



Chair's Report



Peter Lennox, MD, FRCSC

Contents

02	DOBC Section Update
04	Pearls & Perspectives
06	Resident's Corner
08	Resident Cosmetic Clinic
09	Fellowship Program
10	Undergraduate Education
11	New Surgeon Spotlight
12	How I Do It?
14	New Surgeon Spotlight
15	Achievements
20	Editor's Note / The Leech

"The Chinese use two brush strokes to write the word 'crisis.' One brush stroke stands for danger; the other for opportunity. In a crisis, be aware of the danger--but recognize the opportunity."

- John F. Kennedy

When I started writing this submission for this year's Pedicle, the world was "normal." Since then, a global Pandemic has gripped all of us, and upended everyone's lives. On a local level, in the span of 2 weeks, all elective surgery has been cancelled, our residents are on completely different schedules, the Royal College Examinations have been postponed, and our annual Section meeting and Division Research Day has been postponed. On a personal level, we all have new significant concerns including for our patients, our practices, our residents, our finances, and our health and the health of our loved ones. At every level; academic, professional, and personal, these are uncertain and difficult times.

Having said all of that, I also believe that we should not overlook the many positives that keep presenting. I have always been proud of our Division and the people in it. This crisis has simply served to reinforce that. Our faculty, residents and fellows have all stepped forward to help each other and our

colleagues without hesitation. I have had outstanding support from our division in the administrative roles required to navigate this everchanging environment. Many of us have also had to quickly learn new skills, or relearn old skills (virtual health, videoconferencing, appropriate use of PPE), which will serve us well when this resolves. We have found ways to make our practices more efficient and streamlined.

Perhaps most importantly, we have all been forced to slow down and take stock of our lives. We have had to evaluate what is important to us. For many of us, this has been an opportunity to spend more time with our families, to rest, to exercise and to take better care of ourselves and those around us, personally and professionally.

A recent article I read "Why I'm Hopeful, Even Optimistic, and Three Things to do Right Now" was geared towards entrepreneurs, but I think some aspects are relevant to plastic surgeons:

1. REINVENT YOUR BUSINESS:

There are two key pieces of advice here:

FIRST if you haven't digitized your business yet, now is the time! Figure out what processes, assets, products or services you (or your company) currently implement in an analog fashion and figure out how to digitize them.



SECOND if you've got a product or service that is not doing well, **now is the time to kill it**. Once you bury it, you can then take these resources — cognitive, monetary, and human capital — and focus them on a digitized version of what you're delivering.

2. CREATE NEW HABITS/ TRADITIONS:

Consider habits that serve your health... sleep, exercise, diet, family traditions.

3. LEARN NEW THINGS:

Whether "*your business*" is reconstructive or aesthetic surgery, these can

all be applied to what we do to make us more efficient and be able to deliver the best care to our patients. Until the COVID-19 crisis, this past year has been one of continued growth and success for the UBC Division of Plastic Surgery, and those accomplishments are well documented in the ensuing sections of the pedicle.

The key component of any organization is its members, and we are no exception. Based on the compassion, commitment and creativity shown already by all members of our division in the face of this event, I am more confident than

ever about the future and our ability to survive this experience and come out stronger as individuals and a group. Next year is the 50th anniversary of the UBC Residency Program, and we will be hosting another Alumni event to celebrate. Like all of you, I look forward to being able to gather in person, share our experiences, and reflect on our good fortune to have professions that we love and the people we are able to share that with. Until then, I wish you and your families health during this challenging time.



DOBC News

Owen Reid, MD, FRCSC →

➤ This past year contained some familiar highlights such as a new Physician Master Agreement and a fresh round of Disparity Allocation negotiations, but it was the combination of BIA-ALCL, Extra Billing, Compliance Letters and their potential impact on our practice patterns that has really been interesting.



BIA-ALCL

BIA-ALCL and the management of patients with textured implants has been the headline topic of this past year. There has been a stream of formal

updates and announcements. Although prophylactic removal of textured implants has not been recommended many patients are requesting this

procedure. The ambiguous nature of our breast implant removal fee codes meant that clarification from MSP was required. Without consultation, a very brief statement was provided by MSP suggesting that they would cover the removal of textured implants. No conditions or limitations were specified. In response, we outlined important considerations. A government group reconvened on the issue and after several weeks they responded that coverage will be available *"if there is a reasonable basis to conclude that the procedure is medically required"*.

The challenges we face currently are related to ongoing confusion and inconsistency with MSP coverage and practice standards.

We were never given the opportunity to take part in these discussions. The challenges we face currently are related to ongoing confusion and inconsistency with MSP coverage and practice standards. As a section, we need to provide leadership on this issue and consistent care, however, a changing and unsettled legal environment has complicated matters.

EXTRA BILLING

For decades, our provincial government has allowed patients to expedite their own care in private surgical facilities even though it contravenes a portion of the Medicare Protection Act (the Act). The legal precedent of what MSP refers to as 'extra-billing' is the focus of a long-running court case between the Cambie Surgeries

Corporation vs British Columbia (Attorney General). In 2018, while the legal precedent was still under review and therefore still unclear, the NDP government felt compelled to enforce the Act.

Fines, revocation of privileges and de-enrolment have been threatened for any "practitioner who:

- contravenes;
- attempts to contravene; or
- authorizes, assists or allows someone else to contravene, the extra billing provisions in the Act" (Medical Services Commission).

Thankfully, a successful legal injunction has allowed us to continue our current practice patterns. The final day in court was in late February, but, it will be months before a verdict is issued.

In the mean time, perhaps all we can do is continue to maintain the high ethical standard of our profession. In contrast to the legal precedent, the ethical principles pertaining to Extra Billing are clear. *"If it comes to a choice between a physician's responsibility to his or her patient and his or her responsibility to the medicare system overall, the former must take precedence"* B.C. Supreme Court Judgment 1994.

COMPLIANCE LETTERS

Similar judgements have been published in CMAJ and by the BCMA, RCPSC and the CPSBC. It's interesting then and disconcerting that Health Authorities are asking us to sign letters of compliance. Compliance letters have been an unexpected assault on our professionalism and autonomy. Signing such a letter encroaches on our ability

to freely exercise our ethical duty to patients.

These documents are not contracts that have been negotiated, rather, they refer to laws and therefore do not need our signing to be legally enforceable (Oxley).

This could be problematic in certain situations where we find ourselves having to either do the right thing for a patient or uphold a signed contract. These documents are not contracts that have been negotiated, rather, they refer to laws and therefore do not need our signing to be legally enforceable (Oxley). In principle, the compliance letters should not be signed since they violate the relevant legal and ethical principles. How to best handle this as a section has yet to be determined. In court, if the final judgement upholds that Extra Billing is legally prohibited then our current practice patterns will be forced to change with negative consequences for patients, practices and tax payers. Alternatively, we can proactively update and clarify our fee schedule to avoid disruption. With this in mind, we have already submitted one application to Tariff and another is ready to go pending approval by the membership.

