

A Team-work Approach to Cleft Palate Rehabilitation in South Africa

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"A cleft palate is a fissure located in the palate and completely surrounded by a human being." (1)

The problems which a cleft palate* creates are numerous. The condition can affect the function of eating, the normal production of speech, and the physical appearance of the individual. Added to these are the possibilities of allied anatomical and functional disorders which can accompany the inadequate structure, and emotional difficulties which arise from the individual's awareness of his differences. Whose then is the cleft palate "baby"? His complex problems must land him, fairly and squarely, in the capacious lap of a team of experts who are co-operating for the best for this particular child. It is the task of the specialists involved to remember that they are working with a hole, surrounded by a palate, surrounding by a child; and not in a vacuum.

More and more workers have realised the lack of economy in working as individuals on a problem which demands a co-operative approach. McCue, writing on team relationships in the rehabilitation process discusses the difficulties of the patient having to be "shared" among specialists who are "patient or client focused" and not "other discipline focused". She sees corrective approaches as first, sufficient knowledge of each other's role and contribution and, second, appropriate use of the knowledge.

With this knowledge, one can relinquish certain activities to another discipline without loss of face, since the other may at a given time have the principal contribution to offer. Knowledge and respect will enable us to communicate with a minimum of time, which is always at a premium. They will allow us to differ and discuss, rather than listen and take orders we disagree with . . . relationships must be horizontal with each other as well as vertical with the patient or client. (2)

It is the purpose of this article to consider the possibilities of a team approach to the problem of the cleft palate individual, particularly in a country such as South Africa.

The aims of an association such as the American Association for Cleft Palate Rehabilitation could serve as a guide for a discussion on how a team approach could be directed.

1. To encourage scientific research in the causes and nature of cleft palate and lip.
2. To promote the science and art of rehabilita-

* The words "cleft palate" will be used to describe all aspects of cleft lip and/or cleft palate.

tion of persons with cleft lip and associated deformities.

3. To encourage co-operation among and stimulation of those specialists interested in the rehabilitation of cleft palate persons.
4. To stimulate the public interest in, and support of, the rehabilitation of cleft palate persons." (3)

Team work would take as its basic goal the habilitation and rehabilitation of persons with cleft palates. Our ultimate and most far-reaching aim is one of service. This can best be achieved by co-operation among interested specialists; by research which would advance knowledge in the field; and by interesting and obtaining the support of the general public in its understanding of the condition and of the individual problems of each person who has a cleft palate.

The relative youth of a country such as South Africa brings its own special problems when a project such as the one envisaged, is considered. On the one hand it presents certain disadvantages. We suffer from a paucity of specialists. Those that there are, are so involved in the service aspect of their work, that little time can be spent on the more deliberative, philosophical and research aspects. A typical example would be that of speech therapy. Until 1960 (when a second department opened) there has been only one University centre in South Africa which is regarded by the South African Medical and Dental Council as being qualified to train speech therapists. The graduates produced during the short life of the department, which is less than twenty-five years old, have had to fulfil the first requirements of therapists i.e. to give treatment to those who need it. There are pitifully few therapists to treat those speech, voice, language and hearing defectives whose basic psychosocial tool — communication — is impaired; and the energies of this young profession have perforce been channelled into service.

On the other hand we have a distinct advantage in that very few hide-bound traditions exist which could affect the smooth working of a team. Conscious, in the best sense, of the relative youth of each speciality, the majority of our professional workers are keen to consider new ideas, to implement new techniques, to learn from other related disciplines. We do not seem to suffer from what McCue calls the "prima donna syndrome". We are fortunate in that our professional

growth has paralleled the growths of the realisation that not only in spite of, but in fact because of, specialisation, an integrated team of specialists is a necessity when the treatment of a person is considered.

The composition of a team could include the following specialities as recommended by the New York City Department of Health in a memorandum which discusses standards of care for cleft palate rehabilitation centres in hospitals: dentistry (general dental care); nursing (hospital and public health); oral surgery; orthodontia; otolaryngology; pediatrics; plastic surgery; prosthodontia; psychiatry; psychology; social service; speech therapy. A co-ordinator is also necessary for the smooth functioning of a team (4). Working teams could be constructed made up of smaller units than those mentioned, but it is important to realise that all of these are essential for the total well-being of the case.

A specialist not mentioned above is the radiologist. In a unit such as the Northwestern University Cleft Lip and Palate Institute (where the writer was privileged to observe a team at work) X-rays of the child's face are shown which demonstrate the anatomical structure and physiological possibilities of closure during the articulation of various sounds. Although of general interest, these are particularly important for the speech therapist to inform her about the possibilities of closure and to show her if she can work on sounds demanding maximum intra-oral pressure, at the present time.

How can a cleft palate team function? Sufficient knowledge of each other's role and contribution, and appropriate use of this knowledge were mentioned before as the main objectives of a team approach. By the very nature of the cleft palate problem it is obviously impossible to separate the theoretical and the practical aspects entirely, but projects will be discussed which emphasise either the academic or the service view.

