Both the Order of St John and the British Red Cross Society have long been intimately associated with the development of plastic surgery. In World War I the two organisations formed a Joint War Committee and its Report, published in 1921, has a section devoted to Hospitals for Facial Injuries. Early in 1916 Mr Robert Acland had been consulted privately with regard to the special treatment of several men with mutilated faces and suggested the possibility of the establishment of a hospital dedicated solely to the care of facial injuries. The hospital should be in a central position to receive cases of severe facial injury direct from abroad or from other hospitals in the United Kingdom where they could not be dealt with adequately. After some difficulty the Committee accepted 74 Brook Street, a house that had been offered to it by Mr Baxendale. The house was rent-free and the owner paid £100 towards the ground rent. The Government paid the usual capitation grants, and all other outgoings were paid for by the Order of St John. Two of the rooms, with minor alterations, were transformed into an operating theatre and a treatment/dressing room. The War Office initially sanctioned the use of the house for 14 beds only but this was later increased to 37 beds. The hospital opened in May 1916 but, the accommodation soon proving inadequate, a second house at 24 Norfolk Street, close by, was made available by Mr Joseph Duveen. This provided another 40 beds and became an annexe to 74 Brook Street where all the surgery was done.

For purposes of administration the hospital was attached to the 1st London General Hospital, Camberwell—a military extension of Bart's which itself soon had to make beds available to Brook Street to accommodate the overflow of casualties, a remarkable reversal of conventional procedure! The medical and surgical staff of the hospital were honorary; the nursing staff were fully trained and assisted by a number of VADs. Three skilled mechanics were engaged to work for the dental department. The average in-patient stay was 100 days. Both hospitals continued working until February 1919 when Norfolk Street was closed. Brook Street remained open until June 12th 1919 when its patients were transferred to the Queen's Hospital, Sidcup.

The Maxillo-Facial Hospital was opened at Kennington on October 2nd 1916 under the auspices of the British Red Cross, in a new building originally intended as a crêche. The accommodation was for 30 beds and was intended originally for men discharged from the services who were suffering from the effects of wounds to the jaw and face. The first patient was admitted on October 5th 1916 but only eleven patients applied for admission during the first three months. The management applied to the King George Hospital to ascertain if it could be attached to that hospital as an auxiliary hospital for Army patients.

The first Army patients were admitted on January 2nd 1917. After further discussions, operations were allowed in the hospital, from March 18th 1917. Later, the beds were increased to 33. Eighty-seven operations were performed under general anaesthesia as well as many minor operations under local anaesthesia. Twenty-five of the operations were "plastics", eleven were bone grafts and four were wiring of the mandible. One hundred and seventeen new dentures were made on the premises. One hundred and four new admissions took place during the time the hospital was open and there were seven readmissions. The hospital closed on December 31st 1918.

In 1916 the Cambridge Military Hospital in Aldershot, in which Gillies hoped to treat facial and jaw injuries, had 200 beds allocated to the task but this accommodation soon proved quite inadequate. It was not possible to enlarge the hospital, nor were its surroundings considered suitable for patients with facial injuries who needed quietness, fresh air, ample space and some means of outdoor occupation. None of these facilities could be provided at Aldershot and consequently Frognal House and grounds at Sidcup, near the main line to Dover, were taken over by a committee and bought for £16,000 by the Prince of Wales Fund. The house was an old one that had been the home of Lord Sidney. It was eventually agreed that the Red Cross were to become holders of the freehold of the property. The building of the hospital began in February 1917 and Queen's Hospital was opened for 100 patients on August 1st 1917; a further 213 beds were added on August 21st 1917 (Fig. 1.1). This addition, as soon as it became available, was occupied by that section of the Cambridge Military Hospital which had hitherto been dealing with these cases. The Army Medical Director-General decided to make the hospital a Central Military Hospital and designated it as a specialist hospital in the United Kingdom for facial and jaw injuries

Fig. 1.1 The Officers, The Queen's Hospital, "Frognal", Sidcup. November 1917

(Fig. 1.2). The Committee, with the generous aid of the British Red Cross Society, made funds available to increase the in-patient accommodation from 313 to 562 beds (Figs 1.3, 1.4 and 1.5). This number was increased further by affiliating the following auxiliary hospitals:

Parkwood, Swanley	200 beds
Oakley, Bromley	60 beds
Abbey Lodge, Chislehurst	60 beds
The Gorse, Chislehurst	40 beds
Southwood, Bickley	40 beds

The last four hospitals were Red Cross Hospitals and were affiliated to the Queen's Hospital by the ADMS, (Woolwich Area). When the Sir John Ellerman Hospital, St John's Lodge, Regent's Park, London was very kindly placed at its disposal by Sir John in July 1918, the Queen's Hospital had 1,000 beds available for facial and jaw injuries. The Sir John Ellerman Hospital closed in March 1919; it had been one of the earliest to open for facial and jaw injuries, and its 76 beds were fully occupied during the time of its affiliation to the Queen's Hospital. Civilian patients were admitted into both Sidcup and St John's Lodge.

The total sum spent on buildings and equipment at Queen's was about £149,000. From August 1917 to March 1920 the hospital was controlled by the War Office. From the time of its opening until June 30th 1921 11,752 major operations were carried out: there were 5,926 new admissions and 1,758 re-admissions. The museum, painstakingly and carefully established at the Queen's Hospital, contained plaster casts together with photographic and pictorial records of the patients treated and how their wounds were dealt with. Some of these records were displayed at the Inter-Allied Medical Congress in

Fig. 1.2 Queen Mary (centre right) at Sidcup with (standing and in uniform) Lt-Col. J. Colvin (centre left) and Major H. D. Gillies (extreme right)

Rome and in the Imperial War Exhibition (Medical Section).

Queen's Hospital, Sidcup, was renamed Queen Mary's Hospital in 1930, having been transferred to the London County Council. In 1974 a new Queen Mary's Hospital was built in the grounds of Frognal House above the site of the old hospital which was knocked down. In the entrance of the new Queen Mary's Hospital is a plaque which reads, "Presented by the British Association of Plastic Surgeons to commemorate Harold Delf Gillies, CBE, FRCS 1882 to 1960, whose work at this hospital attracted world-wide recognition and led to the foundation of plastic surgery in Great Britain".

Henry Tonks, FRCS, Slade Professor of Fine Art in the University of London, made a series of pastel drawings of patients with facial wounds treated by Gillies—some of these are now in the Royal College of Surgeons of England while most are on loan to the Army in Aldershot. All are reproduced in colour in a recent issue of the Journal (Bennett, 1986). Lady Scott, widow of Captain Robert Falcon Scott, the Antarctic explorer, herself a sculptress and painter of note, made plaster casts from photographs of patients taken before their injury, to help Gillies in his surgical reconstructions. She developed an interest in facial injuries, for later she visited a hospital for facial surgery in Paris, studying methods there.

Few would dispute the claim that Gillies, founder of the British Association of Plastic Surgeons, was the founder of reconstructive plastic surgery as it is practised today in the Western world. (The Editor is aware that other claimants to this priority have been identified both in North America and elsewhere in Europe. Their names appear in this book.) The number of surgeons from diverse countries who came to sit at his feet, and returned to establish the specialty in their own countries, would alone secure him this honour, without a list of his surgical achievements or his "Ten Commandments".

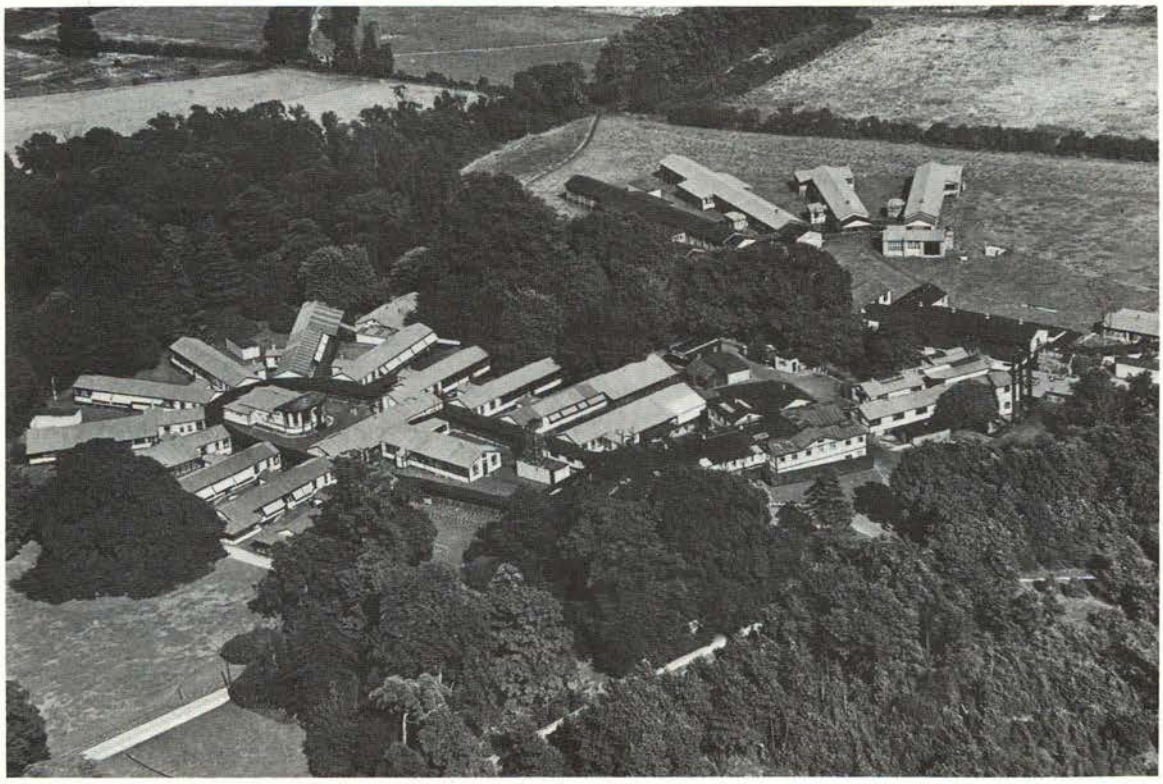

Fig. 1.3 The Queen's Hospital, Sidcup

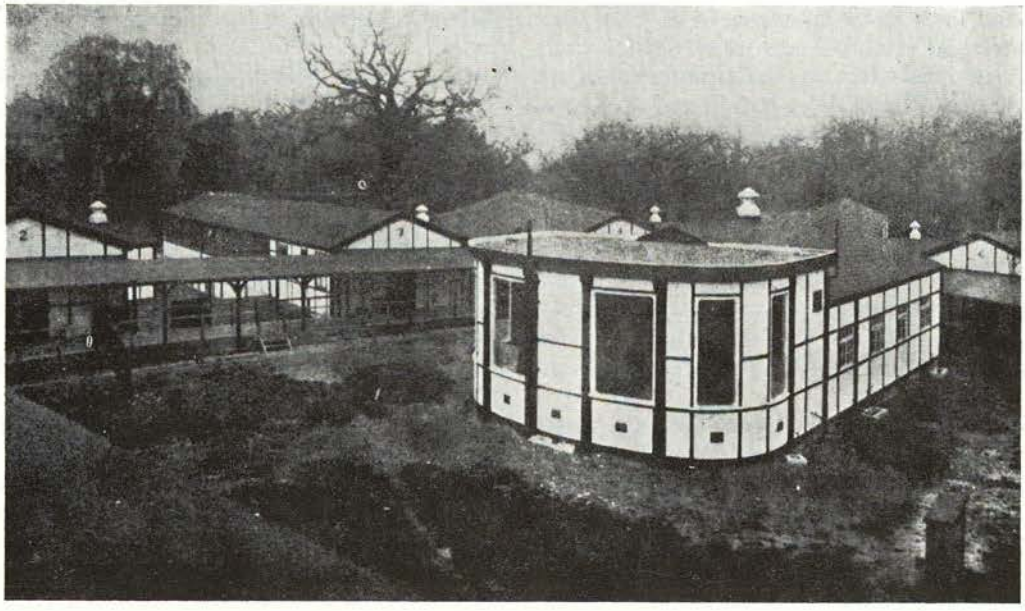

Fig. 1.4 The theatre block at Sidcup (From a 1917 postcard and reproduced in the *British Journal of Plastic Surgery*, 1976, **29**, 298)

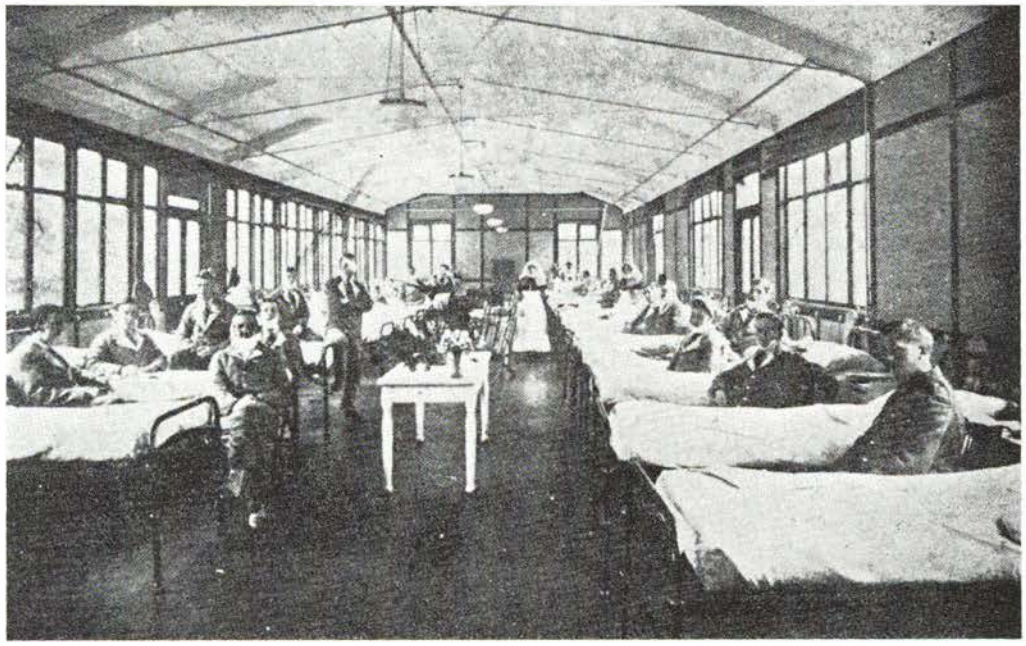

Fig. 1.5 A ward at Sidcup (from a 1917 postcard and reproduced in the *British Journal of Plastic Surgery*, 1976, **29**, 298)

The inter-war years 1919–1939

Although peace was declared in November 1918 the surgical work at Sidcup continued for several years. The staff of the American, Canadian, Australian and New Zealand Units gradually returned to their home countries to develop their work there and establish new units. Others came who had a helpful effect on the development of our specialty. Ivan Magill, who had joined the Royal Army Medical Corps at the beginning of the war, had become a general practitioner by 1919. He applied for the post of anaesthetist at Queen's Hospital, Sidcup, and there developed his endotracheal tube. Captain T. Pomfret Kilner joined Sidcup on March 17th 1919. He had served with a Casualty Clearing Station at the front and at No. 4 Base Hospital in France. He was anxious to return to England to obtain his FRCS and found himself posted to Sidcup.

Gillies left the Army on October 8th 1919. After a lecture tour in the USA he took consulting rooms at 7 Portland Place. Queen's Hospital, Sidcup was taken over by the Ministry of Pensions in March 1920 and Gillies took an ENT post at St Bartholomew's Hospital, London with the responsibility for treating any plastic surgery cases that were referred. He continued to work at Queen's Hospital. In 1920 he published the classic work *Plastic Surgery of the Face*, 419 pages with 824 illustrations which sold at three guineas. Of the 8,749 facial cases treated at Sidcup only 15 remained by the end of 1925. These remaining cases were transferred to Queen Mary's Hospital, Roehampton, where Gillies and Kilner continued to treat them for several more years.

During the inter-war years much of Gillies's work was done at the Prince of Wales Hospital, Tottenham and St Andrew's Hospital, Dollis Hill. In 1923 the *British Medical Journal* announced that a fund of £23,000 was to be raised to provide a wing housing a plastic surgery unit in St Andrew's Hospital, Dollis Hill. This was to be used to provide free places for patients unable to afford the fees for private plastic surgery. Gillies became an Honorary Consultant at two other hospitals—St James's Hospital, Balham, and the Lord Mayor Treloar Hospital for Children at Alton, Hampshire. He represented England against Scotland at golf three times in the 1920s, and became a member of the exclusive Houghton Club for fly fishing on the river Test. In 1930 he was appointed Consulting Surgeon to the Ministry of Pensions. He was awarded a knighthood in the Birthday Honours List in June 1920. The close association between Kilner and Gillies continued until 1929; it had lasted for ten

years when together they *were* "The School of British Plastic Surgery". Archibald Hector McIndoe arrived on the plastic surgery scene in 1931.

During the early 1930s Gillies was one of 36 physicians and surgeons who each undertook to provide a guarantee of £2,000 to open the London Clinic Nursing Home. Gillies had beds at the Hammersmith Hospital and, in January 1931, when the ward medical officer died "from a surfeit of Christmas pudding" according to one report, the post was taken by a young New Zealander, Rainsford Mowlem, who was then about to return to New Zealand. Mowlem rapidly developed an interest in plastic surgery and decided to remain in the United Kingdom. Thereafter "the firm" consisted of Gillies, McIndoe and Mowlem with Ivan Magill as senior anaesthetist.

In 1932 Gillies, who had been a painter of watercolours for many years, took up oil painting, and later helped found the Medical Art Society and became its second President.

In 1936 St Bartholomew's Hospital, so long associated with Gillies and his early work in the specialty, opened a plastic surgery department with four beds. St Thomas's Hospital opened a similar department soon afterwards, and Kilner became Consulting Surgeon. Mowlem was invited to the Middlesex Hospital in 1937.

David Matthews and Richard Battle had been attending Gillies, McIndoe and Kilner at the plastic unit at St Andrew's Dollis Hill, and travelling to the Lord Mayor Treloar Hospital at Alton on Saturdays with Kilner. John Hunter went with them as anaesthetist. They left early in Kilner's car and spent the whole day there, finishing with dinner in the local pub. They drove back to London usually around midnight but sometimes stayed overnight, and they kept up this demanding routine for more than two years.

It was at Dollis Hill that Gillies one day turned up exactly a day late for his operating list and was furious because everyone was not still waiting for him! His fury is also remembered when a junior nurse cut the pedicle of an Abbe flap on the patient's return to the ward because she thought that the patient was "a bit blue".

Gillies, Kilner, McIndoe and Mowlem covered most of England in the mid to late 1930s—Manchester, Birmingham, Stoke-on-Trent ("The Potteries") and the Treloar Crippled Homes at Alton in Hampshire, three London teaching hospitals (St Bartholomew's, St Thomas's and the Middlesex), St Andrew's, Dollis Hill and the Hammersmith Hospital. They worked at weekends, with local help, and Kilner had one free weekend a month.

Battle, in 1936, on seeking advice as to whether plastic surgery would be a good field for him was told, "Really, I do not think you have a chance, my boy, there are four plastic surgeons in the country, and I can't think there can be room for more", but fortunately he was not put off. Matthews, in the late 1930s, was chief assistant to Stanford Cade, the leading cancer surgeon in London—indeed it was due to Cade at the Westminster Hospital that Matthews became involved in plastic surgery. Cade was a radical surgeon and said to Matthews one day, in his guttural voice, "I make big holes, you go and learn how to fill them in": hence Matthews's attendance at the Dollis Hill and Treloar hospitals.

Eric Peet, ENT surgeon at the Radcliffe Infirmary, Oxford before the war, planned to train in plastic surgery and from 1938 he attended Kilner's clinics and operating sessions. J. P. Reidy visited Kilner in 1938 to enquire about training in plastic surgery but was told that there was no vacancy in the specialty in the forseeable future! He, too, was not to be put off.

Matthews and Battle were the only two surgeons of the next generation in formal training at that time, and subsequently became the link with the famous four. They both attended Sanvenero Rosselli's International Meeting in Milan in 1938, which had to be abandoned on the Thursday of that week in September due to the Munich Crisis; they had an exciting journey home with Europe mobilised. By the time they reached Paris the immediate crisis was over and they stopped to watch Victor Veau operate, spellbound as he threaded his beard over a specially made mask before scrubbing up. Gillies, McIndoe, Mowlem and David Officer Brown from Australia had also attended the Milan Meeting.

In 1938, Gillies had been appointed Civil Consultant in Plastic Surgery to the Royal Air Force. He soon had McIndoe appointed as his deputy, and then resigned leaving McIndoe as the Civil Consultant while he became the Honorary Consultant.

World War II

Not only was Gillies Honorary Consultant to the Royal Air Force but he was also given a brief by the Ministry of Health to organise, within the framework of the Emergency Medical Service,

plastic surgery units to treat civilian and service casualties and to train the necessary number of surgeons to do this work, along with dental surgeons and technicians to deal with maxillo-facial injuries. At first regular officers were seconded from the Armed Services, one each from the Navy and RAF and others from the Army. In 1940 civilian surgeons were trained for the two units planned for Bangour and Gloucester. An account of the training received by A. B. Wallace reveals the difficulties of the times. In August 1940 he left Edinburgh to spend three months with Gillies at Park Prewett, with some time at East Grinstead, Stoke Mandeville and St Albans. Six weeks later the disruption caused by the "blitz" on London made it too difficult for him to continue and he returned to Edinburgh. Six months later, in March 1941, he was able to travel south again and spent the remaining six weeks travelling between the four units gaining the experience to start the Unit at Bangour Hospital near Edinburgh.

The Royal Air Force

Of the Armed Services the Royal Air Force was the first to recognise the importance of the specialty, and Plastic, Maxillo-facial and Burn Centres were set up at Ely, Cosford, East Grinstead, Halton and Wroughton with specialist Burns Units at Halton, Cosford, Rauceby, Ely and East Grinstead.

The East Grinstead Unit was not really busy until June 1940 when casualties from Dunkirk arrived. Casualties arrived also from the Norwegian Campaign but it was during the Battle of Britain and the London "blitz" that the Unit became a hive of activity. In the meantime, McIndoe had been very active getting the hutted hospitals built, setting up the Burns Unit, and later the Canadian Wing. McIndoe would take David Matthews to East Grinstead by car with his anaesthetist, John Hunter. Matthews worked at East Grinstead three days a week, staying with the hospital secretary Captain Percival: the remaining four he worked at the Westminster Hospital in London.

The Battle of Britain, which reached its peak in September 1940 over south-east England, brought to East Grinstead the challenge of treating large numbers of air crew suffering from severe burns. McIndoe fully appreciated the consequences of high temperature flame burns of the face and hands; he condemned tannic acid treatment, until then in general use, because of the disastrous results caused by the added tissue destruction of tanning, finger-tip gangrene due to constrictive coagulation, and immobilisation which led to the frozen hand. He introduced the saline bath treatment, with the emphasis on mobilisation and early removal of sloughs. East Grinstead received much publicity for its work on both the surgery and rehabilitation of burned RAF pilots, but casualties from the other Services and civilian patients were also treated there.

McIndoe organised training courses of six months to two years for a number of RAF officers and, later, three courses of two weeks for groups of 20 officers. These were the first courses to be structured with organised lectures to cover the management of burns, facial and soft tissue injuries and fractures of the facial skeleton. The dental department and the anaesthetists arranged parallel courses. Those who were seconded to Basingstoke by the Army also attended the other centres for a few weeks, and interchanges were available to those who took the initiative to seek out the opportunities for themselves.

At East Grinstead the Guinea Pig Club, founded by surviving burnt RAF crew members, still exists, and sponsors the McIndoe Memorial Lecture given at the Royal College of Surgeons in alternate years. Richard Hillary, a Spitfire pilot who was shot down and became a patient in Ward Three at East Grinstead, has given a graphic description of what life was like for a patient undergoing plastic surgery for burns at that time: he recalled the devastating results of streptococcal infection on skin grafts, the powerful impact of McIndoe's personality and the state of the art of general anaesthesia at that time. Hillary flew again but crashed a second time and was killed. His book, *The Last Enemy*, published in 1943, is regarded as one of the most moving personal narratives by those actually involved in the fighting.

Denis Bodenham served in the RAF from 1940–1946. He spent time at East Grinstead in 1941 and then moved to Halton where David Matthews had started the Plastic Surgery and Burns Unit. There were twelve beds for burns and the Unit had special saline baths with full saline-making equipment. He recalls being taken by McIndoe on one of his monthly tours of RAF burns units. In 1944, in an RAF workshop, Bodenham made the first skin grafting knife to employ disposable blades, undivided strips of safety razor blades. All modern skin grafting knives are modifications of this original prototype, which is preserved in the Association's Museum. Percy Jayes served at East Grinstead from the start and throughout the war. George

Morley, a regular RAF medical officer, was trained by McIndoe in 1939–1940 and started the RAF Burns and Plastic Unit at Ely.

The Navy

From the Royal Navy, E. H. Murchison was sent to Rooksdown to work with Gillies. He maintains his interest in plastic surgery to this day and in a letter written from Gibraltar on August 18th 1983 he records how, "In April 1940, at the instigation of Sir Cecil Wakeley, who as Naval Consultant was stationed at Haslar, Charles Pearson and I were sent to Sheffield to train and get better in orthopaedics with Fred Houldsworth (later Sir Frederick). After three to four months we were given the 'OK'. Charles Pearson returned to the RN stream but I was sent to the Maxillo-facial Unit at Rooksdown House, which had been the private wing of Park Prewett Hospital, Basingstoke.

I found my nine months with the Gillies team the most intensive and stimulating in my entire surgical career. Assistance, sound advice and pungent criticism were never in short supply. Severe facial burns, maxillo-facial injuries and gross tissue loss trauma poured in from the air, sea and the London 'blitz'. What with the children and erstwhile gorgeous looking girls mutilated in the 'blitz', my feelings for the enemy became a mixture of aggression and revulsion.

I found the energy of the New Zealand band of plastic surgeons—Gillies, McIndoe, Mowlem and Barron—boundless and to a degree infectious. There was no let-up and it was commonplace to hear Gillies expanding on problems and programmes up to the small hours of the night. Rooksdown House was his headquarters but I always accompanied Sir Harold on his trips to London when treatment was initiated for the wounds, often only preparatory to transfer to one of the main centres. The variety of maxillo-facial injuries was legion and gradually their treatment became a combined effort between plastic surgeons and the dental fraternity.

The war brought a rush of trainees from the Services and from all over Britain, Australia, South Africa and America. Rooksdown House was the Mecca but eventually all trainees, including myself, had to do at least six weeks at the other two centres. This, of course, highlighted the different approaches to various problems. McIndoe's methods of treating fractured mandibles originated from an orthopaedic suggestion at one of the Saturday meetings. Sir Harold was the only one not to treat it with scorn and insisted on its being evolved, largely with the help of RAF technicians.

Whenever possible I was detailed to treat Naval patients and when Sir Harold was called as Consultant to the Navy, usually to Chatham, I always accompanied him. You can imagine the comments of some of our very senior colleagues when I was frequently asked by Sir Harold to 'carry on boy' with the surgery whilst he went off to do some landscape painting (expert in this, too, as well as fishing and golf!). After my return to Haslar in April 1941 and in my subsequent appointments it was arranged by Sir Harold Gillies that I should return to Rooksdown House to complete any Naval surgery I had taken part in and become implicated in fresh cases. The contents of Sir Harold's book—*The Principles and Art of Plastic Surgery*—will give a better outline of Naval plastic surgery than I can unfold and typical of his generosity is Gillies's reference to me in Volume 1 of that book. Later I was moved to RN Auxiliary Hospital, Sherborne which was established as the Orthopaedic Centre and where, in addition, I treated all the plastic problems that came my way. Patients were admitted from all spheres of naval activity including the Pacific and consequently the work was largely reparative orthopaedic and plastic surgery. This type of work went on until 1949 when I moved the Unit to the Royal Naval Hospital at Haslar."

During the war John Bunyan developed the Bunyan-Stannard bag to help in the first aid and definitive treatment of burns. At that time Bunyan was a dental officer in the Royal Navy and on a journey north, his brother-in-law introduced him to Stannard who at that time was involved in covering electrical wiring for aircraft with plastic insulation. Bunyan and Stannard together developed envelopes for the treatment of burns. Often in the early days they visited patients together and the irrigation envelopes were custom made—the forerunner of our present "Flamazine" bag, introduced by R. M. Slater and N. C. Hughes in 1971. For over 40 years he was a protagonist of the use of electrolytic sodium hypochlorite solution first in dental work and later an irrigation solution that could be perfused through the various devices that he invented for the treatment of burns. Stannard made the original "oiled silk envelopes" that kept fresh hypochlorite solution in contact with the burn wound. Various patterns of mittens, arm and leg envelopes, blouses, trousers and even "boiler suits" and beds were devised in this oiled silk material. Later, mitts containing sulphanilamide powder

were issued to air crew and tank crews for the early treatment of burnt hands.

The Army

In the Army a directive on the formation of Maxillo-Facial Units was issued as early as September 12th 1939, nine days after the outbreak of war. R. J. V. (Dickie) Battle, who had joined Kilner at St Thomas's was the first plastic surgeon to be sent abroad with the British Expeditionary Force (BEF) and arrived in Dieppe in December 1939. Although there was no established plastic surgery unit at that time, patients with facial and jaw injuries were being sent to Dieppe where there was an Army Dental Corps specialist, but no special equipment!

A committee was formed under General John Weddell, with Sir Charles Max Page (Consultant Surgeon to the BEF) and the Deputy Director of Dental Services in attendance. Major Paddy Wren was ADC, with Battle as secretary. Plans were made initially for a maxillo-facial unit to be attached to a general hospital. Later General Weddell and Sir Harold Gillies made further plans for the setting up and training of a number of maxillo-facial units. Gillies and the Army Dental Corps selected all the surgeons and dental consultants. The Army units were all trained at Rooksdown House, with the exception of No. 6 that was trained by Mowlem's unit.

Army maxillo-facial units

British Expeditionary Force (1939–40)
Dieppe: R. J. V. Battle; P. Wren (dental)
Boulogne: C. L. Heanley; G. T. Hankey (dental)

Unit No. 1 (Middle East Forces: based at various times in Alexandria, Tripoli, Sicily and Italy)
R. Champion (1940–43)
R. S. Murley (1941–44)
R. J. V. Battle (1943–45)
R. P. G. Sandon (1944–45)
Dental: E. J. Dalling (1940–45)
B. V. Janes (1943–45)
J. F. Lockwood (1945)

Ad hoc Unit (Italy)
A. Smith-Walker (1944–45)
Dental: Hribajevsky (1944–45)
R. Grewcock (1944–45)

Unit No. 2 (Middle East Forces: based in Cairo)
M. C. Oldfield (1940–43)
M. H. Shaw (1943–45)
Dental: W. R. Roberts (1940–45)
R. S. Pook (1940–45)

Unit No. 3 (Far East, India, Burma)
C. L. Heanley (1942–45)
Dental: J. H. Hovell (1942–45)

Unit No. 4 (North Africa, Italy, Normandy)
P. W. Clarkson (1942–45)
R. Lawrie (1943–45)
Dental: T. H. Wilson (1942–45) (died on active service)

Unit No. 5 (Normandy and Germany)
G. M. FitzGibbon (1944–45)
T. Gibson (1944–45)
Dental: N. H. Holland (1944–45)

Unit No. 6 (France and Belgium)
W. Hynes (1944–45)
W. Cowell (1944–45)
Dental: W. B. Hales (1944–45)

Indian Unit No. 1
F. W. Pickard (Canada) (1943–45)
T. Gibson (1945–46)
Dental: N. Thompson (1945–46)

Indian Unit No. 2
E. Peet (1943–45)

Lone Ranger (India)
H. E. Blake (1942–43)

During the course of the war the number of plastic surgeons in the UK multiplied ten-fold. Many civilian surgeons were trained to staff the EMS Plastic Surgery Units that treated not only civilian but service patients—these were sited, for example, in Gloucester, Manchester, Ballochmyle, Bangour and Leeds to name only a few. Many of those who had worked in the plastic units in the Services joined these civilian units on demobilisation and continued their work in our specialty. Some of the Service "specialists" did not remain in whole-time plastic surgical work. Oldfield returned to the teaching staff of Leeds General Infirmary as a general surgeon with an interest in cleft lip and palate. Smith-Walker returned to ENT work. Lawrie became a paediatric surgeon at the Evelina Hospital, while Murley became a general surgeon and eventually a President of the Royal College of Surgeons of England. Gibson remained in plastic surgery and became President of the Royal College of Physicians and Surgeons of Glasgow.

Research

During World War II a great deal of excellent research work was done in the plastic units both at home and abroad. Much of it was devoted to the problem of wound infection and cross-infection and the uses of the sulphonamide drugs and penicillin. In this field the work of Leonard Colebrook was outstanding. The studies on the treatment of burns by Colebrook and Gibson in Glasgow (in 1941 dried plasma became available in the standard MRC 400 ml bottle and the outlook for patients with extensive burns began to improve), the work of Mowlem in the advocacy of cancellous chip bone grafts and Gabarro's observations on skin grafting (1943) are just a few of the items that spring to mind, along with the MRC Memoranda on the Treatment of Wound Shock, Notes on Gas Gangrene: Prevention, Diagnosis and Treatment, Emergency Amputation, Aids to the Investigation of Peripheral Nerve Injuries, The Use of Penicillin in Treating War Wounds, The Prevention of Hospital Infection of Wounds. Tom Gibson was involved in research into the volumes of fluid required in the shock phase of burns and in the development of the Glasgow No. 9 cream for burns: this contained sulphanilamide. In 1942 a Burns Sub-committee of the Council's Wounds Committee was formed to co-ordinate research on burns. J. R. G. Edwards has recorded his memories of those times in the Gloucester Unit and the then current treatment of burns (Edwards, 1985). Events can cast long shadows and, in the light of current research, it is prophetic to recall how, in 1941, Gillies treated a famous QC who had sustained extensive burns in an oil bomb explosion at Hendon. Gillies took a three inches square skin graft from the patient, who was then in Rooksdown House, and had the skin cultured in an Oxford laboratory until it was four times its original size; unfortunately it did not survive when applied to the patient.

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The origins of the BAPS

During the anxious months of 1939 a succession of sinister clouds of war began to march relentlessly across the skies of Europe. These clouds were generated by the Nazi war menace to Austria and to the Sudetenland and they caused considerable turbulence in the corridors of power in England. One such corridor was found in the Ministry of Health in Whitehall from whence emerged a functionary who, at the insistence of Sir Harold Gillies in March 1939, was obliged to discuss the deployment of plastic surgery services should war break out. Sir Harold had been appointed Consultant Adviser to the Ministry early in 1939.

Sir Harold, remembering the problems of World War I, was in favour of putting these services on a rational footing before hostilities could commence. A number of meetings were held both at the Ministry and at Harley Street during that year which Sir Harold, Professor T. Pomfret Kilner, Sir William Kelsey Fry, Archibald McIndoe and Rainsford Mowlem attended. As a result of these discussions the Minister eventually agreed to the formation of four base units in the UK for the treatment of plastic and maxillo-facial casualties, both civilian and from the Armed Forces.

These base units were to be sited at Park Prewett Hospital (Basingstoke), Queen Mary's Hospital (Roehampton), Queen Victoria Hospital (East Grinstead) and Hill End Hospital (St Albans). Orders were given for the immediate evacuation of existing patients on the outbreak of war. Space would thus be made available for ward, theatre and out-patient accommodation when suitable adaptations had been completed.

World War II on the Home Front

It was in these hospitals that the principal training centres for plastic surgery for both civilian and armed services surgeons were to develop, and intensive courses of instruction were available for UK and Commonwealth personnel. In the early months of the war Army, Navy and Air Force officers and other ranks were drafted in, together with Canadian, Australian, South African and New Zealand contingents which were ultimately to become the front line medical services of the Allied Forces. This time can be counted as amongst the finest hours of the fledgling specialty and the "esprit" that was born in those days has since spread to all corners of the globe where it still flourishes and unites succeeding generations.

The heads of department were, Gillies at Rooksdown House, Park Prewett, Kilner at Roehampton (and, after 1941, Stoke Mandeville), McIndoe at East Grinstead and Mowlem at St Albans. There was much to do and little time to waste as events on the Continent were becoming ever more menacing. The first priority was staffing. On the surgical side there was only a handful of younger men who had had any training, and those who had no service commitment were drafted in to form the junior echelon in each unit. Teams were built up by bringing in senior and junior dental surgeons, anaesthetists, technicians, photographers and artists. We were especially fortunate in being able to integrate senior nursing personnel from the teaching hospitals with which the chiefs had been associated. So, with excellent secretarial help, the embryo units began to take shape and in September 1939 a rudimentary service was available. Until the evacuation of Dunkirk in May 1940 there were few war casualties, and the teams were kept busy with patients culled from the teaching hospital waiting lists. This shake-down period was a blessing, and time was available for teaching purposes. Team co-ordination developed, and when the flood of patients poured in during the summer the units were running smoothly and efficiently and were

also able to cope with the results of the massive air-raids which started in September of that year.

Two of the units were sited in mental hospitals, Park Prewett and Hill End. These institutions, of course, boasted no operating facilities. New building was not possible at that time and modifications of existing ward annexes provided the basic accommodation in which the surgical through-put was enormous. Gross overcrowding and the resulting cross-infection were a nightmare at that time, before the advent of modern antibiotic therapy. One of these theatres was obliged to house its sterilising room in a glass-covered conservatory which was far from waterproof, and in wet weather the theatre nurses experienced a most unenviable environment.

Later in the war further centres were formed at Shotley Bridge, Durham (1939), St James's Hospital, Leeds (1939), Baguley, Manchester (1940) Liverpool Broadgreen (1940) and Gloucester (1943). In Scotland the war led to the birth and development of plastic surgery with centres based at Bangour, West Lothian (1940) and at Ballochmyle, Ayrshire, with an auxiliary unit at Stracathro, Brechin (1940). Surgeons were carrying out plastic procedures at a number of these hospitals long before their formal recognition as plastic surgery centres. It had been estimated that 30,000 casualties could be expected from bombing raids but the "phoney war" continued and, by April 1940, only 11 of Rooksdown's 200 beds were filled. In 1941 the vulnerability of the Roehampton unit was realised and it was moved to Stoke Mandeville.

Atraumatic surgical technique

In spite of many problems and conditions which would be unacceptable today, it was during the war years that much of the fundamental philosophy of plastic surgery emerged, and gradually basic principles became apparent. It was not, however, until the Association was formed that a wide forum existed wherein all these thoughts and experiences could be digested properly. Great strides were made in the development of systems of tissue transplantation, of instrumentation, of wound and burn management and in the treatment of facio-skeletal injuries, and the foundations were laid upon which the remarkable developments of the post-war years were based. It is now evident that the cardinal concept which stimulated the many advances that were to come was the adoption of "atraumatic surgical technique". In this concept plastic surgery was pre-eminent, and the tradition was handed down to succeeding generations whose technical achievements arose from the acceptance of this principle.

It has been argued that our observance of non-violation of tissues stems from our war-time association with the ophthalmic and neuro-surgical specialties and there may be something to be said for this theory. Wherever it started, it is our lifeline to the future. And so, once more as in the 1914–1918 conflict, the travails of war sponsored an ever-widening development of the concept of reconstructive surgery.

The tide was turning in 1943 and the advancing Allied armies were raising the hopes of the free world. At the same time the Luftwaffe, the V1 and V2 missiles were creating havoc in the big centres of population in England. London was being seriously inconvenienced and the thousands of casualties were being evacuated to peripheral hospitals after each night's devastation. During this year, supplies of the rationed wonder-drug penicillin were allocated to plastic units so that controlled clinical assessments could be made. Towards the end of the year it became evident that we had had a unique experience with this antibiotic and it was considered that the staffs of these units should meet to discuss the value of this therapy in the management of war injuries.

The "Big Four" agreed with the idea, which had emanated from the clinical pathologist at Hill End. This unit was chosen to be the host for a Clinical Conference on February 24th 1944. Rainsford Mowlem was elected to the chair and under his baton an excellent survey of the drug emerged, from which the 24 surgeons and associates derived considerable benefit. After the morning session lunch was served, consisting of whale meat steaks and other tempting delicacies. This banquet engendered a convivial atmosphere and encouraged the delegates to take a walk in the hazy afternoon sunshine to gather strength for the scientific discussions which were embodied in the afternoon programme.

How about a Plastic Club?

We had formed a group on the hospital lawn endeavouring to digest our lunch when Sir Harold suddenly called for silence and said, "What do you chaps think about forming a Plastic Club?" The reaction was immediate and enthusiastic and it was

then that Archie McIndoe proposed that a committee from the younger generation be elected to develop the idea. The committee as suggested by "The Four" was as follows: James Cuthbert, Percy Jayes, Emlyn Lewis, Roland Osborne, Pete Reidy and John Barron (Secretary).

The committee first met in Gloucester by invitation of Emlyn Lewis on April 22nd and 23rd 1944, and again on May 20th at Harley Street. These three days were spent in controversy and debate and it became obvious that we had little expertise in matters of this sort. In fact, we soon found ourselves in grave trouble. With some difficulty we discarded the suggestion of a Club, much to Sir Harold's annoyance as he had envisaged a more loosely-knit and social group. The argument then centred on the choice between a Society and an Association, because in those days there seemed to be a subtle difference between the two. Finally we agreed to recommend an Association and the name British Association of Plastic Surgeons took precedence over such alternatives as the Association of Plastic Surgeons and others. So the name BAPS was born and under its banner the specialty has grown from strength to strength from that time until the present day.

. . . 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 main 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 and 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 President

Amongst the problems which faced the inaugural committee was which name to put forward as first President. It will be realised that the committee members were very junior to the "Big Four" and did not wish to commit a *faux pas* in matters of this sort. There were obviously two names to be considered, Sir Harold Gillies and Professor T. Pomfret Kilner who was the holder of the only Chair in Plastic Surgery in the United Kingdom at that time. There were six members of our committee and no arrangement had been made for a casting vote. Realisation of our invidious position was immediate when the first Presidency was put to the vote. Three members voted for Sir Harold and three for Professor Kilner.

The decision ultimately taken was that we should recommend a joint Presidency for two years, each of the nominees to take the chair at alternate meetings. The Secretary was requested to inform our two seniors of this decision.

Gillies's reply was as follows: May 9th, 1944, "Would it not, in order to avoid any invidious distinctions amongst so small a number of eligibles, be better to be somewhat unusual as a Society and have no definite President or Vice-President, but merely to have a Committee? If on the other hand you feel that you must have a President then I think it would be much better to have the one and only Professor in our ranks."

Kilner replied in the following terms: May 9th, 1944, "I feel duly honoured that your provisional committee has suggested that I should share in the first Presidency and it would give me great pleasure to accept the invitation."

Fig. 2.1 BAPS Council 1946–7 (from left to right standing) A. B. Wallace, M. C. Oldfield, W. Hynes (from left to right sitting), R. Mowlem, J. N. Barron, Sir Harold Gillies, Prof. T. P. Kilner, R. P. Osborne

The situation which faced us on receipt of the two letters was a daunting one in that we had to choose between having either no President or a joint Presidency. Private investigations uncovered the fact that agreement by the two candidates to either solution would not be forthcoming. The Secretary was asked to approach Archie McIndoe for his advice. He was quite definite that we should nominate Sir Harold and this we did, happy to be relieved of the responsibility.

A final draft of the Constitution was now possible and this was ratified at the London meeting on May 20th 1944. The agreed text was sent to the "Big Four" who discussed it and indicated their acceptance. At this stage Gillies suggested a general meeting to be held at Basingstoke in June at which the Constitution would be presented to those who were interested, and this to be combined with a clinical meeting. This was not to be as Professor Kilner said that a business meeting only should be organised on neutral territory, open by invitation to all those who could be considered as founder members should an Association be formed.

After D-day

June 1944, however, was destined to be the chosen time for the epic D-Day landings in Normandy which led to the Battle for Europe. It was therefore manifestly impossible to arrange any such meeting nor was there time or opportunity to go forward with detailed planning.

The events of the next two years were such that the whole project was put into cold storage; it was resurrected in the summer of 1946, at which time an approach was made to Sir Alfred Webb-Johnson, later Lord Webb-Johnson, who was then President of the Royal College of Surgeons of England. He agreed with the formation of an Association of Plastic Surgeons and had the matter discussed by

the Council of the College. Council agreed and invited us to hold our inaugural meeting on the premises under Sir Alfred's chairmanship on November 20th 1946. Some 38 surgeons attended; 44 had said that they would be present, and after an address from the Chair the proposed Constitution was received and accepted. Enlightened discussions and prognostications as to our future took place and a committee (or council) was elected with Sir Harold as the first President (Fig. 2.1). Lord Webb-Johnson and Sir Gordon Gordon-Taylor gave invaluable advice. Listed below are the surgeons who originally said that they would be present at the inaugural meeting of the Association, and it may be compared with the signatures of those who did attend (Fig. 2.2).

Mr J. R. Ascott	Mr P. J. Jayes
Mr G. Bankoff	Professor T. P. Kilner
Mr J. M. Banks	Mr. R. Lawrie
Mr J. Barron	Mr E. E. Lewis
Mr R. Battle	Mr A. H. McIndoe
Mr H. Elliott Blake	Mr D. N. Matthews
Mr F. Braithwaite	Mr F. T. Moore
Mr A. C. Buchan	Mr G. H. Morley
Mr A. H. R. Champion	Mr R. Mowlem
Mr P. Clarkson	Mr J. C. Mustardé
Mr P. P. Cole	Mr M. C. Oldfield
Mr J. B. Cuthbert	Mr R. P. Osborne
Mr Hiren De	Mr E. W. Peet
Mr N. L. Eckhoff	Mr A. J. B. Phillips
Mr J. R. G. Edwards	Mr J. P. Reidy
Mr. G. M. FitzGibbon	Mr G. deRynck
Sir Harold Gillies	Mr J. N. Sankey
Mr W. Gissane	Mr M. H. Shaw
Mr J. Grocott	Mr H. B. Stallard
Mr C. Heanley	Mr J. S. Tough
Mr T. C. Henry	Mr A. B. Wallace
Mr W. Hynes	Mr W. Wardill

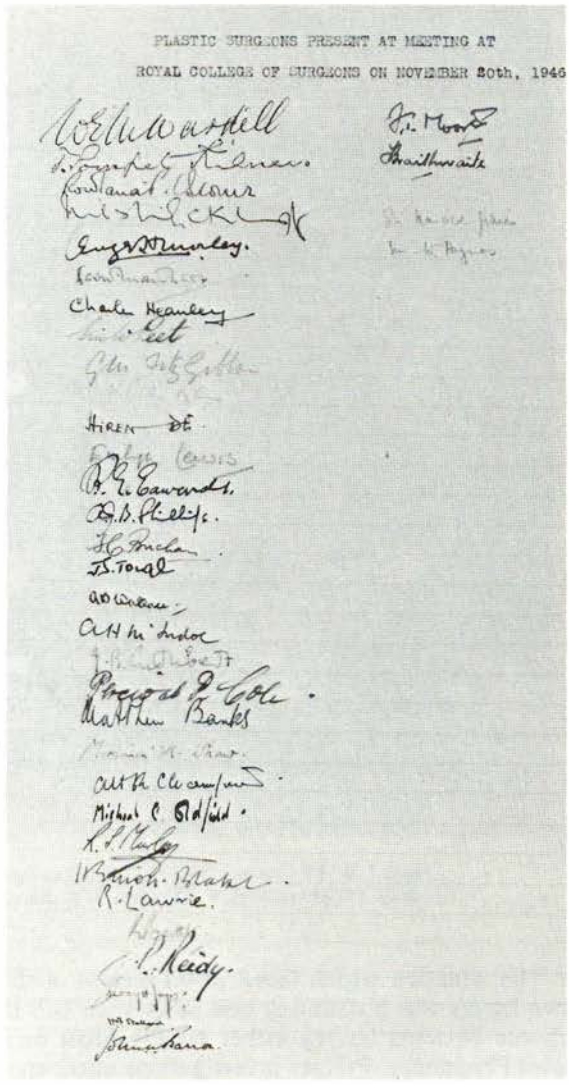


Fig. 2.2 Signatures of the plastic surgeons who attended the First Meeting of the Association at the Royal College of Surgeons of England, November 20th 1946.

It is interesting to record the first letter ever written in the name of the BAPS. This was from Harley Street on November 21st 1946 to Sir Alfred Webb Johnson from Sir Harold.

Dear Alfred,

I cannot let this opportunity go without putting on paper the very deep appreciation of your most kindly and helpful intervention last night. Your handling of the inaugural meeting, your help to me and to others in the later discussions were superb, and I can assure you and the Council of the College that our little Association was happily started. We now feel also that the Royal College is our home and that the President and his team are our friends. We trust that we shall be worthy members of this surgical family.

H.D.G.

And so was launched an institution which has gained in stature during the decades and which has had a powerful effect on the development of the surgical art and science of plastic and reconstructive surgery.

Today there are approximately 600 members from 54 countries and this is surely an indication of the world-wide respect in which the parent body is held. Not only have a large number of plastic surgeons round the world been trained to BAPS standard but many overseas Associations have been

based on the principles fought for, and maintained, in the United Kingdom.

On the occasion of his election to Honorary Membership of the BAPS, Sir Reginald Murley wrote to the President, on January 2nd 1985,

> You will know of my happy wartime experience as an "ersatz" plastic surgeon which led on to my being a founder associate of BAPS. I frequently attended the early meetings of which I have some vivid memories: but of necessity, my attendance became much less common later. However, I count many good friends amongst the membership of your Association of which I have been an associate member for more than 38 years. When I was demobilised in 1945 a number of senior colleagues tried to tempt me to stay in plastic surgery. But I told them that I did not feel that I had been properly trained in the generality of surgery, and that I needed much wider experience before deciding to specialise. In the event I did not return to the fold. However, the decision I made after the War is very relevant to the excellent rules and practice of the Association which always demands that a prospective trainee shall have had a thorough grounding and an FRCS before he is taken on. In this respect the BAPS has set the highest possible standards which other specialties can only ignore at their peril.
>
> There is another side to this particular coin. My intensive exposure in the specialty, and the excellent training I received from Randall Champion, David Officer Brown, Michael Oldfield and Dick Battle has stood me in good stead throughout my surgical life. Moreover, close co-operation with dental and anaesthetic colleagues, as well as with my neurosurgical and ophthalmic colleagues in the "unholy trinity", could not have provided richer surgical foundations. Plastic surgery has given me the opportunity to pass on to all of my trainees a technical expertise and an overall understanding of certain surgical problems which might otherwise have largely been missed. Three of my former general surgical registrars and one of my house surgeons are now established specialists in plastic surgery and I am very proud of them.

Also in November 1946 the Plastic Surgery Planning Committee consisting of Kilner (Chair), Gillies, Hynes, McIndoe and Mowlem published its far-sighted report on the specialty, which is reproduced as an Appendix.

On February 11th 1947 the Honorary Secretary (Barron) wrote to the potential Membership:

> The Council of the British Association of Plastic Surgeons met on January 15th and it was decided to invite you to become a Full Member of the new Association. I shall be happy to learn that you will accept this invitation.
>
> The entrance fee for Full Members is 3 guineas and the annual subscription 2 guineas. If you agree to join, the Honorary Treasurer will be glad to receive your cheque which should be made payable to "The British Association of Plastic Surgeons".
>
> There will be a General Meeting of this Association at the Royal College of Surgeons on Wednesday, March 19th, at 5 p.m., which will be addressed by the President, Sir Harold Gillies, and at which the constitution of the Association will be presented for approval.

APPENDIX

Considering the amount of work with which the Members of the Association had to contend in the immediate post-war period, it is remarkable that they were able to hold five meetings in less than six months and to produce the prescient report which follows on the planning of plastic surgery units for peace-time in the UK. Because of its historic significance and the light thrown on the origin and design of many units in this country the document is reproduced in full.

Report of the *Plastic Surgery Planning Committee*
November, 1946

Sir Harold Gillies
Mr Wilfred Hynes
Professor T. Pomfret Kilner (in the Chair)
Mr A. H. McIndoe
Mr Rainsford Mowlem

The Committee met on five occasions between October 1945 and March 1946. The Chairman apologises for the long delay in presenting this draft of the Committee's findings.

Preamble

The creation of war time units specifically equipped for the treatment of injuries of the face and jaw, of burns and of soft tissue losses, gave facilities for treatment and research greatly in advance of those available in peace time. In spite of unsuitable housing and, in the case of some units, awkward siting, the advantages and economic importance of speedy and efficient treatment have been obvious. Waiting lists have grown to unworkable dimensions: they are as much a reflection of work done as of work waiting to be done and they also indicate the reliance placed on the units by other hospitals in their regions.

It should be clearly understood that these units have been unable to deal with the day-to-day problems of the civilian population. Among congenital defects alone, about 700 infants suffering from cleft lip and/or palate are born each year. The treatment of these must be carried out in stages, varying from one to four or more,

and approximately 2,000 operations each year are therefore required in this group.

Industry and transport are responsible for injuries, the number of which cannot be estimated but which under existing arrangements are seldom treated under optimal conditions.

Defects due to disease or its eradication by surgical or radiotherapeutic measures must also be considered for these demand reconstruction or repair.

All these conditions have come within the scope of plastic surgery and there are many and obvious advantages in housing cases in units specially equipped to provide efficient and immediate treatment. In the past, the majority of those cases most urgently requiring such treatment have gravitated to London but whenever a clinic has been established in the provinces, *e.g.* Stoke-on-Trent, Manchester, Birmingham, the initial facilities have been proved inadequate and waiting lists have mounted to quite impossible proportions within a few months. The most recently established centre at Sheffield has 40 beds, has been open for only five months, already has a waiting list of 70 cases and is compelled to refuse admission to deserving cases from the surrounding towns. The demand grows with the facilities available and is not satisfied by existing arrangements.

Experience in both war and peace makes it evident that at least one unit of a hundred beds is required for every two million of the population.

Siting of Units

The Committee is of the opinion that Main Plastic Units should be based on the General Teaching Hospitals: that they function best in association with other departments but that they should retain their own individuality, possessing their own wards, operating theatres and offices; that whenever possible they should be so located that research facilities are readily available.

Certain of the Main Units should have subsidiary units sited in Non-Teaching hospitals. Such units, in addition to serving the general plastic surgery needs of the district, would meet the traumatic requirements of highly industrialised areas.

Suggested sites for main Units—Provinces

1) Birmingham
2) Bristol
3) Cardiff
4) Leeds
5) Liverpool
6) Manchester
7) Newcastle
8) Oxford
9) Sheffield
10) Aberdeen
11) Edinburgh
12) Glasgow
13) Belfast

The Committee feels that the Unit already in existence at Stoke-on-Trent, in view of its long establishment, should be included in the scheme but should be affiliated with a Main Unit attached to a Teaching hospital.

London

The minimal number of Units required would be five and that "catchment area" may be divided into five zones. It is suggested that these should be N.W., S.W., N.E., W. and S.E., but it is realised that any precise direction on this point would be premature in view of existing schemes for regionalisation and for affiliation of various London hospitals.

The Committee did not decide whether it considered further units attached to the London County Council and other County Hospitals desirable or necessary but it was felt that some of larger hospitals which have already exhibited interest in the problem and have established their own services might wish to continue these. The Committee is of the opinion that these should be affiliated with the nearest Teaching Hospital (Main) Units.

Staffing of Units

The Committee gave careful consideration to the question of optimum size of a Main Unit and came to the conclusion that it would be wise to work out requirements for a basic Unit of 100 active beds plus 50 "continuation-of-treatment" beds. For such a basic Unit the following staff is considered necessary:

1 Plastic Surgeon (Director)
1 Assistant Plastic Surgeon
1 Registrar (Surgeon in Training)
2 House Surgeons
2 Anaesthetists (one full-time: one part-time)
1 Dental Surgeon (Director) (part-time)
1 Dental Registrar (full-time)
1 Dental Mechanic (full-time)
3 Secretaries (see later)
2 Physiotherapists (provided by Main Hospital)

This establishment was considered insufficient by Headquarters. Two Assistant Plastic Surgeons were advised; one of whom should act as Assistant Director. The two House Surgeons would be of the class of Junior Surgical Officers.

Accommodation for private patients

It is suggested that 10 beds per 100 be allocated for private patients: that the Director should be allowed such private practice, both operative and consultative and both within and outside the Unit, as does not interfere with his duties to the Unit: that the Dental Surgeon should have access to the private beds at the discretion of the Director.

Subsidiary Units

These should be staffed on lines similar to those already detailed for Main Units. The number of beds allocated would vary according to the requirements of the area served. It was agreed, however, that a unit would not

function economically with less than 50 beds. Staff requirements would be:

1 Plastic Surgeon
1 Registrar
1 Anaesthetist
1 Registrar Dental Surgeon

The personnel of Subsidiary Units would be recruited from Main Units, and would be employed on a full-time basis. The Registrar of a Main Unit would be eligible for appointment as Plastic Surgeon to a Subsidiary Unit after two years' training. It is estimated that twelve such units might be required eventually: they would be established only as the need is demonstrated and at the discretion of the Main Unit.

Emergencies: First aid
Any Main or Subsidiary Unit should be prepared to send out suitable members of its staff for consultation or to render first-aid treatment anywhere within its area.

Payment of staff
Salaries will presumably conform with a scheme developed under the Consultant Service for the Nation.

Teaching
The requirements under this heading are considered to be:

1) Training of men to succeed to posts on the staffs of Units.
2) Training of men engaged in other branches of surgery in skin-grafting technique and the general principles of plastic surgery.
3) Training of post-graduates from overseas. These should have had ample general surgical experience, should possess suitable qualifications and should be sponsored by competent authorities in their own countries. Their period of training would normally occupy two years and they would be given such facilities for actual operative work as the Unit can provide.
4) Lectures and demonstrations for undergraduates and general practitioners.
5) Training of medical students in the basic principles of reparative surgery by lectures, demonstrations and practical instruction: this to be co-ordinated with the general surgical instruction of the hospital.
6) Dental Department training and teaching organised on similar lines.

Research
The Committee stresses that research is essential to progress and must not be curtailed by lack of funds: grants from all available sources should be encouraged.

Photographic department
There should be in each unit a fully equipped photographic department with an expert photographer capable of producing routine photographs for records, lantern slides and photomicrographs. The department should also be capable of recording theatre technique by still and cine photographs.

Records
The Committee wishes to draw attention to the prime importance of this side of the work. The Secretary in charge of Records, who would also act as private secretary to the Director, should be much more than a stenographer. She should be conversant with Medical Terminology and should have two stenographers working under her direction. Experience indicates that this is the minimum staff required by a Unit of 100 beds.

PRESIDENTS

1946–47	Sir Harold D. Gillies	1961—**13**, 193
1947–48	Prof. T. Pomfret Kilner	
1949	Sir Archibald McIndoe	1961—**13**, 1
1950	R. Mowlem	
1951	A. B. Wallace	
1952	R. J. V. Battle	
1953	J. N. Barron	
1954	D. N. Matthews	
1955	Prof. T. Pomfret Kilner	1964—**17**, 330
1956	W. Hynes	(no obituary published)
1957	R. P. Osborne	1982—**35**, 211
1958	J. S. Tough	1977—**30**, 330
1959	R. Mowlem	1987—**40**, 102
1960	P. H. Jayes	
1961	G. H. Morley	1971—**24**, 419
1962	J. P. Reidy	
1963	A. B. Wallace	1975—**28**, 149
1964	E. W. Peet	1969—**22**, 97
1965	Sir Benjamin Rank	
1966	G. M. FitzGibbon	
1967	R. J. V. Battle	1983—**36**, 129
1968	F. Braithwaite	1986—**39**, 278
1969	J. Watson	
1970	T. Gibson	
1971	D. N. Matthews	
1972	R. P. G. Sandon	
1973	D. C. Bodenham	
1974	R. L. G. Dawson	
1975	J. N. Barron	
1976	S. H. Harrison	
1977	N. C. Hughes	
1978	A. C. Buchan	
1979	I. A. McGregor	
1980	R. T. Routledge	
1981	M. H. Kinmonth	
1982	I. F. K. Muir	
1983	T. L. Barclay	
1984	M. N. Tempest	
1985	I. W. Broomhead	
1986	D. O. Maisels	
1987	Miss A. B. Sutherland	

Honorary Editors

1946–68 A. B. Wallace
1969–79 T. Gibson
1979–84 M. N. Tempest
1985– A. C. H. Watson

Honorary Secretaries

1946–49 J. N. Barron
1950–56 J. P. Reidy
1957–59 C. R. McLaughlin 1980—**33**, 461
1960–62 J. Watson
1963–68 R. P. G. Sandon
1969–74 I. W. Broomhead
1975–77 J. R. Cobbett
1978–80 T. D. Cochrane
1981–83 A. F. Wallace
1984–86 B. D. G. Morgan
1987– R. Sanders

Honorary Treasurers

1946–69 R. P. Osborne 1982—**35**, 211
1970–81 R. P. G. Sandon
1982–87 T. D. Cochrane

References are to Obituaries published in the *British Journal of Plastic Surgery*.

The BAPS abroad

The Commonwealth

The British Association of Plastic Surgeons is regarded as the father figure of plastic surgery in many countries around the world. Its tentacles of surgical culture reach out to the far north, the far south, the far east and the far west and its influence on the scientific and corporate development of the specialty is undeniable. Our first major teaching responsibility was catapulted upon us in 1939 when the outbreak of war demanded that our expertise should be spread urgently among the Commonwealth armed forces who had declared war with Britain at the time of the German invasion of Poland.

In that first winter, medical officers from Australia, Canada, India, Eire, New Zealand and South Africa arrived in England and were allocated to the four recently established plastic surgery units in the United Kingdom:

D. Officer Brown (Australia), B. K. Rank (Australia)
F. Hutter (New Zealand), W. Manchester (New Zealand), H. P. Pickerill (New Zealand)
J. Penn (South Africa), N. Peterson (South Africa)
A. W. Farmer (Canada), S. Gordon (Canada), R. Langston (Canada), A. Ross Tilley (Canada)
N. H. Antia (India)
A. B. Clery (Eire).

This was the period of the "phoney war" and the mass casualties that were expected did not materialise. Instead, a clinical case-load was accepted from the London hospitals and this, together with the somewhat augmented civilian casualty list, formed the basis for clinical teaching. It is interesting to note two important changes in the causes of accidents. Firstly there was the blackout which increased the road and domestic accident rate, and secondly, the drafting of unskilled labour into the munitions factories. How many women, disenchanted by their appearance in the standard factory mop-cap, refused to wear them and were subsequently scalped, their hair being caught in the pulleys and driving belts? An observation made at the time was that none of these scalped ladies admitted having suffered any pain at the time of the accident.

There was abundant teaching material and the Commonwealth and British Officers were subjected to "crash courses" in plastic surgery, the duration of which was a period of a few months only. This imposed a considerable strain on the "Big Four", particularly as at that time very scanty literature was available and this mainly of an historic nature. However, the wards were full and long daily operating lists gave us all the opportunity to learn from our elders.

It was in those anxious days that the ideals of the British Commonwealth were grafted into the young specialty, lasting friendships were formed and an obvious bond developed amongst the English-speaking surgeons. This union has, in the event, played an important part in the development of the specialty in those countries in the post-war era. Following the initial influx from the Anzacs, Canada and South Africa, other Commonwealth countries sent serving officers for training and so we welcomed men from Trinidad and Bermuda, from Newfoundland, from India, Rhodesia and Mauritius, many of whom were to become pioneers in their own lands in later years. Thus the family of British plastic surgeons carried the skills and traditions to the four corners of the earth, and because of this education it was not long before other nationals began to look to Britain for information and guidance in the establishment of the specialty in their many overseas countries.

