In July of 2014 the ASMS Board held its annual summer board meeting in Chicago. The agenda featured a two-day retreat to consider the future direction of the organization. Through spirited discussion, the Board formulated a new strategic plan designed to carry our Society forward into the next decade. Five specific goal areas — education, research, sustainability, member services and communication — were discussed. Existing strengths and perceived weaknesses of the ASMS within each area were identified. In response to this analysis, twenty concrete achievable initiatives were proposed which, if successfully implemented, could greatly strengthen the organization.

I have dedicated my Presidential year towards ushering in
Kant Y. K. Lin, MD

Welcome to the ASMS Winter Newsletter. We have a broad selection of topics for your reading enjoyment. The first is a panel of accomplished ASMS surgeons with very diverse backgrounds. They have encountered numerous successes, and unique struggles, as their careers have developed, that I believe you will find both refreshing and instructional.

You will hear of their own mentors and their desire to mentor others.

Kant Lin describes the work accomplished at the ASMS Summer Retreat, and a montage of the exciting initiatives currently going on within ASMS. We get a chance to read Andy Wexler’s Converse Lecture and hear his unique insight into current changes that will shape the future of Plastic Surgery.

Steve Buchman gives a touching tribute to Peter Randall and his far-reaching accomplishments; Sue Jordan gives us insight into the service that Victor Lewis has consistently given to the ASMS. Frank Papay and his group provide an article on the new Preceptor Program.

Devra Becker gives us a look at the Sunshine Act. You may be surprised at the way it may affect the Visiting Professor Program.

Jordan Steinberg gives his unique perspective on Craniofacial Fellowships and finding a job as a Craniofacial Surgeon. Thanks very much to all contributors and readers.
Panel Discussion: Mentoring New Leaders in Our Midst

What is your history with ASMS?

Mount: My earliest exposure to ASMS was actually taking the Maxillofacial Basic Course as a Plastic Surgery Fellow when I was at UCSF. We flew from San Francisco to Cleveland for the Basic Course. I was excited by the content. The Basic Course was everything that I wanted it to be and that’s really how I started getting involved. I joined as a resident member at that point.

Who encouraged you to go to the course and what steps did you take after that to become involved in ASMS?

Mount: Dr. Stephen Mathes, my Chair, and Dr. Bill Hoffman, my mentor. It was part of our curriculum actually, part of our requirements as Plastic Surgery residents/fellows to attend the course. I was really thankful that it was part of the expected coursework. After that, I finished my fellowship in Craniofacial Surgery and transitioned my Resident membership to Active membership. After I became an active member, I was able to really see how the ASMS fit in, not only with my practice, but also teaching of residents in maxillofacial surgery principles. In addition, it served as a way to develop some leadership skills within the group.

Corcoran: I have a slightly different story. I joined ASMS about 6 months ago.

What made you decide to join?

Corcoran: My Division Chief, Arun Gosain, asked me to join.

Did you come to the Annual Meeting in October?

Corcoran: No. That was the meeting where I was elected.

Lalikos: I first became interested in ASMS because my very first and longest-standing mentor was Paul Manson, from when I was a medical student and a Master’s student. He was my thesis advisor. He presented the ASMS as an organization that he found valuable and personally proved by his service to the organization. My thesis was on bone graft healing and Dr. Manson noted that the ASMS membership would be interested in the results of my work. That is what got me interested in ASMS and the work of its members.

Wilson: I became a member in 1991, so I’ve been a member for almost 24 years now.

Did someone in particular recommend that you become a member?

Wilson: The Craniofacial Fellows who had graduated from our program asked me, “Why aren’t you a member of ASMS?”

Do you remember someone in particular that encouraged you?

Wilson: I’m sure Henry Kawamoto encouraged me; I believe he was President of ASMS. He’s certainly influenced a lot of my decisions, not only ASMS-related, but my career goals and path. I remember meeting Henry when I attended a conference at NYU that John Converse had organized. That was the first time I also met Tessier and Obwegeser. Henry was a resident at NYU and that’s when I met him. I believe it was 1972. That was immediately before Henry went to France for his year with Tessier and transitioned into his role as adopted son of Tessier.

David: I’ve been a member since I finished my Craniofacial Fellowship and joined the faculty at Wake Forest. I didn’t really have a lot of exposure to ASMS prior to joining. I went to the panels at the national meetings. My involvement however has waxed and waned over the years depending on my level of engagement. I’ve been involved doing some teaching and currently, as you know, I’m one of the ASMS Visiting Professors this year.

Was there anyone in particular who encouraged you to get involved in ASMS?

David: Lou Argenta, who has been my long-time mentor, encouraged me to join.

Do you remember what he said?

David: As I remember he felt the focus of ASMS was, and is, on teaching and that’s really who I am. He thought that ASMS was a good fit for me.
I read “Whistling Vivaldi” when it was chosen as the 2014 annual selection for the “One Book, One Faculty” program at Northwestern University. This book examines how stereotypes threaten peak performance of individuals in elite undergraduate and graduate education programs. In this well-written and easily accessible monograph, Dr. Steele leads the reader through the history of stereotype studies from inception to current times. He starts with his own original empirical studies that identified stereotype as a deterrent to achieving full academic potential for any individual who finds herself in a minority position. He also reviews the physiological and psychological work of others that confirm the generalizability of these findings in many groups and situations – white men, Asians, women, African Americans, older people, and Latinos. Having established the phenomenon and its ubiquity, he then reviews empirical studies demonstrating short-term and long-term mitigation of stereotype threat by changing the educational and/or assessment environment. Finally, proven practical solutions that can be implemented in colleges, universities and graduate schools are offered.

Main Definitions and Themes

Individuals experience stereotype threat when performing new or difficult tasks in high-stake situations when they subconsciously feel that they may confirm a negative stereotype about their social group. For example, older surgeons may be concerned that they might confirm the stereotype of memory decline in middle age on a short-term memory test. The subconscious concern not to prove the stereotype true uses brain bandwidth which then causes the “racing brain phenomenon” and distracts the examinee, preventing him from showing his true short-term memory capacity. The assessment underestimates the true ability of the older surgeon to remember well. This poor performance then goes on to confirm to both the examinee and examiner the stereotype, which subsequently leads to progressive, dwindling confidence and a withdrawal from the vanguard activity that would otherwise stretch the learner to new levels. One way to decrease the stereotype threat is to change the description of the test from a short-term memory test to a recall aptitude test. By changing the circumstances from an achievement test to an aptitude test, the threat of proving ability rather than capability is removed and performances rise in a matched cohort of older surgeons.

“Whistling Vivaldi” unravels stereotype threat by taking the reader through the body of research chronologically. Empirical observations of underperformance behaviors are changed into experiments and the data is interpreted. The author explains complex constructs well without either losing the reader or making it too simplistic. The scientific methodology throughout is rigorous. What is not clear from the book is how significant stereotype threat actually is to minority groups. The author contends that stereotype threat is additive starting early in a person’s academic career and peels off individuals as a person hits his personal vanguard. It is an appealing hypothesis to explain some of the achievement gap between promising minority novices and their final potential.

After reading “Whistling Vivaldi” any individual ASMS member will be able to understand stereotype threat and imagine it in his own situation, such as stereotypes of women in math and sciences or crying during stressful situation; stereotypes of majority white males as prejudicial. Practical solutions about how to position individuals who might be suffering stereotype threat, even if subconsciously, into a neutral situation might allow more individuals to sit at the table and achieve greater success both personally and communally. This can be facilitated by ASMS leadership and committee chairs by taking the simple step of inviting new members and minorities to the table.

Save the Dates: BOSTON

ASMS PreConference Symposium: Thursday, October 15, 2015

ASMS DAY: Sunday, October 18, 2015
2014 ASMS Presidential Address: Cultivating the ‘Trees’ that will Leave Lasting Legacies in Maxillofacial Surgery

The following is an edited version of the Opening Ceremonies address by ASMS President Warren Schubert, MD.

It’s an honor for me to be here in Chicago. I’m very humbled and appreciative to have served as President of the American Society of Maxillofacial Surgeons.

I like to think of myself as just a general Plastic Surgeon, and I hope that I can encourage other young surgeons to be similarly proud. These speeches are an opportunity to give thanks, to recognize important people, and to reflect on our careers.

The ASMS is not a “craniofacial society” – there’s another society for that. There are many of us who have not done Craniofacial Fellowships (but) have served in the ASMS. I wish I had done a Craniofacial Fellowship; I wish I’d done a hand fellowship, a microsurgical fellowship and other training. After 12-and-a-half years of residency training, it was time to get a job.

We always are greatly indebted to the people who have paid a high price for our careers – our families, that goes without saying.

For the younger surgeons, never underestimate how indebted we are to our patients, who teach us so much. (The screen behind Dr. Schubert shows a slide of a gunshot wound victim.) This is a 16-year-old male with a self-inflicted gunshot wound who wanted to take his own life. This was not a bad case, compared to many others. This patient has required 18 different operations thus far; often the patients come in, they want to die – and they look so bad, their families want them to die. I’ve never had one of these patients try to commit suicide again. This same patient is now 22 years old and in college; he wants you to see his face – he wants you to know that he wants young plastic surgeons to go out and continue to treat maxillofacial trauma and reconstruction. He has his life together, and he’s mentoring students who are having problems with depression. Don’t give up on these patients!

I’m very thankful to the Plastic Surgeons who are doing hand surgery, micro-reconstruction, and breast surgery. It is wonderful to restore a functioning hand, lower extremity, and to make a woman feel more whole following a mastectomy. But when all of these patients wake up in the morning, most first look at their face.

I’m very thankful for my present colleagues who have taught me more than I learned in my residency. All of my colleagues have done Third World work and/or missions.

We have often had the policy of taking our children, taking high school students, taking residents, getting them involved at a young age.

The people often neglected in these speeches are our support personnel. LuAnn Zeilinger has been my Administrative Secretary and has worked for our department for 38 years. I speak to young surgeons who are Program Directors who have a hard time retaining their secretaries for eight months. I don’t know how they deal with the turnover. LuAnn is responsible for making things work in our Department.

We all know those surgeons who ‘cross the line’ and become administrators who tell us, “We need to cut costs” or “Everyone is expendable.” I’ve always handled my support staff with the attitude that “No one who is good is expendable.”

I’d like to give special thanks to two plastic surgeons – both past ASPS presidents: Bruce Williams, whom I trained under when he was chair at McGill University, and Bruce Cunningham, my academic chair at the University of Minnesota. They convinced me to go on after General Surgery into Plastic Surgery. I’d like to thank Allen Van Beek, who’s an amazing person and a past president of PSF, as well as past president of the Peripheral Nerve and Hand societies.

Allen gave me great opportunities early in my career to be involved in those organizations.

I would also like to thank several ASMS past presidents: Ken Salyer, who let me take over and restructure the ASMS Basic Maxillofacial Course; John Persing, who allowed me to become a member of the ASMS Board; and Mimis Cohen, who was very supportive of me and my presidency.

I would like to thank our three immediate past-presidents: Steven Buchman, Robert Havlik, and Henry Vasconez. They have always been great mentors, always have been supportive of education and the camaraderie that our Society stands for.

The real mark of a great president is one who continues to be active and supports the Society after his presidency. A real mark of a great society or association is one that continues to take advantage of their past presidents after their presidencies.

It’s for this reason that I asked Andrew Wexler to deliver the ASMS Converse Lecture. I’d also like to give special recognition to Seth Thaller who has worked harder than any past president I know to continue to fund-raise and to host our course in Miami.

A very special thanks to many of our board members: there’s no time to name them all of them.

Arun Gosain did a phenomenal job organizing this year’s Annual meeting for us; in the years that he was in charge of Maxillofacial News, he completely restructured and expanded our newsletter, which is now available to everyone online.

Arun was kind enough to host our retreat in Chicago this

(continued on next page)
A Job Well Done: Victor Lewis, MD Retires

Sue Jordan

Thirty years ago, Dr. Victor L. Lewis, Jr. served as the first editor of this very newsletter, *Maxillofacial News*, dedicated to facilitating communication among ASMS members. Today, we would like to congratulate Dr. Lewis on his well-deserved retirement from clinical practice and thank him for his decades of service to our specialty.

Dr. Lewis is a graduate of Yale University (1964) and Northwestern University Feinberg School of Medicine (1968). He completed his General Surgery residency at his beloved Charity Hospital of Louisiana in 1973, followed by a tour in the U.S. Navy from 1973 to 1975, and on Reserve through 1993. Dr. Lewis was Chief-of-Staff at the Rehabilitation Institute of Chicago from 1985-1987, where most recently, he was a Staff Surgeon. His clinical practice has spanned the breadth of Plastic Surgery, specifically including expertise in adult Craniofacial Trauma, Aesthetic Surgery, and pressure ulcer reconstruction.

Dr. Lewis served as the 46th president of the ASMS from 1992-1993. Under his leadership, the ASMS established our Society as THE entity to address credentialing, insurance, and other maxillofacial issues at the national level. Dr. Lewis has represented ASMS as the delegate to the American Medical Association for several years and was the first Plastic and Maxillofacial Surgeon to be appointed to the AMA CPT editorial board, on which he currently serves. Dr. Lewis is also Past President of the Chicago Society of Plastic Surgery (1987-88) and the Midwest Association of Plastic Surgeons (2000-2001).

