MAXILLOFACIAL NEWS

American Society of Maxillofacial Surgeons

INSIDE THIS ISSUE

SPRING 2012

ASMS ADMINISTRATIVE OFFICES
500 Cummings Center, Suite 4550
Beverly, MA 01915
(978) 927-8330
www.maxface.org

FROM THE PRESIDENT

Robert J. Havlik, MD
Indiana University School of Medicine

This is an exciting year for the American Society of Maxillofacial Surgeons! The Society has continued to expand its scope in many areas of activity. You may have noticed some significant changes by visiting our website – *www.maxface.org.* These refinements are long in coming, but the core of ASMS activity has always been education, and this has continued to be the main focus. When I joined the Board of Trustees several years ago, the crucial issue before the Board was should the Society "save" the "Basic Course", a question that was emphatically answered with a resounding 'yes'. This year, the Society continues with its successful Basic Maxillofacial Principles and Techniques Course, held on a semi-annual basis in January and August, as well as the pre-conference symposium. The recent Basic Course was a great success, and the upcoming Basic Course will be held on August 3-5 in Chicago. The ASMS Pre-Conference-Symposium will be held immediately before the ASMS/ ASPS/PSEF Annual Scientific Meeting on October 25th. Dr.

(continued on page 6)

The *"Spirit"* of Maxillofacial Surgery and the Private Practitioner

Stephen A. Chidyllo, MD, DDS, FACS

Somehow I have been assigned a voice as the private practitioner in the solo practice, and how my membership in the ASMS still has relevance and importance to me daily. I am asked repeatedly at local meetings and gatherings as to why in these economically challenging times, do I continue to remain an active *"dues paying"* member in the ASMS. *My answer is consistently and honestly "The Spirit".*

Through years of rich history and tradition which stems back to the beginning of the ASMS in 1947(1), the spirit of our society has been ingrained in each one of us in many different ways. We are all members of the ASMS for many different reasons. Every one of our practices whether, academic or community, solo or group is individual and unique. It was some culmination of forces either during

(continued on page 8)

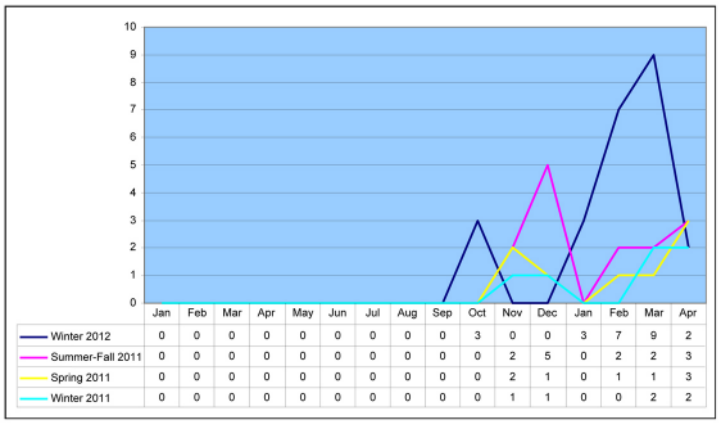
Editor's Column: Changes to ASMS News Access

Arun Gosain, MD, University Hospital (Lakeside)

We are pleased to present the Spring edition of the Maxillofacial Newsletter. During my tenure as Editor we have instituted major changes in the Newsletter. These changes have involved format, presentation, and content of the Newsletter. Beginning with the Winter, 2010 edition, the format of the Newsletter shifted from a print to electronic. This "Go Green" change had several benefits, not the least of which was to conserve expendable resources in an environmentally friendly manner. Printing and mailing of three editions of the Newsletter annually previously cost the society up to $9,000 per year. By changing to an electronic format, the funds previously used for the print version of the Newsletter can now be used to support the core mission of the ASMS through its educational courses and advocacy programs for maxillofacial surgery.

However, simply converting the Newsletter to an electronic version did not guarantee success of this model. What the online version did was to allow us to track access to the Newsletter through the Member's Only site. The following graph demonstrates how online access fared with our initial efforts, in which only members of the ASMS could access the Newsletter.

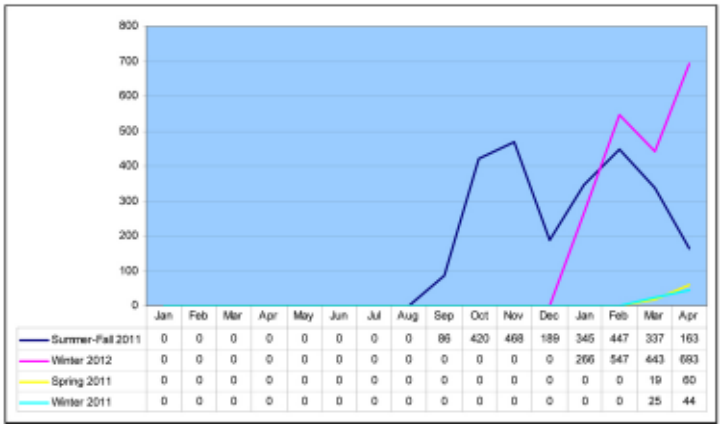
2011 / 2012 Newsletters - Accessed through Members Only Area



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Winter 2012	0	0	0	0	0	0	0	0	0	3	0	0	3	7	9	2
Summer-Fall 2011	0	0	0	0	0	0	0	0	0	0	2	5	0	2	2	3
Spring 2011	0	0	0	0	0	0	0	0	0	0	2	1	0	1	1	3
Winter 2011	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2	2

Following the initiation of online access with the Spring, 2011 edition, usage never exceeded 5 hits per month for the first 3 electronic editions of the Newsletter. With the last edition of the Newsletter (Winter, 2011), electronic usage through the member's only site doubled, but remained less than 10 hits per month. Certainly this would be a discouraging utilization of the online format were the ASMS Newsletter committee not to have reacted to this information. One major advantage of electronic media is that usage can be tracked, and the Newsletter staff quickly reacted to this information with the concept of Open Access. With the Summer-Fall, 2011 edition we decided to make the Newsletter available to all members of the ASPS so as to promote the educational opportunities we offered to all members of our larger sister organization. Plastic Surgery News, the news media of the ASPS, was kind enough to announce this decision via an email blast to all of its readers. Shortly thereafter, Newsletter utlization reached almost 500 hits per month and remained in this range from October, 2011 through February, 2012. The Winter, 2011 issue of the Newsletter was released in December, and we realized that utilization of the previous edition of the Newsletter was far exceeding that of the current issue. The Newsletter committee again responded to this information by extending the Open Acess policy to the Winter, 2011 edition, and soon thereafter utilization of the Newsletter soared to over 500 hits by February, 2012 and continued to climb to a record 700 hits in April, 2012.

2011 / 2012 Newsletters - Open Access



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Summer-Fall 2011	0	0	0	0	0	0	0	0	86	420	468	189	345	447	337	163
Winter 2012	0	0	0	0	0	0	0	0	0	0	0	0	266	547	443	683
Spring 2011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19	60
Winter 2011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	44

With the evolving strategy of the Newsletter Committee based on electronic utilization data, the Newsletter is presently reaching and being accessed by more readers than ever in the history of the ASMS. The end result is that the message of the ASMS is being spread not only to our immediate members, but to our potential membership. By making all plastic surgeons aware of the programs and educational opportunities offered by the ASMS, we can only strengthen our organization. At present, the ASMS Board has agreed to maintain Open Access format for the present issue and all subsequent issues of the Newsletter. We will continue to track Newsletter utilization and correlate these data with ASMS membership. We hope that the skyrocketing utilization of our Newsletter will result in parallel skyrocketing of membership in our organization, and we encourage each of you are reading the present edition to let your colleagues know of our Open Access policy. For those of you who are not members of the ASMS, we further encourage you to consider the many membership opportunities that the ASMS offers tailored separately for residents and fellows, plastic surgeons who are diplomates of the ABPS, and international plastic surgeons. Membership and utilization of its services confirm the ASMS to be the leader in promoting maxillofacial surgery in the United States. With evolution of the electronic version of the Newsletter, the ASMS now has the data to verify this position and to continue to strengthen its mission in the future. We hope you enjoy this edition of our Newsletter as much as you have shown you have enjoyed our last issue. Utilization of our Newsletter is all the thanks our committee is looking for, as we know that this will help to guarantee open access of our Newsletter and continued growth of the as a whole.

