MAXILLOFACIAL NEWS

American Society of Maxillofacial Surgeons

INSIDE THIS ISSUE

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FROM THE PRESIDENT

Robert J. Havlik, MD
Indiana University School of Medicine

It is a pleasure to update the membership on the current ***State of Affairs*** of the American Society of Maxillofacial Surgeons and provide a glimpse ahead to what promises to be a fantastic ***Annual Scientific Meeting*** in New Orleans this month. As is usual, education figures foremost in the Society's activities. The Society has been hard at work providing educational courses for its membership, as well as other trainees. Over the course of the past twelve months, the Society has sponsored and coordinated five separate major educational courses, as well as last year's Annual Scientific Meeting. These included a fantastic pre-conference symposium coordinated by Dr. Henry Vasconez which was attended by well over one hundred surgeons. Our core educational course, *Basic Maxillofacial Principles and Techniques,* was offered in both San Francisco and Chicago, and both of

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To Be or Not to Be…….. ACGME

Joseph K. Williams, MD
Fernando Burstein, MD

Substantive arguments can be made for both sides of a question regarding the role of the ACGME in craniofacial fellowships. Without a doubt the ACGME is critical for organizing , coordinating and maintaining quality over an incredibly complex and important process. It works. Furthermore, it is difficult to argue with the need for some level of quality control and oversite in medical training, even more these days with the need for accountability and transparency.

The question is obvious, 'what is the best way to insure that our specialty continues to consistently produce the best trained and the most innovative surgeons possible?' Maybe the answer is not exclusive of each other. Let me start with several aspects of craniofacial training that may make it difficult to assume completely the current mantle of ACGME monitoring.

Historically, the specialty has existed as a small and unique component of the plastic surgery landscape. The skills and understanding of this specialty has a strong tradition of apprenticeship and a craftsman approach. Many fellowship candidates are promoted by program directors or

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Editor's Column: An Insider's View of the ASMS Visiting Professor Program

Arun Gosain, MD, Lurie Children's Hospital

The ASMS maintains several valuable positions in which I have been honored to serve. Serving as Editor of the *Maxillofacial News* is one position that has been of benefit to me as I have been able to view the highlights and evolution of our organization firsthand and to share these highlights with our membership. Another program in which I have been honored to serve is the ASMS Visiting Professorship, organized by Delora Mount and her committee. I will take the editorial liberty of addressing this column from the perspective of an ASMS Visiting Professor

In 2011-2012, the ASMS sponsored 5 visiting professors, Richard Hopper (Seattle Children's Hospital), Joseph Losee (Children's Hospital of Pittsburgh), Warren Schubert (Regions Hospital of the University of Minnesota), Michael Yaremchuk (Harvard Medical School) and me. The professorship had a banner year with each professor visiting 6 to 10 programs during their one-year term. This provided approximately 45 visits for the visiting professors during the year, which comprises about half of the training programs in plastic surgery in the United States. Therefore, the ASMS Visiting Professorship is one of the most visible programs that the organization sponsors, and without question, one of the most valuable.

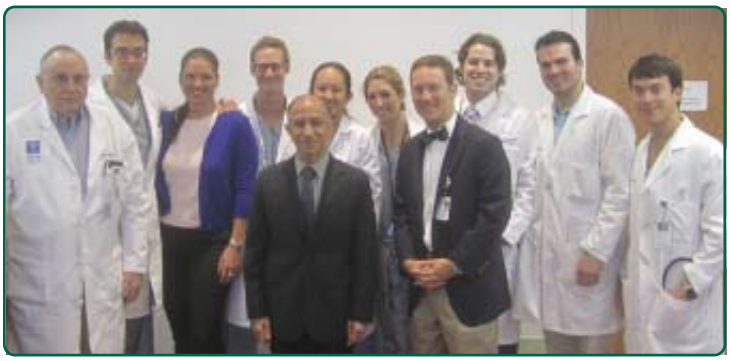
During my year as visiting professor, I was fortunate to be able to visit 9 centers. My professorship began with the Medical College of Georgia hosted by Jack Yu and Ed Ritter. Subsequent visits consisted of the University of Pennsylvania, hosted by Jessie Taylor and Joe Serletti, MD Anderson and the University of Texas, hosted by Ron Yu and Charles Butler, Grand Rapids Hospital hosted by Robert Mann, University of California San Diego, hosted by Amanda Gosman, Loyola University, hosted by Victor Cimino, Yale University, hosted by John Persing, Albert Einstein, hosted by Joseph Shin, and Mount Sinai hosted by Peter Taub and Lester Silver. As a visiting professor, I found that having the opportunity to visit my colleagues at their home institution gave me a completely different perspective on the practice patterns and lifestyles of these individuals. Although I had gotten to know my hosts over the years through our annual meetings and collegial work in our national organizations, these opportunities paled in comparison to visiting them in their home territory. To go to their workplace as a visitor versus running across them at a national meeting can be compared to going to someone's house for dinner versus meeting them at a restaurant. The former is a much more intimate exposure to the individual's lifestyle and results in a much stronger camaraderie. These visits also provided the opportunity to get to know the residents in each of these places and to interact with each of them on a personal basis. On more than one occasion I was able to serve as a resource for a resident who was looking for connections to postgraduate fellowship training. Often, I had come across such connections through my previous trips as ASMS Visiting Professor, providing an excellent avenue for cross-fertilization between programs.

The ASMS visiting professorship is clearly a win-win situation for the visiting professor and the host programs. Residents at the host institution can benefit from exposure to individuals from other institutions, not only from the perspective of education, but also from the perspective of contacts with whom they might continue to correspond as they develop specialty interests in craniomaxillofacial and pediatric plastic surgery. The visiting professor serves as an "ambassador" for the ASMS, and each visiting professor represents the message that is at the core of our organization: the ASMS is the premier organization for directed resident education in craniomaxillofacial and pediatric plastic surgery. This message is amplified since it is a 1-on-1 interaction with the residents in each program.

The ASMS offers many benefits including our ability to promote ongoing education through the newsletter and teleconferences, our upcoming textbook of maxillofacial surgery and our well established basic ASMS course and the growing advanced ASMS courses. We also offer programs for career development through our Cranio scholarships generously funded by Doug Ousterhout and our International scholarship generously funded by Ken Salyer and the World Craniofacial Foundation. While it is difficult to say that any one benefit surpasses the other, I can clearly say that the Visiting Professorship Program is one of the primary benefits of the ASMS.

The ASMS has recently announced four new visiting professors for 2012-2013, and the description of each professor can be found in the Spring edition of our Newsletter and on our website. As always, the selection has honed in on leaders in our specialty who have also distinguished themselves as premier teachers. These individuals will serve as the ambassadors to the ASMS over the coming year, and I encourage each of you to take advantage of their expertise and utilize the visiting professorship to its fullest extent.

The ASMS remains grateful to Stryker for their continued support of the ASMS Visiting Professor program.



Mt. Sinai plastic surgery program at the conclusion of Arun Gosain's 2011-2012 visiting professorship. Front Row (left to right): Lester Silver, Arun Gosain, Peter Taub. Back Row: plastic surgery residents.

Panel Discussion: Cleft Care Around the World

Panel Moderator: John A. van Aalst, MD
Panelists: Gosla Reddy, MD, Hyderabad, India
Scott Corlew, MD, Chief Medical Officer, ReSurge
Bill Magee Jr, MD, DMD, Executive Chairman, Operation Smile
Satish Kolra, Chief Programs Officer, SmileTrain

Editor's Note: *This panel discussion represents a major accomplishment, as it collates the ideas of the leaders in the major organizations addressing cleft care on a global scale. The discussion is divided into two parts. This is the second section and addresses: What do you think is the biggest mistake that newcomers make to international cleft care? Do you look at cleft care as an export product? Where do you see the biggest opportunity, the greatest opportunity to work together with other international cleft organizations? Would you say that Africa is an ideal place to begin expanding collaborative efforts like this? How does your organization ensure safety in international Cleft care? What would you say your organization's biggest safety concern is?Am I right in hearing that when an organization is financially sound, it will be safe, and it will deliver safe care? Could you comment on the statement a child with a cleft is better than a dead child. How does your organization ensure quality surgery for poor children around the world?How do you communicate within your organization that something could be done better from a surgical standpoint? What metrics tell you that a surgeon is ready? What is the best way to teach? Can you speak to the process of Quality Control in your organization?*

The first part of this discussion was published in the the Spring issue of Maxillofacial News and addressed: What is the model that your organization uses to address Cleft care needs in India, and/or the world? How has your model changed since you first started working? Do you have potential projections of how your model may change again in the future? What does your organization feel is the greatest need in international Cleft care? Should international cleft leadership come, not from the developed world, but from the developing world? Where do you think is the greatest need today in international cleft care?