America

On December 7th 1941 the Japanese, without a formal declaration of war, bombed and nearly destroyed the American Pacific fleet at Pearl Harbour on the island of Oahu in Hawaii. The immediate result was the intervention of the USA in World War II. During 1942 vast American forces began to appear in Britain together with superbly equipped surgical hospitals and field units. Amongst these were to be found specialised maxillo-facial and plastic surgery teams including G. Aufricht, J. Converse, R. Ivy, V. H. Kazanjian, E. A. Kitlowski, L. La Dage, N. Owens, L. Peer, G. Warren Pierce and J. P. Webster.

There were, of course, links between the plastic surgeons of the two countries before the war but these were scant and existed mainly on a personal basis. The war, and our common enemies, were the catalysts to both groups and there emerged a camaraderie between the British and American specialties which has strengthened during the subsequent years to the undoubted benefit of those on both sides of the Atlantic. If one American should be chosen for mention in this connection he is D. Ralph Millard Jr of Miami, Florida. His skill as an author matches that of his surgery and his writings after the war have done much to emphasise the importance of our transatlantic friendship. He came under the influence of Gillies at Basingstoke in 1948 and later was invited to be co-author in Sir Harold's epic tome *The Principles and Art of Plastic Surgery* (1957).

In 1972 he delivered the Gillies memorial lecture at the Royal College of Surgeons of England. In June 1986 he was awarded an Honorary FRCSEd. and he has taken many opportunities, by the spoken word and by helping to train many British plastic surgeons, to emphasise the importance of collaboration between our two countries. His British trainees include David Maisels, Bob Campbell, Ron Pigott, John Batstone, Bob Heycock, Malcolm Dean and Tony Watson. It is well known that he speaks for many American surgeons when he talks about the desire to retain the contacts so well fashioned in the furnace of war.

Europe

On the cessation of hostilities there appeared immediately three gallant Scandinavian surgeons from Sweden, Norway and Denmark: W. Loenneken (Oslo), G. Olsen (Copenhagen) and A. Ragnell (Stockholm). H. Schjelderup (Bergen) arrived earlier and describes how, "towards the end of November 1944 I had to go into hiding because I was wanted by the Gestapo and on December 3rd I and a number of other refugees were picked up on the coast north of Bergen by H. Norv. M.S. 'Vigra' under the command of 'Shetland' Larsen. It was a fast American built submarine chaser and brought us across to Scalloway in Shetland in 6 hours. On the following day I went to Aberdeen on the SS 'King Magnus' and then on to London".

They were to be the vanguard of an invasion from the continent of Europe of many who had heard that we were willing to accept overseas doctors for training. There was a considerable number who wished to take undeniable advantage of our established acceptance as a specialty by the Royal Colleges and by our general surgical colleagues. Even in those early days our specialty could develop and expand, but this was far from the case on the Continent. In a number of countries it required long years before plastic surgery was accredited, and the pioneers of those days had daunting medico-political battles on their hands before, ultimately, they were recognised.

The inauguration of the Association in 1946 and the advent of the Journal in 1948 aroused much interest in Europe, and these two events were the stimuli which encouraged many surgeons to come to England, to struggle with the curious pronunciation of our language and to take advantage of the teaching and teamwork in the many units which were set up nationwide under the National Health Service. Because of our system of multi-disciplinary staffing, the training offered to our visitors was indeed appreciated and it was a matter of great satisfaction to see the specialty slowly but surely gaining a hold on the Continent as it became accepted in one country after another.

The countries of Europe from which students came were as follows: Austria, Belgium, Czechoslovakia, Denmark, Finland, France, Germany, Greece, Holland, Italy, Norway, Poland, Portugal, Spain, Sweden, Switzerland and Yugoslavia.

Holland: C. Koch, C. Honig
Belgium: J. Polus, A. de Coninck
France: D. Morel-Fatio, C. Dufourmentel, R. Tubiana
Spain: B. Vilar-Sancho, J. Planas, L. Mir y Mir, P. Gabarro
Portugal: J. Conde, A. M. Fernandes
Italy: S. Rosselli, S. Teich-Alasia, G. Dogo

Austria: R. Trauner, P. Wilflingseder
Switzerland: H. U. Buff, H. L. Obwegeser
Yugoslavia: V. Arneri, I. Cupar, H. Klemencic, M. Derganc, F. Zdravic
Czechoslovakia: F. Burian, S. Demjen
Poland: J. Szlazak
Denmark: P. Fogh-Andersen
Sweden: T. Skoog, B. Johanson.

It is interesting to note that, in the years that followed, contributions to our Journal from all of these 17 countries have been accepted. Today many of these nations have their own plastic surgery societies and their own journals, and a very considerable literature has now been built up. Without exception, all of the pioneers who came to Britain in the early days have paid warm tribute to their British teachers, to the value of our plastic unit system, and to the advantages that the Health Service was able to offer them in the never-ending case load that was available in all units.

The overseas scenario

Apart from the Commonwealth, American and European contacts built up because of World War II, enquiries began to arrive from far afield regarding the possibility of training in plastic surgery in the United Kingdom. Many of the units made great efforts to accommodate foreign surgeons who wished to come to us for longer or shorter periods: M. Gonzalez-Ulloa (Mexico), F. Malbec (Argentina), H. Marino (Argentina), I. Pitanguy (Brazil), S. Widaurre (Chile). Thus the father-figure image became the grandfather-figure image as second generation trainees began knocking on the door. Life in plastic surgery in the 50s, 60s and 70s was truly an international scenario, many tongues were spoken, many guests of all colours were welcomed, and it was gratifying to feel that our efforts were playing a small part in maintaining a dialogue of peace amongst nations. These contacts are precious and, considering that world-wide there are still a relatively small number practising in the specialty, it is reasonable that every effort should be made to keep the family circle intact and in touch.

The Association has done well in this field, having offered hospitality to countless visitors from overseas and having provided an open forum for all to express their views. In this connection it is a remarkable fact that our Journal up to 1985 has accepted 285 contributions from Commonwealth countries, 256 from Europe and 628 from other overseas nationals. There are, of course, many papers given by guests at meetings which have not seen the light of day in print. The conclusion that can be drawn is that foreign surgeons feel welcome here, and in return they have honoured us with over eleven hundred contributions to our literature. This is the essence of international collaboration and friendship and it behoves us to see that we make this facility available for all time. Thus will our stature be assured in the years and for the generations to come.

The foundation upon which we must build is of course BAPS membership. Here we are well founded as currently our lists show 127 members from five Commonwealth countries, 117 members from 18 European countries and 123 members from 34 other countries around the world. So our geographical base (in 1986) has spread to 57 overseas countries from which we attract approximately 360 members. This is a legacy that should be nurtured in the years ahead because of the prestige which comes with it and the rapport which it generates amongst all of these different nations.

Acknowledgements

Helpful information and informative letters were received from: Dennis Walker (Johannesburg), Richard Stark (New York), D. Ralph Millard Jr (Miami), Michael Tempest (Chepstow), Sir Benjamin Rank (Melbourne), William Manchester (Auckland), Raoul Tubiana (Paris), J. van der Meulen (Rotterdam), Jack Penn (Cape Town), Don Robinson (Adelaide), Vasant Chongchet (Bangkok), Noshir Antia (Bombay), Halfdan Schjelderup (Bergen) and Simon Teich-Alasia (Turin).

Reference

Gillies, H. and Millard, D. R. (1957). *The Principles and Art of Plastic Surgery*. Boston: Little, Brown & Co.

The Yugo saga

Devastated by invading armies from both north and south, and by armed internecine strife between opposing national factions, the Yugoslav people found themselves at the end of World War II with one of the highest casualty rates per head of population in Europe. The story of the partisan fighters is one of horrendous hardship but their fortitude, stimulated by a unique leader, Josip Broz Tito, is legendary.

During 1945 hundreds of wounded partisans made their way across the Adriatic at the time of the Allied advance in Italy and it so happened that British Maxillo-Facial Unit No. 1 was stationed at Bari under the command of Major Battle. At one stage this Unit was overwhelmed by Yugoslav casualties because in their own country facilities did not exist for specialist treatment of this sort. News of the surgical problems in Yugoslavia soon reached London from Bari and came to the ears of Sir Harold Gillies. He was activated immediately and, using his contacts in the Foreign Office and the Ministry of Health, arranged for personnel and medical supplies to be sent to Belgrade through the auspices of UNRRA. From November 1945 until the autumn of 1946 four surgical teams went out in sequence. Each team consisted of a plastic surgeon, dental surgeon, anaesthetist, sisters and nurses, dental technician and secretary.

One of the flights in January 1946 took 13 days from Blackbushe airport to Belgrade and this included an engine failure over France and a forced landing near Brindisi. The old DC3 managed to survive and was able to fly on to Bari the following day. A few days were spent with the UK Unit while aircraft spares arrived to allow the trip to Belgrade to be completed. Here we had our first contact with the Yugoslav problems, and when the aircraft was declared fit we were transported across the Adriatic, over the Hertzegovinian mountains, to Belgrade where we found the temperature to be minus 30 degrees centrigrade.

A hospital built just before the war in Belgrade had been allocated to the British plastic surgery teams. It was called the Beogradski Trgovaca Omledina (BTO) and had approximately 100 beds. It was, however, sorely lacking in equipment which had been removed as part of the scorched earth policy during the German retreat. One effect of this was that on occasions patients had to be nursed two to a bed until more equipment became available. Soon the hospital was flooded with both civilian and military casualties, many of whom arrived unannounced and, particularly during the winter months, could not be turned away.

Comparable teams of Yugoslav surgeons, dentists, anaesthetists, nurses and technicians were allocated to us by the military authorities and intensive clinical and teaching programmes continued during the whole of the time the UK teams were there. This sort of surgery was quite new to them and it is interesting to note that the first endotracheal anaesthetic in Yugoslavia was given by Dr Shackleton: this, together with the basic surgical and dental principles, was avidly assimilated and spread to hospitals all over the country. When we returned finally to the UK a fully equipped and competently staffed hospital of 110 beds under the command of Professor Arneri was our legacy to that country.

After the war

Surgeons from all six republics were later drafted into the Unit for training and in this way the specialty was disseminated throughout the whole country so that today the standard of treatment and the quality of care can be compared favourably with that in any other part of the world. During the

years that followed, a number of surgeons and anaesthetists came to Britain for further experience and links were created which have enabled a happy dialogue to develop between the two countries, not only from the medical angle but also from the commercial and political points of view.

Sir Harold, Professor Kilner and Rainsford Mowlem visited the country in the early 50s and these visits stimulated the authorities to maintain a high priority for the continuous expansion of the specialty. One of the leading units was established in conjunction with the University of Ljubljana, the founders being Professors Derganc and Zdravic, both of whom came to Britain for training and took back with them the British traditions upon which this and all other units have been based. The Ljubljana Unit, as that in Belgrade, is in the front line of European surgery and offers special expertise in burns treatment, in microsurgery and in hand surgery. An offshoot is to be found in Maribor where a dedicated pioneer of burns treatment, Professor Janzekovic, has established a world-wide reputation for the early surgery of the burn wound.

In due course fully staffed units were established in Zagreb, Sarajevo and Skopje attached to universities, and there are twelve other departments of surgery which have plastic and maxillo-facial surgeons in the team. In the country as a whole there are approximately 500 beds available for the specialty in which patients can receive the best and most modern treatment. There is an active Plastic and Maxillo-Facial Surgery Association with some 175 members and their journal, which is of the highest quality, portrays their drive for teaching and for research.

The development of plastic surgery in Yugoslavia stems from the initial contacts made in the hectic post-war days from whence it has matured and now stands comparison with that of any other country. The BAPS can indeed be proud of its offspring, its sister Association.

Postcript

In response to very considerable pressure from the Editor, and at the expense of noticeable embarrassment to himself, John Barron agreed to add a personal potscript to the Yugo saga about an aspect of his life which, he says, "has given me immense and lasting pleasure".

"I arrived in Belgrade in January 1946 and found immediately that we were swamped with casualties of every description both military and civilian. We also undertook general reconstructive surgery (congenital defects, burns, noma, cranio-facial, etc., etc). A mammoth operating schedule was instituted and the Yugoslav teams allocated to us were initiated into every aspect of surgical care. We were able to establish contact with all levels of the hierarchy up to and including the leader, Marshal Tito, and to make countless friends within and outside the profession. After several months it became evident that it would be valuable to offer more detailed training to selected Yugoslavs and arrangements were made for the most senior of them to come to units in the UK during the next year or so. This first generation was replaced later by many others so that during the growth of the specialty there, intimate links were formed and sound foundations laid for them to build on.

Over the next 30 years I made many trips to lecture and demonstrate in the new centres in Belgrade, Zagreb, Maribor, Sarajevo and Ljubljana. It was also possible to help with the system of postgraduate instruction for general practitioners, which is a model of its kind.

In the 1970s it became evident that a subspecialty of hand surgery would be valuable and I had the honour of forming a Teaching Institute in the subject in Ljubljana. This has now become an international institute based on the parent university and attracts teachers and students from around the world.

I have had the most wonderful hospitality from the Yugoslav people and, in spite of the language, political and cultural differences, there is no doubt that we in the UK have a devoted ally in the profession of surgery in that country.

You ask for honours received:

1. 'Jugoslovenske Zastave Za Zlatnim Vencem' from Tito. (This is the Jugoslav Flag with Gold Wreath).
2. Honorary Member, Yugoslav Association of Plastic and Maxillo-facial Surgeons.
3. Honorary Member, Serbian Medical Society.
4. Gold Medal and Citation, Slovenian Red Cross".

Acknowledgements

Personal communications received from Vinko Arneri (Belgrade), Franjo Zdravic (Ljubljana) and Borisa Starovic (Sarajevo).

The "Big Four"

The names of Gillies, Kilner, McIndoe and Mowlem will be encountered individually (or collectively) on so many pages of this book that the reader might well wonder why a separate chapter should be devoted to this surgical quartet. The answer is quite simple. These four were not only the first generation of plastic surgeons in the country: they also trained the second generations of plastic surgeons during the early years of World War II. This was the generation that, along with specially trained dental officers and anaesthetists, staffed the plastic and maxillo-facial units and burns centres in all three of the Armed Services at home and abroad and the various specialist units set up in our EMS hospitals to deal with both civilian and military casualties. In the early post-war years some of the smaller EMS units were disbanded, but most of them were taken over by the National Health Service in 1948 and became the first Regional Plastic Surgery Centres in the United Kingdom. Had the first generation of plastic surgeons not done their job supremely well there would have been no civilian plastic surgery centres in this country today, no British Association of Plastic Surgeons, no "History" of the Association and no need to compile this chapter.

Yet today we are already welcoming a fourth generation of plastic surgeons into our midst, to many of whom the names of Gillies, Kilner, McIndoe and Mowlem may mean little more than the distinctive design of a surgical instrument, the title of some memorial lecture, essay prize or award, or the authors of some highly relevant papers that are frequently quoted (and regularly misquoted) in the current surgical literature. To help redress this lamentable state of affairs and retrieve some of our historical roots before they become choked by anecdotal flippancies, apathy or inaccuracy, it was decided to compile a selection of "recollections" that have already appeared in print, arranged in such a way as to preserve their historical continuity. This chapter is by no means a biographical work in the strict sense of the word. To date only two such books have appeared: *Gillies: Surgeon Extraordinary* by Reginald Pound published in 1964 by Michael Joseph (London) and *Faces from the Fire* (about Sir Archibald McIndoe) by L. Mosley published in 1962 (Wiedenfeld and Nicolson, London).

If readers who belong to the third generation of plastic surgeons see in this account some resemblance between the dogmatic and sometimes highly controversial teaching and practice of the "Big Four" and the occasionally unconventional, uncompromising attitudes and behaviour patterns of their former teachers and chiefs (*i.e.* the second generation), so be it! But any consolation so gained is likely to be short-lived: for we can be quite certain that as they read this chapter our own personal idiosyncracies, for better or worse, will be under intense, almost "microscopic" scrutiny by the fourth generation—our trainees and successors.

With the characteristic meticulous attention to detail that is dear to the image of the plastic surgeon, the four most senior founder members of our Association provided themselves with surnames that placed them in impeccable alphabetical order so that no future chronicler could ever doubt the order in which they and their achievements should be set forth and discussed.

Sir Harold D. Gillies, CBE, FRCS

President of the British Association of Plastic Surgeons 1946–47

Harold Delf Gillies was born in Dunedin in 1882, educated at Wanganui College and later left New Zealand for this country for his medical training at Caius College, Cambridge and St Bartholomew's Hospital in London. He qualified in 1908 and

passed his FRCS two years later. Whilst at Cambridge he gained a rowing Blue in the Oxford and Cambridge Boat Race of 1904 and he played golf for his university for three years.

After qualifying, he held various house appointments and developed an interest in otolaryngology, becoming an assistant to Sir Milsom Rees, the senior ENT surgeon at Bart's. This might well have been his chosen specialty had it not been for the outbreak of World War I. Gillies offered his services to the British Red Cross and in January 1915 was sent to France as a general surgeon, his first posting being to a Belgian ambulance unit. However, from his early experiences and observations in France he soon realised the urgent need to establish special centres for the treatment of face and jaw injuries that were appearing in rapidly increasing numbers as the Allied armies on the Western Front became bogged down in the static form of trench warfare that was to continue for another four years. He saw some of the work of Charles Valadier at the 83rd General Hospital in Wimereux where this extraordinary Frenchman, who had practised as a dentist in Paris but had no medical training whatever, had set up a special unit for the treatment of jaw wounds. Valadier, an Honorary Major in the RAMC, was not allowed to operate on his own and had to be supervised by a general surgeon. Another surgeon working at the base hospital centres around Boulogne was Varaztad H. Kazanjian, who was Head of the Prosthetic Department at the Harvard Dental School and had joined the First Harvard Unit as its Chief Dental Officer. In July 1915 this Unit took over a tented hospital (No. 22 General Hospital at Camiers) and established a clinic for treatment of wounds of the face and jaws. It was later transferred to a hutted hospital (No. 20 British General Hospital) where 100 beds were allocated for jaw cases. As Kazanjian has explained ". . . The general army policy of evacuating all sick and wounded to England within three weeks imposed a rapid turnover of patients. As soon as a patient

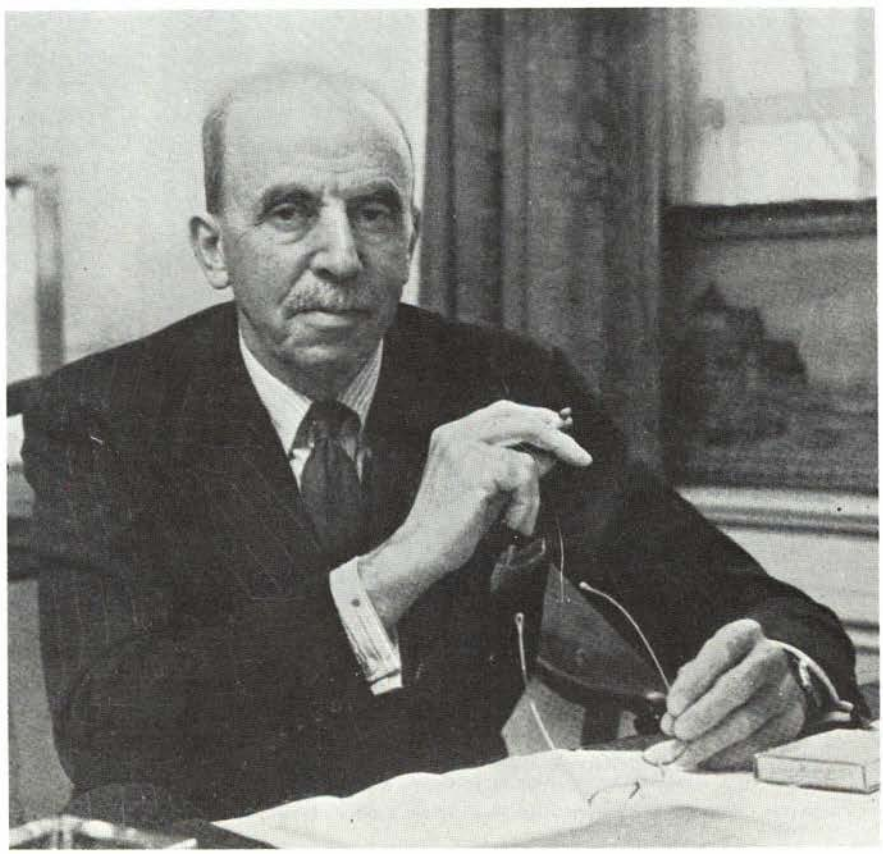
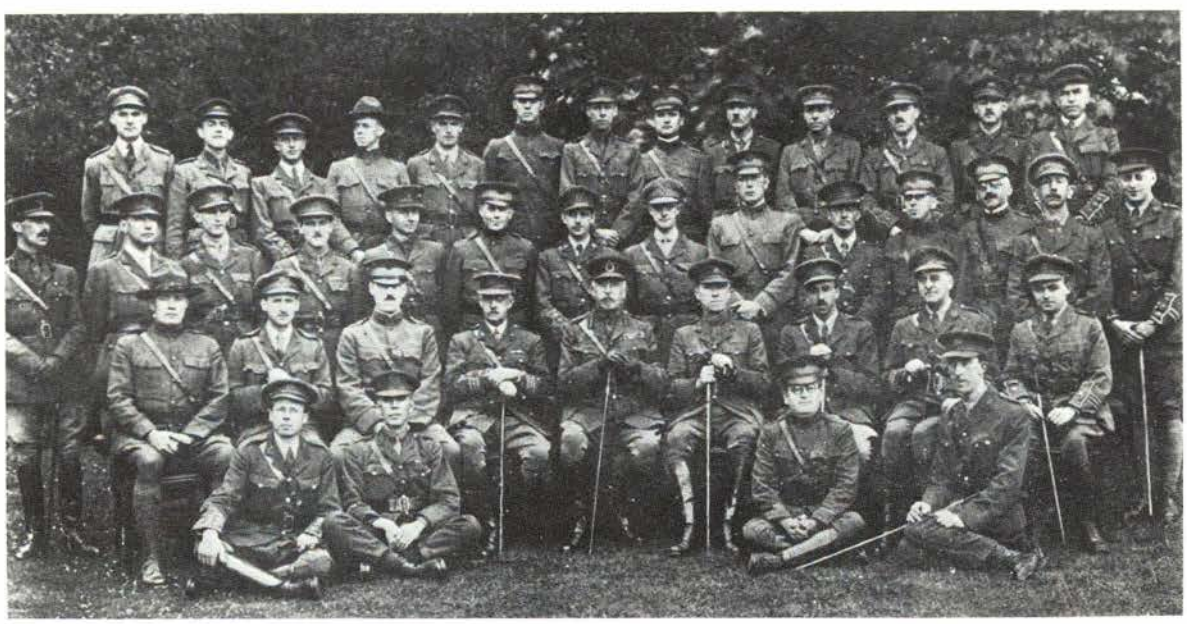


Fig. 5.1 Sir Harold Delf Gillies, CBE, FRCS (*British Journal of Plastic Surgery*, 1949–1950, **2**, 77)

could travel and treatment could be completed on home ground, he was sent on his way . . ." While on leave in Paris, Gillies went to watch Hippolyte Morestin, a pioneer in maxillo-facial surgery, who was doing remarkable work at the Val-de-Grâce Military Hospital. Gillies was profoundly impressed by the technical brilliance and imagination of this man and after watching him deftly turn a local flap to close a facial defect he wrote ". . . I felt that this was the one job in the world that I wanted to do . . ."

Gillies lost no time in persuading the British Army authorities to take urgent action to establish specialist units for the treatment of facial injuries and his determination won the day. He was transferred from the Red Cross to the RAMC and in January 1916 he was ordered to report to the Cambridge Military Hospital at Aldershot "for special duty in connection with plastic surgery". To make quite certain that facial injuries *were* sent from France to this Unit, Gillies at his own expense had special labels printed and distributed in France, directing such casualties to Aldershot. Gillies and his dental colleagues quickly demonstrated what might be done for the rapidly increasing number of mutilating maxillo-facial injuries and this led to the transfer of the Unit in 1917 to the Queen's Hospital at Sidcup, in Kent, which became a hospital of international character that accepted the majority of the facially mutilated casualties from all the fighting services.

Major H. P. Pickerill, a fellow New Zealander, who was Officer in Charge of the New Zealand Section at Sidcup, and later returned to New Zealand where he added distinction to the plastic surgery services in the Antipodes, wrote a delightful vignette about the Queen's Hospital (*British Journal of Plastic Surgery*, 1953, **6**, 247) and included a photograph of the Officers of the Sidcup Hospital taken on the 14th June 1918 (Fig. 5.2).



First Row.—Capt. K. Russell, Capt. E. O. Watson, Capt. G. Johnson. Capt. T. M. Terry, Lieut. R. Wade, Capt. E. F. Lafitte, Capt. G. Seccombe Hett, Major W. J. Scruton, Capt. C. E. Aumsey, Capt. V. Macdonald, Capt. E. G. Robertson, Capt. G. M. Hick, Capt. E. F. Risdon.

Second Row.—Capt. P. Ashworth, A.D.C., Capt. J. C. Clayton, Capt. A. L. Fraser, Capt. W. Kelsey Fry, M.C., Capt. G. C. Birt, Lieut. J. J. Ogden, Capt. J. M. Turner, Capt. R. Montgomery, Capt. H. W. Brent, Lieut. H. M. Johnston, Major Rea P. McGee, Capt. J. M. Waugh, Capt. A. W. L. Campbell, Capt. B. Mendleson.

Third Row.—Major T. C. Stellwagen, Major H. P. Pickerill, Major G. M. Dorrance, Lt.-Col. J. R. Colvin, H.R.H. The Duke of Connaught, Lt.-Col. H. S. Newland, D.S.O., Major H. D. Gillies, Major A. Wheeler, Major C. W. Waldron.

Fourth Row.—Capt. H. C. Malleson, Capt. H. L. Whale, Lieut. E. J. Kelly, Lieut. J. W. Edwards.

Fig. 5.2 HRH The Duke of Connaught's visit to the Queen's Hospital, Sidcup. June 4th 1918 (*British Journal of Plastic Surgery*, 1953–54, **6**, 248)

"The Queen's Hospital was unique in its organisation and conception; in this Sir Arbuthnot Lane, as Consulting Surgeon to the Aldershot Command, played a prominent part. The fundamental idea was that it should be a British Empire Hospital to which all wounded soldiers with facial losses should be sent from all theatres of the war. Thus it was divided into four sections: British, Canadian, Australian and New Zealand, each autonomous and staffed by its own Officers. The British section, however, counted as two sections and took two-fifths of the patients, the remaining sections took one-fifth each. When the Americans arrived they had no section to themselves but were attached in equal numbers to the existing sections. They came and went and were replaced by others. There are ten USA officers (surgical and dental) in the photograph (distinguishable by their uniforms or hats) but there were many others, before and after, amongst them Vilray Blair and Ferris Smith. The officers in charge of the sections are seated in the front row: Major H.D. Gillies (British), Lt Col. H.S. Newland (Australian), Major C.N. Waldron (Canadian) and Major H.P. Pickerill (New Zealand). Lt Col. J.R. Colvin, a retired Indian ASC Officer, was in command of the whole hospital. He was a wise and skilful administrator. He did not know any medicine and claimed that this was a positive advantage from an administrative point of view: it worked excellently. The officers standing are the surgical, dental and anaesthetist officers on the staff of the four sections. The size of the staff will give some idea of the amount of work done, for everyone was working hard all day and every day. There were six operating theatres running to capacity daily. The greatest difficulty was to find beds for the convoys that kept coming in, so that numerous convalescent auxiliary centres were established to which patients with nearly healed wounds could be transferred. These were in addition to regular Dominion Convalescent Hospitals. The dental technicians, artists, photographers and modellers on the staffs of each section are not in this photograph. Although each section was self-contained and autonomous there was a common record office open to all, so that if the officer in charge of one section was too busy to go along and see how the officer in charge of another section dealt with a particular case, he could read all about it in the record office and adopt the same method himself, if he wished, the following day. Thus was progress speeded up . . . Prior to the establishment of this Unit, all facial wounds with large losses were treated by masks of electrolytically deposited silver on plaster moulds that had been built up to normal and painted—all this under the direction and persuasion of Professor Tonks of the Slade School (who was qualified surgically but had deserted medicine for art). His (Tonks) personality and enthusiasm for this means of 'restoration' completely dominated the scene for nearly two years. But it was the soldiers themselves who defeated it by coming back and saying 'These . . . tin faces are no good to us. Can't you give us something that we can wash and shave and won't fall off in the street?' The challenge was accepted and massive grafts, not previously contemplated as possible, were soon found to be practicable and 'tin faces' were a thing of the past . . ."

Professor T. P. Kilner recalls that when he was posted at the end of World War I to Sidcup he found himself

". . . in an atmosphere described by someone as one of 'intellectual fervour and surgical enthusiasm'. It was customary in those days to have plaster casts made of all the more seriously injured men and it was on these that we juniors in the British Section worked out procedures for submission to our chief for his criticism, approval or emendation. These consultations took place in a small office, not more than 8 × 10 feet, which was Gillies's *sanctum sanctorum*, and in which he spent so much of his time thinking and planning when he was not busy operating. Criticism was sometimes cruelly destructive of our immature plans, but it was always kindly presented and followed by constructive advice. It was certainly an advantage to be able to discuss things freely, unhampered by the presence of the patient himself. To Gillies must be given credit for so many of those things no modern plastic surgery unit would dream of being without. Dental collaboration was provided on the spot and dental surgeons, imbued with the same enthusiasm as the surgeon were always at hand for discussion and assistance. It was at Sidcup that I saw the enormous value of clinical photography and of 'continuation of treatment' beds. These latter had been chosen by Gillies in a nearby hospital, where full supervision by the surgeons could be given. They relieved the nursing staff, increased operation output and above all gave a

sense of freedom to patients well enough to be up and about between stages of treatment. Without this careful plan of management it would have been quite impossible to be able to accept convoys of up to 500 face and jaw wounds, and working with negligible ancillary services, to produce results which compare very favourably indeed with the best that can be obtained today . . ."

The practical achievement of that epoch is embodied in Gillies's book *Plastic Surgery of the Face* published in 1920 by Oxford Medical Publications—a volume that was reprinted in facsimile by Gower Medical Publications in 1983. With the exception of two chapters, one on anaesthesia by Capt. R. Wade, RAMC and one on the prosthetic problems of plastic surgery by Capt. W. Kelsey Fry, MC, RAMC, the text was written entirely by Gillies himself and illustrated with black and white photographs and line drawings, many of them by Tonks.

During the inter-war years, only two surgeons were left in England who devoted themselves exclusively to reconstructive surgery, Gillies and Kilner, to whom credit must be given for keeping the new specialty "alive" and attempting to translate the lessons of war injury to the problems of civilian reparative surgery. The teaching hospitals were extremely slow to recognise the specialty and it is extraordinary that Bart's Hospital, to which he had been assistant to the ENT department since 1917, did not formally recognise him as a plastic surgeon until 1936. In the middle thirties, a gradual interest began in reconstructive surgery with the arrival on the scene of McIndoe and Mowlem so that at the outset of World War II there were a few trained plastic surgeons to lead the units that were to train others for service in the Forces or with the civilian EMS units at home. For the organisation and development of these units Gillies and Kelsey Fry were largely responsible and it is hardly surprising that the Sidcup model should have been adopted for the larger home-based centres.

When Sir Harold Gillies was elected first President of the British Association of Plastic Surgeons in 1946, Sir Archibald McIndoe wrote a special Editorial in one of the early numbers of our Journal, from which the following paragraphs have been taken.

". . . By the end of the war, the establishment of the British Association of Plastic Surgeons with its Journal represented the supreme achievement of his career. Who else could be its first President?

Apart from creating a specialty, Gillies' scientific contributions have been many. His name will always be associated with the tubed pedicle, he was the first to recognise the true field of usefulness of Esser's inlay and to adapt it to the wide range of conditions where lining was deficient. On the purely technical side of reconstructive surgery he has been prolific in ideas and he has enriched every subject he has attacked.

A dynamic, if unorthodox teacher, he impresses by paradox, invective, cajolery and teasing raillery. He is an indifferent public speaker, an incorrigible practical joker, an amateur artist of moderate capacity, a fly-fisherman of distinction, a golfer of brilliance and the best plastic surgeon in any country. He is, in addition, the friend of any young man who shows an interest in plastic surgery. In return, his hosts of friends praise him for his achievements, damn and curse him for his unpredictability, his incurable lateness and fiendish sense of humour. All are united in saluting him as the outstanding personality of plastic surgery. Long may he be with us!"

All the Gillies Lecturers (whose names are listed elsewhere in this volume) have illustrated certain aspects of Gillies's character and style, but to get some idea of the impact this remarkable man made on so many of his trainees let us look at Bill Holdsworth's contribution "As I remember" that was published in the *Annals of Plastic Surgery* and which is reprinted here with the permission of both the author and that Journal.

"I first met Harold Gillies in 1942 and in the course of a brief discussion he made a greater impression on me than any of the eminent surgeons I had encountered in my seven years in Britain. There was the bulk of his personality, his readiness to talk, and his electrifying interest in plastic surgery. Almost in minutes he convinced me that this speciality was for me and, furthermore, that if I could secure his support nothing could stop me. Several spells at the hospital where he operated confirmed this view, and five years later, when the war was over, I was accepted onto the staff where I remained for many happy years.

The manner of our first encounter was typical. He had come to visit the hospital where I was working. It was one for which he was responsible,

but instead of staying at the mansion home of the surgical chief, he spent the night on a fold-up bed in the residents' sitting room. I did not know he was coming, and perhaps the chief did not either. (He was never predictable.) I am not sure why he came that way. Perhaps he wanted to talk with the resident doctor, whom he liked, or maybe the view from the side door promised to be more revealing. In any case, we fell into conversation easily and had a long, candid chat about plastic surgery. I was flattered because he paid attention to my ramblings and received them with quiet courtesy. I would have been even more flattered if I had had the remotest idea who he was.

Over the years that followed I found that this was his invariable way. In spite of mutual irritations there was never a cross word. He said once that the reason we accorded so well was that neither of us spoke his mind. This was probably true. Certainly many were less fortunate in their dealings with him. Among early assistants he had the reputation of being inconsiderate and, on occasion, he showed little regard for the feelings and circumstances of others. Inevitably, our affection was tempered with plain fear because he had great power over our futures. More than one who spoke or acted out of turn was obliged to quit the fold—and plastic surgery—precipitately.

But he always had time for teaching. This took priority and he would spend literally hours demonstrating some aspect of treatment. He would regularly have trainees examine a case. Each would be required to submit a plan so that the relative values of the proposed schemes of treatment might be thrashed out and assessed in the group. We would be prodded to speak out and, if some sensitive trainee became angry at the handling of his ideas, this was welcomed. The most outlandish suggestions might receive the warmest welcome and there was never a hint of ridicule. This was during and immediately after the war and patients were presenting with deformities that had never been encountered before. While listening to us advocating our pet solutions, Gillies was all the while hoping to hear something new.

Probably he had always been fascinated by fresh ideas. How else would he have thought of the tubed pedicle? He was ever trying new ways; all could not succeed, but many were valuable. There was the insertion of plastic into the nasal bridge. Earlier there had been the concept of a great clinic in central London with consulting suites, wards, and optimal operating facilities all under one roof. From this developed the London Clinic, perhaps still London's greatest private hospital.

After discussion of a patient and the formulation of a plan, treatment might be entrusted to one of the trainees who was judged capable. Under these circumstances a great deal of independence was allowed, the stipulation being that Gillies must be shown the best and the worst results. His personal information services always defeated the misguided junior who thought he could hide a dead flap, but a confession of skin loss invariably brought the consoling rejoinder that nobody could ever lose as much skin as he had.

Some of the defects we encountered could well have been treated with free grafts, but these were too dull and Gillies was happier using a flap. Since he made so many, his mastery of design was unrivaled, but there was always a tendency to go just too far in freeing the neck of the pedicle. 'Beauty versus blood supply,' he would remark. Through cutting too far, flaps would sometimes be lost, and inevitably, if silently, one might wonder why he had not elected for safety. He took a personal interest in the recovery of ailing skin flaps, and made sure the staff knew what to do. At any hour of the night he might come to have a look, sliding into the ward unobtrusively, he never wanted the house surgeon called and would often probe a suture line to evacuate blood. In crises he would spend the night in the hospital, using a minute cubicle kept for such occasions. If other doctors were about, he might embark on a prolonged discussion of what to do with a particular patient and on at least one occasion a plan was evolved of such urgency that it had to be executed without delay. In the small hours, the theatre had to be opened, the anaesthetist sent for, and the thing done. Whether his family, five miles away, was as appreciative of his enthusiasm as the rest of us might be doubted.

Going back to the hospital after an interval one was always welcomed by a new display, rather like the dog bringing a bone. The bone might be nothing more radical than the infiltration of all wounds with penicillin solution, which was a novelty at that time. On another occasion he showed me how to stitch using a fine skin

hook instead of the conventional forceps to steady the edge in place. He made me do it and it seemed a good idea, if not easy. This was early in our acquaintance and I made the mistake of thinking that this was the 'Gillies method.' Of course there was no such thing, about stitching or anything else. Years later he asked me where on earth I had learned such a curious technique.

He had a great interest in perfecting our stitching. If one of us was inserting sutures while he was engaged on some other part of the patient, there was no limit to the number of times the sutures might have to be taken out and reinserted. On one occasion when I had achieved what seemed superb skin apposition—by stitching and restitching repeatedly, I was obliged to remove the lot and redo them using the other hand. Often he would remove his own stitches and start again because of some new thought prompting a change of design. Such manoeuvres took time, but all his life he had wonderful stamina. After barley sugar all round, he would press on, to the consternation of wilting assistants. As the end approached and relief was in sight, there might come the mischievous suggestion of going on with something else. If a lip had been perfected, he might say, 'Now, boy, shall we go on with the nose?' To which there was no answer.

The treatment of hare lips and cleft palates scarcely interested him and he was happy for someone else to deal with these deformities. At one time he tried, with limited success, to evolve some easy way to introduce a skin pedicle into the palate to correct the shortage of tissue. Only once was this tried in a baby, but it was a failure. Thereafter the patient was passed to me for a routine Wardill closure. Speech following operation was near perfect, a fact that might have enraged a lesser surgeon but which seemed to delight Sir Harold.

There was a similar response once when a very long time had been devoted to the careful sculpturing of a bone graft for the nose. It had been shaped skilfully to occupy precisely the dissected pocket under the skin, but when it became clear that the little graft gave a better result upside down he was highly pleased. Operations for hypospadias were of little interest to him, though reconstruction of the penis was endlessly fascinating to Gillies. It was the same with breast surgery. I doubt if, having published with McIndoe his operation for reduction, he ever performed it again in that way. Reconstruction was more of a challenge. Most hand operations he would pass to his assistants, though to the end he kept trying to reconstruct digits.

Although in a position of great responsibility with regard to Britain's plastic surgery, Gillies never saw himself as an administrator. When feasible he was only too pleased to have someone else make decisions, pointing out sagely that if matters did not turn out well he was then in a position to complain. Unless something really major was at stake he would not attend a committee, though once there his contribution, if not facetious, might be valuable. It is doubtful if he ever read minutes of meetings. Rules were to be broken.

One had the impression that reconstructive surgery was his whole life; he seemed terrified of having to give it up. This is the more surprising because he had so many other interests. He was a good golfer and was very interested in the game. When convalescing from an illness that compelled him to stop playing, he set to and designed a putting green for his local inn, 'The Barley Mow.' There were helpers with the work, but whether his doctors approved or not a great deal of the spade work was done by him. Oil painting he took up late in life and to the end found relaxation in making pleasing pictures. In other respects he was sometimes accused of flamboyance, but I always doubted this and it never showed in his canvases. Fly fishing he enjoyed greatly. He did not read much. (Here too was distrust of formulated opinion.) Writing he did not enjoy. Planning his book and juggling about with format and chapter headings was tolerable, but really getting down to it was resisted to the last. I was amazed Millard ever got him to complete it.

Talking was more his line. Like a worthy Cambridge man he was happy when indulging in relaxed, intelligent conversation. The topic scarcely mattered. Whether it was the old man from the garage or the latest arrival from South America, he enjoyed exploring new thinking and hearing about others' experiences. Over lunch he might talk about the creatures in his garden, and he was inordinately proud of his nightingale. Discussion of a problem or current event might be prolonged limitlessly, but there was always caution about formulating a simple answer. Dogma of any sort was anathema, and he would never accept an answer from a textbook. While not always confident in his own opinions,

especially about people, he was unwilling to accept the judgments of others, the more so if they involved criticism of someone he liked.

He enjoyed recounting his own experiences too, and these always proved interesting. The exotic were of course more to his taste because there was his pride in being different. When the *Times* published letters about the desecration of the Oxford skyline by a huge gasometer, he made the proposal, unfortunately never published, that it be crowned with a spire; since the elevation of the spire would change with the gas content, there would be a constantly changing vista. Absurd? Ridiculous? Or the obvious solution, too bold for anyone else to entertain? We heard how in the early days of motoring he broke the record between Cambridge and London in his own vehicle. He delighted in the unusual interests of his trainees, particularly the one who exercised his steam engine in the hospital precincts and the weekly visitor who, in the gloomy days after the war, arrived piloting his own aircraft. Then we would hear about his lecture in Berlin in the '30s, given in impeccable German with the assistance of a gramophone to a jackbooted audience. Uniforms never impressed. In golfing days he had exulted in the use of a high tee, in fact a bottle, which must have irritated as many as it amused. On a Sydney golf course, acting the part of a has-been, he begged the loan of a ball and club from a passing player and proceeded to knock it within inches of the far hole. Travel was a constant topic. He treasured a lemon presented and autographed by Marshal Tito. When he designed a coathanger on which the jacket could be hung in advance of the trousers, which he described as the natural order, he elected to display this at a large and distinguished dinner party. The presence of ladies did not deter him from removing his own garments in the course of the demonstration. This was not universally approved.

Inevitably he was accused of 'cultivating personality,' but I do not think he had to try very hard. More irksome was his complete disregard for time. Whatever the occasion he would be late, and usually without apology or regret. He was a busy man and often there was some valid excuse, but he rarely expressed it. Perhaps this was another aspect of his personal war against regulation.

He taught me a vast amount, as much about life as about plastic surgery, and after thirty years with him my early impressions were fully confirmed: there were imperfections and regrettable aspects, but he was the greatest of his generation. I was fortunate to encounter him. The thought that you get as much out of a thing as you put into it is not new, but without his showing me I would not have believed there was so much sheer pleasure to be had from practising and teaching surgery."

Professor T. Pomfret Kilner, CBE, FRCS

President of the British Association of Plastic Surgeons: 1947–8, 1955

Thomas Pomfret Kilner was born in 1890, educated at Queen Elizabeth's Grammar School in Blackburn and Manchester University where he qualified in medicine in 1913. His undergraduate career, studded with medals in anatomy and physiology and distinction awards in surgery and pathology, was followed by a year's work as demonstrator in

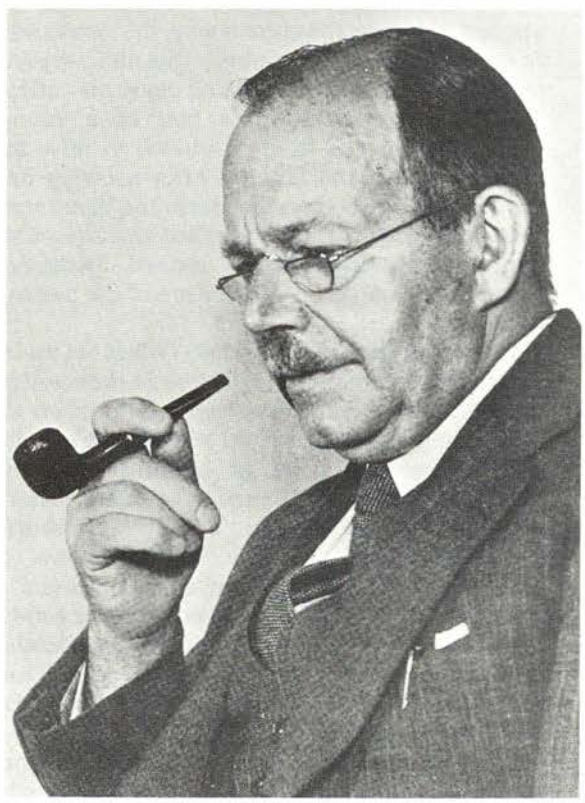


Fig. 5.3 Professor Thomas Pomfret Kilner, CBE, FRCS (*British Journal of Plastic Surgery*, 1949–1950, **2**, 149)

anatomy and a year as senior house surgeon at Manchester Royal Infirmary. He served in World War I as a Captain in the RAMC, surgeon to No 64 CCS in 1915 and surgical specialist to No 4 General Hospital in 1918. At the time of the Armistice he was in charge of an orthopaedic unit for patients suffering from fractured femurs. His consultant surgeon mentioned that there might be an appointment with Major Gillies at a new hospital that had been set up to deal with a new type of specialty—"plastic surgery". So it came about that Kilner found himself at Sidcup. As the late R. J. V. Battle puts it (*British Journal of Plastic Surgery*, 1964, **17**, 330).

> ". . . It is never clear quite how Gillies organised his Unit. There must have been considerable chaos and from what we can gather the surgeons were told 'the plan' for each case, but little else. Kilner's first epithelial inlay seemed to go well, but while at lunch he had doubts and forthwith consulted his anaesthetist. As a result, there followed a quick dash to the ward and removal of the mould with the graft. The skin was re-applied, this time the correct way, the mould was re-inserted and the embryo plastic surgeon returned to finish his lunch and enjoy his coffee. Another diverting story is that of a young colleague who had been instructed to raise an abdominal flap and tube it. After marking out the flap, both incisions were made and then came some hesitation. Kilner was called and arrived to find a completely isolated incised rectangle. Resuture was advised—and return of the patient to the ward . . .
>
> Following the Sidcup period, Gillies set up in practice as the first plastic surgeon in the country and Kilner joined as his assistant. Gillies had all the makings of the successful West-End Consultant—tall, original of mind, athletic, a rowing Blue from Cambridge, expensive tastes, smart car and wealthy friends. Kilner was short, becoming rotund, a much better surgeon, a wonderful organiser with an efficiency usually associated with a first class business, the tidy conservative mind, with as yet no smart friends, a utility car and a hobby of bee-keeping. This association was one of Oxbridge with a Redbrick University, and the two together could have conquered the world. A little commonsense on each side, a little give and take, a little more goodwill in the division of the 'spoils of practice' and they could have been partners for life. This was not to be. They ended by parting company in a most unfortunate atmosphere and never really came to terms until after the formation of the BAPS in 1947. Kilner set up on his own (to Gillies's disgust) on another floor of the London Clinic and proceeded to build up a practice. His team consisted of a qualified assistant (£300 per annum), a nursing sister and Miss Campbell. This hard-working secretary was the sister-in-law of Mr W. E. M. Wardill of Newcastle, with whom Kilner was closely associated on the cleft lip and palate project, and she remained with him till well after the war when the Oxford unit was flourishing. Her devotion and understanding of TPK's whims and peculiarities contributed greatly to the success of the practice and she was in addition the mainstay of the more timorous members of the team. . . .
>
> He overworked steadily and persistently refused to drop any commitments. His voluntary hospital work entailed two sessions at St Thomas's Hospital, a session at Shadwell, another at Dollis Hill and one at Roehampton. He spent three out of four weekends working out of London, one weekend each at Birmingham, Manchester and Alton. He left little time for recreation. He developed and printed all his clinical photographs himself, kept copies of all his cleft lip and palate work, drawing every operation on the palate in duplicate, one at the operation and later at home. . . .
>
> To work with Kilner after acting as Registrar on a general surgical firm was like moving from amateur dramatics to the professional theatre. His meticulous training by which everything was thought out, accurately planned and adhered to was perhaps the first and foremost of his lessons. 'God protect me from the surgeon who changes his plan in the middle of an operation' was a favourite dictum. The next lesson was to allow plenty of time and never to hurry things. 'At Sidcup we never got down to a scar excision within one and a half hours of lunch'. He was, however, a quick operator and like McIndoe and Mowlem could run circles round Gillies when it was a question of progress. He was happiest when operating. His sessions at Alton with John Hunter as the anaesthetist were the real highlights of his professional life. Children meant a great deal to him. Operations on children were his favourites, especially the repair of lip and palate clefts, and all his trainees have shared his enthusiasm. He encouraged the ancillary

services. He excelled in speech therapy and the analysis of speech and was on the Council of the Central School of Speech Therapy and Drama. He understood perfectly the photographic techniques required in his work and strove to have comparable pictures of the patient before and after operation. He was conservative in outlook in everything. This had a steadying effect on trainees and meant that all experiments on patients were 'out'. He found a good method and stuck to it. To effect any change in his outlook was impossible, although if we persisted he became amenable in the end! He had a good reason for everything and this was respected . . . At the outbreak of World War II, Gillies distributed the plastic surgery responsibilities. He himself accepted responsibilities from the Ministry of Health, the Army and the Royal Navy. To Archibald McIndoe he deputed the Royal Air Force, to Kilner, the pensioners at Queen Mary's Hospital, Roehampton and Rainsford Mowlem a unit set up at Hill End, St Albans, where a considerable part of Bart's had been evacuated. The Director General of the Ministry of Pensions organised additional accommodation at Roehampton and a new hospital with 1,000 beds was constructed at Stoke Mandeville in 1940 . . ."

Later, in 1944, Kilner accepted the appointment of Nuffield Professor of Plastic Surgery in Oxford, one of several Nuffield Chairs in Clinical Medicine founded by Lord Nuffield and funded through the Nuffield Provincial Hospitals Trust. This was the first professorial Chair in Plastic Surgery in this country. To quote again from R. J. V. Battle:

". . . The early accommodation in Oxford was somewhat primitive and consisted largely of Nissen huts. Later, permanent buildings were erected. Kilner combined Stoke Mandeville and his section in the Churchill Hospital in Oxford as parts of his Teaching Unit: J. P. Reidy deputised at the former and E. W. Peet at the latter. The Oxford section developed quickly and James Calnan, an early trainee, became a Senior Lecturer. Full of ideas, he kept Kilner on his toes, and it is a fact that the best writing from Oxford came from Calnan—Kilner was tired . . . One example of his general overwork is that he was asked by the *British Journal of Surgery* to edit a section on Plastic Surgery during the 1939–1945 War in the general series of War Supplements that were about to be published. Kilner held on to the contributions for seven years, after which they were returned to the authors. This is why there is no mention whatever of the part played by our specialty to be found in the excellent War Surgery Supplements published by the *British Journal of Surgery* in the early post-War years."

James Calnan in his contribution to "As I remember", published in the *Annals of Plastic Surgery* and reprinted here with his permission, recalls:

". . . Memory is fickle: we remember the good things and forget the bad. Obituaries tend to be eulogies full of hypocrisy—they cloud the picture of the real person. Kilner was a real person: short, fat, bad-tempered, demanding and colourful. I knew him well as his first Senior Registrar and later as Senior Lecturer at Oxford University. He never acknowledged the difference between trainee and Consultant, for TPK recognised only two classes of people: the capable and the fools. Even the capable were watched and directed. For eleven years we worked closely together, day and night (and often weekends) to provide the service he expected from his team and himself.

Patients came first and last for TPK. He loved children and was adept at dealing with even the most fractious: the good child was allowed to choose a coloured sweet at the end of the consultation, the bad child never saw the jar. On the first Saturday of every month we drove 80 miles South in TPK's ancient Rolls Royce to the Lord Mayor Treloar Hospital for Children at Alton. A clinic in the morning, operations all afternoon and well into the evening, then a ward round, supper and the drive home—a long day. Two weeks later Peet or I would visit Alton for a similar day's work and have to report next morning the results of TPK's previous operations. . . .

The Churchill Hospital at Oxford was Kilner's main plastic surgery unit. It served the local population and a large practice from Manchester and South Wales, for he had regularly visited both areas during World War II. The offices were in a Nissen hut, the beds and operating theatres in single story blocks, all linked by covered paths open to the changing climate. We never noticed the weather much, for Kilner was always on the go and kept others that way. As the Nuffield Professor of Plastic Surgery he was involved in many University committees, which he seemed to enjoy and for which he was always in a hurry.

A shout of 'Miss Campbell, where are my papers?', and he was away. He could never have kept up the pace without his faithful secretary, Jean Campbell, who was responsible for filing his precious records (from which he could have extracted valuable statistical data, but never did) as well as a variety of other duties. She was completely devoted to him and bore unjustified criticism with saintly equanimity.

TPK was a perfectionist technician in the operating theatre, an ultra-conservative at heart and in practice. Even at the end he repaired a cleft palate in exactly the same way he had done thirty years before, wrote exactly the same operation note, drew the same diagrams of the procedure—always in pencil with an india rubber nearby to erase and correct a wrong word. Such obsessiveness these days would lead to a recommendation for psychiatric evaluation. But there were obvious advantages, for he followed up his patients, who came from far and wide, until the final assessment satisfied him. Anyone who copied his operation could see what the result would be twenty years later simply by examining Kilner's patients. . . .

I learned much: how to simultaneously deputise for the theatre nurse, who withdrew in tears when he threw an instrument at her (he usually missed) and assist at the operation, how to take photographs in standard positions so that composite illustrations of the patient before and after surgery were comparable in every view, the importance of attention to detail—he used to call it 'millimetre surgery'—and the delicate handling of tissues: the elements of the organisation of a department, the value of personal relationships with patients and the importance of following the progress of patients for many years.

TPK was immensely proud of his eldest son, Hugh, a doctor and an accomplished pianist. After he died suddenly and tragically while on service in Egypt, Kilner was never quite the same. It was a cruel blow that he took badly—almost as badly as he took retirement.

Life oscillates between good times and bad. I have tried to describe both in TPK. What then is it that made Kilner a great man? The times? The man himself? His work? After all these years I still don't know the true answer. Probably a combination of many factors: utter devotion to his specialty, hard work, an obsession with perfection and an inner driving force that has left its mark on all who knew him. . . ."

Sir Archibald H. McIndoe, CBE, MS, MSc, FRCS, FACS

President of the British Association of Plastic Surgeons: 1949

In casual conversation about any aspect of plastic surgery in this country, whether among professional colleagues or laymen, the name that always springs to the surface is that of Archibald Hector McIndoe. The debts that so many patients owe to his foresight, compassion and skill, that our specialty and our Association owe to his teaching and encouragement, and the Royal College of Surgeons of England owe to his guidance and help as their Vice-President, are far more than mere entries on a balance sheet. He projected a very *positive* image of plastic surgery. That his name should grace the Burns Unit at the Queen Victoria Hospital in East Grinstead is a token of the gratitude that is owed for all that he did for the mutilated airmen of World War II, just as the donation of funds to endow the Canadian and American "wings" of that hospital

Fig. 5.4 Sir Archibald Hector McIndoe, CBE, MS, MSc, FRCS, FACS (*British Journal of Plastic Surgery*, 1948–1949, **1**, 219)

reflected the gratitude from other sources overseas. The Royal Air Forces Association and the Guinea Pig Club initiated the foundation of a biennial McIndoe Memorial Lecture in the Royal College of Surgeons of England, the first Lecture being delivered, very appropriately, by the late Air Vice-Marshal George Morley in 1962. Each Lecturer in turn has taken as a theme some aspect of McIndoe's work and interests and the texts of these contributions, with one exception have all been published, albeit in an abridged form, in the *Annals of the Royal College of Surgeons of England*.

One of the most moving of these lectures was that delivered by John Barron, the only surviving foundation member of Council at the inauguration of our Association in 1946 (he was our first Honorary Secretary). His Lecture, given in December 1982, was entitled "McIndoe: the gentle giant" and it is with the kind permission of John Barron and the Editor of the *Annals of the Royal College of Surgeons of England* that the following extracts are taken:

> ". . . Everything about McIndoe was unforgettable and larger than life, but his enthusiasm was infectious and stimulating to all who knew him. At the outbreak of war he was appointed to develop a surgical unit at the Queen Victoria Cottage Hospital at East Grinstead. Here the personality of McIndoe was to be found in every department and in every corner, and from personal experience as a patient not so long ago, I can say that it is still vividly alive . . . What is it in a man that can build up such a high voltage in his environment that the galvanic effect outlives him by so many years? It is basically enthusiasm. But enthusiasm on its own is not enough. Dedication to the pursuit of truth must be the real foundation, and it is here that we find the real McIndoe. His long stint in the Post-mortem Room at the Mayo Clinic taught him basic pathology and he learnt to grope for the truth about the processes of nature, not only as applied to human organs, but also to the human organism itself. Thus he arrived in England in 1930, endowed with a philosophical maturity not often found in men in their third decade.
>
> He was catapulted into plastic surgery by his cousin, Harold Gillies—also a New Zealander—and by the outbreak of war he was fully equipped to lead an important surgical unit. Suffice it to say that his drive and his inborn ability in the course of a very short period of time effectively removed the *Cottage* from the hospital and firmly established his unit as a household name throughout the world. . . ."

John Barron then goes on to discuss the philosophical approach of McIndoe to surgery and the principles that underlined his practice:

> ". . . These principles can be summed up in two compelling phrases: 'Total patient care' and 'It takes a team to treat a patient'. In his mind, a disability or a disease would never be dissociated from the patient himself, whose basic requirement was to function well, to look unremarkable and thus to lead a normal life. This meant that every aspect of the problem had to be taken care of and a diversity of skills was necessary if the ideal result was to be achieved. So the '*clinical team*' was born, the aim of which was total rehabilitation back to 'maxi-life'. In this new world he would become socially acceptable and fit for his occupational and recreational future. This team spirit soon engendered a similar concept among the patients and from this sprang the Guinea Pig Club—which is still alive and active, a living monument to our gentle giant.
>
> In the operating theatre McIndoe was a joy to watch. Lord Moynihan had said to him years before at the Mayo Clinic 'You have hands like a ploughboy, but they behave like an artist's!' And so it was.
>
> Many of his ideals were handed down to the next generation by precept rather than by formal teaching. The student had to work hard in order to follow the master because systematic teaching was not part of his scene. Judging, however, by the subsequent careers of many of those who worked with him at the time, his method of practical demonstration was obviously most effective. . . .
>
> The long hours spent in the study of morbid anatomy were undoubtedly a stimulus to an active and enquiring mind. How, why, when and where became powerful motives for him to probe in depth into his clinical problems, and so were sown the seeds which were ultimately to result in the establishment of an esteemed reseach unit at his hospital—the *Blond McIndoe Centre*. . . .
>
> Apart from burns, many other areas were subject to his scrutiny and we owe much to his guidance in the management of congenital defects of the genitalia, the intricacies of hand surgery, of facial skeletal injuries and the treatment of lymphoedema. Those who are motivated

to pursue his writings will find much of value in the literature. Surely this is a legacy from which we can all draw our inspiration? . . ."

John Barron has referred to some of McIndoe's clinical fields of interest and readers may be interested in some of the important writing that came from his original observations and research. Most of the significant writing was done *before* 1941 and the journals in which these papers appeared make an interesting reading list. We must recall that at that time there were no journals devoted to plastic surgery in the English-speaking world and that we are looking now, with hindsight, at one of the best ways in which plastic and reconstructive surgery can present a credible and distinguished image to our contemporary colleagues and the general public.

Some of the early published work of Sir Archibald H. McIndoe

Experiences in the surgical treatment of lymphoedema. *Proceedings of the Royal Society of Medicine* (Section of Tropical Diseases and Parasitology), 1935, **28**, 45

An operation for the cure of adult hypospadias. *British Medical Journal*, 1937, **1**, 385

The application of cavity grafting. *Surgery*, 1937, **1**, 535

The treatment of old traumatic bony lesions of the face. *Surgery, Gynecology and Obstetrics*, 1937, **64**, 376

The treatment of hypospadias. *American Journal of Surgery*, 1937, **38**, 176

An operation for the cure of congenital absence of the vagina (with J. B. Banister). *Journal of Obstetrics and Gynaecology of the British Empire*, 1938, **45**, 490

The technique of mammaplasty in conditions of hypertrophy of the breast (with Sir Harold Gillies). *Surgery, Gynecology and Obstetrics*, 1939, **68**, 658

Joint discussion of the treatment of burns. (Section of Surgery and Therapeutics and Pharmacology). *Proceedings of the Royal Society of Medicine*, 1940, **34**, 1

First-aid treatment of burns. *Lancet*, 1941, **2**, 377

Surgical and dental treatment of fractures of the upper and lower jaws in wartime: a review of 119 cases. *Proceedings of the Royal Society of Medicine* (Section of Odontology), 1941, **34**, 267

Mr Rainsford Mowlem, FRCS

President of the British Association of Plastic Surgeons: 1950 and 1959

Rainsford Mowlem, the youngest of the "Big Four" and another New Zealander, graduated in medicine in Dunedin in 1924. Some three years later, in 1926, he arrived in England and worked for a short time in a general practice near London before obtaining his Fellowship of the Royal College of Surgeons of England and taking up an appointment as resident surgical officer at Queen Mary's Hospital, Stratford in the east end of London. Later he was appointed resident surgical officer at the Hammersmith Hospital where he came under the influence (one could call it the "spell") of Harold Gillies who was one of the visiting surgeons. This experience fired his imagination and like many others he developed a profound interest in the surgery of repair, its techniques and the temperament required to carry out such work to its conclusion.

He became the fourth and junior partner of the pre-war partnership of Gillies, Kilner and McIndoe. This lasted until the outbreak of World War II, when Mowlem was put in charge of the EMS Unit established at Hill End Hospital in St Albans, to which several of the clinical departments of St Bartholomew's Hospital, London had been evacuated. During the 1939–45 war, the Unit at Hill End took a prominent part in the penicillin trials that were mounted in selected centres in the early years following its discovery. As R. L. G. Dawson recalls, in his recent obituary notice on Rainsford Mowlem:

Fig. 5.5 Mr Rainsford Mowlem, FRCS (*British Journal of Plastic Surgery*, 1949–1950, **2**, 222)

". . . The powder would be delivered from Oxford in small quantities, which was then used as a wound dressing. The residue in the bottle was then washed out and the liquid given to patients with tonsillitis to drink, with beneficial results!"

During this period at Hill End several instructional films were made of plastic surgery techniques: the cameraman, during filming in the operating theatre had the complete "stage" to himself. To avoid detail being obscured by heads and hands, all the surgeons had to stand on one side of the operating table and give the cameraman a completely clear view. The result was a beautiful set of documentary films that are still in the safe keeping of Mount Vernon Hospital.

In the *British Journal of Plastic Surgery* (1950), welcoming Rainsford Mowlem as the incoming President of the Association, Sir Benjamin Rank summed up his fellow-Antipodean's attributes beautifully:

". . . Mere flow of time and practice do not make experience, but Mowlem had a well-developed critical faculty so essential to this end. With patient and lucid exposition his fearless objective criticism of his own mistakes, as of others, has made him one of the world's best teachers of our craft—always with the common-sense approach, his eye focussed on the practical and economic. Shoddy thought to him is a sin no less than shoddy work. He was not born to suffer fools gladly, and no one is better at deflating the proud or debunking the fanciful, but with an effect and kindness all his own. *His reprimands feel like compliments* . . ."

