Public Relations and Contemporary Treatment Concepts

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As I look around our orthodontic societies, I realize that my contemporaries, or men even younger, are now the main torch bearers and that the future of orthodontics will be decided by what we prescribe and practice today. Many new leaders must emerge from among us.

The tempo is fast today, and all of society is accelerated. Our methods of communication have quickened. Scientific knowledge of orthodontics and techniques have been developed remarkably. The demands for our services have never been greater, but our generation is faced with problems never before experienced. Our greatest current problem is public relations.

Now, what is meant by public relations for orthodontists? First it includes relations with the lay public. However, our relationships with the rest of dentistry and other disciplines may be more important. Perhaps a more appropriate label would be "public and professional relations." The whole subject of public relations was developed by commercial firms for better business practices. Human relations is basic to public relations. We tend to forget that, as specialists, we rely on dentists for referrals. This makes the general dentist truly our customer.

Some quotes on public relations which appeared in an edition of the *Los Angeles Times* might be useful. Public relations is "a function of an organization expressed in practices, which serves the public (dentists') interest, and communicated to the public (dentist) to secure its (his) understanding and goodwill"; or another, "to evaluate public (dentists') attitudes, identify procedures with the public (dentists') interest, and execute programs of action to earn understanding and acceptance (by the dentist)".

Professional relations are now at the lowest I've seen in my career. One eminent general dentist told me, "Communication between orthodontist and dentist is at the lowest possible level." I feel compelled to express some ideas and observations. It's time to bring certain problems to attention, some of which you may not know or may not like to hear.

Why the problem? First, let's put ourselves in the position of the general dentist in order to understand what's happened. Until recently, most—but not all—general dentists were loath to look at occlusion. We still are told by patients, referred by their friends, that their dentists never looked at their bite or mentioned orthodontic attention. The average dental practice was characterized by partial dentures or fixed bridges. Dentists tended to look at teeth only with the mouth open, seeking caries. Interest in occlusion was limited to the use of marking paper for high spots at the time of carving restorations. Ultimately many dental practices developed a higher frequency of full upper and lower artificial replacements. Dentures seemed to be the love of the older fellows in dentistry because their practices mature also. Occlusion finally became a problem, but then only for the purpose of stability of artificial teeth. Dentists have tended to transpose that stabilized artificial denture concept to the natural teeth when the subject of occlusion has

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come up. During a lecture in 1964, I canvassed the senior students at a leading dental school and about one half were graduating with the idea that the "balance" prosthetic occlusion was ideal for the natural teeth. In fact, some orthodontists accept this idea.

Meanwhile, the orthodontists in the first half of the twentieth century prided themselves as the masters of occlusion. The emphasis was on a full complement of teeth in normal occlusion, and the master of all was Angle, after whom this society is named.

But in the past two decades the tenor of the usual dental practice has changed. Many general dentists have become more sophisticated. They have become more interested in occlusion. High-speed cutting instruments, routine anesthesia, and improved impression techniques have extended efficiency and possibilities. The articulator has been perfected for the purpose of mouth rehabilitation with fixed precision. Developments in periodontics and endodontics have changed the dentist's attitude to one of preserving the teeth in harmonious function. He has become interested in the dynamics of functional occlusion as a preventive of oral disease and a promotion of dental longevity.

It is rather ironic that his shift toward occlusal concepts occurred when the emphasis on occlusion shifted away from the mainstream of orthodontic practice. Interest during this past two decades in orthodontics became centered on esthetics. The objectives for a straight profile and putting anterior teeth "over the ridge" or upright over the bone overshadowed occlusal perfection. Research in the thirties had suggested the limitation of orthodontics to alveolar bone, so early treatment became unpopular. In addition, for the sake of expedience, a trend developed to wait until the orthodontist could "get in and get out in the shortest time." The extraction of teeth was often deemed necessary as a compromise for stability and esthetics. But, the general dentist has never become "sold" on this idea or need and those orthodontists who have championed this cause have not convinced the general dentists on its merits. Also, the general dentist has observed the young graduate in orthodontics, in only a few short years, overrun with patients and enjoying an abundant financial success. He was naturally envious. The young orthodontist, blown up with success far in excess of his skill and education, often assumed a superior attitude. This was resented and the result was a chasm between the specialty and general dentistry. The dentist began to snipe with some justification.