Panel Discussion: Cleft Care Around the World

Panel Moderator: John A. van Aalst, MD
Panelists: Gosla Reddy, MD, Hyderabad, India
Scott Corlew, MD, Chief Medical Officer, ReSurge
Bill Magee J.r, MD, DMD, Executive Chairman, Operation Smile
Satish Kolra, Chief Programs Officer, SmileTrain

Editor's Note: *This panel discussion represents a major accomplishment, as it collates the ideas of the leaders in the major organizations addressing cleft care on a global scale. The discussion is divided into two parts. The first appears in this issue and will address the following questions: What is the model that your organization uses to address Cleft care needs in India, and/or the world? How has your model changed since you first started working? Do you have potential projections of how your model may change again in the future? What does your organization feel is the greatest need in international Cleft care? Should international cleft leadership come, not from the developed world, but from the developing world? Where do you think is the greatest need today in international cleft care?*

The second part of the discussion will be published in the Fall issue of Maxillofacial News and will address: What do you think is the biggest mistake that newcomers make to international cleft care? Do you look at cleft care as an export product? Where do you see the biggest opportunity, the greatest opportunity to work together with other international cleft organizations? Would you say that Africa is an ideal place to begin expanding collaborative efforts like this? How does your organization ensure safety in international Cleft care? What would you say your organization's biggest safety concern is?Am I right in hearing that when an organization is financially sound, it will be safe, and it will deliver safe care? Could you comment on the statement a child with a cleft is better than a dead child. How does your organization ensure quality surgery for poor children around the world?How do you communicate within your organization that something could be done better from a surgical standpoint? What metrics tell you that a surgeon is ready? What is the best way to teach? Can you speak to the process of Quality Control in your organization?

John: What is the model that your organization uses to address Cleft care needs in India, and/or the world?

Gosla: The basic outreach we have been using is to create a Center of Excellence where comprehensive and standardized cleft care is provided under one roof, and not only Clefts, but all malformations of the face. Our model of cleft care follows the REACH module developed in Hyderabad which is one of the largest cities in India with a population of 7 million. REACH stands for Rural Effective, Affordable and Comprehensive Healthcare. We aim to give patients with clefts surgery with long term follow up, speech therapy and orthodontics. We provide each child with a cleft lip and palate surgery to repair the lip, palate, bone grafting, orthodontics, speech therapy, maxillary advancement (orthognathic surgery or distraction) and rhinoplasty. We have divided our patients into those that cannot pay for their treatment, those that can pay for a part and those that can pay for complete treatment (No Cost, Low Cost and High Cost).

We address our care in a radius of 1000 kilometers around the city of Hyderabad where we are based. We cater to a population of approximately 75 million people. We do about 1,600 cleft surgeries every year.

Satish: Smile Train's model focuses on providing comprehensive care, but where we differ from other Cleft charities, is that we work only with local doctors. We do not bring in foreign missions and doctors. In this process, we enhance and upgrade the medical infrastructure in that country; we'll train young people, and leave the country in a better position medically than we found it. There are six reasons to explain our model: 1) The cleft problem is too large for mission groups to make any *real* difference. For instance, it is estimated that 35,000 children are born with clefts every year in India and there is a backlog of almost a million. There's no way missions can make a dent in these numbers; the Smile Train 'model' on the other hand will deliver well over 50,000 cleft reconstructive surgeries in India this year alone. This is possible only with centers that function 24/7/365 as ours do. 2) For full and complete rehabilitation a child with a cleft needs more than one surgery over a number of years and prolonged interaction with other specialties. This cannot be provided by visiting Missions. 3) Visiting medical missions leave the local doctors with a feeling of resentment and lack of ownership; there is very little 'buy in'. Immediate post-surgical complications (like dehiscence) are not uncommon. Once a visiting Mission leaves the local doctors are reluctant to treat these problems. ("Why have you come to me?" they'll ask. "Go to the one who operated on you!") 4) While a majority of visiting doctors on medical missions go with a strong feeling of compassion and charity, there are always a few that simply want to 'gain experience' on kids with no risk of liability claims. As a matter of fact the number of botched cases requiring secondary surgical correction invariably spikes after such missions. 5) Missions do little to build and bolster the treatment infrastructure in the countries visited; they perpetuate dependence rather than create self-sufficiency; 6) And last but not least, working with local doctors costs a lot less giving much greater value for every dollar spent.

I understand that international cleft work is like a tri-legged stool: two of the legs are political support and the financial support in addition to whatever you want to call it.

-John van Aalst, MD

(continued on page 9)

From the Education Committee

Peter J. Taub, M.D., Chair
Mount Sinai Medical Center, New York, New York

The ASMS Education Committee has focused on the traditional and the digital. This year's course agenda covers all skill levels, incorporating successful basic courses in Chicago and Miami with an advanced maxillofacial course and a facial reconstruction cadaver course in New Orleans. Between now and this year's ASPS meeting, numerous exciting educational opportunities have been organized. The successful basic maxillofacial course will be held in Chicago in August and an exciting new course in facial restoration and rejuvenation will be held on the campus of Louisiana State University in May. Also planned for the summer are two additional courses: one advanced maxillofacial course that builds on the principles of the basic course and a course in virtual surgical planning that explores novel frontiers in the work-up of patients with complex maxillofacial problems. In the fall, the pre-conference symposium will be the most informative ever. Covering "Successful Maxillofacial Surgery in your Practice", lectures from respected colleagues will cover diverse topics including forehead rejuvenation, blepharoplasty, eyelid complications, face-lifting, and a plethora of valuable topics in ambulatory surgery.

The American Society of Maxillofacial Surgeons and the American Society of Craniofacial Surgeons are jointly sponsoring the Basic Techniques of Craniofacial Surgery Course to be held in Phoenix from August 10 – 12.

This very successful course previously under the sole prevue of the ASCFS and chaired by Stephen Beals concentrated on Cranial techniques. The ASMS contribution to the course will be an expanded focus on orthognathic procedures including mandibular osteotomies and osseointegrated implants. This combined course will replace the ASMS Advanced Course. This decision to join the ASCFS was logical, considering that both the ASCFS and ASMS courses had significant overlap and were targeted at the same group of craniofacial fellows and plastic surgeons with a focus on Craniomaxillofacial surgery.

The Barrow Neurological Institutes Neuroscience Research Center provides a state-of the-art venue for the 2 day course. The format will consist of didactic instruction followed by hands-on cadaver dissections. The first day will focus on the cranial procedure and the second day on maxillary and mandibular procedures.

Members should log onto the revised and continuously updated website www.maxface.org. The site is now a valuable resource for important clinical topics, recent news, membership information, and upcoming educational opportunities. The Plastic Surgery Hyperguide continues to add valuable knowledge to its diverse library of lectures, videos, podcasts, and unknown case presentations. It remains an easy access reference for all types of surgery of the head and neck, including aesthetic, reconstructive, and patient safety topics. Finally, the two new maxillofacial textbooks continue to be collated. The second edition of Ferraro's Fundamentals of Maxillofacial Surgery will be published by Springer, International and will feature new chapters and improved illustrations from ASMS authors. And the Atlas of Craniofacial Surgical Procedures will be written in conjunction with the American Society of Craniofacial Surgeons.

ASMS Announces the 2012-2013 Visiting Professors

The American Society of Maxillofacial Surgeons (ASMS) and the Maxillofacial Surgeons Foundation (MSF) are pleased to announce the Visiting Professors for the 2012-2013 academic year.

PETER G. CORDEIRO, MD, FACS	Chief, Plastic and Reconstructive Surgery Memorial Sloan-Kettering Cancer Center
ROBERT HAVLIK, MD	Harbaugh Professor of Surgery, Interim Chair, Department of Surgery, Indiana University School of Medicine; Vice Chief Division of Plastic Surgery, Chief of Plastic Surgery, Director Cleft and Craniofacial Program, Riley Hospital for Children
WILLIAM HOFFMAN, MD	Professor and Chief, Plastic Surgery University of California -San Francisco
LARRY H. HOLLIER, JR., MD, FACS	Professor and Residency Program Director Baylor College of Medicine, Division of Plastic Surgery

For additional information and to request an ASMS Visiting Professor, please visit www.maxface.org.

The ASMS Visiting Program program is supported annually through a generous educational grant from Stryker.

ASMS History Corner

Steven Buchman, MD, ASMS Past President
University of Michigan

This is my first Historians Corner as well as my first article since becoming past president of the ASMS. I must say that the position suits me quite well, you get to act as the "consigliore" to the members of the board but alas have very little responsibility. My perspective of our organization is now a bit more removed which allows a more balanced overview. I think your board has done a wonderful job of continuing the transition I started as we moved to a different management company; PRRI. The board regularly communicates, as always, however, there is much more committee work being done and an infusion of youth has reinvigorated efforts that heretofore were just ambitions. The incorporation of our new capabilities due to "in house" web programming capacities and the knowledge and interest of our young members have led to more progress on our web page than I remember for over a decade. If you have not visited the website I entreat you to make the effort. Our Newsletter on line both brought down cost and significantly expanded our reach to many more people, and this can now even be tracked with web based technology. Our teaching efforts on the web are in their infancy but the amalgamation of efforts on our web site, with the Hyperguide and the Plastic Surgery Education Network is a winning combination that is sure to both raise the level of maxillofacial education as well as place us in the forefront of directing that educational effort. The same groups of dedicated individuals are also working on an "APP" that will be of use to all in our organization and in our specialty. We are embarking on a brand new educational course that is geared to senior level surgeons but open to surgeons of all levels, specifically a cadaver course that combines maxillofacial techniques and aesthetic techniques, allowing hands on teaching and learning. Our inaugural course is in New Orleans in May and is an exciting addition to the ASMS repertoire. We have two ASMS books in the works and a wonderful new and hopefully fruitful collaboration with the ASCFS on one of those books as well as the summer craniofacial course. I can say from, the perspective of a past president and a fairly new historian of our organization, that things have never looked so good and our future looks bright.