During the Hill End period, an important link was established with the newly established Birmingham Accident Hospital to which the late William Gissane had been appointed Director. Both Bill Gissane and Mowlem had worked together at St James's Hospital, Balham in the late 1930s, Gissane as a general surgeon with an interest in orthopaedics, Mowlem as a plastic surgeon. Mowlem was invited to become the Visiting Consultant in Plastic Surgery at the Birmingham Accident Hospital which he used to attend once every three months. He would do an out-patient consultative clinic in the Burns Unit and later the same day perform operations in the main operating theatre. This link with the newly established teams of young accident surgeons (Ruscoe Clarke, Mervyn Evans, Stewart Harrison, John Hicks and Henry Proctor) had a spin-off in many directions, in particular the surgery of major limb trauma, hand surgery and the management of burns. The early contacts made with Leonard Colebrook, J. C. Squire, John Bull, and Douglas Jackson were followed by later contacts with Edward Lowbury, Simon Sevitt, Jack Cason and J. C. Lawrence and had a dynamic and lasting effect on many aspects of our own specialty. To our loss, the pioneering attempts made to revolutionise our concepts of accident surgery that were the hallmark of the Birmingham Accident Hospital did not find much favour with most of the new generation of orthopaedic and traumatic surgeons in our general hospitals in the UK.

During the war years, Mowlem was also plastic surgeon to the Middlesex Hospital and to many of the hospitals that were then run by the Middlesex County Council. Later when the Plastic Surgery Unit moved from Hill End to Mount Vernon Hospital at Northwood, the full impact of Mowlem's influence on the teaching and practice of plastic surgery gained wider recognition. Clinical investigation and research were encouraged and for many years some of the best research studies came from Mount Vernon and the Middlesex Hospital, in the management of burns, trauma and hand injuries. Much work was done with the Royal National Orthopaedic Hospital at Stanmore in the development of "levitation" techniques in nursing complicated pressure sores and circumferential burns, work that in turn led to the invention of the "low air-loss" bed and other "patient-support systems".

Mowlem's name is associated in particular with three surgical procedures:

(i) The "Mowlem-Jackson" strip grafting of burns in which alternate strips of autograft and homograft split-skin were used to resurface extensive burns in those cases where there was a dearth of available donor sites in the victim.

(ii) The use of early bone grafting with cancellous and cortical bone from the iliac crest, once suitable skin cover had been achieved. This was dramatically successful in the case of mandibular reconstruction and in complicated lower limb injuries, especially those fractures presenting with non-union or "delayed union". This work formed the subject for which he was awarded a Hunterian Professorship by the Royal College of Surgeons of England.

(iii) The pin fixation of fractured jaws, a procedure that was developed with his dental colleagues.

The first technique has now been largely replaced by the development of mesh skin grafting and various methods of tissue culture of human skin. The second advance has been eclipsed by the newer microsurgical techniques of revascularised composite tissue transfer of almost any tissue that it is desired to introduce into a complicated limb defect. The third technique has been widely accepted by the oral surgeons of today and it seems likely that once the froth has settled following the current preoccupation with AO-compression plating and fixation, the important place of pin fixation will be rediscovered.

Sir Benjamin Rank, in the contribution to our Journal from which we have already quoted mentioned that

> "... It is unfortunate that we see so little of his clear and constructive thought precipitated in print. He is not active enough with his teaching capacity. There is some consolation in that what little he does write is to the point, devoid of frills and with that soundness which stands the test of time ..."

This is absolutely true: Mowlem's paper "Bone and cartilage transplants: their use and behaviour" (*British Journal of Surgery*, 1941, **29**, 182) in which he reports 40 cases of cartilage transplant and 115 cases of iliac bone transplant, is a perfect example of beautifully clear, uncluttered writing, based on very shrewd clinical observation.

The Mount Vernon "school" of plastic surgery has been a powerful force in the development of plastic surgery in this country along sound and progressive lines. Its very existence is a striking affirmation of the truth of R. W. Emerson's dictum "An institution is the lengthened shadow of one man"—in this case, Rainsford Mowlem.

These four remarkable men laid the foundations of plastic surgery in this country and each in their separate units profoundly influenced the way in which our specialty was taught, developed and practised in the United Kingdom and carried abroad by others who had come to these shores as trainees. In all sincerity we must be deeply grateful to them for their prodigious effort. But the prestige that surrounded these four "giants" and the concentration of political "power" that was vested in their four units, all within the sphere of influence of the London surgical stage, tended to encourage a form of professional patronage that had a stifling effect on certain aspects of this young developing specialty. This stranglehold was only broken when other major plastic surgery centres were established outside London and showed that first-class plastic surgery was not a monopoly of the London-based Regions. The centres in Glasgow, Edinburgh, Newcastle, Manchester, Salisbury, Bristol and Belfast were the first to point another way ahead. There are now many others, extending our understanding of the basic sciences, particularly anatomy, engaging in healthy academic activity and establishing a respectable and distinguished image of reconstructive surgery in everyday surgical practice, in specialist units and in our general hospitals.

Research and the BAPS

During the war years of 1939–45 most surgeons were heavily involved with clinical commitments, and basic research on problems related to plastic surgery was carried out by special units under the auspices of the Medical Research Council.

The work of most significance for plastic surgery was that carried out by MRC teams in the Burns Unit of Glasgow Royal Infirmary in the early 1940s. The studies of T. Gibson on the use of plasma in burns shock and of L. Colebrook on the control of infections laid the basis for much of modern treatment (Colebrook, 1945; Gibson, 1945) It was also in this department that Gibson and Medawar made the original observation on the "second set phenomenon" of homografts which led ultimately to the possibilities of clinical organ transplantation (Gibson and Medawar, 1943).

The MRC involvement was later transferred to the Birmingham Accident Hospital, where the Burns Unit was under the direction of D. Jackson, and it continued to produce work of outstanding quality.

After World War II

The large expansion of clinical plastic surgery from 1948 onwards was not accompanied by a comparable increase in research activities and for this there were a number of reasons. Some of the senior plastic surgeons at that time (*e.g.* McIndoe and A. B. Wallace) had worked on research projects during their training and had continued to carry out clinical research, but they lacked opportunities to engage in basic research. In addition, the main clinical centres for plastic surgery had developed away from university centres. When new units were established, in spite of great efforts in many instances to site them where an academic link could develop they often found themselves in evacuated wartime accommodation, at a distance from centres of academic activity.

In general surgery there was much increased activity in research and a number of new academic posts were created. In plastic surgery a new Chair was created at Oxford, to which T. P. Kilner was appointed. For various reasons, probably unavoidable at the time, this new academic department did not have the impact which had been hoped for and when Professor Kilner retired the Chair was discontinued.

An important additional factor was that there was little literature on plastic surgery available at that time and training was very much by the traditional method of apprenticeship to the acknowledged masters. The appearance in 1948 of the *British Journal of Plastic Surgery* was a major step in making information and ideas more widely available. The first number of the American journal *Plastic and Reconstructive Surgery* had appeared in 1946.

In spite of the difficulties clinical research continued, particularly in burns, and new techniques of investigation became available which could be applied in the clinical field and which began to bridge the gap between pure clinical research and the more academic basic research. Thus radioactive isotopes made it possible to study the blood flow in skin flaps (Barron *et al.*, 1951; Braithwaite *et al.*, 1951) and to measure changes in blood volume and red-cell volumes in burns (Muir, 1961). New radiological techniques improved understanding of palatal and pharyngeal wall movement in cleft palate patients (Calnan, 1955).

The Research Group

In the late 1950s some of the senior members of the Association (particularly A. B. Wallace, Rainsford Mowlem, Fenton Braithwaite and others) were anxious that research projects should be encouraged

and suggested the formation of a group of surgeons who were engaged in research projects.

This research group met first in April 1959. It was an informal organisation, composed of young consultants and surgeons in training, who presented papers on current research. There were no permanent officials and continuity was maintained only by deciding at one meeting where the next was to be held, the arrangements thereafter being the responsibility of the host unit. The first meeting was held at Mount Vernon in April 1959 and subsequent meetings were at Birmingham, Edinburgh, East Grinstead, Roehampton, Oxford, Glasgow, Salisbury, Newcastle and Bristol, usually at intervals of a year.

These meetings were well organised and enjoyable but enthusiasm began to wane, the members of the group felt that some more formal organisation was needed and, in 1964, approached BAPS Council which decided to set up a Research Committee of which one member would be a Council member who would act as a link between the Council and the Committee.

This Committee continued to arrange meetings at various centres round the country. It had been hoped that, in addition to reports of completed projects, speakers would describe work in progress in the expectation that discussion would produce further helpful ideas and also that different centres might co-operate in some cases by pooling resources. Unfortunately, neither of these ambitions was realised. Co-operative ventures between centres, even when distances have not been great, have seldom been successful except in a very limited range of topics. Furthermore, it is very understandable that for many reasons investigators are hesitant to expound embryonic ideas which they may later have to modify or which may be taken up by others, so that they lose precedence. The meetings had been arranged sporadically but, in an attempt to save travelling time and costs, for some years research meetings were arranged to be concurrent with the main Summer or Winter BAPS meetings.

Secretaries

The Secretaries of the Research Committee in chronological order were, Ian Muir, David Crockett, David Maisels, Ian Jackson, Philip Sykes and Hugh Henderson.

Finance

In the early years the BAPS had insufficient funds to make any contribution to research and the funds are still inadequate to give support to research projects. However, it has been possible to help indirectly by sponsoring individuals to travel in the UK, to Europe and to more distant countries aided, for some years, by the Hayward Fund (now lapsed) and by the Association's own finances. In addition, the Mowlem and Kay-Kilner prizes have provided a stimulus to the production of published work. In spite of some improvements as a result of the 1964 changes, enthusiasm for the research meetings again began to lag and doubts began to be voiced about the effectiveness of the Committee and its activities. The problems were discussed in detail by Council and it was decided that research and education should be combined in a single committee.

Reasons for problems

The relative failure of the BAPS to further research activities has a number of causes. Since the Association does not dispose of substantial financial resources it cannot become directly involved in research projects. It can do so only through its Members and, to a limited extent, by influencing research funding bodies. This aspect is unlikely to change in the forseeable future.

The great majority of Members of the Association are heavily committed to clinical practice and, although a substantial number of consultants have honorary university appointments, in most cases these are of very limited value and do not permit them either to be greatly involved in academic work or to have junior staff to do so.

An even greater problem is the complete absence in the UK of a full-time professor with an academic department. The fate of the Oxford Chair has already been mentioned. The department had an outstanding reputation in the clinical field but failed to add sufficient academic work to consolidate its status. The only other full-time Chair, and that not nominally in plastic surgery, to have existed was held by J. Calnan in the London University at the Royal Postgraduate Medical School. Professor Calnan had both the facilities and the background to continue to produce work in the academic field but had the disadvantage that he lacked the backing of an active clinical department in which the results of basic research could be put into clinical practice.

If Chairs in plastic surgery are to be established in the future their success must depend upon a blend of basic research and clinical practice. If the influence of the Association can help to further this

aspect, it cannot fail to be of untold benefit to the future of plastic surgery.

A revitalised Education and Research Committee

C. W. Chapman

In December 1981 it was proposed that the Association reform its Educational Committee as it was felt that the BAPS should be more active in the training field. Council agreed that such a sub-committee should be set up and Mr R. W. Hiles and Mr R. T. Routledge undertook to submit a memorandum on the subject. This was tabled at a meeting of Council on January 7th 1982 when the following membership was proposed: R. W. Hiles (Chairman elect), T. M. Milward and R. T. Routledge, with one senior registrar member to be nominated by the SR Committee. A maximum of five co-opted members would be chosen for their special interest in the following fields: microvascular, aesthetic, hand, craniofacial and burns.

At a Council meeting held on September 23rd 1982 it was suggested that the Committee might amalgamate with the Research Committee.

The first meeting of the Educational Sub-committee was held at the Royal College of Surgeons on Wednesday, 1st December 1982. Present were:

T. L. Barclay (President)
T. D. Cochrane (Hon. Treasurer)
R. W. Hiles (Council member and Chairman)
T. M. Milward (Council member)
R. W. Griffiths (senior registrar)
N. M. Breach (supporting head and neck oncology)
P. K. B. Davis (supporting aesthetic surgery)
D. A. McGrouther (supporting microvascular surgery)
B. C. Sommerlad (supporting craniofacial surgery)
A. B. Sutherland (supporting burns surgery).

Members were informed of the purpose of the new Sub-committee which was to recommend to the Council:

1. The organisation and forward planning of the educational content of the BAPS meetings.
2. Co-ordination of the programme for such meetings to prevent duplication and to ensure wide coverage of the field of plastic surgery.
3. Collaboration between special interest groups, particularly those which were interdisciplinary.
4. To encourage Members to produce good free papers.

There was general agreement at this meeting that the Research and Education Committees should combine. This was implemented in 1984.

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Education and training

It is only during the last 25 years or so that radical changes in the pattern of surgical training have been forced upon us by the speed with which new procedures have been introduced, their increasing complexity and the widespread demand for higher standards. To be fair to our predecessors, it is helpful to understand the background.

Few today will remember when anaesthesia was administered by open mask, using ether or chloroform, and endotracheal intubation was a rarity practised by very few anaesthetists. It is only 50 years ago that the first sulphonamide drug (prontosil red) was discovered, to be followed by a succession of sulphonamide derivatives with many different uses. Penicillin, the first of the new antibiotics, appeared early in World War II, solved the immediate problem of sulphonamide resistance and led to the discovery of newer antibiotics after penicillin resistance itself became a problem. Anaesthesia advanced rapidly with the introduction of new, safer agents and the wider use of intubation leading to the control of respiration with relaxants. The expansion of thoracic physiology stimulated a greater understanding of respiratory postoperative care so that it became reasonably safe to carry out surgical procedures that had previously carried an impossibly high risk particularly in the very young and the elderly.

Until the end of the 30s, in the majority of hospitals the title of "general surgeon" was an apt description for one whose work would be expected to cover the entire range of surgery with the exception of ophthalmology, gynaecology and ENT. Only during the thirties did the first "specialist" surgical posts begin to appear. Most anaesthetics were administered by general practitioners, although there were a handful of whole-time anaesthetists in London and the largest provincial centres. In those days the young surgical trainee could gain his primary Fellowship soon after his second MB and pass his final Fellowship two years after qualifying. There were no preregistration years to be completed. Training was by apprenticeship and opportunity; there was no structured programme as we know it today. The trainee apprentice would work for one or perhaps two general surgeons and the system was able to provide the experience to cope with the limited range and standard expected at the time, standards which would be totally unacceptable today. Many were able to obtain permanent posts as honorary consultant general surgeons by the age of 30.

However, the surgical expansion of World War II and the obvious importance of team work in the rapidly growing specialties of orthopaedics, neurosurgery, vascular surgery and plastic surgery showed that, although the basic specialty of general surgery was necessarily important, better and carefully planned training was needed in the newer specialties. By the end of hostilities there were some 50 war-trained plastic surgeons remaining in the UK and as many again from the Commonwealth and Allies who returned home. In Britain those who had been honorary consultants, mostly in general surgery, returned to the posts which they held before the war. The others took up positions as registrars in the senior grade, continuing their training in general surgery but awaiting the creation of new posts. The 50 or so who had had war training in plastic surgery began at once to use their experience to tackle the day-to-day problems which had not received attention during the war years when only essential and urgent cases could be dealt with. In this way plastic surgery was first introduced to the public in the main hospital centres. These war-trained surgeons were quick to realise the potential for applying their past experience both as general and plastic surgeons to managing the vast backlog of advanced disease which included major deformities, advanced malignancies and radio-

necrosis for which previously there had been no treatment whatever. Many of the patients with malignant lesions had survived because the tumours were locally destructive and non-metastasising, many of them basal cell or squamous cell carcinomata struggling in areas of ischaemia and necrosis due to radiotherapy. Their surgical ablation created problems familiar to those experienced in war surgery and methods of repair were not unlike those following gunshot and explosive injuries. Excision and repair (immediate or delayed) soon became a regular part of the daily work load. Some remarkable results with long-term survival were achieved and the eradication of gross destructive disease affecting the face and oral cavity gave as much benefit to the victims as they gave relief to those who had to live with and care for them.

At this stage both the public and the profession (Fig. 7.1) were still largely unaware of the range and potential of plastic surgery and this gave time to gain experience in those expanding fields of the specialty to which in wartime it had been impossible to devote much attention. The involvement of our specialty in the total management of malignant disease, led by Braithwaite in Newcastle and FitzGibbon in Bristol, was strongly opposed by the traditionalists and came in for criticism when papers were presented on the subject. But the demand for this work was there, the results justified the soundness of the practice and, within ten years, experience in this field became an essential part of training in all the plastic surgery centres. The challenge of repairing so many major defects stimulated the development of new surgical techniques far removed from the traditional tube pedicle, shortening the time in hospital and increasing the certainty of success.

For ten years from the end of the war there had been no new building and money was short, the creation of new posts was slow and the specialty small in numbers and unavailable to many. With cover in the ratio of one plastic surgeon to each million of the population, the opportunities for promotion of those in training grades were uncertain and caused much concern until expansion began to speed up in the early sixties. When the National Health Service came in during 1948 the present pyramidal staffing structure was confirmed. With the largest numbers in the most junior grades, the only hope for a reasonable rate of progression to consultant depended on a majority of the posts being held by overseas graduates who intended to return to their homelands. There has never been an even spread of overseas graduates through the ranks, and promotional opportunities that were hoped for when the NHS was introduced have remained less than satisfactory, particularly at registrar level.

The various civilian units that had been established during the war in this country became the nuclei of the training centres set up after the war and taken over by the NHS. It was no accident that the influence of the "Big Four" moulded the policies and practices of the early units—and one could easily see the various philosophies perpetuated in the major units until new ideas came to the surface as the newer units gained their independence.

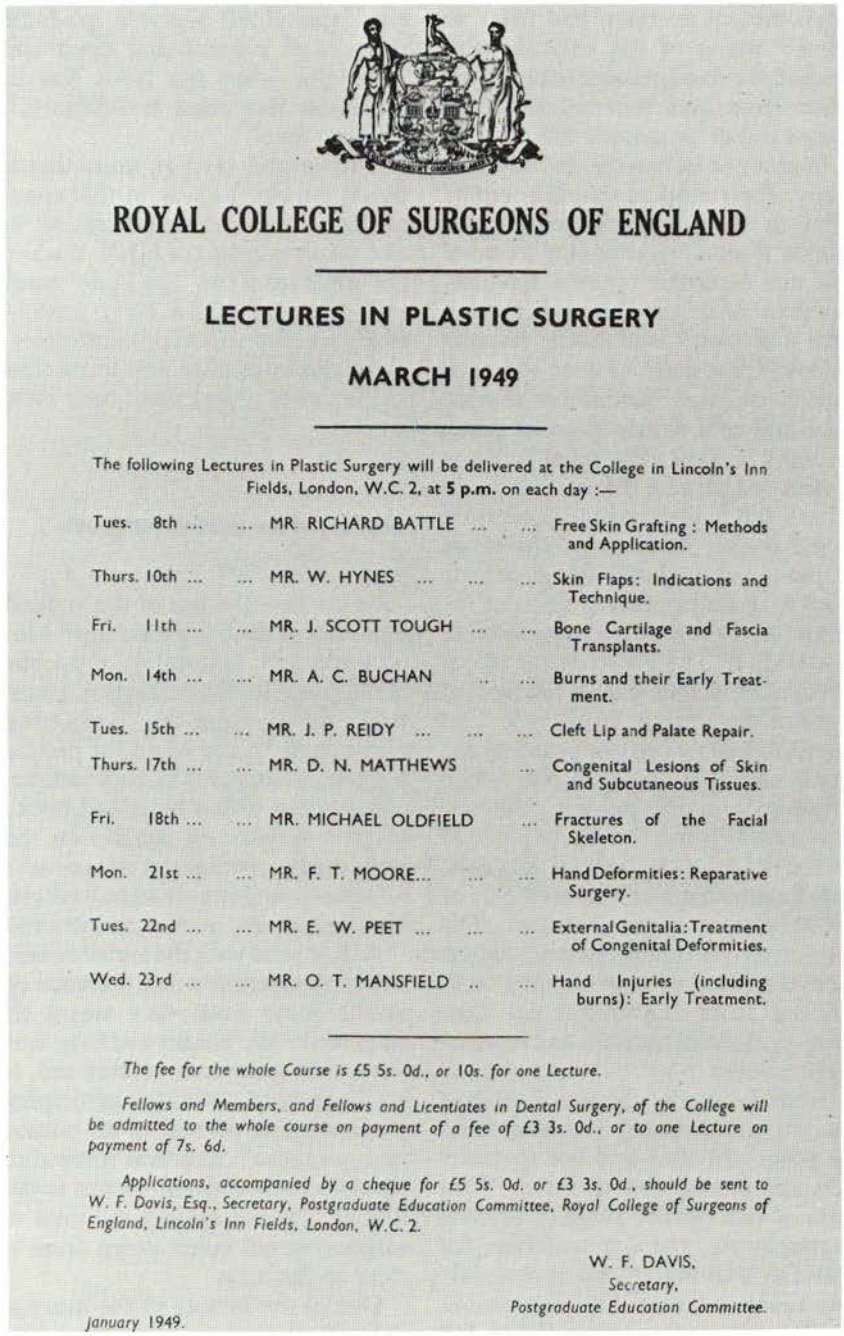
The last of the general surgeons

T. J. S. Patterson

"We are now the last of the general surgeons" was a statement made by Rainsford Mowlem on several occasions. It epitomises the changes that have taken place in plastic surgery since World War II. It is a far cry from the "ivory tower" approach of Gillies and Kilner when the dirty work was left to the general surgeons in, for example, the extirpation of a tumour of the head and neck and the plastic surgeon would only appear on the scene later to perform his specialised tricks—so specialised that no general surgeon could be expected to understand their principles, much less carry them out!

At first, and with the logistic difficulties of getting two busy specialists into the same operating theatre at the same time, this meant that the general surgeon in his ablative efforts would be advised, from a distance and beforehand, to observe some easily grasped "plastic" principles such as, "Replace what is normal in its normal position, and retain it there". Skin was sutured to mucosa round the defect and everything was to be left as neat and tidy as possible against the time when the plastic surgeon would come down from the heights and clear up the mess.

One of the factors in the move away from such *delayed reconstruction* was the greater use of frozen sections, with increasing dependence on their reliability. The next stage was to arrange for general and plastic surgeons to work together on a case; the plastic surgeon would advise the general surgeon as to which bits of tissue it would be helpful to preserve for the future reconstruction. This went so far that general surgeons would ask anxiously whether such



ROYAL COLLEGE OF SURGEONS OF ENGLAND

LECTURES IN PLASTIC SURGERY

MARCH 1949

The following Lectures in Plastic Surgery will be delivered at the College in Lincoln's Inn Fields, London, W.C. 2, at **5 p.m.** on each day :—

Tues. 8th ...	MR. RICHARD BATTLE ...	Free Skin Grafting : Methods and Application.
Thurs. 10th ...	MR. W. HYNES ...	Skin Flaps: Indications and Technique.
Fri. 11th ...	MR. J. SCOTT TOUGH ...	Bone Cartilage and Fascia Transplants.
Mon. 14th ...	MR. A. C. BUCHAN ..	Burns and their Early Treatment.
Tues. 15th ...	MR. J. P. REIDY	Cleft Lip and Palate Repair.
Thurs. 17th ...	MR. D. N. MATTHEWS	Congenital Lesions of Skin and Subcutaneous Tissues.
Fri. 18th ...	MR. MICHAEL OLDFIELD	Fractures of the Facial Skeleton.
Mon. 21st ...	MR. F. T. MOORE... ...	Hand Deformities: Reparative Surgery.
Tues. 22nd ...	MR. E. W. PEET	External Genitalia: Treatment of Congenital Deformities.
Wed. 23rd ...	MR. O. T. MANSFIELD ..	Hand Injuries (including burns): Early Treatment.

The fee for the whole Course is £5 5s. 0d., or 10s. for one Lecture.

Fellows and Members, and Fellows and Licentiates in Dental Surgery, of the College will be admitted to the whole course on payment of a fee of £3 3s. 0d., or to one Lecture on payment of 7s. 6d.

Applications, accompanied by a cheque for £5 5s. 0d. or £3 3s. 0d., should be sent to W. F. Davis, Esq., Secretary, Postgraduate Education Committee, Royal College of Surgeons of England, Lincoln's Inn Fields, London, W.C. 2.

W. F. DAVIS,
Secretary,
Postgraduate Education Committee.

January 1949.

Fig. 7.1 Royal College of Surgeons of England poster (March 1949).

and such a bit would be any use, and there was sometimes a real danger that an imperfect cancer-curative operation would be carried out. The plastic surgeon's cry then became, "You must do a complete ablation; leave as big a defect as you like, the bigger the better—I shall fill it without any trouble". It was thought that general surgeons needed this sort of encouragement in case their

faint hearts might induce them to do an incomplete operation, fearful of the defect they were creating and convinced that no mortal man could ever fill it.

The principle slowly became accepted that *immediate reconstruction* was not only possible, but very much to the patient's advantage. When it became clear that the plastic surgeon knew how to manage the largest defects, he was increasingly consulted, earlier and earlier, in the course of treatment of cancer. This led to a reduction in the sphere of influence of the radiotherapist.

Then came the post-war generations of plastic surgeons, with their mandatory period of training in general surgery, proving that they were capable of the ablative part of the operation as well as the reconstruction, and they gradually took over the whole surgical management of these cases. Plastic surgery was coming more and more into the "market place" and plastic surgeons were found to have techniques applicable to a wide variety of surgical specialties.

The influence of the BAPS on training

Denis C. Bodenham

Now, some 40 years later, it is hard to appreciate the early difficulties of training in plastic surgery. There were few pre-war textbooks on plastic surgery and the first English language journal devoted to the specialty had not yet appeared. First came the Brenthurst Papers from South Africa in 1944 (Jack Penn) then the American journal *Plastic and Reconstructive Surgery* in 1946 followed two years later by the *British Journal of Plastic Surgery*. From time to time a plastic surgical paper appeared in one of the general surgical journals, but no regular meetings took place on plastic surgical topics. Many unsuitable postgraduate students from abroad were being accepted for training in this country by the British Council and other bodies, facilities were limited and British students were likely to suffer. So, early in 1949 (Appendix B) the Council of the Association set up an Educational Sub-committee and at its first meeting it decided that it needed the help of the Royal College of Surgeons. The acting Honorary Secretary wrote on May 11th 1949:

> Dear Sir Archibald,
> Following upon instructions given to me at the last Council meeting, I am enclosing a draft of the questionnaire I propose to send out to the various teaching units throughout the country. If you approve of this and will return it to me immediately I will get it sent off. On the other hand, if it does not meet with your approval, and you will indicate the alterations you wish made, I will get the draft amended accordingly. The following is a list of "teaching units" to which it is proposed to send the questionnaire:

Barron	Basingstoke
Battle	St Thomas's
Elliott Blake	St George's
Braithwaite	Newcastle
Champion	Manchester
Eckhoff	Guy's
FitzGibbon	Bristol
Grocott	Stoke
Heanley	The London
Hynes	Sheffield
Kilner	Oxford
Lewis	Gloucester
McIndoe	East Grinstead
Mansfield	Birmingham
Matthews	UCH, London
Mowlem	Hill End
Oldfield	Leeds
Osborne	Liverpool
Reidy	Westminster
Tough	Glasgow
Wallace	Edinburgh

> Finally I am not quite certain what is the position at Guy's Do you think I ought to send one, and if so, should it go to Clarkson or Eckhoff?

The President of the College, Lord Webb-Johnson, invited the Association to form a Joint Committee on Training in Plastic Surgery. He himself, as Chairman, was supported by the Vice-President and the Association nominated six Members to form the Committee. There were four terms of reference namely:

1. To determine the educational requirements before entry.
2. To determine the most satisfactory method of developing the existing facilities and the need for new ones.
3. To correlate postgraduate training with the College.
4. To determine the range of plastic surgery to be included in the curriculum.

Despite the clarity of the report of May 27th 1954 (revised in 1983, Appendix B) of this early Committee, it lacked any authority to make its recommendations mandatory and some important

ones were not implemented. In a number of centres it had been found that essential facilities and training opportunities were lacking. Some centres had been set up in clinical and geographical isolation from other disciplines and lacked, for example, full pathological and radiological services, full 24-hour cover being available only at neighbouring hospitals. In some regional centres the beds were scattered between three or even four hospitals, with the added problems of continuous supervision and the lack of immediate availability of the specialised skills of our anaesthetic colleagues. Some units treated few, if any, children and in one hospital at least children were being admitted to adult wards. In others, although an adequate number of beds was available, certain types of cases essential to training were not represented. In fairness, it must be remembered that nearly all these centres had been established in wartime in temporary and often improvised buildings, and many of the facilities that we now take for granted simply did not exist.

The specialty grows up

During the late 1950s there began the gradual expansion of our specialty in the establishment of new consultant posts and the provision of better facilities. In some centres funds for research were made available and trainees could undertake specific projects during their training in their base unit. With the rapidly developing interest in plastic surgery at home and abroad local Associations had been established, followed by proposals to set up an International Confederation of Plastic Surgery Societies. But all had not been plain sailing as is shown in a letter from the Honorary Secretary to all Members in June 1952:

> "Following upon the announcement by the Minister of Health of the proposed reduction of the total number of Senior Registrars in Plastic Surgery, the Joint Committee of the British Association of Plastic Surgeons and the Royal College of Surgeons have been giving very serious consideration to the problems and difficulties which will arise. This Committee is to put forward a case to the Minister emphasising why the number suggested by him is inadequate and setting forth their reasons for asking that a much bigger number be agreed upon. In order to help the Committee make this case as strong as possible it is essential that up-to-date information concerning all the Units is available. I have therefore been instructed to send you the enclosed questionnaire with the request that you complete it as accurately as possible. The matter is most urgent and I must ask you to send me the completed return to the above address by June 16th, 1952."

Scholarships, prizes and lecturers

The enormous advantages of the opportunity to visit other centres at home and abroad have always been recognised. The possibility of studying at first hand the work of other units in this and other countries and extending our own understanding of the scope of such a rapidly expanding surgical specialty stimulates both the trainee and the teacher. Many of these visits can be arranged locally without great expense or difficulty and in the early days many visits were arranged by the trainees themselves, with some guidance from their chiefs. The Council of the Association, by attracting funds from generous donors and careful allocation of some of its own revenue, has been able to make grants to assist visits abroad. The major awards given every year (until 1980) were the three Hayward Foundation Scholarships for travel outside Europe, three scholarships to support travel in Europe and three grants to trainees to visit other centres in the UK.

In 1961, following the death of Sir Harold Gillies, the Association founded a memorial lecture to be delivered every two years with the award of a gold medal to the lecturer on the occasion of its delivery at the Winter meeting of the Association. Shortly afterwards, following the early death of Sir Archibald McIndoe, the Guinea Pig Club, founded by RAF patients treated during the war at East Grinstead, donated a sum to the Royal College of Surgeons of England to fund a memorial lecture in his memory. Although the McIndoe Memorial Lecture is an official College occasion, the choice of lecturer is generally made on the nomination of the Council of the BAPS and the Lecture is traditionally given during the Winter meeting of the Association, alternately with the Gillies Memorial Lecture. In 1978, after a particularly successful Summer meeting, the Windsor Lecture was endowed and is normally awarded every two years, the lecture being delivered during the Summer meeting of our Association. These various lectures allow many distinguished colleagues to talk on a subject of their own choice, to enlighten us on the developments in our specialty to which they

themselves have contributed and, finally, to honour the founder members of our Association.

From 1962, following the death of Professor Pomfret Kilner, an annual prize has been awarded for the best essay submitted on a subject chosen by the Council. Some excellent essays have been published in the Journal but, unfortunately, the art of essay writing has suffered badly in the hands of plastic surgeons who prefer the screen on which to project their thoughts and ideas rather than the printed page. For this reason there have been several years when no prize was won. Also in 1962 the Mowlem Award was instituted (see The International Congress, London 1959, p. 77).

In 1961 Ralph Millard, who spent his early years in plastic surgery working with Gillies, was able to use a generous donation to fund a scholarship known as the Johnson Fellowship. This enabled British senior registrars to work with him in Miami for a period of one year. The fund was sufficient for the Fellowship to run for ten years and made it possible for a succession of men to gain valuable experience, particularly in cleft lip and palate surgery. Over the years a number of units have established links with overseas centres, arranging, in some cases, for two-way exchanges; most successful have been Canniesburn, Newcastle and Frenchay.

The most consistent links have been those between Australia and Frenchay and these were strengthened in 1972 when the Australasian College took over the selection of each trainee for the year's training. In 1976 Frenchay began to send a senior registrar to Melbourne for a year's experience in microvascular surgery with Ian Taylor and more recently the opportunity has been widened to include time with David David in Adelaide for craniofacial experience. Both David and Ian had worked at Frenchay.

Gillies Lectures

1961 Thomas Pomfret Kilner—"The birth of a speciality"
1962 Rainsford Mowlem—"Bone grafting" 1963, **16**, 293
1963 Francis Burian—"The past and present of plastic surgery: its problems in future society" 1964, **17**, 351
1964 Allan Ragnell—"The development of plastic surgery in Stockholm in the last decennium"
1965 Sir Ivan Magill—"Plastic surgery and the anaesthetist"
1967 Geoffrey Molyneux FitzGibbon—"The commandments of Gillies" 1968, **21**, 226
1969 Richard John Vulliamy Battle—"Great opportunities in plastic surgery"
1971 D. Ralph Millard—"Jousting with the first knight of plastic surgery" 1972, **25**, 73
1973 Sir Benjamin K. Rank—"Tides and eddies" 1974, **27**, 205
1975 Halfdan Schjelderup—"Plastic surgery from Basingstoke to Norway" 1977, **30**, 59
1977 David Napier Matthews—"Gillies: mastermind of modern plastic surgery" 1979, **32**, 68
1979 Thomas Gibson—"Tissue transplantation before, during and after the life of Sir Harold Gillies"
1981 Douglas Andrew Campbell Reid—"The emergence of hand surgery in the United Kingdom" 1983, **36**, 278
1983 Noshir H. Antia—"Organisation of plastic surgery in developing countries" 1985, **38**, 24
1985 Norman Campbell Hughes—"The legacy of the giants"

(References are to Lectures published in the *British Journal of Plastic Surgery*)

Windsor Lectures

1978 Stewart Hamilton Harrison—"The Hand"
1980 James F. Murray—"The philosophy and principles of reconstructive surgery in the injured hand"
1984 Sir Benjamin K. Rank—"Forty years on"
1987 Dr H. Kleinert, Louisville—"Microsurgery of the upper extremity—a quarter century perspective"

McIndoe Lectures

1962 George Henry Morley—"*Si monumentum requiris circumspice*—Plastic Surgery in war and peace" 1963, **32**, 139
1964 Percy Harris Jayes—"The establishment of the speciality of plastic surgery and its contributions to other specialities" 1966, **38**, 210
1966 David Napier Matthews—"A tribute to the services of Sir Archibald McIndoe to plastic surgery" 1967, **41**, 403
1968 Fenton Braithwaite—"Oral carcinoma in relationship to the reconstruction"
1970 John Watson—"Trends in the treatment of burns—the influence of McIndoe" 1971, **49**, 36
1972 Julian Bruner—"Contributions of Sir Archibald McIndoe to surgery of the hand. Surgical exposure of the flexor tendons in surgery of the hand" 1973, **53**, 1; Surgical Exposure of flexor tendons in the hand. 1973, **53**, 84
1974 Sir Terence George Ward—"The maxillo-facial unit" 1975, **57**, 67
1976 Russell Maddox Davies—"Relationships" 1977, **59**, 359

1978 Douglas Jackson—"Burns: McIndoe's contribution and subsequent advances" 1979, **61**, 335
1980 Denis Charles Bodenham—"In quest of perfection" 1981, **63**, 233
1982 John Netterville Barron—"McIndoe, the Gentle Giant" 1983, **67**, 203
1984 John Turner Hueston—"Dupuytren's disease—the role of the skin" (delivered in 1985)
1986 Sir Michael Wood—"The birth of plastic surgery in East Africa".

(References are to Lectures published in the *Annals of the Royal College of Surgeons of England*)

Kay-Kilner Prize Essays

1962 L. R. McLaren—"Reconstructive surgery in the treatment of malignant disease of the mouth" 1963, **16**, 305
1963 R. F. Brown—"The management of traumatic tissue loss in the lower limb, especially when complicated by skeletal injury" 1965, **18**, 26
1964 A. F. Wallace—"The problem of skin cover in extensive burns" 1966, **19**, 161
1966 D. O. Maisels—"The timing of the various operations required for complete alveolar clefts and their influence on facial growth" 1967, **20**, 230
1967 S. Milton—"The tubed pedicle flap" 1969, **22**, 53
1968 J. S. Calnan—"Whither plastic surgery?—trends for the future" 1970, **23**, 100
1971 G. F. Crikelair—"The influence of surgical pathology on plastic surgery procedures" 1972, **25**, 329
1972 J. P. Bennett—"The treatment of rodent ulcer in the 19th Century and its relationships to the development of British plastic surgery" 1974, **27**, 144
1975 D. Poswillo—"The relationship between oral and plastic surgery" 1977, **30**, 74
1977 K. C. Condon—"The role of the plastic surgeon in the accident service" 1979, **32**, 78
1978 D. E. Tolhurst—"Skin and bone" 1980, **33**, 99
1979 D. A. McGrouther—"The operating microscope—a necessity or a luxury?" 1980, **33**, 453
1980 C. M. Ward—"Breast reconstruction after cancer—aesthetic triumph or surgical disaster?" 1981, **34**, 124
1981 C. T. K. Khoo—"Cosmetic surgery—where does it begin?" 1982, **35**, 277
1983 M. J. Timmons—"Specialist F.R.C.S.—an irritating irrelevance or desirable diploma?" 1984, **37**, 303
1985 D. Elliot—"The management of hypospadias; its relevance to surgical training in the principles and practice of plastic surgery" 1987, **40**, 227
1986 M. N. Tempest—"Is the policy of informed consent in the interests of the surgeons or the patients?" 1987, **40**, 445

(References are to Essays published in the *British Journal of Plastic Surgery*)

Mowlem Award Winners

1962 J. S. Calnan
T. J. S. Patterson
1966 D. C. Bodenham
D. J. Crockett
1970 D. O. Maisels
1974 I. A. McGregor
1978 P. L. G. Townsend
1982 R. W. Pigott
1986 G. I. Taylor

Formation of the Joint Committee on Higher Surgical Education

By 1967 rapid technical progress and the demand for high surgical standards in all branches of surgery prompted a meeting of the Royal College of Surgeons of England to consider a scheme for structuring the training in each surgical specialty within the framework of a common plan of basic surgical training. After a preliminary meeting the English College together with the Royal Colleges of Edinburgh, Glasgow and Ireland, the Association of Clinical Professors of Surgery and a number of specialist associations laid the foundations for a Joint Committee on Higher Surgical Education. The form and function of this Committee was formulated after discussions with the Ministry of Health and other bodies concerned with postgraduate medical education which, once general agreement had been reached, shared the responsibility for its implementation.

Higher surgical training was to be a natural sequel to the period and form of training for the respective Fellowship examinations. Comprehensive training programmes were to be carried out only in posts recognised by the various Colleges. The Joint Committee did not set out to interfere with the freedom of trainees to choose their own posts or with the right of appointing committees to select their own trainees. It set up specialist advisory committees in each of nine surgical specialties. Each specialist advisory committee (SAC) would have five members, three nominated by the relevant specialist Associations and two by the Royal Colleges, and each committee was to choose its own chairman. They were to be given the duty of defining the training programmes, approving by inspection the training centres, and to act generally as agent for the Joint Committee in supervising the

programmes and maintaining a continuous relationship with centres and trainees (Appendix B). The Joint Committee was to receive regular reports from the specialist advisory committees, to offer advice and adjudicate where necessary and, finally, to receive the names of those who had fulfilled the requirements of the training programme. The Joint Committee was then able to assess the relationships between the specialties and to offer each the opportunity to gain by the experience of others.

The SAC in Plastic Surgery had a significant advantage in that is was the only specialty for which a training programme had already been worked out and it was the first of the specialist advisory committees to present the Joint Committee with an up-to-date version of its original plan related to new developments and changed circumstances. It was also the first to make visits of inspection carried out with the full authority of the Joint Committee. Prior to any visitation, the centres were asked to complete a detailed questionnaire on the organisation, staffing, content of work, association with other departments, and the presence of supporting services regarded as essential to training. Requests were made for details of research being carried out and lists of work published or in preparation. The SAC nominated three of its members for each visit which was unhurried and took most of the day. The visitors arranged to meet the oral surgeons and, wherever possible, the Professor of Surgery, Chairman of the Division of Surgery and Postgraduate Dean, with representatives from the departments of anaesthesia and the administration. Discussions were held with all the consultant staff and each member of the junior staff was interviewed separately. During the visit, attention was paid to attendance at seminars, journal clubs, out-patient clinics, supervised operating and the establishment of a correct balance of training, with progressive responsibility for senior house officers, registrars and senior registrars alike. The visitors enquired into the keeping and organisation of medical and photographic records and their use for reviews and research.

It was recognised that each centre would develop its own pattern determined by the environment in which it had grown up and the special interests and skills of the staff. All areas of excellence were observed and it was felt that each centre should be encouraged to retain its identity. Merit in particular fields should be endorsed and any drift to mediocrity, which might be imposed by a rigid standardisation, should be avoided.

The SAC was able to give praise and constructive criticism where due, offering suggestions for rotating appointments, secondments or visits of trainees to other units. It was not surprising that some deficiencies came to light and, in a few instances only, approval of the centre as a training unit was deferred until, for example, rotation schemes were put into operation to fill gaps in the training requirements or better back-up facilities were provided.

Following each visit the SAC submitted a full report to the next meeting of the Joint Committee. Once a training post had been recommended for approval and confirmed by the Joint Committee, the holder of the post could apply for registration. The date of registration would normally be retrospective.

For the first five years only senior registrar posts were approved, later certain registrar posts were approved for one year of the three year training period and time spent at senior level reduced from three to two years. Research posts which had a significant clinical content were inspected also and some were approved as one year of the total three year period. A number of overseas posts were considered as part of the total training period.

Trainees who had completed their training period and fulfilled the necessary criteria could then apply to the SAC for confirmation that they had completed their specialist training. Subject to a satisfactory report from the head of the centre and his colleagues, his or her name would then be submitted to the Joint Committee who in turn would instruct the relevant College to issue a Certificate of Completion of High Surgical Training on behalf of the Joint Committee.

The influence of the SAC

It was the general policy of the SAC to support each centre in the development of its own educational opportunities best suited to its staff and the environment in which they worked. The most successful centres had developed certain features and practices which the SAC thought highly desirable in any training centre. For example, there must be sound leadership with a clear progressive policy. Each member of the team should have a special interest over and above that required for routine practice.

Since the proliferation of clinical, teaching and administrative responsibilities has become very time-consuming, these duties must be shared by

each member of the team. Only in this way could the educational needs of undergraduates, postgraduates, general practitioners, nurses and ancillary workers be identified and fulfilled. In this way possible sources of conflict are removed and a relaxed environment created in which team work can flourish, visitors can come to discuss their problems, questions are encouraged, and all gain by the stimulus given to put forward new ideas and maintain high standards of work and care.

Opportunities for promotion

There has always been a need for those responsible for directing any training programme to maintain some balance between the number of *bona fide* trainees and the opportunities for promotion to the consultant posts. The Council and SAC have always been aware of this obligation but their direct influence has only been successful in maintaining the number of posts in the senior registrar grade as close as possible to filling the average number of consultant vacancies appearing annually. This number is, of course, variable and dependent on the vacancies created by retirement at the age of 65, those who take early retirement and the number of new posts that may be created.

The staffing structure of the NHS tends inevitably to be rigid and pyramidal. The number of SHO and registrar posts has long reached the point where there is an excess in training for promotion to senior registrar within a reasonable time and their future remains uncertain. Overseas graduates holding training posts and returning to their country of origin tend to reduce, but do not eliminate, the excess and this too is unsatisfactory. The one obvious and sensible solution is a major increase in the number of consultant posts but for many reasons, both medical and political, little progress has yet been made. In the present economic state of the country the Government is unlikely to make sufficient funds available and the constantly changing systems of management inflicted on the NHS make long-term financial forecasts a nightmare.

The influence of training on the present form and future of the specialty

Plastic surgery is held together not by anatomical boundaries but by highly developed techniques of tissue management. These include an understanding of tissue viability, wound healing and the ability to plan "in the round", applying the principles of spheroidal geometry. There must be a strong aesthetic sense and consideration of the effects of natural growth and behaviour of scar tissue to make the results lasting. There must, of course, be the highest level of manual dexterity with the skill and steadiness of hand to work with the operating microscope. The goal of every operation should be both visual and functional perfection.

In addition to general surgery, training must include a working knowledge of other surgical specialties, orthopaedic, dental and ENT surgery being the most important. There must also be an understanding of human values and inter-personal relationships, some ability to apportion the psychological, pathological and surgical implications of any reconstructive work.

The plastic surgeon has an advantage in that his specialty is broadly based and constantly facing new problems, many of them presented by colleagues in other specialties. Each new problem is a challenge to develop new answers and improve upon established procedures. Our specialty has remained flexible and progressive and this is the exciting atmosphere in which trainees can spend their formative years—if they take the opportunities that face them.

The private sector

During the last decade there has been a steady growth in the private sector of surgical practice in the UK and there is every indication that this growth will continue. Indeed, the private sector deals with far more "aesthetic" surgery than can be dealt with by the NHS and our training programme in this aspect of the specialty needs some modification, possibly by arranging some form of secondment to certain carefully selected centres.

A specialist Fellowship

B. C. Sommerlad

On more than one occasion Kilner, who died in 1964, said, "If a specialist qualification is ever introduced—which God forbid!—the test that I would set would be the construction of a standard iliac fossa tubed pedicle flap."

The decision to mark completion of training by a certificate based solely on the satisfactory fulfilment of the training programme has come in for some valid criticism since it was introduced in 1969. The UK remained the only country with an advanced training programme that did not include a specialist examination. Overseas graduates who

train here may be at a disadvantage when they return home without an internationally recognised meaningful qualification and indeed the lack of such an examination may well compel them to go to other countries for their basic specialist training.

In the mid 70s the Royal College of Surgeons of Edinburgh came near to introducing a Specialist Fellowship Examination in Plastic Surgery but they lacked the support of the other Colleges and the Association, and the plans for its introduction were laid aside. It was argued that another examination taken during the last period of training would be a burden, and restrictive at a time when the trainees should be broadening their experience, conducting research and preparing generally for the practice of surgery for which many of the qualities required are not examinable.

Nevertheless, the case for a Specialist Fellowship remained strong. It is not always possible to convince others that a consistently high standard is attainable throughout the training centres at all times, and the current Certificate of Accreditation leaves too much to personal recommendation while total supervision by the SAC is impracticable. In the early 1980s the Royal College of Physicians and Surgeons of Glasgow took the first serious steps to set up a Specialist Fellowship (or "Assessment") in Plastic Surgery in the UK. After a good deal of discussion, at an extraordinary GM of the Association at Cardiff in 1984, and following firm representations from the Council of the BAPS, it was agreed to support the proposals of the Glasgow College provided a clear undertaking was given to make this an inter-collegiate examination with full reciprocity between all the surgical Colleges. The decision was endorsed by the senior registrars when their Travelling Club met at Canniesburn in April 1985. The draft of the rules of admission to the examination and a detailed syllabus was agreed (Appendix B) and the first Inter-Collegiate Specialty Board Examination was held in Glasgow on March 26th 1986. Three candidates were successful out of the five who were examined.

The long-term plan of the Colleges appears to be for a two-tiered Fellowship, the first part incorporating the features of the previous primary examination in the basic sciences and surgery in general, the second part being a specialist examination in plastic surgery. The specialist examination would be available only to senior registrars or others of equivalent status subject to stringent safeguards, and the examination would be taken towards the end of training.

The present time

Denis C. Bodenham

Plastic Surgery is present-day general surgery and during the last half century has sustained its momentum of progress. It has remained coherent by containing the narrow specialties which have arisen within the overall pattern. The single most important factor responsible has been the training programme and the quality of the trainees. In the same way the future will be determined by the content of the programme, the manner in which it is implemented and those who undertake it. It is fortunate that the specialty continues to attract a high quality of trainee. Experience of basic plastic procedures by those practising in other disciplines will lead to some loss of what used to form a part of routine work, but new developments in the advancing areas of microvascular and craniofacial surgery, and demands for rising standards, will more than compensate for losses and will ensure full viability for the specialty.

APPENDIX A—British Association of Plastic Surgeons

A meeting of the Education Sub-Committee, appointed by the Council, was held at 149 Harley Street, London, W.1, on March 3rd, 1949.

Present: Sir Archibald McIndoe (President)
Mr Rainsford Mowlem (Vice-President)
Mr Richard Battle
Mr John Barron (Secretary)

Terms of reference

(a) To suggest the minimum standard of post-graduate knowledge and experience required of a student before specialising in plastic surgery.
(b) To determine the optimum period of training in a recognised centre necessary for such a student to achieve specialist status in plastic surgery.
(c) To review the facilities existing within the United Kingdom for the training of specialists in plastic surgery.
(d) To consider and to advise on the proposal that a Faculty in Plastic Surgery should be established, within the Royal College of Surgeons.
(e) To advise on the standard required of a student before he is recognised by the Association of Plastic Surgeons as a fully trained and competent plastic surgeon.
(f) To determine the relative positions of:
    1. UK trainees
    2. Empire trainees
    3. Foreign trainees

(a) The Sub-Committee believes that the qualifications for a Plastic Specialist should be identical with those laid

down for Specialists in the Spens' Report—*i.e.* Grade I specialist trainee should have 4 years general surgical training after qualification and that a higher degree is essential. These should be MS, FRCS, FRCSE, or reciprocal higher surgical degrees from other parts of the Empire.

(b) The average period of Plastic training in an approved centre is set at 4 years. The suitability of the candidate should be reviewed within the first twelve months by the Surgeon-in-charge of the training unit. His decision is final as to the suitability of the candidate to continue in that unit, though the trainee should be free to try elsewhere.

(c) At the present moment, although considerable facilities exist throughout the country in various units, few are at this moment active in training postgraduates. Amongst these is East Grinstead, which has a number of young surgeons almost completely trained and which will maintain a steady flow of two to three fully trained surgeons per year indefinitely.

The following table gives an approximate picture of the situation:

	*Active Beds**	*Active Surgeons*	*Trainees*	*Potential*
East Grinstead	200	6	6	plus 1
Hill End	85	3		3 plus 1
Basingstoke	210	2		3 plus 1
Oxford (Stoke Mandeville and Alton)	104 (44)	4	2	2 plus 1
Sheffield	70	1	1 1 ob	—
Bristol	60	1		1
Glasgow (Ballochmyle)	130 (50)	2	2	2
Edinburgh (Bangour)	96 (148)	2	1	2
Liverpool	40 (82)	1	1	1
Manchester	90	1	1	
Leeds	75 (25)	2	2 1 ob	plus 1
Stoke-on-Trent		1		
Birmingham	?30	1		2
Newcastle	?30	1		2
Gloucester	?	1		2
London Teaching Hospitals: University College Hosp. Middlesex Hospital St Thomas's Hospital London Hospital	12			

* Figures in brackets indicate the number of potential beds

The number of trained plastic surgeons available for national requirements within the next three years will be limited, but it should be possible thereafter to provide a steady flow.

(d) The Committee is strongly of the opinion that as no generally accepted and recognised standards of competence in Plastic Surgery exist, the suggestion of the Council that the help of the Royal College of Surgeons be sought in establishing a Faculty in Plastic Surgery under the aegis of the College be adopted. The President of the Association was invited to discuss this proposal with the President of the Royal College of Surgeons, who has already indicated his willingness to co-operate. It was felt that the present time is opportune for this move. The reasons for desiring the establishment of a Faculty are as follows: Firstly, there is at the present time no means generally acceptable of determining the competence of a Plastic Surgeon beyond the recommendation of another plastic surgeon, who may not have himself the ability to judge a trainee's expertness. Secondly, Plastic Surgery is a young and fast growing specialty. It is felt that this is the opportune moment to set up such standards. That the college should assume the responsibility for the Faculty is prompted by the desire to avoid a schism such as the establishment of an Institute as an outside body would produce. This, it is felt, would be regrettable. Thirdly, the Faculty would have the experience of the College in deciding what are the correct methods of examination, when and how they should be conducted.

(e) The Committee expressed the view that the standard of Plastic competence to be controlled by the proposed Faculty would be best effected by means such as the following:

1. Written examination.
2. Oral examination conducted in the candidate's training centre if he so wished.
3. Practical operative examination also conducted in the candidate's own clinic and observed by selected members of the Faculty.
4. Production of properly drawn up records of a number of cases (say 100—operated on by the candidate).

(f) Application has frequently been made in the past by organisations such as the British Council, the Nuffield Trust, etc., for training of foreign students in Plastic Surgery. These requests are often made to individual members of the Association without previous knowledge of the qualifications of the applicant.

In view of the limited opportunities for training, it is felt that all such applications should be made in the first place to the Council of the Association which will decide if an opportunity does in fact exist.

In general these students fall into two groups:

1. Students from different parts of the Empire willing to remain under training for two or more years and to

take the prescribed examination. It is felt that these should be afforded opportunities provided they are recommended from approved centres and are financed from the country of origin or by the organisation recommending them.

2. Students from foreign countries who wish to devote a relatively short period, say three months, to the study of plastic surgery in a British centre. It is felt that, at the present moment, while these students should be encouraged, facilities should be limited to those of observation.

May 3rd, 1949

APPENDIX B—Joint Committee on Higher Surgical Training

Specialist Advisory Committee in Plastic Surgery

Criteria for recognition of a training programme in plastic surgery—revised version 1985

1. There must be a sufficient number of consultant sessions distributed in such a way as to ensure that adequate supervision and training will be provided throughout the period.
2. The work load must be such that the trainee can acquire a reasonable working knowledge of Plastic Surgery procedures in patients of all age groups. To this end the unit must contain an adequate number of beds for teaching purposes with a reasonable proportion reserved for infants and children.

   Experience in the treatment of burns must be provided, if necessary, by a period of secondment to a Burns Unit.

   Experience in hand surgery and head and neck malignancy is essential, and, if necessary, should be provided by a period of secondment.
3. It is desirable that the unit be closely related to other medical and surgical departments and that there is an active link with an Accident and Emergency Department.

   An association with an oral surgical department is desirable.

   There must be adequate facilities for radiological and laboratory investigations and the unit must possess an efficient records service and photographic department and suitable library facilities.
4. The programme of training must give graded and progressive responsibility to the trainee under the supervision of the responsible consultants.

   There should be regular ward rounds, case discussions, seminars, journal clubs, etc.

   It is not expected that every programme will cover all aspects of training to the same degree.

Eligibility

Before admission to the "assessment" a candidate must produce evidence satisfactory to the Specialist Advisory Board:

(a) of being a Fellow of one of the Royal Colleges of Surgeons of Great Britain and Ireland.

(b) of having completed three years of training in centres recognised by the Specialist Advisory Committee in Plastic Surgery for training at Registrar or Senior Registrar level. At least one year of this period must be at Senior Registrar level.

   Evidence of training must be countersigned by a Fellow of one of the Colleges indicated in para (a).

(c) In exceptional circumstances equivalent training in centres other than those referred to in para (b) may be accepted for entry by the Specialist Advisory Board, but such a candidate will be required to have completed at least one year of training in a centre in the United Kingdom or Ireland approved as in para (b).

   It is considered that a future requirement for entry might be:

   "Accompanying application for admission—candidates must provide a record of their operative experience in Plastic Surgery, supervised and unsupervised, certified by the Consultants responsible for their training. Certified evidence of experience in clinical work, research and teaching should also be submitted".

At present, and until potential future candidates have had adequate warning at the commencement of their training in Plastic Surgery, it would be unrealistic to impose such an entry requirement. Log books cataloguing operative experience would be required by 1990.

"Assessment", format and scope

(a) The format of the "assessment" will consist of clinical and oral components and will contain a significant component of the Basic Sciences related to Plastic Surgery.

(b) The scope of the "assessment" will consist of:

   (i) Principles and practice of wound care and tissue transplantation

   (ii) Principles and practice of managing trauma and/or infection which involves skin as part of the injury

   (iii) Principles of management of maxillo-facial trauma

   (iv) Management of burns, thermal, electrical, chemical and radiation including their sequelae

   (v) Diseases and deformities of the head and neck and their management

   (vi) The management of skin tumours, including management of the regional lymph nodes

   (vii) Management of head and neck tumours

   (viii) Management of congenital and acquired

deformities of the trunk, limbs (including lymphoedema) and other sites where the provision of skin cover is a component

(ix) Plastic surgical aspects of congenital and acquired deformities of the urogenital system and their management

(x) Management of paraplegic skin problems

(xi) All aspects of hand surgery

(xii) Microsurgery in all its applications to reparative and reconstructive surgery

(xiii) Reconstructive surgery of the breast

(xiv) Aesthetic surgery, particularly of eyelids, nose, face and chin, breast and abdomen

(xv) The basic sciences which relate to the foregoing

8 *Michael N. Tempest*

The British Journal of Plastic Surgery

No history of the Association would be complete without an account of the part played by its official organ, the *British Journal of Plastic Surgery*, which first appeared in March 1948, less than 18 months after the Association was formerly declared to "exist" at its inaugural meeting in London on November 20th 1946.

In a very real sense this chapter should be regarded as an attempt to repay what I would regard as the debts of honour that we all owe, as individual members of the Association, to the visionaries who 40 years ago decided to found a Journal and to all those who have kept that dream alive and in print: the Editors and their editorial secretaries: the Editorial Committees: the publishers and especially the production editing teams who have served us so well, and the printers. The biggest debt of all is to our readers and our contributors.

If as they turn the pages of this chapter readers detect some phrases or views that hint more of "personal recollection", I can offer no easy apology because I too cannot help but repay a personal debt of honour to the Association for inviting me to edit the Journal for six years and, more recently, to write this chapter for the History of the Association. I would, however, hasten to add that the text of this chapter has been studied by my predecessor and successor in office and their comments, criticisms and amendments have been deeply appreciated.

The founding Editor of the Journal, A. B. Wallace, when he vacated the Editorial chair in 1968, wrote a short article entitled, "The first twenty-one years: the *British Journal of Plastic Surgery* comes of age" in which he described its birth and early youth. He recalled that the conception of the Journal took place sometime in 1946 or early 1947 following a remark made by Sir Harold Gillies during a visit to Edinburgh: ". . . Wally, I think you are the only person in our Association to start a Journal. You are independent and far removed from the influences of London and you don't belong to any camp". The significance of this remarkably shrewd suggestion—particularly the qualifying reasons given in the second sentence—was not lost on A. B. Wallace who discussed the project in general terms with the late Charles Macmillan (Fig. 8.1), at that time Chairman and Managing Director of E. & S. Livingstone Ltd, a well-known medical book publishing house in Edinburgh. From the outset, Mr Macmillan was enthusiastic although, at that time, his firm had not ventured into the field of journal publication. This encouraging reaction was reported to the fledgling Council of our Association but as A. B. Wallace recalls, "The concept was not received with enthusiasm". It was thought that the Association should not embark upon a financial gamble at such an early stage of its existence. Nevertheless, there were a few members of Council who were convinced that the very possession of a Journal would be a great stimulus to the Association and A. B. Wallace himself felt that ". . . without a Journal the Association would drift aimlessly". Six months later, the matter was raised again in Council and this time permission was given to open formal negotiations with E. & S. Livingstone with a view to early publication of a Journal of Plastic Surgery. A provisional Memorandum of Agreement was drawn up by the legal advisers to E. & S. Livingstone and Charles Macmillan, under which it was agreed that Messrs. E. & S. Livingstone Ltd. would be prepared to bear any financial deficit for the first two years after which time any profit or loss should be shared equally between the publishers and the Association. The financial sums involved in these early negotiations seem remarkably small when compared with figures that appear on present day balance sheets, as will be seen in these extracts from Council Minutes of October 15th 1947; ". . . The Editor reported that 1,000 copies of a

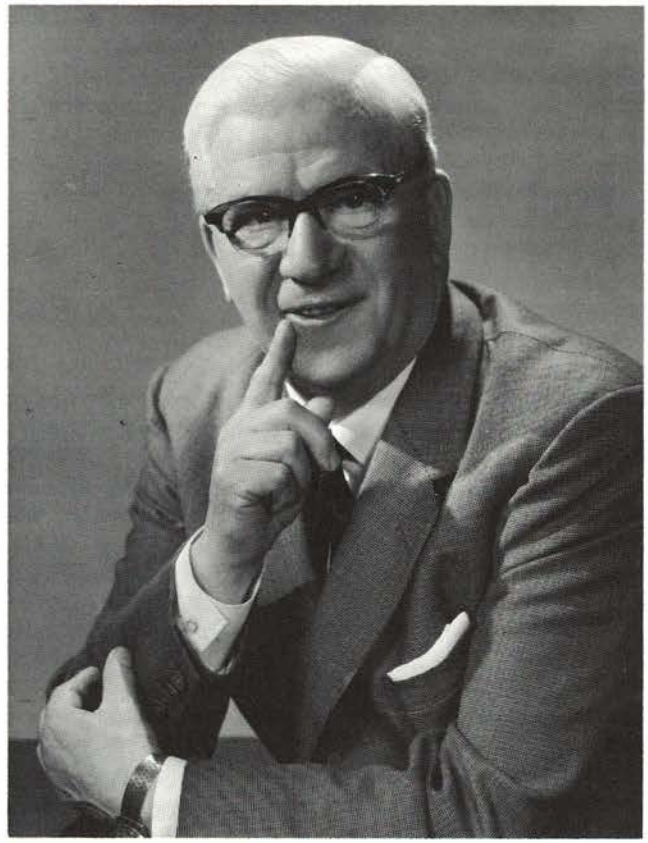


Fig. 8.1 Charles Macmillan

Journal of 60 pages would cost £300 per issue, making an approximate cost of production per copy of 6 shillings. Twelve pages of advertisements at £15 per page would bring in an income of £140 to £150. The maximum loss on production per issue would, therefore, be £150. As the Association had agreed to bear half such a loss, its share would not be more than £75 per issue. . . . An anonymous number of Council members had agreed to stand surety for the possible loss of £75 on the first number . . .".

It was nevertheless an act of courage on the part of the Council of an Association consisting of only 56 Full Members and 18 Associate Members to embark upon such an undertaking. It was an even greater act of goodwill and faith in our Association on the part of Mr Charles Macmillan of E. & S. Livingstone to prepare for the early publication of a specialist Journal of Plastic Surgery. We must be for ever indebted to him for his help and foresight, just as were our orthopaedic colleagues; for at about the same time they were about to launch the British Volumes of the *Journal of Bone and Joint Surgery* with the help of E. & S. Livingstone and indeed the first issue of these volumes, under the Editorship of Sir Reginald Watson-Jones, appeared at almost the same time as our own. Both Associations were indeed fortunate to capture the interest of a publisher of imagination and skills with the technical staff to carry through the project, placed in the home (at that time) of many of Britain's finest printers whose expertise was essential to the success of medical publishing, and with the courage to back a new venture. The definitive Memorandum of Agreement to publish our Association Journal was signed in 1949 by Sir Harold Gillies, Professor T. Pomfret Kilner and Mr. A. B. Wallace on behalf of the Association and it remained untouched until late in 1983 when a revised version, more in accord with current practice, was drawn up with Churchill Livingstone.