Another confusing factor to the dentist and the public was also present. When I was an assistant staff member in the late forties, our orthodontic department's policy was to tell patients not to return until all teeth had erupted. Public pressure for orthodontics was a factor in postponement to the permanent dentition level. But also, orthodontists became more interested in creating alignment to suit their subjective preferences rather than perfecting normal functional occlusion to suit the individual need. Those with a strong background in biology trusted the finishing of a case to "settling" or to nondescript nebulous forces. Finishing by the mechanically-disciplined was left to the positioner. The best orthodontist was often considered the man who could do it quickest or get the teeth back the farthest.

Cephalometrics played its part in tempting the orthodontist to treat to a pragmatic standard rather than to the biological needs or demands of occlusion on an individual basis. Many orthodontists in both camps came to rely too heavily on nature either to close

up extraction spaces or for the patient to grow out of created protrusions.

The general dentist, looking at orthodontics, had reason to be confused or skeptical because he could see the wide division in practices. He began to doubt the profoundness of the profession as a whole.

Now, I'm proud to be an orthodontist. I'm proud of this society and I'm proud of the reputation that its members enjoy the world over as leaders, scholars and clinicians. Orthodontics has given me the opportunity to help my fellow man and an opportunity for a full life. It is my first love, outside of my family. Orthodontics is creative, and it pays well in financial rewards and even greater in personal satisfaction; it has been more than worth the price I paid to learn even though that price was exorbitantly high.

This is why I have defended orthodontists without exception every time our profession has been criticized—often even against my own personal welfare.

As an organized force of the specialty and as an intellectual body, we have a task before us. As a body, this organization has not recognized the challenge. Too many members have sat with complacency and smug satisfaction, taking the fruits of orthodontics without "plowing back" anything. One orthodontist stated, "I don't know of a more cocky, pompous, dogmatic, egocentric and self-satisfied group in orthodontics." Another excellent clinician, in describing the reputation of his local group, remarked, "I don't know of a bigger bunch of snobs than the Angle Society. They are supposed to be the leaders of orthodontics and all they have done in recent years is to play politics. They have done more to promote bad professional relations than any other group. They not only look down on dentists, but on the rest of us orthodontists."

Whether I've liked it or not, I have become a spokesman for orthodontics and protectorate for orthodontists among many disciplines in dentistry as well as medicine. I have represented orthodontics on panels before the largest bodies of practicing dentists in the country. It is not uncommon to hear it said that the orthodontist doesn't know anything about occlusion. The dentists' ideas concerning occlusion relate to a static terminal hinge axis registration and prematurity of contacts. Our approach is on a *longitudinal* basis.

We need strong spokesmen and we must enjoin as many enlightened orthodontists as possible to speak out. This is a bigger job than one local society can accomplish. It is true that many men have established excellent relations, but most have not done nearly as good a job as they may think.

Maybe you think *you* don't have problems, but I'm speaking for the orthodontic profession as a whole when I say that we do have problems. I never realized how poorly orthodontics was considered by some dentists until the summer of 1965, when I was one of the lecturers at the Berkshire Conference in Massachusetts.

In that particular group were some two hundred periodontists and general dentists from all over the country. The orthodontists and the whole field of orthodontics were fair game. Each essayist before me knowingly or unwittingly took broadside shots at the orthodontist. The situation was so extensive that individuals and personalities were involved beyond practical problems. I was deeply concerned at many of the things confided to me by some of the clinicians and participants. It appeared that the climate had grown from envy, jealousy, malice and ridicule to hate—mostly because orthodontics and dentistry had failed to communicate. A recent periodontal meeting was

attended by about eighty people. The subject for three days was adult orthodontics and not a single orthodontist was on the program.

I have learned that the most important factor in communication is to listen. Let's listen to the voices heard. Please try not to become irate or defensive, but seek an empathy with their position.

A New England periodontist after the Berkshire Conference stated, "You are the first orthodontist I have ever heard of who knows anything about the subject of occlusion and is willing to talk about it. The orthodontists in my area won't even talk to me about occlusion."

This is the image of the orthodontist from a dentist in the Northwest: "He is high-priced, secretive, and possesses an untouchable attitude. He won't listen to anyone outside his field and he has departed from dentistry. He doesn't care a hang for occlusion—all he thinks or talks is esthetics. He cares even less about periodontal disease. He keeps himself aloof and above practical problems in dentistry. He is hardly ever seen at regular dental meetings. I just can't talk to orthodontists."