We are facing significant challenges that have the potential to be disruptive and divisive. We need to resolve the confusion surrounding the financial, legal and ethical aspects of treating patients with textured implants and promote consistent practice standards across the province. Better communication and collaboration within the section will help to us accomplish these goals in the months ahead.

Pearls & Perspectives

Jim Boyle, MD, FRCSC →



> I think of myself as a surgeon first, and proudly as the subtype Plastic Surgeon. The work we do is rewarding and visible- be it good or bad – to our colleagues, patients, and their lawyers.

This is a self-indulgent trip down memory lane, likely clouded by false memories. I started my residency in 1980. The memories that stand out are the patients and their problems that I helped with, and the people that I was lucky to work along. Looking back at 40 years of surgery these are some of the things I have learned or at least observed. Nothing is earth shattering.

Reflections / Ramblings on a Surgical Career

1 Do what you like to do. You will be best at this.

I have to say that I am forever grateful to Dr. A D Courtemanche, for taking me into the Residency, and then pointing me in the direction of the Burn Unit when I returned to Vancouver. I love the physical and emotional challenge of the job, and the opportunity to work with the Health Care team. We could make Burn rounds last for 3 hours. I also loved the preciseness and engineering of Hand surgery, and the general challenge of Plastic Surgery "*putting Humpty Dumpty back together again*".

2 The Mysteries of Surgery

A "*perfect*" operation does not always result in a successful outcome. Different surgeons can get different results from the same procedure. Different procedures by different surgeons can both result in good outcomes (Note: these truisms do not prevent great debates at rounds) There are many reasons that wiser persons can opine on. I will just say that outcomes are a) subjective for the surgeon and patient, and b) rely on our memories. Be critical of your outcomes.

3 Bad Things Happen

My first breast reduction patient as a consultant, ended up in ICU 2 weeks post op with sepsis. I strongly considered quitting. And I know of at least 2 other surgeons that had similar "crises" early in their career. I and the others survived, as did my patient. Family and friends got me through. Dr R Warren taught me that "complications ruin your life, so avoid them". When they do occur, it is often better to get a colleague involved that can offer an unclouded view of what is best to do. Don't be ashamed – it happens to everyone.

4 You see further Standing on the Shoulders of Giants

This is an overused phrase but non the less true. I still look back and can recall things I learned from every consultant I had the honour to work with. I was a mid level resident, standing over the patient with a self inflicted GSW to the face, with no idea of where to start. Dr Brian Foley let me stumble, then stepped in and quietly and efficiently identified the pieces and put the man's face back together. Two things came out of this – I had complete admiration for Dr Foley, and I knew that I was in the right field.

5 Learn from your colleagues – Present and Future.

I love rounds; I love hearing colleagues' ideas; brilliant insights about how to approach and tackle a problem. I secretly sit back and take a small amount of pride from the fact that I may have contributed to their knowledge. Our job as teachers is to make residents that are better surgeons than we are. I think I can proudly (?) look at our graduate residents and feel that I have accomplished that goal.

6 Sh*t Happens

AIDS I started my residency in 1980. We were mildly aware that getting punctured while putting on arch bars or other procedures may not be good. I got Hep B (mild) during that time as did at least 3 other Plastic Surgeons that I know of. AIDS was identified in 1985. Hysteria followed. It was felt that you could get AIDS by shaking hands. All of this led to a dramatic shift in how we protected ourselves (and our patients) during surgery.

OPIOIDS In the 1990's and well into the next decade pompous pain practitioners paraded around telling everyone that there was essentially no upper limit to the amount of narcotics that patients could be given for pain. The Burn Unit was the epicenter of pain and we prided ourselves on Pain management.

The amount and duration of use of opioids however did not feel right. It is hard to step in the way of the "wisdom of the day", but we tried.

There is no doubt that the professions of Medicine, Nursing, Pharmacy, and the drug industry harmed many people.

Be on the lookout for the next problem

ADDENDUM since writing this we have entered we have entered another crisis - Coronavirus. We will get through this but there is always another on the horizon.

7 We are Privileged

Over the years, thousands of people have trusted me to cut them open and fix their problem. It is an honour that we should never loose sight of.

Resident's Corner

Alex Seal, MD, FRCSC



> I would like to take this opportunity to greet all of you on behalf of the UBC Division of Plastic Surgery Residency Program, and also highlight some of the great things going on with our residents and program.

Research day in 2019 was memorable and featured Dr. Mark Clemens as the visiting professor. This year, we had been look forward to learning from and spending some time with Dr. Michael Neumeister. As well are all adjusting to the new normal and this challenging situation, it is nice to reflect on the many things we are lucky for in our lives.

From our resident team, Tyler Omeis graduated last year and has transitioned on to fellowship in Toronto, completing a fellowship in hand and wrist surgery. We are fortunate this year to welcome Paige Knight, from Calgary, Mike Carr, from UBC, and Ahmed Al Hosni, from Oman, who have joined our residency program and are our 3 new R1's. All three are exceptional people and have already become outstanding new members of our team. At the other end of the program, Daniel Demsey is graduating and pursuing a fellowship in Hand and Wrist surgery at the University of Toronto. Daniel has been

an active member in our program since 2012, as he has taken time out of clinical trading to complete his CIP and masters during residency. He has excelled in his final year and we congratulate him on all of his current and future success. Daniel had family in Ontario and career goals to pursue practice closer to home. Aaron Van Slyke, and Stahs Pripotnev are both joining Daniel in graduating this spring.

Both have been excellent residents over their 5 years and have transitioned into exceptional surgeons and members of our resident family. We wish Aaron the best during his fellowship in Australia in Paediatric Craniofacial Surgery, and the same to Stahs, where he will be pursuing a prestigious hand fellowship at the University of St. Louis, with Dr. Susan Mackinnon. We would be fortunate to have both of them back in B.C. in the future. This past year has seen a great effort put forth by our faculty, residents, and administration team to get ready for the recent Royal College Accreditation.



Months of work was put into our documentation, and new programs were created to help ensure our program meet all of the new Royal College Standards and remained at the top of those in Canada. The hard work by all of our faculty over the past many years to create such a strong and wonderful training environment and culture within the UBC Division of Plastic Surgery was recognized and we achieve an excellent review with the recommendations for the maximum accreditation allowance for the next 8-year cycle. A sincere thank you goes out to our wonderful faculty, residents and of course, Mo and Parm, for achieve this great success and contributing to the excellent legacy of this program. The next academic year will have some new challenges for us, as we transition into Competency-By-Design training. Our program is well positioned for success and there is opportunity with the change to continue enhance the training

environment. As we come to the end of another academic year, I would like to again personally thank the members within our division, and those working outside of Vancouver, that dedicate their time and expertise to help teach our residents and help make UBC one of the best programs in the country.