Perhaps even more important than his leadership contributions at both local and national levels, Dr. Lewis is a stalwart advocate of resident and medical student education. Dr. Lewis hosted several ASMS Basic Courses in Chicago. Through his affiliation with Northwestern University Feinberg School of Medicine and the Rehabilitation Institute of Chicago, he has mentored and inspired generations of Plastic and Maxillofacial Surgeons in an unforgettable and sincere manner. Dr. Lewis plans to remain active in research and on the CPT editorial board. Best wishes to Dr. Victor Lewis on the next phase of his career!

ASMS 2014 Presidential Address (continued from previous page)

summer, with the whole focus of meeting addressing the questions: How can we make ASMS more relevant? How do we get young people involved and wanting to be part of our Society?

Special thanks to Gaby Doumit, who took my job of organizing our ASMS Maxillofacial course.

Our next Basic Course is in Miami in January, followed by a course in Philadelphia in August.

I would also like to thank ASMS President-elect Kant Lin, who as treasurer got our organization on very firm footing; Frank Papay, our most important committee Chair – the Education Committee; William Hoffman, and Donald Mackay, continue to be so supportive of our organization in every way. Reza Jarrahy, who worked tirelessly to expand our membership; Anand Kumar, who basically built our website, www.maxface.org, out of nothing.

Peter Taub, who co-chaired our first ASMS fresh cadaver course, our first Basic course in New York, and put together a Fundamentals of Maxillofacial Surgery text that will be released shortly. Delora Mount, who for years worked tirelessly for our Visiting ASMS Professor Program, to which anyone can apply.

I also thank two very important people, who are really the godfathers of maxillofacial trauma and reconstruction for North America: Paul Manson, and Joseph Gruss.

I would like to encourage young people to get involved in our Society.

The ASMS stands for education and camaraderie.

I had the opportunity to attend the meeting of the European Association for Cranio-Maxillo-Facial Surgery in Prague two weeks ago. Hugo Obwegeser, the godfather of orthognathic surgery, was there – 95 years old and still dancing. We all want to be remembered for our work, but the bottom line is, unless you’re a Hugo Obwegeser, you’re going to be forgotten within two generations.

We still have opportunities to work with young students and residents who will succeed us; we have opportunities to operate on cleft patients and maxillofacial trauma patients who will outlive us.

I like to plant trees.

I think of my trainees and these patients as my trees. I will never see them to their full growth or fruition, but take satisfaction that they will be alive and well after I am dead.

The question is, if you are interested in making a difference, when should you get involved?

I’d like to paraphrase a Chinese proverb:

*When is the best time to plant a tree? Twenty years ago. When is the next-best time? Today!*  

I would like to warmly encourage our young people to get involved in international work if you haven’t already, get involved with our associations and societies. Get involved in the ASMS.

Thank you very much.
Peter Randall, MD passed away at the age of 91 in Philadelphia, Pennsylvania on November 16, 2014. Dr. Randall was the Chief of Plastic Surgery at the Children’s Hospital of Philadelphia (CHOP) from 1966-1981 and the Chief of the Division of Plastic Surgery at the Hospital of the University of Pennsylvania (HUP) from 1979-1987.

Dr. Randall was a true patrician in the specialty of Plastic Surgery and was particularly renowned for his contributions to the understanding and treatment of the cleft lip deformity, developing a modification of the triangular flap technique that bore his name, The Randall-Tennison repair.

Dr. Randall was born in Philadelphia where his father, Alexander Randall, MD, served as the Chief of Urology at HUP from 1923-1945. Peter Randall’s educational pedigree was privileged and refined as he attended the William Penn Charter School, then matriculated at Princeton University, where he also played on the varsity football team and rowed crew; finally, he graduated from the Johns Hopkins School of Medicine in 1946. After receiving preliminary training in general surgery at the Union Memorial Hospital in Baltimore, the US Naval Hospital in Philadelphia, and at HUP, Dr. Randall decided he wanted to go into the burgeoning field of Plastic Surgery. Without the benefit of an established residency, Dr. Randall was able to secure a highly coveted preceptorship from 1950-1952 with James Barrett Brown, MD, perhaps the most eminent Plastic Surgeon in the United States at that time.

Dr. Brown was not just an outstanding clinical surgeon; he was also a pioneering transplantation scientist whose seminal work helped to pave the way for Joe Murray’s eventual Nobel Prize. Dr. Randall, indeed, was an important and distinguished member of James Barrett Brown’s research team and that success in scientific investigation sowed the seeds for his eventual role as a founding member of the Plastic Surgery Research Council.

Dr. Randall was appointed to the faculty at HUP by I.S. Ravdin, MD where he joined Henry P. Royster, MD the Chief of Plastic Surgery who was already on staff. Dr. Randall also served as the Chief of Plastic Surgery at CHOP under C. Everett Koop before Dr. Koop went on to become the Surgeon General of the United States. Dr. Randall was a leader in the field of Plastic Surgery and served the specialty at the highest levels throughout his career. In addition to helping found the Plastic Surgery Research Council and serving as its chairman in 1964, he was also the President of The American Cleft Palate-Craniofacial Association (1965), The Plastic Surgery Education Foundation (1972), and The American Society of Plastic and Reconstructive Surgery (1977). Dr. Randall was a past President and founding member of the Cleft Palate Foundation as well as the Robert H. Ivy Society; a founding member of the Northeastern Society of Plastic Surgeons, and an Associate Editor of the Journal of Plastic and Reconstructive Surgery from 1982-1988. Dr. Randall also served on the Board of Governors of the American College of Surgeons from 1979-1982 and was their First Vice President in 1985.

Dr. Randall was a consummate Plastic Surgeon that practiced his craft with old school tradition. He was a triple threat who was able to make his mark in the field of Plastic Surgery as a skilled clinician, a pioneering researcher, and an exceptional and knowledgeable educator. He was above all else a gentleman whose interest in Plastic Surgery was a noble pursuit and whose indefatigable curiosity and thirst for knowledge could not help but inspire those around him. He was an innovator who often became as excited about a colleague’s revolutionary new idea as much as his own.

Dr. Randall actually was the Chief of Plastic Surgery that accepted me into the Penn Plastic Surgery Program when I was a second year General Surgery resident at HUP. I was honored to train under him and learn at his side. He had a wonderful way of encouraging me; he often did so with a personal hand written note that he would often send to me through the mail. Those notes came to me after a presentation I may have made or even prompted by what he thought was a pertinent question I had posed from the audience at a national meeting. Those notes also continued to come well after I left Penn and was already well into my practice at the University of Michigan. Each time I received one of those hand-written notes I would make a pledge to try harder to emulate him and attempt to be a better mentor by buoying up the spirits of others as he so ably did for me. I will miss Dr. Randall but I am so very lucky to have been a personal beneficiary of such a glorious career.

If indeed, as Isaac Newton wrote: “if we see further, it is by standing upon the shoulders of giants”, then there is no doubt that Dr. Randall’s Shoulders were broad and his extraordinary life and work as a luminary in Plastic Surgery has served to support innumerable people in our field to glimpse far into an optimistic future.
In previous Coding Corners, I realized that I had discussed the codes for palatoplasty but that the codes for cleft lip surgery had not been discussed. I have decided to dedicate this CPT corner to the cleft lip repair.

Currently, there are only 4 codes that apply directly to the cleft lip repair: codes 40700, 40701, 40702, and 40720. The first three codes relate to primary lip repair with the last code, 40720, delegated to surgery for revision of cleft lip deformities.

Code 40700 relates to a unilateral cleft lip repair. The code descriptor states that the surgeon performs a “plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral.” In essence, this code is the proper code for any primary repair of a unilateral cleft lip. The descriptor further states the deformity can range from a “notch” in the upper lip to a complete cleft of the lip. The code describes separating the muscle from the skin and underlying mucosa with proper repair of each layer. Wound closure using complex closure codes cannot be used in conjunction with this code. The code does not specify the type of repair performed (triangular vs. rotation/advancement). Interestingly, the 22 modifier, increased procedural complexity modifier, can be applied to this code. The operative report must document why this modifier is being applied to a specific case. This code does state that the nasal deformity caused by the cleft lip may be repaired at the same time.

Codes 40701 and 40702 apply to surgery for bilateral cleft lip repair. The first code, 40701, defines bilateral repair in one procedure. The code states that the surgeon performs a plastic repair of the cleft lip/nasal deformity; primary bilateral, 1 stage repair. Essentially, this is a classic one-stage repair for a bilateral cleft lip. This code is exact in its similarities to code 40700 regarding wound closure codes, 22 modifier code, and nasal repair occurring at the same time of the operation.

Code 40702 adds some subtle complexity to the bilateral cleft lip repair coding. This code defines a “plastic repair of cleft lip/nasal deformity; primary bilateral 1 of 2 stages.” This code is utilized when two stages are planned. The descriptor states that the surgeon performs one stage of two to correct a bilateral cleft lip/nasal deformity. A two-stage surgery may be required secondary to the “severity of the cleft” or vascular compromise of the deformity. The code states that typically the lip is repaired first and the nasal component is fixed at a later date after the lip has healed. Several surgeons elect to repair one side of a bilateral cleft and the contralateral side several months later. This case is perfect for this scenario. The discussion about closure is similar to the other codes discussed. This code is reported twice, once for each side if they are repaired independently.

The final code related to cleft lip repair is 40720. The 40720 code is for revision cleft surgery after unfavorable results from the first surgery. This can be related to scar contracture, wound dehiscence or infection. The code states that the surgeon must recreate the cleft margins through full thickness layers including the skin, mucosa and muscle. Each layer is then independently closed. Similar to the other codes, code 40720 includes the complex closure associated with this technique. Interestingly, this code states that the muscle must be “recreated” or taken down for this code to be applied. Some patients require elevation of the skin with re-rotation and resection of the mucosa, but the muscle is intact. Technically, this code should not be applied. One could consider adding a reduced services modifier, if the muscle is not recreated though. If a surgeon performs a more minor revision, like a z-plasty for vermilion notching a different code (an adjacent tissue transfer code like 14060) should be documented. Furthermore, a minor revision of the white roll should not be coded with code 40720. Instead either an adjacent tissue transfer or complex closure code (depending upon the rearrangement/defect created) should be employed.

In the next newsletter, I will review the cleft rhinoplasty codes and their relationship to cleft lip repair codes.

Post Your Open Positions in Maxillofacial News

The ASMS wishes to solicit postings for job openings for maxillofacial surgeons. As a service to individuals who are completing craniofacial fellowships or plastic surgery residencies, we plan to post open academic positions for craniomaxillofacial surgeons at no charge. We feel that this service is justified in keeping with the ASMS philosophy of enhancing the education and practice of maxillofacial surgery. This would enable individuals who are completing craniofacial fellowships to use the ASMS Newsletter as the primary source for academic job opportunities, since we will actively solicit all such positions from academic institutions.

We will also post any non-academic positions of interest for craniomaxillofacial surgeons at the fee structure outlined:

- Job postings for craniomaxillofacial positions at institutions with plastic surgery residency or craniofacial surgery fellowship training programs- to be solicited by the Newsletter so as to insure a complete list and posted at no charge.
- Job postings for craniomaxillofacial positions not affiliated with a plastic surgery residency or craniofacial surgery fellowship will be posted at a fee of $150 for ASMS members and $250 for non-members of the ASMS.

Please contact Lorraine O’Grady (logrady@prri.com) with any positions for craniomaxillofacial surgeons.
Residents and Fellows Corner: Now is a Great Time to Pursue a Career in Craniomaxillofacial Surgery

If you are a resident or fellow reading the ASMS newsletter, you are probably interested in Craniomaxillofacial Surgery. Congratulations! You are considering joining an exciting field brimming with possibilities. Despite the many rewards of this field, there is a good chance that somewhere along the way colleagues may have discouraged your interest, citing a lack of job opportunities. This is a discouraging, yet common, scenario for residents. Despite this, there is a lot going on in Craniomaxillofacial Surgery and the ASMS is here to demonstrate it! As you can see from reading this month’s newsletter or attending any ASMS symposia, there are exciting advances developing in the field of Craniomaxillofacial Surgery and a demand for fellowship-trained surgeons in a variety of practice settings.

At the inception of the field of Craniomaxillofacial Surgery, there was a backlog of patients waiting for surgeons with this unique skill set. Over half-a-century later, this backlog no longer exists in developed countries. Nevertheless, what does exist is a wide array of research-driven surgical techniques that continue to transform our specialty. For example, since the early days of craniomaxillofacial distraction osteogenesis, we have a better understanding of long-term outcomes and have expanded indications and applications for the technique. Complementing this is our ever-improved understanding of bone biology and bone substitutes. In addition, the last decade has brought composite tissue allotransplantation into the realm of facial reconstruction. If advancing the discipline clinically or through research piques your interest, the ASMS will help you get involved by offering courses on cutting-edge topics or by funding deserving maxillofacial research.

Residents often ask the question, “Are there jobs in Craniomaxillofacial Surgery?” If you are interested in applying your skill set broadly—indeed, there are. For the budding Craniomaxillofacial Surgeon primarily interested in pediatrics, dedicated Children’s Hospitals are cropping up all over the country. With them comes a demand for practitioners with subspecialty training. Cleft surgery, for example, was once within the purview of general Plastic Surgeons. Today, patients and families, and the growing number of Children’s Hospitals, demand fellowship-trained surgeons with a focus on pediatric surgical care. For the resident or fellow interested primarily in adult Craniomaxillofacial Surgery, there will always be a demand for your abilities, particularly in the realm of facial trauma. Facial trauma skills mutually complement the Orthognathic practice you may choose to build after fellowship. Moreover, proficiency with surgical approaches to the face and craniofacial anatomy lends itself to facial soft tissue reconstruction for oncology and aesthetic patients.

