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THE EDITOR'S CORNER

An Individualized Approach to Treatment Planning

"The greater the ignorance the greater the dogmatism."

—Sir William Osler

One of the most interesting figures in the history of medical and dental education is Sir William Osler. Although he's little known outside academia, this Canadian laid the foundation for modern pedagogical techniques in the clinical sciences. In 1888, he was recruited to be physician-in-chief of the new Johns Hopkins Hospital in Baltimore and a professor at the planned school of medicine. From this position, he revolutionized the medical curricula of the United States and Canada. Osler blended egalitarian American principles with the British educational system by teaching all his medical students at the bedside. He believed that doctors learned best by doing and that clinical instruction should therefore begin and end with the patient. Books and lectures were merely supportive tools. The same principles applied to the laboratory: all students were expected to do some work in the bacteriology lab. Osler also introduced the German postgraduate training system—one year of general internship followed by several years of residency with increasing clinical responsibilities—to North America. His book, *The Principles and Practice of Medicine*, first published in 1892, remained the standard text on clinical medicine for four decades. (For more information, visit the medical archives at the Johns Hopkins website, www.medicalarchives.jhmi.edu/osler/biography.htm.)

The quotation that begins this Editor's Corner is one of my favorites from Osler's sizable body of pragmatic, plainspoken quotes. His trenchant attack on dogmatism speaks directly to a phenomenon that has plagued the clinical sciences for centuries.

Like most people who go into dental school, I first attended a liberal-arts college, majoring in biology and chemistry with a strong dose of the humanities. Coming from that open-minded, liberal educational background, I was shocked at the foot-stomping dogmatism of my dental-school instructors. There was only one way—*their way*—to cut a crown preparation or to border-mold a den-

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ture impression. I remember thinking what an ignorant and childish form of clinical education this was. When I decided to return to school and specialize in orthodontics after a few years of general dental practice, I fully expected the more enlightened instructors in my specialty program to be more willing to try new and different ways of doing things. To my delight, a few were. But to my great dismay, most weren't.

Now, after nearly a quarter-century in orthodontic education, I'm sorry to say that dogmatism still haunts us. Even though this approach is usually based on a practical personal philosophy—"this is what works in *my* hands" or "that's just how we do it here"—it is limiting in the extreme for the callow student. Compounding the problem are our various "schools of thought" or canned treatment philosophies, generally tied to one of the big-name gurus of the past, a particular appliance philosophy, or a long-serving orthodontic department head. Alumni take pride in doing things the way they were taught by their illustrious chairman, who, more than likely, learned orthodontics in the early days of the previous century.

The more open we are to trying new methods or techniques, the more likely we are to find a better way to serve our patients. As long as we maintain a close-minded, dogmatic outlook, we will be locked into one set of treatment outcomes, which may or may not include the best possible outcome for each individual patient. I've touched on this subject in JCO before, if less directly. For example, in a February 2007 Editor's Corner on facial harmony, I pointed out how treating to cephalometric standards ("treating to the numbers") is tantamount to striving for mediocrity. In October 2008, I observed that partial treatment, unlike most comprehensive therapy, virtually mandates an individualized approach to orthodontic planning.

I'm happy to note that other authors, in recent issues of JCO, have challenged several longstanding dogmas of treatment planning and biomechanics. Actually, the entire fields of temporary skeletal anchorage and three-dimensional radiography have shifted clinical paradigms of days gone by. Also noteworthy was last month's article by Drs. Junji Sugawara, Zaher Aymach, Hiroshi Nagasaka, Hiroshi Kawamura, and Ravindra Nanda on the "surgery-first" approach to orthognathics. In our current issue, we present an article that challenges another esteemed piece of orthodontic dogma: that we should always treat transverse problems first, before dealing with sagittal orthopedic corrections. While this particular dictum serves well in most cases, there are some patients in whom the full potential of the occlusal outcome cannot be achieved and the full depth of the facial esthetic outcome cannot be realized unless the sagittal correction is maximized prior to the transverse correction. Just such a case is presented this month by Drs. Madhan Balasubramanian and Alok Ojha. They demonstrate that an individualized process of treatment planning, particularly with respect to transverse and sagittal corrections, can indeed produce a much better treatment outcome than a traditional dogmatic approach.

RGK