I do want to take the liberty now as is the prerogative of the "historian" to comment on how things are changing over the years. I would specifically like to address the efforts lately regarding administration of the Operating Rooms. In many instances the Operating Rooms around the country have embarked on a crusade for quality and have attempted to change the culture with the laudable goal of increasing safety and reducing mistakes. This has led to the institution of checklists, timeouts, and the introduction of all members of the OR by their first names in the belief that the breakdown of hierarchies will lead to team building, dismantle barriers, and that this familiarity and comfort will allow any member of the operating room to callout a mistake. The claim is that the Operating Room should function as a team and that these changes will ensure good care, promote team building, reduce errors and can be benchmarked with outcomes across the country.

In addition to the aforementioned changes, many of the offices of clinical affairs have opened the door to anonymous complaints on line against physicians and nurses in the operating room from any members of the OR staff in the belief that those unidentified complaints will "lower the bar" for finding unsafe, unethical, and indelicate behavior. Recent efforts along these lines have advocated for cameras in the operating room to monitor for safety and appropriate behavior. These efforts are instituted, again, with the stated meritorious goals of improving safety, quality, and efficacy. I would like to take this opportunity to advise caution, question the logic of such actions, and argue the fallacy that these efforts are so transparently beneficial that there is little need for critical scrutiny. I want to take this opportunity given to surgical leadership to exclaim that the "emperor has no clothes" before we move down a potentially corrosive path laden with unintended consequences. As all things involving safety and security there is a delicate but tremendously important balance between autonomy and repression.

Checklists have been used by pilots and have indeed led to a decrease in mistakes, but surgery is not like flying a plane, they have yet to develop a computer that can do even the simplest operation on its own yet autopilot programs have been in existence for years. The operating theater is

(continued on page 13)

UPCOMING ASMS COURSES

ASMS Basic Course: August 3-5, 2012
Northwestern University, Chicago, Illinois

ASCFS/ASMS Basic Techniques in Craniofacial Surgery: August 10-12, 2012
Barrows Neurological Institute/St Joseph's Medical Center
Phoenix, Arizona

Plastic Surgery 2012: October 26-30, 2012
New Orleans, Louisiana
ASMS Pre-Symposium: Thursday, October 25, 2012
ASMS Day: Sunday, October 28, 2012

ASMS Basic Course: January 18-19, 2013
University of Miami, Miami, Florida

Challenges in Cleft Care in Underdeveloped Countries
January 20, 2013, University of Miami, Miami, Florida

From the President *(continued from page 1)*

Warren Schubert and Dr. Peter Taub have done an outstanding job coordinating a great program – the pre-conference symposium has become a core component for many attending the meeting. Come join us in New Orleans for the Pre-Conference Symposium – just add the Thursday before the meeting to attend a great learning experience.

In addition to these central offerings, the ASMS has also taken a number of initiatives that have broadened the focus of our educational efforts. Warren Schubert MD, Larry Hollier MD, and Henry Kawamoto MD Co-Chaired our first course "Advances in Facial Restoration and Rejuvenation", with the events chronicled in this edition by Peter Taub MD. Despite the fact that this was the first year that this course was held, and this course being held on Mother's Day weekend, the course was a sell-out and people were unfortunately turned away. This course featured both reconstructive and aesthetic techniques, helping those attending to learn the full spectrum from the "Artists of Facial Restoration". The course was held in a new state of the art venue at Louisiana State University in New Orleans, and was the first time ASMS has utilized a cadaver course to instruct surgical techniques – including fat grafting and laser treatment. Plans are underway to add this as an annual programming event by ASMS.

In addition to these central offerings, the ASMS has also taken a number of initiatives that have broadened the focus of our educational efforts.Warren Schubert MD, Larry Hollier MD, and Henry Kawamoto MD Co-Chaired.....

The ASMS is also busy coordinating new activities with the American Society of Craniofacial Surgery this year. The ASMS will provide one day of instruction, coordinated with ASCFS day long program, for all of the new craniofacial fellows (2012-2013) in July in Phoenix at Barrows Neurosurgical Institute. The ASMS is also coordinating the development of a new Craniofacial Surgical Atlas with ASCFS. This book promises to integrate many new approaches in illustration in the synthesis of this important book. In addition, efforts are underway to create a new book based upon Jim Ferraro's text on maxillofacial surgery.

All of these new and existing initiatives have been undertaken and accomplished within the necessity of a balanced budget. Our partnership with our management group PRRI has provided real fiscal assessment and reliable fiscal data on which to judge our programmatic development. I am pleased to report that your Society is as fiscally as strong as it has ever been. This is truly an exciting year – but it is built upon years of commitment and solid and steady growth provided over the past several years. Please enjoy this issue of Maxillofacial News, and pay attention to *www.maxface.org* for updates on course offerings and **your** Society's progress.

Applications now available for
ASMS 2012-2013 Research Grants & CRANIO Fellowships
at www.maxface.org. Deadline: September 1, 2012

THANK YOU to the following for their continued support of ASMS

Douglas Ousterhout, MD

David Genecov, MD, DDS

Carefusion

Operation Smile

American Academy of Pediatrics

Lifecell

Case Study: Microvascular Transplantation of Soft Tissue to Rebuild the Floor of the Nose and Anterior Maxilla

Sean Boutros, MD, FACS,
Houston Plastic and Craniofacial Surgery, Houston, Texas

PE is a 33-year-old male with a history of intranasal cocaine use. He developed a severe infection of the anterior floor of nose, maxilla, and septum, requiring inpatient hospitalization, debridement, and IV antibiotics. He subsequently had loss of a significant portion of the anterior maxilla with loss of the anterior dentition along with soft tissue necrosis and subsequent collapse of the left midface and left nasal support along with tethering of the upper lip. He underwent treatment with BMP grafting at an outside institution which resulted in secondary infection and no improvement.

He presents now for improvement of the overall appearance of the nose and midface along with desires for dental reconstruction. He also desires improvement of his speech which was significantly worsened after his infection.

Pathologic anatomy examination shows loss of anterior maxillary bone and left piriform along with paranasal soft tissues. Antral examination shows tethering of the upper lip to the floor of the nose with loss of the nasal sill, complete loss of the medial crura with loss of a significant portion of the septum and large septal fistula. Approximately 1.5 cm of dorsal septum is present to the cephalic angle. There is scar of the soft palate with resulting velopharyngeal insufficiency and hypernasal speech.

This patient's problem is extensive. He has significant soft tissue and bony needs. The goal of reconstruction of the face should be to replace the bony and soft tissue loss. Bone grafting or BMP grafting especially into a scarred bed will have minimal chance of success and will not treat the overall underlying picture.

The patient will require microvascular transplantation of soft tissue to rebuild the floor of the nose and anterior maxilla. Bone replacement is needed to support the soft tissues and to support the planned dental reconstruction. Bone grafting may be sufficient once vascularized tissue is placed, however, an osteocutaneous flap is advantageous as it provides reliable bone in a single stage.

Treatment

For first stage surgical treatment, the plan was to release the tethering of the intranasal soft tissues and anterior maxilla replacing the intranasal lining with viable vascularized tissue and the anterior maxilla with vascularized bone. Osteocutaneous free radial forearm flap has the advantage of thin soft tissue coverage with providing a relatively independent bone source that can be positioned independently of the skin island based on the septocutaneous perforators.

This procedure was performed replacing the internal lining of the nose and the anterior maxilla. There was improvement of the appearance of the face tethering of the lip and nose. More importantly, an adequate foundation was reconstructed to allow for future reconstruction.

Future plans for complete craniofacial reconstruction include nasal reconstruction via rib cartilage based rhinoplasty, pharyngeal flap for velopharyngeal insufficiency resulting from scar to the soft palate, dental reconstruction with bone graft to augment the radial forearm bone followed by delayed computer assisted dental implant placement.

Fig 1a,b. Preoperative image of patient with loss of nasal lining, anterior maxilla, and tethered upper lip and cheek tissue.

Figure 2 a,b Post operative images of patient after microvascular free radial forearm flap with release of the tethered lip, cheek, and nasal tissue and interposition of vascularized soft tissue along with replacement of the anterior maxillary bone.

