Globalization of Craniofacial Plastic Surgery: Foreign Mission Programs for Cleft Lip and Palate

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Abstract: International Humanitarian Interchanges are a bona fide component of surgery and medicine. Additionally, these programs also provide substantial benefit both to the doers and the recipients. The foreign mission program is potentially a weapon of foreign policy which is underutilized and underestimated.

Physician job dissatisfaction is increasing. However, the happiness and satisfaction of the participants in the short-term multidisciplinary trips, repeated, well-organized and respectful, with rather complete integration of the surgical system of the sister countries (“Plan B”), approaches 100%.

The theory of the International Humanitarian Interchanges is based on substance, on medical theory. These trips are particularly successful in interchanges with medium-resourced countries.

Furthermore, the academic visiting professor (“Plan A”: hi-resource place to hi-resource place), the One Man Can Save the World model (“Plan C”: to the low-resource place), and the intriguing Horton Peace Plan have possibilities for long-term benefit to the doer, recipient, the field of surgery, and the body of knowledge. In all of these, our country and the family of nations advance.

The theoretical basis is not always religious nor the grand strategy plan; both have either proselytizing or political dominance as primary motives, and are mentioned as historically helpful.

Key Words: Cleft lip, cleft palate, humanitarian, international, resident, barriers, improvements, Hippocrates, career, Stanford, Mexicali, driving force, business-medicine synergy, religion, Grand Strategy, One Man Can Save the World

Why the foreign mission program? Why international? Why surgery? Why trainees doing work? Why emphasize the individual, the person, rather than the population? When will the business-medicine synergy blossom? Why humanitarian?

The beauty of the Foreign Mission Program (FMP) is that it benefits everyone who comes in contact with them. The patients are benefited, each and every one, immensely. The act of giving makes us happy; the residents are of benefit to the trip itself and both countries involved. Advances in the field of craniofacial plastic surgery are made. The donors and nonsurgeons on the team become “surrogate surgeons” with great pride. A new team, formed with binational members, feels the impulse to go to a third country—together. The actual initiation, the precipitating reason for the foreign mission trips was a search for the opportunities in teaching, direct patient care, and research. The FMPs are primarily medically based. The program is based on social and medical theory rather than based on a religious inspiration or scientific fact.

Barriers are opportunities in disguise. In fact in some cases the more formidable the barrier, the greater the opportunity is to learn a new discipline and to upgrade social skills to form new contacts useful toward the project.

The driving force is commitment. The commitment is strengthened by the knowledge that the trips are so good and of such great benefit to all.

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The Initiation
On whose social or political theory do you base your foreign mission program?2

The basic motivation for the Foreign Mission Program usually tends to be religious or deeply rooted in the spiritual way of life of the participants.2 The motivation may be intellectually based as in an academic pursuit, or based on a political agenda as in the grand strategy3 of the United States or the former Union of Soviet

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Socialist Republics. However, the Stanford motivation was distinctive in that it was primarily based on a medical and educational theory. It was based on the medical theory of Hippocrates, which is to perfect yourself with skill and knowledge in the field, and then apply it for the benefit of the other. The mastery of cleft lip and palate (CL&P) surgery, along with knowledge of the attendant disciplines was considered by many as an ultimate achievement in plastic and reconstructive surgery (PRS); and of course, we were aiming for the top rung in the ladder, seeking to master every aspect.

Altruism is the underlying way of life for many; and the service instinct is a major reason for entering the medical profession in the first place. Nevertheless, the basic motivation for patient care extramural to the university medical school in a foreign country was medical: it was to achieve success in medicine, in a new academic job. Yours truly (D.R.L.): the young, ambitious faculty member found that research opportunities were magnificent at Stanford, but few patients were available for role model patient care, for teaching in the model of Hippocrates. The motivation in 1965 for the first FMPs by Laub at Stanford was medical. The primacy for the extramural FMP was based on a rather immediate need for the CL&P surgical operations.

This need became the driving force. The force soon morphed into the goal of a new career in International Humanitarian Surgery. This was a fire in the heart. The method was shotgun in nature: work with all who come into contact; “no problem” was the answer to all questions. The method worked. Everyone who came in contact with the FMP benefitted. Great opportunities to expand networking and to make professional friendships were everywhere. The initiation of the FMPs for CL&P was for a medical reason rather than trading surgical operations for conversion. Proselytizing as the primary role and surgery as the means to that end was not our mind-set, nor was it the grand strategy plan of the United States for global dominance.

The foreign mission program is an intrinsically good method to even out the great disparity that exists between the places in the world that differ in their level of medical development. The foreign mission program transplants skill and knowledge from developed places to places in process of developing. This inequality exists not only in the distrusted medical services but also in all the parts of our practice: the teaching, research, and patient care. It is unsatisfying to us that the basic human right of access to medical care is far from universal. Access to surgical care is also maldistributed, with more than 2 billion lacking access worldwide. In the last 50-year era (1965–2015), the developed places have sent missions to countries in lower stage of development and the missions have included on-the-job training, research, and didactic teaching, and the foreign mission programs have become a bona fide part and parcel of plastic reconstructive and hand surgery itself. At this time in 2015, things have changed, and these countries in turn are beginning to develop capability of helping out countries in a lower stage of development. For example, surgeons from countries who were at first recipients have become providers. Surgeons from Nepal, South India, Pakistan, and Ecuador have assumed responsibility at sites without enough resources to take care of themselves to become surgically independent. There seems to be several groupings-subdivisions of nations in respect to ability to address CL&P.

The broad classification of the countries of the world are medium-level resource, medically high resource, and low resource. Surgery access is also classified this way, and notably, progress is happening. The mid-level colleagues are picking up the reins (Table 1).

In the words of Caterson and Ramos, “in a field like surgery, where expertise is gained in experience, and experience is directly correlated with volume of cases, it is important to realize that countries having both an emerging capacity of surgical care specialists and a large volume of need for these services have a unique opportunity to emerge as potential centers of excellence.” This also helps to solve the additional problem which arises “if the literature is generated in a sterile environment remote form the patients in most need. . . there is often a dearth of knowledge viewed from the patient’s perspective.” The FMP is a perfect solution. There is no better way to carry out this multiplication than via the International Surgery Interchange.

**History: Conundrum 1**

It was appropriate that Edward Durrell Stone’s stunning new hospital would be the ideal site for the wonderful new paradigm in medical science to come to fruition. We are talking about the birthplace of Stanford University Hospital, 1959, which was wisely conceived in research. Men of the Nobel laureate class designed this new Nirvana, and it was to be a clean restart on the trusted, age-old model, which affirms that basic research is the foundation of medicine. Research contributions are coupled with the new thoughts and the fresh ideas of geniuses. Research and genius combined are the first step, again, the foundation in this new, refined research paradigm. These contributions were planned to be far and above those derived from any previous incubator system. Our wonderful Nobelists had, thank God, thoughtfully not neglected to insert the discipline of the physician educators as the application of research. These founders began on the molecular biology level: the patients in the nice hospital were regarded as human “subjects,” and they were to be the “N”: the numbers in the data in scientific publications.

The relationship of molecular biology to physician educator was the same as the relationship of physics to engineering, as theory is to practice. “The future, my son, is in research with molecular biology,” was my instruction from my mentor, Dr. Robert A Chase (R.A.C.). He immediately immersed D.R.L. in 3 magnificent projects with 3 of these brilliant and wonderful advisers. The horizon was 8 years distant before excellence would arrive.

**Table 1.** In Medium-Resource Countries Where Surgical Expertise has Become Available in Recent Years, Teams Have Developed and Been Organized to Make CL&P Trips to Places With Few Resources and Without Expertise (personal communications, 2013–2014)

| Surgeon | Home Country | Experience | Projects |
|---------|--------------|------------|---------|
| Jorge Palacios | Rostros Felices, University of Guayaquil, Ecuador | More than 12,000 cases, CL&P, accompanied Interplast trips to Vietnam and Honduras as teacher | Pioneered new paradigm—mobile surgery—the doctor goes to the patient rather than the patient to the doctor. Has performed 7200 cholecystectomies and hernia repairs in his up-to-date operating room in a truck with 1 mortality! (cholecystectomy included for reader’s interest) |
| Edgar Rodas | Cinterandes, leader of Interplast trip in the Andes Mountains of Ecuador | | Craniofacial surgery in Nagercoil, 5000 cases of craniofacial surgery in rural and very south India, Nepal |
| Sunil Richardson | Cape Craniofacial Foundation | | Has performed over 5000 humanitarian cases in rural India and Nepal |
| Shankar Rai | Kathmandu, Nepal | | Over 11,000 humanitarian cleft cases performed in rural Afghanistan, Pakistan |
| Ghulam Qadir Fayyaz | Cleft Lip and Palate Association of Pakistan—CLAPP, Lahore, Pakistan | | |

CL&P = cleft lip and palate.
But Where Are the Patients?

This question constituted Conundrum 1: Marvelous research contributions at a heavenly site, but without the human pathology upon which to apply the breakthroughs. Research was first and foremost and was yielding repeated breakthroughs benefiting a thousand or ten thousand with a single stroke. However, the missing link was psychic income—the rich and satisfying feedback which occurs when a surgeon does something for the benefit of the other single person. This was not abundant, in fact it was scarce.

