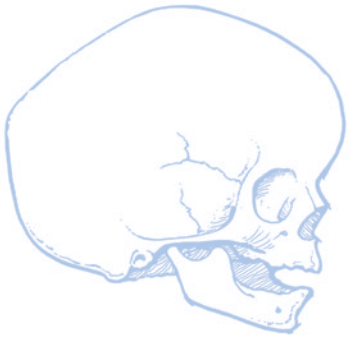


AMERICAN SOCIETY OF CRANIOFACIAL SURGEONS

NEWSLETTER

APRIL 2021

INSIDE THIS ISSUE.....

FROM THE PRESIDENT

Welcome to the third and my final edition of the ASCFS newsletter that I inaugurated last year. As you all well know, this has been an unprecedented time for both our country and our organization as we navigate through the Covid-19 plague. I have been honored to serve a two-year term as your president due to the extraordinary circumstances brought about by the pandemic. The leadership of the organization followed the lead of other well-known established organizations such as the American Association of Plastic Surgeons and agreed that it would be best to continue the same board for a year, while we navigated the choppy and mysterious waters surrounding the local, regional, national and international consequences of the virus.

We were one of the first organizations that decided to cancel our participation in last year's ACPA/ASCFS meeting. We felt that it was too risky, from both a public health, as well as financial standpoint. I think the board was both correct and prescient in that decision as the ACPA followed suit like most of the professional medical organizations in the country.

> ***I think the focus of the board and amazing work put forth by our committees and individual members has resulted in an expansion of our footprint and activities .....***

The key to the ASCFS enduring and thriving as an organization was to find a way to continue to add value to our membership throughout the isolation of the pandemic. I think the focus of the board and amazing work put forth by our committees and individual members has resulted in an expansion of our footprint and activities rather than what might otherwise have been a slowdown and contraction of our organizational undertakings.

I will introduce some of the elements we have included in the newsletter as well as the exciting pursuits that are underway. There will be a national meeting of the ACPA/ASCFS this year but given the continued Covid-19 problems, as well as the

(continued on page 2)

President's Message (continued from page one)

restriction that many institutions have on travel for their employees, the meeting will utilize a virtual format. The meeting will take place April 29th-May 1st. Please go to our website or to the ACPA meeting website (https://acpa-cpf.org/annual-meeting/) to register if you have not already done so. CadmiumCD will be used as the virtual event platform which includes a virtual poster and exhibit hall. The event will offer 14 hours of live educational content with an additional 52.5 hours of pre-recorded session available for 60 days for all attendees. The live schedule will be supplemented with sponsored lunch and learns, social events, and attendee networking opportunities. Specifically with regard to ASCFS, we will have our own programming within the meeting. Please see the outline and schedule of all ASCFS meeting activities in this newsletter so you can best navigate and participate as you wish and not miss what we have in store!

We plan on having a business meeting that the whole membership will be invited to but did not want to be restricted by the constraints of the meeting and wanted to take advantage of the virtual nature of the event by scheduling at a time more of our membership will be able to participate. The business meeting will be held at on **Wednesday, April 28 at 8:00 pm EDT.** Please register to receive the access link: https://us02web.zoom.us/meeting/register/tZEvdeuoqjssGtaf3t4M_02exrIBM1UsVO-e

In addition, we are so lucky to have Ian Munro give the Whitaker Lecture this year. He has not spoken at a major meeting since his retirement and he honors both our organization and Dr. Whitaker with this talk! We hope you had a chance to listen to listen to the live presentation on Saturday, April 17th. However, if you missed it will be replayed during the ACPA/ASCFS meeting on Friday April 30th from 3-4:00 PM and will be available on the ASCFS website, following the meeting.

The election of our officers has been completed after the Nominating Committee met and put forth the slate of candidates, subsequently voted electronically by the membership. Please see and welcome your new incoming board listed in this newsletter. Our passing of the gavel will take place at the business meeting outlined previously.

Our joint effort for the ASMS/ASCFS on line Journal FACE continues to make amazing progress. Please read the article by John Van Aalst, Editor-in-Chief, to understand where we have been with the journal and where we are going. I think it is very important to understand that this is *YOUR* journal, so I ask that you contribute in any way; from submitting articles (as content is king) to reviewing articles and sending ideas that you would like included.

Given that it will potentially be 2 years without an in-person meeting, we are seriously considering a joint meeting with the Pediatric Neurosurgeons again in Hawaii early in 2022! Please see Mark Urata's article that will outline and inform you of this exciting potential program that might bring us all together again, when Covid-19 promises to be largely behind us!

Davinder Singh has been directing the Fellows Bootcamp initiative with the help of Stephen Beals. This past year we went to a virtual type format and we are carefully gauging the potential for an in-person boot camp this coming year. Please see Davinder's article outlining where we are now and how we are moving forward.

Jack Yu has written an insightful attempt at a craniofacial syllabus that ASCFS could potentially endorse to organize and codify a set of elements that would be uniform across our fellowships to assure quality and consistency. Continuing with our efforts contributing to a craniofacial ERAS project (Enhanced Recovery After Surgery), please see Jeff Fearon's piece on the efforts he has been putting forth. Joe Williams has been amazingly active in chairing committees and pushing forward efforts in regards to our fellowship task force as well as the Legends project and the related Joe Gruss initiative. Please take the time to read Joe Williams' 2 articles outlining our efforts in each of those programs. We have included a report from the Secretary and a report from the Treasurer that briefly explain where we are currently and can serve as a short primer to their reports at the planned business meeting. Paymon Sanati-Mehrizy is a 5th year plastic surgery resident at Mount Sinai and has put together a joint effort on behalf of the ASMS and the ASCFS to present a Fellowship Webinar series. Please see his article outlining the genesis of the idea, the reasons fellows will be interested, the plans and the schedule of implementation.

Rounding out the newsletter, I have included a column that I started in the last newsletter called "Perspectives of a Past President". Please see Kant Lin's article. Christian Verlcer, our resident ASCFS ethicist, has also written an article on the ethics of virtual visits, an interesting and controversial topic that has arisen more pointedly since the pandemic. Finally Steven Cohen has treated us to an article on how the Covid-19 plague affected his practice. See if you can relate to the tribulations that required many of us to deftly try and survive, particularly those in private practice!!

I cannot even begin to tell you how privileged I feel to have been your president for this two year term. I hope I have left this organization in a better place and can now pass the baton to the next president, feeling I have done well by all of you. I again ask for all of you to find a way to be involved in any of the efforts we have underway. You could even embark on new efforts if you have a novel idea and want to present it to the board. I look forward to Dr. Munro's talk, our virtual meeting and our business meeting when I once again interact with all of the friends and colleagues that make this organization such a special one.