A good deal of thought was given by our founding fathers to the objectives and format of the new Journal. It was agreed that its prime objective

should be the advancement of plastic surgery and that its pages should provide for the publication of research, clinical observations and experimental work and "foster, in a small way, friendly relations with plastic surgeons in other countries". It was tentatively suggested that each number should consist of approximately 80 pages with five original articles each of approximately 3,000 words, one short article of 1,000 words or so on some subject such as a new surgical technique, and an invited contribution of at least 3,000 words by a specialist in some field related to plastic surgery. There should be five case reports of two to three pages each, an invited Editorial devoted to a particular subject and annotations on subjects of current interest. Some ten pages would be allocated to abstracts from foreign and domestic literature, book reviews and reports of the transactions of various specialist Societies connected with our specialty. Illustrations would be "scattered throughout" (*sic*) for which 6 pages would be set aside and 12 pages would be allotted to advertisements. The Journal would be published quarterly and it was the declared wish of the provisional Editorial Committee that the Journal should include ". . . only the best British, Dominion and world plastic surgery of the day". An ad-hoc triumvirate of Professor Kilner, Rainsford Mowlem and A. B. Wallace was set up to select the papers to be published in the first numbers.

The first issue (March 1948) carried two welcoming Forewords: one by Sir Alfred Webb-Johnson, then President of the Royal College of Surgeons of England, the other by Mr James M. Graham, Past President of the Royal College of Surgeons of Edinburgh. The first article in the Journal was a paper on "Plastic Surgery in the training of a Surgeon" by Professor James Paterson Ross who, at that time, was Surgeon and Director of the Surgical Professorial Unit at St Bartholomew's Hospital in London.

The names of the authors of the 36 original papers published in Volume I of the Journal make an impressive list and no fewer than 11 of them later became President of our Association. The papers too, many of them invited contributions, were equally impressive:

Sir Harold Gillies and R. J. Harrison on "Congenital absence of the penis".

Sir Archibald McIndoe on "Deformities of the male urethra".

Two papers on "Pollicisation of the index finger", one by James Cuthbert, the other by F. T. Moore.

Fenton Braithwaite and F. T. Moore on "Some observations of anaemia in patients with burns".

A. Ragnell on "Breast reduction and lactation".

Oliver Mansfield on "Fractures of the malar-zygomatic compound".

A. M. Loughran on "Observations on hypospadias".

J. Hutchison, J. S. Tough and G. M. Wyburn on "Comparison of cutaneous sensory patterns of different regions of the body".

Wilfred Hynes on "A simple method of estimating blood flow with special reference to the circulation in pedicled skin flaps and tubes".

H. P. Pickerill on "Plastic surgery in the treatment of malignancy".

A. B. Wallace on "The treatment of burns".

Rainsford Mowlem on "The treatment of lymphoedema".

Such a wide range of topics discussed authoritatively within the compass of one volume, the simplicity of the style of writing and the excellence of the illustrations all helped to explain why the Journal in its early years played such an important part in our surgical education and the communication of ideas. The plastic surgical trainees of today who have easy access to innumerable textbooks, journals and video tapes with opportunities to attend or take part in an endless succession of postgraduate study courses, seminars, conferences and "workshops" organised at local, national and international levels, have no idea whatever of the dearth of surgical information relevant to our specialty that existed in this country immediately after World War II. Paper was scarce and the publishing of textbooks in any specialty, quite apart from medicine itself, was given a very low priority. The only relevant textbooks in the English language available at that time in this country were David Matthews's textbook *The Surgery of Repair* published originally in 1943 and reissued in 1946, and the two-volume compendium on the *Dental Treatment of Maxillo-Facial Injuries* by Kelsey Fry, Shepherd, McLeod and Parfitt published in 1942 and 1943 with a section written by Archie McIndoe on "Middle-third fractures of the face". We had to wait until 1949 for the Kazanjian and Converse book on *Surgical Treatment of Facial Injuries* and until 1950 for A. J. Barsky's book on *Principles of Plastic Surgery*. The first edition of B. K. Rank and A. R. Wakefield's book on *The Surgery of Repair as applied to Hand Injuries* appeared in 1953. The first

edition of Ian McGregor's book on *Fundamental Techniques in Plastic Surgery* appeared in 1960; Clarkson and Pelly's book *The General and Plastic Surgery of the Hand* in 1962; E. W. Peet and T. J. S. Patterson's *The Essentials of Plastic Surgery* in 1963 and R. J. V. Battle's book on *Plastic Surgery* in 1964. There was also Tom Gibson's *Modern Trends in Plastic Surgery*: Volume I published in 1964, Volume II in 1966. It was another four years before the first edition of Grabb and Smith's *Plastic Surgery* was published in 1968. The American journal, *Plastic and Reconstructive Surgery*, had first appeared in 1946 under the able Editorship of Robert Ivy, and it was to this publication and increasingly to our own Journal that the British and most European trainees turned for guidance to supplement the daily training they had from surgical apprenticeship to their chiefs and from the deliberations of the Winter and Summer Meetings of our Association. Indeed the arrival of the most recent issue of either Journal was greeted with the same degree of excitement that our great-grandfathers recalled as they awaited the publication of the next instalment of the *Pickwick Papers*. For, whoever got hold of the Journal first in any unit could easily display his personal brand of "one-upmanship" to all and sundry—at least until some other member of the unit got his own copy.

It is no exaggeration to claim that for at least the first 15 years of its existence, the *British Journal of Plastic Surgery* reported and recorded, often for the first time, many of the fundamental techniques that most of us nowadays take for granted (or find that we have sadly forgotten!). In its pages you will discover many well illustrated and beautifully written detailed accounts of experimental and clinical work that have stood the test of time. Some of these ideas have been "rediscovered" and have appeared in many more glamorous and glossy publications written, alas, with a staggering disregard for the beauty of the English language.

The Journal covers the whole spectrum of plastic and reconstructive surgery, with contributions dealing with congenital malformations (particularly cleft lip and palate), skin loss, major trauma with particular emphasis on limb trauma and maxillofacial injuries, the surgical management of malignant disease, anaesthesia, burns, hand surgery, aesthetic surgery and research work both clinical and experimental. Many of these fields of activity have now become specialties in their own right and in turn have produced their own professional specialist Associations and journals. Indeed there are now some 20 journals written entirely in the English language that share a common interest in burns, anaesthesia, aesthetic surgery, hand surgery, head and neck surgery, trauma and microsurgery to mention only a few. There are also at least six European plastic surgery journals that appear regularly with understandable summaries of the papers written in the English language.

At a very early stage (November 1949) it was decided not to publish abstracts of the current plastic surgical literature; it was felt that in their excessively abbreviated form they were seldom read and very liable to be incomplete or inaccurate. It was decided instead to draw up an Index of Titles of the current literature likely to be of interest to plastic surgeons. Sir Archibald McIndoe offered the services of his library staff to supply this information for six months only, in the first instance. The compilation of this Index was supervised by Charles Redmond McLaughlin at East Grinstead and it was a regular feature in the Journal from 1951 to 1969 (Volumes 4 to 22). It was later discontinued, partly because of the sheer volume of work being published and partly because other indexing or abstracting publications became available (*Index Medicus*, *Excerpta Medica*, the *McDowell Indexes*) and, more recently, the various postgraduate libraries have access to computerised systems of record retrieval and indexing.

The Journal for nearly 40 years has been a quarterly publication, and for good reason. The Editor and members of the Editorial Committee were all busy practising surgeons. The work they did for the Journal was unpaid and had to be fitted into what spare time was available. To publish a Journal more frequently would have been impossibly difficult, bearing in mind the techniques of printing and reproduction of the art work that was in current use until the early 1970s. The tradition of a quarterly Journal has much to commend it and it served the Association well. The absence of correspondence columns and pages filled with ephemeral Association gossip gives the Editor plenty of space for book reviews, invited editorials, advance notice of newly established Societies and brief reports of their transactions. He can more easily exercise his discretion in publishing short but important isolated case reports and rejecting some of the excessively long contributions submitted by certain indefatigable international and national authors who seem more interested in counting papers than in reading them. The constraints of space in a quarterly Journal also call for a good deal

of what has been termed "crisp" editing. There is no doubt at all that in the process many important, but dreadfully written, papers are improved beyond recognition but it is a time-consuming task that is exhausting for the Editor and exasperating for his wife and family. Furthermore not all the contributors who are subjected to the treatment see this monumental editorial effort in quite the same light! To press home their point they may sometimes taunt the Editor with the remark "What about Volume 6?", just like a professional political heckler. Within the framework of a quarterly Journal it was always possible to accommodate some important new work by increasing the number of pages in a given issue, and consideration was even given to publishing the occasional extra issue or even a supplement, along the lines of our Scandinavian sister Journal. The first of these alternatives is an untidy compromise that would require complicated and frequent adjustment to the subscription rates: the second is more suited to the publication of certain selected theses or special items (like this History of the Association). It is true that some of the pressure has been taken off the Editor and the Editorial Committee by the mushroom development of other Journals that deal with trauma, maxillofacial work, malignant disease of the head and neck, hand surgery, burns and aesthetic surgery. But our Journal has deliberately maintained its interest in all these fields of activity and any drop in the number of papers on these topics has been rapidly made up by the astonishing number of papers submitted describing the newer possibilities of reconstruction offered by free flap transfers of isolated or combined skeletal and visceral structures. Indeed such is the quantity of first rate material now being submitted for publication that from January 1987 the Journal has been published bi-monthly and this major step, helped enormously by the recent revolution in printing and publishing techniques, should satisfy the needs of this and the next generation. The commitment to six issues only a year retains some of the very real advantages offered by quarterly production and provides some protection against the risk of the Journal becoming a "monthly" that is forced to accept some indifferent material to fill each issue.

The Editor and the Editorial Committee

Each Editor in turn has used his own discretion and judgement to mould the Journal into the form that he feels most accurately expresses his interpretation of its function in the communication of ideas. By selecting the best of the submitted texts and keeping abreast of the most promising current developments, he can give the Journal an appearance and value that does credit to the production team, distinction to the authors, and, not least, interest and enjoyment to its readers. It is unreasonable to expect any one individual to do this entirely on his own and the Editor has always been supported by a small group of professional colleagues. In the very early years the Editorial Committee was very much an ad-hoc affair consisting of the Editor and a few dedicated members of the Council of the Association, who met usually for no longer than 30 minutes before the quarterly meetings of Council. Its formal constitution as a permanent sub-committee of the Council of the Association was not drawn up and approved until 1952. Its membership rapidly became far too large and unwieldy. In 1959 it listed no fewer than 16 distinguished members: several of them lived abroad, could not reasonably be expected to attend meetings and it would have been far more sensible to regard them as "corresponding" members. However, from 1969 onwards the Editorial Committee was reduced to six Members of the Association (excluding the Editor), two of whom retired in succession after serving three years on the Committee. The Editorial Committee can meet as often as it likes but two extended meetings are always held at the time of the Summer and Winter Meetings to which the publisher and the production editing manager are invited. The Editor also has frequent meetings with the production team and indeed these contacts have helped enormously in educating the Editor and improving the layout of the Journal.

Three Officers of the Association are *ex-officio* members of the Editorial Committee. The President, during his term of office, travels a great deal at home and abroad and in this capacity can act as a roving ambassador, bringing back helpful comments and criticism from colleagues and subscribers abroad, not least concerning the difficulties that some of them experience in receiving their copy of the Journal on time and in good condition. The Honorary Treasurer takes good care that the Trustees of the Association are not plunged into insolvency by hasty financial decisions made by the Editorial Committee, or editorial indiscretions, and with the help of the financial forecasts provided by the publishers can help guide the Editorial Committee to recommend to Council appropriate

changes in the subscription rate. The Journal has never made a loss and has always provided a sizeable portion of the income of the Association. It is interesting to note that in the year 1950–51, when the Journal subscription rate was only two guineas (£2.2.0 for the 4 issues or 12/6 for single issues), the profit on the Journal was £224 which was shared equally between the Association and the publishers. In 1984 when the subscription rate was £24 per year the surplus profit on publishing the Journal due to the Association was in excess of £18,000. In January 1984 a special trainee subscription rate was introduced for *bona fide* trainees in plastic surgery and related disciplines. This concessionary rate was limited to a maximum period of four years after which the full subscription rate would become payable. The response to this offer was encouraging and has been maintained. The Honorary Secretary's presence also guarantees that the publishers have advance notice of important conferences, congresses and meetings at home and abroad: he draws attention to items that he feels could merit editorial comment, an obituary notice or special mention and any other information that is not already available from the Association Secretariat in the broad sheets that are circulated at least twice a year.

The help that an Editorial Committee can give the Editor is deeply appreciated. Its most obvious expression takes the form of assistance in refereeing manuscripts, reviewing books, checking statistical data and references to work that may be well outside the Editor's personal field of professional experience or knowledge and, above all, in helping the Editor, when necessary, to rewrite in good English some excellent papers from overseas colleagues who themselves are not familiar with the English language and whose submitted manuscripts would otherwise never see the light of day. To anyone who has ever experienced the loneliness of the Editorial Chair, the open, honest and uninhibited opinions of colleagues on the Editorial Committee come like a breath of fresh air, whether sought in correspondence or, perhaps, more urgently over the telephone, and at all times, in general discussion at the more formal Committee meetings with the publishers and production team. Their guidance and moral support is even more warmly appreciated in those times of crisis when an internationally acclaimed plastic surgical "superstar" is incensed because a submitted paper has been rejected or a book review is not to his or her liking.

The editorial office

It is a popular misconception that once a manuscript has been accepted for publication little more needs to be done before the finished article appears in the author's hands or in its even greater glory on the library shelf. The reality is very different. It is true that the new advances in word processing, typesetting, art work origination and colour printing have replaced many of the tedious, hallowed practices of journal production, but the basic function of the editorial office in the selection, editing and preparation of "copy" for the production team and the printers is another story. One of the biggest debts of honour owed by our Association (and the publishers) is to the generosity of so many individuals, authorities and institutions in providing space for an editorial office and helping it to work effectively. Heating, lighting and basic office equipment facilities have often been provided at a nominal charge, if any, but the costs of telephone calls, photocopying facilities and postage have always been shared by the Association and the publishers.

Every manuscript that reaches the editorial office is registered and acknowledged after checking the contents of the package and envelope. The term "safe arrival" needs qualification: many contributions are so poorly protected and casually packed that some authors should spare a thought for the postal workers who have carefully repaired the more severely damaged packages. Unfortunately, even in an apparently undamaged package, photographs, drawings and diagrams may be so badly creased, cracked or smudged by ink from careless lettering on the backs of adjacent photographs that the whole set must be replaced. Tables may have been untidily drawn with scant regard to international symbols or specifications and drawings and diagrams so badly constructed that their reproduction is impossible. Some packages of illustrations have measured 1×1.5 metres and on one occasion a massive collection of art work, obviously used in a large wall poster exhibition, had simply been dismantled and packed without any labelling, orientation or captions for the individual illustrations. This is all in the day's work for the editorial office but it takes time and tempers can be easily frayed. The size and choice of typeface used by the author for his manuscript may seriously affect the Editor's equanimity. Variant A assumes that the Editor is blind: Variant B will certainly ruin his eyesight and Variant C make him sincerely wish he were blind!

Unless the author has submitted duplicate copies of the manuscript, the original paper will need photocopying to provide a "working" copy and a file copy. The edited manuscript must then be retyped and a photocopy of the revised version of the text sent to the author(s) for comment and approval before the paper is despatched to the publisher's production team. Unless this is done, the author will be justifiably incensed to find, perhaps too late to make amends, that over-enthusiastic editing has misinterpreted and perhaps inadvertently demolished the sense of the paper on which he had taken so much trouble. By the same token, the conscientious Editor, whose knowledge of English composition is likely to be considerable, cannot help being annoyed by the punctuation paranoia displayed by certain contributors when marking the author's proofs. Small wonder that some Editors, in the tradition of Gilbert and Sullivan's Lord High Executioner, keep a secret "little list" of authors "who never would be missed: they'll none of them be missed".

The Edinburgh office

The first Editorial Office of the *British Journal of Plastic Surgery* was set up by A. B. Wallace (Fig. 8.2) in the Department of Surgery in the University of Edinburgh, by kind permission of the late Sir James Learmonth, and his successor the late Sir John Bruce continued to offer the same hospitality. It soon became clear that assistance was required in the organisation of the office and in the Minutes of the Editorial Committee dated December 25th 1949 we read that ". . . the Editor reported that it was possible to obtain the services of an experienced lay Editor, through the courtesy of the Court of the University of Edinburgh, at the cost of £50 per annum and proposed acceptance of this chance. Sir Archibald McIndoe strongly supported this proposal and pointed out several discrepancies in the Journal which would have been avoided with expert help and the meeting unanimously approved. It was decided to request that Council grant up to £120 per annum to defray the expenses of secretarial help to the Editor and lay-editing . . .". Thus it came about that Miss Julia B. Gardner, the editorial secretary to the Department of Surgery in the University of Edinburgh became intimately involved with the editorial affairs of our Journal and indeed with the affairs of our Association. Immediately after graduating MA in the University of Edinburgh she was appointed as secretary to the late Dr John D. Comrie, lecturer in the History of Medicine in the University of Edinburgh, who at that time was writing the 2nd Edition of his *History of Scottish Medicine* and also one of his many editions of *Black's Medical Dictionary*. In her own words ". . . From these and his other papers I learnt a great deal and found the work in research in libraries, etc. of absorbing interest. In 1940 after the death of Dr Comrie, I joined the Department of Surgery at the University of Edinburgh and again had another brilliant and stimulating 'boss', Sir James Learmonth, who knew that I already had some experience of publishing and printing. As well as helping with the *British Journal of Plastic Surgery*, I also 'did' the *British Journal of Urology* and helped the 'boys' with books, papers and theses, so that I was kept busy but also very happy. . . ." She served A. B. Wallace throughout the first 20 years of the Journal's existence and is still alive to tell the tale. It is due very largely to her energy, accuracy and commitment that the Journal editorial

Fig. 8.2 Alister or "A.B." Wallace

office worked so well: it is true that both the publishers and printers were located in the same city, but A. B. Wallace was often heavily engaged in responsible work at home and abroad and many important decisions fell to her. In 1959 she was also largely responsible for the publication of the *Transactions of the Second Congress of the International Society of Plastic Surgery* held in London. The Congress was organised by the British Association of Plastic Surgeons and the 570 page volume of the *Transactions* was edited by A. B. Wallace with the abstracts of all the papers presented translated into French, German and Spanish by the writer, W. Grossman and Raoul Sandon. In his introduction A. B. Wallace paid tribute to Miss Gardner who ". . . edited all the papers and read the proofs, a mammoth task and one accomplished, considering unforeseen difficulties, in remarkably short time . . .". In 1965, she carried out a similar task in editing and reading the proofs of the *Transactions of the Second International Congress on Research in Burns* in Edinburgh during which the International Society for Burn Injuries was launched. This too was a large volume edited jointly by A. B. Wallace and Professor A. W. Wilkinson and published by E. & S. Livingstone.

The expenses of the editorial office in those early days could never have been regarded as a serious drain on the financial resources of the Association for in the Minutes of the Editorial Committee on April 24th 1953 we read that ". . . the Editor submitted his expenses over the year. These amounted to £7.17.6½ . . .".

The Glasgow office

During the Editorship of Tom Gibson (Fig. 8.3) from 1969–1979 the editorial office was transferred to Canniesburn Hospital in Glasgow and for those ten years the editorial secretary was Miss Lesley Cook.

During this period, the Journal took a great leap forward in the publication of scientific papers. There was a rapid increase in the world-wide interest and involvement of plastic surgeons in clinical and experimental research work but, as could be expected, a great deal of the writing that emerged was of mediocre quality, hastily cobbled together and published often with greater attention devoted to gaining additional research funds for a given Unit than in producing accurate, scientifically valid results. However, with an Editor who was an extremely experienced research worker and plastic surgeon, a senior lecturer in tissue transplantation and closely involved with the Department of Bio-Engineering in the University of Strathclyde, an incomplete, inadequate or unethical scientific paper stood little chance of easy acceptance. Some of the most remarkable papers came from the Editor's own pen and in Volume 31 (1978) we were offered a priceless translation of Karl Langer's study of *The Anatomy and Physiology of the Skin*, originally published in five separate papers presented at meetings of the Royal Academy of Science in Vienna in the Autumn of 1861. The difficulties of translation of the German text were immense but the end result was five excellent papers in beautiful English that explained precisely the argument that Langer was advancing in his original work.

Many fascinating historical articles came from Tom Gibson's pen. Two papers that appeared in Volume 30 (1977) presented some excellent surgical bibliographical detective work, so that we now have no longer any excuse for confusing Simonart

Fig. 8.3 Tom Gibson

(and what *he* described) with his more often quoted namesake who was really a typographical impostor, whose real name was Gustav Simon (Artz).

The Chepstow office

From 1979 to 1984 Michael Tempest (Fig. 8.4) became Editor and the editorial office was moved to the Welsh Regional Plastic Surgery, Burns and Jaw Injuries Centre at St Lawrence Hospital in Chepstow. Office accommodation was provided by the Gwent Health Authority, Mrs Ann Dymock was appointed as a part-time editorial secretary and for the first time the editorial office had its own photocopier, electric typewriter and dictation transcribing equipment. The libraries of the Welsh National School of Medicine in Cardiff and the Postgraduate Medical Centre in Newport gave invaluable help in the checking of some of the more puzzling references to Journals that were either extinct or so new that they had not yet been added to the *Index Medicus*. The Medical Illustration Department at St Lawrence Hospital worked wonders in salvaging and improving many of the substandard or damaged photographs submitted by authors, and Stephen McAllister the senior medical illustrator to the Tenovus Institute for Cancer Research in Cardiff redrew many of the anatomical line drawings and by redesigning several of the complicated but badly designed scientific charts vastly improved the standard of line illustration in the Journal. During this period several changes were made to improve the format and presentation of the Journal, to extend the Book Review section, to initiate the Trainee Subscription rate and to make reports available of the Proceedings of the Research Group and of the Microsurgical Society. However, it was the first occasion on which the Journal had been faced with serious geographical problems that complicated production. The publisher's office was based in Edinburgh, the editorial office in Chepstow, the production editing team first in Harlow, Essex and later in Edinburgh, and the printing first in Glasgow, then in Edinburgh and later in Beccles, Suffolk.

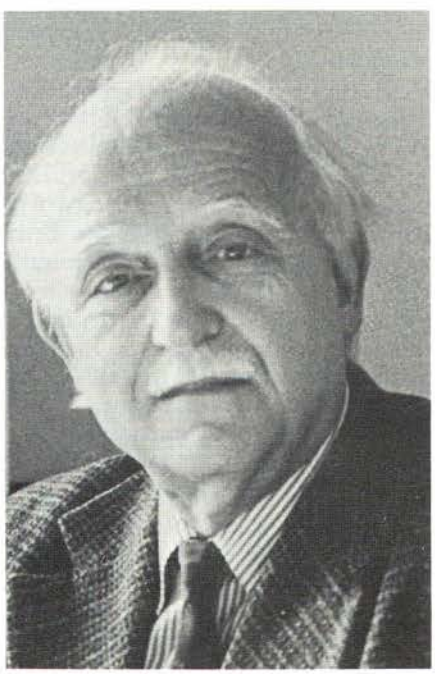


Fig. 8.4 Michael N. Tempest

An Edinburgh office again

In 1985 the editorial office moved back to Scotland and, by kind permission of the Royal College of Surgeons of Edinburgh, office space and facilities in the College were made available to the new Editor, Mr A. C. H. Watson (Fig. 8.5) and his part-time editorial secretary, Helen Stein.

The publishers and the production editing team

Once the text has been edited and typed according to the "house style" adopted by the publishing house, it is sent along with all the tables, diagrammatic illustrations and photographs to the production editing team. This is a small, highly trained group of professionals in the publishing house who are responsible directly to the Editor and Trustees of the Association for producing the Journal in its final visible form. The supervision of the page layout, paste-up and preparation of the illustrations (enlarging, reducing or cropping), and choice of typeface is their responsibility but it would be a very imprudent Editor who did not make himself familiar with these duties by meeting regularly the members of the production team and discussing with them possible changes and improvements. In scientific journals like our own where the clarity of the reproduction of the art work is so important, mistakes must be avoided and this is only possible if the Editor works closely with the production editing team. The actual printing, distribution, marketing promotion and advertising are, of course, the direct responsibility of the publisher, who also advises the Association on all management aspects of the Journal.

Fig. 8.5 Antony C. H. Watson

These crucial activities are often forgotten or easily taken for granted. Yet there is little point in producing a good scientific journal that is attractive to look at, easy to hold and a joy to read unless each new issue can be guaranteed to reach every subscriber intact, on time and at the correct address. The computer, the credit card and mailing in bulk by air freight have so revolutionised the marketing and distribution of books and journals that it is hard to understand how any other system could have delivered the goods. Miss Lilias Peebles, who looked after the subscriptions to our Journal in the early years, takes up the story.

> ". . . The office staff worked hard: new subscriber's names were registered by hand in record books and their names and addresses were typed on to cards. The envelopes in which the copies of the Journal were sent out were all individually typed. Quicker progress was made when addressograph plates were introduced and many years later scriptocards were made and then computerisation. . . . The *British Journal of Plastic Surgery* was what the staff at E. & S. Livingstone (in 1948) called a 'nice' journal. Issues were published on time due to the excellent work of the Editors, the production team and the printers. This meant a great deal to the 'Subscription staff' as it cut down the number of enquiries. On publication day it was 'all systems go' to get the issues out. If the warehouse staff were overwhelmed, the office staff joined in and packed the journals, and in all departments the enthusiasm and dedication of the staff to supply a good service was infectious . . ."

Miss Sheena Gibb, who managed contracts and "permissions" for the company (first of all E. & S. Livingstone and later Churchill Livingstone) confirmed that ". . . during the first 20 years of the Journal's existence, all the advertising and subscription arrangements involved hard hand-work. Individual letters were typed to all potential advertisers and subscribers and a remarkably fool-proof manual system of filing and recording was devised and maintained . . ."

Our Journal is still published by the same firm that produced the first issue in 1948, though over the years the title has varied as a result of various mergers and, what is euphemistically termed, "rationalisation of the publishing process". The first publishers were E. & S. Livingstone Ltd in Edinburgh from 1948 until 1977, when the Journal appeared under the Longman title. From 1979 onwards to the present day it has been published by Churchill Livingstone, the Medical Division of Longman, formed by the merger of two of the finest long-established medical publishers in Britain, E & S. Livingstone and J. and A. Churchill. The production editing work was transferred for a period of five years (1977–1982) from Edinburgh to Harlow in Essex where a new production editing team was formed within the Journals and Directories Division of the Longman Group. During this period in Harlow major improvements were made in the layout and typography of the Journal; double columns were first introduced in 1981 and great credit is due to the late John Hedger, Tina Webb and Sandra Alexander-Barrett for the imagination and enthusiasm they injected into the work. Unfortunately their efforts were hampered by a steady deterioration in the quality of reproduction of the art work, due very largely to poor half-tone origination by the printers who did not appear to

be familiar with the very high standards of art work reproduction that were needed. However, in 1982, a major policy decision was made by the Longman Group who decided to make Churchill Livingstone (their medical book publishing division) responsible for all their medical journals. A new production team was set up in Edinburgh at Robert Stevenson House under the general control of John Richardson as production editing manager and a succession of publishers including Fiona Foley, then Gillian Ritchie and later Sally Morris, all under the watchful eye of Andrew Stevenson. Now that the editorial office has also returned to Edinburgh the former close working relationships that existed in the early days of the Journal have been restored and already the advantages of this relationship are clear. The Journal has already adopted an extremely attractive new cover, is making more use of colour reproduction and has begun bi-monthly publication.

The Journal was printed in Edinburgh by the Darien Press Ltd from 1948 to 1971 and scrutiny of the early volumes of the Journal will confirm the high standard of the typography and particularly the quality of the art work reproduction using the techniques available at that time. Later the Journal was printed, on the same presses, by T. & A. Constable Ltd. from 1972 to 1979. For three years (1980–1983) printing was carried out by Messrs Bell & Bain of Glasgow who were succeeded in 1983 by Messrs Pillans and Wilson Ltd of Edinburgh. This latter firm printed the Journal for just one year and since January 1984 the printers have been William Clowes Ltd of Beccles in Suffolk. Traditional type setting and block making is a thing of the past and though the proof correcting symbols remain the same, the speed with which typescript can now be transferred to type and the proofs corrected by computerised techniques is staggering. The ease with which text and illustrations can be rearranged has greatly simplified the work of the production team and in due course will enable colour illustrations to be more widely available.

Mr A. D. ("Sandy") Lewis, who knows more about our Journal than anyone else, takes up the story. ". . . Having served an apprenticeship as a compositor I joined E. & S. Livingstone as assistant to James Parker who was the Director in charge of Production and I took over the production of all the journals, five in number at that time. I was fortunate to work with Julia Gardner whose office was close by and I would call on her to collect and discuss the manuscripts and illustrations for each succeeding copy of the Journal. As the standard of illustration reproduction was required to be very high, A. B. Wallace would call in to my office and together we would mark each photograph to show the maximum area to be reproduced and the detail which was required to be highlighted. On occasion I would have to reject an illustration as being too poor in quality to reproduce. The Journal was printed by letterpress and this required the making of half-tone copper printing plates. We were again fortunate in having the services of Hislop and Day Ltd whose representative would discuss with me the illustrations to ensure the best possible result. The printers, The Darien Press Ltd, were in an adjoining street and I was thus able to watch the printed sheets being delivered and to compare the standard of reproduction of the illustrations with the proofs supplied by the blockmaker.

The standard of printing was of course dependent on the quality of the paper, which was supplied by a mill on the outskirts of Edinburgh. Paper coated with China clay is one of the most difficult to produce and the risk of foreign bodies in the clay or the esparto grass base is very high so that in the early days of the Journal each and every sheet of paper was examined before it left the mill. How times have changed! The base paper is now straw or wood and the coating is latex. The heavier the weight of paper, the smoother the surface and therefore the better the standard of reproduction. But unfortunately this factor had literally to be weighed against the cost of postage, so that a balance had to be struck. On the other hand a base paper that is too light will not hold the coating which is liable to "pick off" during printing and a paper that is too heavy will cost too much to post. . . . On delivery of the Journal to our warehouse we would all "muck in" and wrap, string and label the copies so that every copy was posted off on the same day as received from the printer!"

The use of more colour illustrations in the Journal has been raised at many an Editorial Committee. As long ago as December 1952 there is a brief note in the Minutes of the Editorial Committee that ". . . it was agreed that Council should be asked to grant the Editor an allowance of up to £100 for use at his discretion for colour photographs". The request was granted and the first colour plates (eight in all) appeared in 1953 (Volume 6) to illustrate three separate articles: a paper by Tom Gibson and W. B. Davies on "The fate of preserved bovine cartilage implants in man"; an Editorial by

B. K. Rank on "The considered use of facial prostheses" and a paper by the late Charles McCash on "Eyebrow reconstruction by a biological flap". Some indication of the time and cost involved in producing colour plates at the time can be judged in extracts from a letter to A. B. Wallace dated January 19th 1951 from Mr James Parker, one of the Directors of E. & S. Livingstone: ". . . The cost of making 6 sets of colour blocks, the same size as the slides would be £55.10.0. If enlarged to 1½ times, the cost of the 6 would be £115.10.0. . . . I will require at least 3 months for making colour blocks . . .". There is little doubt that colour can be used to very good effect, for example in the assessment of the results of the treatment of certain pigmented or vascular lesions such as port-wine stains or for recording some of the aesthetically unacceptable complications of plastic surgery. There are also special occasions when its use is absolutely essential as in the case of the reproduction of the Tonks pastels in the January 1986 issue of the Journal. To use colour throughout the Journal would be, no doubt, visually attractive but in the writer's view would have a deadening academic effect and could reduce the publication to the state of a commercial colour magazine. A surfeit of colour can too easily put a shine on some pretty shoddy scientific work and the temptation to accept this for publication because the author is willing to pay all the additional costs without question can place the Editor and the Journal in danger of yielding to unwelcome and unethical pressures, tantamount to literary blackmail.

Authors and readers

In his survey of the papers published in the first 20 years of the Journal, A. B. Wallace (1968) grouped the subject matter of the 902 published articles in Volumes 1 to 20 under twelve separate headings and claimed that in his opinion this gave ". . . a very fair picture of plastic surgery as presented in Britain" at that time. The topics discussed in the Journal over that period certainly confirm that the "mix" was good but this probably reflects the British "school" of plastic surgery rather than the surgery practised in Britain. Many of the early contributors to the Journal came from Europe but their training had been heavily influenced by their British teachers and many of the authors from the Dominions were also under influences that were of British rather than American parentage.

A comparable classification of the papers published over the next 18 years is difficult because the headings under which one can confidently classify a particular paper are not so clear-cut. It is the same dilemma that faces the professional indexer when confronted with a long list of "key words" which themselves are not properly standardised and which only confirm one's worst suspicions that many a paper could easily be filed under at least four or five separate headings. However, an attempt has been made to sort out the subject matter of the papers in the second set of volumes (21–38) published over the years 1968 to 1985 (Table 1). The broad range of categories remain the same with the exception of the numbers of papers under the various headings Hand, Maxillofacial and Trauma and Burns which now show a significant fall, in part due to the emergence of other specialist journals dealing with these particular fields of study. What the figures do not reveal is the remarkable change in the contents of the work listed. For example under the heading "Congenital", work on genetics, foetoscopy and various aspects of intra-uterine surgery will be encountered. Under the heading "Experimental", detailed anatomical investigations of the blood supply to various skeletal and visceral structures will be found that have revolutionised the design of

Table 1 Subject matter of the articles appearing in the Journal

	Volumes 1–20 1948–1967	*Volumes 21–38 1968–1985*
Educational and Philosophical	18	22
Historical	36	40
Experimental	121	200
Congenital	124	137
Trauma including Burns	98	79
Pathological	59	*
Surgical technique	191	*
Hand	85	83
Maxillo-facial	72	49
Carcinoma	52	144
Eyelid and orbit	26	*
Cosmetic	16	36

* There is no easy way of classifying items under this heading since the classification used by A. B. Wallace in the first column is too "simple" when attempting to classify articles which may include experimental work, different (and often new) surgical techniques and complicated pathological findings.

flaps and have introduced the possibility of using compound flaps and microvascular techniques to allow vascularised tissue transfers to almost any part of the human body. We tend to forget the way in which the introduction of new implants, new techniques and experimental surgical work can swing the main topics of discussion in a journal from one extreme to another in a remarkably short period. For example papers on the use of silicone implants for breast reconstruction began to appear from 1969 onwards. Microvascular techniques were first described in papers published in the Journal in 1972, myocutaneous flaps in 1972 and fasciocutaneous flaps in 1981. Anatomical dissections and studies in cadavers now carried out in many centres by anatomists and plastic surgeons have led to a whole new range of compound flaps. This is a field in which our own surgeons along with Australasian, European, Chinese and Japanese colleagues have made such striking progress, many of their reports appearing for the first time in the pages of our Journal. The obvious applications of tissue expansion and the less obvious applications of liposuction techniques are the newest stars on the experimental horizon. A good idea of the wide-ranging content of the Journal can be gained by looking at the titles of the 72 papers that were published in Volume 25 (1972) in which you will find, for example, the following well written and beautifully illustrated contributions:

The groin flap, by Ian McGregor and Ian T. Jackson. J-P. Lalardrie's pen portrait of Hippolyte Morestin, along with an excellent photograph of this father figure of French and indeed European plastic surgery.

Ralph Millard's Gillies Lecture entitled "Jousting with the first Knight of plastic surgery".

Miguel Orticochoea on "The muscular cutaneous flap method; an immediate and heroic substitute for the method of delay".

"Collagen metabolism in iso- and homografts of tendons" by M. Tobias and K. E. Seiffert.

C. P. Sawhney on "Combined autograft and homograft cover in extensive deep burns".

D. Mahler and Russell M. Davies on "Colorimetric estimation of blood loss during surgery of burns".

Roberto Farina on "Surgical treatment of hypospadias: experience in the treatment of 400 consecutive cases using Leveuf's technique".

T. J. Robinson, B. Bubna-Kasteliz and M. F. Stranc on "Alterations in pulmonary ventilation and blood gases in acute burns".

G. D. Lister and Tom Gibson on "Closure of rhomboid skin defects: the flaps of Limberg and Dufourmentel".

D. M. Jackson and P. A. Stone on "Tangential excision and grafting of burns".

Edith Frederiks on "Vascular pattern in normal and cleft primary and secondary palates in human embryos".

J. C. Lawrence on "Storage and skin metabolism".

Many of these papers are now well established "classics" and, as will be seen, several of the authors come from countries other than Great Britain. A table showing the country of origin of the papers published in our Journal (Table 2) shows how wide is the background from which our contributors are drawn. When the two groups are compared it is striking to note the increase in papers published from the USA, Australia and New Zealand, South America, Japan, India and the Middle East and the first trickle of papers coming from indigenous Africa (not South Africa), South-East Asia, Hong Kong and China from 1968 onwards. When one looks at the top ten contributors from the European continent (Table 3), there is a striking increase in the number of papers from The Netherlands, Switzerland, West Germany and Denmark with an equally striking fall in the number from Sweden and France. Our French colleagues in the *Annales de Chirurgie Plastique, Reconstructive et Esthétique*, under the Editorship of J. P. Lalardrie now often publish an English translation alongside the French

Table 2 Country of origin of articles published in the British Journal of Plastic Surgery

	Volumes 1–20 1948–1967	*Volumes 21–38 1968–1985*
UK	583	650
USA	65	241
Australia/NZ	40	89
Canada	21	17
South Africa	19	14
South America	28	58
India	24	61
Japan	5	79
African Continent (excluding SA)	0	13
South East Asia	0	11
Hong Kong/China	0	12
Middle East/Israel/Egypt/ Turkey/Iran and Iraq	32	84

text of the major articles and brief abstracts in English for the shorter papers. This may partly explain the fall in the number of French papers submitted to our Journal and in a sense it is our loss. For it is the very high literary standards and love of their mother tongue that makes the writings of our French colleagues so "incisive" and enjoyable to read—and yet so difficult to translate!

For those who are addicted to the *Guinness Book of Records*, the longest article ever published in the Journal (71 pages in all) was that entitled "Reaction of healing wounds and granulation tissue in man to auto-Thiersch, auto-dermal and homo-dermal grafts" by T. Gillman, Jack Penn, D. Bronks and Marie Roux (1953, **6**, 153–224). It took up almost the whole of one issue, leaving space for only one other paper and two book reviews! According to the Minutes of the Editorial Committee (December 1952) ". . . A letter had been received from Professor Penn (South Africa) who said that he would like to submit an article . . . It would be much longer than the customary one and the Committee suggested that the Editor should invite Professor Penn to submit his article and possibly increase the number of pages in the particular number of the Journal. Otherwise it was suggested that the article would have to be divided into two . . .". The appearance of the article provoked several protests, some written, many verbal and, as has already been mentioned, "Volume 6" became the battle cry for years to come from aggrieved potential authors and readers who felt that the Journal had given too much space to an over-lengthy article and had delayed by at least three months many worthy papers that had been accepted for publication. The episode certainly highlighted the potential hazards of the "invited article" and the same mistake was not repeated.

By contrast, the shortest article—one paragraph of text, one illustration and no bibliography, occupying less than one page, would appear to be the paper by S. K. Das on "A new method for transferring skin patterns" (1978, **31**, 361).

At a time when well written papers in specialist surgical journals are in danger of being swamped by extremely technical papers couched in semi-computerised scientific jargon, drained of all human feeling and warmth, we must be grateful that so many of our contributors have not lost touch with the delight given by the English language with words well chosen and skilfully arranged. Sir Theodore Fox, himself an extremely distinguished Editor of *The Lancet*, recalls that his predecessor, Egbert Morland, used to say "Be accurate if you can: but whatever happens don't be dull". Readers of past issues of the Journal will have their own little lists of authors whose contributions have delighted, bored or enraged them. This is the joy of being able to pull out the volumes from the library shelves and recapture the magic moments for which the microfilm reel, floppy discs, video cassettes and tape recordings are but poor substitutes.

In the early issues of the Journal little space was devoted to book reviews for the simple reason (already noted) that very few new books were published in the immediate post-war years. But as time passed book reviews became an increasingly important feature of the Journal. From the replies received in response to a detailed questionnaire that was sent to our readers in 1983, it was clear that many readers genuinely appreciated the book reviews and specifically commented upon their usefulness and the obvious trouble that the reviewers had taken. However one reader admitted that he *never* read the book reviews: another reader

Table 3 Country of origin in Europe of papers published in the Journal

	Volumes 1–20 1948–1967	*Volumes 21–38 1968–1985*
UK	583	650
Holland	7	52
Switzerland	2	26
West Germany	4	19
Denmark	2	20
Sweden	14	5
France	15	3
Italy	6	8
Yugoslavia	9	2
Czechoslovakia	7	2
Austria	6	3
Norway	2	2
Belgium	1	3
East Germany	2	1
Spain	2	3
Greece	0	1
Finland	0	6
Hungary	5	3
Bulgaria	3	3
Poland	3	2
Portugal	1	0
USSR	2	0

simply "glanced at them": four readers felt that they were "irrelevant" and nine thought they were "unfair". Until 1970 the name of the book reviewer could be identified only by background knowledge of the initials presented at the end of each review. This may have given some reviewers a certain degree of immunity from attack but from 1971 (Volume 24) onwards such "cover" was removed, and since 1980 (Volume 33) the name of the reviewer was always given in full with a brief biographical note printed at the end of the Book Reviews section.

Care is usually taken to choose reviewers who are familiar with the subject of the book and the language in which it is written, and to encourage them to be honest and forthright in their opinions. There is little merit in a book review that is a simple paraphrase of the publisher's blurb on the book jacket or carries the time-worn recommendation that ". . . This book should be on every surgeon's/unit's/library's shelf" (delete as required) though a cunning reviewer could produce a devastating and masterly review by specifying exactly which shelf! It is also difficult, for example, to take seriously a review of a book on cleft palate and speech that consists of a mere three-and-a-half lines.

Colleagues who by bitter experience have proved that they know something of the difficulties of good writing are less likely to indulge in spiteful nit-picking on points of minor importance and there is much to be said for the adage "He has the right to criticise who has the heart to help". A thoroughly bad book should be either "hit for six" or not reviewed at all, but if the former advice is followed you must take care that your master stroke does not land the ball, you yourself and the Trustees of the Association in the Law Courts. As a general rule, our Association's Secretariat in Lincoln's Inn Fields is a far safer place than Lincoln's Inn! On fortunately rare occasions, the conscientious book reviewer may catch sight of some strikingly familiar drawings or photographs or even come across some paragraphs that he recalls having read somewhere else. Further investigation may reveal that sections of text and art work have been lifted wholesale from another Journal, article or book without any attempt to acknowledge formally the name of the original author(s) or the publishers. No attempt may have been made to disguise the signature or initials of the artist on the reproduced "borrowed" drawings or the patient's name on the visibly identifiable X-ray plate. The book reviewer under these circumstances has every right to draw attention to this act of plagiarism. A far more explosive scenario is set when the unsuspecting reviewer finds that the "literary theft" has involved some of his own published work. The dividing line between fair comment and libel is not always as clear-cut as a book reviewer or Editor may assume and for this reason it may be wise to seek legal advice when a potentially inflammatory review is returned to the Editor. To date, none of our book reviewers has been "horse whipped" though comments have been received on a few occasions strongly recommending this form of punishment.

A classic hoax

There can be few Journals that have not at some time been the victim of a practical joke or have themselves indirectly fooled others. A classic example of the latter was the pseudo-biographical note on "Emile Coudé" that was published in *The Leech*, the Journal of the Cardiff Medical Students Club in 1958, and which led the late Hamilton Bailey and others to imagine that such a person had really existed. But no history of our own Journal would be complete if we did not refer to a remarkable hoax that was played on the author of a paper that was published in Volume 1. It was an achievement that was never noticed by the author, the Editor, the printers, the publishers, the proof readers or indeed any of our readers. Indeed the "skeleton in the cupboard" would never have come to light at all had not the perpetrator of the hoax confessed to a friend of the Editor some 24 years later the precise nature of his crime.

One day he had noticed some drawings lying on his chief's desk which were intended to illustrate an article in preparation on, "Operative treatment of abdominal obesity, especially pendulous abdomen". These drawings showed some of the incisions used by various surgeons in abdominal reduction operations. He could not resist the temptation to add a few finishing touches to two of the rather indifferent sketches and there they still remain for us all to see (Fig. 8.6) (1948, **1**, 280). We can only guess at the motives that inspired these artistic embellishments and sympathise with the tyro plastic surgeon who has struggled with the Küster "Trilby Hat" approach. He would have been far safer with the Weinhold "Wasp" design though neither would have given the patient much satisfaction or have enhanced the reputation of the surgeon.

In his summing up of the first 20 years of the Journal's progress A. B. Wallace admitted

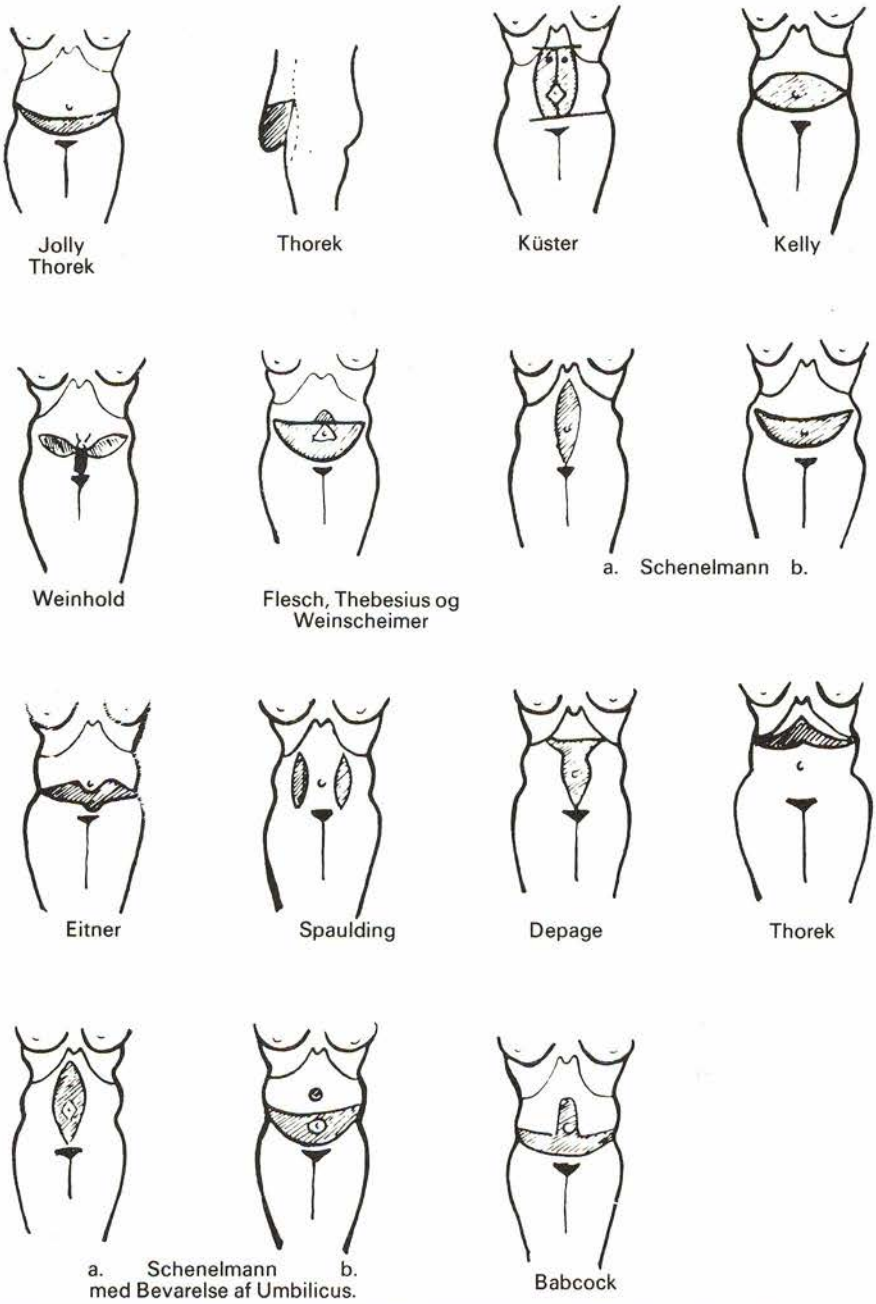


Fig. 8.6 "Operative treatment of abdominal obesity, especially pendulous abdomen" by Jens Foged (*British Journal of Plastic Surgery* 1948, **1**, 274)

". . . There have been criticisms and there have been mistakes. Manuscripts have been lost and found. Authors have resorted to several devices in the hope of early publication. I do not think any enemies have been made."

The succeeding Editors over the next 20 years would not, I am sure, wish to dissociate themselves from those very shrewd observations: *plus ça change, plus c'est la même chose*. There would, indeed, be something seriously wrong if everything ran perfectly, if nothing was ever mislaid and if some potential authors lost their low-down cunning in

dealing with the editorial office. In the opening pages of this chapter the reader will have gathered some understanding of the basic philosophy that guided the founder fathers of the Association and the reason why the educational function of the Journal was so important in the achievement of the first objective laid down in the Constitution of our Association "... To promote and direct the development of plastic surgery along sound and progressive lines". What cannot be so easily conveyed in these pages is the heady atmosphere of those early post-war years—a mood that was caught so deftly by William Wordsworth expressing his feelings and many of his contemporaries on the aspirations of the French Revolution:

> "Bliss was it in that dawn to be alive, but to be young was very heaven!"

It was the energy and enthusiasm of the young surgeons, anaesthetists, dental surgeons and nurses who had learned during World War II, probably for the first time in their lives, the comradeship, discipline and excitement of team work both in the services and in the EMS Plastic and Maxillofacial Units here at home that acted as the essential catalyst to bring about the revolution in plastic and reconstructive surgery that has enriched and expanded our specialty over the last 40 years. There is no doubt whatever that other revolutions will have to be fought and won to keep our specialty on "sound and progressive lines". May the new generations of revolutionaries have in good measure the same courage and determination shown by their predecessors and never lose sight of the unifying and stimulating effect of a lively Association and a well written Journal.

Grant of Arms

The Editor notes that whilst a Grant of Arms was not sought until 1952 an Association Crest had been under consideration five years earlier. On June 13th 1947 the Honorary Secretary wrote, "The Council is making arrangements for the publication of a Journal of the Association, and it is suggested that the Association should have a crest which would appear on the front cover. A prize of one guinea is offered for the design selected by the Council and Members are asked to submit their ideas as soon as possible to me at the above address." No responses are on record. The paper which follows is a compilation of two articles by A. B. Wallace published in the Journal in April 1956 and July 1972. The Arms of the British Association of Plastic Surgeons are reproduced on the frontispiece.

BY receiving a Grant of Arms the British Association of Plastic Surgeons reached maturity. The full significance of this Grant is that ideals for which the Association stands are understood and recorded. "The purpose of the Association is to promote and safeguard the interests of the surgeons practising plastic surgery and to direct the development of plastic surgery along sound and progressive lines." This Grant of Arms was first sought in 1952 and received in 1955. The Presidents of the Association during that period—Richard Battle (1952), John Barron (1953), David Matthews (1954), and T. Pomfret Kilner (1955)—all contributed a great deal of time and thought to this problem together with the Council members for those years.

The Grant was made and recorded by the College of Arms. This College was founded in mediæval times to control the design of armorial bearings, the title to which is awarded by the sovereign. The complete achievement consists of the shield with supporters, a crest, a badge, and a motto. This is described below in the Grant, which reads as follows:—

"TO ALL AND SINGULAR to whom these Presents shall come, the Honourable Sir George Rothe Bellew, Knight Commander of the Royal Victorian Order, Garter Principal King of Arms, Archibald George Blomefield Russell, Esquire, Commander of the Royal Victorian Order, Clarenceux King of Arms and Sir Gerald Woods Wollaston, Knight Commander of the Most Honourable Order of the Bath, Knight Commander of the Royal Victorian Order, Norroy and Ulster King of Arms, Send Greeting WHEREAS *Richard John Vulliamy Battle*, Esquire, Member of the Most Excellent Order of the British Empire, Fellow of the Royal College of Surgeons of England, President of the BRITISH ASSOCIATION OF PLASTIC SURGEONS, hath represented unto the Most Noble Bernard Marmaduke, Duke of Norfolk, Knight of the Most Noble Order of the Garter, Knight Grand Cross of the Royal Victorian Order, Earl Marshal and Hereditary Marshal of England and One of Her Majesty's Most Honourable Privy Council, that the purpose of the Said Association is to promote and safeguard the interests of Surgeons practising plastic surgery and to direct the development of plastic surgery along sound and progressive lines. That the Council of the said Association is desirous of having Armorial Bearings duly assigned for the Association under lawful authority and he hath requested the favour of His Grace's Warrant for Our granting and assigning such Armorial Ensigns and in the same Patent such Supporters and such Device or Badge as may be proper to be borne and used for the British Association of Plastic Surgeons on Seals, Shields or otherwise according to the Laws of Arms AND FORASMUCH as the Said Earl Marshal did by Warrant under his hand and Seal bearing date the Twelfth day of December 1952, authorize and direct Us to grant and assign such Armorial Ensigns, Supporters and Device or Badge accordingly KNOW YE THEREFORE that We the said Garter, Clarenceux and Norroy and Ulster in pursuance of His Grace's Warrant and by virtue of the Letters Patent of Our several Offices to each of Us respectively granted do by these Present grant and assign the Arms following for THE BRITISH ASSOCIATION OF PLASTIC SURGEONS that is to say: *Gules the branch of an Apple-Tree couped and leaved proper fructed Or with a slip of Apple Tree leaved also proper grafted to the top in dexter chief a Dagger in bend point upwards Gold around the hilt and handle a Thread loosely tied Argent.*

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. And by the Authority aforesaid We do further grant and assign the following Device or Badge that is to say: *A Dagger point upwards proper hilt and pomel Or around the hilt and handle a Thread loosely tied Sable* as here depicted to be borne and used upon Standards or otherwise. And by the Authority aforesaid I the Said Garter do by these Presents further grant and assign the Supporters following for the BRITISH ASSOCIATION OF PLASTIC SURGEONS that is to say: *On the dexter side a figure representing Podalirius habited in a Robe Argent resting his exterior Hand on a Staff Or entwined by a Serpent and on the sinister side a figure representing Machaon habited as the dexter holding in his exterior Hand a Dart broken the point downwards Gold around the neck of each figure a garland of Flowers of the British Empire* as the same are also in the margin hereof more plainly depicted the whole to be borne and used for the British Association of Plastic Surgeons on Seals, Shields or Otherwise according to the Laws of Arms. IN WITNESS whereof We the Said Garter Clarenceux and Norroy and Ulster Kings of Arms have to these Presents subscribed Our names and affixed the Seals of Our Several Offices this Twenty-Seventh day of April in the Fourth year of the Reign of Our Sovereign Lady Elizabeth the Second by the Grace of God of the United Kingdom of Great Britain and Northern Ireland and of Her other Realms and Territories Queen, Head of the Commonwealth, Defender of the Faith and in the year of Our Lord One thousand nine hundred and fifty-five."

G. R. BELLEW, *Garter.*
ARCHIBALD G. B. RUSSELL, *Clarenceux.*
GERALD W. WOLLASTON, *Norroy and Ulster.*

Why were these symbols chosen and what in fact do they imply? On the shield the grafted slip of apple tree is intended to symbolise the process of grafting flesh to flesh so basic in the art of plastic surgery. The dagger and thread can be regarded as an heraldic illustration of a surgeon's knife with the entwined suture denoting the material for the closure of wounds; it is this part of the shield which was chosen as the badge of the Association. In other words, the shield represents the art and craft of plastic surgery.

On the crest the lizard standing on the 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 replacement of lost tissue in plastic surgery.

The supporters, Machaon and Podalirius, who tend to dominate the scene, were the two sons of Aesculapius and are garlanded with flowers of the British Empire, indicating the area of the Association's main activities and its status as a British organisation and the incorporation of the description "British" in the title. Podalirius holds the Rod of Aesculapius, a staff entwined with a serpent, the traditional and classical symbol of Medicine. The figure of Machaon holds a broken dart, an attribute which perhaps could commemorate his healing powers over the sharpness of the onset of pain and disease. There may however be other explanations which I will indicate.

The motto, "*Manu Sciente*",* may be translated as "with a skilled hand", appropriate to a plastic surgeon.

To the details already offered I would like to submit additional information on the two Supporter-surgeon-physicians of Greek mythology.

Aesculapius, the father of Machaon and Podalirius, was the son of the god Apollo and the nymph Coronis who was but a mortal woman. Hesiod, around 700 B.C., recounts the legend of the operative removal of the baby Aesculapius from the belly of his beautiful mother Coronis. He was then taken in care by Chiron on Mount Pelion.

Chiron was a Centaur, half horse and half god, and was the first instructor in the healing cult to whom Aesculapius was apprenticed. He dwelt in a cave on Mount Pelion in Thessaly and unlike the other centaurs he was gentle and skilled in the arts of hunting, music and medicine, and was the discoverer of the powers of many medicinal herbs. He shared his vast knowledge with his pupils. When he died Chiron was transported to the skies where he became Sagittarius, or Centaur of the Zodiac.

Chiron encouraged his apprentices to treat patients with soothing incantations, with potions, with externally applied drugs, as well as with the knife. His most famous disciples were Achilles and Aesculapius.

The Aesculapian cult became very strong and of all the pagan gods he, even at the time of Christ, was a very considerable force. In the end, Zeus jealous and afraid that Aesculapius with his great powers might render all men immortal, slew him with a thunderbolt.

With Aesculapius as chief God of Healing in Greece and since the common people were eager to know more about his sons, many legends arose of their unusual gifts. For instance, the surgical care of the wounds of Philoctetes is described in this manner—"They were washed clean by the oracles of Apollo, and he fell asleep; then Machaon, removing the gangrenous flesh from the festering ulcer and deluging it with wine, sprinkled over the wound an herb which Aesculapius got from Chiron and in this way the hero was cured." In a similar fashion Podalirius is depicted in post-Homeric literature curing wounds by squeezing them out, stitching them and spreading on salves "which his father once placed in his hands and by which even the unhealing wounds of men are quickly healed of their deadly evil on the very day".

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* John Barron writes: "During the period 1952/53 I was involved in research for a suitable achievement of arms and I had at that time a friend who was a classical scholar, Capt. P. Dudley-Hill. We discussed mottoes from time to time and it was he who made the suggestion of '*Manu Sciente*'".

The two brothers were also warriors who, like other chiefs, joined their country's expeditionary force and fought valiantly in battles as well as being skilled healers, or leeches or physicians. Obviously they had been well instructed by their father.

It is recorded that when Machaon was smitten "on the right shoulder with a three barbed arrow" (*Iliad* XI, 504 ff.) the Greeks were in great fear for his life so Idomeneus delegated Nestor to take him from the battlefield back to the ships and spoke the oft quoted words:

> "*For a leech is of the worth of many other men*
> *For the cutting out of arrows and the spreading*
> *of soothing simples.*" (*Iliad*, XI, 514–515).

Podalirius, although a surgeon-physician like his brother, is never recorded as a surgeon in the Iliad where he is mentioned on only two occasions. Machaon, on the other hand, is mentioned more often, and one episode is the following: "When Menelaus was wounded Machaon treated him and drew forth the arrow from the clasped belt; and as it was drawn forth the keen barbs were broken backwards. Then he loosed the glistening belt . . . and when he saw the wound where the bitter arrow had lighted, he sucked out the blood and cunningly spread thereon soothing drugs" (*Iliad*, IV, 2 ff.). Machaon's association with broken arrows has therefore more than one explanation.

With Machaon's great reputation in wound care he is generally known as the "Father of Surgery". Podalirius, on the other hand, could be looked on as the "Father of Dietetics". In later texts he appears as the physician who "worked with the subject of diet" and who "treated diseases by diet" (*Scholia in Homerum ad Iliadem*, XI, 515). Podalirius also enjoys the distinction of being the first phlebotomist. He opened a vein in either arm of the daughter of the King of Caria, injured in a fall, and was later rewarded with the hand of the fair princess.

Arctinus in his poem "The Sack of Troy" wrote of the two brothers: "for their father himself gave them both honours, but one he made more renowned than the other. To the one he gave more agile hands to draw darts from the flesh and to heal all wounds; to the other he gave the power to know accurately in his heart all matters that are unseen, and to heal things incapable of healing".

The British Association of Plastic Surgeons by their choice and acceptance of the symbols on their Grant of Arms set high standards, to some extent unwittingly, of which all Members should be aware and do their best to observe.

The International Congress, London 1959

The Scandinavian Association of Plastic Surgeons resolved, at its annual meeting in 1953, to hold an International Congress, and the decision led to the meeting in Stockholm in August 1955 (1st–5th). This was the first international meeting of plastic surgeons since that held in Milan under the Presidency of Professor Sanvenero-Rosselli in September 1938, and which had to be abandoned in mid-week because of the Munich crisis. War caused the cancellation of a meeting planned for Paris in 1940. The Milan meeting of 1938 had been preceded by a meeting in London in October 1937 and before that by one in Brussels in 1936. The Brussels meeting was called the "Premier Congrès de Chirurgie Structive" and was convened under the Presidency of Dr M. Coelst with Dr J. F. S. Esser as its Président d'Honneur; the London meeting was called the "Second European Congress of Structive Surgery". It is pleasing to be able to record that Dr Coelst, although elderly, was fit enough to attend and enjoy the meeting in Stockholm. Before 1936, the only record of an international meeting which I have been able to trace is of one in Paris in June 1925. This was attended by surgeons from France, America and Britain who had been engaged in the treatment of men wounded in World War I. It is to the great credit of Scandinavian plastic surgeons and of Dr Tord Skoog in particular, as the organising secretary of the Stockholm meeting, that the concept of international meetings was revived after so long an interval.

The Stockholm Congress was held under the Presidency of Professor Erik Aschan of Finland with Sir Harold Gillies as its Honorary President. It was attended by 505 members of whom 316 were scientific and 189 social. There is no record in the *Transactions* of the Congress as to how individuals were selected for invitation, but the meeting was so successful that at the end a formal discussion took place at which Dr Skoog proposed that an International Society of Plastic Surgeons should be formed and that meetings should be held every four years. Statutes were put forward by Dr Skoog but these were opposed by many at the meeting. The British surgeons present voiced particularly strongly their criticism of the proposal that the Society should consist of individual members because they felt that this would make it impossible, in practice, to refuse anyone who applied. The proposal to found a society on these lines was, however, adopted by the meeting and an Executive Committee of seven surgeons was elected; Sir Archibald McIndoe was asked to represent English speaking members, other than those from the United States of America, on this committee. In response to a suggestion that the next meeting should be in Britain, the British surgeons present agreed to ask the Council of the British Association of Plastic Surgeons to consider the matter. This led to long and sometimes difficult negotiations with Dr Skoog, General Secretary of the newly formed, but memberless, International Society.

Within a month of the Stockholm meeting, the Council of the BAPS considered the matter but decided that it could not agree to recommend membership of the International Society to its Members, in its present form. Council did, however, agree to host an international congress in London in 1959 provided that it was run entirely by the British Association which would be responsible for organisation, membership and finance. These decisions were conveyed to Dr Skoog and the matter took up much time thereafter in every Council meeting during the next four years. Council's view was that it was not possible for any body except the host society to run an international meeting and that membership of any international organisation should be of national societies, not of individuals. In this way attendance would be guaranteed to be restricted to surgeons who already had been

accepted by their own national organisations or, in the absence of such a national body, accepted as associate members of one of the established associations. Attendance at an international congress by a surgeon or scientist not covered by these regulations would be at the discretion of, and on the invitation of, the host society; all attending under this dispensation would be ineligible to participate in business meetings of the international body.

