

Evolution of a Sustainable Surgical Delivery Model

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Abstract: For the past 28 years, Operation Smile has mobilized thousands of volunteers to provide life-changing cleft lip, cleft palate, and other facial deformity surgery to more than 150,000 children in countries all over the world. Our mission is to provide surgical care for children with the goal of developing sustainable health care delivery models for surgical services worldwide. For more than a quarter century, we have learned that good judgment comes from experience and that experience comes from bad judgment. However, it has been woven throughout this sometimes painful, always exhilarating growth process in which we have realized that our mission had so much more power than we initially anticipated that it would. Originally, we focused on the face of a child and our ability to provide a surgery that would change that child's life forever. Today, we still stand in awe of the transformative power of this experience, but we have also realized the great power that lies in educating medical professionals and providing state-of-the-art equipment. For us, action took shape in the form of us establishing a business model at home and in each of our partner countries. This included setting up financial reporting systems and creating program models that organized volunteers to provide care for children outside the reach of where surgery was currently available. Through our journey, we have realized that there is power in the healed face of a child. That moment gives us the opportunity to feel the passion for the service we have the privilege to provide. It is that emotion that leads us to action.

Key Words: Surgical delivery models, Operation Smile, cleft lip, cleft palate, genetic research

HISTORY OF OUR ORIGINS

In November of 1982, my wife Kathy and I were given an incredible opportunity to travel to the Philippines with Philplast (now Operation Rainbow from Oakland, CA) led by Dr Bill Riley. The last of the 3 sites we visited during our 2-week trip was Naga City in the Camarines Sur region of the Philippines. This experience would inevitably change the course and the direction of our lives.

As a young plastic surgeon, I never could have anticipated the reality of what I saw. Three hundred children and their families pushed forward into the crowded screening area with the hope that their child would be selected for surgery. We were only able to take care of approximately 40 children for the next 2 days while hundreds were

sent home with no plans for a return visit. There were no physicians in the area that treated children with clefts. The chance was remote that any of these children would ever receive surgical care.

The governor of the province had invited Philplast to participate on this trip, as he knew that there were many families that had children with clefts who were untreated. These children were literally imprisoned in their own body. The team brought their own instruments and supplies packed with their luggage. Most of the cleft lip surgery was undertaken using ketamine intravenously and xylocaine with epinephrine locally. Monitoring was done by stethoscopes and palpations of the dorsalis pedis pulse by an anesthesiologist positioned between 2 stretchers while observing 2 children at a time.

All the children were safely treated without any immediate complications. No postoperative team was left behind. Without doubt, these children were given a chance to live a normal life. Having never been on a "medical mission" before, to say that it was a powerful experience would be a massive understatement. The images of poverty, hopelessness, and the needs of those families were unforgettable. Because Philplast did not have plans to return to Naga City the following year, we asked Dr Riley if it would be okay to gather a group of our friends and return to help those who had been turned away. This was the birth of Operation Smile.

Reason leads to conclusions. It is emotion which leads to action.

The memory of a mother, with a basket of ripe bananas in her arms, and her 8-year-old daughter at her side with a gaping hole in her lip and nose will always stick with me. She said, "I would like to give you these bananas, for it is the only thing I have to give you for trying to take care of my daughter." Her gesture came although we had turned her daughter away. With tears rolling down her cheek, and ultimately tears rolling down ours, all we could say was maybe next year. At this point, we knew that there was no next year.

"Reason leads to conclusions. It is emotion which leads to action." I would imagine that this is the way that most groups begin. There was an obvious void when you compare the number of children who needed care with the amount of infrastructure available. Therefore, groups such as Operation Smile will naturally be drawn into areas that attempt to meet the needs that exist. The bottom line is, if there is a void, nature will fill it. We returned to Naga City with a group of well-intentioned people who were skilled in the medical care we aimed to deliver.

FIRST AND SECOND LESSONS LEARNED

During our second trip to Naga City, the leader of a church outreach organization in Manila organized a busload of children with untreated clefts to take the 12-hour ride to Naga. Our supporters in Naga were not thrilled that children from Manila were taking spots in the operating room while their children were being turned away. We learned our first lesson in that we could not be everything to everyone. Although there was an obvious need for the children of Naga City and the children of Manila, if we did not stay loyal to the children at the site in Naga City, we would have jeopardized our strong relationships there. In attempts to remedy this, we organized a second team to travel to Manila the next year.