We are facing an unparalleled time currently and our residents have been exceptional in their hard work and commitment to division, patients and each other. The UBC Plastic Surgery Program is lucky to have a group of resident stars and we look forward to all getting together again in the

not so distant future.

Two quotes that I think embody our resident crew:

"Tough times never last. Tough people do."

"When it rains looks for rainbows, when it is dark, look for stars."

Residents 2020



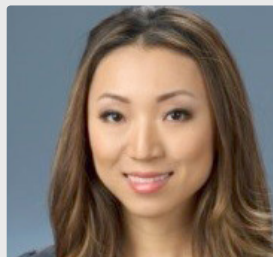
Daniel Demsey, R5 CIP



Aaron Van Slyke, R5



Stahs Pripotnev, R5



Diana Forbes, R3 CIP



Peter Mankowski, R3 CIP



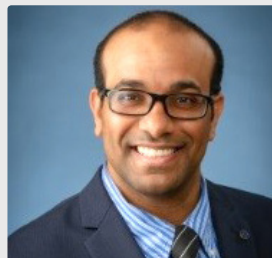
Sofie Schlagintweit, R3



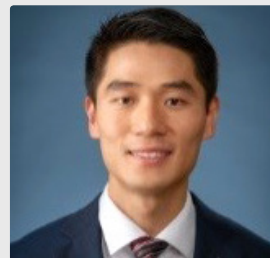
Jacques Zhang, R3



Janine Roller, R3



Nawaf Al Muqaimi, R3



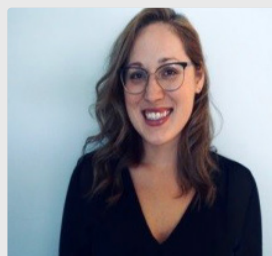
Zhi Hao Zhang, R2



Mike Carr, R1



Ahmed Al Hosni, R1



Paige Knight, R1

Resident Cosmetic Clinic Update

Arko Demianczuk, MD, FRCSC →



➤ The UBC Resident Cosmetic Clinic allows residents in their final year of training to assess, operate and manage aesthetic patients with an elevated level of autonomy.

The UBC Resident Cosmetic Clinic allows residents in their final year of training to assess, operate and manage aesthetic patients with an elevated level of autonomy. This clinic has been a unique feature of the UBC Division of Plastic Surgery residency for over 25 years.

In this academic year, three senior residents participated in the Cosmetic Clinic: Dr's Aaron Van Slyke, Stahs Pripotnev, and Daniel Demsey. Each was provided with eight surgical days, and under the guidance of staff surgeons, they performed over 25 procedures each. In addition to learning the technical aspects of aesthetic surgery, the residents learn how to evaluate and select ideal surgical candidates, and manage post surgical expectations.

A wide variety of aesthetic procedures were performed, and their cases will be presented in Grand Rounds in June. We encourage everyone to come out and show their support,

and share in their success. The pillars of the program remain the same: Supervising staff surgeons, tireless administrative support, and corporate sponsorship.

A HUGE thank you goes out to all supervising surgeons and their administrative staff in supporting this clinical endeavor. In this time of diminishing resources, without your continued support, the clinic would not be as successful as it is. Administrative support for the clinic has been instrumental in keeping the wheels greased, and Lisa Lamb has ensured that the both the residents, patients and staff remain coordinated. She has worked tirelessly to maintain the clinic patient database, and to manage patient flow.

Continued financial support from Mentor and Allergan allows the clinic to function in good fiscal health, and we look forward to their continued support in 2020.

➔ If any surgeon has a patient who is seeking cosmetic surgery, but the financial obligation is too great, consider a referral to the UBC Resident Cosmetic Clinic (ubc.rcc@vch.ca).

Fellowship Program

Erin Brown, MD, PhD, FRCSC



I was recently asked by one of our General Surgery colleagues if our Residents completed Fellowship training after residency at UBC, to which I responded "Yup, all of them". Although we still strive to produce "practice ready" graduates; trainees themselves and the communities that hire them expect more.

Eighty percent of graduating American Surgical Residents apply for fellowship training, despite the opportunity costs associated with delaying independent practice (and the massive debts they invariably hold). It would appear that an even greater proportion of graduating Canadian Plastic Surgeons seek fellowship training. However, unlike most Fellowships in the US, Canadian surgical fellowships do not lead to additional certification. The aspiration for sub-speciality training appears to

reflect a desire to obtain additional competence, confidence and skills for subsequent independent practice, as well as the goal of being desirable to those doing the hiring. UBC has demonstrated more than 20 years of commitment to this aspect of Plastic Surgery professional development. We offer subspecialty training in all of the major areas of Plastic Surgery (Breast Reconstruction, Craniofacial Surgery, Hand & Microsurgery, Paediatric Plastic Surgery, Aesthetic & Breast Surgery), other than Burn Surgery.

The philosophy of training at UBC remains to provide subspecialty level experiences to fully trained Plastic Surgeons, as opposed to "general" Fellowship programs (R6 year). UBC Plastic Surgery continues to evolve our delivery of training to reflect "universal challenges" recognized by the ACGME in the 1980s (impact on residency training, ensuring adequate skills and knowledge of graduating fellows and the experience of foreign-trained fellows).

Given the ongoing development and expansion of Plastic Surgery Fellowship training in Canada I strongly believe that UBC should remain a leader in the promotion of the goals and standards of this critical component of professional development of our future colleagues.

Fellows Jul 1, 2019 to Jun 30, 2020

VICTOR FUERTES BIELSA

Breast Reconstruction Fellow

Residency: University Hospital Dr. Negrin, Las Palmas de Canaria, Spain
July 1, 2019 to December 31, 2019

MARIE NOLAND

Aesthetic Fellow

Residency: Dalhousie University
August 1, 2019 to December 31, 2019

ROSEMARIE MARCK

Craniofacial Fellow / Breast Reconstruction Fellow

Residency: July 1, 2019 to June 30, 2020

SARAH GARDINER

Paediatric Fellow

Residency: Adelaide South Australia / New Zealand
July 1, 2019 to June 30, 2020

ZAHIR FADEL

Hand & Microsurgery Fellow

Residency: Dalhousie University
July 1, 2019 to June 30, 2020

JAMES FINKEMEYER

Craniofacial Fellow

Residency: Melbourne, Australia
January 1, 2020 to June 30, 2020

KERRI MOONEY

Aesthetic Fellow, Kelowna

Residency: New Zealand
January 1, 2020 to June 30, 2020

Undergraduate Update

Dr. Esta Bovill MD, PhD, FRCSC →

#Millennials *eye-rolling emoji*

➤ Medical student wellness, including physical health, emotional health, and levels of perceived stress, appears to decline during training, with students reporting high levels of depression, anxiety, and burnout as early as the first year of medical school ¹.

