



MAXILLOFACIAL NEWS

American Society of Maxillofacial Surgeons

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Fall 2014

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ASMS Introduces Preceptorship Program

The ASMS Education Committee announces a new preceptorship program to provide a mentoring opportunity, furthering the educational mission of the organization.

ASMS Presidential Awards

Dr. Schubert will present the annual awards of distinction at the Presidential Reception on Sunday, October 12 in Chicago.

Panel Discussion: ASMS and its Younger Members

Dr. van Aalst talked with several younger members to gain insight into their reasons why they belong to ASMS and what they hope to achieve by being involved.

ASMS 2014-2015 Visiting Professors

Four leaders in the specialty will be this year's Visiting Professors.

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Devra Becker explains how she became involved with the ASMS and how her career has been shaped by the organization.

ASMS Member Update

A new feature focusing on an ASMS members.

FROM THE PRESIDENT

On July 12-13, 2014 the American Society for Maxillofacial Surgery (ASMS) had our first Board retreat in a decade.

The reason for the retreat was to discuss strategies and focus for the next several years.

As a result of this retreat, our Board members and several Committee Chairs and Past Presidents decided upon our new mission statement for the ASMS: *'The leaders in the education, art and science of facial reconstruction.'*

Five pillars that we included in this mission include education, excellence in patient care, community connectivity, research, and advocacy.

Several initiatives include continuation of the Basic Maxillofacial Course with at least two each year (there were three in
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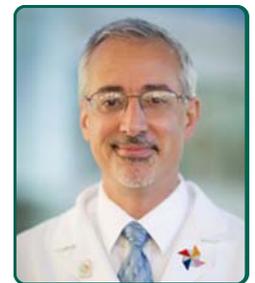
Warren Schubert, MD
University of Minnesota

EDITOR'S COLUMN:

A Focus on Young ASMS Surgeons

This edition of ASMS News is dedicated to young ASMS surgeons. We gathered a group of surgeons who completed their pediatric and craniofacial Fellowships in the last 6 years, and asked them why they joined ASMS, what they expected when they joined; whether these expectations were met or not; how they have participated in emerging leadership positions at ASMS, and what advice they would give about reaching out to other young surgeons.

Many of the panelists' were initially drawn into ASMS through the Basic Course, followed by the Advanced Course, and the Pre-Conference Symposium, where they met leaders in the field, made friends, and established a sense of community. What has kept them in ASMS has been a chance to be heard, a sense of value; and a belief that current leadership is interested in training them to become leaders. Their advice to ASMS leadership is to continue ASMS's unique educational opportunities, and possibly, to consider an educational course directed at guiding Craniomaxillofacial Surgeons who are establishing new practices.
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John van Aalst, MD
UNC, Chapel Hill

Why I Joined the American Society of Maxillofacial Surgeons

Peter J. Taub, ASMS Member

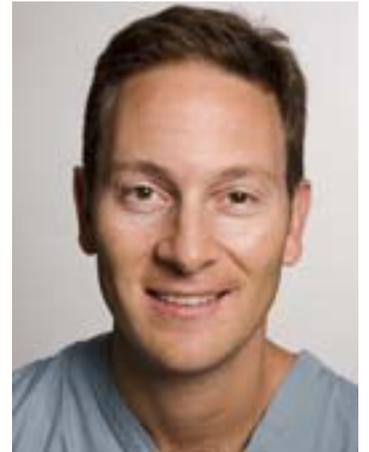
When beginning my fellowship in Craniofacial Surgery, I had minimal interaction with any of the major Plastic Surgery Societies. I had joined some as a member when I presented at sponsored meetings, but the true value of membership was lost on me. That changed during my Fellowship with Henry Kawamoto at UCLA. In the first half of my Fellowship year, Dr. Kawamoto asked me to help with the Basic Maxillofacial Course sponsored by the ASMS and hosted that winter at UCLA. A little research taught me that Dr. Kawamoto was a former ASMS President whose roster also included Drs. Kazanjian, Dingman, Georgiade, Manson, and Salyer— among others.

The Basic Principles course remains unlike any course I have participated in to date. It is a hands-on opportunity to learn about simple and complex cases in maxillofacial aesthetic and reconstructive surgery. The faculty of my first course included many other prominent surgeons not only in Maxillofacial Surgery but also in Plastic Surgery as a whole. They included Andy Wexler, whom I had known from rotating at Kaiser, James Ferraro from Ohio State, and Kevin Kelly from Vanderbilt – all of who have served as Presidents of ASMS. I was amazed how every one of these surgeons showed genuine interest in helping students master the basics of Maxillofacial Surgery. It was refreshing to see how much these faculty enjoyed “getting dirty” in the laboratory with students, by taking

algininate impressions, pouring plaster models, and fabricating acrylic splints. They were also easy to talk to about questions and ideas I had. They also showed interest in me as a surgeon and my future development as an educator.

Today, the course continues to be updated by highly committed educators (among them, our current President, Warren Schubert), with new modalities such as distraction osteogenesis and computer modeling.

Since my first exposure to ASMS at the Basic Course, I have continued to be involved with the Society by teaching at the biannual Basic Course, participating in the annual Pre-Conference Symposium, and serving on the Society’s Board. The ASMS is unique among medical and surgical societies, and it starts with a long history of member dedication to education, which is second to none.



Book Review: “Scarcity: Why Having too Little Means So Much”

by Sendhil Mullainathan and Eldar Shafir

Review by John van Aalst, MD,



Scarcity, defined as “having less than you feel you need,” affects all of our lives, in multiple forms: lack of money, food, time, friends, energy, and space. The brilliance of this book is that it suggests that all forms of scarcity have similarities because they elicit common behaviors in all of us (that a poor man in India with no food behaves similarly to a busy Los Angeles surgeon, who has no time).

What are the behaviors that scarcity elicits in all of us? Scarcity causes us to “tunnel”—to focus on whatever the most important item is in front of us (finding food for the hungry man; finishing the project for a busy professional) at the complete exclusion of other issues. Tunneling causes us to ignore the other things that require our attention (family, work, the next project); eventually these very things become the next problem that causes us to tunnel.

Scarcity taxes us, causes us to think specifically and particularly about the missing item. It stresses us, and makes us less capable of making good decisions about all the other things that need our attention.

By taxing us, scarcity narrows our bandwidth, meaning that it makes us less efficient, less able to be productive. We simply cannot handle the number of items coming our way.

Dealing with scarcity as a condition, as an algorithm (rather than in its various forms—poverty, being time strapped, or hungry), can teach us why our patients don’t take our advice (even if we give them a handout explaining what we’ve said); why a poor patient may not take his medication, even if the medication is given to him without charge; why surgeons overseas don’t appear to want to volunteer on behalf of children from their own country.

The condition of scarcity and our predictable responses to it, may also give us answers about how to combat the reality that we are moving from project to project in an absolute and endless frenzy. Why, though we work hard, from week to week, yet simply spin our wheels.

