

The Disappearance of Excellence: One Orthodontist's Opinion

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Brainerd F. Swain, DDS, one of my mentors, was wont to say, "The difference between a good Orthodontist and a great Orthodontist is attention to detail". Dr. Swain was, by every measure, a great Orthodontist and I am privileged to call myself one of his students. Over the last five decades improvements in orthodontic appliances, coupled with improved dento-facial growth and development understanding, has resulted in shorter treatment times, a significant reduction in permanent tooth extractions, and dramatically optimized orthodontic treatment results. When I began private practice more than 40 years ago, the average time in comprehensive treatment was 24 months. Today the average treatment time is 18 months. That's a huge paradigm shift. When I began my career it was not unusual to order permanent tooth extractions for almost 70% of our patients. Today the percentage has fallen to the mid to low 20s, which again represents a huge paradigm shift.

Insurance

Over the past 15 years, however, three factors have arisen which conspire to adversely affect the orthodontic community's drive for excellence. The first of these is the ubiquitous intrusion of dental insurance into the Orthodontic Health Care Delivery System. Every procedure has a code, and each insurance company assigns their specific benefit-payable amount to each code. The amount payable differs from company to company, and from plan to plan within each company. Nowhere is provision made for an adjustment based on case complexity. Just as the dental insurance carrier does not pay more for complex crown preparation and temporization of a badly tipped and rotated tooth, than it does for the same procedure on an easier to treat straight tooth, there is no provision for an orthodontic treatment complexity fee.

The orthodontic fee is predicated upon anticipated time in treatment, not on the complexity of treatment within that time frame. This creates the mind set among our patients that health care, like a can of soup at the supermarket, is a commodity, not a professional service. It denigrates how the public perceives both the art and the science of orthodontic health care delivery.

And in orthodontics, we don't claim against the insurance company for "treatment completed." We submit before treatment begins, for "anticipated time in treatment." The Orthodontist must therefore base anticipated time in treatment on a worst case scenario. And if treatment does not go as planned, and becomes protracted beyond the anticipated time in treatment, there is no financial recourse.

Additionally, participation in an insurance plan usually means discounting the practitioner's usual and customary fee to match the plan's maximum allowable fee. The insurance company does not take a hit, the employer does not take a hit, the practitioner does. Yet the insurance company advertises that they are keeping health care costs in check, not by reducing their fees, but by reducing ours. Additionally, insurance benefit schedules do not keep pace with real world expenditures, with payable benefit increases lagging well behind cost-of-living increases. To accommodate these fiscal problems, practices have to become more efficient, putting pressure on the practitioner to work more cheaply, to be more expedient, to see more patients in less time, to reduce office overhead, to pay our staff less, and

to purchase less costly supplies and equipment, all of which can adversely impact the quality of care. Do we want acceptable, or would we prefer excellence?

Less than fixed

The second factor is the resurgence of removable, rather than fixed, appliance therapy. Removable and semi-removable appliances are less efficient than clear aligners, and clear aligners are less efficient than fixed appliances. Considerable research has shown that in the hands of fully qualified orthodontic specialists, patients treated with fixed appliances had post treatment results that more closely approached American Board of Orthodontics standards than patients treated with any other type of appliance, including clear aligners. Aligner results may be more than acceptable, and there is a place for them in the Orthodontic lexicon, but the patient should be made aware of the treatment result differences before choosing a course of treatment. Although aligner results have improved dramatically, over the last 5 years in particular, braces are still the gold standard. Braces results are dramatically closer to ABO Standards than aligner results.

Subscription Dental Journals are rife with articles touting the wonders of clear aligner therapy, but improvement does not mean optimization. All too often cases appear in the non-scientific literature showing improvement following aligner treatment, but to the trained eye there is still a lot to be done. And all too often, sadly, the non-Orthodontist aligner treated case winds up in the Orthodontist's office needing revision.

Articles published in well refereed scientific Dental Journals are more even handed. In the former case, practitioners doing only aligner therapy in their non-Orthodontic general practices have no basis for comparison. They don't offer fixed therapy, and therefore don't have a quantitative or qualitative data base armamentarium. In the latter case, classically trained Orthodontists who have the opportunity to compare results side by side understand that fixed appliance therapy is still the best treatment for most patients, while for others removable appliance therapy may result in an exceedingly acceptable compromise. They can help their patients discriminate between acceptable and exemplary care, and make recommendations that are in the patient's best interest.