In Figures 1 and 2, we describe that the initiation of the foreign mission program completed this missing link. Figure 1 shows that there was somewhat more skill and knowledge in the resource rich places of the globe. The conundrum was that these same places may be wanting in human pathology for training and research. The reciprocal is that the medium resource places have more opportunities for training. Research opportunities exist in both places. Figure 2 shows that the medium resource places have knowledge and the desire to obtain the equipment, the skills and knowledge surrounding the hi-level advances in the developed places. They have great need and desire to be educated in the United States and in the developed places.

The mountains of CL&P individuals for surgery, teaching, and all types of research in the medium resourced countries were a source for surgery teaching and all types of research. Here in the partially developed countries was a wonderful opportunity for experiencing psychic income from work with individual patients—a very important component in the training of residents. Psychic income is the rich feeling associated with the satisfaction of helping another person. The conundrum was further intensified by the fact that psychic income was also associated to some extent with the marvelous research, because in research you have the feeling of being deified. Nevertheless, it was nowhere near the proportion of the intensity of the psychic income which is associated with the single gift of helping in an individual case, and the great amount of psychic income after a well-done repair of a cleft lip or palate, particularly on the FMP; which is a dramatic result, hugely significant to the patient’s life, and provides sustainability through education and by providing for succession.

A third factor further intensified conundrum 1: the scarcity of good cases caused by the fact that the clinical patients were already well taken care of in another corner. Stanford’s new paradigm was set down exactly in the middle of an affluent area where clinical medicine was already superb, at “Mayo Clinic West”: the Palo Alto Medical Clinic—a center for clinical excellence, but on the private practice model. Recruiting young plastic surgery faculty members to Stanford was therefore made doubly difficult, and furthermore the young faculty had their career compass set on the epitome of skill symbolized in the CL&P surgery. This would be the apogee, the high point, of their surgical career. It became obvious to D.R.L.

Finding Patients

Where Will the Patients be? Particularly, Cleft Lip and Palate?

We travelled to Central Valley Hospitals, conducted a lecture circuit through Northern California, productive of burns and spinal cord injury/decubitus ulcers, but not clefts. We surveyed jails for any socially deviant patients who might be good cases by which to look at the Lombroso Theory, but located only a few; and went to the Menlo Park Veterans Administration domicile for 2000 veterans, but again, no CL&P at all. These locales failed to provide young clinically aggressive Stanford faculty assistant Professor Laub with good cases for his job; and CL&P pathology was nonexistent except for the few referred by the California Cleft Palate Panel System.

Deus Ex Machina

A deus ex machina intervention solved the conundrum and was in the form of a boy with a unilateral CL&P, Antonio Cruz, who was presented to Dr. Chase. He was referred to Stanford from Mexico by the Latin American Mission Program (LAMP), an organization following the edicts of Vatican II. Vatican II was an encyclical passed down from the Pope and a worldwide Bishop’s meeting that was interpreted by many as instructing priests to leave the parish itself, leave behind a self-referential clergy career, and go to the real down-and-out places and help the people there. This was LAMP.
Dr. Chase went on to operate on the boy, Antonio, free of charge. A mere 2 operations produced a miracle: the boy was changed for life. He was handsome and could later speak well. He had become a card-carrying member of the human race. This was a case surely sent by the spirit of Hippocrates himself. Laub helped only a little on the case, but he was in receipt of a huge dose of psychic income.

Conundrum 2

Conundrum 2 was developing simultaneously with Conundrum 1. The United States of Mexico had launched their ideal political system in 1911 as the United States had in 1776. The Mexican system was logically an ingenious combination of 50% capitalistic principles melded with 50% socialistic principles. In the medical sphere, this meant free medical and surgical care for all, with physicians working gratis or at low salary in the university teaching hospital in the A.M., and then at 1 P.M., they would begin their capitalistic life at their own private clinics. Another feature was that physicians were exposed, especially at their universities, to social ideals and community projects to “do things for the group.” (Latin American university medical schools have 4 tenets: teaching, research, patient care, and community projects; American universities have 3: teaching, research, patient care, but seldom “community projects.” We are learning from them.) These ideas had been acquired during education in Havana; on the other hand, many surgeons were educated in the United States. Every new graduate of a Latin American medical school was to accomplish a year in social service, an internship at a rural clinic for the poor, doing a gratis humanitarian practice. However, having just married an upper class wife created pressure on the heretofore idealistic graduate to charge fees to the poor. An ongoing problem, and an example of the difficulty in applying the social principles.

In Mexico and South America, medical professionals were becoming familiar with capitalistic advantages through American television and media. These countries were medically medium-resource. Their medical practitioners had been exposed to the latest medical breakthroughs and were knowledgeable enough to desire acquiring these miracles for the treatment of their patients, as well as to acquire all the new good things in our economy for their families and for themselves, for instance, house on the hill, private education, telemedicine, laparoscopic surgery, open heart surgery.

And thus, conundrum 2 was born. At Stanford, in the most beautiful place in the world, and the most ideal for the new research system, research was being done that could cure a million with 1 stroke, but again there was a lack of human pathology (conundrum 1). Also, in Mexico, the level of medical skill and knowledge was a bit less, but they were working hard, ideologically motivated. A plethora of pathology, good cases, were evident and noticed by Stanford’s PRS department. In the medium-resource places there existed a surplus of pathology and plenty of medical practitioners eager to help these patients and eager to learn (conundrum 2). As it would turn out, the answers to conundrum 2 were found in one of the worst and most inhospitable places in the world. Advances in patient care, teaching, and research would take place extramural to Nirvana, in a place which would marry the 2 opposites. A Mexicali-Stanford linkage was a miracle begging to be born.¹¹ The huge bonus was that the psychic income in the medium-resource places, and in Mexicali, was apparently approaching infinite.

Coincidences and conundrums are created by God; and you and your free will must come up with action and the solution.¹⁶,¹⁷

The Solution Was the Marriage of Stanford

With Desierto de Altar

The quest for the good case served as a motor. The requirements of the job of teaching, research, and patient care at Stanford would be satisfied with good cases. It was hard to conceive that the job fulfillment for the most wonderful place would happen in the most god-forsaken place in the world! This was the paradox: in Hell we found Heaven!

Here is where both conundrums were solved in the form of a peak experience: it was this patient with bag on the head (Fig. 3). I asked, “Why the bag?”—“He’s hiding...he has a scar.” In societies without much money or technology, the physical appearance is not only the most important thing, it is the only thing. The peak experience was here at my early stage. I suddenly realized that it would be possible to change a life with 2 ½ hours of surgery; a 1 ½ year horizon to become proficient in the PR&S craft compared with 8 years preparation for scientific research. The choice was for the more immediate gratification, via the plan which was in actuality the foreign missions. Here in this inhospitable climate, a plethora of patients were available, great cooperative collaboration from the Mexican counterpart surgeons, 4 trips a year, 10 cases each weekend in an entirely new milieu; teaching by role modeling, an incomparable experience for each resident with bonus added value: adventure, the requirement for courage, opportunity for making a myriad of new contacts, and an experience with a completely new culture. It allowed for fulfillment of the doctor instinct, the service instinct. Uncle Hippocrates would be very proud of us! This pattern of planning followed the theory of peak experience—the sudden coalescence of all previous training and experience into one clear career path.

The multidisciplinary, short-term, surgical trip focused on a single diagnosis, well developed by principles and eventually by experience, was being born.

The Vision

At the time of that peak experience, the vision was that 25% of plastic surgeons would be involved at some time in foreign mission programs, especially for CL&P. In a 2009 survey of residents who were members of the American College of Surgeons, it was found that 85% of their respondents planned to volunteer while in practice, despite many being in debt. They pointed to 2 main barriers: financial and logistic, and had high motivation to acquire international training experience and they planned to volunteer in the future.¹⁸

It all happened; actually, the vision for the training program has come into reality.¹⁹ On the local basis, 5 of our former resident surgeons have retired and do foreign medical missions on a continuous schedule—multiplication happens! Mexicali became a virtual Stanford extension, and a synergy developed between the university medical school, which held the same tenets of

FIGURE 3. Line at first intake clinic, Mexicali, November, 1966. The stigma of physical deformity is all-important.
Barriers
The barriers to the globalization of craniofacial plastic surgery and the FMP are daunting. They appear huge, and may mightily discourage even the initiated. The solution of these seemingly insoluble problems lies in the use of the theory of the paradox. Obstacles are not obstacles; they are actually opportunities to meet people, to make contacts helpful to the future of the project. Each barrier presents you with a diverse discipline in a nonpolitical area with a happy, smiling new friend, an expert who is eager to help others in medicine. You are able to learn helpful principles.

The second method to solve barriers is the method distinctive to plastic surgery. “The plan is tailor made to the patient and to the problem,” that is, to the country or to the site, rather than fit the problem to a page in a solution book or text, as in dentistry or orthopedics. This is real; solutions happen with our plastic surgery method.

And the third method to solve barriers is to pull some principles out of the bag, for example, the power of the group”—interdependency causes unity in function through commonality in purpose. This is not entirely an American concept. It draws from theory of rehabilitation of predelinquent socially deviant behavior, which has been treated successfully in 4 instances: the US Navy, the Norwegian court system’s synergistic collaboration with their Merchant Marine, the Sea Scouts of America, and the Re-Education Camps of many Communist governments. Because on a ship, one must work together; deviant behavior is rewarded with real danger of everybody drowning. Principles of socialism are mandatory. Commonality of purpose empowers the group.

