The potential benefits and complications of this approach are discussed throughout the article.

Methods: The single endaural approach was performed to replace bilateral TMJs in 4 patients in the Department of Oral and Maxillofacial Surgery, University of Texas Health Science Center at San Antonio. All 4 patients were followed up and examined once immediately after the procedure on postoperative day 1, 1 week postoperatively, and at varied times for up to 6 months.

Results: Postoperative exams were scheduled for 1-week and consecutive 1-month evaluations until symptoms resolved. Full head and neck exams were performed at each appointment. All patients had increased maximal interincisal opening (MIO) with very minimal swelling on day 1 of postoperative evaluation. They also reported a decrease in myofascial pain and headache. All 4 patients had temporary bilateral frontal and zygomatic facial nerve dysfunction that resolved with a mean time of 110 days.

Conclusion: All 4 patients in the research study had complications presenting as temporary bilateral frontal and zygomatic facial nerve dysfunction resolving within 4 months postsurgery. Directly after procedures were performed, the patients demonstrated increased function including greater mouth opening and conveyed experiencing diminished pain sensations. Although the preauricular endaural combined with a submandibular approach is considered the standard for temporomandibular joint (TMJ), the endaural only approach was adequate in this case providing immediate increases in MIO and decreases in patient perceived disability after the procedure. The single endaural method only created minor small incisions through the skin to extend to and increase the visibility of the appropriate area. It is a less invasive technique resulting in minimal tissue disturbance with immediately functional and aesthetically preferable results.

FEEDBACK IN ORAL AND MAXILLOFACIAL SURGERY EDUCATION

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Purpose: The practice of giving feedback has never been evaluated in OMS (oral and maxillofacial surgery) education. The aim of this study was to characterize variations in feedback-giving strategies utilized in resident education and compare this to their preferred ways of receiving feedback. As a secondary aim, we wish to gauge residents' satisfaction with the feedback they receive. As a tertiary aim, we wish to compare residents' and attendings' perception of said feedback.

Methods: We sent surveys to all OMS residency program directors nationwide for completion by their residents and faculty (Figures 1, 2). All responses were recorded via a 5-point Likert scale. Responses were grouped into categories of *agreee + strongly agree*, *neutral*, and *disagree + strongly disagree* for statements of preference or agreement and *almost never + seldom*, *sometimes*, *most of the time + nearly all of the time* for statements of setting and time. Wilcoxon-Mann-Whitney *U* tests were used to compare responses between 2 groups, with $P < .05$ for statistical significance.

Results: Our results show significant differences between how feedback is given, based on the residents' perspectives, and how they prefer it be given. Most notable, 79% would like feedback to occur during a postoperative debrief immediately after the case; however, only 27% report that this is the usual setting ($P < .0001$). Additionally, 92.95% prefer verbal, face-to-face feedback, whereas they agree that it occurs this way 59% of the time ($P < .0001$). In terms of resident satisfaction, only 47% were satisfied with the current feedback practices. The biggest deficiencies appear to be in the quality and specificity of said feedback, with only 43% agreeing that each of these are adequate. Additionally, only 49% felt that the amount was adequate. In regards to faculty vs resident perceptions, significant differences were found in nearly all responses. The groups only agreed on the seldom use of rating tools and the importance of feedback in OMS education, which was nearly unanimous (94% vs 96%). The largest difference was in the use of postoperative debriefing, which faculty reported to occur often 65% of the time, while residents reported only 27% ($P < .0001$). Ninety-four percent of faculty responded that feedback is most often delivered verbally, face-to-face, while only 59% of residents agreed ($P < .0001$). Additionally, 76% of faculty believed the quality of their feedback to be adequate, versus only 43% of residents who felt that this was the case ($P < .0001$).

