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Newsletter

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INTRODUCTION TO THIS SPECIAL EDITION OF THE AACMFS NEWSLETTER

September 2017 was the month of passing of two giants of Oral and Maxillofacial Surgery whose impact on our specialty was so profound and so transformative that the American Academy of Craniomaxillofacial Surgery will commemorate their lives and contributions with this special edition of the AACMFS Newsletter. Walter Guralnick of Boston and Hugo Obwegeser of Zürich were entirely different as men and as surgeons, but the mark each made on the generations that followed was indelible.

Guralnick was the visionary leader, and debatably the founder, of the dual-degree movement within the United States. His combined degree/oral surgery program at Harvard was the seed of a growing phenomenon that currently encompasses about half of the OMFS programs in the US. In the early 1970's the specialty was oral surgery and our organization was entitled the American Society of Oral Surgeons. The word Maxillofacial was officially added to our name and to our lexicon later in that decade. Guralnick's April 1973 publication in the Journal of Oral Surgery, "The Combined Oral Surgery – MD Program: the Harvard Plan" described their dual-degree residency program and was read and re-read by many at that time, your President included. That April 1973 JOS issue also contained a counterpoint advocacy of the single-degree approach, authored by Vanderbilt's H. David Hall. Hall had already added a dual-degree track to his program in 1971 and in 1975, Hall returned to medical school to obtain his M.D. Walter Guralnick's mentorship guided his alumni to positions of leadership and influence throughout his career and he was a founder and an Emeritus Fellow of AACMFS.

Obwegeser's legacy centers more on his surgical innovations and less on his leadership in education and training. Some of Obwegeser's surgical advances have become eponymic, such as the sagittal split osteotomy, the origin of which can be the subject of debate but which was referred to during my training as the "Obwegeser osteotomy". Like Guralnick, Obwegeser's trainees and the trainees of his trainees have made their mark widely; throughout Europe and the world, where they broadly disseminated his innovations in orthognathic and craniofacial surgery. During Obwegeser's heyday from the 1960's on, the dual-degree movement had already been established in Europe along with an evolving delineation between the single degree oral surgeons and the dual-degree oral and maxillofacial surgeons. Unlike the inclusive Guralnick, Obwegeser staunchly advocated for dual qualifications, to the point of being dismissive toward single degree colleagues. His stance later softened as he welcomed single-degree American military trainees to his maxillofacial unit at the Cantonspittal in Zürich. Obwegeser's leadership and surgical tradition are an important part of oral and maxillofacial surgery globally.

Join me in honoring and learning more about these two greats in this special edition of the AACMFS Newsletter.

Eric J. Dierks

President, American Academy of Craniomaxillofacial Surgeons

October 2017

In This Issue

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Walter Guralnick Memorial


Walter Guralnick, Leonard Kaban and Joseph Murphy

Dr. Walter Guralnick died in the late evening of September 6, 2017 of natural causes. To the end, Dr. G, or Walter as he was known by some or Wally as he preferred, was a role model and inspiration for all his family members, friends, colleagues and trainees. He entered the hospital several weeks prior to his death in possession of all his mental capacity, his memory and his sense of humor and made the courageous decision to forego any additional treatment. He died peacefully and content, surrounded by family and friends in the hospital that he loved and served for 65 years.

The purpose of this remembrance is not to repeat Walter's biography, as this has been done elsewhere (see the memorial on the Harvard School of Dental Medicine website https://hsdm.harvard.edu/ and the tribute to him for his 100th birthday and his 75th Harvard Reunion last year https://www.youtube.com/watch?v=66OCK3XKQf8&feature=youtube

but rather to pay tribute to his significant and unique contributions to the specialty of Oral and Maxillofacial Surgery.

As an individual, he had a tremendous impact on our specialty because of his role as a teacher and mentor of generations of Harvard students and MGH residents and faculty. Many of the students and residents he took under his wing went on to become leaders in our specialty. It is no accident that, over the years, 30-40% of MGH graduates have gone on to academic careers. Many have become Department Heads, Program Directors and Deans. Perusing the title page of the JOMS from December 2015, the editor-in-chief, the associate editor and one of the 2 editors-emeritus, were students of Dr. G. One section editor, 3 members of the editorial board, the continuing education consultant and the statistical reviewer were also influenced by him. There are currently at least 9 OMFS Department Chairs across the country who have had some relationship with Dr. Guralnick during their student or OMFS training years.

