

The CLEFT PALATE Journal

JANUARY 1964 VOLUME 1

TABLE OF CONTENTS

HONORS OF THE ASSOCIATION, 1963, TO ROBERT H. IVY.....	1
ADVANCES IN THERAPY IN CLEFT PALATE—OUR FIRST TWENTY YEARS <i>Richard C. Webster, M.D.</i>	5
SYMPOSIUM: EXPANSION PROSTHESIS AND BONE GRAFTING	
NEONATAL ORTHOPEDIC CORRECTION FOR CLEFT LIP AND PALATE PATIENTS: A PRELIMINARY REPORT <i>F. R. Shiere, D.D.S., J. H. Fisher, M.D.</i>	17
THE PREVENTION OF MAXILLARY COLLAPSE IN CONGENITAL LIP AND PALATE CASES <i>Charles E. Horton, M.D., Hugh H. Crawford, M.D., Jerome E. Adamson, M.D., Samuel Buxton, D.D.S., Reuben Cooper, M.S., Jack Kanter, D.D.S.</i>	25
MAXILLARY ORTHOPEDICS AND ANTERIOR PALATE REPAIR WITH BONE GRAFTING <i>Raymond O. Brauer, M.D., Thomas D. Cronin, M.D.</i>	31
VARYING CONCEPTS IN BONE GRAFTING OF ALVEOLAR PALATAL DEFECTS..... <i>Nicholas C. Georgiade, D.D.S., M.D., Kenneth L. Pickrell, M.D., Galen W. Quinn, D.D.S.</i>	43
A PRESSURE FLOW TECHNIQUE FOR MEASURING VELOPHARYNGEAL ORIFICE AREA DURING CONTINUOUS SPEECH <i>Donald W. Warren, D.D.S., Ph.D., Arthur B. DuBois, M.D.</i>	52
SILICONE IMPLANTS FOR VELOPHARYNGEAL INCOMPETENCE: A PROG- RESS REPORT..... <i>Ralph Blocksma, M.D., F.A.C.S.</i>	72
AN ORTHODONTIC APPROACH TO THE VEAU TYPE IV CLEFT LIP AND PALATE PROBLEM IN THE PRESCHOOL CHILD <i>L. D. Garner, D.D.S.</i>	82
A RATING SCALE FOR EVALUATING OF VIDEO TAPE RECORDED X-RAY STUDIES <i>Betty J. McWilliams Neely, Ph.D., Doris P. Bradley, Ph.D.</i>	88
PROSTHETICS AS A DIAGNOSTIC AID IN PHARYNGEAL FLAP SURGERY <i>Thomas A. Curtis, D.D.S., George Chierici, D.D.S.</i>	95
VISCERAL VARIATIONS AND DEFECTS ASSOCIATED WITH CLEFT LIPS AND PALATE IN HUMAN FETUSES: A MACROSCOPIC DESCRIPTION <i>Hironori Kitamura, D.D.S., Bertram S. Kraus, Ph.D.</i>	99

FORKED FLAP COLUMELLAR ADVANCE	
<i>Richard B. Stark, M.D., F.A.C.S., Clayton R. DeHaan, M.D.,</i>	
<i>Hiroshi Washio, M.D.</i>	116
OBJECTIVE MEASUREMENT OF NASALITY IN CLEFT PALATE PATIENTS:	
A PRELIMINARY REPORT	
<i>R. C. A. Weatherley-White, M.D.,</i>	
<i>William C. Dersch, Ruth M. Anderson, M.A.</i>	120
VILRAY PAPIN BLAIR'S EARLY CONCEPT OF THE CLEFT PALATE	
PROBLEM	
<i>Gordon Letterman, M.D., Maxine Schurter, M.D.,</i>	
<i>Bahman Teimourian, M.D.</i>	125
PERSONALITY ADJUSTMENT IN BOYS WITH CLEFT LIPS AND PALATES	
<i>Charles G. Watson, Ph.D.</i>	130
BOOK REVIEWS	139
ABSTRACTS	143
ANNOUNCEMENTS	148

Editorial Consultants for this Issue

Ralph Blocksma, M.D.
 John Des Prez, M.D.
 David R. Dickson, Ph.D.
 Robert F. Hagerty, M.D.
 James C. Hardy, Ph.D.
 C. M. Heartwell, Jr., D.D.S.
 Philip G. Hubbard, Ph.D.
 James F. Lubker
 James E. McIver, D.D.S.
 Kenneth L. Moll, Ph.D.
 J. Douglas Noll, Ph.D.
 Ralph L. Shelton, Jr., Ph.D.

