LETTERS

GENERAL DENTISTS HAVE CONTRIBUTED GREATLY TO THE ADVANCEMENT OF ORTHODONTICS, PIONEERING MANY CURRENTLY ACCEPTED TREATMENT TECHNIQUES

I read Dr. J. Franklin Whipps'letter with much interest. I, like Dr. Whipps, have been in practice for over 20 years practicing orthodontics, but I am a general dentist. His concern about "who should treat" raises many interesting points that should be discussed.

Perhaps most general dentists enter the orthodontic arena because of quality-of-care issues. Twenty years ago, most of the cases were treated with extraction techniques of with fixed, edgewise appliances on the adult dentition. All too often, the results were not quality results. Esthetics and function often were compromised by the "conventional treatments."

Dr. Whipps discusses "timely delivery of quality care." The orthodontist did not treat the problem when it was first noticed, but, rather, waited until the patient was at a state where the permanent dentition was erupted. This was not timely quality care, but what was expedient for the practitioner. The general dentists and pedodontists lead the profession into early treatment care.

Twenty years ago, functional orthopedic appliances were not accepted nor were they taught in many, if any, specialty programs. Many articles were written and promoted by the specialist, stating these appliances did not work. Legal actions have been raised by the specialist regarding malpractice when these appliances were used. Today, these appliances are widely accepted. Since functional, orthopedic appliances were probably not taught to many senior orthodontists, one can only wonder how these practitioners learned about them.

In regard to general practitioners not having proper courses of training, this is easy to understand when general dentists and pedodontists have been discriminated against by not being allowed to attend the orthodontic lectures. There are many instances of programs being "for orthodontists only," where the general dentist is excluded or, if they did show up, they were denied admission. I do not think a single specialist has ever been denied admission to a presentation by a general dentist.

At least three separate times, specialists have presented general dentists cases at national meetings, as the specialist didn't have cases out of treatment to show or the right type of cases to show. These even included treatments designed and patented by the general dentist, but because he wasn't a specialist, he was not allowed to present his own work.

There have been many changes in treatment philosophies regarding extraction and non-extraction-treatment cases. The orthodontic specialty programs were geared toward extraction treatments, as non-extraction treatments were deemed unstable. The concepts that you could not alter the cuspid width, that non-extraction cases would relapse, etc., have been proven false. These changes were championed by the general dentist and pedodontist.

Quality of care is indeed an issue. One practitioner presented more than half of his International Board cases, which were re-treating orthodontic specialists' failed cases. To my knowledge, the only method of treating TMJ patients with orthodontics, which has been accepted by the Missouri State Dental Board, was presented by a general dentist. This was accomplished by presenting 74 cases that were initially treated by orthodontic specialists, which were re-treated to stable joint positions by the general dentist. I also believe that the only dentist with a United States Patent on a Method and Apparatus for Treating TMJ patients With Orthodontics is a general dentist.

To deny the American populace the opportunity to be treated by general dentists and pedodontists would possibly be returning to the dark ages of orthodontics before general dentists and pedodontists caused the changes to occur. The specialists have not changed because they wanted to, but because the general dentist and pedodontist demonstrated newer and better methods. Most specialists have been hesitant to change, until they began to lose patients to other practitioners and the financial limitations caused them to change to the newer methods. It has been the general dentist and pedodontist who have led the orthodontic specialty into the new fields and treatments, not the specialist.

I think it is pretty clear who should be doing the majority of orthodontic therapy in the United States. The specialist should treat those cases requiring extractions for which they are so well-prepared. The rest of the cases should be treated by those practitioners versed in these other treatments.

What is best for the patient is most important, not "who should treat what." This opinion should be shared by all ethical practitioners.

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