The overarching principle is that the multidisciplinary short-term, single surgical focus trip, scheduled in advance, developed in the 4 steps, with changeable standard operating procedure (SOP) but never a change in core values, with meticulous follow-up and good care of complications, full collaboration with the other country with counterparts at every level, seems to be best model for the surgical interchange for medium-resource countries.

Lack of Contacts in the Country
Principle: Make friends with all levels, from janitor to king. Cultural integration requires that we learn from them, not the other way around.

Solution: Upgrade personal social abilities. Talk to the person in the next seat and talk about them, not about us. Smile at every person who makes eye contact. “YES” is the standard answer to questions. Thoughtfully manage professional jealousy.

Resource: Familiarize with the other culture. Read “How to Act in a Foreign Country” blog.21

Geographic Separation
Principle: The interaction with the person face to face, trumps cyber communication, even Skype.

Solution: Think big and small, design a personal Navy, personal volunteer Air Force, commercial air, automobile, bus and burro. Marry other disciplines.

Resource: Retired military, mothball fleet, experienced pilots chomping at the bit to help.

Permisos (Professional Permissions) (Backing of your profession)
Principle: Marry the other places, that is, marry their problems. Assuming their problems as your own is the definition of compassion.

Resource: The Colegio Medico: the equivalent of our County Medical Society has commonly assigned 4 spies who check our method and motives in person. Therefore, make them life-long friends.

How to: This trade-off actually exists: the formal lectures to the professionals are traded for the permission to help the rural poor. Also, attending the wives’ social events elevates their social profile.

The social act, the party, is political/friendship, and is a resource that cannot be forgotten nor underestimated.

Instruments, Supplies, Equipment
Principle: Acquire used medical equipment. (specific warehouses on request).

Resource: Military equipment, phase out sale from insurance-owned hospital.

Forming a Team
Principle: A team consists of individual experts and specialists, glued together with commonality of purpose. On the Board of Directors, do not mix CEOs of the large corporations with the visionaries and the policy makers, nor mix in the workers, students, residents and volunteers.

How to: The team begins as a family/close friend group, and soon morphs into a Board of Directors from various disciplines, each top in their field. This Board of Directors is in charge of policy, where to go, what not to do, how large, how small, the charter, bylaws, and core values. The temptation at that point of development is to expand the Board of Directors to include an Executive and several CEOs, as well as venture capitalists and presidents of famous companies, and lastly, brilliant but inexperienced young people. Personal experience from 18 boards shows that this does not work as well as does the more modern Hashimoto plan. (Gail Hashimoto, personal communication, 2010).

Resource: The principle of Hashimoto, with separation of the circles, rectangles, and triangles, is the modern set-up for the larger NGOs.

Incompetency in Language
Principle: Language reflects the culture. Learn the culture.

Solution: In the operating room (OR), hand signals are universal language. This is an easy solution. The smile goes a long way socially. Smile at the occasion of every eye contact. Learning 12 new words in each new country is impressive. A translator is
necessary for appreciation of the nuances in interview with patients, in the formal lecture, and in higher politics.

Resource: Learn from experience. Use the language 24/7. Do not be afraid of error, ask.

Political Boundary/Customs With Rules on Importation of Commercial Goods and Medical Equipment and Drugs, and Visa

Principle: Learn the rules of the psychological "Type 4" of bureaucrats and follow them exactly.

Solution: Only occasionally will a bureaucrat act on the personal motivation of helping his or her countryman. Bribing will work, but the consequences are too high.

How to: Make lists of everything coming in and out, especially drugs and commercially saleable equipment. Signed "receipts" crossing the border in both directions is sine qua non. Place dramatic before and after photos right in the inspected areas. The bureaucracy here is necessary for entry.

Money

Principle: Money is absolutely needed to run anything in a more developed place. Money is however, a double-edged sword because the its presence in your group, university, or foundation prompts enlarging of the money topics on the agenda, and many of the conversations are then about finance. The mind-set shifts from helping the poor who are without access to how to deploy the money. The scenario happens almost universally. Obviously, on the other hand, profit-making corporations must devote all time to finances.

How to: Clearly written bylaws help decrease the conversations regarding how to spend the income. Commonality of purpose helps somewhat. The separation of the rectangles from the circles and the triangles is a huge help.

Examples: Good resources have been: wealthy patients, an immediate resource, the Willie Sutton theory, US government/ CIA which have budgets which do not require "line item approval," largest foundations, Gates & Rockefeller, San Mateo Surgeon’s Association, the Transsexual Community. The golfing friendship is an effective 1-year fund-raising program, using Jim Southern’s method.23 Donations from the public at large requires credentials built up over 10 to 15 years. The decision to donate depends on advice from the "big 3": your guru, visibility in advertisement, and personal reputation—experience indicates all 3 are usually required.

Desire

Principle: Use a sense of greater purpose, the good of the whole, principles of Eastern religion. Little items may make a big difference. Personal contact and the power of the group helps. Many say that the FMP is very similar to a religion.

Solution: Love, power, and money are secondary, not primary.

Managing the International Incident

Incidents with international consequences invariably occur.

Principle: Politics may be your friend, doctor. Politics are interpersonal relationships with emphasis on the person. The benefit is to them, not yourself. Read blog “Politics may be your friend, Doctor.”

Solution: Assuming their problems as your own.

The international incident may happen to you. This first international incident, and the second and third, all point to the use of offering the personal benefit to the other person as being a key ingredient. The person is required in solution of the incident and to the all-important continuation of the project. Personal friendship between you and the “adversary” cannot be underestimated.

On a very early trip to foreign land for plastic surgery to Culiacán, Sinaloa, Mexico, a place that soon was to be known as the drug and murder capital of the world, we were asked to leave. Our presence there doing surgery was thought by them to be the tip of a wedge of the gringo coming to make money in some way they did not yet understand. Also, we thought our dismissal was part of a huge iceberg of misunderstanding of intentions. It was the second multidisciplinary short-term trip to Sinaloa, Mexico, and was backed by the invitation of the governor of the state, who assigned us his personal aide-de-camp 24/7. His instructions were to do anything we wanted. It had been arranged with the hospital and the local plastic surgeon, Jaime Galindo. The Dean of the Plastic Surgeons of Latin America, Fernando Ortiz Monasterio (F.O.M.) himself, came by plane to personally tell me, his friend and colleague, that Latin America could take care of itself in medicine and plastic surgery. He took me to all of the 8 patients ready to go in the hospital, and he did 4 cases. The governor held a special reception and detailed the incident to us. The event was nationally publicized and an erudite, politically astute writer for the premier newspaper of the capital compared us to McArthur when I arrogantly stated, “We shall return.” The rivalry of the 3 PPSs (prominent plastic surgeons) in Mexico City in their super competitive capacity helped us and was to our advantage: one of the other three was Irene Talamas, who as President of the Association later invited me to her national meeting to lecture. In person, at dinner, she informed me that my situation was felt by some to be muy equivocado (quite wrong), but by herself and others, to be the right thing. Jaime Galindo and Irene Talamas applied through appropriate bureaucracy to the federal minister of health, and were okayed to be sponsors and monitors, with full permission. We also later used this method of capitalizing on an internal political fracture in obtaining federal permission for work in Mexicali and Mazatlan. FOM met with me at a national meeting and ceded to us all of Mexico north of Navajoa, Sonora, “which is America anyway.” I invited him as visiting professor. He operated on members of my family. We remained friends.

In Ecuador, the international incident was again solved by the invitation personally by whom will we ever know? We were still in residency in Rio de Janeiro, Jorge Palacios was handpicked by banker, Gerardo Borrero, whose wife Margary’s family was regarded as presidential calibre citizens. They were parents of a CL&P patient, and had personal connection with us at Stanford. Jorge’s first years in practice featured several visits with us to interchange in CL&P plastic surgery. Savage local competition was seen on the horizon and Jorge was denied membership in the Plastic Society for consorting with the gringos. This was a political act. Jorge’s wife, Miss Ecuador, asked her friend, the wife of President Fabres, for advice. Fabres awarded D.R.L. the highest medal in the land, the Award of Merit, in a very public, formal reception for the 2500 cases performed in his country by Interplast. This political act triumphed the previous act of personal jealousy.

The third international incident was subsequent to the above second incident, and happened at the meeting of all the societies in the Iberoamerican Plastic Reconstructive and Aesthetic Societies coalition in Cartagena, Colombia. The Cartagena Accords were passed, stating that none of the participating nations would allow any American NPO to work in their country without certification by the American Society of Plastic Surgery (ASPS). The ASPS did not certify or review anybody. Therefore the International Confederation for Plastic Reconstructive and Aesthetic Surgery appointed one from their own ranks: a surgeon most expert with gringos who was, thank God, Jorge Palacios himself. My professional brother Jorge immediately certified Interplast.