Honors Award Presentation to Robert H. Ivy, M.D., D.D.S., Sc.D., F.A.C.S.

At the business meeting of the American Cleft Palate Association on May 6, 1961 in Montreal, Canada, an Honors and Awards Committee was established and its duties were set forth. The Executive Committee then selected Dr. Robert Ivy to be the first recipient of an Honors Award. An Honors and Awards Committee was then selected by the President; I serve as the current chairman. It therefore becomes a personal honor and privilege to me to be able to present this first award to a good friend. Dr. Ivy has had a long and brilliant career in the field of plastic surgery with a particular interest in the cleft lip and palate patient. It will be possible for us to mention only a very few of Dr. Ivy's many accomplishments in our allotted time here today. I would, therefore, like to recommend to you two publications which will give you more insight into the life of our honored guest.

The first is a brief resumé of Dr. Ivy's life published by the Robert H. Ivy Society in the July, 1962 issue of the *Journal of Plastic and Reconstructive Surgery*. And better still, I would like to recommend a delightful book, entitled *A Link with the Past*, which is an autobiography of Dr. Ivy recently published by the Williams and Wilkins Company of Baltimore, Maryland. This little book is pleasant reading and not only covers the life and experiences of Dr. Ivy, but also the development of plastic surgery in this century with which he has been closely associated. There is also to be found information on the development and purposes of some of our professional organizations, the development of the Cleft Palate Program in the Commonwealth of Pennsylvania under Dr. Ivy's direction, and many other interesting historical bits of information relating to both Medicine and Dentistry in the present century. I am sure you will find this book to your liking.

Robert Henry Ivy was born in Southport, England, and came to the United States just before the turn of the century where he enrolled as a student at the University of Pennsylvania. He graduated first from the dental school and later from the medical school of that University. He was one of the first two dental interns in the United States. Dr. Ivy served as a resident physician from 1907 to 1910 at the Episcopal Hospital in Philadelphia at a time when few physicians devoted much, if any, time to a residency for postgraduate training. Dr. Ivy immediately showed an interest in the field of oral and plastic surgery although no such specialty

Prepared and delivered by Robert L. Harding, M.D., at the 1963 Convention of the American Cleft Palate Association, Washington, D. C.

Dr. Harding is Chairman, Honors and Awards Committee of the Association.



Robert H. Ivy

existed at that time. He served as assistant to his uncle, Dr. Matthew H. Cryer, Professor of Oral Surgery in the School of Dentistry of the University. Cryer is a name familiar to many oral surgeons. Dr. Ivy was also interested in urology and was one of the early workers with the Wassermann test. We shall have to agree that Dr. Ivy developed a firm educational foundation for his future work and this thoroughness has characterized him throughout his active life.

Dr. Ivy served in the Army of the United States in World War I and many of his interesting experiences are contained in his autobiography *A Link with the Past*. From World War I until World War II, he served as a consultant to the Walter Reed Army Hospital in Washington. He was again active in his special field during World War II. Dr. Ivy has been a devoted *teacher*, whose inspiring guidance has given many young men added zeal and resolution to become outstanding physicians and dentists. He has served as professor in the School of Dentistry, the School of Medicine, and the Graduate School of the University of Pennsylvania and was made Professor Emeritus in those three departments. There are today 34 plastic surgeons practicing throughout the world, some of whom in a teaching capacity, that have received all or part of their training from Dr. Ivy.

