

EDITORIAL

Improving standards in orthognathic care: the bigger picture (a national and international perspective)

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There can be no doubt that improvement of facial aesthetics and its psychosocial impact are dominant factors that define the perceived treatment benefit of combined surgical-orthodontics. Indeed, it is likely that psychological factors, rather than the actual severity of the malocclusion, actually determines the demand for orthognathic treatment. However, despite professionals being seemingly in agreement on this point, there are currently few psychometric instruments either available or regularly used to assess objectively the impact of orthognathic treatment on our patients' well-being.¹ It almost seems as if we have chosen to ignore this aspect of our treatment outcome, focusing instead on solely clinical, provider-based outcomes, e.g. cephalometric analyses and occlusal indices (e.g. Peer Assessment Rating (PAR)) scores. Such outcome measurements are relatively meaningless to patients no matter where in the world. Are we therefore doing ourselves an injustice with this approach?

In the UK, a minimum dataset for orthognathic patients was jointly agreed between the British Orthodontic Society (BOS) and the British Association of Oral and Maxillofacial Surgeons (BAOMS) in 2005. This document is an initial attempt to rationalize and justify our record collection strategy. It has been widely circulated and is available on the web sites of both specialities. Ethical approval is not required in order to follow the advice from the dataset document. However, if a local or regional orthognathic database is to be developed in conjunction with the minimum dataset, then Central Office for Research Ethics Committees (COREC) approval should be sought as usual. An earlier development to assist with the assessment of orthognathic treatment outcome has been the surgical-orthodontic cephalometric analysis sheet developed by Chris Johnston in Belfast. This document evolved from a 1999 national audit of consecutively treated orthognathic cases and enables a relatively quick assessment of the complexity of orthognathic caseload against a national standard. Both documents are available to BOS

members from either the Members Download section or the Consultant Orthodontist Group (COG) section of the BOS web site (www.bos.org.uk).

Internationally, there is an ever-increasing interest in consumer-centred outcomes of dental treatment. In addition to our routine clinically based outcome measures, we too need to concentrate our attention on more subjective patient-based measures² to allow us to distinguish between patient and provider viewpoints and serve as a means of documenting the true benefits of orthognathic treatment in health policy discussions. Patient-centred research can influence and ultimately improve clinical practice. Currently, there is a lack of qualitative, scientific research into this aspect of our orthognathic treatment. Some UK-based individuals are trying to address this issue by developing specific consumer questionnaires based on face-to-face interviews and focus group analysis.^{3,4} The orthognathic patient satisfaction questionnaire³ has been our most recent nationally-based outcome project. The Clinical Effectiveness Committee of the BOS is supporting this national survey. Questionnaires were distributed at the end of 2005 and the findings should be available later this year. It is to be hoped that soon this specific questionnaire will be used prospectively as part of routine record-collection procedures for orthognathic patients.

An improvement in the quality of life of our orthognathic patients is an important patient-outcome measure and can be a strong motive for surgical-orthodontic treatment.⁵ Recently, there has been increased involvement of clinical psychology services within the field of cosmetic surgery. However, surveys have shown that lack of funding and manpower has severely limited the role of psychologists as part of the orthognathic team. Clinical psychologists could potentially contribute to the assessment of suitability for surgery, assist with patient decision-making and provide therapeutic interventions. I carried out an unpublished informal survey in 1999 with the aim of establishing whether orthognathic teams within the UK had access

to a clinical psychology service. Sixteen orthognathic services within UK dental teaching hospitals were asked to participate in the survey; 13 responded. Ten departments reported that a clinical psychology input would be of value. However, only six had access to a clinical psychologist with four of these having appropriate funding in place. The psychology service available varied from sessional arrangements with a clinical psychologist to being able to refer to a general clinical psychology department—the latter arrangement was often problematic due to lengthy waiting times. This brief survey concluded that clinical psychology was a scarce resource within orthognathic services.

The recent paper by Juggins *et al.*⁶ suggests very little has changed since 1999. This questionnaire-based study revealed a confusing split between consultant orthodontists on the benefit of psychological support. Nearly 40% felt that up to 10% of their orthognathic patients would benefit from psychological referral. Where this 10% figure has been plucked from is unclear as the available evidence seems to be anecdotal. The reality is that we simply ‘don’t know’ the answer to the question as we are currently not collecting the relevant information prospectively. What is clear, however, is that the main barriers to referral still remain access and funding. A fully supported ‘grown-up’ service needs the correct personnel doing their own specific jobs for which they are qualified. Training programmes in psychology for orthodontists has been suggested,⁶ but is this really the answer? We wouldn’t expect a clinical psychologist to treatment plan our orthognathic patients for us so why do we think we should dabble in their field of expertise, i.e. Orthodontist with a Special Interest in Psychology (OwSIPs). I think that we are missing the bigger picture here. The role of psychology within the orthognathic framework should not be seen solely as providing the ability to ‘spot the nutter’.

Shortages in the provision of psychological services to treat depression in children and young people have been recently highlighted.⁷ Orthognathic services are therefore unlikely to be a priority so it is essential that we produce evidence to demonstrate scientifically that the provision of orthognathic treatment is ethically appropriate. We must show that the overall improvement found in our orthognathic patients is of significance in general society.⁸ By using an appropriately-developed, specific, standardized psychological questionnaire, it will help us to predict the psychological outcome of our patients and provide scientific evidence as to the need (or not) for a ‘hands-on’ clinical psychology service for our orthognathic patients. I see there being two distinct aspects to such questionnaires. First, they will enable identification of those patients who would benefit from

some form of psychological support either prior to or following their orthognathic treatment. Secondly (but probably more importantly), the routine collection of this psychological ‘profiles’ data on a prospective, long-term and longitudinal basis will provide us with our most valid outcome measure, i.e. the psychosocial benefits actually being achieved for our patients. Surely, this is our *raison d’être*? Psychological well-being can be an intangible benefit to society. We must be able to justify provision of orthognathic treatment and demonstrate its benefits by utilizing a more patient-centred approach. In turn, this scientific data may strengthen any potential future negotiations for formal funding of clinical psychological services.

Currently, no nationally or internationally recognized and agreed questionnaire exists to assess the psychological benefits of surgical-orthodontic treatment. Any such questionnaire needs to be simple to administer and straightforward to assess. This must be our Society’s next national task. The possibility and benefits of international collaboration with this project should also be considered. It will enable an evidence-based, qualitative assessment of orthognathic treatment to be carried out. This would have both beneficial risk management and clinical governance implications. Without appropriate psychological input, our orthognathic service is akin to running a sleep apnoea service without the assistance of a chest physician.

References

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