Orthodontics and its discontents

As the debate over the appropriate goals of medicine and dentistry gains the attention of bioethicists and public policy analysts, the specialty of orthodontics must be proactive in defining its contemporary mission. Physicians, who have traditionally been educated to diagnose and treat illness, are now being asked by healthy patients to provide services that enhance physical, mental, and social traits. This has raised many ethical questions and created concern whether health care manpower is being utilized in its proper role. In this context of distribution of needs and services, treatments assigned high priority would most likely be limited to those interventions that are medically necessary. Enhancements or those elective treatments that are in many cases desirable but not medically necessary would be subject to greater scrutiny. The President's Council on Bioethics has discussed the ambiguity between therapy and enhancement. In a staff working paper, the council writes:

> 'A therapy, roughly defined, is a treatment for a disorder or deficiency, which aims to bring an unhealthy person to health. An enhancement is an improvement or extension of some characteristic, capacity, or activity. Both definitions assume at least some general sense of a human norm, which individuals must either be helped to reach, or which they might be aided in surpassing'.[1]

To date, there is no universally accepted definition of what orthodontic health is and surely no universally accepted definition of the point at which further improvement in occlusion represents enhancement rather than necessity.

The dichotomy that exists in conventional orthodontic practice is between functional and esthetic goals of treatment. An age-old question in orthodontics is why do patients seek treatment? The answer, usually said with disdain is 'What patients want is merely straight teeth'. Others say with equal disdain 'Most seek treatment for cosmetic reasons'. With embarrassment and self-deprecation, orthodontists say, 'We have become estheticians'. It is true that the most common chief complaint of a prospective orthodontic patient is 'My teeth are crooked'. Nonetheless, we are living in a society in which a driving force is individual improvement through the enhancement of human traits. These traits include intelligence, stature, body size and shape, dentofacial appearance, athletic prowess, sexual performance, etc. There are numerous enhancement technologies ranging from education, administration of hormones, drugs, surgical procedures, and braces, which are all designed to enhance an individual's traits. The body is now seen as a project to be formed and reshaped in conformity with the prevailing societal standards. For most of these enhancements, it is physicians and dentists who are the change agents.

So where does the specialty of orthodontics fit in the emerging paradigm of enhancement health care? Orthodontics, by virtue of its ability to effect the hard and soft tissue components of the craniofacial complex, should be one of the key specialties that drive enhancement therapies. However, as long as we orthodontists and our specialty board continue to market ourselves primarily as agents for preventing and treating malocclusion-the 'disease', the public's stock and trust in our ability to provide enhancements will diminish. We should embrace the concept of enhancement as a facet of wellness and include it in the continuum of the orthodontic services we render. A patient's desire for esthetic change is inextricably linked to their emotional wellness. If we view enhancement as part of a holistic approach to health care, the specialty will continue to enjoy the economic and social benefits that have already been afforded us. It is the advances in esthetic enhancement that bring our patients through the office door, and it is these same advances that keep orthodontists engaged in clinical practice.

It is notable that some of these recent advances in orthodontic mechanotherapy have been directly marketed to the consumer as more comfortable, more esthetic, and more in tune with a patient's needs. What's even more remarkable is that general practitioners and orthodontists alike are providing this

[1]The Presidents Council on Bioethics-Staff Working Paper: 'Distinguishing Therapy and Enhancement', http://www.bioethics.gov.

technology in relatively equal numbers. So today, the patient with a solely esthetic concern can potentially bypass the orthodontist's constraint of needing to comprehensively treat their malocclusion, and seek an enhancement-based remedy with their primary care dentist. This demonstrates that we are living in an era where patients are not only autonomous but are willing to seek any health care professional who will satisfy their enhancement needs. Aside from numerous ethical questions this raises, the desirability of attaining the 'orthodontic ideal' needs critical revision.

Progress in orthodontic education, research, and clinical care has heretofore been limited because of our adherence to the Victorian concept of the 'ideal occlusion' as the primary goal of treatment. By narrowly defining malocclusion as any deviation from this imaginary hard tissue ideal, the specialty of orthodontics has effectively underestimated and undervalued the importance of enhancement therapies. Within the specialty, excellence in clinical orthodontic care is unfortunately measured in terms of parity between marginal ridge heights and cusp/groove relationships, with less emphasis placed on the enhancement decisions involved in everyday diagnosis and treatment planning. Unless the data can better support the ideal occlusion model as a biologically desirable, a mechanically obtainable, and a physiologically sustainable goal for all patients, it is an unrealistic standard by which clinical competence should be judged and clinical care constructed.

Wendell Wylie[2] many years ago asked a question which has ever since confounded orthodontic thinking. He asked, is malocclusion a malady or malformation? Today, we know that only approximately 5% of the population has handicapping orthodontic conditions which can be considered maladies or malformations. What about the other 95%? By current definition, over half of these people will profit from some type of orthodontic treatment. What is their condition, which warrants this intervention? Their condition is almost always a recognizable variation of a dental trait, which makes them a candidate for improvement through enhancement technology (braces). These misconceptions in orthodontics have led to terminologies, which confound and confuse rather than define and clarify. Thus, why do patients seek treatment? They are simply seeking improvement of a recognizable variation of a human trait. Orthodontists are neither occlusionists nor estheticians; they are the change agents who enhance the appearance and function of teeth and faces. This terminology frees the specialty from the straightjacket of ideal occlusion as the always-desired endpoint rather than a theoretical goal to aspire to.

Plastic surgeons treat a range of problems from burn victims (esthetics and function) to soft tissue cosmetic procedures; however, unlike orthodontists they do not recriminate or apologize for what they do. Nor is there any concern about the fact that most of what they do is elective (not medically necessary). On the contrary, since their acknowledgement that cosmetic surgery is elective, it puts them outside the purview of third party payers who might otherwise challenge whether their services should be reimbursable. Plastic surgeons do not have an all or nothing approach to treatment planning, nor do they insist that patients embrace suspect norms called the ideal. Orthodontists have wanted to maintain orthodontic coverage by insurance programs and inclusion of orthodontics in Medicaid; however, we can not have it both ways and the plastic surgeons have chosen a wiser path by opting out of payment arrangements whereby treatment has to be deemed medically necessary.

The future wellness of the specialty will lie in our ability to shift paradigms and redefine our mission. It has been said that the decline of the railroads in the USA resulted from a misperception of their mission. The railroad executives saw themselves in the train business rather than the transportation industry. If they had recognized their flawed thinking they could have easily diversified and maintained their dominance in the field of transportation. Similarly, many orthodontists think of themselves as being in the braces business rather than in the field of enhancement. If orthodontic health care is viewed and promoted as both therapy and enhancement, we will have greater capacity for expanding our patient pool to include those individuals who are seeking an alternative to traditional 'comprehensive' orthodontic care. As we have learned recently, if we do not provide these alternative enhancement services, our colleagues in general practice, ever eager to enlarge their sphere of practice, will be happy to assist.

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[2]Wylie W. Malocclusion-malady or malformation? *Angle Orthod* 1949;19(1): 3–11.

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