MAXILLOFACIAL NEWS

American Society of Maxillofacial Surgeons

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FALL 2011

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PESN is Live
Log in and see that the new site is all about.

CPT Coding Corner
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Don't Miss ORBIT 2011 in Ferrara, Italy

The Presidential Message

Steven R. Buchman MD
University of Michigan

As we move out of the heat of August and into the crisp beginnings of fall, my presidential year is now in its twilight. I am excited to report that the culmination of my year in office promises to be magnificent as we have a fantastic annual meeting planned for Denver. Henry Vasconez has put together an informative and educational program that is filled with potential clinical pearls that will provide some ideas and techniques that can be brought home and incorporated into surgical practice in order to improve patient care. It starts with a very pragmatic pre-symposium "***Solutions to Complex Craniofacial Problems: Aesthetic and Reconstructive Surgery"*** on Thursday September 22nd that is sure to provoke thought and generate discussion by a distinguished and knowledgeable faculty. Saturday we again have two

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ASMS Education Committee Continues to Provide Outstanding Courses

Warren Schubert, MD, FACS
ASMS Education Committee Chair

Since the meeting of the Education Committee held during the Annual meeting in Toronto, the ASMS Education Committee has had three additional conference calls to work on the many ASMS educational initiatives.

The core of our educational program continues to be the Basic Maxillofacial Course, structured for Residents, Fellows and Practitioners, with a focus on teaching dental occlusion, taking dental models, teaching cephalometrics, orthognathic surgery, and maxillofacial trauma. We have just completed our course at the University

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Editor's Column: Highlights of Fall 2011 Maxillofacial News

Arun Gosain, MD, University Hospital (Lakeside)

The present Newsletter will serve as a guide to ASMS activities at our upcoming meeting in Denver, and it represents the culmination of several efforts by our organization. Steve Buchman is concluding his leadership of the ASMS, and he will be making several key Presidential Awards in Denver, providing special recognition to the lifetime contributions to maxillofacial surgery made by Linton Whitaker, Joe Gruss, Paul Manson, Joe Murray, and Peter Randall. Steve Buchman's tenure marks the initiation of the relationship between the ASMS and our newly appointed management organization, PRRI. Through the management of PRRI, the Newsletter is now an online edition, providing our membership the opportunity to access not only the present version, but also past versions of the Newsletter. This service provides a wealth of information at your fingertips and will allow our readers to trace significant issues impacting the ASMS over time.

The Newsletter continues to highlight key areas in our specialty. The teleconferences provide insight into challenging concepts in maxillofacial surgery through the dialog of leading authorities in the field. Chuck Butler led a discussion of post-maxillectomy reconstruction in the Spring Newsletter.

...the Newsletter contains caveats for all walks of a maxillofacial surgeon's career, from the trainee to the well-rounded, retired surgeon. I hope you enjoy reading this Newsletter as much as I have enjoyed working with all of the contributors

In the present Newsletter Devra Becker directs a teleconference with Bill Schneider and Mark Migliori, the lead authors of a manuscript which appears in the September issue of Plastic and Reconstructive Surgery, "Volunteers in Plastic Surgery (VIPS) guidelines for providing surgical care for children in the less developed world: Part II - ethical considerations." The format of a teleconference brings key concepts into dialog to further elaborate on the fundamental questions of how to approach ethically sensitive situations that are inherent in surgical mission trips to the developing world.

In the CPT corner Greg Pearson has provided insight into the global period in CPT coding, pointing out that a global period of 90 days does not apply for all maxillofacial procedures.

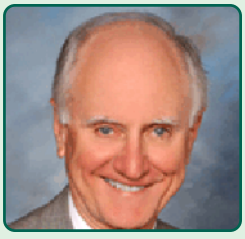
Jeff Marcus and Alesandro Allori provide a book review of *Decision Making in Plastic Surgery* by Jeff Marsh and Chad Perlyn. They emphasize the algorithmic nature of the text, which provides useful clinical algorithms for the treatment of common maxillofacial problems.

John Mesa has contributed to the Resident Corner by indicating ways that residents can become involved in the grant writing process, targeting both ASMS and PSF grants that are typically awarded to plastic surgery residents.

The Newsletter continues to trace the roots of the ASMS, beginning with a contribution by Ed Luce summarizing the critical issues during his tenure on the ASMS Board from 1985 to 1991. On reading this article one is reminded that history repeats itself, since the four major issues faced by the society a quarter of a century ago were dealing with the expanding practice domain of competing specialties, the relationship of the ASMS to the ASPS, the identity of the ASMS as a society, and accreditation of fellowship training in maxillofacial surgery.

The Newsletter is rounded out by the wisdom of Reudi Gingrass, a retired ASMS member who reflects on the factors that have contributed to a healthy and productive retirement. In summary, the Newsletter contains caveats for all walks of a maxillofacial surgeon's career, from the trainee to the well-rounded, retired surgeon. I hope you enjoy reading this Newsletter as much as I have enjoyed working with all of the contributors who have made this edition possible.

2011 Presidential Award Recipients



Distinguished Service Award
Linton Whitaker, MD

Lifetime Achievement Award
Joe Gruss, MD

President's Honorary Award
Paul Manson, MD

Special Honorary Award
Joseph Murray, MD

Tagliacozzi Award
Peter Randall, MD

Panel Discussion: The Ethics of Mission Trips in Plastic Surgery

Devra Becker, MD, Moderator
Mark Migliori, MD and William Schneider, MD
Plastic Surgery Foundation Volunteers in Plastic Surgery Committee

Devra Becker (DB): What would be interesting—I know to me as a reader and probably to the general ASMS readership, is if you could both offer some specific examples of things that have come up and how you've handled it, and how those things informed how you wrote the manuscript in the current issue of *Plastic and Reconstructive Surgery* entitled "Volunteers in Plastic Surgery (VIPS) guidelines for providing surgical care for children in the less developed world: Part II - ethical considerations.[1]

[1]Schneider WJ, Migliori MR, Gosain AK, Gregory G, Flick R. Volunteers in Plastic Surgery (VIPS) guidelines for providing surgical care for children in the less developed world: Part II - ethical considerations. Plast Reconstr Surg 2011 Sept 128(3): 216e-222e.

Mark Migliori (MM): In the manuscript, we start out with a number of vignettes. Those are based on real things, or some version of real things that have happened to us on actual missions. We thought that was a way to engage people in the topic, because there's no unequivocally correct answer to some of those things. But I think both Bill and I felt that it is important to place some emphasis on not only deciding which instruments to take, but also how to manage some of the ethical things that come up. It is important to go with a stated philosophy and avoid trying to figure it out on the fly. The point is, being prepared for ethical considerations is as important as being prepared for the surgery.

Bill Schneider (BS): As I recall, all of those vignettes at the beginning happened to Mark or me.

DB: I know you didn't specifically answer some of those topics that came up in the vignettes. But I do think it would be interesting to go over at least some of how you handled them in the field. Do any of them stand out in your minds as particularly interesting or ones that have stayed with you?

MM: Well, Bill why don't you start? I know some of these were very interesting on your trips. And then I'll add in as we go.

DB: A hospital in one case was charging the families. How do you manage hospital billing of patients in volunteer surgery?