As busy surgeons, if we want to obtain a seat at the decision-making tables at the hospitals where we work, in the healthcare systems we are all a part of, we may want to find the time to read “Scarcity.”

New Initiatives for the ASMS Developed in Collaboration with the ABPS, the ASPS, and the PSF Highlight the Upcoming Fall Meeting

Arun Gosain, MD, Chair
Anand Kumar, MD, Co-Chair

This fall the ASMS will once again organize and sponsor the annual Pre Conference Symposium on October 9th, 2014 in conjunction with the annual American Society of Plastic Surgeons meeting in Chicago, Illinois.

The Pre Conference program this coming fall features an emphasis on keeping current in the age of MOC (Maintenance of Certification) and for the first time a unified theme uniting the preconference and the main conference meeting that will allow participants to uniquely shape their experience for in-depth education and MOC credits within Maxillofacial Surgery.

There will be ample opportunity for participants to complete the didactic component of MOC through ASMS-sponsored activities at the annual combined meeting. The Pre Conference Symposium includes 9 MOC eligible lectures that for the first time unify cosmetic, oncologic, congenital, and traumatic topics within the scope of Maxillofacial Surgery.

The MOC modules based on these lectures will be:

- Belpharoplasty and Face Lift (Cosmetic)
- Non-Melanoma Skin Cancer (Oncologic)
- Cleft lip
- Cleft palate
- Cleft nasal deformity
- Non-Syndromic Craniosynostosis (Congenital) and Zygoma/Orbits
- Mandible Fracture (Trauma)

Unique to this year's main meeting, we will employ a "Thread Concept" for educational activities for participants who have specific interests in key topics and who wish to pursue these through different venues. ASPS and ASMS leadership have designated five such threads, beginning with the Pre Conference Symposium and concluding with the final courses and discussion sessions at the ASPS meeting.

These 5 Threads will be:

1. Cleft Lip
2. Cleft Palate
3. Cleft Nasal Deformity and Consideration of Accompanying Functional Airway Compromise
4. Facial Fractures: Mandible and Pan-facial
5. Orthognathic Surgery

Greater depth and study will be available during the main meeting in three revised and updated MOC-eligible courses during the meeting: Cleft Palate (Arun Gosain and John van Aalst), Secondary Cleft Nasal Deformity (Don Mackay and Tom Samson), and Mandible Fractures (Larry Hollier).

We look forward to seeing members, residents, fellows—and most of all—new surgeons interested in expanding their knowledge of maxillofacial conditions. We hope to foster further education, research and stimulate greater interest in the ASMS and Maxillofacial Surgery in an unprecedented manner this coming fall!

See you in Chicago!

www.MAXFACE.ORG



American Society of Maxillofacial Surgeons
Artists in Facial Reconstruction

PRE-CONFERENCE ASMS SYMPOSIUM

Thursday, October 9, 2014

ASMS DAY

Sunday, October 12, 2014

**For additional information and to register, please visit the ASMS Website:
www.maxface.org**

The American Society of Maxillofacial Surgery (ASMS) Preceptorship Program: A Product of the 2013 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 can 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" preceptors¹. 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^{2,3}, and is the first such program 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 by 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, 2. Pre-preceptorship expectation and post-preceptorship evaluation forms. 3. A Likert scale based evaluation to be completed by both preceptor and preceptee.

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 procedures⁴. 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, hands on skills training, and case observation⁵. 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-up⁶.

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.

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ASMS Preceptorship Program *(continued from previous page)*

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Table 2: Subspecialty Areas to Improve Proficiency
Subspecialty Proficiency

- 1 Orthognathic Surgery
- 2 Cephalometric Analysis
- 3 Craniofacial Osseous Integrated Implants
- 4 Dental Osseous Integrated Implants
- 5 Biomodeling
- 6 Craniosynostosis
- 7 Maxillary/Mandibular Distraction
- 8 Cranial Distraction
- 9 Skull Base Tumor Ablation
- 10 Microvascular Craniomaxillofacial Reconstruction
- 11 Cleft Lip and Palate
- 12 Secondary Craniomaxillary Reconstruction
- 13 Facial Implants
- 14 Auricular Reconstruction
- 15 Cleft Lip Nasal Rhinoplasty
- 16 Primary and Secondary Rhinoplasty
- 17 Nasal Valve and Turbinate Surgery
- 18 Osseous Genioplasty
- 19 Obstructive Sleep Apnea
- 20 Endoscopic Sinus Surgery
- 21 Orbital Surgery
- 22 Dental Extraction (Third Molar)
- 23 Facial Nerve Reanimation
- 24 Vascular Malformation of The Head And Neck
- 25 Headache – Facial Pain
- 26 Facial Aesthetic Surgery

Table 1: Areas of Specialty for Preceptorship

- 1 Cranial Surgery
- 2 Orbital Surgery
- 3 Orthognathic Surgery
- 4 Craniomaxillofacial Trauma Primary Reconstruction
- 5 Craniomaxillofacial Trauma Secondary Reconstruction
- 6 Cleft Lip and Palate
- 7 Primary Maxillofacial Trauma

Complete details on the ASMS Preceptorship Program, including assessment and evaluation forms, as well as responsibilities and expectations of both preceptee and preceptor, are available on the ASMS Website: www.maxface.org

ASMS 2014 Presidential Awards - to be presented at the ASMS Presidential Reception on Sunday, October 12, The Art Institute - Chicago

Distinguished Service Award

Melvin Spira, MD

The award is presented to a physician who is being honored for his/her exemplary service, dedication, commitment and selfless contributions to the field of Maxillofacial Surgery.

Special Honorary Award

Andrew Wexler, MD

The award is presented to a physician who has contributed significantly to the advancement of maxillofacial surgery and who has demonstrated leadership in the specialty through clinical practice, teaching or research.

President's Honorary Award

S. Anthony Wolfe, MD

The award is presented to a physician to honor his/her countless contributions and service to the specialty and for his/her enormous impact on the profession by educating and mentoring generations of plastic surgeons.

Lifetime Achievement Award

Joachim Prein, MD, DDS

The award is presented to a physician who is being honored for his/her career dedicated to enriching and enhancing the practice of Maxillofacial Surgery.

Tagliacozzi Award

Sam Noordoff, MD

The award is presented to a physician who is being honored for outstanding service to others above and beyond ones routine surgical practice.

Special Presidential Award

Douglas Ousterhout MD

The ASMS wishes to acknowledge and thank Dr. Ousterhout for his many years of support of the ASMS CRANIO Fellowship Program and for his many contributions to the specialty throughout his distinguished career.

Panel Discussion: ASMS and its Younger Members

The Panel

Devra Becker:	Assistant Professor of Surgery, Case Western Reserve; finished Craniofacial Fellowship at Washington University in 2008.
Joshua Lampert:	Private practice, Miami, FL; Clinical Assistant Professor at F.I.U. Herbert Wertheim College of Medicine; finished Craniofacial Fellowship at the University of Miami in 2011.
James Liau:	Assistant Professor of Surgery, University of Kentucky Medical Center; finished Craniofacial Fellowship at the University of North Carolina at Chapel Hill in 2009.
Adam Oppenheimer:	Private Practice in Melbourne, FL; finished Pediatric Plastic Surgery Fellowship at the University of Washington/Seattle Children's Hospital in 2013.
Parit Patel:	Assistant Professor of Surgery, Loyola University Health System, Chicago, IL; finished Craniofacial Fellowship at NYU Medical Center in 2013.

van Aalst: Why did you join ASMS?

