

# The Accredited Cosmetic Facial Surgery Office: A Paradigm Shift in Oral and Maxillofacial Surgery

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In the recent past, it was not unusual to admit elective surgery patients the day before their surgery to obtain the laboratory assessment, history, and physical examination and to “settle them in” to the hospital routine. Today, outpatient surgery is the norm, and the surgeon must justify any hospital stay. Also, surgical reimbursement is much lower than in the past, and efficiency in care is needed.

My personal story illustrates the issues faced today in ambulatory major surgery. I began private practice in 1983 similar to all enthusiastic residents ready to “hit the private practice pavement running.” I hired 2 staff members and opened a 1,200 square-foot office. The practice quickly took off, and we have not slowed down since. We now have a group practice of 8 surgeons in 6 offices with 75 employees. I did as much major surgery as a practitioner could do, and, with the help of my competent partners, our business has continued to grow and prosper.

Oral and maxillofacial surgery (OMS) is hard work. When someone describes a difficult task, they often use the phrase “it was like pulling teeth.” They are correct; this is hard work. So is trying to put a chain around a bleeding impacted canine, placing an implant abutting vital structures, fixing an orbital blow-out fracture, placing a total temporomandibular joint, performing multisegment osteotomies, and sweating over a tiny root tip of the lower right third molar that is lying on “the nerve.” Our profession is hard work. Using a power grip day in and day out aggravated old sports injuries of mine, and over the years I have undergone 4 elbow and 2 shoulder surgeries. It was getting harder and harder to take out teeth and move bone. In addition, I must admit that I was longing for new academic stimulation.

About 1995, I made the observation that cosmetic facial surgery was being taught in our residency pro-

grams, was a part of our American Board of Oral and Maxillofacial Surgery examination, and was covered by OMS National Insurance Company malpractice insurance. This piqued my interest, and, having been out of residency for 13 years, I was in need of some academic stimulation. In 1996, I attended a meeting at which one of our stellar oral and maxillofacial surgeons gave a talk about cosmetic facial surgery. After attending this lecture, it set me on fire, and I developed a fierce interest in cosmetic facial surgery. I began reading everything I could get my hands on and doing observational preceptorships all over the United States, not to mention hundreds of hours of continuing medical education. I also joined the American Academy of Cosmetic Surgery and submitted enough cases to become a fellow.

As I applied this new scope to my practice, it was becoming evident that general OMS was undergoing a paradigm shift. I was spending more time writing letters to protest low-paying claims and for preauthorization than I was doing surgery on some days. Cosmetic facial surgery began increasing in my practice from 10% to 20% to 50% within a period of about 6 years. I consumed myself with teaching and publishing on the subject and thus found the academic stimulation I was looking for. The Virginia Dental Practice Act was opened in the General Assembly to include cosmetic facial surgery for qualified oral and maxillofacial surgeons. The medical community banded together, because they were exasperated at the thought of a “dentist” performing cosmetic surgery, even though multiple publications have detailed the dearth of cosmetic surgery training by specialties that have claimed to “own the face.”<sup>1</sup> They never complained when I went to the emergency room on Christmas Eve to treat a blow out fracture on an indigent patient, but now that I wanted to perform cosmetic procedures in my anatomic zone I was all of a sudden “just a dentist.” Thus, the dental community banded together and with the help of numerous political oral and maxillofacial surgeons around the state and some good lawyers, we were successful in becoming the first state to have a cosmetic surgery license, and my license number was 000001.

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In 2005, I limited my practice to cosmetic facial surgery. This was a true leap into cosmetic surgery as I had a 20-year referral base of general dentists and specialists that I was walking away from, not sure if I could ever go back. Fortunately, it all worked out, and my practice and passion remain limited to cosmetic facial surgery.

With this professional paradigm shift also came the need for a safe, convenient, and readily accessible place to perform surgery. Although I was successful in obtaining cosmetic facial surgery privileges at some local hospitals, I was unsuccessful at others. Thus, I decided to have my office accredited by the Accreditation Association for Ambulatory Health Care.<sup>2</sup> I was concerned that this was going to be a serious and arduous undertaking and that I would be required to purchase thousands of dollars of equipment and so forth. It was time-consuming but much easier than I thought and very helpful in improving my clinical operations. We developed policy and governance documents with my staff. I provided an emergency power back-up source, changed the ceiling tiles in my operating room, and made some other minor changes, but we did it. We have been fully accredited since 2003, including passing an unannounced site visit.