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Because of this decision, we learned our second lesson. This did not thrill many of the plastic surgeons in Manila who felt that they had cleft care under control. It was with no intended malice on our part. However, in retrospect, it was insensitive and disrespectful not to approach (and in an ideal world incorporate) their leadership beforehand. We would learn many other lessons along the way as our organization matured.

We expanded into Liberia and Kenya in 1987 and then into Columbia and Vietnam the following year. As our organization experienced major growth, we felt the need to expand our resources. It became obvious that to create a sustainable model, we needed to add well-trained colleagues from our host countries into the group. With the help of a few very open-minded senior surgeons and anesthesiologists, we held education days that included lectures and presentations. They brought along their residents to participate, and these young men and women became the catalyst for the organic growth of what is now approximately 5000 volunteers worldwide.

As we began this expansion, we also realized that to become sustainable, we needed more than just plastic surgeons. Without great anesthesiologists, nurses, pediatricians, dentists, speech pathologists, record keeping, child life specialists, and logistical personnel, the comprehensive care that was necessary could not be given. In most of the mission surroundings, there was no capacity whatsoever for orthodontic treatment or speech therapy. However, it was obvious that if we did not demonstrate their importance by including these specialties on missions, we would not show in a concrete way what a complete team should look like. This inclusion of specialties on our teams certainly paid off down the road.

It also became obvious that none of this could be done without funding. We realized that we needed the support of political and business communities if we were to develop a sustainable model. This leads to the creation of legal entities in each country. Boards of directors were organized, and education in fundraising began.

THIRD LESSON LEARNED: THE BUSINESS OF HUMANITARIAN CARE

Good judgment comes from experience; experience comes from bad judgment!

By the end of the 1980s, we were now in 5 countries. We had hired our first employee in 1985 and, by the end of the decade, had 12 employees, an office, and a warehouse. These early days involved surgery by the seat of our pants with no specific guidelines, other than operating by what was considered to be appropriate in that country. We recognized it was not the same level of care that existed in the United States; however, it was considered acceptable in that time and in that setting.

We hired our first chief executive officer recognizing that we needed to strengthen our business infrastructure to be able to handle the increased complexity and added responsibilities that the 5 countries brought us. We had established a board of directors and become a bona fide nonprofit organization "501(c)(3)." Our third lesson was that we still had a lot to learn. We awoke 1 morning to find that the organization was bankrupt and had to let all 12 employees go as the front page of the local newspaper carried the story. Fortunately for us and the children that we had promised care, one of our original businessmen, who helped us begin the organization, arranged financial support, and within a week, this enabled us to hire our people back and to raise funds that would not have appeared had the crisis not been created.

It was certainly not enough to just have the right intentions nor was it enough to educate plastic surgeons, anesthesiologists, pediatricians, nurses, dentists, speech pathologists, and other prac-

tioners. It was also extremely important to have a strong business structure and the capacity to raise funds in an open and transparent manner that was necessary to deliver this care. To say the least, these painful lessons gained in our first decade of experience led to our growth throughout the second decade.

INTO OUR SECOND DECADE

As we entered our second decade, we learned that programs that we had started needed to be amplified and strengthened. Although we had developed strong relationships with the countries that we were in, we now recognized the need for funding and the capacity that these countries had to raise money on their own. Although we always recognized the importance of education, we knew that we also had to develop stronger programs in that regard. We felt that to truly have a sustainable relationship, we had to create an adult-adult activity. Each group had to significantly contribute to these processes. If not, an adult-child relationship would develop. This leads to dependency not self-sufficiency.

We began to raise money for fellowship and started our Physician Training Program (PTP). Physician Training Program began in 1987 with a handful of surgeons coming to our headquarters in Norfolk, VA, for a 2- to 3-week period of intensive training in craniofacial surgery. At that time, Dr Paul Tessier was coming to Norfolk to work on craniofacial cases with me for 2 weeks every 6 months. Most of these surgeons would have never had the chance to meet Dr Tessier, so we decided to organize education around his visits. The PTP, which started as a handful of surgeons, has grown into a yearly activity. To date, more than 800 health care professionals in all aspects of cleft surgery have participated in this program at our headquarters in Norfolk. Our teams of surgeons have traveled to Duke for surgical cadaver dissection and associated lectures. Anesthesiologists have traveled to George Washington University and Penn State in Hershey Pennsylvania for education at their simulator laboratories. Pediatricians have made regular visits to the Children's Hospital in Philadelphia. Dentists have gone to the University of Maryland, and nurses have traveled to Old Dominion University. Microsurgical education and fellowships have been established in far to reach places as Taipei with Dr Fu-Chan Wei.