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These were learning experiences and helped me on the needs assessment trip to each Central American republic. We had been discouraged to go to Central America by colleagues who had previously worked in the countries (Gil Snyder, University of Miami, and David Ohiwiler, a former TACA (Salvadorian airline) pilot who was moved by compassion upon seeing the scope of the cleft birth defects to enter medical school and train as a plastic surgeon). Not heeding these, we instead sought counsel of higher authority and wrote to the wife of the President of each republic and to the Chief AID Medical Officer of each country, making a personal relationship by mail, offering free repairs of CL&P and burn scars by university-level colleagues, complete with instruments, anesthesia, drugs, supplies, *todos gastos pagados* (all expenses paid). The response was excessively positive; we couldn’t handle all of the work. The trip was a combination of needs assessment and formation of collaborative model simultaneously (letter of intention), and leading to training of American residents, as well as by their country’s professors training our residents, educational interchanges. David Dibbell and myself received professorships at the University of Guayaquil and the Catholic University in San Pedro Sula, Honduras.25

Quality and Making no Mistake Depends not on Making Rules, but on the Quality of Good Experienced People

In general, another solution to the barriers is not well recognized. The Board of Directors and the executive directors of organizations, or departments, in the process of growing quickly tend to solve the problems that are presented to them by reflexively making a rule, a fiat, after due consideration. This actually codifies the standards. However, the assurance of quality may actually lie in the experience of the very, very high quality individuals, and the judgment in these superior persons is able to take into consideration many factors. Three of these extraordinary persons are Mark Gorney, David Dibbell, and David Fogarty. They are so knowledgeable of humanity that they are rightfully able to form newer policies as conditions change. The principle is: SOPs are required to change with experience; core values never change.

Certification is required because of the need for regulation. On the other hand, if we make a little rule or regulation for every problem, we will fall victim to what happened in aviation—a book of regulations 4" thick. In aviation, a regulation is made for every problem, and the record for safety is the model for others: very few mistakes ever happen. However, in medicine, surgeons and physicians in general are trained in deductive reasoning—a vast, vast education coupled with a vast experience selects the 1% of individuals who are able to make decisions better than the 4" thick rule book. When given algorithms and rulebooks by insurance carriers, hospital committees, and government regulations, surgeons become unhappy and ineffective. This states the case for competency trumping certification, rather than having an unlimited number of small regulations, that is, inductive reasoning. In the FMP, extreme competency trumps over-certification. We give you 3 persons in the top 1 percentile—highly, highly competent.

• The Legend of Fogarty: David Fogarty was proud of his cultural heritage of the West Virginia mountains. He was a young oral surgeon when he applied for the residency. His typed out personal letter explained that the program was just what he had dreamed of. He was of course, in the top 1%, but that 1% did not refer to academic work. Fogarty was dedicated with a fire in his whole being. Where was the fire of Fogarty directed? Toward perfection, young man; the perfect life. His “mentors” were Jesus, Ignatius Loyola, and all the plastic surgery role models taken into himself. He never said any of these names because he was not verbal and did not persuade with words, ever. Fogarty liked people and persons; and lived that out. Let me tell you: he only wore socks, no shoes, in his private practice, just like the patients, who were the hill people of Appalachia. He was interested in the person. Also, he made each 1 laugh, and he gently nudged their shoulder in the process, leaning 15° forward. He became the other person. He was a model Catholic. He had 2 wives, nevertheless. You see, in this instance, he did what was right according to a well thought out philosophy, not a personal philosophy, but a philosophy of the world and of a universal body of knowledge. Underneath the layers of the mountain man behavior facade was a plastic and reconstructive surgeon who was the perfect FMP leader, a global person personified indeed not by any word, only in deed. He attempted adoption of a child in “every country he worked in.” One baby adopted in the mountains of Honduras became All-State in basketball and then an attorney in West Virginia. He adopted all colors and all types. All people were equal.

He lived life to the fullest, that is, until 4 A.M. each night on trips. He did all types of cases, as he was trained in: head and neck cancer surgery, hand surgery, and trained in Stanford Plastic Surgery Program. He actually wore his heart on his sleeve. He wore his philosophy in his practice and in his measurement, but you would never notice any of these tendencies or ideals or principles; he was Fogarty, a person first and foremost. Nothing more, señor. He had taken more classes in more disciplines than anyone, ever, at the University of West Virginia.

• Mark Gorney is an example of how to overcome barriers simply by the quality of selection of the team. He is easy to describe: the best adjective to describe a plastic surgeon in a positive manner. He is a unique person, none other like him. His intelligence is at the genius level and he could have made a vocation as a natural stand-up comedian, yet he is a very intense and serious surgeon, always aware of the world around him, constantly worrying over impending negative circumstances. Fluent in all languages (Greek, French and Spanish, educated in medicine in both Paris and Mexico City. He is wonderful, sad, and all-suffering at the same time. He appears to be one of the boys, an ordinary participant on trips for foreign countries, but yet he is a superior person. Vomiting into his straw hat on the DC-3, bouncing along the cumulus clouds on a warm day along the border over Laredo, Texas/Mexico, crying, yet happy to be on the mission. Gorney is the poster boy for the entire FMP, a very high compliment, as those who participate in these trips are each unique, alpha-type people, not simply a bunch of volunteers. Gorney was one of the most empathetic persons, and because of that, as well as his fluency in communication, we asked him to be the one who turns down the cases when there is overscheduling or severe medical problems. He’s able to converse with everyone from janitor to king, but he had trouble turning down patients, and I have seen him alone in a room crying after turning down a case. He has been President of the American Society of Plastic Surgery as well as the California Society of Plastic Surgery.

• A second Deus Ex Machina arrived in the form of a real living, larger-than-life surgeon. He was David Gilmore Dibbell, Colonel in USAF and future Chief of Plastic Surgery, University of Wisconsin-Madison, and was professor there for 30 years. With John Noon, Professor of Surgery, University of Wisconsin Madison, he founded Eduplast,
plastic surgery international education, working in synergy with University of Wisconsin Madison and University of Guayaquil—Rostros Felices Foundation (Michael Bentz is now Chief and supervisor of the bi-national program). Dibbell gained experience as cofounder of Interplast. With Eduplast, Nicaragua and Ecuador are able to be the professors and the providers of the education (not the recipients). In Nicaragua, we educated a resident in their university training program, Gustavo Herdocia, who spent a full year at the University of Wisconsin. Dr. Herdocia was essential counterpart in the surgical interactions with Eduplast to Ecuador for the big, complex surgeries and for the cadaver dissections to show the myocutaneous flaps (Dibbell is actual cofounder of the myocutaneous flap). I examined Gustavo for the certification for the Ecuador boards, and he passed without missing any of my questions. He is now Chairman and Director of Plastic Surgery at the León Medical School, Nicaragua. In the spirit of Many People, Many Passports, Dibbell’s diversity was a big part of formulating the spirit of Interplast. He came saying in his swashbuckling manner, “Don’t worry, I’m here.” He began his “training” having been paid on a 2-year indentured payback for each training year, undergone through the kindness of his Commander in Chief, President Nixon. David’s indentured time was in Vietnam with special rotating duty to perform pedestrian humanitarian cases on Vietnamese citizens and Viet Cong both. “All persons are equal.”

From Multiplication to Globalization

In 1966 to 1967, the peak experience was like a light bulb which was lighted to expose and unfold the layers of the vision, which were multiplication factors at its onset. On the other hand the fact that the FMP for CL&P became more widespread and became a usual plastic surgery activity merely proves that it was the right thing to do. More than that, it shows that the need was present, and the energy to carry the activity out was latent in the Plastic Reconstructive Surgery field. It was as if a wick had been lit; or that the seed sprouted with all the vigor that our PRS forefathers had instilled.

We consider that the FMP is made more potent by the multiplication factor spreading the activity in 8 ways: (1) via residents popularity and request; (2) via the other independent domestic Interplasts; (3) in the post hoc organizations, who are the same model on their own design, not because (propter) of us but chronologically after; (4) via the spread to many large international Interplast organizations, all of which are independent replications rather than franchise-like divisions of a large umbrella organization, as well as (5) other propter hoc organizations; (6) the medium-resource places have developed expertise and resources and now help other midlevel places; (7) the national plastic surgery societies have begun to swallow many of the FMPs, taking them over into organized plastic surgery, showing that the movement is becoming more mainstream; and (8) the more than 58 organizations now doing FMPs, most of them using a close variation of the methodology described here, many post hoc, and some propter hoc. Post hoc (from Latin: “after the thing”) refers to organizations that have chronologically followed but which required some of their own philosophy for proper functioning; propter hoc (“because of the thing”) refers to organizations which exist because of Interplast Spirit and example, or because of branches of the organization itself. The multiplication factor, unbelievable and unprecedented, proves that the FMP is a good idea and is a successful project. The FMPs are popular in the developed world and offers its advantages to all comers, students included. It is so intrinsically good that it is worth dealing with the many hurdles. Students are encouraged to show self-starting ability in becoming a working participant on a trip. In fact, it is also helpful and proper that they are encouraged to the point of kissing their backside and providing all of the details and incentives; everybody should have that life experience.

The organization which illustrates the ability for the FMP to multiply logarithmically is Plastic Surgeons for the World (Cirujanos Plásticos Mundial [CPM]), of Dr. Javier Beut. This group uses the workshop method for the multiplication of foreign missions. The expansion is impressive: 2 workshops per year, training 20 student plastic surgeons, for over 13 years (520 persons trained). (Javier Beut, personal communication, October 2014) Each newly trained surgeon in their career will do either 100 cases or 1000; that is a total of 52,000 or 520,000. This is the example of how a surgeon educator infected with the virus of practicing medicine according to Hippocrates has a big effect on the world. One person influences the performance of many operations—this is indeed a logarithmic expansion. The CPM is a post hoc organization; the workshop is the best way to carry out multiplication both theoretically and on a practical basis.