Dr. Guralnick had a strong vision of the future for OMFS which included improving OMFS education, making it equivalent to that of other surgical specialties; gaining acceptance of OMF surgeons in the hospital and the community of General Surgeons and Surgical Specialists; expanding the field of OMFS and improving patient care. These, in my mind, are his legacy for our specialty.

To achieve these goals, he realized that two things had to happen: 1. Dual degree education with post graduate General Surgery training and 2. Institution of a full-time faculty model in our training programs. Oral Surgery training, according to Guralnick, had to include enrollment in medical school to obtain the MD degree, which would then allow oral and maxillofacial surgeons to receive 12-24 months of legitimate general surgery training. He very much valued the educational opportunity that medical school would provide, but he realized that it was especially critical to allow full participation as a general surgery resident and not as a "dentist" rotator.

This was new ground and Walter was a skilled politician. He went about it in an organized fashion. As a first step, he pushed for the integrated OMFS curriculum to include rotations in medicine, surgery and anesthesia as part of a 3-year integrated hospital based program. The standard after World War II was 1 year internship, then a year didactic training in a dental school and finishing with a 1 year residency in oral surgery, all of which could be done at different institutions.

During his tenure as chairman of CRET, the OMSITE examination was developed to assess outcomes of our educational programs.

Dr. Guralnick also was one of the first OMFS educators to appreciate the necessity of having our programs populated by full-time, hospital based surgeons. Equivalency would never be achieved with only part-time office-based faculty in hospitals with mostly full-time surgeons. When he became chief of OMFS at MGH, he recruited and developed a full-time faculty which is the foundation for the MGH program to this day and which is the model OMFS programs are required to follow in our current standards for accreditation.

Our specialty as it is today has been shaped by the implementation of these ideas. I have discussed these issues with Walter many times, particularly in the last few years, as I have stepped down as Chief and have reflected on my own career. He recognized the importance of both the MD degree plus general surgery training and the full-time faculty model.

Walter was courageous and always strove to do what he was convinced was the right thing. He was opposed by many OMFS leaders when he instituted the dual degree program officially in 1971. But he proceeded. In 1974, when he and Dr. Joseph Murray started a collaboration between MGH and Boston Children's Hospital, with me as the oral and maxillofacial surgeon functioning along-side plastic surgeons, both the plastic surgery and oral surgery communities were very unhappy. But Guralnick and Murray both proceeded to do what they thought was the right thing. Today, dual degree training programs are well accepted and the graduates have advanced our specialty in head and neck oncology, pediatric OMFS and cleft and craniofacial surgery among other areas. More importantly, single and dual degree OMFSs respect each other, work together, and are now both accepted as fellows of the American College of Surgeons.

Dr. Guralnick was very proud when I was inducted into the ACS in 1980---the third OMFS---and he was particularly proud when I became a member of the Boston Surgical Society, which he was never able to join because he was not a fellow of the ACS himself. He very much enjoyed attending the meetings of the BSS to which I invited him and I have a nice photo of myself, Dr. Guralnick and Dr. Murray together at the Boston Surgical when Dr. Murray turned 90 years of age.

Finally, he was very supportive of the concept of the AACMFS and he was happy to join as an honorary fellow at the first meeting in Boston. He thought that an organization composed of senior OMFSs along with accomplished younger surgeons would be an important forum for new ideas and could play an advisory role to the specialty without being competitive with AAOMS or the Foundation.

Wally, you were the greatest!

Leonard B. Kaban

Boston, Massachusetts

Some Thoughts on Medical Education in OMFS Training

My memoir on the passing of Drs. Guralnick and Obwegeser and on the evolution of the dual degree movement within the United States that they both impacted is inherently autobiographical. Please bear with me and with my journey.

I became interested in obtaining a medical degree in the mid-1960s when Dr. Scottie McCallum came to Dallas for the Midwinter meeting. As a junior faculty at UT Southwestern at the time, I was his "go-for" during his visit and Dr. Walker told me that I was not to allow McCallum to spend one nickel on anything. McCallum, himself a dual-degree man, invited me to come to Alabama for a visit and advised me to consider attending medical school. Dr. Walker on the other hand, encouraged me to stay in Dallas. Dr. Walker told me that Dr. Pepper Jenkins, the influential and well-known Chief of Anesthesia at Parkland Hospital, had actually wanted Dr. Walker to go to medical school years before, and his statement to Jenkins was, "What's wrong with me as I am?" That ended the discussion. There was no retort to his statement because Walker had developed an outstanding OMFS program at Parkland Hospital. He was strongly committed to the single degree OMFS training as it was structured at that time.