In the past few years, we have established relationships with major universities in the United States and around the world including Harvard, Yale, University of Southern California, Toronto Hospital for Sick Children, the University of Southern Illinois, University of Pennsylvania in Hershey, University of Rome, and many others.

Equally as important as the training that these individuals received was bringing them together to understand that they were part of a global organization. Although all of this was based around academic opportunities, the real long-term benefit to Operation Smile was the development of camaraderie through dinners, music, and dancing. Having fun became the consistent icebreaker. This inevitably led to long-term trust and relationships.

As the end of the 1990s approached, we had grown to be in 18 countries and had been able to secure strong corporate and foundation support to augment the growing base of personal donations that sustained the organization (Fig. 1).

As the millennium approached, we knew that to create true sustainability in our partner countries, there needed to be year-round care given. This needed to be done with better equipment and supplies. We came up with the idea that we should undertake a "World Journey of Hope" (WJOH). Our goal was to not only highlight the need for volunteerism but also serve as the seed to catalyze the concept of providing local missions year-round by local volunteers in each of our 18 countries.

About the same time, a business author, Jim Collins, had written a book titled *Built to Last*. The book discussed the success of great companies of the twentieth century and what those companies had in common. One of the characteristic consistent programs that they have is what he called a “big hairy audacious goal” (BHAG). By doing something out of the ordinary, an organization is stretched and forced into maturation. This is necessary for infrastructure expansion that will allow stable growth to occur. A goal of this magnitude inevitably creates internal excitement that motivates people to accomplish more than what they think would have been possible. The World Journey of Hope would become our incredible BHAG.

THE WORLD JOURNEY OF HOPE 1999

We decided to go to all of our 18 countries (25 sites) for a 9-week timeframe with the goal of safely operating on more than 5000 children with First World standards. This would require approximately 1000 volunteers. We raised a total of US \$10 million for the World Journey of Hope. With these extra funds, we purchased the equivalent of 1 operating room of equipment and supplies for each of our 18 countries. We developed a contract that specified that with that donation came the responsibility for each country to operate on 1 child per day year-round.

We leased an L-1011 airplane “The Flying Hospital” that was equipped with 3 fully functioning operating rooms that included sterilizers, pulse oximeters, end-tidal carbon dioxide monitors, anesthesiology machines, instruments, and many others. Our teams circled the globe with 1000 volunteers prepositioned in local hospitals as the plane touched down in each country. There were no mortalities and minimal morbidity. In 9 weeks, we traveled to 18 countries and operated on more than 5300 children (Fig. 2).

Our endeavor resulted in donated fuel and landing rights in every one of our sites as business and political leaders took notice and visited not only the flying hospital but also the local operating rooms. This dramatically enhanced the appearance and branding of Operation Smile in every one of our host countries. Most importantly, it significantly increased fundraising and local patient care, creating sustainable year-round care. This was the spark that resulted in the growth of our in-country programs. Now, more than 60% of children cared for by Operation Smile are done by local volunteers on a year-round basis.

Having achieved the goal of WJOH by operating on 5300 children in those 9 weeks with no mortality and minimal morbidity, our staff and volunteers were filled with well-deserved pride in their accomplishments. “Life was good.”

No good deed goes unpunished

However, little did we know that the WJOH would usher in one of the most difficult eras of the organization. A lot of controversy surrounded the WJOH. This resulted in polarizing views held



FIGURE 1. Medical professionals and the flags of their countries at our PTP.



FIGURE 2. Patients and families wait to be screened outside The Flying Hospital.

at the board level. The breadth and the magnitude of the endeavor had created a tremendous amount of internal stress.