"Spirit" of Maxillofacial Surgery and the Private Practitioner *(continued from page 1)*

our residency, fellowship, mentorship, or other, which molded us into who we are today. My practice is an even split of reconstructive and cosmetic surgery. I have found that performing cosmetic surgery may be fashionable, sexy and socially and financially rewarding; however the real gratification in my practice and life comes from the thousands of people and families I have touched through my art of maxillofacial reconstruction. We are all members of the ASMS for many different reasons. In my case ***" I need"*** this society to help ground me and constantly remind me of where I came from, as a dental practitioner, as well as what I now have to offer my patients and my community in field of plastic, reconstructive and maxillofacial surgery.

In the over 20 years which I have been practicing, I have seen too many of my colleagues "give up" and "give away" our specialty piece by piece. Whether it is hand surgery, skin cancer, maxillofacial surgery, burns or wound care, it seems like our specialty is being "sub-contracted" out to other specialists. Some are not surgeons and in some cases not even physicians. I remember my Chief of Plastic Surgery, Dr. Mimis Cohen, telling us, I mean *Yelling* at us, that we should never turn down or give a case away. He referred to the fact, in his own way of course, that when you are in private practice, you may need every case, no matter how small, to make ends meet. How true it is, and more so today! It did not take me long to realize that it was my extensive training in the fields of maxillofacial and craniofacial surgery which provided me with the basis for my success today.

...however the real gratification in my practice and life comes from the thousands of people and families I have touched through my art of maxillofacial reconstruction.

In my community in New Jersey, no one really wants to take ownership or responsibility for the maxillofacial patients. A majority of the Oral and Maxillofacial Surgeons are too busy performing cosmetic facial surgery, dermal fillers, injectable neurotoxins or dental implants. Few of my plastic surgical colleagues incorporate maxillofacial surgery into their elective practice and only perform these procedures when covering the emergency room. I have found that the art of maxillofacial surgery, both emergent and elective is both personally, as well spiritually rewarding to me. It is not a specialty which one can master if they perform it infrequently. I would assume that is also true of microsurgery, never having performed a DIEP flap breast reconstruction. Like everything good in life, it needs to be nurtured and matured within the surgeon, almost in a spiritual way. Those that have been in the operating room with me know that I have a brief moment of silent prayer before I start a case. And in reality I try to invoke the spirit of all of the surgeons before me, to assist me and guide me during the case. Yes it is that spirit of the ASMS and all the founding fathers which is as relevant to us today as it was at that first organizational meeting held on February 13, 1947 in Chicago.[1]

1. Ecker, HA, Crawley,WA: *The American Society of Maxillofacial Surgeons,* 1947-1997, Walsworth Publishing, Missouri, 1997.

Stephen A. Chidyllo, MD, DDS, FACS,
Chief Division of: Plastic and Reconstructive Surgery, Jersey Shore University Medical Center, Neptune, New Jersey

PSEN (www.psenetwork.org) wants YOU!

The Plastic Surgery Education Network (PSEN) was designed to be a valuable tool for plastic surgeons in all arenas of practice. But for it to truly serve everyone, it needs broad participation. The more plastic surgeons use it, the faster and more useful it will become to all. The new site has a Community section, which allows plastic surgeons to pose questions and suggestions to each other on clinical topics at their leisure, which should make for a valuable "watering hole" for all clinicians. This is an area that all plastic surgeons can contribute to at any time. But plastic surgeons can also contribute to the site's other content areas.

The site's main content is managed by Section Editors for each distinct topic area (Aesthetic, Breast, Hand/Peripheral Nerve, Patient Safety, Pediatric/Craniofacial, Reconstructive/Microsurgery and Special Topics). And each Section Editor has solicited a team of assistant editors to bring in new, fresh content to the site every month, whether in the form of literature reviews, case reports or videos.

The more people who contribute case reports and videos, the richer the site will be for everyone. Plastic surgeons who are interested in working with the PSEN editorial team to contribute content either occasionally, or more regularly as an assistant editor, are encouraged to contact online education@plasticsurgery.org and specify their areas of interest.

Panel Discussion: Cleft Care Around the World

(continued from page 3)

Scott: I would say it depends on the country. In some places in the world, even in 2012, there is still a need for direct foreign service. That used to be the only thing we did, 15 to 30 years ago. Now it is only a very small part of what we do. There are so many qualified surgeons in the United States who are very willing to share their skills, but the reality around the world in 2012 is that there isn't that big a need for this type of service. A larger part of what we do is to identify surgeons around the world who have cleft experience and help them improve, expand and advance their skills through educational programs. We also directly support their work. For us, we do this with surgeons we have worked with directly that have been vetted by US surgeons. We are very comfortable with their surgical judgment, their technical abilities, and with their integrity. With these surgeons, we directly fund them. We…emphasize the comprehensive care model that is totally dependent on the local host. The environment of some local hosts is conducive to this. For others it is very difficult. Others with a difficult environment have learned how to work their country and system to the point where they can manage. As an NGO, you are very dependent on your local partners, their energy, their ability to leverage you as well as other organizations and other support services is very important. Frankly, the local partner, who is able to leverage your support with support from various other NGOs and government forces are your most effective local partners. Our poster child for this is in Nepal, where a general surgery resident frankly stumbled into the room where we had a team trip and was absolutely fascinated by cleft work. He selected plastic surgery as his interest in life over the years. He has developed a speech pathology program, first out of his mother's shack in Kathmandu, and in various places around the country. He now has nursing, anesthesia, a dental component, started orthodontics, and developed maxillofacial surgeons. All of them could be making more money elsewhere.

Bill: We initially took a trip with a group from Houston back in 82 and we went to 3 sites, and operated during the days; what dramatically hit us was that in the city where we were working about 300 kids had arrived. Each one of them with gaping holes in the lip and the roof of their mouths, unable to eat normally or speak intelligible words; yet we could only take care of 40 kids and watched over 250 sent away. I thought that this was an isolated pocket of humanity; at the time I had never seen anything like it in my life. We felt extremely guilty leaving because we knew the group we were with wasn't planning on returning. That first trip was really a trip that took care of kids that had never ever been treated; so was the next one and the next one. We brought with us speech pathologists, child life specialists. We felt it was important to set the stage for team care from the beginning; we didn't want to look like a bunch of surgeons coming in and out; we had an opportunity to set an example of what the comprehensive group should look like. After 3 years we ended up in Manilla and continued that same model: always bringing people from multiple specialties; we do this more an example of what should be created then anything that we had ever hoped would be sustainable at that moment in time. As time went on, we were invited to Kenya, India, and Liberia. As time went on we realized we had to do more for education. We developed a physician training program and started to bring doctors to the United States for 2 weeks for multi-disciplinary care, including craniofacial surgery. This was because Dr. Paul Tessier was coming to Norfolk every 6 months and from 1982 to 1988. We operated on about 160 patients here with Dr. Tessier. People who would never have met Dr. Tessier any other way were able to meet him. Really the most important part of this program was the development of friendship and trust with people from around the world; that was the glue that helped hold everything together.

Back in 1999 we decided to put together the World Journey of Hope where we raised 10 million dollars, took an L-1011 flying hospital and visited 18 countries in 9 weeks, operating on 5300 kids. Our purpose was to donate equipment and supplies to each site if local surgeons promised to do one child a day when we left. It was an incentive for them to be sustainable year-round— in fact that's exactly what happened. We track the number of in-country missions that went on after World Journey of Hope and have seen this gradually increase so that now 60% of all surgeries are done by in-country doctors year-round. Intermixed with training people in plastic surgery or anesthesia or nursing, we need to teach them how to raise money, how to have a business structure with a board and transparency in order to be sustainable. Sustainability isn't just giving them medical knowledge; it is also about giving them the acumen to learn how to raise money.

In 2007 we raised 7-8 million dollars and went simultaneously to 40 sites in 25 countries; all 1900 volunteers landed on November 7, 2007 at their respective sites. Of the 1900 volunteers 700 were from the US and 1200 were from 43 countries around the world. Out of this effort, on we've developed a center in Guwadi in the state of Assam, India. This is a public-private partnership Center with 8 operating tables, all with broadband IT. Each table is side by side with one another; there are no walls; there is sophisticated monitoring that comes back to a central ICU station 10 to 15 steps from any one of the tables. In this setting we're starting to do a lot of education, not only for residents around the world but also for the local doctors who have an interest and gain experience rapidly, because there's a backlog of about 30,000 patients in the state of Assam that we're addressing.

Really the most important part of this program was the development of friendship and trust with people from around the world; that was the glue that helped hold everything together.

-Bill Magee, MD

John: How has your model changed since you first started working?

Gosla: Our model did change according to the times but the protocols have to be seamless and sustainable. We can change the model based on changing needs, but we have kept the philosophy and primary goals, which are to create an effective and affordable, comprehensive system for the care of Cleft malformations. Our group was initially a one- man operation that went to patients

(continued on next page)

Panel Discussion: Cleft Care Around the World

(continued from previous page)

in the remote areas to treat patients. This was 15 years ago. Now we are a 50-bed hospital that exclusively gives comprehensive treatment to such patients.