During my previous fellowship at Mt. Vernon Hospital in London, I was aware that most of the residents were doing a combined degree program. I had realized that medical school was inevitably going to become an important part of our advancement as an American surgical specialty. I later made my decision, left Parkland and Dallas, and enrolled at Baylor medical school simply because I was a Texas resident and the tuition at Baylor was one-tenth of what it would be at most the other institutions. I received a lot of resistance to my decision, not only from Dr. Walker, but also from Dr. Marv Revzin, a well-known oral surgeon who was then then Dean at Kansas City. Both told me I would end up in another surgical specialty if I pursued medical school. Dr. Walker was persistent, and at my going away party he asked me what he could do to stop me or change my mind. Of course, I was later presented with opportunities by other surgical specialties, but I had promised Dr. Walker that I was coming back to oral and maxillofacial surgery, and I did. Several prominent oral and maxillofacial surgeons were supportive of my medical education, among them Dr. Walter Guralnick. I had met him previously and had discussed with him my thoughts about medical school and he supported the concept wholeheartedly.

After my graduation from medical school and a year of general surgery in 1975, I joined the faculty at the University of Texas Medical School in Houston. I became an Associate Professor and Chief of Oral Maxillofacial Surgery, a division of the Department of Surgery. I was hired in July, and that September I invited Dr. Walker to come to Houston to present General Surgery Grand Rounds. He gave an excellent talk on surgery of the temporomandibular joint and our friendship was re-established. My position at UT Houston was became possible because of an iconic general trauma surgeon, Dr. James "Red" Duke, who has been a supporter of OMFS throughout his life and was influential in my staying in Houston. I had not entered another medical specialty but my medical qualification had enabled me to establish this valuable alliance.

The dual degree controversy persisted. During my first year in Houston, there was a meeting in Chicago concerning dual-degrees in OMFS with speakers presenting on both sides. Dr. Dan Laskin spoke against medical education for OMFS at that meeting. I subsequently became Dean for Student and Academic Affairs at the University of Texas Medical School in Houston and Dan called about his son's chances of medical school admission as an OMFS resident. I viewed Dr. Laskin's call on behalf of his son as a "yes" vote for medical education within OMFS, and I have always respected his ability to weigh both sides of this debate. Similarly, Dr. Walker re-assessed his position on the dual degree issue and in the 1990's began a 6 year combined degree program at Parkland. Dr. Guralnick invited me to do a formal review of his dual-degree program at Harvard. I was delighted by what I saw and it made me certain that I had made the right personal choice.

At an AAOMS meeting in 1990 in New Orleans, I spoke with Drs. Eric Dierks, a dual trained OMFS-ENT and Phil Freeman, OMFS-Plastic surgery. I was serving as an ABOMS director and I asked them to become board examiners. Both did and Dr. Dierks later told me that the opportunity to become an ABOMS board examiner defined him as an OMFS in his career. Their work with residents and training has provided great opportunities for our residents in Portland and in Houston. Perhaps training in a medical discipline has benefits for the specialty of OMFS and is not the disaster that others had predicted to me.

The American College of Surgeons is an organization that has been huge changes in its acceptance of OMFS. My application to the ACS, while at the University of Texas in Houston was blackballed by plastic surgery. Dr. Paul Ebert, who was from Ohio State, where I had gone to dental school, remembered meeting me while he was in medical school at a meeting with Mr. Bernard Degan. Mr. Degan played a significant early role in our ABOMS, AAOMS, and ACS relationship. When I was turned down by the American College of Surgeons, Dr. Ebert told me that I need not reapply and that he would let me know when I had been accepted. Two years later, I became a Fellow of the American College of Surgeons. In 1990, three OMFS; Dr. Harry Schwartz, Dr. Bruce Donoff, and myself, were inducted into the American College of Surgeons in a pathway that was made possible through our medical qualifications. Now, we have singly qualified DDS/DMD OMFS being inducted into the ACS as fellows.

Fellowship training has made OMFS a very strong surgical specialty. With medical training as part of our foundation, along with fellowship training, oral and maxillofacial surgeons have become trained in cleft and craniofacial surgery, oncological surgery, reconstructive free flap surgery, bone grafting, implants, TMJ, orthognathic, cosmetic, and advanced trauma surgery, all of which has made OMFS a complete specialty recognized by the American College of Surgeons. The OMFS role has changed greatly in the past 50 years because of Guralnick, Obwegeser and many others who have shared their passion. Medical qualification is among the reasons, but is not the only reason, for building OMFS into a strong surgical specialty.