So states the Oregon Health & Science University School of Medicine who recently assessed the mental health and wellness effect of their recently instituted competency - based curriculum. Physical, emotional, and overall health were highest at baseline and lowest at the end of Year 1, after which they improved but never again reached baseline levels. They commented that early in training, stress and poor overall health may be related to concerns about self - efficacy and workload.

As undergraduate director I have had the privilege of frequent exchange with approximately 90 MSI students again this year. In spite of the above study, I am struck by the overwhelmingly positive attitude and enthusiasm these students bring to our ORs, emergency department and



clinics. However, it is unsurprising that on occasion, we have also needed to guide students who have been given poor evaluations, whether it be by staff or residents.

Whilst negative feedback has almost always been absorbed with a growth mindset, on occasion I have been surprised to see some students struggle to accept feedback with the humility I would presume. We had one complaint that the rotation didn't allocate enough time off to see the sights of Vancouver.

Is theirs really a more entitled generation? Does this high sense of prerogative lead to inevitable disenchantment and declining psychosocial health? I don't have an evidence-based answer to that question. One personal theory is that

This was fuelled recently by my own visceral response to the eye-opening discovery that we, the Faculty, are also subject to (frequent!) on-line evaluation.

akin to social media, the constant and unrelenting evaluation they are subject to is, at least partly, culpable for waning wellness. This was fuelled recently by my own visceral response to the eye-opening discovery that we, the Faculty, are also subject to (frequent!) on-line evaluation. It seems that, unlike previous generations, there exists as many mechanisms to complain about our failings as teachers, as there are tick-boxes in the undergraduate evaluation portal. Some facts for context: Unlike our appraisals of them, MSI-sourced

evaluation is anonymous and optional (hence hopefully honest, if potentially subject to polarised reporting bias). So, in case you have yet to find the time, I want to share that there is in fact a notably positive vibe to the feedback; it is kind, considered, tactful and mature. There is appreciation for the

value of our time. There is insight as to the difficulties of teaching in high-stress clinical situations. The very worst grumble was that they wanted to be a little more involved. Humbling, actually. So while we may occasionally begrudge the onslaught of 'on-line eval', we must remember that it affects

all sides. And I am glad to report that while this generation of students is comfortable letting us know how to be better, they also remain passionate, respectful and enthusiastic to learn plastic surgery. My online evaluation told me so.

Med Educ Online. 2020 Dec;25(1):1709278.

New Surgeon Spotlight



Chris Doherty, MD, MPH, FRCSC

Q Where did you do medical school, residency and fellowships and any other degrees; what are your areas of clinical and research interest?

I completed my medical school studies at the University of Calgary, followed by residency training in plastic surgery. During residency, I enrolled in the Surgeon Scientist program and completed a Master of Public Health

at Harvard University. Fellowship included subspecialty training in Hand and Upper Extremity Surgery at Western University. Following this, I was appointed faculty in the Western Division of Plastic Surgery in 2014 and served as Research Director for the division from 2017 - 2019. In May of 2019, I joined faculty in the UBC Division of Plastic Surgery. My clinical and research interests include peripheral nerve-brachial plexus surgery, hand surgery and breast reconstruction.

Q What do you see as the greatest challenge you have faced in starting practice?

Getting used to the gravity of your decisions when taking care of a patient, as every decision is important and can have consequences. I manage this by relying on my training, trusting my instincts and thinking of what my trusted mentors would do in a given situation.

Q What advice would you give current residents and fellows about the transition to practice?

There are a lot of competing interests in medicine, all that matters is the patient's well-being. Keep this as the top priority and the rest will take of itself.

Q Where do you see the practice of medicine going over the course of your career?

Increased use of advancing technologies (robotic surgery, targeted gene therapy, myoelectric prosthesis), further sub-specialization of existing disciplines and increased multidisciplinary subspecialty clinics.

Q What operation do you think we will not be doing in the future that we are doing now?

I don't see us doing hand and extremity replants in the future as I anticipate myoelectric prosthesis and targeted muscle reinnervation to provide favourable results in comparison.

How I do It?

Erin Brown, MD, PhD, FRCSC →

Starting A New Program



For reasons that are likely too complicated to delineate and certainly only partially accurate in their retelling, I undertook a mini sabbatical last year with the hope of obtaining the knowledge and skills to help develop a provincial lymphedema program.

Since the time I was a resident, the UBC Division of Plastic Surgery has made a concerted effort to identify areas of deficit, both clinically and academically, and try to slowly but surely rectified these perceived shortcomings. This involved the development of a formal research laboratory, the recruitment of multiple surgeons with formal research training, as well as the development of specific clinical areas of patient care, such as the Gender Affirmation Program and the BC Peripheral Nerve Clinic.

I have had the good fortune of being involved in the Arthritis Clinic and the Tetraplegic Clinic which had been started by my colleague and mentor Dr. Gropper. Unfortunately, this previous clinic experience woefully misinformed my expectations and of the challenges that arise when trying

to “*create something from nothing*”. I understood, or believed I understood, that there would be financial limitations in trying to create the infrastructure and obtained the required capital materials to see this program to fruition. Nevertheless, the process of trying to prepare to deliver a complex new treatment for an underserved group of patients while paddling upstream can be disheartening.


To better understand the landscape I was entering, I reviewed the “*Enhancing Surgical Care in BC*” from 2011. I will summarize this document by suggesting it is essentially a description of rearranging deck chairs and how to do it more quickly. There is little, if any, discussion of how to introduce new areas of treatment.

So as I reflect on this process over the past 18 months I would make a few general comments for anyone considering the development or implementation of a new program.

1 Engage the Stakeholders



After many years, we now observe the forward progression of the Gender Affirmation Program. Undoubtedly, there are many factors that led to the incremental and meaningful progress of this program. However, the critical importance of support and pressure from the community of impacted patients is almost certainly a critical determinant in the development and successful launch of this essential area of patient care. Fortunately, we have experienced enviable support and engagement from the BC Lymphedema Association. These relationships aide in the creation of a “functional” program and allows for meaningful feedback to insure that the provided service is appropriate and beneficial.



2 Engage the Foundation

Everything costs money. Despite your strong urging, the hospital is unlikely willing to open the pursestrings for you to purchase lots of shiny new equipment to do your fancy new surgeries. Your engagement and relationships with your Hospital Foundation will be essential to deliver on your capital campaign. Again, our relationship with the BC Lymphedema Association has been essential for enhancing our engagement with the Foundation.

