

Satisfaction with Career Choice among U.S. Plastic Surgeons: Results from a National Survey

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Background: The authors' purpose was to describe patterns and correlates of satisfaction with career choice among U.S. plastic surgeons.

Methods: A mailed, self-administered survey was sent to 708 U.S. plastic surgeons who were randomly sampled from the American Society of Plastic Surgeons registry (71 percent response rate, $n = 505$). The dependent variable was satisfaction with the decision to become a plastic surgeon, which was created from a scale of four validated questions measuring decisional satisfaction and decisional regret. The independent variables included surgeon and practice characteristics. Logistic regression was used to evaluate associations between satisfaction with the decision to become a plastic surgeon and independent factors.

Results: Few respondents (4 percent) regretted becoming plastic surgeons. Factors independently associated with greater satisfaction with the decision to become a plastic surgeon included group practice compared with solo practice (odds ratio, 1.65; 95 percent confidence interval, 1.0 to 2.71), resident educator (odds ratio, 1.88; 95 percent confidence interval, 1.06 to 3.31), and a highly cosmetic practice mix: primarily cosmetic versus primarily reconstructive (odds ratio, 2.42; 95 percent confidence interval, 1.25 to 4.66) and mixed versus primarily reconstructive (odds ratio, 1.59, 95 percent confidence interval, 0.92 to 2.76). Demographic factors such as age and gender were not associated with surgeon satisfaction.

Conclusions: Overall, the majority of plastic surgeons are satisfied with their career choice despite the current health care and economic environment. Factors significantly associated with greater satisfaction with career choice included group practice, involvement in resident education, and a highly elective cosmetic practice. (*Plast. Reconstr. Surg.* 126: 636, 2010.)

Plastic surgeons' satisfaction with career choice has important implications regarding future workforce shortages and the quality of patient care the specialty provides. There are many reasons why surgeons may be less satisfied with their career choice. Reimbursement for plastic surgery procedures is declining¹⁻³; overhead is rising⁴; professional competition is increasing^{5,6}; and the environment in which medicine is practiced is becoming more litigious, with continu-

ously increasing malpractice premiums.^{7,8} Workplace stress may be further amplified by the 2008 economic recession and impending health care reform. It is possible that these factors are contributing to the intention of many plastic surgeons to leave practice earlier than physicians in other specialties. In 2006, over 50 percent of active plastic surgeons in the United States were older than 50 years and were planning on early retirement.⁹ These older surgeons reported being highly satisfied with their career choice but indicated that their plans for retiring earlier than physicians in other specialties were fueled by rising malpractice costs, declining reimbursement, and competitive forces.⁹ Early retirement will worsen the imped-

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ing workforce shortages in surgery. It is important to identify how large of a problem this is for plastic surgery so that interventions can be designed to improve surgeons' quality of life and ultimately maintain a stable workforce.

Career satisfaction of providers has been linked to the delivery of high-quality care.¹⁰ However, previous work has concentrated mainly on primary care specialties.^{11,12} We know little about the factors that contribute to the satisfaction with career choice for surgical specialties. Understanding the significant modifiers of career satisfaction has implications for helping surgeons-in-training make better career decisions and improving work-life conditions for those currently in practice, and may ultimately improve the provision of surgical care.

Our purpose was to use a national sample of plastic surgeons to describe the proportion of surgeons who are not satisfied with their career decision and at risk for early retirement. We also wanted to identify factors associated with satisfaction with the decision to become a plastic surgeon. In particular, we wanted to evaluate the impact of different surgeon characteristics (e.g., age and gender) and practice characteristics (e.g., case mix, work hours, and call responsibilities) on satisfaction with the decision to become a plastic surgeon.

MATERIALS AND METHODS

Study Population

We mailed a self-administered survey to a national sample of plastic surgeons in the United States to evaluate satisfaction with their career choice. Women were oversampled so that there was sufficient study power to evaluate differences by surgeon gender. A total of 708 plastic surgeons (354 male and 354 female surgeons) were sampled randomly from the American Society of Plastic Surgeons membership. Surgeons were mailed a self-administered survey containing a \$10 cash gift.^{13,14} Within 4 weeks, nonresponders were mailed a reminder letter and duplicate questionnaire. Follow-up letters were sent to responders with missing questions to improve the completeness of the data set. The response rate was 71 percent ($n = 505$). Approximately half of the responses came from the initial mailing, and the other half came from the follow-up mailing. The study protocol was approved by the Institutional Review Board of the University of Michigan.