James Bertz

Scottsdale, Arizona

TAPS for the Professor

Hugo Obwegeser's march into history on September 2, 2017, signaled the termination of perhaps the most spectacular career in the history of oral and maxillofacial surgery, one unique in innovation, versatility, durability, and influence.

Obwegeser's rise to the pinnacle spanned seven of the most dynamic decades of history: The Second World War, which he witnessed as a seaman; the tumultuous post-war years during which he attained his medical training in his devastated and occupied Austrian homeland; the productive and stabilizing decades of the 1950s and 60s which saw him move to Switzerland to establish the explosively successful Oral and Maxillofacial Surgery Department at the University of Zurich; and the subsequent decades of great international flux in which he harvested acclaim from every global quarter into the new century.

Nowhere was Obwegeser's influence more profound than in the United States, where fertile ground gifted him the opportunity to display his wares in English, and thus bring support to his aspirations for universality within the specialty. His 1966 Walter Reed lectures in Washington, D.C. inspired and reformed the American specialty.

Obwegeser's first American civilian trainee (this author) was in Zürich at the time of the Washington lectures. Beginning the next year, and for several years thereafter, through his friendship with and respect for Major General Robert B. Shira, Chief of the U.S. Army Dental Corps, Obwegeser accepted a series of military oral surgeons for one year's training. All these individuals were single-degree surgeons, and in accepting them Obwegeser broke not only with European precedent, but also with his own precepts of appropriate training for a career in oral and maxillofacial surgery. Hugo Obwegeser was a product of classical European education, and was convinced that any surgical training should be anchored in formal medical education, particularly if it were to be recognized in conventional medical circles. He also insisted, however, that comprehensive OMFS qualification entail proper dental certification. He could insist on the requirement of the medical degree, but he could not mandate the dental degree because several European nations included dentistry within medicine, and offered only certificates for that appended education.

Obwegeser carried these educational precepts into his energies in founding – along with Franc Celesnik of Slovenia – the European Association of Oral and Maxillofacial Surgery (EACMFS) in 1970. This new organization restricted Active Membership to candidates satisfying the dual training stipulation; those with single degree of either discipline would be Associate Members. Unfortunately, the American specialty leadership which was unsympathetic to European history and circumstance and was insistent that oral surgery be strictly a dental specialty, at its 1970 Annual Meeting resolved not to recognize the new EACMFS requirements for membership, and thus, to wit, the organization itself.

Professor Obwegeser responded with a thunderous reaction – rejection of single (dental) degree trainees, tuition for short-term visitors to his Zürich clinic, refusal of American speaking invitations. This was all to the great chagrin and frustration of the by-then great body of American devotees who recognized Obwegeser for what he was. Thirty-five years passed before the AAOMS made official amends by bestowing its Honorary Fellowship on him. In 2006, the EACMFS accepted its first European single-degree surgeons to Active Membership, and in 2008 its first American; the latter with the personal endorsement of Hugo Obwegeser.

The Professor lived robustly, alert, and was perpetually intrigued by new information or challenge. He was at times charming, or abrupt, or impatient, or even stubborn. He was never known to avoid argument, and sometimes inclined to start one. He was always demanding of detail, whether with the lowliest trainee, the chief of nursing, or the maître'd at the Hotel Ritz. But he was fair and honest, and never failed to acknowledge appropriate authorship or his educational debts to his mentors, Trauner, Schmid, Gillies, and later Rowe and Tessier.