(1) Residents—The Top 1%

Residents cause logarithmic multiplication of the theory. They are critical element of the FMP. We present 16 examples of exceptionally potent superheroes. The residents were selected carefully and almost everyone was actually in the top 1 percentile. There were 4 residents and 1 genetic son who continued FMP as a way of life after residency; they had a significant impact on the world using the power of the multiplication factor. The following residents and fellows have had enlargement of their value system as a result of the foreign mission program, and make the trips almost full time:

- R.J.S., also known as Richard J. Siegel, is an energy. He came out of the East where great parents begot him. I sort of was an extension of them and provided muscle, that is, political, academic, and philosophic mentoring. We collaborated as hand in glove. Examples are in rehabilitating patients utilizing the principles of multiplication in both the plastic reconstructive surgery and the phyisiatry field. Some “unrehabilitatable” patients were rehabilitated! The waterbed, the 360’ twist over bed, the silicone gel seat pad, the custom-fitted molding of an entire half-person below the pelvis—a prosthetic wheelchair for George Abreau. Siegel, Asensio, and Laub prepared an article which was published by Asensio, an accomplished oral surgeon, on CL&P repair, using the technique of the genius and humanitarian from Antigua, Guatemala. Richard spent 3 months on Asensio on a foreign mission residency rotation, through his typhoid fever and incidents with adunas and through cultural incidents “intended” to roadblock us. What enrichment of character, what sparks of life; this is what foreign mission programs are all about. He wanted to build in himself the immunity of the Native persons in Antigua, Guatemala. His technique was to eat food purchased from the street vendors. He may well have acquired that immunity, but at a high price: he paid a 108 fever, IV chloromycetin, blood passing out his anus in the shower. I was happy for the molding process, or maturation, distinctive in different ways. Other residents in the top 1%:

- Bill McClure:
  “Put applicant for residency named McClure in, Linda. Give him a rotation.”
  “We have no room, either at VAH (Veterans Affairs Hospital), Santa Clara County, Kaiser, or San Mateo County.”
  “Put him in anyway.”
Linda Farrell, the “mean” secretary happened to put him in at Santa Clara Country Hospital with the wisest and most experienced clinical plastic surgeon. Dr. Bob Mills was previously society surgeon in Marin County. The Sunday newspaper once showed a photo of Mills himself in his Mercedes convertible with a society guru woman draped in jewels. However, he had finally bolted from that life at age 63 years, discarded all of his previous trappings, and went to the Reconstructive Surgery Barsky Hospital in Vietnam. Returning from “Nam” he stayed off at my office and related that he had a different set of values, different goals and objectives, having had peak experience. He discussed participating in the FMP and that he “would like to go on many of our trips having divorced his previous life.”

Having just designed the Santa Clara County Hospital Burn Unit intended “for all the Pacific Basin,” I asked, “Would you like to run the Santa Clara County Burn Unit, and be Chief of Plastic Surgery at the hospital?”

“Sure.”

Did you say that God is the one who arranges the coincidences? Isn’t it strange that Bill McClure and Bob Mills had exactly similar principles at that point? Each fed off of the other, and produced several progeny of Mills himself—starting with William McClure.

McClure was hoping he would qualify for the residency program without a high grade point average and without a sterling academic record, but he had the right idea which included the goals of an ideal, or rather, a real plastic and reconstructive surgery trainee who would not be an academic slave of the NIH grant decisions, but rather of the newly combined general surgery and plastic surgery 6 year training program, preparing for a practice treating people with objectives of helping them with new and wonderful surgery breakthroughs and doing significant international humanitarian work, teaching at every corner, early psychomotor skill acquisition, and responsibility in graduated steps, always with an eye toward business and medicine to be synergized.

The interview went like this: “Bill, excuse me, I have a 1 P.M. start time at San Mateo Hospital Operating Room. Male-to-female conversion, making a super vagina. Let me show you up there how to use the Reese dermatome for thick split-thickness skin graft harvest. Could you give me a lift up there to the hospital?”

“Yes, sure.”

Bill’s VW Beetle had a dead battery, and no functioning brakes. We manually pushed the vehicle to start it, and I pulled on the handbrake for stopping when needed. I was working at “Chopie” with urologist Duncan Govan, Associate Professor. I was all the time reading the chart and the psychiatric review for the upcoming surgery. Neither of us were embarrassed with any of this.

Later that day McClure saw 4 faculty for interview, and the selection committee included him for future resident. He was evaluated at that time with the 7 tests. Two years later, McClure was married in San Francisco at a gala affair. He and his wife left the reception for the airport, catching the team’s plane for San Pedro Sula, Honduras, at Guanajuato, Mexico, based on his life’s work of many trips to countries, leading teams as chief surgeon, and who had written at least 1 scientific article on a novel cleft lip repair, and who had founded and developed a division at a university medical school, was the first to engage multidisciplinary short-term FMP trips, and had trained 52 residents and 6 fellows. Who would this authority himself choose? The person choosing would obviously have one the greatest numbers of active contacts among the practitioners in these fields. You would trust that person to give an accurate answer on whose shoulder he would give responsibility to operate and rehabilitate a child born with CL&P, the child being his very own. That selected surgeon would be a top surgeon, and it would be Ernie Kaplan, an American, in California at Stanford. Ernie is a pediatric plastic surgeon, cofounder of Interplast, and veteran of the first and many continuing trips with Interplast and other organizations. He is a contributing member of the Interplast spirit and now works with ReSurge as well. He is an active Clinical Professor at Stanford University Medical School Plastic Reconstructive Surgery Hand Division.

Kaplan is for the children, with CL&P as the number 1 goal in his life. Kaplan is an innovator in the rhinoplasty for cleft lip, and for speech therapy treatment for CL&P. He now travels to Guanajuato, Mexico, based on his life’s work of many trips to San Pedro Sula, Honduras, and Antigua, Guatemala with Professor Asensio.

• Don Laub, Jr.: first son and primary resident and student and mentee. In Latin America, when introducing your family to your guests or colleagues, you say for example, “This is Donald Laub, Jr., my first born son: he gives me no problem.” This is the greatest compliment possible in Latin America. You then say the same introducing your wife, the foremen on your farm, and your grandchildren: none of them give me any problem. However, in the Laub philosophy, we say, “This is my first born son. He is the greatest plastic surgeon in the continent.” Your culture is in your language and it shows in every word. D-2 is the “greatest” and I advance his interest and his cause in any and every way, because he deserves such. He is the most brilliant of a long line of liberal and prominent ancestors. The liberal Count, Carl Schurz, in 1840, emigrated from the German Republic and was an advisor to Lincoln in the State Department, General in the Civil War, and after the war, served in McKinley’s cabinet. On the other side of the family, our ancestor emigrated from Austria, being able to exchange part of the family fortune for the privilege of exemption from wartime armed conflict. He moved to New Orleans and raised vegetables, selling them in Cincinnati, a city designated to be the center of commerce between the Atlantic and Pacific. When railroads became of more commercial importance than the river traffic, he moved to...
the nexus of railways (Chicago) and repaired passenger cars for New York Central and several other railroads. He founded the public park system in South Chicago and the Lincoln Park Golf Course. D-2 has in his body my cells, with my DNA, who are joined in him with the happy combination of those of my beautiful wife. He is obviously a great surgeon for plastic reconstructive and hand surgery in FMP. He specializes in the McComb-Richard Siegel—Laub Jr. Z-plasty lip repair, mentored directly from Bob Poole of Detroit as his teacher on cases in Mato Grosso, Brazil. He runs a cleft palate panel in Vermont, and has published a paper on the family actively participating in the panel decisions.

All the residents who participated in Interplast trips carry the Interplast spirit with them. All of the residents could have vignettes attached. Some former trainees who portray the attitude and the values learned on the trips and the value system learned in the Stanford Plastic Surgery residency program are:

- Terry Knapp: cofounder of Collagen Corporation and Magellan Corporation; a plan for workers for large mines in undeveloped countries to have medical care paid for by the developer of the resource.
- Douglas Ousterhout, DDS, MD: first American trainee of Paul Tessier, the craniofacial surgery pioneer in Paris.
- Robert Pearl: became administrative and professional chief of Kaiser Permanente Hospitals of Northern California (which has reduced chances of patients dying from cardiovascular disease 50% lower than the surrounding community, death by stroke by 42%, from sepsis by 40%, and death by HIV/AIDS by 50%) (information from personal communications: October 2014).
- Ronald E. Iversen: president of almost every plastic and reconstructive surgery society.
- D.R.L.: Founder Interplast, Designer Santa Clara County Hospital Burn Unit, Founder Physicians Assistant Program Stanford, Cofounder Anaplastology (artificial eyes) Training Program Stanford. He has primacy as the first to introduce multidisciplinary, short-term, single surgical focus, surgery trips etc. as he was directed by Robert A. Chase.
- Joseph Rosen: founder Project Reconstructive International Cooperation Exchange, North Vietnam, Adviser to Surgeon General Koop.
- Professor Adolph Schmauss of the original Charité Universitätmedizin, East Berlin, founded Communist-Based Cooperation Exchange, North Vietnam, Adviser to Surgeon General Koop.
- Professor Adolph Schmauss of the original Charité Universitätmedizin, East Berlin, founded Communist-Based Surgical Trauma Teaching Research and Patient Care in North Vietnam.

