

RECENT TRENDS IN THE  
MANAGEMENT OF THE  
INDIVIDUAL WITH ORAL-FACIAL  
AND SPEECH HANDICAPS

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# *Recent trends in the management of the individual with oral-facial and speech handicaps*

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## INTRODUCTION

TWENTY-TWO years ago I had the privilege of reading before this Society an essay entitled "Crippled Children?" This subject was chosen because I had served as dental consultant to a crippled children's hospital for the previous twelve years. From the experience thus gained in observing the treatment of all types of deformities, I was greatly concerned to learn that there was a group of children for whose treatment there were neither services nor funds available. These were the children afflicted with an aggravated malocclusion and a resultant deformity of the face and/or speech defect (Fig. 1).

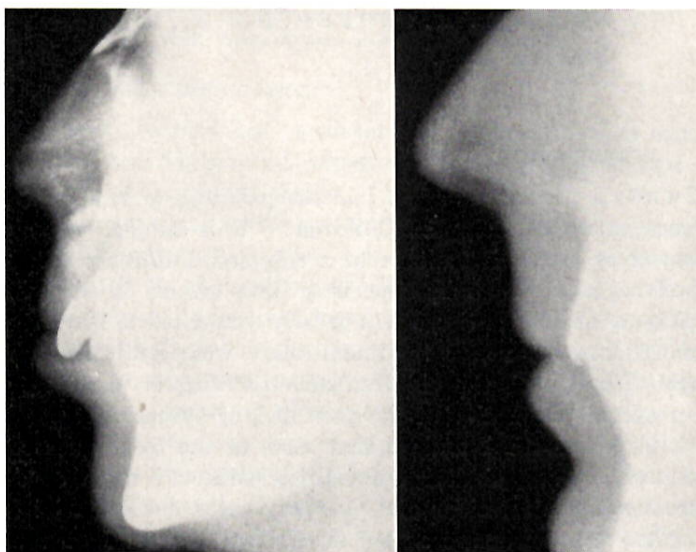
Furthermore, I noticed that some of the techniques used in the treatment of scoliosis and similar deformities corrected these conditions but, in turn, produced malocclusions and, in many cases, severe facial deformities by exerting too much pressure on the mandible (Fig. 2). As a result of these observations, I attempted to start in that hospital a clinic for the treatment of all gross malocclusions and oral-facial deformities, with or without speech defects, but to no avail. Later we tried to demonstrate the need for the same type of clinic at a large university where all disciplines and techniques necessary for successful treatment of these cases are taught, but still the idea was ignored. Concurrently, we had organized a small group of interested professional men and had started our own clinic in Lancaster. From that beginning in 1938, our clinic has now grown into an institutional member of the American Hospital Association. Although our interest was in all types of oral-facial and jaw deformities,

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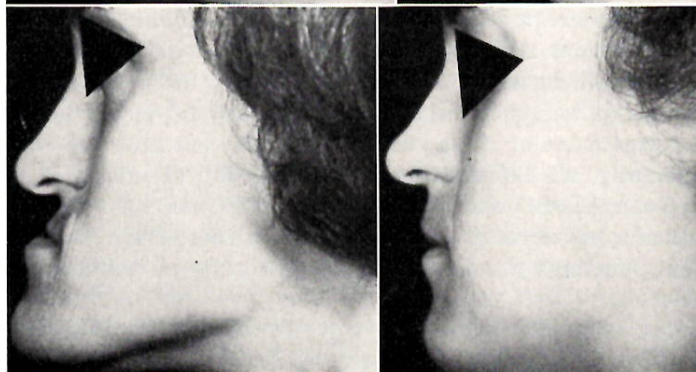
\*Director, Lancaster Cleft Palate Clinic.



A.