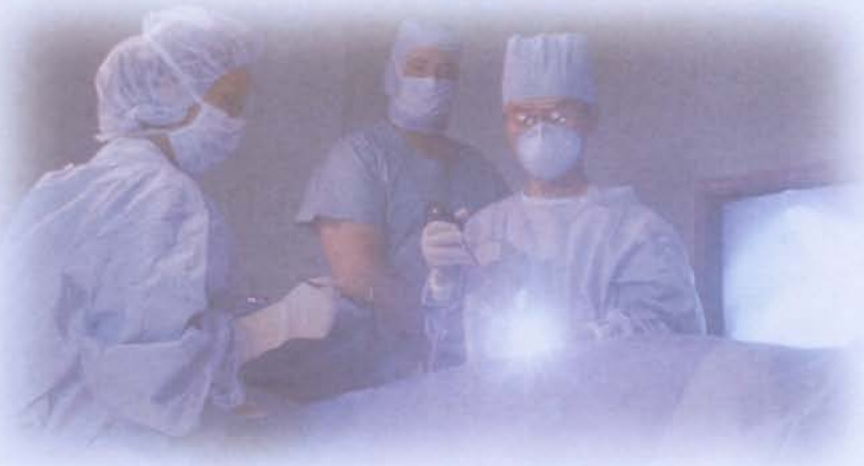
His personal life he devoted to his family and to outdoor activities. He hunted wild boar in the Czech Republic and in the Belgian Ardennes, he fished in Alaska, in Iceland, and in South America, and he paneled his home with the antler trophies of Alpine chamois. His six children were the delights of his life, and his abiding concern in his final weeks was the welfare of his wife, Luise, who now survives him.

Though he occasionally visited the operating room as late as his 95th year, The Professor was of failing gait over his last decade, so increasingly focused on targets intellectual. He joined the debates of the European Association meetings, he wrestled with the recording of his Legacy, and two Septembers ago, he returned to the AAOMS in Washington, D.C. on his final western visit, to celebrate his spectacular performance in that city of some fifty years earlier.

Hugo Obwegeser was a giant of no peer. He was born a son of the Alpine reaches of western Austria - he died a citizen of the world.

Robert Bruce MacIntosh

Detroit, Michigan



Hugo Obwegeser: Forty Years Later

Robert Bruce MacIntosh, D.D.S.

At a time when it needed it most, the specialty of oral surgery was revitalized in the United States by a surgeon from Switzerland, who taught his American colleagues to be more aggressive in the application of their knowledge and skills.

BY MID-WAY THROUGH THE 1960s, the American specialty of oral surgery lay, by many accounts, dead in the water. Indeed, it had established its expertise in exodontia, had demonstrated in two major military conflicts its predominance in the management of facial fractures, had contributed significantly to the literature of orofacial infections and had established its preeminence in the delivery of outpatient general anesthesia. But, by then, from all quarters, the specialty had become besieged professionally, politically and administratively. It was inhibited from making skin incisions in many parts of the nation, and from managing midface injuries in most; obtaining its own grafts was disallowed; dual admission protocols for its inpatients were mandated; and whatever gains it had achieved in the management of clefts in previous decades had been lost. Training rotations on anesthesia services occurred regionally and only rarely, and on general surgery or medical services chiefly in the minds of imaginative mentors. Only a few of our training centers dealt comprehensively with maxillofacial trauma, the temporomandibular joint, clefts or malignant disease; and our correction of maxillo-mandibular imbalance dealt almost exclusively with mandibular "progs." "Orthodontic surgery" and "orthognathics" were terms foreign to our lexicon.

Beginnings and Clinical Impact

In mid-June 1966, Hugo Obwegeser, in his first American lectures, set a charge to events that would change all that hampered oral surgery and transform the American specialty forever. In a few short days of spectacular lectures, films and commentaries at the Walter Reed Army Medical Center, Dr. Obwegeser demonstrated his vast experience with an array of surgical procedures about which his American audience had never dreamed.

He demonstrated that these procedures were within the scope of dentistry and oral surgery and beyond the ken and interest or molestation of other surgical specialties; and, perhaps most importantly, he inspired and encouraged his audiences to believe that his experience could be their experiences, that anything he had done they could do. Time magazine (July 1, 1966) commented:

"....last week, 500 of the most eminent U.S. oral surgeons sat on the edges of their chairs at Washington's Walter Reed Army Medical Center as a respected Swiss practitioner described his radical jaw-splitting procedures...American oral surgeons have never been so impressed...."

Memorably, Dr. Obwegeser brought orthodontic surgery into common parlance and practice (orthognathic was a later, American modification). Certainly the single most impressive procedure introduced at that time, and the one within orthognathic surgery by which Dr. Obwegeser even today is most readily recognized, was the bilateral sagittal ramus osteotomy, the venerable sagittal split. Dr. Obwegeser was not the first person to propose approaching the ramus in sagittal fashion, but, in his writings of 1957 and his lectures in 1966, he did demonstrate his particular technique, the

most effective refinement of this entirely intraoral advance. While Dr. Obwegeser emphasized the versatility of his procedure as being its chief attribute, his American audience saw its intraoral approach as the major attraction in avoiding scars and keeping the surgery within confines into which competing surgeons often feared to tread.