Academic discussion should precede practical work but it must lead to direct application. If a team is to be set up some sort of "in-service training" must be given, by each specialist putting forward the aims of his work with a cleft palate individual. It is important, for example, that the surgeon, prosthodontist and orthodontist know how far the speech therapist can go with her programme while there is still an incomplete mechanism; it is important for the prosthodontist and surgeon to know each others' views about the optimum time for surgery and the role of appliances before that time is reached. These and many other aspects of the problem can be discussed.

The discussions can take the form of regular seminars, or of conferences. The American Association for Cleft Palate Rehabilitation holds an annual meeting

which includes a one-day short course and two days of contributed papers. The geography of our country would seem to support both regular seminars and occasional conventions; the former by virtue of the fact that the majority of specialists are centred in a few large cities, and can, with time and other such limitations permitting, convene relatively easily; but nation-wide conventions are also very necessary to supply the needs of the growing numbers of professional workers who are servicing the smaller towns and country areas.

The word "academic" was deliberately chosen to carry the implications of student training. Whether on an undergraduate, or post-graduate level, student training should be an integral part of a team approach. When qualified, many students will be working in hospitals, universities, or clinics, and they will have acquired knowledge and experience regarding the need for implementation of a team in the rehabilitation of cleft palate cases.

A working cleft-palate team with service as its immediate goal, as contrasted with an academic emphasis, could function in one of the following ways:

1. Independent examination of the child, and any one member of the team can contact any other who is working on the case,
2. Group examination of the child and group discussion,
3. Independent examination, and a group discussion among the specialists who have seen the child.

Each of these has its advantages and disadvantages. The first course is one which has in the main been followed up to now. It has the advantage of an economical use of the valuable commodity, time, but it is necessarily cursory and omits the handling of many problems which do not fall directly into the areas of the two specialists concerned.

Group examination, followed by group discussion, presents the opposite side of the coin. The advantage is in the obvious thoroughness of the approach; the disadvantage lies in the time-consuming nature of the examination. This approach could, however, be used to great advantage in the regular recheck of cases who are under treatment. Each worker, at a recheck, is familiar with the individual problems of the case; he is not looking at a new mouth, but is looking for something — further growth of tissue, better occlusion, more adequate functioning of the velopharyngeal mechanism, than at the last examination. His recheck examination is much more brief than his original, and it is particularly at the recheck that he needs to have the other workers on hand to discuss what future co-operation can be brought about to benefit the case further.

Independent examination, and a group discussion of the problems of each case, is the third, and probably most practicable of the possibilities. It is both thorough and economical. Using this structure, each member of the team comes to the discussion to present the salient points of his examination, and to plan a continued programme which will fit in with the programmes of the other team members.

The academic and service aims of a team bring with them two other major by-products i.e. research and publicity. The need for research need not be stressed; a country such as South Africa, with its different cultural groups, and resultant physical and psycho-social differences, provides a rich sub-soil for research at any level. In a field such as the one under discussion, different dietary habits and incidence of cleft palate can be investigated; our rural, particularly African, population can provide many cases with whom no treatment has been carried out and comparison with treated cases can be made at all levels; these are but two of the many research projects which could be carried out.

A team working on rehabilitation must also be involved with publicity. Probably one of the most important functions of a team is to make known the facilities which exist. To parents, the birth of a newborn cleft palate baby can be traumatic. It is of vital

importance that these parents are assured that much can be done to help their child, and that, with proper treatment, he can grow into a normal, adequate individual. Too often parents are told by those who are ignorant of the available treatment that "he will never talk normally", or "nothing can be done about his hare-lip". It should be incumbent on everyone who delivers a cleft palate baby, to inform the parents that highly specialised plastic surgeons are available to perform the necessary operations; that other workers exist who will help the child to grow into a normal individual who will "look well, eat well, speak well." Wherever possible the team should be on hand to explain to the parents what the situation is and what can be done in the future. In this way, with the best facilities open to him and qualified specialists available to treat the infant in the best possible way, the child who is born with a cleft palate should be able to grow into an adequate person, not a handicapped individual; public relations work must also be done to give the public some knowledge of the problem, as well as an awareness of the normality of people who were born with cleft lips and palates, and a realisation that an acceptance of the person is basic to his adjustment.

SUMMARY

There is an important need for teamwork in the habilitation and rehabilitation of the cleft palate child, particularly in a country such as South Africa. The main sub-goals of a team approach are academic and service; research and publicity are seen as by-products of these goals.

I should like to express my thanks to Professor H. Westlake of Northwestern University and Dr. K. Bzoch of Northwestern University Cleft Lip and Palate Institute, for their instruction, and permission to observe at the Institute; and Professor J. Dreyer, and Dr. G. Gavron of the Oral and Dental Hospital, University of the Witwatersrand, for helpful discussions.

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