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EDITORIAL

What is orthodontics?

What is orthodontics? This may seem an odd question to be posed in an orthodontic journal, but there is no doubt that we are living through changing times within our speciality. There has recently been an explosion of new, exciting and heavily-marketed techniques to offer our patients including self-ligating bracket systems, aesthetic appliances and 'do it all' removables. These systems are revolutionizing contemporary practice. Never before have patients been faced with such choice in orthodontics. Around every corner, on every high street and on the internet there appears to be someone who does not take teeth out and offers 'invisible' braces. It is now possible to offer our patients the 'six month smile', with a minimum of fuss and inconvenience not to mention financial outlay.

The fear of being left behind prompts many of us to buy the latest brackets systems, however untested they are; and sign up to yet another accreditation course, however expensive it is. All this to become versed at providing better-marketed, although not necessarily better treatment. However, we sleep soundly in the knowledge that we remain 'contemporary' in our practice and happily feel part of the zeitgeist that is sweeping through our speciality. However, by broadening our armamentarium, are our clinical outcomes likely to improve?

There is of course no doubt that these systems can align teeth and there is some evidence to support this. However, the question that remains is not whether we can move teeth but where should we move them to? Specialist orthodontic teaching in the UK has traditionally been based upon several bedrocks and whilst there are no absolute truths in what we do, these have proved to be good tenets on which to base clinical practice. It was believed that there was a limit to where the dentition could be placed both transversely and anteriorly,[1] in general terms the lower labial segment position was regarded as inviolable and of course, the lower intercanine width was seen as sacrosanct.[2]

These principles formed a foundation for treatment planning, and were based upon many years of clinical practice. However, now the paradigm is shifting. We are now told not to extract for space but rather for the face; we are led to believe that big protrusive smiles are what our patients want, and there is an increasing acceptance of long-term retention. So where should we now put the teeth? Anywhere it seems. Suddenly the house of cards on which we based our treatment philosophies has come tumbling down. Or has it? Haven't we been here before?[3,4] The appliances have become more sophisticated, even gift wrapped with their own philosophy in some cases, but the arguments remain the same. The biology of our patients has not changed, nor have the causes of malocclusion.

Is orthodontics now just treating tooth malalignment or should we still be trying to treat malocclusion? Surely we should have some watertight treatment principles and definite individualized treatment goals, and not feel obliged to treat each case without extractions just because we have the ability and the mechanics to so do. The exciting thing about our specialty is that every malocclusion we treat is different. We should therefore try to avoid a formulaic approach to treatment planning. The orthodontist should dictate treatment, not the appliance or indeed the manufacturer. Whilst innovations such as self-ligation allow us to rethink our mechanics, these mechanics should not drive our treatment planning; in fact, the reverse should be true. Just because you may have recently taken delivery of a new bracket system and some very bendy wires, it does not mean that your postgraduate training should be eschewed and your treatment philosophy irrevocably changed to make every case that walks into your office a non-extraction case. After all, brackets and wires are the tools of our trade but practicing orthodontics involves more than being a mere slave to the appliance.

It is deceptively easy to straighten teeth and there are many new, user-friendly and exciting ways to do it. However, comprehensive treatment is a more complex process, with a premium on placing the dentition in the correct position relative to the soft tissues and to the opposing arch. In the current climate of increased marketing, high patient expectation and the orthodontist as salesman, it can be difficult to remain committed to this. Of course there is always room for compromise and in certain cases it is appropriate to treat the complaint as opposed to comprehensively addressing the malocclusion. Notwithstanding this, such compromised treatment would represent the exception occasionally pre-empted by patient choice, rather than becoming a pervasive form of 'orthodontics'.

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The question therefore remains: what is orthodontics? I suppose each of us will have to decide that for ourselves.

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