MESSAGE FROM THE PRESIDENT

Nassau in January

In four months, while the North winds bite through Pittsburgh, we will be enjoying an umbrella-donned drink by the pool at the Atlantis. The Program Committee reviewed a record number of submissions and has put together a great collection of instructional courses, symposia and paper presentations.

The meeting is suffused with music. The opening ceremony begins with a performance by local high students. The Steve Lee Band will rock the Mentors reception. Just prior to the Presidential Address, Jason Rovak will accompany harmonicist PC Ho. Guest speaker, Charles Limb will show us how the brain looks when a musician gets creative. Finally, the Nassau band Ambassah with guest hand surgeon musicians, will get us jumping and swaying at the Friday night gala.

Other highlights of the meeting include: Novelist Ramez Naam who will talk about the scientific basis for his science-fiction trilogy on the compound Nexus, which allows individuals to share thoughts and experiences. You can learn more about Ramez at http://rameznnaam.com. Dr. Scott Kozin will give the Danyo lecture on volunteerism and Dr. Mike Hayton from the UK will talk about accelerated rehabilitation and the return to play in professional and amateur athletes.

Many of our members have been involved with medical work oversees. This past year I went to Guatemala with Lynn Bassini through her Guatemala Healing Hands Foundation and to Haiti with Scott Kozin’s inaugural Touching Hands mission. Transformative.

The Board of the Hand Surgery Endowment, led by Jeff Greenberg, has put a significant effort toward the “Hand’s at Work” campaign. It is our goal to have the AAHS become a leader in facilitating outreach programs throughout the world. We hope to raise one million dollars in order to offer 10 scholarships to young surgeons and therapists to travel to sites in the US, Africa, Haiti and Guatemala. To date we have raised about $820,000. Please visit the HSE website: http://www.handsurgery.org/endowment/. This is a project we can do together. Consider a donation: no gift is too small.
PROGRAM HIGHLIGHTS

► Panels:
  • Hand Injuries in Athletes: From the Weekend Warrior to the Professional Athlete (ISSPORTH)
  • 911 Complications: When Bad Things Happen to Good People
  • The Affordable Care Act and Its Impact on the Surgeon

► Hands-On Surgeon Development Workshop

► MOC Instructional Courses
  • Carpal Tunnel
  • Metacarpal Fracture

► New Sessions This Year
  • Women in Hand Surgery - Love’s Labor Not Lost: Perspectives on Life and Career
  • Nerve Transfers: Distal Ulnar, Radial & Median Nerve

► Comprehensive Hand Review Course (Separate Registration Required)

► Invited Guest Lecture: Michael Hayton, MD | “When Can I Play Doc?”

► Invited Guest Speaker: Charles J. Limb, MD | “The Neuroscience of Musical Creativity”

► Danyo Lecture: Scott Kozin, MD | “Volunteerism - A Way To Shape the Global Community”

► AAHS/APSN Joint Invited Speaker:
  Susan E. Mackinnon, MD | “Pathway to Innovation in Academic Surgery: The Good, The Bad and The Ugly”

## Schedule-at-a-Glance

### 2015 ANNUAL MEETING

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<th>THURSDAY • 1/22</th>
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### AAHS Program

- **Instructional Courses**
- **Welcome & Invited Speaker** Jane Fedorczyk, PT, PhD, CHT, ABC
- **Panel:** Hand Injuries in Athletes
- **Coffee Break**
- **Panel:** Hand Surgery & Therapy - Tips & Pearls
- **Invited Guest Lecture** Michael Hayton, MD
- **Hands-On Surgeon Development Workshop**
- **Hands-On Therapist Development Workshop**
- **Welcome Reception in the Exhibit Hall**

### AAHS & ASPN Program

- **Instructional Courses**
- **Welcome & Invited Speakers**
  - Wahl C. Lees, MD, NB, BC/CHS & William H. Setz, MD
- **Panel:** 911 Complications
- **Presidential Address**
  - Mark E. Baratz, MD
- **Invited Guest Speaker**
  - Charles J. Limb, MD
- **Coffee Break with Exhibitors**
- **Concurrent Scientific Paper Sessions**
- **Nerve Transfers: Distal Ulnar, Radial & Median Nerve**
- **Women in Hand Surgery: Perspectives on Life & Career**
- **Mentors Reception**
- **Comprehensive Hand Review Course**
  - (Separate Registration Required)
- **AAHS Annual Meeting Dinner Dance**