BS: Actually, that's a good example. And this has happened on a number of occasions working in developing countries. I think it's important that these patients not be charged anything financially. And of course, these people are often the poorest of the poor and really don't have the resources—which is why we're there. But sometimes, charging takes place. You have to be very conscious of it. The local hosts often deal with the patients to register them, and things like that. There may be a situation where they're asking them to pay something that we don't necessarily know about. We try to pay close attention to that, and have our translators talking to people and finding out what's going on. Because, in fact, there may be real issues. The hospital may have some costs involved, and often does have costs involved. And if that's the case, then the group that's working there, I think, needs to work it out with the hospital in advance that they're going to cover some of those costs so that the patients don't have to. In other words, it's legitimate that both hospitals and the trip organizers are involved in this process.

DB: Before you go on the trips, do you designate one person on your team to be sort of the office manager and to negotiate those sorts of things—the administrative aspects, like billing?

MM: I think both of us agree with the notion of a pre-mission "planning trip" to meet and discuss some of these issues with the local host, before the actual mission. It does mean an extra trip. But the pre-trip planning includes making sure the facilities can handle certain technical and clinical things, but also finding out what is the host's philosophy. I've had the experience, as well, of finding out that the local hospital is charging the patients. Sometimes the local hosts say, "We feel that we have to charge something, otherwise the patients and their families will feel it may not be of worth. So, they may not have as good compliance. Or they may not have as good follow-up. And that it makes them engaged in their own care."

We don't necessarily think that way. On a planning trip it is best to work with the local host and say, "Charging patients for care is one of our concerns. We really don't want to create burdens, not only for the local host or the hospital, but also for the patient. What kind of resources do you need to make sure we don't need to charge patients anything, so that money is not a barrier to getting care?"

Before you go on the trips, do you designate one person on your team to be sort of the office manager and to negotiate those sorts of things—the administrative aspects, like billing?

-Devra Becker, MD

BS: I agree completely. This is the kind of thing you would like to have decided in advance of any team arriving. You don't really want to be doing this on the spot. But if it comes up and you find out they're being charged, of course, you need to deal with it. But ideally, as Mark says, it's handled in advance.

DB: Something that came up in the article that I was curious about in practical application—and in terms of coming up with a plan in advance—was the idea of excessive enthusiasm. You mention that when you go with a team, often everybody starts out with a lot of energy, but can become tired and exhausted. Can you talk about situations in which that happened, and what sort of steps you take or how you monitor exhaustion?

BS: I think that's an important point because everyone is very enthusiastic. Everyone is already there and has volunteered for this because they want to help, and they want to make a difference. And we all have skills that we can apply to this situation with great

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Education Committee *(continued from page 1)*

of Pennsylvania. Upcoming **ASMS Basic Courses** are planned for the following dates:

University of California, San Francisco, February 17-19, 2012

Northwestern University, Chicago, August 3-5, 2012

University of Miami, January 18-19, 2013

We have recruited a plethora of new west coast faculty for our San Francisco course, and hope that it will be one of our most successful courses.

A completely new course for our membership and other practicing surgeons will be offered for the first time on May 12-13, 2012, at the new LSU facility in New Orleans. The title will be ***"Advances in Facial Restoration and Rejuvenation."*** This will be the first time that we will offer a course with fresh cadavers and it will include an opportunity for participants to practice genioplasty, orthognathic surgery, neck lifts, brow lifts, blepharoplasty, otoplasty, the use of injectable synthetic and adipose fillers, and laser resurfacing. We have recruited an internationally known group of faculty members from multiple specialties for this course.

Henry Vasconez has done a great job putting together our ASMS / ASPS Annual Meeting planned in Denver this fall. The Pre-Symposium meeting will be ***"Solutions to Complex Craniofacial Problems: Aesthetic and Reconstructive Surgery"***, and will be held on Thursday, September 22, 2011. This will be followed by great panels and papers at our Annual Meeting. We strongly encourage our membership to enroll in our special one day, pre-ASPS symposium.

Don Mackay is working with Steve Beals from the American Society of Craniofacial Surgery to launch a new coordinated effort for an Advanced ASCFS/ASMS course for the summer of 2012.

We plan to offer our ***"Challenges in Cleft Care in Underdeveloped Countries"*** in Miami on a two year cycle, with the next course planned for January 20, 2013, at the University of Miami.

Pravin Patel, Sean Boutros and Patrick Kelley have been working on the groundwork for a ***"Complex Virtual Surgical Planning Course"*** that we hope to offer in future years.

This will be the first time that we will offer a course with fresh cadavers and it will include an opportunity for participants to practice genioplasty, orthognathic surgery, neck lifts, brow lifts, blepharoplasty, otoplasty, the use of injectable synthetic and adipose fillers, and laser resurfacing.

Anand Kumar is now in charge of our ASMS website (www.maxface.org). He and his team have completely redesigned the ASMS website with information on our activities and plan to include additional educational materials and links in the near future. Please do not hesitate to contact Anand if you have any recommendations for change or improvement of our website (anand.kumar@chp.edu).

Reza Jarrahy has initiated an **Educational Video Subcommittee** with plans to offer many of these videos on our website. Please forward any videos that you would like to post to Reza (rjarrahy@mednet.ucla.edu).

It was decided at our Summer ASMS Board meeting that our educational videos will be available only to ASMS members. Please note that Resident and Fellow membership is gratis and only requires completion of a membership form.

Devra Becker Chairs the **Web Link Subcommittee**. The goal of this Committee is to review materials offered online, and include links to these educational materials on the ASMS website. Please forward any good web links that you come across to Devra (devra.becker@uhhospitals.org).

Delora Mount is in charge of the **ASMS Visiting Professor Committee**. Information on the application and funding for a Visiting Professor for your institution may be obtained on our website (www.maxface.org).

Peter Taub is working on an update of the 'Ferraro Book' and John Mesa and Joe Losee are working on an **"Atlas on Operative Craniofacial Surgery"**.

Mimis Cohen is serving as Editor of the ASMS portion of the PSEN, and Seth Thaller and Mimis Cohen continue to seek contributions for the Hyperguide.

Finally, this **ASMS Newsletter**, under the leadership of Arun Gosain, continues as a great source of information and education for our Society.

As Chair of the ASMS Education Committee, I would like to encourage our membership to get involved and contact the various Committee Chairs to make a contribution to our Society. For surgeons who are not members, the ASMS has many opportunities for young surgeons to get involved in our organization.

Residents and Fellows Corner: Improving Research Grant Writing Skills

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

Performing research as a plastic surgery resident or craniofacial fellow is an exciting pathway to shape your career as an academic surgeon. Combining clinical training with research, either bench or clinical, is very rewarding. However, in order to perform research it is necessary to obtain funding, usually in the form of research grants. Attaining research grants is like playing soccer: you need to train a lot, compete in multiple small tournaments (small grants), then move up to compete in larger sized tournaments (larger sized grants) until you are qualified to compete in the 'Soccer World Cup-equivalent' of research: the NIH grant.

Learning how to write a successful research grant proposal can be challenging and therefore requires commitment and perseverance. Initially, you need to determine the field of interest and the potential question to solve. To do so you have to become up to date with the current literature about your research question. Next you need to find a mentor in the field that can advise you through the process. Once you come up with potential solutions to your research question, the process of testing them (testing the hypothesis) becomes your research project. As a resident you can improve your research skills during your build in years or resident or elective rotations. Research can be time consuming, but with organization and efficiency in your busy clinical schedule, everyone if resident or fellow can make it work and conduct research.