Now, I have my own “little hospital” that is convenient, safe, and a great marketing aspect for my practice (Fig 1). It is not without work, but the work is mostly for my staff. Numerous forms to complete, inspections, peer review, and dictated operating reports, but I love it. I can do simple cases in my operating room with my staff and “regular” OMS anesthesia or 6-hour cases with an anesthesiologist. I rarely go to the hospital (similar to most cosmetic facial surgeons), and if I have medically compromised cosmetic surgery patients, I also have the option of taking them to other local



**FIGURE 1.** One of my two accredited in-office operating suites. Joe Niamtu, III. Accredited Cosmetic Facial Surgery Office. *J Oral Maxillofac Surg* 2009.

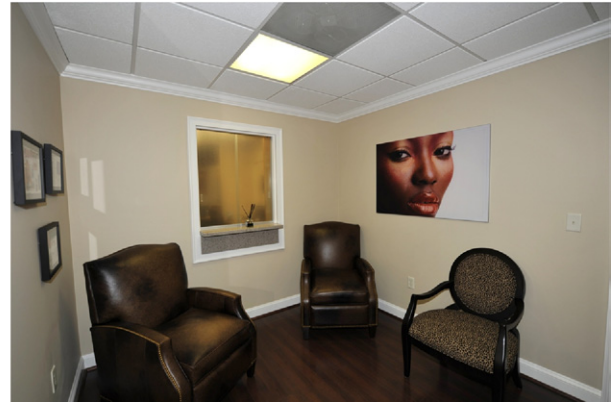
surgery centers where I have privileges. My partners also perform cases in our accredited operating room, including osteotomies, and we have private duty nurses for a 23-hour stay if necessary. Again, the marketing concept has been great. I can tell my patients with pride that we have a fully accredited facility, one of the few in the city.

Because the spirit of this special series is the paradigm shift in OMS, I have detailed this transition and the paradigm shift occurring in OMS. When shifting to a cosmetic-oriented practice, whether full time or as part of a general OMS practice, many differences must be addressed. Cosmetic surgery patients have totally different needs from the average OMS patient. People need oral and maxillofacial surgery, but no one “needs” cosmetic facial surgery. Cosmetic facial surgery is totally elective and does not heal disease or improve function. These patients are finicky. This service is an upper-class luxury and, although rapidly gaining acceptance in middle-class patients, still requires a “concierge” environment.

## Physical Plant

Cosmetic surgery patients expect comfortable, upscale surroundings and receive this from other specialties that provide these services. Many OMS offices are already opulent; however, attention to the details is imperative for the cosmetic facial surgery patient (Figs 2, 3). These patients do not want to be sitting in a waiting room with patients walking through with bloody gauze hanging out of their mouths and such. They also do not want to interact with patients undergoing typical ambulatory oral surgical procedures. They do not want to present for a facelift consultation and see posters and fliers for root canals and other similar procedures. I am not implying anything negative about OMS offices or patients, but an oral and maxillofacial surgeon performing cosmetic facial surgery must have the office set up using the characteristics both of a surgical setting and a 5-star hotel. These patients expect it. Additionally, most of the following points are applicable to the OMS practice. Paying attention to these details can also improve any OMS practice; they do not apply to cosmetic surgery only.

My practice is about 97% female (similar to most cosmetic practices), and it is important to help this clientele be at ease. Comfortable, if not plush, surroundings are what the competition has and should be the standard for the oral and maxillofacial surgeon who performs cosmetic facial surgery. Privacy is also very important. Cosmetic evaluation patients do not want to see patients in facelift bandages or with laser burns on their face. Having separate



**FIGURE 2.** Two separate reception rooms shown, one for preoperative and consultation patients and a private reception room exclusively for postoperative patients with bandages (eg, after laser surgery). Segregating these patients reduces the fear factor for new patients and provides privacy for healing patients.

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waiting rooms and keeping pre- and postoperative patients separated is a must. Serenity and comfort are also important. Fresh flowers, art, nice furniture, and feminine reading material are also important. These patients are not interested in car or sports magazines.

Having a cosmetic coordinator (just as many practices have implant coordinators) is also helpful. Someone dressed in business attire to greet these patients, get them a cup of coffee, assist with their registration, and generally help them to be comfortable is somewhat standard in successful progressive cosmetic offices.

