

AMERICAN SOCIETY OF CRANIOFACIAL SURGEONS NEWSLETTER

SUMMER 2020

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FROM THE PRESIDENT



Welcome to the second edition of the ASCFS Newsletter. It seems that the inaugural edition we published this past winter was well timed and fortuitous, as our newsletter was established to enhance the ability to better communicate with our membership. Such a mechanism of bolstered communication is perhaps most advanta-

geous and valuable in times of increased isolation which is where we find ourselves as we all endure the COVID-19 crisis.

To begin with I want to inform you of a unanimous ASCFS Board decision, after my recusal, to have me continue to serve as your president for a second consecutive year and have the current board configuration stay as it is for an additional year. This action was taken because of the cancellation of our joint national meeting with the ACPA and the elimination of our 2020 program for our membership. Similar organizations such as the AAPS had taken similar steps in order to both navigate the uncertain future and the impact of COVID-19 in the upcoming year and to give the opportunity of the leadership to potentially organize and assemble their own national meeting. I am grateful for the opportunity to lead this wonderful organization over the coming year and hope that with some advances in medical technology we can all get back to a sense of normalcy as soon as possible.

I am grateful for the opportunity to lead this wonderful organization over the coming year and hope that with some advances in medical technology we can all get back to a sense of normalcy as soon as possible.

The COVID -19 crisis has also effected a number of other efforts the ASCFS had been planning for the upcoming year. The Craniofacial Boot Camp has been cancelled in its usual

(continued on page 2)

President's Message (continued from page one)

format, however, an alternative program has been developed by Davinder Singh and Stephen Beals. Please read Dr. Singh's article that addresses the board's decision to cancel the meeting, usually held in August and the Video Learning program that has been organized in lieu of our in-person Boot Camp. The article also outlines the follow up plans coming this fall.

In addition, given the uncertainty of the COVID-19 crisis, the board has made the decision not to pursue the joint meeting with the American Society of Pediatric Neurosurgeons (ASPN) in Kapolei, Hawaii in January of 2021. Although we hope to organize another joint meeting in the future, the restrictions on travel at many university centers for attendings, residents, and fellows, the health concerns, and the potential financial hazards, precluded our participation this coming year. Please read Mark Urata's article that outlines the decision, the amiable interaction with the ASPN, and the potential plans for the future.

Since we have not had our national meeting and therefore not able to have a regular business meeting, I have asked our treasurer Patrick Kelley and our Secretary William Hoffman to give an abridged report appropriate for consumption in a newsletter. Please see their respective articles below to gain an up to date financial and administrative perspective on the state of our organization.

For fear of our membership hearing of all of the postponements of our usual activities and thinking the ASCFS is succumbing to a newfound "cancel culture" I want to assure you that our organizational activities are not exclusively meeting based. We have embarked on multiple fronts to expand our reach and to add value to our society and create additional benefits to our members by addressing issues relevant to our specialty and developing new consequential programs and initiatives. Perhaps the most impactful of those projects is the establishment of our new Journal "FACE" as the joint official organ of both the ASMS and the ASCFS under the banner of SAGE publications. The inaugural issue comes on line in late July with 12 articles and provides a forum that is organized and operated by our two organizations. Please see John Van Aalst's article chronicling the development of our new Journal "FACE" as well as describing its mission and presenting a synopsis of the contents of the first edition. I encourage all of our members to see this Journal as our premier subspecialty publication and to send in content as your support will underwrite and endorse the eventual success of this historical enterprise.

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Also included in this second edition of our newsletter I have incorporated an article by Jack Yu and Davinder Singh outlining an ERAS (Enhanced Recovery After Surgery) Protocol for Surgical Correction of Cleft Lip. Those same authors along with Alex Lin, Anand Kumar, and Mark Urata have also written up a set of Guidelines for Craniofacial Trauma Care in a Respiratory Pandemic and are tendered below.

Joe Williams has put together an update on an analysis of our craniofacial fellowships operative and training experiences with some plans for the future of ensuring the quality of our trainees. In addition, Dr. Williams has also written an article about a project he is spearheading that will allow the ASCFS to remember, document, and celebrate the past leaders of our subspecialty, please read his piece that explains this initiative and his call for interested members to join a committee to help him to accomplish this worthy undertaking. Jesse Goldstein has written an article that addresses the unique challenges to recruitment and selection of

our new crop of craniofacial fellows this coming year given the restrictions imposed by the COVID-19 crisis and Christian Vercler has written another ethics corner that tackles the ethos and morality that the craniofacial surgeon faces during this challenging time. Finally, I have added another column to our newsletter entitled "Perspectives from a Past President". I thought recruiting the viewpoint from past presidents, now removed from the everyday administration of our organization would be both interesting and instructive. In that spirit, Jeff Fearon comments on the tribulations of the current peer review process as we continue to publish our scientific findings.

I hope that you find the second edition of our newsletter informative, interesting, relevant, and most importantly a thread that helps to bind our organization together as we isolate and socially distance during this COVID-19 crisis. Once more I ask you to participate in the evolution of this newsletter and I ask you to write me and let me know of any articles or issues you would like to contribute going forward. Please feel free to write me at sbuchman@umich.edu about any concerns you may have or with an interest and desire to get more involved. Most of all I would like to thank you for the honor of continuing to serve as your president during these unprecedented times, I am grateful for the opportunity to lead this impressive organization and can continue to see a very bright future moving forward.



Steven R. Buchman, MD, President

FROM THE SECRETARY



Membership has continued to grow and in March of this year we reached a new milestone – 100 active members! For perspective, we were at 74 active members just 4 years ago. There are 15 more applications for active membership (including upgrades from resident) currently in process as well. Total membership is presently 390 - as-

associate membership remains stable around 60, life members have been roughly stable at 13. We have seen a big rise in resident/fellow membership from 128 in 2016 to 210 at present. Many of these members should upgrade to affiliate, or even

active membership and we are contacting all to ensure members are listed in the correct category, based on qualifications and cases.

The annual Craniofacial Fellows Boot Camp in Phoenix has traditionally been an opportunity to promote membership to the current class of craniofacial fellows; we will still have this chance but in a video based format as things stand at present.

We encourage you to talk to your colleagues who are still listed as resident members and ask them to upgrade and to your new fellows to make sure they join. Direct them to the ASCFS website (www.ascfs.org) to review the categories of membership and to apply online.

Please contact me or Lorraine O'Grady with any membership related questions or suggestions.

William F. Hoffman, MD, Secretary

FROM THE TREASURER



As we get past a full quarter of the COVID epidemic, causing the cancellation of ASCFS' annual meeting, there may be a few out there wondering what the impact has been to our society. The treasurer reports on the finances of the society at the annual meeting. Since we did not have one this year, I am providing you my report

via the newsletter. I am happy to report that the organization remains financially strong despite these very unique times.

The ASCFS has three main sources of revenue: member dues, meeting registration, and industry support. Member dues represent the bulk of net revenue as the general administrative cost burden of the organization through our partnership with PRRI is relatively low. In general, the registration fees of our educational meetings are set to cover the cost of the meet-

ing so they are essentially run as revenue neutral events. The society works hard to keep registration fees as low as possible for the members. Our society recruits very limited and targeted industry funds to balance out any cost overrides during educational events (eg. fellows' course) in order to maintain cost neutrality of each event. The society has

reached one hundred fifty-nine paying members (110 Active; 58 Affiliate) this year which is the highest number of all time! Additionally, the members continue to pay dues as I am happy to report that we are a bit ahead of last year's first quarter dues revenue. We are hoping to avoid any apathy with dues payments in light of the cancelled annual meeting. The board is actively looking for educational opportunities to go along with ASPS in the fall if that meeting indeed occurs. Additionally, the board is in the process of contemplating plans for the second joint meeting with ASPN giving us two major educational meetings in 2021. The first meeting was a great success. Dr. Hopper put together an amazing program. We anticipate an equally intriguing program from Dr. Urata if the Covid situation allows. As the joint meeting was one of our most expensive in history and we will start incurring costs for the meeting in the fall of 2020, we will need strong dues revenue this year. We have a lot to look forward to in the coming year. Look for more information on all future meetings including the joint meetings in this and subsequent newsletters.

