this statement. The one study cited, Mioton et al.,[2] examined one *reconstructive* procedure, panniculectomy, and did not include a single surgeon who is identified as a diplomate of the ABCS, rendering it irrelevant.

Another falsity reported is that 21 percent of California ABCS diplomates have been subjected to disciplinary action by the Medical Board of California versus 3.7 percent of plastic surgeons. Debra Johnson, M.D., former president of the California Society of Plastic Surgeons, made this claim during an adversarial hearing before the Medical Board of California, but her statement was not subject to cross-examination and is inaccurate. In fact, more than 8 percent of ABPS surgeons in California have been subject to disciplinary action. Furthermore, Dr. Johnson stated that she had personally reported ABCS surgeons *solely for making references to being certified by the ABCS*, making it clear the ABCS number was falsely inflated by a targeted attack on the commercial free speech of ABCS diplomates.

The many issues with this study (not limited to the above) flow directly from poor research and organizational bias. The authors made no effort to contact the ABCS, relying on incomplete records and faulty logic—an affront to proper research methods.

The ABCS shares the goals espoused by the authors of the article: ensuring patient safety, setting the highest standards for training, and ethical practice of cosmetic surgery. We expect a retraction and hope the *Plastic and Reconstructive Surgery* journal will require future studies to meet normative scientific standards with reproducible facts subject to third-party confirmation.

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Wilbur Hah, M.D., M.B.A.

On behalf of the American Board of Cosmetic Surgery Trustees
American Board of Cosmetic Surgery
Munster, Ind.

Correspondence to Dr. Hah
American Board of Cosmetic Surgery
8840 Calumet Avenue, Suite 205
Munster, Ind. 46321
info@abcsurg.org

DISCLOSURE

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Reply: Board Certification in Cosmetic Surgery: An Evaluation of Training Backgrounds and Scope of Practice

Dr. Hah's mischaracterization of our research is without merit and ostensibly biased by his role as president of the American Board of Cosmetic Surgery (ABCS). His letter presents no published data or research to support his claims—the only data point that he presents is unreferenced. Our peer-reviewed research demonstrates that 62.6 percent of ABCS diplomates advertise surgical procedures that are outside the scope of their accredited residency training.[1]

Although medical licensure allows for an almost unlimited scope of practice regardless of residency background, the scope of accredited training is clearly defined for each specialty by the Accreditation Council for Graduate Medical Education or the Commission on Dental Accreditation. This study has shown that most ABCS diplomates advertise procedures beyond the scope of their accredited residency training.

The only Accreditation Council for Graduate Medical Education–accredited training pathways with significant requirements for aesthetic surgery are plastic surgery residencies. We recommend that anyone interested in performing complex and comprehensive aesthetic surgery pursue one of these Accreditation Council for Graduate Medical Education–accredited programs. They are open to all who have completed the prerequisite training. Moreover, the Medical Board of California previously found that ABCS fellowships are not equivalent in scope, content, and structure when compared with Accreditation Council for Graduate Medical Education–accredited plastic surgery residency training.[2]

Ultimately, patients deserve to know the accredited training background of their surgeons. Likewise, physicians are ethically bound to disclose both the accredited and unaccredited training they have undergone to their patients. Such disclosure is necessary for patients to make informed, autonomous decisions. The practice of comprehensive and complex aesthetic surgery should result from a congruent, dedicated pathway from residency into practice—like that found in plastic surgery training. Lastly, our research is methodologically sound, is unbiased, and has undergone peer review, and therefore the request for retraction is moot.

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Brian C. Drolet, M.D.

Kyle Gabrick, M.D.
Department of Plastic Surgery
Vanderbilt University Medical Center

Jeffrey E. Janis, M.D.
Department of Plastic Surgery
The Ohio State University

Galen Perdikis, M.D.
Department of Plastic Surgery
Vanderbilt University Medical Center

Correspondence to Dr. Drolet
Department of Plastic Surgery
Vanderbilt University Medical Center
D-4207 Medical Center North
1161 21st Avenue South
Nashville, Tenn. 37212
brian.c.drolet@vumc.org

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The authors have no financial interest to declare in relation to the content of this communication.

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Preparation for Hand Surgery Fellowship: A Comparison of Resident Training Pathways

We read with great interest the article by Drinane et al.[1] analyzing the hand surgery case logs of graduating residents from the general surgery, orthopedic surgery, and plastic surgery pathways. We would like to congratulate the authors on an excellent overview of the disparities in experience among the different groups of applicants to hand surgery fellowships. We wish to some offer additional perspective to the authors' key findings from this study.

While case logs of general surgery residents accounted for the majority evaluated in this study (11,189 out of 19,159), it is important to note that general surgery residents represent a small fraction of the total matched hand surgery fellowship applicants. According to data from the 2020 National Resident Matching Program for hand surgery,[2] only five out of 175 matched applicants (2.9 percent) came directly from general surgery residencies. These five applicants matched into the one enrolled general surgery–based hand fellowship currently offered.[2] This makes us wonder if it is indeed an unwritten clause that general surgery residents interested in hand surgery fellowships need to pursue an independent plastic surgery fellowship first to make themselves competitive for selection to this field. The authors do mention a need for a more standardized hand experience for applicants from different pathways to improve the education of graduating hand surgeons. Is this best achieved by a plastic surgery fellowship following general surgery training, to set up such candidates for success in a 1-year focused fellowship program?

Furthermore, while the data for integrated plastic surgery case logs were not publicly available and analyzed, the use of only independent plastic surgery resident case logs limits the determination of the hand surgery experience of graduating plastic surgery *residents.* Integrated plastic surgery residents pursuing a 6-year residency would possibly accrue greater exposure compared to independent plastic surgery fellows pursuing a 3-year fellowship. Moreover, Bhadkamkar et al.[3] demonstrated a strong trend toward the increasing number of positions in the integrated plastic surgery match and a concomitant decrease in independent positions available. From 2007 to 2019, the number of integrated positions has increased from 92 to 172, while the number of independent positions has decreased from 93 to 63.[3] General surgery is the most common pathway to an independent plastic surgery residency, but matched applicants to independent plastic surgery programs may have previously completed residencies in neurosurgery, orthopedic surgery, otolaryngology, thoracic and cardiac surgery, or urology.[4] Indeed, a candidate progressing from an orthopedic residency to a plastics fellowship would likely have significantly more hand experience. As such, future studies examining the case logs of integrated plastic surgery residents would add immensely to our understanding of the baseline surgical experience of different applicant cohorts. With these data, hand surgery training can be focused and individualized for these groups in order to maximize the value of their 1-year fellowship.

As the authors rightly point out, embracing the differences among the three distinct residency pathways is imperative for offering the best education to future hand surgeons.

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David Mitchell, B.S.
Department of Surgery
University of Texas Health Science Center at Houston
Houston, Texas

Allison Laffoon, M.D.

Aashish Rajesh, M.B.B.S.
Department of Surgery
UT Health San Antonio
San Antonio, Texas

Correspondence to Dr. Rajesh
Department of Surgery
UT Health San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78229
rajesha@uthscsa.edu
Instagram: aashish.rajesh
Twitter: @AashishRajesh1

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