I again ask for all of you to find a way to be involved in any of the efforts we have underway. You could even embark on new efforts if you have a novel idea and want to present it to the board.

FROM THE SECRETARY

William Hoffman, MD

ASCFS Membership Continues to Grow

Our current membership total is 387, with 102 Active Members, 57 Associate member, 209 resident members, 7 Honorary and 12 Life members.

In addition, the Executive Council is reviewing the current completed membership applications and we hope to present 6 new Active members, 2 new Associate members, 24 new Resident members, 3 upgrades to Active and 2 upgrades to Associate. Once reviewed and approved by the Council, they will be presented to the membership for ratification during the Virtual Annual Business Meeting on April 28.

If you know of any colleagues who would benefit from membership, please direct them to the ASCFS website for additional information and the online membeship application.

FROM THE TREASURER

Patrick Kelley, MD

In the last newsletter I reported that the organization's finances remained strong despite the pandemic and its decimating impact on the academic activity of the organization. As you may recall member dues support the financial health of the organization, whereas meeting registration and industry support allow us to run academic events on a revenue neutral basis. We have heard many stories of health systems freezing dues payments and support to organizations like ours. It has been a difficult year for members to either convince their parent organizations to continue to support the ASCFS. And for those members who pay out of pocket it has especially been difficult to justify the added cost in a down economic year.

I am happy to report that our membership has stayed strong and committed to the viability and mission of the organization. Despite the hardship, revenue from dues was $25,250 for the fiscal year 2020, slightly edging revenues in 2019. That is remarkable to say the least. PRRI, our management partner, has worked hard this year to keep our administrative costs down. We owe Lorraine O'Grady a special thanks for her efforts in dealing with the various challenges associated with the new virtual platform. Additionally, her astute and timely advice kept the organization from getting trapped into contractual venue rental fees as meetings were being cancelled.

Total assets/liabilities for ASCFS were $62,184, again slightly edging 2019. Total assets for ASCFS Foundation were $84,729, edging upward roughly $8000 from the previous year. The assets of the foundation have reached a point where the board is contemplating a very conservative investment strategy for a portion of the funds to help bolster the long-term health of the ASCFS Foundation. The foundation's mission is an academic one and over the years it has been used to support keynote speakers at our national meetings. The new strategy will work to ensure that we always have funds to maintain this activity into the future.

I appreciate the confidence and trust that the society has placed in me over the last three years. As of the coming ASCFS national meeting, I will be passing the torch to Dr. Davinder Singh.

This newsletter will be my last one as Treasurer as I move on to the President-elect position. I appreciate the confidence and trust that the society has placed in me over the last three years. As of the coming ASCFS national meeting, I will be passing the torch to Dr. Davinder Singh. We hope to see everyone in the year to come. Let's keep our fingers crossed for a return to normalcy!

2021-2022 ASCFS Council

President	John van Aalst, MD	2021-2022
President-Elect	Patrick Kelley	2021-2022
Secretary	William Hoffman	2020-2022
Treasurer	Davinder Singh, MD	2021-2023
Immediate Past President	Steve Buchman	2021-2022
Council Members:	Christopher Forrest	2020-2022
	Raymond Harshbarger	2021-2023
	Lisa David	2019-2022
	Joseph Williams, MD	2021-2023

Honoring Our Mentors: The Legends Project


Joseph Williams, MD

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 ASCFS began to explore avenues to actively capture and honor the leaders of our subspecialty. We have assembled three members, **Michael Golinko, Colin Brady** and myself to begin the acquisition of these interviews. We welcome others, especially those who have video skills.

Our goal is to obtain one or two interviews annually during our national meeting with the ACPA. As with much that is COVID, these plans have been postponed until our next live meeting, hopefully in 2022. Until that time, we will focus on creating video documentaries that honor two of our recently departed colleagues, Joseph Gruss and Ken Salyer. These two figures will initiate our Legends library. The link below will provide a depository for all who may have contributions in the form of videos or photos that capture memories of their wonderful career. We will also reach out to individuals for interviews regarding unique memories that they may wish to share.

https://drive.google.com/drive/folders/1_WEx4M48wBrthQwqZHAtlL9JhnG3vEc9?usp=sharing

The details regarding the selection process for future interviews will be provided in the next newsletter. Thank you for your support of the Legends project now and in the future.

Craniofacial Fellowships: An Update

Two proposals were recently approved by the ASCFS board regarding our fellowship program.

Proposal 1

The ASCFS provides an avenue for official endorsement of their fellowship programs. Currently the criteria would include all programs participating in the match process through the San Francisco Match. The sponsorship would include:

a. a certificate from the ASCFS counsel to the fellow at the completion of the sponsored fellowship
b. An acknowledgement on the ASCFS website endorsing the participating programs.

This is a broadly inclusive group based on an agreement by programs to participate in the SF match. The endorsement will provide a level of legitimacy gained through recognition and oversite from our national organization.

Proposal 2

Form a craniofacial fellowship committee with the following charge (all to be approved by Council:

a. create guidelines for current fellowships in the area of curricula, case numbers and any other activity deemed necessary to create uniformed and quantifiable metrics.
b. create guidelines for all new fellowship programs wishing to participate in the area of curricula, case numbers and any other activity deemed necessary to create uniformed and quantifiable metrics to meet criteria for sponsorship.
c. oversee current fellowship programs and provide a biannual report to the Counsel.

The members of the committee were selected to represent a variety of current fellowship structures and content. Chris Forrest, Craig Birgfeld, Richard Kirshner, Jordan Steinberg, Jeff Hammoudeh, Jesse Goldstein, Joe Williams / Ex oficio : Steve Buchman, Mark Urata

General Areas of Development

a. Create standards of content within a craniofacial fellowship, including Case logs, Teaching, and Other
b. Create a tract for programs requesting new fellowships including Criteria for probation/ full fellowship
c. Maintain an active roster of sponsored programs, including sponsorship recognition at the completion of the fellowship, maintain a fellowship webpage that will list sonsored programs with a characterization of the programs (strengths)
d. Create an oversite structure for program reviews
e. Create and maintain a CF fellowship Syllabus (see related article by Jack Yu)
f. Communication of committee activities with council, program directors and members through the website and this newsletter.
g. Other Considerations include the interview process (scheduling, etc) and post fellowship testing

There is no current agenda as to the eventual structure of our fellowship programs. The committee recognizes the sensitive nature of change and the traditions embedded in our current fellowship structure. The committee will be transparent with the process and, as always, open to discussions/suggestions from our Society, especially program directors.

Our mission is to create a national fellowship program providing consistency in experience and strengthening our national identity while maintaining the flexibility to allow individual programs to build on their unique strengths.