Total assets for the society to date are \$69,121 with a very limited liability for the remaining year. (The occurrence of the fellow's course is still being debated.) With the forecast of very limited educational activity due to COVID, the society will end the year in a very good position to start off 2021. Dr. Williams has done amazing work regarding the collection of current craniofacial fellowship training at no cost to the society. I anticipate that the society will start to incur some costs related to our efforts to establish the supremacy of the society's sponsored training programs in the coming years.

The ASCFS Foundation has total assets of \$83,103. The mission of the foundation is to improve the quality of life of craniofacial patients through education, research and development. Annually the two major expenses of the foundation are support of the Kawamoto and Whitaker lectures at the annual meeting. I don't anticipate any additional costs in 2020 to the Foundation.

Patrick K. Kelley MD, Treasurer

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The Craniofacial Fellowship Application Process in the Era of COVID-19



At the University of Pittsburgh Graduate Educational Committee (GMEC) bimonthly meeting last month, the leadership made clear to the assembled residency and fellowship program directors, that our institution would not support in person interviews during the upcoming application cycle. Period. Over the past few weeks since this

meeting, as the coronavirus landscape across our country has evolved, this guidance has made more and more sense. The unpredictability of the outbreak has become evident as the Once hot-spots in the East Coast are now cooling, just as new flare-ups in the South and South-west are becoming more apparent. Air travel and social distancing guidelines are changing by the day as is our understanding of how coronavirus spreads.

With this landscape as backdrop, rising chief residents across the country and abroad are busy preparing their applications for craniofacial fellowship programs for the 2020-2021 cycle. For some, they have been preparing themselves for this process since starting residency. Still others are scrambling to buff up their CV's and spend time with craniofacial faculty to get some final career coaching. For all, this is an exciting, yet stressful process made more so by the COVID-19 pandemic.

In June, the *Journal of the American Medical Association* published a "Viewpoints" article focused on the effect Coronavirus will undoubtedly have on residency applications across the nation.¹ The authors catalogue the challenges residency programs may face attracting and evaluating qualified candidates for the 2020-2021 application cycle and list a series of steps that programs can take to address these challenges. Luckily for our fellowship applicants, they do not have to contend with standardized testing schedules and mandatory away rotations. Nonetheless, applicants this cycle face new and significant challenges.

In previous years, applicants without a close craniofacial mentor or strong program at their home institution spent some of their elective time on "mini-away" rotations, allowing them to show off their abilities and demonstrate their commitment to our field. This year many medical centers are prohibiting such activity. In previous years, applicants could obtain some valuable face time with fellowship directors across the nation and regionally at our national and regional meetings. This year, every major meeting has either cancelled or moved to a virtual format and provide no such opportunities. In past years, in person interviews allowed applicants to get a "feel" for a program just as it served as an opportunity for mutual education and evaluation. This year, many, if not all health systems are prohibiting such opportunities.

It's important to remember that although these factors affect applicants across the board, they most certainly are felt more heavily by applicants without close ties to major residency

and craniofacial programs and without close craniofacial mentorship. Indeed, women and under-represented minority applicants as well as applicants from more rural residencies may be more affected by COVID-related changes this cycle than others. This factor heightens the need for thoughtful and decisive solutions.

One clear way to address many of these issues is for our society to fully embrace virtual interviews. For many, the idea of a virtual interview is like drinking a fine wine with your nose plugged—devoid of the flavor that truly helps to differentiate candidates and programs alike. But it doesn't have to be. In fact, there are substantial benefits to the program and applicants, as long as virtual interviews are fully embraced by all. For one, the interview process is less stressful and less costly. Second, residents spend less time traveling for interviews and more time finishing their plastic surgery training. Additionally, if interviews are coordinated thoughtfully, residents may not have to decide between programs because of travel conflicts. Of course, there are some drawbacks to virtual interviews. They can be cumbersome and impersonal, and it's more challenging for programs and applicants to get a true "feel" for each other. There is no way for applicants to familiarize themselves with the city or the hospital. And some candidates (and faculty) may not be at their best in online settings.²

In addition to virtual interviews, the ASCFS should consider initiating several other opportunities. First, the ASCFS could potentially host regular Q and A sessions with fellowship programs on social media or podcasts so applicants can get a much-needed feel for the programs. Additionally, programs could significantly beef up programmatic descriptions and content available on their web-pages to give applicants a better feel for the fellowship and the location. Finally, programs could also make available the contact information for the last five years of graduating fellows so that applicants can perform self-directed due diligence.

Some of these changes are, by their very nature, temporary. When the coronavirus is behind us, we may easily revert to more normal operations. But we may find that a few, if not all, of the practices we adopt today outlast this pandemic and become our new normal.

Jesse Goldstein, MD, FAAP, FACS, Associate Program Director, Plastic Surgery Residency, Director, Craniofacial Fellowship / University of Pittsburgh Medical Center and UPMC Children's Hospital of Pittsburgh

References

1. Hammoud MM, Standiford T, Carmody JB. Potential Implications of COVID-19 for the 2020-2021 Residency Application Cycle. *JAMA*. Published online June 3, 2020. doi:10.1001/jama.2020.8911
2. Jones RE, Abdelfattah KR. Virtual Interviews in the Era of COVID-19: A Primer for Applicants. *J Surg Educ*. Published online April 8, 2020. doi:10.1016/j.jsurg.2020.03.020

Craniofacial Fellowships: An Update

As a follow up to our comments in the last newsletter, we have completed the analysis of the data collection taken during the fellowship year 2017-2018. We have moved forward with some conclusions based on our review. The implications of these findings as we adjust and realign our fellowship structure is currently being discussed. I have included a very limited portion of our analysis in this newsletter. The complete manuscript may be found in the journal "FACE" (<https://mc.manuscriptcentral.com/face>).

The study had two objectives: 1. Create a clearer picture of the skill sets that fellows are exposed to during training 2. Provide some threshold of case numbers shared by programs that may be used to establish shared expectations for the fellow's experience.

The cumulative data base was categorized into nine groupings, capturing surgeries of the facial skeleton, cleft surgeries and specialty surgeries in the area of microsurgery, facial reanimation, and ear reconstruction. These groups were chosen because they capture traditional craniofacial cases and expanded areas of expertise in our fellowship training.

These nine groupings were used to establish three tiers. These tiers provided an opportunity to discover thresholds of experience that captured consistent skill set experiences for the majority of the programs (Figure 1).