### Other Events
- **ASPNI Welcome**
- **HSE and HANF Journal Update**
- **Annual Business Meeting**
- **Danyo Lecture**
  - Scott Kozin, MD
- **Concurrent AAHS/ASPN Scientific Paper Sessions**
- **Joint AAHS/ASPN Invited Speaker**
  - Susan E. Mackinnon, MD
- **APKN Poster Session**
- **Lunch with Exhibitors**
Hand Surgery Quarterly
Fall 2014

SATURDAY • 1/24
- Combined Day
  AAHS/ASPN/ASRM Programs
  6:30 am - 8:00 am
  Continental Breakfast
  Instructional Courses
  Combined Panel:
  The Affordable Care Act
  Coffee Break with Exhibitors
  Joint Presidential Keynote Lecture
  Ramez Naam
  Joint Outstanding Papers
  Scientific Paper Session III
  Masters Series in Microsurgery

SUNDAY • 1/25
- ASPN & ASRM Programs
  6:30 am - 7:30 am
  Continental Breakfast
  Instructional Courses
  ASRM Welcome
  ASPN/ASRM Combined Paper Session
  Coffee Break with Exhibitors
  Scientific Paper Session IV
  President’s Invited Lecture
  Michael V. Wood, MD
  Invited Guest Speaker
  ASPN Presidential Address
  Founding Member/ Past President Invited Panel
  International Panel
  Closing/Reception
  ASPN Business Meeting
  Break Out Panels
  Scientific Paper Session
  Lunch
  YMG Open Forum
  Break Out Panels
  Scientific Paper Session
  ASRM Business Meeting
  Lunch

MONDAY • 1/26
- ASRM Program
  6:30 am - 7:30 am
  Continental Breakfast
  Break Out Panels
  Scientific Paper Session
  ASRT Update Panel
  Presidential Lecture
  Allen Bishop, MD
  Coffee Break with Exhibitors
  YMG Panel
  Break Out Panels
  Scientific Paper Session
  ASRM Business Meeting
  Lunch
  Godina Lecture
  Matthew Hanasono, MD
  Old Turks: Young Turks
  Smack Down
  Poster Reception
  ASLS Programming

TUESDAY • 1/27
- ASRM Program
  6:30 am - 7:30 am
  Continental Breakfast
  Break Out Panels
  Scientific Paper Session
  Bunche Lecture
  Julia K. Terzis, MD, PhD
  Concurrent Scientific Paper Sessions
  Panel: Disasters of the Masters
  Closing Remarks

YMG/New Member Reception
ASRM Welcome Reception
Godina Alumni Club Reception
WMG Reception
ASRM Celebration!
FROM THE EDITOR’S DESK

AAHS Annual Meeting in the Bahamas

I am fortunate enough this year to be co-director of the 2015 Annual Meeting in the Bahamas. Along with Chris Novak, we are putting together, what we hope you will agree is, a top notch program. Mark Baratz’s Column puts forth a lot of the highlights of the meeting, and I am sure all who attend will find it educational, stimulating, and fun.

What is more surprising to me is the amount of work that it takes to put on a meeting like this. There are a significant number of “moving parts” to get a meeting like this together. Certainly, for Chris Novak and myself, it has involved countless emails and phone calls. Crystal Beatrice, our fearless staff leader, has guided us through the process. But it is more the work put in by the membership to which I am referring.

It takes member volunteers to review abstracts, participate in instructional courses and symposia, and to moderate paper sessions. Each of those volunteers puts hours of preparation into their talks and presentations. They take time out of their practices now to prepare, and again in January to come to make this meeting a reality.

So I’d like to take this opportunity to thank all of those volunteers who have made Chris and my job so much easier by making themselves available and giving so freely of their time.

I will thank them again when I see them in January and I hope you will take the time to come to the Bahamas to thank them as well!
K-wire Guided Lalonde® Bone Clamp for Reducing Oblique/Spiral Fractures from ASSI®

With the K-wire Guided Lalonde® Bone Clamp, the surgeon can select the ideal location for fracture fixation by quickly and easily firing the K-wire through the guide into an exact position on the bone.

ASSI® AG 77426

ASSI® AG 77726
Lalonde Oblique/Spiral Metacarpal Fracture Small Bone Clamp Max. opening 17mm

The Lalonde Bone Clamps work like a towel clip but are designed to fit around bones.

ASSI® AG 77826
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The Anatomy Glove Learning System (www.anatomysoftware.com) was created by University of Toronto Professors Pat McKee and Anne Agur. The Learning System was developed over a 12-year period to assist students and professionals in medicine and allied health to understand the complexities of hand anatomy and function.