Satish: About a year ago, SmileTrain made a slight deviation in it model: we said it is all very good to work only with local doctors and to create local sufficiency. But what do you say to children with clefts in countries who have no surgeons? A country that has no doctors? We can't tell them that we are so wedded to our model that we ignore you. So, about a year ago, we started carrying out missions in a limited fashion. The total number of surgeries carried out during these missions is less than half of a percent of our total. But we had the humility to acknowledge that though what we've done has been very successful, the model is not beyond question. The second part of the model that has changed is that—until recently—we confined ourselves more to private research universities and some elective secondary procedures; we didn't participate in the final rehabilitation of the Cleft child. Of late we have started creating official orthognathic surgeries. A lot of charities have supported orthognathic surgeries for a long time; now we have started also.

Scott: When Interplast (now Resurge) started in 1969, it was the only organization that took foreign surgeons and shipped them around the world to treat patients with congenital malformations. Now there are 150 to 200 other organizations that have all started doing the same thing and they have evolved as we have. Mostly US surgeons are going to operate; they take their residents with them. So, frankly the model of going to developing countries as part of a resident training program, we have evolved into much more of an interactive and educational type organization; now, instead of doing 40 cases, we now do a few cases as part of an educational program to support surgeons in these countries. I would characterize this as a shift from direct service with US training capacity into more of a development organization. We are now more interested in overall global development.

Bill: There's obviously a tremendous amount of need in the world. There are some organizations that focus heavily on numbers. Although we do a lot of numbers, I think that our forte is to continue to deliver high quality care—the same quality that we would have if we were here in the US. We also want to establish the underpinnings of good health care, like pediatric advanced life support, cardiac life support, and basic life support. We've invested well over a million dollars and credentialed over 12,000 individuals through the American Heart Association. The next step is to figure out ways to get equally excellent results—but not after people go through 15-17 years of training—like surgeons in the States. If we train local surgeons for 15 years, they are never going to stay in remote areas to continue working; secondly we'll be postponing the treatment of children for 15-17 years. It doesn't seem practical. How we'll achieve these goals, time will tell.

John: Do you have potential projections of how your model may change again in the future?

Gosla: Once we have standardized one center, it becomes easy to replicate these centers to the multiple of countries where there is a need. One of the basic problems we face in India is human resources, and unlike some other countries these people are not well trained. So the key is to train these people, give them an opportunity to start their own centers and their own local teams. Once we have a standardized model, it will be very easy for young surgeons that we train to replicate this model in their own situation as needed. Our plan is to replicate our model of running cleft centers in different parts of India.

We acknowledge that no 'model' is perfect and we should be flexible enough to do what's in the best interest of cleft affected kids in the world.

-Satish Kalra, MD

Satish: Let's just start by saying that clefts are not a medical problem. Clefts are an economic problem. The reason hundreds of thousands of kids and older people live with Clefts is not because it's not correctable, but because they are poor. Now, all the work that is done by all Cleft Organizations is hostage to the economic climate. The first thing that suffers during an economic downturn is charitable giving. For the next few years as Europe slides into economic turmoil, the U.S. is not quite out of its recession, all of the giving companies of the world are in for severe economic stress. The worst impact is going to be on charities in general and Cleft Charities in particular. So all Cleft Charities will have to think beyond surgery, and see what can be done to leverage the fewer dollars that are given to deliver a bigger bang for the buck. So it's going to be as much a medical challenge as a financial challenge. And I think the sooner we acknowledge this fact, the sooner we start adjusting our compass to that situation. We acknowledge that no 'model' is perfect and we should be flexible enough to do what's in the best interest of cleft affected kids in the world.

Scott: The future projection of how our model may get changed again is a good question to ask: the better we see the future, the better we can control it. From what I can see, we will have greater emphasis on development of comprehensive care. In many places surgeons are present and the surgery goes well. Speech pathology, orthodontics, the overall big picture does not necessarily go well. For example, how many developing country programs have a clinical psychologist on their team? At most one to two.

John: What does your organization feel is the greatest need in international Cleft care?

Gosla: I think the greatest problem that we have is in the training of the human resources. Once we can establish good quality of training of professionals, then needs can be met. In a few areas, in a few parts of the year, organizations are training these human resources and then they release support from the local organizations, either from the government or from the local universities. The first step for anything is economical growth and the financial support. Once this can be provided we need to collaborate so that everyone supports the effort together. The greatest need for effective cleft care is to have permanent centers of excellence for cleft care, where the patient does not have to travel more than

(continued on next page

Panel Discussion: Cleft Care Around the World

(continued from previous page)

200 kilometers. We also feel that the patient has to be able to access comprehensive cleft care under one roof. She should always see the same team every time she visits the center. In other words we feel that locally trained doctors and cleft teams are essential.

Satish: Exactly. Gosla hits the nail on the head. I think the future of cleft charities lies in working in collaboration rather than in competition. When this happens, the donated money will be put to good use. We are not going halfway around the world competing with the Euros given by German charities. If we can work smarter than the dollars and Euros we are getting could be put to better advantage—cooperation and not for competition. Cooperation among various cleft charities – complementing each other's efforts; collaborating rather than competing.

Gosla: I think you said it perfectly Satish that really the thing for the future is to collaborate and cooperate and love more.

Bill: Well you take countries like China and India where 35,000 kids with clefts are being born every year and with a back log that is still massive. There's obviously tremendous need there in sub-Saharan Africa, and places like Rwanda that have 9 surgeons for 12 million people, but only a handful of anesthesiologists: this is an obvious need; the same situation exists in Liberia. I think there are 9 surgeons and no anesthesiologists in all of Liberia. There's tremendous need in a lot of these countries, it's just a matter of making sure that when we return to these countries we work side by side with the medical, business, and the political communities, so that we're all one together and we all share the same goal and direction. Our efforts should not be looked upon as a foreign intervention in the country.

Scott: Anesthesia can be a really anxiety provoking part of the entire cleft care equation, and we surgeons may have moved along what we can do, the anesthesia providers are still much more limited in number than surgeons around the world. Overall, I think that surgical organizations are going to need to shore up other aspects of cleft care—including anesthesia—that are beyond taking a knife and operating on children.

John: 85 to 95 of children born with clefts are in the developing world. Should international cleft leadership come, not from the developed world, but from the developing world?

Gosla: Yes, I think part of cleft care has to be what you call an "exported product". However, it needs to be shared by the Norhoff transfer and through a technology transfer.

Satish: My view is that reconstruction surgery for clefts is not equipment oriented. It is skill-oriented. We are not talking about new surgeries that are dependent on expensive and highly sophisticated equipment. The most important piece of equipment in case of cleft surgery is the pair of surgeon hands. The more surgeries a surgeon can do, the better he gets. That is a truism. It is not rocket science. A surgeon who has done 1,000 is bound to be better than the one who has done 100. So, taking all the cleft charities in the developing countries with more surgeons coming up, look at where they now. Gosla and I stand shoulder to shoulder with the best cleft professionals in the world. It is simply because Gosla has a skill. He is not off stage to any particular piece of sophisticated equipment. If cleft equipment costs 10 million dollars, yes, he would be at a disadvantage but he isn't. Leadership and innovation will all gradually shift to where the developing countries where the numbers are there with a surgeon doing more surgeries, getting better results, thinking about what they are doing, innovating, and pretty soon the leadership will come from the India and not from New York.

John: Where do you think is the greatest need today in international cleft care? When I say that, I mean geographically, a place, a continent.

Satish: I would say the biggest need is in Africa. Africa is a huge disaster. I go there—and I have been to some very poor parts of India and to some very poor countries in the India-subcontinent—and now that I have been Africa, I say, "Oh my God! This is really dismal."

Gosla: The problem of Arica is huge. The last four years, we have been training surgeons from Africa. We have been offering them a program for a single year. We have already had two surgeons from Nigeria and one from Kenya. After the training they go back and already have started feeling different. They are using basic equipment and are providing what care they can offer. We have to be proactive in Africa.

Overall, I think that surgical organizations are going to need to shore up other aspects of cleft care—including anesthesia—that are beyond taking a knife and operating on children.

-Scott Corlew, MD

Satish: I have traveled a lot in Africa in the last few months, I would say the problem with Africa runs deep, very deep. It is not just a lack of surgeons, a lack of trained hands. First, every reconstructive surgeon that I have met has told me, "You have got to be kidding." Cleftcare is not an Africa problem. Burns are. If you go and see the kind of problems that exist like burns, primary burns, burn contractions; the problems are so overwhelming. With regard to numbers, burns outnumber clefts 10 to 1. The biggest problem that Africa has is a lack of support services. At an African conference of anesthesiologists in Nairobi, I was horrified to learn that in Africa, there is one trained anesthesiologist for 75 surgeons.