6018 cases were entered of which 3469.5 cases were placed into nine specified groups (57.6%). Group 1 (cranio-

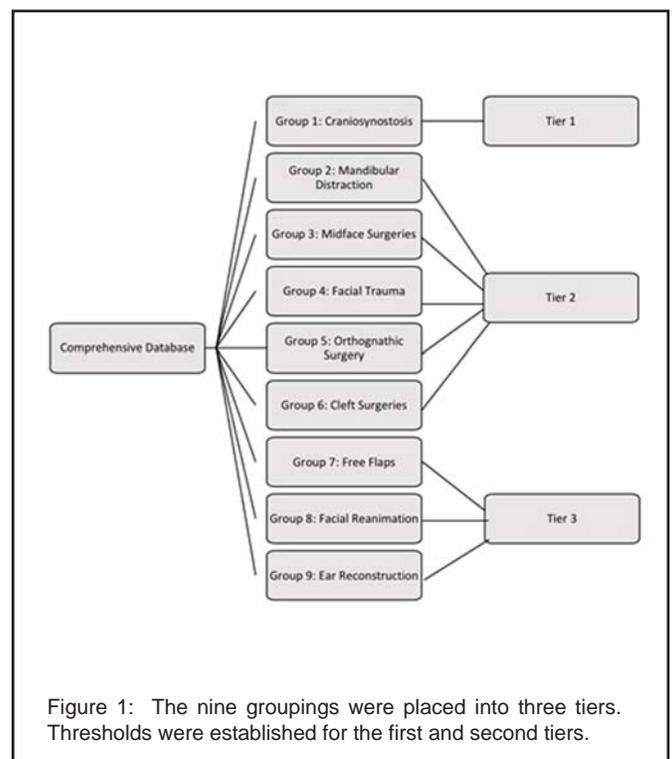
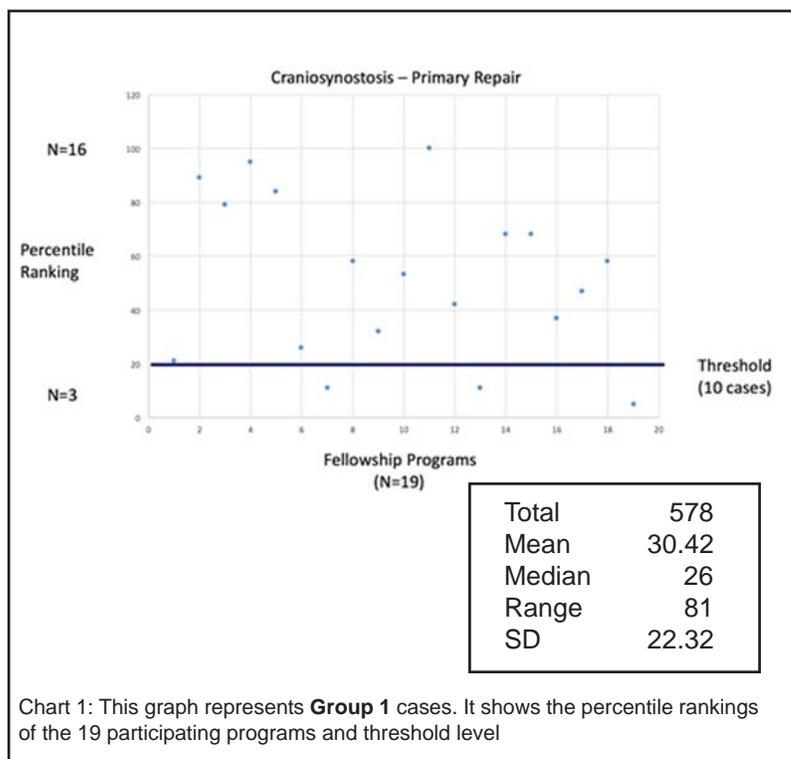
synostosis) had 578 cases (mean=30.4, SD=22.3). Sixteen of the nineteen programs participating (84.2%) were found to be at or above the 20th percentile ranking for this procedure (20th percentile = 10 cases) (Chart 1). Group 2 consisted of Mandibular distraction (144 cases), Group 3 midface skeletal surgeries (87), Group 4 facial trauma (641.5), Group 5 orthognathic surgery (506), Group 6 cleft surgeries (1303.5), Group 7 microsurgery (67), Group 8 facial reanimation (40.5) and Group 9 ear reconstruction (113). Percentile rankings were found for each group.

Three tiers were created for comparison, Tier 1 (group 1), Tier 2 (groups 2-6), Tier 3 (groups 7-9). When a 20th percentile threshold for case numbers was created for groups 1-6, 78.9% of programs met the 20th percentile (95% CI:67.9% -90.0%).

Our conclusion was that fellows are receiving consistent exposure to areas of training related to the facial skeleton with the exception of midface operative procedures. A significant volume of both cleft surgery and facial trauma was noted. The majority of the participating programs met a threshold of 20% for skill sets associated with our subspecialty.

We feel that these thresholds could be used as guides by fellowship programs and the ASCFS to better structure our training goals. We hope that in the next several months, the Society will be able to present a clear outline of expectations for training programs that wish to be categorized as an accredited program using these threshold guidelines.

Joseph K. Williams, MD



Fellows Boot Camp 2020 Cancelled: Video Modules Available Online



The annual **ASCFS/ASMS Boot Camp: Essential Training for Craniofacial Fellows** is usually held in Phoenix at the beginning of August with all of the craniofacial fellows and the national craniofacial faculty in attendance. Plans were well underway for the 2020 Boot Camp this summer and the ASCFS looked forward to welcoming the fellows into the community of Craniofacial Plastic Surgery.

However, due to the ongoing concerns and uncertainty surrounding COVID-19, the 2020 ASCFS Craniofacial Fellows Course has been cancelled. It is a course held in a lecture room and utilizes a cadaver lab with very close proximity to others over a two-day period, with an inability to “socially distance” from one another due to the lab portion. We wanted to ensure the participants’ health and safety as well as that of the instructors and staff who run the course.

We did consider holding a “virtual or on-line” boot camp but have decided against this as the greatest benefit of this course is the “hands-on” experience of the dissection and osteotomies. In lieu of the boot camp this year, we will be making available video recordings of the prior two years of lectures and cadaver dissections to all of the 2020 Craniofacial Fellows via the ASCFS website. The video recordings will be separated into the same modules as the course is organized

and we will also post the course agenda. This will be a password protected portion of the ASCFS website in order to maintain HIPPA compliance and should not be shared with others.

The following modules (lectures and cadaver dissections) will be covered:

- Module 1** Craniosynostosis and Vault Remodeling
- Module 2** LeFort III/Monobloc/Bipartition
- Module 3** Transfacial Approaches to Skull Base
- Module 4** TMJ Exposure (Facial Nerve Exposure via Superficial Parotidectomy)
- Module 5** Hypertelorism/Transnasal Wiring
- Module 6** LeFort I
- Module 7** Mandibular Osteotomy (BSSO) / Genioplasty
- Module 8** Application of Distraction Devices

We are strongly encouraging all of our new craniofacial fellows to complete these modules within the first month of their fellowship and to discuss questions with their fellowship directors, many of whom have served as faculty for the course over the past ten years. In mid- August, the ASCFS will then send out a survey to all of the craniofacial fellows to determine if they feel that a Question/Answer Webinar with the Course Faculty whose videos were viewed would be needed or helpful to them. Depending on the responses we receive, we will then consider arranging a Webinar on a Saturday in September.

We will miss hosting all of new fellows in Phoenix this year for the annual boot camp and will miss witnessing and participating in the comradery that is formed each year among the fellows and faculty.

The ASCFS wishes the new Craniofacial Fellows a safe and successful year of fellowship training and we warmly welcome them to join ASCFS as a craniofacial fellow.

Davinder Singh, MD

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Attention New Craniofacial Fellows: Join ASCFS TODAY

Visit the ASCFS website to apply online to ensure you are able to access the Boot Camp videos and participate in this unique learning experience. There is no membership fee for Resident Members.

If you are a Program Director, please encourage your new fellow to join today.