In terms of actual craniomaxillofacial job availability, as with every other area of Plastic Surgery, it depends largely on the specificity of your search criteria and breadth of your training. If you only will consider a Pediatric Craniomaxillofacial position in a specific location, yes, you will have a hard time finding a job. But, if you are willing to look broadly and apply your skills creatively, you will be in much better shape. Review of advertisements over the last year demonstrates at least 13 academic Craniomaxillofacial or Cleft/Pediatric Plastic Surgery positions and a handful of Craniomaxillofacial Surgery positions at academic hospitals and large HMO/group practices. Among these, there was a strong interest in surgeons with maxillofacial/orthognathic training. There may also be positions created for the right person at the right time or positions not exclusively dedicated to Craniomaxillofacial Surgery where your skill set will still be a huge asset.

The ASMS is here to help you develop your career in Craniomaxillofacial Surgery. The ASMS website provides one of the most comprehensive job listings for Craniomaxillofacial Surgeons. In addition, the various courses, events, and Visiting Professor Program hosted by the ASMS are a fantastic opportunity to get inspired and advance your education while networking with surgeons currently in the field. Don’t be discouraged. This field needs bright young surgeons to continue its legacy. With the right attitude and a creative approach, YOU have a bright future in Craniomaxillofacial Surgery and the ASMS is here to help you.

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Jordan P. Steinberg, MD, PhD

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Jordan P. Steinberg, MD, PhD
Fellowship Training and a Career in Craniomaxillofacial Surgery: How the ASMS Can Help You Get Started

Jordan P. Steinberg, M.D., Ph.D.,
Children’s Healthcare of Atlanta, Pediatric Craniofacial Surgery Fellow

It was August, 2012—the second month of six that I would spend at Lurie Children’s Hospital of Chicago for my Pediatric Plastic Surgery rotation. During these months in my fifth clinical year of residency training, it quickly became clear that I had found my own “click:” from cleft repair to cranial vault remodeling to facial trauma—it was a fit for me. Microtia reconstruction and Orthognathic surgery at Shriner’s Hospital in Chicago the following year helped to further crystallize my interest in Craniofacial Surgery.

I would be remiss if I did not acknowledge the strong influence of my teachers, both past and present, in shaping my plans. And that is where I’ll begin with my pitch for your involvement in our very special organization, the American Society of Maxillofacial Surgeons. ASMS members are some of our most influential leaders in Craniofacial Surgery and can help you as residents and fellows with career-changing or confirming advice. They will also become your close colleagues in the future.

A great place to start with the ASMS is to enroll in the Basic Maxillofacial Course. Courses are held multiple times per year in various rotating locations throughout the U.S. They are held over a two-day period, and provide comprehensive introductions to orbital, midface, and mandibular trauma as well as Orthognathic Surgery. The focus on dental anatomy and rehabilitation is unique; participants learn to take impressions, work with plaster models to re-establish occlusion for dentoalveolar trauma, and make tracings for basic orthognathic planning. Attendance by seasoned faculty is a major advantage of the course. For those of you from programs where funding for attendance may be tight, scholarships are available.

The ASMS Basic Course and the ASMS website (www.maxface.org) are two places where residents and fellows can sign up for candidate membership. Membership and dues allow the organization to continue our quality work in Craniofacial Surgery, to fund the Basic Course, and to host the annual ASMS Day at the American Society of Plastic Surgeons meeting. ASMS Day closes with an evening Presidential Reception, to which all members are invited, including resident and fellow members. This is an excellent venue for each of us to interact with ASMS faculty and chat about fellowships and career planning. This reception has been, and continues to be, a major highlight of the ASPS program each year. As suggested by past president Dr. Warren Schubert, the “No Nametag, No Drink” rule is always in effect: we want to know you and want you to know us.

A sister organization to the ASMS, the American Society of Craniofacial Surgeons (ASCFS), runs the Craniofacial Fellowship Match. While the ASMS traditionally has focused on surgery below the orbits, and the ASCFS specializes in surgery above the orbits, the two societies include many of the same members and leaders. ASMS leaders can certainly offer valuable advice regarding fellowship training, and many lead Craniofacial Fellowships at their own institutions. Residents with interest in Craniofacial Fellowships are encouraged to attend ASMS Day at the ASPS meeting the year prior to, and the year of, their Craniofacial Match applications to meet with Fellowship Directors and begin collecting information on programs. Current fellows who are members of the ASMS can be a great resource for Fellowship candidates. Fellowship applications are typically submitted by mid-August, and interviews take place in September and October. Rank lists are due at the end of October and match results are announced in mid-November.

Craniofacial fellowships vary widely across the country, with approximately 30 programs currently involved in the Match. Applicants should solicit as much information as possible from current and former fellows. Some programs have particularly concentrated experiences in adult facial trauma; others have little to none. Some Fellowships offer Cleft and Craniofacial Surgery within a broad pediatric context at stand-alone Children’s Hospitals; others have no direct affiliations with any Children’s Hospital, and include little or no pediatric soft tissue reconstruction. Some offer an intense experience in Orthognathic Surgery and dental rehabilitation whereas others have no exposure. A few programs have intensive research experiences (and may even incorporate so-called “academic days”), whereas others are solely clinical. And finally, practical issues like monetary support and the call schedule may differ significantly among programs. Once again, ASMS events as well as the websites for both ASMS and the ASCFS are excellent starting places for more information on available fellowships.

When it comes to jobs in Craniomaxillofacial Surgery, it is clear that prospects for academic positions in recent years have given many trainees some pause. Twenty-eight Craniofacial Fellows will graduate in the summer of 2015; clearly there are far fewer traditional Craniofacial Academic jobs available to them. As emphasized by Dr. Andrew Wexler during his recent ASMS Day Presidential Address, the future is nevertheless bright for aspiring young Craniofacial Surgeons. Clever innovations and unique solutions to age-old problems including, for example, virtual planning and 3-D printing as well as multipotent stem cells for bone regeneration, will always leave a place for those who are truly engaged and dedicated to improving the care of our patients. “Alternative” venues for craniomaxillofacial practice have become feasible and more commonplace, including hospital-employed positions with or without university affiliations. Wider access to IRBs and efforts to standardize care across multiple centers has made it easier for Craniofacial Surgeons outside large academic centers to contribute to clinical data collection and outcomes studies. Whatever the job location and setting you find, we all need the ASMS as a partner that champions our specialty as we move into the future.

Based on these changes and so much more, there is no better time than now to get involved in ASMS!
Art and Science are in Harmony as ASMS Delegates Take Stage in Prague

Dr. Joseph Kamal Muhammad, International ASMS Member, Abu Dhabi, UAE

It came as no surprise that our ASMS delegates would appreciate the aesthetics, function and form of the architecture of the Czech capital, Prague. A city with an abundance of beautiful buildings, bridges and parks, these structures had instant appeal because of their design and execution. Built for durability by master craftsmen with immense pride for continued use and pleasure, these magnificent edifices represent the type of sustainable outcomes ASMS members aspire to.

The ASMS contingent were also cognizant of the role that this fine city played in the development of art and literature. Indeed, their presentations to the pre-congress AOCMF workshop and the EACMF congress reflected these traditions inevitably touching upon the philosophical aspects and holistic approach to our patients.

**ASMS Pre-Congress Contribution to AOCMF Research Day**

As with most big events there is a lot of planning involved. I had a chance to speak to Dr. Warren Schubert on the sidelines about his role as AOCMF chairman. Busy as usual, he found time to have a chat about the past year. It would be an understatement to say that Dr Schubert has sacrificed a lot to ensure that his tenure as both ASMS and AOCMF chairman adds value to both associations.

ASMS delegate, Dr. Sabine Girod spoke at the pre-congress AOCMF research day on imaging and planning in surgery. She cited the difficulties and challenges that exist when trying to establish some predictability in estimating the soft tissue changes that may occur following bimaxillary surgery for obstructive sleep apnea (OSA). With so many variables to consider in evaluating patients with OSA and the current limits in computational software, collaborative work has to be the way forward.

**ASMS Guest Symposium**

**Dr. Donald Mackay**

The ASMS guest presenters at this congress were Dr. Donald Mackay, Dr. Andrew Wexler, Dr. Robert Havlik. Dr. Frank Papay was called away to an emergency so Dr. Mackay very kindly presented Dr. Papay’s paper. Donald Mackay commented on how much the city of Prague and the organization of EACMFS had left such good impressions on the ASMS team. These kind words were followed by an admission of guilt.

Apparenty, Dr. Mackay had written in a paper in 1993 that fat injections had no value. One had to smile. How many times have we said something only for Mother time to correct us. Of course we could all play it safe and not commit ourselves to an opinion or take a long-term view as did the Chinese Premier when asked about the French Revolution, to which he replied it was “too early.”

It would be difficult to envisage surgeons acting in the same way, as most of us like to share our views through a form of verbal combat and mental wrestling. Dr. Mackay then proceeded to show the audience how fat injections have become an important adjunct to his reconstructive surgery techniques especially in the craniofacial region. For example, Dr. Mackay has used fat to augment the lip in cleft lip patients. High patient satisfaction levels and good outcomes are not just based on hearsay but supported by both high Asher-McDade and PENN lip and nose scores. Ultimately the final arbiters in deciding if a procedure has made a positive impact are the patients themselves. So there can be no argument about outcomes if these patients say that they have no regrets about the procedure and would gladly have it done again.

Hemifacial microsomia (HFM) is another condition, which poses considerable challenges for the reconstructive surgeon. Despite surgeons having achieved good skeletal improvements in patients with HFM, correcting the soft tissue deficiency on the affected side has been a major surgical undertaking. However, after the introduction of fat grafting into the affected areas of these patients, there has been an improvement not only in symmetry but also better skin color and texture. Indeed, Dr. Mackay feels that there has been a paradigm shift in the way HFM patients are managed since the advent of fat augmentation, with a tendency to move away from the use of microvascular free tissue. Is it a game changer for soft tissue surgery akin to the impact that mini-plate fixation had on hard tissue maxillofacial work? Other indications for fat grafting cited by Dr Mackay include the injections in the forehead region of craniosynostosis patients to improve eyebrow shape.

So Dr. Mackay took us, the audience from an admission of guilt to a tour de force on the value of fat grafting in maxillofacial surgery. A quote by Douglas Adams sums up neatly what it says about the character of a person who shares his guilt and uses it in a positive way, “To give real service you must add something which cannot be bought or measured with money, and that is sincerity and integrity.”

**Dr. Andrew Wexler**

The next guest ASMS speaker, Dr. Andrew Wexler, has been a regular ASMS contributor to past EACMF congresses. He started his presentation not by an admission of guilt but by sharing a little about himself. He mentioned that prior to medicine he had majored in philosophy, which is reflected in his way of thinking and approach to patient care. One gets the

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ASMS Preceptorship Program: A Product of the 2014 ASMS Executive Board Strategy Session and Survey

Francis Papay MD, Peter J. Taub MD, Gaby Doumit MD, Roberto L. Flores MD, Anna A. Kuang MD, Karolina Mlynek MD, Kashyap Tadisina BS, Bahar Bassiri Gharb MD, PhD

Introduction
One of the main goals of the 2013 American Society of Maxillofacial Surgery (ASMS) executive committee meeting was to identify strategies for developing educational programs that could increase expertise in maxillofacial surgery. Towards this end, a survey was conducted to evaluate current members' expertise, identify topics that they wished to learn about and gauge their willingness to be "no cost" preceptors. We describe the results of this survey and outline the new ASMS Preceptorship Program, a collective effort by all members to increase access to all areas of maxillofacial surgery. This innovative program continues a great tradition of innovation and educational endeavors, and is the first such program that is available on a national level, exclusively for maxillofacial surgeons.

Methods
An online survey was emailed to 799 members (335 active, 4 associate, 38 candidates, 31 international and 391 resident/affiliates) with a follow-up to email to non-responders.

Results
Sixty-seven members (17%) responded, reporting an average of 14.5 +/- 9.9 years of maxillofacial surgery experience. A total of 54 (80%) responders reported being interested in being preceptors, with 25 willing to be observational preceptors 1-4 times per year for 1-5 working days, and an additional 29 willing to consider being preceptors.

Preceptor List and Program Structure
Details of members willing to serve as preceptors are available on the ASMS website (http://maxface.org/membersOnly.cgi), along with areas of expertise (Tables 1 and 2). To ensure dedication and excellence from both preceptors and preceptees, as well as ongoing self-evaluation and improvement, the ASMS has established the following guidelines for both preceptors and preceptees: 1. A list of standardized responsibilities (Table 3), 2. Pre-preceptorship expectation and post-preceptorship evaluation forms (Figures 1, 2), and 3. A Likert scale based evaluation to be completed by both preceptor and preceptee (Figures 3, 4).

Discussion
The term preceptor was defined by Poulin et al. as "a specialist in a profession...who gives practical training to a student". In a recent American College of Surgeons Bulletin regarding teaching robotic surgery, observer preceptorships were found to be an effective method particularly when designed as a group learning model for safe implementation of surgical modalities and procedures. The success of short preceptorship programs has been documented in the surgical literature. Kolla et al reported the success of a five-day mini fellowship in laparoscopic techniques provided to urology trainee surgeons. At 1 and 3 year follow up, the study found that the five day experience with a mentor, preceptor and potential proctor helped surgeons increase the scope of their practice by introducing them to new techniques with which they were previously unfamiliar. The five-day session included tutorial sessions.