Being an oral and maxillofacial surgeon and limiting my practice to cosmetic facial surgery is somewhat unusual, and most surgeons will not want limit their practices. If they do intend to care for a significant number of cosmetic surgery patients, certain items can be modified to make the best of both worlds. Oral and maxillofacial surgeons (whether with a single or dual degree) are an easy target for competing specialties. "Do not go to him, he is a dentist" is a mantra of competitors internationally. Yes, internationally. I have lectured on cosmetic facial surgery worldwide, and it is always the same. This is of little importance to the oral and maxillofacial surgeon who performs competent cosmetic surgery and has good outcomes with happy patients. Competitors can claim anything they want; however, after a while, one's reputation will outstrip that of the competition. Similarly, if an oral and maxillofacial surgeon begins to treat a significant number of cosmetic patients, the surgeon might decide to "segregate" these patients. For all the aforementioned reasons, it is sometimes beneficial to separate cosmetic patients from the general OMS patients. This can be done by dedicating a half day for cosmetic patients only and adjusting the schedule

appropriately as the cosmetic aspect of the practice increases.

#### ANESTHESIA CONCERNS

Our ability to provide safe and effective sedation and anesthesia is one of the hallmarks of our specialty. Other than anesthesiology, no other specialty is as well versed as OMS on outpatient office ambulatory anesthesia. We have a big head start on other practitioners who must take even the simplest cases to the hospital. This means we can be safer, more convenient, more private, and more cost-effective than our competition.

The average oral and maxillofacial surgeon is trained and used to providing short anesthetic cases



**FIGURE 3.** Water wall with practice name and soothing sound greets patients entering the office. I borrowed this idea from another oral and maxillofacial surgeon, because I thought it an esthetically pleasing fixture.

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for younger, healthy patients. With cosmetic facial surgery, the inverse is often true. The average cosmetic facial surgeon will be confronted with an older population and surgeries that can routinely last 2 to 6 hours. This requires significant rethinking for the cosmetic-oriented average oral and maxillofacial surgeon including utilization of additional dedicated anesthesia care resources.

We all have the basics for anesthesia including emergency equipment, airway support and anesthetic agents and we need to build on these. Although most cosmetic facial surgery can be performed with IV sedation some patients do better with inhalation general anesthesia and/or propofol pump with concomitant advanced airway management.

Although most contemporary average oral and maxillofacial surgeons have adequate emergency medications, there is a higher level of care required for accreditation with inhalation anesthesia. The office must have adequate doses of Dantrolene (dantrolene sodium, Merck Research Laboratories, Whitehouse, NJ) for malignant hyperthermia. Laryngeal mask airways (LMA) and intubation equipment is also necessary. If deep sedation or general anesthesia is used a monitor with end tidal CO<sub>2</sub> must also be available.

Other equipment that is required includes some type of power back-up source that can maintain surgery for 40 minutes. Accreditation also requires certain standards such as nonporous ceiling tiles, emergency lights that come on during power failure, exit signs, fire extinguishers, annual fire and pharmacy inspection, detailed medication records, and emergency transfer protocol to a local hospital. Another area of increased scrutiny for being accredited is adequately addressing patient confidentiality (HIPPA concerns). Other surgeons or partners who use the facility must undergo credentialing and have an approved privilege list. This is one of the many prohibitive sounding rules, but in reality is an easy aspect of accreditation. Any procedure that is done with anesthesia must be formally dictated as in a hospital. Additional forms must be added to the routine chart and a higher level of documentation is necessary.

Peer review is also an important part of the accreditation process, and my patient care records are required to be reviewed by another practitioner with a similar practice on a quarterly basis. All of this might sound difficult and prohibitive, but it has made me a better doctor with a safer and more organized practice.

The average oral and maxillofacial surgeon must also rethink the recovery process, because normal OMS patients have short surgeries and short recoveries. Long cosmetic cases can portend long recoveries, and it is essential to have an appropriate



**FIGURE 4.** My recovery suite.

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recovery site and personnel for prolonged patient recovery (Fig 4).

## Marketing Concerns

### INTERNAL MARKETING

Every successful oral and maxillofacial surgeon knows how to market. The crux of OMS marketing circles around general dentists and dental specialists. Most OMS practices do not perform direct public marketing. The same referral base that applies to routine OMS is initially useful for cosmetic facial surgery, because these offices can refer cosmetic patients, as well as dentoalveolar patients. One problem that I encountered when I was performing both cosmetic and routine OMS was that some of the dentists believed my interest in dentoalveolar surgery was waning owing to my enthusiasm for cosmetic facial surgery. This was also fueled by some competing oral and maxillofacial surgeons. I personally made it known to my referring dentists that cosmetic facial surgery was my “crown and bridge.” An esthetic dental practice of crown and bridge placement, veneers, and so forth is the goal of many progressive general dentists, and I explained to them that cosmetic facial surgery was a part of the contemporary scope of oral and maxillofacial surgeons and that I was not abandoning the rest of the specialty, I was merely focusing on something that I loved and that I did well. Initially, I heard a lot of “Joe wants to be a plastic surgeon” and such, but, after several years, I was “doing their eyelids” and performing facelifts on their wives and staff. Again, when you prove you are serious and proficient, the work will follow. When I did finally limit my practice, my referral base understood and was happy for me and largely has continued to refer patients.