One of his greatest achievements, in my opinion, is that of an eminent *surgeon* to whom so many owe health and a better life. When Dr. Ivy resumed his practice in Philadelphia following World War I, he immediately took an exceptional interest in cleft lip and palate surgery. In those years, cleft lip and palates, not being considered clean cases, were usually scheduled at the end of a (general) surgical list and were frequently turned over to the inexperienced assistants at the end of the morning. After Dr. Ivy and a few other surgeons in the 1920's manifested interest in these patients, more and more of them gravitated to or were referred to their services. Their efforts raised the hopes of these handicapped individuals. Dr. Ivy was impressed by the work of Dr. Victor Veau of Paris and introduced many of his methods to the American surgeons. Dr. Ivy performed the first vomer flap operation in this country in 1934. In 1938, he assisted the Department of Health of the Commonwealth of Pennsylvania in setting up a program for cleft lip and palate patients in their Crippled Children's Division and he served as one of the surgeons. In 1949, the Department of Health established a Cleft Palate Division with Dr. Ivy as its first *director* and he is still serving in that capacity. Under his guidance, the multi-disciplinary care of cleft lip and palate patients in Pennsylvania has improved tremendously and his Department has served as a model for clinics in many other states.

Dr. Ivy's many publications have been widely read and have exerted a profound influence in the practice of the specialty which he has cherished. He is the *author* of approximately 140 papers and the author or co-author of several textbooks. These publications are too numerous to mention in the allotted time. Since 1947, Dr. Ivy has been *Editor-in-Chief* of the

Journal of the American Society of Plastic and Reconstructive Surgery, which is the oldest existing journal devoted to this specialty. This is merely one of Dr. Ivy's many activities which keep him busy in retirement. He is also a member and active participant of many professional and social organizations, some of which are our most esteemed societies.

Destiny has made Dr. Ivy an internationally recognized professional leader upon whom his colleagues have bestowed many deserved honors. It would not have been possible for him to have accomplished so many things in life without the help and encouragement of a faithful wife and family. It is our privilege today to add one more honor to Dr. Ivy's long list for his distinguished contributions to the understanding, care and welfare of cleft lip and palate individuals.

The inscription on the plaque appeared as follows:

AMERICAN CLEFT PALATE ASSOCIATION
HONORS AWARD

ROBERT HENRY IVY, M.D., D.D.S., Sc.D., F.A.C.S.

For his outstanding contributions as a
teacher, surgeon, author, editor, and
public health official.

(At the ceremony Dr. Robert Moran of Washington, D. C., then spoke briefly of the help and encouragement he received from Dr. Ivy during his early years after he had manifested an interest in plastic surgery.)

making supplies and transporting them and our manpower to those parts of the world where they could be best used to put down tyranny. At that moment in history, very little thought could be given to congenital defects.

The sulfa drugs had come in shortly before and were still relied on heavily in the control of infections; the antibiotics were just beginning their era; endotracheal anesthesia was not available in many areas at all; and today's relative science of electrolyte, blood, and nutritional imbalance correction was in most hands a poorly or empirically practiced art at best.

Speech pathologists were almost unheard of then; many cleft palate patients had as their only speech guidance the sounds made by their relatives, their teachers, and their schoolmates. When they were able to get speech therapy, it was often from graduates of schools oriented toward drama and elocution and certainly not toward the physiology of speech or the anatomy involved in poorly functioning velopharyngeal structures. I well remember the son of a physician in Baltimore who, after sixteen years of speech therapy, had a tremendous chest, a diaphragm that just delighted the therapist, and the ability to *project* across a large room a short burst of hypernasal, almost completely unintelligible speech.

Children with cleft lips and palates often were having their surgery performed by general practitioners or general surgeons with little or no experience or background in the special problems involved. It was not uncommon to see patients who had had four or five attempts at lip closure, and six to ten or more attempts at palate cleft closure. Prolabia and premaxillae were being sacrificed to the God of Surgical Zeal in many parts of the country; sawing or chiseling of vomers to set the premaxilla back was not rare; vomer flap primary repairs were rare; and lateral labial segments were being approximated beneath the prolabium in many areas.

Because it had been found that undermining the cheeks allowed more certain cleft closure, some men were radically denuding almost the entire outer, lower maxilla as far back as the maxillary tuberosities in their routine closures of cleft lips. Others were still wiring and compressing palatal and maxillary segments in infants to get palatal cleft narrowing.