Scott: Geographically the biggest need is in Africa. India has 1.2 billion people, but it also has a thousand incredibly well-trained plastic surgeons who can operate circles around most of us. Consequently, overall cleft care in India has really been elevated in the last 10-15 years. In Africa, especially sub-Saharan Africa, the needs are much more basic primary care needs. We often talk about the Goldilocks model. For a country in need an outside NGO that comes in needs to understand these needs. If the needs are vaccinations and vitamin A supplementation and protein calories, the NGOs don't need to move too much in the realm of surgery for congenital defects.

(continued on next page

Panel Discussion: Cleft Care Around the World

(continued from previous page)

Satish: In Africa, hospitals don't have electrical power. They have no oxygen cylinders; they have no anesthetics. What's the point of having trained surgeons in a place like that? You know, I have been to hospitals and I have kind of pulled my hair out saying "Oh my god, what do we do here?" Training a surgeon is very difficult for us in this environment.

Gosla: I think that Africa has a long way to go, but there are a few parts of Africa especially on the east coast and the central Africa where there basic infrastructure exists. I think we should start from there and slowly start spreading outward from these locations.

I think that Africa has a long way to go, but there are a few parts of Africa especially on the east coast and the central Africa where the basic infrastructure exists.

-Gosla Reddy, MD

Satish: In Africa, there are such huge political problems. Places are not safe. There is genocide and civil war. When people are being killed who bothers about clefts in a place where you don't even know if you will be back home at night? It is such a humbling experience, traveling to some of those underdeveloped countries of Africa. People have a distorted view of Africa. Africa is really a mosaic. You have a developed country in South Africa. Countries above the Sahara are really part of the Arab world. What lies in the wind below the Sahara and above South Africa is where the big problem is. There is no government, no law order, no state. How do you work with the cleft problem there? You know, you work on this and then you go and see that the gift you can give begins with caring for burns. What do you do? I have worked with an organization call AVNIFF. AVNIFF is doing an amazing job in Africa. I have traveled with them and I despair. I mean, each time I visit Africa, I go into a depression.

Gosla: There are so many other problems in Africa which need more priority than the cleft issue. There are so many other problems that need to be fixed there.

John: There needs to be a growing sense of local social responsibility for children with clefts.

Bill: Yes you get it. What you find is very creative and energized Ministers of Health. A minister of health in the state of Assam for instance is now in Guwadi where we've built this hospital. He.wants to build an attachment to that hospital and make it an full service pediatric hospital that will take care of hernias, appendices, orthopedic needs, because his vision now sees that as spectacular as we have been working side by side with them, he could do that with other types of pediatric needs also. If you find that creative leader who is visionary and willing to put the money into the shared project and you get that start to amalgamate these creative people—they're isolated right now—but once people see that it can be done, then they're going to be more energized in trying to start a socially responsible project because they want a good name for themselves.

John: I understand that international cleft work is like a tri-legged stool: two of the legs are political support and the financial support in addition to whatever you want to call it. The third leg is infrastructure, technique capability, human resources, in sum, the capacity to safely complete the surgeries.

Bill: It's amazing how people talk at a Plastic's Meeting about sustainability, but they don't even talk about the subject of anesthesia; they don't talk about nursing, they don't talk about any of those things. They think that we just go to train people to do cleft lip or cleft palate surgery. But the reality is that the big risk is in anesthesia. So if you don't have great pediatric anesthesia, with monitoring equipment; if you don't bring in Sevofluorane and use it instead of Halothane, you're going to have problems. There is a myriad of infrastructural things that you need to be thinking about if you want to give really high quality care as if you were operating on your child.

Post Your Open Positions in *Maxillofacial News*

The ASMS wishes to solicit postings for job openings for maxillofacial surgeons. As a service to individuals who are completing craniofacial fellowships or plastic surgery residencies, we plan to post open academic positions for craniomaxillofacial surgeons at no charge. We feel that this service is justified in keeping with the ASMS philosophy of enhancing the education and practice of maxillofacial surgery. This would enable individuals who are completing craniofacial fellowships to use the ASMS Newsletter as the primary source for academic job opportunities, since we will actively solicit all such positions from academic institutions.

We will also post any non-academic positions of interest for craniomaxillofacial surgeons at the fee structure outlined below:

- Job postings for craniomaxillofacial positions at institutions with plastic surgery residency or craniofacial surgery fellowship training programs - to be solicited by the Newsletter so as to insure a complete list and posted at no charge.
- Job postings for craniomaxillofacial positions not affiliated with a plastic surgery residency or craniofacial surgery fellowship will be posted at a fee of $150 for ASMS members and $250 for non-members of the ASMS.

Please contact Lorraine O'Grady (lograd y@prri.com) with any positions for craniomaxillofacial surgeons.

History Corner *(continued from page 2)*

much more complicated and nuanced; does that mean there is no place for checklists? Of course not, but overuse, over reliance, and lack of deference to the surgeon is a dangerous road to go down and moderation in the implementation and the avoidance of obsequious application of checklists is called for. Timeouts also certainly have merit as they attempt to double check the identity of the patient and make sure all those in the Operating Room at that time are on the same page. Timeouts however have proliferated; there are now multiple timeouts, often there are two timeouts before the case and one after. Some of these timeouts now include all sorts of information. Our institution has included fire risk…. for the time being risk of natural disasters and emergency exit plans have not been included. As these timeouts become greater in number, more bloated, and less specific, they become diverted from their original intent, lose focus, and perhaps most importantly become almost mundane threatening the very efficacy and exceptional status that they first engendered. Administrators have been lured into a trap that if something is good and works, more of it is better, I would argue that there is a dose/response curve that continues to be ignored.

The idea that first names break down hierarchies and that such efforts will lead to team building fly's in the face of both logic and experience. There are perhaps no better teams than the Navy Seals or the British SAS, a model for the Special Forces all over the world, yet hierarchies are an integral part of their make-up, chain of command is an inherent and essential part of their structure. These exemplary teams do not address each other by their first names nor do they rely on such superficial efforts to ensure competence, quality, or excellence. They derive their special status because of discipline, practice, and selectiveness of those in the team as well as an absolute abhorrence of incompetence. Their dedication to mission, pride in their group, and constant drilling results in true teamwork, mutual respect at every level of the hierarchy, and most importantly it results in excellence. Calling the group in the operating room a team because they call each other by their first name and go through a check list is naïve at best and conveniently manipulative at worst. Often the only two people that are in the operating room from the beginning of the case to the end of the case are the surgeon and the patient as many of the others rotate in and out and rarely have the ability to be part of a real team even if they want to. Union work rules, financial constraints, and restriction of flexibility have discouraged most hospital administrations from creating and implementing true teams that drill, practice, and organize around excellence. Instead they choose an inexpensive substitute by mandating scripted group behaviors that only result in what I would call "TINO" Teams In Name Only. I, for one, would come in on weekends to work, practice, and drill with a team to be able to gain efficiency, increase quality, improve safety, and most importantly achieve absolute excellence. If that was truly the main goal, the system that we have now would need to be changed and efforts in that regard would be both welcomed and fruitful.

The idea of benchmarking also has merit and is the rage now in health reform circles; however, you cannot benchmark excellence you can only aspire to it!! This very comment came to me from the Dean of our Medical School as he battles the tendency to reduce the complexity of what we do to simple metrics. These metrics do not strive for excellence and may even establish acceptable levels of mediocrity. Surgeons, by nature, are often intense, focused and driven individuals that do not tolerate mediocrity. Those surgeons that are the "best of breed" often push the envelope to new discoveries and techniques; they are the true example of staying on the cutting edge. Such behavior and actions have led them to excel, but often such behavior can be intimidating and make those not accustomed to the challenge very uncomfortable. Striving for excellence can be very daunting and overwhelming but that is exactly what is needed to consistently challenge the status quo, innovate, and excel. Though it is without saying that, profanity, physical violence, and personal attacks are intolerable, the intense and single-minded pursuit of excellence and the capacity to test limits should be valued and prized. I fear that administrative initiatives such as cameras in the operating rooms will have a chilling effect on surgeons independence and judgment as well as on their approach to teaching. The culture of the operating room may well change for the worse and the surgeons may start to second guess both the decisions as to when it is appropriate to let a resident participate at a greater level as well as stifle the very qualities that make many of the great surgeons great. The operating room can be a very intense place and the use of music, humor, and acts of exuberance could definitely be misconstrued without proper context on a videotape, the legal and public relations nightmares that could come about from such situations are enormous, and few believe that they would stay secure and never leak out or be "discovered".