Lampert: I joined ASMS as a resident after going to the Basic Course in Philadelphia. I always had an interest in Craniofacial Surgery and Plastic Surgery of the face. I liked the Basic Course very much and ended up joining ASMS for that reason, initially as a resident. Starting out in practice—early on—I found it difficult to initially get on call schedules and acquire specific privileges. I think that being a part of ASMS added value for me in Miami. Being a member of ASMS demonstrated to others that: 1) I had done a Craniofacial Fellowship. 2) I was a member of a dedicated society 3) I had and have some commitment to the field. It demonstrated my goal to continue with ongoing CMEs, courses, and trying to stay up to date on a complex area of study that's ever evolving.

Liau: In the last two years of my integrated Plastic Surgery residency, ASMS offered a lot of great courses. For example, the ASMS Basics course was a great exposure to me and to the residents because of the great faculty, all of them leading members in the field. This provided a much more approachable and conducive way of getting to know people. I ended up doing a fellowship in Pediatric Craniofacial anyway, so it was quite an easy transition to mix with this group. Being able to talk to these faculty members and to have a hands-on approach in the course reaffirmed my decision for membership. Everyone has his own specialty group; ASPS is too big for a dialing down for what we do as craniofacial surgeons. The ASMS obviously fits this role.

Oppenheimer: My grandfather was President of the American Maxillofacial Society in 1977. So, I would say that I didn't have any choice about joining. I may have had the ASMS Pin before I was ever actually a member of ASMS. I don't know if I am supposed to have admitted that!

van Aalst: Do you remember any story about your grandfather where he encouraged you to join ASMS?

Oppenheimer: I did head and neck cases with him when I was home over one college summer, and the approach he had with these patients helped me to gravitate toward Maxillofacial Surgery. But it really was the ASMS basic course—it was a requisite for us at the University of Michigan—when I technically became a society member.

van Aalst: Talk a little bit more about the Basic Course. What was good about it?

Oppenheimer: I think part of the difficulty in Plastic Surgery residency training is that it can be highly variable. If there is an exceptional Craniomaxillofacial Surgeon at a teaching hospital, then the experience can be energizing for the residents. If there is not one such surgeon, there is a deficit. So, the Basic Course really levels the playing field to allow access to specific aspects of Orthognathic Surgery and Craniofacial Surgery that you may not otherwise get in residency. I think that this knowledge is central for all Plastic Surgeons, Maxillofacial Surgeons, and Oral Surgeons regardless of a person's specific area of interest. The best part about ASMS is that the focus seems to me to be on education above all else—which is really not the case with some other societies that I am involved with.



...the Basic Course really levels the playing field to allow access to specific aspects of Orthognathic Surgery and Craniofacial Surgery that you may not otherwise get in residency.

- Adam Oppenheimer, MD

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Panel Discussion *(continued from previous page)*

van Aalst: It sounds like education is what drew you to ASMS and has been an on-going reason that you have continued with ASMS.

Oppenheimer: I also took the Advanced Course because of my interest. The greatest value of the ASMS courses is the faculty connection: working with them is as close to a one-on-one situation as possible. They are very hands-on, and I think this is unique. They are not classroom courses. There are lab courses and the access to professors is unmatched. This isn't a Master Course where there is one surgeon in an auditorium. There are a dozen experienced surgeons present who are known in the field that are training one to two dozen residents. It was a very positive and fun experience.

Lampert: During the Basic Course, I remember that we did a saw bones skull project. I remember Joe Losee, MD was showing approaches to and plating techniques for basic facial fractures. I was a PGY2. I think that really was a great piece of the course. I remember that I was able to implement that knowledge soon after that course doing facial trauma cases with Dr. Taub. I had more confidence after that course, and Dr. Taub allowed me to do more surgically to treat the patient. I think that the introductory course was great. It was Dr. Taub who encouraged me to join ASMS.

Becker: I joined ASMS because the educational mission resonated with me, as well as the commitment of other ASMS members to that mission. The leadership seeks to elevate the membership toward academic pursuits.

van Aalst: Would you say that ASMS has encouraged you to pursue both academic and educational pursuits?

Becker: Yes. ASMS leadership has actively provided accessible opportunities for me, which is key to engagement in an organization. There are educational projects the leadership would ask me to participate in, and these were very attainable goals. As I did these projects I was able to use them as a spring board for larger educational projects.

Patel: I decided to join ASMS because I wanted to be part of an organization committed to the advancement, treatment of and advocacy for patients with facial differences. As a surgeon, early in my career, I believe it is important to connect with others in the field who have dedicated their careers to Craniofacial and Maxillofacial Surgery.

van Aalst: Were there other member benefits that you were looking for when you joined ASMS?

Liau: The biggest part for me was the educational component. As I went to more meetings, I started recognizing people and meeting new colleagues. I started recognizing names and that was fun to find this community with other surgeons.

van Aalst: Who initially recommended that you join?

Liau: Dr. Henry Vasconez.

van Aalst: You touched on this a little bit before saying that ASPS was big and that ASMS gave you a feeling of connectedness, but are there reasons that you specifically did not join other organizations?

Liau: It seems like everyone joins ASPS and then they join their respective specialty fields like Microsurgery or Hand. For my interests and practice, ASMS offered more for me both in technical practice, and overall direction. It offered more community and the idea that we are in this together, figuring the best way to approach craniofacial problems; how our techniques and our management is evolving, especially in today's healthcare scenario.

Patel: I think some of the best benefits for surgeons in training and young surgeons are the ASMS instructional courses. As a surgeon I believe the educational process never ends and that we were in a perpetual state of learning and evolution. At some point in my career I'd like to participate as a faculty member for one of these courses. I also believe that it's important to connect with other Craniofacial and Maxillofacial surgeons for collaboration and for the dissemination of innovative ideas.

van Aalst: Was there someone in particular that recommended you join?

Patel: As the Craniofacial Fellow at New York University, one of my mentors, Dr. McCarthy always emphasized participation in national societies such as ASMS. He would state that a rewarding aspect of his career was mentorship and education of residents and fellows through organizations like the ASMS. So he was definitely a major influence in my decision to join.

van Aalst: Were there reasons that separated ASMS from other organizations that led you to join?

Patel: I believe my career goals and clinical interest were most in line with the members of the ASMS and the mission of the ASMS. So that's why I am very interested in participating in the ASMS as a young surgeon.

van Aalst: What were your expectations in joining ASMS and do you feel that they've been fulfilled?