<https://ascfs.org/Professionals/Membership/>

FACE: The New Journal of the ASMS and ASCFS Launches in July



We are proud to introduce the new Journal FACE, the official organ of both the ASMS and the ASCFS. The Journal FACE is the outgrowth of many years of sustained effort by multiple people.

In many ways, the beginning of FACE can be traced to the initial ASMS Newsletter, which was first published in 1985, with Victor

Lewis as the Editor (see Appendix 1). The Newsletter focused on society announcements, messages from leadership, with information about upcoming meetings. The most recent Newsletter Editors have been Arun Gosain (2003 to 2004 and 2008 to 2014), Bob Havlik (2005 to 2007) and John van Aalst (2015 to 2018). Steven Buchman, President of the ASCFS inaugurated the first newsletter of that organization in the winter of 2019.

In 2017, ASMS leadership initiated a discussion about how to broaden the scope of the Newsletter and create a Journal, with the eventual goal being to index the Journal. We decided to make this transition within ASMS, rather than partner immediately with a publishing entity. The Green Journal was borne out of this transition.

The Green Journal

Though many aspects of the Newsletter were continued in the Green Journal (ASMS news, Notes from the President), we also made several key additions, including the Ethics Corner (Christian Vercler), the CPT corner (Greg Pearson), Pearls of Wisdom (Stacey Francis), New Member profiles (Seun Adetayo), transcriptions of the ASMS webinars (Joe Williams), and most importantly, original articles from ASMS members. The articles ranged in topics from descriptions of the Operation Smile training facility in Gwahati, India to techniques for pain control after alveolar bone grafting, and management of infants requiring mandibular distraction. The idea behind the Green Journal was to build a repository of original articles that would eventually enable indexing of the journal.

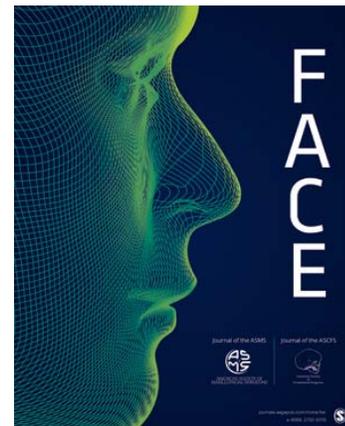
In 2019, Russell Reid won the Paper of the Year Award for the Green Journal with an article entitled "Polysomnographic Titration of Mandibular Lengthening by Distraction in Tongue-Based Airway Obstruction."

As the Green Journal was published quarterly, on-going discussions were held among ASMS leaders about the next step. Early in 2019, the decision was made to discuss a formal relationship with a publishing house. Among several candidates, and the assistance of Paula Gantz, we chose SAGE publishing as our partner.

At the 2019 ASMS Business Meeting, under Peter Taub's leadership, ASMS members voted overwhelmingly to pursue a formal relationship with SAGE to publish our journal. During this meeting, Steve Buchman, president of ASCFS, voiced the

strong need for a journal that would be the voice of not only the ASMS, but also the ASCFS. This discussion resulted in a finalized relationship with SAGE publishing to publish the journal FACE as the official organ of the ASMS and the ASCFS.

In March 2020, a final decision was made by the ASMS Board regarding the editors for FACE, with John van Aalst, Jack Yu, Steve Buchman and Peter Taub serving as the Executive Editorial members. In a measured, but quick sequence, decisions were made about the section editors and associate editors, and papers were reviewed for the inaugural issue of the Journal FACE (See Appendix 2).



The Journal FACE

The inaugural issue of FACE is an exciting milestone. The journal will be published in July 2020. The editorial staff has compiled a group of high-caliber articles that will resonate with members of both the ASCFS and ASMS (see list on next page).

FACE will be dedicated to the advancement of the Art and Science of Craniomaxillofacial Surgery through the dissemination of cutting edge evidence-based, data-driven manuscripts from experts in their respective fields. The Journal will be an authoritative reporting platform that is Fast, Accurate, Comprehensive, and Educational, expanding knowledge and disclosing discoveries, novel procedures and ideas, through original articles, brief communications, systemic reviews, and case

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FACE: The New Journal *(continued from previous page)*

reports. FACE promotes and propels the tradition of excellence of its founding organizations through the publication of leading edge reports at the forefront of the specialty, devoted toward a better understanding of the comprehensive topics and subjects associated with the FACE. Pertinent fields for publication in FACE include: Clefts, Craniomaxillofacial Surgery, Orthognathic Surgery, Basic Science, Aesthetic Surgery, Head

and Neck Cancer, Trauma, Gender Reaffirmation, as well as Government Policy and Advocacy. The objective and aspiration of FACE is to educate and inform our readers in order to improve patient care and enhance public health.

Following our initial publication, we plan to publish the second issue of FACE on October 1, 2020. We look forward to your submissions to FACE at <https://mc.manuscriptcentral.com/face>.

John van Aalst, MD

Articles in the Inaugural Issue of FACE, July, 2020

Promoting Advocacy in Plastic Surgery

Arun K. Gosain, MD and Delora Mount, MD

Faculty Preferences in Clinical Education Recognition: A Survey of Faculty at three institutions

Connie Ju, MD, Devra Becker, MD

Using a 3D printed 'Phantom of the Opera' Soft Tissue Surgical Guide for Complex Facial Reconstruction.

Gina Sacks, MD, Raquel M. Ulma, DDS, MD, Samuel D. Dolphin, BSE Stephanie Kline, MSE, MS, Steven R. Buchman, MD

The Impact of Bilateral Suprazygomatic Maxillary Nerve Blocks on Postoperative Pain Control in Patients Undergoing Orthognathic Surgery

Gabriela D. Garcia Nores, MD, Daniel A. Cuzzone, MD, Stefanie E. Hush, MMSc, PA-C, Kalyani Pandya, PA-C, Adam Stuart, MD, Joseph K. Williams, MD, Colin M. Brady, MD

Alternative Factors Associated with Failure of Mandibular Distraction Osteogenesis

Richard Ramirez-Garcia, BS, Laura S Humphries, MD, Russell R Reid MD, PhD

Craniomaxillofacial abstracts from the Ohio Valley Plastic Surgery Meeting

8 podium presentations and
12 poster presentations

Filling the Void: Use of the Interpositional Buccal Fat Pad to Decrease Palatal Contraction and Fistula Formation

Todd E Thurston MS MD, James Vargo MD, Katelyn Bennett MD, Christian Vercler MA MD, Steven Kasten MPHE, MD, Steve Buchman MD

Success with Monobloc Advancement in Mission Surgery

Peter J. Taub MD, Anand Kumar MD, Alex Lin MD, Chris Bonfield MD, Cheryl Gooden MD, Franklyn Cladis MD, Jeffrey Weinzwieg MD

Ethical Issues in Scarce Resource Allocation in a Global Pandemic: Relevance to Craniofacial Surgery

Christian J. Vercler, MD, MA

Lessons from Zika and Other Virus Induced Skull Deformity

M. Masoumy, E. Masoumy, B. Baban, J. Yu

Otoplasty Using Perichondrocutaneous Flap as an Adjunct to Mustarde Suture Technique

Christina M. Pasick, MD, Ilana G. Margulies, MD, MS, Peter J. Taub, MD, MS

A Review of Craniofacial Training Programs in North America

Stefanie Hush, PA, Joseph K. Williams MD

Perspectives from a Past President: How Good is This Study?