But Dr. Obwegeser's contributions in orthognathics went far beyond a single procedure. He taught his American colleagues the exciting gains to be achieved with maxillary surgery and with moving individual segments of either arch; and he stressed the need for strong union and cooperation with the specialty of orthodontics.

The Washington lectures also enormously expanded American perspectives in the domains of pre-prosthetic surgery. Dr. Obwegeser outlined a scheme of soft-tissue manipulations and hard-tissue augmentations designed to provide foundations for prosthetic reconstruction that theretofore had remained foreign to American surgeons. These efforts drew on the experiences of continental surgeons, derived from two world wars, and demonstrated the efficacy of autogenous intraoral bone grafting and split-thickness skin grafting. The former was absolutely taboo in the United States at the time, and the latter a concept generally unrecognized by American oral surgery.

Dr. Obwegeser's additional emphasis fell on concepts of intraoral reconstruction in general. He described techniques of alveolar cleft obliteration and oro-antro-nasal fistula repair, elements long neglected or inadequately addressed on the American side of the Atlantic. He demonstrated the intraoral removal of even large maxillary and mandibular tumors or segments of necrotic bone, and immediate obliteration of the resultant defects with autogenous hard- and soft-tissue grafts. He taught that most facial fractures could be managed intraorally, but emphasized equally strongly the importance of wound disguise in all extraoral approaches to the face and jaws.

The expansive effects of Dr. Obwegeser's influence became patently evident within a decade of his Walter Reed inaugural. If American oral surgery wanted to graft and close alveolar clefts, who cared? No one else was paying much attention to those problems. And if American oral surgeons had the ability to handle and precisely place an intraoral skin graft, perhaps they also had sufficient skill to handle the harvesting of the graft. If the oral surgeon had the knowledge and ability to electively section and reposition a maxilla into a more esthetically and functionally desirable relationship, did the surgeon not also have the skill to resect those same parts in cases of neoplastic disease or infection? These observations in the eyes of fair-minded observers allowed the American specialty to advance into the fields of ablative, cleft and elective, reconstructive maxillofacial surgery.

Educational Influences

Hugo Obwegeser accepted his first American oral surgical trainee in 1965, a year before his Walter Reed exposure. He subsequently designed a program of formal training for Army oral surgeons, accepted legions of American specialty members for short-time visits, and embarked on frequent return visits to the United States to serve as featured speaker in dozens of regional and national forums.

His relationship with American oral surgery was symbiotic: His celebration in the United States became recognized worldwide, not only in oral surgery circles but in those of otolaryngology and plastic surgery, as well; soon he was lecturing around the globe in the corridors of every surgical specialty. The explosion in American clinical experience evoked by Dr. Obwegeser's teachings provided an impetus to American clinical and bench investigation previously unimagined; extensive vascular studies on surgerized jaw segments, investigation of new methods of segment fixation, increasing sophistication in patient diagnosis and evaluation, long-term postoperative stability studies, and an expansion of interest into soft tissue considerations in maxillofacial reconstruction all reflected Dr. Obwegeser's inspiration.

By the 1980s, paradoxically, American investigative efforts in the surgeries spawned in Europe far surpassed anything achieved there previously.

Organizational Influences

Dr. Obwegeser's educational contributions in the United States were paralleled by his organizational achievements on his own ground. In 1970, he was the prime mover in bringing the disparate voices of the European specialty together in founding the European Association of Maxillofacial Surgeons (now the European Association for Craniomaxillofacial Surgery), and its Journal of Maxillofacial Surgery, which he led as first editor. Considering the general histories of the European nations and their individual surgical heritages, these organizational undertakings called for great fortitude and resolve—and foresight as well, as best manifested by Dr. Obwegeser's insistence that the scientific meeting of the EAMFS be taken to Warsaw in 1980, anticipating the collapse of the Berlin Wall and the Iron Curtain by almost a decade.

Such accomplishments are not gained without force of will, and Dr. Obwegeser's initiatives and intense defense of his positions and philosophies have not left him beyond controversy. His mandate of the dual degree fundament for membership in the EAMFS brought fire from his European confreres with only single medical or dental degrees. It also frustrated many in the American community, who were woefully unfamiliar with European educational circumstances and who misinterpreted his intentions.