Lampert: The expectations I currently have for ASMS will be continuing with new courses, new material, and the evolution of the field. This should be available in on-going courses and CMEs so that I can stay on top of what's going on. I think that the basic plastic surgery skills should include aesthetic and reconstructive treatment of the entire body, including above the neck. If you have even more focus or commitment to this area, I think that ASMS provides a society where you can further identify yourself. ASMS gives you some legitimacy and support in dealing with competing specialties like ENT or Oral Surgery. In Miami, referring doctors often ask why a Plastic Surgeon should be treating

The greatest value of the ASMS courses is the faculty connection: working with them is as close to a one-on-one situation as possible. They are very hands-on, and I think this is unique. They are not classroom courses.

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Panel Discussion *(continued from previous page)*

orbital fractures or even a nasal fracture. When people ask this, it blows my mind! It's very different from New York, where I trained. At Mount Sinai in New York, we took a third of the facial trauma. Subsequently, we were identified as the physicians that treated facial fractures and performed rhinoplasty. At some of the private hospitals in South Florida, there are very few Plastic Surgeons on the facial trauma call schedule. Some of them require a dental degree in order to cover any, and all, facial trauma call. This includes nasal fracture treatment as well.

van Aalst: I wonder if this is unique to Miami and to Florida. Plastic Surgeons may be partly to blame for this “face call” culture. There are places in the US where Plastics Surgeons could be on the call schedule for facial trauma, but they choose not to be. Because these services are absolutely essential to any hospital, the specialties willing to provide these services then get access to cases that may be more desirable—possibly the nasal surgeries you mentioned. By providing service, you also can participate in hospital decision-making. There are places around the country where Plastic Surgeons are refusing to take face or hand call and lose their place at the table. The specialties—Oral Surgery, ENT, Orthopedics—that are willing to provide the service, are the ones who are then invited to help make decisions at these hospitals.

Lampert: There was a very good article in PRS a few years ago, suggesting that the field of Plastic Surgery may eventually go extinct. Historically, Plastic Surgeons have been pioneers. With the inevitable dissemination of information, the inventions of Plastic Surgery have been allowed to move into the hands of referring physicians, who once needed us to deal with their more complex problems. As a more defined solution became available and then was described to the medical community, we lose ownership of it. The economy of using the solution overrides the fact that we may be the best trained and experienced surgeons to deal with it. Maybe, it has to do with our own willingness to let it go as other procedures become more economical or convenient.

Whether it's a Breast Oncologist who is now doing “oncoplastic surgery”, or the Oral Surgeons now doing their own free flaps, or the General Surgeons doing their own component separation, or Dermatologists doing their own forehead flaps: these non-plastic surgeons are more frequently performing procedures originally described and defined by Plastic Surgeons—but now without the Plastic Surgeon. These are procedures that continue to be fundamental techniques required in Plastic Surgery residency training and ultimately for Board Certification. As a Plastic Surgeon, I feel that we have the most vigorous training, education, and experience with these procedures. I feel that patients and the general public should better understand this, and that ASMS can play a role in helping to define that Plastic Surgeons are the best reconstructive surgeons.

Liau: My first expectation in joining ASMS was just learning from the Masters, and now I feel it has gone beyond that. I have gotten to meet other members, who are in the same generation of practice and sharing our experiences in itself has been well worth it. Hearing about everyone's experiences and how we follow the lectures and the textbooks, but after a period of time realizing

that I am developing a more nuanced understanding is both a relief and reassuring. When listening to the masters, hearing the 1st person evolution of a certain technique or of a certain way they managed something, is great since in essence, we are experiencing the same dynamic.

van Aalst: In what ASMS venue do you feel like you have met these people?

Liau: For me, I think the Pre-Conference symposium is probably the most important part of the year.

Oppenheimer: My major expectations from ASMS were for the educational component and I can say without a doubt that they have been fulfilled. I was selected as an ASMS resident scholar. I don't know of many organizations that bring the focus onto the small-timers in the field. Often these organizations are looking upward to their leadership, recognizing long-standing pillars in the Plastic Surgery and Maxillofacial Surgery community. So for them to see the research I was doing as a resident and recognize that on the national level was flattering and encouraging.

Becker: For me, access to educational endeavors was the initial big draw. Also the membership itself and the access to leadership was a big draw for me.

van Aalst: Was there anyone in particular who encouraged you to join ASMS?

Becker: It was Arun Gosain who originally encouraged me to join ASMS. After I joined I was able to meet a lot of people who are at a similar level in their careers as Arun, and my circle of mentors expanded. Each member offered something different but there was a sense of a common mission. When I first joined, I didn't really have a vision for what I was going to do. My involvement has evolved as I have had good experiences with the organization, and I wanted to get more involved. I remember being at an Education Committee meeting once that was led by Warren Schubert. There was a discussion about a way to pursue a particular goal, and there was disagreement among the members on the best way to proceed. War-



Now that I am in solo private practice Having medical students is great, but we don't have a plastic surgery residency yet. I miss the more advanced instruction and conversation regarding anatomy and technique. This is a big reason that I think participating more with ASMS courses would be fun for me.

-Joshua Lambert, MD

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ren Schubert turned to a member who had voiced opposition and said, "You know, you really have some important ideas and I want you to be involved in this process as it unfolds." The entire meeting proceeded like this with everybody being included, although I had been quiet. Towards the end of the meeting, Dr. Schubert turned to me and said, "Devra what do you think? Do you have anything to add?" I was so struck by the inclusive attitude. To be fair, it was not only Dr. Schubert. In the meetings that I've been to all the members and leaders wanted to involve everybody.

van Aalst: As you've evolved with ASMS, what leadership roles do you hope to play in ASMS?

Becker: I want to continue to contribute in a meaningful way, and I want to continue to learn about being a good and effective leader from the leaders who are in the organization right now. I hope I will be able to take on the leadership opportunities that help me grow in ways that I wouldn't have expected. Some of the most powerful academic growth stories are when people take something on that they didn't expect. I hope to continue to develop my leadership skills using the opportunities that the ASMS has without necessarily pigeon-holing myself into one particular role. Access to leadership is what helps propel a person's career forward. Overall, plastic surgeons as a group are accessible. I feel comfortable calling anybody on the ASPS roster and asking for advice. But one of the unique things that ASMS members can do is provide advice that is informed by their knowledge of me and my work. It's a smaller organization, and they've interacted with me more and they know me. They're able to give me a more balanced perspective of whether something is a good idea to pursue.

van Aalst: Developing a leadership role in ASMS gave you the confidence to begin developing leadership roles at larger organizations.

Becker: That's exactly right. As a resident or junior faculty member, you see education as the finished product. At the ASMS, junior people are really invited to be involved in the process of the educational endeavors, and you see each step of the process. In my case, I gained familiarity with development of educational products, and it encouraged me to pursue opportunities at my local institution. I applied to be a Faculty Scholar for a prestigious interdisciplinary educational program at my institution. I'm doing that now, and that was a direct result of my experience with the ASMS.



Being part of ASMS has helped me develop skills that I was able to leverage to pursue educational endeavors on a local and institutional level.