There are multiple grant opportunities out there waiting for you to apply. Some are easier than others, and some give you more funding than others. The important point is to start writing grant proposals. As a toddler that is trying to walk for the first time, you will "fall" multiple times. Getting your grant rejected ("falling"), even though it is not a desirable feeling, is not negative at all. Actually, it is quite positive from the point of view of grant writing. Revising a rejected grant proposal allows you to see your grant with a "different eye", that will allow you to correct the pitfalls that were missed prior to your grant submission. If the grant review denial letter gives you feedback about your grant, it is even better because the reviewer's criticisms will help you to re-write a stronger research proposal.

The ASMS, though the Maxillofacial Surgeons Foundation, provides funding for research proposals within the scope of the Society. The ASMS Research Grant is an excellent pathway to obtain funding for pilot research projects. Serving as a PI, Co-PI or co-investigator on an ASMS grant will significantly improve your research grant writing skills. Other sources of funding are also available for your research pilot project elsewhere. If you feel prepared "to run" and would like to experience the feeling of writing a grant "NIH-Style" I highly recommend you to apply for a Plastic Surgery Foundation (PSF) research grant. In the past these grant application were simple and straight forward. Nowadays, the structure of the PSF grant application process is very similar to an NIH grant application (I had the opportunity of assisting in writing both NIH Grants and the new PSF grants, and I can attest that it is true).

I welcome all residents and fellows to write grant research proposals. You could write grants as a PI or could assist in the process of writing as a co-PI and/or collaborator. The process of grant writing is challenging, and depending on your workload it could be stressful. However, obtaining a grant acceptance letter and being able to perform funded research is quite rewarding (it feels like winning the soccer world cup yourself).

Remember, the deadline for the ASMS Research Grants is every July 15th.

A Happy Retirement

Ruedi Gingrass, MD

Dr. Ruedi Gingrass, a retired plastic surgeon and past member of the ASMS and the Society of Head and Neck Surgeons, has developed a rich life after retirement. Dr. Gingrass served the gamut of roles as a plastic surgeon, including Chief of Plastic Surgery at the Medical College of Wisconsin in Milwaukee during which time he was President of the Plastic Surgery Educational Foundation, followed by development of a private practice in plastic surgery, and extensive work in overseas plastic surgical missions. He is one of the few plastic surgeons I have known who has maintained a strong balance of activities both during his professional life and in his life in retirement over the past 13 years. I have asked Dr. Gingrass to summarize some of his thoughts on how to set oneself up for a happy retirement. It is a privilege to be able to share these with our readership.
Arun Gosain, MD, Editor

The subject of a happy retirement has spawned a lot of books. This is just one man's thoughts after 13 years of experience.

The number1 factor should be obvious. You have to be ready to quit. Work isn't nearly as much fun as it once was. Your patients are more demanding of perfect results, the insurance companies are more recalcitrant, and the present and coming government rules are nauseating. So why work and be miserable if you can afford to stop? I am assuming that you have squirreled enough away to be comfortable. You don't need beaucoup millions of dollars. If you think that you do, then keep on plugging and be miserable in the process.

Number 2 is just about as important. Your spouse (I am making an assumption here!) must be looking forward to having you around a lot more. If your relationship is a little shaky and she has a life of her own and doesn't want it interfered with, then beware. I was fortunate that my wife worked in the office and in the OR with me, so we were together 24/7 and were very compatible both at work and at home. She loves to cook and is wonderful at it. We look forward to meals together and share a good bottle of wine with dinner, frequently watching some golden oldie movie in the process. Simply put, she is my best friend.

After those two biggies, the key is to have enough to do to stay busy all day every day. Just staring at a blank wall all day leads to alcoholism or worse. I'll spend the rest of this little dissertation describing what we do to be happy.

Family becomes more and more important as you get older. I am blessed with five children and ten grandchildren and am friends with all. I have been to more soccer games around the country than I can remember. Plus basketball and tennis. I am also close to my five siblings, all of whom live close by.

Taking care of three houses keeps us busy. One is our home home. Then we have a "camp" in the Upper Peninsula of Michigan. It is on Lake Superior and we love it in winter as well as in summer. It is a retreat and going there is like going on vacation. The third is my wife's family home in Iowa. We are about ready to downsize when the grandkids finish high school and leave for college, so we will sell the home and move to Iowa.

We also have two big yards and gardens and enjoy gardening. Our yards are lovely especially in spring when everything is blooming and fragrant. Downsizing to one garden will make the work that goes with it that much easier.

I took up golf after retiring and it has become a modest passion. It is a joy to be outside in a park like setting, playing with fun people, perhaps for low stakes. Hitting a few good shots is always a pleasure and keeps you coming back for more. The game is a physical and mental challenge. Highly recommended.

We love to travel together and have seen a big share of the world. Some trips are with groups like the Smithsonian for the educational value. However, our favorite is driving around on our own. We've seen much of Europe that way, eating the local food and drinking the local wine and beer. We haven't seen a country or people yet that we haven't liked.

After we retired we did mission work in Peru (once) and Bhutan (six trips). We helped train their oral surgeon to do clefts, and he is doing an excellent job now on his own. After my wife (and assistant) decided that I should stop operating some years ago, Bhutan then came to us. The oral surgeon lived with us for three months while enhancing his skills, and a general surgeon was with us for a year while he studied urology. He is now the only urologist in the country. And a Peruvian medical student also spent time with us and is now finishing an oculoplastic fellowship and will go on the staff at Johns Hopkins. Very gratifying.

Another key is staying healthy. We exercise regularly and eat well and keep the weight down. My winter hobby is stamp collecting. I love history and geography and initially collected stamps from the entire world from 1840 to 1955. Now I am working on "hands on stamps", given my past interest in hand surgery. Stamps, at least the 1955 ones, are miniature works of art. Most were hand engraved and this is appealing to someone who admires delicate work. And all those holes on an album page need to be filled. It is like putting a skin graft or flap in a defect!

Professionally, I am still a clinical professor and attend conferences frequently. I also do mock boards with the residents and with those who have finished and are preparing for their oral boards.

I love to read, mostly nonfiction and am quite eclectic in my interest. The Economist magazine keeps me updated, since we dislike US newspapers and especially TV news.

All of the above keeps me happy in retirement. I love it, and so does my wife.

A Look Back at the Evolution of the ASMS

Edward Luce, MD, FACS, ASMS Past President

Not having written a personal perspective of a societal or organizational history in the past, I was pleasantly surprised on how the process lends to moments of reflection that otherwise might have passed me by. My time period as an officer of the ASMS (1985-1991) was initially as Assistant Treasurer, culminating of course in the Presidency. The issues that arose with ASMS during that tenure have dogged the specialty (plastic surgery) both before and since, sometimes cloaked in attire to give an appearance of a different character. Those issues were expansion of practice domain by other specialties, the relationship with ASPS (then ASPRS), societal identity, and recognition of subspecialization.