I was reading a new study the other day. In their introduction, the authors claimed this particular surgical technique has been shown to be the best. Intrigued, I looked up the citation. It described a novel technical variation and included a retrospective review of 58 cases. Two examples were presented, which while not astonishing did

show some clear postoperative improvement. The complication rate was 18%. The authors concluded their technique was safe and effective. Sound familiar? It should. These types of studies predominate in our published literature. Instead of beginning with a hypothesis, which is then tested in order to either establish proof or to be rejected, many studies appear to have been designed with a particular conclusion already in mind, which the authors then work to support in any way possible. Disciples of the scientific method find this type of methodology unconvincing, and for good reason. If one were to meticulously review all the studies underlying much of what we do day-to-day, it would be easy to be left with the impression that most of our daily surgical decision-making is based on a house of cards. Are things really that bad, or are we smart enough to see our way through?

Although cynics might complain about the incentives to publish in academia (if there is any hope of rising up in the ranks, and increasing compensation!), I prefer to believe that most studies are the result of a genuine intellectual curiosity. Furthermore, is it really fair to rest blame for scientifically unsound studies entirely on the shoulders of authors? One tenet of the scientific method is that the peer-review process is critical to ensuring quality publications. Reviewers are necessary to safeguard that the appropriate methodology has been utilized. They also must ensure that conclusions are based on hard data and are not simply a reflection of the authors' beliefs. Yet, this system does not function perfectly. In 2005, researchers at the Massachusetts Institute of Technology devised a program to crank out research papers that were filled with gibberish (http://www.nature.com/news/publishers-withdraw-more-than-120-gibberish-papers-1.14763?WT.mc_id=TWT_NatureNews). Is it funny, sad, or both, that over 120 of these nonsensical manuscripts got published in peer-reviewed journals? The stated purpose of this hoax was to highlight inadequacies of the peer-review system. Today, the majority of published studies pass muster with only two to three reviewers, personally selected by an editor

(With an outcome in mind?). Not infrequently, the reviewers are less familiar with the subject matter, and even methodology, than the authors. If more than one reviewer happens to hold the same opinion as the authors, publication is more or less assured. Most journals are money-making enterprises; therefore, they need material just as much as most authors need to publish. Once a study is in print and then subsequently cited, opinion becomes fact.

So, returning to the aforementioned study, when the authors conclude that their procedure is safe and effective, exactly what does this mean? With respect to safety, the best way to answer this question might be to pose another: What complication rate would I accept for my own child undergoing this procedure? Is 18% okay? Personally, no thanks. I think anything over 5% is probably more than I would be willing to risk. Above this 5% level, I would at least want to see a side-by-side comparison of complication rates to all alternative procedures. As for a technique being judged as "effective," how does one measure efficacy? Does effective mean that the procedure always fixes the problem? Can it provide a lasting result that accounts for all future growth, without the need for future operations? Unclear terms such as "effective" should have no place in scientific reports. As consumers of published literature we must all be vigilant to parse out opinion, while focusing our attention on the quality of the presented data.

Which brings us to confirmation bias. Just as entropy describes the driving force towards disorganization, confirmation bias wreaks havoc with our ability to see things clearly. If I develop a procedure, I want it to work. In my retrospective review, my bias will be to latch on to anything that might pop up as statistically significant in support of my beliefs. I am also more likely to characterize any identified complications as being more minor. If I am reading someone else's report that supports my viewpoints, I am more likely to both view the study's methodology favorably and to be able to later recall this report.

The reverse holds true for analyses that contradict my beliefs. Confirmation bias is an extremely powerful force. Once a neural network has been established, it is very hard to rewire. This has been somewhat humorously demonstrated by Destin Sandlin, whose team designed a bicycle that worked the exact opposite of the bicycles we all learned to ride: when handlebars are turned to the right, instead of the front tire going to the right, it turns in the opposite direction. Realizing this, we should all be able to ride this bicycle, right? The problem is that, as much as we might believe we can, we are unable to easily rewire our brains. As it turns out, it can take an adult up to 8 months of daily attempts

Once we have a way of thinking, it is really hard to change. The Nobel Laureate, Max Planck, once noted that "A scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die

Continued on next page

Presidential Prospective *(continued from previous page)*

before they are able to relearn how to ride this altered bicycle (watch the TED talk: *The Backwards Brain Bicycle*, ed.ted.com/best_of_web/bf2mRAfC).

Once we have a way of thinking, it is really hard to change. The Nobel Laureate, Max Planck, once noted that “A scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die and a new generation grows up that is familiar with

it.”¹ Or to put it another way, science advances one funeral at a time. Maybe we all can’t ride that backwards bicycle, but we at least owe it to our patients to begin by realizing that without a lot of work, we really aren’t able to ride that thing.

Jeffrey A. Fearon, MD, The Craniofacial Center

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The ASCFS Foundation

The Kawamoto Best Paper Award



Henry Kawamoto, MD

Several years ago, the ASCFS began a tradition of recognizing outstanding craniofacial papers presented during the annual meeting. An annual Best Paper Award, was named in honor of Henry Kawamoto, a founding father of the organization and leader in craniofacial surgery. The Kawamoto Best Paper Award provides recognition for the best craniofacial paper presented at the ASCFS annual meeting.

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[Donate to the Kawamoto Fund](#)

The J.G. McCarthy Visiting Scholar Award



Joseph G. McCarthy, MD

The award will provide a stipend of \$1,500 award to support the recipient to visit a craniofacial center of their choice during their first year of practice, with the purpose of expanding their appreciation of craniofacial surgery. The award will be granted to the applicant who best demonstrates these personal qualities with the goal to use their talents in the pursuit of excellence in academic craniofacial surgery.

The ASCFS Board welcomes applications from current ASCFS fellows. To apply, please send your CV and a letter describing how the use of this award would contribute to your career in craniofacial surgery to [Lorraine O'Grady](#), before July 31st.

[Apply Now](#)

[Career Summary](#)

[Donate to the McCarthy Fund](#)

The Linton A. Whitaker Lecture



Linton A. Whitaker, MD

Given during the ASCFS Annual Meeting, the Lecturer is given by a person whose work or career exemplifies the very best in the art and science of craniofacial surgery. Dr. Whitaker had a distinguished career as a master clinician, educator and researcher, which spanned over four decades at the University of Pennsylvania and at the Children’s Hospital of Philadelphia. Stemming from his time spent with Paul Tessier, he was responsible for introducing craniofacial surgery to North America along with Ken Salyer, Fernando Ortiz Monasterio, Ian Munro, Ian Jackson, Henry Kawamoto and Tony Wolfe. Along with these other giants of craniofacial surgery, he founded the premier organization within craniofacial surgery, the International Society of Craniofacial Surgery.

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[Career Summary](#)

[Donate to the Whitaker Fund](#)

ASCFS Foundation

The American Society of Craniofacial Surgery (ASCFS) created the ASCFS Foundation to serve as the education, research and philanthropic arm of the organization. The mission of the Foundation is to improve the quality of life of craniofacial patients through education, research and development.

The Foundation will accomplish its mission by supporting education and research through grant and award programs, including lectureships and research scholarships. We hope that you will consider a donation to the ASCFS Foundation. You may select to give to the general Foundation Fund or you may support one of the current initiatives, created to honor the esteemed founders of the specialty.

[Donate Today](#)

Guidelines for Craniofacial Trauma Care in a Respiratory Pandemic

Jack Yu, Alex Lin, Anand Kumar, Davinder Singh, Mark Urata

Pandemic, defined as “world-wide spread of a new disease” by WHO, has been and will always be a recurring part of life, with some variations. Bubonic plague spread at 200 to 400 miles per year from December 1347 to December 1350, starting from Italy and arriving in Scandinavia five years later. SARS-CoV-2 infected 215 countries and regions in less than 6 months. In the US, there are more than 1.8 million cases and 105,000 deaths as of June 2020. Importantly, viral shedding can occur prior to the onset of signs and symptoms. Healthcare personnel (HCP) are at increased risks due to close and frequent contacts. More than 3,000 HCP in China had COVID-19 with at least 22 mortalities and documented spread to their family members. Craniofacial trauma care in a respiratory pandemic requires special measures to reduce the risk to HCP. This guideline is to enhance the personal protection in managing craniofacial trauma.