As a result of one or more of these factors, some patients, who would not die today, did die and many cleft palate patients ended with clefts wider than they had before, perforations that were quite large, or tight, short, immobile soft palates. Teeth often were sprawled around in the mouth; the maxillary arches were often collapsed or overriding or tilted; and premaxillae were all too frequently missing or flopping about.

I think it can be safely said that our main surgical goal in those days was cleft closure—just cleft closure. Without anesthetic advances known to us all now, and without the benefits of antibiotics and more enlightened general care of patients, the one thing we could do to get as many closures

as possible was to reduce tension on our suture lines. If this meant radical undermining, cutting bone, pushing or cutting something out of the way, complex or brutal distant wiring or suturing, so be it. Do it! Get closure! Of course, the fact that we might deform or destroy structures important in subsequent growth was recognized by some, but was accepted in the drive to get closure.

Though not common in better hands, sloughing of entire mucoperiosteal flaps did occur, usually from excess undermining, and sometimes dreadful losses took place from infection not controlled by sulfa drugs. The one result common to all of this was deformity based on malposition or loss of certain structures, and on the effects of great sheets of thick, tight, avascular scar tissue.

This was the heyday of the plastic surgeon skilled in secondary maneuvers designed to accomplish palatal cleft and perforation closures. A surgeon could build up a large series because there were plenty of these patients needing secondary surgery. Because speech results were poor often enough to make the surgery possible, plastic surgeons were rushing into print with their variations of the theme of the palatal push-back procedure as the way to handle velopharyngeal incompetency. Gross under-development of the middle third of the face led to the then fairly frequent moving of lower lip tissue into the upper lip region and sometimes even into part of the nose.

Pediatricians and family doctors knew essentially nothing about Pierre Robin syndrome or congenital insufficiency or submucous clefts of the palate. All too many children with former clefts were having tonsillectomies and adenoidectomies done, usually by men who were completely unaware of the special hazards involved in these cases. The frequent association of cleft palate with rhinitis, pharyngitis, and chronic otitis media had been mentioned but was not generally appreciated. The relationship between clefts and chronic progressive deafness was recognized by some, but its frequency was not known because very few of these patients ever had hearing tests. Often the only time an otorhinolaryngologist saw one of these children was when he was asked to lance an abscessed ear or to do a mastoidectomy.

Feeding of these children before cleft closure was a terrible problem in some parts of this country. Things that we take for granted today, such as easily prepared formulae, protein supplements, and conveniently available and packaged baby foods were just coming in or not in existence at all. Special devices and obturator nipples were made by some men to help the tired and frantic parents. In certain areas children with wide clefts of lip and palate went home with the mothers to be "fed up" and to grow until they would be "safe for surgery", despite the fact that no one, neither the surgeon nor the family doctor, knew what to tell the mothers to do to feed the children. This was still the day of gavage, aspiration, pneumonitis, pneumonia, and lung abscess. Penicillin was just coming in

but for the soldiers and sailors and marines. This, unfortunately, was still the time of inanition and starvation for many of these infants.

Parents and patients were counselled, when there was time, by the friendly doctor. Social workers were unheard of in some areas, and overworked and unskilled in many others. Psychological testing and help, and psychiatric diagnosis and treatment were practically nowhere to be found.

General dental care for almost all people in this country was inadequate; for cleft lip and cleft palate patients it was often unavailable or atrocious. Pedodontia as a specialty was not in existence. Restorative dentists were not on the staffs of hospitals.

Rare indeed was the orthodontist who could be interested in taking care of these children twenty years ago. There were not many available anyway, and to find one who could afford to take on enough of these problems to become skilled and experienced in their handling was almost impossible. A scattered few were working in this field and laying down some of the principles, but it is safe to say that very large numbers of cleft lip and cleft palate patients received either inadequate orthodontic treatment or none at all.

To keep things in perspective, we must remember that only two decades ago, our country was fully engaged in an enormously expensive war, and that for a decade before the war, it had been suffering through a grave depression. The level of education and medical sophistication was far lower than it is now.