3 Engage the Hospital Administration

Sometimes it's better to ask for forgiveness, but this is likely a scenario where you want permission. Bring your data, bring your enthusiasm, and demonstrate the need. I can't speak for any other institutions, but of all the obstacles that we had had to overcome, the Hospital administration was undeniably the smallest. They quickly recognized the lack of service and the need within the community and were quick to try and facilitate moving forward. The one large blind spot in our proposal was the unknown anticipated demand. Quite simply, we are unaware of how many patients are being underserved. However, this is extremely valuable information for any hospital so that they can project the activity onto their ongoing service delivery.

4 Measure what you do

Despite the relatively obvious benefit from auditing our clinical activity for everything we do, this is essential for new programs. A great deal of time, effort and money is required to deliver a new program. If it is experiencing problems, they should be corrected. If you are observing successes, they should be trumpeted for the people that have helped you make things happen, especially if you don't want things to be shutdown. This also provides you an opportunity to compare your program to others nationally and internationally, and ensure the delivery of the highest level of care.

5 Engage your Colleagues

For practical and professional reasons, I would highly encourage anyone considering embarking on a new program to engage the direct involvement of colleagues – not just any colleagues, the right colleagues. You should try to ensure that you have a shared vision of the program, and that any member's personal engagement isn't for any reason other than the progress of patient care and the opportunity to work together. I have been remarkably fortunate to “hitch my wagon” to Elliott Weiss and Kathryn Isaac which has made this process remarkably more enjoyable and engaging. It also reinforces the privilege it is to work with committed intelligent individuals. As surgeons, we almost always fly solo. Don't miss the chance to join a flock.

New Surgeon Spotlight

Krista Genoway, MD, FRCSC →



Q Where did you do medical school, residency and fellowships and any other degrees; what are your areas of clinical and research interest?

I am very much a home-grown surgeon. I completed both my medical school and residency here in British Columbia at UBC prior to moving to San Francisco to do a fellowship in hand and reconstructive microsurgery at the Buncke clinic.

Ahead of my fellowship I was fortunate to have been able to complete several locums throughout the lower mainland, getting to know my future colleagues and learning new facets of plastic surgery. One such area was working in the field of gender surgery. This work really spoke to me and I was equally excited to find out that my future fellowship mentors were some of the world innovators and leaders in

this field. After having completed my fellowship I was fortunate to team up with TransCare BC and was offered a position within the VCH /UBC Division of Plastic Surgery to help expand the gender surgery program.

Two years later, we are delighted to have established the first publicly delivered comprehensive gender surgery program in Canada. Our clinic and program includes; multidisciplinary collaboration between surgical specialties, nursing clinicians, health navigators and PT / OT. This winter we have completed our first primary lower surgery cases and are excited to continue to expand the services and care being offered to the gender diverse community of British Columbia. We look forward to growing our surgical capacity over the next five years, creating new educational and research initiatives.

Q What do you see as the greatest challenge you have faced in starting practice?

The greatest challenge I have faced in starting my practice has been balancing clinical practice, family commitments and getting the gender surgery program off the ground. While exciting there seems to be endless moving parts in introducing a new subspecialty program. This past few years has provided a crash course in program administration and I look forward to the changes and challenges ahead. I have endeavored to meet these challenges by trying to

collaborate with experts and people round the world whom have developed similar programs as much as I can.

Q What advice would you give current residents and fellows about the transition to practice?

I would suggest trying your best to seize every opportunity to expand your skillset and knowledge base. For me, collaboration and mentorship has been crucial, and I am so thankful for the generous colleagues and mentors I have has so far.

Q Where do you see the practice of medicine going over the course of your career?

I think the future of medicine will be greatly be influenced by technology an innovation. We will likely see digital innovation drastically change the way we deliver surgical and patient care. In the future I suspect we will be doing far less late stage radical reconstruction as the screening and diagnostic capabilities of medicine will hopefully allow us to detect and treat patients at much earlier stages.

Division Achievements

Sheina Macadam, MD, MHS, FRCSC 



2019 proved to be our best year since the inception of The Pedicle! Our division and labs published a total of 40 journal articles in peer-reviewed publications and were awarded \$1.35M in grants. This number is due in a large part to our Burn & Wound Healing and ICORD labs.

Congratulations to all of the team members who are contributing to these projects. Dr Marija Bucevska was awarded the 2019 Nicky Dorken Award for Excellence in Service which recognized her dedicated service, excellent performance and outstanding achievement in her role as research coordinator within our division. Dr Richard Warren was recognized internationally as the award recipient for special merit within ASAPS and received the Ralph Millard Award from CSAPS.

Congratulations!

CONGRATULATIONS TO OUR MEMBERS WHO CONTINUE TO ENHANCE THE REPUTATION OF THE UBC DIVISION OF PLASTIC SURGERY. WE WOULD LIKE TO HIGHLIGHT THE FOLLOWING INDIVIDUALS:

AWARDS/GRANTS/DISTINCTIONS

GRANTING AGENCY	TITLE	AMOUNT	PI
UBC DEPARTMENT OF SURGERY	2019 NICKY DORKEN AWARD FOR EXCELLENCE IN SERVICE		DR. MARIJA BUCEVSKA
UBC DIVISION OF PLASTIC SURGERY ACADEMIC GRANT	USING COLOURS, ICONS, AND INTERACTIVE SLIDERS IN THE DESIGN OF A QUESTIONNAIRE	\$4,849	DR DOUGLAS COURTEMANCHE
CIHR/NSERC, COLLABORATION GRANT	THERAPEUTIC USE OF MICRO-SPONGE EMBEDDED LIQUID SCAFFOLD FOR TREATMENT OF NON-HEALING WOUNDS	\$800,000	DR. AZIZ GHAHARY
CIHR GRANT	IN VITRO EVALUATION OF MULTIFUNCTIONAL SCAFFOLD CONTAINING SILVER PARTICLES	\$100,000	DR. AZIZ GHAHARY
WORKSAFE BC GRANT	IMPROVEMENT OF PRESSURE ULCERS DUE TO WORK-RELATED SPINAL CORD INJURY	\$72,000	DR. AZIZ GHAHARY
AMERICAN BURN ASSOCIATION, ROBERT B. LINDBERG BASIC SCIENTIST PAPER AWARD	SPLIT THICKNESS GRAFTS GROW FROM BOTTOM UP IN LARGE SKIN INJURIES		DR. AZIZ GHAHARY
ECZEMA SOCIETY OF CANADA GRANT	A NOVEL THERAPEUTIC FOR ATOPIC DERMATITIS	\$25,000	DR. DAVID GRANVILLE