Over the years, we observed that learners struggled to understand the extensor mechanism - the combined effect of extrinsic finger extensors and intrinsic muscles. To assist with this concept, we initially showed learners how to draw the extensor expansion onto paper, printed with outlines of the hand bones. However, since paper is two dimensional, many learners were confused by how the volar interossei and lumbricals attached distally into the dorsal aspect of the fingers. They struggled to understand how volar structures could be part of the extensor mechanism and extend the interphalangeal joints.

In the early 2000s, we introduced a 3-D teaching concept whereby learners used written instructions to draw the metacarpal and phalangeal bones, followed by the extrinsic finger tendons and intrinsic muscles, onto an examination glove.

While the 3-D glove-drawing approach proved superior to our previous 2-D paper-drawing approach, it had its limitations. The learner-drawn bones lacked precision, which in turn adversely affected the accuracy of the drawn muscles. In addition, the examination gloves quickly deteriorated and the colored lines, even when drawn with permanent markers, bled into the glove material. Consequently, the drawn examination glove did not serve well as a long-lasting, useful reference tool.

Over the next several years, the learning experience evolved to the point where we now have a learn-
ing system consisting of (1) instructional videos and (2) a fabric glove. This led to the name Anatomy Softwear because the glove material is soft and the glove is wearable. The stretchy glove fits adult hands from small to large and is printed on palmar and dorsal surfaces with anatomically-correct bones that align with the joints of the person wearing the glove. The glove now serves as an accurate “canvas” on which to draw the muscles (Figure 1).

The learner-controlled online videos show (a) hand anatomy on dissected human specimens and (b) how to draw extrinsic and intrinsic muscles and tendons onto the glove. An additional feature of the videos is demonstration of the anatomical pathology of common clinical conditions.

Learners watch each video segment, then draw the extrinsic tendons and intrinsic muscles, from deep to superficial, onto the glove, which is worn on the non-drawing hand (Figure 2). Learners told us that the glove-drawing experience helped them to better understand the complexities of hand anatomy and function. They also appreciated that they were able to re-watch the videos to review and consolidate their comprehension of the structure and function of hand muscles.

The learning system can be adjusted to all levels of learners (undergraduate and post-graduate students, as well as clinicians). It is used for online learning as well as classroom and workshop settings (Figure 3). It is also used for patient education to explain injury, arthritis and surgical procedures.

An article published April 2014 in Anatomical Sciences Education, titled “Student Perceptions and Effectiveness of an Innovative Learning Tool: Anatomy Glove Learning System” reported that the majority of allied health students in the study strongly preferred the system to traditional 2-D drawing methods. Students found the learning system to be an enjoyable, interactive and useful tool to grasp 3D concepts of functional hand anatomy.

The Anatomy Glove Learning System has been shown internationally at conferences and used in hand surgery and hand therapy continuing education courses in numerous countries. As of September 2014, instructors in 10 countries, on six continents, use the Anatomy Glove Learning System with their students.

For more information about the learning system, please refer to www.anatomysoftwear.com.

Figure 3. Students reviewing hand anatomy using their completed Anatomy Softwear glove.

Calendar

2014

October 15, 2014
AAHS/AACM Pre-Course Surgical Advances In Elbow, Wrist And Hand Surgery
Buenos Aires, Argentina

October 16-18, 2014
Congress Asociacion Argentina de Cirugia de la Mano
Buenos Aires, Argentina

November 8-10, 2014
Hong Kong International Wrist Arthroscopy Workshop
Prince of Wales Hospital, Shatin, New Territories, Hong Kong

2015

January 21-24, 2015
AAHS Annual Meeting Atlantis Resort Paradise Island, Bahamas

June 17-20, 2015
XX FESSH Congress Milan, Italy

2016

January 13-16, 2016
AAHS Annual Meeting Westin Kierland Hotel Scottsdale, Arizona

Additional information on these and other upcoming meetings can be found on the AAHS website: handsurgery.org
CODING CORNER: Thumb Carpometacarpal (CMC) Osteoarthritis

Thumb carpometacarpal (CMC) osteoarthritis is a highly ubiquitous disorder, typically observed in elderly females. Patients will often present with radial sided or thumb base discomfort, exacerbated by common activities such as pinching or grasping. The pain can be mitigated by anti-inflammatory medications, splint immobilization, corticosteroid injections, and possible surgical treatment. Since there may be some confusion over the appropriate use of Current Procedural Terminology (CPT) codes for surgical interventions aimed at treating thumb CMC osteoarthritis, this will be our focus in this issue of Hand Surgery Quarterly.

Treatment options for thumb CMC osteoarthritis include arthroscopically assisted arthroplasty, hematoma distraction arthroplasty, and ligament reconstruction tendon interposition (LRTI). Associated procedures may also include metacarpophalangeal (MCP) joint stabilization for instability.