People still had few dollars left over for fancy surgery and dentistry. Few local, state, or federal agencies could do much to help. Private agencies were engaged largely with other problems, and pre-pay health insurance plans were just over the horizon, waiting to begin their explosive growth.

A look at the literature of the times will quickly show two fundamental problems. Men whom we now know were leaders in the various specialties were beginning to sense the need for closer cooperation between disciplines, but their contributions and their pleas appeared almost routinely in meetings and in journals devoted to their own specialties. Nowhere was there a real forum for discussion between various groups. Even the language spoken by one specialty was incomprehensible to the others. Moreover, there was little quantification of results, primarily because worthwhile criteria were hard to come by. Pruzansky had not carried out his monumental studies; there were almost as many speech tests as there were speech therapists; cineradiography was yet to come; Chase had not graduated from college; and surgeons and prosthodontists usually reported their results in statistically insignificant fashions and in terms often meaningless to men in other fields. Audiometry and cephalometry were still to bring some degree of control over exaggerated claims or inaccurate observations.

In 1943, patients who had problems resulting from surgical catastrophes

or inadequacies who had not "just plainly given up" finally knocked on the prosthodontists' doors. These men were not all competent, but some had specialized training within the field, and had built up enormous experience with cleft lip and cleft palate cases. It is certainly true that they had opportunity to do so in those days.

Their devices were extraordinarily ingenious and at times very complex. Vulcanite rubber and metals had been their materials; the plastics were just beginning. Literally thousands of cleft palate patients got their only chances for satisfactory chewing and swallowing and understandable speech from these dedicated men. Many others could face their world only with appliances, constructed by these experts, which provided support for their lips, and which provided teeth that could bite and be seen without causing revulsion.

I do not mean to imply that all surgery was bad and that all prosthodontia was good. I do say that the surgical armamentarium was limited, and that the surgical results were bad in numbers sufficient to provide plenty of work for the prosthodontist willing to take on these cases. Thus the prosthodontist had the opportunity to study the failures of surgery and those cases where surgery could not even be attempted. He quite legitimately wondered why, in many cases, he could not make his contribution earlier in the care of the patient. His group, perhaps more than any other, sensed the need for something better, and it was his group that started this organization.

This then was part of the picture of 1943. I have spent time listing some of the larger facets because I think that many of we older members tend to forget, in the rush of just trying to keep up, how the situation was back in those days, and because I believe that, naturally, the younger members tend to take for granted today's bounty, having not been in the thick of things when our past unfolded into their great present. It is precisely because I believe that our Association has made part of our present possible that I felt it worthwhile to evoke the past; for in doing so, perhaps we can better evaluate what we have done and what we may be destined to do.

In 1949, the year that our Association reorganized to provide a broader membership base, and took the name "The American Association for Cleft Palate Rehabilitation," I wrote the following in a monograph reviewing the recent and past literature in the area of cleft palate:

If the reader has ended this review with the idea that the care of the cleft palate patient requires the services of many experts over many years, that real teamwork is needed among these specialties, that much can be done to restore the cleft palate patient and return him to society an economic asset—then the reviewer is satisfied that his mission has been accomplished.

Our Association has preached and lived this doctrine since that reorganization in 1949. It is old hat now to many of us that teams or a multi-

discipline approach may often succeed where an individual may fail, but in those days many people had to be sold on the concept, and this organization did much of the selling and still does.

Its annual meetings have provided for many the only place, and now provide the main place, where a member of one discipline can introduce to leaders of every other discipline involved in the care of cleft palate patients, a contribution or an idea for broad discussion. And for rapid dissemination of information leading to action throughout the country, how can we find a better existing forum than one made up of the versatile and critical members of this audience?