At that time, ASMS struggled with a cohesive approach to the efforts of oral surgery to re-define a dental specialty. On the one hand, ASMS wanted to link with ASPRS to offset the public education campaign by oral surgery about "maxillofacial surgery", yet on the other hand, entertain application for membership by "double-degree" (dental and medical degrees) candidates, namely, oral surgeons.

The roots of ASMS were planted firmly and equally in both the dental and medical professions since the original membership requirements were graduation from a "class A dental school and a class A medical school" as well as a rotating internship, one to three years of general surgery and two years of "maxillofacial" surgery.[1,2] Ultimately, the membership issue was resolved by a survey conducted by an ad hoc Forward Planning Committee appointed by Stu Landa, then President (1985) and chaired by Jack Hoopes, one of my mentors. The survey indicated the membership would consider "specific" oral surgeons with an MD and five years of training for ASMS membership.

The roots of ASMS were planted firmly and equally in both the dental and medical professions since the original membership requirements were graduation from a "class A dental school and a class A medical school" .....

With respect to any initiative to offset or neutralize expansionist policies of oral surgery, no single effective congruent approach to such an initiative could be successfully envisioned. Our difficulties with successful address of similar expansionist campaigns by other specialties continues today.

The second issue, our relationship with our parent society, ASPRS, occupied a considerable amount of time and energy of the officers and Board. The year prior to my entry as Assistant Treasurer on the Board, the bill or charges to ASMS from ASPRS for participation in the annual national meeting increased substantially. In addition, although members of the ASMS conducted several successful Instructional Courses at the meeting, ASMS did not share in that income. Some consideration and discussion was given to the option of a separate (from the ASPS) annual meeting. Again, a survey conducted by the Forward Planning Committee indicated the respondents preferred continuance of a joint meeting with ASPRS which, of course, has continued into current times. Much like the first issue, relationships with other specialties, and the analogous conflicts today, the discussions of how a "sister" society should relate to the mother institution embodied in the dispute between ASMS and ASPRS over a quarter of century ago, also continues in contemporary debate most particularly between ASAPS and ASPS. The tension lines that exist in any such force field are between collaboration and conjoint strength vs. societal autonomy.

The third issue during the tenure or time frame outlined above was the efforts of ASMS to attain identity on the larger stage of organized medicine and surgery. Prior to, and subsequent to 1985, ASMS petitioned the AMA for a seat in the House of Delegates, initially unsuccessfully. The sticking point appeared to be, at least on the surface, the percentage membership in the AMA by members of ASMS, a reflection perhaps of the growing disillusionment of specialists with the value of AMA membership. The ASMS also sought a national identity by pursuit of a seat on the Board of Governors of the American College of Surgeons (ACS), a pursuit assigned to me and a pursuit that foundered on the rocks of organizational politics. We assembled a well-detailed proposal to the ACS leadership with a logical rationale for a ASMS governor within ACS. Initially tabled because the ASMS membership was of insufficient numbers, we countered with a list of general surgical societies with smaller membership rolls. The final message delivered to us was that the ACS had decided to "freeze" further new seats. Eventually, I sat on the Board of Governors, but as a representative from ASPS, not ASMS.

The fourth issue was the accreditation of fellowship training in craniomaxillofacial surgery. Similar to the other three, the issue of subspecialty recognition resonates in discussions today. In the early 1950s ASMS received applications and approved programs to conduct "residency training"[1] in maxillofacial surgery. In doing so, ASMS was following (or perhaps blazing), a trail established by other surgical specialty societies, most notably vascular, of approval, namely, accreditation of resident training. This societal assumption of the role of accreditation of resident (actually fellowship) training was natural and an inevitable byproduct of specialty differentiation. With the development of a new expertise or surgical approach and the attendant body of cognitive knowledge and operative procedures, launched initially by practitioners of a broader specialty, a process of focus of interest, the evolution is toward formation

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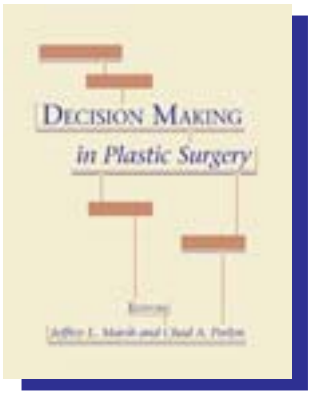
Book Review: Decision Making in Plastic Surgery

Authors: Jeffrey R. Marcus, M.D., and Alesandro Allori, MD

Edited by Jeffrey L. Marsh and Chad A. Perlyn

Review by Jeffrey Marcus, MD



Surely, that old adage holds true – the hardest decision in surgery is to decide when not to operate. The key to success in plastic surgery, then, lies in the indispensible pre-operative decision-making process, which is aimed at doing the right things at the right times in order to avoid complications and achieve excellent outcomes. *Decision Making in Plastic Surgery*, edited by Drs. Jeffrey Marsh and Chad Perlyn, is designed to make this decision-making process easier.

Updated and greatly expanded since its original release in 1993, this 340-page book consists of 137 chapters authored by over 100 contributors, many of whom are renowned leaders in their respective fields. The text is organized into three main sections (Fundamentals of Wound Management [12 chapters], Reconstructive Surgery [97 chapters] and Aesthetic Surgery [28 chapters]) and numerous sub-sections. The breadth and diversity covered is impressive, including topics as disparate as metacarpal fractures, aesthetic rhinoplasty, lip cancer and congenital and acquired genitourinary anomalies. The most noteworthy quality of this book lies in its unique and intriguing format: Each chapter presents one clinical problem which is then explained by way of an algorithmic decision tree on one page and corresponding explanatory text on the facing page. The text is keyed into the algorithm so that the reader may refer to the commentary at the relevant stage in the algorithm. Each algorithm covers the entire scope of care, from initial history and physical to post-operative follow-up, and key factors in the decision-making process are designated as branch points in the decision tree.

Consideration of a specific example from the text may serve to better illustrate the book's format and utility: From the Reconstructive Surgery section, one of the less complex algorithms is Algorithm 42 on zygomaticomaxillary complex (ZMC) fractures, written by Drs. Paul Manson and Eduardo Rodriguez. The algorithm begins with a patient with a zygomatic or zygomaticoorbital complex fracture. The accompanying text describes the anatomy of the zygoma and adjacent structures of the face. It then emphasizes what to consider in the history, physical examination and initial assessment. An important cross-reference to Algorithm 38 reviews steps in acute management of facial fractures (e.g., methods for dealing with hemorrhage and airway compromise) as well as general principles in the focused head-and-neck examination and radiographic workup. Algorithm 42 then proceeds with categorization of the fracture into either isolated arch or complex zygomatic fracture, and each is sub-categorized as displaced or non-displaced. Non-displaced fractures are treated by observation, whereas displacement requires operative intervention: For the displaced isolated arch fracture, reduction without fixation using a temporal (Gillies) or intraoral approach is advocated, and the methods are described on the facing page. The displaced ZMC fracture is further characterized by type of displacement and whether or not the orbit is disrupted, and treatment options are presented for each branch in the tree.

This example may serve to highlight the fact that describing even the simplest case *in words* proves rather difficult and cumbersome – Truly, this is a wonderful testament to the utility and efficiency of the diagrammatic approach that this book employs. Whereas a text synopsis might occupy several pages, and would certainly be pithy and difficult to follow, the pictorial algorithm is able to capture and convey all the necessary elements, presented neatly for quick review.