In arthroscopically assisted arthroplasty, a small arthroscope is typically inserted into the thumb CMC articulation through the 1-R or 1-U portals. A burr is then used to complete a distal hemitrapeziectomy. Tendon graft or some sort of soft tissue interposition can be placed within the hemitrapeziectomy site to complete the arthroplasty procedure. Since the thumb CMC joint is considered to be part of the wrist joint, it is appropriate to use CPT 29846 to reflect the work of performing a wrist arthroscopy and debriding the CMC joint. CPT 20924 can then be applied (with modifier -51) to describe the work involved in harvesting and placing a tendon graft, like the palmaris longus.

Hematoma distraction arthroplasty involves the resection of the trapezium and usually the placement of one or two Kirschner wires to stabilize the thumb metacarpal to the index metacarpal. CPT 25210 (carpectomy; one bone) best describes this procedure since it does not technically fulfill the definition of an interposition arthroplasty.

Finally, it is appropriate to use two CPT codes for LRTI procedures, specifically CPT 25447 and CPT 26480 with modifier -51. CPT 25447 describes the work involved in performing a CMC interposition arthroplasty. CPT 26480 appropriately reimburses for a tendon transfer to the CMC area, as long as the tendon being transferred is weaved through another tendon or the metacarpal base.

If a concomitant MCP stabilization procedure is performed, two codes ought to be utilized. For capsulodesis procedures, CPT 26516 is recommended. For MCP arthrodesis, one should utilize CPT 26850. If bone graft is obtained (which would be a rare occurrence for an MCP arthrodesis), CPT 26852 is appropriate.

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Panel Discussion: Research Mentoring

David: I’m your moderator. I’m Chief of Hand and Surgery at Mass General Hospital in Boston. I’ve started at MGH as a surgical intern 21 years ago, and I’ve been doing hand surgery for 14 years. I have a passion for research and a broad interest ranging from common upper extremity illnesses, trauma and post-traumatic reconstruction, psychosocial aspects of human illness, and quality and safety.

Kevin: I am a hand surgeon at the University of Michigan. I’ve been here for close to 20 years and my practice is primarily hand, upper extremity, and microsurgery reconstruction for limb salvage. My research interest is Outcomes Research, Health Policy, and Economic Analysis in Healthcare.

Johnathan: I’m an orthopedic surgeon at Virginia Commonwealth University in Richmond, Virginia. I’ve been in practice for 12 years. I do bread and butter hand surgery; probably a little bit more trauma with an interest in peripheral nerve regeneration and brachial plexus.

John: I’m at the University of Pittsburgh and just finished my first year of practice. I care for the fingertips to the shoulder and my research interests are in musculoskeletal ultrasound and carpal tunnel syndrome.

David: Why do you think the AAHS was interested in a round table on research mentoring?

Kevin: My impression is that the AAHS wants to participate in the national discussion on health policy and outcomes research as well as translational research. For this to be successful, we need to develop young investigators and encourage seasoned investigators to become suitable mentors to support hand and upper extremity research.

David: What is science, why did humans invent it, and why do we use it?

John: I think that science comes down to curiosity. Advancing knowledge by testing hypotheses. Confirming and revising what we think we know. We use science because that’s really the only way we confirm that our impressions are accurate.

David: Science and research generally doesn’t pay. We do it on our free time for the most part. Is that a viable system and can we count on future generations doing research within this system?

Jonathan: With respect to getting funded, I think it’s like a politician whose whole goal is to get re-elected and the politics gets a little skewed. Hot topics and positive results get rewarded. There is often a lot of pressure to pursue a “fundable” idea as opposed to something that you are really passionate about. And on top of that, a lot of pressure to get positive results. For the majority of us working without funding, we are fortunate that—at least currently—hand surgeons make a good living as clinicians. This allows some of us to choose to devote some of our free time to research. I would say that it needs to be a combination - that there needs to be people that do it purely for the passion of it, and there also needs to be people that can make a living doing it.

David: As a science enthusiast in the way that John Fowler described it, and a research mentor trying to build the next generation of hand surgery scientists, I’m a bit concerned. I afraid that if we don’t make science more than a passion—if we don’t create some other

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incentives—not enough of us will contribute. But I do think that is the main job of the research mentor—to encourage an undying love of the scientific method.