Dr Skoog attended a meeting of the Council of the BAPS in Sheffield in 1956 when these proposals were discussed with him very fully and much correspondence and many telephone conversations followed. The proposals were put by letter to the American Society of Plastic Surgeons, the Canadian Society and the French Society and all three accepted them without reservation. They were also put to the Scandinavian Association which, however, preferred the concept of the International Society as put forward in Stockholm. Eventually, after more lengthy correspondence and many discussions, the proposals put forward by the British Association were agreed by Dr Skoog, who put them to the original Executive Committee set up in Stockholm, which met at the beginning of the Congress in London. They were accepted, which permitted Mr Mowlem, as President of the London Congress, to call a meeting of the elected delegates of national societies two days later; the delegates accepted them, as did the General Assembly called on the last day of the London Congress. In this way, and at this time, the International Confederation of Plastic and Reconstructive Surgeons was born (Fig. 10.1).

It had been a long and difficult road but the result rewarded the effort and the Confederation has stood the test of time. Without Dr Skoog's dedication it is extremely unlikely that there would be any international organisation today, and it is to be noted that Article 1 of the Confederation Statutes is identical in intent and wording with Article 1 of the proposed International Society and reads, "The purpose ... is to promote plastic surgery both

Fig. 10.1 Handing over the book of Members of both the Stockholm and the London Congress (from left to right) T. Skoog, R. Mowlem, K. Pickrell and T. G. Blocker. The International Congress, London, 1959.

scientifically and clinically, to further education and to encourage friendship between physicians in all countries". Also the emblem or logo, decided upon in 1955, remains unchanged.

The background to the London Congress would be inadequate without reference to the perplexing question of what to call it. This generated heated debate, with our President, Mr Mowlem, in the forefront. He argued persuasively and passionately against the assumption by the Stockholm meeting of the title "First International Congress of Plastic Surgery", which is the title of its transactions. He, and others, felt that the Congresses held before the war should not be ignored and that, therefore, the 1959 meeting should not on any account be called the Second International Congress. Council agreed at its meeting on November 28th, 1957 that it should be known as "The International Congress, London 1959" and Mr Mowlem explained this at some length to the Annual General Meeting of the British Association the following week. All the advance notices, Congress booklets and invitations are headed in this way, but perhaps one can be permitted a wry smile when noting that our *Transactions* of the London meeting are not only titled "*SECOND* Congress" but also "Transactions of the International *SOCIETY* of Plastic Surgeons". So much for four years of heated discussion!

Pre-Congress planning

On October 11th, 1956 Council proposed Mr Rainsford Mowlem to be President of the BAPS in 1959, hence he became *ex-officio* President of the Congress. By a similar proposal Professor T. P. Kilner was made Vice-President of the Association and of the Congress for 1959. At the same meeting Council appointed an organising Executive Committee consisting of Mr R. Mowlem (President), Mr R. J. V. Battle, Mr R. P. Osborne, Mr J. S. Tough and Mr D. N. Matthews (Secretary and Treasurer); later Mr R. L. G. Dawson joined the Committee as Assistant Secretary.

It is important to point out that every Member of the British Association who served on a committee was a busy practising surgeon and that the extra time involved had to be fitted into spare moments of free time. Moreover the secretarial assistance affordable by the Association was very small for at least the first ten years of its existence. There was no spare capacity to take on Congress work and, in practice, all the officers of the Association had to depend very much on the help of their own private secretaries in carrying on the Association's day-to-day business. This was unavoidable but it had the very real disadvantage that much of the work was carried out away from the Association's headquarters. This can, and did on occasion, lead to failures of communication and, sometimes, of corporate decision-making. In those early days Presidents were fully stretched by the preparation of the Summer and Winter meetings.

The Executive Committee met frequently and, at first, mostly in Mr Mowlem's consulting rooms. Later, my colleague at the Hospital for Sick Children, Alan Moncrieff, Professor of Child Health, lent me a room free of charge in the building of the Institute of Child Health. The Congress secretarial staff worked from this room from early in 1958 until ten weeks after the Congress in September 1959. In retrospect, it is difficult to see how we could have managed without it. A junior secretary was employed part-time from early in 1958 and a senior secretary, Miss L. Woodgate, from September 1958. We were soon joined by Miss P. R. Cridland as Congress Secretary; she was an experienced professional congress organiser. Miss Cridland remained with us for six weeks after the Congress and Miss Woodgate for ten weeks.

Very few professional organisations like the BAPS have sufficient funds to absorb the expenses which occur early on from, for example, the booking of congress accommodation and payment in advance for social events. The first crisis of this kind was resolved by loans to the Congress funds from all the Association's committee members but it soon became apparent that additional money was needed urgently. It fell to me to write personally to industrial concerns seeking sponsorship. I wrote to 277 firms of which 71 helped us. In the same letter also, I invited suitable companies to hire space in a trade exhibition to be held during Congress week at the Royal College of Surgeons. Fourteen did so and the exhibitors were pleased with the resulting business. Sponsored donations and the Trade Exhibition realised £6,874 17s. 4d.

The Executive Committee worked also on the preparation of the first announcement of the Congress, which was sent to all members of national societies early in 1958. This had a tear-off card which had to be returned if further communications were wanted. A second announcement was sent in September 1958 to all who had replied; this included an enrolment form for Congress membership with a request for payment of Congress fees, together with forms to be returned giving details and an

abstract of a paper and/or a film which the participant wanted to be considered for inclusion in the programme. These were acknowledged and a card was sent giving a registration number for the delegate. In April 1959 everyone who had submitted scientific material for consideration was notified of the result and a provisional scientific time-table sent together with a questionnaire for accompanying ladies about the social programme. By this time there were 650 registrations of which approximately one-third were social members. The only other advertisement of the Congress was a request in October 1958 to 78 periodicals of general medical interest throughout the world to include a brief announcement of the Congress in their next issue.

During 1958 much time was given to the preparation of the Congress Handbook. This involved the preparation of information about the Congress facilities and about London and its amenities. Effort was made to sell as much advertising space in it as was possible to boost revenue. Invitations and handouts were prepared at this time and a detailed card index system set up to monitor every delegate.

The Executive Congress Committee reported to Council on March 21st 1957 their recommendation that three sub-committees should be formed—financial, scientific and social. This was agreed (Table 1). To these was added a Ladies Committee. It is impossible to record all the hard work of these sub-committees, and space would not permit, but it is right to describe briefly the main activities of each.

Table 1 Committee Members. The International Congress, London, 1959

COMMITTEE MEMBERS

Executive Committee
MR R. MOWLEM—Chairman
MR D. N. MATTHEWS—Organising Secretary
MR R. J. V. BATTLE — MR R. P. OSBORNE
MR R. L. G. DAWSON — MR J. S. TOUGH

Financial Sub-Committee
MR R. P. OSBORNE—Chairman
MR J. S. CALNAN — MR D. N. MATTHEWS
SIR ARCHIBALD MCINDOE — MR J. P. REIDY

Scientific Sub-Committee
MR J. S. TOUGH—Chairman — MR W. HYNES
MR D. C. BODENHAM — PROFESSOR T. P. KILNER
MR F. BRAITHWAITE — MR C. R. MCLAUGHLIN
MR B. W. FICKLING — MR I. F. K. MUIR
MR T. GIBSON — MR A. B. WALLACE

Social Sub-Committee
MR R. J. V. BATTLE—Chairman
MR J. N. BARRON — MR P. H. JAYES
MR H. ELLIOTT BLAKE — LADY MCINDOE
MRS H. ELLIOTT BLAKE

Ladies Committee
MRS H. ELLIOTT BLAKE and LADY MCINDOE—Co-Chairmen
MRS J. N. BARRON — MRS C. R. MCLAUGHLIN
MRS R. J. V. BATTLE — MRS D. N. MATTHEWS
MRS R. L. G. DAWSON — MRS R. MOWLEM
MRS B. W. FICKLING — MRS J. S. TOUGH
LADY GILLIES — MRS A. B. WALLACE
MRS T. P. KILNER

Editor of Transactions—Mr A. B. Wallace
Secretary—Miss P. R. Cridland
Assistant Secretary—Miss L. Woodgate

Financial Sub-committee

In the initial stages it was advantageous that I should act as Treasurer and as Secretary since, at first, it fell almost entirely upon me to sanction major financial commitments and I was in the best position to know if these were realistic and justifiable. As time went on I was too busy to handle the finance, besides which the auditors were insistent that Congress monies should go through the Association's accounts. Mr Osborne, as Treasurer of the Association, was obviously the right man to be Chairman of the Financial Sub-committee and he made an excellent job of it.

It is interesting and perhaps amazing to recall that up to January 1959 full membership of the Congress cost only £15 and social membership £10; subsequently the figures were increased to £18 and £13 respectively. Daily membership (up to a maximum of 3 days) cost £1 per day. These figures are all the more remarkable because for both full and social membership they included all the main social events such as the visit to the opera and the banquet. The only extras were the social outings in the ladies programme. The statement of account up to September 1960 is available (Table 2). The main items covered by the entry on it of "Donations to date £2,410", were £2,000 donated to the Royal College of Surgeons in recognition of the facilities and services given, £350 to the newly formed International Confederation and £25 for shipment of the large official scroll book to the USA. It is also worth recording that the premium for public liability insurance was only £10 10s. 0d., to secure an indemnity of a quarter-of-a-million pounds for any one accident and a similar sum for damage resulting from the sale of food or beverages. A cancellation or curtailment policy covering the period December 10th 1958 to July 17th 1959 in the sum of £10,000 cost only £262 10s. 0d.

Table 2 Congress Accounts. The International Congress, London, 1959

INCOME AND EXPENDITURE ACCOUNT FOR THE PERIOD FROM 12TH AUGUST 1957 TO 30TH SEPTEMBER 1960

INCOME		
Delegates Subscriptions	11,880 9 11	
Donations including Trade Exhibitors	6,874 17 4	
Advertisement Revenue	218 7 6	
Sundry Receipts	50 3 7	
		19,023 18 4
Less:		
EXPENDITURE		
Administrative Expenses including Trade Exhibition	3,964 14 4	
Publication of Congress Proceedings	1,750 – –	
Cost of Typewriters less Sale Proceeds	26 9 –	
Hire of Projection Equipment	276 – –	
Social Functions	7,421 9 3	
Luncheon Tickets	75 5 –	
Expenses of Congress Officers	400 – –	
Professional Fee-Insurance	262 10 –	
		14,176 7 7
Estimated Surplus at 30th September 1960		4,847 10 9
Less: Donations to Date		2,410 – –
ESTIMATED SURPLUS CARRIED TO BALANCE SHEET		£2,437 10 9

The final surplus, when all outstanding debts had been paid, was approximately £2,000. Fifteen hundred pounds of this was invested to provide £300 to finance a new award to be known as the Mowlem Award. This is made every four years in the year preceding an International Congress with the intention of assisting with travelling expenses. The winner is judged by a panel, originally consisting of the President of the Association, the Editor of the Journal and Mr Mowlem. The award was introduced to commemorate Mr Mowlem's Presidency of the International Congress and is available to Members and Associate Members of the BAPS for work presented to a meeting of the Association and/or published in the Journal. The first award was made in 1962 and was shared between Mr J. S. Calnan and Mr T. J. S. Patterson. The remaining surplus of the Congress account, amounting to approximately £500, was spent in assisting Members of the Association with their travelling expenses in attending the Congress in Washington in 1963.

Scientific Sub-committee

This was chaired ably by Mr J. S. Tough. Committee members were drawn from many parts of the country and it is greatly to their credit that they overcame the difficulties imposed by distance to produce faultless scientific presentations throughout the week, without a slide or speaker out of place, a dead microphone or a single verbal overspill. This was the result of meticulous preparation which included duty rosters of Sub-committee members for the platform, of registrars for the speaker's desk, and of medical students to act as stewards in the auditorium. Everyone was rehearsed in their duties and informative notes were given to every speaker.

The Sub-committee chose the speakers from the papers submitted and was responsible for the preparation of both the scientific programme booklet and the handbook of papers read "by title", both of which were included in the Congress folders; 102 papers were delivered and 112 read "by title". The provisional list of speakers and subject matter which was circulated to speakers is noteworthy because it shows how much less time was devoted to burns and to cosmetic surgery than has been the case in succeeding congresses, both national and international (Table 3). This provisional list needed some last-minute adjustment for a variety of reasons including the arrival, unannounced, of a delegation of 17 Soviet surgeons at the Royal College of Surgeons on Sunday afternoon, July 12th! Happily, Mr Tough and his Committee rose to the occasion and no tempers were lost, although several of the Russian surgeons, congenial Congress members, were much embarrassed.

Table 3 Scientific Sessions and Speakers. The International Congress, London, 1959

MONDAY, July 13th, 1959

Morning

CLEFT LIP AND PALATE SURGERY

Dr R. H. Ivy	USA
Dr J. Gabka	Germany
Mr D. A. Kernahan	England
Dr Lyndon Peer	USA
Professor W. Rosenthal	Germany
Professor F. Burian	Czechoslovakia
Mr R. P. Osborne	England
Dr W. R. Burston	England
Mr T. D. Foster	England
Mr D. Greer Walker	England
Mr T. G. Battersby	England

Afternoon

CLEFT PALATE
ANAESTHESIA IN PLASTIC SURGERY
MISCELLANEOUS PAPERS

Dr D. R. Millard	USA
Dr K. M. Marcks	USA
Dr R. O. Dingman	USA
Professor V. Popescu	Rumania
Mr G. E. Hale Enderby	England
Dr D. Morel-Fatio	France
Professor K. Schuchardt	Germany
Professor I. Cupar	Yugoslavia
Dr A. Ragnell	Sweden
Dr L. A. Bornstein	Israel

TUESDAY, July 14th, 1959

FACIAL CANCER

Dr C. Kiehn	USA
Dr T. de Cholnoky	USA
Dr W. B. Macomber	USA
Mr E. W. Gibson	Australia
Dr H. Janvier	France
Dr P. Wilflingseder	Austria
Dr R. Mouly	France
Dr F. Lagrot	Algeria

MAXILLO-FACIAL

Professor J. Hertz	Sweden
Dr S. W. Leslie	Canada
Dr O. H. Stuteville	USA
Dr Luis Calatrava	Spain
Mr T. Cradock Henry	England

WEDNESDAY, July 15th, 1959

Morning

SURGERY OF THE HAND
MISCELLANEOUS PAPERS

Dr C. C. Snyder	USA
Dr J. W. Littler	USA
Dr M. A. Entin	Canada
Dr J. Fonseca Ely	Brazil
Dr W. L. White	USA
Dr J. Planas	Spain
Mr S. H. Harrison	England
Dr E. L. S. Robertson	Br. W. Indies
Professor V. Karfik	Czechoslovakia
Dr T. Kostek	Switzerland
Dr J. M. Bruner	USA
Dr E. d'Alessio	Italy
Professor H. Z. Konuralp	Turkey

Afternoon

FACIAL TRAUMA

Mr M. N. Tempest	England
Mr T. L. Barclay	England
Dr Neal Owens	USA
Dr John M. Converse	USA
Dr J. J. Longacre	USA
Dr E. V. Gruzdkova	Russia
Dr E. C. Hinds	USA
Dr I. Clerici-Bagozzi	Italy

THURSDAY, July 16th, 1959

RECONSTRUCTION OF THE EAR

Mr A. J. Evans	England
Mr D. N. Matthews	England
Dr R. C. Tanzer	USA
Dr Robert Henner	USA
Mr E. W. Peet	England

HYPOSPADIAS MALE PSEUDOHERMAPHRODITISM

Mr Denis Browne	England
Dr A. Cardoso	Brazil
Dr P. Fogh-Andersen	Denmark

LESIONS OF THE EYELID AND ORBIT

Dr I. Isaksson	Sweden
Lt-Col B. T. Sayoc	Philippines
Dr P. E. Aschan	Finland
Dr J. J. Conley	USA
Dr E. Schmid	Germany
Dr G. S. Polycratis	Greece

FRIDAY, July 17th, 1959

Morning

HOMOGRAFTS AND TISSUE BANKS

Dr Blair O. Rogers	USA
Dr Hector Marino	Argentina
Dr Hamilton Baxter	Canada
Dr J. Grignon	France
Mr T. Gibson	Scotland
Dr N. C. Georgiade	USA
Dr R. K. Snyderman	USA

RESEARCH SUBJECTS AND BURNS

Dr K. Ostrowski	Poland
Dr Stuart D. Gordon	Canada
Mr A. B. Wallace	Scotland
Dr K. E. Hogeman	Sweden
Mr I. F. K. Muir	England
Mr Douglas Jackson	England
Dr M. C. Chytilova	Czechoslovakia

Afternoon

COSMETIC SURGERY

Dr Milton Edgerton	USA
Dr G. Aufricht	USA
Mr Jack Penn	South Africa
Dr I. Pitanguy	Brazil
Dr Sidney Kahn	USA
Dr M. Gonzalez-Ulloa	Mexico
Professor R. Takahashi	Japan
Dr E. M. Lipsett	USA
Dr N. H. Antia	India

Mr I. F. K. Muir was the Committee member responsible for the showing of films. Two rooms were available and films were shown continuously during the scientific session. The films were arranged in nine groups and all the 82 offered had been shown once by midday on the Thursday of the Congress week. A ballot box was used for members to state their preferences and the most popular were shown again on the Friday.

Some members of the sub-committee, together with other linguists in the Association, assisted in the gigantic task of preparing the Transactions of the Congress for publication which was the responsibility of Mr A. B. Wallace, the Editor of the Journal. The volume was beautifully produced by E. & S. Livingstone but, despite the ludicrously low cost even for those days, of £3 3s. 0d. per copy, sold disappointingly slowly at first. Ultimately sales picked up and the stock was cleared, many copies being sold at the American Congress in 1963.

Social Sub-committee

Mr Battle was the ideal Chairman. He enjoyed every moment and his enthusiasm infected his fellow committee members. The result was an outstandingly successful social week in which even the weather was helpful: hot sun and cloudless skies prevailed throughout. On Sunday evening, July 12th, the BAPS gave a welcoming cocktail party at the Royal College of Surgeons to follow registration. It was highly successful and created an atmosphere of friendliness which characterised the whole week.

The reception by the Corporation of the City of London at the Guildhall on Monday evening, July 13th, was a brilliant occasion. We were lucky not only to receive this much-sought-after invitation but also to have it at the beginning of the Congress week. It was unique in pageantry and setting. Nowhere else in the world can it be staged, and delegates were entranced. The evening contributed much to the success of the week. The Lord Mayor of London, Sir Harold Gillett, and the Lady Mayoress received us, escorted and guarded by Pikemen and Musketeers in traditional uniform who, later in the evening, gave a display of picturesque drill in the Guildhall courtyard. Music was provided by the Guildhall School of Music and Drama, lavish food and wine were available, there was dancing in the Livery Hall, and Sheriffs and Aldermen were present to show us many of the treasures of the Corporation. There is an understandable keenness to be the beneficiary of one of these splendid evenings, which occur only rarely, and persuasion by many wellwishers was offered on our behalf; we owe them much gratitude. We were also much indebted to Mr Elliott Blake, the Committee member personally responsible for liaison with the dignitaries of the Guildhall.

Tuesday evening, July 14th, saw us as the guests of the Right Honourable Derek Walker-Smith, Minister of Health, at a reception at the Savoy Hotel, and Wednesday, July 15th, at a similar reception at the Senate House of the University of London as guests of Dr C. F. Harris, the Vice-Chancellor, and Mrs Harris. Thus in three days we had enjoyed the privilege of association with the City of London, the Government and the University of London.

Thursday evening, July 16th, saw us at the Royal Opera House, Covent Garden for a memorable performance of *Lucia di Lammermoor* with the world-famous Miss Joan Sutherland in the title rôle. Once again fortune favoured us because, when we booked a block of 800 seats over two years in advance, the programme was not known. The purchase of so many tickets so far in advance was a considerable gamble because of uncertainties about the numbers who would attend, or even whether there would be a Congress! Payment put a great strain on our resources at the time. The performance was followed by a buffet supper in the foyer of the Opera House for all Congress members, at which we were joined by the cast of the Opera Company.

Friday, July 17th, was the occasion of a farewell banquet at the Dorchester Hotel. Mr Percy Jayes was the Social Sub-committee member responsible for this function, which ran without a hitch and without the speeches being too long. I remember being fascinated by the logistics of the menu produced by the banqueting manager to ensure that the time needed to serve the meal did not involve us in the expense of overtime; the time required for every different course was known by him exactly to the minute. The company was entertained during the meal by the band of the Royal Army Medical Corps; all members of the Congress received an engraved glass ashtray as a memento, and all the ladies a small folding clothes brush for their handbag.

It is worth re-emphasising that all these social events were included in the £15 registration fee for full members and the £10 fee for social members: discounting inflation these are impressive figures by today's standards. Tickets had to be purchased

at the registration desk for some of the ladies' social outings, for example visits to the Tate Gallery, the Silver Vaults, the Changing of the Guard, the Tower of London, Kew Gardens and the BBC Television studios. The expenses for these events were mostly for coaches to take participants to and fro. The demand for these excursions was less than was planned for and facilities were reduced appropriately; this is a common experience with meetings in London because the capital City has so much to offer that delegates mostly prefer to find their own way around, unaided. A fashion show at Fortnum and Mason, provided generously by Mr Garfield Weston and the Directors, was a popular event in the social programme.

Ladies Committee

This was formed late in 1958 and its co-Chairwomen, Mrs Elliott Blake and Lady McIndoe, were co-opted on to the Social Sub-committee. The Ladies Committee was concerned primarily with putting together the ladies' social programme and with making arrangements to accompany the coach parties. Its members also did much to foster private hospitality during Congress week, both by personal example and by encouraging others to invite the wives and children of delegates to their homes.

During the week preceding the Congress the members of the Ladies Committee worked tirelessly in filling over 800 folders; a heat wave at the time made this all the more demanding. The task took four full days, with an average of four workers at a time, and the members of the Committee were assisted in this work by the private secretaries of many of the Congress officers. This task is all important to the smooth running of a congress; it is time-consuming, demands great accuracy and cannot be started until immediately before the congress. It puts a great strain on the resources of such a congress and we were very fortunate to have so much skilled help so generously given.

Members of the Ladies Committee manned the registration desk throughout the week and were assisted in this work by members of the Women's Voluntary Service and a cadet from the St John's Ambulance Brigade. Banking facilities were provided by the Westminster Bank and a representative of Thomas Cook, the official travel agency of the Congress, was available. Medical students who could speak foreign languages were present as interpreters, in return for which services they had free entry to the scientific sessions whenever they were not needed. The registration desk was the overall responsibility of Miss Cridland but the bulk of the day-to-day work fell on the shoulders of members of the Ladies Committee.

The opening ceremony

This was conducted in the Edward Lumley Hall of the Royal College of Surgeons of England on Monday morning, July 13th 1959. The platform party processed to the dais led by the College Mace Bearer and heralded with a fanfare by the trumpeters of the Royal Army Medical Corps (Fig. 10.2). The procession was headed by Sir James Paterson Ross, President of the Royal College of Surgeons. He was followed by Mr Rainsford Mowlem, President of the BAPS and of the Congress, Sir John Charles, Chief Medical Officer of the Ministry of Health, Professor T. P. Kilner, Vice-President of the BAPS and of the Congress, Mr D. N. Matthews, Secretary of the Congress and Mr R. L. G. Dawson, Assistant Secretary. Already assembled on the platform were the appointed delegates of the 29 National Societies of Plastic Surgery attending the Congress, each seated below his national flag.

His Royal Highness Prince Philip, Duke of Edinburgh, who had graciously consented to be the Patron of the Congress, had recorded an address of welcome which was broadcast to the assembled company of both social and scientific members. Sir James then welcomed the delegates on behalf of the College, followed by Sir John on behalf of the Government. Mr Mowlem then introduced each of the official delegates of the national societies and welcomed everyone on behalf of the BAPS. This concluded the official proceedings, and Professor Kilner then took the Chair at the first scientific session.

Post-Congress activities

During the run-up to the Congress a questionnaire was sent to all plastic surgical units in Britain asking them to indicate the facilities they could offer to plastic surgeons wishing to visit them after the Congress, and details were included in the Congress Handbook. As a result many units had enjoyable visits from overseas colleagues.

The Congress office resumed its activities in the Institute of Child Health at the conclusion of the Congress and continued to function for ten more weeks. During this time many delegates who were

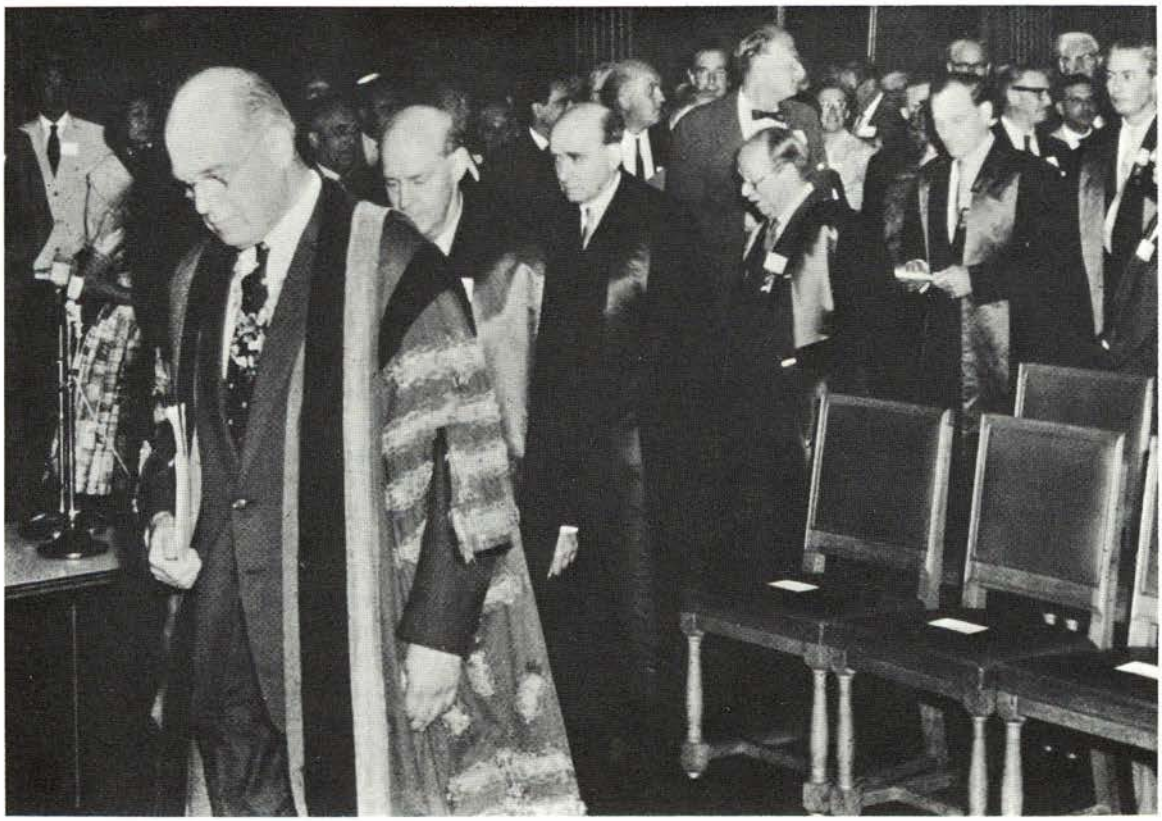


Fig. 10.2 The platform party with Sir James Paterson Ross (in front), R. Mowlem, Sir John Charles, Professor T. P. Kilner, D. N. Matthews and R. L. G. Dawson. The International Congress, London, 1959.

touring Europe asked the office for help and advice on a number of points and it is amusing to recall that requests for "Certificates of Attendance" at the Congress spanned dates encompassing five weeks, although the Congress lasted only five days! Such is the influence of the taxman, worldwide. The office was concerned during this final phase mainly with administrative matters, the settlement of outstanding accounts and the writing of many letters of thanks to the large number of individuals and institutions whose help, financial support and goodwill had contributed so greatly to the success of the Congress. The London Congress was attended by 865 members of whom 538 were full members, 243 social members and 84 day members. They came from 51 countries.

11 *John Watson*

Ethics, law and the Press

In 1961 there occurred a damaging event which not only shook the fabric of the British Association of Plastic Surgeons to its foundations, but also highlighted certain aspects of the ethics of specialist practice in the full glare of world-wide publicity. In this year seven highly reputable plastic surgeons, Members of the Association, found themselves arraigned before the Disciplinary Committee of the GMC on charges of advertising, as a direct consequence of the policy which had been adopted by the Association in its relations with the lay public and the Press. The principles involved in this lamentable affair were quite intricate, and if a proper assessment is to be made the facts need to be reviewed in some detail in the context of the conditions of practice and *mores* of 25 years ago.

The background

In the post-war years, practising plastic surgeons in this newly-emerging specialty could not but be impressed by the difficulties experienced, and the hurdles to be overcome, by patients seeking expert consultation whether in the hospital or the private sphere. This applied particularly to the main body of patients of average or low income rather than to the wealthy. Although such patients were often seeking treatment for disfigurement of one kind or another, the problem was by no means confined to the cosmetic field. The difficulty arose usually after patients had consulted their own general practitioners who, for a variety of reasons ranging from mere ignorance of the capabilities of this expanded and developing specialty and the wider hospital cover now available together with a failure to appreciate the effects of disfigurement on the patient's psyche, lifestyle and efficiency, had an active distrust of plastic surgery, regarded by some as a fringe surgical activity. When such circumstances arose, the patient was bereft of the opportunity to find reliable assessment or treatment. To a proportion of practitioners the specialty was evidently a closed book. In addition, patients from the Commonwealth or elsewhere abroad, seeking treatment in the UK, experienced difficulty in obtaining the names of reputable surgeons to consult and claimed that plastic surgery seemed to be shrouded in mystery. The consequences of this situation could be unfortunate, not merely because patients were failing to obtain treatment, but also because, particularly in the cosmetic field, of an increasing tendency for the public to seek treatment in response to the advertisements of untrained or even unqualified practitioners, of whom there were a number in practice particularly in London.

For these reasons, an increasing number of enquiries from the lay public were arriving at the BAPS Secretariat asking for reliable information about the names and locations of surgeons properly trained in the specialty, and from 1951 onwards these had been dealt with by the Honorary Secretary himself. In 1957 arrangements were rationalised further, when the then Secretary authorised the Secretariat to furnish enquirers with lists of names and addresses of all the Full Members of the Association practising in the geographical area from which the enquiry originated. It was considered that as a full choice of Members was always offered, this practice could not be construed as advertising by any one individual, and this service was certainly offered from the highest motives as fulfilling a real public need. Indeed, the furnishing of names direct to the lay public was not unique; both the BMA and the RCS occasionally gave such information to patients seeking consultation, and the Diabetic Association, for example, regularly supplied lists of names of diabetic specialists to sufferers who might require urgent assistance. Ethical problems were not anticipated. However, this practice of the Association, which was to have

such far-reaching consequences, had been established by its officers without seeking legal advice as to its propriety and without formal discussion by, or approval of, the Council. At least, there was no evidence of this in the Council minute book although, later, two Scottish members were to claim that they had vented their unease in Council but that their protest had been brushed aside.

The position of the Association became further complicated by Press relations. Plastic surgery, and especially its cosmetic aspects, had become a topic increasingly discussed by journalists and a number of feature articles appeared in the popular press and in women's magazines. Such articles led to large numbers of enquiries from readers seeking information as to where such treatment was obtainable. Such an article was published in 1954 in an issue of *Woman and Beauty*, whose consultant Beauty Editor was Miss Ruth Jordan. The article, entitled "Women and Plastic Surgery", opened by saying: "In an age of many wonders, perhaps one of the greatest of them is Plastic Surgery" and continued "Anyone can find out the qualification of a surgeon by applying to the British Association of Plastic Surgeons, London WC2 . . . FRCS are the letters which proclaim a surgeon, but all surgeons specializing in plastic operations have had to do three or four years' extra training after their general surgical training . . .". After an account of some operations performed, the article concluded: "Those who perform these wonderful miracles of skin grafting and surgery know that they leave many grateful women (and men) in their trail . . . Leading plastic surgeons find more and more satisfaction in the great work they are doing . . ."

A further article in *Woman's Own* in 1959 entitled "Operation Beauty" invited readers to write for a pamphlet, under the same title which stated: "Very few cosmetic operations can be done on the National Health Service, and only your doctor can advise you. In the same way, your own doctor is the one to put you in touch with the most competent plastic surgeon for your case—it is, of course, vitally important to approach one who is fully accredited. There are, however, some more conservative doctors who are not sympathetic to cosmetic surgery and yours may be one. If this is the case . . . you can write . . . for a list of accredited specialists in your area to the British Association of Plastic Surgeons, 47 Lincoln's Inn Fields, London W.2".

Both Miss Jordan, the Editor of *Woman and Beauty* and Mrs Digby Morton, the Beauty Editor of *Woman's Own*, were later to claim that they had sought and obtained the co-operation of the Honorary Secretary of the BAPS and of Sir Archibald McIndoe in the preparation of this material. Sir Archibald was not to live long enough to confirm or refute this assertion, or to assert his views in the spirited way of which he was certainly capable.

By 1959 enquiries of this kind were reaching the BAPS Secretariat at the rate of about 1,000 a year, some 60% of which came from the provinces. It is evident that, although the practice had never been ratified formally by the Association, a considerable number of Members must have been made aware that the BAPS had given their names to the lay public, and no doubt assumed that the officers of the Association were satisfied with the propriety of the system.

The state of affairs continued until December 8th 1959 when the practice was abruptly brought to an end on the instructions of the President to the Secretariat, for reasons not recorded. Thereafter, any such communications to the lay public stated that the names of plastic surgeons could be supplied only to medical practitioners.

The plot

In May 1960 Mr Leslie Gardiner, who whilst not a Member or Associate Member of the BAPS was practising plastic surgery in London, had appeared before the Disciplinary Committee of the GMC and his name had been ordered to be erased from the medical register. Mr Gardiner, who was known to me personally as a one-time ENT colleague at Lewisham Hospital, had adopted plastic surgery as a private practice specialty and was the author of a book entitled *Face, Figures, Feelings* widely read by the lay public. He had not received a formal training at any of the British plastic surgery centres. The charge had been of advertising, and he had appealed against the GMC decision to the only available authority, the Privy Council, which did not uphold his appeal. Mr Gardiner had written for a copy of the leaflet "Operation Beauty", and had subsequently entered into correspondence with the BAPS President in the spring of 1959, in the following terms: ". . . It is not the publicity that I deprecate but the restrictive trades union method employed and in particular its effect on my practice now and in the future . . . I know it is fashionable to blame the Press but I have found in this matter that the blame attaches to those of your Members who for

years past have quite deliberately sought to use the Press for their personal ambitions under the guise of protecting the public from anyone who does this work, excepting of course themselves . . .".

Here, in passing, one may note a recurrent laxity in the BAPS administration. Not infrequently, officers of the Association would collect incoming mail from the Secretariat and answer it elsewhere with the assistance of their personal secretaries. This is the probable explanation of why this correspondence, which might have struck a warning bell of potential trouble in store, was never lodged in the Secretariat files.

In October 1959 two letters arrived at the Secretariat apparently from *bona fide* patients requiring advice, as follows:

> 27 New Road
> Ammanford
> Carm.
>
> October 17th, 1959
>
> Dear Sir,
>
> With reference to the leaflet "Operation Beauty" from *Woman's Own* magazine will you please recommend a suitable plastic surgeon to improve the shape of my nose. I enclose a stamped addressed envelope.
>
> Yours truly,
>
> (Mrs) Mary A. Evans

and:

> HOTEL CONTINENTAL
> PARIS
>
> 3, Rue de Castiglione
> October 19th, 1959
>
> Dear Sir,
>
> I have the pamphlet "Operation Beauty" from the magazine *Woman's Own*.
>
> Can you please recommend to me a surgeon in England who can perform a cosmetic operation on my nose in the near future. I can travel any day after October 23rd.
>
> Yours faithfully,
>
> (Mrs) Anne Gardiner

Mrs Mary Evans proved to be Mrs Leslie Gardiner's niece, although both letters were in Mrs Gardiner's hand. Both these letters were dealt with in the routine manner, with the provision of the lists of names of Full Members of the Association working in London and Wales respectively. That concerning Wales does not seem to have borne fruit but in the case of the London list letters arrived to the surgeons concerned couched in the following terms:

> . . . I have been given your name by the British Association of Plastic Surgeons, whom I wrote to on the advice contained in the pamphlet Operation Beauty circulated on request by the magazine *Woman's Own* to their readers. I am an English girl studying in Paris and I would like to have the shape of my nose improved by cosmetic plastic surgery. I shall be returning to London for two weeks on November 14th. I should like to know your fees for this operation and whether you would be able to operate on me at this time.
>
> P.S. I greatly admired the nose illustrated in this article in *Woman's Own*, and I would like to know whether you are the surgeon who performed this operation . . .

The letter was signed in the name of Miss Mary Evans.

When affirmative replies had been received from the surgeons concerned or their secretaries, a complaint was lodged with the GMC by one Mr Ludevicki, who said he was a friend of Mr Gardiner. The wheels were thus set in motion and the preliminary investigating body of the GMC got to work to assess whether or not there was a possible case to answer. In view of the nature of the complaint the GMC obtained a statutory declaration from Mrs Gardiner.

Disengagement

I was appointed Honorary Secretary as from January 1960. Although I had been alerted by my predecessor in office of the possibility of trouble developing over the issue of Members' names to lay persons, I had no idea of the extent of the problem or where it might lead. Up to then I had even been unaware that the Association ever furnished Members' names in this way. I learned that an intimation had been received by a Member's defence society that the practice might be held to contravene the GMC's warning notice against advertising. My initial reaction was to investigate the original authorisation of the policy which had previously been adopted and was now in use, and discovered to my surprise that the matter had never been recorded in Council minutes. So I placed the whole topic of public relations for the first time on the agenda for a Council meeting held in February 1960. Council decided that the existing practice of

releasing Members' names only to medical practitioners should for the present be maintained pending legal advice, which should now be sought. This I did and the opinion given was that it was possible that if a professional body of restricted membership issued the names of its members to the lay public, particularly in response to invitations from the lay press, this could be held to be advertising.

It was now urgently necessary to undertake a carefully conducted process of disengagement from the lay press, whose journalists were already reacting with surprised indignation at the sudden reversal in BAPS policy, with some danger of the development of a hostile campaign and yet further publicity. This was not altogether an easy task because it had to be conducted without any admission of guilt over past practices and, at the same time, attempt to preserve goodwill; peremptory "choking-off" letters were obviously inapposite. To this end I wrote to the editors of a considerable number of lay publications and it is perhaps worth quoting a sample of this type of correspondence and the replies received, to crystallise the nature of the problem faced by the Association.

First, a letter written to the Principal of the *Daily Mirror* Readers' Service, Philip Wright. This Service had been in correspondence with a reader seeking consultation with a plastic surgeon but whose general practitioner, it was said, had reacted in a rather basic fashion stating that as the patient was patently well and not ill he did not propose to interest himself in the matter. The reader had been advised to write to the BAPS, only to be told to consult his own GP, which had placed the Readers' Service in an embarrassing position.

Dear Mr Hubble,

. . . It used to be our practice to provide regional lists of the names of plastic surgeons who were Members of this Association to enquiring doctors and members of the general public; although the provision of such information was not, strictly speaking, one of the functions for which this Association was constituted, the service was given freely because we felt that it filled a real public need.

As this correspondence, both from home and overseas, grew considerably in volume and complexity, however, doubts arose as to whether this service might not be held to be an infringement of medical ethics, on the general ground that potential patients were being channelled, even indirectly, through a particular professional Association. In order to clarify this difficult issue, legal advice was taken, and it was established quite clearly that the provision of a list containing the names of surgeons to the laity, although given in good faith to fulfil a public need, might be held to be an infringement of the ethical requirements of the General Medical Council.

Once this was established, there was no alternative but to change the policy of the Association, which as a highly reputable organisation would not wish that it should even be *thought* that any question of infringement of the ethical code of the profession was involved. The policy was changed last year, and we now only furnish information of this kind to medical practitioners who seek our assistance.

I am sure you will understand the reasons for our inability to assist your correspondent, which are based on ethical and legal considerations and not on any indifference to this recurrent problem. Indeed, it is the desire of the Association wherever possible to safeguard patients in a field of surgery which is beset with pitfalls for the inexperienced, ill-trained or untrained surgeon as a result of which such lamentable disasters can occur. It would seem that now, as indeed in days gone by, a reliable and co-operative general practitioner is the best safeguard available to the patient when making arrangements for surgical treatment.

I am in full agreement with the point you make in the last paragraph of your letter re. the G.P.'s abrogation of responsibility whether the patient is paying fees or not. We have already pointed out to your correspondent, as in many other similar cases, that plastic and reconstructive surgery, involving, as it does, a surgical operation, is very much the concern of the general practitioner who is responsible for the medical welfare of his patient.

I hope this provides you with the information you request; needless to say, this letter is for information only and not intended for publication in any part.

And some sample replies to this kind of correspondence:

I was very disappointed to get your reply, because I am sure you appreciate this represents a complete dead end for a high proportion of readers enquiring about plastic surgeons. They

only write to me in the first place because either they do not wish to discuss their problem with their own family doctor, or because they have done so and the doctor has refused to consider the matter seriously.

Thank you all the same for taking the trouble to give me an official answer, however unsatisfactory it may be.

(The Editor of *She*)

and:

Thank you for your letter of 5th March, 1960, in which you inform us of your Association's standpoint on the matter of supplying addresses of members on request to any reader of *Woman's Own* who write to you for them.

We quite understand your difficulty, and have in fact already amended our "Operation Beauty" leaflet to this effect and enclose a copy for you to see.

(Mrs Phyllis Digby Morton, Executive Editor *Woman's Own*)

Thus 1960 drew to a close, with the Association apparently back on an even keel so far as these troubled waters were concerned. I confess at that time to a feeling of some dissatisfaction with the situation because I felt that there was an element of cowardice in our abrogation of responsibility for the welfare of the patient, which was what good medical practice was all about, for fear of censure. Nevertheless, it was vital to protect our Members. In retrospect it seems strange that as Honorary Secretary, primarily responsible for dealing with correspondence and the day-to-day administration of the Association, I remained in blissful ignorance of any impending activity by the GMC relating to our Members.

A troubled year

By a stroke of good fortune the Association had nominated Air Vice-Marshal G. H. Morley as President for 1961, a man of outstanding administrative ability, integrity and thoroughness. He was quite unflappable and as a serving officer had no possible implication in the problems about to beset the BAPS. George Morley, released by the Air Ministry for the task, was to devote a great deal of his time and energy over the period of the next two years to the welfare of the BAPS. So far as I am aware, he was unaware at the commencement of his term of office of any processes under way at the GMC. However, the general unease about publicity and the past practices of the Association were such that George Morley suggested that I should seek an interview with the Registrar at the GMC, with the aim of discussing freely with him the difficulties experienced and to explore in this way the ethical standpoint on such matters which might be held by the GMC.

With unwitting naïvety I rang the GMC requesting such an interview, and was startled to be told by an obviously horrified official that I must surely be aware of the fact that seven of our Members were under active investigation following allegations of advertising, that the matter was *sub judice*, that "one didn't ring up a potential hangman to enquire about a possible verdict", that the best thing the Association could do was to seek urgent legal advice, and that if I would get off the line he was prepared to forget our conversation. A very chastened Honorary Secretary communicated these dismal facts to his President.

Even at this stage the whole affair seemed to be a storm in a teacup. The motivation of the Association in providing the public with reliable information solely *pro bono publico* seemed patently self evident, and in the specific case the surgeon's affirmative reply to a request from an overseas patient, where the intervention of a GP was not relevant, seemed entirely blameless; furthermore, the setting of an elaborate trap to form the basis of the allegations would surely be viewed with disfavour by any enquiring body. It seemed likely that the affair would blow over without any case being found. This view proved wrong.

As soon as it became known that the GMC had decided that there was a case to answer, and to take action, George Morley wrote to each of the seven surgeons concerned expressing sympathy and support. The Association itself, however, was in a rather curious position. It had not been named directly in the case and therefore had no *locus standi*; it was thus out on a limb, unable to retain counsel to defend its actions or to take positive action to assist its Members. However, it was decided that the Association should take parallel legal advice and I spent many weary hours with Mr Hawkins, of Le Brasseur and Oakley; he in his turn put in a prodigious amount of time searching through the minute books and files of the Association in an attempt to find material which might be of help to the defence. Meantime Sir Arthur Porritt, President of the Royal College of Surgeons, had expressed his interest and anxiety over the turn of

events; George Morley had been to see him to give a full explanation of the background of the Association's troubles and had received a sympathetic hearing.

Professor Pomfret Kilner, who was a member of the GMC, very courageously determined to give evidence on behalf of the Association, proferring his resignation from the Council of the GMC if necessary in order so to do. Fortunately, his resignation was not accepted by the President, Lord Cohen of Birkenhead, and he was later to be elected to membership of the Disciplinary Committee.

The legal advice we were receiving was, in general, depressing. Legal opinion seemed unimpressed by the claim that the actions of the BAPS had been solely for public benefit, and more concerned with the minutiae of legal interpretation of the precepts of the GMC. From the legal point of view the outlook was none too hopeful.

Nothing further could be done than to await anxiously the GMC hearing scheduled for late November.

A fatal flaw

In the course of a general scrutiny of all relevant documents in the Secretariat an astonishing fact came to light. A review of the geographical lists of names of Members, which had formerly been furnished to the laity, showed that these duly comprised all the full membership, except in the case of London. In London 17 surgeons were in practice, but only eight names appeared on the London list. Enquiry showed that there had originally been a list of all 17 names but that, "to avoid inundating enquirers", this list had arbitrarily been subdivided into two lists of eight and nine names respectively. The lists were intended to be sent out strictly alternately. The second list had been unaccountably lost and, in fact, there was no evidence that it had ever gone out to the public since the scheme was started on a geographical basis. The loss had occurred during the period of employment of a secretary responsible for this section of the work, who had since married, had emigrated to South Africa and was not available for questioning. The secretary taking over her work had just accepted the lists as she found them. The basis on which the original list had been subdivided was not obvious, being certainly neither alphabetic nor on a criterion of seniority, and this disappearance of all names but eight remains an unsolved mystery. However, this administrative accident, of which my predecessor in office was unaware, did not improve the image of the BAPS administration and meant, moreover, that it could no longer be asserted that the lists of Members' names furnished were all-inclusive, laying the Association open to a possible charge that a selection had been made.

The meeting of the Disciplinary Committee

The Disciplinary Committee met on November 22nd, 1961 under the Presidency of Sir David Campbell and the hearing continued over four days.

The charges against the seven surgeons were on two counts as follows:

1. That they had combined together and with other persons unknown (being members of the British Association of Plastic Surgeons) to advertise for patients in the manner set out in the subjoined particulars, and
2. That each of them severally (a) had advertised for patients in the manner set out in the subjoined particulars; (b) had sought to profit by the publication of matter referred to in the subjoined particulars and had shown himself prepared to accept patients notwithstanding that he knew such patients had been induced to seek his services in the circumstances set out in the particulars; and that in relation to the facts so alleged each one of them had been guilty of infamous conduct in a professional respect.

The "subjoined particulars" were these:

1. Whereas, according to its written constitution, the Association was formed "to promote and direct the development of plastic surgery along sound and progressive lines" and for other purposes of a similar character, in fact, as each of you well know, it was or became the policy or practice of the Association to promote the professional advantage of its members by advertising their proficiency in plastic surgery (including cosmetic surgery) and to influence the public against seeking the services of plastic surgeons other than its own members.

2. In pursuance of the policy or practice aforesaid

(a) the Association through its members and officials has invited inquiries from members of the public who need, or may be induced to think they need, the services of plastic surgeons. Such inquiries have been invited in general by announcements of the Association's existence

and, more specifically, by (1) an article entitled "Women and Plastic Surgery" published in the issue dated October 1954, of the magazine *Woman and Beauty*; (2) an article entitled "Operation Beauty" published in the issue dated October 1959, of the magazine *Woman's Own*; and (3) a leaflet also entitled "Operation Beauty" published by the proprietors of *Woman's Own* and referred to in the article.

Each of the articles and the leaflet emphasised the specially high degree of surgical skill required to qualify a practitioner for the performance of cosmetic operations, and both the article "Women and Plastic Surgery" and the leaflet "Operation Beauty" expressly recommend application to the Association for the names of practitioners so qualified. The article "Operation Beauty" made the same recommendation indirectly by inviting readers to apply for a free copy of the leaflet.

(b) the Association through its members and officers has, in response to inquiries received in consequence of such invitations or otherwise, supplied from time to time your names and addresses to inquirers seeking treatment in the London area. In particular, by letters October 14th and 20th, 1959, the Association recommended you (and one other of its members, now deceased) to Mrs L. E. Gardiner as plastic surgeons practising in London and able to advise and treat her.

(c) (refers back to correspondence of 1954).

3. You have promoted or acquiesced in or connived at the said policy and practice of the Association

(a) by being and remaining members of the Association at all material times . . .

(b) by failing to take reasonable steps to prevent the Association from inviting and responding to inquiries as described above, and by failing to exercise the influence over the Association which you possessed by virtue of your membership . . .

4. By a letter dated October 25th, 1959, and written in identical terms to each of you by Miss Mary Evans you were informed that on the advice contained in the leaflet "Operation Beauty" circulated on request to readers of *Woman's Own* she had written to the Association and had been given your name. The letter expressed her desire to have the shape of her nose improved by plastic surgery and asked what your fees would be for this operation and whether you would be able to perform it during the two weeks following November 14th, 1959. In reply to the said letter . . . you and each of you wrote to Miss Evans, either personally or by your secretary, giving the information asked for and inviting her to become your patient.

The hearing

Mr Peter Boydell, QC appeared for the solicitors to the Council to present the alleged facts of the case. He gave a detailed account of the articles which had appeared in the lay press inviting members of the public to approach the BAPS for assistance. He called in evidence the Editor of *Woman's Own* and the Beauty Editor of *Woman and Beauty* and established that the articles had been vetted before publication by the officers of the Association and Sir Archibald McIndoe and that advice had been given. He detailed the letters which had been written by Mrs Gardiner, calling Mrs Gardiner to confirm, and the various replies made by the surgeons concerned. He also called Mr L. Gardiner over the subject matter of his past correspondence with the Association mentioned above. He said that, to put it in one word, the surgeons were charged with advertising.

The several counsel representing the surgeons then submitted that there was no case to answer.

At this juncture, after legal argument, the Legal Assessor (Mr C. P. Harvey, QC) said that on Count (1) there was no evidence against three of the surgeons, and after deliberation in camera the President announced that these three were cleared of any charge under Count (1). The Committee did not uphold the other submissions made.

For the defence, the first witness was my predecessor in office, C. R. McLaughlin. He described how the BAPS Secretariat received many enquiries from the public and how he had designed a standardised reply to cover almost all cases and containing the names of Members on a regional basis. The replies were not signed by him and he had continued a pre-existent practice solely in the interests of the public. He had not consulted the President of the Association nor any Member in this matter. He said that the Association was a body formed for scientific purposes and controlled by men of the highest repute and eminence. He agreed that he had corrected the leaflet "Operation Beauty" over clinical matters. He had not known that the London list of names had been restricted.

Professor Kilner stated that, in his view, the practice of answering enquiries by giving names

was not unethical. Whilst agreeing that, in an ideal world, the starting point for a patient was to go to a GP he did not consider that in present circumstances that avenue of enquiry was of itself sufficient for every kind of patient in every circumstance. He deplored operations being carried out by unqualified practitioners and could not see any other way of providing lay people with a link with qualified plastic surgeons, however he would not consider it right to see patients who were referred to him by a woman's magazine.

Each of the seven surgeons was then examined and cross-examined, and each claimed that there was no moral or ethical wrong in circulating lists of properly trained surgeons to the public. Each regarded the British Association of Plastic Surgeons as a most respectable and highly reputable body. The questions posed and the answers elicited covered a broad spectrum of all the patient and public relations problems discussed above.

I was then called to give evidence merely on the existing practices and policy of the Association. It may be of interest to the majority who have never suffered the misfortune of being summoned before the Disciplinary Committee to know something of the ambience and atmosphere of the hearing and the manner of conduct of business, if only the better to appreciate the ordeal sustained by our seven Members—quite apart from the length of time this cloud had been hanging over them.

As a witness, one waited to be called in a small waiting-room, which I was mildly disconcerted to find was occupied also by Mrs Gardiner, and where the time dragged in stony silence. On being summoned to the court one was ushered to the witness box situated at one end of the large courtroom and sworn in. Above was a crowded Press gallery (in which Mrs Gardiner had now reappeared). The President of the Committee and his advisers were seated at a long raised desk at one side halfway down the courtroom, whilst prosecuting and defending counsel with their legal entourage occupied the centre of the room. The defendant Association Members were seated in a row to one side, a sight which compelled a surge of sympathy; here were seven hard-working and skilled surgeons, three of whom had been Presidents of the Association, caught up in this legalistic web which had arisen from circumstances outside their control and whose action, to any clinician engaged in normal private practice, would appear to be blameless. Beyond, extending to the far side of the room, sat the members of the Disciplinary Committee; their number was impressive and presumably representative of the varied functions of the GMC, these members not necessarily having experience of clinical practice. The procedure permitted any member to intervene in the cross-examination of a witness by raising his hand to ask the witness a question. The right was exercised freely, sometimes with questions which appeared not directly relevant to the immediate matter of cross-examination. The type of question, however, did tend to reveal the preconceived opinions held by the questioners, showing an element of mistrust of plastic surgery generally and of cosmetic surgery in particular, and giving the impression that for a consultant to see a patient without the intervention of a GP was in itself an ethical crime—even if the patient emerged from Timbuctoo. My impression was of an atmosphere of general hostility, and I felt that I was in a real star-chamber. I had hoped to be able to make some small contribution in support of the Association and, to show the difficulties experienced, had come armed with specimen correspondence demonstrating how patients in need of treatment had been blocked by their GPs, but no such opportunity was afforded in cross-examination (and of course there was no counsel representing the Association to present its case). I explained how the BAPS had now changed its policy and dissociated itself from the lay press, and managed to get in the view that this meant raising a barrier which might lead the public to seek the services of unregistered practitioners; the letters of enquiry still being received showed that there was a real need for accurate information. I was inevitably asked how it came about that my own name did not appear on the London list furnished to the public, although I was practising in London, and to this there could be no satisfactory reply. I left for the relatively fresh air of Hallam Street in a profound state of dejection. Finally, all defence counsel addressed the Committee. The fullest and most informative address was made by Mr J. T. Molony who had been instructed by the solicitors of the Medical Defence Union. The suggestion had been made three days ago, he said, that the BAPS was a sort of advertising agency for public and private advantage, that its standing as a learned association of professional people was nothing but a cloak for personal advantage. Its *bona fides* had now, however, been established beyond question. It was an honourable and normally conducted professional society. It had applied itself to the advancement, in a professional and scientific sense, of its own field of specialist interest. The

activities which had led to the present inquiry had taken place under the wing of three Honorary Secretaries, busy men who were getting nothing out of it and were, of necessity, delegating routine matters to others. Plastic surgery held an interest for the general public perhaps peculiar to that branch of surgery, very likely because, as Mr Leigh Taylor had suggested, it was not the concomitant of illness. It was associated with womanly beauty, and it was impossible to stop the women's papers and the national papers writing about it.

> "Is it in the public interest", he asked, "that such articles should be full of rubbish, as they may well be, or shall they be as correct as they can be? When Sir Archibald McIndoe, in 1954 and 1959, checked the two articles about which we have been talking was he doing something wrong, or, as I venture to think, was he doing something sensible? He was approached by people who knew him personally and who said, 'We are going to do this. Will you help us to get it right?'. Ought he to have said, 'I am sorry, but I cannot associate myself with this publication in any way'? He did not do that, and that gentleman, now deceased, has caused an awful lot of trouble for those who have remained in the profession.
>
> In my view, a fair view of the position is this. You cannot stop the public being interested, but there is no harm in seeing that that interest is stimulated in a way which correctly represents the scope of this sort of surgery and does not create false hopes and embarrassment for those who make use of it. It must not, of course, be used for personal advertisement.
>
> Mr Boydell suggested that this was an echo of Gardiner's case. It is a very faint tinkle, hardly more than is evoked by the fact that the name of Gardiner appears once again. The difference is obvious. No one here is advertising himself for his own professional advantage. Everything that has happened has been under the wing of a reputable professional body. When there is public interest in these matters, is it right that a professional body should turn away *bona fide* inquirers? ... Education is taking its toll of ignorance. People are becoming more knowledgeable and interested and are no longer to be told 'This is our holy of holies; you shall not enter or probe.' We have to move a bit with the times; the old idea of shutting the public out is out of date.
>
> Was the giving of names advertising or the response to a real need? The rule of going first to a general practitioner could not be universal. It was essential to be realistic where for one reason or another approach through the normal channels was not a practical way of dealing with an individual problem. There might be some reluctance to put plastic surgery in a class of its own, but to some extent it is in a class of its own. Let us view the Association of Plastic Surgeons as a closed shop; who is outside clamouring to get in? There is nobody because, on the evidence, everybody who attains the standards laid down by the Joint Committee of the Royal College of Surgeons and the Association is in fact a full member of the Association."

The verdict

After the Committee had sat for an hour in camera the President announced its welcome decision, that none of the seven surgeons was guilty of any of the charges, made in the following terms:

> "The Committee have found that none of you has advertised for the purposes of obtaining patients as alleged in the charge, and accordingly that none of you has combined to advertise. The Committee have, however, found it proved that you have shown yourselves prepared to accept a patient, notwithstanding that you knew that the patient had been induced to seek your services in the circumstances alleged in paragraph (4) of the particulars. But this finding of fact is in the opinion of the Committee insufficient to support a finding of infamous conduct in a professional respect. The Committee have accordingly recorded their finding that you and each of you is not guilty of infamous conduct in a professional respect in relation to any of the matters alleged against any of you in the charge."

The President continued with a rider which was evidently directed to the Association rather than to the seven surgeons alone. He said:

> "The inquiry has however disclosed a state of affairs which the Committee could not view without serious misgiving. In particular, the Committee have noted with much concern the following circumstances.
>
> 1. Officers or members of the British Association of Plastic Surgeons have, wittingly or unwittingly, co-operated in the publication in the lay press of articles calculated to stimulate

members of the public to apply to the Association for information about the services of plastic surgeons.
2. The Association have subsequently made available to persons who applied to them as a result of such articles the names of a limited number of plastic surgeons, all Members of your Association.
3. Members of the Association have been prepared to accept patients who have been led to seek their services in this way.

The Committee are concerned that members and officers of an association of specialists should at any time have lent themselves to such practices. The Committee trust that note will be taken of these proceedings and that there will be no recurrence of the events."

The aftermath

As might be expected, the affair attracted a great deal of publicity both in the lay and the medical press worldwide. In an attempt to stem the tide of speculation and comment, George Morley wrote the following letter for publication to the Editors of the *Lancet* and the *British Medical Journal*:

Plastic surgeons and the GMC

Sir,

The British Association of Plastic Surgeons has taken notice of the observations of the President of the Disciplinary Committee of the General Medical Council on November 25, with the respect which is due to the authoritative tribunal of all registered British medical practitioners.

Our colleagues of the medical profession may be assured that the serious misgivings will be allayed.

George H. Morley
President, British Association of Plastic Surgeons

I thought at the time that we were, perhaps, gratuitously eating a piece of humble pie having previously been at such lengths to justify the policy of the Association; however, the decision to publish such a letter was no doubt politically wise. George Morley also wrote to the President of the GMC:

5th December 1961

Dear Lord Cohen,

I must inform you that the British Association of Plastic Surgeons has taken notice of the observations of the President of the Disciplinary Committee of the General Medical Council on November 25th, 1961, with the respect which is due to the authoritative tribunal of all registered British medical practitioners. Our colleagues of the medical profession may be assured that the serious misgivings will be allayed.

I have today sent a letter in similar terms to the Editors of the *British Medical Journal* and the *Lancet* for the information of the profession at large.

I feel that a useful purpose would be served if I had the opportunity to tell you the steps we propose to take and it would give me great pleasure to call upon you at any time except Monday and Tuesday, December 11th and 12th when I am otherwise engaged. If you agree to this, perhaps you would be kind enough to give me an appointment . . .

This request for an interview was courteously declined by Lord Cohen after consultation with his colleagues, but he said that he would welcome any further details of the proposed steps to be taken and would communicate these to the Disciplinary Committee. George Morley replied to the effect that, as Lord Cohen was aware, the chief grounds for misgivings had ceased in 1959; however, further steps were being taken by the Association (to be described below) which would culminate in a special General Meeting of the Association in July 1962, following which he would furnish Lord Cohen with a full list of final instructions.

Meantime, coverage in both lay and medical press continued. Predictably, the lay press tended to view the affair as evidence of a struggle against an authoritarian system to provide open information, opinion aligned in favour of the past practices of the Association. One columnist wrote: ". . . any attempt on the part of the Press to help readers find a suitable surgeon comes up against the medical profession's ban on advertising. If I gave (as I'd dearly love to) enquirers a list of surgeons, they could be struck off the register for advertising! Yet dozens of readers say their own doctors refuse to help. Correct procedure is for the family doctor to write to the British Association of Plastic Surgeons, 47 Lincoln's Inn Fields, W.C.2. The Association can only give information to doctors though. What a dead end!"

The Beauty Editor of the *Daily Mail* wrote to the Association even at that stage, suggesting that it would be a good idea to issue a complete list, in alphabetical order, of all qualified plastic surgeons

throughout Britain. "It is rather ironical," she said, "that the GMC enquiry must have been a wonderful involuntary advertisement for all the doctors concerned, and I should think they must be booked up for years ahead!" In the medical press, as might be expected, specialist opinion in general, though not in every case, was sympathetic to the BAPS. The correspondence from general practitioners was adverse, ranging to the abusive. One such, for example, accused the Association of "having been caught stealing the apples"—a gross travesty of the facts. Another wrote the following gem to "Mr Morley" to say that ". . . our estimate of Plastic Surgeons themselves might be raised if they publicly campaigned for the reinstatement on the register of Mr Gardiner (sic), whose main fault, in the opinion of most of us, was that he did not sin in the best company". The *British Medical Journal* carried a lengthy leading article which was very restrained in tone. After commenting generally on the points at issue, not forgetting the dilemma of the patient as well as that of the doctor, the author concluded that, "The ordeal of inquiry undergone by the seven plastic surgeons last week will have served at least one valuable purpose if it brings sharply home to doctors the need for scrupulous care in their relationship with each other and with the people among whom they live".

However, the immediate task was to take urgent steps to stabilise and re-unify a troubled, confused and potentially divided Association. It was decided to set up, at the earliest possible moment, a powerful sub-committee of the Council, with the following suggested membership: J. P. Reidy (President-Elect for the forthcoming year), R. P. Osborne (Treasurer), J. S. Tough, G. M. FitzGibbon and George Morley (later to be elected Chairman). The terms of reference were hastily evolved by George Morley in consultation with all concerned, including our solicitors, in time to present to Council at its next meeting on December 1st, 1961. These terms of reference were:

1. *To take notice* of the observation of the President of the Disciplinary Committee of the GMC on 25 November 1961 and of matters leading thereto.
2. *To consult* with leaders of the profession (*e.g.* the Presidents of the Royal Colleges, of other specialist associations, of general practitioner associations and College, and the British Medical Association) *to determine*:
   (a) A proper, lawful and ethical method of responding to calls for medical or surgical aid from sundry persons who approach a Consultant or a Consultant's association directly, either
      1. because they claim that they do not have a regular general practitioner in the United Kingdom, *e.g.* patients normally resident abroad;
      2. because they have consulted their general practitioners privately or under the National Health Service with a view to being referred to a specialist for some particular form of treatment, but the general practitioner has not seen fit to agree with the patient's request;
      3. because they do not wish to consult their general practitioner for some personal reason.