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I am really honored to be chosen for this lecture. When I look at the names of those distinguished surgeons chosen in the past for the alternating Converse /Kazanjian lecture, I admit to feeling a little bit like Obama accepting the Noble Peace Prize. Like Obama I have had some professional accomplishments but mostly I may have been chosen because I’m a good talker.

I also want to thank ASMS President Warren Shubert whose long history of hard work and dedication to our society will undoubtedly be sullied by providing me this opportunity.

In the past Converse and Kazanjian lecturers have often focused on lesions learned from their own personal journeys through their plastic surgery careers. We older surgeons will reminisce and identify with the lecturer and enjoy the historic pictures of past mentors. Today, however I want to focus on our future and where I believe we have to be to be successful in this new health care environment. In doing so I will question the current mind set of our profession and probably piss off a number of you sitting in the audience. If my body is fished from Lake Michigan tomorrow you will know the reason why. But, for our younger surgeons in particular “this one’s for you.”

When I started practice in 1987 the standard career paths for plastic surgery were primarily academic vs. private practice. Within private practice the usual evolution was, build your practice doing everything for the first years and then gradually evolve to a more lucrative mix of primarily Aesthetic Surgery. Fellowships in Craniofacial, Microsurgery and hand surgery were available but had not assumed the popularity that they have today. I chose the private practice path and I was interested in building a Pediatric and Maxillofacial practice, and to practice the full spectrum of plastic surgery I had spent years learning to perform. However, to remain solvent, I had to encourage as much cosmetic surgery as I could get. In this regard I was lucky in that I somehow became the plastic surgeon to the largest escort agency in town. The payments were in cash and my work was evidently appreciated by many. When I left town one of my multiple procedure pts wanted to take me out to lunch so I told my wife ,Geri , if someone sees me out to lunch with a hooker , don’t worry ,she’s paying.

What I found in private practice is what most of us find that we spend half our time being surgeons and half our time being small business entrepreneurs. The former we are trained for, the later, not so much. While it was exciting for me to start my life outside of residency, I came to realize there was much about private practice that I did not like.

I did not like arguing with insurance companies to get paid for work that I had already argued with them to cover. I did not like running a small business hiring and firing, accounting, and dealing with all the meticulous oversight it takes to be successful in a private practice.

I did not like the uncertainty of each month’s income.

I did not like being on call 24/7 or losing money if I took a vacation.

I did not like green eggs and Ham I did not like them Sam I am.

I also did not like the sense of isolation a private office may engender. We all train in Academic Centers and we are stimulated by our colleagues and the challenge of problem solving with people we trust and admire. We get each other’s input into cases and this not only helps us be better surgeons but in the long run is also beneficial to the pt. I found private practice removed me from this stimulation and collegiality. I found it isolating despite the fact I often operated at the university hospital and operated with residents.

But, there was another thing that bothered me. I did not like the feeling that I was selling surgery. We can all relate to the situation where Mrs. Gotsthebucks comes in for visual obstruction from her upper eyelids and 3 weeks later is having upper lids, lower lids, and a face lift done under general anesthesia. In essence we can take a contented person show them their flaws and make them discontented enough to make them, want us, to make them happy again. And while we surgically can do that that it comes with a cost and a risk neither of which is necessary. This is not malicious on our part because we truly believe that making the patient look younger and more beautiful will in fact make them more happy. While this may be true for many unhappy patients that see us, there are loads of patients who are perfectly happy the way they are, until we unwittingly or unwittingly convince them they are not. This is not unique to or profession it is basic marketing. Create in the consumer the need for the service and then provide that service for a cost. There is nothing wrong with convincing someone they need a more stylish pair of shoes or a quieter blender this is a simple exchange of cash for an item or service, but that is without the risk of life or limb, and too often I fear despite our best intentions, we may be cavalier with those risks.

After 3 years in Private practice much of the joy I had experienced taking care of people in the practice of surgery had been overshadowed by the burdens and hassles of the business aspect of running a practice. Hey, I get it. No margin no mission, but, I felt there must be a better way for me to love my practice and reignite all those passions which first drove me to becoming a doctor and a surgeon. I would ask every one of you sitting here, why did you want to become a doctor? Why did you want to become a surgeon? I bet it had a lot more to do with taking care of patients then taking care of business and reconstructing broken bodies versus broken websites.

I was lucky that when I wished to leave my practice I had a number of very nice offers in both the private and academic world but the one that interested me the most was out of the mainstream for most plastic surgeons at that time, and that was a salaried position with a large non-profit HMO, Kaiser (continued on page 23)
What is the Sunshine Act?

The stated purpose of the Physician Payments Sunshine Act—also known as the Open Payments Program of the Centers for Medicare and Medicaid Services (CMS)—is to provide transparency in financial interactions between industry and “covered recipients” (including physicians and teaching hospitals.) The Sunshine Act went through several iterations, first as a Proposed Rule, in which stakeholders were invited to comment, and in its current form as the Final Rule in February 2013. On October 31st, 2014, CMS issued some changes to the Final Rule in response to feedback: http://policymed.typepad.com/files/sunshine-provisions-in-physician-fee-schedule-2014.pdf.

In brief, industry is required to report financial interactions to CMS in accordance with new regulations, and these interactions are posted on the Open Payments website at http://www.cms.gov/OpenPayments/index.html. As a physician, you can register on the web site, and you have a certain amount of time to review reported payments before they are posted. Once the payments are posted, you have the opportunity to dispute them.

What is reported?

The Sunshine Act requires that industry report any “payments or transfers of value.” Payments are subdivided into “direct” payments and “indirect” payments. Direct payments are those in which you receive money directly from industry—as a paid consultant or speaker, for example. An indirect payment, defined by 42 C.F.R. § 403.902, is “a payment or transfer of value made by an applicable manufacturer...to a covered recipient...through a third party, where the applicable manufacturer...requires, instructs, directs, or otherwise causes the third party to provide the payment or transfer of value, in whole or in part, to a covered recipient...”

While the burden of reporting falls on industry, keep in mind that there is no downside to industry in over-reporting, but there is a downside to under-reporting in the form of fines.

I don’t accept gifts and I’m not a paid consultant. Will it affect me?

It might, and this is where the Sunshine Act is nuanced. Some indirect payments seem straightforward. An industry-sponsored dinner—even one that is for the purpose of networking—may be reportable. A trip to visit a company headquarters or factory may be reportable.

But let’s say you want to be above reproach—you do not want to attend any function or participate in any activity that has any industry money involved. Suppose you are invited to speak at a conference based on your expertise in Maxillofacial Trauma. The Conference has industry sponsors (as almost all of our conferences do). If you avoid this activity, would the act then have an unintended consequence of limiting educational opportunities and the exchange of ideas?

To avoid this potential effect until the calendar year 2015 CMS created an exclusion to the reporting requirement for CME activities provided certain conditions are met. In the Final Rule, compensation for speakers in CME activities is excluded from reporting if: 1) the event has CME certification from one of five bodies (the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, the American Dental Association’s Continuing Education Recognition Program, the American Medical Association, and the American Osteopathic Association), 2) the applicable manufacturer does not pay the covered recipient speaker directly, and 3) the applicable manufacturer does not select the covered recipient speaker or provide the third party (such as a continuing education vendor) with a distinct, identifiable set of individuals to be considered as speakers for the continuing education program.

http://www.ecfr.gov/cgi-bin/textidx?c=ecfr&SID=86e5a409488f225390f32ea1e96a1b60&rgn=div8&view=text&node=42:2.0.1.1.4.9.9.3&idno=42

What if an educational event is not a CME event?

There is an additional exception for speakers if the industry sponsor does not know who the speaker is, detailed in “Exclusions from Reporting.” The following are excluded from the reporting requirements specified in this section: (1) Indirect payments or other transfers of value (as defined in §403.902), where the applicable manufacturer is unaware of the identity of the covered recipient. An applicable manufacturer is unaware of the identity of a covered recipient if the applicable manufacturer does not know (as defined in §403.902) the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.”

How is the Visiting Professors Program involved?

The ASMS receives grants from industry, which are used to support Visiting Professor (VP) programs. The VPs are chosen by ASMS, but they are currently considered indirect pay-

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Panel Discussion  (continued from page 2)

What leadership roles have you played with ASMS?

Mount: Early on, I was invited to be part of the faculty for the basic course by Dr. Warren Schubert, who was the Chair of the Education Committee. I enjoyed the teaching interactions I had with the resident trainees, the other course participants, and faculty. Just by happenstance, I was discussing some of my academic goals with Andy Wexler and he appointed me to a position on the Board. I began as Parliamentarian. I really enjoyed the camaraderie and the exposure to the high level people within the ASMS membership. I have developed some very lasting friendships and mentor/mentee relationships with several of them. After serving as Parliamentarian, I was elected to other positions and then served as Chair of the Visiting Professor Committee.

The initial catalyst being the Visiting Professor Program was actually Joe Losee. Joe handed the program to me and mentored me in that position. My time has Chair has been very fulfilling, not only in helping to bridge national educational needs, but also to be the middleman in the selection process, and oversee the program. The program has grown and I’m very proud of the growth. I was able to pay the work forward by mentoring Greg Pearson, who is very capable, and is the current Chair.

Corcoran: Though new to ASMS, I’ve spent the last 18 years doing two full-time jobs, raising 2 children, running a household and being a really good Pediatric Plastic Surgeon. But I had very little time between these responsibilities to turn my efforts towards organized medicine. I had to keep my academic and clinical work standing, along with my home life. In the next 5 years, I will have an empty nest. It will be my time to turn around and think about going back to the area that’s been in the background - contributing to the organized body of Plastic Surgery. In the next 3-4 years I’m not going to need to be home as much and there’ll be time and energy to do this.

Being new to ASMS, you will be much more intentional about what you’re doing. Explain how joining ASMS now versus 18 years ago may be different?

Corcoran: Eighteen years ago, I was trying to figure out who I was as a surgeon. Could I really do this without a mentor directly behind me or upstairs or two operating rooms over? Could I actually build a practice? Would people want to refer patients to me? Do I really know this well enough to do it? I have had a remarkable career. I spent the first 5 years in Cincinnati. I had 5 years where I practiced both as an adult and a pediatric surgeon. When I came to Chicago, I made the choice that pediatrics was all I was going to practice. Eighteen years ago, organized medicine was not an easy place for a woman. Now I know who I am, technically, personally, and maturity wise. I understand what my public persona is. And I have the maturity to know what interests me and what doesn’t. Rather than grasping at everything and trying to figure out which rung is going to lead somewhere, I know where I can and want to participate.

Because of my own experience with mentoring, I know that mentoring and timely feedback is important. Mentorship, oftentimes, happens by accident. You might have met someone and it works, or you may have had a mentor at your institution.

We know that medical students often pick their specialty because they see an attending who is doing something and they think that this is the kind of life/practice they want. We also know there is a lot of good literature that says mentoring requires a great skill. It doesn’t have to be two people who like each other who happen to be in the same time and space. It has opened things up in a much different way. We know that it can be done well in a formal manner.

Lalikos: I have tried to become more involved in the ASMS sponsored teaching curriculum. I have also applied for ASMS Research grants. We will apply again in 2015. My practice pattern reflects the membership of ASMS.

What energizes you in teaching that has encouraged you to get involved in some of these ASMS teaching enterprises?

Lalikos: I like facial fracture work and I actually feel—at this point in my career—that I’m an expert. I’ve always wanted to teach and that’s why I’m in Academics to begin with. Heading into my second decade of practice, I feel like I can go to the podium and defend what I do and teach others about fracture repair.

As Paul Manson did for you, have you recommended that medical students and residents get involved with ASMS?

Lalikos: Absolutely. Our residency has the ASMS Basic Course as a mandatory curriculum. Now that we’re integrated, it’s on my agenda to make sure that every junior gets to the basic course once; in a rolling fashion—and hopefully on the East Coast. We will look at who has gone and who needs to attend and make arrangements for them to attend. If finances permit, they go to an advanced course in their senior year.

Wilson: Whenever I have gone to ASPS, I always attend ASMS Day and the annual business meeting. I have always been involved as a member. One year I was involved in awarding the journal article of the year. When the Craniofacial Fellows complete their year, I always encourage them to check out ASMS. Not all of them are destined to join Craniofacial Programs, but certainly the ones that do, I encourage them to become active ASMS members. A lot of our former Fellows are members, including Reza Jarrah, Peter Taub, Pravin Patel, Anand Kumar, and Steve Buchman. Henry Kawamoto was always adamant about having them participate. You know we weren’t doing the intracranial procedures, but we were doing all of the jaw cases at Rancho. Henry wanted them to experience the variation in the operating pattern.

The primary reason for not... (continued on next page)
Panel Discussion  (continued from previous page)

being more involved in leadership roles with ASMS was because of my work with the American Cleft Palate Association. Between ACPA and my clinical obligations, I really did not have a lot of extra time. I became President of the American Cleft Palate Association in 1993-1994, which was immediately after I joined ASMS in 1991. I was on that leadership track. I have colleagues who can do multiple things, but I have to focus. I was also very active in our Nepal program. I started in Nepal because I enjoyed hiking and was drawn back by the genuine warmth and need of the people. I met individuals in Nepalese healthcare and realized that it would be more effective to do this with a group. I took the first Interplast (now Resurge) group into Katmandu at the teaching hospital in 1987. And then I went back twice a year from 1987 to 2001. I think there were even some years that I went three times, along with the ACPA work and my clinical work. I was also working with the Cleft Palate Program at that time at Ranchos Los Amigos in Los Angeles. We had 900 kids in active treatment. We had the Craniofacial Fellow from UCLA as well as residents from USC and UCLA. We had a full complement of people to support the home program that allowed me to go overseas.