-Devra Becker, MD

ASMS and potentially participate in the Visiting Professor program at some point in my career. As a resident in training I believe the ASMS Visiting Professor program was the best available resource for interacting with and learning from leaders in the field of Plastic and Reconstructive Surgery. In terms of what I'm doing now, I am currently involved in a Committee for Young Maxillofacial Surgeons.

van Aalst: You mentioned earlier about wanting to eventually be one of the teachers at the Basic Course?

Patel: Yes, just as I participated in the ASMS Basic Course and had an opportunity to learn from leaders in the field through the Visiting Professor Program, I would like to participate in giving back through these programs.

Oppenheimer: I can certainly see myself involved in the Young ASMS Committee, perhaps from the perspective of a private practice Plastic Surgeon.

Lampert: With regard to leadership roles, I would like to participate and help out with the ASMS courses. I miss the teaching component I had regularly as a resident. As a senior or chief resident, I frequently gave lectures or took junior residents through a case. That was fun. Now that I am in solo private practice with a Clinical Assistant Professor position at F.I.U. Herbert Wertheim College of Medicine. Having medical students is great, but we don't have a plastic surgery residency yet. I miss the more advanced instruction and conversation regarding anatomy and technique. This is a big reason that I think participating more with ASMS courses would be fun for me. It would be something that I would like to participate in as an assistant, moderator or faculty member in the future. I think that it is really a good time to reach out to the younger population of residents. It also should help to keep my own skill base current.

van Aalst: What role do you now believe ASMS can play in your development as a surgeon?

Oppenheimer: I think there is an opportunity to provide concrete practice-based solutions that senior surgeons could help to impart to younger surgeons, particularly those of us who are in community practice. I have a patient in clinic that had a previous lip repair and now needs a Le Fort advancement. How do I piece together a community dentist and orthodontist in private practice for the first time? I am about 2 hours from the nearest Academic Medical Center. If there were advice in that realm it would be something uniquely valuable to me, and I believe to others in the ASMS membership.

Liau: Ultimately, what I really want to do is surgery. I really like hearing about everyone's experiences. It is a good place for peer reviewed work. We can read all sorts of things about how to do a particular variation of a cleft lip repair, or how a new technology has changed cranioplasty, but the experience, history, and wisdom in the ASMS, allows a screening for all these new ideas. Last year there was a great panel about cleft rhinoplasty. Seeing that difference of experience, seeing the results and then comparing those results to your own results makes you think: "Well, I

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need to do a lot more work” or “My results are up to par and I’m doing well. I am confident that what I am providing my patients is on the national standard.”

Patel: I think ASMS will play an important role in my development as a surgeon, especially related to connectivity and the community of senior members in the ASMS and through some of the research initiatives offered by ASMS. As the science of surgery changes, surgeons are learning and modifying techniques and treatment algorithms throughout their careers. Being involved with the ASMS creates an environment for collaboration with other Craniofacial and Maxillofacial Surgeons.

Becker: Being part of ASMS has helped me develop skills that I was able to leverage to pursue educational endeavors on a local and institutional level. Having access to the educational products of ASMS, and to the individuals who create those projects, has made me a better surgeon as I approach operative cases. There is a direct link between my involvement with the ASMS and my involvement in educational activities at my institution—not just with the residents but for the medical school as a whole. Having a voice for Plastic Surgeons and for Craniofacial Surgeons at an institutional level is huge for our specialty. I’m on the Committee for Medical Education. There aren’t a lot of surgical subspecialists represented compared to Pediatrics or Internal Medicine, and I think we offer a unique perspective.

van Aalst: As surgeons we can sometimes fall back on the excuse of being too busy to be involved. Because we are busy, we basically cut ourselves off in terms of leadership roles at our own institutions because we either can’t or don’t want to make the time to join these decision-making groups.



As a resident in training I believe the ASMS Visiting Professor program was the best available resource for interacting with and learning from leaders in the field of Plastic and Reconstructive Surgery.

-Parit Patel, MD

Becker: That’s a great point. I am on the Faculty Council for Case Western Reserve Medical School. I ran for the Faculty Council Steering Committee, a committee within the larger Faculty Council. The steering committee is important because it has influence on the agenda Faculty Council. When I was running a surgeon turned to me and said, “How are you possibly going to have time to participate in this committee?” There was a very high representation of basic scientists, and so not only as a clinician but as a surgeon, I thought it was important that our voice be heard. I said, “I’m just going to have to make the time.”

van Aalst: There is no other answer is there? You simply have to make the time. Did you win?

Becker: I did.

van Aalst: Congratulations.

Oppenheimer: Yes congratulations. Only a few of us have the privilege to be in the academic world and rather end up in a private world with a unique subset of challenges. An educational course directed at some of these community-based practices could be an area of emphasis that otherwise is currently unavailable. I would say this globally about residency training, that there really is a deficit in learning about the practical aspects of being a surgeon.

Lampert: Another issue for me is that there are many non-plastic surgeons that control the credentialing and call schedules for craniofacial trauma, especially at the more desirable and competitive locations. I noticed it when I was a fellow with Dr. Anthony Wolfe, MD. There were many plastic surgeons who have had a hard time getting on the call schedule for facial trauma. Quite frankly, we are still facing these issues. There are a lot of politics involved. When it comes to privileges and call schedules, I have found that it is not necessarily based on who is the most qualified, or who has trained the most, or who is doing the best, working the hardest to take care of patients. This is the unfortunate truth.

van Aalst: An educational course that focuses on something as simple as “how to incorporate facial fractures into your practice?” and how to get on the community facial trauma call schedule” would have value?

Oppenheimer: How to break into the facial trauma call pool at a community hospital would be a big plus. Connecting with referral sources for cutaneous oncology, making inroads with local pediatricians to treat children in private practice. All of these are common and recurrent themes in “real world” of Maxillofacial Surgery.

van Aalst: What would you say if someone reading this article said “Give us a whitepaper on how to set this course up!”

Oppenheimer: Sure! I would be happy to weigh in. It obviously is very fresh in my mind right now: contract negotiations, hospital privileges. These are all things that I am learning the hard way, and I would be more than happy to contribute to the education of chief residents and young surgeons.

Lampert: I think that that would be good course to go to. Practice development is a major effort in any private practice. Craniofacial surgery practice models have changed significantly over the years. I think that the dedicated pediatric plastic surgeon, employed by the pediatric hospital, is the trend now. I think that there will be less and less mixed practice plastic surgeons performing the larger pediatric plastic surgery procedures (like cranial vaults or even cleft care). To care appropriately for the complicated pediatric cases, you need to be part of the multi-disciplinary team. With health care reform and reimbursement, most

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pediatric hospitals that want to support these teams will hire a full time plastic surgeon onto staff. Their responsibility is to the pediatric hospital. I don't know how things are going to be in another 15-20 years. I don't know how many people are going to be doing that whole mix. I definitely do way more surgery on adults these days. I think that there are a lot of Craniofacial Surgeons in private practice doing more surgery on adults. I think that it would be nice to have a practice development course for craniofacial surgeons in private practice.