A MAN OF ENERGY AND INDEPENDENCE

Hugo Obwegeser

HUGO OBWEGESER, the icon, remains today an example of the complete professional man. The energies that carried him from simple Alpine beginnings through his early stringent and self-sacrificing days of professional life following the Second World War, and then through the halcyon days of his extraordinary clinical and educational career, support him still in his afterglow activities. Now in his 80s, he remains an active hunter and outdoorsman, a dedicated internationalist, a congenial bon vivant in any social group, but always a man ready to wrestle intellectually with any challenger in matters of surgery or specialty education.

Beyond his early years, he was not a researcher, but he has always registered strong support for hard scientific investigation. He remains consistently "his own man," but, on demand, can become the astute politician and effective organizational animal. He remains true to his roots, delights in being an excellent family man, but all the time maintains a world view and variegated interests.

Every avenue of endeavor honors its forebears, and Hugo Obwegeser has harvested accolades from surgical groups from every point on the compass. Albeit much belatedly, the American Association of Oral and Maxillofacial Surgeons recognized this giant with honorary membership in 2005. He was not the first influence from abroad to indelibly brand the American specialty—Kazanjian and Thoma are others who come to mind—but his journey to our shores buoyed, and perhaps saved, the American specialty at a time of its great vulnerability.

Hugo Obwegeser was truly the wind beneath our wings. He was and remains, quite manifestly, the most influential oral and maxillofacial surgeon of our time.

Dr. Obwegeser was well aware that dental training was wholly essential to the molding of the competent maxillofacial surgeon, but he was also a product of the medical milieu that had been the spawning ground of maxillofacial surgeons for generations. For Dr. Obwegeser, it was eminently clear that Europeans training in the specialty should have double qualification. As American oral and maxillofacial surgery practice has become broader, his views on medical education have gained validity in the minds of many American educators, so that the medical degree is now incorporated in over 40% of our training programs.

Significance and Stature Today

The magnitude of Dr. Obwegeser's influence over the years since his appearance at Walter Reed is inestimable. Ironically, though it was his particular corrective procedures—the ramus osteotomies, the segmental movements, the vestibuloplasties—that first captivated his American audience and which since have brought functional and esthetic betterment to thousands of patients, it is these fields of orthognathic and pre-prosthetic surgery that have retreated so markedly in American practice in recent years. The withdrawal of insurance reimbursement has injured the practice of orthognathic surgery mightily, but, if the truth be known, so has the imperfect surgical result that discourages the participating orthodontist.

The incorporation of osseointegrated implants into the rehabilitation of the edentulous ridge has obviated to great degree the need for anatomical restoration of the denture-bearing tissues. Nonetheless, considerations for surgery remain integral to proper treatment planning in the minds of every orthodontic and prosthodontic trainee and practitioner. Orthognathic and pre-prosthetic surgical management is demanding in diagnosis, execution and post-surgical care; regrettably, it seems that a significant section of the practicing community, probably as a reflection of society at large, seems less willing to invest the hard work and accept the surgical and legal risks that these intricate operations mandate.

More positively, the influence of Hugo Obwegeser is responsible for the monumental increase in the number of patients treated across the vistas of cleft deformities and major maxillofacial deformities of all kinds, and ablative and reconstructive innovations everywhere in the maxillofacial skeleton. It has empowered the American specialty to add "maxillofacial" to its official designation.

Much of what has been gained within the specialty over the last two decades—in understanding the biology of the diseases and abnormalities we treat, in improved medical management, in understanding the intricacies of the temporomandibular joint, in implantology—derives from the energies and intellects of our home-grown leaders. But even these achievements owe at least indirect homage to the professor from Switzerland who excited and inspired us nearly 40 years ago.

Hugo Obwegeser put more American oral surgeons into the operating room than any man before or since, and, through his own efforts and through the encouragement he gave us all, has provided the American specialty the widest pallet of privileges in its history. ■

MEDICINE

ORAL SURGERY

A Radical New Technique

If an American dentist were to say to his patient, "I'm going to break your jaw," he might confidently expect to lose the patient. Yet, last week 500 of the most eminent U.S. oral surgeons* sat on the edges of their chairs at Washington's Walter Reed Army Medical Center, as a respected Swiss practitioner described his radical, jaw-splitting procedures for correcting severe malformations. When Zurich's Dr. Hugo Obwegeser had finished a presentation that took most of three days, Cornell University's Dr. Stanley Behrman stated flatly: "American oral surgeons have never been so impressed, and I think that all over the country they will try his methods."