By 1999, we had operated on approximately 50,000 children and had the unfortunate experience of approximately 18 deaths. This was on par with other organizations doing similar work. One of these in China, in August 1998, became the rallying cry for anonymous e-mails that were derogatory about the organization. These were transmitted worldwide to individuals and corporate donors alike. *The New York Times* ran a story on the front page based on these anonymous e-mails for 2 days in a row about the organization in November 1999. To say that this was painful would be to minimize its impact.

Following the article, it was obviously necessary for a look at the organization anew from every aspect including the governance and medical policies and procedures. An outside firm was brought in at the suggestion of the board to analyze everything. The ultimate result, less than a year later, was a change in leadership at the top of organization and a complete revamping of the policies and procedures to fill in any cracks that were found. The magnitude of this attack stimulated most of the personnel, who, still very loyal to the organization and what it stood for, knew we had to “hunker down” and make sure that any possible frailties in the organization were corrected.

Although this was an extraordinarily painful time in the life of the organization, it allowed us to do something that we would have never done otherwise. The attack forced us into a whole new way of thinking with the realization that we should not operate on any child, in any country, by any different standards than we would operate on a child in our own country. Most of the deaths were anesthesia related, some were postoperative, related to respiratory obstruction, or dehydration after discharge. The introduction of compulsory end-tidal carbon dioxide monitoring, pulse oximetry, and portable Hawk anesthesiology machines with sevoflurane improved the safety of subsequent anesthesia delivery. More rigorous screening of the credentials of volunteers was instituted. Medical councils, global standards of care, and education by the country boards were all put into place. This ensured an improvement in patient safety.

During the next year while this evaluation process unfolded, it ultimately led to not only change the leadership of the organization but also lead to the institution of significant new positions. These included the posts of chief medical officer and an in-house director of technology. Greater emphasis on the governance of the organization was instituted. Quality control protocols were put in place, and standards of care was included to augment equipment and a more thorough evaluation of local sites and practices. We convened leaders from each one of our countries at our headquarters in Norfolk and were able to create standards of care that would be upheld at every organizational level.

As the new decade began, our focus on education continued to advance at all levels. A partnership with the American Heart

Association gave us the ability to teach and credential volunteers in basic life support, advanced cardiac life support, and pediatric advanced life support that provided them with an American Heart Association accreditation. We were also given the right to train trainers in our mission countries to allow them to replicate this process. More than 7000 individuals have been accredited under this program.

INTO OUR THIRD DECADE

Throughout the new millennium, we recognized that it was time to expand, again, some of the direction of the organization. To continue to treat more children, we could not rely solely on the model that we had for the past 20 years. For the cleft child, we realized that year-round comprehensive cleft care was an essential ingredient to excellence in patient care. However, we also believed that we needed to maintain our mission model for the emotional and dynamic components that it added to our organization.

As we planned for the 25th anniversary of Operation Smile, we wanted to again stretch the organization. To prepare the necessary infrastructure for more significant growth, we knew that another BHAG was in order. In 2007, we created this BHAG to celebrate our 25th anniversary of Operation Smile. We decided on November 7, 2007, our anniversary date, that we would initiate the World Journey of Smiles. This required the mobilization and placement of approximately 1900 volunteers (700 from the United States and 1200 from 43 other countries around the world) simultaneously landing at 41 sites in 25 countries. In a 10-day period, we screened 7414 patients and operated on 4086 children. All the children were treated with First World standards of care, with no mortality and minimal morbidity, because of the systems that had been put in place over the past years.

The importance of this exercise was not only to help more children but also to expand the infrastructure and to provide a global understanding to all of our partner countries of how powerful we could be as a global unit. Volunteer photographers and videographers were at every site to document what was happening. They were able to share our experiences on daily blogs with all of our mission countries and all of our volunteers and donors worldwide. For the first time, people could visually and dramatically see and understand the power that we had as a global volunteer base. This could have never been done without the base of volunteers from the 43 countries who participated outside the United States. It was a tribute to the years of trust, education, and relationship building that had occurred for those 25 years.

This also set the stage for our 20th anniversary celebration in Vietnam. This was again a global mobilization of volunteers who went to 16 sites simultaneously in November of 2009 to treat more than 850 patients surgically. Four of the 16 sites were dental sites where 6000 patients received dental care in that same period.

