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# ORTHODONTICS IN GENERAL PRACTICE: Part 1
# SCOPE AND LIMITS RELATED TO ORTHODONTIC EDUCATION*

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## Orthodontic Roles.

I think that everyone would accept that the general practitioner can have an orthodontic role, just as he could be said to have periodontic, endodontic, exodontic, prosthodontic and pedodontic roles. But can the general practitioner's orthodontic role be readily defined (remembering that orthodontics in its completeness is supposed to be a specialist role)? At various times attempts are made to set down these respective roles by spelling out "scope" and "limits" of practice.

"Scope" carries a sense of wide-ranging action, liberty, or free outlook.

"Limits," or "limitations," conveys rather the opposite sense of restriction, if not exclusion.

So, although these terms have been used in the title of this essay, they might well appear odious and objectionable to different groups, say, of specialists and general practitioners.

In fact, I do not believe that the orthodontic role of the general practitioner can be so defined, for it is impossible to set the scope and limits of his dental practice where this takes in treatment of the teeth and dental occlusion. The nearest approach to such definition would be one concerning the work of the dentist at the start of his practising career, or at the end of his career as an undergraduate student. Here a serious attempt must be made to set scope and limits to orthodontic instruction of students, and at the Dental School at Sydney they could be said to operate to the following principles:—

**The scope of Orthodontics in general practice is the recognition, diagnosis and treatment of only Class I, Class II and Class III malocclusions of intact dentitions of young patients.**

**The limits of Orthodontics in general practice are set by knowledge and understanding, skill and all that comes of clinical experience.**

**Knowledge and understanding derive from mastering of "First Principles."**

**First principles of Orthodontic diagnosis and treatment planning in general practice start with intact young dentitions and finish with intact permanent dentitions.**

**First principles of appliance treatment start with molar band fitting and finish with stable dental arch relationships.**

Parts of the above may appear cryptogrammic, whilst there is a risk that the remainder will be judged glibly meaningless. Before attempting with explanation to forestall possible rejection by the reader there is, as it were, another side of the ledger to complete, unless I do not see a role for a specialist orthodontist. If I do, then it should complement that of the general practitioner. The latter leaves off and the specialist takes over, and vice versa. Thus:—

**The scope of Orthodontics in specialist practice consists of the diagnosis and treatment of "difficult" problems of Class I, Class II and Class III and deforming malocclusions.**

**The lower limits of orthodontic treatment in specialist practice are set by the upper limits of progress of orthodontic treatment in general practice.**

## "Orthodontic Sociology."

The above indicated "division of labour" is marked by a separation of orthodontic care of patients which has sometimes been likened to an unbridged chasm, or what long ago was

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called "a no-man's land of dentistry" for children. This zone of separation, has at least two determinants:—

1. Economics — relating to the ability of patients to pay for treatment, depending very often upon its nature, i.e., simple or complex, and often equated with a general practitioner as opposed to a specialist service.
2. Know-how — again a distinction being made between general practitioner and specialist.

This is one expression of the orthodontic dichotomy. Another might be stated as: "a problem of equating our community's orthodontic needs with resources to attend to them."

Orthodontic "needs" are what the Community "has" in the way of malocclusion, and what the Community requires in the way of orthodontic services.

From a dental viewpoint, problems concerning needs and resources can be posed in another way as: "What should be the orthodontic objectives of the Dental Profession?"

Thus I am led to attempt a general statement of objectives: **To provide satisfying dental aesthetics and a functional natural occlusion which is stable and capable of withstanding the ravages of time for each and every person.** Economics and know-how must be turned to better fulfilment of these objectives.

So-called specialist services do not and cannot fulfil these objectives for more than a small minority of people. Rather, specialist orthodontics tends too much to be a luxury which is denied to more people than can buy it (or insure adequately for it), instead of being developed as a service for special problems of malocclusion, such as involving the permanent dentition, or diseased and non-intact dentitions, particularly those associated with deformed jaws. (c.f., those "difficult" malocclusions referred to earlier). By the same token, general practitioner orthodontics has tended to be a very poor man's service, so that there is indeed a substantial chasm between the two orthodontic services. It is fortunate that, dentally speaking, our community is still relatively unsophisticated and doesn't appreciate what is "good" for it although inexorably it is losing its dental innocence.