One hurdle I've hit is that I don't do difficult tooth extractions, like going after tooth roots that have been fractured. I don't have privileges to do that alone, and some of the hospitals require that privilege in order to take call for facial trauma. And that's been a real hurdle for me. If ASMS offered a course on tooth extractions, I would be interested. The other thing that I'd personally like to see is more Orthognathic Surgery. Courses on the newest computer software. What's the best software and then legitimately setting it up in your office. We made the molds and we did it all in training, but what materials do I need to start. How do I set up my office without going overboard?

van Aalst: So if there were a course that included the range of the following skills: tooth extraction, how to set up a practice that can do orthognathic surgery: literally what is the best virtual software; how to build relationships with hospitals, how to get onto the facial trauma call schedule; how to deal with trauma CPT coding issues to maximize collections—that this course would have major value to you?

Oppenheimer/Lampert: Absolutely.

van Aalst: What should ASMS do to stay relevant with young surgeons?

Lampert: The Basic Course is good. I don't see mid-level courses as often though. I would like to see more hands-on advanced courses, maybe technique courses with cadavers and more endoscopic approach training. I'd like to see more courses that are going to potentially help me with my practice.

Becker: ASMS is a smaller, but influential organization, which is an asset that the ASMS can leverage. Having mentorship and encouragement from senior surgeons and leaders in the organization has been very important. As the ASMS encourages on a personal level the junior surgeons, that's what will make the difference.

van Aalst: So it's not as much an issue about relevance as it is with sort of that personal touch and a sense of community?

Becker: The educational products are already good. The community is made up of the heavyweights in the field, and when those people take an interest in the careers of the junior members, it provides something really valuable.

Oppenheimer: Getting an early exposure during training and making it an emphasis on the educational side. I think if you tie into the organization as a resident, then you are more likely to stay involved as you mature and leave training. I think the ASMS already knows the answer, and expanding the educational land-

scape beyond the standard orthognathic-type courses. How about a course that combines craniofacial access for trauma and aesthetic surgery? This could cater to a community physician more than an exclusively trauma-based course.

I think it goes back to what we said about the focus on academics. Making a living in private practice is like a dirty word or a taboo concept as a trainee and it is completely glossed over. So, I think there would be an opportunity to discuss these issues and capture surgeons at a transition point in their careers. Addressing how the upcoming changes in healthcare, for example, affect the maxillofacial surgeon and what we can do to protect ourselves moving forward, would be an interesting and relevant topic.

Becker: For me and my involvement in the organization, the important aspects were the accessibility, the inclusion, and the active encouragement. At the last meeting more than one person came up to me and said, "Devra you're not on the membership committee, why not? This is committee that you should be on." And I talked to Reza Jerrahy and he said, "Oh absolutely we would love to have you on this committee." If the ASMS had waited for me to decide to join a certain committee, I'm not sure that I necessarily would have joined, or even chosen the right one.

van Aalst: It can actually be discouraging if people are trying to exercise some participation and leadership options and then get stuck in the wrong committee. It could actually doom their future involvement.

Becker: Right, or which committees where you can really have an impact. Let's be honest: some committees are not necessarily the right place for junior members, for a number of reasons—maybe they don't have the experience to lend something of value, maybe they haven't learned how to articulate their ideas very well. But joining the *right* committee where you can have a meaningful voice is really important. We should have all of the people graduating from craniofacial fellowships on our radar, and be actively encouraging them to join appropriate committees.

Patel: I think the main way to reach other young surgeons is through the educational programs. That is where the ASMS can reach other young surgeons who have not joined. Also through the support of maxillofacial courses and the Visiting Professor program. I feel through these ASMS initiatives, residents will have an opportunity to seek mentorship, attain educational resources, and learn about the mission of ASMS.

van Aalst: So for you, the educational courses, the Visiting Professor program are the two strong points in remaining relevant for younger surgeons.

Patel: Yes. These are two points the ASMS should continue to remain relevant with young surgeons.

van Aalst: What other benchmarks of relevance do you think there may be? High end website design, information that's easy to access, twitter feeds, informational and social media connections? Do you feel any of this is important to you?

Patel: Yes to a certain extent. I think as technology changes and

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more people are plugged into the web and these online resources, it's important to have a user-friendly website that is up to date and is easy to maneuver. But I really believe it's the substance of the organization that is the most important. For example, the things that we've talked about before—the bread and butter of the organization—are the educational programs and the core mission of the ASMS. Then how you disseminate the educational information is important to stay relevant with young surgeons.

Liau: Getting new members is tough since it is a sub-specialty group. I think just getting someone in the door is more than half the battle. Focusing on people who are just graduating, and people who are in the first year would also help the transition of craniofacial or pediatric plastic techniques and skills to aesthetics. As much as we make a distinction between the two, for the general practitioner, that is something he or she needs to consider when they are finishing their training.

Relevance starts with providing answers or solutions to today's healthcare problems. For example, things that we are very good at, such as facial trauma. We know how to do this technically and clinically, but how do we capitalize on this and improve how well we do in today's medical market? Addressing these concerns and dynamics, as well as the clinical aspect of how to do it, is how we stay relevant.

van Aalst: Answers relevant to how they are going to practice, what they are going to be doing, how they are going to be doing it. Would a course like this interest you?

Liau: I think it would be great. An example is Sam Boutros giving a talk on how to get adequate compensation for facial fractures. Things of that nature are great because you can make the panel begin from step one...."What is the deal with ER call? How does that work for you? How do you make that work for you?" You can dispel the myths of, "Well, this guy doesn't have insurance. I am not going to see this." Or "This guy only has ACA. I don't want to see this"....but there are practitioners out there who are veterans at dealing with this. They have been doing this for a while and know how you make the compensation work for you, or in some cases, how it won't work.

van Aalst: There is an assumption among people at ASMS that all of us work in academic environments. So, if you're in private practice and you want ER call, take boxes of pizza to the ER and leave them there with a thank you note. They are guaranteed to call you again.

Liau: Absolutely! Well, it is a common joke. June 30th they call you for a laceration to the face and as chief resident, you say "What?! I'm not coming to see that!" July 1st you say, "I'll be right there!"

As young surgeons, what additional recommendations would you give ASMS leadership?

Liau: I think ASMS is doing a good job of keeping up the flow of mixing the generations. Craniofacial Surgery, as we all know it, has been a relatively recent development. The passing of the greats—Tessier, Marchac, Monasterio—emphasizes that we are

basically only 3 to 4 generations into modern Craniofacial Surgery. But things have changed a lot with technology and techniques and sometimes the dogma of the first of two generations can be stifling. I think ASMS does a good job of offsetting that and really letting the younger generation come in to show their experiences and techniques. I think this helps out a lot. It makes ASMS more relevant to the younger generations. It doesn't turn them off.