Measures

Our primary outcome was a measure of surgeon satisfaction with career choice. The measure

was developed from four individual items: two items each from established decisional satisfaction and decisional regret scales, respectively.^{15,16} We modified these instruments for our study population to evaluate satisfaction with and regret related to the choice of a plastic surgery career. Specifically, surgeons were asked whether becoming a plastic surgeon was the right decision for them; whether they would choose to become a plastic surgeon if they had to do it over again; whether they regretted becoming a plastic surgeon; and whether they were adequately informed about issues important to their decision to become a plastic surgeon. Responses were measured on a five-point Likert scale and then summed and categorized into a dichotomous measure of high satisfaction versus low satisfaction (1 to 2 versus 3 to 5). Using different cutoff points did not significantly change the results.

Additional questions were designed to address overall career satisfaction with six separate items. Surgeons were asked whether they (1) were satisfied with their career, (2) were satisfied with their income, (3) considered retraining in another medical specialty, (4) considered retraining in another surgical specialty, (5) considered retiring early (<55 years old), and (6) would encourage their child (or close relative) to choose a career in plastic surgery. Responses were measured on a five-point Likert scale and then summed and categorized into a dichotomous measure of strongly agree versus strongly disagree (1 to 2 versus 3 to 5). Using different cutoff points did not significantly change the results. Therefore, we used the more stringent cutoff for dichotomizing the data (1 to 2 rather than 1 to 3), which allows us to identify factors associated with very high levels of satisfaction.

The independent variables included (1) surgeon characteristics (i.e., age, gender, marital status, and number of children) and (2) professional characteristics (i.e., practice size, resident training, amount of emergency room call, and work hours per week). Surgeon age was categorized into four groups: younger than 40, 41 to 50, 51 to 60, and older than 60 years. Surgeon gender was a two-level categorical variable. Marital status was grouped as married/partnered, single-divorced, and single/never married. Practice size was dichotomized into solo versus group with two or more physicians. Participation in resident training was dichotomized: yes versus no. Emergency room call was dichotomized into none versus one or more calls per month. Approximately half of the sample reported working less than 60 hours per

week. We therefore chose this as a cutoff to dichotomize work hours into 60 or fewer versus more than 60 hours per week. Furthermore, practice mix was described as the proportion of cosmetic cases the surgeon performed, where less than 25 percent was considered “primarily reconstructive,” 25 to 75 percent was considered “mixed practice,” and more than 75 percent was considered “primarily cosmetic.” Of note, we did evaluate the association between our satisfaction outcomes and type of practice (e.g., academic, private, and managed care) and found no significant differences.

Statistical Analyses

We first described surgeons’ practice mix across all independent variables. The Pearson chi-square test was used for the bivariate analyses between the practice mix and categorical independent variables. We then performed a multivariate logistic regression to evaluate factors associated with high satisfaction with the decision to become a plastic surgeon. Odds ratios and associated 95 percent confidence intervals were calculated for each of the independent variables in the multivariate logistic regression model. In the case of categorical variables (such as participation in resident training), the odds ratio measures the odds of being satisfied for the indicated category rela-

tive to the reference category. For example, in comparing satisfaction with career choice for surgeons by participation in resident training (with “those that do not” being the reference variable), an odds ratio of 1.88 indicates that surgeons who participate in resident training are almost twice as likely to be satisfied with their career choice compared with those who do not participate in resident training.

The Wald test and the likelihood ratio test were used to test the significance of individual predictive variables, and the model chi-square statistic was applied to test the overall significance of the model. We tested for second-order interactions between surgeon gender and independent variables that were significant in the bivariate analyses. None of the interactions was statistically significant; therefore, results were presented without inclusion of interaction terms. Lastly, we evaluated each of the six overall career satisfaction items by surgeon and practice characteristics. Responses were shown by case mix, which was the only significant variable in the Pearson chi-square bivariate analyses. All statistical tests were performed with Stata version 8.0 (Stata Corp., College Station, Texas).

