

Orthodontics and its Relationship to the General Dentist

By Dr. Robert Scholz



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Having spent twenty years in orthodontic education and the last five years as the PCSO representative to the America Association of Orthodontic's Council on Communications, I have been a student of the orthodontic general dentist relationship for some time now.

It has been an endeavor occasionally fraught with frustration as it appears to me that organized orthodontics at times insists on "shooting ourselves in the foot" attempting to accomplish the impossible while at the same time alienating our GP friends.

The issue of "who should treat" has been lingering as a dark cloud over the head of organized orthodontics, and while it is bothersome to certain groups, we have not dealt with it in an effective manner and appear to heading in the direction of reinventing a wheel that has not worked in the past.

A little history is in order to explain what I think is the root of the problem.

In 1975, The American Dental Association conducted a Study of Curriculums of United States Dental Schools. The results of this study were published by the Council on Dental Education in cooperation with the American Association of

Dental Schools in a volume entitled "Dental Education in the United States 1976". The following is quoted from this publication:

"For many years dental graduates have expressed concerns about their lack of knowledge of orthodontics. Orthodontics, however, was reported in the 1975 American Dental Association Survey of Dental School Graduates as the clinical subject which students liked the least.

In addition, the respondents' self-evaluation of their clinical competency at the time of graduation indicated orthodontics as the area in which students felt the least qualified.

Because of a generally recognized national need, the Commission on Accreditation of Dental and Dental Auxiliary Education Programs, with the assistance of various orthodontic consultants, developed at its December 1976 meeting "Guidelines for Teaching Orthodontics in Dental Education." I was privileged to serve on the two ADA ad hoc committees that structured these guidelines so I followed the results carefully. Included in this publication were the specific orthodontic curriculum hours reported by the various schools with the range of instruction ranging from 14 hours in one school to 971 in another.

In October of 1990 the American Association of Orthodontists (AAO) conducted a similar survey of the predoctoral situation in the United States. While the instructional categories were different than the 1975 survey, the results were similar in that there still existed a lack of curriculum consistency among the various schools. It appears that the Guidelines for Teaching Orthodontics in Dental Education have had little or no impact on improving the situation in teaching orthodontics at the predoctoral level in dental schools in the United States. It is quite clear that we have done a less than satisfactory job at educating our GDP friends in the area of orthodontics.

The most compelling piece of evidence that our GDP friends are still poorly informed on the subject of orthodontics appears in the April 1997 Survey of General Dentists completed by the Research and Planning Group and published by the AAO. According to this statistically significant sample, only 7% of the GDP's feel their predoctoral orthodontic education is very useful while a full 64% feel it is not useful.

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Ironically, this same survey reveals the paradox that while our GDP's are not skilled at referring, they feel they are quite suited to filling this role! And furthermore, the Moms of our future patients quite agree, as according to another AAO consumer survey published at the same time, they feel the GDP (rather than the orthodontist) is the first person from whom to seek orthodontic advice.

Given these compelling facts, I will submit for your consideration that the solution to the "who should treat" problem must be accomplished by educating our GP friends rather than by attempting to mandate who should treat.

Historically, the schools have not done the job and I assume they will not do so in the future. It is therefore up to you and me, the practicing orthodontist, to educate our friends. Enter "Professionally Speaking".

The AAO, through the COC, has realized we must do more at improving relationships with our referring GDP's from the grass roots level. The recently launched "Professionally Speaking" program abounds with many ideas for you to do just that – educate your referral base. Space does not permit me to expound on this project here, but recent copies of the AAO's bulletin have and will continue to provide information on the subject.

I would like to conclude with some comments of activities I see developing that I view as counterproductive to the AAO's effort toward improving relationships with the GDP. Most of these have been tried previously and have failed.

1. Taking an aggressive stance toward making it law that GP's practicing orthodontics must announce that they are not orthodontists and do not have the additional education to qualify them as orthodontists.
2. This to me is an attempt to legislate morality and is replete with policing problems as evidenced by the few states that attempt specialty laws.
3. As one example, what is orthodontics? Would a GP who decides to rotate a maxillary central incisor with a removable appliance be compelled to change his/her signage and letterhead? Or would this be limited to only those who extract teeth during orthodontic therapy? How would this approach be monitored?
4. The "bite down early" brochure is a fine piece of work for us to purchase and provide our patient Mom's to check out siblings, etc. Since its inception, it has included the phrase "Please share this brochure with your family dentist" which I view as one of the most demeaning things we can do for our GDP friends.

5. How would you feel if one of your patient's Mom's handed you a CDA brochure demonstrating what caries looks like and asked you to check out the siblings? This is an example of our lack of sensitivity in our attempt to "educate" our referring dentists.
6. Interest in creating other "educational" formats to assist the general dentist in identifying problems that require an orthodontic referral. Handing a referring general dentist a "simple diagnostic aid" such as a chart with diagrammatic illustrations of the problems you like to treat early is demeaning and reflective of that individual's poor predoctoral orthodontic experience. What is the expected behavior here? Does the GDP check out the child's occlusion then refer to the chart to see if one of those is there? This message must be delivered to your referral base in a much more personal, one to one encounter by you!
7. Expanding the effort to direct the public to seek orthodontic services directly without the need to consult with their family dentist. This is related to increased interest in the New Jersey approach. Circumventing the family dentist is counterproductive to the AAO's effort to improve relationships with him/her. Furthermore, since the GDP feels eminently qualified to play this role, this approach will be offensive. And finally, this effort would have to undo all the faith that currently exists between the Mom's of our future patients and their family dentist as seen by the consumer surveys completed in 1997.

You and I are professionals, orthodontists
BUT dentists first!

We do not need to attempt to legislate or mandate our desires on "who should treat" as this approach has been tried and does not work.

Our general dentist friends are professionals also and deserve professional treatment by us. They have been by and large poorly educated in the intricacies of orthodontics so of course, some have strayed to the "motel courses" to fill the gap in what they feel is a missing link in their education. Are these lost sheep dishonest? Probably some are but I think most just don't know any better and have been sold a bill of goods by those who teach the motel courses. What we need to do, in a one-to-one professional manner, is educate them! We do not need to attempt to legislate or mandate our desires on "who should treat" as this approach has been tried and does not work.

General dentists are responsible for at least half of our referred patients. Let's help them fill the missing link in their orthodontic education and above all, let's be professionals!