

### *Read the label before taking*

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**T**he designation of a specialty and of specialty practice requires advanced training. Specialty orthodontic practice should form a particular unity and purpose, working within the basic sciences and the biomechanical function of appliances.

Graduates of approved courses at the university level have received the basic knowledge and stamp of approval from both the ADA and the AAO. The nature of their qualifications is such that the designation of "orthodontist" is sufficient for both the profession and for the public to denote competence in diagnosis and judgment, and in treatment modalities.

Forty years of research and intellectual refinement were required to break the barriers that existed between various universities and schools, and to agree in a general unity about the needs and academic requirements necessary to become a qualified orthodontist. Three basic areas of intellectual performance and exposure have become standard in all graduate and postgraduate courses. The three requirements are instruction in didactic and academic subjects, clinical and laboratory instruction, and the rigors of research with understanding of the investigative literature.

Educators had assumed that by instructive standardization, through minimum requirements, a more comprehensive service could be rendered to the patient in the "art and science" of orthodontics and would still afford flexibility in the array of treatment modalities and techniques indigenous to various schools, universities, and philosophies. Unfortunately, this has not been the case.

As the autocratic philosophies and techniques declined, due to retirement or the decease of willful leaders at the universities, a new breed of leadership has sprung forth, outside of the academic mainstream. These new leaders have claimed originality of purpose or profound discoveries not yet heralded by their academic colleagues. The new leaders sincerely promote techniques, philosophies, or appliances in which they have a large proprietary interest. Too often, the new philosophies and techniques are minuscule modifica-

tions of tried or abandoned methods that have been renamed, reworked, and repromoted.

Some of these new appliances and techniques can be likened to the reinvention of the wheel—and a square one at that—carrying a copyrighted name, an impending patent, and imbued with mystical qualities.

Teeth are stupid; teeth respond to pressure whether by a thumb or by an orthodontic appliance. Teeth move as a response to pressure and the cascade of biochemical, cellular, and substrate responses are usually the same, regardless of the charismatic leader, the manufacturer's claim, the size and shape of the bracket, the chemical composition of the wire, or the philosophy of the operator. In short, when the appliances have been removed, it is impossible to tell which appliance had been used or misused to obtain a given result. The result must speak for itself as to whether the goals of function, stability, and esthetics have been achieved.

There are some among us in orthodontics and in general practice who still seek the Holy Grail in the form of the perfect appliance, the perfect wire, the perfect technique, and who have not yet mastered the basics of tooth movement nor the discipline of perfection in banding and arch formation. It is these lost professionals who seek answers at the feet of gurus and self-proclaimed authorities for the ritual, philosophy, and secrets of competent treatment; and it is these same persons who switch and grasp at each fashionable change promoted by the purveyors.

Wendell Wylie, one of my great teachers, once said (with tongue in cheek), "A good orthodontist who knows the basics can treat well with barbed wire if need be; a poorly trained orthodontist will never treat well, even with the most sophisticated appliance."

Thirty years ago we used gold appliances and it took 1½ to 2 years to treat a malocclusion properly. When stainless steel was introduced to the profession, the treatment time remained 1½ to 2 years. Today, with all the fancy brackets and appliances, highly resilient wire, a multitude of techniques, and the use of trained auxiliaries, it only takes 18 to 24 months to treat the average malocclusion. The lesson to be learned is that the biology of the stomatognathic system is the limiting factor, not the appliance.

The evolution of the orthodontic appliance from Fouchard's "Bandolette" through Angle's "E" arch to-

ward the "pin and tube" and "fixed appliances" was a step forward in the control of tooth positions. The pin and tube evolved into the "ribbon arch" and "edgewise" appliances. The "ribbon arch" became Atkinson's "universal appliance" and the "Begg appliance," which was the ribbon arch placed upside down. Both Cecil Steiner and Charles Tweed modified the edgewise bracket into the one used today.

Glen Terwiliger, of the University of California, San Francisco, advocated soldering brackets at angles on the bands to build as much into the appliance as possible. Ivan Lee modified the concept into the angulated bracket. Dr. Terwiliger had already conceived the concept of pretipped and pretorqued brackets, and vertical slots to incorporate uprighting springs and rotational hooks. Dr. Terwiliger had also experimented with lingual appliances, applied with black copper cement.

The "step-down" or "bypass arch," used as standard procedure in the ribbon arch by George Hahn to upright molars and depress anterior teeth, has reappeared as the "utility arch," but was commonly used in the Angle school since 1920.