FACE: The Future


John vanAalst, MD

FACE has had a successful first year. We are now moving into our second year of publication. In order to more fully develop our voice as the official organ of both the ASCFS and the ASMS, we need broad participation from our members and implementation of national and international strategies. Our national strategy has the end-goal of becoming the "go-to" journal for all Craniomaxillofacial topics through high-caliber articles, review articles that target inadequately addressed topics, promotion of strategies to standardize education among US-based Craniofacial Fellowships, promotion and publication of enhanced recovery after surgery (ERAS) protocols, advertising to achieve financial sustainability, developing relationships with reginal and national surgical organizations, and targeted development strategies to generate a greater volume of high quality articles. Our international strategy is based on an open invitation to international authors to publish their best work in a new and exciting journal, by and for experts in craniomaxillofacial surgery, with a quick turn-around time for publication, and at no charge to authors.

Our **national strategy** begins with our Editorial Board, who are currently working at their home institutions to promote FACE. Section Editors are now targeting high-profile authors to submit specific articles for publication in FACE, including review articles, that should generate high numbers of citations for future indexing.

Review articles will be subjected to extremely rigorous evaluation because they need to be of the highest quality. These articles will target subject matters that have either been inadequately addressed or were published long-enough ago, that they are no longer relevant. These review articles should be written in a manner that can be used as tools to train residents and fellows and as potential references for board examination. Possible review topics include, but are not limited, to: scar revision of the face, statistics, epidemiology, molecular biology of craniosynostosis, branchial cleft embryology, facial nerve pathologies, benign tumors of the jaws, maxillary distraction in the current cleft algorithm, vascular anomalies, giant congenital nevi, orbital hypertelorism, migraine headaches, management of congenital eyelid ptosis, facial feminization, scalp reconstruction, facial reanimation, nasal reconstruction, lip reconstruction, eyelid reconstruction, management of microtia and otoplasty. If any of you are interested in joining a group of authors to write any of these articles, please contact Peter Taub (peterjtaub@gmail.com), Jack Yu (jyu@augusta.edu), Steve Buchman (sbuchman@umich.edu) or John van Aalst (johnavanaalst@gmail.com).

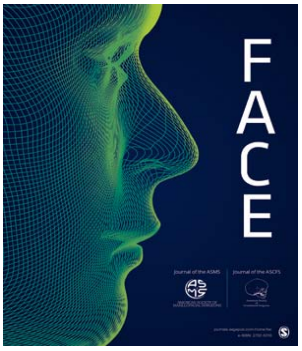
FACE will also be used as a vehicle to promote and publish work currently being done to standardize training in **US-based Craniofacial Fellowships** (lead by Joe Williams) and to promote and publish protocols currently being developed by the ASCFS Presidential Taskforce on Craniofacial **ERAS** (members include Craig Brigfeld, Jeff Fearon, Stacey Francis, Jesse Goldstein, Anand Kumar, Aaron Mason, Albert Oh, Alex Rottgers, Davinder Singh, Joe Williams, and Jack Yu).

Our eventual goal for **advertising** is to make FACE a self-sustaining business venture. Jack Yu and Stacey Francis are leading efforts to increase advertising among the companies with which our members do business. If you have relationships with companies that you believe would benefit from advertising in FACE, please contact Stacey Francis (Stacey.H.Francis@kp.org).

We are currently developing and expanding relationships with **regional and national societies**, including the Ohio Valley SPS, Northeastern SPS, Southeastern SPS, ACPA, and the Plastic Surgery Research Council, to publish abstracts from their annual meetings. The purpose of these relationships is to increase the number of authors associated with FACE, and to encourage these authors to publish future work in FACE. These associations will result in increased citations that will be a key metric in our goal for indexing.

Lastly, in order to improve the number and quality of articles submitted to FACE, Ray Harshbarger has agreed to fill the role of **Editor for Development.** He will assist each pair of section editors (sections include Clefts, Craniofacial and Orthognathic Surgery, Basic Science, Aesthetic Surgery, Trauma, Head and Neck Cancer, Business and Education, Advocacy and Policy, and Gender Affirmation) to approach nationally and internationally recognized authors to provide targeted manuscripts for publication in FACE.

Our **international strategy** will focus on increasing the number of quality submissions from international authors. In our first year, we accepted articles for publication from South America, the Middle East, Asia, Africa, and Australia. Over the last 6 months FACE articles have been viewed in rank order by readers from the following countries: 1) United States, 2) India, 3) United Kingdom, 4) Brazil, 5) Turkey, 6) Australia, 7) Canada, 8) China, 9) Philippines, and 10) Taiwan.



The first step for increased submissions will focus on the home countries of our inter- national editors: in Brazil (Cassio Raposo,M: cassioraposo@hotmail.com), Taiwan (Tien Cian Thomas Wang, MD, PhD: ichibangwang@gmail.com), the Netherlands (Irene Mathijssen, MD: i.mathijssen@erasmusmc.nl), and Egypt (Amir Elbabary, MD: amir_elbarbary@yahoo.com). Letters and flyers crafted by Ray Harshbarger with our international authors will be sent to surgical societies in these countries, encouraging their members

Continued on next page

Fellows Boot Camp 2021 Going Virtual


Davinder Singh, MD

The annual **ASCFS/ASMS Boot Camp: Essential Training for Craniofacial Fellows** has been held in Phoenix at the beginning of August with all craniofacial fellows and national craniofacial faculty in attendance since 2010. Unfortunately, due to COVID-19 restrictions, we had to convert the 2020 Boot Camp to an online learning platform and shared video recordings of the 2018 and 2019 lectures and cadaver dissections with the 2020 Craniofacial Fellows.

Based on current travel restricitons and feedback from program directors and fellows, plans are now underway to hold the 2021 Boot Camp virtually. The ASCFS looks forward to welcoming the fellows into the community of Craniofacial Plastic Surgery.

Details are being reviewed and confirmed to have live faculty lectures and while we are unable to have a hahnds-on component, thre will be ample opportunity for interaction with faculty and samll group discussions.

We will continue to maintain the video recordings of prior lectures and cadaver labs on the ASCFS website and may be used for reference prior to and after the Boot Camp.

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

Module 1 – Craniosynostosis: Suturectomy and Open Techniques
Module 2 - LeFort III/Monobloc/Bipartition
Module 3 – Microvascular craniofacial reconstruction
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

It is a great opportunity to not only learn from one another but also to form lifelong colleagues and friendships. The ASCFS wishes you all the best in the start of your fellowship training and warmly welcomes you to join ASCFS as a craniofacial fellow.

FACE: The Future *(continued from previous page)*

to submit manuscripts to FACE. In addition, with the assistance of Arun Gosain, we have recently reached out to the Indian Society of Plastic and Reconstructive Surgery, with the hope of increasing article submission by Indian authors.