Kevin: There’s no way that one can make money on the kind of research that we strive to do. Having said that, research can take many different forms. For example, if one has interesting personal experiences, one can present them in case report or a case series. Those interested in basic science really need a fostering institution that can support one’s time away from clinical work and support a laboratory. I am the dean for tenure and promotions at Michigan where the institutional commitment to supporting research is strong. All the faculty members on the tenure track have protected time to compete for NIH grants and publish papers. My view is that research is an engaging activity that contributes to society and is intellectually rewarding.

David: When someone comes to you interested in doing research, what do you feel is the most important thing you could do or say to help them make a lifelong passion of research?

Kevin: For me a researcher needs to have an interest and curiosity in discovery rather than simply adding entries to their CV. There’s no such thing as dabbling in research. To conduct research that is meaningful, one has to have the appropriate training. If one wants to do outcomes research, one needs to train and practice. One might even work towards a degree or coursework in epidemiology, statistics, large database analysis, or social sciences, to name a few. My best advice for a person who wants to do research is to know what kind of research you want to do. Where do you see yourself going? And based on that, what type of training can you afford to take so that the kind of research you do is going to be meaningful, and hopefully, help society.

David: Kevin: you and I do a lot of research and publishing. Each of us has maintained a passion for research for over 20 years. I notice that we both tend to rely on young people—people trying to get into medical school residency, fellowship, or trying to get a job. So let me ask the youngest member of the panel - John Fowler. How can we transform this more self-interested, career-building approach to science and research, into a true, career-long love of science?

John: In my view, having good mentors is important. Mentors that have the time, or take the time, to explain to us their approach to research, how to think about a problem, and how to design studies. My residency did not have a strong clinical research background. I had no idea how to get grant funding. It was more you show up and do a retrospective chart review and that was about as good as you could accomplish. And then fellowship at University of Pittsburgh really opened my eyes to what a good translational science collaboration can be. Getting a chance to work with you, David, on the research committee has opened my eyes to what true research can be. The kind of things that really have the potential to change practice and make a difference. And I think that trying to foster that kind of interest in young people by walking them through some of the early steps is probably the best way to develop that passion.

Jonathan: People that want to do research to build their CV don’t usually end up being devoted researchers. I tell potential student and resident researchers about my ideas but not in detail. And then, if they show up and if they start getting involved, we embrace them and try to get them more and more involved. There are certain people (I don’t know if they have the gene or if they were motivated or nurtured) that research just excites them. If you find those people, you just have to help them down the road.

Kevin: I will tell my mentees that research is a calling and a devotion. I spend some of my evening, weekend, and holiday time doing research. I have a full time surgical practice, so in addition to time with my family and time with other avocations, I do research largely in my spare time. When I find someone with the same passion for research I think I have a winner. When they get to work, we find out whether they’re actually committed. I take pride that many of my trainees are now successful researchers. One needs to be able to identify a mentor who is magnanimous; someone that mentors because they want to see the young generation become successful. They want to have the camaraderie with the mentees and they want to...
Hand Table (continued from previous page)

advancing science. They don’t want to add to their own CV on the backs of the trainees. To find a mentor who is willing to give everything to ensure that the mentee is successful is perhaps the most challenging task. Those mentors are hard to find, but once you find them, the mentor really needs to dedicate himself or herself to be sure that he or she can leverage everything that mentor has to offer to become successful. A good mentor is someone who will stay in the background when the mentees are on the podium, publishing papers, receiving grants, and progressing through the academic ranks without having the fear or maybe even intimidation that the mentee will overshadow them.

David: What are the main barriers doing good research?

Jonathan: Money and time

John: Funding is always an issue. Starting off as a young researcher funding is almost non-existent. Most grants that you apply for want to see other grant funding or publications in that field or a very narrowed research focused. I have found that I’m still interested in a lot of widely different research areas. More seasoned researchers may have much more focused areas of interest. Time is also an issue. I was much busier when I first started practicing than I thought I was going to be and had all these great dreams of writing IRB’s and getting all my clinical outcomes set up and I walked into practice my first day and had 50 patients in the office and had 10 cases on the OR schedule. That definitely caught me off guard. Another thing for me is inexperience and needing to learn how to design a good study. I think the AAHS Research Listserv (aahsresearch@list.handsurgery.org) has been very helpful with that and getting to see how people approach problems. I think part of it is knowing the question to ask and I think I’m still getting better at that. We mentioned earlier how asking the right research question that is interesting for people to read or an attempt to answer a true clinical conundrum is sometimes hard.

David: Give me some ideas for overcoming some of those barriers.

