Public Relations and Contemporary Treatment Concepts, Part II

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The paper in the previous issue[1] constitutes the problem looking from without. Let's look at the problem from within. As I look back now on orthodontics twenty years ago, I realize how much has changed. In fact, historians might label mid-century 1900 as the time in orthodontic evolution of "The Era of the Doctrine of Limitations." Within this general era I can cite two dozen axioms or tenets purported to be basic truths on which decisions in treatment planning rested. These ideas, all developed or conceived in good faith, are:

1. The growth pattern is established by the first year and thereafter is stable.
2. The rest position is constant and unchangeable.
3. Orthodontics is limited to alveolar bone.
4. The maxilla is fixed and cannot be altered.
5. The growth of the mandible is not influenced by teeth.
6. The molars cannot be moved distally.
7. The first molar always moves forward to take up the leeway of the second deciduous molars.
8. The intercanine width cannot be permanently increased.
9. Teeth cannot be intruded so overbite must be corrected by extrusion of posterior teeth.
10. Even if teeth are intruded, they will always return.
11. The apices of teeth will be damaged if moved.
12. Tooth apices will return if "displaced."
13. The lower incisors must be over basal bone to be stable and should never be moved forward.
14. Retracted anteriors will return if bicuspids are extracted in double protrusions due to tongue activity.
15. Principal anchorage comes from the pull of the periodontal membrane.
16. Toe-hold positions provide the best anchorage.
17. Movement of deciduous teeth has no effect on the permanent teeth.
18. Teeth do not influence the esthetics of the lips.
19. Nothing should be done until the permanent teeth are erupted because retreatment will be needed.
20. Malocclusion is only a genetic problem due to skeletal makeup.
21. It is impossible to obtain a decent occlusion with extraction.
22. There is always a relapse of overbite in extraction cases.
23. The growth of the face is so complicated, it is unpredictable.
24. It really doesn't make any difference what appliance is used.

Today, in my view, not a single one of these limitations is acceptable. I like to think of contemporary orthodontics with exciting possibilities. Perhaps the philosophies emerging now will be recorded by historians as "The Era of Freedom in Orthodontics."

The problem from within is, therefore, one of insufficient profound knowledge for common agreement. Many have closed the book to any idea slanted in a different direction other than that to which they are accustomed. We still have within our own ranks those who are unwilling to accept extraction at all and use almost inconceivable measures to treat to the full

complement of teeth. They condemn bicuspid extraction, but can hardly wait to make a referral for the surgeon to get his forceps on the third molars. On the other hand, we have within our ranks those who virtually have a library of excuses to extract, routinely, the four first bicuspids and we now actually see advertisements for reverse headgears to help close spaces where extractions needlessly were made. Nature and the public must surely be kind to permit all these philosophies to flourish.

I can't forget the conversation that a Boston orthodontist related to me. He was getting on an elevator and, by chance, met the father of an old patient. The greeting opened with the father saying, "I should hate you!" and, after recovering from the shock, the orthodontist questioned why. The answer was, "Because you ruined my son's face. He looks edentulous now that he is grown. His teeth are straight, but his mouth and smile are horrible." This same orthodontist admitted that he had been a victim of an inconceivably amateurish diagnosis of extraction need on the basis of any slight crowding in the lower arch and he was quite regretful. That experience is very poor for public relations, as well as its opposite, the expression heard so often, "I guess I didn't wear my retainer long enough because my teeth went back."

Public Relations and Solutions

Now, what can *we do* about this situation from a public relations standpoint? Several comments can be made, but are only exploratory:

1. It is high time committees in organized orthodontics are assigned and the best brains employed. We should bring the professionals into the field, hire them and do it properly. I'm happy to say this is underway in some societies, the Southwestern Society having taken a lead.

2. Let's recognize and study the multiple problems. Education, communication and human relations are mainly involved. It is human nature to be envious or jealous of someone more successful, based on the feeling of "what's he got that I don't have?" The result is the tendency to attempt to tear him down.

Eventually malice and hate result, and people suspect anyone who is successful. The United States is facing this problem with its world image simply because we live more comfortably and enjoy more, economically, so we are feared and resented. Special courses should be given in human relations and psychology *sponsored* by our organizations. Maybe the Angle Society should assume leadership here.

3. Let's get at the truth, be understanding. Find out what's happening yourself rather than spending time broiling in pessimism. Does a removable monobloc type or screen really work? The answer is yes, it does. It doesn't do everything, no, but what can't it do? General practitioners on a world front are using these appliances. They are taught in the schools of many countries. Does a removable crib work? Yes, it does. What is its application? Its limitation? Several courses are given each year to general practitioners in the use of removable cribs as old as Jackson and some outstanding results are attained. I use it myself in select cases. Where are the voices that have found this appliance limited? Where are the truthful answers?

4. Answer the problems with action, and launch a campaign to educate the orthodontist and the dentist, particularly the men in rehabilitation and periodontics who are the most outspoken critics. Exchange knowledge and find his complaints. Come to grips with problems in your own area. Be forceful and stand up for orthodontics. Fight

back and go on the offense. Explain why there is disagreement on patients.