Our selling point to international authors is simple: we want to include them in a new and exciting journal that is focused exclusively on craniomaxillofacial topics. Our turn-around time for publication is quick, and lastly, all accepted articles will be published at no cost to authors.

Having completed a successful inauguration to FACE in 2020, we need to achieve greater success in 2021. Read FACE, submit to FACE, and cite FACE. Our success depends on all of us. When you read articles from FACE, share them with colleagues. In addition, you can receive notices about new articles published in FACE by using this link: https://journals.sagepub.com/connected/FAC#email-alert.

Best to all of you and your families in the coming year.

FACE forward in 2021.

FACE Vol. 2, No. 1, March 1, 2021 Available Online

Articles

Impact of COVID-19 on Cleft Surgical Care

Influenza as a Measure of Maternal Immune Activation and Its Effects on the Incidence of Encephalocele and Microtia

The Association Between Influenza Infection Rates and the Incidence of Orofacial Clefts in the United States

Multidisciplinary Rehabilitation of an Adult with a Cleft Lip and Palate: An Illustration of a Dental Substitution Approach for the Management of Unilateral Agenesis of Central and Lateral Incisors

Monobloc Facial Advancement in the World of COVID-19 Testing: A New Potential Risk for Iatrogenic Injury

Le Fort III Distraction Osteogenesis: Early Experience With an Internal Bilevel Midface Distraction System

Foreign Accent Syndrome: A Rare Sequelae after Orthognathic Surgery

Millennials Are Interested in Botulinum Toxin Injections for Prevention of Facial Rhytids

Administration of Steroids Is Associated With Increased Length of Stay But Not Post-Operative Complications or Readmissions in Patients Undergoing Orthognathic Surgery

Tongue-Based Procedures in Treating Refractory Obstructive Sleep Apnea in Down Syndrome Patients: A Systematic Review and Meta-Analysis

Polysomnography in the Early Consolidation Phase of Mandibular Distraction as a Tool to Identify Residual Tongue-Based Airway Obstruction and Need for Further Distraction: A Follow-Up Study

Use of Ultrasound in the Planning of Spring-Assisted Cranioplasty for Correction of Scaphocephaly

A Novel Surgical Technique for Large Frontoencephalocele Management: The Mercy Ships Approach

Trends in Craniofacial Injuries Associated with the Introduction of Electric Scooter Sharing Services

How Did COVID Affect my Practice and I: A Personal Perspective

Steven R. Cohen, MD

I was delighted to receive an email from one of my favorite people in the world, Dr. Steven Buchman, asking me to write a short article about how Covid affected my medical practice and I. Here is a short recap. On March 24, 2020, I returned from my last trip, as a visiting professor at Stanford University Medical Center. The next day, we shut our practice down. My first thought was to consider the worse case scenario- What if I had to close my practice? This was the bottom line question for me and the answer that came to me, was I would be fine, I was flexible and creative and had saved well, and if forced into "retirement", I would take up Art full time and start a consulting business in medicine and teach creativity. My family would be fine as well since our kids were already in eCommerce and businesses that were amendable to online and remote work. My wife was ok as well since Sheri was enrolled in a low residency MFA program in creative writing, which was already 90% online.

Next, I called our COO. Kris is an amazing woman. Married to a Navy Seal, a true hero, she knows how you have to be flexible in life and deal with the unexpected. Immediately, I contacted our building about deferring rent. I was first to call them and their answer was not pleasant or humane, but it didn't matter because protecting my staff took precedent and I was prepared to deal with the building management if necessary. We then applied and received an emergency government loan under the payroll protection loan program and this along with my personal contribution of several hundred thousands of dollars, took care of our salaries and rent for 3 months. My practice has 15 employees and one went on unemployment, but the rest did fine and were paid their full salary. On May 15, we reopened. The first week there was a trickle of patients and then it was full steam ahead. I am as busy now as our busiest time with surgery and it has not let up.

As far as career, everything was ported to the internet. I did numerous grand rounds at major universities, something I had wanted to do for years, but didn't have time because of my overseas travel and practice schedule. I improved my communication skills, my talks became more professional. I became much more involved with an organization I truly enjoy, the International Society of Aesthetic Plastic Surgery (ISAPS), giving courses and planning for future courses in the area I have become most interested in, facial rejuvenation and regenerative medicine. I was able to nearly finish my textbook on Regenerative Facial Surgery and publish a half dozen articles and another 4 chapters on Injectable Tissue Replacement and Regeneration, a new anatomic and regenerative way to fat graft the face and to reconstruct youth. I also became very involved with "the Superneck Group". Encouraged by the founder, a brilliant Brazilian surgeon, Andres Auswald and Jim Grotting, Jerry O'Daniels, Ozan Sozer and Foad Nahai, and many others in the US and around the world, I have vastly improved my results which were already pretty good, but have gotten exponentially better with the support and education from many peers from around the world.

I painted more than ever, completing nearly 150 paintings. I published 71 of them in a collection called Pandemic Paintings ....

All and all, things are different. I feel compressed in a strange way. My dreams are more limited, but hopefully will return full force as things settle down and become the new normal. I want to travel again. On a personal level, I read extensively…novels, poetry, non-fiction. I painted more than ever, completing nearly 150 paintings. I published 71 of them in a collection called Pandemic Paintings and received many texts and messages from galleries and individuals who loved my work. I sent numerous original paintings to my favorite people all of the world as little surprises. I read 5 novels by Murakami, an amazing Japanese writer, who will likely get a Nobel prize one day. I read Czeslaw Milosz's poetry, which is absolutely brilliant, yet so simple and humble. I exercised a lot and changed my eating habits for the better. And most importantly, I realized who I was as a person and began to come to terms with my deficiencies as well as my strengths. I realized, and was never under the illusion, that beyond a few, I would not be remembered for my work, but nevertheless, I planned to continue to do what I am here to do: create things so pure and beautiful from the heart, that it doesn't matter how large they are or who might see them!

Perspectives from a Past President:
Top Ten Reasons For Being a Craniofacial Surgeon

Kant Lin, MD

My entire career has been spent on the faculty of one of several academic university medical centers, all as a practicing craniofacial surgeon. In addition to my clinical work and research efforts, teaching and mentoring medical students, residents and fellows has also been an integral part of my job description. Each year I am asked for career planning advice, along with writing letters of recommendation, on behalf of eager and ambitious young doctors or doctors to be as they strategize and plot out their careers. Through this process, I have become aware of and increasingly concerned over two trends that I will address in this commentary.