Kevin: I trained in general surgery, plastic surgery, and hand surgery. After that I decided rather late that I wanted to embark on an academic career. But I had no idea how to proceed. I didn’t even know what a P value was or what was clinical trial or outcomes research. But I knew I could not flourish in an academic environment if I did not have the appropriate research training. So I did another 2 years of training in research. I took a resident salary for an extra 2 years and entered into the Robert Wood Johnson Clinical Scholars Program where I got a master’s degree in statistics and research design. It was difficult because I had not been to school in 8 years and I had to sit through those epidemiology and statistics classes. But I recognized that for me to do the meaningful research I wanted to do I had to have the knowledge. After those 2 years of training and being engaged with people from other fields in public health and health economics, I am able to speak the language they speak. I may not be doing research as well as they do, but at least I understand where I should be going. Time management is an important as training. One can be much more efficient by assembling a team of people - from epidemiologists to health behavior scientists – to help design the projects that you want to do without individually running every facet of the project. But everyone can be involved in research. Many people may not have the training but may want to contribute patients to a collaborative study. That is still research, team science research. There is something for everyone.

David: A big part of it is just to lower the intimidation. Once you understand some of the major aspects of research such as research design and statistical analysis, the intimidation melts away, and even a busy clinician can find it more feasible to do research.

Kevin: If one understands the basic mechanisms of doing clinical or translational research, and one has the necessary credentials, then one is positioned to compete for high profile research grants from the NIH, and the trajectory for success can be much faster.

David: John Fowler back to you. As a young academician with a growing passion for research, what do you think would quench that fire? What would slow your interest?

John: Probably rejection. Repeated rejection. If I felt that the ideas I had either didn’t seem worthwhile or that I didn’t have any support. I think that would make it difficult and it would make it more of a
headache to me, which might overcome the passion to try and make a difference and really change the way we practice medicine. If you have a paper that gets rejected by 15 different journals, there is a sense of failure. If you don’t get a paper out there and published, it's almost like your hard work was for nothing. Because if you don’t get published, there is no awareness of your work. I think repeated rejections can definitely be demoralizing. Even in my short time doing this, I’ve got a folder on my computer of dead projects that either were just bad ideas or didn’t go anywhere. Thankfully I’ve had enough successful projects that I haven’t given up. But I can imagine that if, over and over again, that dead projects folder became much larger than the successful projects folder, it might be enough to put some people out of doing research.

David: Another important role of a mentor is to choose projects with a high likelihood of success and minimize wasted effort of the junior researchers. Kevin, as an experienced and accomplished researcher, John mentioned things that are demoralizing. I wonder what keeps you serious and motivated, but also what things are demoralizing? Even to somebody that’s been doing this awhile and is very accomplished.

Kevin: I had few mentors when I started in research because surgical disciplines were embarking on outcomes research when it was unfamiliar. I was designing ambitious projects, like trying to cure cancer, trying to solve the nation’s escalating cost of healthcare, which were ephemeral themes that went nowhere. Every one of my ideas failed and for 2 years I generated meager returns. The only thing that became successful was the Michigan Hand Questionnaire that came out at the same time as the DASH. A neophyte designing an outcomes questionnaire was considered crazy because of the rigor required to learn about social sciences and extensive pilot testing of preliminary versions of the questionnaire. But I stuck with it for 2 years. The experience of failure is actually helpful for a researcher because after 2 years of failure, I know where not to go. I can consolidate research ideas sequentially so my trainees do not have to go through the same difficulties I went through. In my training module, I give my trainees a few months time to explore and perhaps fail, because they need to learn to overcome hurdles.

I want them to experience failure, at least for the first couple months. I want them to explore ideas that may not materialize. Then I need to direct them carefully to set them on the right path. These failures are part of the research culture and hopefully one can identify the mentor who would allow one to fail, but also provide a safety net and a caring environment so that the mentee does not continue to sink. Some winning projects and early successes can rejuvenate one’s interest and not let the failures drag one down.

David: When I was making my own transition from residency and fellowship into academics, there were a lot of people that had a passion for academics. But many of them got caught up in the business of medicine. All of a sudden, you see what your clinical work can achieve, and it’s easy to get focused on seeing more patients, doing more surgeries, generating more income. My concern is that research has little hope against such incentives?

Jonathan: I think the reason why I’ve been successful is because I had a supportive chairman who was willing to give me financial support in the form of a lab manager - a person that does most of the hands on experiments. So essentially we pay his salary and we keep the lab running all the time. And to Kevin’s point, you have to always have momentum going with the research. As soon as you stop, you lose that momentum. You always have to be moving forward. And you have to have somebody in the lab that’s going to help you. When I first started, I would take a day off every week and go to the lab and operate on rats. But it benefits the department financially if I see patients that day and we pay somebody who I taught do nerve repairs in the rats. I still analyze the data and I still write up the papers. I enjoy that stuff and that’s the stuff that I do on the evenings and on the weekends. I think that was the key for my department - to see that we could produce research in a more economical way if we paid somebody who wasn’t a surgeon to do the day-to-day work in the lab.