In the Emergency Room or Inpatient ward

1. Assume the patient is COVID-19+ unless documented to be negative
2. Obtain COVID-19 test for all non-emergent injuries (no immediate threat to life, brain, eye) and await result prior to performing any aerosolizing procedure
3. Wear gloves, N95 mask or equivalent, and face shield or goggle when examining
4. Reduce personnel and conversation in patient room to absolutely necessary
5. Avoid touching cell phone, ID badge, keys, mask, goggle while in contact with the patient
6. Wash hands afterwards with soap and water for 20 seconds

In the Operating Room

1. All of the above; unless emergent, proceed to OR **after** COVID-19 test
2. If COVID-19 positive or with unknown status:
 - a. Use negative pressure, HEPA (High-Efficiency Particulate Air, ASME 99.95 to 99.97% of 0.3 micrometer particulate) filter-equipped rooms with air change rate of 25/hr (25 times the entire volume of air in the room is replaced per hour)
 - b. Reduce the RPM and saw speed to minimum that is necessary and with judicious irrigation
 - c. Reduce OR trafficking
 - d. Wipe down all surfaces (loupes, googles, etc.) after the case with proper disinfectants (70% alcohol or 1 ppm sodium hypochlorite)
 - e. Change scrubs afterwards

In the Office or Outpatient Clinic

1. Screening questionnaire for COVID-19 exposure, and signs/symptoms
2. Vitals including temperature and pulse oximeter reading
3. Wear surgical mask, goggles, and gloves
4. Supplement in-person visit with telemedicine whenever possible

Data Source:

Compiled from members of ASMS and ASCFS with input from AO and Level-I trauma centers

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ERAS Protocol for Surgical Correction of Cleft Lip

Davinder Singh, Jack Yu

This is the first in a series of craniofacial ERAS (Enhanced Recovery after Surgery) protocols developed by the ASCFS Presidential Taskforce. Using data-driven, evidence-based approach, the ERAS for lip repair, following standardized ERAS format, contains four phases: Pre-Hospital, Pre-Operative, Intra-Operative, and Post-Operative. Although there is a paucity of published articles on ERAS for pediatric plastic surgery in general, to the extent possible, we extracted information from the peer-reviewed literature and our own collective experience. The goal is to simplify and strengthen decision making during the four key phases of surgical care and thus enhance outcomes though reducing complications. Inherently, this is a closed-loop, iterative process with repeated re-assessments and refinements. This initial protocol leverages the lessons learned from the large number of patients cared for by the members of the ASCFS over the years. Good decision comes from experience. Experience, unfortunately, comes from bad decisions. Using “group intelligence” of the ASCFS and data when available, we leap forward and attempt to reduce the need for individual bad experience before arriving at good decisions.

With computerized physician order entry (CPOE) gaining near complete penetration in US hospitals, in order to implement ERAS, the institutional IT personnel must convert the attached protocol (see below) into computerized physician order sets. Through the internet portals of the individual craniofacial programs, the Pre-hospital phase and Post-discharge instructions can be available to the public online.

Lip repair, defined as a clean-contaminated surgery (American College of Surgeons Class II), has a reported post-operative infection rate of 5%. But we experience a much lower infection rate than 1 in 20, with most published series reporting

1.1 to 1.5%. A majority of the patients receive a single dose of pre-operative broad-spectrum antibiotics (Cefazolin 30 mg/kg), but there is no evidence that such prophylaxis decreases infection. The use of narcotics after discharge is no longer common practice. In this age range, respiratory suppression is a valid concern and most surgeons now engage in opiate sparing and opiate avoiding practice after babies' discharge to home. The use of IV non-steroidal analgesics such as ketorolac and acetaminophen are both safe and effective if used at age appropriate times.

Some centers practice, and a few have recently reported, discharging patients following lip repair on the same day of surgery in a carefully selected group of patients. While other centers keep infants overnight following lip repair, indications for admission versus discharge await further delineation. Some indications for admission e.g. cardiac or other systemic comorbidities and poor feeding post-surgery are clear. The use of arm restraints has come under scrutiny, with some centers now not placing any restraints around the arms post-operatively. However, here too, the definitive answer awaits better evidence than the Level 4s and 5s that are currently available. Regarding dressing for lip repair, permanent sutures versus steri-strips versus tissue glues such as octyl-2 cyanoacrylate, most samples in published reports are too small to have sufficient power to reach a recommendation. Tissue glue allows for earlier washing. Permanent sutures may require removal under sedation or general anesthesia.

Lastly, and importantly, the “A” in ERAS is “After”. To have good recovery *after* surgery requires excellent performance *during* surgery. While the pre- and post-operative protocols certainly contribute to enhanced recovery, they cannot and will not substitute for good operative techniques and intraoperative anesthetic management.

Continued on next page

ERAS Protocol *(continued from previous page)*

<p>Pre-Hospital Phase Outline the procedure for the parents, what to do before the procedure, what to expect after the procedure, post-operative, post-discharge care. Explain to parents that: Some pain following surgery is unavoidable, even with narcotic medications. However, attempts will be made to reduce pain and discomfort such as nausea and vomiting as much as possible. Short-acting opioids will be used while the infant is under close monitoring in the hospital. Opioid side effects are difficult to monitor at home and should be avoided when possible at this age Other non-opioid drugs will be used. Bath and shampoo the baby the night before using liquid soap and water. Feed the baby (formula) until 6 hours and Breast milk until 4 hours before scheduled time of surgery. May have clear fluids 2 hours before the scheduled time of surgery. Make sure parents have the contact information of the cleft team clinical coordinator.</p>	<p>Targeted/Desired Effects Parents understand the procedure and what to do before, during, and after the procedure. Goal to alleviate fear and anxiety for the parents.</p> <p>Parents understand why opioids should be used judiciously and cautiously at home.</p>
<p>Pre-Operative Phase Gabapentin 15 mg/kg PO 2 to 3 hours before surgery.</p>	<p>To increase the inhibitory input and modulate glutamatergic nociception as an opioid-sparing maneuver. This also reduces post-operative agitation.</p>
<p>Intra-Operative Phase IV line in left hand or wrist. Oral intubation, taped at midline. Table turned 90 degrees with anesthesia at the left side of the operating table.</p> <p>Identify the landmarks and design the repair. Tattoo the design, with special emphasis on the VCJ and the wet-dry line. Local Infiltration with 0.25% bupivacaine with 1:200,000 epinephrine at the beginning of the case (1 mL/kg), wait 7 minutes before incision. Local infiltration with plain 0.2 % ropivacaine at the end of the case (Keep all solutions containing epinephrine covered and away from ambient light) Dexamethasone 0.5mg/kg IV at the beginning of the case. Dexmedetomidine (Precedex) 1mcg/kg IV at the beginning of the case. Acetaminophen 15mg/kg IV at the start of the case</p>	<p>Allows for correct anatomic alignment</p> <p>Reduce blood loss Facilitate visualization Visible light degrades epinephrine. To keep its potency and efficacy, keep it covered.</p> <p>Alpha 2 agonist is given to reduce anxiety without cardiovascular suppression</p> <p>Analgesia Antiemetic</p>