First, the level of anxiety and angst that our young trainees now exhibit as they attempt to obtain a coveted, but very limited in number, position in a plastic surgery residency program has increased to near toxic levels. Second, and what I find even more distressing, is that I have heard the following comment made repeatedly, and with increasing frequency: ***"I really enjoyed my experience with craniofacial surgery, and I even considered it for a career, BUT…",*** with the sentence usually ending in some verbiage regarding either the lack of employment opportunities or the poor renumeration potential of a craniofacial surgeon. With these two factors weighing heavily on their minds, I see most of these very promising young candidates unfortunately go off to pursue training either outside of plastic surgery altogether, or as microsurgeons or in hand surgery thinking that this would increase their chances of obtaining future employment or making a sufficient living.

The renowned physician, Sir William Osler, one of the four founders of the Johns Hopkins Hospital and the creator of the first residency program for specialty training of physicians, once wrote ***"The practice of medicine is an art, not a trade; a calling, not a business, a calling in which your heart will be exercised as much as your head"***.[1] I believe this sentiment to be as relevant and true today as it was when first written in the late 1800's. Unfortunately however, it appears to have not been taken to heart by many of the new generation of physicians who make their career decisions based primarily on economic considerations rather than what appeals to their passions, heart and soul. There is little doubt that one can and will make a comfortable living as a plastic surgeon, no matter which sub-specialty, but I would urge those budding young trainees to give consideration beyond merely the dollars and financial projections. In my mind, being a craniofacial surgeon is not just a job, it's a calling! Follow your passions and pursue that which makes your heart beat skip just a bit quicker!

...what I consider are the "Top Ten Reasons for Being A Craniofacial Surgeon". I do so with the hope that these observations might inspire those young physicians who have been discouraged from pursuing a craniofacial career to reconsider before it's too late.

Readers of a certain age will undoubtedly remember the late night television talk show "The Late Show" hosted by David Letterman. Among the show's most memorable segments was his nightly "Top Ten List" which revolved around a common theme and was usually humorous and sometimes ironic in nature. This segment inspired me to compile, based on my own personal journey, what I consider are the ***"Top Ten Reasons for Being A Craniofacial Surgeon"***. I do so with the hope that these observations might inspire those young physicians who have been discouraged from pursuing a craniofacial career to reconsider before it's too late.

10. Craniofacial training provides an additional skill set and level of expertise which can be applied in other areas within plastic surgery of the head and neck region.
    Facial aesthetic surgery, rhinoplasty, facial trauma reconstruction, facial reanimation and transgender care are all examples of ways that craniofacial training can be used to enhance and diversify one's practice.
9. Craniofacial surgery is predominantly practiced at hospitals affiliated with universities.
    This provides the opportunity for a stimulating academic work environment involved in the training of residents, fellows and medical students.
8. Academia provides opportunities to do collaborative cutting edge research.
    Trans-discipline collaboration can open up avenues of research beyond the normal scope of plastic surgery and these possibilities are only limited by one's time and imagination.
7. The community of craniofacial surgeons is small with a limited number of colleagues.
    This engenders close working relationships and personal friendships of like-minded individuals from around the world. The various craniofacial societies (ASCFS, ISCFS, ACPA, ASMS) are full of wonderful people that I have had the privilege of getting to know.
6. Craniofacial surgery is considered "socially redeemable".
    These procedures can be readily applied to global medicine initiatives and mission trips in underdeveloped countries as a way of "giving back" and improving the over all human condition.

Continued on next page

Presidential Prospective *(continued from previous page)*

5. Craniofacial surgery taps into one's creative thinking and problem solving abilities.
   No two deformities are exactly alike but the basic principles are constant, and it is left up to you on how best to apply them.
4. Craniofacial surgery oftentimes entail "BIG" cases.
   Procedures involving the simultaneous reconstruction of bone, soft tissues and skin of the face and head are always challenging, exciting and never routine in nature.
3. Craniofacial procedures can have a life altering impact on patients.
   In as little as 45 minutes someone's face and head can be transformed, for which they and their family's are always so grateful for.
2. The privilege of working with and on kids inspires me each and every day.
   Children by nature are optimists and make a habit of persisting in the face of challenges and overcoming obstacles. How can that not rub off on you?
1. I can't imagine having more FUN doing anything else!

As a Past President of this society, I am fortunate to have been both a witness and a participant in the evolution of the specialty, since its inception with the pioneering work of Paul Tessier. The many diagnostic and technological advances that have become reality during my time, which did not exist when I was in training, is an indication of the thriving and evolving nature of the field. I have no doubt that there will be many more new and exciting innovations to come as the torch is passed from the "Founders" to the next generation.

In closing, I would like to acknowledge the mentorship and friendships that I have experienced, especially being part of the "Penn Mafia" family.[2.] In addition, I owe special gratitude to Henry Kawamoto, Joe Gruss (posthumously), John Persing, John Jane (posthumously), and my brothers-in-arms, Steve Buchman, Jack Yu, Bob Havlik, Frank Papay, Mark Urata, and Bill Hoffman, all proudly craniofacial surgeons, who have been either guiding me, or by my side, on the journey every step of the way. Following and embracing my passion has ultimately led me to a fulfilling, satisfying and arguably successful career. I have no doubt that once you've committed to following your passion, that the same will happen for you.

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ASCFS Annual Meeting at ACPA: HIGHLIGHTS

WEDNESDAY, APRIL 28 / 8:00 pm EDT

ASCFS Virtual Annual Business Meeting

All ASCFS members are invited to register via the following link:
https://us02web.zoom.us/meeting/register/tZEvdeuoqjssGtaf3t4M_02exrIBM1UsVO-e

FRIDAY, APRIL 30 / 3:00 – 4:00 PM

Linton Whitaker Lecture
Ian Munro, MD: An Interesting Life….With Luck

SATURDAY, MAY 1 / 5:00 – 6:00 pm

ASCFS Panel:
Co-Chairs: Jack Yu, MD and Joseph Williams, MD
Panelists: Davinder Singh, MD, Jeffrey Fearon, MD, Mark Urata, MD, Colin Brady, MD

Craniofacial PAPERS AVAILABLE THROUGH the ACPA MEETING PORTAL FROM MAY 2 – JUNE 30

Craniofacial Breakout I:

Physiologic Timeline of Cranial-Base Suture and Synchondrosis Closure: A Primary Investigation
Dynamics of Fat Graft Growth in Adolescents: A Longitudinal, Quantitative, Split-Face-Controlled Assessment of Hemifacial Fat Transfer

Computed Tomography In Patients With Craniosynostosis: A Survey To Ascertain Practice Patterns Among Craniofacial Surgeons

Prenatal Diagnosis of Craniofacial Anomalies: How Positive are we about that Positive Result?

Risk Factors for Occipital Step-off Deformities in Posterior Vault Distraction Osteogenesis

Do Sociodemographic Factors Impact The Timing Of Surgical Repair For Craniosynostosis? - A Regional And National Assessment

Mandibular Distraction in Neonatal Pierre Robin Sequence: Is Immediate Extubation Both Feasible and Safe?

