of the techniques used in these procedures overlap with core principles/procedures in these specialties; however, these are on cis-gender patients. There are unique challenges that are inherent in taking care of transgender patients. The World Professional Association for Transgender Health Clinical Guidelines establish a framework for delivering truly comprehensive, collaborative care, a model that goes beyond time spent in the operating room.[4] To consider surgery alone, there are 43 different procedures that can be performed for both male-to-female and female-to-male patients. The surgical algorithm must be optimized for each individual. Preoperatively, clinicians must understand World Professional Association for Transgender Health guidelines and appreciate the medical, legal, and ethical implications of their work.[2] For example, hospital administration will not prevent a credentialed surgeon from booking a phalloplasty for a transmale patient; however, if the surgeon did not ensure that two high-quality letters were obtained from different mental health specialists, they could be placing the patient, themselves, and the hospital at risk. There are also numerous postoperative concerns to consider as well. Surely, these are accepted realities for any surgeon, but proficiency in managing these complications can only come by means of extensive experience, which is certainly in excess of 18 hours during residency training.

The preparedness of surgical centers must also be considered. Although many procedures can be performed in an outpatient surgery center, for patients that are higher risk or undergoing more complicated procedures, a hospital setting is more appropriate. Most hospitals currently define and require proof of proficiency with specialty-specific procedures before granting privileges to treating surgeons. Many U.S. hospitals have begun mandating that surgeons who seek to perform gender-affirmation surgery be fellowship trained in the field or be proctored by an already credentialed gender surgeon. Weekend instructional courses on gender surgery, for all their utility and importance, will not provide the surgeon with sufficient training and skills to perform these complex procedures, thereby placing the patient at increased risk of morbidity and mortality.

We are presently at a unique crossroads, where the health care field has the opportunity to recognize and treat patients with gender dysphoria on a scale that was previously unattainable. However, with this opportunity comes tremendous responsibility. It is incumbent on all of us who seek to treat this previously vulnerable population to recognize the complexity involved and current lapse in traditional medical training. Through increased awareness and dialogue, we can propagate the number of qualified surgeons to treat the growing needs of our patients. This can be accomplished by changes to current medical curriculum, or more acutely, by offering fellowships in subspecialty training for those with a desire to safely and ethically take care of patients with gender dysphoria.

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Digital Native Plastic Surgeons

Sir:

I wanted to share these reflections with the teachers of future plastic surgeons. I learned to operate yesterday, with the information from before yesterday, so I consider myself a "digital immigrant," but still training plastic surgeons of the generation of "digital natives" and that were born after 1982.

I met an emotionally stable, sociable, perfectionist, and transparent generation of general surgeons, with high expectations and motivated to serve patients; also disciplined, persevering, and persistent and who wanted to receive information immediately, because they grew under the principle of reward. I also noticed that they make quick decisions, show greed for links and hypertexts (random digital access) instead of content, and properly use their memory, which is more superficial.

They have given up their privacy in a natural way. They share and distribute the information they receive,

and do not hide anything because they know that everything is in the network. They no longer believe that "knowledge is power," because now the Internet is the power.

They have developed their own tools to solve problems. They are attracted by multitasking and parallel processes. They prefer graphics to text. They yield more and work better when they are online. They prefer virtual instead of face-to-face instruction and much better if it is through play concepts. They are not fond of the traditional repetitive surgical work and are self-taught.

They read very little of books and much on websites. They depend on and are eager for technological growth, entertainment technology, and social networks. They are comfortable with consumerism and hedonism and operate on the basis of cross-cutting organizations.

They learn by "immersion" in virtual and augmented reality, and also by holographic projection. They permanently say that "everything is online" but they recognize as indispensable the "face-to-face" work with the teachers, because they look for and respect their figure, to reinforce their knowledge and content.

They were born surrounded by computers, cell phones, video games, and the Internet[1] and were raised using the "digital language" that is "postsymbolic" because it uses mathematical logic to introduce digital images and is representative of a function that does not refer to any previous reality. This new digital or numeric image means an historical emergence of a new type of figure elaborated by means of mechanical instruments, which does not interfere with any type of analogic reproduction (necessarily comparative with respect to some type of reality that precedes it), but is constructed translated in terms of the mathematical model that originates it.

After reporting on these neurocognitive characteristics of these new surgeons younger than 40 years, I must add that I am impressed by their comfort with this consumer and free-market society, where money means transactional power and their efficiency in obtaining it. However, I think I have read from them that what is most precious (more than money and more than power) is their time.

Finally, I suggest to the teachers of these digital native plastic surgeons, to offer them a lot of opportunities and possibilities and keep them always challenged and busy, with many projects, jobs, and with permanent feedback, and never forget that they see us as mentors (by our greater experience) and rank us based on concepts of help, advice, recommendations, guidelines, transparent relationships, and shared experiences.

In the end, a word of warning: these new surgeons react to what they consider "intellectual pride" of some of their mentors, because they perfectly distinguish between strategy and tactics. The strategy is the plan that specifies a series of steps and concepts and that has as the purpose the attainment of a certain objective, and that these surgeons with their practical intelligence and reasoning, already have integrated, because it is already on the web. Tactics, in contrast, is a method that helps to put resources in order to obtain an objective, and this is what they do not find on the web, and where teachers are sought and recognized as "indispensables."

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A Hidden Legacy of D. Ralph Millard, Jr., M.D.

Sir:

I recently found my "soft" notes of Dr. Ralph Millard Jr.'s thoughts during my fellowship in Miami. He was a man of principles and integrity, but at the same time rough, demanding and, for many, unmannered.

Several times I finished assisting him in his operations between tears. He once asked me to drive his Cadillac back to his office and he talked to me about an "indivisible" internal consistency, and that he represented as "personal integrity" consisting of a wide range of attributes, such as honesty, respect for others, being direct, appropriate, neat, disciplined, and congruent. He also said that integrity was doing the right thing, even when you were not being watched.

For Dr. Millard, we, residents and fellows, were nothing more than a combination of beliefs, words, and actions. Many of us did not realize that one of the causes of his anger was because we did not have a point of view and we were satisfied with the acceptance of his opinions without objections.

From my notes, I wanted to highlight the firm adherence of Dr. Millard to a strict morality, to a code of conduct in relation to the care of words, obligations, incorruptibility, violation of the principle of temptations, expenses and preferences of others, and his contempt for those who welcome a disposition to change