John: What do you think is the biggest mistake that newcomers make to international cleft care?

Satish: I think the main mistake a lot of people make is that they try to do too much. They spread themselves too thin. I have seen number of organizations, a number of very well meaning charities, a number of very well meaning individuals, that spread themselves too thin and end up doing very little. I would say, whatever you have, resources and finances, skills, doctors, surgeons, training materials, whatever, focus on where you can get the best results. Don't try to be everything everywhere.

Gosla: The fundamental problem here is that most of the charity organizations come during a mission to help people—I call them the charities of pity—they don't know about sustainability. Cleft care is not a one-day event. It is care that needs to be delivered for years and years. So, unless the organization has created a sustainable model, this charity cannot function in cleft care. Cleft care requires dedicated and sustained efforts in one place for it to be effective, which many foundations do not understand when they enter the field. That is why we created a totally distant, but effective, model, called Reach. For it to be effective it should be corporatized. This is a model taken from some of the most organized businesses – like NY University. We understand that to make it sustainable, there needs to be an ongoing operation that is low-cost, where local doctors provide the care, organizing their own financial resources, not depending only on the charity, but generating local resources for patient care services—eventually. So, only if we can follow the corporate model, then ultimately the charity becomes more effective.

Bill: The biggest mistake is not making enough trips ahead of time to develop a relationship with the local medical, business, and political community. Right and understandable they look at it and say, well here are a hundred kids that have come in and I know how to take care of them. These kids aren't going to live a normal life. In a relatively short period of time and at a relatively small cost, we can take care of them. They'll be brave; we feel good; this is totally understandable why they feel this way. The dilemma is that you get a reaction to this and you are accused of being a Safari Surgeon. The local people pick up this mantra; then instead of embracing the visitors, the locals criticize them. I have given talks in Mexico and developed relationships with Mexican plastic surgeons who do cleft work. I have said to them, doesn't it make sense that you simply say that the numbers are too much for us to physically take care of. If we invite surgeons from around the world to come and help, side by side they're going to help us take care of the backlog because we can't take care of ourselves. That creates a situation of real ownership and it is not offensive to the local doctor.

This panel discussion represents a major accomplishment, as it collates the ideas of the leaders in the major organizations addressing cleft care on a global scale.

-John van Aalst, MD

Scott: Many people without international health experience often enter the cleft field with the idea that developing countries have nothing and whatever the newcomer has to offer is better than

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From the Education Committee

Peter J. Taub, M.D., Chair
Mount Sinai Medical Center, New York, New York

This year ushered in several new courses that build on the highly successful Basic Science course and focused on advanced techniques in maxillofacial surgery. Under the direction of Larry Hollier, Warren Schubert, and Henry Kawamoto, the ASMS put on a hands-on cadaver course at LSU Health Sciences Center. The course offered participants the opportunity to learn from and watch experts perform the procedures that have made them world-reknown. Dr. Syd Coleman demonstrated his techniques of fat injection, Dr. Kawamoto performed a Lefort I osteotomy, and Gary Burget showed his technique for nasal reconstruction with a paramedian forehead flap, among others. Participants were also given the opportunity to perform full facial laser resurfacing on fresh cadaver specimens. In conjunction with the American Society of Craniofacial Surgeons, a separate course designed for fellows was staged in Phoenix this summer to highlight the major osteotomies used in reconstruction of the craniofacial skeleton.

This year's preconference symposium in New Orleans to lead off the ASPS Annual meeting will focus on bringing the techniques of maxillofacial surgery into one's practice. Lectures will focus on techniques of painless anesthesia, avoiding eyelid complications in blepharoplasty, and simultaneous fat grafting with rhytidectomy, among others. For the ASMS Day during the meeting, numerous exciting educational panels and speakers will present challenges in maxillofacial surgery for both residents and attending surgeons alike.

The successful basic maxillofacial course will continue, being hosted in the upcoming year by Seth Thaller at the University of Miami in January and Joseph Serletti at the University of Pennsylvania in August. At the conclusion of the Miami course there will be an additional refresher course offered in cleft lip and palate surgery.

The two new maxillofacial textbooks continued to be developed. These include the second edition of Ferraro's Fundamentals of Maxillofacial Surgery to be published by Springer and an atlas of craniofacial surgical procedures to be written in conjunction with the American Society of Craniofacial Surgeons.

Finally, the Plastic Surgery Hyperguide continues to add valuable information to its diverse library of lectures, video, podcasts, and unknown cases. It remains an easy access reference for all types of surgery of the head and neck, including aesthetic and patient safety topics.

ASMS History Corner

John Persing, M.D., ASMS President, 2003

I was fortunate to be President of ASMS approximately 10 years ago. This time period was both similar and distinct from today in many ways. The similarities were that we are attempting to develop improved efficiency in our administrative work, provide educational programs of relevance to the membership, and sponsor research, in collaboration with our industry partners, related to maxillofacial and craniofacial pathologies. We were fortunate during this time period to have the generosity of our membership and industry in establishing two new Fellowships, one of which persists today, as the CRANIO Fellowship supported by Doug Ousterhout, M.D.,DDS. This Fellowship provided for a recent graduate of Craniofacial Fellowship in the U.S.the opportunity to visit areas of expertise to complement residency and fellowship training in maxillofacial surgery. The second Fellowship, initiated with the support of leadership from W. Lorenz Corp, now KLS, to bring plastic surgeons from around the world to have the same opportunity to visit and learn from centers of excellence in the U.S. Both Fellowship efforts are forward thinking, and were greatly appreciated.

We are indeed fortunate for the highly eclectic, forward thinking, individuals who helped forged what ASMS is today. A strong emphasis on reconstructive aspects of maxillofacial surgery and an acknowledgment of aesthetic features which, when blended in an appropriate manner, yield the best functional and cosmetic results.

The thing that stands out most in my mind during my tenure, however, was the discussion related to the relevance of ASMS, in a world where reimbursement for craniofacial and maxillofacial reconstructive procedures were diminishing, and aesthetic (facial) surgery was booming. After multiple years of this, and reverse growth in interest in ASMS, with declining membership and seemingly diminished relevance of reconstructive surgery, many in the membership were conflicted. There was difficulty in attracting new members to joint ASMS, when the avenue toward cosmetic surgery seemed to be much more rewarded financially. The relevance and the very future of ASMS was being called into question. Should we even change the name of the organization from the American Society of Maxillofacial Surgeons, to the American Society of Facial Surgeons, to reflect the expertise of the membership in cosmetic facial, as well as reconstrctive procedures? Should we de-emphasize the "reconstructive" and focus more on the cosmetic operations which were more remunerative? Basically, the answer was "NO." Fortunately, we had many strong minded senior members at that time who had "longitudinal memory."

The senior members emphasized that there is a cyclical movement of interest and expertise in virtually every field, and lack of supporting a strong base in maxillofacial reconstructive surgery would potentially risk loss of continued expertise in facial trauma, and head and neck reconstruction, and orthognathic surgery. Similar concerns were raised years ago by many related to the loss of extirpation procedures for head and neck cancer.

We had a number of forward thinking colleagues who proceeded me, and followed me, in and out of leadership who initiated new initiatives to develop further support for energizing the organization's base and emphasis on reconstructive surgery. Bahman Guyuron was instrumental in reorganizing the administrative structure of ASMS and developing a campaign for encouraging new members, Ken Salyer and colleagues, in the development of additional new relevant formats for educational programs. Clearly, with hindsight, it is easy to say that those favoring a strong emphasis on reconstructive surgery were correct. Without understanding the cyclical nature of emphasis and enthusiasm for various aspects of clinical medicine, one would have lost ASMS's integral role in securing leadership by plastic surgery in the head and neck region: both reconstructive and aesthetic. One can understand that any loss of emphasis in the reconstructive aspects of ASMS would have been devastating. I am deeply indebted to the many "advisors" among the senior membership who encouraged continued emphasis on orthognathic surgery, basic and advanced maxillofacial trauma reconstructive surgery, and other aspects of congenital anomaly treatments, as these areas would likely be ceded to other specialties, were attention and interest diverted to only a smaller segment of our members' interest. We are indeed fortunate for the highly eclectic, forward thinking, individuals who helped forged what ASMS is today. A strong emphasis on reconstructive aspects of maxillofacial surgery and an acknowledgment of aesthetic features which, when blended in an appropriate manner, yield the best functional and cosmetic results. These are lessons that must be remembered for the future.