Continued on next page

ERAS Protocol *(continued from previous page)*

<p>Ketorolac (Toradol) 0.5 mg/kg IV during the case. Ondansetron 0.15mg/kg up to 4mg IV during the case.</p>	
<p>Post-Operative Phase PACU Fentanyl 1 mcg/kg IV q 1-2 hours PRN pain Lorazepam 50 mcg/kg IV prn agitation Ketorolac (Toradol) IV 0.5 mg/kg Use of arm restraints is optional. Assessment for discharge Stable vitals Oxygen saturation above 98% in room air Normothermic Tolerating PO at 4 mL/kg/hour Pain, nausea, and vomiting are well controlled without narcotics ASA 1 Parents express understanding of post-operative care Parents consent to take baby home from PACU Direct discharge from PACU to home is dependent on meeting criteria and lack of co-morbidities that would benefit from admission Admit (extended PACU or Observation Unit) if not meeting discharge criteria Inpatient analgesic orders: Gabapentin 10mg/kg PO TID Ketorolac (Toradol) 0.5mg/kg IV q6h prn (vs. Ibuprofen 4-10mg/kg q6h prn) Acetaminophen 10mg/kg PO q4h prn Home (usually the day after surgery) See detailed instruction sheet Feed the baby with the bottle and nipple that she or he used preoperatively; may benefit from increased flow by upsizing nipple Gabapentin 10mg/kg PO TID x 2 days if needed Acetaminophen 10 mg/kg PO q 4 to 6 hours alternating with Ibuprofen 4 mg/kg PO q 4 (PRN) No Rx for narcotics given at discharge unless same day discharge. Suggested regimen (as needed): Breakfast: Ibuprofen + Acetaminophen + Gabapentin Lunch: Ibuprofen + Acetaminophen + Gabapentin Dinner : Ibuprofen + Acetaminophen + Gabapentin Bedtime: Ibuprofen + Acetaminophen</p>	<p>Analgesic Anxiolytic Analgesic and anti-inflammatory (No evidence that such NSAID use causes increase in post-operative bleeding)</p>

EVIDENCE SUPPORTING ERAS PROTOCOL FOR LIP REPAIR

Continued on next page

ERAS Protocol *(continued from previous page)*

Sample of Post-Discharge Instructions for the Parents

Lip Repair Post-Operative Care

Home usually after 1 night stay in the hospital

Expect some swelling which peaks by day 3 and, on occasions, small amount of blood draining from the nose

Let the baby have fluids (apple juice, water, formula, milk) as much as wanted throughout the day

Monitor the diaper, making sure the baby is making urine

The lining of the mouth should be moist, as is the conjunctiva of the eyes

Oral feeding using baby's bottle and nipple from home starts in the recovery room with clear liquids/breastmilk and advance to formula as tolerated

Advance to stage 1 baby food using the tip of a small plastic-covered baby spoon by day 6-7

Acetaminophen elixir (Tylenol) 8-10 mg/kg by mouth every 4 to 6 hours alternating with Ibuprofen (Motrin) 3-4 mg/kg by mouth every 4 hours as needed (Please see and follow instructions on the discharge papers)

Keep no-no on arms for the first week, including at night, removing them to bath the baby or when you are with the baby

Keep wound dry for 3 days. Cleanse gently the nose and lip with soft baby washcloth 2-3 times a day as needed. Sponge bath until day 5. Regular baby bath after day 5.

The steri-strips will come off on their own by a week to 10 days

Apply small amount of topical antibiotic ointment (e.g. Bacitracin or Polysporin) twice daily after the steri-strips have separated.

Follow up in our outpatient clinic in 2 weeks

Contact number: 000-00-0000 during the regular hour, and 111-11-1111 in the after work hour

The members of the ASCFS Presidential Taskforce on Craniofacial ERAS:

Craig Birgfeld, Jeff Fearon, Stacey Francis, Jesse Goldstein, Anand Kumar, Aaron Mason, Albert Oh, Alex Rottgers, Davinder Singh, Joe Williams, Jack Yu

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Honoring Our Mentors



Many organizations have created libraries that capture video interviews of our mentors and leaders in our selected professions. In the surgical arena, we have had the ability to not only store operative procedures from our most skilled colleagues but to also hear directly from them about their careers, insights and innovations. For

many of us who have stood on those broad shoulders, it is most satisfying. For those who have perhaps only known our leaders through papers or indirect conversation, an opportunity to hear and see these giants of our profession as they reveal themselves is a unique source of inspiration and provides depth and better appreciation of our history and identity.

It is to this end that the American Society of Craniofacial Surgery is exploring avenues to actively capture and honor the leaders of our subspecialty. Much of the roadmap has been completed through the American Association of Plastic Surgery via the ICONs project. Each year, four physicians are selected by the AAPS board with no intent to select from differ-

ent specialties. A video-taped interview is created and stored in the ICON's library. This wonderful resource is not limited to members only (<https://aaps1921.org>). Of the 33 physicians already selected for this honor, 7 (21%) have been from our subspecialty.

Milton Edgerton
John Mulliken
Joe McCarthy
Linton Whitaker
Jack Hoopes
Joe Murray
Paul Manson

What an amazing group!

In the near future, we will offer a structure within our Society to identify those among us who we would like to offer as part of this wonderful heritage. At this time, we are asking for those who are interested in being involved on a committee for selection and production of these videos to contact Lorraine O'Grady (logrady@prri.com).

Joseph K. Williams, MD

ASCFS and ASPN Joint Meeting Postponed



In 2016, Rich Hopper, M.D., then President of the ASCFS and Richard Ellenbogen, M.D. of the ASPN initiated and chaired the first combined ASCFS/ASPN Meeting in Maui at the Fairmont Hotel. The combined meeting was added to the bi-annual ASPN meeting with the first stand-alone ASCFS meeting scheduled to take place at an

adjacent venue. The joint society program consisted of a half-day symposium focusing on the treatment of intracranial pressure, chiari malformations, and sagittal synostosis with paired neurosurgeon and craniofacial surgeon presentations. Our neurosurgery colleagues were then invited to join us for any sessions at the ASCFS conference that followed at the Grand Wailea Hotel. The half day sessions allowing members and their families to enjoy time on the beach and in the surrounding mountains.

The ASCFS was intent on again combining with the ASPN for a joint meeting in Hawaii in 2021. Over the past year, both Mark Urata, M.D., D.D.S. and Lorraine O'Grady participated in several phone calls with the ASPN leadership in this endeavor. The ASPN had selected the Four Seasons at Ko Oliana as the meeting venue and plans were well under way for another half day meeting followed by a combined social event. However, like many national and international academic meetings, the Covid 19 pandemic posed challenges for travel, financing, and safety and in June, with Dr. Buchman presiding, the Board of the ASCFS voted to cancel our participation in this year's meeting. Since we had not placed any deposits, there were no financial losses associated with this decision. We have communicated to the ASPN that we are committed to continuing our collaboration and look forward to re-visiting our combined meeting in two years in an atmosphere where this can be conducted safely.

Mark Urata, MD

The Shift in Ethical Focus During the COVID-19 Pandemic



“Hello, is this Jaxon’s mom? I am calling to let you know that his operation for tomorrow is cancelled. I’m sorry, but there is an executive “stay at home” order and our hospital is not performing any operations that are not immediately life- or limb-saving. I don’t know when we will be able to reschedule. I am very sorry.”