Today, each change in angulation and torque gives rise to a new technique with a fanciful name dutifully patented and sold as a "scientific" breakthrough and a quantum leap forward. Strangely enough, the results demonstrated at meetings and by the ABO candidates have not proved the claims purported by either the manufacturers or the leading exponents of a particular technique.

It would seem that each new appliance or concept needs new adherents to promote its use, to create a demand, and to generate income. The promotional need has expanded into the formation of organizations, splinter groups, and foundations, some new and some old, that expound high-minded objectives, proclaiming results beyond reality and some beyond provable benefit except to the leaders and manufacturers.

The need to form groups is akin to the herd instinct, where protection is gained and anonymity is provided for a commitment to a new appliance or a fallacious concept, wherein untoward results can be praised. The umbrella of belonging to a special group or organization imparts the aura of a cult, complete with rhetoric and catch phrases.

The ambition of special interests is to gain, through publicity and claims, that which cannot be gained through the close observance of research and academic rigor. Attempts through television commercials to demonstrate that some starlet or sports personality is having teeth straightened by a revolutionary appliance smacks of pure commercialism. When a starlet or sports per-

sonality is a willing "guinea pig" to create a need in the public and a demand upon the orthodontic profession, this hot-wires the experimental process of research and clinical trial.

With the advent of modified curricula and requirements, it was expected that the profession would see beyond the gadgets and proprietary schools. Now it appears that the proprietary schools, with blatant self-interests and charismatic leaderships, are proliferating.

It is possible today to spend between \$2500 and \$18,000 to learn the secrets of occlusion, the mysteries of the TMJ, the benefits of high colonics and vitamins, and to have the opportunity to share in occult knowledge regarding growth, new appliances, craniopathy, and the relationship of malocclusion to the sacrum. Many reputable teachers and professionals have been lured into aiding and abetting, lending their prestige to unsavory courses because of favorable economics. Some teachers and practitioners have spurned their colleagues and their professional obligations to give "secrets" to general practitioners for high fees, while deriding the less enlightened in order to justify the fees to their participants and the cost of the course, and to sell appliances and techniques.

Fragmentation and division of the orthodontic specialty based upon appliance use are passé in this enlightened age and speak of elitism, rather than looking toward gainful results to the patient. For some, jumping on the bandwagon to obtain the proper label is more important than using the knowledge acquired in school, in research, and in basic science.

Orthodontics has progressed from camps of "extraction" versus "nonextraction," from "headgear" to "no headgear," from eyeball diagnosis to cephalometrics, from "heavy forces" to "light forces," from "functional" appliances to, I suppose, "nonfunctional" appliances. The profession has moved through the factions and schisms of "labial appliances," "lingual appliances," and "labiolingual appliances."

The need to be a "Crozat" man, a "Begg" man, an "edgewise" man, or to adopt any other label is inadequate to being a good certified orthodontist. Being an "orthodontist" and doing good "orthodontics," and the achievement of stable, functional, and esthetic results speak eloquently to our patients and the public.

I must submit that the fostering of factions and organizations whose main thrust is to encourage the economic needs of certain individuals, manufacturers, and charismatic leaders goes beyond the ethics of this fine profession and subverts the trust of the public we serve.

In the plight of present economic upheaval, future academic change, and with the erosion of our profes-

sional well-being, orthodontists should strive for excellence in performance, service, and results. Unity and pride, coupled with solid intellectual goals, do not require labels to determine who is right or best. The uphill fight for orthodontics to survive as a discipline within which we call ourselves "orthodontists" demands protection and unity from us all.

The use of labels to fragment the unity of modern orthodontics through appliance use or philosophy of

practice makes us prey to every charlatan who would use us and our patients. The main thrust of our deliberations and concerns should be *good treatment* versus *bad treatment*. It is that simple. No labels are needed. Put the records on the table and label yourself.

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#### **AAO MEETING CALENDAR**

1988—New Orleans, La., May 1 to 4, New Orleans Convention Center

1989—Anaheim, Calif., May 14 to 17, Anaheim Convention Center

1990—Washington, D.C., May 6 to 9, Washington Convention Center

1991—Seattle, Wash., May 12 to 15, Seattle Convention Center

1992—St. Louis, Mo., May 10 to 13, St. Louis Convention Center

1993—Toronto, Canada, May 16 to 19, Metropolitan Toronto Convention Center

1994—Orlando, Fla., May 1 to 4, Orange County Convention and Civic Center