RESULTS

Table 1 lists surgeon and practice characteristics of the study population by case mix, repre-

Table 1. Surgeon and Practice Characteristics by Proportion of Cosmetic Case Mix

	Primarily Reconstructive (<i>n</i> = 134) (%)	Mixed (<i>n</i> = 213) (%)	Primarily Cosmetic (<i>n</i> = 150) (%)	<i>p</i>
Surgeon characteristics				
Age				0.008
<40 years	10.5	7.1	2.0	
41–50 years	47.0	40.3	43.9	
51–60 years	33.6	46.0	49.3	
>60 years	9.0	6.6	4.7	
Gender				0.360
Male	52.2	51.1	44.7	
Female	47.8	48.8	55.3	
Marital status				0.001
Married/partnered	75.4	85.4	82.0	
Single-divorced	9.0	10.4	13.3	
Single-never married	15.7	4.3	4.7	
Practice characteristics				
Practice size				<0.001
Solo	38.8	58.2	70.7	
Group ≥2	61.2	41.8	29.3	
Participate in training residents				<0.001
Yes	41.5	30.3	18.0	
ER call days per month				<0.001
None	19.4	26.3	58.7	
≥1	80.6	73.7	41.3	
Work hours per week				0.002
≤60 hours	67.0	76.9	87.2	
>60 hours	33.0	23.1	12.8	

ER, emergency room.

sented by the proportion of cosmetic surgery. Surgeons with a primarily reconstructive practice were significantly younger ($p = 0.008$) and more likely to never have been married ($p = 0.001$) compared with those performing more cosmetic surgery. Surgeons who had a primarily reconstructive practice were also significantly more likely to be in group practice ($p < 0.001$), participate in resident training ($p < 0.001$), take more emergency room call ($p < 0.001$), and work more hours per week ($p = 0.002$) than those with a primarily cosmetic practice.

Table 2 describes the distribution of responses for each of the four items in our model measuring the satisfaction with the decision to become a plastic surgeon. Almost all respondents (93 percent) felt that becoming a plastic surgeon was the right decision for them, and 78 percent of the sample said they would make the same career choice if they had to do it over again. Two-thirds of respondents also felt that they were adequately informed about issues important to their decision to become a plastic surgeon. Very few (4 percent) regretted pursuing plastic surgery as a career.

Table 3 lists the results of the logistic regression, which evaluated significant correlates of satisfaction with the decision to become a plastic surgeon. Factors associated with being highly satisfied versus less satisfied with the decision to become a plastic surgeon included having a primarily cosmetic practice (cosmetic versus reconstructive: odds ratio, 2.42; 95 percent confidence interval, 1.25 to 4.66); being in a group practice (versus solo practice: odds ratio, 1.65, 95 percent confidence interval, 1.00 to 2.71); and participation in training residents (odds ratio, 1.88, 95 percent confidence interval, 1.06 to 3.31). Demographic factors such as age and gender were not significantly associated with the

respondent's satisfaction with the decision to become a plastic surgeon.

Table 4 describes plastic surgeons' overall career satisfaction by practice mix. Compared with those with a mixed or primarily cosmetic practice, those with a primarily reconstructive practice were significantly less likely to be satisfied with their career (83 percent and 86 percent versus 72 percent, respectively; $p = 0.01$) and with their income (45 percent and 58 percent versus 44 percent, respectively; $p = 0.029$). The primarily reconstructive surgeons also appeared to be more uncertain about their career choice compared with the other groups. Primarily reconstructive surgeons compared with those with a mixed or primarily cosmetic practice were significantly more likely to have considered pursuing another surgical specialty (17 percent versus 10 percent and 7 percent, respectively; $p = 0.022$).