5. Educate the public.' Dr. James Mulick in Woodland Hills, California, is doing an admirable job here. Join speakers bureaus and talk to lay groups. How many have made efforts here? Have the correct answers. Tell people the truth. Don't wait to be asked, make the opportunities.

6. Accept our responsibility for the malocclusion *even at the deciduous level.* We are dentists first, with the privilege of being in the specialty of orthodontics. We have the responsibility of all orthodontic problems, be they small children or adults. This includes newborn cleft palate cases and those on their terminal days with the natural teeth and perhaps even edentulous.

7. Educate the educators. Being in institutions, they are in the best position for the exchange of information, but I don't know of many institutions where deciduous and mixed dentition treatment is taught, except in pedodontic departments.

8. Learn how to finish and detail and stick to the highest objectives. Don't be afraid or ashamed to retreat cases. Let's come to some agreement as to what constitutes completed cases.

9. Don't be afraid to ask for consultation with the family dentist or with another orthodontist. Explain why a patient is taking longer to treat than usual.

10. Sell *dentistry* as a whole and let the dentist know you are building him up.

11. Finally, many of these accusations do have a basis in truth and we should try to make corrections clinically.

12. Adapt techniques and practices which are up to date and have proven fruitful.

The above discussion will serve as a lead for a description of some of the changes we have made in our approach to treatment over the last fifteen years. Why? Because these recognized problems and accusations are the motivating factors. Revisions in diagnosis, technique, and mechanics have been made in the interest of better, more efficient treatment and healthier mouths with more routinely superior results, with teeth out only when it is necessary.

In the light of these accusations, let us discuss clinical changes.

1. It is said that orthodontics damages roots and alveolar bone. Most of this problem revolves around force application. We have investigated clinically the works of Reitan and Storey and can find no exception to their findings. Much has been repeated and their conclusions have been corroborated.

We have measured forces clinically, photographed results, and carefully analyzed treatment on a time basis from cephalometric head plates, laminagraphic sections, as well as intraoral radiography. These findings have led to many changes in technique. Forces now used are in the range of one-tenth of those formerly employed.

In order to prevent necrosis of bone and needless damage, we have adopted archwire dimensions and temper for systems of impulse in keeping with the most ideal ranges of force from these scientific studies. These have progressively reduced dimensions down to .016 x .016 wire; loops have been incorporated with designs on square wire to maintain control. We call our present technique the *Light Square Progressive* technique, or simply the *Progressive* technique. I agree with certain of the principals of force in the Begg technique, but I do not concur with the application and objectives of that philosophy. There is no question that lighter continuous forces are superior to heavy intermittent force if interrupted.

2. Orthodontics is reported to produce damage to the attachment apparatus. Most of the objections here relate to gingival problems. We have helped design smaller, thinner, stronger and more adaptable chrome alloy bands with less overhang of margins than conventional gold bands. These designs now characterize the majority produced by the manufacturers and new improvements will continue. Tapping or driving of contoured and festooned bands is routine. The band is adapted to the embrasure and cervical margin in this manner to provide less tissue contact at the gingival margins.

3. Bands and arches are unsightly and do collect debris. The smaller band placed higher on the tooth is less obtrusive. There is no way to stop debris collection, it must be removed; concentrate on home hygiene by using stain technique and water pik.

4. Children complain of pain. Very little painful separation is done, contacts may be sometimes stripped with automatic strippers. We don't band all the teeth at one time, progressively band and progressively strip. We stay away from upper anteriors until we're sure we have a place to go. Pain is the exception rather than the rule and is of very short duration. Teeth are *not moved* one direction and then back again. Continuous translatory movements are less painful. Torque brackets make anterior alignment automatic. Many movements are automatic with the appliance design. Light forces do not rupture the membrane; no tie backs are used. The brackets are .018 and maximum size treatment wire is soft .016 x .016. The patient is not overpowered. The larger strong appliances force teeth to positions desired by the operator, while lighter wires permit more adaptation of the arches to individual tissues.

5. Orthodontics is said to cause caries. Steel bands hold better with cementation than gold. We use an affluence of cement, quick set with vibrator and measured parcels to insure a good seal. Bands are fitted below the curve of the marginal ridge to prevent overhang with caries at the marginal ridge and are tested at each appointment for looseness. Ionic fluoridation is employed in every single case at the start and during treatment if caries are noted.

6. Orthodontics is accused of producing occlusal trauma and TMJ problems. This is a big one and includes broadest treatment implications. We finish cases properly so nature is given a chance to settle properly and we avoid throwing bicuspids at each other with elastics as some techniques prescribe. We watch the effect of prolonged heavy Class III elastics in the joint, and mesial shifts during treatment.

7. Treatment for orthopedic changes is done early and we finish with cuspid lifts or cuspid protected occlusion. Up to sixteen normal contacts should be present in the buccal occlusion on each side, and never less than nine or eleven in extraction cases. Occlusogram studies should be routine. About ten to fifteen per cent of cases need minor spotting of the buccal occlusion after settling.