The World Journey of Smiles also laid the groundwork for our tremendous expansion in India. Within the past year, we have laid the cornerstone on an 8000- to 10,000-ft² extension of the Mahendra Mohan Choudhury Hospital in Guwahati, India, within the state of Assam. The Chief Minister and the Minister of Health have stood by our side with the challenge of operating on what they feel is at least 35,000 children who have not been treated with clefts in this state, which has a population of 35 million people. This has led to not only the treatment of approximately 1500 children at that site in less than a year after this memorandum was signed but also the impetuous to join with Penn State Hershey (Department of Plastic Surgery and Anesthesiology), the University of Pennsylvania Children's Hospital, and Children's Hospital in Philadelphia, through its department of pediatrics, to help develop education modules that will dramati-

cally increase the number of caregivers necessary to treat the tens of thousands of individuals who await care.

We know that it would not be possible to take care of all the children in need of care using only a mission model. Ongoing care on a year-round basis is the essential component of a sustainable model. However, the ultimate dilemma is that there are not enough caregivers in our world to meet the needs that exist. In this third decade, comprehensive care centers have been opened in Vietnam, Colombia, Panama, China, Morocco, Jordan, and Honduras to provide year-round treatment for children with clefts. The continued development of fixed centers for year-round care in these countries will be one of the mainstays of future development. We have found that the development of these public-private partnerships becomes the most efficient and effective mechanism for care. As these continue to develop, a decentralization process is occurring where regional centers will provide administrative guidance and structure. It will allow us to preposition our supplies and equipment and to develop missions out of the local areas efficiently and effectively so that we can take care of more children.

Our latest realization, with the devastation of the earthquake in Haiti, was that our surgical delivery model for cleft lips and palates did not require much adaptation to be able to emergently develop volunteer teams that would be functional within that country. Based on the friendships of our existing volunteer pool, teams of trauma surgeons, orthopedic surgeons, nurses, and critical care specialists were mobilized with the necessary equipment and infrastructure to land in Haiti. Within 24 hours of their arrival, they were able to have functioning operating rooms in action. Existing partnerships with organizations such as Partners in Health were augmented, and new partnerships with organizations such as Harvard Humanitarian Initiative were built. A consortium from the State of Virginia including Physicians for Peace, the Medical Society of Virginia, Operation Blessing, and the University of Virginia allowed us to man 2 fixed sites in Haiti and expand the professional infrastructure on the US Ship Comfort, which is stationed off the shores of Haiti. Our chief medical officer, Dr Randy Sherman, helped orchestrate the necessary medical professionals along with the tremendous help from the Penn State Hershey's general surgery, orthopedic surgery, and anesthesiology departments. This provided us with a crash course in disaster relief that was relatively easy to understand and absorb and that provided a realization that we could provide significant help in this field in the future.

To expand, increases in consistent and reliable funding were essential. To raise the necessary funds, our internal programs also had to be expanded. The infusion of US \$3 million from 3 donors led to develop a direct response television program that has enabled us to show the need that exists to the public who have responded generously. The use of the Internet for fundraising has also shown an incredible benefit. Our organization has grown from an US \$8-million organization in 2002 to a US \$40-million cash organization in 2009. If one was to add the donated services and supplies to that figure, one would get to approximately a \$60-million figure. It is important to understand the inherent expenses an organization must accept to grow efficiently and effectively. To support development of the patient care model, a robust infrastructure is essential. We must invest in this to continue to develop a sustainable model of health care delivery. This has been the result of the growth of the business structure of the organization to meet the medical needs that we saw.

The development of information technology capabilities was also essential in our development. This was not only for communication but also for some of the educational products that we now deliver. Programs such as computerized medical records and the ability to keep digital imaging of all of the patients at the time of surgery, immediately after surgery, and when feasible, 6 months

after surgery had to be instituted. This will enable us to make significant contributions into the value of different procedures at the hands of different surgeons. Our goal is to quantify what works best.

Another investment in long-term growth was the creation of the organization's research capacity. This development was possible because of the trust created with ministries of health in our countries around the world. It was also made possible by working in collaboration with each country's health professionals while we continued to collectively expand the possibilities—continuously pointing to what is possible, instead of pointing to the faults of the current system. Current work includes genetic and epidemiological research that examines genetic samples from patients and their parents and environmental exposure data. This helps us to understand the causes and possible prevention of clefting. Also underway are outcomes studies that evaluate the quality of the result of surgical procedures to audit the organization's outputs, provide feedback and education for volunteers, and research various aspects of cleft care, including surgical technique, to provide optimal care options (Fig. 3).