From the President *(continued from page 1)*

these courses were extremely well attended. Dr. Bill Hoffman served as local host in San Francisco and Dr. Vic Lewis hosted in Chicago. Dr. Warren Schubert and Dr. Patel served as co-chairs.

In addition, we offered a first time ever course in *Advances in Facial Restoration and Rejuvenation,* chaired by Dr. Warren Schubert, Dr. Peter Taub, and Dr. Larry Hollier, Jr. in New Orleans. This course allowed cutting edge, hands-on instruction in both reconstructive and aesthetic facial surgery using a cadaver based paradigm. This course was sold out and is destined to be an annual spring event in the ASMS portfolio of educational offerings. I would like to thank Dr. Taub, Dr. Schubert and Dr. Hollier for their tremendous work in pulling this new educational offering together and driving its success.

In addition, for the first time, the ASMS joined forces with our sister society, the American Society of Craniofacial Surgery to offer a two day course as a "boot camp" to all of the new craniofacial fellows. The specific aim of this course is to bring the new fellows "up to speed" in craniomaxillofacial principles and techniques as they launch into their respective fellowships. The course is run in top notch facilities at the Barrows Neurosurgical Institute in Phoenix in August, just as the new fellows are starting their fellowships. The course was coordinated by Dr. Stephen Beals, Dr. Kant Lin and myself. Nobody seemed to mind the 111 degree temperature outside!

I am also pleased to report that the Society shows it health and strength in many other ways. Fiscally, the Society and its companion, the Maxillofacial Surgery Foundation, are in excellent financial shape. This is through the hard work and discipline of our Board of Trustees, our Committee Chairs, and our management firm – PRRI. Membership has been a strong point this year. The Society has made a deliberate and purposeful effort to update our application process and web site to modern standards. I would like to thank Dr. Reza Jarrahy and Dr. Anand Kumar, who through

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THANK YOU to the following for their continued support of ASMS

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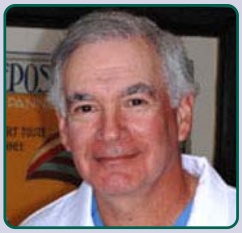
Douglas Ousterhout, MD

Kenneth E. Salyer, MD
World Craniofacial Foundation

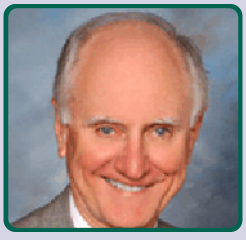
2012 Presidential Award Recipients

Distinguished Service Award
Mimis N. Cohen, M.D.



Special Honorary Award
Harvey Rosen MD, DDS

President's Honorary Award
Kenneth E. Salyer, MD



Lifetime Achievement Award and Converse Lecturer
Linton A. Whitaker MD

Tagliacozzi Award
James A. Lehman, Jr., MD

Case Study: Gunsot Wound to the Mandible

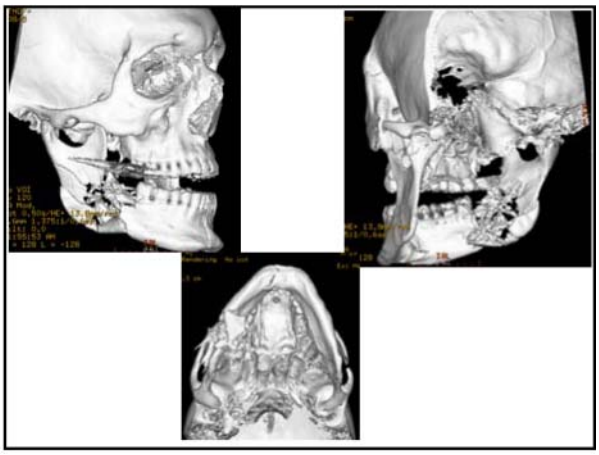
Craig Birgfeld, MD, Seattle Childrens Hospital

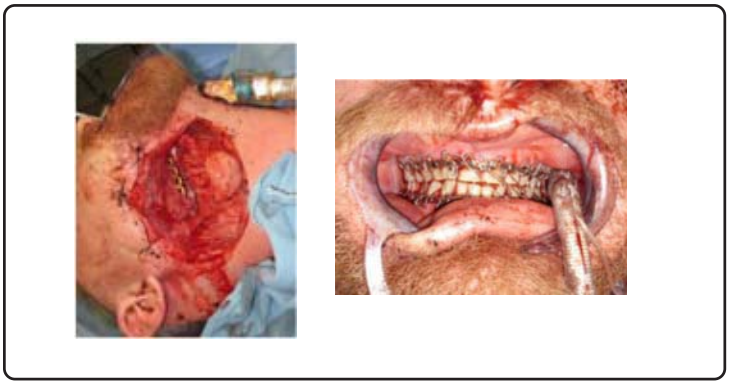
The patient is a 32 year old male who suffered a gunshot wound to his mandible 3 years ago. This injury was treated acutely with washout and debridement, ORIF of comminuted right mandible parasymphyseal/body and angle fracture, placement of arch bars and primary closure of soft tissue defect. A bony defect of the right mandible body was spanned with a 2.4 recon plate.

Over the subsequent 12 months, the patient presented twice with local infections due to sequestrum which required I&D and washout. However, he went on to a stable bony union of his mandible fractures with the exception of the bony gap of his right mandibular angle.

During the following year, the patient complained of increasing pain along his jaw when eating. A CT scan was obtained which revealed a 5 cm bony defect of the right mandible angle with no evidence of hardware malfunction. At this time he was 2 years post-injury and had been infection free for over 1 year. He demonstrated a class I occlusion with mild gonial splaying, extensive scarring of his right neck, a right marginal mandibular palsy and loss of sensibility in the V3 distribution on the right.

The patient underwent reconstruction of his mandible with bone graft taken from the left ilium. A 5 cm cortical bone graft was harvested as was cancellous bone. The cortical





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Case Study: Gunsot Wound to the Mandible

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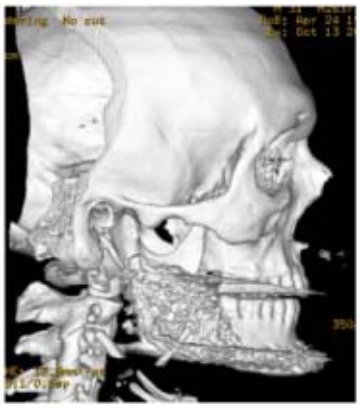
graft was rigidly fixated across the defect and the edges were packed with cancellous bone.

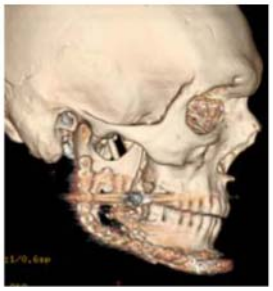
Approximately 2 months after surgery, the patient presented with purulent drainage from his right neck. He was treated with antibiotics, but the drainage persisted. 3 months post-op, the patient was taken back to the OR for a washout where it was determined that most, if not all, of the bone graft had resorbed and the patient had a non-union with bony gap. The area was débrided, the hardware was removed and an external fixator was placed.

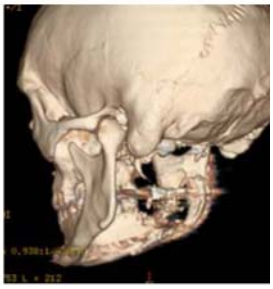
Bone Graft



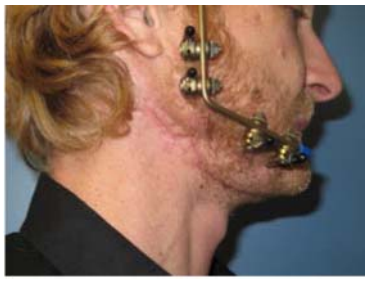
5 months after the patient's infection had cleared, he was taken back to the OR where the malunion and partially resorbed bone graft was débrided. Again, a 5 cm bony gap was identified. The patient was placed in MMF and a fibula free flap was used to span the residual bony gap, utilizing a skin paddle to treat the extensive scarring of the patient's right neck. The patient went on to bony union across his mandible and fibula free flap with good occlusion, adequate soft tissue of the neck, and is now pain free when chewing.