Division Achievements

GRANTING AGENCY CONT.	TITLE	AMOUNT	PI
MSFHR 12C PHASE II, GRANT	A NOVEL THERAPEUTIC FOR INFLAMMATORY SKIN DISEASES	\$300,000	DR. DAVID GRANVILLE
BC CHILDREN'S HOSPITAL RESEARCH INSTITUTE, EARLY CAREER INVESTIGATOR SEED GRANT	EVIDENCE TO INNOVATION RESEARCH THEME AWARD. FETAL CLEFT STUDY	\$10,000	DR ERIKA HENKELMAN
BC CHILDREN'S HOSPITAL RESEARCH INSTITUTE, EARLY CAREER INVESTIGATOR SEED GRANT – EVIDENCE TO INNOVATION RESEARCH THEME AWARD	IDENTIFICATION OF REJECTION-RESISTANT FIBROBLASTS FOR THE IMPROVEMENT OF TRANSPLANTATION OUTCOMES AND WOUND HEALING: PHASE 2. EARLY WOUND HEALING EXPERIMENTS	\$10,000	DR. SALLY HYNES
RARE DISEASE FOUNDATION MICRO-GRANT	IDENTIFICATION OF REJECTION-RESISTANT FIBROBLASTS FOR USE IN BIO-ENGINEERED SKIN SUBSTITUTES	\$5,000	DR. SALLY HYNES
BC CHILDREN'S HOSPITAL RESEARCH INSTITUTE, CLINICAL & TRANSLATIONAL RESEARCH SEED GRANT	IDENTIFICATION OF REJECTION-RESISTANT FIBROBLASTS FOR THE IMPROVEMENT OF TRANSPLANTATION OUTCOMES AND WOUND HEALING	\$10,000	DR. SALLY HYNES
UBC DIVISION OF PLASTIC SURGERY ACADEMIC GRANT	TRANSFORMING THE BREAST CANCER PATIENT JOURNEY	\$10,000	DR. KATHRYN ISAAC
FACULTY OF DENTISTRY RESEARCH DAY MSC CLINICAL/PUBLIC HEALTH AWARD	EVALUATION OF FACIAL TAPING FOR CLEFT LIP DEFORMITIES USING STEREOPHOTOGRAMMETRY	\$500	DR. PETER MANKOWSKI
W.B. AND H.M CHUNG RESEARCH DAY BEST SHORT ORAL PRESENTATION AWARD	RESIDENT BEHAVIOURS TO PRIORITIZE ACCORDING TO CANADIAN PLASTIC SURGEONS		DR. PETER MANKOWSKI
OFFICE OF PEDIATRIC SURGICAL EVALUATION AND INNOVATION STUDENT GRANT	EAR MOLDING	\$1,181	DR. CYNTHIA VERCHERE
THE CANADIAN INSTITUTES OF HEALTH RESEARCH AWARD	CREATION OF AN ADVANCEMENT IN BURN CARE IN CANADA NETWORK (EXTENSION)	\$4,000	DR. CYNTHIA VERCHERE
AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY	AWARD FOR SPECIAL MERIT		DR. RICK WARREN
CANADIAN SOCIETY FOR AESTHETIC PLASTIC SURGERY	RALPH MILLARD AWARD		DR. RICK WARREN
37TH ANNUAL UBC DIVISION OF PLASTIC SURGERY RESEARCH DAY BEST CLINICAL RESEARCH PAPER	SURGICAL SMELLS: INVESTIGATING SOLUTIONS TO NOXIOUS SMELLS IN THE OPERATING ROOM		DR. AARON VAN SLYKE
W.B. AND H.M CHUNG RESEARCH DAY BEST SHORT ORAL PRESENTATION AWARD	PERIOPERATIVE PREDICTORS OF DIGITAL REPLANTATION SUCCESS. A REVIEW OF INSTITUTIONAL EXPERIENCE	\$3,200	DR. ZACH ZHANG

PUBLICATIONS

BURNS

- Cherukupalli A, Duan N, Papp A. A third of burn outpatient referrals are unnecessary: estimating the prevalence and severity of burn injuries referred to a provincial burn outpatient clinic. *Burns*. 2019 Jun;45(4):805-817.
- Dempsey D, Mordhorst A, Griesdale D, Papp A. Improved outcomes of renal injury following a burn trauma. *Burns*. 2019 Aug;45(5):1024-1030.
- Pangli H, Papp A. The relationship between screening positive results and MRSA infections in burn patients. *Burns*. 2019 Nov;45(7):1585-1592.
- Papp A. Incisional negative pressure therapy reduces complications and costs in pressure ulcer reconstruction. *Int Wound J*. 2019 Apr;16(2):394-400.
- Papp A, Berhanu A, Thomas M, Pham T. Interrupting the seams: the principle of preventive burn reconstruction. *Burns Open*. 10.1016/j.burnso.2019.04.001, 2019.
- Turner C, Zeglinski M, Zhao H, Shen, Papp A, Bird P, Granville D. Granzyme K expressed by classically activated macrophages contributes to burn inflammation and remodeling. *J Investig Derm*. 2019 Apr;139(4):930-939.

WOUND HEALING LAB/ BASIC SCIENCE

- Forbes D, Russ B, Kilani R, Ghahary A, Jalili R. Liquid dermal scaffold with adipose-derived stem cells improve tissue quality in a murine model of impaired wound healing. *J Burn Care Res*. 2019 Aug;40(5):550-557.
- Cait J, Hughes MR, Zeglinski MR, Chan A, Osterhof S, Canals D, Cait A, Vogl W, Bernatchez P, Granville DJ, Murphy TH, Roskelley CD, McNagny KM. Podocalyxin is required for appropriate endothelial cell-cell junction formation and maintenance of blood brain barrier integrity during acute inflammation. *Acad Sci USA*. 2019 Feb;116(10):4518-4527.
- Hanson PJ, Lin V, Qiu Y, Zhang HM, Zhao G, Li C, Hossain AR, Suliamon S, Fung G, Jan E, McManus BM, Granville DJ, Yang D. Cleavage and sub-cellular redistribution of nuclear pore protein 98 by coxsackievirus B3 protease 2A impairs cardioprotection. *Front Cell Infect Microbiol*. 2019 Jul;9:265.
- Hiroyasu S, Turner CT, Richardson KC, Granville DJ. Proteases in pemphigoid disease. *Front Immunol*. 2019 Jun. Review Article.
- Jalili R, Pourghadiri A, Yunyuan L, Cleversey C, Kilani RT, Ghahary A. Split thickness grafts grow from bottom up in large skin injuries. *J Burn Care Res*. 2019 Oct;40(6):727-733.
- Pakyari M, Farokhi A, Jalili RB, Kilani RT, Brown E, Ghahary B. Local expression of indoleamine 2,3, dioxygenase prolongs allogeneic skin graft take in a mouse model. *Adv Wound Care*. 2019 Feb;8(2):58-70.
- Sellers SL, Turner CT, Sathananthan J, Cartledge TRG, Sin F, Bouchareb R, et al. Transcatheter aortic heart valves: histological analysis providing insight to leaflet thickening and structural valve degeneration. *JACC Cardiovasc Imaging*. 2019 Jan;12(1):135-145.
- Turner C, Hiroyasu S., Granville DJ. Granzyme B as a therapeutic target for wound healing. *Exp Opin Therapeutic Targets*. 2019 Sep;23(9):745-754.
- Turner CT, Lim D, Granville DJ. Granzyme B in skin inflammation and disease. *Matrix Biol*. 2019 Jan;75-76:126-140.
- Turner CT, Zeglinski MR, Richardson KC, Zhao H, Shen Y, Papp A, Bird PI, Granville DJ. Granzyme K expressed by classically activated macrophages contributes to inflammation and impaired remodeling. *J Invest Dermatol*. 2019 Apr;139(4):930-939.