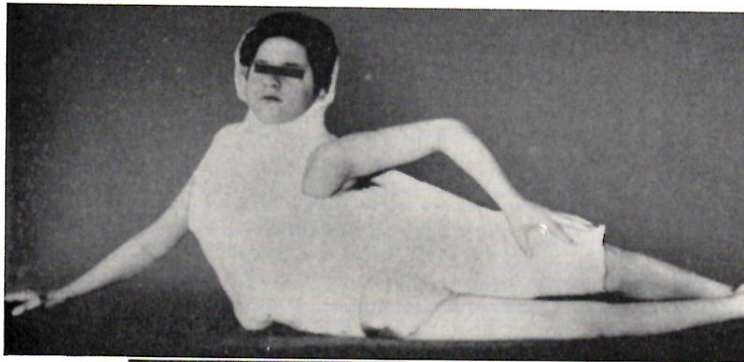


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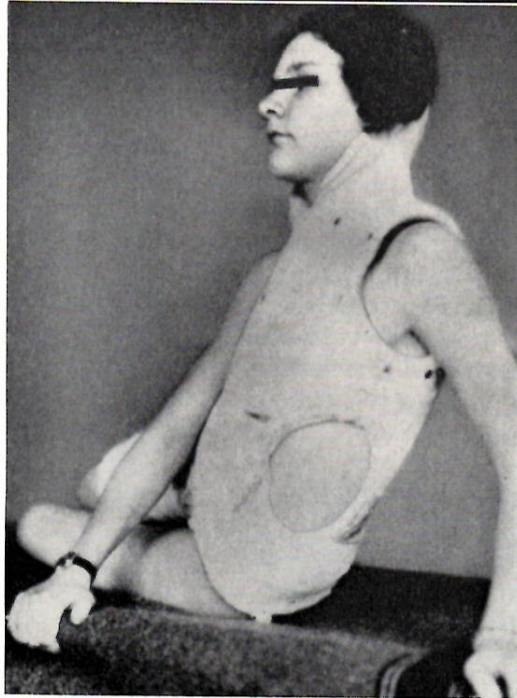


C.

Fig. 1. (For legends, see opposite page.)



A.



B.

Fig. 2. *A*, This type of appliance has produced a definite malocclusion by having the cast exert too much pressure on the mandible.

*B*, When the orthodontist's efforts were coordinated with those of the orthopedist, it was decided that the plaster cast should be changed. Note that there is no pressure on mandible, and no deformity or malocclusion has been produced.

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Fig. 1. *A*, Malocclusion with facial deformity. Although this child was considered mentally retarded, all tests were normal, leaving both patient and family much disturbed and confused.

*B*, Radiograph of oral-facial deformity before and after orthodontic treatment. This was another disturbed patient with an additional speech defect.

*C*, A case in which an orthodontic and surgical approach was required for treatment. The psychological effect of the deformity was a matter of grave concern to physicians and family. This patient graduated from college after treatment.



we called it the Cleft Palate Clinic because many of the cleft palate cases were the most deforming. I am certain that if we had named our center the Lancaster Orthodontic or Dental Clinic we would never have been recognized as a needed service organization at that time.

At first we had local Rotary Club sponsorship, and in order to give the project a legal birth in a short time a charter was granted the clinic as a non-profit hospital for specialized services to supplement the services of our local hospitals. The following excerpt from the charter explains its objectives:

ARTICLE II: That the corporation shall be formed for the purposes of establishing, equipping, maintaining and operating an institution, hospital for special services, or clinic for the treatment of all defective formations of the mouth, teeth, palate and face; for the establishment and operation of a school for the training of those with speech or hearing defects associated with or without oral defects; and to conduct research in, and to publish information relative to, the above fields.

No profit from the operations of the corporation is to accrue directly or indirectly to any member or director thereof.

All of the foregoing led me to ask, in the paper given before this Society 22 years ago: "Why cannot the treatment of oral facial deformities be carried out as any other branch of orthopedics?" I stated that one is almost forced to regard as doubtful the statement that orthodontics is really dentofacial orthopedics, and I went on to cite a hypothetical case in which I compared the plight of two children, one with a crippling condition such as scoliosis and the other with the equally crippling deformity of cleft lip or cleft palate. In this way I demonstrated the bewilderment in the minds of the afflicted and their families when they realized that existing state and private programs made treatment and funds available for only certain types of defects.

I continued in that paper:

We assume that it is the intention of the State that every crippled child should be made self-supporting and whole. If he is lame, he is made to walk, so that he can go out in the world and become a useful, self-supporting citizen. But how singular it is that a child who has a facial deformity, either with or without a speech defect, according to the standards now established, is relatively so unimportant—yet we try to prepare one child to walk up to ask for a job, while the other, who can walk there but cannot ask for it when he gets there, is neglected.

If one would take the very definition of a cripple as defined by the International Society for the Welfare of Cripples, one could assume that our crippled children's hospitals were guilty of gross discrimination, overlooking the indigent or partially indigent child with an oral-facial deformity. It is strange that it has taken so long to realize that many patients whom we see in our offices fit the description of a crippled child to the letter, but the facially or dentally handicapped were never included in any of the crippled children's programs. Others had made similar observations long before this time—Kingsley,<sup>2</sup> Case,<sup>3</sup> and Ottolengui,<sup>4</sup> to mention a few. These are some of the men who stood on the front line while the profession was "growing up."

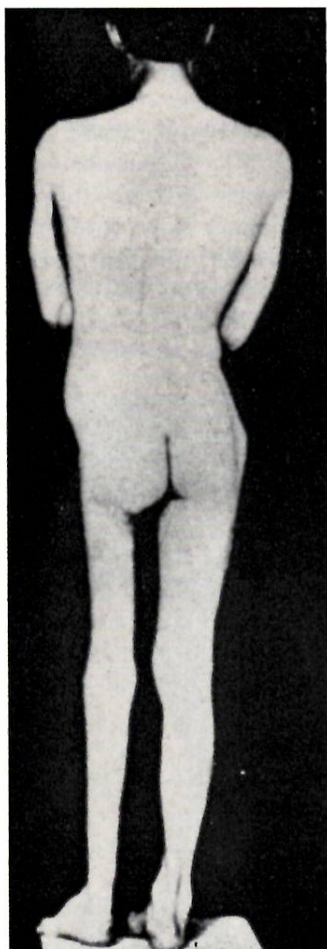
The present article will attempt to show only a few of the many changes that have taken place since that time. Some are good and offer a bright future.

