The Virtual Center for VCFS

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VCFS News: Your Information Resource

This issue: An article from Dr. Shprintzen on teams and how they function

- Announcements: Peer Group program will begin in September. Date to be announced
- Free copies of the book, ***MY FRIENDS, THE SUN AND THE MOON*** by Ali Oppenheimer are still available. Contact Raymond.cheng@vcfscenter.org to receive one free of charge.

Article
Team Care: Pluses and Minuses and How to Judge

Robert J. Shprintzen, Ph.D.
Founder, President, and Director
The Virtual Center for Velo-Cardio-Facial Syndrome, Inc.

Many people ask me what I do professionally. I never know how to respond because I do a lot of different things, but if I look back to when I finished my doctoral studies in 1973, the short answer is, I direct. No, I am not the conductor of a symphony orchestra (although secretly I would like to be), but I have 50 years of experience sitting at the head of interdisciplinary programs designed to provide optimal team care to people with craniofacial and other anomalies.

Immediately after I completed my doctoral degree in Syracuse, NY, the country was in a major recession and jobs were not easy to find. I took the only job I was offered as an Assistant Professor at Auburn University. I left my wife and newborn daughter with her parents in New Rochelle, NY, a close Westchester suburb of the Big Apple, for a week after which my in-laws would take them to LaGuardia Airport in Queens for a flight to Columbus, Georgia, a 45-minute drive from Auburn. I managed to squeeze our belongings into a U-Haul and with my faithful dog, Duke, then a 5-year-old German shepherd-golden retriever mix filling the entire back seat, I drove from New Rochelle to Auburn, Alabama to meet the movers in our new home three days later.

We settled into a new house in Auburn where we encountered nice people, friendly neighbors, polite students who always called me “sir,” and an admitted bit of culture shock probably common for two Brooklyn-born natives. After a few months we realized that we were not a good fit for life in rural Alabama (not Alabama’s fault) and I was not a good fit as a university professor. I was more of a clinical science researcher than a teacher. Without another job in sight, on June 1 of 1974, we packed up another U-Haul, I drove my wife and 10-month-old daughter back to Columbus, Georgia’s airport, and started the drive back to New York with Duke.

I was officially an unemployed 27-year-old with no prospects, in a terrible 1974 economy. Luckily, my wonderful in-laws had room for us in their house. Years earlier when I was a teenager, a family friend had gotten me a full-time, nonpaying volunteer summer job as a lab assistant at Montefiore Medical Center in the Bronx. It was scut work, but I was glad to do it to see how a major academic medical center worked. While there, I met many people including some who were friends of my parents and went to the same synagogue that

we did. The friend who arranged my volunteer job, Dr. Morris Rubin, was a general surgeon at Montefiore. The Rubins were very good friends with my parents' and were frequently at our home for social occasions, and over the years after my volunteer job, I saw them at our synagogue. Shortly after we returned to my in-laws in 1974, I saw Dr. Rubin at a social event. He asked me what I was doing since returning to New Rochelle. I said (and I quote), "Nothing."

Fortunately, Dr. Rubin was friendly with the Chairman of Plastic Surgery at Montefiore Medical Center, the late Michael Lewin who was, at the time, looking for a new Director of The Center for Craniofacial Disorders at Montefiore. Dr. Rubin told me of the job opening and introduced me to Dr. Lewin. I asked about the open position and an interview was scheduled. The next day, I had a telephone conversation with Betty Jane McWilliams, Ph.D. who at the time was the Director of the Cleft Palate Clinic at the University of Pittsburgh and also Chairman of the Department of Communication Disorders at the University.

A true giant in the field of speech-language pathology, she and I had become acquainted because she was the Editor of the Cleft Palate Journal, and I had submitted several papers for publication in the journal in 1974. She asked how I was doing, and I told her of my situation and of my interview with Dr. Lewin. In one of the most momentous moments of my life, Betty Jane said, "Oh, I know Michael very well. I'll call him and put in a good word for you." That kindness literally changed my entire path in life. I owe her a lot and continued to tell her so until she passed away several years ago.

Dr. Lewin was an imposing figure, and he was a highly regarded plastic surgeon, serving in the military during World War II as a surgeon where he developed many surgical reconstruction techniques. He then applied them to cleft lip, palate and craniofacial surgery. Although I anticipated him being a commanding and regal figure as chairman of a large department, I found him to be a very kind man who was vitally interested in his faculty's success. The interview was thorough and long. I was introduced to Dr. Eugene Sidoti, a pediatrician who was the current Director of the Center for Craniofacial Disorders The scope of the Center was impressive under his direction and was clinically a superb service. A new director was being recruited because the case load was growing and Dr. Sidoti could not manage it by himself any longer. He would become the Medical Director of the program while nurturing me as the new Director. It was Dr. Lewin's desire to have someone with research experience who would be designated to involve the interdisciplinary team in a productive research program. I received a phone call from Dr. Lewin within a few days and he asked if I would come for a second interview.