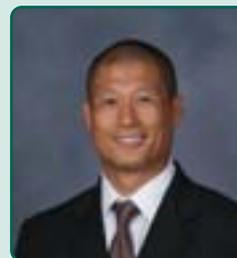
Oppenheimer: I think there are a lot of things that ASMS has done right: The emphasis on training young surgeons, on having these educational courses, really to me was central to my involvement in ASMS. Recognizing resident scholars and bringing the focus back to the trainee is another thing that I think has been done correctly. Lastly, the breaking of barriers between disciplines is something that the ASMS embraces: you have an Oral Surgeon, an Otolaryngologist and a Plastic Surgeon all presenting at the same meeting. This is a unique synergy that the ASMS has realized, when most societies are putting up boundaries.

Becker: The ASMS has seemed to be gender blind, as far as I can tell. I've always felt like any opportunity that I've been given has been for the quality of my work, or out of the general value of inclusiveness. I have never felt like a token.

Patel: I would say that so far the ASMS leadership is doing a great job. The suggestion that I have is to continue the commitment to their educational programs. Also to continue the support research through grants that provide young surgeons an opportunity to advance the field of Craniofacial and Maxillofacial Surgery.

Lampert: I would like to see the ASMS take a more aggressive role in dealing with defining what a plastic surgeon is? It has become very confusing to the general public. Better information could be disseminated via traditional mass media, new technologies, and interpersonal networks. I believe that this would be a good use of our annual society dues. Ultimately, patients deserve the treatment and opinion of expert surgeons.

van Aalst: The reality is that Plastic Surgery started as an innovative reconstructive specialty. The reminder to the public needs to be that as Plastic Surgeons, we are reconstructive surgeons at heart.



Absolutely! Well, it is a common joke. June 30th they call you for a laceration to the face and as chief resident, you say "What?! I'm not coming to see that!" July 1st you say, "I'll be right there!"

-James Liou, MD

ASMS MEMBER UPDATE: What's New with ASMS Members

Dr. Court Cutting

As you are aware I recently retired from clinical surgery to work full time on the development of computer based surgical simulation. Cognitive surgical processes for the novice plastic surgeon should develop on a simulator as much as possible before, usually indigent, patients are cared for by the trainee. Pilots are trained to handle unforeseen circumstances in a simulator. The young surgeon should develop in an analogous manner.

I felt I had developed my personal cleft technique as far as I could take it. The period of surgical innovation that marked my early career was diminishing. Perhaps I was getting too old and staid. Health issues arose. Time to clear out the dead wood and pass the baton to the younger generation we worked

so hard to train. At the same time increases in computer power and algorithmic improvements made surgical simulator development more tractable. It continued to be new and exciting for me. As there are not a lot of surgeon-programmers, it was time for me to put down the scalpel.

My wife and I relocated to the California coast. I blow the saxophone in a local jazz workshop in my spare time.

My best wishes to all of you personally, as well as for the continued development of surgery to correct pediatric facial malformations. I will continue to actively watch as long as I breathe.

Do you know an ASMS Member that could be featured here? Please contact the Administrative Office (logrady@prri.com) with the details.

2014-2015 ASMS Visiting Professors

LISA DAVID, MD, FACS



Professor and Program Director, Department of Plastic and Reconstructive Surgery, Wake Forest University

- ♦ Use of Spring Assisted Surgery in the Treatment of Sagittal Craniosynostosis
- ♦ Evolution of Spring Assisted Surgery and Its Implementation in Craniosynostosis
- ♦ Management of Vascular Lesions in the Pediatric Patient
- ♦ Evolution of the Management of Positional Plagiocephaly
- ♦ Craniofacial Anomalies- Assessment and Treatment Algorithm

HENRY VASCONEZ, MD



William S. Farish Endowed Chair of Plastic Surgery, Professor of Surgery and Pediatrics Chief of Plastic Surgery, University of Kentucky College of Medicine, Lexington, Kentucky

- ♦ Update on Cranio-Maxillofacial Trauma
- ♦ Craniofacial Surgery: Art and Science
- ♦ Treacher-Collins Syndrome – Aspects of Treatment
- ♦ Vascular Anomalies – Diagnosis and Treatment

PRAVIN PATEL, MD



Professor of Surgery, Chief of Pediatric Plastic & Craniofacial Surgery, University of Illinois, Chicago, Chief of Plastic Surgery Shriners Hospitals for Children, Chicago

- ♦ Craniofacial Surgery: Has Virtual Surgery Come of Age?
- ♦ New Horizons: Digital Integration of Orthodontics and Orthognathic Surgery
- ♦ Cleft Skeletal Reconstruction
- ♦ Orthognathic Surgery for the Rest of Us
- ♦ Reconstructing the Face and the Art of Upholstery
- ♦ Structural Engineering and Skeletal Fixation

ANDREW WEXLER, MD, MA, FACS



Chief Department of Plastic Surgery, Regional Director for Craniofacial Services, Southern California Kaiser Permanente, Clinical Professor of Plastic Surgery, USC

- ♦ Post Traumatic Facial Restoration
- ♦ Achieving Excellence in Cleft Surgery
- ♦ Anatomy of a Smile, Lower Facial Restoration
- ♦ A guide to international Mission Surgery
- ♦ Head and Neck Anatomy for the Surgeon
- ♦ Oral and Dental Anatomy for the Maxillofacial Surgeon
- ♦ Anatomy Bowl Resident Competition
- ♦ Embryology of Cranial- Facial Deformity

To Request a Visiting Professor, please visit the ASMS Website: www.maxface.org and complete the online request form.

The American Society of Maxillofacial Surgeons (ASMS) gratefully acknowledges Stryker for their continued support of the Visiting Professor Program.

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From the President

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2014), our Pre-Conference Symposium before our Annual ASMS /ASPS meetings, and continued evaluation of the need for Advanced Courses. MOC courses will be offered at this year's Pre-Conference Symposium before our Annual Meeting. The plan is to continue and expand the MOC offerings.

Within the last few years we have seen a significant improvement of our web site— www.maxface.org. Our plan is to continue to expand the educational information available on our web site.

We are developing plans to utilize an introductory reference for medical students and residents, and to have this available on line as well.

Our ASMS Newsletter will be further expanded to include vignettes on our members. As we expand our educational material in our Newsletter, our hope is to have this indexed.

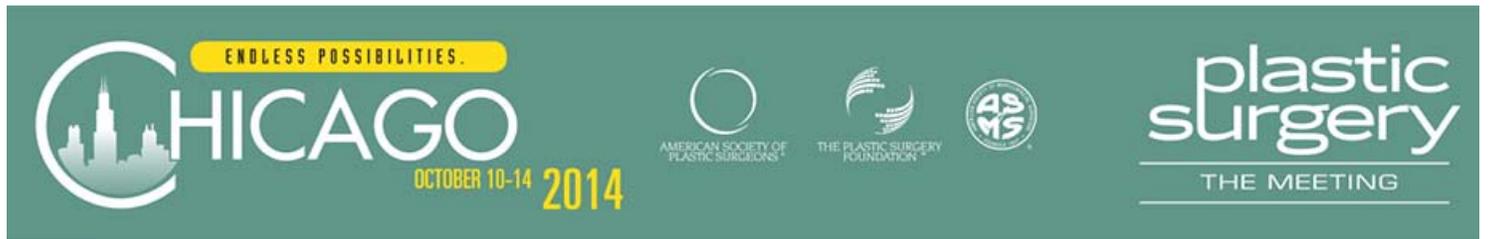
Within the next year we hope to have our first webinar, and have future webinars available on our website.