Others, in my opinion, are poor and require the closest scrutiny by our specialty and by the entire dental profession. Some other situations remain much the same.

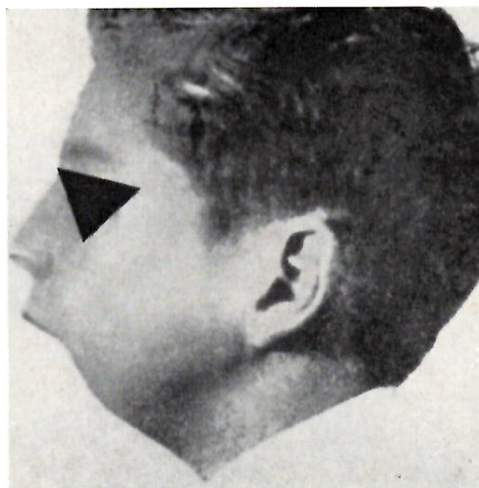
TWENTY-FIVE YEARS LATER

One of the first noticeable changes is the change in the name of this organization from the New York Society of Orthodontists to the Northeastern Society of Orthodontists. Because of that change, I am now a member of the Middle Atlantic Society. However, I still feel a strong attachment to this component society because it was my birthplace into orthodontics.

These changes are minor as compared to the professional ones. For example, the oral surgeon referred to in my former essay is now called the plastic and



A.



B.

Fig. 3. *A*, Leg deformity caused by poliomyelitis. (From Whitman, R.: *Orthopaedic Surgery*, Philadelphia, 1930, by permission of Lea & Febiger.)  
*B*, Facial deformity caused by temporomandibular ankylosis. (From Thoma, K. H.: *Oral Pathology*, St. Louis, 1941, The C. V. Mosby Company.)



reconstructive surgeon. The oral surgeon of today was the exodontist of that era. The speech teacher or correctionist of that time is now a speech therapist or a speech pathologist. In the former paper I was trying to promote the idea of a "team approach" to many of our problems, similar to the team approach used by the orthopedist at that time. I had in mind Webster's definition of teamwork as "work done by a number of associates, all subordinating personal prominence to the efficiency of the whole." It is my opinion that in the average program where dental problems are involved we have not yet reached the state where this definition can be applied, for too often each service strives to put the emphasis on its own particular area of interest.

This trend is noticed in many articles appearing at one time or another in current issues of our journals. I am afraid that we are all guilty of emphasizing the importance of our own field, to the detriment of the patient's welfare. Our primary concern should encompass the larger concept of the total person so that, for example, we see not only the hole in the mouth of a baby but, rather, the baby with a hole in his mouth. There is a world of difference.

This procedure of emphasizing one particular field has created quite a predicament in many areas of health service today, and it is particularly noticeable in the treatment of conditions requiring the services of many disciplines. One example is found in cleft palate cases in which there have been multiple operations, with the result that speech and appearance are still poor. Although further treatment is indicated, we firmly believe that no decision should be made as to the next procedure without an interchange of views, *on an equal basis*, between the surgeon, the experienced dentist, and the speech therapist (Fig. 4).



Fig. 4. Treatment-planning conference involving, left to right, speech therapist, prosthodontist, plastic surgeon, pediatrician, and orthodontist.

The following excerpt from a letter that we received from a family physician well illustrates what can happen when the specialties run in all directions and without a definite coordinated plan:

The individual is now approaching her 16th birthday and is being referred to your clinic for consultation regarding the question of further treatment. The patient was born on March 28, 1944, and in August, 1944, a first attempt was made to close the palatal defect. Further surgery toward this end was made in August, 1945, 1946, 1947, 1948, 1949, and 1951, 1954, 1957, 1958, and October of 1959.

The patient, in addition, had received speech lessons through most of these years, and during the last five years had been under the care of an orthodontist. Failure to close the defect at the last attempt was very disheartening to the patient and the parents, who are now anxiously seeking help elsewhere. What is needed now is a critical review of what has been done and a frank decision with the patient and the parents as to chances for successful treatment at this time, and what improvements to her appearance and speech might be expected to follow, and offer some specific recommendations.

Now this letter obviously was written just 15 years too late. How much grief and heartache might have been spared the patient—and, I suspect, the surgeon, the speech therapist, and the orthodontist—had there been an exchange of views while the treatment was proceeding.<sup>7</sup> Why twelve operations? Why 5 years of orthodontic treatment and, in addition, all those years of speech training?

In the past we have been accused of prejudices by some surgeons who felt their procedure was being questioned.<sup>10</sup> It would be relevant to state here that there was never any intention of criticism of the surgeon per se but, instead, we have questioned the wisdom of a system which advocated a surgical approach only and allowed no alternative in cases where initial surgery has failed to produce satisfactory results.