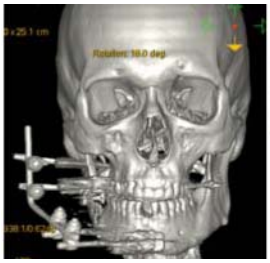
One year post op

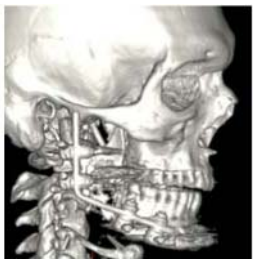




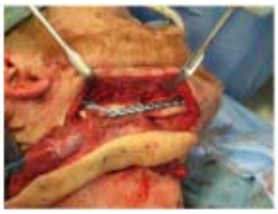
Ex-Fix

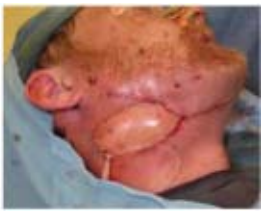


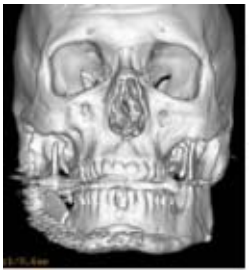


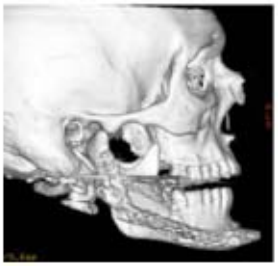


Fibula free Flap









ASCFS / Komedyplast Research Grants Available

The Komedy*plast* Craniofacial Research Grant Program has been established in cooperation with the American Society of Craniofacial Surgery to provide annual grants for clinical and basic science research that strives to elucidate mechanisms of craniofacial pathogenesis and develop strategies to treat resultant craniofacial anomalies.

Grant applications for the 2013 Komedy*plast* Craniofacial Research Grants are being accepted through April 1, 2013. Applications are available on the ASCFS (www.ascfs.org) or Komedy*Plast* (www.komedyplast.org) websites.

Research emanating from the grants should help explain and clarify mechanisms of craniofacial pathology and assist in the development of treatment strategies, which will help Komedy*plast* in its international mission to treat patients with congenital craniofacial anomalies.

The Grant will be presented during the ASCFS Annual Business Meeting. Each Komedyplast Craniofacial Research Grant recipient will be funded up to $5,000. The Grant Review Committee, composed of Komedyplast and ASCFS members, will determine the number of recipients and the exact dollar amounts.

Komedy*plast*, a 501(c)(3) non-profit organization, provides a unique approach to the international care of children afflicted with congenital craniofacial anomalies. The Komedy*plast* Craniofacial Research Grant is an integral component of Komedy*plast*'s triad mission of treatment, training, and research.

ACGME (continued from page 1)

chiefs of their programs through personal discussion, again creating a cottage industry of sorts. We owe this wonderful and intimate approach to our early leaders, eager to try new innovations and teach those skills to us. This individuality in teaching has provided continued innovation and fresh approaches to the complex problems we struggle with even to the point of being an attractant to those few candidates drawn fully into this specialty. This tradition broaches the first reason.

The size of the individual program may prohibit the work required to establish and maintain accreditation. Craniofacial programs are usually quite small; having a single fellow. Some of the most productive fellowship programs may not have significant support staff required to fulfill the requirements, maintain the records, and create the appropriate evidence during site visits and periodic reviews required by the ACGME. This kind of diligence requires an institution well-practiced in residency and fellowship training programs, eg large and/or academic institutions. The training of the individual craniofacial surgeon would fall to these institutions, eliminating many of the fellowships through smaller organizations often burdened with practice-based tasks as well. Without a doubt, requiring ACGME accreditation would eliminate some of our most experienced craniofacial teachers (and perhaps our international partners). In short, monitoring is a full time job!

Another consideration is the freedom to structure the program to the teaching content and financial needs of the fellow. Participating in the ACGME program eliminates the ability of an institution to provide opportunities to financially support a fellowship through billings and provide avenues to supplement a fellows' base salary. After years of commitment to their general surgery and plastic surgery programs, fellows are asked to consider another year of hospital duties and limited salaries. Many of these fellows have established families and must consider how to integrate the desire to follow their passion with the needs to provide for their families. Programs outside of the ACGME have opportunities through call and independent cases to offer some addition to the base salary. This kind of flexibility may be important as we compete with the lifestyles and enticements found in other areas of plastic surgery.

Our craniofacial program has a strong relationship with our Children's hospital and our teaching institution (Emory University). However, the existence of our program in a private practice setting has provided a unique and effective management of a busy hospital practice while providing teaching to residents and fellows. Despite daily teaching responsibilities to our residents, we have elected to maintain a relationship with our fellow separate from our teaching institution. This allows us to provide opportunities for structuring the fellowship individually without some of the cumbersome obligations that may be required for the residency training programs. We simply enjoy the ability to retain the freedom to modify the fellowship experience both in the area of teaching and reimbursement. We do not feel that this has diluted the experience of the fellow or compromised the level of his training.

Sometimes what is a great fit for one situation may not work for others despite obvious similarities. The required assimilation of all craniofacial fellowships into the ACGME would be cumbersome at best and may actually be a hinderance to our ultimate goal.

Of the twenty nine programs listed to participate in the 2011 fellowship match through the American Society of Craniofacial Surgery, only 3 programs specifically mentioned the fellowship as accredited through the ACGME (all university affilitations). However, 18 of the 29 were university named fellowships, 4 were international fellowships and 7 were independent or associated with free standing Children's Hospitals. Whether as an active decision on the part of the programs or simply"just not there yet", there has been hesitation to place these fellowships through the ACGME.

To return to the beginning, we must again address the problem of providing some standards of competency that are expected upon completion of a fellowship. Because of the tradition we have in craniofacial surgery, the small and unique numbers that our specialty produces and the unique position of the fellow, it might be best to consider an alternative set of requirements perhaps even borrowing some from the ACGME to create guidelines that provide a better fit. The ACPA provides an example of one way to perhaps monitor programs through membership requirements for cases and participants as well as updates. Fellowships may need to support certain thresholds to qualify as legitimate training programs through numbers of cases presented and even requirements for mentors through participation in various meetings, etc. This is probably a topic for other newsletters.

Sometimes what is a great fit for one situation may not work for others despite obvious similarities. The required assimilation of all craniofacial fellowships into the ACGME would be cumbersome at best and may actually be a hinderance to our ultimate goal.

CPT Coding: Zygomaticomaxillary (ZMC) Fractures

Gregory D. Pearson, MD

Zygomaticomaxillary (ZMC) fractures are frequent maxillofacial trauma consults after someone has been assaulted. Although most ZMC fractures are associated with orbital fractures, ZMC fractures can be coded independently from orbital fractures depending upon the approach and reconstruction performed for repair. From a cpt coding perspective, ZMC fractures are either classified as percutaneous treatment or open treatment.

ZMC fractures have 5 CPT codes assigned to them (21355, 21356, 21360, 21365, 21366). Code 21355, percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation is defined as a stab incision is made through the skin overlying the fracture. An instrument such as a Carroll-Girard screw is placed percutaneously and then used to lift, elevate, and reduce the fracture. Skin closure is included in this code. Code 21355 implies no dissection only insertion of the instrument and reduction. Code 21356, open treatment of depressed zygomatic arch fracture (e.g. Gillies approach); differs from code 21355. Code 21356 involves reducing the fracture from an indirect approach (typically either subtemporal fascia, Gilles, or intra-orally, Keen). An instrument is then inserted into the incision, placed underneath the depressed arch, and used to reduce the fracture back into position. Similar to code 21355, closure is included with this code. Code 21360, open treatment of depressed malar fracture, including zygomatic arch and malar tripod, states the physician makes facial incisions through the scalp, eyebrow, and or lower eyelid and an intra-oral incision. The fracture sites are exposed and reduced manually (this code includes use of instruments for reduction). Interestingly, this code states that internal fixation is **not** used. I have no doubt that many surgeons have utilized this code when they have performed an ORIF thus under-coding for our services. Like the previous codes, closure of the wounds and removal of the packing are bundled with this code. Unlike the previous codes, code 21365 and 21366 are associated with internal fixation after reduction of the ZMC or arch fracture. Code 21365, open treatment of complicated (e.g. communited or involving cranial nerve foramina) fracture(s) of malar area including zygomatic arch and malar tripod, with internal fixation and multiple surgical approaches, has the same exposure description as code 21360 as well as bony reduction. The fracture is then fixated with wires, plates and/or screws. Code 21366, open treatment of complicated (e.g. communited or involving cranial nerve foramina) fracture(s) of malar area including zygomatic arch and malar tripod, with internal fixation and multiple surgical approaches with bone graft, has an identical description to code 21365 except a bone graft is harvested from the hip, ribs, or skull. The procuring of the bone graft including opening, osteotomies and wound closure are included in the description associated with this cpt code and cannot be unbundled. Codes 21365 and 21366 have closure of all operative incisions as part of their description.