I have first hand knowledge of this. Dr. Padgett, one of the most brilliant plastic surgeons who ever lived, introduced the use of posterior pharyngeal flaps to this country. Over twenty years later, in 1950, almost the only men using them were Dr. Moran in Washington, and Dr. Dunn and Dr. Conway in New York. Some of you here today may remember that at this Association's 1955 Annual Meeting, my group presented a series of complex cases of palatal clefts, paralyses, insufficiencies, and losses from tumor surgery, trauma, and infection, all treated with pharyngeal flaps. In addition to the movie, we had patients there to be seen and evaluated. At that time, almost everywhere the answers to velopharyngeal incompetency were either push-back procedures or prostheses. That this picture had changed within four years, and has changed dramatically in the eight years since, is attributable largely, I sincerely believe, to the fact that we chose to present the material and the followups to it to this group, rather than bury it in our specialty meetings or in the general or plastic surgical literature where our predecessors had presented their material. In fact, if anyone chooses to search, he will find that despite all my talking about pharyngeal flaps at meetings of this Association, the only article we have written on these flaps—aside from those appearing in the *Cleft Palate Bulletin*—was one on a proposed classification of the procedures for my specialty journal. What I am saying is that if you believe something is worthwhile in relation to cleft palate patients, and you want it rapidly spread to those taking care of these patients, this Association provides the finest built-in dissemination mechanisms available today.

Yesterday morning we were privileged to hear a symposium on a group of techniques, relatively new to this country, relating to maxillary bone grafting and position adjusting prostheses. Some of this country's finest plastic surgeons, children's surgeons, pedodontists, orthodontists and prosthodontists presented material. In what many might interpret as an attack, an orthodontist, who has risen to the status of a giant in the field of growth and development, raised important questions about the approach; about economic factors involved; and about the long term results. Opportunity was given for rebuttal. The role of the Association was not to take a stand here; it was to provide through its Annual Meeting the place where these men could introduce their ideas and their

work to a large number of people from all of the disciplines. Well over 300 professional workers from all over this country and from other countries witnessed the events. Would anyone here, who felt the heat, who heard the thunder, who saw the light, not go back to their centers more enlightened about this approach than before? In the pulling and hauling, did not some significant aspects manifest themselves? Were not some of you surgeons who have been on the fence persuaded to start using bone grafts? Were not others dissuaded, at least temporarily? Were not some orthodontists and prosthodontists convinced to go back home and tell the surgical members of their teams about this work and the discussion ensuing? Were not others whose positions in schools and on teams, and part of whose earnings may depend on late orthodontic and prosthodontic treatment of cleft palate patients alerted to watch carefully this development? Were not many speech pathologists and therapists aroused to desire to determine whether these patients develop good speech earlier or later? Were not all participants and all observers made acutely aware of the need for long term studies; for accurate use of words or terminology; for exacting criteria; and for massive quantification of data? I find it hard to believe that presentation of this material at a specialty meeting would have had so profound an effect as I believe this symposium will have.

We have talked mainly of the contributor or presenter and his wish to disseminate his material widely and quickly. In providing a forum, this Association has also provided a place where many have learned much from the other fields; the only place where routinely the surgeon can hear, question, and argue with many experts in speech, hearing, prosthodontia, and orthodontia. This remark applies in turn to each of the other fields, but I said surgeon because that is what I am. Over the years, I have learned a great deal from men like Harkins, Subtelny, Lindquist, and Mazahari as to what dentistry can contribute in the care of and in the research on cleft palate patients. Those of you in speech who know the surgeons coming regularly to these meetings are as aware as I that they know much more about speech terminology and mechanisms than do their colleagues. Well, why should they not? Through the Association's short course, the speech papers, and the chance to discuss our questions with them at dinners and in hotel rooms, we have been exposed to Koepp-Baker, Priestersbach, Westlake, Matthews, McWilliams, and others making up a faculty in speech pathology that no one university in the world could provide us. And, by the same token, you in speech are better informed because you have learned from surgeons like Ivy, Glover, Randall, Chase, and Stark.