Office Changes

Many steps have been incorporated in our office routines which have helped to elevate the "image" and many more will be made after study. We are already in the process of changing contract and form letters and some office policies after reading some of these collected by the Southwest group.

Several policies we have adopted have met with marked public approval and perhaps we should pass them on. They include several which will be categorized.

The Office Layout

We place our tooth brush or hygiene center in a conspicuous area of the office where attention is always focused on personal mouth care. This promotes all of dentistry and builds respect for the patients' home care. Our stain routine and stressed supervision keep the mouth clean and gingiva in good tone. Mouth care comes first. Brushes are kept in the office and personal pride is promoted as the basic element in continual mouth health. We so inform our referring dentists and so inform the parents.

Caries Prevention

We routinely prescribe menus for the patients' eating habits when caries are experienced in any quantity. We consider caries prevention a part of our responsibility and not just that of the dentist. Routine ionic fluoridation is our service as well as the dentists. The worst relations I have experienced with general practitioners are due to patients with numerous caries present at the close of a long siege of orthodontics. I am reluctant to a fault, however, to remove all appliances "just for cleaning purposes." Perhaps this should be on a selected basis. This is a source of communication breakdown between dentist and orthodontist.

The Consultation

Some time ago I finally realized that the number one opportunity to educate the whole family to dentistry, not just orthodontics, was the consultation. I therefore began to insist that the whole family join together for this experience. When I explained normal occlusion, it was to the family. When I talked hygiene and diet it was to the family. When I talked of the benefits of a bright, healthy, beautiful smile, it was to the family. When I explained facial orthopedics, it was to the family. I gave the patient a set of his own models to promote dental consciousness. Finally, when I showed them anticipated results with the cephalometric set-up and showed them how far teeth were to be moved, it gained the greatest respect and the image of orthodontics ascended even beyond some branches of medicine. This sophistication should elevate the stature of all dentistry. The dentist should be reminded of the benefits of this kind of detailed planning, and it should be adopted by most orthodontists rather than the asinine criticism heard in our own ranks that cephalometrics has no place in clinical orthodontics.

The Patient Review

Our treatment staff routinely explores the records to determine whether or not we are going past the estimated time. It is not unusual to call a patient in for a special "psychologic" consultation to find the nature of a cooperation problem. This gains respect from the parent and our image is enhanced as well. The dentist also may be asked for opinions and, in many instances, I have learned more about families from him than I would have otherwise. A great deal can be accomplished here in professional relations.

The Posttreatment Consultation

This has been our greatest step for public and professional relations. It has been a great source of satisfaction as well as being constructive.

This usually is handled by our dental counselor as a third party in the office; however, the receptionist or any auxiliary could conduct it with guidance.

The original records are laid out alongside the final records. The original course of treatment is reviewed and the results achieved are shown. The original blueprint or "prediction" is superimposed on the final to show the execution of the plan. The final models are gone over and the purpose of retention is explained. Continued need for

hygiene is also explained and the patient is informed that he should be phasing out of the orthodontist's office and back to the operative dentist. The need for concern of the third molars is discussed and, therefore, the need for continued surveillance from our office.

Finally, it has afforded the opportunity for feedback. The Number One complaint turned up is *time*. Mothers are busy today and resent any waiting at all. We have become much more respectful of the patient's time since this procedure was initiated.

Our appointment book has been tightened up and we try not to keep children overtime even if we have time for major work that was unscheduled.

Final Remarks

Orthodontists are in the unique position of being damned if we do or damned if we don't. We are condemned on the one hand for always making a major case out of a simple problem, while the same dentist will damn us for not finishing or perfecting our results.

We are caught in a web of trying to protect and upgrade our specialty from the charlatan and the fraud and, on the other hand, caught in the vice of ridicule for being secretive and clandestine.

We are segregated as the affluent society within the ranks of dentistry while the increased fees for dentistry have far overshadowed our increases. If general dentists were as efficient and highly organized as orthodontists, I seriously doubt that there would be any difference in the financial return.

We can't advertise, we cannot pass out pamphlets on the street; but certainly there are measures that can be taken. The firm of Bevel and Winthrop has made several constructive suggestions for orthodontics. These can take the form of motion pictures sponsored by societies, displays for public areas on orthodontics and dentistry, speakers before lay groups and societies by executive representatives of the societies; newsletters for the press by special society sponsorship and basic publicity of all kinds.

For professional relations, I think we should start by delivering the goods in terms of superb service. While technical excellence is a first cause, it will not stand alone. In Winthrop's words, public relations is critical in a free society. *Failure* to use public relations in the continuing combat of the marketplace, in competition for goodwill and understanding, is like climbing into the ring with one arm tied.

If steps are not taken to broaden the base of orthodontics and move with our times, it could well be that in the next decade or two orthodontics will no longer be a specialty.

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REFERENCE

1. Ricketts, R. M.: Public Relations and Contemporary Treatment Concepts, Part I. *Angle Ortho.*, 38:321, 1968.