The average oral and maxillofacial surgeon will not want to limit his or her practice and will want to make



**FIGURE 5.** Digital picture frame.

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cosmetic surgery a small, but enjoyable, part of their scope. This is actually very easy to market, because we have a new daily list of potential patients. All adolescents presenting for dentoalveolar treatment will be accompanied by 1 or more adults. These adults often want Botox, lip and wrinkle fillers, eyelid surgery, and facelifts. By simply using basic internal marketing, the average oral and maxillofacial surgeon can launch cosmetic facial surgery from his or her waiting room and evaluation suites. Simply by putting cosmetic facial surgery literature, fliers, and before and after pictures in the office rooms, a respectable amount of cosmetic facial surgery can be generated. While potential patients are waiting for their child's surgery, they can just as easily read about the cosmetic services available as read a magazine. Digital picture frames that loop a continuing slide show have proved effective for many practitioners (Fig 5). Additionally, using the "call on hold" tape to discuss the cosmetic services available can pique patient interest. Providing samples of skin care products, sunscreen, and cosmetics can also generate interest. One word of caution is to not become too overzealous with dentoalveolar patients when they do not inquire about cosmetic surgery. I have admittedly made this mistake in the past by discussing eyelid surgery with a dentoalveolar patient who subsequently complained to his or her general dentist. The "build it and they will come" mentality must be kept in mind. Do not be "pushy" with your new-found subspecialty; simply put enough information in conspicuous places that interested patients will self inquire (Fig 6).

Informing and marketing to dentists that constitute your dentoalveolar referral base is also a powerful method of generating interest in cosmetic facial procedures. Speaking to dental societies, study clubs, and hygienist and dental assistant meetings are very effective.

As mentioned, separating the cosmetic and dentoalveolar aspects of the practice (physically or mentally) can assist in marketing the cosmetic facial procedures, just as some oral and maxillofacial surgeons do with the implant aspect of their practice. When I was practicing routine oral and maxillofacial and cosmetic facial surgery, I had separate letterhead, stationery, and business cards specific to each discipline.

#### EXTERNAL MARKETING

The decision to market cosmetic services externally is a big one, because it will totally change the complexion of one's working relationships with competing specialties. Plan on losing friends. The surgeons from competing specialties that I trained with and were friends with quickly turned a cold shoulder when I began advertising. Not wanting me to perform cosmetic surgery was understandable;



**FIGURE 6.** Information wall to inform patients about cosmetic facial surgery practice.

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FIGURE 7. Informative Web page should be paramount to any marketing in OMS, especially cosmetic surgery. Joe Niamtu, III. Accredited Cosmetic Facial Surgery Office. J Oral Maxillofac Surg 2009.

informing me that I was not qualified and berating me to others was not. If you advertise, expect criticism and deal with it.

To successfully market cosmetic procedures, one must understand the target market, which is generally 35- to 65-year-old women who have expendable income. This can be done in a multitude of ways. I spend at least 10% of my production on multimedia marketing.

The first and undisputable modality is a Web site (Fig 7). Some oral and maxillofacial surgeons simply put up cosmetic surgery pages and others make a new and dedicated Web site for cosmetic facial surgery. The Internet has become the king of marketing. During the past decade, I went from treating patients from all over the city, to all over the state to all over the United States, and now from all over the world. The Web site should be designed around the female patient but should suffice for the male patient as well. Patients love information, and the procedures performed by oral and maxillofacial surgeons should be detailed and contain before and after pictures. Also, patients love to ask questions; thus, having an "Ask the Doctor" link is a good idea. To be effective, search engine optimization is necessary.

Public seminars are also an effective means of marketing a cosmetic surgery practice. Placing signs in the office and/or running an ad in local media can generate interested patients. Giving away gifts, door prizes, or treatments can also make a big difference. The OMS can host these seminars in his or her office with snacks and beverages or use a local hotel if the size warrants. Frequently cosmetic surgery-related companies will assist in sponsoring these seminars. Having a booth at local shows or health fairs is also effective in marketing (Fig 8).