Positions Available

The University of North Carolina at Chapel Hill,
Assistant Professor

The University of North Carolina at Chapel Hill is pleased to announce the hiring of a tenured faculty position at the level of Assistant Professor who will primarily care for children with a broad range of craniofacial anomalies, including cleft lip/palate, microtia, craniosynostosis, facial paralysis, facial lesions, and congenital hand anomalies. The candidate should have completed a plastic surgery residency and be board certified or pending board certification. Fellowship training in either Craniofacial Surgery or Pediatric Plastic Surgery is required. Anticipated start date is July 2013.
The University of North Carolina is an Equal Opportunity Employer.
Contact: John A. van Aalst: john_vanaalst@med.unc.edu

Johns Hopkins University School of Medicine / Johns Hopkins Hospital, Baltimore, Maryland,
Craniofacial Surgeon-Scientist

The Johns Hopkins School of Medicine, Department of Plastic and Reconstructive Surgery, is seeking a Craniofacial Surgeon-Scientist to join our full-time academic faculty. Minimum qualifications include fellowship training in craniofacial surgery, ABPS board certification/eligibility with a strong interest in patient care, teaching and research. Candidates with experience in all areas of pediatric plastic/craniofacial surgery and prior accomplishment in basic science or clinical research are encouraged to apply.
Contact: Qualified candidates may electronically submit CV and cover letter to: Richard Redett, M.D., rredett@jhmi.edu

University of Michigan, Section of Plastic Surgery,
Faculty opportunity in pediatric plastic surgery

The Section of Plastic Surgery at the University of Michigan is seeking a BC/BE plastic surgeon with fellowship training in pediatric/craniofacial plastic surgery to join our exceptional full-time academic faculty. This position presents an outstanding opportunity to join a busy clinical practice in a superb teaching and research environment. This individual will join two existing pediatric/craniofacial surgeons in the brand-new, 1,000,000 sq. ft. Mott Children's Hospital, which will open its doors November 2011. She/he will be included in the faculty of the ACGME-accredited integrated plastic surgery residency and craniofacial fellowship programs and should therefore have excellent clinical and teaching skills. Clinical responsibilities of the position include facial trauma call, care of patients with clefts and other congenital craniofacial anomalies, vascular anomalies/laser procedures, and general pediatric plastic surgery. Academic/scholarly productivity is also expected. Contact: Qualified candidates should send a letter of interest and CV to Steven R. Buchman, MD, via email: sbuchman@umich.edu.

University of California, Irvine, PGY IV Plastic Surgery Resident

The Aesthetic and Plastic Surgery Institute at The University of California, Irvine has been approved for an increase in their resident numbers by the ACGME. Consequently, we are looking to hire an additional resident into the PGY IV position. Candidates must have completed General Surgery, Otolaryngology, Orthopedic Surgery, Urology or Neurosurgery to be eligible for this position. Candidates would complete a 3 year training program in Plastic Surgery and be eligible to sit for their boards by ABPS. Interested candidates should send CV, 3 letters of recommendation, ABSITE or In-Service Examination Scores, USMLEs and a statement of interest: Daniel Jaffurs, MD, djaffurs@uci.edu

Panel Discussion: Cleft Care Around the World

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what is currently there; this is not necessarily true. In these developing countries, there is a capacity, but just not enough of it. So, I think a healthy respect for what developing countries already have and what they are doing is probably the biggest issue that would be helpful.

John: Do you look at cleft care as an export product?

Gosla: In Hyderabad, India in 1993 in India the first cleft surgery was demonstrated by Dr. Marcus from the UK. At first cleft care was mostly only surgical care, and people like me started learning and got interested. Others came and taught for a short period of time. So, in that sense we first needed to import cleft care. Now, on average we have a minimum of 2 or 3 international physicians visiting us everything month. Having grown in our capacity, now we are able to export cleft care. It becomes what we call to "take and to give it back". So, it is just a cycle. We have to take when we are in need then we have to give it to people who need it. The know-how transfer and technology transfer has to be made from the developed world to the developing world. However, we believe that export missions have a very limited use in cleft care.

Satish: The 'exported commodity' should be knowledge. We must all aim for the 'problem' to be eventually solved locally with local resources.

Scott: I guess it depends on how you call an export product. I think that if we mean that cleft care is a high enough priority in terms of developmental needs? Very much so. I think that if you look at cleft care in the language of economics, leaving people with unrepaired and uncared for clefts is a massive drag on societal economics. Leaving clefts unrepaired generates a group of people who are not allowed to enter the work force, because they have speech and hearing problems; or, if they do work, they are very limited in what they can do in the workforce; this is a huge economic drag on a country's GDP. But we can take care of these problems. As a general rule, when you take care of a surgical problem, it is finished. Take as an example, HIV retrovirals given in sub-Saharan Africa; there has been a wonderful change in the last 10 years; all those who have done such a tremendous job in lowering the price of those drugs so that they are accessible and available. The reality is after giving the retroviral today, the sun rises tomorrow and you have to give them again. A year from now, the sun still is going to rise and you are still going to have to give them. If you can take care of surgical problem today, it might cost you a little bit of money but it is done. A year from now, the patient has almost forgotten that they had an operation. They are in the workforce; they are in society, and they are doing what they want to do at no cost whatsoever. So, in the long run, cleft surgery is a very cost-effective intervention. So, in terms of priorities, it is very worthwhile to facilitate and foster this being done in the developing world.

It needs to be stressed that this isn't just a medical collaboration; it's a political collaboration; it is developing a model that financially can stand on its own two feet.

-Bill Magee, MD

Bill: It sounds kind of harsh to put it in the terms of an export product. I think that any of these types of endeavors are endeavors that are a collaborative effort between the people within the country and the people coming from outside of the country. It needs to be stressed that this isn't just a medical collaboration; it's a political collaboration; it is developing a model that financially can stand on its own two feet. Whether it's a public-private partnership or whether it's private-private for a limited time, it needs to stimulate and engage. For instance when we first went into Vietnam 1988 they proudly told us that 1,000 kids with clefts had been taken care of from 1951 to 1988— that's what 37 years? There were 80 million people in the country at that time, which means that about 160,000 people were left with clefts. Obviously there was a massive need. We went to Vietnam in a very visual way, with media coverage; it obviously got the attention of the political leaders in the country. As we train people to raise money and as we train the surgeons there to do this also, they started running more cleft groups then were coming into the country; then Madame Wing Thi Binh who was the Vice President of Vietnam took it upon herself to bring in individuals from the rural areas into the hospitals where we trained people year round to take care of clefts. Today Vietnam Operation Smile will raise about a million US dollars. They do an enormous number of local missions on their own; they do educational programs on their own, and the government sees it as part of their social responsibility to get these kids taken care of. Let's say we've taken care of 20-25,000 kids in Vietnam since we first went there. Obviously tens of thousands more have been taken care of by other groups who generate buy-in from the social sector. I think when you create a social movement of this kind and it is replicated by people within the country, then it takes on a life of its own.

John: Where do you see the biggest opportunity, the greatest opportunity to work together with other international cleft organizations?

Gosla: There are amazing cleft care organizations throughout the world. Now, all that needs to be done is to join hands. The first step is creating awareness in the public about cleft care—in this we should all join hands—and help people realize that clefts are a treatable defect and that there are centers available for care. The first step in working together is patient care and the second would be with donors; I would say that donors are always getting too many organizations trying to "market" for donations. They become confused. Who is the best? Where should we give? So, I think there should be formal cooperation with other organizations so that we can meet the health care needs of patients with clefts; making cleft care delivery a singular organization so that they all can stand on one platform. This will give more support to cleft care centers around the world. Partnerships within the philanthropic cleft organizations will definitely help bring about change in the way cleft services are delivered. But since each foundation has varied objectives in the delivery of care it has not been possible so far. At some point cleft organizations should come together to raise funds in order to deliver care more effectively.

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Panel Discussion: Cleft Care Around the World

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Satish: Sharing plans and cooperating rather than competing. I agree.

Gosla: I think that established centers should give hope. They can always use their connections for financial support. They have the capacity for connecting. I'll give you an example. We train a lot of fellows who come from different parts of the country, and also from other parts of the world. So when we train them, we also train them regarding the model for the Cleft care, about how to handle finances and where to get financing. So we send these fellows for a short program to one of our mentors. And then these mentors who have mentored us continue mentoring these young people. We call this knowledge transfer and networking so that the young trainees can go back to these mentors and receive the further training through networking.