Development of a High-Fidelity 3D Printed Craniofacial Simulator

Comprehensive Mid-Term Outcomes Following Infant Mandibular Distraction Osteogenesis

Reconstructive Strategies For High-Risk Complex Cranial Defects: A 10-Year Experience

Diagnosis, Evaluation, And Treatment In Freeman-Burian Syndrome: Clinical Practice Guideline For A Rare And Complex Craniofacial Syndrome

Craniofacial Breakout II:

Pediatric Plastic Surgery Operating Room Block-Time Utilization: A Casualty Of Illness

The Expanding Role of Posterior Vault Distraction Osteogenesis in Idiopathic Intracranial Hypertension and Slit Ventricle Syndrome

Factors Associated with Delayed Presentation of Patients with Craniosynostosis

Three-Dimensional Facial Asymmetry in Non-Syndromic and Muenke Syndrome Associated Unicoronal Synostosis

Surgical Complexity and Physician Workload in Craniofacial Surgery: Do RVUs Need to be Adjusted?

Comparison of Longitudinal Outcomes following Mandibular Distraction Osteogenesis or Continuous Positive Airway Pressure for Robin Sequence

Calvarial Vault Reconstruction for Sagittal Craniosynostosis in Patients 12-Months and Older

Incidence And Perioperative Management Of Von Willebrand Disease In Craniosynostosis Operative Cases

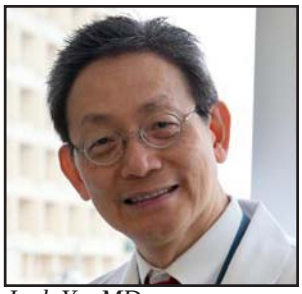
Orbital And Periorbital Dysmorphology In Untreated Pfeiffer Syndrome

Morphometric Analysis Of Hypoplasic Mandible: How Is It Different From The Pediatric Healthy Mandible?

External Ear Reconstruction with Porous Polyethylene Implants: Assessing Outcomes and Surgeon Learning Curve

Fat Grafts Supplemented With Adipose-Derived Stromal Cells In The Rehabilitation Of Pediatric Patients With Craniofacial Microsomia

A Craniofacial Syllabus



Jack Yu, MD

As of 2020, there are 30 craniofacial fellowships in the US. [Nguyen, 2020] Significant variations exist in the educational experience of these programs, as evidenced, for example, by the high relative dispersion (sometimes known as coefficient of variation, or CV. CV= standard deviation/mean) of 73.36% in the 578 reported operations for craniosynostosis from academic year 2018. The mean was 30.4 cases with a standard deviation of 22.3 cases. [Hush and Williams, 2020] As large as this may seem, it is less than four other groups included in the survey: 105% for mandibular distraction (7.94 +/-7.58), 121% for midface surgery (5.56 +/- 4.58), 84.45% for facial trauma (28.51 +/- 33.76), and 77.62% for orthognathic surgery (20.67 +/- 26.63). The only group with less variation in the operative experience is cleft surgery: 56.23%, with a mean of 68.61 cases and standard deviation of 38.58 cases.

While some differences in fellowship training programs are inevitable, due to locations, referral patterns, and interests/focus/skills of the faculty, certain common requirements are necessary as stipulated by Accreditation Council for Graduate Medical Education, ACGME. [ACGME, 2019] The most recent revisions became effective on July 1st, 2019, and contains six key sections from appointment, educational program, evaluation, oversight, to personnel, and work environment. This proposed craniofacial syllabus is a tool to provide shared structures of the educational program so that we can achieve better content consistency. A syllabus is an important part of any curriculum, supplying detailed plans of what the learners will go through, the proper sequence within the allocated frame of time, to achieve the desired transformation.

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Like ASCFS taskforce on ERAS for craniofacial surgery, we apply the principle of Group Intelligence [Galton, 1907] and harness the experience and expertise of our members. This is only the beginning of a continuous massive, collective effort and will need sustained commitments from every craniofacial educator. *FACE*, the official journal of ASCFS and ASMS will be the principle periodical to publish these educational as they become available, covering all three pedagogical domains: cognitive, psychomotor, and affective. There are many print and online depositories and portals that exist now to provide contents, but not in a centralized and organized manner. Both ASMS and ASCFS will host contents in its homepages with different emphasis, as well as the PSEN and ACPA for their relevant educational materials. There are 18 modules for a 12-month period in this syllabus, with the first 6 months covering 2 modules and one per months for the second 6 months. Below is the outline of the 18 modules:

SECTION 1: Surgical topics
This section has seven modules:

1. Orofacial clefts
2. Craniosynostosis
3. Facial Trauma
4. Craniofacial Tumors
5. Facial reanimation
6. Ear reconstruction
7. Gender reassignment

SECTION 2: Non -Surgical Expertise
This section has five modules:

1. Dental
2. Orthodontic treatment (including pre-surgical orthodontic preparations)
3. Speech and swallowing
4. Genetics and craniofacial morphogensis
5. Essential basic biomechanics

SECTION 3: The multidisciplinary clinic
This section has four modules:

1. Team building
2. The business aspects of sustaining a team
3. The mechanics of the team
4. Leadership

SECTION 4 : The affective domain
This section has two modules:

1. The Code of Craniofacial Ethics
2. Setting the proper internal value systems

References

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The Combined ASCFS /ASPN Hawaii Symposium is Back!

Mark Urata, MD, DDS

The combined ASCFS/ASPN Meeting is now back on the schedule for January 30th- February 2, 2022 at the Four Seasons Resort Oahu at Ko Olina. The combined symposium will take place on Monday morning with three General Sessions followed by a shared luncheon. The ASCFS will then hold our own meeting on Tuesday and Wednesday mornings (February 1 and 2), again with afternoons free to enjoy the island, ocean, and the average temperature in January and February of 78 degrees! With several cancelled national meetings over this past year, this will be a wonderful opportunity for focused and high level presentations and discussions on craniofacial topics.

The American Society of Craniofacial Surgery had originally planned to join with the American Society of Pediatric Neurosurgery in Hawaii in 2021 for the combined symposium. This would have been the second iteration of this combined meeting, the first having convened in Maui on January 23rd, 2017. Immediate Past-President at the time, Richard Hopper, M.D. organized the original meeting with his Seattle neurosurgical counterparts, Richard Ellenbogen, M.D. and Sam Browd, M.D. This was incredibly well attended with over 113 colleagues, representing all geographic regions of the country joining with our ASPN colleagues in the inaugural event.

In the early Summer of 2020, the ASCFS Council leadership made the difficult decision to pull out from the meeting given what appeared at the time, to be a trajectory rise in the pandemic and increasing Institutional travel restrictions. Several months following that, the ASPN postponed their meeting.