The following former residents and mentees fall into a special category, integral to the FMPs, even though there are not in plastic surgery itself. The virus has spread outside the confines of plastic surgery, and here are just 4 examples:

- Catherine Devries: founder of IVUmed (formerly International Volunteers in Urology), a large organization that makes short-term multidisciplinary urological surgery trips, taking students, reaching 30 countries, with 1800 doctors trained, and over 5800 patients served.31
- Arlene Samen: One Heart Worldwide—an organization with a great record of reducing perinatal child and also maternal mortality in Tibet, and in Copper Canyon of Mexico, and Nepal. She has personally made over 50 trips since founding One Heart Worldwide, and has helped 60,000 pregnant women and their babies, totaling 120,000 persons. (information from personal communications: October 2014).
- Edgar Rodas: former minister of Health of the Republic of Ecuador, Founder of Cinterandes and pioneer of the new paradigm of mobile surgery: the surgeon goes to the patient not the other way around, doing laparoscopic removal of gallbladder in jungle, high in Andes, and seashore, with a mobile truck OR. He is Dean of the Medical School, Professor of Surgery, and a teacher of community medicine program in medical school. Using his new paradigm, Rodas has performed over 7200 operations with only 1 mortality. (Edgar Rodas, personal communication, September 2013). Receiving surgical training in Miami, it was natural for Rodas to utilize exacting checklists and stringent demands for loyal members of team, including of students and residents, a well honed supply line, excellent integration of local intake and follow-up physicians, and beautiful ability to contact directly to remote patient via cellphone, connecting to actual surgeon.
- Andrea (Andi) Jobe, wife of cofounder of Interplast Dr. Richard Jobe (dec.); Andi Jobe carries on the legacy of Interplast and the globalization of CL&P in the related discipline of speech therapy. Through her organization RSF-Earthspeak, Andi Jobe has devised, and is the pioneer, of a highly functional speech therapy method administered by the parents who are taught by special instructors, who in turn are supervised by speech therapists. For that reason, it has eliminated the need for a speech therapist to travel. The system is bona fide and workable, and is named “Corrective Babbling.”32 The foundation has active programs in Ecuador, Honduras, and Mexico. The novel theory is in the process of verification and popularization.

Each of the above residents and colleagues have caught the virus of international humanitarian surgery, the foreign mission programs virus.

A Teacher Affects Eternity; He Can Never Tell Where His Influence Stops
—Henry Brooks Adams-Burlin

(2) Domestic Interplasts—Independent replicas of Interplast with Separate Funds and Directors

- Interplast Florida—Brent Seagle, President, Kathryn Seagle, Treasurer, Vernon Turner, Director.
- Interplast Florida, West Virginia affiliate—born 1981.
- Interplast South—born May 31, 1979—Richard Ott and Roberto Palma.
- WiCare—Medical College of Wisconsin Foreign Mission Program, Sue Ewens, President.

3) Post Hoc Organizations

Other organizations possess a spirit similar to Interplast Spirit and are post hoc, not directly influenced by Interplast, but live under somewhat different guidelines:

- CPM (Plastic Surgeons of the World) has a driving force and a spirit which was a product of founder Javier Beut’s principles and way of life—founded in 2000 by Beat of Mallorca, Spain. Dr. Beut’s personality is reflected in his foundation CPM, which provides reconstructive surgery and care from related specialties to children and adults with congenital malformities and degenerative illnesses. His organization is distinctive in that he does but does not specialize in direct patient care, but rather he teaches using the methodology of workshops, which is probably the most effective way of educating in the plastic surgery discipline. He stages workshops in foreign countries where he directly supervises surgeons on repair of CL&P and repair of traumatic injuries of...
the eyelids. Since starting his volunteer relationship with Wamba Hospital in East Kenya in 1989, he has provided over 1720 surgeries through his organization (information from personal communications: October 2014). He is also an international leader in eyelid reconstruction.

(4) Propert Hoc Organizations and International Interplasts

• Operation Smile—My brother Bill Magee founded and has continued to make Operation Smile (OpSmile) his life. OpSmile is his baby. He and OpSmile function not as 2 entities, but as 1 person. Magee has had some exposure to Jesuitical scholarship and the way of putting people first. At one point, we discussed merging. This would have created a virtual monopoly. Monopolies have drawbacks, whereas 2 organizations side-by-side almost as competitors make great things. I have often dreamt of working with Bill as partners and professional brothers, but I am glad that we remained 2 entities and not one because the results have bordered on magnificent.

(Bill) “We can be nicely well-funded with Pat Robertson raising the money through Christian television.”

“Wow, fantastic, sounds great... Isn’t proselytizing his first and real goal? He is using you.”

“No, I am using him as a means to my end.”

“I understand.”

The marriage of OpSmile and Interplast did not materialize. And lucky it did not.

1 + 1 = 3; one organization and another synergistic organization working independently, striving for the top rung, is equivalent to the work of 3 organizations. Businessmen have said that with this symbiosis of Interplast, Operation Smile, SmileTrain, Stanford University Medical School, and Swanson (used U.S. Army capital equipment and supplies), a new industry was born, marking the initiation of the plastic surgery foreign mission programs.

Magee’s organization and Laub’s spiritual leadership have commonality of 1 purpose, and they work through 2 organizations. Bill Magee and his wife, Cathy, have done a beautiful job with OpSmile, which has developed in parallel fashion to Interplast. Dr. Magee always gives first credit to me for primacy in the field and he provides wonderful backing. He is a huge success in the globalization of plastic surgery through the FMP. He deserves to be Laureate of the Prize of Nobel. OpSmile, since its inception in 1982, has provided over 220,000 free surgical procedures in over 60 countries, with emphasis on training local medical professionals and strengthening healthcare systems in developing nations. 33

• Rotaplast International—founded in 1992 by Angelo Capozzi and the President of the Rotary Club, Peter Lugarias. Rotaplast is a great example to cite as one of the many organizations which use the Interplast principles propert hoc. Rotaplast is a portmanteau of plastic surgery, Interplast, and Rotary Club. It is a perfect example of how the spirit in America, which lives in the Rotary Service Club and the foundations, directs the 10 fingers of the plastic surgeon’s hands to carry out Hippocrates’s mandate to help, which is the other-than-government method to mobilize wealth for the benefit of those in need, for example, the plastic surgery patients, using the IRS exemption for the 501(c)(3) organizations. Rotaplast gathers team work from many medical disciplines and brings all sorts of business power to bear. Rotaplast’s record is worthy of applause: Rotaplast has made over 175 missions and provided free CL&P surgery and burn scar reconstruction to over 15,000 children in 24 nations.34

• Child Family Health International (CFHI)—of the then student Evalene Jones in 1984, now surgeon and President. Many organizations mentioned reflect the fact that the virus of FMPs is contagious and appeals to many superior persons, but that the field is not large enough to accommodate them. Specifically when extant organizations are confronted with splendid new formulas and programs for foreign missions in general, the plastic surgery organizations’ focus will not be able to include them. These fresh ideas are brilliant, and this is how the fields advance. The brilliant concept of then student Evalene Jones, now certified as OB/GYN Surgeon, was such that her system grew outside of Interplast, as did IVUmed and OneHeart Worldwide. All 3 are well-designed and successful international projects. Dr. Jones engages communities in projects: students provide work in these focused projects according to letter of intention (LOI) contract. “Tuition” of the student underwrites the project of the community and the student’s own expenses. All 3 programs are several million dollars in budget size and involved over 30 countries total. CFHI works at over 20 sites in 7 countries with over 250 partners, and has more than 7000 alumni to date.35

• Plasticos: founded by Dr. Larry Nichter. The Plasticos foundation provides reconstructive surgery in the treatment of congenital deformities, trauma care, burn and hand reconstruction, and emphasizes training surgeons around the world. It is an organization parallel with Interplast. Since 1987, Larry Nichter has overseen the treatment of approximately 3000 patients on over 30 missions in countries in Central and South America as well as Asia.36

• The first international Interplast out of the gate was Interplast Germany, an association, rather than a large umbrella corporation because, as one of our German colleagues told us, 47 years after the fact, “we had a lot of trouble in World War II over overcentralization.” The association consists of 12 independent German Interplasts, each one with a separate fundraising and board of directors, corresponding to each city.37 Gottfried Lemperle is the father, and the father of all German Interplasts, He was inspired in Tijuana in 1974 and Ecuador in 1978, and his idea expanded and multiplied logarithmically into the formal grouping starting 1979.

• At the present, Andre Borsche (recent past president of Interplast Germany) has had 33 years at the helm, and records 1050 missions and 80,000 patients treated with Interplast Germany, and has personally been on 44 missions and operated on 3500 patients. The current Chairman of the Board of the 12 independent Interplasts is Dr. Arnulf Lehmköster (information from personal communications: October 2014).

• Interplast Germany association now performs 70 missions and 3800 patients per year, with 80 to 150 operations per trip (information from personal communications: October 2014).

• The second international Interplast out of the gate was Interplast Australia. Starting in 1983 under the inspiration of Rotarian Keith Walter, of Melbourne, its record is 22,600 medical procedures. In 2014, they worked in 27 locations across 16 countries, with 704 operations (information from personal communications: October 2014). They have now “globalized” to New Zealand as Interplast Australia & New Zealand.