A New Orleans dentist's opinion is: "You orthodontists sit in a terrific spot. We find the patient, motivate him, tie him with a ribbon and hand him to you on a platter. If *you* do a good job, you're great. If you do a *bad* job, *I'm* the man who sent the patient to you, and I'm responsible. I have to verify your results as correct. When I get the patient back, I almost always must equilibrate his occlusion. Don't forget the patient is my charge for the rest of his life." But a little later this same dentist asked, "If the occlusion was right, why do you need retainers"? This further stresses the need for communication by his orthodontic colleagues to him on the forces of occlusion. The general dentist thinks of bone and muscle as static and fixed structures.

Another mature West Coast dentist remarked: "I'm very reluctant to send any child to certain orthodontists and, if I do, I could just as well remove four first bicuspids before I send him, because they always come out for some reason anyway. Then, when I get the patient back, the occlusion is terrible and I must apologize to the parent, spot-grind or treat periodontal problems caused by the treatment in the first place." I later approached the orthodontist about whom the dentist was referring and he stated he had excellent relations with the dentists in his area, which proves he worked under an illusion.

From a California pedodontist: "I pleaded with orthodontists in my area to do something for the seven-year-olds with protrusions. The parents were told that nothing could be done until all the teeth had erupted. The child would encounter an accident and the mother would come to me in tears. When the front teeth are fractured because they 'stuck out,' the orthodontist doesn't have to treat them—I do! So, I started doing the orthodontics myself. I've found that I can do it at that age. Tell me, why couldn't the orthodontist do it"?

I put this predicament directly to an orthodontist in that area who held the viewpoint that waiting for the permanent teeth was necessary, and he said, "It's all right to let the pedodontists fiddle with the kids. I'll get them to treat later, anyway, and I can't clutter up my office with a lot of problems for five or six years when I can wait and do it in two years."

Three out of four of my patients present for consultation before all the permanent teeth have erupted and have always done so. I will ask you all a question: Who is best prepared to diag-

nose and treat the deciduous and mixed dentition, the pedodontist or the orthodontist? One thing appears increasingly evident today—it's going to be treated by someone. Is it going to be a bite plate, a promiscuous headgear, a removable appliance, or the best sophisticated total approach? Is it any wonder that the pedodontist is moving into the field of orthodontics as rapidly as he can when orthodontists have traditionally, as a group, turned their backs on deciduous or mixed problems. They have taken over the diagnosis. I have been impressed with some courses in "Preventative Orthodontics," and perhaps we should embrace them.

I gave a talk to an entire dental audience at a dental school which I had entitled *Objectives of Orthodontics in Light of Present Possibilities.* As an introduction, one dentist facetiously renamed my lecture *Objections to Orthodontics in Light of Periodontal Destruction.*

All this is not just happening, it has occurred. One Ohio orthodontist exclaimed, "You know, community fluoridation has really made a difference in my practice and all the general dentists say the same thing." Some years ago another Ohio dentist remarked, "I'm getting into orthodontics before it is too late. I think it is a good racket and they are going to eventually wipe out caries and all we'll have left is orthodontics." He is now an orthodontist, but his motivation is interesting. There is fear among some dentists that they may have nothing to do in the future. General dentists all over the country have started doing orthodontics with no training whatsoever. All this while competent orthodontists are being maligned and doing nothing about it.

An educator once assailed me when I expressed the notion that the general dentist should stay away from orthodontics. He likened orthodontics to periodontics, endodontics and prosthetics, and said, "Well, if the orthodontists can make mistakes, why shouldn't the dentist be permitted the same opportunity to learn on the public"? My answer, of course, was a standard one: "If the orthodontist, even with his special training, gets into trouble, just what do you think the man with no training will do"?

A well-disciplined Los Angeles dentist called on the phone one day seeking a different orthodontist. In his own words: "I want someone else because I'm tired of my patients coming back with their mouths looking as puckered-up as the hind end of an old hen." The orthodontist to whom he referred proudly claims to extract in about seventy-five percent of his patients.

Other broadside accusations and remarks are standard and historical.

1. Orthodontics, with fixed appliances, causes root resorption and destroys supporting bone.
2. Orthodontic appliances produce damage to the attachment apparatus.
3. Bands and arches are unsightly and dirty.
4. Children complain of too much pain.
5. Orthodontics causes caries.
6. Orthodontics creates traumatic occlusion and causes temporomandibular joint disease.