We have been working in complete accord with excellent plastic surgeons and have nothing but the greatest praise for their skill. Nor do we minimize the importance of their contribution to the successful treatment of the patient. In fact, a strict rule in our clinic procedure, as taken from our by-laws, reads as follows: "In this hospital the plastic surgeon is the chairman of the team. Most important in the entire program of treatment is properly considered and well-timed surgery."

All cleft lip cases require plastic surgery. If this is not done in early infancy, harmful psychological traumas may be carried into the patient's life.

In cases of cleft palate in infancy, whether or not associated with cleft lip, the decision as to type and extent of surgical intervention is made by the plastic surgeons. Whenever further surgery on the palate may be indicated in adolescent and adult patients or patients who have been operated upon no decision is made as to procedure without an interchange of views between members of the surgical, dental, and speech departments. Definitely, there is a place where a prosthetic speech aid is indicated long before the surgeon has exhausted every means at his command.<sup>11</sup> In many instances when surgical treatment has failed and/or an orthodontic-prosthetic approach is attempted, the chance for a successful result will be very poor.

Successful treatment of cleft palate deformities will always require a closely integrated program of various services. I believe it is safe to say that such a



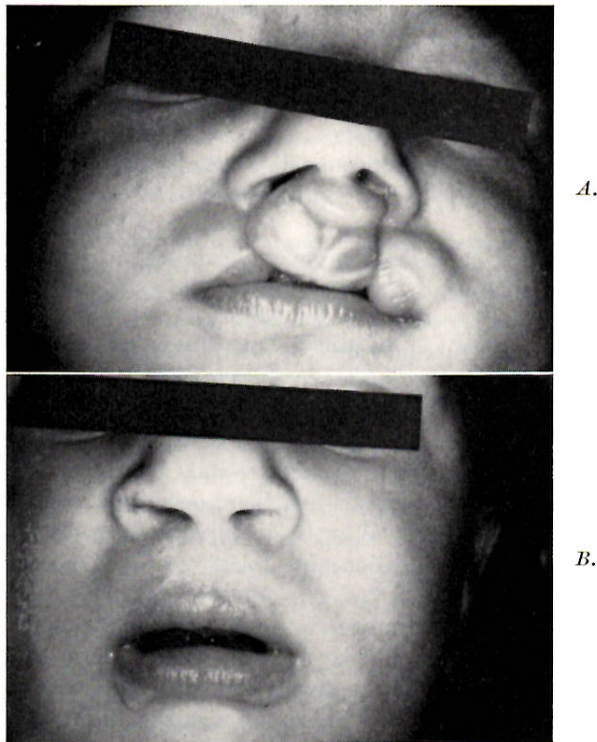


Fig. 5. Bilateral cleft of lip and palate. *A.*, Loose premaxilla. *B.*, Excellent results. Poor lip surgery can be a great hindrance to later orthodontic and/or prosthetic treatment.

policy is pursued at the present time more often than it was in the past, but we find many places where the dental problems are given low priority or considered only as a last resort. Quite recently I was surprised to receive a letter from a medical member of a so-called "cleft palate team" which read in part: "All integrated services have been functioning very satisfactorily except dentistry." *All* services? How can any group feel that it is functioning properly with a vital link missing? A chain is only as strong as its weakest link.

Many conflicts between medicine and dentistry still exist. In some areas they are remarkably improved, and in others there is some kind of "peaceful coexistence" which at times is not too peaceful.

We recognize the need for good medical care in all health<sup>6</sup> services and agree that such services should have medical supervision. But we cannot help asking: "What constitutes a medical examination? Is a dental examination included in that? And who does the oral and dental examination?" I ask these questions with a desire to promote a better understanding and an improved relationship with our medical brethren. At the present time it is my humble opinion, based on the observation of many cases, that too often oral conditions are overlooked with our existing methods of uncoordinated medical or health examinations. On the other hand, we in dentistry too often criticize our medical

brethren for overlooking dental anomalies. In reality they were not overlooked; they were never observed in the first place, and understandably so since these conditions are beyond their area of training and interest.

In all probability, this type of situation prompted Dr. William J. Gies<sup>5</sup> to state, in 1926:

Antagonism between medicine and dentistry is not in the public interest and the only way at present to give the public a real total health service is by earnest cooperation between the two.

On the subject of medical education, Gies wrote:

In the complex task of seeking to teach young men in four years, split into many units of time, these fundamental services, the theory and practice of general medicine and medical specialties, it was inevitable that certain specialties should be underrated in the medical school and others lost to view. The most notable of the omissions has been the absence of a specialty in medicine relating to diseases of the mouth. This has been due mainly to two causes. In the first place, only in recent years has it been fully recognized that dental disorders are directly related to the general health. The present courses of medical education do not include instruction in dentistry comparable to that of diseases of the eye, throat, nose, and ear. In the second place, the unusual mechanical requirements in dentistry have established an almost universal opinion, even among physicians, that dentistry was a mechanical art and not a branch of medicine—notwithstanding the fact that the teeth and mouth contributed one of the most important fields of medicine.