Scott: I think that cooperative efforts are part of our ongoing teaching responsibilities. For example there are young training programs that have started up in the last few years in various developing countries—many of them only have 1 to 3 plastic surgery faculty who are very hungry for their residents to have a much more varied experience. So, shared sites through different organizations can send visiting professors to help those residency programs. I think another major area of synergy is the "comprehensive care" idea. Take NGOs that are not necessarily surgical. For example, speech pathology NGOs: instead of trying to reinvent the wheel of your own speech pathology program, work with these NGOs and try to coordinate the type work in this way. We have done that both with cleft and with burn care rather than reinventing the wheel and developing duplicate services.

John: Would you say that Africa is an ideal place to begin expanding collaborative efforts like this?

Scott: That sounds like a reasonable statement simply because I think that Africa is more hungry than many other areas of the world.

John: How does your organization ensure safety in international Cleft care?Gosla: Cleft outreach keeps changing. It is like driving a car. When you start, the roads are very bad. So the first step is you try to organize yourself in a comfortable car. Later you start thinking about safety. Then you start looking after the safety of the people on the road when you're driving. So we had our own problems when we started twenty years ago. But now safety means not only the safety of the patients but of all of our collaborators; safety is based upon the quality of care. Once you organize the quality of care, the drugs, equipment, and most importantly, the quality of the trained human resources around you. Then you should not have any problem anywhere. Once you have standard protocols, then you should not have a problem with safety. But to get to the point of standardization can be difficult. We are a cleft hospital and have been in the same place for the last 12 years. We have operated on more than 15,000 children with clefts in the same place. We developed systems that are effective for the local population.

Satish: For us Safety is and shall always be Priority #1. We will never, ever put a child to an unacceptable level of risk for an essentially elective procedure. And since Safety is more of an Anesthesia issue, we work very closely with anesthesiologists. Our Medical Advisory Board has developed comprehensive Safety and Quality Improvement Protocols, laid down clear and firm Guidelines for Surgical Outreach Missions, and issues regular Advisories for better safety. We are perhaps the only cleft charity that carries out formal periodic Safety Audits at our partner hospitals – naturally by very senior and highly experienced pediatric anesthesiologists.

For us, safety is, and shall always be, Priority #1. We will never, ever put a child to an unacceptable level of risk for an essentially elective procedure.

-Satish Kalra, MD

Bill: We bring every single thing to the sites where we operate that we would use in our home pediatric hospitals. So there is absolutely nothing that we don't have there that we would have here. To give you an example from a good hospital in the United States: one out of every 18,500 people die at surgery. Our rate now is about one out of every 35,000. So we're better than the good hospitals in the States. Why is that? Because we bring in extra anesthesiologist and surgeon compared to the number of tables. We ensure that all anesthesiologists and pediatricians are PALS and ACLS certified. We make sure that all the nurses that come with us are PALS certified. These are the kind of safety factors that are critical to put into practice.

John: Operation Smile has become very active in teaching PALS as part of its outreach to to local providers.

Bill: Correct and of the people that we train, there is a group that becomes trainers. This is replication: if you start to train the right people, then you no longer need to keep track of all the people who have PALS, ACLS, PLS training because of what you did.

Scott: We instituted a formal quality improvement program about twenty years ago. This has enabled us to develop and continually refine policies and procedures, as well to continually examine individual performance. As programs have evolved, so has the QI process. This has led to very low complication rates and no deaths in our team trip program for at least the last ten years. One issue that has emerged in the transition of programs from foreigner(US)-based to local surgeon based is that of differing standards in different environments. Under the "mission" model, it is possible to have complete control over every aspect of care, from sending state of the art equipment for the visit to credentialing of personnel. When working completely with local personnel and health care systems, one must work within those systems. Specific factors that exist in the US system such as the way in which anesthesia records are kept, or some aspects of monitoring for example, are done quite differently. There are the issues not only of improving standards, but also of examining local ways of doing things to see if those ways really are a lower standard. Atul Gawande and Tom Weiser have led the charge toward things such as the WHO surgical checklist which move us all toward a better standard everywhere.

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John: What would you say your organization's biggest safety concern is?

Gosla: The biggest safety concern is actually whether the financial resources are sustainable? Sustainability is the biggest concern. It's not for the patient, but for the organization itself.The biggest safety concern for our organization is patient safety. The other major concern is to have well trained human resources to provide patient safety. Since most specialists working in cleft charities are working full time they have to be adequately compensated on par with their local contemporaries.

John: Am I right in hearing that when an organization is financially sound, it will be safe, and it will deliver safe care?

Gosla: Yes. It's fundamental. It there is economic instability within an organization, it cannot provide good standard quality. The people need to be paid - the surgeon, the anesthesiologists, the nurses—and then obtaining high standard equipment, good anesthesia workstations, monitors, equipment needed for impromptu surgery. You know, all this costs money and maintenance. Sound finances and safety go hand in hand.

Satish: The most common problems with cleft patients in poor countries are malnutrition and anemia. Many are turned away from surgery for this reason, but with appropriate advice and supplements with instructions to bring the child back when healthy. This is obviously not possible with medical missions! The biggest post-surgical safety issue is the loss of airway for a variety of reasons. We put strong emphasis on detecting hypoxia early and rapid intervention, but unfortunately with varying degrees of success.

Bill: Operation Smile's biggest safety concern is to make sure that every kid gets on and off the table in good shape.

John: Could you comment on the statement a child with a cleft is better than a dead child.

Gosla: There was a time ten to fifteen years ago—when we didn't know better—that people used poor quality anesthesia, monitors, and deficient equipment. Surgical skills were poor. Standards have now improved and safety has improved. The biggest problem for us is creating the awareness in the public that there is a chance for them to get an operation. Receiving hope and healing the child. I think creating awareness is more important presently.

The medical field has sufficiently advanced that even very remote parts of the world are able to put together adequate infrastructure and doctors to at least repair the lip and palate without have a large percentage of mortalities.

Satish: Regarding the statement, "A child with a cleft is better than a dead child?" Absolutely! This is the guiding principle derived from our overriding concern for Safety. Our doctors strongly believe in not taking unacceptable risks; the general rule is: if in doubt, don't. And 'better safe than sorry.' For instance patients are turned away if they have any evidence of upper respiratory infection, low body weight, anemia; surgeries are aborted if the intubation isn't smooth.

Scott: I think that is a no-brainer. I would take it even further and say that it is better to have an unrepaired cleft than a poorly repaired one, emphasizing the point that clefts are best addressed by surgeons living in the community who have experience with the various operations necessary to provide optimal cleft care. I think a family with a child who has a cleft would much rather have that child left un-operated than to have the child die. From the perspective of foreigners operating, the local partner may be able to operate on the child next month. If a child is sick, there is absolutely no reason on earth to put him at risk. If you are operating in a place where there is no local surgeon and the place is honestly still dependent on foreign surgeons, it still is not in your interest or the child's best interest to surgically address the child's cleft. There is no doubt that it is much better to err on the side of safety and not have a dead child.

John: How does your organization ensure quality surgery for poor children around the world?

Gosla: I would say that we need a four-pillar system that includes quality human resources—well-trained surgeons for example. The next is infrastructure; the third is ethical thinking and open auditing of what we have done, and what could be done better. The fourth pillar is knowledge transfer and training other people. If we have the four pillars working together, I'm sure anyone can provide great quality anywhere in the world. We essentially have four verticals that support our system. They are patient care, human resources, infrastructure and research. We raise funds and designate the required money for each of these verticals separately. Since the donors know exactly what their donation will be used for, we ensure that we have the best doctors and other professionals working full time with the best infrastructure that can be procured to give optimal treatment to children with clefts. Research helps us publish the results of our system so that others can use our model.

I would take it even further and say that it is better to have an unrepaired cleft than a poorly repaired one, emphasizing the point that clefts are best addressed by surgeons living in the community who have experience with the various operations necessary to provide optimal cleft care.

-Scott Corlew, MD

Satish: Again we are perhaps the only cleft charity in the world with a formally laid down Outcome Monitoring protocol that continually tracks the results of every surgeon we work with. Through a complex and totally IT driven system we have numerical ratings of the Quality of surgery each surgeon is delivering. These are used to identify training needs and in extreme cases de credentialing!

John: How do you communicate within your organization that something could be done better from a surgical standpoint?

Gosla: The only way to improve quality of surgeries is to make sure that a stable delivery of care module is established in every region with local doctors, nurses and other specialists in a hospital. This local team should be supported by cleft teams from the

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developed world to provide know-how and technology transfer. The experience that local specialists get by treating large volumes of patients will ensure that know-how transfer can be initiated.

Satish: Not an easy one to answer, but numbers do improve quality. Like any other surgical procedure the more cleft repairs a surgeon does, the better he gets. We also organize some of the best seminars, symposia, and workshops where the best and the brightest come and share their experiences. We have digital virtual surgery videos for basic training of cleft surgeons. We encourage interaction among Smile Train partners in the belief that shared experiences will lead to better quality.

