The word “plastic” to describe reconstructive surgery was coined by Von Graefe in 1818 and popularized 20 years later by Zeis. Over the course of the first half of the 20th century, as a result of the assiduous efforts of several highly regarded surgeons who unified and advanced the specialty, the field of plastic surgery was born as an independent entity. Several professional and academic societies related to the plastic surgery field were established during the 1920s and 1930s. In 1924, under the stewardship of John Davis, the first formal training program and fellowship in plastic surgery was established at Johns Hopkins. In 1937, the American Board of Plastic Surgery was founded to help ensure patient safety, adequate training, and surgical competence. Plastic surgery was recognized as an academic and clinical discipline when the Department of Surgery at Johns Hopkins University, an organization traditionally opposed to plastic surgery as a separate specialty, appointed Davis as the first Professor of Plastic Surgery in the country.1

Today, plastic surgery has evolved into a diverse discipline. The breadth of the field has necessitated the emergence of multiple subspecialties. Some of these subspecialties of plastic surgery, such as hand surgery, have become large and distinct enough entities to merit having a separate certification process. Over the last seven decades, many societies have been founded to deal with the specific political and academic needs of plastic surgeons.1 There is no question that this prominent, powerful, and well recognized surgical specialty needs more administrative autonomy. This will come about by conversion of all of the plastic surgery divisions to departments. The trend in institutional acknowledgement of plastic surgery as an independent specialty has begun and, in recent years, nine divisions of plastic surgery have been granted departmental status by prestigious universities.

ADVANTAGES OF AN INDEPENDENT DEPARTMENT
There are many tangible advantages of having an independent department. These include elimination of bureaucracy and layers of administration, financial independence, ability to use surplus revenues to maintain more academic plastic surgeons in the field, ability to implement educational plans more effectively and expeditiously, and ability to attract better scientists and faculty members who will see less potential for instability in the governance. The other notable benefits of departmental status include direct involvement in the decisions regarding education at the medical school, direct involvement in the financial decisions (specifically when there is a faculty plan), and ability to communicate on an equal basis with chairs of other departments, most of whom have overlapping and sometimes conflicting areas of interest. In addition, there is an opportunity to fully represent the interests of plastic surgery residents and faculty at the chair level rather than through the surgery department chair. Research programs can also be served far more effectively, starting with negotiations for research laboratory space directly with the dean rather than sharing it with multiple surgery divisions, and academic appointments can be facilitated with a direct line between the chair of the plastic surgery department and the dean of the medical school.

DEVELOPING A CONVERSION STRATEGY
Conversion of a division to a department is slow, tortuous, demands patience, and requires a strategy which may differ from one organization to another. It is essential to plan the conversion, analyze the ramifications and potential problems, and deal with the stakeholders and decision makers individually before starting the process. It is vital that all of the plastic surgery programs and organizations join forces in order to rally behind those programs which are still functioning as divisions to become departments.

The most opportune time to convert a division to a department is when the clinical organization and the dean of the medical school are searching for a division chief. If one of the conditions of every candidate accepting the offered academic division chief position becomes

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having a department, it is more likely that the chair of the department of surgery and the dean may acquiesce, especially to secure a strong candidate. This could be negotiated masterfully, starting the position as a division chief to be converted to a department after reaching some milestones.

Most organizations that are searching for a division chief have only few faculty and suboptimal clinical, academic, and financial conditions. The expectation of having a department under this scenario may not be realistic. Here, one can set some goals and objectives that if they are achieved, the negotiated reward would be transition from a division to a department. Again, this will occur if all the candidates ask for a similar arrangement. This may require a major campaign and education across the academic community, involving all those who have the ambition of attaining an academic chief or chair position.

The change from a division to a department would be facilitated by several actions. Involvement of the faculty and the chief of the division in all of the affairs of the medical school and health care organization plays a prodigious role. Whether it is educating the medical students, modifying the medical school core curriculum, or serving on committees, visibility is crucial. In fact, one of the requirements of most medical schools for changing a division to a department is sufficient participation in medical education. Another strong element is a business plan that demonstrates financial viability and independence. A proposal for a change from a division to a department can be blocked by other departments. In order to minimize this potential, a close alliance, specifically with the otolaryngology, ophthalmology, and dermatology departments through cooperative programs, will be extremely beneficial. One more fundamental factor is genuine and constant participation in fulfilling the important medical school missions. Again, this will not only increase the visibility, it will clearly demonstrate the commitment of a plastic surgery division to providing support to the institution. Not only is participation in educational and administrative activities in the medical school central for a change from a division to a department, similar activities within the healthcare organization (main hospital system) will also be essential.

One of the highly valued factors in favor of a department change is having a recognized research program, especially when the extramural grants provide significant indirect revenues to the medical school. Endowed chairs and extramural grants increase the potential for division to department change. Manpower is an additional imperative factor. Demanding to have a department that comprises only a few faculty members could be a futile exercise. On the other hand, the plastic surgery division that has at least five or more faculty members will have a better chance of conversion. The larger the number of faculty, within a fiscally sound plan, the greater the chance that the division would be changed to a department.

LOOKING FORWARD, STANDING TOGETHER
I look forward to the day that all divisions of plastic surgery become departments. Those of us who have secured departmental status stand ready to eagerly help those who wish to undergo this transformation. ❖

REFERENCES

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