Twenty-five years ago one of our big problems was that of informing the public of the need for early dental care. Although much has been done by our dental schools, organizations, publications, lecturers, and "toothpaste manufacturers," we have barely scratched the surface. Many years ago Martin Dewey stormed the country for better dental educational publicity, but his ideas were turned down by his own profession. (In fact, some of his intimate friends believe that disappointment over this defeat hastened his untimely death.) The need is still as great as ever.

The orthodontist and the dentist are still seeing our children too late (Fig. 6). Many dental and orthodontic problems have their beginning in the pre-



Fig. 6. A 4-year-old child with cleft lip and palate whose teeth are all carious. Fluoridation and a more realistic preschool dental health program could prevent many of these dental problems.



school years. We must find a way for a more realistic program to start at that time.

The need is particularly noticeable in the case of the cleft palate child. One cannot overemphasize the importance of good dental supervision, which not only instructs the parent concerning the need for constant care and attention but also teaches the importance of saving as much as possible of the dentition which will be so badly needed for future restorations and orthodontic treatment as the child grows.

Unfortunately, the average school dental health programs consist mainly of examinations at various intervals. How effective these examinations have been is still a question, for before we start we know the percentage of caries we will find. Often many extreme malocclusions are overlooked. Then, if the child is in the lower bracket economically or is truly indigent, we are hampered in our efforts by those who claim that such services, if "freely" given, represent a trend toward socialistic practice. If it is socialistic to treat the indigent child for caries and/or a deforming malocclusion, what is it called when he becomes a part of our aging indigent or partially indigent population?

If anyone doubts the severe oral health situation of our school children, let him look briefly at the figures taken from the records of young men entering the Armed Forces. These inductees were in our school system only yesterday. Their records give us a clue as to how effective the preschool and school programs have been.

A recent study of Army, Navy, and Air Force inductees showed that 90.3 per cent presented dental disease; 8,000 dental treatments of various types were required per 1,000 inductees. These treatments included restorations, surgical procedures, full dentures, and partial dentures. Again, let me emphasize the fact that a few years before these inductees were our school children.

School health examinations<sup>6</sup> can be effective and will prevent later problems and expense if they are followed by the indicated treatment. Unfortunately, we lack the power to enforce those recommendations. A real paradox seems to exist in this area. A child with dirty hands or face may be sent home from school and told not to return until he is clean. However, that is not true so far as the mouth and teeth are concerned. Unfortunately, many of these children stay right on and are examined year after year while their mouths remain neglected, until the boys at least are eligible for the Armed Forces, where they are finally cared for to the extent that is possible under those circumstances.

In closing this partial review of the past, it is sad to note that help for the indigent or partially indigent person with severe dental or orthodontic difficulties is far from satisfactory. If we study the list of recognized services in our various insurance plans, such as Blue Cross, etc., we find that the specialty which removes teeth has high priority. However, when we consider that cleft palate and/or cleft lip alone is the second most frequently found birth defect, and when we add all the many other types of facial deformities, we must admit that efforts on behalf of these persons are small indeed. It is even more tragic when we consider the money and effort now being spent on other defects which are less frequently found.



The relationship between the need for services and the demand are still far apart. Some states and communities have established programs for helping these individuals, but when these programs are carefully examined they leave much to be desired. Most of them are still on the drawing board.

On the optimistic side, however, we recognize that these efforts represent a step forward and must be diligently fostered, for they comprise an opening wedge for further education concerning the plight of these handicapped persons. When an aroused public is fully aware of the need for such services, we will then have to be prepared to meet that demand.

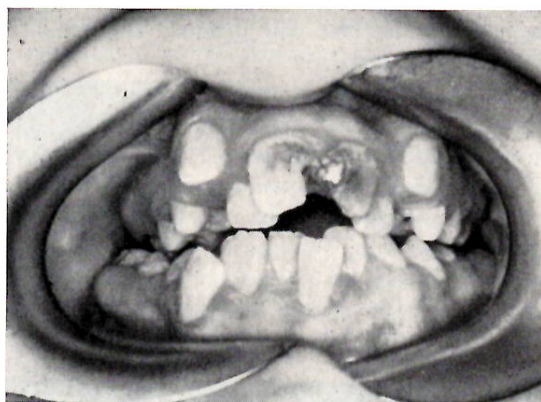


Fig. 7. This patient was receiving speech therapy in a tax-supported crippled children's program. He had a severe malocclusion, extensive caries, and aggravated periodontal disease. Giving speech therapy when such conditions are present is comparable to giving a child trumpet lessons on a trumpet in which all the valves are stuck. It is firmly believed that a dentist and an orthodontist should be regular members of the staff of every speech clinic, just as a speech therapist should have a part in the management of many persons with an oral-facial and speech handicap.