• Interplast Italy—born 1988, founded by Paolo Morselli. As of 2009, Interplast Italy had performed 5235 operations in over 13 nations.38 Interplast Italy started spontaneously (previous
The trend is continuing in 2013, with the number dropping from 61% in 2008 to 51% in 2012. A recent study from 2012 has shown that half of physicians in the United States, a developed country, are dissatisfied. They also showed that in 1 recent year, 2012, the percentage of doctors who would choose medicine again as a career dropped from 69% to 54%. The trend is continuing in 2013, with the number dropping to 51%. There are 5 factors which contribute to the physician’s dissatisfaction: (1) reduced fees, (2) reduced autonomy, (3) transference of wealth to trial lawyers, (4) increasing amounts of paperwork, and (5) inability to use deductive reasoning. In contrast to the dissatisfaction in domestic practice, the international missions seem to produce universal happiness. In the Stanford course Principles and Practice of international Humanitarian Surgery, each year 15 lecturers show approximately 40 slides each, with at least 4 persons per slide: all of the 2400 images, persons, on the humanitarian trips are smiling and happy.

Yours truly uses this evidence to convince himself that the Foreign Mission Program will save the domestic practice of medicine in the face of increasing dissatisfaction. In contrast to the unhappiness at home, practice in the international system comes with complete satisfaction.

Value to the Residents and Students

The value of foreign missions in the training of the residents from more developed places is significant and of importance. We must remember that the original reason for initiating the multidisciplinary short-term trip was to fill the need to train American residents. We recall that it was to solve the second of the 2 conundrums: lack of medical pathology for training in our academic hospital, while at the same time there was a surfeit of human pathology in the medium-resourced countries. The relative need for added skill and knowledge in plastic reconstructive surgery in these medium-resourced places was accentuated by the 6 miracle breakthroughs in our field (homotransplantation of cadaver skin in burn infection, homotransplantation of the kidney and other organs, microsurgery–movement of larger chunks of tissue from one place to another on the same person, craniofacial surgery, popularization...
of aesthetic surgery, and abrogation of the rejection reaction). These skills and the attendant specialized equipment were needed in these medium-resource places, where surgeons knew what they were missing. On the other hand, these things were present in the American university medical schools and private practice hospitals. Likewise, there existed many patients, a plethora of human pathology, and multiple opportunities for patient care and clinical research in 1 place, and need for patients and patient care and research in another place. The solution was international humanitarian surgery, and to solve the geographic and other barriers. Plastic reconstructive surgery has primacy in being the first specialty working in foreign medical places. The method best suited for the medium-resource countries was different than the method in the lower-resourced countries or in the higher-resourced countries. It is the ’model B’—multidisciplinary teams, short-term stays, focused on a single surgical diagnosis with teaching, research, and patient care, carried in an almost identical way as in the academic and private practices in the developed country.

Here we present the values to trainees:

1. The foreign mission trips have proved to be the best place to embed the 6 values of global surgery: international, humanitarian, surgery sciences, early training in psychomotor skill, and the younger ones do much actual work, and value of the person. The International aspect involves the residents making widespread contacts with persons and colleagues, improving their ability to converse with top experts in the field of International Surgery. The residents learn the 3 aspects which add to the value of humanitarian. Humanitarian is more meaningful if done gratis, if it has a huge effect on the recipient’s life, and when the recipient many times repeats the system for another person. Furthermore, early training in the psychomotor skills of surgery happens. For example, the advantage of Tiger Woods and skiers and tennis players who have had training at a young age.

2. Robert Chase wrote to over 100, that is, all of the former Stanford Plastic Surgery residents. Of the questions he asked, one was, “what was the most important experience in your training?” The vast majority of those who went on an Interplast trip placed that experience as number 1. At that time, 508 experiences in foreign lands were reported to R.A.C. He states that that activity continues today, and he still hears from many of our graduates about their continuing experiences in underdeveloped areas of the world.

Value of the Residents and Students to the Foreign Missions

Historically, and in the beginning, the initial impetus, the compelling need, the primary reason for the foreign missions was to provide training for the residents. Specifically, training in CL&P, including the entire package of teaching, research, and surgical expertise. The residents provide to the foreign missions not only work, in fact all the tasks and jobs and work of a certified surgeon except for the exact heart of the surgery, the judgment of experience, and the critical skill required for the nuances. Residents do directly contribute to the bottom line, “the number of cases of CL&P repairs per trip and per year.” The residents also contribute to the quality as follows: the residents form long-term professional relationships (LTPRs) with the international counterparts made on trips. The residents also bring an atmosphere of compassion and are literature savvy. They critique and promote constant open discussion. Their teaching and education being infectious. This is the 10-year bottom line. Our businessmen, although successful with Silicon Valley miracle corporations, do not prefer to think in this educational, longer-term perspective. The long-term professional relationships are the sine qua non of sustainability and will provide for succession of the project for 150 years rather than 1 lifetime. These are 4 ways by which the residents in turn help the FMP.

But How do Trainees Help the Success of the Foreign Missions?

The residents help a great deal. The idea is that residents and students do all of the work, except the critical parts of the surgery. The residents and students do patient care and the clinical intake. Stanford students are research-savvy and are able to set up research protocols. The experienced surgeons are able to concentrate on the surgery itself, the public relations, and on their own counterparts, and are not preoccupied doing entry of data, routine post-op rounds, and care of the usual complications. The usual question of the uninhibited is who does the surgery? The answer is that everyone should know that every surgical training program in the world trains by actual doing, according to the theory of graduated responsibility. With each operation, trainees little by little assume more surgical responsibility. Over time, they learn to do perfectly well most every vital part of the surgery, until they reach year 4 of a 6- or 7-year program.

How Does the FMP Help the Residency Training Program Itself?

The grapevine of the residents spreads information from single resident to residents in other programs. When the news of acquisition of early psychomotor skill in CL&P goes into the grapevine, for example, “I did 10 cleft lip and 5 cleft palate repairs with the professor,” becomes known to students, residents, and applicants to training programs, the number of applicants soars exponentially, thus increasing the quality of the program overall. In surgery, the acquisition of skills is a goal which drives residents and most all surgeons.

Business-Medicine Synergy

Nowadays, many young, newly trained MBA businessmen on a board of directors do not actually buy into the 10-year investment of a surgical education. Additionally, another problem in the business-medicine synergy is the fact that a growing 501(c)(3) foundation expands its board of directors by logically but incorrectly adding young minds of brilliant residents, who contribute new thoughts to the organization. The maturation of these great new ideas is stunted inadvertently by the greater ability to contribute wisdom by high-level venture capitalists in Silicon Valley, the veteran billionaires, who are also on the board. The original visionaries and the experienced CEOs are sitting side-by-side trying to work hand-in-glove with the young minds. This mix does not work in the Board of Directors meeting regarding the policy. Division and argument ensue. I have been on 18 boards and have attained verification from attorneys who are experts in the more modern way of building boards.

The more recent advice from attorneys who specialize in corporate structures of nonprofit organizations is to structure 3 boards, each with a distinct area of responsibility: the 1st group is the original founding surgeons, the visionaries, set policy—who, where, how, medical ethics, the mortality and morbidity reviews, and the medical quality assurance. The superhero businessmen of the venture capital class are a 2nd Board of Directors, and are associated with financial matters and money, the area in which they are world-class. They do have a secondary measure of psychic income, however. This group forms a separate board: they are the foundation of finance.

The third group involved in governance are the clubs and the workers, the boots on the ground. They raise money from events in the university and in the community of small-to-moderate scale, not massive galas. For example, in the old system of 1 conglomerate
board, the businessmen eliminated residents and students, citing the direct, one-year bottom line issue rather than the 10 year bottom line.

The improvements in the foreign mission program cannot be underestimated: four hugely important improvements to the foreign missions programs have been:

1. The Residency Review Committee (RRC) for PRS has approved the foreign mission as a bona fide part of an approved surgical residency program. Review and approval by the RRC has happened, and the FMPs can become mainstream.

2. The decision of the American Board of Plastic Surgery (ABPS) that candidates may submit cases performed in the course of their work on approved foreign mission programs.

3. University level courses, for instance, Principles and Practice of Humanitarian Surgery—Surgery 150, are having a great multiplier effect on the validity of the FMP.

4. It has been found that significant improvement in the set-up of the foreign mission program utilizes the Management By Objective (MBO)/Peter Drucker methodology which is also the step-wise development process used in the discipline of physiatry, which consists of:
   - (A) Needs Assessment Trip: to assess their needs as they mesh with our ability to deliver solutions to them.
   - (B) The All Important Collaborative Model trip: which places responsibilities for the components of the trip (patient gathering, lectures, local transport) into appropriate departments or organizations in either country. In medium-resource countries of Latin America this constitutes a very important formal signing of the convenio—the letter of intention (LOI), usually followed by an official party celebrating this event.
   - (C) Task analysis—assignments to individual persons.
   - (D) Implementation and immediate debriefing, followed by change of SOP, but never core values, as needed.
   - (E) Adjustment of the standard operating procedure is necessary, but never a change in core values, which would be dangerous to the primary purpose.

This is part of model B and it allows bureaucratic approval by both institutions and participants as stakeholders.