David: I think the biggest leadership role for me has been the Visiting Professor opportunity. I really haven’t been on the leadership tract for this organization, but have play more of a teaching role. I get a lot out of meeting students from different places and hearing the questions they have. That’s why we teach because half the time we get as much as we give because they challenge us to know our subject better, but also to teach better. So one of the main reasons I did it was because I wanted to meet other residents that were outside of my residency and be challenged by them. I also enjoy the opportunity to see how other Craniofacial Programs are run.

Are there future leadership roles you would like to play?

David: Well I think the roles involving teaching would most interest me because that is a priority for me. I would be happy to do anything that involves teaching such as giving talks or being on a panel. I am happy to help however I can.

Have you played a teaching role in one of the Basic Courses?

David: I did when Kant Lin was in charge of the course. I’d love to do that again.

Mount: I’m currently the Vice President for Administrative Duties. I would hope that after some experience in this position that I will be able to try on some different hats and understand the entire process of the organization, including the financial aspects as Treasurer, and then Vice President and President. I still have a lot to learn. I’ve been a long-standing member on the Education Committee and that’s where my passion lies, with education. ASMS has allowed me to continue as an educator, teaching at the Basic Courses and continuing to have input on the Education Committee with development of new courses and technologies. I’ve been able to provide my opinion on educational issues, like website development, based on my committee work. ASMS participation has also helped my career, giving me a structure for academic promotion within a leadership capacity. At our University there are multiple tracks that you can pursue for promotion and I’m on the clinical hybrid track. The hybrid track definitely looks very strongly at leadership committee work, service work, in addition to research. ASMS has really been instrumental in my advancement within the academic promotion cycle.

What specific leadership skills have you learned from involvement with ASMS?

Mount: There are two leadership skills that I view as invaluable. One is consistency - being at the meetings, voicing your opinion, and contributing on a grassroots level. Second, is the skill of how to run a meeting. I’ve seen various styles of Executive Committee leadership and I have learned from the styles of each of the presidents that have served during my time on the Board of Trustees. It’s been really eye-opening in teaching me how to run an effective and successful meeting: how to stay on time, to get maximum participation from everyone. I’ve learned techniques and skills to set up a meeting, how to run a meeting that’s efficient, how to move on when things are getting bogged down. This has helped me lead successful, efficient meetings, in my daily life and in other leadership positions. The keys to a meeting are starting on time and having an agenda that you follow to a “t” and moving the agenda along. I think that the job of the President in running the meeting is to be a facilitator and not a dictator. Some of the most effective meetings have been the ones where the President is there to nudge, to move, to clarify, but yet doesn’t do the majority of the talking. A second key is to distribute talking points and topics ahead of time (in electronic form to be environmentally responsible.) Having all of the ducks in a row before the meeting actually starts is key to getting everyone to participate. And then being very watchful of the time so that the meeting ends on time. I would say another important factor is for the leader to solicit input from people that haven’t spoken up. Some people are just not going to try to talk over other people. I’ve witnessed good leaders drawing out opinions from the quieter people and getting valuable information that would otherwise have been passed over.

How do you elicit information from the quiet individual when you also have another individual who is talkative?

Mount: That’s a skill we all need to master - that listening skill. The meeting leader needs to be able to say, “Thank you for your opinion, let’s move on to the next item.” He/she needs to interrupt in a very gentle way, without making the person feel devalued but yet keeping the person from dominating the entire conversation. In the end, it’s an art. It has to be done very gently. I have learned much about that skill during my time on the ASMS Board.

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Panel Discussion  (continued from previous page)

**Warren Schubert does this well.**

**Mount:** I would add Andy Wexler, Bob Havlik, and Henry Vasconez. I’ve felt very warmly welcomed and I have not felt (even in the slightest bit) “gender-divided” from the other members of the Executive Committee. That’s one of the keys to why I have really liked the ASMS and the leadership platform - it is gender neutral.

**Corcoran:** I spent my last 18 years developing leadership skills in education. I received a Masters in Health Professional Education from the University of Illinois in Chicago. I started as Director of the M3 Surgery Clerkship at Northwestern University School of Medicine. At that time, no one from the Medical School class had gone into Plastic Surgery for 4 to 5 years. Just having somebody from the Plastic Surgery Division has given prominence to the specialty. Now we have 2 to 3 students every year apply in Plastic Surgery. I’ve also moved myself into the Dean’s office. I run the Subcommittee on Student Assessment for the entire Medical School. It’s one of the three major arms of the Curriculum Committee. And so eventually, the general leadership skills, have been building. Also an expertise in curriculum development and learner assessment has been built up. Sooner or later, there will be opportunity to apply the leadership skills and the content expertise.

**We did a recent ASMS panel with younger ASMS surgeons, all of whom finished their Craniofacial Fellowship within the last five years. They were struggling with whether to spend more energy in national leadership endeavors or to spend more time in their home institution? What is your advice to a younger surgeon struggling with this dilemma?**

**Corcoran:** Know what is required by your institution to move up and know where you want to concentrate. Most people start at the instructor level and need to move up to Assistant Professor. It’s about building your career. Are you going to focus on Education? Clinical Translational Research? Clinical Trials? Or, re you going to focus on a National presence? Initially, it’s about local influence, wherever that first step is. At the Assistant Professor level you’re expected to be regionally noted and you’re expected to have some national prominence. And finally when you get to the Professor level, you know it’s meant to be a full meal deal.

A lot of academic institutions often separate the research and clinical tracks. Start by looking at what your institution wants and what they expect from you. And ask yourself what your career is going to be. I wouldn’t join every single organization. I’d join the main national organization. So that you can get all of the organizational things for promotion, and pick what appeals to you. You can’t pay dues to every organization either. If you’re in private practice, you can be a big contributor through the societies and education outside of universities. There are a lot of great examples of this. Look at the Baker, Gordon & Stuzen Annual Symposium. Look at somebody like Betsy Hall-Findlay—how she has changed our perspective on breast reduction. Lots of people in private practice have made enormous contributions to Plastic Surgery. They’ve done so by taking opportunities. I remember how Elvin Zook had each resident on a committee in the ASPS by the time everybody left Southern Illinois University. Many of his residents and clinical partners have been our national leaders – Roxy Guy and Mike Neumeister, just to name two.

**Promotion like this starts at home with key mentorship. The issue then is finding a way to copy that model and provide it to others more junior to you: What are you interested in? What are your priorities? Choose carefully.**

**Corcoran:** There’s always a little bit of luck too, meaning being at the right place at the right time. A lot of people think mentoring relationships are friendly. They can be, but they don’t need to be. They’re generally not antagonistic. Sometimes it’s sort of like feedback. A lot of time, we are being given feedback and we don’t recognize it. Sometimes we actually change our behavior based on what someone says. If somebody says hold your needle this way, or envision yourself at the table this way - you don’t think about it as feedback, you just think about it as a correction. They’ve got a lot in common and you don’t know necessarily know you’re being mentored. Sometimes a mentoring relationship is clearly identifiable and sometimes it exists but is not clearly defined.

**Lalikos:** I’m juggling a lot of things, not the least of which is getting 3 high school kids through what they need to do and into college. Right now I’m the President of the New England Society, and I’m in the queue in the Northeastern Society, and so I’m going to let those timelines roll through. If life goes along, my future organizational involvements would be national and I think ASMS and the Cleft Palate Association would be the next two. I don’t have any big sights on the ASPS. Getting more involved in the ACPA and ASMS are my next goals.

**It’s smart to have a carefully laid plan, because the tendency is to try to do everything and to move up simultaneously in multiple organizations. The danger is that you’re suddenly in an important role in several venues and you can’t do any one of them justice.**

**Lalikos:** When I had kids I knew that I was going to have to slow down the pathways in these other things. Especially since my husband works out of state, so it makes me sort of a subsidized single mother. I knew that was my trajectory and it was fortunate that others have wanted me to move up in these regional organizations. I’m just trying to see if I can play it smart and avoid the burn out. I’m a member of...
Panel Discussion  (continued from previous page)

of ACAPS and an Assistant Program Director so that decision is also sitting on a path for a future leadership role. Being a potential Program Director will be a huge challenge.

You seem to be approaching leadership issues wisely.

Lalikos: I still have Paul Manson who is my living father figure and he keeps me on the right path.

David: Roles that involve teaching most interest me. I would be happy to do anything that involves teaching such as giving talks or being on a panel. I am happy to help however I can.

Have you played a teaching role in one of the Basic Courses?

David: I did some time ago when Kant Lin was in charge.

And would you like to circle back to that?

David: I’d be happy to do that.

Wilson: In the future, I hope to provide mentorship for individuals who are new to the field or new to the organization; as a senior mentor role.

How has ASMS participation aligned with your career goals?

Wilson: My career goals both in the States and overseas have always been to provide service to the patient and instruction to my fellow physicians and surgeons. I think ASMS in that senior mentor position, allows me to do that.

David: I’ll focus on what I’ve done; trying to teach the leaders of the future. ASMS has allowed me to do that and that’s part of who I am and what I do. It’s not so important to me to be in a title role as it is to inspire young people.

Lalikos: ASMS has always aligned well with my clinical interests and to the degree that I’m qualified (without a Dental Degree), I’m going to be honest about what I’m an expert in and a colleague with my oral surgery people. ASMS provides continued support of Plastics as well as OMFS. It’s not an exclusive kind of organization. You’re not pitted against one another. And it’s that philosophy I try to take into the practice field. We’ve just signed another Craniofacial Surgeon so I now have a like-minded colleague to try to build on what I’ve done here, and hopefully she’ll want to use ASMS as a national support system to try to increase our infrastructure.

Is she an ASMS member?

Lalikos: If not, she will be. She’s a graduate of ours who has done her Craniofacial Fellowship elsewhere and is now coming back.

And you’re going to be her “Paul Manson?”

Lalikos: I hope so. I have been her supporter throughout this process so far – helping get her the Fellowship and figuring out what she wants to do.

Corcoran: I think one of the things that interests me clinically is how little we think about education, teaching others and planning to do it well. We produce a lot of programs, but none of us were trained to be teachers. There is an assumption that because we can do Plastic Surgery, we must intrinsically be able to teach it—which isn’t really true. You actually have to have some expertise in teaching. Academics is about sharing knowledge. You may be teaching and sharing knowledge by doing bench research or translational research. But you’ve got to be spreading knowledge somehow or you’re not an Academic. If we’ve got a bench laboratory that makes sense. If you’ve got research grants that makes sense. But it’s this idea that you can teach that doesn’t make sense. Those things are not necessarily something we’ve been taught to do. There are going to be surgeons who are not bench researchers; that are not going to be translation researchers, but we’re always going to need people to propagate the actual knowledge of surgery and do it well. Teaching is the highest form of mentorship.

Have you ever read the book “Lean In,” by Sheryl Sandberg? It’s a great book. It’s written from a woman’s perspective about why women don’t step up or as she calls it “lean in.” Another study about why individuals don’t participate as we expect they should is the book “Whistling Vivaldi” by Claude Steele. “Whistling Vivaldi” was selected by Northwestern University the “One Book, One Northwestern” book selection for this year. The book is a psychologist’s view of social contingencies that affect minority performance. It identifies contingencies in our environment that signal one thing to one group of people that might be a threat to another group of people. He started to study minorities, particularly looking at black students, but then also looked at other minorities – women, Asians, older people. Both books are about why under-represented people hold themselves back. “Whistling Vivaldi” talks about underrepresented people at the high performance edges and discusses why people are afraid to put themselves out there, take a risk. One of the things about Surgery is that the number of women is still small. I don’t feel it on a day-to-day basis because the group of people I’m with is so small. You know there are three of us and one of us is a female. But when I look at the larger Northwestern community, I have been the only female faculty member here until a year ago. And when you go to National meetings, you realize you are really still a small number. So these high performing individuals subconsciously hold themselves back because they feel stereotyped and have a responsibility for a larger group of individuals who are not present.

How should ASMS encourage participation by women surgeons, and encourage the pursuit of leadership roles?

Mount: The key is continuing their current management and (continued on next page)
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maintain their interest in hearing all opinions. The best way to encourage more participation, considering that roughly 50% of plastic surgery residents are women, is to strive to mentor every resident as they come through. If they demonstrate an interest in Cranio-maxillofacial Specialties, continue to mentor them in the same manner you would mentor a male. Push them to consider leadership opportunities. I wouldn’t say that I ever felt different or excluded on the Executive Committee. I do remember one time being asked, “What do women want out of ASMS membership?” I remember my response was two-fold; one, the same thing that men want out of ASMS membership. Secondly, an ASMS gift that wasn’t a man’s necktie. That was the first discussion about gender that I ever encountered. When I explained that it was pretty much the same that everyone wants out of ASMS membership and there’s nothing unique or practice-based or mentorship-based that’s different for women versus men. Based on the discussion, leadership actually got a woman’s scarf and lapel pins and other items that were gender-neutral.