The details for our accommodations and the general session topics are currently being finalized between the two organizations, but we anticipate that this resort setting will be an optimal environment as we return to in person academic meetings.

The combined ASCFS/ASPN Meeting is now back on the schedule for January 30th- February 2, 2022 at the Four Seasons Resort Oahu at Ko Olina.

ERAS PANEL AT ASPS ANNUAL MEETING

This past year, Jack Yu, MD, DDS convened a panel centered on the Enhanced Recovery After Surgery (ERAS) for a virtual presentation at the 89th ASPS Annual Meeting. The presenters included Jeff Fearon, M.D., Albert Woo, M.D., Joe Williams, M.D., Prasanth Patcha, M.D., Aaron Mason, M.D. Laura Monson, M.D. and myself. Our presentations were based on the foundational work done by the ERAS Work Group of the ASCFS. I was asked to review the LeFort I ERAS protocols and adapt them for LeFort III/I/BSSO procedures understanding that much of the initial iteration was not yet completely evidenced based.

The protocol is a work in progress as components of this require scientific verification. It is a starting point, a "living document," that will be modified over time....

As craniofacial surgeons, we mostly develop protocols based on our own experience over decades of operating and only 1-2 craniofacial patient generations. During that learning process, patient care may not be optimized so pooling of experience and expanding our body of evidence based medicine into ERAS protocols will minimize "learning on the job." And surgeons with less experience or lower volumes will then potentially improve outcomes at the same rate as more experienced surgeons by deploying established ERAS protocols.

For that to be the case, the ERAS protocols must possess broad applicability and allow easy compliance while allowing for variance in technique from one surgeon to another. However, it must be specific enough to provide substantive improvements in measurable outcomes including length of stay, complications, re-admissions, patient experience, economic throughput costs, etc. The ERAS protocols assume that the surgeon has the best comprehensive view to guide the patient care process through the various points of care. The protocols are divided into four phases: preadmission, preoperative, intraoperative, and postoperative. The protocol is a work in progress as components of this require scientific verification. It is a starting point, a "living document," that will be modified over time, but these guidelines will allow us to take the valuable step toward aligning our approach to improve patient outcomes.

ERAS Following Craniosynostosis Repairs

Jeffrey Fearon, MD

Like many developments in surgery, the path to crafting an enhanced recovery after surgery (ERAS) protocol for craniosynostosis corrections has not been a direct one. I recall reading Dr. Henrik Kehlet's pioneering work on reducing lengths of hospitalizations following colectomies. With the calvaria so far removed from the bowels, his work seemed interesting, but unrelated. During my training, the generally accepted protocol was to keep children hospitalized after craniosynostosis repairs until they were able see out of one eye. I never quite understood the concept underlying this, especially for non-ambulatory infants. So once out in practice, my discharge criteria gradually morphed towards meeting two general requirements: being appropriately alert and being able to tolerate oral hydration. Yet, it was the observation that most children vomited for days following craniosynostosis repairs that instigated my own journey towards an ERAS approach. It was easy to blame any postoperative vomiting on anesthesia, at least for the first day or so. After that point, I reasoned any persistent nausea was probably the result of the morphine required for pain control. But were these narcotics really necessary? I read this study in medical school that underscored the importance anxiety played in the perception of pain; with the same stimulus, lower anxiety = less painful. With this background, and after reading studies showing ibuprofen and acetaminophen to be equally efficacious to oral opioids, I decided to experiment with a non-narcotic postoperative protocol (keeping I.V. morphine in reserve); additionally supplementing with anti-anxiety tactics, including encouraging parents to hold their child for the entire hospitalization, playing soft music in the room, and adding medications such as diphenhydramine (Benadryl) and lorazepam (Ativan), as needed. It turned out that the morphine we were holding in reserve was never used. Still, many children continued to vomit, although less frequently. It was the nursing staff that pointed out the connection between oral acetaminophen, or ibuprofen, and emesis. It seems these sweetened syrupy medications were triggering nausea, especially following a general anesthetic. This observation led us to design a prospective randomized study to compare the oral to intravenous administration of these medications on nausea and vomiting. We found the intravenous route was associated with a much lower rate of nausea and vomiting. There was also the added benefit of children always getting the full dose, instead of sometimes losing most of it from emesis, which then required completing a 6-hour period before re-administration. Around this same time, we also started using the sedative, dexmedetomadine (Precedex), just prior to emergence from anesthesia, which was continued over the first postoperative night. We found this addition, along with alternating I.V. acetaminophen (Ofirmev) and ibuprofen (Ketorolac), kept children extremely comfortable during their overnight stay in the PICU.

Besides controlling nausea, a second important factor in reaching sufficient homeostasis for discharge is hydration. I was never convinced that the commonplace usage of drainage tubes following skull surgery was all that effective at reducing postoperative swelling. It was also clear that removing these tubes hurts. The post-surgical inflammatory response includes a bradykinin-induced microvascular leakage. This phenomenon progresses to the point that there is sufficient backpressure to limit further extravasation. Drainage tubes limit this counter pressure, prolonging "third space" losses that increase the need for additional fluid replacement. Eliminating external drainage should therefore be expected to accelerate the achievement of homeostasis. Another important factor is total blood volume. The avoidance of allogeneic red blood cell transfusions by preoperatively increasing red cell mass with iron supplementation, and the addition of recombinant erythropoietin in infants, as well as the use of intraoperative blood recycling, all contribute to blood conservation (our transfusion rates are currently below 5%), which should further expedite a return to homeostasis.

The decision-making process associated with determining a hospital discharge is not entirely objective, and it is the associated subjectivity that makes it challenging to test the impacts of any specific alteration in care on shortening lengths of stay. With these challenges in mind, the preoperative use of supplemental iron for all children and erythropoietin in infants, the use of intraoperative blood recycling and the avoidance of allogeneic transfusions, eliminating external drainage, the use of a dexmedetomadine infusion overnight, substituting intravenous acetaminophen and ibuprofen for postoperative narcotics, and the maintenance of full I.V. hydration in spite of oral intake, have together been associated with a more expeditious recovery. With this protocol in place, 99% of children at our center are being discharged from the hospital 48 hours post-cranial remodeling procedures.

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Ethical Pitfalls in Virtual Care

Christian J. Vercler, MD

Virtual visits and telehealth increased 154% when the pandemic hit America in the latter half of March 2020,[1] when most of our hospitals shut down all outpatient clinics and elective operations. The abrupt disruption of care was a seismic interruption[2] from which we have now mostly recovered as we have settled into a "new normal." We have long communicated with our patients and families via telephone and it made perfect sense to utilize the latest technologies to provide virtual care when in-person visits were restricted. It was "better than nothing."