In 1951 our first Newsletter was published. In 1954 it became the *Cleft Palate Bulletin* because there was a clear and present need for it to enlarge. It has served as a means of disseminating information quickly to large numbers of people taking care of cleft palate patients. I mentioned

before that my group used it for just this purpose and so have others. I think that those concerned with its publication and distribution have been amazed at the requests for it over the years, and at the influence it has seemed to have in so many places on individuals not in the Association. Connected with its publication has been the publishing of a monograph supplement on heredity and cephalo-facial growth, and the printing of our Directory, of so much use to our membership, libraries, and others. In 1962 many of us felt that a clear and present need existed for another jump forward, and took the first steps toward changing our *Bulletin* to a larger journal form. I am pleased to tell you that many actions allowing publication of this new journal, beginning early in 1964, have taken place this year. You will hear more of this later today. However, at this moment, I wish to suggest to you that a reorientation in thinking by some of us about where we publish our work may be in order. In the past, only a few of us (some interested in action and not having to compete in the academic rat race for prestige publications, and others, out of loyalty to the Association and its editors) published original articles in the *Cleft Palate Bulletin*. In the future, the *Journal* should provide rapid dissemination of your material on cleft palate and associated deformities of the mouth and face *where it counts* and, it is expected, the same kind of prestige offered at present in the specialty journals. Thus, I would suggest that whenever your work cuts across specialty lines, the new *Journal* should be considered. Into this category fits a large amount of the work done in this field today. Most of the papers in this meeting's program are examples because even the surgical technique papers, in the by and large, must be reported partly in terms of factors relating to growth and development, orthodontic aspects, and speech. I portend a glowing future for this *Journal*. I have been, and want to continue to be, part of its beginning, and I hope you will too.

An Association of people from many disciplines must develop techniques for communicating in ways that have meaning between disciplines. A mutual understanding was bound to grow by the mere existence of an organization providing a periodical and a yearly meeting place where representatives of one discipline could see, hear, and form friendly person to person relationships with people from other disciplines. To further this growth in understanding, and to make our professional language more exact, a Nomenclature Committee was formed several years ago. This Committee has worked long and hard and you members have already seen some of the fruits of its labors. In January of 1962 this committee and the Association published an article entitled, "A Classification of Cleft Lip and Cleft Palate," in *Plastic and Reconstructive Surgery*. This is but the first attempt, but it is beginning to be used, and undoubtedly will make its influence felt on our thinking in years to come. The work of this committee continues and will become of more significance as more specialized glossaries and classifications emerge.

I referred to the lack of criteria in quantitating results twenty years ago. Since then, our members have made many contributions in establishing criteria and in developing or applying techniques and equipment for scientifically measuring phenomena and results relating to our work. I shudder when I think of how I reported some of my work a few years ago, but I used the best techniques I had available to me then and even developed some others in trying to be more exact. The orthodontists and their study models, better cavity photography, cineradiography, Randall and his lateral still x-rays, Chase and simple pressure measurements, Spriestersbach and others and their standardization of speech testing, flowmeters, and air volume and velocity measurements are but a few of the factors introduced during the life of our Association to make us report in ways that are more exact and have more meaning. The day when a prosthodontist could just say "speech was normal" and not have to define how he arrived at the meaning of "normal" has passed. The day when a surgeon could come before this body and back up his triumphs with tapes poorly recorded and even then still showing inadequate speech results has long gone, as we witnessed several years ago.

Earlier, I listed many aspects of cleft palate care and research as observed twenty years ago. I felt it appropriate to do so for I wanted to show what this Association had done in its first score of years. Right now, at the end of two decades, it cannot claim sole credit for all the changes. But it can claim to have played a large, and in some cases, an all-important role in many parts of the drama of cleft care. So much, ladies and gentlemen, from so modest an organization. Very few people have joined this group for prestige purposes; some, in fact, joined in the face of passive opposition from their specialty groups. Yet this Association, with rehabilitation no longer in its name though it was one of the earliest of all groups to unite around the concept of a multidiscipline approach to rehabilitation, has served a very important purpose and has grown in prestige and numbers. As you will hear in more detail at our business meeting, we now have 650 members. Almost all states are represented, and our membership west of the Mississippi is going up rapidly. During this next year we will pick up many more members from the West and we have an expanding foreign membership. We are today larger than some of the specialty societies covering some of our disciplines. Already well over 300 people registered for this meeting.