Division Achievements

PUBLICATIONS CONT.

WOUND HEALING LAB/BASIC SCIENCE

- Zeglinski MR, Turner CT, Zeng R, Schwartz C, Santacruz S, Pawluk MA, Zhao H, Chan AWH, Carlsten C, Granville DJ. Soluble wood smoke compounds and particulate promote barrier dysfunction in alveolar epithelial cells through a MAPK signaling pathway. *Sci Rep.* 2019 Jul;9(1):10027.

BREAST

- Arnaout A, Ross D, Khayat E, Richardson J, Kapala M, Hanrahan R, Zhang J, Doherty C, Brackstone M. Position statement on defining and standardizing an oncoplastic approach to breast conserving surgery in Canada. *Curr Oncol.* 2019 Jun;26(3): e405-e409.
- Bovill ES, McKeivitt EC. ASO Author reflections: trimming the fat: improving access to immediate breast reconstruction surgery by streamlining operating room resources. *Ann Surg Oncol.* 2019 Dec;26(Suppl 3):729-730.
- Greig H, Roller J, Ziazaris W, Van Laeken NY. A retrospective review of breast reconstruction outcomes comparing AlloDerm and DermaCell. *JPRAS Open.* 2019 Dec;22: 19-26.
- McKeivitt E, Kuusk U, Dingee C, Warburton R, Pao JS, Van Laeken NY Bovill ES. Immediate reconstruction swing room scheduling reduces wait times to surgery and increases breast reconstruction rates. *Ann Surg Oncol.* 2019 May;26(5): 1276-1283.
- Ng T, Knowles S, Brackstone M, Doherty C. Mastectomy flap necrosis after nipple-sparing mastectomy and immediate implant-based reconstruction: an evaluation of tumescence and sharp dissection technique on surgical outcomes. *Breast J.* 2019 Nov;25(6): 1079-1083.
- Van Slyke AC, Carr NJ. Reply: Not all breast implants are equal: A 13-year review of implant longevity and reasons for explantation. *Plast Reconstr Surg.* 2019 Mar;143(3): 664e-665e.
- Zawadiuk Z, Van Slyke AC, Macadam S. Recurrent breast CSF pseudocyst: a rare complication of ventriculoperitoneal shunt placement. *Ann Plast Surg.* 2019 Jul;83 (1): 108-111.

PEDIATRIC

- Bjornson L. A, Bucevska M, Verchere C. Tissue expansion in pediatric patients: a 10-year review. *J Pediatr Surg.* 2019 Jul;54(7): 1471-1476.
 - Chan R, Van Slyke AC, Bucevska M, Verchere C. A 3-year review of an outpatient burn sedation program in a tertiary burn care centre: is it safe and does it work? *Plast Surg.* 2019; 27(4) 305-310.
 - Goobie SM, Zurakowski D, Isaac KV, Taicher BM, Fernandez PG, Derderian CK, Hetmaniuk M, Stricker PA and the Pediatric Craniofacial Collaborative Group. Predictors of perioperative complications in pediatric cranial vault reconstruction surgery. A multicenter observational study from the pediatric craniofacial collaborative group. *Br J Anaesth.* 2019;122(2):215-223.
 - Leung LTF, Loock CA, Courtemanche R, Courtemanche DJ. A cross-sectional analysis of the BC Children's Hospital cleft palate program waitlist. *Plast Surg.* 2019 Nov;27(4): 311-318.
 - Meuli M, Hartmann-Fritsch F, Hüging M, Marino D, Saglini M, Hynes S, et al. A cultured autologous dermo-epidermal skin substitute for full-thickness skin defects: a phase I, open, prospective clinical trial in children. *Plast Reconstr Surg.* 2019 Jul;144(1): 188-198.
 - Moxham LMR, Chadha NK, Courtemanche DJ. Is there a role for computed tomography scanning in microtia with complete aural atresia to rule out cholesteatoma? *Int J Pediatr Otorhinolaryngol.* 2019 Nov;126:109-610.
 - Shih JG, Quong WL, Knox ADC, Zhygan N, Courtemanche DJ, Brown MH, Fish JS. Burn care and surgical exposure amongst Canadian plastic surgery residents: recommendations for transitioning to a competency-based medical education model. *J Burn Care Res.* 2019 Oct 16;40(6):796-804.
-

PUBLICATIONS CONT.

PEDIATRIC

- Wan M, Zhang JX, Ding Y, Jin Y, Bedford J, Nagarajan M, Bucevska M, Courtemanche DJ, Arneja JS. High-risk plastic surgery: an analysis of 108,303 cases from the American college of surgeons national surgical quality improvement program (ACS NSQIP). *Plast Surg*. 2019 Oct;28(1): 57-66.
- Wong Riff KWY, Tsangaris E, Forrest CR, Goodacre T, Longmire NM, Allen G, Courtemanche DJ, Goldstein J, O'Mahony A, Pusic AL, Slator R, Swan MC, Thoma A, Vargas F, Klassen AF. CLEFT-Q: detecting differences in outcomes among 2434 patients with varying cleft types. *Plast Reconstr Surg*. 2019;144(1):78e-88e.
- Yen P, Verchere C. Donor site calcification and deformation following microtia repair in a pediatric patient with mosaic trisomy 22. *Plast Surg Case Stud*. 2019 Jan;(5):1-3.
- Zhang ZZ, Haddock C, Verchere C, Arneja JS, Skarsgard ED. Management of narrow stalked giant omphalocele using tissue expansion, staged closure, and amnion preservation technique. *J Ped Surg Case Rep*. 2019 Dec;1(51):101311.

LOWER EXTREMITY

- Demsey D, Arrunategui J, Carr N, Hodgson A. Feasibility of using optical sensing to measure bone depth in surgical bone drilling. *Clin Orth Rel Res*. 2019 Nov;477(11):2579-2585.