**Orthodontic Education for General Practice.**

In order to be able to treat malocclusions effectively, a minimum rather than a maximum of guiding principles has to be sought for general practitioner orthodontics. Nevertheless, undergraduate instruction should make a serious attempt to involve students, as future practitioners, in general treatment concepts, not just in the recognition of malocclusion and minor tooth movements. The latter can hardly be considered as more than "fiddling" with a malocclusion. There is a substantial risk that the dentist is concentrating his attention on one or two teeth, while the concept of dealing with the patient's total occlusion could be lost to him. If a dentist is to be given a comprehensive and comprehensible concept of dental occlusion, then he must be encouraged to first consider total, that is intact, dentitions. With hope for improving community awareness of dental health measures and with the benefits deriving from specific preventive dentistry programmes, there should be greater opportunity and reason to think about intact dentitions, deciduous, mixed and permanent. Thinking about such intact dentitions leads to a ready forecast of increasing prevalence of crowded dentitions in children.

It is more than likely that where a practitioner is using his ingenuity to design some finger spring to move a particular malposed tooth he is attempting to deal with one complexity underlying a basic malocclusion. Such complexities may be sequels to extraction of teeth, or to anomalies of size and shape, and number of teeth, or ectopic positions of development. General principles of guidance of development of occlusion rather than ingenuities are what is wanted to treat Class I, Class II and Class III malocclusions of intact dentitions not additionally distorted in the presence of these dental anomalies and misadventures. The latter problems enter into treatment calculations at deeper levels of orthodontic understanding obtained beyond undergraduate training.

An important clinical objective of orthodontic care is to develop long term stability of tooth positions and occlusal relations by adequate cusp locking and upright orientation of teeth. This can be met more simply and more certainly by retaining all permanent teeth from first molars forwards. The general practitioner should not be burdened with the heavy responsibilities entailed in dealing with crowding problems of Class I malocclusions, where premolar extractions are contemplated. However, as I have been arguing, the dentist must be encouraged to undertake orthodontic therapy which means providing him with some "safer" general alternatives. This can be done by conservation of mixed dentition arch

perimeter length in order to retain the dentition intact. Important to such conservation may be dental arch expansion, bucco-lingually and antero-posteriorly, but with the likely subsequent expenditure of second or third molar teeth. It is by reason of use of control or expansion-type simple fixed appliances that "molar band fitting" came in for mention earlier. Similarly, molar bands provide the basis of appliance therapy which is advocated for Class II malocclusions during the mixed dentition period using extra-oral anchorage and bite-opening appliances; and for treatment of early-appearing Class III malocclusion employing maxillary expansion and headcap-chincap. So long as the dentist understands the distinction between orthopaedic and orthodontic therapy there seems no reason why he should not use either.

**Conclusion.**

There are very many "difficult" problems of malocclusion which could, in the future, occupy the concern of a much larger specialist group than presently exists in this country. There is a concomitant need for more dentists who are able to attend to less difficult clinical problems.

It is but a short step from this dentist-orthodontist relationship to a new relationship which could offer a wider orthodontic service in the face of increasing public demand, and in spite of some continuing economic limitations. Such a change might be envisaged with general practitioners acting more as clinicians and specialists more as consultants.

On the face of it, these suggestions are in no way remarkable, except for one clear inference that general practitioner orthodontic education needs to be upgraded. This might best be done by some kind of upgrading of undergraduate education. Perhaps "upgrading" may be replaced by "renewed thinking" (open to everyone) away from stereotyped attitudes which lead to professional stasis: by this I mean maintaining a critical, quizzical and rational approach to existing clinical concepts and prejudices, and to continuing formulation and testing of new concepts. This is the hope and endeavour of our goals of education in orthodontics which are explicit and implicit in the earlier-expressed scope and limitations of orthodontics in specialist and general practice.

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