In this rather sketchy review, one problem seems to be ascending above the horizon. I refer to the new specialty of pedodontics and its relation to orthodontics. It seems to me that a real conflict of interests is in the making. Dentistry has already had many conflicts with other medical specialties since its beginning. This is especially true in the field of cleft palate and cleft lip and surgery of the face and jaws. Are we not producing another similar situation within our own profession? It is true that we are living in an age of specialization, both in training and in practice. Boundary lines are being established and challenged to such an extent that when several specialties have the same area of interest some very delicate situations can arise. This can become bad for the profession and for the specialists involved, and it can surely be very confusing to the patient.

The orthodontist has always been interested in the growth and development of the infant's face and jaws from the time of birth. In fact, orthodontists have engaged in much study and effort in the field of genetics and prenatal influence in their search for the causes of malocclusion.

These statements are being made in the interest of better professional relations. I can find no fault with a trained general practitioner rendering orthodontic care to a child, provided he keeps the child under treatment until the case is completed, regardless of age. He also should then assume sole responsibility for that case. If pedodontics as a specialty of dentistry has as its purpose "the limiting of practice to children," one questions the need for establishing a specialty by itself. In that case, it would be just as logical to establish a specialty of dentistry for adults. However, if the intent is to assume responsibility for "interceptal care" for suspected malocclusions, then the practitioner should assume the entire responsibility for completion of the case, regardless of the patient's age. Otherwise, we will produce the greatest "buck-passing" situation ever known in dentistry.

Dr. Percy T. Phillips, in a recent article entitled "This I Believe," published in the *New York Journal of Dentistry* made the following statement: "I believe that specialty status, if our people are to be served properly, must depend upon one thing solely, *competency*. Limitation of practice, economies and other similar regulations can never be true evaluations of specialty status."

On the other side of the coin, it seems to me, as I review the trends of the last 25 years, that orthodontics as a specialty has helped, in part at least, to produce this situation. We have become so engrossed in various techniques that we seem to have lost sight of the parent profession.



Fig. 8. Group therapy proves valuable in motivating patients to improve their attitudes and general speech habits. This type of therapy can help the orthodontist by aiding in the correction of faulty tongue habits. (See Fig. 10.)



Anyone who has lived through those years must admit that our concern with the questions of extraction or nonextraction, bands or no bands, and all the other contrivances has caused us to forget or overlook caries, periodontal disease, and again the total person.

This great trend toward overspecialization generally has produced the dilemma that is now of much concern to all who are familiar with the situation.

#### SPEECH AND ORTHODONTICS

In the earlier paper<sup>1</sup> that I presented before this Society I said:

Let us now consider the problem of speech. . . . We refer to those speech problems which are caused by malformation of the jaws and irregularities of the teeth. Does it not seem strange that every hospital in the country has a well-equipped and well-staffed department for the treatment of eyes, nose and throat, while the problem of speech . . . is handed for solution to the speech correctionist in the public schools *before* anything is done to correct the anatomic background which is more often than not the contributing factor? Then conceding that the speech correctionist does find the causative factors of this condition, we wonder where, most generally speaking, these patients can be sent except to men in private practice who cannot afford the time or money required to accept the cases unassisted. Speech is extremely pertinent to dentistry. Why it has not been stressed more is beyond understanding. We have been taught that the teeth and their associated structures are primarily organs of mastication, but the secondary function is associated with speech and esthetics. We have stressed mastication and esthetics but have ignored the problem of speech.

It should be pointed out here that speech therapy is no longer considered in the field of education alone. In reviewing the terminology used in describing the professional persons dealing with the treatment of speech problems, one can see the evolution taking place in that field. In our literature we find the terms *elocution teacher*, *speech teacher*, *speech correctionist*, and now *speech therapist* or *speech pathologist*. The speech profession is now a recognized service in the public health field, and no longer is it confined to the classroom. Let us analyze the conditions mentioned earlier in this discussion which, by their very nature, are purely dental or oral and treatable by the dentist and the speech pathologist.

The face is the one part of our anatomy that actually "faces" the world in which we live. It is the one part of us that is not usually covered. As part of

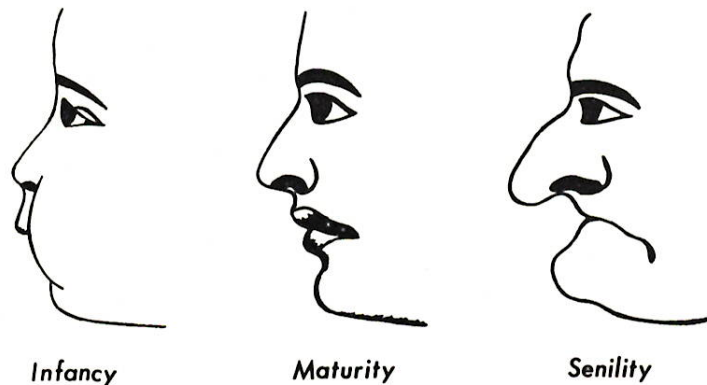


Fig. 9. The shape of the face is largely influenced by the teeth and jaws.



this face we have the oral cavity, with the implications of teeth, jaws, occlusion, etc., and the effect that all these have on the growth of the face (Fig. 9). More than that, these are the structures which the individual uses to communicate with the world in which he lives. In addition, these same structures are also a great part of his speech-producing mechanism.