David: What I’m hearing is that it helps to have the support of an entire institution and a department that says “we care about research”, “we care about science”, “there’s more to us than just the balance sheet”. A higher calling. A nurtur-
Every patient I see in the office represents a unique opportunity—a problem I want to solve. I’m inspired by my patients to conduct research that is meaningful to them......

- Kevin Chung, MD, MS

David: What can the AAHS and other professional organizations do to help you succeed as a researcher?

John: I think mentoring is important. I have very little true research training, but I learn from going to meetings and using published articles as a guide. I had the chance to go to the OREF and ORS Clinician Scientist Development Program and grant writing courses and learned so much on how to approach the grant process and research in general. I think the research listserv is very good to see how ideas are generated. I think it would be nice to have formal mentorship, but it’s really hard to do over the phone. I think a lot of that has to be done on a local level where you can sit, meet and talk.

David: I want each of you to describe one person who influenced your interest in research and what they did for you.

Johnathan: I would say Rajan Gupta. My first or second year of practice I applied for a grant through the ASSH and got it. At the time they had some of their experienced researchers reach out to me. Jim Chang came and found me and talked to me and said that they really wanted to encourage me to do this. And I ended up having a long phone conversation with Rajan Gupta. He convinced me that I could be a researcher and a clinician if that was my desire. And he kind of gave me permission to choose what, as the four of us know, is a relatively less traveled path. Just having a long conversation with somebody who had already been successful really helped convince me that I could do this.

Kevin: I think that I would say David Smith. Dr. Smith was Past President of AAHS and was Chair of Plastic Surgery at Michigan. He saw something in me that I did not see in myself. He thought I could do research and he asked me to apply for the Robert Wood Johnson Clinical Scholars Program at Michigan. I always listen to my Chiefs. Whatever I was told, I would do. I thought I was not going to get this coveted training because the Robert Wood Johnson Foundation had not selected a surgeon for about 30 years. I thought that if I sent the application and did not get it, then I would just go back to Georgia, my hometown, to be a hand surgeon in private practice. Amazingly, I actually got it. Now I am in trouble because I now have to be a researcher! It was David Smith who pushed me into my current career and I am grateful to him for showing me the path. I am indebted to the Robert Wood Johnson Foundation. They have trained many of the top health policy researchers in the country. And since then, I have trained 7 Robert Wood Johnson Clinical Scholars. Many of them are hand surgeons and should be making their mark in the very near future. Finally, I owe a great deal to my patients. Every patient I see in the office represents a unique opportunity—a problem I want to solve. I’m inspired by my patients to conduct research that is meaningful to them and projects that can help my surgery colleagues to address problems that vex them.

John: Asif Ilyas had a big influence on me in residency and inspired me to pursue research. He was a fellow under you (David) at Massachusetts General Hospital and was the residency program director at Temple when I was in residency. He gave us a lot of opportunity and also encouragement. I think that’s a lot of what I needed when I first got started.

David: I think we owe a lot to the mentors you mention. People who start and encourage a passion for research. You’ve all been very open about the joys and opportunities of research.

I think young researchers, and even people in the midst of their career who are interested in research reading this will be inspired. They’ll see some of the struggles that you’ve had, but also your passion and they will be devoted as much as ever to figuring out what works, and being able to make accurate predictions for our patients—our primary inspiration.

For them we need to figure out what really helps as opposed to what seems to help or holds great appeal. I hope this will also inspire the established researchers as mentors. One of my greatest joys is to mentor the next researcher. To light that fire under the next generation: that passion, that love of research.

So anyone reading this who needs a little guidance, needs a little support and advice, I think all of us would be more than willing to help mentor them.
From the Research Committee

The AAHS Research Committee continues to work towards the AAHS mission with the launch of the AAHS Research Listserv, a global network of experienced researchers focusing in hand care studies. This system serves as a forum to discuss ongoing research projects; to discuss potential projects for feedback; to provide support and resources for those just beginning research careers; and as a network for collaboration and coordination.

Our hope is that this forum of front end peer reviews will result in creation of stronger studies, creative collaboration and higher quality research.

To join this active research support group, email contact@handsurgery.org with your preferred email address to be added to the system.