Corcoran: I would suggest being aware of mid-career women surgeons. There are a lot of mid-level women who have passed up on earlier leadership opportunities for one reason or another and now feel hesitant to say, “Well I want to start now.” You’ve been in your career for 10, 15, or 20 years and you assume someone that senior would not want to start on a new track. If I say that was the second half of my life and you decide to try something different at a freedom time point that’s an interesting thing that it set itself up for. But I think one of the other things is how serious is ASMS about doing that? The larger area to open up is the facial surgery portion than there is in the Cranio-maxillofacial. Let’s face it, there are only so many kids born with these conditions; there are only so many skull base tumors. That’s a relatively limiting portion of the surgery and very few of the surgeons make 100% of their living that way. I think that you may find that there is a wealth of people who are mature in their surgical careers and who can help move agendas and programs along faster than they’d otherwise get moved along.

This process requires intentionality.

Lalikos: To be honest, you’re doing it now. Acknowledging the female percentage of your membership and networking us together better is probably going to be your best effort. I have this sort of bristly feeling about being singled out for a leadership role just because of my genetics but understanding that the female percentage is likely going to move up in all of the Plastic Surgery specialties. Having the membership represented appropriately at all the leadership levels, is the way you’re going to help the whole system. Once females are up there they’ll be able to understand what is best needed moving forward. It’s hard sometimes to tease out what is most helpful. I sit on the promotions committee internally. And we have noticed that female faculty members are less likely to put themselves up for promotion. They’ve identified this and would like to make it equitable. They are trying it figure out why there’s inequity and trying to make sure there aren’t any barriers that they don’t understand. To create parity that they think is appropriate, and I think that’s what’s happening here.

As part of your discussion you’ve talked about the fact that women at equivalent levels are often paid less, are not targeted for promotion or leadership. There’s something less aggressive and “Me first” about women so that a man with equal credentials.

Lalikos: My institutional Division is extremely understanding of the hats that I wear that they don’t wear. Maybe there will be a single dad somewhere along the line but at this point, all of my partners are men; they’re all married, and their wives do much of the away-from-work stuff that I do. My boss understands that I do a lot more juggling. It is reflected in my RVUs; however I’m also doing a lot of revenue generating things that aren’t on the RVU books—like fundraising for the Craniofacial Clinic and bringing in money that helps support our research grants. I don’t ask for salary-support to work on these grants because it would kill the grant. I’m doing all the juggling to try to stay on the books in a way that makes me value added, rather than just an RVU en-

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Panel Discussion  (continued from previous page)

gine, which I can’t do at the same pace as someone who is un-encumbered by four children and only so many parents that can help me. y value added from a lot of different perspectives is a broader piece of this puzzle than just being a clinical RVU generator. I think it’s a fact that a lot of women doing a surgeon’s job are coming at it from different angles and then they look at the promotion thing and go, well I don’t fit that very well. Or maybe they aren’t generating the same number of RVUs so that’s why they’re not getting paid as much.

You mentioned networking and how women surgeons need to be their own biggest advocates from the networking side of things. You bring people together and they will create whatever value out of the networking.

Lalikos: Yes, exactly. It’s an interesting catch 22. Susan McKinnon has been a huge supporter at the AAPS level to try to get women members talking to each other. Each individual will have to decide when she’s going to make it happen. At a certain point, the woman herself has to decide to make time for this. I’m part of the American Association of Women Surgeons. I’m a part of all these things and there’s a million emails that come in about networking, and I think, “I don’t have time for that.” But eventually I get to a point where I say, you know what? I need to get to this. Leadership needs to keep making sure that these forums are available.

What then should ASMS do in order to get women into leadership roles?

Lalikos: I’m what’s called Faculty Liaison to the Department of Surgery. I’m basically the nagger, but in a nice way. The first thing I had to do was promote myself. I was an Associate and I had to get myself promoted up to full Professor. Which I was hesitant to do because I didn’t think I had the chops and I went through all this other stuff. Once I was promoted, my job to promote others has mostly been electronic and a little face-to-face with somebody basically saying, you know this is doable. The Promotions Committee said look, men and women, these were people who are in ar-rears for getting promoted, and there’s another whole issue with getting promoted, why bother. I would be the one to say “Hey, if we’re interested, it’s not as huge a hurdle as we think it is.” There have been some takers, and then I would say, “I’m not on the Promotions Committee, but I can shepherd you through the process. Here are the right websites, if you don’t know who to contact. This advocate doesn’t necessarily even have to be a woman.

The goal is to understand that there is inequity and to correct it; ultimately you’d like to have everybody fulfill their professional potentials.

David: Encouraging women surgeon participation is a challenge for many of the Plastic Surgery Organizations. If ASMS wants to be more inclusive then they need to work hard to engage all of the members. There have been women leaders in AAPs and ASPS; now, there is a next group of emerging leaders in all of the organizations you name. I think in the end due to all the pulls in different directions, we have to identify which organizations are absolutely the most important to us and that’s where we spend all the extra hours. We spend more time on panels and committees because we’ll eventually work our way up in the organizations we value most.

Are women more selective in the leadership roles they pursue?

David: I think they are. For me, I look at everything I am involved in and say, “Ok which one means the most to me and at the end of the day, will I want to spend the extra time on this?” And that’s where I put my focus. Not because I wouldn’t aspire necessarily to be involved in all of the societies I am a member of, but it’s not possible. So I am going to selectively pick the one I want and really focus on that because it does take the extra effort to attain a leadership role.

Wilson: Encouraging women in leadership can be a tough question. I think that being receptive to individuals regardless of whether they are women or men is important. If someone volunteers or indicates that they have the interest in assuming a leadership role, they should be given the opportunity. To encourage them? I think that has to come from within the individual. I don’t think you can drag it out of them. I think it has to originate within the individual. And yes you can support it.

You have been a mentor to many young surgeons. Could you comment further?

Wilson: Yes, I have mentored multiple individuals. Many more have been men, but for the last three years at UCLA, the Craniofacial Fellows have been females. I have encouraged all of them. Justine Lee has stayed on with the Craniofacial Program at UCLA. Kristen Ye has returned to the Bay Area and I have continued to support her by providing evaluations as she requests privileges at various hospitals as she establishes herself in the field. Ruth Gill is our Craniofacial Fellow this year. All of them are very accomplished surgeons to start with and I think they would be excellent members of ASMS and potential candidates for leadership roles in the organization.

Using those three individuals as an example, how would you recommend that others mentor?

Wilson: Mentoring has to be done one-on-one to start with and I make it my responsibility to advocate for them. The other individuals in the program need to do the same thing. Jim Bradley, also a graduate of the UCLA Fellowship, is another individual who is very supportive of having individuals move into leadership roles. And of course Henry has always been that way. The organization needs to indicate that it is receptive and it needs to

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encourage leadership. We recently received an email soliciting our involvement in committees. That certainly is one way to do it, but I think the best way is if everyone who is working on a committee turns around to one of their colleagues and says, “I really have enjoyed this work and I’ve felt rewarded by my participation in ASMS. You should consider it.” I think that’s almost the best way to do it.

Would you consider someone like Henry Kawamoto to be the ideal mentor?

Wilson: Yes, absolutely. Henry has always been supportive in that way. Seth Thaller is another one of those guys - all busy clinicians, all busy academically, and yet they find time and continue their involvement.

David: ASMS should engage women surgeons early after joining the society and involve them often and of course, nominate them for leadership roles. Ask them to do something of substance. I can’t even think of the last time I saw a young member or minority member on an ASMS panel. So put them on the panel every time you have a panel. I’m sure most members feel that if they were asked to be on an ASMS panel, they’re not going to say no. They’re going to say yes. But if you never ask them, if you only ask the same people every time, then it doesn’t happen. Sometimes to engage people who are in the quieter minority, whether it be young people or resident members or a female members, you have to engage them by asking them, because we generally don’t say no. I rarely say no.

This is similar to what Warren Schubert (Immediate Past President) has done. Devra Becker attributed to him exactly what you’re suggesting. Dr. Schubert asked her to be involved and she said yes. We need all leaders to be inclusive.

David: And perhaps the next time you have a nomination for the Board or a Committee, you should nominate a young member or a female member.

Any last word?

David: Minorities in ASMS are very engaged and they really would like to be more involved. We need to find ways to do that. It is an honor for me to be an ASMS Visiting Professor; I’m looking forward to doing it. Del Mount talked to me about it and I think having Del as the chair of that committee has facilitated a women’s involvement in this program.

Wilson: ASMS should continue to evolve. It is an excellent organization and representative of the field in a very special niche. I’m glad to see that Oral Maxillofacial Surgeons are encouraged to join as well as Plastic Surgeons. I think it’s important to be as broad as possible in encouraging our membership and publicizing who we are.

You’re very strongly supportive of Oral Maxillofacial Surgeons being involved.

Wilson: Yes. We’ve also had people who have backgrounds in ENT who have been excellent Craniofacial Fellows. I think we tend to put people into little pigeon holes or boxes. That’s not necessary. You have to judge an individual on his or her own abilities and not their particular pigeon hole.

“ASMS should engage women surgeons early after joining the society and involve them often and of course, nominate them for leadership roles. Ask them to do something of substance....

So put them on the panel every time you have a panel.”

-Lisa David, MD
From the President (continued from page 1)

as many of these initiatives into reality as possible. Through the diligence and hard work of the leadership of our Society and from many of you in the membership, I am happy to report that most if not all of these action items are well on their way to completion. The purpose of this message is to highlight many of these initiatives and to solicit any suggestions and comments from you, the members, about the process as we go forward into 2015 to make our Society even better as the standard bearer for Maxillofacial Surgery.

The Board affirmed that Education should remain as the central mission of the ASMS. We have continued to enjoy great success with our Basic Maxillofacial Course under the expert guidance of Gaby Doumit. The curriculum for the 2015 courses, in Miami in January and in Philadelphia in August, has been updated to incorporate exciting new virtual and computer-assisted planning technology for Orthognathic and facial fracture surgery. This will supplement the traditional lectures and the hands-on laboratory work of creating dental models and fabricating splints.

Thanks to the efforts of Peter Taub and his committee, the newly updated and vastly expanded course companion book, entitled Ferraro’s Fundamentals of Maxillofacial Surgery, is now completed and available for purchase both in print and in electronic form. The plan is to make this book available for all future course participants. With the many new illustrations and clinical photos, along with the expanded scope of the book to cover all aspects of Maxillofacial Surgery, this book is destined to become a classic!

On the horizon, exciting plans are underway to hold the first international Basics Course in Eastern Europe in the early Fall of 2015. This promises to give the ASMS new opportunities through global educational outreach and expanded name recognition. Following the success of the Advanced Course on Maxillofacial Surgery held at the LSU cadaver lab in 2013, the Board, led by Peter Taub and Larry Hollier, is exploring the feasibility of organizing an updated and expanded 2016 version with a possible collaborative effort with the ASPS. Finally, coming up in sunny Arizona in August 2015, this year’s two day cadaver Bootcamp Course on advanced Craniomaxillo-facial Surgery techniques will mark the fourth consecutive year of our Society’s collaboration with the American Society of Craniofacial Surgeons. This course has been universally praised and since its inception, has been attended by nearly every craniofacial fellow in the country. All told there have now been 132 alumni of the Bootcamp!

Planning for this year’s preconference symposium and program at the Annual Meeting in Boston in October is being spearheaded by Bill Hoffman and Anna Kuang. The symposium will focus on international missions for cleft care and will feature many distinguished speakers such Sam Noordhoff and Andy Wexler. During the Annual Meeting, seven maxillofacial-specific panels will be offered on topics of interest to our members, including secondary rhinoplasty, treatment options for migraine headaches and facial fractures “when things go wrong,” as well as two sessions of scientific and clinical paper presentations. Finally you won’t want to miss the annual ASMS Presidential Reception which will be held at the Isabella Gardner Museum, the converted home of a 19th century Boston socialite and art collector housing an eclectic collection of paintings and other curios, and also the site of one of the most infamous and still unsolved art thefts. Be sure to join us for a fabulous night of art and intrigue in historic Beantown!

Additional educational initiatives worth highlighting include the formation of a task force under the direction of Frank Papay to explore the possibility of creating a new journal specifically for and run by the ASMS. The goal would be to offer our members a dedicated forum and easier access for publishing on topics related to Craniomaxillofacial Surgery, both reconstructive and aesthetic. In line with the theme of promoting global medicine, in November 2015, the ASMS will be co-sponsoring a symposium entitled “Global Pediatric Facial Surgery Summit” to be held in Austin, Texas hosted by ASMS members Ray Harshbarger and Pirko Maguina and will feature many ASMS members as speakers. The previously published primer entitled “Essentials of Maxillofacial Surgery” written by Barry Eppley and designed to provide basic knowledge and awareness of Maxillofacial Surgery primarily for medical students and residents, has now been digitalized and made available for download at our website.

Finally, our Visiting Professor program remains one of the most popular and sought after benefits of the Society. We continue to send our ambassadors to training programs throughout the country to increase awareness and educate about Craniomaxillofacial Surgery. I would like to personally thank this year’s Visiting Professors, former ASMS Presidents Andrew Wexler and Henry Vasconez, in addition to Lisa David and Pravin Patel, for taking time away from their busy practices and lives to volunteer for this most important task. Due to the popularity of this program, the Board, led by Greg Pearson, is exploring the possibility of increasing the number of visiting professors and/or creating the first international visiting professor.