We cannot overemphasize the importance of good communication. The ability to speak clearly makes it possible for one person with a severe physical handicap of a certain kind to become President of the United States, while persons with many of the handicaps that we are discussing today will not have the same opportunity even though they have the same mental capacity.

I will admit that not all tooth irregularities cause speech problems. However, there are many orthodontic and speech problems which must be considered together. We have seen children with lateral lisp (Fig. 10, *A*) being treated in a speech clinic when they should have been treated first by an orthodontist, in which case the speech therapy probably could have been reduced to a minimum. Likewise, we have seen just as many persons with poor tongue habits (Fig. 10, *B*) who should have had speech advice and treatment before any orthodontic

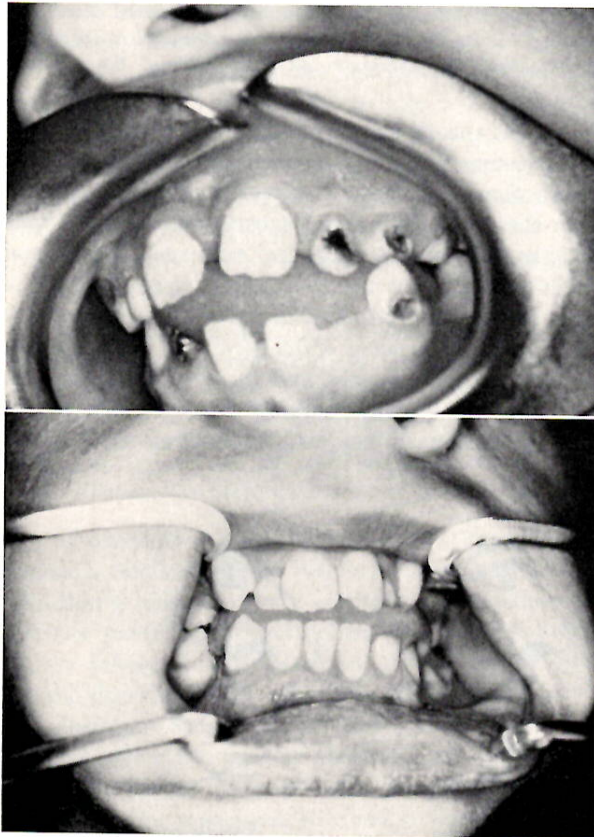
*A.**B.*

Fig. 10. Coordination of the services of the speech therapist and the orthodontist is very important in the management of oral-facial abnormalities of this type.

procedure was attempted. It is unfortunate that our large universities, which are training physicians, speech pathologists, psychologists, and dentists all on the same campus, do not have a better system for teaching integration in their training. Most of these professional workers find all this necessary only after they leave the university.

#### RESEARCH

Ever since the advent of the first "sputnik," the emphasis on research has been accelerated. The recent trends in that direction are very interesting to observe. I do not claim to be a research-oriented person; however, I do feel qualified to assume a small role as a "clinical observer."

We are constantly hearing men say, "If we only had money we would do some research." Consequently, Congress has become research conscious, and we surely are getting the money. However, it is my sincere opinion that this is putting the cart before the horse. Research obviously does not start with money. It begins with an idea coupled with a prepared mind. Money can merely implement the idea. We must learn to differentiate between basic research, clinical research, and statistical study if we are to eliminate some of the confusion which exists in this field. I agree with Sir Thomas Lewis,<sup>14</sup> who wrote:

The First and Last must be Clinical:—Knowledge that is to be applied usefully to the health of mankind will almost come by a series of steps, the first of which is the recognition of the human need, the last of which is the application of a test directly to the human problem. It is in the nature of things, however many steps may intervene, that the first and last must be clinical; as it is also in the nature of things that almost all important physiological discoveries that are immediately applicable to the treatment of disease have their original source in clinical observation . . . .

Many years ago someone posed the question: "Who shall decide when doctors disagree?" Through research and statistical studies in improving our methods in diagnosis and treatment planning, we can answer that question, in part at least, by developing procedures which will help doctors decide when they disagree.

Through research conducted at our Lancaster Clinic we have been able to demonstrate, by the use of cinefluorography<sup>12</sup> with image amplification, the functions of mastication and deglutition. Such graphic records of the movement of these parts have heretofore been unknown, and these functions have been a source of speculation and controversy. Through cinefluorography, we can now see in motion parts which were hard to define when we used a tongue depressor and had the patient say, "Ah."

The sonograph, a machine for recording visible speech, gives a more accurate measurement of the degree of improvement than does the less certain human ear when used for the interpretation of some speech defects.