Aligners and braces are not equivalent appliances, and end-of-treatment results are noticeably different. And as aligners provide considerable improvement, but do not achieve optimum results, the retention phase of treatment is even more challenging than it is with the braces-treated patient. If treatment does not result in teeth that are upright over good basal bone, well confined by the alveolar housing, the alveolus becomes compromised, and post-treatment destabilization is to be expected. Do we want acceptable, or would we prefer excellence?

You only see what you know

The third, and most distressing factor is the misguided belief that taking a 2-day clear aligner course at the local airport express motel is the equivalent of a 5,000+ hour orthodontic specialty residency. Or that completing the 500 hour AGD recognition program, with the hours divided among all the specialty areas of dentistry, is the equivalent of that same concentrated 5,000+ hour post-doctoral residency in just one specialty area. Or that slipping an occasional Orthodontic patient into the schedule between the crown prep and the periodic examination provides the same level of experience as doing orthodontics, and nothing but orthodontics, all day, every day.

Learning how to order orthodontic appliances from a lab is not the same as learning how to properly diagnose, plan treatment, and then actually treat the orthodontic patient. Sending models to a laboratory for fabrication of removable appliances, aligners, or fixed "align the social 6 in just a few months," is not the same as a three-dimensional fact-based orthodontic diagnosis and treatment plan carefully crafted to provide the patient with exemplary treatment. And when treatment does not go exactly as predicted by the appliance fabrication lab, who's going to fix the snafu? Just the other day I had a patient come to my office with a history of seven and a half years of treatment by a non-Orthodontist, and he didn't fix her malocclusion. Esthetically and functionally the patient was worse off than when

she started, and at the expense of her gingival attachment apparatus. He tried to resolve an extended dental and skeletal malocclusion by tooth movement alone, and was totally unprepared to “fix” the mess that he created.

Research has shown that non-Orthodontists who occasionally do orthodontic treatment may on occasion achieve excellent results. Orthodontists who do nothing but orthodontic care may on occasion have a mediocre treatment result. However, the overall level of orthodontic care in an orthodontic specialty practice is demonstrably higher than the level of orthodontic care provided in a non-specialty practice, with treatment completed in less time, better proximal and occlusal contacts of the teeth, more favorable esthetics, with better post-treatment stability, and generally at a lower cost.

The Orthodontist is trained to recognize normal versus aberrant growth, the arch length compromised case, the dental versus the extended skeletal case, the case that would benefit from aligner therapy versus the case beyond aligner therapy capabilities, the case that can be completed via arch length development versus the case that requires reduction in the amount of tooth material, and so much more. Orthodontists do braces, or aligners, or TADs, or head gear, or functional appliances, or expanders, or any other orthodontic treatment modality, better than non-Orthodontists. They do it better, faster, cheaper. Do we want acceptable, or would we prefer excellence?

Ethical dilemma

As Dentist's, GP and Specialist alike, shouldn't our first consideration be the quality of care we provide for our patients? As an Orthodontic Specialist I do not do pre- or post-Orthodontic bleaching, restorations, or any procedures other than orthodontic procedures, because I know my GP colleagues can do non-orthodontic procedures faster, better, and less expensively than I can. There isn't an Orthodontic Specialist that I know who has not been called upon to “bail out” a non-Orthodontist practitioner who made a diagnostic or application error, primarily because of lack of training.

We all had the same 60 hours of formal orthodontic training in dental school. We all took the 16-hour aligner “qualification” course, we all read the same vested interest articles in journals. But in between, what's missing, is the 5,000+ hour specialty residency training program. You only see what you know.

If an Orthodontist can do malocclusion correction faster, better, and less expensively than a GP, with better post-treatment stability, isn't the patient better served by being referred to an Orthodontist? If the patient is not referred, who benefits? Certainly not the patient. Is the decision made based on bottom line or on the patient's best interests? If the non-Orthodontist cherry-picks one treatment modality to practice, but the patient would receive better orthodontic care if allowed a full range of choices, shouldn't the patient have the opportunity to avail themselves of the best care possible? When did mediocre become acceptable, especially when excellence may be available just around the corner? I think it is time that we, members of the dental profession, return to Barney Swain's guidelines. Do we want acceptable, or would we prefer excellence?

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