Finally, I would like to question the idea of on line anonymous complaints of any Operating Room staff against another with the thought that those unidentified complaints will "lower the bar" for finding unsafe, unethical, and indelicate behavior. I also fear that such an on line instrument dissuades many a conflict from attaining the best possible outcome which would be to resolve such issues between the parties. Such policies may lead to every misunderstanding or episode of passionate discourse to rise to the level of an "event" that now requires a third party. More importantly, such an instrument can be used to rally against an unpopular individual or a surgeon that uncomfortably has an absolute abhorrence of incompetence. The problem of finding unsafe, unethical, and indelicate behavior does not mandate anonymity but rather a culture that does not endure it and those in the operating room that prize excellence. The overt and politically correct hyper-attention to the sensitivity and feelings of those in the operating room and the lowering of the bar of what constitutes mistreatment potentially threatens the courageous battle demanding a push past discomfort, an intolerance of mediocrity, and a continual resolute purpose in attaining the holy grail of excellence.

2012-2013 ASMS Slate of Candidates

The following ASMS Slate of Candidates was proposed by the 2012 ASMS Nominating Committee, chaired by Steven Buchman, MD. An email will be sent to all Active and Senior Members informing them of the ASMS slate of nominees electronic balloting process, website information and voting instructions.

President

HENRY VASCONEZ, MD

Lexington, Kentucky

Academic Position/Title: Chief, Professor of Surgery, Division of Plastic Surgery; Professor, Surgery and Pediatrics; Associate Program Director, Division of Plastic Surgery Residency Program, University of Kentucky Medical Center; William Stamps Farish Endowed Chair of Plastic Surgery
Current ASMS Board Position: First Vice President, President-Elect
Past ASMS Board Position: Treasurer, Assistant Treasurer, Assistant Secretary
Current ASMS Committee Work: ASMS Educational Grants Committee, ASMS Finance Committee; ASMS Maxillofacial News Committee, ASMS Scientific Program Committee
Other/Past Committee Work: ASMS Scientific Program Committee (Chair); ASMS Membership Committee (Chair); ASMS Outcomes Committee (Chair); ASMS Auditing Committee (Chair); ASMS Biomaterials Committee; Finance & Investment Committee; Scientific Program Committee; ASPS Guidelines Subcommittee; Scientific Program Committee (Craniomaxillofacial); Socioeconomic Committee; Council of Regional Societies Steering Committee; International Committee; PSEF Nominating Committee; Educational Technology Committee; ASPS/PSEF Marketing Committee; Undergraduate Education Committee (Chair); Research Fund Proposals Committee; In-Service Examination Committee; International Task Force; CPT/RUC Committee; ASPS/PSEF Joint Outcomes Committee; Patient Care Parameters Committee; Council of Plastic Surgery Organizations; Finance & Investment Committee; Computer-Based Education Committee
Medical Degree: Central University Medical School; General Surgery Residency:University of Illinois; Plastic Surgery Residency: Emory University; Craniofacial Surgery Fellowship: International Craniofacial Institute, Dallas
Years in Practice: 24
ABPS Certification: 1989

Immediate Past President

ROBERT HAVLIK, MD

Indianapolis, Indiana

Academic Position/Title: Harbaugh Professor of Surgery, Indiana University School of Medicine; Interim Chair, Department of Surgery Indiana University School of Medicine; Vice Chief Division of Plastic Surgery; Chief of Plastic Surgery, Riley Hospital for Children; Director Cleft and Craniofacial Program, Riley Hospital for Children
Current ASMS Board Position: President
Past ASMS Board Positions: 1st Vice President, Assistant Secretary, Vice President of Administrative Duties, Historian, Parliamentarian, —-Member-at-Large
Current ASMS Committee Work: ASMS Education Committee, ASMS Finance Committee, ASMS Maxillofacial News Committee, ASMS Scientific Program Committee, ASMS Task Force on Socioeconomic Issues and Reimbursement (Vice Chair), ASMS Nominating Committee
Other/Past Committee Work: ASMS Membership Committee (Chair), ASMS Maxillofacial News Committee (Chair), Coding and Payment Policy Committee, Strategic Education Council, Quality and Performance Measurement Committee, Plastic Surgery Caucus, Maintenance of Certification (MOC) Task Force, Scientific Program Committee, Program Committee (Craniomaxillofacial/Head and Neck Subcommittee (Chair), Quality and Performance Measures Committee, In-Service Examination Committee, Government Relations Committee, Health Policy Analysis Committee, ASPS/PSEF Young Plastic Surgeons Forum
Medical Degree: Yale University School of Medicine; General Surgery and Plastic Surgery: Yale University; Hand Fellowship: Harvard University; Craniofacial Fellowship: Hospital of the University of Pennsylvania/Children's Hospital of Philadelphia
Years In Practice: 17
ABPS Certification: 1995, Re-certification 2003; ABPS CAQ Surgery of the Hand 1996, Re-certification 2005

President-Elect

WARREN SCHUBERT, MD

St. Paul, Minnesota

Academic Position/Title: Professor, Department of Surgery, Professor, Department of Orthopaedics, University of Minnesota; Chair, Department of Plastics & Hand Surgery, Regions Hospital
Current ASMS Board Position: 1st Vice President
Past ASMS Board Positions: Assistant Treasurer, Member-At-Large
Current ASMS Committee Work: Course Organizer for 16 ASMS Courses; ASMS Education Committee; ASMS Scientific Program Committee (Chair); ASMS Web Page Committee; ASMS Finance Committee, ASMS Maxillofacial News Committee
Other / Past Committee Work: ASMS Constitution and Bylaws Committee; ASMS Ethics Committee (Chair); ASMS Finance Committee; CME Committee; Scientific Program Committee; Program Committee; Plastic Surgery Work Force Task Force; Academics Task Force.
Medical Degree: University of North Dakota; Family Practice Residency: University of Texas, San Antonio; General Surgery Residency: McGill University; Plastic Surgery Residency: Case Western Reserve University; Maxillofacial Trauma Fellowship: Atlanta.
Years in Practice: 21
ABPS Certification: 1993

First Vice President

KANT Y.K. LIN, MD

Charlottesville, Virginia

Academic Position/Title: Professor, Department of Plastic Surgery; Chief,Division of Craniofacial Surgery, University of Virginia School of Medicine
Current ASMS Board Position: Treasurer
Past ASMS Board Position: Assistant Treasurer, Assistant Secretary, Member-At-Large
Current ASMS Committee Work: ASMS Auditing Committee; ASMS Finance Committee
Other/Past Committee Work: ASMS Finance Committee (Chair); ASMS Task Force on Socioeconomic Issues; ASMS Research Committee (Chair); ASMS Best Paper Committee (Chair); ASMS Practice Parameters Committee; ASMS Scientific Program Committee; ASMS Nominating Committee; ASMS Fellowship Review Committee; ASMS Membership Committee; ASMS Education Committee; Scientific Program Committee

(continued on next page)

Medical Degree: Mount Sinai School of Medicine; Residency General Surgery and Plastic Surgery: Hospital of the University of Pennsylvania; Fellowship Pediatric Craniomaxillofacial Surgery: Hospital for Sick Children, University of Toronto
Years in Practice: 20
ABPS Certification: 1994

Secretary
PETER J. TAUB, MD
New York, New York

Academic Position/Title: Professor, Surgery and Pediatrics, Mount Sinai Kravis Children's Hospital; Co-Director, Mount Sinai Cleft and Craniofacial Center
Current ASMS Board Position: Secretary
Current ASMS Committee Work: ASMS Education Committee (Chair); ASMS Membership Committee; ASMS Scientific Program Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery; ASMS Web Page Committee
Other/Past Committee Work: ASMS Best Paper Award Committee; ASMS Finance Committee; ASMS Membership Committee (Chair); Public Education Committee; In-Service Examination Committee; Program Committee; Finance & Investment Committee Young Plastic Surgeons Steering Committee; Curriculum Development Committee; Program Committee (Craniomaxillofacial/Head and Neck Subcommittee)
Medical Degree: Albert Einstein College of Medicine, 1993
Years in Practice: 11
ABPS Certification: 2003 (ABS Certification: 2001)

Assistant Secretary
JOSEPH LOSEE, MD
Pittsburgh, Pennsylvania

Academic Position/Title: Professor of Surgery and Pediatrics, University of Pittsburgh School of Medicine; Chief, Division of Pediatric Plastic Surgery, Children's Hospital of Pittsburgh
Current ASMS Board Position: Assistant Secretary
Past ASMS Board Position: VP of Communications, Member-At-Large
Current Committee Work: ASMS Education Committee; ASMS Scientific Program Committee; ASMS Visiting Professor Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery
Other/Past Committee Work: ASMS Visiting Professor (2011-2012); ASMS Finance Committee; ASMS Visiting Professor Committee (Chair); ASMS Task Force on Socioeconomic Issues; Strategic Education Council; In-Service Examination Committee; ASPS/PSEF Board of Directors (AACPS Representative); PRS Editorial Board (Associate Editor); Research Oversight Committee (AACPS Representative); Curriculum Development Committee; Group Practice Task Force; PSEF Nominating Committee; Program Committee; Publications Committee; CME Committee; ASPS/PSEF Young Plastic Surgeons Forum; Undergraduate Education Committee; Resident Information Committee; International Scholar Committee; President-Elect, American Council of Academic Plastic Surgeons
Medical Degree: University of Rochester; General Surgery Residency: Strong Memorial Hospital, University of Rochester; Plastic Surgery Residency: Strong Memorial Hospital, University of Rochester; Craniofacial Surgery Fellowship: Children's Hospital of Philadelphia, University of Pennsylvania
Years in Practice: 12
ABPS Certification: 2001