Inside Only. Dr. Obwegeser's research in "the geography of the mouth" and his resulting new methods are not for the average youngster suffering from a "bad bite." He will still need conventional orthodontics and have to wear braces. Jawbone surgery is mainly for people who have stopped growing. Sometimes it is needed by the aged to permit the successful fitting of dentures; but more often it is needed by the many young adults who have the chinless "Andy Gump" profile commonly associated with a severe case of "buck teeth," a jaw that sags too far, or marked malformation or misplacement of either jaw.

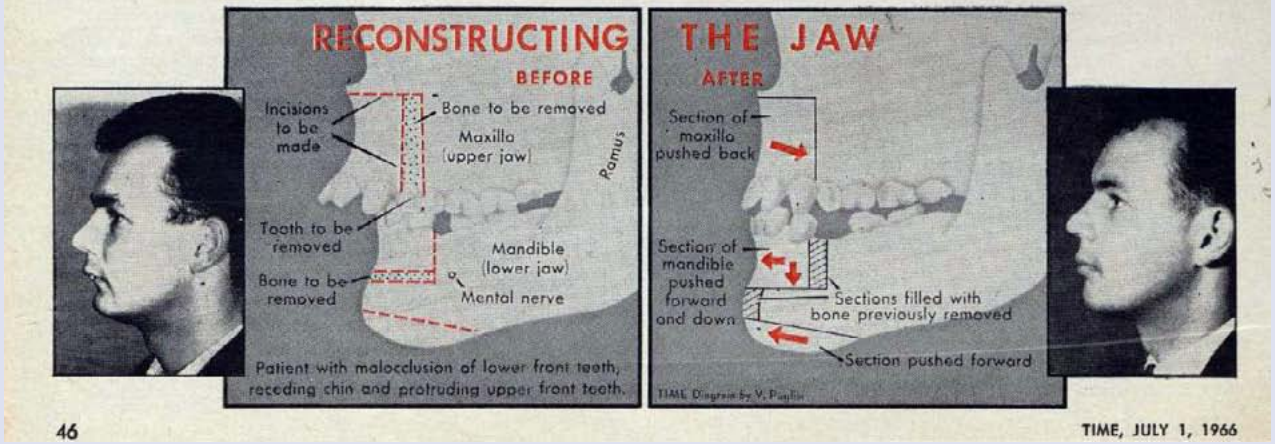
Most U.S. oral surgeons have operated from outside the mouth, through the neck, usually cutting through the jawbone to shorten or lengthen jaws. The procedure is likely to leave a scar and carries the risk of damaging a nerve, thus causing facial paralysis, and it does not permit the free repositioning of parts of the jaw. Only occasionally have U.S. surgeons operated entirely inside the mouth to move the jaw, something Dr. Obwegeser has made a standard practice. His techniques for moving and repositioning entire segments of bone, with teeth affixed, speedily correct severe defects U.S. surgeons have despaired of treating. Because his operations are performed entirely inside the mouth, his work has the added advantage of leaving no visible scars.

If the lower jaw is too short, Dr. Obwegeser cuts halfway through its rearward, ascending segment, the ramus, on the inner side. On the cheek side, he cuts halfway through the bottom part of the jawbone. Then he divides the bone lengthwise, leaving two pieces with half-thickness ends. He slides these pieces apart, lengthening the jawbone but leaving a space where the lower cut was made. Where nonalignment is too great to be corrected by an operation on the lower jaw alone, Dr. Obwegeser may move all or part of the upper jaw. With remarkable versatility, he can even move it upward or downward, sometimes removing small pieces of bone to achieve the desired repositioning (*see diagram*) and using the chips to space out the lower jaw. Bone from a receding chin may be removed and replaced at the front.

Disease & Distress. The Austrian-born surgeon has operated on more than 500 patients for a variety of developmental defects and for conditions resulting from injuries. Some of his "before" photographs showed such startling malformations that they distressed even the military surgeons, but the "after" pictures showed astonishingly attractive repairs.

"A man may have a first-class brain, and yet be unable to get a good job because he has an ugly protruding jaw," said the Army's Colonel Robert B. Shira, president of the American Society of Oral Surgeons. "If he has difficulty in chewing, he cannot eat many normal foods. He may develop disease in the mouth because his teeth don't meet properly. And he may get a complex because he doesn't look like other people. The psychological factors are enormously important. Now, with Obwegeser's techniques, we can completely alter the appearance of the face."

* In the U.S., an oral surgeon is a dentist who has taken at least three years of additional, specialized training in the treatment of the jaw and related structures.



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