   (b) The desirability or otherwise of urging legislation or other means to protect the public from the publication of improper, false, or misleading information on medical matters whether in the Press, by broadcast, or by other means;
   (c) Whether the practice of unregistered practitioners should not be controlled either directly or indirectly by changes in the law.
   (d) How properly and ethically the public should be kept informed of advances in Medicine; how to advise the public *pro bono publico* without advertising to that public.
3. To report to the Council on progress and especially for consideration prior to the Extraordinary General Meeting called for the Summer Meeting of the BAPS in 1962.
4. For these various purposes, to consult legal advice as shall be requisite from solicitors: Mr Leigh Taylor of Hempsons, solicitor to the Medical Defence Union and/or Mr Hawkins of Le Brasseur & Oakley, solicitor to the Medical Protection Society.
5. The terms of reference as above to be a guide and not a restrictive upon the Committee from including matters which may arise from a study of this problem.
6. The Committee will appoint its own Chairman on commencing business at its first meeting.
7. The Committee should be empowered to make recommendations on the business procedure of the Association and be able to take advice from whomever it wished.

Council duly met on December 1st, faced with an ensuing Annual General Meeting. The above Committee was formally established and its powers authorised. Letters had been received from two

Scottish Council members of the "I told you so" type, but both asserted their strong loyalty to the Association and their determination to do all they could to uphold it. The affair had upset the overseas membership, where conditions of practice and patient referral differed from the home country. The overseas member of Council from Australia was later to write:

> . . . You will realize therefore that we have to bear the brunt of this adverse publicity and I feel sure the same has happened in New Zealand, South Africa, Canada, and elsewhere . . . Decisions taken by the Council and criticisms of the Council by anybody, be it the General Medical Council, or anyone else, are of Commonwealth, indeed world-wide significance in relation to Plastic Surgery . . . I must say that what disturbs me most is the passive acceptance by the Association of certain censures laid upon it by the General Medical Council and in particular that censure which referred to the acceptance of patients in any other manner than by reference from a general practitioner . . . if the Association as a whole, through its Council and President, accepts the censure and undertakes to abide by the expressed opinions of the General Medical Council, it might be assumed that this is Council policy hereafter and binding on members wherever they may reside. In short, Commonwealth members of the Association, whose views on this matter may differ from their English colleagues and whose conditions of practice and specialist referral may similarly differ, may have to seriously consider their position as members. I cannot therefore support the letter of the Past-President appearing in the recent *British Medical Journal* issue, whose implication is—"we have been naughty boys, we will not do it again". I believe that this letter was ill-considered and that far more thought should have been given to the matter before this statement was made . . .

The AGM which followed was turbulent, with Members vociferously expressing a wide variety of views and, in general, an atmosphere of confusion and mis- or undirected anger at the turn of events. However, the announcement of the formation of the special committee, which would report back to an Extraordinary General Meeting to be held in the summer, achieved some stability.

The Sub-committee held its first meeting on January 11th, 1962, and in March 1962 George Morley as Immediate Past-President circulated a full memorandum to all members carefully explaining the circumstances which had led up to the action of the GMC, and the *raison d'être* of the actions taken subsequently. At a Special General Meeting held on July 12th 1962, the recommendations of the Sub-committee were accepted by the Association, following which this unique event in the history of the BAPS commenced its recession into the limbo of the past.

If there was fault, it would seem evident that the collision with the GMC occurred as a result of failure of correct administration of the BAPS, and was only very indirectly related to those who chanced to have been caught personally in this medico-legal trap. It should be remembered that the Association was still a relatively young organisation, still emerging from the early days of its inception when it was very much controlled by a small hierarchy of senior Members. Even with its rapid expansion in numbers, there remained a tendency for its officers and senior Members, with the best intentions and the highest aims, to institute policies and practices which were never ratified by its Council, still less by the Membership as a whole. The establishment of connections with the lay press against a background of cosmetic surgery was an obvious minefield and the failure to obtain legal advice over, or Council sanction for, the practices pursued an evident error of judgement. If Council had been properly aware of its own policy in this respect, and if legal advice had been obtained at the outset, these events would in all probability never have occurred.

The General Medical Council was very properly concerned with the maintenance of the ethics of the profession, the natural corollary being that this in itself would lead to the best medical service for the patient. However, it is left as an exercise for the reader to consider whether, in this instance, the action taken by the General Medical Council really furthered the interests of the patient or whether it did no more than shore up our peculiarly British system of patient referral, which had proved its efficiency in general but in this particular context had been found wanting.

The First European Congress of Plastic Surgery, 1969

The International Confederation of Plastic and Reconstructive Surgery, as an expanding and developing organisation, had decided at the Rome Congress in 1967 to form sub-groups of Societies in certain areas of the world, namely (at the outset) the European and Asian-Pacific Sections. These sections would hold their own international meetings at four-yearly intervals, timed to take place two years after each full International Congress of the IPRS, and the host of such intervening section meetings would be the National Society of the country elected as venue. Thus a European Section was formed, with David Matthews as Convener and Co-ordinator of the Administrative Committee, and this country received the honour of being chosen as host for the first meeting to be held in 1969.

As Vice-President of the BAPS in 1968 and President in 1969 I found myself responsible for organising this event, a new venture for which the nearest precedent was the International Congress held in London ten years previously; however, I had reasonable time to plan the arrangements. I was most fortunate in the strength of the support available for general and detailed organisation. The highly energetic and capable Honorary Secretary of the BAPS, Raoul Sandon, proffered his London family business premises (including the assistance of the staff, notably the chief clerk, Mr P. Eddy) as the HQ office for the meeting—a generous act which, by centralising the administration, greatly facilitated all the organisational work involved. In addition, the redoubtable Miss Margaret Bennett, as chief of the Secretariat at the Royal College, contributed her expertise from long experience in conference organisation. David Matthews and his secretary, Miss McClaren, put in a great deal of background work handling the administrative details with the Societies of the other countries of the European Section. Finally at East Grinstead, my colleagues Percy Jayes, Redmond McLaughlin, Robin Beare, John Cobbett and Tom Cochrane were ready to form a local organisational committee and we prepared enthusiastically to undertake individually the various tasks essential in running such a conference—food, transportation, scientific and social programmes, accommodation, *etc.* Mr Percy of Down Bros, Ltd undertook to organise a trade exhibition.

The obvious decision was to hold the Congress in place of the normal BAPS Summer meeting, and we fixed on June 15th to 19th.

Location and finance

As a summer meeting we felt that it would be pleasant to vary the venue from London, with its transport and accommodation difficulties apart from expense, and Brighton seemed a good choice, having reasonable communications by rail and air from Gatwick airport, ample accommodation in various grades, and a recently built full-scale conference centre in the Hotel Metropole complex, together with a welcoming civic administration. Since this type of meeting had not been held before, the besetting problem was to estimate the likely number of participants. My aim throughout was to keep individual costs low (£12 registration) in the hope of attracting attendance from as many European countries as possible. However, the Congress had to be self-financing and there was always the background fear that from faulty financial estimation we might inadvertently saddle the not-too-well-endowed BAPS with debt. In the event, we were lucky with our estimate of the imponderable factors and came out at the end with a modest profit of about £500 from a total expenditure of some £6,000—a sizeable sum in 1969. I was offered a choice of two conference halls, a large main hall which we could not have filled,

and a less resplendent smaller hall which might prove to be inadequate for the estimated attendance. I opted for the larger hall and had to book this at the outset. Unforeseen events were later to change this arrangement.

Promotional literature was designed and printed, and forwarded to all the European Societies together with invitations to register and participate with papers, films or exhibits. This circulation led to my first minor setback, in the form of somewhat distressed correspondence from Bill Manchester in New Zealand, General Secretary of the IPRS, to the effect that the title of the meeting should have read "The First Meeting of the European Section of the IPRS." The word "Congress" had apparently been reserved for the full world meetings of the IPRS. This was a justifiable criticism, and the problem had arisen solely because of my own virtual ignorance of the political and administrative structure of the parent organisation at that time—a shortcoming to be remedied later when I succeeded him as General Secretary! It was really too late to make changes without creating confusion, so we continued under our chosen title notwithstanding. We had also adopted an IPRS "Europa" logo designed by Raoul Sandon for our letter headings, which was viewed, a little unreasonably I thought, as a deviation from the strict code of practice of the IPRS.

In the light of unfortunate experiences at some previous international meetings, we took particular care to ensure that participants would be strictly restricted to members of the European Societies. Any applicant not on a National Society list required to be authorised both by the relevant Society as a guest and by our own committee.

Potential disaster

About three weeks before the meeting, whilst dining at the Reform Club, a friend came over to tell me that it had just come through on the news teleprinter that the Conference Centre in Brighton was in flames. Thinking this to be merely a bad joke, I checked the teleprinter to find that the roof of the main conference hall had just fallen in. I spent a poor night wondering how at this late stage, with all our local and international arrangements complete, it would be possible either to change the location or even to cancel. It thus came about that the following morning Raoul Sandon and I found ourselves in Brighton surveying a scene of acridly smoking ashes and embers. However, the smaller auditorium fortunately proved to be still intact and with the co-operation of the civic officials who organised a massive clean-up operation, we were enabled to shift all our arrangements to the smaller hall, a move which despite some difficulties did have the benefit of reducing our overall costs.

Scientific meeting

The official language of the Congress was to be English. The possibility of simultaneous translation was explored fully but had to be abandoned because of prohibitive costs. We arranged that each Session should have a European chairman accompanied by a British vice-chairman.

The Congress was attended by 309 full members from 18 European and 4 non-European countries (members having dual membership with European Societies). At the Opening Ceremony on 16th June (Fig. 12.1), after I had formally declared the Congress open, the Mayor of Brighton (Alderman Frank Masefield Baker) also gave a welcoming address, followed by David Matthews as Co-ordinator of the Administrative Committee of the IPRS, and Dr J. Hage, the Delegate from the Netherlands. Dr Hage was kind enough to extol the virtues of the BAPS and its Journal, and the quality of the training arrangements for plastic surgeons in Great Britain.

There had been an extremely good response to requests for papers, films and exhibits, necessitating considerable selection. Our primary aim in this respect was to select the best scientific material whilst at the same time, whenever possible, securing representation of all the constituent European nations. It is perhaps regrettable that publication of the transactions of the Congress was not considered practicable; however, this left the speakers free to offer their papers for publication in the journals. A general survey of programme subjects and chairmen of sessions may be of interest:

Congenital Deformities: Prof. Teich-Alasia (Italy)
Maxillo-facial Surgery: Prof. Trauner (Austria), Prof. Schuchardt (Germany)
Cleft Lip and Palate: Dr Edith Frederiks (Netherlands), Dr Fogh-Andersen (Denmark)
Research and Anatomy: Dr J. Hage (Netherlands)
Homografting: Dr John Converse (France & USA)
Breast Surgery: Dr J. O. Strömbeck (Sweden)
Hand Surgery: Dr V. Arneri (Yugoslavia)
Eyelid Surgery: Dr R. Mouly (France)

Fig. 12.1 Opening Ceremony of the First European Congress (from left to right) Jaco Hage (Netherlands), Alderman F. M. Baker (Mayor of Brighton), J. Watson, D. N. Matthews, R. P. G. Sandon.

Burns: Dr M. Derganc (Yugoslavia), Prof. H. U. Buff (Switzerland)
General Soft Tissue Repair: Dr Vilar-Sancho (Spain)
Malignancy: Dr H. Schelderup (Norway)

Fifty-seven scientific papers were read and 37 films shown, with 19 exhibits in the scientific exhibition. There were 14 trade exhibitors. As the papers were all delivered by the speakers in one hall, there was no competition between speakers—an aspect which was appreciated by most participants but which is possible only at a relatively small congress. Perhaps the most memorable features of the Scientific Exhibition were the three scientific exhibits by Paul Tessier from Paris of his cranio-facial work. A film by John Cobbett on free pollicisation with the great toe demonstrated the advance made in the micro-vascular field at that time. It may be noted in passing that no specific session was devoted to cosmetic surgery—the few contributions in this field appeared in the film programme.

Time and space has to be found on these occasions for various administrative meetings. In the course of this Congress there were meetings of the Council of European Delegates, the Council of the BAPS, and the Comité d'Étude sur la Chirurgie Plastique of the Union Européen des Médecins Spécialistes. At the latter a proportion of the agenda was taken up with a lengthy discussion of the problem of plastic surgery as a monospecialty in Europe, with particular reference to the situation in Germany at that time. At the Congress were representatives of the old (mixed membership) and new (monospecialist) Societies in Germany, a situation which led to open verbal conflict and to some embarrassment. This particular problem confronting the IPRS was not to be resolved for a further two years and, sadly, was impossible to resolve to the satisfaction of all concerned in Germany.

Social programme

Apart from a good deal of individually organised hospitality within the Hotel Metropole complex

(which contained a Casino in its basement!), a full social programme had been arranged. Here the wives of my colleagues on the local organising committee at East Grinstead played sterling rôles. There were various optional activities which included attendance at the Brighton Races, the Theatre Royal, shopping for antiques in "The Lanes", and several local places of interest to be visited; with some difficulty we had also been able to secure a block booking of seats for the opera at Glyndebourne (Pelleas and Melisande). The latter performance—unfortunately it rained—was appreciated greatly in particular by Professor Sanvanero-Roselli, a pillar of the opera in Milan. The Mayor and Mayoress gave a civic reception at the Royal Pavilion in Brighton; this was an interesting location, but I was somewhat disconcerted to find the borough cash-registers in operation when drinks were served—a matter which we did not seem to have discussed in the original planning!

An official banquet, followed by dancing, was held in the Hotel Metropole, and as guest speaker I had asked an old acquaintance, Lord Shawcross, then Vice-Chancellor of the neighbouring Sussex University. Hartley gave a masterly speech as a toast to the Congress. I became slightly alarmed at the tone of this speech as it developed, extolling the qualities of the British nation in Europe and its superiority, with some reference to the Nazi war trials at which he had been prosecutor; however, nobody walked out!

In retrospect

Looking back over 20 years on this Congress as a whole, it will be appreciated that it was mounted almost entirely by the voluntary efforts of those concerned, who had to set aside a great deal of both time and effort over many months. Later feed-back suggested that the Congress had been appreciated by the participating Societies and rated a success. It was certainly enjoyed by the host society! It is probable that nowadays the organisation of such an affair would have to be turned over to a professional team, probably with greater efficiency but at the cost of increased expense to the participants and perhaps some loss of personal touch.

BAPS meetings

The excellence of the menu for the dinner of the inaugural meeting of the BAPS on November 20th 1946 doubtless reflects the affability and grace of the occasion. Mock turtle soup was followed by roast pheasant, game chips, sprouts and cauliflower, and capped with charlotte Venetienne. Each course, extravagant in those days of austerity and rationing, was accompanied by an excellent wine, then port and brandy! Mercifully, not all the elegance of the pre-war days had been forgotten. The scientific programme of that first meeting (if there was one) has been lost; perhaps it was of secondary importance to the coalition of kindred spirits, foetal in nature but destined to become the adult to which it has now matured.

The second meeting, held in March 1947, was addressed by the President, Sir Harold Gillies at 5 pm and followed by dinner at the Royal College of Surgeons in London (25/- per head). The first recorded scientific session took place in the following November; this meeting lasted all of one afternoon from 2 pm, contained a paper by Rainsford Mowlem on "Clinical reminiscences of the American Plastic Surgery Conference" and one by Richard Battle on "Wartime experiences in No. 1 Maxillo-facial Unit"—doubtless spiced with the light-hearted witticisms that were his hallmark on such a potentially serious subject. An open discussion followed on the "Use of cartilage in reconstructive surgery", with prepared contributions by Gillies, William Wardill, J. B. Cuthbert and Pomfret Kilner—fireworks here with such dominating characters!? On the morning following, the meeting took itself to Hill End Plastic Surgery Unit, St Albans and in the afternoon to Rooksdown House, Basingstoke for dinner. Transport arrangements were "friendly", those with cars taking those without, all under the co-ordination of John Barron, the first Secretary.

Papers seem to have been inordinately long compared with those of today. At the Winter meeting in 1948 three hours of the afternoon were occupied by three papers and one "Brief Communication". Hopefully for the enthusiastic audience the time sped by.

The early meetings were dominated by Gillies, Kilner and McIndoe; discussions were often swayed by them. Because there was little in the way of literature, advances and ideas were conveyed by word of mouth, for which the BAPS meetings were a main forum. The senior registrars were very active and the research-minded were a prominent pressure group.

In 1948 the Association numbered 56 Full Members and 18 Associates and a full turnout was expected at all the meetings (Fig. 13.1). Since these were held three times a year until 1953, a considerable burden was placed on the Secretariat and the host Units. Two of the meetings were outside London and the Winter meeting, as at present, was at the English College of Surgeons (Table 1).

Considerable kudos was attached to the hosting of the meeting. This is clear from the individuality of the printed programmes each Unit produced—not in those days the standard programme pamphlet with the Association crest emblazoned on the front. Programmes tied with a blue bow, large, small, multicoloured, printed in script, printed in Roman, vied with each other for attention. The enthusiasm of that tightly-knit, intimate membership at its meetings is plainly apparent, a legacy which still exists in the expanded membership at present-day meetings.

The social side

The social side was regarded as important from early days, with the ladies encouraged to play their part. To this day the Ladies' Social Programme is an integral part of the arrangements of BAPS

Fig. 13.1. The Association's Meeting at Stoke Mandeville, 1948. BACK ROW (*left to right*): P. H. Jayes, A. L. Schofield, D. N. Matthews, T. C. Henry, R. J. Cowan, C. A. Honig, N. C. Hughes, J. Watson, I. Arneodo, A. E. Panter, R. Shackleton, M. S. Harrison, C. De Rynck, W. Bakewell, C. R. McCash, R. H. Dale. THIRD ROW (*left to right*): J. North, H. De, A. E. Flatt, G. FitzGibbon, J. Grocott, E. E. Lewis, M. Barnes, D. A. Kernahan, J. H. Kirkham, P. A. Toller, D. C. Bodenham, J. S. P. Wilson, M. Shaw, W. G. Holdsworth, J. B. Shield, W. Loennecken, G. Johnson, J. C. Mustarde, J. A. P. Bowen, J. M. Banks, J. R. Ascot, J. W. Bowden, J. Poilus, R. Millard, J. R. G. Edwards, J. McCagie. SECOND ROW (*left to right*): J. Davies, G. H. Morley, C. R. McLaughlin, J. Potter, N. L. Rowe, E. Dalling, J. H. Hovell, C. Heanley, J. Szlazak, R. Murley, H. J. Richards, F. Braithwaite, F. T. Moore, T. Gibson, J. Bunyan, E. W. Peet, D. G. Walker, A. H. Champion, P. Clarkson, J. M. Rouillard, P. H. Beales, A. J. B. Phillips, A. H. M. Littlewood. FRONT ROW (*left to right*): R. G. Mason, J. P. Reidy, G. Olsen, P. Fogh Andersen, A. B. Wallace, G. Aufricht, M. C. Oldfield, R. P. Osborne, Neal Owens, R. Mowlem, Milton W. Adams, Sumner L. Koch, T. P. Kilner, H. D. Gillies, E. Prideaux, W. Hynes, L. Colebrook, J. N. Barron, A. Ragnell, A. B. Clery, N. L. Eckhoff, H. E. Blake, O. T. Mansfield, J. S. Tough, R. J. V. Battle.

Table 1 The Association's Summer Meeting Accounts, 1949

Summer Meeting, Birmingham Accident Hospital, June 1949

Expenses		
53 lunches at 7/6d each		£19.17.6
53 morning coffees at 1/- each		2.13.0
53 teas at 2/9d each		7. 5.9
Ale for lunch		2.14.8
55 dinners at 11/6 each		31.12.6
Wines and cigarettes at top table		17.15.1
Gratuities at dinner		4.16.0
Printing dinner menus		3. 2.6
Bouquet for Lady Mayoress		1.10.0
		91. 7.0
Receipts		
42 Teas at 2/9d	5.15.6	
43 Lunches at 8.6d	18. 5.6	
43 Dinners at 15/-	32. 5.0	56. 6.0
	Deficit	£35. 1.0

Summer Meeting, Hill End Hospital, St. Albans, 1950
The registration fee will be at the rate of 10s. per day. This will cover all meals and drinks. Please remit immediately either 10s. if you are coming for one day or £1 if you intend to be present both days, to the Secretary, British Association of Plastic Surgeons, 45 Lincoln's Inn Fields, London W.C.2

meetings. The 1953 meeting at Salisbury is often recalled as an example of the good socialising. Accommodation was provided in the Teachers' Training College within the Cathedral Close whose gates were locked at night. Thus Members and ladies had no choice but to get to know one another within the closed confines of the Sanctum.

Until the mid-1950s the duration of the meetings varied from half to one-and-a-half days, but at the longer meetings at least half a day was allocated for "visiting the unit" or a visit to a local factory or beauty spot, a euphemism for the informal exchange of views. Of the scientific sessions, topics were not unlike those of today but, conscious of its World War origins, a considerably greater number of papers were presented on jaw and maxillo-facial problems of reconstruction. In 1965 a two-day meeting was shared equally with the British Association of Oral Surgeons.

In 1959 the BAPS hosted the International Congress in London at the Royal College of Surgeons under the Presidency of Rainsford Mowlem. Some 600 delegates and their wives from 51 countries from Czechoslovakia to Uruguay registered. The scientific sessions were liberally intermingled with other events: a reception at the Guildhall, a Government reception, a gala soirée at the Royal Opera House and a banquet at the Dorchester Hotel. An ominous note appears at the foot of the page: "Since accommodation for these functions is limited not every Congress Member will be able to attend". How much anguish was engendered by so great a restriction! Where else could one gain access to such a plethora of grace and favour, all for the fee of £15 including all the scientific meetings and social events. But then a double room with bath in a five star London hotel could be booked for £7 10s. 0d. a night!

Format of meetings

From the early 1960s the meetings took on more of the present day format. Symposia occupying a half-day were held on the Hand (1963), Cleft Lip and Palate (1964), Head and Neck Cancer (1966), and these have continued intermittently to the present day.

In the spring of 1965 the Summer meeting moved to Leiden, Holland under the Presidency of Benjamin Rank (now Sir Benjamin). Although it was, and is, the custom for the President's home Unit to host the Summer meeting, he felt clearly that the venue of Melbourne might prove to be a few bridges too far! One-and-a-half days were devoted to the scientific papers, the norm up until then, but in 1966 the Summer meeting at Bristol occupied two full days with a new record number of papers.

The second foray overseas for a Summer meeting occurred in 1972 when the BAPS met jointly with the French Society of Plastic and Reconstructive Surgery at Deauville, perhaps appropriately, in the Casino. The "entente" extended to dual projection with simultaneous translation for those not quite familiar with their opposite number's language, a visit to Bayeux and the Normandy beaches. The programme, written in both languages, ends with a subtle difference, perhaps representing how each country viewed the gravity of the business in hand; the English programme ends with a simple "End of Session", the French version with a relieved and exhausted "Fin de Travail"! In December of the same year the first Instructional Course was added to the Winter meeting and for a number of years these courses were a major feature. The Bristol meeting in 1973 introduced the printing of abstracts in the programme under the title, a great boon for the hot after-lunch sessions when attention was apt to wander away from the speakers. How grateful has many a delegate been for that abstract when

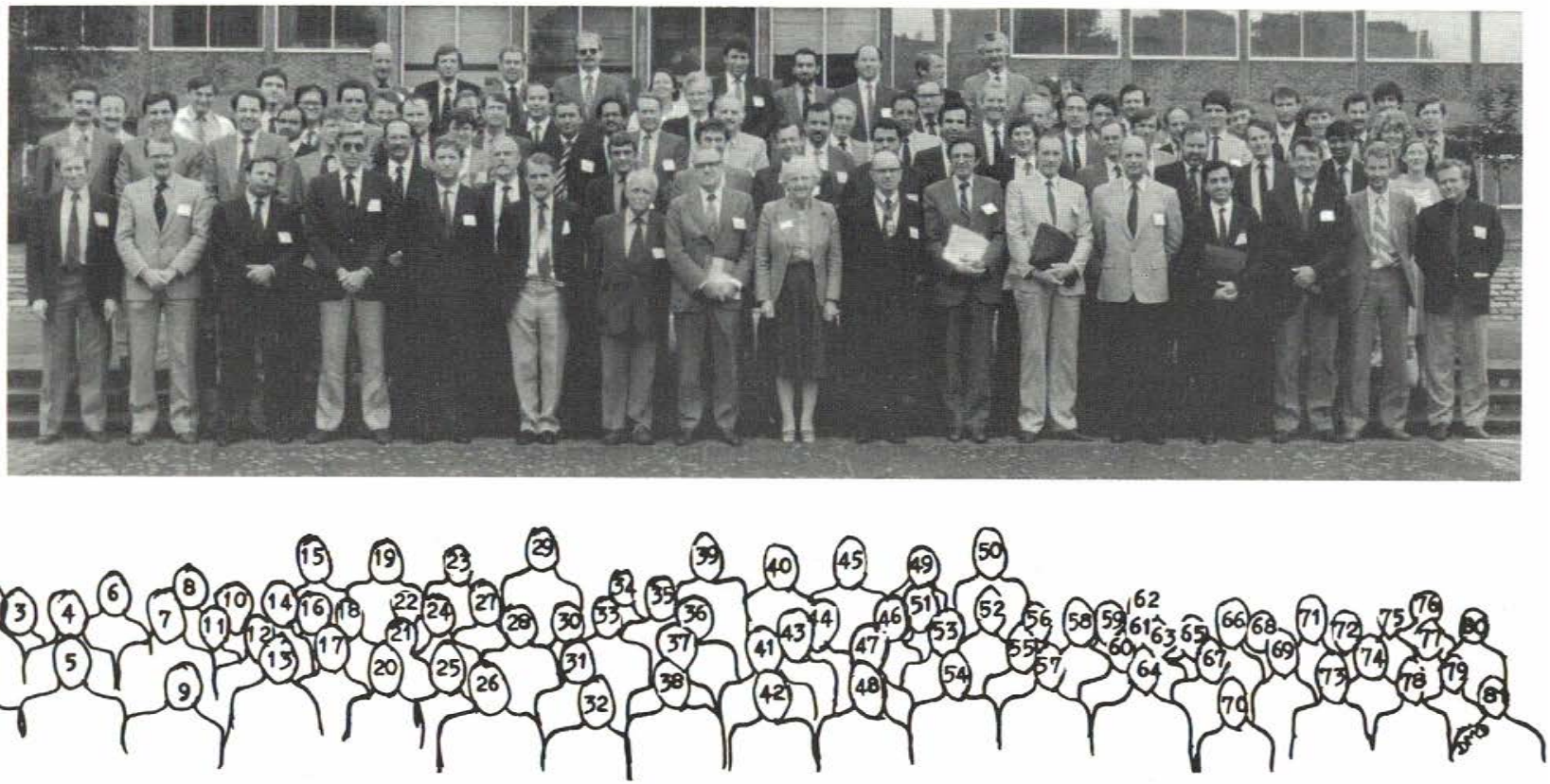


Fig. 13.2. The Association's Meeting at Liverpool, 1986. (Photograph by Mrs Dorothy M. Daw of Whiston Hospital, Merseyside). 1. D. Mercer, 2. B. C. Sommerlad, 3. P. M. O'Hare, 4. A. F. S. Fleming, 5. P. C. Nelligan, 6. C. Rayner, 7. A. D. McGregor, 8. M. A. D. S. Cooper, 9. A. Gilbert, 10. J. Laitung, 11. P. Luthra, 12. A. Bardsley, 13. A. Lamont, 14. J. Small, 15. J. James, 16. ?, 17. M. J. Earley, 18. A. Batchelor, 19. J. H. Stilwell, 20. J. B. Boyd, 21. O. M. Fenton, 22. J. Holmes, 23. J. Martin, 24. L. Sully, 25. S. O'Rian, 26. L. A. Holbrook, 27. D. L. Martin, 28. A. Rowsell, 29. Phillips, 30. S. Elekiabi, 31. M. Gipson, 32. M. N. Tempest, 33. R. F. Brown, 34. D. V. Nield, 35. A. C. H. Watson, 36. P. J. Sykes, 37. R. Paige, 38. I. W. Broomhead, 39. D. J. Whitby, 40. D. Sammut, 41. J. R. Bryson, 42. A. B. Sutherland, 43. Daib, 44. J. Colville, 45. B. H. Milner, 46. ?, 47. ?Hmza, 48. D. O. Maisels, 49. P. J. Saxby, 50. R. A. W. McDowell, 51. H. Brown, 52. P. Townsend, 53. A. A. Quaba, 54. B. D. G. Morgan, 55. J. J. McCann, 56. T. D. Cochrane, 57. L. Clodius, 58. A. F. Wallace, 59. D. Elliot, 60. D. J. Hanley, 61. ?, 62. A. L. H. Moss, 63. G. Lister, 65. W. H. Reid, 66. A. Bracka, 67. A. J. Howcroft, 68. ?, 69. J. M. Porter, 70. L. DiMeo, 71. N. J. Percival, 72. ?, 73. A. M. Morris, 74. U. Shankar, 75. N. Zoltie, 76. D. Gault, 77. M. Fahy, 78. D. M. Evans, 79. F. Wylie, 80. A. R. Green, 81. A. J. J. Emmett.

called out of his slumbers to comment on the paper just delivered.

The rise in the number of papers presented at meetings from five in 1955, 21 in 1966, 24 in 1976 to 37 in 1985 is mirrored by the lengthening of the meeting from half, to one-and-a-half (in 1949) to two days (in 1972). The length of the papers has shortened to ten or fifteen minutes from 30 or even 45 minutes in the early days, but the titles of the papers show a stubborn resistance to change although no doubt the content has altered. "Pure research" papers have always been in the minority, and a statistically valid evaluation has stood out as a welcome beacon from the newly-tried method of operation or the case presentation.

The major advances in flap design, for example, the axial pattern and "free" microvascular flaps, breast reconstruction after mastectomy and tissue replantation have all been reflected in the number of papers presented on these subjects, and in our Journal.

The Association has always been conscious of its past and in its memorial lectures rightly honour the founders of the specialty and its Association. The Gillies Memorial Lecture, the first given in December 1961 by Professor Kilner, and the McIndoe Memorial Lecture, the first delivered in December 1964 by Percy Jayes, help to remind us of our roots and stimulate the husbandry needed to look after the future, particularly the continuing search for new and better techniques, the need to convey correctly the place of the specialty alongside those of our surgical colleagues, and the pressing consequences of unprecedented financial restraints imposed on the National Health Service as a whole.

The BAPS in the Republic of Ireland

An unofficial National Branch of the BAPS is based in Cork, which includes the consultant plastic surgeons working in the Republic of Ireland. It meets once or twice a year on a fairly informal basis to discuss matters of mutual interest, and makes recommendations to the Royal College of Surgeons of Ireland, Comhairle n-Oispideal and other official bodies about the training and the needs of plastic surgery within the Irish Republic. At the present time K. C. Condon of Cork Regional Hospital is acting as Chairman, having succeeded Brendan Prendiville, and the Secretary is Denis Lawlor of Dr Steeven's Hospital, Dublin.

The BAPS meetings continue to be the forge and the anvil upon which new ideas, methods and results are hammered, tempored, polished or rejected (Fig. 13.2). The transformation of these hammer blows on the anvil, to the finesse of the atraumatic technique that we have shown to be the essence of good reconstructive work, is the justification of the Association and its scientific meetings.

Acknowledgement

I am grateful to John Barron for some of the earlier reminiscences, and to K. C. Condon for his note about Ireland.

Places at which meetings of the Association have been held

1946: London
1947: Basingstoke
St Albans
London
1948: East Grinstead
Oxford and
Stoke Mandeville
London
1949: Birmingham
East Grinstead
London
1950: London
St. Albans
London
1951: London
Edinburgh
London
1952: London
Roehampton
London
1953: London
Salisbury
London
1954: London
London
1955: Oxford and
Stoke Mandeville
London
1956: Sheffield
London
1957: Liverpool
London
1958: Glasgow
London
1959: 2nd International
Congress, London
London
1960: East Grinstead
London
1961: Halton
London
1962: London
London
1963: London
London
1964: Oxford
London
1965: Holland
London
1966: Bristol
London
1967: Roehampton
London
1968: Newcastle upon Tyne
London
1969: Brighton
(1st European Congress)
London
1970: Aviemore
London
1971: London
London
1972: Deauville
London
1973: Bristol
London
1974: Mount Vernon
London
1975: London
1976: Windsor
London
1977: London
1978: Peebles
London
1979: Glasgow
London
1980: Bristol
London
1981: Leicester
London
1982: Aberdeen
London
1983: Bradford
London
1984: Cardiff
London
1985: Cambridge
London

14

Presidents' memories of their year of office

The Editor invited Past Presidents to comment briefly on the high points and low points of their year of office and many replied—some at considerable length! Others, with characteristic modesty and at risk of inaccuracy, said that nothing of lasting interest had happened during their twelve months at the helm. Selected quotations follow.

Barron, 1953

"The Summer meeting was held in Salisbury and we were able to accommodate all the delegates in the Diocesan Teachers Training College situated in the Cathedral Close. The Close gates were locked at 11 pm, and the Close Constable was responsible for maintaining the proprieties suitable to the ecclesiastical environment. A number of delegates were not aware of this rule and engaged in explorations of Salisbury by night. It was only because the Constable was a friend of mine that we were able to arrange for latecomers to get back to the College and to their wives and friends."

Matthews, 1954

"The close circuit television to the Boardroom at Great Ormond Street was the first use of this medium to show operations at a BAPS meeting; I am fairly sure it was in black and white. In my second year in 1971 I introduced craniofacial surgery to the BAPS with the operations performed by Tessier relayed to the lecture hall in the Institute of Child Health on the big colour screen. In a way both were landmarks."

Rank, 1965

"It had been decided for the first time to hold the Summer meeting away from Britain at Leyden in Holland, in association with the Dutch plastic surgeons. This was a gesture to foster the status of plastic surgery in Holland. The Dutch plastic surgeons did most of the on-site organisation though I had the formalities to contend with as Chairman and as respondent voice of the British Association—a strange role for an Australian. Fortunately my friend, Walter Crocker, with whom I had stayed in India, was Australian Ambassador at the Hague at the time and the British Ambassador was another Australian, Sir Peter Garran. Thanks to them, we were able to dispense some special hospitality to the British and Dutch surgeons. At the Winter meeting in London, a good deal of discussion concerned the future membership of the British Association. Straws in the wind of change were obvious. The National Health Service with its fixed establishment was starting to bite; registrar training posts were becoming static. On the contrary, overseas applicants for membership in developing countries were mounting and it was becoming increasingly difficult to adjudicate on their credentials."

Fitzgibbon, 1966

"I thought, towards the end of the year, that I was really beginning to get the whole job in perspective and I think I could have done it better during a second year. I mean two consecutive years—not two separate years separated by several years. I feel sure that the Association would be better with each President serving for two consecutive years."

Gibson, 1970

"The outstanding event of my presidency was the Summer meeting which was held in the Aviemore Centre. Unlike much of Scotland's weather we had almost a sub-tropical climate which showed off the Highlands to perfection."

Bodenham, 1973

"For the Summer meeting the Hand Club, with John Barron as Chairman, and the British Burn Association with Douglas Jackson were invited to present symposia, and Roy Routledge, my colleague at Frenchay, was asked to present a symposium on head and neck cancer. Each of these, aimed at bringing us up to date with recent advances, more than fulfilled the objectives. For the Winter Meeting, microvascular surgery was a must and maxillofacial surgery was the remaining theme to be covered; the latter had been undergoing major changes with the rapid growth of oral surgery and its separation from plastic surgery. In 1971 microvascular surgery was in its infancy, yet during the following ten years it was to change the whole approach to plastic surgery and every trainee had to become competent in its practice. John Cobbett, who had pioneered microvascular surgery in this country, was invited to present this symposium. It is perhaps surprising that there was criticism in 1973 for making a profit on meetings at all. This was achieved without increasing the registration fee of charges for the events of both the Summer and Winter Meetings. Today each President is expected to make a profit for the Association."

Harrison, 1976

"I wrote 'A Review of Plastic Surgery in the United Kingdom' (Dec. 1976) and received the advice and help of Council. It was submitted to the Department of Health and Social Security who agreed that the number of plastic surgeons should be increased. I do not think that sufficient emphasis has been put on this document (an omission rectified in the Appendix to this chapter—Ed.). The highlight was the Summer meeting in Windsor. 1976 was one of the best summers ever recorded in England and the number attending was so great that enough money was made to endow the Windsor Lecture."

Buchan, 1978

"Peebles Hydro proved ideal for the Summer meeting without being too expensive. By having accommodation for the scientific and the social programmes in the same building, greater personal contact was possible and transport problems were simplified. The dinner at the London meeting on the restaurant ship "Hispaniola" was also a memorable occasion for me and I was indebted to Raoul Sandon for making this possible. The most horrifying and disturbing aspect of 1978 was the general advertising of private plastic surgery clinics. As I recall it, this subject dominated Council meetings throughout the year and culminated in a rather difficult and unpleasant AGM."

McGregor, 1979

"It might be worthy of record that I set up the idea of a tie to represent the Association. Others, of course, played a significant role in the form this took but I still claim the idea as my own!"

Routledge, 1980

"The Association's funds had become somewhat depleted and Raoul Sandon decided, contrary to usual practice, that an effort should be made to run the Summer meeting as a money-making exercise, without in any way financially penalising the delegates. This was achieved very largely as a result of the generosity of local Bristol firms, and an all-time record profit resulted (I think around £10 000). I was commissioned by the BAPS to represent it at the American Society's golden anniversary, in New York in 1981. This was an enormously big "do" and at the opening I presented a congratulatory address on behalf of the Brits together with a very fine Stuart crystal fruit compote as a gift from the Association."

Kinmonth, 1981

"The main preoccupation of the BAPS during my presidential year was the revision of the Constitution. The other recurring item of business was the Association's concern with the growing number of cosmetic surgical clinics advertising in the public press."

Barclay, 1983

"At the AGM in December the subject of the proposed Higher Diploma in Plastic Surgery was raised by arrangement, by Ian McGregor. After his statement the questions began; he kept calm, but it was clear that he might be overwhelmed by some vociferous and over-persistent individuals. It suddenly occurred to me that the Parliamentary system, whereby one and only one supplementary question is allowed, might save the day, and I announced to the next questioner that this would be the procedure that I would follow. There was no open disagree-

ment rather to my surprise. In the event, every Member who wished was able to ask his question and make his point. I think everyone was reasonably satisfied. The high point for me came after the meeting had closed, while I was still mopping my brow, when a Member not noted for his sympathetic comments, and not a particular friend, said to me, 'Well done, you kept control; they know a thing or two in Parliament, don't they?'"

Tempest, 1984

"If 1984 was, for some people, an excuse for over-indulgence in an orgy of Orwellian trivialities it was a momentous year for our Association, dominated by anxious, occasionally acrimonious and sometimes ill-informed debate of the proposal by the Royal College of Physicians and Surgeons of Glasgow to introduce a post-graduate specialist 'Fellowship' examination in plastic surgery. Many discussion papers were circulated, lengthy deliberations took place in and out of Council and with the various Surgical Colleges (in which Ian McGregor, then President of the Glasgow College, was a prime mover), culminating in the decision taken at an Extraordinary General Meeting of the Association held in Cardiff in July, later ratified after further discussion at the Annual General Meeting in December 1984, to give general approval to the proposals submitted by the Glasgow College, provided that the Fellowship would be established as an inter-Collegiate specialist qualification in plastic surgery. That proposal has compelled our Association to recognise that the pattern of training in plastic surgery in this country needs a 'new look'."

Broomhead, 1985

"Much of the year was spent in discussing proposals for training in plastic surgery, which were generally approved at the AGM in December 1985. There was considerable activity from the Growth and Development Sub-Committee, chaired by John Lendrum. Early moves to try to set up a professorial Chair and Academic Unit in Plastic Surgery were encouraged."

APPENDIX—A review of plastic surgery in the United Kingdom, December 1976

Introduction

Plastic Surgery has advanced rapidly into the modern field of surgery where it now makes an essential contribution to other specialities, and to undergraduate and postgraduate training.

The subject covers trauma, including burns; congenital deformities, particularly of the face and hands and pathological conditions, both benign and malignant. Head and neck cancer and maxillo-facial surgery have been within the domain of plastic surgery since its recognition as a speciality, and considerable advances have been made recently in cranio-facial surgery for severe facial defects, which heretofore have not been treated.

Transplantation of skin and other tissues, and micro surgical techniques, bring the subject into the forefront of modern medicine.

Rapid development has stretched facilities to the limit, as can be seen from a study of the waiting lists, and the hopelessly inadequate consultant and registrar staffing.

A questionnaire was sent to all consultant plastic surgeons in Great Britain, and thirty-six units replied. The situation of staffing in the country is:

Consultants	78	
Senior Registrars	28	(of whom 19 have completed training)
Registrars	36	
Senior House Officers	47	

Total waiting list in the country: 30,670

Population of Great Britain: 54,422,000

The Council of the British Association of Plastic Surgeons ("The Council") believes that there should be a ratio of one consultant plastic surgeon for every 250,000 of the population. This gives a total of 216.

From the 36 units which replied to the questionnaire, there was a need expressed for the immediate appointment of 19 consultants: of these, four had been approved, but not advertised because of shortage of funds. Four-and-a-half were in the process of seeking regional backing to put to the Central Department, and no action had yet been taken at area or regional level on nine.

It is the Council's opinion that all these appointments should be energetically pursued. The initiative has to come from the plastic surgeons in the regions concerned, and the Regional Advisory Committee for Plastic Surgery has to convince its Regional Manpower Committee to back its demands for increase in consultant establishment. The Central Manpower Committee has not, so far, rejected any request reaching it for an increase in consultant establishment in plastic surgery. It has, however, stated its intention to withdraw permission already granted in every medical and surgical speciality if the posts are not advertised after a certain length of time (DHSS Dec. 1975 REF. B/M97/025.)

The Council appreciates that Regional Advisory Committees in Plastic Surgery have a difficult task, because they are numerically small, in competing with larger specialities, especially in the current period of financial stringency.

The Council, and the Advisor to the DHSS, would welcome information from plastic surgeons who have experienced difficulty in getting a proposal for an increase in consultant establishment accepted at regional level.

It is important, also, to appreciate that any increase in senior registrar establishment is dependent on an increase in consultant establishment.

The Manpower Report by the DHSS (HS204. SR2A. May 1976) acknowledges the large increase in the waiting lists for plastic surgery, quoting (Table 2) a 35% increase in the decade 1965/1975. This table, when considered in relation to the numbers of consultants practising in specialities, shows that the number of patients on the waiting list per consultant is much greater in plastic surgery than in any other speciality. This same departmental document (SBH 203) also shows that in September 1975, more than 71% of cases marked as urgent had waited more than one month for admission and more than 50% of those marked as non-urgent had waited more than one year.

It is important, also, to record that the waiting list figures cannot be used to represent the full work-load undertaken by plastic surgical units, since cases of trauma, emergencies and most urgencies such as for cancer, are admitted at once and do not appear in waiting list figures.

It has also to be noted that the waiting list situation is adversely affected by shortage of nurses leading to closure of wards, reduction in the numbers of available acute beds and, in some units, inadequate operating theatre time.

The average length of stay in hospital of a plastic surgical patient has been reduced from 17.6 days in 1955 to 11.3 days in 1970, and the number of discharges per annum per available bed, over the same period of time, has been increased from 16.9 to 23.

For 1974, which are the latest statistics available, the average length of stay was 9.5 days and the discharges per available bed per year were 26.7. In this year, the average number of beds available daily was 1.7 per thousand of population, and the average daily occupation was 1.2 per thousand.

It is evident that plastic surgery is grossly understaffed in relationship to the population and its requirements in plastic surgery. It is essential for the growth and proper development of our speciality that the number of consultants should be increased to provide the necessary service.

Undergraduate training

It has been recommended that the Presidents of the Royal Colleges and the Deans of the Universities should be notified that, in our opinion, it is essential to provide undergraduate teaching in plastic surgery, and to provide basic teaching in wound care and repair, as well as the recognition of facial and hand injuries. Practical and systematic teaching should be obligatory, and part of the training should be provided in the Accident Department.

Postgraduate training

Due to lack in undergraduate training, and partly due to failure to disseminate information throughout provincial areas, general practitioners are unaware of the services that can be provided by plastic surgeons in conditions such as burns, congenital deformities, skin cancers, breast deformities and hand injuries. It is recommended that the Regional Health Authorities should be approached by the consultant plastic surgeons of the region, with a request to hold a symposium periodically throughout the year, preferably at the weekend, when better attendances might be expected.

Future developments

It has been suggested that plastic surgery may in time become fragmented, *e.g.* head and neck cancer, hand surgery, and maxillo-facial surgery. It is the opinion of Council, that these subjects should be developed individually in the larger plastic units to provide the most economical service and adequate facilities for trainees.

In regard to head and neck cancer, this branch of surgery should be developed in a unit where full back-up facilities are available and where the best service can be provided on a team basis.

Advanced knowledge in hand surgery should be acquired by one member of the plastic surgery team, and their experience should be made available to a regional, or sub-regional area, centred on a plastic or orthopaedic centre. The hand surgeon should be familiar with all branches of hand surgery, and his duties should include clinics within the Accident and Emergency Department.

The specialty of maxillo-facial surgery was discussed because of its recognition in Europe, and the need to equate standards of training and specialization. It was considered that maxillo-facial surgeons should be surgically orientated, should not necessarily be dentally qualified, but must have experience in advanced odontological techniques.

The questionnaire has shown that in the majority of plastic surgery units in this country, there are long waiting lists, shortage of staff and limited facilities. We are being prevented from providing the type of service we would wish to provide for our patients and which the public have every right to expect. This evidence is to be presented to the Royal Commission on the National Health Service and recommendation made to rationalise the plastic surgery services in order to deal with the increasing work load and other service deficiencies which have become evident as a result of this questionnaire.

Summary

1. The Council of the British Association of Plastic Surgeons has reviewed the present staffing situation in this country and is of the opinion that the number of consultant plastic surgeons needs to be increased from the present number (78) to 216, on the basis of one consultant for every 250,000 of the population.

2. The daily bed occupancy of 1.2 per thousand of population with an availability of 1.7 per thousand (67%) highlights the consultant staffing deficiency.
3. The number of patients for plastic surgery on the national waiting list (September, 1975) per consultant available to treat them is far in excess of that for all other specialities. Comparing plastic surgery with orthopaedic surgery, the figures are as follows:

	Number of consultants	Waiting list September 1975	Waiting list per consultant
Orthopaedic	593	80,829	136
Plastic	78	30,670	393

Plastic and orthopaedic surgery are both growth specialities and both are much concerned with the treatment of trauma.

4. There should be rationalisation of the development of some of the major subspecialities in plastic surgery in one or more of the major plastic units, in order to improve the quality of service, economise in facilities and personnel and expose trainees by rotating appointments to all subspecialities.
5. The number of trainees should be closely correlated with requirements for expansion and retirements. This cannot be achieved with any degree of accuracy until the proposed policy of expansion is agreed.

BAPS Council meetings

The first Council meeting of the BAPS was held on January 15th 1947. The members of Council had been elected at the inaugural meeting on November 20th 1946. Present at this first meeting were: Sir Harold Gillies (President), Professor T. P. Kilner (Vice-President), Mr R. P. Osborne (Honorary Treasurer), Mr John Barron (Honorary Secretary), Mr W. Hynes, Mr A. M. McIndoe, Mr R. Mowlem, Mr M. Oldfield and Mr. A. B. Wallace.

One might have expected this first meeting to have reached some momentous decisions, yet most of the topics were common to future Council meetings. There was already some dispute as to eligibility for membership. Members should be British nationals whose prime interest was in plastic surgery, but it was considered that this definition should be widened to include members of the dental profession and practitioners from abroad. The subscription was fixed at two guineas, with an entrance fee of three guineas. Plans were laid for the foundation of the *British Journal of Plastic Surgery*, the official organ of the Association, under the editorship of A. B. Wallace. The Secretary reported the death of John Staige Davis and recorded that an invitation had been received from the American Society of Plastic Surgery to visit their annual convention in Nashville, Tennessee.

There were four further meetings of Council in the first year of its existence. The main work was the launching of the Journal and the election of Members to the Association. Another topic which appeared regularly in the early meetings was the "Medical History of the War". The Ministry of Health was anxious that a section on plastic surgery should be written for the History. A section on plastic surgery for the War Surgery Supplements published in 1947, 1948 and 1949 by the *British Journal of Surgery* was sought. It was first mentioned in March 1947, an official invitation arrived in July and contributions were planned in March 1948. There was to be an introduction by Sir Harold Gillies. McIndoe was to write a chapter on the RAF, Murchison on the Royal Navy and Battle on the Army. The Ministry of Pensions was to be covered by Kilner and Reidy, and the EMS by Mowlem and Barron. A sub-committee was set up to correlate the chapters which had to be finished by June 1948; however, in June and September, there were comments in the Council meeting that "there were still some contributions outstanding". In November it was "complete except for one paper". There is no further information and certainly no history appeared in print*; however, one chapter by Major T. Gibson on "Primary Closure of Maxillo-facial Wounds" was published in 1986! At the end of the first year it was reported that the Association had a surplus of £203 2. 2. and that this surplus was to be invested in the Post Office Savings Bank.

The National Health Service gets started

This was a time of change in the medical profession because of the introduction of the National Health Service and there is an amusing Minute in the Council meeting of September 16th 1948 regarding pay beds: "The Council notes the extreme vagueness of the details of the third schedule of these regulations and regards them as being so inadequate as to have no bearing upon the practice of plastic surgery!" The Association was asked for the "criteria for consultants in plastic surgery in the National Health Service". The Council deliberated and replied that "no definite criteria could be laid down". The Ministry of Health recommended that for three million population there were to be 100

* Note: this mystery is explained in Chapter 5.

beds plus 50 for continuation of treatment, staffed by one consultant plastic surgeon, one assistant and two registrars. There were other problems and the following correspondence is revealing:

29th August 1951

Dear Mr Holmes Sellors,

I have a letter that you wrote to Rainsford Mowlem on the question of exceptional visits of neuro, plastic and thoracic surgeons to Hospitals outside the ordinary contracts. Rainsford has passed it to me for reply.

What you state is true that a surgeon holding a contract in a Region is expected to make calls to any other Hospitals in the Region without a fee. Equally true is the fact that in a Region for which one does not hold a contract one is also expected to make Hospital visits in emergencies without payment.

Some of us do a fair amount of this Hospital visiting as follows:

R. P. Osborne, of Liverpool, is called upon once a week regularly to visit a Hospital at Southport and even to operate there without fee. He is under contract to the Region, but has no appointment to that particular Hospital. For my own part, I have a contract with the North West Metropolitan Region at the West Middlesex Hospital and this also includes visits as required to Hillingdon Hospital for emergencies. This is not so bad as I get paid under this contract whether I go to Hillingdon or not. On the other hand, I am expected to visit the Central Middlesex, Edgware General, Hounslow Hospitals and the North-West Fever Hospital at Neasden, and to operate at these places if need be, without fee. My average number for these outlying Hospitals is three visits per month. My visits to Hillingdon average one a week. I may say that I am due to operate there tonight on a road accident, although I am in the middle of my holiday. In the past six months I have twice been asked to visit Amersham General Hospital (I live in Amersham) to operate there, although I am not under contract to the Oxford Regional Board. My application for fees has been flatly refused.

These figures, I hope, will be of some help to you and when I am in Edinburgh next week for a Plastic Surgical Meeting, I will endeavour to get figures from other people so that I may forward them to you.

I shall be very interested if you will let me know, from time to time, what progress is being made.

Yours very sincerely,

J. P. Reidy
Honorary Secretary.

30th August 1951

Dear Reidy,

Many thanks for your letter and for the information which we are adding up to take to the Whitley Council. I would also welcome any information from your other members as soon as you could let me have it.

If you care to push the point, which I think as a matter of principle you should, you are entitled to the five guinea exceptional consultation fee for working in Amersham as you are not under contract with the Board, and if they refuse again refer the matter to us*, and we can take it to the Ministry.

* By us, I mean representatives of the Central Consultants Committee of the Joint Committee.

Yours sincerely,

T. Holmes Sellors.

31 October 1951

Dear Mr Holmes Sellors,

I promised to let you know what number of visits is done by Plastic Surgeons to the various Hospitals in or out of their Region. You remember that you proposed to put these figures forward to the Whitley Council so that they may be classed as Domiciliary Visits from the point of view of payment.

I circulated nine of my colleagues, and I asked them three questions—

1. The average number of emergency visits per quarter to the Hospitals to which they are under contract.
2. The average number of emergency visits per quarter to Hospitals where no contract is held—
   (a) In their own Region, and
   (b) in other Regions.

Taking an average of the various figures supplied, the answers are as follows:

1. The average number of visits per surgeon per quarter is 10.5

2. (a) The average number of visits per surgeon per quarter is 5.5
   (b) The average number of visits per surgeon per quarter is 2

I hope these figures may be of some help, and I shall be interested to hear from you in due course.

Yours sincerely,

J. P. Reidy
Hon. Secretary

On November 30th 1951 Sir Harold Gillies was congratulated on his exhibition on plastic surgery for the Festival of Britain.

A Faculty of Plastic Surgery?

Reviewing the early Minutes one is struck by the similarity of issues then and now. Our present desire for an academic figurehead was mirrored in the suggestion by McIndoe (February, 1949) that a Faculty of Plastic Surgery under the aegis of the College should be set up and that perhaps a Fellowship could be granted to senior Members and later to others by examination. It was not felt advisable to have a diploma. It was decided eventually that there were too few plastic surgeons to form a faculty but instead, a committee on plastic surgery was set up by the Royal College of Surgeons. Was it an error not to have formed a Faculty at this juncture? However, the Royal College of Surgeons' Committee on Plastic Surgery, otherwise known as the Joint Committee, performed a very useful function. In 1954, under the chairmanship of Sir Cecil Wakeley, it published a report on the criteria for recognition of training for registrars in plastic surgery. This is a fine and well thought out document and makes interesting reading today. It lists the units that were considered eligible for senior registrars but omitted Rooksdown House so, at the Annual General Meeting on December 3rd 1954, there were complaints. In 1958 there was a deputation from the Joint Committee to the Department of Health because of the discrepancy between the number of senior registrar and consultant posts available. The Joint Committee felt that there should be sixteen registrars only and that the Ministry should be advised on the readvertising of these posts.

In 1959 the Joint Working Party on Hospital Staffing asked for evidence from the BAPS and this request was passed to the Joint Committee for its observations but it was somewhat dilatory in answering. In 1962 the Joint Committee discussed the criteria for consultant status and whether a specialist examination was desirable. In the mid-60s the effect on the training programme of joining the EEC was considered, as was again the possibility of a diploma in plastic surgery and the development of a Faculty. I presume that the Joint Committee ceased to function when most of its work was taken over by the Specialist Advisory Committee in plastic surgery.

The academic status of the specialty

The academic status of plastic surgery in this country has been a recurring theme in the Council Minutes. Professor Kilner had been made Nuffield Professor of Plastic Surgery in Oxford University in 1944. This was a Chair instituted for a period of ten years. In 1953 the situation was reviewed and it was decided to continue the Professorship until August 1957 when Professor Kilner was due to retire. In 1956 a Nuffield sub-committee proposed that there should be no Professor and no Reader to replace Professor Kilner, and on June 19th 1957, a special meeting of the Council was called to discuss the situation. A letter was drafted and sent to the President of the Royal College of Surgeons and to Oxford University and to Viscount Nuffield recommending strongly, and asking for, a continuation of the Chair. This did little good and Viscount Nuffield replied "this Chair is not being discontinued on Professor Kilner's retirement: the period for which it was established has run out as it was established for a limited period only". In 1959 a Chair of Plastic Surgery was proposed at Cambridge; early in 1960 this subject was again discussed. There was some doubt as to whether it was the right time and the right university for such a Chair. Later in the year it was reported that Cambridge University had given a commitment to establish a Chair in Plastic Surgery. This was the last mention of it. One cannot help wondering what happened and why this project never came to fruition.

The Oxford Professorial Unit and the Kilner Library

C. W. Chapman and T. J. S. Patterson

In the Summer of 1937 J. Eastman Sheehan of New York was invited to Spain by General Franco to deal with superficial injuries. On arrival there he found himself at a disadvantage as endotracheal anaesthesia was unknown in Spain at the time and

many of the lesions referred to Sheehan involved the head and neck. Sheehan contacted Robert Macintosh (later Sir Robert) who had been appointed Professor of Anaesthetics in Oxford in February 1937. Macintosh set out to join Sheehan with a laryngoscope, some endotracheal tubes and the necessary papers from Franco's representatives in London.

Lady Nuffield suffered from exophthalmic goitre and at the beginning of World War II it was decided to send her out of the country. At Sir William Morris's (later Lord Nuffield) request Professor Macintosh contacted Sheehan and took Lady Nuffield over by sea, handing her over to Sheehan in New York. Sheehan looked after Lady Nuffield for the duration of the war.

Sheehan appeared in London in 1944 with a letter from Lord Nuffield offering to found for him a professorial Chair in Plastic Surgery in the United Kingdom but this development was unpopular with Sir Harold because Sheehan had accepted the invitation to go to Spain to treat Franco's troops during the Civil War. Gillies apparently had a conversation with the Prime Minister and this was reported to Lord Nuffield who decided that he would not include Sir Harold in his future plans. Sheehan, who had no wish to remain in the United Kingdom, suggested Kilner's name for the new Chair and Lord Nuffield made available to Oxford University a sum exceeding £80,000. The funds supported the Nuffield Department of Plastic Surgery in Kilner's time (1944–57) and there was even a little left over. Kilner's cautious and conservative approach probably accounts for his not making many significant innovations, but his detailed note-taking was unequalled and an example for us all: his records on cleft lip and palate cases are classics.

The library of the department at Oxford, now at the Radcliffe Infirmary, is based on the books and reprints collected by Kilner. The books are a fair representation of the literature up to the 1960s, and include some nice "Association" copies—notably of Gillies and Victor Veau. The reprints are a comprehensive collection on all aspects of the specialty, going back to the 1920s. After Kilner's retirement in 1957 the collection was re-classified on a card index system by author and subject. With annual grants from the University, all relevant new books have been bought, and complete runs of all the main journals continued. In 1963, with the consent of the University, the library was officially named the Kilner Library of Plastic Surgery.

The BAPS Newsletters

T. J. S. Patterson

During the 1960s there had been growing dissatisfaction among the Members both at the lack of information about the affairs of the Association and the way in which important decisions were taken and implemented by Council before proper discussion at the Annual General Meeting. For instance there had been an unhappy scene at the AGM in 1964 when a certain name was put forward by Council for conferment of Honorary Membership. There was vigorous opposition from the floor and a feeling that there had been insufficient consultation with Members beforehand. When a vote was taken there was found to be a small majority in favour. It was suggested then that, since our Honorary Members should be able to be informed that their election was the unanimous wish of the Association and as a majority had voted in favour, the motion should be put again so that its opponents might have an opportunity to reflect on this. Two important new steps were taken to remedy this cause for dissatisfaction. It was decided to enlarge the size of the Council, to allow a greater number of members to rotate through Council, to let them learn how hard it worked to reach acceptable decisions on matters that often would seem obscure or reactionary to those not in the know.

It was also decided to disseminate information about the workings of the BAPS by circulating Newsletters to each of the Members of the Association. I undertook the task of editing these which could be kept in a specially designed loose-leaf folder. However, they had a short life, October 1966 to June 1969. Their Editor, in spite of widespread exhortations, found it hard to gather enough "news" to fill more than four issues and their function, which had been to a certain extent duplicated by the information sections in the Journal, was taken over by the expansion of these sections and the information circulated regularly by the Secretariat at the time of the Winter and Summer meetings.

Membership

B. D. G. Morgan

With few exceptions, at every Council meeting there has been a discussion of applications for membership or associate membership. Not only has there been discussion about the eligibility of

individual members but also about the general principles of eligibility. For instance, in 1957, there was a question as to whether plastic surgeons of the Irish Republic could become Full Members; Council was helped in its deliberations then by the GMC who considered that they should. Yet again, in 1963, Council discussed whether dental or oral surgeons could become Full rather than Associate Members; eventually this was brought up at the AGM in that year and there was a majority vote against. The criteria for membership were reconsidered in 1965 and the ruling at that time was that a person was eligible if he or she had completed four years' training at SR level, at least one year of which must have been in this country. At that time Mr Rank was President; he objected, and the wording was changed to "senior registrar or its equivalent post approved by Council". At that time a sub-committee was set up to consider the criteria for associate membership. The Sub-committee's report, which considered that there should be Honorary Fellows, Senior Fellows, Fellows, Members and temporary Associates, was not accepted by Council. The first Member to be removed was Wardill in 1950, who had moved to South Africa and who was asked to pay his outstanding subscription. He wrote back that he now derived little benefit from the Association, and Council regretted that he saw no point in continuing his membership! Dr Jorgen Ernst wrote in 1952 that "as he had no appointment he was unable to pay his entrance fee and subscription". It is not recorded whether he was ever given membership.

Until 1958 there was no power to expel a member of the Association for any reason other than failure to pay his subscription. According to the Council Minutes of February 11th it was reported that there had been a series of articles published in the *Sunday Graphic* about a Full Member of the BAPS, Matthew Banks. As Mr Banks disclaimed prior knowledge, it was decided to obtain a legal opinion from the solicitor to the Association and later from a barrister who, on consulting the Constitution of the Association, pointed out that there was no power to expel a member apart from his failure to pay his subscription! For this reason two clauses were added to the Constitution at the Annual General Meeting of December 5th 1958. These stated that if the conduct of a member is or has at any time been such to be prejudicial to the Association and/or the objects for which it was formed and exists, Council has power to suspend the member until the next AGM. The AGM could then terminate the membership, if passed by two-thirds of those present. The suggestion was made that an ethical committee should be set up but, as was rather common in Council meetings of this era, the idea was "not regarded with favour". In view of the problems encountered some two years later, perhaps this was a wrong move. It has taken until 1986 for it to happen!

What must have been quite clear to the writer of Council Minutes at the time of preparation does not necessarily come across in explaining the reasons for certain views and actions when read years later. Without Chapter 12 it would remain a puzzle as to why the Council of the BAPS should have reacted without enthusiasm to Torg Skoog's idea in 1955 of an International Society of Plastic Surgery. The Minute on September 27th 1955 says, "Council had difficulty in understanding what function it would perform". The President was very much in favour of international congresses but was not convinced that an international society of plastic surgeons was necessary! He was puzzled at no invitation to nominate a delegate having been received by BAPS and there is later reference to a misunderstanding between Dr Skoog and the Association. This really revolved around a letter written by Dr Skoog in August 1953 which was never received.