DISCUSSION

In this national physician survey, we found that the majority (93 percent) of respondents were satisfied with their decision to become a plastic surgeon. Almost two-thirds of surgeons were not considering early retirement and nearly half would encourage their own children or close relatives to pursue a career in plastic surgery. However, it did appear that more isolated surgeons such as those in solo practice and those not involved with resident education were less satisfied with their decision to become a plastic surgeon compared with their counterparts. We also found that surgeons who had a primarily reconstructive practice mix were less satisfied with their career choice compared with those with a more balanced or primarily cosmetic practice mix. Significantly fewer reconstructive surgeons reported being satisfied with their careers and their incomes, and nearly one-fifth of these surgeons had considered retraining in another surgical specialty.

Over half of our study sample was professionally isolated (i.e., in solo practice and/or not involved with resident education) and at risk for dissatisfaction with their career choice. Professional isolation has also been associated with diminished professional growth and poor clinical performance in other specialties such as primary care physicians practicing in rural locations or in solo practices.¹⁷ Isolated physicians in any specialty may be confronted with a wide range of nonclinical responsibilities that involve the business of medicine and detract from the gratifying aspects of patient care. Isolated physicians also have limited resources for sharing clinical ideas

Table 2. Proportion of Respondents Satisfied with the Decision to Become a Plastic Surgeon*

	Strongly Agree/ Agree (%)
Becoming a plastic surgeon was the right decision for me.	92.9
I would decide to become a plastic surgeon if I had to do it over again.	78.0
I am satisfied that I was adequately informed about the issues important to my decision to become a plastic surgeon.	64.6
I regret becoming a plastic surgeon.	3.70

*Measured on a five-point Likert scale (strongly agree to strongly disagree).

about difficult cases with colleagues and have limited coverage for patient care responsibilities. Furthermore, surgeons in solo compared with group practices are less able to attend national societal meetings.¹⁸ These factors may contribute to increased clinical burden and increased intellectual isolation and result in diminished satisfaction in career choice among plastic surgeons.

Table 3. Multivariate Analysis of Respondents' Satisfaction with the Decision to Become a Plastic Surgeon

Independent Variables	Satisfaction with the Decision to Become a Plastic Surgeon*	
	Adjusted OR	95% CI
Surgeon characteristics		
Age		
<40 years	1.00	—
41–50 years	0.99	0.41–2.43
51–60 years	0.99	0.40–2.47
>60 years	2.17	0.57–8.26
Gender		
Male	1.00	—
Female	0.83	0.52–1.30
Marital status		
Married/partnered	1.00	—
Single-divorced	0.79	0.40–1.55
Single-never married	1.46	0.60–3.54
Practice characteristics		
Case mix		
Primarily reconstructive	1.00	—
Mixed	1.59	0.92–2.76
Primarily cosmetic	2.42	1.25–4.66
Practice size		
Solo	1.00	—
Group ≥2	1.65	1.00–2.71
Participate in training residents		
No	1.00	—
Yes	1.88	1.06–3.31
ER call days per month		
None	1.00	—
≥1	0.65	0.39–1.1
Work hours per week		
≤60 hours	1.00	—
>60 hours	1.29	0.74–2.24

OR, odds ratio; CI, confidence interval; ER, emergency room.
 *Constructed from four items with 5-point Likert scales measuring satisfaction with the decision to become a plastic surgeon.

We can only speculate as to why surgeons who have a mostly reconstructive practice have diminished satisfaction with their decision to become a plastic surgeon. Primarily reconstructive surgeons face many challenges to patient care. Reconstructive cases are complex and time-consuming and are often performed in patients with lower baseline health status because of cancer or traumatic injuries. Postoperative complications also tend to be higher in reconstructive compared with elective cosmetic surgery cases. These cases require a great deal of preparation and planning and high levels of coordination with multidisciplinary teams. These complexities often add urgency to reconstructive efforts to avoid delays in treatment by multidisciplinary teams. Furthermore, reconstructive surgeons are at risk for limited third-party reimbursement that often does not adequately reflect the intensity of these procedures, as demonstrated by reimbursement for autogenous tissue procedures for postmastectomy breast reconstruction.³ These many challenges may contribute to reconstructive surgeons' diminished satisfaction with the decision to become a plastic surgeon.