Conclusion: Our results indicate several issues regarding the current practices of feedback in OMS training. Residents most prefer feedback given verbally, face-to-face, in a postoperative debriefing, while they indicate that this is often not the case. Interestingly, faculty believe that both of these occur significantly more frequently than the residents report. Faculty also

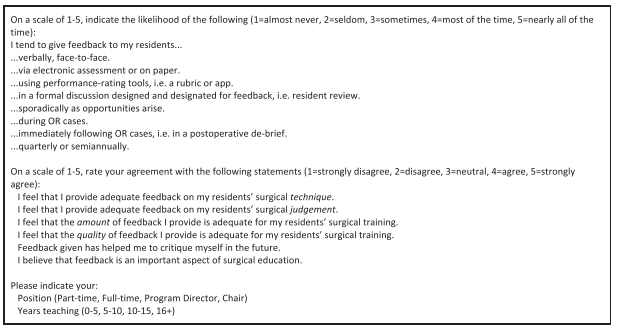
On a scale of 1-5, indicate the likelihood of the following (1=almost never, 2=seldom, 3=sometimes, 4=most of the time, 5=nearly all of the time):
In my training program, feedback is given...
...verbally, face-to-face.
...via electronic assessment or on paper.
...using performance-rating tools, i.e. a rubric or app.
...in a formal discussion designed and designated for feedback, i.e. resident review.
...sporadically as opportunities arise.
...during OR cases.
...immediately following OR cases, i.e. in a postoperative de-brief.
...quarterly or semiannually.

On a scale of 1-5, indicate your preference (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree):
In general, I prefer feedback to be given...
...verbally, face-to-face.
...via electronic assessment or on paper.
...using performance-rating tools, i.e. a rubric or app.
...in a formal discussion designed and designated for feedback, i.e. resident review.
...sporadically as opportunities arise.
...during OR cases.
...immediately following OR cases, i.e. in a postoperative de-brief.
...quarterly or semiannually.

On a scale of 1-5, rate your agreement with the following statements (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree):
A large portion of the feedback I receive is from *attending faculty.*
A large portion of the feedback I receive is from *senior residents.*
Those who directly observe me are those who provide me feedback.
I am given adequate feedback on my surgical *technique.*
I am given adequate feedback on my surgical *judgement.*
I feel that the *amount* of feedback given is adequate for my surgical training.
I feel that the *quality* of feedback given is adequate for my surgical training.
I receive specific enough feedback to direct my learning.
My faculty ask me for feedback, i.e. suggestions on how they might improve their teaching.
Overall, I am satisfied with the quality and quantity of feedback given in my training program.
Feedback given has helped me to critique myself in the future.
I feel that the feedback given during my surgical training has been pivotal for shaping me into the budding surgeon I am today.
I believe that feedback is an important aspect of surgical education.

Please indicate your:
PGY level (1-6)
Residency program type (4- or 6- year)

Figure 1. Resident RedCap Survey.



On a scale of 1-5, indicate the likelihood of the following (1=almost never, 2=seldom, 3=sometimes, 4=most of the time, 5=nearly all of the time):
I tend to give feedback to my residents…
…verbally, face-to-face.
…via electronic assessment or on paper.
…using performance-rating tools, i.e. a rubric or app.
…in a formal discussion designed and designated for feedback, i.e. resident review.
…sporadically as opportunities arise.
…during OR cases.
…immediately following OR cases, i.e. in a postoperative de-brief.
…quarterly or semiannually.

On a scale of 1-5, rate your agreement with the following statements (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree):
I feel that I provide adequate feedback on my residents' surgical *technique*.
I feel that I provide adequate feedback on my residents' surgical *judgement*.
I feel that the *amount* of feedback I provide is adequate for my residents' surgical training.
I feel that the *quality* of feedback I provide is adequate for my residents' surgical training.
Feedback given has helped me to critique myself in the future.
I believe that feedback is an important aspect of surgical education.

Please indicate your:
Position (Part-time, Full-time, Program Director, Chair)
Years teaching (0-5, 5-10, 10-15, 16+)

Figure 2. Faculty RedCap Survey.

believe that the quality of their feedback given is adequate, while residents disagree. Overall, it appears that resident satisfaction with current practices is low, and our study identifies multiple opportunities for improvement.

Figures 1 and 2.