The clash between form and function is never seen or experienced more precisely than when specialists disagree in caring for patients with complex congenital craniofacial deformities. These discussions, some academic and others archaic and all continuing in real time, are intended to be for the betterment of the treatment outcome but may be detrimental to the patient. Since specialized healthcare providers are confident, focused, and opinionated, recurrent detrimental outcomes may only be obvious when viewed over the course of the patient’s life. Sometimes throughout a lifetime career, the professional keeps looking for that light at the end of the tunnel. That light may never show up or it may be that of an eighteen-wheeler coming in the opposite direction. I finished my postsurgical education over 30 years ago; my first exposure to professional arguments was the controversy regarding the repair for the patient with cleft palate. At that time I thought the incisor war based on pursuit of structural form was a product of the time and it would end very soon: it would finish in a year or so and the controversy would be over. Well, it is now 30 years later and the war still goes on. The intensity was so high while the stakes were so low then, and the same continues today. Whenever I go to visit and teach residents or to take part in open discussions, the interaction always ends up with a fuming argument about the timing for repair of the cleft palate. At that time I thought the incisor war based on pursuit of structural form was a product of the time and it would end very soon: it would finish in a year or so and the controversy would be over. Well, it is now 30 years later and the war still goes on. The intensity was so high while the stakes were so low then, and the same continues today. Whenever I go to visit and teach residents or to take part in open discussions, the interaction always ends up with a fuming argument about the timing for repair of the cleft palate. Usually the emphasis on form has been oriented to the size of flaps and the different incisions to initiate the repair, as if these make a difference, or the techniques are major determining factors. The name of the game is that the technical aspects of repair have nothing whatsoever to do with the ability of the patient to speak properly providing that the technique is done in a professional fashion. The scientific portion of the repair is not how it looks at the end but whether the repaired structure functions well. We all know that speech is a learned process and that the ability of the patient to produce balanced, articulate speech is not dependent on surgical technique or whether the house officer is instructed to use a specific technique the first time or the tenth time in repairing a cleft palate, or whether he follows the same steps of the procedure that are labeled under that technique. However the resident’s ability comes into question if a presentation is done about a reparative procedure and the surgeon is questioned by colleagues about the complications, fistula formation, and rhinophonia, which are more prevalent with one technique versus the others. The overused excuse is always that the residents are only interested in cosmetic surgery. For those who did well most of these patients’ outcomes are presented as an advantage of the technique. It is very interesting then that we crippled the child for life if we were unable to do an adequate repair of a birth defect. For the outcome of adequate repair is primarily a functional outcome. If we look closely and scientifically at the recurring argument related to specific techniques and individual experience, we can see that they have become meaningless in the recurrence of postulates on each side. Instead, patients continue to be crippled by the absence of a third critical element that we always neglect in our discussions because we want it to be ignored. That is the timing of surgery. The early timing of surgery is changing slowly on one side of the Atlantic, but the other side is still fighting the incisor war. That is, the patient will do better growth-wise if we delay the surgery long enough to show evidence that growth is not disturbed by age eight, or even into the teen years. But in these patients we must add to the psychosocial effects of late intervention the patients’ inability to communicate with peers and others in their social networks. Those who favor form or structural outcomes delay the repair, and those who are interested in function as in balanced resonance and articulate speech favor early intervention. Evidence accumulated in the last 30 years has a floating point, but the intensity of the arguments continues to be the same as it was 30 years ago. Perhaps there is not going to be any agreement and we the controversy will continue for another 30 years. Your guess is as good as mine.

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