External Surveys

The Association is regularly solicited to distribute surveys to AAHS membership, however, we want to control the quantity and quality of external surveys distributed throughout the year. The Research Committee has created strict guidelines and new protocol has been put in place. Please be aware that any external survey distributed in the future will have been vetted through the Research Listserv and approved by the Research Committee. Members will only receive external surveys that the Research Committee feels are in line with the goals of AAHS and HSE. If you would not like to receive survey requests from the Association in the future, aside from AAHS based evaluations, an opt out option will be available within every e-blast.

Process for external survey requests:
1. Survey request is sent to contact@handsurgery.org. Instructions are sent to the survey author regarding approval process.
2. Survey must be vetted through the Research Listserv for evaluation and feedback. Once author has received feedback, the survey is submitted to the Research Committee for consideration.
3. Final survey request is sent to the Research Committee. Survey author must submit the following with request:
   - Expected timeline of completion
   - Purpose/background/methods/expectations/justification/format
   - Target audience (surgeons, therapists, specialties etc.)
   - Final survey questions
   - $250 donation to HSE is encouraged
4. Survey approved or not approved by Research Committee.
5. Survey link and cover letter distributed to membership via e-blast, clearly stating the topic of the survey so AAHS members can easily identify if it relates to his/her practice. The AAHS members choose to proceed to the survey or not.
6. A solicitation will be sent post-survey distribution to encourage the survey author to make a donation to Hand Surgery Endowment, if they have not done so already.
7. A second reminder e-blast is sent to AAHS members one week after the original e-blast survey is distributed.

Please feel free to email contact@handsurgery.org with any questions regarding the external survey request process. Thank you in advance for participating in these surveys which the Research Committee feels are in line with the goals of the Association and Hand Surgery Endowment.

Important Grant Application Deadline Reminders:

October 1 | 2015 AAHS Annual Research Grant
The American Association for Hand Surgery awards Annual Research Grants to clinicians and therapists in private or academic practice for small clinical studies focused in hand care, or for pilot studies leading to a more major hand care study.

December 1 | AAHS/PSF Combined Pilot Research Grant
The AAHS and PSF are committed to increasing the amount of research funding dedicated to funding pilot research studies that set the stage for applications to larger funding agencies.

For Additional Information, please click here to visit the AAHS Website.
Lisa Cyr is the current Junior Affiliate Director At Large for the American Association for Hand Surgery. She has been an active member since 2009 when she was introduced to the Association by Sharon Andruskiwe, Lynn Bassini and Dr. Steven McCabe while she was in Guatemala on her first of three missions with the Guatemala Healing Hands Foundation.

Lisa graduated from Colorado State University with a B.S. in Occupational Therapy. After exploring many of the facets of Occupational Therapy she decided to specialize in hand therapy. She has specialized in orthopedic intervention for the hand and upper extremity for over 20 years and still loves it! She became a Certified Hand Therapist (CHT) in 1996 and was employed at an orthopedic clinic in CT for the past 13 years where she worked her way up from a staff OT to the primary hand therapist and manager of the Physical Therapy Department of 18 staff. Last summer she decided to simplify her life and focus on her passion; treating patients. She resigned and accepted a position at Coastal Orthopaedics in Norwalk CT where she is one of two occupational therapists working with two board certified hand surgeons. She is happier than she’s been in years!

Lisa also teaches as an adjunct faculty at Sacred Heart University part-time. She recently returned to school to attain her Clinical Doctorate in Occupational Therapy, and completed her Capstone Project on Conservative Interventions for Women with Basal Joint Disease. She converted this project into a simple website: www.ProtectYourThumbs.com, targeted at women with pain at the first CMC, who are doing a preliminary internet search for potential causes and solutions to their pain before it progresses to the point of seeking medical attention.

Lisa is active in the hand therapy community and is also a member of ASHT, AOTA, and CONNOTA. She has lectured both nationally and internationally on various hand therapy topics, and was privileged to be invited to participate in two Hand Therapy Think Tanks with many of the leaders in the hand therapy community. She has authored a peer-reviewed journal article and book chapter. She is currently collaborating on a project with Kris Valdes, the current Senior Affiliate Director At Large of AAHS.

In her spare time, Lisa loves to hike with her dogs, cycle, kayak, garden, and explore the country from the back of her husband’s motorcycle.
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Download the HAND journal mobile app! The app is available to AAHS members for download on Apple devices in the App Store by searching for “HAND Journal” or “AAHS Journal”, and provides instant access to all current and past issues of the journal.

Once the app has downloaded to your device, you will need to login with your personal AAHS username and password once for authentication (contact the AAHS administrative office to obtain your personal username and password).

Members can use the app functions to browse volumes and full text articles, search for work by specific authors, and more.