On the research front, the ASMS, led by Arun Gosain and Richard Hopper, has focused on increasing its grant dollars by partnering with the Plastic Surgery Education Foundation in two combined/matching research grants. Every dollar put into the grant by the ASMS will be matched by the PSF, thereby

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doubling the total dollar amount, up to $10,000 per grant. A representative of the ASMS will have a permanent seat on the PSF Research Grants Oversight Committee thereby insuring that the ASMS maintains control over the distribution of funds designed to support Craniofacial Surgery and our Society. We are also looking into the feasibility for the ASMS to build and manage one or more data registries for craniofacial outcomes. Our model here is the national breast implant registry currently being run by the PSF. If you have ideas about possible craniofacial outcome topics, please send in your thoughts to our national office now!

Speaking of looking for data, a partnership with the Journal of Plastic and Reconstructive Surgery, under the leadership of Reza Jarrah and Anand Kumar, has been established. An index of key articles on evidence-based medicine with craniofacial subject matter is now available for download for all ASMS members on the Society website. When it’s time for you to undergo the MOC recertification process, and if you choose a craniofacial tracer module, you’ll need a MOC approved educational activity. Your Society is working hard to make this process easy by providing these materials through expansion of the ASMS website. If you haven’t already done so, I urge you to explore the website: you will see many new features including patient-oriented public information about what Maxillofacial Surgery entails, how to find a maxillofacial surgeon and job opportunity advertisements for those looking for employment. The website also contains the expanded ASMS Newsletter, edited by John van Aalst, produced quarterly with panel discussions on timely subjects, such as the discussion about women in plastic surgery seen in this edition, book reviews, editorial and guest commentary such as Devra Becker’s summary on the impact of the Physicians Payment Sunshine Act also in this edition, along with personal membership interest stories.

Of course, none of this would be possible if the organization were not grounded on a solid financial foundation. Through prudent stewardship and a sound investment strategy led by Don Mackay and the rest of the Finance Committee, our coffers have continued to accrue capital with a positive margin. I would also like to acknowledge Warren Shubert, our immediate Past President, and his ongoing and constant work in leading our Development Committee, charged with creating new opportunities for securing financial support in our current times of financial uncertainty within the new health system environment. Warren’s tireless efforts have resulted in new sponsors and support which will ensure that the ASMS mission of providing the best educational experience possible in the field of Craniofacial Surgery will continue in the future.

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Speaking of looking for data, a partnership with the Journal of Plastic and Reconstructive Surgery, under the leadership of Reza Jarrah and Anand Kumar, has been established. An index of key articles on evidence-based medicine with craniofacial subject matter is now available for download for all ASMS members on the Society website. When it’s time for you to undergo the MOC recertification process, and if you choose a craniofacial tracer module, you’ll need a MOC approved educational activity. Your Society is working hard to make this process easy by providing these materials through expansion of the ASMS website. If you haven’t already done so, I urge you to explore the website: you will see many new features including patient-oriented public information about what Maxillofacial Surgery entails, how to find a maxillofacial surgeon and job opportunity advertisements for those looking for employment. The website also contains the expanded ASMS Newsletter, edited by John van Aalst, produced quarterly with panel discussions on timely subjects, such as the discussion about women in plastic surgery seen in this edition, book reviews, editorial and guest commentary such as Devra Becker’s summary on the impact of the Physicians Payment Sunshine Act also in this edition, along with personal membership interest stories.
2014 Converse Lecturer: Wexler

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Permanente. In the late 80s and 90s HMO connoted inferior medicine, restrictive of patients options, and penurious when it came to doctors reimbursements. If fact in the 60s and 70s you could not be a member of the AMA if you worked for Kaiser as it was “communist—socialized medicine” and the AMA actively lobbied to have physicians licenses suspended if they worked for Kaiser. A particularly caustic and surgically enhanced mother—in-law of my cousin said to me “why would someone of your training and talent want to work for such an organization when you could have so much more recognition and money being in private practice?” What she said was true, my status on the cocktail circuit was going to take a big hit but the salary was good, the paid vacation time good, the department was made up of 7 highly skilled and collegial Plastic Surgeons who all shared call; and my office and OR schedule would be filled every day with the full variety of reconstructive plastic surgery cases I had trained to perform. The best part however was that I didn’t have to worry about all the business aspects of running a practice. I never had to worry about my pts insurance or getting paid by it. I never had to worry about advertising for pts or creating a web page or marketing. I never had to worry about mal practice and in fact I never ever had to produce CPT or ICDM codes for any procedure I did. All that was required of me was to do the right thing for the patient so that they would be happy and tell their friends that Kaiser had provided them with a top rate medical experience. If this was communism then call me Dr. Lenin.

For 24 years I have been very happy and totally fulfilled in this form of practice. Our department practices the highest levels of reconstructive plastic surgery including Hand Surgery, Maxillofacial, Craniofacial, Brachial Plexus, Facial Reanimation and Microsurgery. We do everything that plastic surgery residencies train you to do and we are a valued resource to other departments whom we help with difficult problems. Additionally other departments are our colleagues and partners in the system so we do not see the internecine turf battles between head and neck and oral surgery and dermatology that we routinely hear about in the private practice world. We cooperate and do not compete for the best care of our patients. It’s nice.

Could I have made more money in a private practice? Perhaps, but I live in a nice house in a lovely neighborhood, I had time to spend with my children growing up. We took terrific vacations together and I could pay for them to go to elite private universities and when the time came and a wonderful wedding for one so far—all without “breaking the bank.” Additionally, when I retire I have a generous pension plan on top of my Keogh and 401k accounts. In a word I am secure and happy. No I don’t drive a Ferrari nor do I live in a mansion I can’t compete with hedge fund managers but I have enough and more would not really pay for the time that my form of practice afforded me to spend with the family I love. Also, I can still introduce my spouse, Geri, as my first wife. I consider myself one of the most fortunate people on the planet and I am grateful for that. In Buddhist philosophy we create our own unhappiness by our desires for more. Yes, my taxes are high and will I expect be more this year. Yes, the changes in health care will cause more regulatory hassles but none of that will substantially change my life or my happiness and complaining about it will only stress me and not the system.

So, Why am I telling you all this? I am telling you all this because health care is rapidly changing and the practice choices that this generation and the next generation of plastic surgeons will face will force a dramatic schism in our current practice patterns and in the future, more of your practices will look like mine then the majority of surgeons sitting in this room.

In the United States health care consumes 17% of our GDP with projections of 30% of GDP by 2030 with an inflationary rate of about 4% or more a year in the year prior to the affordable health care act. The next closest country to us is the Netherlands which spends 12% of its GDP on health care which is still significantly above the 9.5% of GDP average of the OECD states, the Organization for Economic Cooperation and Development which consists of 34 of the worlds most developed nations. Yet despite our expenditures we are not getting what we paid for. We don’t live the longest, our primary care control rates for chronic diseases is well below the OECD average and our children have the highest rates increase in obesity of any country in the world. Additionally we had some 40 million Americans who had no health care at all. We have spent significantly more both in hospital administration and cost of procedures than anyone else in the world. Our fee for service, cost plus medial system had to change because in a word it was unsustainable. Despite that, our professional medical societies and medical device and drug manufactures, and our legislators, as a whole, acted more like union shop stewards whose primary role is to protect revenue streams and resist change, despite what benefit it might have to the health care of the average patient or the economic health of the country. In the end however even those vested interests understood that something had to be done and as a result we got the affordable health care act, Obama care if you like, an imperfect conglomeration of incomplete measures at best but at least a start. The effect of this legislation will dramatically affect everyone in our profession but most importantly our next generation of plastic sur-

“I am telling you all this because health care is rapidly changing and the practice choices that this generation and the next generation of plastic surgeons will face will force a dramatic schism in our current practice patterns and in the future, more of your practices will look like mine then the majority of surgeons sitting in this room.”

(continued on next page)
2014 Converse Lecturer: Wexler (continued from previous page)

doctors not hospitals run the groups or at least doctors have a significant place at the table. Currently young physicians are flocking to these salaried types of arrangements and today roughly 50% of graduating Plastic Surgery residents are seeking this sort of position and that number is growing. I believe the only solo practice that can survive in his environment will be cosmetic surgery unassociated with 3rd party payers. As a result the great schism in plastic surgery is about to take place and just as the Eastern Orthodox church split from the Latin church in 1054 and Protestants split from the Catholics in 1517 this schism will be just as contentious but I hope with a little less bloodshed. The choice for young surgeons will no longer be academic vs. private practice but rather hospital and large group based reconstructive plastic surgery or, what I will refer to as an entrepreneurial medicine, the business of creating profit by selling non-essential medical services, or essential medical services at extremely high mark ups.

This is not a new phenomenon. Dr Arnold Relman the highly regarded long time editor of the New England Journal of medicine wrote an essay in the journal in October of 1980 where he warned of the burgeoning “medical industrial complex”, profit driven hospitals, nursing homes and diagnostic laboratories, home care services, and renal dialysis centers where he warned of the burgeoning “medical industrial complex”, profit driven hospitals, nursing homes and diagnostic laboratories, home care services, and renal dialysis centers that make up a multi-billion dollar industry. He wrote “the private health care industry is primarily interested in selling services that are profitable, but patients are interested only in the services they need” Dr. Relman died this year but in 2012 he was asked how his prediction had turned out Dr. Relman said that medical profiteering had become even worse than he could have imagined. To those of you who choose to go into entrepreneurial surgery to my mind there is nothing wrong with this when it comes to elective surgery. Price gouging for essential services is however another issue.

The cosmetic surgeon can make a great many patients happy, but being successful in this field is not easy. You must not only show good surgical results but perhaps more importantly you must be able to market your services and have a good business plan. I am sure you are all well aware that the field of entrepreneurial surgery is highly competitive and not just between plastic surgeons but between plastic surgeons and Dermatologists and Otolaryngologists and OB-Gyn and General Surgeons and family practice docs and anyone else who can promise fabulous results on a web site. It’s great to be a board certified plastic surgeon but you can be buried by

“The so called staff model physician run groups like Kaiser, the Cleveland clinic, and Mayo clinic and employ physicians on a salary and benefits basis and assume the business aspects of running the practice.”

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2014 Converse Lecturer: Wexler  (continued from previous page)

the gynecologist down the street with a flashier web site and a
better business plan. Let’s be honest you do not need 6 to 8
years of surgical training to be able to inject Botox or perform
liposuction. You do not need extensive microsurgical training
or knowledge of hand anatomy or cleft lip expertise to be able
to perform a face lift so if the oral surgeon down the street can
do as good a face lift as you can don’t be surprised.

And by the way its not just the guys down the street who
you are competing with but also the cosmetic practices across
the border in Mexico or Costa Rica or Thailand all of whom can
do the surgery at a much lower cost. Is it safer? No.

Do they have higher complications? Yes, from what I see I
believe so.

Are they having trouble attracting patients absolutely not!

One consequence to this pressure of competition is the
increase in advertised hype some feel is necessary to attract
new patients. As the ads and web sites become more decep-
tive, and platforms for surgeons self-aggrandizement,
a real erosion in ethics may take place. Perhaps the most
dangerous situation is when the surgeon starts to believe his
own hype and ego overrides responsibility. An additional un-
fortunate victim of the cosmetic battlefield is the loss of
colegially between surgeons. There is an old aphorism, when
portions at the table become smaller, etiquette suffers. Harvey
Zarem my old chief at UCLA and an enduring gentleman, used
to say “there is only one thing that two plastic surgeons can
agree on and that is how bad the third one is.” We all know that
a great many suits are initiated by the comments of colleagues
when they disparage something another has done, to a pa-
ient. For those of us who choose the cosmetic path you will
be most successful if you always remember it’s not about you,
it’s about the patient.

For those of us who choose a hospital based practice or
are refugees from private practice I believe the future is bright.
I also believe that the return to a hospital based environment
will reestablish our importance in the medical system and al-
low us to return to some of the basic core skills and values that
we were all taught in residency and that attracted us to plastic
surgery in the first place.

Our historical evolution has its roots in acute care General
Surgery and Maxillofacial Trauma Surgery. Gillies, Kazanjian,
Converse, Cannon, rebuilt war torn faces and resected and
reconstructed the resultant deformities of cancer. We expanded
the field of general and oral surgery, we innovated, and we
attracted some of the best and the brightest in the surgical
spectrum. We have however, unfortunately over the years cre-
ated a reputation in the eyes of the public and our medical
brethren of being surgical dessert and not main-course medi-
cine.

Tell someone you are a plastic surgeon and all they think
is that you put in breast implants and do facelifts. They fail to
see us as creative problem solvers for difficult surgical prob-
lems. They fail to see us as hand surgeons and craniofacial surgeons, and Burnsurgeons, and all the other highly specialized reconstruction
and functional restoration that we do better than anyone else.

As surgeons in large multispecialty groups and in hospi-
tals we have the visibility to market our skill sets and prove our
value as part of the medical team. If you are interested in
marketing let’s stop marketing our head shots and start mar-
ketting our value, because as I noted before the new medical
paradigm is all about value.

Last year at our meetings Dr. Joe Rosen gave a wonderful
talk on the aftermath of the Boston marathon bombings and
cited papers that showed that those hospital trauma teams that
included plastic surgeons as part of the team had pts with lower
amputation rates, better surgical outcomes and fewer hospital
days. That’s value, and that’s value that others can see and

As a personality type plastic surgeons are creative prob-
lem solvers with an artistic bent. We do more than “bone broke
must fix, or gall bladder hot, must take out.” Today we are the
only surgeons in the hospital who operate on the entire body.
We combine our unique knowledge of anatomy with a tool set
that includes complex tissue rearrangement, micro surgery,
bone reconstruction, and wound management. We enjoy find-
ing new solutions to tough problems and we do not shy away
from innovation. Paul Tessier the innovator of craniofacial surgery when
asked why he embarked upon such radical complex
new surgery his response was “Pour quoi pas?” —
“Why not?” This is the im-
age we must promote.