When I arrived at his office the next day, Dr. Lewin, who was born, raised and educated in Poland before World War II and had a thick Eastern European accent, but an excellent command of English, said to me, "Bob, you have wonderful credentials and some very interesting ideas of how to grow the Center, but I wish you had a few white hairs in your beard." He had a half-smile on his face as he said that. However, I still understood him to mean that I was young at 27 years of age, and inexperienced.

I replied to him, "Dr. Lewin, I understand your concern, so I will not try to negate them. What I can tell you is that I am impressed with this program, so I do not see my job as overhauling the Center, but rather as enhancing and adding to it, but doing so from the perspective as a scientist. My first job would be to focus on treatment outcomes. I would also, right up front, convince the professionals working within the Center that they are not working for me, but rather that I am working for them. I would want all of them to have an easy path to sound clinical research, the ability to publish and get grants, and therefore the ability for them to be promoted and progress in their careers. Most importantly, I want to learn from them. I see the staff covers more than 25 distinct disciplines. I want to learn about pediatrics, otolaryngology, psychiatry, endocrinology, ophthalmology, etcetera, etcetera, etcetera." When I repeated the etceteras, I did it with a subtle smile and my best imitation of Yul Brynner saying the same thing in the movie version of "The King and I." To my relief, Dr. Lewin smiled

back at my injection of humor. He stared at me for a long while, and finally offered me the job. That was my first job as a titular Director of a team. I loved it because the wonderful staff at Montefiore in 1974 was in tune with my plan and they were all excellent team players. Dr. Sidoti was the major influence on my growth as a clinician. Everything he did was patient centric. He loved children and had a way with them that won them over immediately. In my 25 years at Montefiore, with his help, I learned how to make a Center not just multidisciplinary, not just interdisciplinary, but also transdisciplinary. In other words, it was not enough that the team members cooperate with all the specialists at the Center. But also to learn from them so that the surgeons would learn about speech, and the speech pathologists learn about orthodontics, and the orthodontists learn from the psychologist, etc. It worked like a charm.

Twenty-five years later, an opportunity presented itself to me that I could not refuse. I moved from New York City to Syracuse, New York to direct three different programs at Upstate Medical University: The Communication Disorder Unit, The International Center for Velo-Cardio-Facial Syndrome, and the Center for Genetic Communication Disorders. All three programs thrived but after 16 years, I decided to retire from Upstate Medical University at 66 years of age in 2012 to pursue an idea: The Virtual Center for Velo-Cardio-Facial Syndrome, Inc., the charitable foundation that I now head.

Over the years at Montefiore, the Center for Craniofacial Disorders expanded as the Center began to publish excellent treatment outcomes, and the public relations information followed reporting those results to the public via local and national news, and the publication of more than a hundred peer reviewed papers in the medical and behavioral literature. The annual referral rate of new patients grew from 70 to more than 500. My interpretation was that the increase in staff I had implemented was largely responsible for this increase, so I continued to follow that path allowing the number of specialists on our team to exceed 50 people from more than 20 disciplines from various medical, dental, and behavioral fields. All team members were selected from the large full-time faculty at Montefiore and its medical college, the Albert Einstein College of Medicine. A couple of years later, in his textbook about cleft lip and palate surgery, Ralph Millard, a famous and innovative plastic surgeon from Miami, referred to our Center as a “Super Center.” I thought it was the only way to build a team to get the best results for patients.

Along the way, some of my perceptions of "absolute truths" were shaken, and in the next section, I will discuss how my solid belief that team care is an absolute necessity for complex disorders. I no longer believe that to be true. I also believed that experience is imperative so that big teams with lots of cases always are best. I don't believe that any more either.