The ASMS will continue to focus on means to expand membership. One of the perks of future membership will be to offer a mentorship program for younger surgeons.

Several new research goals and initiatives were also discussed.

Various members volunteered to take responsibility to achieve these goals. These projects will form the basis for discussion at future Board meetings. The initiatives discussed at this retreat will be the foundation for regular extended summer ASMS Board meetings in future years.

ASMS will continue to focus on means to expand membership. One of the perks of future membership will be to offer a mentorship program for younger surgeons.



HIGHLIGHTS of ASMS DAY - SUNDAY, OCTOBER 12, 2013
McCormick Place West W375c

Converse Lecturer: Andrew Wexler, MD

*“Plastic Surgery at the Crossroads.
 Generation Next, This One’s for You.”*
 11:00 am - 11:45 am

ASMS Grant Awards
 11:45 am - 12:00 noon

ASMS Annual Business Meeting Luncheon
 McCormick W 183 bc
 12:00 noon - 1:15 pm

ASMS Presidential Reception
 7:00 pm - 9:00 pm
The Art Institute Chicago

All ASMS Members are welcome.
Others by invitation only.

Scientific Sessions

- 8:00 – 8:45 Marking Panel: Cleft Lip – Marking and Planning the Repair to Address the Deformities
- 8:45 – 9:30 Panel: Facial Fractures - Ongoing Controversies
- 10:15 – 11:00 Panel: Reconstruction of Soft Tissue Defects of the Face: Are Local Flaps Sufficient, And If So, Which Ones?
- 1:15 – 2:00 Panel: Contouring the Deficient Face - What Should We Be Using?
- 2:00 – 2:30 Panel: Orthognathic Surgery - Is There Still a Role for Plaster and Stone Modeling in the Current Era of Virtual Surgery?
- 3:15 – 4:00 Panel: Functional Airway Reconstruction in the Cleft Nasal Deformity: Timing and Steps Needed?
- 4:00 – 4:30 Panel: Face Transplant vs. Autologous Tissue Transfer for Facial Reconstruction – When Does the Defect Warrant the Morbidity of Chronic Immunosuppression?

A Seat at the Table: How the ASMS Prepares Future Leaders

Devra Becker, MD

When invited to write about a young ASMS member's perspective on the organization's role in my career and development as a surgeon, I reflected on Sheryl Sandberg, Chief Operating Officer of Facebook and author of "Lean in: women, work, and the will to lead." The central advice of that book became a movement, with women's *Lean In* groups sprouting across the country. The "lean in" troupe traveled through my own circle of friends, where we discussed the critical importance of taking opportunities as they arose and claiming, as Sheryl Sandberg put it, a seat at the table: a call to "carpe diem," seize the day. Leaning in is a necessary—but not sufficient—component of career success; as an undergraduate at Harvard, Ms. Sandberg met and became a protégé of Lawrence Summers, Professor of Economics, and later president of Harvard University. She had a powerful mentor in Larry Summers. Sandberg's ability to claim her "seat at the table" was made possible, in large part, by a mentor who advocated for her.

Before *Lean in*, evolutionary biologist and Harvard historian Stephen Jay Gould made the observation that he was "less interested in the weight and convolutions of Einstein's brain than in the near certainty that people of equal talent have lived and died in cotton fields and sweatshops." I believe Gould's idea is applicable to surgical organizations today. How many people of Sheryl Sandberg's talent are there in professional surgical organizations that never get a seat at the table? Exactly because no one advocates for them?

The ASMS approach to leadership combines the two ideas that members must "lean in," but that talented people may well go unrecognized if they are not sought out and encouraged, or more appropriately, mentored. Mentoring is a process that a friend of mine describes as "lean back"—once a leader has achieved success and stature in his field, he should "lean back" and carry someone else forward. What I've found is that the ASMS leadership knows exactly how to lean back and develop the careers of its newer members.

Shortly after I joined ASMS, I was invited to sit on the Education Committee. It soon became clear that the approach to

leadership development at the ASMS is inclusive—the seat at the table was not an audition, but an opportunity to share my ideas. The leadership was interested in what I was saying, and what others were saying. The leadership was actively identifying the strengths of the junior members, and finding places within the organization that those members could showcase our skills.

To be fair, that's not entirely correct. "Showcase" overstates what I actually did. I struggled—like many junior member surgeons—to articulate my ideas, and demonstrated my growing leadership skills in ways that were often probably NOT helpful. The ASMS leadership, however, would take me aside, give me suggestions for improvement, guide me into committees where I might not only improve my own skills but learn from the example of others on that committee, and encourage me to do more.

This approach has had concrete effects on my own development as a mentor. I currently supervise a Nurse Practitioner, and was involved in her hiring and initial training. She had no Plastic Surgery experience, but she was smart and motivated. I encouraged her to take risks, and explained that I expected her to make bad decisions—but that I also trusted her to learn from her mistakes. She has grown tremendously knowing that she too has a seat at the table—that her ideas matter.

I think about a seat at the table, while driving to work: I turn off the radio in my car every morning for ten minutes, and use the time to think about how I can be a better mentor to my residents and students. I expect a lot from them, but it is my hope that they will surprise themselves with their talent—learning that they too have a seat at the table.

Participating in ASMS has led me to education endeavors at my own institution, and I am now involved in committees and educational research. The value added by the ASMS to my career has been in giving me, and all junior members, a seat at the table, and teaching us how to make that seat mean something. It is an

approach to leadership that will ensure diverse and meaningful leadership for the future.

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Editor's Corner

(continued from page 1)

Peter Taub reflects on why he initially joined ASMS. Devra Becker ponders what it means to be given a seat at the table: simply being asked what she would do, and being included in leadership roles. Frank Papay and colleagues discuss a new program in preceptorship. Warren Shubert discusses the summer Board Meeting and Retreat, where the ASMS mission statement was revised, and key goals were identified.

The book "Scarcity" is reviewed: if you don't have time to read it, you should.

We are introducing a new section to the newsletter: a member update section. If there is someone you haven't heard from and would like an update, please contact members of the Newsletter Committee (john.vanaalst@cchmc.org). In this edition, Court Cutting gives a glimpse into his retirement.

We are also looking into the process of indexing the Newsletter.

We all hope you enjoy this issue of the ASMS Newsletter.

JVA

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 below:

- ◆ 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.

VISIT THE ASMS WEBSITE: WWW.MAXFACE.ORG

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ASMS ADMINISTRATIVE OFFICES

500 Cummings Center, Suite 4550

Beverly, MA 01915

(978) 927-8330

admin@maxface.org