The team ensures the best quality. This is true now and will be true for the future. The team generates sustainable and consistent quality, and we can only do this by sharing our knowledge.

-Gosla Reddy, MD

Scott: With regard to quality surgery for children, the question revolves around provision of quality anesthesia care: anesthesia resources, human resources and infrastructure resources and we have tried to offer this. In terms of quality of operations, I think it centers on anesthesia, but also on trying to improve and expand the capacity and the number of surgeons in the developing world who can take care of these children. The world is a big place. We all have our own corner, trying to concentrate on trying not to spread ourselves too thin where we do things badly and at the same time, trying to address as much as we can.

Bill: The average child that we take care of doesn't have the foggiest idea of what quality care is. He just sees a big hole in his face and wants it closed. That responsibility of quality care is up to the caregivers and so we credential everybody going into a trip. But really that's just on paper and that's peoples' recommendations; the real credentialing occurs at the end of every single trip that anybody is on. Even if a volunteer has been on 20 trips, if performance on the 19th trip is inadequate, then there will need to be re-credentialing for the 20th trip. If people are using techniques that are not up to par, we don't discard those individuals; we team them up with individuals who can bring them along; we don't denigrate their desire to serve; but we don't give them independent responsibilities until they are ready to do a great job. I think that it's important for your host medical people to understand that because some of their people will have to be mentored also, and some of the people from the States will have to be mentored as you see that the quality isn't. The other thing we're doing is to develop electronic medical records that allow us to do before and after follow up and to be able to assess type of repair done based on the surgeon and on nuances of the repairs; so that once and for all we will be able to say that in the average surgeons hands this type of repair will give the best results based on study of thousands of kids.

John: What metrics tell you that a surgeon is ready?

Bill: A seasoned practitioner can see readiness with his eyes. When somebody marks a case and it shows that they understand the length discrepancy that exists in a lip and are making the markings to address those length discrepancies; that they are in the right planes when they dissect; that they know how to approach the nose. A season practitioner can just see those things. If you see patients that are massively swollen consistently after one surgeon's work, you know that they're not dissecting in the right plane. If patients bleed more than average, then they're not injecting in the right plane. There's a myriad of things. Let's say a surgeon operates on over a hundred kids with clefts; in the beginning he was just trying to make the right moves. After that it's artistic in a way: you see symmetry that you're trying to recreate; you know what you want to recreate, how to shuffle around tissues to do the job you want to do.

John: What is the best way to teach?

Bill: Its hands on. It's one-on-one mentoring. This means finding a mentor and its volume. The higher the volume the repetitive nature of the procedure that you do that gets people to see things that they didn't used to see, so you're looking at the same face.

John: This means 5-10 single unilateral clefts a day?

Bill: Exactly. Not to be worried about how fast you do it worried about how well you do it.

John: Can you speak to the process of Quality Control in your organization?

Scott: The QI committee meets quarterly. It is a multi-disciplinary committee. Its current chair is an anesthesiologist. We use the chair of that committee anesthesiologist within the multi-disciplinary committee and the committee goes over the records. The committee, at least the chair, has usually discussed the case with a couple of the people who were involved with the case. The main thing we are looking for is if there is something structural? Is there something systemic that could have been done that we could do differently that would have prevented this particular problem? We also look at problems that may seem to be occurring more often than we like; at that point, the first time that problem occurred we may have said, "I am not sure I see anything systemic;" but if something happens more frequently than you'd like, you need to start looking at something systemic that you can correct. So, an individual case goes before the committee. The committee sorts it out and tries to get a handle on what happened. If there seems to be a performance issue, then those are addressed with the people involved by the chairman of the committee. Honestly, this is a very unusual circumstance. Most of the time, performance issues are unusual. They are addressed when necessary.

John: We have found that local families often prefer foreign surgeons even though local surgeons can do these surgeries competently and safely. The transition to local families trusting local surgeons can sometimes be a great hurdle.

Scott: I think that is a huge hurdle. Your word "transition" is right on target because in the past, many places have depended on foreigners. Now that they are not, that barrier is overcome. So, it behooves foreign NGOs to do anything possible to increase the

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stature of local surgeons. In some places we have stopped sending teams to make the point to our civic hosts that the local surgeon is present and capable. If we do send teams or visiting educators, we make the point that the foreigners are purely support for the local surgeons. The reality in many cases is that the local surgeon can operate circles around most of us. So, we try to make that point to our civic partners who may have more contact with the families. This is all dependent on the attitude or philosophy of the foreigners going in.

John: Is there anything further you would like to communicate regarding Cleft Care?

Gosla: The team ensures the best quality. This is true now and will be true for the future. The team generates sustainable and consistent quality, and we can only do this by sharing our knowledge.

Bill: I think that a lot of times there's too much negativity expressed towards good-hearted individuals who want to do something to help their fellow man. We need to capture that spirit in individuals; it exists is spades in the plastic surgery community. I think what we have to make sure that we organize this good heart into a systematic approach to make sure that the results meet the expectations of the organization and of the people that we serve. I think that requires an infrastructure which has to get developed; the approach can't just be helter-skelter. Having said this, everyone has to start some place. None of us started with our 100th cleft; we started with our first. Each of us has gone through this process and I believe we have to do at least a hundred of any procedure before someone becomes comfortable. I think it takes time and patience and the integrity of an individual who is delivering care to be humble enough (rightfully proud for what their good at) to admit what they're not good at something because that's the only way that they will get better.

Scott: As a last thought, I think the heat of the matter is safety concerns. In sub-Saharan Africa, there is a dire need for quality anesthesia (human resources and infrastructure. Several efforts are being made in Kenya; there is now a superb anesthesia CRNA training program that was basically started by anesthesiologist by Dr. Mark Newton at Vanderbilt; it took him a couple of false starts to figure out exactly who in the local medical community was set to train. This is just like plastic surgery programs; you get one program started and hopefully it has an exponential effect. Over the next 10 to 20 years, we can change the culture of anesthesia in terms of expectation. Right now—in many places—the expectation is that between 1 and 5% of people who undergo general anesthesia are not going to wake up. When that is the expectation, humans often live up to expectations. Over the next 10 to 20 years, if we can change that expectation to one where the local population expects patients will wake up and be normal and healthy—this would be a major step forward.

Consensus Summary

According to panelists, the greatest need for improvements in cleft care delivery is in Sub-Saharan Africa. This area is also the greatest opportunity for large cleft care organizations to cooperate with each other. The biggest medical safety concern is the delivery of quality anesthesia. A broader safety concern is the sustainability of organizations that have made inroads in providing cleft care around the world. This sustainability requires local political and social buy in: a sense that the local community must help bear the burden of caring for patients with clefts; sustainability also requires adequate financial resources, which with proper infrastructure development, can and should lead to excellent delivery of cleft care.

Post Your Open Positions in *Maxillofacial News*

The ASMS wishes to solicit postings for job openings for maxillofacial surgeons. As a service to individuals who are completing craniofacial fellowships or plastic surgery residencies, we plan to post open academic positions for craniomaxillofacial surgeons at no charge. We feel that this service is justified in keeping with the ASMS philosophy of enhancing the education and practice of maxillofacial surgery. This would enable individuals who are completing craniofacial fellowships to use the ASMS Newsletter as the primary source for academic job opportunities, since we will actively solicit all such positions from academic institutions.

We will also post any non-academic positions of interest for craniomaxillofacial surgeons at the fee structure outlined below:

- Job postings for craniomaxillofacial positions at institutions with plastic surgery residency or craniofacial surgery fellowship training programs - to be solicited by the Newsletter so as to insure a complete list and posted at no charge.
- Job postings for craniomaxillofacial positions not affiliated with a plastic surgery residency or craniofacial surgery fellowship will be posted at a fee of $150 for ASMS members and $250 for non-members of the ASMS.

Please contact Lorraine O'Grady (lograd y@prri.com) with any positions for craniomaxillofacial surgeons.

Residents and Fellows Corner: ASMS Pres-Symposium Conference

John Mesa, MD
University of Michigan, Ann Arbor, Michigan

One of the main goals of the American Society of Maxillofacial Courses is provide education to its members, candidate members, residents, fellows and medical students. One of the most intellectually cutting edge educational programs offered by the ASMS is the annual *ASMS Pre-Conference Symposium* at the ASPS.