Two Lessons Learned

In the 1980s, I received an invitation from a former professor, the late Bill Jones, to consult twice a year at a small cleft palate clinic based in a rehabilitation hospital in New Jersey that saw fewer than 10 new patients each year. The entire staff of this clinic was fewer than 10 people including two plastic surgeons, several speech pathologists, a pediatrician, an orthodontist, and an audiologist. I was given the task of performing nasopharyngoscopic examinations, assessing the possibility of syndromic diagnoses, and acting as the team leader tasked to negotiate treatment plans. I stayed in that role for nearly a decade. I was amazed to learn that this small team was achieving excellent outcomes from this small team of clinicians, none of whom were well-known and none who saw a lot of patients. What they did do was to track outcomes, change protocols when the results obtained were unsatisfactory, and to learn from colleagues, who reported excellent outcomes. Moreover, the surgeons did not take the leadership in the sense that they did not behave as if the non-physicians were subservient to them. My conclusion about teams shifted away from my original thought that "bigger is better" and changed to "honest, thoughtful, and collaborative is best."

A second experience was also illuminating for me. In the late 1980s. I was invited to a craniofacial surgery meeting in Asia as a keynote speaker. Another invited speaker was a good friend, an orthodontist from London who had also worked in a large team there for many years. I gave my opening address to the meeting and then sat down in the audience for a series of papers, the topic being cleft lip and palate surgery. The presenter was a plastic surgeon from a large Asian country that had many areas where cleft surgeons were not available. This surgeon led a team in the capital, a very large city with advanced medical care. He would go to these remote areas and operate on hundreds of people with cleft-related deformities, including cleft lip and palate. His presentation was nothing more than flashing rapidly through hundreds of cases with before-and-after facial photographs, dental models and intraoral pictures of the palate and teeth. I sat there watching, aghast at the truly awful outcomes of the surgical results. My good friend from London was sitting next to me and we stared at each other for a long moment with the same dumbfounded looks on our faces. The presenter then completed his presentation by stating that the outcomes he obtained were only possible because of his many years of experience and the thousands of cases he had treated. When he left the podium, I asked my friend, "have you ever seen such terrible outcomes?"

"Never," he said.

I followed up with, "I guess practice doesn't make perfect…or even simply OK!"

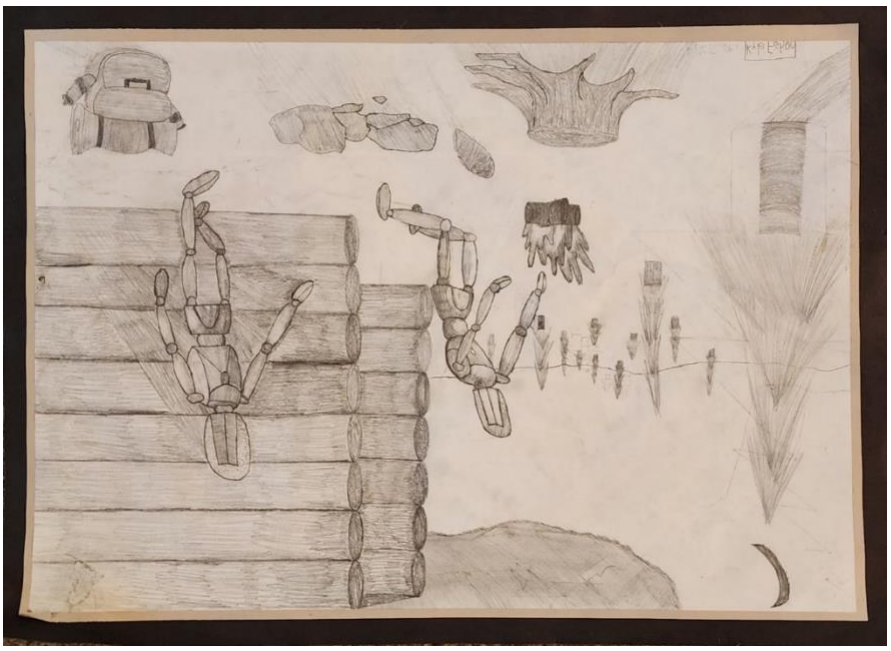
These two events convinced me that teams are not always a necessity and also that practitioners who are not on a team don't yield poor results.

What Else Have I Learned

What I also learned can be summed up into one short phrase. “It isn’t the team; it isn’t the institution; it is the people.” Teams, after all, are made of people. Institutions are run by people. I cannot think of a single institution I have ever visited anywhere in the world that had excellence in every single department or program. It is unusual to find a team where every person on the team is a true expert or very successful practitioner. Another phenomenon on teams is the assumption that if the director or leader of the team is very famous and a great practitioner that the team will be a great team. I am an avid baseball fan and have been following the New York Yankees since the era of Joe DiMaggio, Phil Rizzuto, Mickey Mantle and Yogi Berra. In the 1950s, the Yankees were almost unbeatable, and they had superstars like Mantle and DiMaggio, and good teammates like Berra and Rizzuto, on a team that meshed behind a great manager, Casey Stengel. The Yankees won the World Series 6 out of 10 seasons. In the 1980s, the reputable Yankees did not win a single world series, and only made it into the series once. Although they had some great players including Don Mattingly, Dave Winfield, Willie Randolph, Ron Guidry, and Rickey Henderson, the Yankees stunk as a team! Nonetheless, they were still a team.