There has long been a push to increase telemedicine, which was shown to be feasible as early as 1905, when Dutch physician Willem Einthoven successfully transmitted heart sounds via telephone.[3] When Trump authorized CMS coverage of telehealth services in March 2020 it became ubiquitous. Few craniofacial surgeons were utilizing video visits before the pandemic and now the only surgeons not performing "virtual care" are those who have retired.

There are many advantages to video visits. Our patients no longer have to travel long distances to see us. When we are running behind in clinic patients and families are waiting in the comfort of their home, not the boring clinic room. They do not have to navigate the potentially-high-risk waiting room. The bar for quick "check-ins" post-op is lower and pre-op questions that parents forgot to ask can be addressed with an additional virtual visit rather than a second face-to-face pre-op appointment. In many ways it improves patient access to our services and to our expertise. For many patients it is much more convenient. It can also facilitate team-based care by not requiring all specialists to be in the same physical location at the same time.

Virtual care also increases the capacity of a surgeon to see more patients in a given day without utilizing additional clinic space, office staff, or supplies. Video visits can occur outside of "normal business hours." For example, I schedule most of my telehealth visits before my office staff arrive in the morning and after they leave at night. Some of my colleagues see patients virtually all weekend. This improved access and expanded hours of service has a positive effect on the bottom line as well, and many healthcare administrators have incorporated target numbers for virtual care from all their "providers." For example, a large university hospital in the Midwest withholds certain bonuses unless 20% of clinic patients are seen virtually.

This move to financially incentivize virtual care raises some important questions. Is it an adequate substitute for an in-person clinical encounter? Do we know if outcomes are equivalent and what are the appropriate metrics to evaluate in that regard? Knowing that not all patients have equal access to a stable internet and the devices required for a video visit, does this increase health disparities? What sort of choices do we give patients? Should all post-op visits be done virtually? The COVID pandemic has established that public health should trump patient preference, but what about expediency and clinic throughput?

"Being there" for a patient—real physical presence—is one of the core aspects of a virtuous surgeon.[4] One of the main responsibilities of a surgeon is to not abandon the patient upon whom she has operated. So, while in some ways virtual care facilitates this, in other ways it is but a simulacrum of care. The four techniques of physical exam (inspection, palpation, percussion, auscultation) are reduced to just inspection, and that is actually a two-dimensional inspection mediated by a camera on a smartphone or laptop. It is exceedingly difficult to adequately assess occlusion. It is impossible to detect the foul smell of an infection, or the smell of cigarette smoke. Our clinical judgments are informed by a large amount of information that we have learned to process over our long training period and practical experience. Much of this information is what the scientist-philosopher Michael Polanyi called *tacit knowledge.*[5] This basic idea is that we can know more than we can say. When our interactions with our patients are limited to the virtual realm, we risk making decisions that are based on only what can be observed on a video screen and articulated by the patient. This might not be a problem for many of the problems we address, but we are fooling ourselves if we think that the virtual encounter is a 1:1 replacement for the physical encounter.

Presently we are in the midst of a change in practice that was thrust upon us by necessity and not quality improvement initiatives. Virtual care is better than no care when those are our only options. However, virtual care is not straightforwardly equivalent to the high quality patient-focused care that is irreducibly physical and interpersonal.

This is where the ethical pitfalls are. Enthusiasm for the beneficial aspects of video visits and the administrative pressure to increase the use of telehealth can contribute to a blind spot in our vision of what is in the best interest of the patient. For example, a patient with a non-displaced mandible fracture who I was following virtually developed a worsening malocclusion that I did not detect for several weeks. The delay in my detecting the worsening malocclusion led to a delay in definitive management. This is just one example, but as craniofacial surgeons we rely on palpation to detect

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New Ways to Connect — A Webinar Series on Craniofacial Fellowships

Paymon Sanati-Mehrizy, MD

This time last year, many plastic surgery residents were aiding colleagues in ICUs and Emergency Rooms. Since then, training programs have quickly adapted, creating a new normal to allow for continued training. Despite this, the ability for residents to explore craniofacial fellowships has remained largely interrupted.

In previous years, senior residents would often visit programs they were interested in, allowing for mutual evaluation. Residents looked forward to attending regional or national meetings, which brought essential networking opportunities with fellowship directors. In-person interviews encouraged applicants to learn about programs in a more personal and genuine fashion. Meanwhile, being on the interview trail with other applicants made for a collegial cohort of future colleagues. With the halt of away rotations, national meetings, and in-person interviews, selecting a fellowship program (and selecting the right fellow) has become challenging. In an attempt to alleviate some of these obstacles for residents, the ASCFS and the ASMS are collaborating to host a three-part webinar for residents interested in craniofacial surgery.

The webinar series has three primary goals: to shed light on the application process, provide insight into post-fellowship career paths, and connect residents with potential mentors in the field. Residents will have an opportunity to learn from previous applicants how to develop a list of priorities when selecting a fellowship and what factors to consider. Additionally, it is critical for residents to learn about different career paths post-fellowship, and when to begin considering job opportunities. Finally, these webinars will provide an initial connection point between residents and previous applicants to support additional conversations and possible mentorship opportunities.

This three-part series will begin in April and continue through June, preparing residents who are applying in July for the 2022-2023 fellowship cycle. Each webinar will feature panelists from different stages in training: previous fellows, current fellows, and soon-to-be fellows (graduating residents who have matched for the 2021-2022 fellowship year). These webinars will primarily have an informal Q and A format, fostering earnest conversations, relationships, and preparing residents for their next steps.

As a current PGY-5 plastic surgery resident, I am excited to be back on the interview e-trail with other residents from around the country later this year, seeing familiar faces and talking about future plans. While I am hopeful that this webinar series will make residents better prepared to tackle the fellowship application process this year, I am confident a virtual platform for resident and fellow discussion will be a valuable resource to future trainees in a post COVID-19 era.

Finally, these webinars will provide an initial connection point between residents and previous applicants to support additional conversations and possible mentorship opportunities.

Ethical Pitfalls *(continued from previous page)*

bony defects and anomalies and we operate not only in three dimensions but also in the fourth dimension, so it is unlikely that these mediated visits will be sufficient.

It may be that the quality of care that we can provide will progress as technology improves and as we individually gain more experience with interpreting proxies for the information we glean when we are in the room with our patient. Presently we are in the midst of a change in practice that was thrust upon us by necessity and not quality improvement initiatives. Virtual care is better than no care when those are our only options. However, virtual care is not straightforwardly equivalent to the high quality patient-focused care that is irreducibly physical and interpersonal. Defining objective measures that can be used to determine the specific circumstances when the consensus is that virtual care is superior is a fruitful endeavor going forward. Until those guidelines exist we should remain ever vigilant in the midst of forces that threaten the care we owe our patients.

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