Treasurer
WILLIAM HOFFMAN, MD
San Francisco, California

Academic Position/Title: Professor and Chief, Plastic Surgery, University of California -San Francisco
Current ASMS Board Position: VP of Education
Past ASMS Board Position: Member-at-Large, Secretary
Current ASMS Committee Work: ASMS Best Paper Award Committee; ASMS Education Committee; ASMS Finance Committee; ASMS Scientific Program Committee; ASMS Task Force on Socioeconomic Issues/Reimbursements (Chair)
Other/ Past Committee Work: ASMS Best Paper Award (Chair); ASMS Educational Grants Committee; ASMS Maxillofacial News Committee; ASMS Task Force on Socioeconomic Issues; ASPS Nominating Committee; Computer Based Education Committee; ASPS/PSEF Young Plastic Surgeons Forum; Scientific Program Committee; PSEF Symposia Committee; Teleplast Committee; Resident Information Committee; Visiting Professor Committee; CPT/RUC Committee; PSEF/ASPS Committee on Maintenance of Certification; ASPS Clinical Symposia Committee; Program Committee (Cranio/Maxillofacial/Head and Neck); Curriculum Development Committee
Medical Degree: University of Rochester
Years in Practice: 26
ABPS Certification: 1987

Assistant Treasurer
DONALD MACKAY, MD
Hershey, Pennsylvania

Academic Position/Title: William P. Graham III, Professor of Plastic Surgery; Professor of Surgery and Pediatrics, Vice Chair Department of Surgery, Penn State Milton S. Hershey Medical Center
Current ASMS Board Position: Assistant Treasurer
Past ASMS Board Position: Vice President of Administrative Duties Current ASMS Committee Work: ASMS Education Committee; ASMS Finance Committee (Chair); ASMS Scientific Program Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery; ASMS Task Force Socioeconomic Issues/Reimbursements
Other/Past Committee Work: ASMS Education Committee (Chair); Instructional Course Committee; Program Committee; Curriculum Development Committee; MOC Coordinating Council (ABPS Advisory Council Representative, ASMS)
Medical Degree: Medical School University of Witwatersrand, South Africa; Residency: Penn State Milton S. Hershey Medical Center
Years in Practice: 25
ABPS Certification: 1997, Re-certification 2006

VP of Administrative Duties
ARUN GOSAIN, MD
Chicago, Illinois

Academic Position/Title: Professor and Chief of Plastic Surgery, Lurie Children's Hospital, Division of Plastic Surgery, Feinberg School of Medicine of Northwestern University
Current ASMS Board Position: VP of Administrative Duties
Past ASMS Board Position: Historian, Treasurer, Parliamentarian
Current ASMS Committee Work: ASMS Visiting Professor (2011-2012), ASMS Maxillofacial News Committee (Chair); ASMS Education Committee, ASMS Educational Grants Committee; ASMS Finance Committee

(continued on next page)

Other/Past Committee Work: ASMS Auditing Committee (Chair); ASMS Educational Grants Committee (Co-Chair); ASMS Scientific Program Committee; PSEF Volunteers in Plastic Surgery Steering Committee; ASPS/PSEF Bylaws Committee; Visiting Professor Committee; International Scholar Committee; Health Policy Committee; PSEF Nominating Committee; PRS Editorial Board; Senior Residents Conference Committee; E-Learning Committee; Scientific Program Committee; PSEF In-Service Examination Committee; ASPS/PSEF Maintenance of Certification (MOC) Committee; Computer Based Education Committee; ASPS/PSEF Joint Outcomes Committee; Research Grants Committee; ASPS/PSEF Marketing Committee; PSEF Volunteers in Plastic Surgery Steering Committee; ASPS/PSEF Bylaws Committee; ASPS/PSEF Visiting Professor Committee; ASPS/PSEF International Scholar Committee (Chair)
Medical Degree: UCLA School of Medicine
Years in Practice: 20
ABPS Certification: 1994

VP of Communications
REZA JARRAHY, MD
Los Angeles, California

Academic Position/Title: Assistant Professor, Division of Plastic and Reconstructive Surgery, David Geffen School of Medicine at UCLA
Current ASMS Board Position: VP of Communications
Current ASMS Committee Work: ASMS Membership Committee (Chair); ASMS Best Paper Award Committee; ASMS Education Committee; ASMS Maxillofacial News Committee; ASMS Web Page Committee
Other/Past Committee Work:
Medical Degree: State University of New York at Stony Brook
Years in Practice: 5
ABPS Certification: 2008

VP of Education
FRANK PAPAY, MD
Cleveland, Ohio

Academic Position/Title: Chairman, Dermatology & Plastic Surgery Institute, Cleveland Clinic
Current ASMS Board Position: Chairman, Constitution & Bylaws Committee 2000-2012 Member, Scientific Program Committee
Medical Degree: MD Residency: 1991-1992 Primary Children's Medical Center University of Utah-Craniofacial Fellowship 1989-1991 Plastic & Reconstructive Surgery-Cleveland Clinic 1984-1989 Otolaryngology Head and Neck Surgery-Cleveland Clinic
Years in Practice: 20
ABPS Certification: Plastic Surgery, 1994; Otolaryngology, 1989

Historian
DELORA MOUNT, MD
Madison, Wisconsin

Academic Position/Title: Associate Professor, Division of Plastic and Reconstructive Surgery Chief, Pediatric Plastic Surgery at American Family Children's Hospital, Director of Craniofacial Anomalies Clinic
Current ASMS Board Position: Historian
Past ASMS Board Position: Parliamentarian
Current ASMS Committee Work: ASMS Education Committee; ASMS Membership Committee; ASMS Visiting Professor Committee (Chair);
Other/Past Committee Work: ASMS Constitution & Bylaws Committee; PSEF Volunteers in Plastic Surgery Steering Committee; Program Committee; International Services Committee; In-Service Examination Committee; Young Plastic Surgeons Steering Committee; Curriculum Development Committee; PSEF Volunteers in Plastic Surgery Steering Committee; Program Committee (Research/Technology Subcommittee);
Medical Degree: University of Illinois; General Surgery Residency: Indiana University Medical Center; Plastic and Reconstructive Surgery Residency: University of California; Craniofacial & Pediatric Plastic Surgery Fellowship: Washington University, St. Louis Children's Hospitals
Years in Practice: 11
ABPS Certification: 2002

VP of Socioeconomic Issues
JACK YU, MD
Augusta, Georgia

Academic Position/Title: Milford B. Hatcher Professor; Chief, Section of Plastic& Reconstructive Surgery, Georgia Health Sciences University; Chief, Pediatric Plastic & Reconstructive Surgery, Children's Medical Center
Current ASMS Board Position: VP of Socioeconomic Issues
Past ASMS Board Position: Member-At-Large, Parliamentarian
Current ASMS Committee Work: ASMS Constitution & Bylaws Committee; ASMS Educational Grants Committee
Other/Past Committee Work: ASMS Scientific Program Committee; ASMS Education Committee (Chair); ASMS Educational Grants Committee (Chair); ASMS Membership Committee; ASMS Nominating Committee; ASMS Scientific Program Committee; ASMS Fellowship Grant Committee; ASMS Biomaterials Committee; PSRC Development Committee; PSEF/ASMS International Scholar Committee; Curriculum Development Committee
Medical Degree: University of Pennsylvania
Years in Practice: 18
ABPS Certification: 1996, Re-Certification 2004

Resident/Fellow Representative
CAROLYN ROGERS, MD
Madison, Wisconsin

Academic Position/Title: Chief Resident, Plastic Surgery, University of Wisconsin Hospital and Clinics (through June, 2012) and Fellow, Craniofacial Surgery, Children's Hospital Boston (starting July, 2012) Current ASMS Board Position: Resident/Fellow Representative
Medical Degree: MD, University of Pittsburgh, 2007
Years in Practice: Graduating Resident
ABPS Certification: Not yet eligible

You know the benefits of ASMS Memberhip.. .....Now's the chance to pass it on!

ASMS membership provides numerous benefits including:

- Access to the latest information and technology in Maxillofacial and Craniofacial surgery
- Educational opportunities and peer recognition in the field of Maxillofacial and Craniofacial surgery
- Reduced registration fees for the annual meeting and other symposia
- Subscription to the ASMS newsletter, Maxillofacial News
- Research grant awards
- Access to the website "Members Only" section where you can view educational videos and more.