ALL TEAMS ARE NOT CREATED EQUAL

Decades ago, the field of cleft palate and craniofacial disorders was one of the fields of medicine that actively pushed the notion that team medicine was absolutely essential to successful management of the problems associated with craniofacial anomalies. This runs contrary to my own experience from learning that no two teams are the same. In the worst-case scenario, teams are only as good as their weakest link. In the best-case scenario, teams are greater than the sum of their parts. Here are some basic findings from my observations of more than 100 Centers from the U.S. and more than 30 countries in Europe, Asia, Africa, South America and Australia. The first thing is that it is important to have a system that regulates how team members do their jobs and how they reach conclusions. And how they make their conclusions known, meaning is what they say in front of patients consistent with what their colleagues are saying. In other words, a team decision. No one should be treated as an underling, no one should be belittled in any way, and no sign of disagreement should be demonstrated in front of patients. Politeness and civility must be obvious at all times. If students, residents or Fellows are present, teach but do not preach. After all examinations are completed, all team members should stay to discuss the treatment plan. No one’s recommendations should be derided or be discussed with contempt. All recommended treatments should be of unanimous choice among the team members. I admit that this is a very high bar to reach, but my experience over a half century tells me that it is possible.



Models for Team Members

These are the different types of teams I have encountered over 50 years:

Clinics: Clinics are scheduled sessions that occur periodically depending on the demand for complex cases to be seen by multiple specialists. All necessary specialists are asked to be in a specific place at a specific time to do a quick examination of a patient and decisions for patient management are usually made on the spot before moving on to the next case. If more information is needed to reach a decision, the necessary tests or records for review are ordered and the

patient is scheduled for another visit to the clinic. I dislike this type of approach. There is too little information about the patient reviewed in too short a time. Information is typically truncated and incomplete because of time constraints. Also, clinics in hospitals are often attended by students and residents thereby teaching them how to reach a conclusion quickly rather than correctly. My experience is that "clinics" proceed no matter if everyone who should be there is there or not.

Multidisciplinary model: Multidisciplinary teams usually meet periodically and have clinicians from different disciplines examine a patient independently and render a judgment which is then given to the director of the clinic/center to decide what should be done. Face-to-face discussion does not usually occur, and follow-up of the case is left to the individual team member who is following the patient. I am also not in favor of this type of program because the care is fragmented with nothing there to hold things together. Sort of rather than .

Interdisciplinary model: Like multidisciplinary programs, interdisciplinary models have a variety of clinicians from different disciplines and perhaps even several clinicians from the same discipline who all examine a patient within the same session and location and at the end of the session, findings are discussed with all the clinicians present. It is typical to have a single report from the team, usually put together by whoever is leading the team. Many larger teams are constructed this way and it can be an efficient model if all the team members are knowledgeable about the disorder that has prompted the establishment of the team. However, there can be some aspects that can flaw interdisciplinary teams that will be discussed in more detail later in the article. Another aspect of interdisciplinary teams in academic medical centers is the possibility using the team meetings as an opportunity to teach students about the patients being seen and what to do about the type of problems seen by the team. This is a very valuable component of the interdisciplinary model assuming that the recommendations are discussed by the team members in an open forum so that the decision-making process of interaction between disciplines is open and even the students can participate.

Transdisciplinary model: The make-up of the transdisciplinary model is essentially the same as the interdisciplinary model. The format is the same in terms of having all disciplines present at the same time with all records available to review. In the transdisciplinary model, it is important to have each discipline present their observations and evaluations and offer possible treatment options that are open to discussion by everyone present. This provides an opportunity for each discipline to evaluate the way other disciplines are thinking about the problem so that the discussion becomes an educational process. This is also exceptionally valuable to students, residents and interns, and others in training by focusing on the big picture rather than just that discipline's, "slice of the pie." It is the job of the director of the program to meld these discussions together in what would be a final plan that would be presented on the spot to everyone present at the meeting to make sure that there is unanimous agreement for the entire plan. The plan should include every aspect of treatment and future diagnostics in an ordered timeline. After the meeting is concluded, the director generates a report that includes the thoughts of each discipline with the final section detailing the recommendations of the team with unanimous agreement of every team member in attendance. Therefore, the transdisciplinary team provides both the best options relative to long term care while at the same time providing each team member with new information from other disciplines that could become valuable to them in managing these cases as a unit rather than as 20 people.