I predict that in the future we shall see common usage of such tools in determining the best position for a pharyngeal flap or a speech aid. Furthermore, the troublesome tongue habits can now be properly evaluated.

Still another area for important studies concerns the rehabilitation of handicapped persons. Why does one patient accept therapy for his defect while



another refuses any aid whatsoever? Why does one patient put so much effort into helping his treatment program while another with the same abilities seemingly refuses to cooperate?

This discussion on research cannot be closed without a word about fluoridation. The work done in this field by the dental profession has been outstanding. We have high hopes for the results of fluoridation for future generations. Once fluoridation is generally accepted, the tremendous burden of caries control should be greatly lightened, especially among our children. It is difficult to understand why a referendum on the use of fluorides is still required by so many communities. That vote has already been cast by the people who know something about it—all public health agencies, the American Medical Association, the American Dental Association, the American Public Health Association, etc., as well as the scientists who have worked so long and well on the various projects relating to it. Their vote is in, and they have won. Yet we allow the man on the street, who usually is not too well informed on this subject, to make the decision. *It would be interesting to know how some of our other public health regulations would fare if that same procedure were followed.*

#### REHABILITATION AND PHYSICAL RESTORATION

Rehabilitation<sup>13</sup> has been described as “a concept of treatment which combines medical, psychological, sociological and educational methods to give a person independence in respect to his limitations.”

Since the present discussion deals with modern trends in the management of persons with oral-facial handicaps, we must ask ourselves a few questions.

Are we becoming confused by the word *rehabilitation*? Has not the word lost some of its semantic strength? It seems to have become diluted by the many techniques and disciplines necessary for its development, especially in the minds of the public. It is common to hear someone say: “I rehabilitated him” when he really means that he gave that person a physical restoration, by either surgical, prosthetic, or orthodontic means. One person can be well rehabilitated without any physical restoration; another person with an excellent physical restoration may never be truly rehabilitated. It seems that we are using the term *rehabilitation* too lightly, in a more or less superficial manner.<sup>8</sup> True rehabilitation has been accomplished only when the affected person learns to “accept with serenity the things he cannot change, has the courage to change the things he can, and the wisdom to know the difference.” *Physical restoration by surgical, orthodontic, or prosthetic means does not always indicate rehabilitation of the total person* (Fig. 11).

At this particular time we are hearing a great deal about the mentally retarded child. This interest is long overdue, and we subscribe wholeheartedly to the efforts being made in behalf of these children. At the same time, something no less tragic is taking place in our own field. *Unfortunately, persons with oral-facial and speech handicaps all too frequently have also been considered mentally retarded.* Their appearance, speech, or hearing is such that they withdraw from normal human contact. Think of the many children with oral-facial and speech handicaps who are not mentally retarded and yet are categorized





Fig. 11. Residency programs designed to offer physical restoration, speech retraining, and social adjustment are a great aid in the patient's total rehabilitation.

as such by society. Consider the many children with aggravated Class II and Class III malocclusions, each child labeled with an appropriate nickname. Finally, and most serious of all, consider the cleft lip and cleft palate child with his or her typical speech. Fortunately, in the latter cases, most of the lip surgery done by the well-trained surgeon has improved remarkably (Fig. 5). However, the many speech and facial growth problems that these cases present are still grave and give rise to severe psychological reactions.

Allow me to illustrate. It is not the mentally retarded cleft palate child who refuses to recite in school. It is the more normal child with an appearance and speech problem who is wise enough to know the reaction that his speech and/or appearance will produce. It is not the retarded person who turns away or lowers his head when trying to speak. It is the more normal person, who is reacting to the way that society reacts to him.

One helpful statement in this connection has been published by Dr. Eugene McDonald<sup>9</sup> in a textbook entitled *Understand Those Feelings*. Dr. McDonald compares the problems we face in handling our cases to an iceberg; three-eighths of it, which we can see, is above water, but we are forgetting the five-eighths of it below water that we cannot see. Many persons who have been lost to society might have been rehabilitated had we as a group understood that larger part of the iceberg—the five-eighths of it that is not seen.

#### SUMMARY

1. An attempt has been made to show some recent trends in the management of persons with oral-facial and/or speech handicaps.

2. It can be truthfully stated that dentistry has made more progress in the last 25 years than it did in the previous century. Whether dentistry is now or ever will be considered a branch of medicine is no longer the question. The fact remains that dentistry as a part of the public health services is equal in importance to many of the now accepted branches of medicine.<sup>5</sup> At times it appears almost tragic that the teaching of stomatology was separated from medicine.

3. The public should be made to accept responsibility as a part of the "team" in helping the oral-facially handicapped person gain his rightful place in society.

4. It should be a basic assumption that if a person is going to do anything at all, he should be able to know that he looks like a normal person and he should be able to speak easily and clearly. Nothing else is so necessary to his social and educational development. It is difficult to give first importance to any one of the many other problems with which persons with cleft palate speech and/or facial deformities must contend.

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