These represent the voices and the accusations mentioned frequently about orthodontists and orthodontic treatment. Is it any wonder that the uninformed dentist looks for a cheaper, easier way, free of bands or archwires, and looks desperately with hope at even a promise of a better method? Is it any wonder that removable appliances attract general practitioners in dentistry? Is it any wonder that dentists find courage to go ahead with radical

expansion for years when a Milwaukee dentist insists that they do so because they know more about it than orthodontists?

Profile of the Orthodontist

The following is abstracted from a study conducted for the A.A.O. by James R. Hanson & Associates. I will also mention the result of my personal inquiry in human relations from reading and courses. The purpose of the study was to describe the orthodontist's image, identify the problem and offer solutions. The study by Hanson was broad coverage rather than specific. It suggested that flexible, long-range programs were indicated. It showed that the *minority* fault must be considered —not just the majority. Fifty-two orthodontists were studied. Published orthodontic literature and educational films were analyzed. Discussions from twenty periodicals concerning what was said about orthodontists were investigated. Close-range observations were made of orthodontists at a national meeting.

According to Hanson, "Against the backdrop of the extremes of those who are born with affluence and those who depend on the welfare state for security, the firm finds most orthodontists in the middle where they must work and compete for security. The orthodontist's specializing places him almost in a sellers market and he arrives at financial independence early.

"By the time he starts practice, he is scientifically bent and his long years of training help him to retain the image of a student. His job of updating ideas is commendable, but he has done a *poor* job of getting due credit for his research. These three personal qualities of science, continued pursuit of knowledge, and built-in need for personal security limit him as a business manager."

Nathan Bailey, Dean of the American University of Business Administration in Washington, D.C., believes the orthodontist, like other technicians such as engineers, has the highest degree of technical skill which equips him to do things himself; but he knows little of human relations or how to work through other people. The running of an office requires wearing two hats: the first is the manager and the second is the operating executive. This means a total conceptual skill, not just technical competence. It requires a ruthless self-discipline because the total job is not glamorous and most are not interested in it, but want only to be left alone with what does interest him—straightening teeth, at the chair.

Thus, three skills are needed for the contemporary dentist and orthodontist, only one of which we learn in school. The first is technical, the second conceptive, and the third, human relations. Technical work should be no problem with training. The conceptual skills of coordinating auxiliary personnel and planning can also be appraised with cold logic and planning. The third area—human relations, actually is psychological. The manual skills and artistic imagination that made the orthodontist previously successful now provide him with no tools or natural inclinations in human relations. This frequently results in exasperating experiences. Human relations, in the end, is the most difficult part. The same cold, calculated input that works in technique does not always produce the same result when dealing with human relations.

Going back to the profile study . . . "the orthodontist as a whole, and the dentist as well, seems to lack the genuine good-will effort. His business skills are weak. He is not seen regularly at dental meetings. The young orthodontist feels he is a cut above the general practitioner or above his own customer." Please keep in mind that I

am quoting studies and I warned that you may not like it.

"The default of good-will is the most serious relation problem. There is reluctance on the part of many general dentists to refer patients and voices from these ranks assail orthodontists as a "closed shop" and a barrier to dental education. The orthodontist may fail to acknowledge referrals, make no effort to inform dentists on progress, and claim no credit for return."

Orthodontics and the whole profession of dentistry is in a world of change. There is a question whether the entire professional rank and file is yet aware of this change. In dentistry, twenty-three per cent insist they are not working to desired capacity; about forty per cent of American dentists claim to have more than they can handle.

Dental care for the masses is upon us by government, union and other group insurance plans. The clamor is heard for more prevention and less care. The demands will swell from one million orthodontic patients yearly to manyfold figures if all seek care who need it. The question is, will the general practitioner in dentistry assume orthodontic treatment to fill his appointment book?

The study thus expressed three main needs: (1) the orthodontist should stand right in the eyes of the public and dentists, (2) he must devote *more time* to being understood or to defend his position, and (3) these forces demand stronger leadership.

The members of the orthodontic societies are disunited within their ranks. Splinter groups in dentistry are emerging into a federation under the name of orthodontics and are supported strongly by the A.D.A.

Professionals in the field of human relations looking from the outside into the specialty of orthodontics wonder if the orthodontists are not too tightly corseted to their code of ethics. If better ambassadors are to emerge, more liberal interpretations of the code must be available to free him as a spokesman and to spare him the jealousy or condemnation on the part of his fellows. There is a big problem in evaluation of problems from the "bottom up" or "top down." Orthodontists evaluate from the "top down," or from perfection. Dentists' views are characteristically from the bottom up, or anything that will work reasonably in good function.

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