Those familiar with flowcharts used in process analysis may be disappointed that the algorithms do not employ standardized flowchart symbols (e.g., diamonds for conditional statements or where decisions are necessary); as a result, some diagrams may appear slightly crowded or difficult to follow. However, the schematic notation is explained in a legend and remains consistent throughout the text. Greatly appreciated is a yellow box highlighting operative interventions, making it quick and easy to jump to specific stages in the algorithm. Unfortunately missing, however, is an indication of comparative effectiveness of the various treatment options. In this day and age of evidence-based medicine, it would have been extremely helpful and instructive to see the "success rate" (i.e., outcomes and complications) associated with a particular alternative. While the diagrams occasionally feature a hierarchical arrow prioritizing possible interventions by order of preference, the level of evidence supporting this statement (i.e., whether by rigorous outcomes research or purely anecdotal expert opinion) is not specified. The addition of this information would enable clinicians to make truly informed decisions regarding treatment options. That said, the text accompanying the algorithm does occasionally comment on outcomes or complications, and a short but helpful bibliography guides the reader who is interested in learning more.

Decision Making in Plastic Surgery is an intriguing text that organizes difficult and complex information succinctly and practically. Its algorithmic approach – common in medical disciplines, but rare in surgery – is a welcome addition to more detailed specialty texts. While it is probably better suited for quick reference when faced with a challenging case and less useful for general study, even more experienced clinicians will find it useful in refreshing their fund of knowledge.

EUROPEAN ASSOCIATION FOR CRANIO-MAXILLO-FACIAL SURGERY
www.eurofaces.com

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www.sicmf.org

"ORBIT 2011 - Ten Years Later: Perspectives and Advances in Orbital, Cranio-Orbital Pathology & Surgery", October 13-16 2011, Ferrara – Italy

Dear Colleagues;

It gives us a great pleasure to invite you to participate in the International Symposium "ORBIT 2011 - Ten Years Later: Perspectives and Advances in Orbital, Cranio-Orbital Pathology & Surgery" on October 13-16 in Ferrara – Italy.

It is exactly 10 years ago that ORBIT 2001 was held in Ferrara and that was the year in which an International Faculty established some guidelines in the field of Orbital Surgery & Pathology. The guest of honour at that time was Dr. Paul L. Tessier who delivered the main lecture "Craniofacial Surgery: The Origins, Principles, Basic Techniques and Perspectives."

ORBIT 2011 will also be celebrating the 10th anniversary of Tessier's very last talk, an honour that was bestowed upon Ferrara. Internationally known experts will present the current status and likely future developments in all aspects of this field, thereby focusing in that small anatomical area that is the orbit.

It would be a pleasure to welcome you to Ferrara and to be your host, both scientifically and socially. We trust that you will find the scientific program to be educational, the social program enjoyable, and the whole event rewarding.

We look forward to seeing you in Ferrara for an unforgettable Symposium and experience that will be remembered for years to come.

See you in Ferrara, October 2011.

Chairman
Prof. Luigi C. Clauser M.D., D.M.D., FEBOMFS
Director and Chief, Unit of Cranio-Maxillo-Facial Surgery
St. Anna Hospital & University, *Ferrara, Italy*

Co-Chairman
Prof. Julio Acero M.D., D.M.D., PhD., FEBOMFS
Education and Training Officer EACMFS
Madrid, Spain

PROGRAM HIGHLIGHTS

Surgical Anatomy
Update in Imaging and Software 3D Simulation
Genetics and Syndromology
Different Approaches in Orbital and Periorbital Surgery
State of the Art in Orbital Surgery&Distraction Osteogenesis
Craniofacial Surgery: Congenital, Trauma, Tumours
Tissue Engineering
Structural Fat Grafting
Surgery of Adnexa
Tumour and Tumour like Lesions
Vascular Lesions
Facial Transplantation and Bioethics
Microsurgery
Endoscopic Surgery
Ultrasonic Bone Surgery
Aesthetic Surgery
Fronto-Orbital Rejuvenation
Botulinum toxins and fillers
Orbital Trauma and Sequelae
Rigid Fixation and Reabsorbable Devices
Biomaterials
Endocrine Orbitopathy (Graves' Disease)
Orbital and Periorbital Inflammation and Cellulitis
Orbital Pain
Pharmacology and Medical Therapy
Microphthalmia
Anophthalmia
How I do It
Unusual Cases
Complications in Orbital and Cranio-Orbital Surgery

INVITED FACULTY

Julio Acero, *Spain*
Mihaela Baciut, *Romania*
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Chiara Botti, *Italy*
Giovanni Botti, *Italy*
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Claes Lauritzen, *Sweden*
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Miso Virag, *Croatia*
Linton A. Whitaker, *USA*
S. Anthony Wolfe, *USA*

CPT Coding: Global Periods and CPT Codes

Gregory D. Pearson, MD

Frequently, surgeons worry about what CPT code to use after they have performed a procedure. We do not tend to worry about the post-operative coding responsibilities and resultant CPT coding related to evaluation and management (E/M) that will ensue after the case is performed. In short, we do not tend to think about the global period related to each CPT code.

A CPT code implies that the physician performing the procedure sees and evaluates the patient pre-operatively, documents a history and physical if necessary to prepare a patient for surgery, performs the stated surgical procedure, and provides routine post-operative care associated with the procedure performed as delineated by the CPT code utilized. The routine post-operative care associated with the CPT is known as the global period. During the global period, a patient cannot be billed a CPT code by the physician if the E/M is related to the procedure performed. Any visits (related to the procedure performed) during the global period should be coded with the standard 99024 CPT code. Code 99024 reads, "postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management (E/M) service was performed during a postoperative period for a reason(s) related to the original procedure." After the global period is over, the patient encounter can be coded with standard office visit codes related to the complexity of their visit (codes 99211-99215).

During the global period, a patient cannot be billed a CPT code by the physician if the E/M is related to the procedure performed. Any visits (related to the procedure performed) during the global period should be coded with the standard 99024 CPT code.

I was a bit surprised by the related global periods associated with common CPT codes related to facial trauma. My coding associate in our business office has informed me that the many CPT codes carry a 90 day global period regardless of the type of surgery performed (body contouring, breast reconstruction). This fact is certainly true for most maxillofacial trauma codes. The CPT codes for closed reduction and ORIF of mandible fractures (21453, -61, -62, -65, -70), ORIF of LeForte I, II, III (21422, -23; 21436, -47, -48; and 21432, -33, -35), ORIF of orbital fractures (21385, -86, -87, -90, -95), ORIF of NOE and frontal sinus fractures (21338, -39, -43, -44), and ORIF of malar fractures (21360, -65) all carry a 90 day global period. Interestingly, the common CPT codes used for nasal fractures (21315, -20) carry only a 10 day global period. Furthermore, CPT code 21356 (open treatment of a depressed zygomatic arch fracture e.g. Gilles approach) carries only a 10 day global period as well which is stark contrast to the other open fracture codes.

Presidential Address *(continued from page 1)*

Cranio-maxillofacial Surgery paper sessions that will be back to back from 7:30AM-8:30AM and 10:15- 11:45 AM.

