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THE EDITOR'S CORNER

Down with Dogma

As I write this, the nation is winding down from a spirited presidential election. No matter which candidate you chose to endorse, you had to endure the harsh accusations and questionable criticisms from the other side. Now, I have never been content to be silent on any issue about which I have strong feelings, but the very idea of narrow-minded partisanship has always baffled me. If a candidate's positions meet my own personal criteria for ideological content, honesty of intent, and practicality of implementation, I am going to vote for that person, regardless of party.

The same outlook applies to my clinical decision-making process. Over the course of my orthodontic career, I have been intimately involved with three different graduate orthodontic programs: one on the East Coast, one in the mid-South, and one on the West Coast. Although accreditation standards require that all programs in advanced orthodontic education offer more than just one treatment philosophy, in most cases the differences are little more than variations on a common theme—for example, using both .018" and .022" bracket slots. Most programs have a dominant treatment philosophy, primarily defined by a particular appliance system.

This "dominant system" approach has many pragmatic advantages: simplification of logistics in the clinic, ease of coordination among the faculty, and avoidance of baffling information overload for beginning students. But the approach has a fatal flaw, which can be summarized in one word: Dogma. An online dictionary defines *dogma* as "an authoritative principle, belief, or statement of ideas or opinion, especially one considered to be absolutely true". I learned early in life that there is no such thing as absolute truth, and many 20th-century philosophers and scientists, from Dewey to Heisenberg, felt the same way. I would no more adhere to one exclusive treatment philosophy or appliance system than I would vote a straight party ticket.

I trained in a program that placed a heavy emphasis on equilibrium of muscular forces and employed such

appliances as functional bite blocks and lip bumpers. You can imagine my surprise when I accepted a faculty position in a program that held to an extractionist philosophy and was told that bite blocks and lip bumpers were not valid treatment modalities. This department relied heavily on extractions and J-hook headgear. The program with which I am currently affiliated teaches various straightwire modifications of the diagnostic and mechanical philosophies first expounded by Cecil Steiner. Amazingly, however, when I compare the cases presented by each of these orthodontic departments in the annual resident case displays at the AAO convention, they look much the same—all very good. I have concluded that dogmatic adherence to any one clinical decision-making process is, like partisan politics, a voluntary surrender of one's critical thinking skills.

Since long before I took the reins as Editor of JCO, this journal has served as the primary medium for the presentation of new orthodontic ideas, new appliances, and new philosophies of diagnosis and treatment planning. As such, we have been praised by some for treading new territory, and damned by others for violating a variety of orthodontic dogmas. If that remains the case, I will feel gratified about the direction of the journal. As a case in point, the current issue presents some ideas for approaching such common problems as Class II malocclusions, ankylosed teeth, overerupted molars, and facial asymmetries. There are those who will find these ideas logical and the techniques worthy of clinical trial. On the other hand, there are those who will see them as infringements of more conservative doctrines and therefore unworthy of consideration.

In orthodontics, as in politics, rather than adhering blindly to habitual dogmatic approaches, I strongly encourage all our readers to exercise their own critical thinking faculties.

RGK