So much for our past and our present. What about our future? I assume that in those aspects of therapy and research and education where we contribute already, we shall continue to do so and in a growing capacity. I have mentioned the *Journal*; its role will be a significant one as a tool for enlisting new friends and members and for expediting our education and research goals. Our policy of meeting all over this country and now in foreign countries cannot help but expand the role of the Association over an ever larger part of the world.

There are many areas of need calling for solutions. Most enlightened men today recognize the need for teamwork. But how to provide efficient, smoothly working teams without undue expense is the question. More work needs to be done on team dynamics and motivational factors. With as many teams as are involved in our Association, it is time for some work by psychologists and perhaps by business or administrative people (efficiency experts, etc.) and some reports to our group on the results of these studies.

We really could use more contributions from engineers and physicists. They are changing the world and we need their help and interpretations in keeping us abreast of the changes. In no way do I wish to limit the Program Committee, but I hope that when we go to New York in two years we will have a chance to hear some of the scientists from the Bell Telephone Laboratory. I use this hope as just an example of what I mean.

Anyone familiar with "the cleft palate story" knows how much we need standardization of terminology and criteria. Spriestersbach's and Huffman's conference next fall for an investigation into criteria being presently used should be aided in any way possible, and its results should be awaited eagerly by every member. If the results of this study are as significant as I hope they will be, I think that it would be wise for the Association to set a standing committee for criteria or standards to which the members can look for help along these lines in the future.

I am concerned about the cost of things. I believe that every responsible person involved in the care of patients should have due regard for inefficient use of human, physical, and financial resources. I have a very real fear that our burgeoning government's role in therapy, research, and education will lead to waste and a diminution in the freedom of our patients, our research investigators, our teachers, and our clinicians. I happen to believe that our system, our competitive way of life, our desire to do things for ourselves has led to a fantastic kind of civilization with wealth so great in amount and so widespread as to be unheard of before. I think there are real dangers in the trend seen beginning everywhere in academic life today toward setting up research programs designed to please a federal agency and one or more on-site inspectors, running to Washington for monies, and then expending these in some ways that many of us would not spend them were they coming directly out of our own pockets. Our group, concerned as it is with habilitation or rehabilitation of crippled children, interested as it is in research and teaching, and involved already as it is in providing therapeutic, research, and teaching services often financed in whole or in part by the government agencies, is particularly likely to become economically dependent on Government. If and as the individual becomes dependent on government, his freedom will suffer. In the ultimate analysis, our future progress depends on the creativity of individuals. As was mentioned in *Time* recently, the late Whitney Griswold asked: "Could 'Hamlet' have been written by a committee, or the 'Mona

Lisa' painted by a club?" I, therefore, propose at this meeting in Washington, where we have been greeted so cordially by individuals working for government, that our Executive Council address itself next fall to ways and means of guaranteeing that our Association remain truly independent. I further propose that it set up a mechanism whereby our membership can report problems relating to the field of endeavor with which our Association concerns itself and arising from suspected waste of funds or any imposition on academic or clinical freedom, should any ever arise. With one piece of equipment costing \$60,000 or more and with grants now going into the six-figure category, I think we owe this assumption of a new responsibility to our membership at large, and since the Association exists in society for the public good, to the individuals who, in toto, make up the governmental and nongovernmental segments of our country. One thing is certain: mature people assume responsibility for good citizenship and the fostering of freedom; it is easy and the mark of the immature or the sick to shift blame and to shirk responsibility.

Ladies and gentlemen and honored guests. It has been an exciting and rewarding twenty years. And my year as your President has been full of worthwhile events and warm experiences. To all of you, and to those who have worked so hard with me this year, my heartfelt thanks.

*1101 Beacon Street
Brookline, 46, Massachusetts*

Editor's Note:

There was, at the 1963 Convention of the American Cleft Palate Association, a symposium entitled *Expansion Prosthesis and Bone Grafting*. The symposium consisted of five papers and a discussant. Because the topics are of great current interest to members of the Association, those papers and the paper of the discussant will be published in the *Cleft Palate Journal*.

A minimum of editing has been performed in order to retain the original intent and flavor of the presentations.

Following in this issue are four of the papers from the panel. The fifth paper, the discussants' paper, and the resulting commentaries will appear in the next issue of the *Journal*.