The President's chain

In the first year of its existence it was decided that the Association should have a crest. Apart from Gillies's suggestion of offering a guinea prize for the best design, there were weightier decisions to be made and discussion was continually deferred. In 1948 A. B. Wallace suggested that there should be a chain of office but this idea fell on stony ground and he had to repeat his suggestion in 1951. At that time a firm called Fattorini prepared a design for the Presidential badge. The College of Heralds was approached and, after a meeting with the Chester Herald, the President was authorised to obtain a design from it for consideration at the next Council meeting. This design, when it appeared in 1953, was not generally acceptable and a sub-committee was set up to discuss alternate suggestions with Sir John Heaton-Armstrong of the College of Arms.

At the January 1954 Council meeting "It was decided to insert a notice in the Journal asking any member with a knowledge of heraldry to get in touch with the President". In December 1954 the President reported that a final design had been

approved by the Garter King of Arms. On April 14th 1955 Mr Matthews reported that "the design was now in the hands of the College of Heralds for production", and he was requested to "animate" the heralds regarding this particular item. Once there was a coat of arms, the Presidential badge and chain could be made and designs were obtained from Garrards. A design in gold costing £517 10s. was selected: the design was unique and had to be approved by the Council of Industrial Design. The badge and collar were available for Council to view at their meeting on July 12th 1956 (Fig. 15.1). It was decided that the name of each President and his year of office should be engraved on a separate link of the chain and that each President should be invited to subscribe £10 for every year of office to offset the cost of the insignia. In 1961 it was decided that a President holding office twice should have his name on only one link of the chain. In 1963 the Presidential badge was found to have a crack across the back and Council authorised its repair at a cost of £3 4s. The President was authorised to take the badge to Washington for the International Congress to wear on official occasions and a special case was made to protect it from damage.

The Council meetings were usually held in the Royal College of Surgeons except at the Summer meetings which were held in the President's Unit. Some of the early Council meetings were held at 149 Harley Street and there were two other notable meetings, on October 15th 1963 at the Sheraton Park Hotel, Washington and in 1965 in the British Embassy at The Hague, Holland.

The cost of the Annual Dinner provided by the Royal College of Surgeons, inclusive of wines, was to be 2 guineas per head in 1950. It was suggested that enquiries should be made concerning dinner at a lower price and the matter was left in the hands of the President and Honorary Secretary. There was a note in a later Council minute to say that the

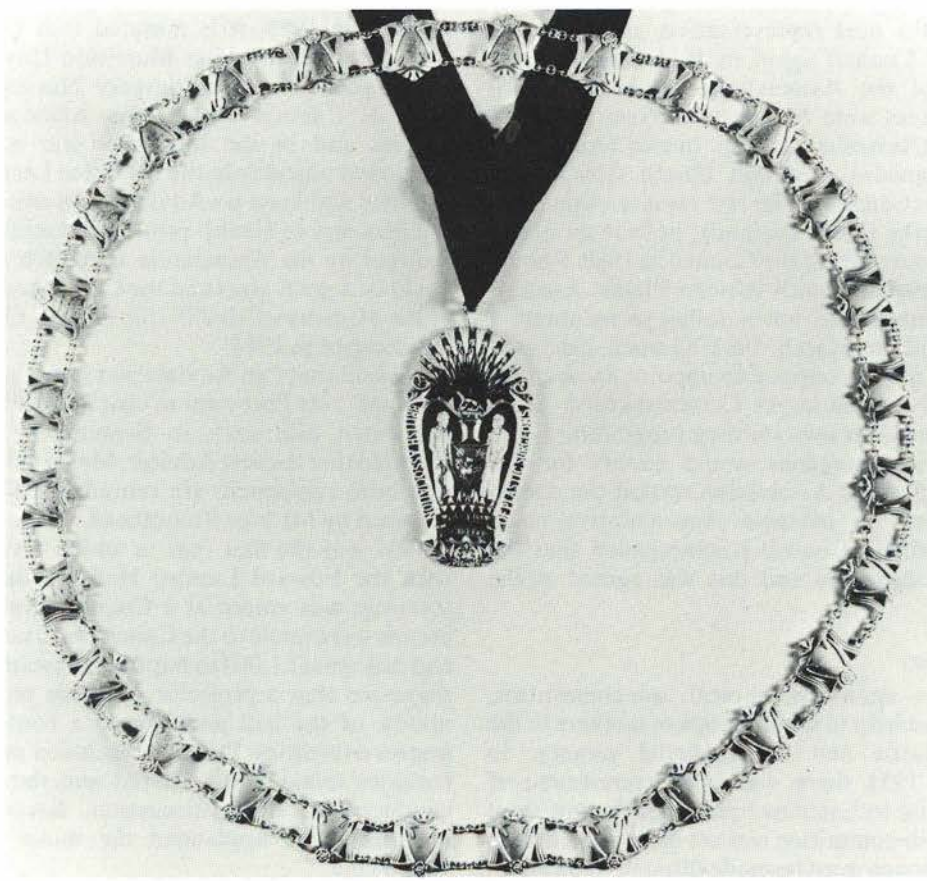


Fig. 15.1 The President's Badge and Chain. The Badge is reproduced in colour on the frontispiece.

annual dinner had cost 30/- per head. Well done the President and the Secretary! In 1956, however, there was a complaint from Chepstow at the high cost of the dinner at the Sheffield meeting!

Overseas member of Council

The Annual General Meeting on December 5th 1952 proposed that Council should have the power to co-opt a Commonwealth representative. H. P. Pickerill from New Zealand asked that the Member be elected and not co-opted. In practice, Council either asked each of the major Commonwealth countries to nominate a representative or itself suggested a name. The 1954 Constitution said that, "The overseas member of Council must be a Full Member, normally resident in the Commonwealth outside the British Isles." Many eminent plastic surgeons from the Commonwealth were members of Council. Jack Penn was the representative in 1953 and attended Council meetings; on more than one occasion he attempted to persuade BAPS to hold a meeting in Johannesburg. Sir Benjamin Rank was the next representative, and he was a member of Council again in 1965 when he was President of the Association. Other prominent representatives were Manchester (New Zealand), Wakefield (Australia), Officer Brown (Australia), Farmer (Canada), Cuthbert (South Africa) and Ross Tilley (Canada). The last representative was Graham Blake (New Zealand); he was an active and helpful member of the Council in 1980. For the following year the South African Plastic Association was approached but it failed to nominate a member and in March 1982 Council discussed whether or not to continue to appoint an overseas representative. The larger Commonwealth countries now had their own training programmes, and fewer overseas surgeons would qualify for full membership of the Association so that the contribution which an overseas representative could make was small. Council recommended that the post be discontinued and this was agreed at the 1982 AGM.

Help to others

As well as spawning several sub-committees, Council gave help to other groups of workers in the field of plastic and maxillo-facial surgery. In September 1951 there was poor recruitment of maxillo-facial technicians because of the low rates of pay. A sub-committee was set up which advised that an approach must be made through trade union channels to the Whitley Council, and helped to bring this about. A similar problem arose later with operating theatre technicians and, along with our anaesthetic colleagues, a committee was set up to consider the provision of a suitable course of training and the design of a suitable examination. There is no further record of any action in this respect. Training in plastic surgery for nurses was raised on several occasions. Many units had their own independent courses. Chepstow, for example, ran a one-year course while a sixth-month course was run at Oxford, and a typewritten letter signed by the director of the unit and the matron was given to nurses who had completed the six months. Council queried the suggestion that the Association itself should provide such nursing certificates but it was felt that these really should be issued by the General Nursing Council or the Regional Hospital Boards. The same decision was made when the subject was raised again in 1959. In 1963 some of the nurses particularly interested in plastic surgery began to think about forming a group or association and BAPS welcomed this and agreed to support it. Finally, in 1965, it is minuted that Council had been informed by Miss Morriston-Davies that an Association of Plastic Surgery Nurses had been formed; Council wished the Association every success and in the following year nurses were welcomed officially to the McIndoe Lecture.

There had been no Adviser in Plastic Surgery to the Ministry of Health prior to the mid-60s. It was realised by the Association that such an Adviser could be a great asset and the Chief Medical Officer at the Ministry of Health (Sir George Godber) was approached in 1964.

He said that "an Adviser was not required at the moment". Mr Peet went to visit him and eventually persuaded him and, in September 1966, it is reported that the first Adviser, Mr David Matthews, had been appointed. He retired in 1971 and was replaced by Mr Ivor Broomhead.

1967 was the first year in which dissatisfaction with the Edward Lumley Hall for the scientific meetings was voiced at a Council meeting. Complaints were made to the College who said that they had just spent £1,000 to improve the sound. Council suggested that a projector could be placed in the middle of the hall and offered a contribution to improve facilities. Despite continued pressure, the facilities remain little altered and the hall is not conducive to lively discussion. Recent Council meetings have applauded the move to Lecture Room One.

The Tonks pastels have been a recurring theme

at Council meetings. Firstly, one of the drawings (caricatures) was offered to the Association by Sir Harold Gillies (October 23rd 1958). At the following meeting it was reported that Sir Harold had now given the Tonks drawings to the Royal College of Surgeons: these were probably the pencil sketches of operations in progress during World War I. The pastels of soldiers, of which there are 60, resided for many years in the pathology museum at the College but in the 60s were lent to the Royal Army Dental Museum at Aldershot. Over the last four years attempts by the Council of BAPS to have the pastels returned to London for easy access and viewing have not been successful.

UK training posts and the Commonwealth

In 1960 the suitability of some of our training posts for the requirements of other countries was raised. The problem was passed to the Joint Committee which doesn't appear to have answered the call. In 1963 the Canadians asked specifically which were the acceptable training posts in plastic surgery in the United Kingdom. The then President, A. B. Wallace, and R. L. G. Dawson were to visit (and inspect) all the plastic surgery centres in this country and to ascertain the facts. There is no report of this ever having been carried out. There was a special meeting of the Council on October 8th 1964 to consider the training of surgeons, followed by a conference on this subject at the Royal College of Surgeons on the following day. There was concern about the registrar bottle-neck but no positive suggestions were made on how to deal with it. In Council on November 4th 1964 it was reported that a meeting with other surgical specialties had agreed on the training of surgeons to include:

1. similar pre-Fellowship training for all specialties,
2. three years pre-FRCS training: one year general surgery, half a year accident and emergency, half a year specialty, one year in a recognised post for any specialty,
3. recognition that the FRCS was evidence of a sound basic training in any branch of surgery.

An archivist

The idea of a historian or archivist for the Association was first mooted in October 1963: this was quite distinct from the plan to write an account of plastic surgery services during World War II. The name of Mr Reidy was proposed as the first historian. Nothing came of this suggestion and in 1965, when asked again, Mr Reidy declined. In 1966 Mr Barron agreed to perform this function. He collected a great deal of information and considered that at last a start could soon be made in producing a History of the Association. In April 1981 Council appointed Tony Wallace as Honorary Archivist of the Association.

Reference

Gibson T. (1986). Primary closure of maxillo-facial wounds. *Journal of the Royal Army Medical Corps*, **132**, 96

The BAPS Secretariat

"It all began in a darkened room" is a not quite accurate description of the beginning of a secretariat that was destined to lead the British Association of Plastic Surgeons from relative obscurity, through adverse publicity, to its present respected position as a "voice" from whom recommendation and information are sought from both high and low.

At its Inaugural Meeting in November 1946 in a moderately dark room in the Royal College of Surgeons, when the present staff were either babes in arms, in the first bloom of their youth or not even a twinkle in their father's eye, the Association, under the Chairmanship of Sir Alfred (later Lord) Webb-Johnson, agreed to seek permission from the College for admission into its Joint Secretariat. This Secretariat had been in existence since 1945, when Miss Barbara Key started offering secretarial services to various, mainly surgical, specialties amongst whom were the orthopaedic surgeons, the radiologists and general surgeons. Miss Key was to be responsible for the supervision of the Association until well into the 1960s and she then continued as Head of the Joint Secretariat until her retirement in 1970.

Until this time most of the initial work of the Association, whose formation had been under discussion since as early as 1944, had been done by the various surgeons through their own secretaries, a situation which was to continue for several years despite the increasing need to use the Joint Secretariat. This unsatisfactory state of affairs was brought to a head in 1961 when the Association was involved in an altercation with the General Medical Council over the understanding of the word "advertising" and it was agreed that, although blame for the distribution of the Association's List of Members could not be laid fully at the feet of the Secretariat, the practice of answering correspondence in various parts of the country without reference back to the Secretariat was not a good thing and had been, in part, responsible for the misunderstanding.

During these early years the link with the orthopaedic surgeons was being forged gradually until, in 1969, both Associations were run by the same senior secretary. Although the orthopaedic workload has always been greater, the combination has worked well and its was therefore with considerable regret that the present staff learned recently, and without discussion, of the BOA's desire to sever these links and "go it alone". The office staff of the BAPS and the British Society for Surgery of the Hand feel differently. This devolution will necessitate the formation of a new BOA Secretariat and some of the serving founder members still recall the trials and tribulations of the past, and trust that they will be spared some of the difficulties that they experienced in their youth!

Over the years the basic work of the Secretariat has changed little but has expanded a great deal. From the beginning it has been responsible for the organisation of meetings, minute taking, for the Council and various sub-committees, the collection of subscriptions and dealing with general correspondence and telephone enquiries, particularly from the public, which can be both tedious and obscure. There are, of course, many more tasks too mundane to mention that make up a day in the life of the Secretariat.

Although there has nearly always been, along with Miss Key, one secretary with particular responsibility for the BAPS, it was not until 1966 that thoughts turned towards the possible enlargement and modernisation of the Secretariat set-up as a whole. This was to involve an increase in the contribution paid into the Secretariat by the BAPS, one which had increased and is still increasing as the years go by. In 1945 the administration costs of the BAPS were £37 per annum, in 1966 these had

risen to approximately £1,000 per annum and in 1985 were £28,000 per annum. Hopefully, it is worth it!

After considerable thought and negotiation, by 1967 the BAPS had a full-time senior secretary and the use of a junior secretary. During this time the British Orthopaedic Association was also pushing to have its own full-time secretary and this too was achieved, also in 1967. By 1968, with the expansion of the Secretariat and the impending retirement of Miss Key, the College, although wishing to keep most of the surgical specialties, felt that consideration should be given to the possible rehousing of the Secretariat. At this point the BAPS could see themselves becoming homeless and decided to form a small sub-committee to look into the possibility of finding other accommodation: this was also being considered by the BOA. While these negotiations were taking place it was decided that the secretary of the BOA whould take on responsibility for BAPS as well, so that by the time of the European Congress in Brighton the Association had the services of a new, although slightly "green", secretary—the "green" referring to the fact that her previous career had been as a highly respected flower arranger and teacher. This person is, of course, Miss Margaret Bennett, to whom the Association owes a great deal. After losing two junior secretaries in as many years she was joined in 1970 by an ex-naval nurse of doubtful qualification. We have, however, worked together quite successfully since.

By 1970 the BAPS and the BOA were totally combined and, although still in the Joint Secretariat, effectively had made the break in that their new accommodation on the fourth floor was being converted while the responsibility for salaries, *etc.* had been transferred to the jurisdiction of the two Associations.

In 1972 the BAPS and the BOA were joined by the British Society for Surgery of the Hand and the need for more space and staff was increasing, in true "Parkinson's Law" fashion. This syndrome has continued and the present number of staff is nine, of which seven are full-time administrators and two are part-time—this description covering hidden talents and a multitude of "sins"! Over the years we have employed and lost several staff from various circumstances as for example, marriage, childbirth, South Africa, Kuala Lumpur, a nervous breakdown and the Women's Institute—the latter lady taking leave to go to a WI Meeting at the Royal Albert Hall and never returning: we have still to hear further from her. There have been staff with predilections for cheese and onion sandwiches, eaten surreptitiously in the stock cupboard, for gin and for the Open University.

The current members of the Secretariat have had different and varied careers before, in some cases, finishing "their days" administering to the needs of the Association. There are ex-dancers, ex-nurses, ex-teachers all suitably troubled with orthopaedic rather than plastic surgical problems, personnel managers and personal secretaries, as well as one long-serving youngster who joined us straight from school and is still here despite living in the country and getting married.

With the workload gradually increasing as well as the number of staff, a move to new offices within the College was made in 1975. The location of these, on the third floor of the College, included the provision of a much-needed boardroom. In 1982, hopefully to decrease the workload and to take the boredom out of the more laborious tasks of keeping the membership addresses and subscriptions up to date, a computer linked with a word processing system was installed. Only now is it being used to its maximum capacity, having needed at least two years to iron out its teething problems.

The Combined Secretariat has worked well and it is sad to relate that it is to be disbanded in 1990. Hopefully, the BAPS and the BSSH will remain close and, who knows, but that in the year 2000 an up-dated version of this saga may well be put to paper, detailing then the many idiosyncracies of today's staff.

17 *Charles W. Chapman*

Burns, the BAPS and the British Burn Association

From 1916 a close relationship developed between the specialty and burn injuries. Initially, patients were referred for the release of contractures and correction of other deformities. Gillies's first tube pedicle patient—Able Seaman Vicarage burned in the Battle of Jutland—had a tubed pedicle flap raised on October 3rd 1917, and operations on other burned patients followed. In 1920 Gillies had a Mrs Brown, an epileptic, brought to his clinic to see if anything could be done for her. Three years previously she had fallen face-forward into the embers of a smouldering fire. She sustained horrific injuries to her face. Gillies decided to operate and the results obtained in this patient nearly 70 years ago, and illustrated in his *Principles and Art*, deserve careful study to this day. In 1924 Gillies visited Copenhagen at the request of the Danish Authorities and carried out surgery on some Danish Naval personnel who had received phosphorus burns when a bomb exploded on the cruiser *Geyser*. Further reconstructive surgery was carried out on some of these patients by Gillies in England. In general, however, few patients with extensive burns survived more than a few days. At Glasgow Royal Infirmary records from 1937 to 1941 show that in a series of 1,200 burn admissions 49% of the deaths occurred within 24 hours and 72% within three days, and only four patients received plasma or serum intravenously.

In 1939, with the outbreak of World War II, the scene was set for rapid advances in management (see Chapters 1 and 6). 1940 saw the Medical Research Council forming a special co-ordinating sub-committee for the treatment of burns. It is noteworthy that at the time of the Battle of Britain, when burns in air crew were beginning to appear in large numbers, burn patients were not infused according to the area burned. In November 1940 Black advised giving half-strength plasma to keep the haemoglobin level below 110%.

Important post-war publications by BAPS members

The end of World War II signalled a slowing down of burns research as surgeons left the Services. Nevertheless burn injuries had seen major advances in treatment initiated by founder members of the BAPS, and more were to follow.

In 1949 A. B. Wallace's presence was felt widely—he recommended the adoption of the "Rule of Nines" and soon afterwards published a paper on "The Exposure Method" for the treatment of burns, of which he was an enthusiast. Later, he was to be co-editor of *Research in Burns*, the proceedings of the first International Congress. In Roehampton A. J. Evans was an advocate of the exposure method of treating burns using polyurethane foam on mesh beds, with nylon mesh chairs available also. His use of Dextran in the shock phase (120 ml per 1% burn in adults) has withstood the test of time. It was certainly in use in 1950 and has been adopted by the Armed Services for the treatment of burns in forward areas, proving its suitability for the treatment of large numbers of burn casualties in the South Atlantic in 1982.

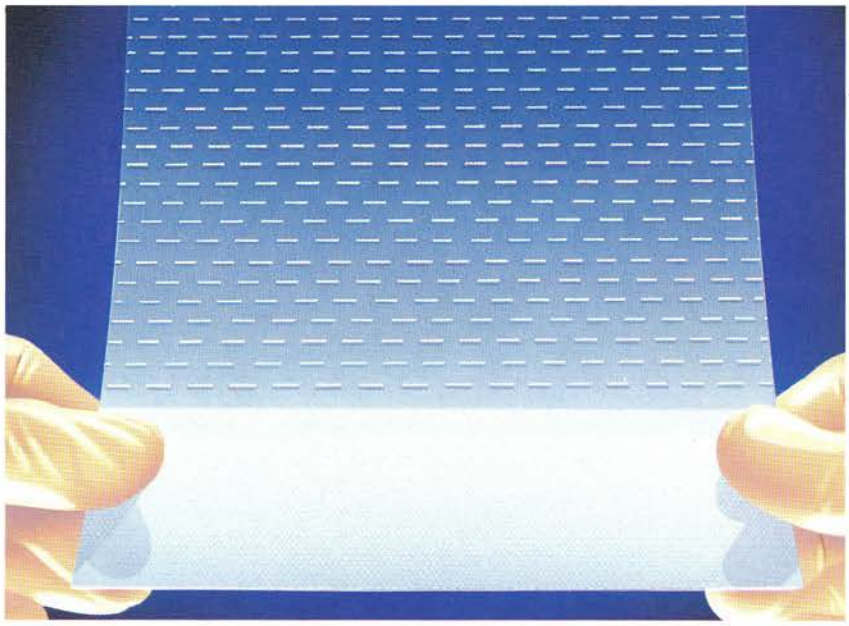
Leonard Colebrook, in 1950, advocated the establishment of special burns units and on September 28th 1950 a Burn Sub-Committee of BAPS was selected with five members, R. J. V. Battle, P. Clarkson, R. Mowlem, R. P. Osborne and A. B. Wallace. Its terms of reference were threefold:

1. The organisation to deal with ordinary civilian burns.
2. How far this organisation could be used for dealing with burns in warfare.
3. The treatment to be employed for mass burns in warfare.

At the Burn Sub-Committee's request the following letter was sent, on May 16th 1951, by the Honorary Secretary of BAPS to the underlisted Members:

TRANSITE

ACTIVE WOUND DRESSING



NO MESSING

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TRANSITE* actively controls the volume of wound exudate which passes through the film to a secondary absorbent dressing.

As exudate builds up from a moderate or heavily exuding wound, the aperture of the fine slits in the surface of TRANSITE enlarges, to allow excessive exudate to pass through. And then, as the moisture levels drop, the aperture reduces – so reducing exudate transfer. The result is an ideal moist healing environment and a far less painful procedure for the patient.

TRANSITE exudate transfer film is easy to apply, is non-adherent, non-greasy, conformable, and transparent. It also features two self-adhesive handles which can be used to secure the dressing.

With fewer dressing changes needed and faster wound healing, TRANSITE is clearly a major step forward in wound management. And no messing.

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Facsimile: 0482 28326

Smith+Nephew

The Association has been asked by the Ministry of Health to give them details of the Plastic Units in the British Isles who can and do treat burns. As this information is required urgently, would you kindly let me have a reply immediately, telling me:

1. Whether you treat burns.
2. The number of beds in your unit and also the number of beds that you have been putting aside (if any) for the treatment of burns.
3. Whether you have any special equipment or facilities for the treatment of burns (*e.g.* side wards, special beds or special baths).

J. N. Barron	W. Hynes
R. J. V. Battle	E. E. Lewis
F. Braithwaite	D. N. Matthews
A. H. R. Champion	F. T. Moore
P. Clarkson	G. H. Morley
N. L. Eckhoff	M. C. Oldfield
H. Elliott Blake	J. P. Reidy
G. M. Fitzgibbon	L. M. Rouillard
J. Grocott	J. S. Tough
C. L. Heanley	

The Sub-Committee produced its final report in February 1952 (Appendix), and later that year the Ministry of Health recommended the setting up of special centres in all Regions. During January and February 1954 six articles on the "Management of Burns" written by members of the Association's Sub-Committee on Burns were published in the *Lancet*. Help was given to the Sub-Committee by T. L. Barclay, A. D. R. Batchelor, R. L. G. Dawson and Anne Sutherland. The articles were later republished by the *Lancet* as a small booklet, priced 2/6d. A helpful pyrogram was published by Allen and Hanbury's Ltd. of London for giving suitable sedative doses of morphine, oral glucose water and plasma.

In 1958 A. H. McIndoe gave his unique experience in reconstruction of the burned face in a Bradshaw Lecture at the Royal College of Surgeons entitled "The Total Reconstruction of the Burned Face". The lecture was published in our Journal in October 1983. In 1962 the first edition of I. F. K. Muir and T. L. Barclay's *Burns and their Treatment* (Lloyd Luke) was published. It became, and remained, the standard work on burns in the UK. A second edition was published in 1974. Its influence on the management of burns patients in the United Kingdom cannot be overestimated. A. B. Wallace and T. L. Barclay edited *Research in Burns*.

Important advances

MRC research at Glasgow moved to Birmingham Accident Hospital in 1944. This hospital houses the Medical Research Council Burns Unit. Important research on burns dressings, depth of burning and epidemiology led to legislation on nightdresses and fireguards. More recently J. Gower and P. Levick have started a skin culture laboratory there. The first custom-built centre for the treatment of burns in the United Kingdom was opened at Wakefield in 1964, followed by East Grinstead in 1965, Odstock, Salisbury in 1966, Bangour, Edinburgh in 1968 and Mount Vernon, Northwood in 1974.

Russell Davies, anaesthetist, and John Watson, supported by Robin Beare, proposed the founding of a Research Unit at East Grinstead and approached Elaine and Neville Blond, on Boxing Day 1958. Sir Archibald McIndoe supported the scheme with his customary enthusiasm and the first meeting of the East Grinstead Research Trust was held on December 14th 1959. The Blond McIndoe Laboratories were opened on March 22nd 1961 and, in September 1961, Dr Morten Simonsen of the University of Copenhagen undertook duties as Director of the Unit. An extension of the building was opened on March 30th 1962 by Sir Arthur Porritt. In 1963, the hospital's centenary year, Her Majesty Queen Elizabeth the Queen Mother laid the foundation stone of the McIndoe Burn Centre, which became operational in January 1965. Research is associated closely with the burns unit and has covered such projects as the use of homograft and heterograft skin and immunological problems, as well as skin banks and other subjects including the molecular biology of human leucocytes and genetic coding. The world famous Guinea Pig Club, concerned with the welfare and rehabilitation of burns casualties and started by McIndoe at East Grinstead during the 1939–45 war, flourishes under the medical guidance of T. D. Cochrane: other Burns Clubs are appearing in the other burns units.

The Laing Laboratory was started by Jim Ellsworth Laing in 1969 in surplus theatre accommodation in Odstock Hospital, Salisbury, which it still occupies. Laing developed the Odstock Formula for the resuscitation of extensive burns. The first Scientific Director was Mr D. R. Davies, after his return from the Chemical Defence Establishment, Porton Down, Salisbury: he received no salary for his services. An assistant, Mrs Errol Spurr, was taken on and she is now employed as senior scientific officer in the Unit. In 1974 Laing

persuaded the Wiltshire Area Health Authority to fund three posts in the Unit including that of Dr Peter Shakespeare, its present Scientific Director. There are now, in addition, two more grant-funded workers. Jim Laing was the first Medical Director. The Unit has always studied general and specific aspects of burn injury. Recently, work has been done on more basic investigation of cell biology of wound healing, and the development of treatment methods including the culture of human keratinocytes to provide autograft for wound repair: this method has the potential to provide unlimited autograft cover for repair of burns and other wounds involving skin loss.

The Bangour Burns Unit opened in 1941 when the population was largely service personnel. A. B. Wallace was concerned with the care of burn patients from the earliest days of the Unit, and he was associated also with the Royal Hospital for Sick Children. By the late 1940s he had begun to publish a considerable amount of material on his experience in burn care, especially the care of the burned child, and it was largely from his early work that he developed the Rules of Nine. When first described, the plural was used as nine was used also to calculate fluid needs and an acceptable urine output. The latter two "rules" were dropped later and the Rule became associated with body surface area only. He thought originally of a Rules of Ten but after early discussions with Pulaski from the Brooke Army Unit, San Antonio, Texas decided on the Rule of Nine. Alistair Batchelor became closely associated with the development of burn care in Bangour, basing his formula for resuscitation on Everitt Evans' formula. In burn surgery the Unit has always laid emphasis on Janzecovic's work in tangential excision. Pain relief in the management of burns is a subject of particular concern at Bangour, general anaesthesia being used frequently for treatment in adult and children's burns. From the early 1950s there has been emphasis on nutritional support. A custom-built twelve-bedded Burn Unit was provided in 1968.

The Mount Vernon Burns Unit was established in 1963 when plastic surgery moved there from Hill End. Ian Muir and Ed Waschansky developed the idea of the "mini desert", an enclosure into which hot air was pumped, and the rapid drying of burns was found to be possible. Dr J. T. Scales took up this idea with Rainsford Mowlem and, using the principle of a hovercraft (with the support of the National Research Development Corporation, the Army, the Medical Research Council and many other bodies), developed the hoverbed, tried first in 1965. Muir and Stranc carried out an assessment of the hoverbed on two patients and, finding it practical in drying burns, development proceeded. In 1968–69, Sanders, Scales and Muir carried out a further trial with the new equipment and found that burns dried very rapidly. On the basis of experiments on seven patients an extended trial was recommended. The NRDC, MRC and Regional Health Authority joined together to provide a new Regional Centre and the MRC funded three years of research. During the time of the building of the Unit the low air loss bed was developed jointly between Mount Vernon and the National Orthopaedic Hospital, under the auspices of the NRDC. The new Burns Unit was opened by Group Captain Douglas Bader on February 13th 1974, and it housed two hoverbeds, two low air loss beds and four laminar air-flow enclosures—the latter had to be removed as being impractical. Further developments in burns surgery and topical chemotherapeutic agents made treatment of burns by exposure less important and the hoverbeds ceased to be used. Sophisticated low air loss beds have since been developed and are used for a wide variety of sick patients and in the treatment and prevention of pressure sores.

. . . and recent tragedies

In 1982, during the confrontation with Argentina, a Member of the Association served in the hospital ship *Uganda* stationed in Falkland Sound: casualties with burns and other injuries were treated. In 1985 burn casualties from a disastrous fire in the Bradford City football ground were treated by a number of Members of the Association who rallied to help the Bradford Unit as soon as news of the fire became known.

The British Burn Association

A special Burns Conference was held in April 1968 near Salisbury, organised by James Ellsworth Laing. The meeting was held at the disused RAF Station, Old Sarum. Burns as a subject was covered in the Association's meetings but the feeling was that there was a strong case for a more widely based association, and the British Burn Association was formed.

Douglas Jackson from the Birmingham Accident Hospital and James Evans from Roehampton were present, as were Air Commodore Ronnie F. Brown

and A. B. Wallace. Douglas Jackson had been to the United States to give the Everett Evans Memorial Lecture and had been made an Honorary Member of the American Burn Association. He has been the UK representative of the International Society of Burn Injuries since 1968: the ISBI had about 90 UK members. He had been impressed with the size and keenness of the American Burn Association and by the way in which it had followed the wide membership pattern started by the ISBI, by the inclusion of all disciplines connected with burn prevention and therapy. Andrew Wilkinson, Professor of Paediatric Surgery at the Hospital for Sick Children, Great Ormond Street, was invited to be Chairman of the British Burn Association and James Laing became Secretary/Treasurer; later these two posts were separated. Jim Evans was on the committee and the membership included Patrick Clarkson, Peter Craig, Bertie Sachs and Anne Sutherland.

The Association has gone from strength to strength. A three-day meeting is held annually, usually in March or April, when all disciplines involved with treatment of burn casualties are present; a social programme is also held. The A. B. Wallace Memorial Lecture is a feature of the meetings which are now attended by well over 100 members.

British Burn Association: A. B. Wallace Memorial Lectures

*First	1978	Sheffield	E. J. L. Lowbury	"Fact or fiction—the rationale of some anti-infective measures"
*Second	1979	Glasgow	D. McG. Jackson	"Destructive burns: some orthopaedic complications"
Third	1981	Preston	M. N. Tempest	"The crisis in communication"
*Fourth	1982	Brighton	Bent Sørensen	"The value of centralisation"
Fifth	1983	Newcastle-upon-Tyne	Jim Laing	"A. B. Wallace: a man of Vision"
*Sixth	1984	Chelmsford	Basil Pruitt	"Diagnosis and treatment of infection in the burned patient"
Seventh	1985	Aberdeen	Ian Muir	"Exposure treatment of burns and the micro-climate"
Eighth	1986	Birmingham	Anne Sutherland	"Is it new?"

* Published in *Burns*.

APPENDIX—Burns Sub-committee of the BAPS

Final Report—February 1952

The Organisation to deal with ordinary Civilian Burns

If a civilian is burnt today his treatment might be carried out in one of the several ways as will be described.

1. **Haphazard.** He will be admitted to a general hospital where the treatment will be carried out by a registrar or consultant surgeon. If he is fortunate his surgeon, of whatever status, may be interested in the problem, may have studied the different aspects of treatment and may be prepared to carry out the régime from beginning to end and produce a satisfactory result within a reasonable length of time.

It may be however that his surgeon will carry out the resuscitation measures on general principles and then show little interest until eventually it will be realised that the bed is being occupied for a long period. Not until then will efforts be made to have the case transferred to a plastic unit. By this time, in some cases, the general condition of the patient will be poor and the most favourable time for the application of skin cover missed.

There remains the possibility that a surgeon with little or no experience will try to carry out the resurfacing himself and in so doing lose the skin grafts applied and possibly damage potential donor areas.

2. **Reference to a Plastic Unit.** In certain areas in the country a patient is referred at once to a Plastic Unit. Admission to such a Unit either takes place or a member of such Unit visits the General Hospital where he either advises upon or carries out treatment. On the other hand there are Plastic Units where for reasons of accommodation and staffing the admission of burns is not favoured.

3. **Admission to a Burn Unit.** In Glasgow and Birmingham there exist burn units where all the staff are engaged solely in the problem, undertaking treatment from beginning to end. As is to be expected these Units produce a consistently high standard of good results. In addition there are specialised facilities within the established Plastic Units at Basingstoke, East Grinstead, Edinburgh, St Albans, Chepstow and Bristol. Similar

facilities will be available in the near future at Stoke Mandeville, Aylesbury, and Odstock, Salisbury.

Comments

The general problem is too urgent and too serious to be dealt with by such apparently casual methods. It is almost impossible to obtain a good result by modern standards for an extensive deep burn except when the patient is treated in a Burn or a Plastic Unit. As it is impossible to ensure that at least one surgeon interested in burns is available in every Hospital in the country a more concrete service should be available.

Whilst the Birmingham conception of a Burn Unit, which includes the services of a plastic surgeon, may be good in principle it is to be noted that it tends to sterilise able men for any other kind of work. The requisite skill for efficient fluid replacement work can be acquired in a few months. The clinical judgment and surgical skill necessary for early resurfacing need take little longer. Apart from research the work thereafter tends to become repetitive and stultifying.

The Committee are of the opinion that:

A burn section should be attached to every plastic unit.
Every plastic unit should be part of a teaching hospital or part of a general hospital.
The plastic surgeon should be in charge of the burn section and clinically responsible for all the patients.
Instruction in the treatment of burns should be given to all surgical residents and registrars.

It is suggested that if burn sections are established, attached to plastic units, teaching could be offered to surgical registrars from other hospitals in the neighbourhood. However, the Committee has to stress that it is not necessary to await the establishment of burn sections before this teaching can be commenced. The existing plastic units are already in a position to carry out this teaching.

It is recognised that it will be difficult and may be impossible to establish a burn section in a teaching hospital but it would be desirable for the closest co-operation to exist between the general and the plastic surgeon.

It is felt that if a teaching hospital has amongst the staff a plastic surgeon, then he should be responsible for the treatment of burns, though not to the exclusion of any general surgeon who is interested in the problem.

Transport of Burns. The establishment of special units automatically introduces the tendency for all patients to be sent to that unit immediately they are seen. This can be disastrous, particularly in children. It is agreed that it is safe to transport a burn if signs of clinical shock have not appeared, if the area burned is not extensive, and the hospital be within easy reach. But even under these conditions the final decision must be based upon a very accurate clinical appraisal.

If signs of clinical shock have appeared it is probably safer to wait until the 4th or 5th day. If mass casualties appear in a conflict where there is no plastic surgeon it would be wise not to transfer such cases before a plastic surgeon has been consulted. Better still, the plastic surgeon, or one of his staff, or a mobile unit should be in a position to go to the incident hospital and institute treatment. Such co-operation between plastic units and general hospitals should not, however, be confined to mass casualties.

Research. The problems of burns are not yet within sight of solution and more plastic units with burn sections should carry out more research. This research should be carried out where university facilities exist providing the necessary support of, and co-operation from physicists, biochemists, physiologists, bacteriologists, dermatologists, etc.

Summary

1. More Burn Sections should be established as extensions within existing and projected plastic units.
2. All surgical residents and registrars should receive training at these burn units—such teaching to include the taking and the application of skin grafts.
3. Closer co-operation should exist between the general and the plastic surgeon.
4. It should be possible for a plastic unit to provide personnel to visit other hospitals when the transport of a burn case is inadvisable.
5. More research should be carried out at suitable units aided by research grants.

How far can this organisation deal with burns in warfare?

If the suggestions outlined above are carried out and if more Plastic Units are sited then *ipso facto* there will, year by year, be more surgeons who can be relied upon to carry out the initial treatment of the shock, the burn, and indeed the resurfacing.

If War occurs and the above suggestions have been carried out, such plastic and burn units could train (during the War) more young surgeons but it would be preferable to train as many people as possible before a War occurs. Such training could be offered not only to surgical residents, but to general surgeons, general practitioners, nurses, auxiliaries, C.D. personnel, etc.

Even under optimal circumstances it is realised that the Plastic Units could not deal with but a minute proportion of the total casualties. They could, however, by preliminary training provide a reasonable bulk of personnel possessing some knowledge of the problem who would be scattered throughout the country. So far as the Units themselves are concerned it would seem they will be of most value not in dealing with the extensive burns whose recovery is doubtful and whose economic future is negligible, but rather in conserving the function of hands and eyelids when these represent the most serious lesion in an otherwise fit patient.

If War occurs the Burns Units outlined above will have to be enlarged—as a beginning additional beds will be

provided in the Plastic Unit itself by ceasing to admit the routine cold cases. At the same time the staffs of such units will have to be increased as the demand increases.

The provision of extra beds to deal with an incident should be in three groups.

All hospitals within a Region should be designated before an incident as being suitable for use as:

A: a CUSHION HOSPITAL
B: a HOLDING HOSPITAL
C: an ANNEXE

The ring of CUSHION HOSPITALS will serve to screen primary casualties and to deal with the shock and initial treatment.

The enlarged plastic units will be amongst the HOLDING HOSPITALS and will hereafter be referred to as PARENT UNITS. They will continue treatment and commence early resurfacing.

The ANNEXE will absorb cases from the Parent Units in the resting phase.

The treatment to be employed for mass burns in warfare

It is to be appreciated that the following programme is intended to cover the burns of Atomic Warfare, but the organisation can, and will, still be called upon to treat burns and injuries due to high explosives.

The requirements, personnel, beds, equipment, etc. are hereafter based per 100 casualties. The distribution of this 100 will vary with the time lapse after the incident. Initially the entire 100 will be in cushion hospitals, but at the end of 5–7 days the distribution may well be 20 remaining in the cushion hospital by reason of the severity of the burns or of other associated injuries, 50 in the parent unit, and 30 in the annexe. These figures have been used as a basis in calculating the requisite personnel and equipment.

The duties of the staff of the parent unit will therefore vary according to the phase. They will, as mobile teams, be available within the first few hours for consultation and assistance at the cushion hospitals but this responsibility will rapidly be passed to less highly trained staff as the demands at the parent unit increase.

The demands upon the services of mobile teams will obviously arise from more than one Cushion Hospital at a time. It is not recommended that such teams shall proceed automatically to these hospitals. Experience has shown that personal direct contact between the responsible surgeons concerned can eliminate waste of effort, personnel and time.

Cushion hospitals

1. **Beds.** It is assumed that it will have been planned to have available a large number of potentially active beds.

2. **Medical personnel.** It is assumed that there will be a requisite medical staff some of whom will have received training in the initial treatment of burns.

In addition the services of a fully trained mobile team from the parent unit should be available for consultation and assistance.

3. **Treatment**

OUT-PATIENTS

It will be impossible to admit every case and outpatient treatment is envisaged for a considerable number.

The indication for admission of a burn of the hand is exposure of tendons, or the interphalangeal joints, or any case remaining unhealed after 14 days.

The most serious risk of a burn of the face is ectropion of the eyelid with its attendant risk of corneal damage. If this cannot be controlled by tarsorraphy then immediate admission to a Plastic Unit is desirable.

Cleansing: Facilities should be available for washing burned areas with a warm detergent solution (Cetrimide 1% or G.11) by means of hoses or sprays.

Drying: A large supply of absorbent towels would be desirable but much can be done with hot air driers.

Cover: Faces: Patients will be given a water soluble vanishing cream, for their own use, to be applied to the eyelids, lips and nostrils.

Hands: The ideal general principle appears to be the promotion of a *dry surface* and protection against infection by contamination. Since but few of these cases can be admitted, dressings should not preclude the use of the hand.

One method whereby this could be effected may be the use of a protective dressing, the inner surface of which is lined with a fine mesh gauze to reduce the liability to adhere. The outer surface would be of material to provide an absorbent and protective layer. Such a dressing if 6 inches by 24 could be so tied as to cover the palm and the dorsum including the wrist but excluding the thumb (which in any case is less liable to injury) to permit use of the hand.

An alternative method consists of drying the hand by powdering and thereafter affording protection if necessary by the use of a transparent envelope which will allow of evaporation. It is not yet clear whether such a material is available.

Neither method has undergone sufficiently rigorous field trials to enable the Committee to decide which is preferable in any respect, but if dryness is accepted as an essential it is obvious that most materials utilised in envelope form will fail to produce this result except under conditions of meticulous supervision.

Follow-up attendances: Despite the large number envisaged it is thought that out-patients should reattend every 24 or 48 hours for inspection.

Anti-biotics: No local anti-biotic to be used but systemic penicillin (0.5 mega units) to be given when the case is first dressed. Thereafter its use will not be necessary if the burn is dry but in other cases it should be efficiently administered, i.e. every 24 hours.

Anti-tetanus injection: It is considered that the risk of tetanus (and there is a statistical risk of this complication in any burn) is probably no greater than the risk of anti-body reaction following uncontrolled injections. Therefore anti-tetanus injections are not recommended as a routine for post burn infection. Active immunisation would be preferable.

IN-PATIENTS

Fluid replacement: By mouth

The only exception to the rule that all burned patients shall be offered copious fluid by mouth immediately upon admission to hospital is when vomiting is already established. *It must be appreciated that the normal fluid requirements still require to be satisfied and that any fluid loss as a result of a burn represents an additional demand.* So far therefore as is practicable, both of these demands should be met by increased oral intake. This will not always provide a sufficiency and the intravenous route is then used.

By intravenous route

It must be expected that any adult with a 20% or more, and any child with an 8% or more body burn will require fluid given by the intravenous route—the fluids being plasma, blood and saline. All medical officers will not possess the requisite clinical judgment to enable them to prescribe the correct dosage and type of fluid (saline, blood, plasma and plasma substitutes). They will be assisted by a chart such as that suggested by the Ministry of Health Burns Committee which is shown in Appendix 1.

It is unlikely that sufficient plasma will be available so that some substitute will be required—at the moment none of those suggested appears to be ideal. DEXTRAN is anticoagulant, expensive and the chemistry is not fully worked out. There is some experimental evidence suggesting that its use increases sensitivity to radiation. It is a poly-saccharide substitute for protein loss.

PLASMOSAN (P.V.P.) extensively used by the Germans is another carbohydrate substitute, cheaper than Dextran and not yet generally available in Great Britain.

Of the other substitutes GELATIN appears to be promising and GUM ACACIA might have a greater freedom from secondary effects than any other. The practical difficulty is the shortage of bones and gum. In view of these difficulties very large supplies of saline and dextrose saline should be available.

Cleansing: By warm Cetrimide (1%) or G.11 by means of hoses or sprays, but many cases will require general anaesthesia.

Cover: Faces: Apply a water soluble vanishing cream to eyelids, lips and nostrils.

Hands: If the hand is capable of some use the same type of dressing suggested for the out-patient is advised. If the hand is totally incapable of use it should be splinted in the position of function using a Mason Allen splint after applying the suggested dressing. The Mason Allen splint is so easy to apply and is reversible, that it is recommended that stocks, in two sizes, should be available stamped out in light alloy. It should then be elevated preferably by slinging a roller towel to an overhead beam, or saline stand. The Committee desire to stress the dangers of using slings for elevation which take a purchase anywhere distal to the elbow joint.

Trunk: A similar dressing to that suggested for the hand but measuring 2 feet square with tapes attached to two of the sides to allow of fixation.

Leg: A similar dressing to the trunk, but half the width.

Anti-biotics: None to be used locally. It is felt that the absence of bacteriological control and of technical facilities of a high degree render the risk of secondary contamination so great that penicillin cream is considered undesirable. The haphazard and inefficiently controlled application of any anti-biotic tends to produce resistant strains of organisms without any guarantee of even initial sterility. Nothing is gained and much may be lost in the later phases of treatment when the anti-biotics may be essential. Adequate daily parenteral injections of penicillin, or modern alternatives as they become available are not subject to the same risk.

Protein loss: At the end of 48–72 hours the maintenance of normal blood levels by the intravenous route should no longer continuously be necessary. The problems of falling blood protein level are best attacked by mouth though if the patient is still vomiting a duodenal tube may be required. The diet should have a high calorie value, chiefly of protein but carbohydrates, saline and the vitamins must not be forgotten. Considerable quantities of fluid are still essential. In spite of this haemoglobin levels will still tend to fall and should be rectified as early as possible by repeated transfusion endeavouring to keep the level above 70%.

Continuation of treatment: During this stage a consultation team from the parent unit should be supervising the treatment as they will presumably be attending the hospital daily to advise when the more extensive burns should be transferred to the parent unit.

4. **Equipment.** In addition to the basic ward equipment stocks of the following will be required:

(a) *Fluids*
- Sodium bicarbonate
- Saline
- Glucose saline
- Blood
- Plasma
- Plasma substitutes
- 5% dextrose in 0.18 saline by mouth
- 5% dextrose in normal saline for intravenous route.

(b) *Dressings*
Tulle gras—in strips not squares and, Trunk, Leg—dressings as described above
Safety pins—large
Cetrimide 1% or G.11
Hoses or sprays
Containers for cleansing solutions
Towels—absorbent
Towels—roller.

(c) *Diet*
Protein substitutes
Casinal
Protein hydrolysates
Provisions for high protein diet by mouth
Ryles tubes
Polythene tubing (3 mm diameter)
Muslin
Vitamin C

(d) *Splints, etc.*
Mason Allen
Foot and back splints
Overhead beams
Saline stands
Electric fans
Electric hair driers
Kramer wire
Undines
Plaster of Paris

(e) *Instruments*
McIndoe forceps
Gillies forceps
Scissors
Intravenous sets and instruments

(f) *Refrigerators*

Parent hospital

1. **Beds.** The immediate stress will be taken by the existing beds but it is visualised that the total number of beds will have to be very materially increased in an emergency. Such expansion should be made into accommodation similar and adjacent to that already possessed by the plastic unit.

Operating theatres: There should be three operating tables for every 100 beds.

Dressing rooms: Facilities for carrying out dressings under conditions approaching theatre requirements are essential. There should be one dressing room for every 25 beds. Specialised bathing facilities should be available.

N.B. Both the operating theatres and dressing rooms will require staff additional to that needed for general nursing, e.g. 4 nurses and 2 orderlies per room or table per 24 hours.

2. **Medical personnel.** Ideally there will be for every 50 beds in the parent unit a minimum of 50 additional patients under its consultative or directive control either in cushion hospitals or annexes. To cover this total of 100 casualties the ideal staff would be—

2 Consultant Plastic Surgeons
1 Plastic Surgery Registrar
1 General Duties Officer
2 Anaesthetists
25 Nurses
5 Orderlies

These figures presuppose that the parent unit will have full assistance and co-operation from all the ancillary services, i.e. pathologist, haematologist, biochemist and dietitian.

3. **Treatment.** Will be directed by the Plastic Surgeon in charge of the Unit.

4. **Equipment.** Any increase over and above the normal number of beds, operating tables and dressing rooms existing in the parent unit in peace-time conditions, will require corresponding increases in instruments, trolleys, theatre lights, bowls, crockery, splints, overhead beams, saline stands, etc. etc. as listed under cushion hospital equipment.

Electric dermatomes require urgent investigation and should be made available immediately.

Annexe

Ideally this will be a small hospital but may well have to be a requisitioned nursing home or a large house, school, etc. It should be within easy reach of the parent unit and have a good water and sanitary supply. Cases will be sent to and from the parent unit in the intermediate stages of their surgical treatment.

1. **Beds.** It is impossible to estimate but it is assumed that approximately 30 beds will be needed for every 50 beds in the parent unit. The Committee realise however that this figure might be very greatly exceeded.

2. **Medical personnel.** There should be one General Duty Officer for every 60 beds. The Annexe will be visited as often as can be arranged, by a senior member of the parent unit.

There should be one day and one night sister for every 30 beds together with 12 nurses in training or V.A.D's.

3. **Treatment.** Will be directed by the surgeon sending the case supplemented as required during the visits of the surgeon from the parent unit.

4. **Equipment**

(a) *Fluids*
Blood, plasma, etc. will be drawn from the parent unit.

(b) *Dressings*
Tulle Gras
Gauze
Wool
Crepe bandages
Safety pins (large and small)
Cetrimide 1%
Hydrogen peroxide
Saline
Mercurochome
Spirit and powder for pressure points
Ether
Strapping ½″ 1″

(c) *Diet*	Provision for high protein diet by mouth.
(d) *Instruments*	McIndoe forceps Scissors Blood specimens collecting syringes Urine analysis set Urinals Bed pans Wheel chairs Intravenous and cutting down sets Foot and back splints Arm splints.
(e) *Sterilisers*	
(f) *Refrigerators*	

Summary of treatment of mass burns in warfare

It is felt that this will be best illustrated by describing the fate of four different cases. In discussing these however it is presupposed that they will have been screened to assess the likelihood of their suffering from a severe degree of incipient acute diffusing radiation illness. The presence of this factor may determine the patient's fate irrespective of the more obvious burn.

There will also be cases suffering from injuries associated with burns but with the exception of fractures of the spine it is anticipated the burn will usually take priority in primary treatment. But it is envisaged that at any time during the course of treatment of any patient the services of any other specialist e.g. neuro-surgeon, orthopaedic or thoracic surgeon, etc., will be available.

1. **Minor flash burn.** A considerable number of minor flash burns will be able to look after themselves and need not be diverted to a Hospital. It is suggested a patient coming under this category shall be issued with a small pot of some innocuous vanishing cream which he can apply to the affected area. Vanishing cream will serve two functions: (1) to limit cracking over joints, and (2) to act as a reassurance to the patient. Stocks of this cream could be kept by all C.D. personnel and A.R.P. Units.

2. **Moderate burn.** This patient will be seen first by a member of the Civil Defence. It is suggested that the burned area, other than the face, shall be covered by the cleanest material available—either some light linen or cotton sheeting preferably not more than one yard square with tapes on the corners. He will then proceed or be taken to the nearest Cushion Hospital, where the burn will be cleaned, dried and dressed; an injection of penicillin will be given. He can then return to his home or Evacuation Centre understanding that he is to be supervised every 24 hours.

3. **Severe burn.** This patient will have been covered with the light linen or cotton material by the C.D. personnel, given sedation without medical supervision and transported to the Cushion Hospital. He will be admitted, given systemic penicillin, and receive resuscitation measures. Upon recovery from the shock the affected areas will be cleansed and covered. Severe damage to the hands or face will be best treated by transference to the Parent Unit though it is envisaged that the numbers may preclude the admission of all cases. Under these circumstances the consultative assistance of a plastic surgeon would remain equally desirable. It is felt that these cases will constitute the bulk of those whom it is justifiable to treat. If he is admitted to the Parent Unit the affected area will be surfaced by skin grafts as soon as is possible after which the patient will be transferred to an Annexe. He will either be discharged from the Annexe if uneventful progress is made or return to the Parent Unit for further application of skin grafts at a time decided by the visiting Plastic Surgeon.

4. **Very severe burn.** The initial steps will be as in the severe burn but this patient will remain in the Cushion Hospital at least 4 days during which time resuscitation measures will continue, together with systemic penicillin.

He will not receive any treatment to the burn itself and certainly not an anaesthetic unless his general condition improves to such an extent as to warrant it. Otherwise he will be kept as comfortable as possible until death takes place.

Any decision to transfer these patients to the Parent Unit would preferably be made after consultation with the plastic surgeon as it is felt that this type of injury will not respond sufficiently rapidly to treatment to justify the occupancy of a bed to the exclusion of the less severely injured whose chances of economic and functional recovery are so much greater.

Note: This Burns Sub-committee report of 1952 is reproduced here for historical interest only as an Archive of the Association. Some 35 years later, many of its assumptions and recommendations for the treatment of mass burns in warfare appear remarkably naïve and their relevance in the context of a modern conventional or nuclear war would be negligible.

The British Society for Surgery of the Hand

At the invitation of Patrick Clarkson a dinner was held on November 7th 1952 at the Athenaeum. Present were Ronnie Furlong, J. I. P. James, Archibald McIndoe, Gerry Moore, Rainsford Mowlem, Guy Pulvertaft and James Whillis. It was decided to form a club to be known as "The Hand Club". Its object was to encourage the study of the surgery of the hand (Fig. 18.1). Jim Seddon and the Presidents of the British Orthopaedic Association and the British Association of Plastic Surgeons were invited to join for the duration of their terms of office and accepted. John Barron joined The Hand Club in 1953. The Club met regularly for the next twelve years at the hospitals of members, for lunch and a clinical morning. The membership was increased to twelve with an even balance kept between orthopaedic surgeons, anatomists, specialists in physical medicine and plastic surgeons. The Residents of the hospitals where these annual meetings were held were invited to the clinical part of the meetings but membership of the club was by invitation only; this allowed open criticism on clinical matters, a privilege enjoyed by everyone.

The restricted membership and exclusive nature of The Hand Club was a source of regret to many other surgeons who were interested in hand surgery.

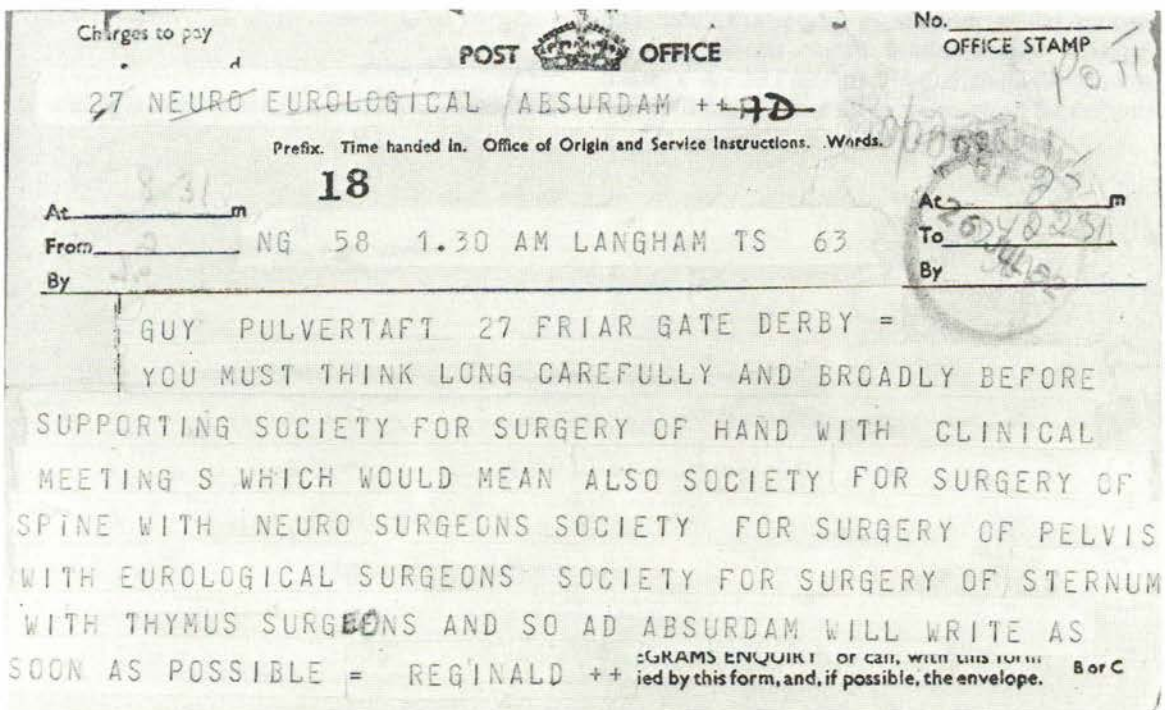
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Fig. 18.1 Telegram from Sir Reginald Watson-Jones, July 26th, 1952.

Partly as a result of this failure Donal Brooks, Dick Dawson, Adrian Flatt, Stewart Harrison, Douglas Reid, Robert Robins and Graham Stack held a meeting at the Royal Society of Medicine on January 13th 1956. They met in the bar, had dinner (price ten shillings and sixpence) and discussion followed. Adrian Flatt invited those attending to a clinical meeting at the London Hospital on the morning following. That weekend the talk was of forming a "Hand Society". On May 11th 1956 Adrian Flatt, Stewart Harrison, Douglas Reid, Robert Robins, and Graham Stack met in Derby and a decision was made to form "The Second Hand Club". With invitations to others initial membership numbered 19. Graham Stack was the permanent secretary of The Second Hand Club and the British Club until, in 1968, the post was taken over by Douglas Lamb.

The expected rivalry between the two clubs did not materialise and a joint meeting of the two was held at the Royal College of Surgeons on November 22nd 1958 under the Chairmanship of Sir Archibald McIndoe. A formal merger between the two clubs took place eventually, on October 8th 1964 at Charing Cross Hospital when "The British Club for Surgery of the Hand" was formed. On November 30th 1967 John Barron wrote to Graham Stack pointing out a number of important facts and suggested that Graham Stack should put the specialty of hand surgery in the UK on a much more formal basis—that of an association (but this would have produced the BASH!). On November 15th 1968 The British Club for Surgery of the Hand changed its constitution and became "The British Society for Surgery of the Hand". Agreement to publish the journal *The Hand* followed soon afterwards.

The "proceedings" of the early meetings of The Second Hand Club were cyclostyled sheets bound together quite simply by the enthusiastic secretary, Graham Stack. They were really designed as an *aide mémoire* of the formal discussions that had taken place and were for private circulation only. Their existence could not be concealed for long and those early cyclostyled pages later became the prototype Journal of the British Club for Surgery of the Hand, and later the official Journal of the British Society for Surgery of the Hand.

Soon the "informality" of the early travelling club became lost in the wider development of the Association of Hand Surgeons at national and international levels, with major regional, continental and international conferences. Organised seminars and workshops were held regularly in many different countries. The scientific contribution to the training sessions still relies heavily on input from plastic surgical and orthopaedic colleagues.

Acknowledgements

Invaluable assistance has been given by Graham Stack.

The British Association of Oral and Maxillo-Facial Surgeons

At the outbreak of World War I no provision had been made for dental treatment in the Field and no dental surgeons accompanied the Expeditionary Force to France. This long-drawn-out conflict, with static trench warfare, inflicted an enormous number of maxillo-facial casualties.

Charles Auguste Valadier, a Frenchman who had been taken by his parents as an immigrant to the United States, qualified from Philadelphia Dental College in 1901 and, later, returned to practise in Paris. It has been claimed (although not fully authenticated) that his arrival in a specially equipped Rolls-Royce to treat a severe toothache, suffered by General Sir Douglas Haig during the Battle of the Aisne in October 1914, was instrumental in the War Office being persuaded to send dental surgeons to France for service with Casualty Clearing Stations, being commissioned in the rank of lieutenant on the General List. In passing, it should be mentioned that the Army Dental Corps did not come into existence until January 4th 1921 but Valadier, although not medically qualified, was appointed as an honorary major in the Royal Army Medical Corps and established a special service for maxillo-facial injuries based at the 33rd General Hospital in Wimereux. About the same time, Varaztad Kazanjian, an Armenian by birth who had graduated from the Harvard Dental School in Boston, Massachusetts, was appointed chief dental officer of the volunteer Harvard University Medical Unit which proceeded to France shortly after the outbreak of hostilities and was attached to No. 22 British General Hospital based at Camiers. His remarkable success in the treatment of maxillo-facial injuries resulted in such descriptions by the Press as "The Miracle Man of the Western Front" and attracted the attention of Captain Harold Gillies, serving at that time as a general surgeon. He visited the hospitals at Wimereux and Camiers to learn the new techniques being developed and applied by Valadier and Kazanjian and was so impressed by the results that he decided to devote his remarkable energy and talents towards the establishment of a specialised hospital for the treatment of such complex and disfiguring wounds. His unique achievements require no further elaboration here.

The value of close co-operation with a dental surgeon in the treatment of such injuries had, therefore, already been impressed upon Gillies who was able to enlist the services of Captain Kelsey Fry, a dentally qualified medical officer who was, in 1916, recovering from wounds sustained from rescuing casualties from "No Man's Land", an achievement for which he was awarded the Military Cross. Kelsey Fry was later joined by Captain A. Fraser at Sidcup and major contributions were made by eminent dental surgeons in civilian hospitals such as Frank Colyer at Croydon, Alan Sheffield at Leeds and Warwick James at the Third London Hospital. The Unit at Sidcup closed in 1925. Kazanjian, to whom reference has already been made, returned to Boston, Massachusetts, where he received a medical degree from Harvard University in 1921. His services to the Allies were recognised by King George V who created him a Companion of St Michael and St George, while both Gillies and Kelsey Fry subsequently received knighthoods.

Between the First and Second World Wars

The sound foundations upon which plastic surgery had been laid down during the 1914–18 war enabled this specialty to survive, albeit with some difficulty, during the interim period before the onset of the 1939–45 conflict, although its existence depended, in the absence of the National Health Service, more upon private practice than the establishment of a national network of hospital departments such as

exists at the present time. However, dentistry had made a significant contribution to the treatment of maxillo-facial injuries. This was essentially on an individual rather than a co-ordinated national basis and did not result as in the case of plastic surgery, in the creation of a new specialty at the cessation of hostilities. This may well have been due to the fact that the dental contribution was primarily prosthetic rather than surgical.

In 1936 the Army Advisory Standing Committee published a White Paper in which it was recommended that, in the event of any future conflict, special hospitals or departments of general hospitals, should be established for the specific treatment of maxillo-facial injuries. It was, furthermore, recommended that dental officers should be attached to field ambulances, main dressing stations and casualty clearing stations.

World War II

The Emergency Medical Service in 1939 decided to establish a number of Plastic and Jaw Units in the United Kingdom under the general direction of Sir Harold Gillies and Sir William Kelsey Fry, which were organised upon similar lines to those which had proved so successful at Sidcup. Two military maxillo-facial units accompanied the British Expeditionary Force to France, being based at Dieppe and Boulogne. At the latter location Major George Hankey was the specialist dental officer who had the misfortune to be taken prisoner of war at the time of Dunkirk and who was subsequently to become the second President of the British Association of Oral Surgeons.

After the evacuation from France, six Plastic and Maxillo-Facial Surgery Units were formed. In addition there were two other Units which served exclusively in India (see Chapter 1). The formation of these specialised teams of plastic surgeon, specialist anaesthetist and dental surgeon, working closely with neurosurgeons, created the foundation upon which the post-war development of these specialties would be based. The rôle of the supporting services during the war and subsequently should not be overlooked, in particular the contributions made by the dental technicians without whose expertise many of the advances in treatment would not have been possible.