And, of course, if it is Sunday, it is ASMS day! We have six noteworthy panels set up that will appeal to all areas of our sub-specialty. The highlight of Sunday will be the Kazanjian Lecture by Dr. Henry Kawamoto. His talk, entitled ***"Learning from the Masters"*** is guaranteed to be both entertaining and insightful. Our Social Program continues the tradition as the premier reception of the meeting and is again generously sponsored by KLS Martin. This year's venue "Kevin Taylor's at the Opera House" is especially enchanting and sets up well for the music, drinks, and socializing that has become our trademark on Sunday night. All ASMS members are invited to the reception and are encouraged to help me congratulate and celebrate this year's presidential Award winners: Linton Whitaker, Joe Gruss, Paul Manson, Peter Randall and Joe Murray.

Osteomed has munificently sponsored our resident scholar program this year which will underwrite three resident/fellows attendance to our pre-symposium as well defray the cost of attendance to the overall meeting. Our Scholars will be honored at a special reception recognizing their accomplishments and encouraging and welcoming them as they embark into our specialty.

The Summer Board meeting was again the first we have had since taking on our new management company, and, as has been the pattern since we engaged PRRI, they have helped to facilitate a tremendously productive meeting. The current board approved the nominating committee's slate of candidates for next year and our membership will be asked to vote on-line in advance of our business meeting in Denver which is scheduled for 11:45 am-1:00 pm on ASMS day - Sunday September 25th.

Exciting developments that continue to come about in our organization include the Website Committee's stellar work to improve and reinvent our website. If you have not visited, I encourage you to do so at www.maxface.org . There are plans to keep improving our site and to make it more relevant and helpful to you, our members. If you have any suggestions at all in regards to making the website better and more assessable and valuable, please let me know!

Our Education Committee has also continued to push the boundaries of innovation and instruction. In addition to our Basic Course, which remains our brand, we have advanced the mantle of the ASMS by taking on two new and exciting projects. The first, which I mentioned in my last letter, is a cutting-edge course aimed at you… our practicing membership that addresses Advances in Facial Restoration and Rejuvenation. This lab cadaver course will have a limited attendance to give participants a unique opportunity to have a talented faculty give personal instruction on the latest techniques and fillers, while participants can actually attempt these procedures and use the products for themselves. We are expecting a rousing response to this course and the sponsors have also been excited to have a teaching venue where clinicians can actually try out their wares. Look for our registration materials as you will not want to miss this course.

I have truly enjoyed my term in office and I feel that I have set our Society on a sure footing that will allow it to continue as the leading organization in the world dedicated to our sub-specialty.

In addition, we have entered an agreement in principle to join with the American Society of Craniofacial Surgery (ASCFS) to co-sponsor and extend their summer course for Craniofacial Fellows. With the able tandem of Don Mackay and Stephen Beals working on this project together it is a sure bet that the Craniofacial Fellows course will move to another level.

In addition, you will get a comprehensive report on our finances at our business meeting and I want to assure you that because of the outstanding work by Kant Lin, we have a very good handle on our finances. I am happy to say that our fiscal house is in order.

This will be my last message to you as your president. It has been both a pleasure and honor to have served you in this capacity and I hope that you will come to Denver for both the social and educational aspects of our first rate program and to help me celebrate this outstanding transitional year for our organization. I have truly enjoyed my term in office and I feel that I have set our Society on a sure footing that will allow it to continue as the leading organization in the world dedicated to our sub-specialty.

I thank you for your encouragement and support of my initiatives and I look forward to seeing you in Colorado!

2011 ASMS KAZANJIAN LECTURE

Henry Kawamoto, Jr., MD, DDS

"Learning from the Masters"

Sunday, September 25, 2011, 11:15 am - 11:45 am

Colorado Convention Center, Four Seasons Ballroom

A Look Back..... *(continued from page seven)*

of a society of mutual interests and education. The next step in that evolutionary process is to transmit that knowledge to interested preceptors or fellows. Soon, the desire to establish standards or formalization of such training leads to accreditation directed by the involved society. Yet, a recognized mechanism already existed, for better or worse, the Accreditation Council of Graduate Medical Education (ACGME). ASMS adopted the high road, a petition to the ACGME to accredit the rapidly-proliferating fellowships, some formal and some informal, in craniofacial and maxillofacial surgery. My position with ASMS at the time was the immediate past-president and member of the Board of Trustees and because of my recent election to the RRC, was asked to spearhead the effort. Chairing a subcommittee on the RRC with Steve Aryian and Tom Krizek, we plowed through the bureaucracy and the maze of the ACGME to exit the other end with approval for the RRC in Plastic Surgery to accredit craniomaxillofacial fellowships (the terminology selected). This mechanism, accreditation without certification, the approval of graduate medical education in a subspecialty, yet deferment of certification (a Board or subboard) to this writer is a vastly preferable method of subspecialty recognition.[3]

Chairing a subcommittee on the RRC with Steve Aryian and Tom Krizek, we plowed through the bureaucracy and the maze of the ACGME to exit the other end with approval for the RRC in Plastic Surgery to accredit craniomaxillofacial fellowships (the terminology selected).

The other items that arose were considerably less sweeping in impact but from an internal perspective were important to the overall functioning of ASMS. As the organization grew, the administration and management became more of a burden than the officers could manage and an agreement was entered with Plastic Surgery Management Services, an off-shoot of ASPRS (although semi-autonomous) to provide some managerial functions. That agreement or relationship was, at times, less than harmonious and perhaps did not contribute to intraspecialty harmony as envisioned. A number of factors were operative including that of "management creep", a phenomenon I witnessed repeated in other organizations later in my career. "Management creep" (a verb not a noun) was the progressive offloading of routine officer and committee chair tasks to the contracted management firm until the services performed and hours expanded are substantially greater than originally contracted. As a result, the new contract proposed and negotiated is considerably more costly and less acceptable to the leadership. This mutual dissatisfaction between a Society and management services has occurred not infrequently in our, plastic surgery, recent history.

The other item was the composition of the ASMS Board. At some point prior to 1985, the Board of Trustees consisted of the five past-presidents and even in that year, 1985, the three past-presidents occupied seats on the Board. Although those three individuals provided institutional memory, frequently they represented a citadel or bastion of reactionary attitude, not unlike the ASPS Board of the past when six trustees, all past-presidents of plastic surgery societies were a component of the Board. A Bylaws change brought ASMS into line with other societies by service of the immediate past-president only. Yet to me, the size of the ASMS Board, often deterred us from effective strategic planning since, on occasion, the discussions and debate were contentious to the point of anarchy.

Those ASMS board meetings, though, provided this writer with the opportunity to establish friendships with individuals such as Henry Kawamoto and Tony Wolfe who preceeded and followed me in the presidency, as well as Paul Manson, friendships that persist to the present.

1. Ecker, H., American Society Maxillofacial Surgery, Grit Publishing Williams Port, PA, (1987).
2. Cohen, S. R., et al., "History of the American Society of Maxillofacial Surgeons: 1947-1997" *PRS*, (1997); 100(3):766-801.
3. Luce, E. A., "Accreditation before Certification" Presentation to joint ABMS – ACGME conference Chicago, IL (June 1989).