Tucked away in remote
private offices, operating in
an office Surgicenter, no
one sees the value we can
bring to patients care. In a
hospital setting we get the
tough problems and others see what we can do for them. In
my hospital-based Department we have 8 Plastic Surgeons
and we practice the full scope of Plastic Surgery. We routinely
interact with General Surgery, Vascular Surgery, Orthopedics,
Otolaryngology, Ophthalmology, Oral-maxillofacial Surgery,
Neurosurgery, Dermatology, Pediatrics, and Genetics. Our
surgical and medical peers regard us as one of the highest
performing departments with some of the best surgeons in the
medical center. My work may not be recognized on the Beverly
Hills cocktail circuit, but our reputation for excellence amongst
our medical and surgical peers along with the thanks and ad-
miration of our patients is all the ego-boost I need.

The future of plastic surgery is not only tied to promoting
our value with our current techniques but also to the innova-
tion we can and should bring to future solutions to hard prob-
lems. We should be the ones responsible for the advance-
ment of tissue regeneration techniques which will radically
change health care of the future. This is why it is so important
that we stay engaged in the research and science needed to
(continued on next page)
In 2012 Sir John Gurdon and Shinya Yamanaka were awarded the Nobel Prize for the discovery that mature cells could be reprogrammed to become pluripotent stem cells. This discovery along with other important contributions in regenerative medicine means to me that face transplantation is really the last significant advancement in a soon to be obsolete field of cadaveric and donor tissue transplantation. A field I would note pioneered by a plastic surgeon Dr Joseph Murray who received the Nobel Prize in 1990 for the first successful organ transplant in 1954.

I believe in the future we will 3D print biologically compatible organ scaffolds on which we will direct pluripotential stem cells to grow human replacement parts that will not require immune suppression and can be customized to the individual. Will we really need to transfer a DIEP flap or can we just grow a new breast? Should we recreate a youthful appearance by pulling on wrinkles or instead recreate real youth using stem cells? How cool is that? And who better to be involved in this revolution then Plastic Surgeons? We should not just think out of the box we should think that there is no box…. Pour quoi pas?

Over all I believe despite the grumblings of some of our older surgeons the future of plastic surgery and the futures of the younger surgeons in this room is bright if you heed the words of Hockey legend Wayne Gretzky. When asked what made him so good he replied, “I skate to where the puck is going to be, not to where it has been.”

Those of you who know me well, know that one of my favorite quotes is from Gaspar Taligiacozzi a founding father of plastic surgery in the 16th century. He said, “We restore and repair that which nature has given but fortune has taken away. Not so much that it pleases the eye of the beholder but that it buoys the spirit of the afflicted.” “I would like to add that in doing so it will buoy the spirit of the surgeon as well.

For over twenty years I have volunteered to repair clefts in developing countries. For me it is always the high point of my year and re kindles the sense of purpose that led me to be a physician and then a surgeon . It is medicine in its purest form . You have a skill to give those who suffer a chance for a new life. Your payment is their thanks and love you receive from those patients and it will buoy your spirit and give purpose to your life and enduring satisfaction to your practice. IF you need to escape from the bureaucracy and the overblown and unnecessary complexity of the American medical care system, make volunteering a routine part of your practice it will add value to your practice, to your family and to you as an individual. It’s all the fun of face book with real faces.

Through my 30 years of practice I have been fortunate to have had a broad and fulfilling practice in reconstructive plastic surgery with a wonderful depth of supportive and close knit colleagues. I was fortunate to have parents who could provide me with the opportunities to fulfill my ambitions and I am thankful to have had the mentorship of surgeons like Harvey Zarem, and Mal Lesavoy, and most of all my enduring friend Henry Kawamoto. I am blessed and thankful that my life’s work has been balanced by the love and support of my wife Geri and my two daughters Becca and Sarah. An additional word of advice for those of you worried about finances in modern medicine, its much cheaper to go through life with just one spouse. We have a vibrant and exciting specialty; embrace change, never forget our core reconstructive skills and consider well the words of the baseball great, Yogi Berra, “the future is not what it used to be.”

Thank You.
ASMS at EACMS (continued from page 10)

impression that Dr. Wexler not only listens to his patients but works with them in planning their surgical destiny. Rather than being prescriptive in his management there is a recognition that patients are also customers with a voice.

Indeed, facial restoration is not a technique but a marriage of two surgical philosophies, namely aesthetic and reconstructive surgery. It cannot be applied selectively on a case by case basis as all patients want good aesthetic and functional outcomes. Dr. Wexler states that he does not start with the CT scan but with the patient and treats all trauma patients as though they are a cosmetic patient.

Provoking more thought he discuss how we are “hard wired” to accept symmetry and this view should not be restricted just to the frontal view but other angles and planes. He talked about the golden mean and getting the skeletal framework correct before proceeding with the soft tissues.

Although, Dr. Wexler had said that he adopts a similar reconstructive and aesthetic approach to both trauma and cosmetic patients approaches he added that there was an additional challenge of making sure that intervention for complex craniofacial trauma is done as early as possible to counteract contraction and distortion of the soft tissue facial envelope. Of course, in the presence of severe head injury or significant comorbidities the decision to proceed would be a multidisciplinary one. After all, we are in the profession of treating patients not CT scans and work as part of a team.

Dr. Frank Papay’s paper

Dr. Donald Mackay was having a busy day. He presented Dr. Frank Papay’s paper. The theme of Dr. Frank Papay’s presentation was how advances in technology can improve predictability and deliver improve outcomes. Successful applications of advances in technology for medical use often require a change in our mindset and how we interact with others. As Dr. Frank Wouters says innovation is a people’s affair. People innovate not organizations. However, there has to be in the workplace an environment that facilitates innovation.

Multidisciplinary team are common in medicine and surgery but to leverage the revolution in informational technology requires interdisciplinary collaboration, often with the clinician leading a diverse team that may consist of IT application specialists, biomedical engineers, imaging specialists and mathematicians.

The work of Cleveland Clinic has been focused on harnessing technology to facilitate the planning and execution of complex surgery. For example the use of 3D printing, modeling and prototyping to generate 3D models of the hepatobiliary system and craniofacial anatomy can assist in identifying potential problems in surgery and allow the surgical team to become familiar with the relevant anatomy. 3D models may also assist in obtaining informed consent. Calvarial plates and custom made cutting jigs can also be produced which not only reduce operating time but can make surgery more predictable and cost effective. As Dr. Sabine Girod mentioned earlier, both the validation and accuracy of the processes that are involved in the manufacture of such models need to be robustly assessed.

Dr. Robert Havlik

ASMS final guest speaker was Dr. Robert Havlik who started by sharing his experience with distraction osteogenesis, which he felt was best applied to children with syndromic midface anomalies. He posed several thought provoking questions to the attentive audience. These included how do we minimize the surgical stages for such patients, maximize their facial rehabilitation and how best to use rigid fixation knowing that it does not stop relapse.

Dr. Havlik mentioned his chief goals for children with syndromic patients. They were establishment of facial convexity, alignment of midlines and the creation of upper incisor show. Correction of obstructive sleep apnea and proptosis in patients with Aperts are also important targets. The technicalities of the operations were shared with the audience. With a 15 year follow up, Dr. Havlik had a lot to offer. He urged caution in how the frontozygomatic suture is used in distraction osteogenesis as it may dislocate.

In terms of preparing these children for school and the community, Dr. Havlik feels that the more severe the deformity the earlier is the indication for surgical intervention. Another condition that Dr. Havlik has had the opportunity to witness the change in treatment over the years is Pierre Robin Sequence from 1994 to 2004 he used tongue - lip adhesion to manage the airway problems arising from a hypoplastic mandible and a tongue that tended to fall back into the oropharynx. However, since 2004 he has used distraction osteogenesis for such patients whilst ensuring that they continue to receive close intensive care support in the post operative phase of treatment. Like all ASMS delegates, Dr. Havlik’s outlook for the future is forward looking, a future shaped by a candid appraisal of the past. As ASMS delegates have shown, experience is not what happens to a person but what he or she does with it.
hands on skills training, and case observation. These findings are corroborated by Garneau et al, who studied a two part training program, the first of which was observation based preceptorship of laparoscopic sleeve gastrectomy, and the second part was a proctorship, where a consulting surgeon and accompanying support staff came on site to the trainee surgeon’s hospital to teach. Both aspects of training were found to be an effective way of teaching the new technique, and subsequent surgeries resulted in a low complication rate and sufficient weight loss at 6 months follow-up.

Along similar lines, the ASMS preceptorship program will follow up with both preceptors and preceptees, and assess the viability of the program, the impact of observation, and finally members’ opinions of proficiency in areas of weakness identified by the 2013 ASMS survey. Despite a 17% response rate, the willingness of a large majority of members to help fellow members is deeply encouraging, and more members are expected to add themselves to the list of preceptors upon program implementation. We hope that by identifying and strengthening areas of perceived weakness along with the development of a powerful academic tool, the ASMS Preceptorship Program, the ASMS can continue to make strides in influencing maxillofacial surgery on a large scale. We expect the preceptorship program to be an excellent resource for members to continue mentoring one another, developing intellectual and academic curiosity, providing avenues for collaboration, and further contributing to the ASMS’s role in shaping maxillofacial surgery into the future.

Table 3: Responsibilities of the Preceptor and Preceptee within the ASMS Preceptorship Program

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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</table>
| Preceptor| 1) Assign and identify an individual (secretary, coordinator, fellow or yourself) to act as the chief organizer and contact person for the Preceptee. A phone number and email address should be provided to the Preceptee.  
  2) Make appropriate efforts to schedule the Preceptee’s visit to expose them to the case(s) of interest.  
  3) Schedule the visit at a time when you will be there.  
  4) Provide all necessary paperwork for hospital and operating room access to the Preceptee prior to the visit.  
  5) The Preceptor cannot charge a professional fee to the Preceptee.  
  6) Complete the ASMS evaluation form at the end of the Preceptee’s visit.  
  7) Serve as a representative of the ASMS.  |
| Preceptee| 1) Provide a CV and background of yourself when you are scheduling your visit to the Preceptor.  
  2) Be flexible with the Preceptor’s visit schedule.  
  3) Respect the professional and social norms of the hospital and practice you are visiting.  
  4) Be responsible for all financial aspects of the visit.  
  5) Complete the ASMS evaluation form at the end of your visit.  
  6) Serve as a representative of the ASMS.  |

References

ASMS Preceptorship Program  (continued from previous page)

Figure 1a: Preceptee Pre-Preceptorship Evaluation Form
Preceptor Name & Date:
Preceptee Name:

1. What do you expect from this experience?
2. Which part of the training do you think will be particularly valuable?
3. How will the skills you learn benefit you in your role?
4. What do you hope to do differently when you have completed this experience?
5. How would you rate your level of knowledge/skills/abilities on a scale of 1 to 5, 5 being very good

Figure 1b: Preceptee Post-Preceptorship Evaluation Form
Post Course Evaluation (this is to be completed as soon as possible after preceptorship is completed)
Preceptor Name & Date:
Preceptee Name:

1. Which part of this experience did you find particularly valuable?
2. Are there any aspects of the preceptorship which you feel require improvement?
3. How relevant was the training?
4. Were the timing and duration acceptable?
5. In your opinion, was sufficient material covered?
6. In what ways have you increased your knowledge of the subject?
7. How will the skills that you’ve learnt benefit you in your role?
8. How would you now rate your potential ability on a scale of 1 to 5, 5 being very good since attending the preceptorship?

Figure 2a: Preceptor Pre-Preceptorship Evaluation Form
Preceptee Name & Date:
Preceptor Name:

1. Why do you want to be a preceptor? (ie: enjoy teaching, giving back to my profession, intellectual stimulation, teaching recognition, serve as role model? )
2. Which part of the interaction do you think will be particularly valuable?
3. How will the interaction benefit you in your role?
4. What do you hope to do differently after this interaction?
5. How would you rate your level as a preceptor/teacher/role model on a scale of 1 to 5, 5 being very good since the interaction?

Figure 2b: Preceptor Post-Preceptorship Evaluation Form
Post Course Evaluation (this is to be completed as soon as possible after preceptorship is completed)
Preceptee Name and date:
Preceptor Name:

1. Which part of the interaction did you find particularly valuable?
2. Are there any aspects of the interaction, which you feel require improvement?
3. How relevant was the interaction?
4. Were the timing and duration acceptable?
5. In your opinion, was sufficient material covered?
6. In what ways has the interaction changed how you practice?
7. How would you now rate your abilities as a preceptor/teacher/role model on a scale of 1 to 5, 5 being very good since the interaction?
GLOBAL PEDIATRIC
FACIAL SURGERY SUMMIT

Dell Children’s Medical Center of Central Texas
The University of Texas at Austin
Dell Medical School

November 21, 2015
7:30 a.m. – 5 p.m.

Co-organizers:
Raymond Harshbarger, MD, FACS, FAAP
Pirko Maguina, MD, FACS

Panel and Poster Format
Multiple Perspectives on Cleft/Craniofacial Care
in the Developing World

Focus Areas:
- Models of Care
- Education
- Building Programs
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- Health Policy
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- Dental and Orthodontic Care

For more information, contact Ashley Andreano at ASAndreano@seton.org.
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