The ASMS Pre-Conference Symposium is an outstanding one-day conference where prominent and innovative craniofacial surgeons discuss high yield craniofacial surgery topics in an educational and collegial environment. The Pre-Conference Symposium is always held on the Thursday just before the inaugural day of the ASPS meeting. Last year's Pre-Conference focused on "Solutions to Complex Craniofacial Problems". During this past meeting, experts in the field like Dr. McCarthy, Dr. Wolf, Dr. Brent, and Dr. Menick among others had a highly educational discussion about a great array of very difficult craniofacial problems. Since the pre-symposium is designed to have multiple breaks, it is possible to both network with the presenters and attendees, as well as to ask questions to the presenters if not done so during the Q&A sections. For example, just before last year's Pre-Symposium Conference, I received a patient with a devastating dog bite to the face that required a complex nasal reconstruction. Although multiple options for reconstruction were available to treat the patient, I wondered about choosing the best option for the patient (all seemed good). Since I happen to have a picture of the devastating injury in my smart phone, I approached Dr. Mannik and asked him for his advice. He pointed out a number of pearls to take into account when choosing the surgical technique to be used with this specific challenging patient. I am glad to say that with Dr. Manick's knowledgeable and experienced advice, I was able obtain an outstanding nasal reconstruction on this specific patient.

This year, the ASMS Pre-conference Symposium in New Orleans dedicates to discuss about "Successful Maxillofacial Surgery In Your Practice". Topics will include: How to Set Up and Outpatient Surgery Center; Entropion & Ectropion: How to Avoid It, How to Fix It; Maxillofacial Implants, and Eliminating the Wet Lab in Orthognathic Surgery: Incorporating CAD/CAM into Pre-surgical Planning for Orthognathic Surgery. These high yield topics are quite interesting and excellent to adapt to the challenges that the current economical times imposes into the craniofacial surgery practice.

The ASMS provides excellent educational courses for its members, candidate members, and meeting attendees during the ASPS meeting and also throughout the year. Please don't forget to check the ASMS website (www.maxface.org/Educational-Programs) to check the ASPS Pre-Conference Symposium Program details, as well as additional upcoming educational courses.

PSEN (www.psenetwork.org) wants YOU!

The Plastic Surgery Education Network (PSEN) was designed to be a valuable tool for plastic surgeons in all arenas of practice. But for it to truly serve everyone, it needs broad participation. The more plastic surgeons use it, the faster and more useful it will become to all. The new site has a Community section, which allows plastic surgeons to pose questions and suggestions to each other on clinical topics at their leisure, which should make for a valuable "watering hole" for all clinicians. This is an area that all plastic surgeons can contribute to at any time. But plastic surgeons can also contribute to the site's other content areas.

The site's main content is managed by Section Editors for each distinct topic area (Aesthetic, Breast, Hand/Peripheral Nerve, Patient Safety, Pediatric/Craniofacial, Reconstructive/Microsurgery and Special Topics). And each Section Editor has solicited a team of assistant editors to bring in new, fresh content to the site every month, whether in the form of literature reviews, case reports or videos.

The more people who contribute case reports and videos, the richer the site will be for everyone. Plastic surgeons who are interested in working with the PSEN editorial team to contribute content either occasionally, or more regularly as an assistant editor, are encouraged to contact online education@plasticsurgery.org and specify their areas of interest.

From the President *(continued from page 6)*

their hard work have completely updated our web site, both appearance wise, but more importantly, the functionality has been improved. It is now possible to submit applications and pay dues online – a first for ASMS. This has facilitated the Society being able to offer active membership to many additional members – in fact, we are near a ten percent increase in new members this year.

The ***Annual Scientific Meeting*** of the ASMS in New Orleans will lead off on Thursday October 25th with a spectacular Pre-Conference Symposium - *Successful Maxillofacial Surgery in Your Practice*, co-chaired by Dr. Warren Schubert and Dr. Peter Taub. This program will take place in the Sheraton Hotel. The program features techniques in local and regional anesthesia to allow you to accomplish these procedures in your office, as well as updates on ocular surgery and facelift techniques. The course also features cutting edge review of computer based orthognathic surgery – now possible without a 'wet lab'. Other components of the course are designed to assist you in routinely offering maxillofacial surgery based techniques to your patients. The ***Official Opening Ceremonies*** are on Friday, and will feature keynote speakers James Carville and Mary Matalin – sure to be a great discussion in this tight presidential race !!! This is followed by a tour through the Mardi Gras float fabrication factory, and on to a reception on the banks of Old Man River. Saturday will start off with two open paper sessions for ASMS – one at 10:15 am, followed by a second session at 1:15 pm.

ASMS Day will take place on Sunday and features morning panels on *Controversies in Cleft Care*, *Managing Late Post-Traumatic Nasal Deformities* and *Putting Your Best Chin Forward.* The morning's activities will be capped by our 2012 Converse Lecturer, Dr. Linton Whitaker, who will speak on *Terroir and the Cultivation of Excellence*. This lecture promises to be a highlight of the entire meeting. The ***Annual ASMS Business Meeting*** will take place at noon in the Convention Center**.** Please be sure to attend – we welcome all members to participate! The afternoon features a panel on *Controversies in Cleft Care*, as well as a second focused on *Perioral Rejuvenation*. Overall, a very strong program based upon many hours of deliberation of programmatic topics and enlistment of engaging speakers b your program chairs – Dr. Warren Schubert and Dr. Peter Taub.

The ***ASMS Presidential Reception*** will be on Sunday evening in *La Chinoiserie* located on the top floor of the Windsor Court Hotel, with an open deck overlooking the river. The event will feature the New Orleans legendary band "*Terrance Simien and the Zydeco Experience*". All ASMS members are welcome to attend!

The ASMS programming continues on Monday, with a special panel on overseas missions – ASMS Volunteer Surgical Missions at 1:30 pm. If you have participated in an overseas mission, or ever thought about participating, please attend!

The American Society of Maxillofacial Surgeons continues to present top flight educational programming and continues to thrive through the hard work and commitment of our Board and our Members. Please join us in New Orleans for education and a celebration!

AMERICAN SOCIETY OF MAXILLOFACIAL SURGEONS
ASMS
FOUNDED 1947

HIGHLIGHTS of ASMS DAY SUNDAY, OCTOBER 28, 2012

Scientific Sessions
8:00 am - 4:30 pm

Converse Lecturer: Linton A. Whitaker, MD
11:15 am - 12:00 noon

ASMS Luncheon & Annual Business Meeting
11:45am - 1:00pm

ASMS Presidential Reception
7:00 pm - 10:00 pm
Windsor Court Hotel
All ASMS Members are welcome. Others by invitation only.

ASMS PRE-CONFERENCE SYMPOSIUM:
Successful Maxillofacial Surgery In Your Practice

Thursday, October 25, 2012
Sheraton New Orleans Hotel

Successful Maxillofacial Surgery In Your Practice

6:15 am	Registration / Continental Breakfast	
7:15 am	Introduction	Co-Chairs: Warren Schubert, MD & Peter J. Taub, MD
7:20 am	Welcome	Robert Havlik, MD, ASMS President
7:30 am	How to Set Up an Outpatient Center	Robert Cooper, MD & Jason S. Cooper, MD
8:00 am	Ethics in Advertising	Barry Noone, MD
8:15 am	Tips for Safe Ambulatory Anesthesia	Isabelle De Leon, MD
8:45 am	Making Local Anesthesia Almost Painless so You Can Do Way More with Less Fuss	Don LaLonde, MD
9:15 am	Forehead Lifts Made Simple	Richard Warren, MD
9:45 am	Q&A	
10:00-10:30 am	Break / Exhibits	
10:30 am	Blepharoplasty in Your Office	Seth Thaller, MD
10:45 am	Entropion & Ectropion: How to Avoid It, How to Fix It.	Michael Grant, MD
11:15 am	High SMAS Facelift: Single Flap Lifting of the Midface, Cheek and Jowl	Tim Marten, MD
11:45 am	Q&A	
Noon- 1:00 pm	Lunch / Exhibits	
1:00 pm	Neck Lifts	Joel Feldman, MD
1:30 pm	The Crooked Nose	Rollin Daniel, MD
2:00 pm	Simultaneous Facelift and Fat Grafting	Tim Marten, MD
2:30 pm	Q&A	
2:45-3:15pm	Break / Exhibits	
3:15 pm	Maxillofacial Implants	Ed Terino, MD
4:00 pm	Eliminating the Wet Lab in Orthognathic Surgery: Incorporating CAD/CAM into Pre-surgical Planning for Orthognathic Surgery	Stephen Baker, MD
4:30 pm	Maximizing Maxillofacial Reimbursement: Rhinoplasty, Trauma and Beyond	Sean Boutros, MD
5:00 pm	Q&A	
5:15 pm	Evaluations / Adjourn	

For more information and to register visit http://www.maxface.org/Educational-Programs/