Events since 1945 and the National Health Service

During the early years of the war the national Government of the day invited Sir William Beveridge to report on Social Insurance and Allied Services. The report that bears his name was published in November 1942. One of its recommendations was the establishment of a National Health Service and this was introduced under the first post-war Government. Without the financial backing provided by the National Health Service it is highly unlikely that the war-time plastic, oral and maxillo-facial surgery units would have survived the transition to peace. The Emergency Medical Service, which continued to function until the start of the National Health Service in July 1948, offered a number of trainee registrar appointments to ex-Servicemen who wished to specialise and take higher qualifications. For the younger generation, recently demobilised and without a previously established practice or appointment to which to return, this was an attractive proposition which offered, at the same time, the opportunity to be trained while receiving a pensionable salary together with the possibility of achieving consultant status in the impending National Health Service. In so far as dentistry was concerned, events had taken place which would be of paramount importance in establishing the position of this specialty within the general framework of hospital practice from which oral surgery would evolve.

The formation of the Faculty of Dental Surgery in 1947 and the establishment of the Fellowship examination in May 1948 were important steps in effecting a proper status for, and adequate recognition of, the dental specialist and consultant within the projected National Health Service, and enabled a suitable training pathway to be devised for the future.

The development of oral surgery

During the early years of the National Health Service it was expected that oral surgery would develop primarily in the civilian Plastic and Jaw Surgery Units which had been established during the war, and that a close integration with plastic surgery and the British Association of Plastic Surgeons would be maintained. This was, indeed, the case initially and most consultant dental surgeons became Associate Members of that organisation. In 1952 some concern had been expressed with regard to the reduction, by the Ministry of Health, in the establishment of senior dental registrars in plastic surgery units and the Honorary Secretary of the BAPS circulated a fact-finding

questionnaire. On October 22nd 1952 he wrote the first of several letters

> At a recent meeting of the Joint Committee of the Royal College of Surgeons and the British Association of Plastic Surgeons, the effect of the recent reduction in the total number of senior dental registrars upon the dental surgery departments of plastic surgery units was considered. It was noted that some plastic surgery units hitherto enjoying the services of a senior dental registrar are now without such a man on their establishment. Other units were allowed the part time services of such a registrar who spent the remainder of his time at the local School of Dentistry.
>
> If any approach is to be made to the Ministry of Health or Faculty of Dental Surgery with a view to increasing the number of senior dental registrars allocated to plastic surgery units it is essential that the representatives possess the fullest information. The Committee have therefore instructed me to write to you on this matter requesting that you complete the enclosed questionnaire and return it to me at the above address within the next three weeks.

In March 1953 a letter was sent to the Honorary Secretary concerning the specific problem of a senior registrar at Rooksdown House, Basingstoke. This was considered by the Council of the BAPS and referred to the Joint Committee which included representatives of the Royal College of Surgeons of England and which, in turn, suggested that it would be best if a meeting of consultant dental surgeons working in Plastic and Jaw Units were to be convened to discuss such problems and report back. The President of the BAPS therefore convened a meeting at Salisbury on September 11th 1953 to ascertain whether those consultant dental surgeons present were in favour of forming a Dental Section. The matter was adjourned until the following day when it was resolved that a committee should be elected to represent a dental section of the BAPS, and that membership should be restricted to Associate Members of the BAPS.

A further meeting was held later at the Royal College of Surgeons of England when, *inter alia*, it was resolved that a committee should be formed, based upon regional representation, to promote the interests of dental surgery in relation to plastic surgery. The Council of the BAPS was then asked to consider the incorporation of this committee of dental surgeons as a sub-committee of the Council of the BAPS, at their meeting on January 21st 1954. On February 12th 1954 a letter was received from the President who stated that the Council considered that the purpose of the Salisbury Meeting of Dental Surgeons was to review the dental registrar position, and that the approach to the Ministry of Health for such a purpose should be made through the Faculty of Dental Surgery of the Royal College of Surgeons of England and/or the British Dental Association. The letter concluded by affirming that the BAPS was too small and too new to sustain the fragmentation of separate sections. It was also suggested that a meeting should take place between the President and Honorary Secretary of the BAPS, N. L. Rowe (Chairman of the Salisbury "Dental Section") and E. J. Dalling (Honorary Secretary). This took place at the Royal Society of Medicine on March 8th 1954 and, in a Memorandum of March 31st 1954, the Honorary Secretary of the BAPS reaffirmed the views which had been set out previously by the Council.

Hospital dental staff

Although a Hospitals Group of the British Dental Association had been in existence prior to the introduction of the NHS there was now a growing sense of conviction that hospital dental staff had no effective means of representation with the Ministry of Health comparable with that which existed for hospital medical staff who had an effective negotiating machinery through the medium of the Central Committee for Hospital Medical Services and the Joint Consultants Committee. At the Annual General Meeting of the Hospitals Group of the BDA in September 1954 it was resolved that a Central Committee for Hospital Dental Services should be formed but, when this failed to materialise after some six years, a further meeting was convened at the Royal College of Surgeons of England, on July 23rd 1960, with the encouragement and support of Sir William Kelsey Fry and Professor Frank Wilkinson. This resulted in the formation, in 1962, of the Central Committee for Hospital Dental Services with, eventually, representation on both its Central Medical counterpart and the Joint Consultants Committee.

Contemporaneously with the events described, and arising out of an informal discussion between Norman Rowe and John Hovell one winter's evening in 1960, the conclusion was reached that the specialty of oral surgery had reached the stage when it should form an association and publish its

own journal. Accordingly, a Steering Committee was set up which met at the Royal Society of Medicine at monthly intervals, the members of which were: T. Ward (Chairman), N. L. Rowe (Honorary Secretary), D. Downton, B. W. Fickling, G. T. Hankey (President Elect), T. Cradock Henry, J. H. Hovell (Honorary Editor), Professor H. C. Killey (Honorary Treasurer), D. M. Macdonald, B. Steadman and R. Sutton Taylor.

The birth of the British Association of Oral Surgeons

The Committee formally resolved, on February 26th 1962, that a British Association of Oral Surgeons should be formed. A draft constitution was drawn up and circulated to 75 consultants inviting them to become Foundation Fellows and to attend an Inaugural Meeting in the Cuthbert Wallace lecture theatre of the Royal College of Surgeons of England on April 14th 1962; 73 acceptances were received and 52 signified their intention of attending.

Mr Rowe, as Chairman, commenced the proceedings with a short introductory talk in which he gave the reasons for forming a British Association of Oral Surgeons. He said that the status and scope of the specialty in the United Kingdom was somewhat confused at the present time. There were at least two professorial Chairs and, in recent years, advertisements were constantly appearing relating to hospital posts in oral surgery. However difficult it might be to define this specialty and however diverse might be the qualifications and experience of those who were interested in this field of surgery, it was becoming abundantly clear that both medical and dental practitioners in general practice were tending to refer problems related to the teeth, jaws and their associated structures to certain specialised centres in each Region.

This changing concept of hospital dentistry had been brought about partly by the retention within the National Health Service of the concept of Maxillo-Facial Surgery Units formed during the Second World War, partly by the greatly improved academic standards brought about by the introduction of the Fellowship in Dental Surgery and other higher qualifications and partly by the opportunity afforded by the NHS for the pursuit of a specialised career in the hospital service. These factors had led to the gradual emergence of Oral Surgery as a special branch of hospital practice, and the acceptance of this specialty as an integral part of the hospital surgical team.

A motion was put, "That this Meeting is in favour of the formation of a British Association of Oral Surgeons", proposed by Mr A. Weldon Moule and seconded by Mr J. Draper Cambrook. This was agreed unanimously.

The first Clinical Meeting and Annual Dinner were held at The Queen Victoria Hospital, East Grinstead on October 5th–6th 1962. The Arms and Crest of the Association were assigned on June 30th 1962 and *The British Journal of Oral Surgery*, now entitled *The British Journal of Oral and Maxillo-Facial Surgery*, was first published in July 1963.

In 1985 the membership totalled 1,073 with representatives in over 50 countries. Fellows of the Association, who must be predominantly engaged in the practice of oral and maxillofacial surgery in the British Isles and employed in this capacity as consultants in the National Health Service, amounted to 247. Further recognition of the evolution of the specialty was given by the Royal College of Surgeons of Edinburgh by the institution of the FRCS in Oral and Maxillofacial Surgery, the first examination being held in January 1985.

Thus the necessity for professional unity, for both clinical and representative reasons, led to the formation of the British Association of Oral Surgeons, which changed its name to the British Association of Oral and Maxillofacial Surgeons on September 25th 1982 so as to represent more exactly the functions and objectives of the Members who appreciate, nonetheless, that maxillofacial surgery involves many disciplines and is not the prerogative of a single surgical entity.

References

McDowell, F. (1963). History of the American Association of Plastic Surgeons to 1963. *Plastic and Reconstructive Surgery*, **32**, 240.

Paletta, F. X. (1963). History of the American Society of Plastic and Reconstructive Surgery. *Plastic and Reconstructive Surgery*, **32**, 101.

Rowe, N. L. and Killey, H. C. (1968). The evolution of the treatment of maxillofacial injuries. In *Fractures of the Facial Skeleton*. 2nd Ed., p. 825. Edinburgh: Livingstone.

The British Association of Plastic Surgery Nurses

The formation of the Association of Plastic Surgery Nurses in 1963 was the brainchild of A. B. Wallace, consultant plastic surgeon in Edinburgh. Mr Wallace had long recognised the vital role of the nurse in the plastic surgery and burns team and devoted much of his professional life to raising standards of nursing care by encouraging improved specialist education and professional organisation. One of his major contributions in this respect was to organise and chair a meeting, in spring 1963, of a group of nurses working in the plastic surgery and burns specialty, at which he proposed the formation of an Association of nurses and others working in plastic surgery and burn units to complement the Association of Plastic Surgeons. This inaugural meeting was attended by:

Miss McKnoughton	Senior Nursing Officer, Ministry of Health Scotland
Miss M. Morriston Davies	Sister, Mount Vernon Hospital, Northwood, Middlesex
Miss E. Redpath	Edinburgh
Miss M. J. Wright	Sister, Mount Vernon Hospital

A Chairman and Secretary were elected provisionally and the aims of the Association which were agreed then remain, in principle, the same in 1986:

1. To promote and develop the art and science of nursing patients following plastic surgery, burn trauma and maxillofacial surgery.
2. To encourage and co-ordinate education and research in the field of plastic surgery and burns nursing.
3. To conduct and participate in conference meetings and study groups in furtherance of plastic surgery and burns care expertise.
4. To encourage and promote the interchange of knowledge and ideas between the Association and similar bodies overseas which are affiliated to the International Confederation of Plastic Surgeons, by arranging and facilitating visits and travel to Commonwealth and foreign countries and by arranging and facilitating visits by members of such bodies to the United Kingdom.
5. To form and maintain a close liaison with the British Association of Plastic Surgeons and to co-operate with them in all matters pertaining to plastic surgery and burn care.

Surgeons, matrons and ward sisters of plastic surgery and burn units throughout the British Isles were circulated with information about the inaugural meeting and about a second meeting to be held later the same year in The Hospital for Sick Children, Great Ormond Street, London. The response was varied; some surgeons supported the formation of a Plastic Surgery Nurses Association, some were against it, some matrons for, some against, but 95% of ward sisters were for the Association. As is always the case, some letters were unanswered.

Proper recognition

Representation was made to the Royal College of Nursing for affiliation, or at least a recognition of interest. At this stage they were not interested and actually objected to the idea on the grounds that "breakaway organisations" might damage professional unity.

The Great Ormond Street Hospital meeting was a great success. The Constitution was agreed and Officers and Committee members were duly appointed:

President:	Lady Gillies
Vice-President:	Mr A. B. Wallace
Treasurer:	Mr A. Wooton
Chairman:	Miss M. Morriston Davies
Secretary:	Miss E. Redpath

Members from Newcastle offered to host the next meeting in May 1964 which was to be a clinical meeting or conference. This offer of hospitality for future conferences has become a regular feature of the Association's annual general meetings. The meeting in Newcastle was well attended and consisted of interesting and well illustrated lectures and visits to the local plastic surgery wards. The social events of the meeting were generously sponsored and social interaction has remained a feature of all subsequent meetings. During 1964 the Association was put on a firm legal footing with printed rules, and the first Newsletter was circulated to all members. Later that year Miss Redpath had to resign as Secretary because of ill-health and the Association was fortunate in that Miss M. J. Wright agreed to undertake the considerable secretarial work needed to maintain the Association's progress.

In April 1965 a combined Annual General Meeting and clinical meeting was held at Mount Vernon Hospital, Northwood, Middlesex. By this time there were 88 Members, including representatives from England, Scotland, Wales and Northern Ireland.

In May 1965 a letter was received from Mr J. Hage, a Dutch plastic surgeon, suggesting liaison with Dutch plastic surgery nurses who, at that time, had no association of their own. As a result of this letter some Dutch Members joined the British Association and attended the next BAPSN Conference held at Queen Mary's Hospital, Roehampton. Members of the Association were then invited to attend a meeting in Edinburgh of the International Society for Burn Injuries and the Association sponsored a delegation to attend in September 1965. In November 1965 our Annual General Meeting was held at St Mary's Hospital, Roehampton. Lady Gillies and A. B. Wallace both presented papers at this well attended meeting and the committee members met with the British Association of Plastic Surgeons at its meeting in London to exchange ideas regarding the future aims of the Association.

Miss D. Mosebury, from Whiston Hospital, Prescot, who was the Association Secretary from 1965 to 1971, was responsible for arranging for 18 BAPSN Members to attend the 4th International Conference of Plastic Surgeons in Rome in 1967.

Association badge

In 1967 the Members decided to have an Association badge. A design competition was arranged and it was agreed that the choice be made at the next meeting, to be held in Spring 1968 at Bangour General Hospital and the Hospital for Sick Children, Edinburgh. The badge design carries the head of Nefertiti. This choice was made because she was said to be a woman of perfection and the design therefore signifies "perfection as the ideal result of plastic surgery, and perfection in one's work as the ideal of the nurse". The words "Ad Perfectionem" were inscribed around the top of the badge and the initials BAPSN around the lower edge. Due to some clerical error the head on the badge is facing the wrong way! However, this has never detracted from its attractiveness and nurses are still proud to wear it.

Over the next two years Miss Mosebury organised the first International Congress of Plastic Surgery Nurses, held in Holland in 1970, hosted by the recently formed Netherlands Association of Plastic Surgery Nurses. The venue for this 5-day meeting was the Tiltenburg Congress Centre, Vogelenzang. The Association Members gave lectures on a variety of subjects and the enthusiastic reports recorded in the Newsletters clearly indicate the value of this liaison with our European colleagues.

The Rose Bowl

During the early years of the Association Mr F. I. Herbert, consultant plastic surgeon, Shotley Bridge Hospital, Consett, gave his wholehearted support and helped to host the June 1967 clinical meeting. Following his death, a memorial fund was set up and the proceeds spent on providing a silver rose bowl which is presented annually to the winner of a competition for the best patient-care study. In 1971 the first presentation of the F. I. Herbert Rose Bowl was made to Miss M. C. Bromley of Wexham Park Hospital, Slough for a care study on the use of "Halo" fixation for the treatment of fractures of the mandible. The Rose Bowl was presented by S. H. Harrison who gave a small replica bowl for Miss Bromley to keep, and this practice of presenting the winner of the competition with a replica bowl has continued. The Rose Bowl was christened with champagne which, it was believed, would have been in accordance with Mr Herbert's wishes.

In 1963 the Association published its first Newsletter, edited by Miss E. Laye, and this annual publication has continued, graduating from a duplicated Newsletter to a printed magazine in 1973.

Presentation to Lady Gillies

The Association held its 18th Annual Meeting at Caerleon, near Chepstow, Wales on September 12–14 1984. The President, Lady Gillies, was invested by Miss Lamb with the silver chain and medallion of office (Fig. 20.1) which had been made personally by Miss Queenie Jackson who, until she retired in 1982, was Matron of St Andrew's Hospital, Billericay, Essex. The heavy medallion measures 8.5 cm × 6 cm and on its obverse the head of the Nefertiti is shown in relief (Fig. 20.2).

Fig. 20.1 The presentation of the chain and medallion to Lady Gillies by Miss B. E. Lamb. September 1984. (Reproduced in the *British Journal of Plastic Surgery*, 1985, **38**, 133.)

Textbooks for plastic surgery nurses

Over the years, in addition to several articles in the medical and nursing journals, five textbooks for plastic surgery nurses have been written by Members of the Association and Members of the British Association of Plastic Surgeons.

Plastic Surgery: An Introduction for Nurses. C. R. McLaughlin. London: Faber, 1951.

Plastic Surgery for Nurses. I. A. McGregor and W. Reid. Edinburgh: Livingstone, 1966.

The Management and Nursing of Burns. J. Ellsworth Laing and Joyce Harvey. Hodder and Stoughton 1967 1st Edition, 1971 2nd edition.

Plastic Surgery and Burns Nursing. J. V. Harvey Kemble and Brenda E. Lamb. London: Ballière Tindall, 1984.

Essentials of Plastic and Reconstructive Surgery. B. D. G. Morgan and Margaret Wright. London: Faber, 1986.

Nationally organised Courses for plastic surgery nurses

From the outset one of the stated aims of the Association was to encourage a nationally co-ordinated training course for plastic surgery and burns nursing. In 1963 a few plastic surgery centres offered their own specialised training schemes, and many more followed their example. It was not until 1977 that a national training scheme for SRNs and SENs was implemented by the Joint Board of Clinical Nursing Studies. These were registered as Course No. 264 Plastic Surgery and Burns Nursing for SRNs, and Course No. 268 Plastic Surgery and Burns Nursing for SENs. This national recognition of the need for specialised training and the subsequent co-ordination and monitoring of courses has contributed much to nursing education. In 1983 the Joint Board of Clinical Nursing Studies was disbanded and replaced by the English National Board. The two Plastic Surgery and Burns Nursing Courses were immediately registered with the ENB, retaining the same course and titles. The National

Fig. 20.2 The silver medallion and chain of office of the President of the British Association of Plastic Surgery Nurses. (Reproduced in the *British Journal of Plastic Surgery*, 1985, **38**, 133.)

Board for Nursing, Midwifery and Health Visiting for Scotland performs a similar function and has registered one course for RGNs in Burns and Plastic Surgery.

The present time

In 1986 there are 400 Members and the Association continues to provide a forum for the updating of education in the specialty and exchanging ideas and information. New faces appear and some older ones linger on. Miss Morriston Davies, a founder member, continues to participate actively in all the Association's activities and she supplied almost all of the information included in this brief history of the Association. Meetings continue to be held in different parts of the country each year. The British Association of Plastic Surgery Nurses is now 23 years old: long may it continue to flourish.

Annual Meetings of the British Association of Plastic Surgery Nurses

1963	Great Ormond Street Hospital, London
1964	Royal Victoria Infirmary Hospital and Hospital for Sick Children, Newcastle
1965	Mount Vernon Hospital, Northwood, Middlesex
1965	Queen Mary's Hospital, Roehampton, London
1966	? Queen Victoria Hospital, East Grinstead
1967	Shotley Bridge General Hospital, Consett
1967	Odstock Hospital, Salisbury
1968	Royal Hospital for Sick Children and Bangour General Hospital, Edinburgh
1968	Frenchay Hospital, Bristol
1969	Alder Hey Childrens Hospital Whiston Hospital, Liverpool
1969	Wexham Park Hospital, Slough
1970	Holland (International Meeting)
1970	Mount Vernon Hospital, Northwood, Middlesex
1971	Canniesburn Hospital, Glasgow
1972	Odstock Hospital, Salisbury
1973	St Lawrence Hospital, Chepstow, Wales
1974	St Andrew's Hospital, Billericay, Essex
1975	Glasgow Royal Infirmary
1976	Bridge of Earn Hospital, Perth
1977	Wexham Park Hospital, Slough
1978	Sharoe Green Hospital, Preston
1979	West Norwich Hospital, Norfolk
1980	Withington Hospital, Manchester
1981	St Andrew's Hospital, Billericay, Essex
1982	Ulster Hospital, Dundonald and Royal Victoria Hospital, Belfast
1983	Odstock Hospital, Salisbury
1984	St Lawrence Hospital, Chepstow, Wales
1985	Queen Mary's Hospital, Roehampton, Aylesbury
1986	Mount Vernon Hospital, Northwood, Middlesex

Association officers

President 1963–date	Lady Gillies
Vice-President 1963–1974	A. B. Wallace
Vice-President 1983–date	Miss O. M. Jackson
Treasurer 1963–1976	Mr A. L. Wooton
Treasurer 1976–date	Miss J. Harvey
Chairman 1963–1964	Miss M. Morriston Davies
Chairman 1965	Miss Carter
	Mr Worthington
Chairman 1966–1967	Miss M. J. Wright
Chairman 1968–1980	Miss M. Morriston Davies
Chairman 1980–date	Miss B. E. Lamb
Secretary 1963	Miss E. Redpath
Secretary 1964	Miss McLaren
	Miss M. J. Wright
Secretary 1965–1971	Miss D. Mosebury
1971–1980	Miss M. J. Wright
1980–1981	Miss B. E. Lamb
1981–1984	Miss S. Skeete
1981–date	Miss S. Martin

Newsletter/Magazine Editors

1963	Miss E. Laye
1964	Miss M. Morriston Davies
1965	Miss D. M. Walsh
1966	Mrs I. Carter
1967–1972	Miss J. A. Allsop
1973–1981	Miss T. Woods
1982–date	Miss B. E. Lamb

The Plastic Surgery Senior Registrars' Travelling Club

For several years after its foundation in 1946 the Winter and Summer Meetings of the Association were the focal point of activity, exchange of views, lectures and medico-political gossip. At this time very few senior registrars were in post and it is easily forgotten how many of the big plastic surgery units relied on registrars to "hold the fort" when their seniors were away at these clinico-social meetings. Study leave was not a statutory feature of the junior medical staff contract and "study days" were unknown. Inter-unit visits were often made, occasionally overseas visits could be organised by arrangements with one's chief and various overseas contacts, but financial support was not always easy to obtain. As the Association grew in size and more senior registrars were appointed, the subject of the formation of a Senior Registrars Committee was raised at BAPS Council, one of the main proponents being Mr John Barron. It seems that this suggestion engendered a good deal of debate and a fair amount of opposition, one of the main concerns being that the group might become politically powerful. After much deliberation it was agreed that Mr Ivor Broomhead, then Honorary Secretary, should write to all the consultant plastic surgeons suggesting that the senior registrars might wish to take up the initiative to form a committee, which would be given the full support of the Association.

The reaction to this suggestion was immediate. A letter was distributed, signed by Barry Corps, Patrick Whitfield, Brian Morgan and Magdy Saad, to call all senior registrars to the forthcoming BAPS Research Meeting to be held at Wexham Park Hospital on April 19th, 1969. There were twelve SRs present at this, the inaugural, meeting of the Senior Registrars Committee, including:

John Bowen (East Grinstead)
Bob Campbell (Leeds)
Tom Cochrane (East Grinstead)
Barry Corps (Birmingham)
Peter Davis (Oxford)
Malcolm Deane (Bristol)
Sanu Desai (Stoke Mandeville)
David Harris (Manchester)
Len Holbrook (Liverpool)
Brian Morgan (Mount Vernon)
Magdy Saad (Salisbury)
David Tolhurst (East Grinstead)

It was decided that they should meet twice annually, at the BAPS Research Meeting. Barry Corps was elected Chairman and Magdy Saad Secretary. By the end of the year, however, both had been "elevated to the peerage" and it was decided to continue with a single officer, that of Secretary, and the task of steering the Committee was given to John Bowen.

At the Spring meeting 1970 at East Grinstead a "formal" constitution was written. The aims of the Committee were documented as follows:

1. To keep an eye on the senior registrar's training and appointments.
2. For the promotion of friendship between senior registrars.
3. To provide a spokesman to represent the senior registrars' views when BAPS Council wished to ascertain them.
4. To organise joint research projects between units.

After this meeting further meetings were marred by lack of support, being badly attended, rather brief and possibly too political. In the following year, 1971, David Evans (Oxford) and John Lendrum (Bristol) learned of the newly formed Neurological Senior Registrars' Travelling Club and along with Roy Sanders (Mount Vernon) who had expressed a good deal of dissatisfaction with the state of affairs, suggested at the SRC Meeting at the Royal College of Surgeons in London on

December 2nd 1971 that a similar club be established for plastic surgery. Thus the SRTC was formed and Roy Sanders elected as its first Secretary. It was agreed to continue to hold twice-yearly meetings but that these should be at times completely separate from other national meetings (which in the present day is becoming increasingly difficult!). It was felt that not only should these meetings be a forum in which to discuss political problems but that they should also give an opportunity for the local consultants to demonstrate their particular expertise. The local senior registrar would be the organiser and host for the event.

With characteristic dynamism, Graham Lister (Canniesburn) quickly offered his services for the inaugural meeting.

The first Canniesburn meeting

The first meeting of the SRTC was held in Canniesburn from March 23rd to March 25th 1972 (Fig. 21.1). Graham Lister and Gwyn Morgan were given the enthusiastic support of the Glasgow Unit and organised a meeting whose excellence set the standard for the future and ensured the success of the Club. Each day began at 8 am, there being a series of operative demonstrations and formal talks, given by Messrs. Gibson, McGregor, Mustardé, Reid and Jackson. Lectures were also given by pathologists, radiotherapists and dermatologists and a talk on the future of higher surgical training was given by Sir Robert Wright, PPRCPS (Glasgow). The social scene, however, was not to be outclassed by the superb content of the scientific. Two dinners and a memorable Saturday in the Trossachs were included and the meeting brought to a close by an expedition led by Mr Tom Gibson across the Lake of Mentieth to Inchmahome Priory. Those recalling the events of these three days mention the Club's logo (Fig. 21.2) which seemed to appear everywhere, from the ferry boat landing stage to the cisterns in the toilets! Subsequent meetings would obviously have extreme difficulty in surpassing this success.

Meetings of Senior Registrars' Travelling Club

Date	*Venue*	*Hosts*	*Secretary*
1972 Spring	Canniesburn	Graham Lister/Gwyn Morgan	Roy Sanders
Autumn	Mount Vernon	Roy Sanders	Roy Sanders
1973 Spring	Oxford/Stoke Mandeville	David Evans/Phil Sykes	Roy Sanders
Autumn	Roehampton/GOS/St. Thomas	Tim Milward/Henry Goldin	Tim Milward
1974 Spring	Bristol	Paul Townsend	Tim Milward
Autumn	Leeds/Bradford	Mike Green/Chips Browning	Tim Milward
1975 Spring	East Grinstead	Bob McDowall	Eric Gustavson
Autumn	Billericay	Brian Sommerlad	Tim Milward
1976 Spring	Dublin	Matt McHugh	Brian Sommerlad
Autumn	Manchester	Clive Orton/Colin Rayner	Brian Sommerlad
1977 Spring	Salisbury	John Hobby	Brian Sommerlad
Autumn	Canniesburn	Gus McGrouther/Lance Sully	Brian Sommerlad
1978 Spring	Stourbridge	Douglas Murray	Gus McGrouther
Autumn	Newcastle	Mike Black	Gus McGrouther
1979 Spring	Belfast		Peter Davenport
Autumn	Sheffield	Hugh Henderson	Peter Davenport
1980 Spring	Chepstow	Martin Milling	Bob Page
Autumn	Edinburgh	John McGregor	Peter Davenport
1981 Spring	Bristol	Clive Reid/Teung Eu	Peter Davenport
Autumn	Mount Vernon	Paul Smith	Paul Smith
1982 Spring	Stoke Mandeville/Oxford	Chris Khoo	Paul Smith
Autumn	Leeds/Bradford	David Sharpe	James Emerson
1983 Spring	Billericay	Brook Berry	James Emerson
Autumn	Liverpool	John Stilwell	James Emerson
1984 Spring	West Middlesex	Barry Jones/Richard Matthews	Richard Matthews
Autumn	East Grinstead	Derek Mercer/Trevor O'Neill	Richard Matthews
1985 Spring	Canniesburn	Andy Batchelor/Eric Freedlander	Simon Kay
Autumn	Oxford	Tony Rowsell	Richard Matthews/ Roger Green
1986 Spring	Stourbridge	Aiver Bracka	Roger Green
Autumn	Wexham Park	Ruth Rayment	Roger Green

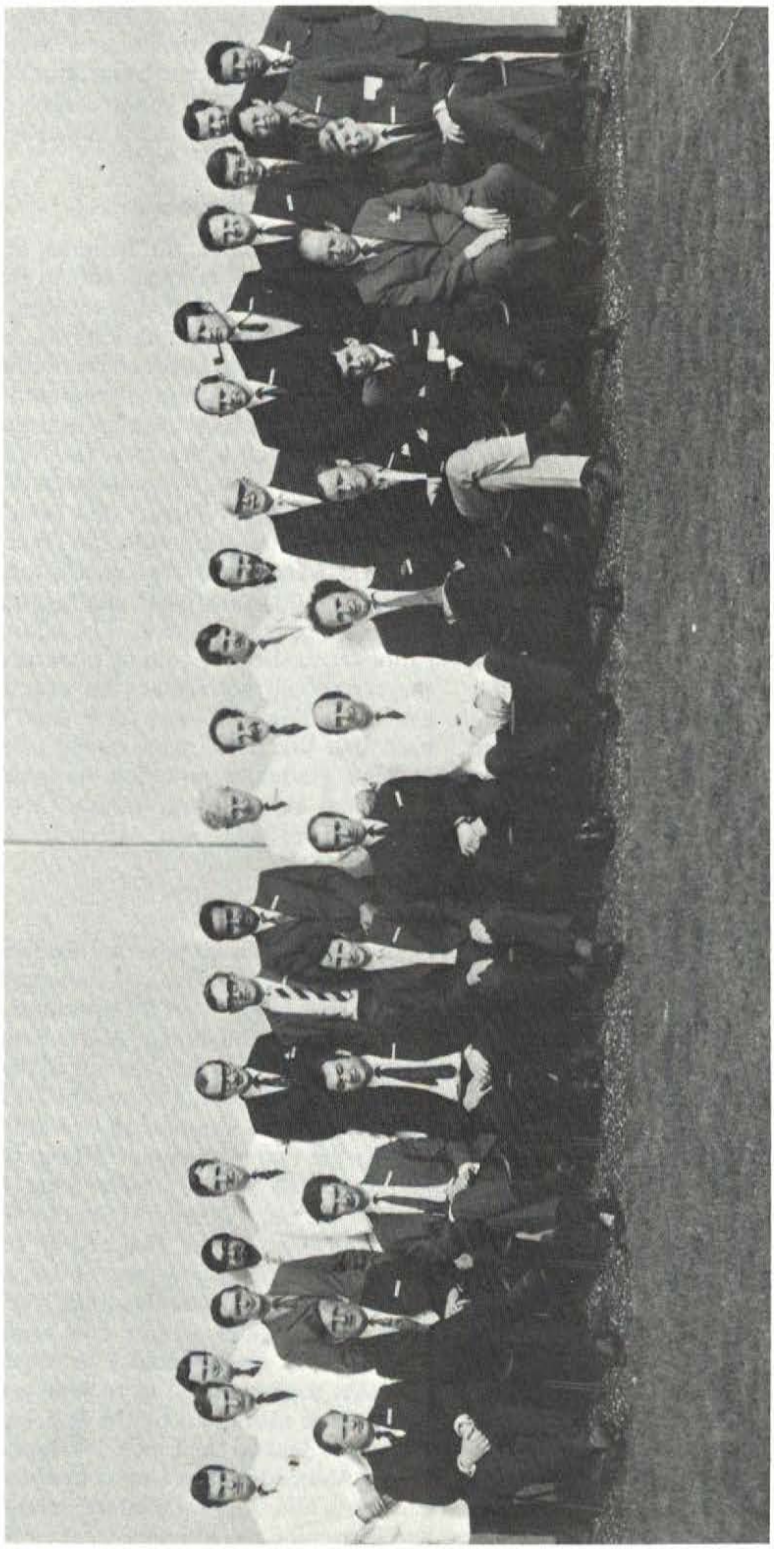


Fig. 21.1 The Plastic Surgery Senior Registrars' Travelling Club at its Inaugural Meeting at Canniesburn, March 1972.
Rear row (from left to right): A. Morris, T. M. Milward, M. H. C. Webster, I. T. Jackson, G. S. Jeetle, I. A. McGregor, F. S. C. (Chips) Browning, J. Lendrum, S. N. Desai, T. Gibson, W. H. Reid, R. G. Morgan, Derek Henderson, J. C. Mustardé, G. Blake, C. W. Williams, M. F. Green, ——, R. Page (rear), ——, ——. *Front row* (from left to right): J. P. Bennett, M. E. H. Hackett, R. A. W. McDowall, J. H. Goldin, D. M. Evans, R. Sanders, G. D. Lister, J. E. Bowen, D. E. Tolhurst, M. Gipson, D. Crockford, K. C. Paton.

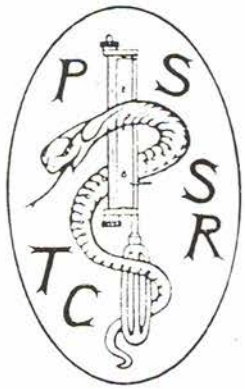


Fig. 21.2

Training and accreditation

From its inception, the SRTC has had as its main medico-political aim improvement in the standards of plastic surgical training in the country and, as such, has always played an active part in discussions and proposals.

After an editorial in the Journal in April 1970 on "Training of Plastic Surgeons", written by Mr Denis Bodenham, then Chairman of the Joint Committee on Higher Surgical Training, which severely criticised "the haphazard method of 'do-it-yourself' training", John Bowen invited Mr Bodenham to discussions with the SR Committee and several meetings took place. These resulted in the setting up, in 1972, of the Instructional Courses held on the first day of the BAPS meetings.

Two years later Tim Milward circulated all SRs prior to the Presidency of Mr John Barron, who again met the SRs for regular discussions on training and this pattern has been the basis for the regular subsequent presidential meetings.

A most important step forward with regard to training has, in very recent years, followed surveys conducted by Richard Griffiths and Richard Matthews. These surveys formed the basis for lengthy discussions from which a list of suggestions and recommendations were drawn up and presented to Mr Tempest at the West Middlesex Meeting in the early part of 1984. This envisaged a "tubular concept" of training whereby an SHO, once taken into specialised training, should be able, if found competent, to proceed to a consultancy without fear of lack of an available job. These suggested patterns of training were presented at the Winter Meeting of BAPS in December 1984 and it was recommended by BAPS Council that a committee should be set up as an offshoot of the Research and Education Committee and that two senior registrars, Richard Matthews and Simon Kay, be included in the six person training and accreditation working party. This has recently published its proposals for future training in plastic surgery.

The Specialist Fellowship

The first mention in the Minutes of a Specialist Fellowship examination appears in 1977, following discussion at the September meeting in Glasgow. It was felt that an examination was undesirable for several reasons, but particularly because of the fear that it would discourage original and independent thought during plastic surgical training and that it would be difficult to set up a "fair" examination at this level of training. The question of instituting a Diploma in Plastic Surgery had been discussed by BAPS Council on June 14th 1962 but, since plastic surgeons were essentially general surgeons, it was considered that their basic qualifications should be those of a general surgeon. The additional qualifications requisite to becoming a consultant in plastic surgery should not include an examination. This general feeling held sway for several years but the hard line taken changed slowly as the Glasgow College gradually unfolded its plans and after discussion at the Extraordinary General Meeting at Cardiff in 1984.

Visits to other units

One of the major reasons for forming the SRTC was the insular approach of some individual units and the lack of facilities for inter-unit secondment.

After the establishment of the Senior Registrar Committee in 1970 the Council of the Association inaugurated the United Kingdom Travelling Scholarships awarded annually to two senior registrars, usually the two most senior SRs in the Club. The first two UK Scholars were Sanu Desai (Stoke Mandeville) and Donald McNeill (Salisbury). The financial value of the Fellowship was initially a daily subsistence allowance of £6, and it would appear that as many as five units were intended to have been visited within one week! This was obviously an unsatisfactory arrangement so the idea was soon changed to include a more flexible programme submitted by the Scholars themselves and dependent on their own developing interests.

The Association has also awarded annually both European and International travelling scholarships and the senior registrars have taken full advantage

of these sources of financial help to travel abroad. The problem of deciding which units to visit has been common, and both the SRs and the Council of the BAPS were keen to know how the various Scholars had fared. It was felt that a report should be penned by each SR following his travels to other units, to recall the highlights of his visits and to help appreciate lessons that could be learned from the mishaps or mistakes of others. The first of these was the "Hands across the Atlantic" letter of Graham Lister, read at the Mount Vernon meeting. There have since been reports accumulated from all corners of the globe, which have been kept by the Secretary for reference when Travelling Scholars are planning trips abroad. In recent years there has been a little reluctance to put the frankest of opinions on paper and there are lengthy discussions, often long into the night, at our Travelling Club meetings.

Appointments

It was not long after the Club's formation that Roy Sanders wrote to the Council of BAPS complaining about a statement "That only five of every six senior registrars would obtain consultant posts". The Club has continually monitored the advertisement of consultant posts and has, on several occasions, been requested to investigate the reasons for delay in the advertisement of consultant vacancies.

Senior registrar posts have been less of a problem. The threat of non-renewal of a contract in 1978 on the grounds that the holder was "fully trained" was deprecated and correspondence was exchanged between the SRTC and the appropriate Regional Health Authority. More recently the loss of a senior registrar post at Dr Steeven's Hospital in Dublin has been noted sadly and it is hoped that it will be reinstated soon.

The senior registrars have not ignored the lot of registrars and SHOs in training as there is no other forum wherein their interests can be discussed, other than with the SAC in Plastic Surgery. Indeed, it was the concern of the plight of the "time expired" registrar that led to the proposals for adoption of a concept of tubular training.

Relationship with the BAPS

From the first letters of 1969 it can be seen that a close liaison was kindled with our parent Association. Regular meetings to discuss the salient points of training and other problems have been held with the President of the day and have been seen to be of immense help and use both to the SR Club and, it is hoped, to BAPS Council. In recent years an annual report has been presented to BAPS Council by the Secretary, although an initial request by the SRs that a Member should sit in on all Council meetings was refused as it was felt by Council that he or she should attend only if there was a specific matter which the SR Club wished to be tabled.

It was decided in 1977 that all fully accredited senior registrars were eligible to apply for membership of the Association. This has been noted in endless Minutes in which SR Members have been encouraged to take out full membership with the subsequent right to vote at the AGM, even though it means a substantial increase in subscription!

The future

The Club, like many, has had its high and low points and, of course, relies entirely for its success upon the effort and enthusiasm of its members and their attendance at meetings. Attendance on several occasions has fallen so low that at one meeting a list of those not present was compiled. Trade exhibitors voiced their displeasure at supporting meetings with only a few participants, a complaint that produced the idea of establishing a quiz with clues at each stand. This lapse of interest in the Club was, fortunately, only a passing phase. The Travelling Club has recently purchased an IBM typewriter with computer memory to assist the secretary, stationery and letterheading has been printed, and a Club tie has been produced based on a design by Michael Earley.

The Senior Registrars' Travelling Club has become an excellent forum where individual ideas can be aired in relaxed surroundings with a glass in hand, where contemporaries can meet, where problems can be discussed and where friendships can be cemented. It is hoped that the future of British plastic surgery will continue to be influenced by these regular deliberations.

Acknowledgements

I should like to record my appreciation of the many people who have helped in the research of this chapter, in particular Mr Michael Tempest.

The Section of Plastic Surgery of the Royal Society of Medicine

For the first half of its life the BAPS regarded the Royal Society of Medicine as a competitor, respected, of course, but not to be involved with corporately lest it damage our own progress. A number of our Members were Fellows thereof, naturally enough, but this was on an individual basis and had arisen usually during the course of their preliminary training or from the desire to make use of the world-famous library facilities. Their number was small, they had espoused diverse Sections according to their earlier interests, and such scattered bases provided no forum for elaborate discussion of plastic surgical themes which is just what suited the fledgling BAPS.

The Association had been founded closely following the reversion of a sizeable group of war-time trained surgeons from both Service and EMS units into a civilian life which, before the war, had hardly known the specialty and which now could be slow to accept it. There was inducement for group support and a need for a forum for teaching and debate, so that within a year or two the BAPS had been joined by all those surgeons who wished to remain in this novel discipline and whose experience could be judged acceptable. To its lasting benefit, the criteria for membership were set high and strict by the opening constitution, and the initial wave of enthusiastic joiners saw its numbers thinned and firmly held. Membership was therefore small, and time was needed to build up case-loads, so there was no abundance of papers in the early years.

Summer meetings were then held within the working hospital of the current President and might only last one day. Time could be eked out by touring the premises, by conducting selective ward rounds in separate groups or by showing interesting cases in a spartan lecture room. The afternoon papers were mainly efforts from the "home team" of varying standing and merit, but warmly appreciated and, of course, useful for training.

Papers from the membership at large were mostly presented at the Winter meeting, invariably in a lecture room situation at the Royal College of Surgeons. Even there the habitual paucity of papers meant that longer speaking periods were the rule and flagging discussions had sometimes to be stoked, almost desperately, from the chair to reach an acceptable tea interval.

The Association blows cool

Readers will thus understand why in the early years any suggestion of an additional forum for discussions on plastic surgery were met in Council and indeed among Members generally by the immediate retort that we had barely enough papers sent in and that any additional demand would wreck our own progress.

This defensive reaction must have found general support among the membership, as it effectively resisted for more than fifteen years occasional resurgent proposals from a small group of enthusiasts whose spokesmen were notably Patrick Clarkson and Henry Elliot Blake.

Circumstances were gradually altering in several respects, and, in particular, a greater supply of worthy papers had become an established norm. There was also a feeling that our colleagues at large, both in practice and even in hospitals, did not fully apprehend our scope, and that referrals were at times too long delayed in areas where we could help. Increasing the already overtaxed student curriculum was proving slow and difficult: would it not also be helpful to publish in open journals and, yes, to hold debates in more open forums? Then again there was the burgeoning emergence of the exclusively "cosmetic" practitioner with, at times,

the skimpiest of training: would it not be important for our specialty to proclaim our interest and excellence while also demonstrating our wider and more dependable scope?

. . . then a little warmer

Thus Patrick Clarkson's formal approach in September 1966 was timely and found Council more responsive than heretofore. In effect, he merely fired a warning salvo by asking whether it would be in order for him to rise from the floor at the AGM and propose the formation of a Plastic Surgery Section at the RSM. The Minute states that of course Mr Clarkson would be at liberty to make such a proposition at the AGM but that it would be fair to say that on the whole the general opinion expressed within Council was not favourable to this idea. Indeed, at its later meeting on the eve of the AGM, Council minuted its agreement that the AGM should decide but that no proposal either way would be put forward by Council.

The situation was, predictably, not quite so simple as it appeared. It had always been the unfettered right of those who felt sufficiently keenly to apply to the RSM for the formation of a Section, but the signatures of 25 or more Fellows would have been needed and clearly that had never been possible. In addition, the RSM had been caught before by short-lived Sections started on a wave of unsustained enthusiasm and nowadays required to know the feelings of the relevant specialist association. The then President of the RSM, Sir Terence Cawthorne, had been one of my teachers and took kindly trouble to spell out our position. The creation of a new Section was of concern to the entire Society and would not be granted lightly: indeed one of the aspects it would wish to consider was the quality of the demand and the sustained support that it could be shown to command, in other words sponsorship of the BAPS would prove essential. In return, and to facilitate matters, the RSM would allow the application to be made by the BAPS on behalf of 25 named Fellows in whatever specialty, providing that we actually held their signatures. There were at that time two new Sections awaiting recognition, but if the BAPS showed support it was likely that the Council of the RSM would be sympathetic and refer the application to the Society at large without great delay. It would stand posted on the notice board for three months to attract support or objections and their Council would then decide upon the matter. An intriguing touch was that posting of individual Fellows requires one month only so that aspiring supporters could race their applications through so as to be ready for the eventual inauguration.

All this I reported to the meeting, pointing out that the BAPS was being asked to sign a formal undertaking of support, with potential financial consequences, in order to facilitate participation of some of our Members in the activities of another independent Society. An unusual enough situation, though not for that reason irresponsible.

Finally, it blows hot

Patrick Clarkson was a well-liked character, whose somewhat battered features were offset by his height and his always impeccable dress usually adorned by a button-hole. He had, however, a mannerism of talking very fast while hardly moving his lips which ensured that few could understand him at any distance over 20 feet. It would therefore be wrong to claim that his oratory swayed the meeting, but his interest was known and his conviction clearly genuine. He based his appeal on three scores: first the public image of plastic surgery which alone lacked a Section, secondly the potential for holding meetings with and among other specialists, thirdly the framework for demonstrating actual patients. The resolution was passed unanimously and I was charged with its implementation.

In early January 1967 we sent out a circular to the BAPS membership enclosing two forms. Signatories to the first declared themselves already Fellows of the RSM supporting the creation of a Section of Plastic Surgery: 25 were needed to back our application and within weeks 27 were to hand. The second form declared an interest in the establishment of a Section and an intention to seek Fellowship if the Section were formed. This was intended to demonstrate support and backing for the project and 13 signatures were returned at that stage, but three years later none of these supporters had implemented their declaration!

Nonetheless, at their meeting in late January 1967 our Council instructed the Hon. Sec. to send in a petition to the RSM in the name of the 27 signatories and it was agreed that Patrick Clarkson should be named as the instigator.

The Steering Committee

By the Summer meeting it could be reported that Council of the RSM had approved the application

to establish a Section of Plastic Surgery. Directions had been given that, if no objections were raised during the three-month posting, this Section would come into existence automatically and without further reference which would allow the inaugural meeting to be held in October at the start of the sessional year. A steering committee would be required to draft the Constitution and it was decided to invite Beare, Calnan, Clarkson, Dawson, Hovell and Sandon, the last to act as convener. It was further decided that dental members would be welcome and Hovell, then dental representative on our Council, undertook to notify members of the Odontological Section.

At the September Council meeting it had to be reported that the steering committee had not yet met and the Hon. Sec. was instructed to "get on with it himself". The period for possible objection had been passed and the Section was now in being. The first meeting would be held early in December and by custom the President of the RSM would take the chair. It seemed appropriate that Patrick Clarkson be asked to be the first Chairman of the Section.

It appears odd how, even at this advanced stage, it is the Council of the BAPS which is making the dispositions for this new society and it is an obvious mark of the initial relationship and the responsibility which the BAPS had undertaken.

It fell to me as Hon. Sec. of the BAPS to draw up the framework of the new Section in concert with the RSM's section officer, Mrs Coley. This involved several evening after-work sessions, and I record my appreciation of her efficiency and of her patient tolerance of my strange requirements.

The draft Regulations, the detailed headings of the Constitution and the structure of the executive Council were put together after perusal of examples from several existing Sections and I saw no difficulty in "selling" them to the eventual electors. The difficulties arose over the definition of membership. We were, as I have mentioned, going through a somewhat paranoic stage over the proliferation of "cosmetic" surgeons and concern had been expressed at the AGM over the possibility of such operators gaining entrance, as of right, to our meetings and drawing advantage from our technical discussions. Criteria for membership of the Section could be permissibly tightened to our satisfaction, but whatever restrictions I could think up with regard to admission always fell counter to the inviolable provision that *any* Fellow of the RSM is entitled to attend *any* meeting of *any* Section. In the end I had to report back to the BAPS that since we had sought access to a mixed and open forum we must accept that only the Society's own limitations may be placed upon the attendance.

The first meeting of the Section

At the inaugural meeting of the Section of Plastic Surgery on Tuesday, December 5th 1967, the chair was first taken by the President of the RSM, Sir Hector MacLennan, 21 Fellows being present. The draft Regulations which had been prepared were recommended to the Council of the RSM for approval and for review by the Council of the Section after one year.

Elected as Founder Members of the Section were the 47 names who had written in support of its formation and, following the election of the proposed panel of officers for the session 1967–68 with Beare and Dawson as Secretaries, the first President, Patrick Clarkson, was acclaimed to the chair. The address by Sir Hector congratulating the new Section was followed by one from Richard Battle as President of the BAPS.

Although membership remains preponderantly common to both, this represents the point where the Section receives its mandate and henceforth regulates its own decisions and marks out its own programme, and it is also the point at which this paper detailing the part played by the BAPS must come to its end.

Two cameos perhaps, from the year 1969 when I served as second Secretary: the enchanting suggestion, minuted but alas never carried out, that the second President and noted painter, Henry Elliot Blake, should design and donate a Presidential Badge and that Robin Beare, skilled at work with precious metals, should fashion it himself.

Lastly, an occasion of sadness and grief upon the death, in December of that year, of Patrick Clarkson whose many and repeated endeavours to create a Section of Plastic Surgery in the RSM were so happily crowned just in time for us to show him our esteem as the First President of this prestigious venture.

The British Microsurgical Society

In the United Kingdom John Cobbett became interested in microsurgical techniques as early as 1964, and delivered a paper on "technique" in the following year, although it was not published until 1966. Partly as a result of this he was awarded the Moynihan Travelling Fellowship of the Association of Surgeons and travelled to Japan, the United States and Canada.

The first digital replant was done by Susumu Tamai of Japan in 1965, Cobbett performing the first in the United Kingdom at East Grinstead in 1966. (John Barron notes: Bernie O'Brien and I attempted replantations of fingers at Odstock in the late 1950s. I realise that this was not microsurgery but it was attempted with environmental control.) Bob Acland arrived on the microvascular scene soon afterwards and John Cobbett followed his initial success by doing the first free composite flap transfer by microsurgery (a great toe transfer) on April 18th 1968. During his time in Japan Cobbett had demonstrated microsurgery to Seichii Ohmori and his friends in Tokyo, and it is of interest that the next major advance in microsurgery—the free flap—was carried out by Ohmori's son at almost the same time as the Australians, in 1973. Despite Cobbett's early work, there was a pause in the UK before the first free flap transfer was carried out.

Martyn Webster in Canniesburn, Paul Townsend in Bristol, Bruce Bailey in Stoke Mandeville, Michael Black in Newcastle and David Evans were all proceeding along similar lines and at the same time. In 1977 David Evans and Martyn Webster started the British Microsurgical Travelling Club. Their first visit was to Edgar Biemer in Munich from 22–26 April 1978. In March 1979 they visited Hans Anderl in Innsbruck and in May 1980 the Club visited Marko Godina in Ljubljana. In 1981 Dieter Buck-Gramcko was visited in Hamburg, followed in 1982 by a visit to China and Hong Kong visiting Chen Zhong-Wei, Professor Chang Ti-Sheng, Professor Ru Yao-Song, Professor Wang and P. C. Leung. Visits to France in 1983 and to Finland in 1984 followed.

In 1980 the Travelling Club had considered the need for a more formal, open microsurgical society but this idea was overtaken by events when Douglas Harrison sent a circular to those involved in microsurgery. Receiving encouraging replies he arranged the first meeting of a proposed microsurgical society for September 1981 at Mount Vernon Hospital. At that meeting it was decided to form a society to be known as the British Microsurgical Society, Roy Sanders, David Evans and others joining Douglas Harrison for the meeting. The second meeting of the Society was held in St Bartholomew's Hospital, London in April 1982. The secretary at the second meeting was Professor John Lumley and the visiting speaker was Alain Gilbert who presented his work on fibula transfers. The third meeting was held in Frenchay Hospital, Bristol in September 1982, the Secretary being Paul Townsend; the fourth meeting was held in Glasgow in September 1983, Martyn Webster being the Secretary, with the fifth meeting at the Hammersmith Hospital in September 1984, Dai Davies being the Secretary and Dr Harold Kleinert the guest speaker. At this meeting it was decided that the Society should become slightly more formal and Dr Colin Green from the MRC Clinical Research Centre at Northwick Park Hospital is now the Secretary of the Society.

The proceedings of the Society's meetings, in the form of Abstracts written by the contributors themselves, have appeared from time to time in the Journal and help keep plastic surgeons abreast of developments in microsurgical techniques and their clinical application in fields other than their own.

The British Association of Aesthetic Plastic Surgeons

During May and October 1977, two meetings took place in London of small groups of consultant plastic surgeons. At these meetings the topic of the development of private "cosmetic clinics" was discussed, and it was felt that a society should be formed of fully trained plastic surgeons who had a particular interest in aesthetic plastic surgery. Patrick Whitfield and Peter Davis undertook the task of sounding out opinion and of setting out a framework from which such a society could develop. It was felt that membership should be limited initially to Full Members of the British Association of Plastic Surgeons and that other forms of membership could be discussed at a later stage. At that time it was stressed that such a society in no way sought to act in any way to pre-empt the activities of the British Association of Plastic Surgeons, but that it was to be complementary to it.

It was also felt that no person could become, or remain, a Member if associated in any way with an organisation which advertised. Further informal soundings were made among plastic surgeons in the United Kingdom and, whilst it was felt generally to be a useful concept and an inevitable development, it was considered that the time had not yet arrived to form a separate Association. Some surgeons also considered it might be yet another Society! Others considered that the private clinics and the concern for them would abate and if this did not happen then an initiative from the BAPS would go a long way to making the use of such clinics undesirable. Therefore, at this stage, the decision was made only to form an organisation by name which would be serviced by Patrick Whitfield as Honorary Secretary. Paper was to be printed, a telephone installed, and the only function was to be the dispensing of information to legitimate enquiries.

During the next year private cosmetic clinics continued to mushroom and, with this proliferation, an increasing concern by plastic surgeons regarding the quality of skill and expertise at such establishments. The Honorary Secretary was charged, therefore, with carrying out a comprehensive survey of all Full Members of the BAPS of their opinion regarding the formal formation of the British Association of Aesthetic Plastic Surgeons. After first contacting the President and Secretary of the International Society of Aesthetic Plastic Surgeons and receiving their approval, all Full Members of the BAPS were canvassed once again as to the desirability of forming the new society.

The results were as follows:

Unequivocal support for the organisation	32
Unequivocal support for the organisation, but uncommitted as to whether they would join or not	15
Support for the organisation but wished to know more before deciding	18
Did not support such an organisation (of the 20, nine were retired)	20

The balance of the BAPS members did not reply.

From this return it appeared that there was sufficient support to form a new Society and an inaugural meeting was organised for 12 November 1979 at the Royal Society of Medicine in London, with 22 plastic surgeons present. The declared aims of the Association are as follows:

1. To promote an interchange of knowledge for the advancement of aesthetic plastic surgery amongst suitably qualified surgeons.
2. To stimulate the training in this aspect of plastic surgery among plastic and reconstructive surgeons and their trainees.

3. To ensure that aesthetic plastic surgery remains a recognised and respected discipline.
4. To develop and encourage the practice of high standards of personal, professional and ethical conduct among the members.
5. To establish links with the International Society of Aesthetic Plastic Surgeons and the British Association of Plastic Surgeons.
6. To advise those who wish to obtain information about aesthetic plastic surgery.
7. To promote a better understanding of aesthetic plastic surgery among general practitioners.
8. To disseminate recent information, and the results of research, to the members of the Association and the medical profession.

The formation of the BAAPS

With these objectives agreed unanimously, the British Association of Aesthetic Plastic Surgeons was formed on November 12th 1979 and a Constitution drawn up. Twenty-two plastic surgeons were present:

R. C. Bell	J. Laing
J. Bowen	J. Lendrum
N. M. Breach	R. A. W. McDowall
A. H. R. Champion	T. Milward
J. R. Cobbett	F. V. Nicolle
M. Deane	M. Saad
P. K. B. Davis	R. Sanders
H. Goldin	R. P. G. Sandon
M. F. Green	A. F. Wallace
D. H. Harrison	P. J. Whitfield
S. Harrison	J. S. P. Wilson

There were 44 Founder Members: Stewart Harrison was elected the first President, Peter Davis the Vice-President and Patrick Whitfield the Secretary. The formation of this new Association created considerable debate, both within and outside the membership, and it was suggested by some that the new Association would act as a splinter group from the BAPS, thereby weakening the older organisation. Fortunately, this has not been the case and from the outset it has sought, and been granted, affiliation with the BAPS and with the International Society of Aesthetic Plastic Surgeons. Since these early days, the Association has flourished and has demonstrated considerable muscle in the direction of its declared objectives.

The name of the Association produced considerable debate during the early formation and although the word "cosmetic" was proposed first, it was discarded because of its association with the previously formed British Association of Cosmetic Surgeons. Initially, the Society was given the title of the British Society of Aesthetic Surgeons and then, one year later, this was modified to the British Association of Aesthetic Plastic Surgeons in order to align it more clearly with the associated bodies of the BAPS and the ISAPS. During the initial stages of the formation of the Association very considerable work was involved in drawing up the Constitution, so that it would be both acceptable to the Charity Commissioners and to the Registrar of Businesses in Wales. This work was continued by Peter Davis, who succeeded as the second President of the Association, and it is only recently that this lengthy work has been completed and the Association established as a registered company with charitable status. I am the third President.

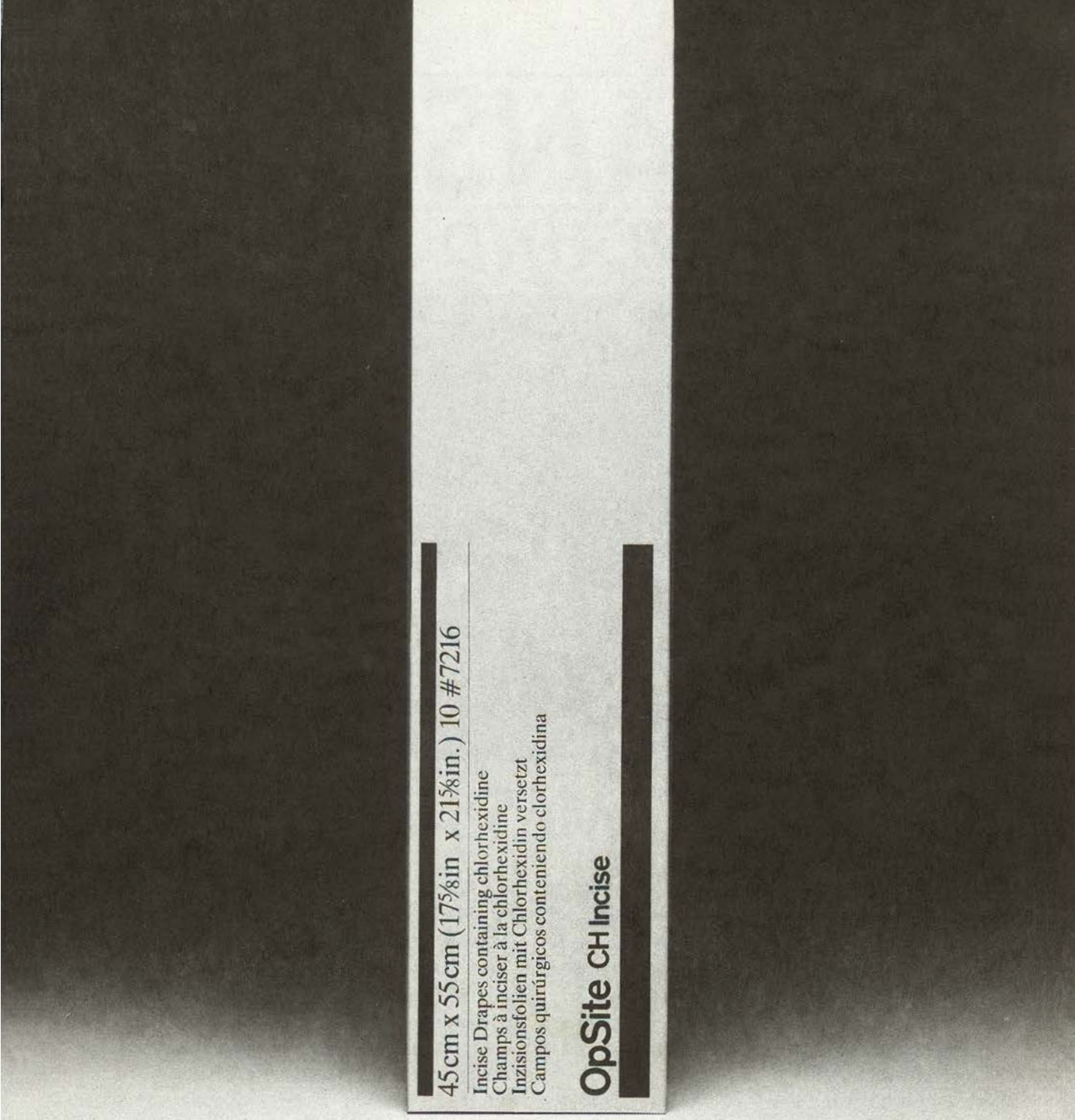
The Association has now reached a membership of approximately 100 and holds an Instructional Course twice yearly, usually in June and December. A single subject is chosen and studied in depth. The policy has generally been to have at least two invited experts with such courses aimed at the level of trainees and junior consultants. These meetings have proved to be highly successful, with an enthusiastic degree of interest shown by all participants. Initially such courses were open to the membership only and their trainees, but in more recent years invitations have been sent also to the ISAPS members since it was recognised that the Association had grown in stature and represented an internationally recognised educational forum of particular value to our European colleagues.

The membership booklet

A declared aim was to promote a better understanding of aesthetic plastic surgery among general practitioners. For this purpose, and at considerable expense, a booklet was prepared (with the generous financial support of Kirby Warrick Pharmaceuticals) containing the names of Members, their addresses and geographical distribution, the aims and objectives of the Association and its Constitution. This booklet was prepared largely through the efforts of Stewart Harrison and Peter Davis and involved negotiations with the Medical Defence Union who in turn consulted the joint Defence Unions of England, Scotland, Wales and Northern Ireland, as well as discussions with committees of the General Medical Council and the British

Association of Plastic Surgeons. An offer was made to Members of the BAPS so that those who wished could have their names included, although some of these were not Members of the BAAPS. This booklet was circulated to approximately 30,000 general practitioners throughout the British Isles. It is the declared intention of the Association to update this circulated information every two years.

There can no longer be doubt as to the beneficial effect at large that the formation of the BAAPS has had, both in the formal training of plastic surgeons in this country and in the wider recognition of the importance of this rapidly growing part of plastic surgery which, it is emphasised, should always remain an inseparable part of the whole discipline of plastic and reconstructive surgery.



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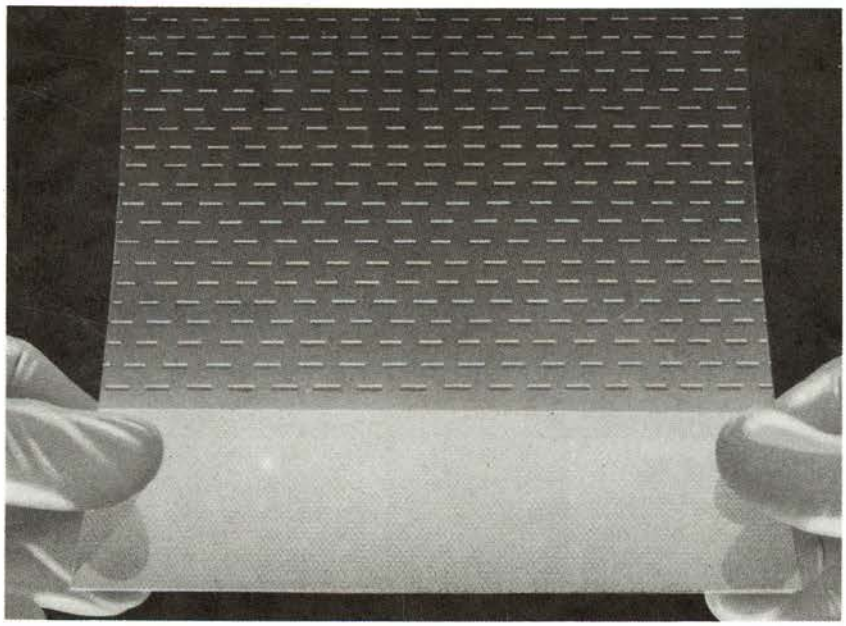

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