How many of us had to make these phone calls in March 2020? If we didn’t personally do it, then our surgical schedulers did—having tough conversations that no one was prepared to have. Guides and scripts for navigating these discussions started to be widely circulated among the clerical staff. These scripts became necessary because very little in our training to become craniofacial surgeons prepared us what was being asked of us: subordinate the best interests of our patient to the best interests of society at large. We generally strive for shared decision-making and work to respect patient and parental autonomy in our surgical decision-making, but that mode of interacting with our patients was taken away. How did we respond to this? I posit that there was wide variability in what cases were cancelled and which ones we argued for doing anyway, perhaps inflating the perceived risks of waiting. Is this fair? Where these decisions made affected by our implicit biases? Did we potentially increase inequalities in access? How did we weigh the risks to ourselves, the risk to our patients, the risks to staff, and the risks to society? There is no one universally agreed upon framework that can give us the one right answer. In what follows I will discuss the dominant ideas in conflict in our current global crisis.

Medical ethics, the rules and precepts that inform our thoughts about what constitutes good and right behavior vis-à-vis our patients, is often noted to be a “rescue ethics.” That is, we tend to focus on the patient in front of us and do everything we can to help them, while downplaying our responsibilities to others we cannot see or with whom we have no relationship. For the most part, this serves us well. The patient-physician relationship has been the foundation of the professional responsibility we have to our individual patients since the birth of the medical profession. **But in a global pandemic, the physician is forced to shift her focus to the health of the population.** Individual decisions must be weighed in relation to our obligation to “flatten the curve” and conserve scarce resources such as hospital beds, personal protective equipment (PPE,) and medications. The high-quality, patient-and-family-centered, streamlined, and expedited care we pride ourselves in providing to our patients was made nearly impossible as our healthcare system strained under the weight of the surge. During this time the care of patients with COVID-19 necessarily eclipsed the care of other diagnoses and conditions.

Our widely adopted principles of biomedical ethics of respect for autonomy, beneficence, non-maleficence, and justice (1) are all challenged in the COVID-19 crisis. The most shocking is respect for autonomy. In contemporary American culture this principle is considered sacrosanct by many, but currently individual wishes are significantly constrained. This ranges from who is allowed to visit a patient in the hospital, to if and when a patient can have a requested operation, to whether or not a patient will be offered CPR. Beneficence, the principle that physicians should choose what is good and right for our patients has been completely subordinated and transformed into choosing what is best for society overall. Nonmaleficence, the modern version of *primum non nocere* (the Hippocratic dictum to do no harm) is challenged when surgeons are prevented from operating on growing tumors, or a ventilator is re-allocated from one patient to another based on triage criteria. Justice, the principle that often gets the least attention in our everyday ethical analyses, is now the primary focus of attention. A fair and just distribution of scarce resources is the discourse that has dominated both the bioethics literature and popular press since February 2020.

On March 28, 2020, the National Academy of Sciences, Engineering, and Medicine (NASSEM) issued a report, “Rapid expert consultation on crisis standards of care for the COVID-19 pandemic,” (2) in which they noted that the normal standard of care is currently replaced by a crisis standard of care, where the dictum is to save the most lives possible. The ethical principles in this crisis standard of care are: fairness, duty to care, duty to steward resources, transparency, consistency, proportionality, and accountability. In this crisis we are faced with finite resources such as personnel, personal protective equipment, physical space, medications, and capital. The utilitarian mantra of “do the greatest good for the greatest number” resonates throughout this notion that when we know that we do not have enough resources to save everyone, the resources should be allocated in a way to save the most that we can. (3)

The patient-physician relationship has been the foundation of the professional responsibility we have to our individual patients since the birth of the medical profession. But in a global pandemic, the physician is forced to shift her focus to the health of the population.

Continued on next page

The Shift in Ethical Focus *(continued from previous page)*

This puts the physician in an impossible situation. She has a fundamental duty to prioritize the care of her patient and to advocate for her patient's optimal care. Just because there is a crisis, the physician is not relieved of this primary fiduciary responsibility. What sort of surgeon would any one of us be if we were to easily put other priorities ahead of our patient's best interest? The solution is to take the decision to ration scarce resources out of the hands of the bedside physician and to utilize a policy and triage committee to dispassionately decide. (4) Interestingly, drug shortages are not uncommon in American healthcare, so guidelines on how to ration drugs have been present for a long time and the ideas are applicable currently as well. While most cringe at the idea of rationing, the *status quo* in America is that *laissez faire* capitalism leads to rationing based on access, insurance, and ability to pay. To deal with a crisis though, it is recommended to create a policy that takes into account the views of the relevant stakeholders, to be able to evolve to a rapidly changing ratio of supply to demand, and to avoid relying solely on individual clinician judgment. (5)

Almost all of the ethical discourse around the allocation of scarce resources has been focused on life-saving interventions such as ventilators, ICU-level care, extracorporeal membrane oxygenation (ECMO), and dialysis. While it is important to understand these guidelines, it is not entirely clear how they apply to the care of the patients of craniofacial surgeons. **The concepts of maximizing benefit to the many, transparency, and consistency in application of the guidelines seem to be principles that should be used as we make decisions in an environment where our options are constrained by external forces.** The problem is that because these are not life or death decisions, there has not been as much institutional will to codify uniform guidelines. Without uniform guidelines to draw upon, each individual surgeon is left making decisions as best she can. Should a cleft palate repair be considered elective or urgent? How many months can it be delayed before speech outcomes irreparably suffer? How does that compare to a 3-month old scheduled for an endoscopic strip craniectomy for sagittal synostosis? If delayed longer than a month the child will need a more invasive operation. Should the Lefort I distraction in the teen with severe obstructive sleep apnea go before the man who shot himself in the face who now has oral incompetence and needs a free fibula scheduled? The outcomes of craniofacial surgeons cannot easily be plotted on Kaplan-Meier curves, and there is no universal scale upon which to weigh all the variables that affect cases like these. As we all know, three different surgeons may rank these cases in a different order of priority. This situation gives ethicists a lot of concern, as it is a situation with uncontrolled variability and relies on a decision-making process that is opaque. These types of situations are ones where inequalities of access can be amplified, and patients who are privileged enough to have parents to effectively advocate for them win out over those who do not.

The list of ethical concerns that face us during these trying

times is endless. Visitor policies in our hospitals are quite restrictive—for which of our patients do we advocate for an exception? All of them? Some of them? The ones who complain? The ones who look like us? Some free-standing children's hospitals in some states were not impacted as severely as others with "shut-down" orders. Is it ethically permissible that some of those hospitals advertised through for-profit craniofacial websites that they were still operating and that parents should bring their children to them? Does that place an undue burden on parents? Does that further exacerbate disparities and reward privileged families who can afford to travel, even when travel is being discouraged? Does this violate our sense of justice that "we are all in this together?" Or is it laudable because it allows those fortunate few children the opportunity to have the operation they need in the time-frame that we normally recommend?

There are no easy answers to these questions. Ethics rarely gives us *one* right answer, but allows us the opportunity for reflection on moral ambiguities and requires us to define what we value and what we are willing to sacrifice to achieve the highest good. A crucial principle that we all must adhere to is that of non-abandonment of our patients. The COVID-19 pandemic has disrupted the fabric of our society, our economy, and our healthcare system. The patients and families we are lucky enough to serve, are generally suffering more than any of us. While the constraints on our clinics and ORs have prevented most of the physical face-to-face contact that is the foundation of our relationship with our patients, we cannot allow those impediments to prevent us from maintaining contact with them. Though we have an imperfect ability to create a scale upon which we can judge all cases in terms of "importance" when ramping up our operative capacity, it is critically important that we try, as the default "first come, first served" is unacceptable when so many patients have had their cases abruptly and unilaterally cancelled.

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