Panel Discussion: Ethical Considerations *(continued from page 3)*

benefit. But there's often more to do than it's reasonable to be able to do, at least in some situations. I've been on trips in the early years where people worked until nine o'clock at night every night. People become exhausted—and the problem with that actually goes back to our first paper, which has to do with the emphasis on safety and quality of care. And I think if the team members are tired, that can easily impact adversely the quality of care and the safety issues because if people get tired they may not be paying as close attention.

I think the best thing to do is to try to work a reasonable day, a full day, a busy day but a reasonable day so that everyone gets a good night's sleep and is ready to go again the next morning.

Another issue which you might want to discus is prioritization. How do you decide, if you can't do everyone, what needs to be done and what should be done first.

DB: How have you decided that in the past?

BS: Why don't you go with that, Mark?

MM: Experience is the key, I think, to answering some of those questions. Obviously, you want to consider functional considerations before aesthetic considerations. So, one of the examples in the preamble to the article is four-year-old with cleft palate and a six-month-old with a cleft lip. Well, the four-year-old with the cleft palate is about to start school, and speech is such an important functional thing to being accepted in the society that there's a priority that that function is going to be more important than the aesthetic part at least for a six-month-old who will probably have other opportunities to have the lip repaired. So, a lot of it has to do with form versus function. And then some of it has to do with resources and maybe resources of how much time you have to operate. So, if you can do four cleft operations versus doing one total ear reconstruction in the same amount of time, the clefts are going to take some precedence. It may be about numbers, how many you can do to affect the greater good for the most patients. And some of it is going to be about the equipment you have and the expertise you have on the team. That's where experience on missions helps, too, because you start to realize that you do have to set up a plan for the day and follow it. I think it's really important that the host physicians know, the expectations of numbers of cases that can be done in a day and the types of cases that can safely be performed. You don't want to inadvertently create a devastating problem in an attempt to "help" only to realize you actually aren't in a good position to succeed. One bad outcome can ruin all the best intentions in the world.

You don't want to inadvertently create a devastating problem in an attempt to "help" only to realize you actually aren't in a good position to succeed. One bad outcome can ruin all the best intentions in the world.

-Mark Migliori, MD

BS: Another part of that in a way is the fact that just because we know how to do something doesn't mean we should do it. And that's a little bit of a bearing on what we're talking about, because as plastic surgeons, we have a lot of skills and a lot of ability, and we've done many things. But the reality in developing countries is very different. And sometimes—Mark kind of started this by referring to surgical judgment, because surgical judgment becomes even more important. It's very important to make the decision not to do something if there's any reason to think the facility may not be adequate, the care in the local hospital—any number of many reasons why you would choose not to something even though you theoretically know how to do that.

MM: Sometimes you do things and you come back home and you start to think about it, and you think, "Maybe I shouldn't have done that." There are a couple of specific cases that I know of in my history. One was we were working along and in the middle of the week, a well-dressed teenager comes in and he had fractured his nose a long time ago. He had a little bit of deviation and a dorsal hump. It turns out that it was the nephew of a local official. There was pressure basically to do a rhinoplasty. This was very much an aesthetic situation in a sense because there really wasn't much of a functional issue. But there were some politics involved in terms of our ability to continue to use the hospital and the resources of the town. And it turned out that we had the time to do it. And in fact, I did a rhinoplasty. As I reflected when I got back home, I realized, although I didn't prevent another child from having their surgery, did I really send the right message there? So, in the interest of politics I thought I was doing the right thing. Going down there now, I'm not sure I would have made the same decision. This was pretty early in my own personal experience of doing this work. It was thinking on the fly, and I convinced myself that it was the right thing to do. Suppose that young man had a serious complication. That would have done a lot more to hurt the mission.

In another instance, there was an ambulating child that had a meningocele on his back that had very tenuous soft tissue coverage that was about to break down. Of course the fear was that he was going to get meningitis and potentially die if he didn't get adequate coverage there. So, with high stakes, we ended up going ahead and closing it with a local flap. Everything worked out. He didn't get meningitis. But the reality is we did the surgery in the middle of the week. We left over the weekend. We could have left with a horrible problem. And although we had every good intention that we were doing the right thing, it exposed a risk that was probably more than we should have taken. I think you're always doing things because you think you're doing the right thing, but I think you have to be a lot more conservative on a mission trip—I've gotten a lot more conservative instead of aggressive over the years because I think that you can do more harm with good intention but bad execution.

DB:I think that there's kind of been a paradigm shift with the idea of these volunteer trips from Americans kind of going in and solving the problem to Americans going in more as teachers to help build infrastructure locally in terms of training local surgeons. Has that shift—if I'm correct—changed how you prioritize cases? Because I would imagine as an outsider that knowing that you are training a local surgeon to perform a case, you may choose different cases to do, to maximize the benefit after you leave.

(continued on next page)

Panel Discussion: Maxillectomy Reconstruction

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MM: Well, I think different missions have different focuses. There are clearly those missions which go out with the stated purpose of educating local surgeons and this has been the philosophy of the organization that Bill is with: to put yourself out of business and to teach local physicians to take care of the problems. But there are lots of missions that go out that are truly service missions because there's nobody there to teach. There may be nobody that has the skill set to provide these services, and the goal of the mission may be to reach patients who otherwise would not be given the opportunity for that type of service.

BS: I agree completely with Mark. There's places where there simply is no one. So, in fact, it's very beneficial to have teams go to these places and provide the care that no one else could be providing there. I believe you're right though, Devra, that there has been a shift in the paradigm. And there is a great deal of emphasis, appropriately I think ,on educating and empowering local physicians and there are many very capable local plastic surgeons in developing countries. Finding them and training them and empowering them to be able to do the work year-round is certainly an advantage.

And there is a great deal of emphasis, appropriately I think,on educating and empowering local physicians and there are many very capable local plastic surgeons in developing countries.

DB: You talk in the manuscript about appropriate cultural sensitivity. I wonder if you could give specific examples of how that has come up and what sort of cultural sensitivity training you've done, and how your views on cultural sensitivity have changed over the years.

BS: Well, you know early on, I went with a different organization I only went with one time. But we went to a place in Mexico. And we had a very capable team with nurses and physicians. And we're working, and by coincidence, there was a wreck—a bus wreck that came into the emergency room of this small Mexican hospital while we were there. And some of the nurses who were very capable—some were ER nurses, recovery nurses—I don't remember, but they immediately stepped in and began to do exactly what needed to be done. And one of them—I was between cases—asked me to come to the emergency room and look at a patient. And the patient had a laceration. Well, I went in and looked at the patient. But I also looked up, and the local doctor, and the two local nurses were standing back, sort of being ignored. I said to the nurses at that point, "You know, they probably see these kinds of things all the time." These are not complicated problems, I might add, lacerations and such and I said, "I think we need to let them take care of this because they know how to do this. We're here to do the things that they don't know how to do." So, it's very easy, you know, as Americans, we're very skilled; we know what to do. And we step in and do it. We have that sort of can-do attitude. But sometimes the best thing to do is not to do that. In this case, I could tell that it was very hurtful and even offensive to the locals that we were stepping in to do something that they already know how to do. So that would be one example in a developing country situation.