Print advertising in newspapers and local magazines is also effective but can be expensive and requires the services of a marketing professional. The marketing person can also assist with a dedicated brochure that details your cosmetic procedures, and these can be used in the office, as well as distributed to potential patients and referral sources.

There is no more effective or affordable marketing than word of mouth. This obviously applies to all patients, not just cosmetic patients. If you treat patients better than anyone else and make their experience memorable, they will become your marketing partners. I give all patients my cell phone and e-mail address and telephone all of them on the night of their surgery. I did the same when I practiced general OMS, and it has continued to be a winning combination.



**FIGURE 8.** Promoting cosmetic services at women's shows or health fairs is an effective method of informing a target market about cosmetic OMS.

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## What Does the Future Hold?

Paradigms will always continue to shift. Someone told me 30 years ago that someday they would be able to send electronic mail across the ocean and the recipient would receive it within seconds. Sounded pretty similar to the telegraph, so I thought they were a bit crazy. Not long after this conversation, a huge paradigm shift occurred for communication called the facsimile (fax) machine, and that person seemed a little less crazy. Shortly after that came electronic mail, and the crazy person had become a visionary.

Life and everything in it is dynamic and not static. The only constant is change. Naturally, our specialty and every other one will continue to change. Some will change for the better and some for the worse. However, I see unfavorable changes for oral and maxillofacial surgeons, and it is the fault of the younger surgeons and not the specialty. We are getting soft, and we are getting selfish.

I hate to use the "when I was your age I walked 5 miles to school" reasoning, but I truly think the altruistic attitude of the average graduating resident during the past decade has changed. Oral and maxillofacial surgeons are the "cream of the crop," and no one achieves that without ability, intelligence, leadership, and hard work. In the past, oral and maxillofacial surgeons were more altruistic. They "took call" and did not whine, they did pro bono work because someone needs to care for the unfortunate, they operated in the hospital because that is where the sick patients are and where OMS is needed. A huge paradigm shift has occurred in these attitudes, and it is not just my opinion but that of many others. Many new oral and maxillofacial surgeons finishing residency

(and many who have been finished for longer) refuse to “take call,” refuse to treat trauma patients who do not have reimbursement, and rarely use the hospital. The paradigm is shifting from full-scope OMS with frequent hospital use to a “teeth and titanium” mentality. Many younger surgeons have no desire to “take one for the team” and have become selfish. None of us relish doing something for nothing or for unfair reimbursement, but it is a part of every specialty. Does every appendectomy patient have coverage, or every head trauma patient, or every coronary bypass patient? Absolutely not. OMS is also not the only specialty that has experienced this; I have seen similar editorials about ear nose and throat and plastic surgery specialties, and in those editorials they have warned their readership that if their ranks do not “take call,” the oral surgeons will end up capturing that segment.

Several years ago, Hupp<sup>3</sup> penned a very effective article about this very subject, and every oral and maxillofacial surgeon should read it because it predicts ominous changes within our specialty. It predicts that we will withdraw from 50 years of progress to achieve access to the hospital. It predicts that we will become an office-based specialty such as periodontics or orthodontics. My late chief Elmer Bear, with other giants in OMS, gave blood, sweat, and tears to gain the respect of our colleagues. He would hang his head low if he could see the current state of affairs.

I implore every oral and maxillofacial surgeon, regardless of age, to rethink where we have come from and where we are going. Cosmetic surgery is an important part of the future relevance of our specialty. Share the pain and do your part to uphold the

specialty as we stand on the shoulders of the giants who preceded us.

OMS is a dynamic specialty, and the scope of the practice has continued to increase during the past 30 years. There is a much greater scope of practice on our board examinations than when I took them 25 years ago; I am glad I do not have to take that test today. For most oral and maxillofacial surgeons, practice is a lifestyle and not a job. We are very fortunate to have a specialty that has endured and prospered and remains progressive. I see my friends with whom I trained in general surgery, cardiac surgery, and many other specialties hating life because they have become pawns to hospitals, insurance companies, and government. I am so fortunate that I am involved in OMS, because it has served as a focus for my life. I recently gave a lecture to a senior high school class, and we discussed success. I asked them what they thought success constitutes, and, of course, I received all the expected answers: a big house, a nice car, a good income, and so forth. I told them that the true definition of success is when a person goes to sleep on Sunday night and is excited about going to work on Monday. It is almost midnight on Sunday as I finish this article, and I am excited that I get to go to work tomorrow and practice my profession. Everyone should be so lucky!

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