CRANIO- FACIAL

- Guest W, Forbes D, Schlosser C, Yip S, Coope R, Chew J. Imaging-based 3D printing for improved maxillofacial presurgical planning: a single center case series. *Can Assoc Radiol J*. 2019 Feb;70(1):74-82.
- Isaac KV, Tan RA, Ganske IM, Mulliken JB. Beware the alar base optical illusion in assessment of unilateral cleft lip nasal deformity. *Plast Reconstr Surg*. 2019;143(4):1157-1162.
- Isaac KV, MacKinnon S, Dagi LR, Rogers GF, Meara JG, Proctor MR. Nonsyndromic unilateral coronal synostosis: a comparison of fronto-orbital advancement and endoscopic suturectomy. *Plast Reconstr Surg*. 2019 Mar;143(3):838-848.
- Stein MJ, Zhang Z, Fell M, Mercer N, Malic C. Determining postoperative outcomes after cleft palate repair: a systematic review and meta-analysis. *J Plast Reconstr Aesthet Surg*. 2019 Jan;72(1):85-91.

BOOK CHAPTERS

- Warren R. Open Coronal Brow Lift. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Plastic Surgery Operative Techniques*; 2019
- Warren R. Subcutaneous Brown Lift. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Plastic Surgery Operative Technique*; 2019.
- Kwan-Wong T. and Arneja J.S. Nasal Tip Hemangioma. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Operative Techniques in Plastic Surgery*, 1st Ed. Lippincott Williams & Wilkins, 2019, 293-298.
- Quong W.L. and Arneja J.S. Nasal Septal Hematoma. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Operative Techniques in Plastic Surgery*, 1st Ed. Lippincott Williams & Wilkins, 2019, 299-303.
- Felton M., Arneja J.S., Chadha N. Branchial Cleft Sinuses and Cysts. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Operative Techniques in Plastic Surgery*, 1st Ed. Lippincott Williams & Wilkins, 2019, 304-310.
- Felton M., Arneja J.S., Chadha N. Thyroglossal Duct Cysts. In: Chung K., Disa J, Gosain A., Lee G, Mehrara B, Thorne C.H. and van Aalst J (eds). *Operative Techniques in Plastic Surgery*, 1st Ed. Lippincott Williams & Wilkins, 2019, 311-316.

Editor's Note

Jugpal Arneja, MD, MBA, FRCSC



"It is not the strongest or the most intelligent who will survive but those who can best manage change."

- Charles Darwin

The Pedicle is an annual account of the activities and achievements of our UBC Division of Plastic Surgery and published in conjunction with our Resident Research Day. Despite the COVID-19 Crisis taking centre stage and deferring this audience, the editorial team felt it important to forge ahead with The Pedicle nonetheless, if nothing more than an opportunity to

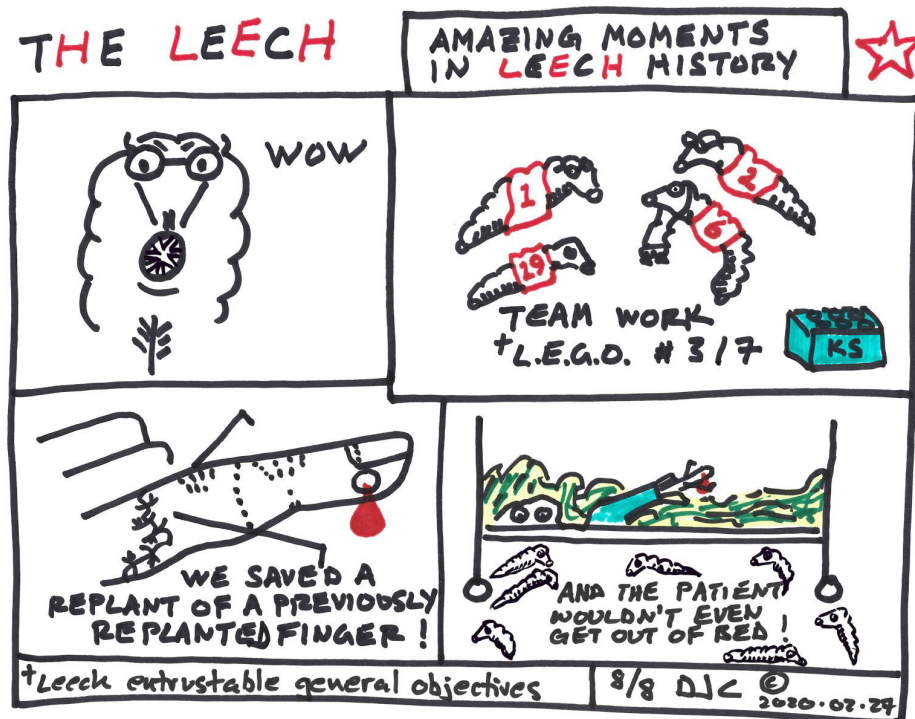
reflect and offer gratitude for all the division offers its various stakeholders.

Pandemics aren't good for the practice of Plastic surgery; the knife & gun club is largely on hiatus, less cars are on the road and thus accidents, social distancing has reduced sporting injury, elective surgery is on hold, and cosmetic surgicentres shuttered. Adversity indeed. Yet, there is always a learning opportunity amidst adversity and change. Any study of the life of Nelson Mandela would uncover this quote: *"Do not judge me by my success, judge me by how many times I fell down and got back up again"*. Change and its associated adversity seem to often go hand-in-hand. Pre-COVID-19, change at multiple levels were coming fast and furious. Competency By Design (CBD) at the resident training paradigm, redevelopment and Clinical Systems Transformation (CST) at the health authority vanguard seemed like monumental changes in the way we do business, yet pale in comparison to the consequences and change associated with COVID-19 (some yet to unfold).

When some doors close, others open. Who'd have thought the acceleration of telehealth out of this necessity would emerge, and in fact likely be sustained post COVID-19? Education has also pivoted; this week schools launched online platforms and residency education continues in this vein as well. Those of us with research manuscripts stacked up on the corner of our desks now have time in our schedules to catch up. However, I'm not sure if a company like Da Vinci will be able to create a living room based surgery console for the inevitable pent up demand for elective surgery while we wait to get to the other side.

We will be judged by how we react to adversity, how resilient we are, and how adaptable to change we become. As academic surgeons, we are on the teaching and learning frontier, and although many of these skills don't show up on any Royal College Daisy Framework, it's our job to model and champion this behavior.

Many thanks to Mo, Parm, and Norine for all they do, the Pedicle team (Cindy, Sheina, and Peter), and to our colleagues, trainees and most importantly our patients, who teach us about resilience every day.



Support Us

If you are interested in financially supporting any of the UBC Division of Plastic Surgery Programs please contact Maureen Berard at 604.875.4084.