There is little research about the career satisfaction across different surgical specialties with which to compare our results. However, the plastic surgeons in our study were generally more satisfied with their career choice than surgical oncologists, of whom only 79 percent were satisfied with their career choice in a study conducted by Kuerer et al.^{19–21} Our study also supports the findings of others in which surgeon gender was not a significant predictor of career satisfaction.^{19,22–24} Advanced surgeon age, in other studies, has been a significant predictor of greater career satisfaction.^{9,19,25,26} Our study shows a trend for this association, although age was not significantly associated with career satisfaction once we controlled for other personal

Table 4. Plastics Surgeons' Overall Career Satisfaction

	Primarily Reconstructive (n = 134) (%)	Mixed (n = 213) (%)	Primarily Cosmetic (n = 150) (%)	p
Career satisfaction				
Satisfied with career	72.2	82.8	85.7	0.010
Satisfied with income	44.4	45.0	57.8	0.029
Would encourage their child (or close relative) to pursue a career in plastic surgery	33.1	44.5	44.0	0.081
Career uncertainty				
Considered pursuing another medical specialty	12.0	9.6	6.7	0.299
Considered pursuing another surgical specialty	16.5	9.6	6.7	0.022
Considered early retirement (<55 years old)	43.6	36.4	34.0	0.222

and practice characteristics. A more satisfied older cohort of surgeons may be attributed to the phenomenon of the dissatisfied surgeons “dropping out,” or retiring, at a younger age.^{9,25}

Limitations

Our findings should be interpreted in the context of some limitations. Our analyses may be subject to response bias because those who responded may have had higher levels of satisfaction than those who did not. However, our high response rate (71 percent) suggests that our sample was highly representative of the national population of U.S. plastic surgeons. Also, our data were derived from self-report and were subject to respondent recall and physician interpretation biases. Lastly, our study was performed during a unique economic climate in the United States, which has likely altered the responses of many surgeons regarding their current financial situation.

Implications

Our findings have important implications for practicing plastic surgeons in the United States. The surgeons who practice in the solo setting and/or without interaction with surgical residents are more likely to suffer from stresses borne from the isolated settings in which they practice. These surgeons may consider the benefits of practicing in a group setting or engaging in resident teaching activities, which could help lessen their burden of clinical care responsibilities. In addition, the development of highly interactive online virtual forums and conferencing, similar to those implemented by the American College of Surgeons,²⁷ may help provide resources for solo practitioners to interact with their peers. Group practice may also provide financial help to reconstructive surgeons through greater negotiating power with third-party carriers.²⁸ Finally, health policy efforts should be aimed at improving third-party reimbursement for reconstructive services. Reimbursement must match the intensity of services provided to ensure the future availability of complex reconstructive procedures, such as autogenous tissue postmastectomy breast reconstruction.³ Future efforts should focus on supporting more isolated surgeons and those performing complex reconstructive surgery to maintain this important component of the plastic surgery workforce.