Parenthetically, another “improvement,” which will not happen, is the formation of an umbrella organization over all the foreign medical foundations and/or university medical school programs. D.R.L. has been part of 4 such umbrella ambitions which failed to flourish for the reason that many surgeons enjoy their own foundation, giving them a sense of ownership and control. The concept of becoming a part of an organization rather than founding an organization, controlling it, and running it, is not compatible.

The Driving Force

The driving spirit is commitment, intellectual and emotional in nature, coupled with an unquenchable fire to do the right thing. The overarching goal is to correct the disparity in delivery of medical services, in teaching, research, and patient care. The commitment to solve the conundrums such as we have described, soon becomes a goal with a driving force. Many surgeons have developed this quality of unstoppable and emotional commitment: Bill Magee (OpSmile), D.R.L. (Interplast, now ReSurge), Brian Mullaney (SmileTrain), Gottfried Lemperle (cofounder of all of the European Interplasts), Namik Baran, President of Turkish Plastic Surgeons, Physicians for Peace, and Interplast Turkey, Nurse Arlene Samen (OneHeart Worldwide), Catherine Devries (IVUmed), Evalene Jones (Child Family Health International) are excellent examples. The driving force, the fire in the belly also burns in Laub junior and in former residents: Richard Siegel, Ernie Kaplan, John Zimmermann, Dave Fogarty, Terry Knapp. They have been infected by a virus; many have retired and devote virtually full-time to an almost nonstop series of trips.

The magic of commitment includes the mind-set that anything is possible. Simply devote 24/7, 365/year, for 20 years. Make every daily decision based upon whether or not it advances the cause of your project. The Interplast spirit is the product of this theory, the Ray Henry Theory. It was applied from 1965–1985, D.R.L. devoting 7.5% of all intellectual, physical, emotional, and social energy. The Hippocrates principle, part and parcel of this driving force, states that perfection of skill and knowledge in yourself precedes its application for the benefit of the other person. The level of intensity of acquiring personal skill and knowledge in your preparation for the FMP has been compared to strategically placing a kerosene rag in the backside. This crude aphorism expressed the quality and quantity of the driving force.

The Goals of Foreign Missions

In the FMP the first goal is education, which provides for succession. This is particularly effective in the interchange missions with the medium-resource places, using the multidisciplinary, short-term, single-diagnosis-focused trip, well planned, scheduled in advance, with excellent care for complications, good follow-up, with counterparts at each level. Education is for those from both countries and is considered sine qua non. Patient care is a close second to direct teaching. Patient care is in the form of on-the-job training as often as possible. The practice in the FMP mimics the home practice in mind-set and attitude. What is added is the sometimes greater enrichment of psychic income. Participants, especially new recruits, verbalize, “This is what I went into medicine for in the first place,” and I have heard on 38 occasions, “I want to do this for the rest of my life.” We learn from our counterparts how to be happy without money nor technology, and reciprocally we show them everything we have. An interchange it is. We learn “Lesson 29” in How to Live.

The third and most important goal is the LTPR—the long-term friendships—sustainability. This sustainability is a personal joining of mind, of family, of way of life. Incredible it is that the contact with this other person is not forced, and may not even be conscious. It does not require a formal introduction; in fact, many times you find yourself at the reception time talking to someone whose name is not yet known to you, but who evidently holds the self same principles. The pick-up conversation validates that the individual person is of great importance.

The meeting of someone who holds the same principles can happen in a myriad of ways: in the form of a patient, or the mid-level bureaucrat, the Chief OR nurse, or the commercial businessman. The objective is to know people at all levels: from janitor to king. This technique is particularly effective with your direct counterpart.

The fourth goal is also termed the 4th dimension. It is to join with the persons from the new country to form a new bi-national team; a team formed with personnel of both countries to engage a yet-another site and repeat the process, a cycle.

The Future

The 4 future programs that are “hanging on the cusp” of serious consideration by our field are:

1. The Horton Fellowship for Peace: 2 residents meet on a short-term multidisciplinary humanitarian surgical trip: each is from a country that is not friendly to the country of the other fellow. They become friendly as they train together for several years, for example, during craniofacial plastic surgery.
residency and fellowship. They are underwritten by the Horton Fellowship to travel together in their special niche of interest and research, visiting the top places in the world, for the first year of their project. They spend the next year applying their skills in humanitarian surgery. Of course, they return to their home countries, but there remains a link of lasting friendship to the nonfriendly place. This plan has a record of success. For example, Syria being on our side in the Gulf War after Horton trained Assad along with, shoulder-to-shoulder, with residents at Medical College of Eastern Virginia, many of differing faith.

(2) The Gorney Plan—the USA’s weapon of foreign policy (Fig. 4). The successful multidisciplinary short-term trips—proved by virtue of 500,000 operations and 1800+ trips over 45 years (1970–2015)—may become a weapon of United States foreign policy approved and funded by the citizens of the United States of America. “The ten fingers of the plastic surgeons’ hands represent one of the most powerful and underutilized tools for human betterment that exists in the world.” The surgeons are available, compensated by the richness of psychic income and with appropriate per diem support (tangible income). Total cost: much, much less than a billion dollars.

(3) A future upgrade will be an imprimatur program, to qualify an international faculty, teachers from the foreign sites. The RRC will be required to inspect international surgeons on site. A flattering but well-earned title and certification is appropriate.

(4) The James Chang vision of equalization of surgery training worldwide—all who wear the badge of surgery will be regarded as similarly well trained and with equivalent standards.

When these principles are actualized and equality in training is achieved, you will never again hear the accusation, “the American residents are using our citizens as guinea pigs.”

The FMPs have been vital to the globalization of plastic surgery. The FMPs have become a bona fide plastic surgery activity, and is on the verge of being one of the major sections of plastic surgery. The FMP has taken a starting large bite out of the 2 billion persons living on our globe who are without access to surgery. The challenge before us is a number with 10 digits (2 billion), which incidentally is a 10-digit number also.

We as plastic surgeons have had a sort of primacy in addressing the world’s surgery problems. The foreign mission program prioritizes quality over quantity. Educational interchange takes the front seat over the humanitarian act. And the LTTPR is the sustainability. On the other hand, the individual interaction coupled with education and the psychic income is the most powerful motivating force for the surgeon. In the university medical schools, the actual doing of these projects with community partnership is in its beginning. The changes in the med schools will synergize and validate the motive springing from the hearts beating in the 501(c)(3) foundation. Improvement in the quality of the FMP, judging by almost every criterion, is happening. And here are the raw numbers:

Total number of operations: 504,809, by those persons and organizations just contacted recently.
Total number of trips: 1817
At $500 per operation, the value of donated services (VOS):
$ 252,404,500
VOS at $5000 per operation: $ 2,522,045,000

In an attempt to compare significant qualitative changes with the numbers, for example, number of surgeons who have been affected: we are not able to enumerate residents as we may have taught them 2 or 50 times each. However, if we count the physicians that have started their own organizations and how many international colleagues have taken up the initiative, and we apply the ridiculously low multiplier of $500 per operation, we arrive at $25,240,450,000. The quantity, or the monetization, is a very soft and underestimated number. Nevertheless, we are not numbers people; rather it is all about the quality of our work.

The day will come when the FMPs have become fully globalization, that 2 surgeons will be running down the corridor of a hospital in “Ulu Ulu” competing for who will do the last unrepaired cleft lip in the world. The obligation may soon be completely fulfilled and the diagnosis will no longer be cleft lip and cleft palate, but another. Burns is a vast field: it includes reconstruction, prevention, acute care, treatment of infection, treatment of nutrition, and the psychological rehabilitation. The battle against bacteria is on a daily basis and requires an army in its treatment. Hand surgery and the collaboration with plastic surgery, orthopedic surgery, and general surgery is another low-lying fruit, as well as microsurgery, and hypospadias. Microsurgery is in the final stages of the globalization process. General surgery and urology and dental sciences are performing advanced and great international programs.

Human nature condemns each of us to an emotional struggle to balance 2 primal impulses: to acquire what we need to survive, and the altruistic care for others. Each was essential and complementary in human evolution. In the 20th century, we witnessed a decline in raw survival needs, affording us much greater emotional and material wherewithal to pursue the care of others.

My lucky destiny has been to experience a revolutionary change in the way we, as surgeons, can use our skills as keepers of our brothers on a global scale. Modern psychology confirms what religions have always taught: that the happiness derived from helping others is the greatest and most enduring.

If our work produces the effect we hoped for, it is wonderful for the patient. However, it is the act of giving which makes us happy.
Donald Laub, MD, FACS, is the founder of Interplast, Inc., now ReSurge International, Adjunct Clinical Professor of Surgery, Stanford University School of Medicine, and former Head of the Department of Plastic Reconstructive Surgery (1967–80). Currently, D.R.L. is the spiritual leader of SURG 150: Principles and Practice of International Humanitarian Surgery, a Stanford course connecting medical and undergraduate students with visiting lecturers: medical professionals from around the globe, and teaching them the necessary theory and psychomotor skills in order to be a productive member of any foreign mission. D.R.L. maintains a blog focused on humanitarianism in surgery titled, “Many People, Many Passports.” For further reading, as well as for citations to the blog in this document, please visit: http://dlaub.wordpress.com. In the production of Many People, Many Passports, as well as this article, Richard Frye, B.A., has unique expertise: a design and technological savvy, combined with an editorial and stenographic wizardry. He is the ultimate market test. He deserves a high station in life.

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