CONCLUSIONS

The road toward sustainability has been one of discovery and of finding the power to create change in unlikely ways and places. Over the years, we have realized the power of a child and believe that a child is the only language that we all have in common. We know that medicine is a powerful vehicle, and their combination has the ability to unite nations and people. The act of coming together to take care of the children of our world creates a platform for global understanding. It provides our volunteers with hands-on experience in others' countries and cultures. It also creates a personal appreciation and respect for those various countries and cultures. Since our inception, we have committed ourselves to this process.

We strongly believe that volunteerism should be the key to this process. An individual financial incentive may in many ways mitigate the emotional rewards that are the main driver of our volunteer base. That our volunteers selflessly give their time and talent remains the fuel necessary to run their personal engines.

The long-term goal of Operation Smile is certainly to make sure that every child who is born with a facial deformity can be treated as early as possible after birth. Operation Smile by itself will never be able to achieve this task; it is only in the action of hundreds if not thousands of caring organizations that this will make this a possibility. Ultimately, it is necessary for the care of the cleft child to be incorporated within the health care social fabric of a country. The



FIGURE 4. A child's new smile.

huge limiting factor for this to happen is that the number of well-trained people to provide this care is limited in one third of our world. Atul Gawande has noted that there is only 1 operating room available for every 200,000 people in one third of our world. This essentially means that surgical care is not delivered to approximately 2 billion people. To think that within the next decade or 2, this can be turned around is not logical if we continue to provide that care using our standard models of education. New systems of education and treatment need to be developed that will never sacrifice quality of care but will increase the number of caregivers. To do this effectively still remains a dilemma; however, creative individuals who are willing to think outside the box will be a valuable resource in these endeavors.

Operation Smile has always believed that the value of what we do transcends that of just taking care of a child and their family. The ripple effect of the activity is significant. To accomplish these goals, we will continue as an organization to merge the best of the private, corporate, political sectors; the everyday individuals; and the medical volunteers to use each of our talents to the maximum to create something that is greater than any one of us could deliver by ourselves. We will continue to leverage our collective resources to help children with correctable facial deformities around the world, motivated by the fact that each of us has the power to dramatically change a child's life.

Obviously, the care of a cleft child is but a small fraction of the advanced surgical care or even everyday care that is necessary in the developing world. However, what we have the privilege of doing as plastic surgeons is very powerful. We may take for granted that in little as 45 minutes to an hour, one can totally transform the face of a child and, in doing so, take that child from hopelessness to possibility. What is created by that exercise, concretely showing this transformation, becomes a metaphor that says involvement can create change. This metaphor, which we as plastic surgeons can hold in the palm of our hands, can be the catalyst to create change on a much broader dimension.

What we do as plastic surgeons could never be done without skilled anesthesiologists, nurses, pediatricians, and many other health care providers. By taking care of a child, we augment the capacities of each of these other specialists, which are the very bedrock of safe surgical care for children injured by trauma, infected with appendicitis, or so many other instances where surgical intervention is necessary. By osmosis, we will augment the surgical delivery models through the faces of the children that we are able to touch.

It is our hope that by sharing the evolution of our organization, it will become evident that the road to sustainability is multifaceted and marked by the commitment of many talented self-less

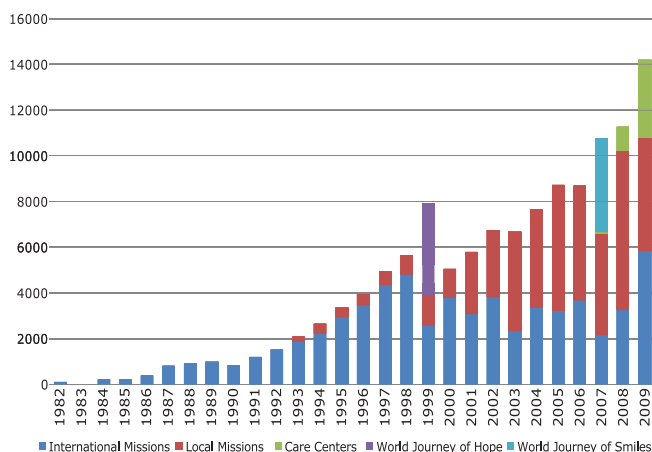


FIGURE 3. Surgeries performed by Operation Smile as of 2009.



