Guest editorial

The future of our specialty – How toothless are we going to be?

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Orthodontics always talks about its future, but how much time and effort has actually been spent on effecting change or placing measures in place to help shape and direct the future of the specialty?

A provocative question was raised at a recent webinar organised by the Australian Society of Orthodontists regarding ‘Controversies in Orthodontics’ which addressed the future of the specialty and where it would be in 15 years.

I happened to be one of the panellists and my views on that question were multidimensional. I briefly outlined my humble opinion during my allocated two minutes. I hope to elaborate more in this editorial.

Firstly, if we look at the orthodontic specialty over the last 30 years, it may be seen that it has substantially declined in terms of its stature, respect and exclusivity. Even the quality and calibre of global academics and clinical leaders has been significantly reduced. Yes, the Golden Era of orthodontics is now extinct. It certainly does not take a rocket scientist to figure out that the specialty in the next 15 years will be in a much worse position that it is in now.

It is not about whether it might be better. It is unequivocally going to be worse. It is about how much worse it is going to be. And that depends on several factors.

We could spend many hours and, of course, pages discussing why the specialty is in the dire position it is in today, but that is only going to lead to unnecessary blame and unending rhetoric as well as a wave of meaningless hate mail.

Today, we are seeing the de-regulation of oral health therapists (OHTs) and a blurring of the boundaries or scope of practice of general dentists. What does this mean? Well, OHTs can now do more and without direct supervision, and dentists can essentially do more if they ‘feel’ that they have ‘studied’ and, as a result, say they are ‘competent’ enough. What does ‘studied’ and ‘competent’ mean? Well, that has not been clearly defined by the Australian Health Practitioner Regulation Agency (AHPRA). Let us look at this in an analogous situation. If a plumber is not busy enough, he can decide to increase his revenue by undertaking further so-called ‘higher’ education that may involve anywhere from two days to six months of study. If and when this plumber feels that he is competent following this study, he can now service Ferraris unsupervised. Therein lies the problem. This plumber can go back to plumbing whenever he feels like it, all while continuing to service Ferraris. Further, if this plumber feels like he now wants to fly helicopters, design landscapes, or change light bulbs he can do so, again, if he feels he has ‘studied’ and feels ‘competent’ enough. The sky is literally the limit.

As we weaken regulation and increase the scope of practice of OHTs and dentists, authorities are still increasing the demands and criteria for the education of orthodontic postgraduate students while maintaining the tight practice regulation of orthodontic specialists. Am I the only one who can see a problem with this? Is AHPRA’s argument to us “What is all the fuss about? No one really dies from ineffective and even bizarre attempts to correct a malocclusion by a general dentist”? Worse still, by and large, most patients do not even know enough to be unhappy or concerned.

Furthermore, the universities continue to graduate large numbers of undergraduate dental students, while also continuing to graduate orthodontic postgraduates.

As the public demand for orthodontic treatment is not increasing as quickly as the insatiable demand to treat malocclusions by general dentists, we are gradually seeing them treat increasingly more difficult problems. Further, trade companies and the so-called ‘key opinion leaders’ are conducting courses to train dentists to carry out orthodontics often based on financially rewarding ‘evidence,’ such as expansion and non-extraction-at-all-costs to improve profiles, grow mandibles, provide fuller lips, increase tongue and airway space, and at the same time cure sleep apnoea and TMD. Interestingly, many of these private and unaccredited courses are supported by accredited dental organisations.

Comments from members of our orthodontic specialty such as ‘we just need to keep doing good clinical work’
and ‘teach our post-graduates to be better clinicians’ are simply unacceptable and downright ignorant. Haven’t most of the ASO members been teaching and practicing good orthodontics for the last 30 years? So, do we need to teach and practice better? The answer is no! That holy ship sailed a long time ago and is now foundering.

In good and almost blind faith we devote a significant amount of members’ funds towards advertising to the masses regarding the services of our great specialty, along with tracking Facebook likes and Instagram posts. This strategy is not going to deal with the real issue of our future. Again, am I the only one who can see this?

In addition, more and more orthodontic specialists are now embracing the various digital platforms, and rightly so, given their benefits in the treatment of selected patients. In the process, they are also increasing the time between adjustments or patient visits, monitoring more online than chairside, and increasing the delegation of significant duties to OHTs, including digital planning, triaging, adjustments, appliance fabrication, placement and removal.

How do you think this looks to general dentists and OHTs outside looking into our specialty? They do not see what and how we do our work and the layers of associated complexities and responsibilities. Moreover, if more ‘computerisation’ or more ‘delegation’ means a reduction in hands-on treatment, is this worth the integrity of our specialty? Just because you can does not mean you should. Is the dollar so much more important than the future of orthodontics? Furthermore, can dentists be held responsible for inadequate treatments when members of our own specialty are guilty of doing the same? We need to also look more closely at ourselves. Food for thought.

We have all seen the loss of standing and respect for the once great specialty of prosthetics, why have we not learnt from their failings and lack of action? Do we believe we are immune to this?

As more and more dentists realise that they can do orthodontics and, at the same time, are unaware of the limitations of the digital platform in relation to growth and development or disinterested in the standards to which the orthodontic profession aspires, it will soon be realised, if it is not already, that post-graduate study in the specialty is not as attractive or necessary as it once was. This reduction will undoubtedly affect the number and quality of students applying for specialty training as the calibre of these individuals applying declines and the landscape of orthodontic practice changes. This is unfortunately a sad reality.

The future of our specialty depends on several factors.
1. A reduction of the number of dentists graduating, which is unlikely to happen;
2. A reduction by the regulatory authorities regarding the scope of practice of general dentists and possibly OHTs, which is also unlikely to happen;
3. More effective utilisation of available funds to politically lobby to reduce the scope of practice of dentists;
4. A proactive and aggressive approach to public education outlining the risks, motives and consequences of treatment by general dentists;
5. A proactive and aggressive approach to making general dentists and members of the orthodontic specialty accountable for inadequate treatments and results;
6. A concerted effort towards ethical and evidence-based orthodontic practice rather than financially driven practice by members of the specialty; and
7. Better regulation of continuing education courses by, and for, general dental and specialty organisations.

As indicated in the recent ASO webinar, my life has been dedicated to orthodontics and I hope to continue to oppose poorly justified treatment modalities and philosophies well into the future. Although I might not witness the full demise of the specialty in my practicing career, I hope that the orthodontic generations to come will be affected much less than has been implied here.

How toothless is the orthodontic specialty going to be in effecting change? The profession’s status as an evidence-based learned calling in 15 years’ time ultimately lies in the hands of members and the current and future students of our great specialty.

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