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REFERENCES

1. Krieger LM, Lee GK. The economics of plastic surgery practices: Trends in income, procedure mix, and volume. *Plast Reconstr Surg.* 2004;114:192–199.
2. Egger E. Changes in plastic surgery laws pose challenges, opportunities for hospitals. *Health Care Strateg Manage.* 1999; 17:14–15.
3. Alderman AK, Storey AF, Nair NS, Chung KC. Financial impact of breast reconstruction on an academic surgical practice. *Plast Reconstr Surg.* 2009;123:1408–1413.
4. Krieger LM. The changing health care marketplace: Current industry trends, new provider organizational structures, and effects on plastic surgeons. *Plast Reconstr Surg.* 1998;102:900–907.
5. Krieger LM, Shaw WW. Aesthetic surgery economics: Lessons from corporate boardrooms to plastic surgery practices. *Plast Reconstr Surg.* 2000;105:1205–1210; discussion 1211–1212.
6. Krieger LM, Shaw WW. The effect of increased plastic surgeon supply on fees for aesthetic surgery: An economic analysis. *Plast Reconstr Surg.* 1999;104:559–563; discussion 564–565.
7. Mavroforou AG, Giannoukas A, Michalodimitrakis E. Medical litigation in cosmetic plastic surgery. *Med Law* 2004;23: 479–488.
8. McKinley A. Health care providers and facilities: Medical malpractice and tort reform—2005. End of Year Issue Brief. *Issue Brief Health Policy Track Serv.* 2005;Dec 31:1–19.
9. Rohrich RJ, McGrath MH, Lawrence TW. Plastic surgeons over 50: Practice patterns, satisfaction, and retirement plans. *Plast Reconstr Surg.* 2008;121:1458–1474; discussion 1475–1477.
10. Williams ES, Skinner AC. Outcomes of physician job satisfaction: A narrative review, implications, and directions for future research. *Health Care Manage Rev.* 2003;28: 119–139.
11. Leigh JP, Kravitz RL, Schembri M, Samuels SJ, Mobley S. Physician career satisfaction across specialties. *Arch Intern Med.* 2002;162:1577–1584.
12. Wetterneck TB, Linzer M, McMurray JE, et al. Worklife and satisfaction of general internists. *Arch Intern Med.* 2002;162: 649–656.
13. Cummings SM, Savitz LA, Konrad TR. Reported response rates to mailed physician questionnaires. *Health Serv Res.* 2001;35:1347–1355.
14. Bourque L. *How to Conduct Self-Administered and Mail Surveys.* London: Sage; 1995.
15. Holmes-Rovner M, Kroll J, Schmitt N, et al. Patient satisfaction with health care decisions: The satisfaction with decision scale. *Med Decis Making* 1996;16:58–64.
16. Brehaut JC, O'Connor AM, Wood TJ, et al. Validation of a decision regret scale. *Med Decis Making* 2003;23:281–292.
17. St George IM. Professional isolation and performance assessment in New Zealand. *J Contin Educ Health Prof.* 2006;26: 216–221.
18. Schroen AT, Brownstein MR, Sheldon GF. Comparison of private versus academic practice for general surgeons: A

- guide for medical students and residents. *J Am Coll Surg.* 2003;197:1000–1011.
19. Kuerer HM, Eberlein TJ, Pollock RE, et al. Career satisfaction, practice patterns and burnout among surgical oncologists: Report on the quality of life of members of the Society of Surgical Oncology. *Ann Surg Oncol.* 2007;14:3043–3053.
 20. Kuerer HM, Breslin T, Shanafelt TD, Baile WF, Crawford W, Balch CM. Road map for maintaining career satisfaction and balance in surgical oncology. *J Am Coll Surg.* 2008;207:435–442.
 21. Balch CM, Copeland E. Stress and burnout among surgical oncologists: A call for personal wellness and a supportive workplace environment. *Ann Surg Oncol.* 2007;14:3029–3032.
 22. Mizgala CL, Mackinnon SE, Walters BC, Ferris LE, McNeill IY, Knighton T. Women surgeons: Results of the Canadian Population Study. *Ann Surg.* 1993;218:37–46.
 23. Keeton K, Fenner DE, Johnson TR, Hayward RA. Predictors of physician career satisfaction, work-life balance, and burnout. *Obstet Gynecol.* 2007;109:949–955.
 24. McMurray JE, Linzer M, Konrad TR, Douglas J, Shugerman R, Nelson K. The work lives of women physicians results from the physician work life study. The SGIM Career Satisfaction Study Group. *J Gen Intern Med.* 2000;15:372–380.
 25. Campbell DA Jr, Sonnad SS, Eckhauser FE, Campbell KK, Greenfield LJ. Burnout among American surgeons. *Surgery* 2001;130:696–702; discussion 702–705.
 26. Bruce SM, Conaglen HM, Conaglen JV. Burnout in physicians: A case for peer-support. *Intern Med J.* 2005;35: 272–278.
 27. American College of Surgeons. Live Practice Management Webcasts. Available at: <http://www.yourmedpractice.com/acs>. Accessed May 10, 2010.
 28. Casalino LP, Devers KJ, Lake TK, Reed M, Stoddard JJ. Benefits of and barriers to large medical group practice in the United States. *Arch Intern Med.* 2003;163:1958–1964.

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