Possible Obstacles and Flaws

Of course, no system of any type is perfect. Complicated plans of operation are always prone to issues that could make meetings unsuccessful or provide information that is in error. Some of these flaws are operational and cannot be avoided, such as absence from a meeting related to an emergency or illness, that would prevent key members of the team from opining on the case. It is always a good practice to remind people ahead of time of their obligation to show up at all meetings. If some people have vacations or travel that interfere with the meeting and it would impair the outcome if there were not redundancy in the experts coming to the meeting,

then it is often a good idea to postpone the meeting to another date. In other words, the pool of knowledge necessary to make correct decisions should always be present.

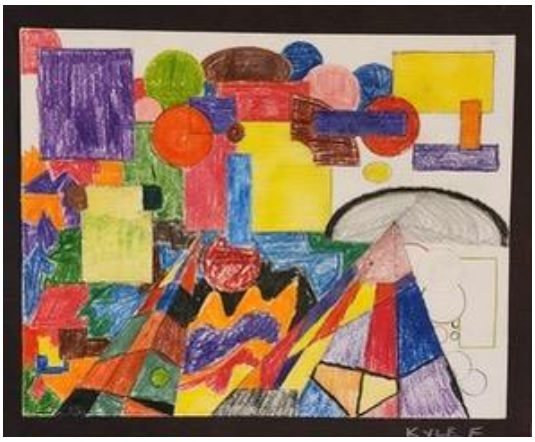
The more difficult problems relate to personalities and methods of solving problems. Personalities are most often a problem if one or more people function as if they know everything so that the other members of the team are simply window dressing. Even if data is presented to such individuals that demonstrates certain decisions to be erroneous, they will often stick to a particular decision for any number of reasons. This type of issue can be identified by reviewing outcomes from treatments recommended by the team. This is why retrospective review of outcomes becomes essential in keeping teams sharp and not repeating the same mistakes repeatedly. This is more common a problem than most people might think. Because science rarely ever stands still, the opportunity for avoiding newer, more efficient options increases overtime. Having someone on the team who checks up with previously treated patients to review efficacy of decisions made is exceptionally important. While dominant personalities can cause problems with the smooth functioning of an interdisciplinary or transdisciplinary team, they may also benefit the team in terms of recognition of their work by other professionals and the public. This is a good reason for making sure that the team members are polite and civil to each other and that they create a friendly bond, if possible.

What can you do?

There is a simple answer to this question. Be a good consumer of health care. Ask questions! Do not be intimidated by people who have the word “doctor” in front of their last name. It is not inappropriate to ask about outcomes of treatments from the team. If you went to buy a new car, you would ask a lot of questions: Are the seats leather? What gas mileage does it get? Does it have satellite radio? Do the same for health care. If answers are vague, ask for numbers. How many cases have successful outcomes? How many have complications? What are the side-effects of the medication? Another option is to do some research of your own. Ask for specific details of the operation, medication, or therapy that is being recommended and go to the Internet. On the Internet, do not look for sponsored information or information from specific individuals. Go to the medical literature. Another place to look are postings about specific diseases by reputable hospitals like the Mayo Clinic, the Cleveland Clinic, Johns Hopkins among others. Of course, registrants to The Virtual Center for Velo-Cardio-Facial Syndrome can get information at any time, any day for free by telephone, email, or video conference. You can also have access to the medical literature by going to PubMed, Medline, or the National Institutes of Health (NIH). Not all information online is perfectly accurate, but it will allow you to ask appropriate questions and get specific answers. Also, make sure you can contact the leader/director of the team treating you or your child and ask them if you can contact them at any time to get answers to your questions. There are not many things that are more important than information, especially when it relates to health and well-being.

The beautiful artwork you see adorning the article were donated to the Virtual Center by Kyle Fisher of Stanfordville, NY in the Hudson Valley region of New York State. The titles of each piece are shown on the next page.

Artwork by Kyle Fisher:



“Everlasting Bliss”
Kyle associates this painting with energy and happiness 😊

“Morning Dove”
Kyle associates this painting with happiness.

“Hiking the Appalachian Trail”
Kyle’s inspiration for this picture is a sense of adventure.

The Virtual Center for VCFS