MM: I think that's actually one of the biggest examples because the physicians and the nurses are well respected in their community. Their community looks to them in the same way as the caregivers we have in our community. And if you go in and circumvent them, you really leave something in your wake, when you're gone, that you didn't intend to; potential uncertainty with the community about the value of their own physicians or their own nurses. We are participating in the mission at their blessing, at their invitation, and to serve their community. We have to be careful that we don't inadvertently leave a different message.

I will say when it comes to cultural issues, there are some things for the team to learn about the world and about a different way of looking at it. It's a rare situation where a child will die, but there have been situations where that has happened. In some of the places where this kind of work is done, it's no less heartbreaking to the parents for a death, but their philosophy about death may be different. There was a general surgery part of one of the missions I was on, where they were doing pediatric hernias. A child was going to have a hernia repair. And they found on induction he had a respiratory problem. It turned out that there was a congenital heart problem that was undiagnosed. He never had the surgery.. He was recovered all night and but still struggled with his breathing. We got him to a hospital three hours away and when they tried to intubate him, he ended up dying. Well, the mission team was devastated when they heard the news. One of the local doctors said, "Listen, we deal with death all the time. You know, this family is grateful that you thought it was worth your effort to try to fix his hernia." It was a very strange thing for us to hear because that's obviously not the way we were processing this horrible event. In another case, I had returned to the same place every six months for missions over the course of years. And at the very end of one of the missions, a child with a cleft was brought in. The parents must have been about 17 or 18 years old. It was their first child. It was about a two-week-old baby with a cleft. We were done with our mission. We were packing up and the parents wanted to know what to do. They were distraught. I had my computer with all the pictures and I explained to them what the process was. I had come to find out in talking to them there was a lot of pressure from their community to bring the child into the forest and allow him to die because the thought was the child would bring bad luck to the community. It would be a bad influence on the community. All the elders of the community were putting this pressure on this young couple. So, I felt very empowered that I was showing the pictures of the likely outcome. This is going to be a normal child. And we were going to be back in six months. We gave food and vitamins, and informed the parents that he would be healthier for that operation because at the current age of two weeks, he would not have been a candidate for the operation by our mission standards. I came back 6 months later with such anticipation that we really made a difference for this child. We later learned the pressure from the community was so great, that the couple did exactly what the community had suggested. And the child was allowed to die in the forest. You learn a lot and some of the stuff is not necessarily pleasant, but learning about the world is part of going. It's not about changing the world.

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Panel Discussion: Maxillectomy Reconstruction

(continued from previous page)

DB: It's interesting to see things through that lens. Has that changed how you get informed consent? Because you had mentioned informed consent in the manuscript and how there may be different sorts of pressures when you do these volunteer trips. Not only because you're only there for a short time, but because there are different sorts of cultural pressures. How has the way that you get informed consent for these evolved over time?

I think that what we do, we need to do very well. And we need to do it ethically and responsibly providing quality and safe care. I realize that's a broad statement. But I think that's the message that needs to be delivered and presented.

-William Schneider, MD

BS: Well, the reality is, of course, we feel strongly that informed consent, just as we do in this country, is absolutely necessary. The practical problem is you are often speaking to this person through a translator, number one; number two, you're speaking to a person who may have not a very good knowledge of medically the kinds of things we're talking about. We feel it's very important to give the best possible informed consent we can give. And we obviously don't have any way of exactly understanding how that's being received. But we want to tell patients what a reasonable expectation is, what the possibilities of complications are. And again, these are not easy things to do for a family that may not be very well educated and, again, through a translator. The best translators actually have excellent medical knowledge and medical terminology. So, they can probably do it about as well as anyone can.

MM: I think that having a relationship with the local physicians is also important because they speak the language and dialects and patient education is what they do every day. So having a relationship with somebody who is your host, can help you understand cultural issues or any of the nuances that may be occurring behind the scenes that there would be no way for you to know about. For example, you might see four kids from a village that's three hours away by bus. There may be one adult. The other parents all have to work, tending the fields or whatever. One adult with these four kids from different families. So it is complex because you really have to get a sense if you are doing your ethical best to inform patients' families with local caregivers and explaining what you're planning to do and what the risks are.

DB: As a final point, do each of you have any kind of take-home message that you would like to get across to anybody who is—to the general membership or people who are interested in volunteer missions or volunteer trips in general, but who do want to do them mindfully and ethically?

BS: Well, one thing I would say is that sometimes you run across—not in groups of plastic surgeons generally, but there can be an attitude that people working in developing countries that doing something is better than doing nothing. That's entirely incorrect. I think that what we do, we need to do very well. And we need to do it ethically and responsibly providing quality and safe care. I realize that's a broad statement, but I think that's the message that needs to be delivered and presented. And I think that's what's been done, at least in part by this manuscript to people who are going to be working in developing countries.

MM: What I would add to that as well is if there's an interest in participating in these kind of missions, there is a fair amount of experience out there; people that have made mistakes and have responded to those mistakes. The more that we have dialogue between people who are interested in going and people who have experience going and the more we share our stories, the more we can anticipate problems. If you anticipate them, you may be able to avoid them or, at least, they end up being much less of an ordeal. If everything is an improvisation on the fly, the chance of you having an unexpected or unintended outcome is much greater. So I think this newsletter is a mechanism to create dialogue so that this isn't reinvented every time there's a mission. Our goals for setting the guideline paper and the ethical paper is really to say a lot of this stuff has been done before and a lot of this stuff has been thought through. Talk about it so that before you go, you have a stated philosophy of your mission. You understand at least what the foundational principles are so that you're responding off of those and not from scratch."

SUNDAY, SEPTEMBER 25, 2011 - ASMS DAY

Scientific Sessions
8:00 am - 4:15 pm
Four Seasons Ballroom 2-3

ASMS Luncheon & Annual Business Meeting
11:45am - 1:00pm
Korbel Ballroom 4a-c, Ground Level (CCC)

ASMS Presidential Reception
6:30 pm - 9:30 pm
Kevin Taylor's at the Opera House
All ASMS Members are welcome. Others by invitation only.

2011 ASMS Best Paper Awards

Clinical Paper : First U.S. Near-Total Human Face Transplantation: A Paradigm Shift for Massive Complex Injuries

Siemionow, Maria Z.; Papay, Frank; Djohan, Risal; Bernard, Steven; Gordon, Chad R.; Alam, Daniel; Hendrickson, Mark; Lohman, Robert; Eghtesad, Bijan; Fung, John

Research Paper: Regenerate Healing Outcomes in Unilateral Mandibular Distraction Osteogenesis Using Quantitative Histomorphometry

Buchman, Steven R; Schwarz, Daniel A.; Arman, Krikor G.; Kakwan, Mehreen S.; Jamali, Ameen M.; Elmeligy, Ayman A.

Young Investigator Award

Osteoprogenitor Cell Differentiation Into Bone Is Accelerated by a Novel Delivery System of High-Frequency Pulsed Electromagnetic Fields

Chad Teven, BS, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL

Matthew Greives, MD, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL; Ryan Natale, MS, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL; Deana Shenaq, BA, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL; Michael Rossi, MD, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL; Kristopher Chenard, BS, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL; Tong-Chuan He, MD, PhD, Section of Orthopaedic Surgery and Rehabilitation, University of Chicago, Chicago, IL; Russell Reid, MD, PhD, Section of Plastic and Reconstructive Surgery, University of Chicago, Chicago, IL