FIGURE 5. Students at an Operation Smile Student Leadership Conference.

individuals who are endlessly committed to providing an excellent system of health care delivery with the resources and assets necessary to provide care for all those who have disabilities.

This is the long-term goal of Operation Smile. It is embedded in a strong desire to use our skill sets: “Changing Lives—One Smile at a Time” (Fig. 4).

ADDENDUM

Student Programs

If an organization believes that it is there for the long term, it is incredibly important to develop leadership resources decades in advance. The first trip we took to the Philippines in 1982 allowed our 13-year-old daughter to travel with us and work as my scrub nurse during those 14-hour days. Seeing the energy that she had and the impact that it had on her, we committed ourselves to taking high school kids with us on each trip in the future. Her involvement led to the establishment of a student club at her high school, which has now led to the development of more than 750 high school clubs in the United States. Each year, for the last 15 years, we have held 1-week student leadership conferences at a different university each summer. Close to 500 children attend yearly. They receive more in-depth exposure not only to Operation Smile but also to great motivation speakers and humanitarian causes. For each of our international missions, we select 2 students of the thousands of students who belong to Operation Smile clubs to participate. These students have later become not only our employees but also, in many instances, our benefactors as they grow in their educational position within their own communities. They completely understand the culture of Operation Smile, and their commitment to embracing it leads to a succession of leadership that will continue to carry the same values upon which the organization was founded decades into the future.

A number of years ago, my wife Kathy was on a panel with Dr T. Berry Brazelton, a noted child psychologist. He commended the organization for its commitment to the education of teenagers but noted that in child development, most values are formed at approximately the sixth grade level. Because of that we have now begun, a program where a parent and a child of approximately 11 or 12 years old can also become part of our team and experience the impact of those mission moments. To date, Dr Brazelton’s insight has proved to be 100% on the mark. The high school student programs have now been developed in more than 17 countries that participate with us worldwide and continue to grow a department within our organization. We have realized that students ultimately hold the key to the organization’s future success (Fig. 5).

SOFT POWER

The term *soft power* has been used many times in recent years as a coined phrase. It refers to humanitarian efforts that are sponsored by a country to produce trust and understanding around the world that, within time, will hopefully mitigate the use of military tactics and interventions.

Twenty years ago, at the invitation of General John Vessey, who was then the head of the Joint Chiefs of Staff under President Ronald Reagan, we were invited to travel to Vietnam to work together with the Vietnamese to help children born with clefts. Our first surgical mission to Hanoi in February of 1989 resulted in the care of more than 100 children side by side with our Vietnamese colleagues. That sole intervention led to a dialog for the release of the remains of those missing in action that had been held by the Vietnamese since the end of the war. Before that moment, General Vessey had not been able to establish a serious dialog and has attributed the return of the remains of those missing in action to the interaction of Operation Smile in that country. Twenty years ago, soft power had its proving ground on the soil of that country, not on the battlefield but at the Olof Palme Children’s Hospital in Hanoi.

In the early 1990s, shortly after the overthrow of General Noriega in Panama, Operation Smile again developed a partnership. More than 2000 Panamanian children had never been treated for their cleft needs. Our partnership with Panama led to this backlog being eliminated for the next 5 years. Today, Operation Smile Panama takes care of children at their center on a day-in-day-out basis. Similar relationships have been established with many other countries, Columbia being a fine example. Their local Operation Smile organization traveled with the peace commission to the area of the Revolutionary Armed Forces of Colombia (FARC) to operate on children within that area. Today, Operation Smile Jordan and Operation Smile International participate in the care of Iraqi children and children from the West Bank through the center created in Jordan.

The opportunity we have as plastic surgeons to create meaningful, trustworthy, and lasting relationships with our colleagues and with everyday people around the world is in all likelihood limitless. The fact is that we are an organization with no religious or political basis. Our goal is to unite caring people from every race and culture to share their time, talents, and treasures to help a child somewhere in our world who awaits our arrival.