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INTERVIEW

THREE PROFESSORS
A Crucial Coincidence

This interview with Dr Vic West of the Royal Melbourne Dental School, is the third and final interview with academics retiring from the Orthodontic Departments of Australian Dental Schools in recent times. Dr West was interviewed by the Editor.

Dr Lee: Vic, with retirement from your position at the Royal Melbourne Dental School imminent, I, as Editor of this Journal would like to interview you so that the Society may have a record of your contributions to orthodontic teaching.

Firstly, would you give me an outline of your career in dentistry?

Dr West: I graduated in 1955 and had a brief time in general dentistry in Collins Street, Melbourne. Shortly after, I went to the United States for a little while to look around and came back in 1956 – just in time for the Olympic Games in Melbourne. I then took up a position in the hospital "Dressers" department and the various parts of the old Dental Hospital. On one particular day, Dr Wallace, the Director of the Hospital, told me to "go round to the shed out the back" and from that moment on I was an Orthodontist. That was how it happened! I used to have to run in to the next surgery where you had been established for a while and say: "what do I do now Brian?" and you'd say: "what have you got in there at the moment?" and I'd say: "it's an 018" or "an 020" and you'd say: "well now you go up to the next stage." My original orthodontic training consisted of running backwards and forwards to your surgery finding out what to do next.

Dr Lee: I can recall that now.

Dr West: You may remember Geoff Coleman who was in the Department as well and who was busy with studies in Bacteriology. Also Tony Storey, he was peripheral to the whole thing; he didn't actually appear in our area very much, but was still in his research mode with the NHMRC scholarship. At any rate, that situation persisted until I married and went off to England for an extended honeymoon – about 6 years in fact. There, I was able to take a more formal interest in Orthodontics, which I did for many years with Professor Walther – one of the great gentlemen of Orthodontics – at the Royal Dental Hospital in Leicester Square in London. Professor Walther was the author of the *Walther Notes*. They were basically his undergraduate lecture notes put into a book form and revised by Bill Houston. At the same time I was in part-time practice. Firstly in Putney and later at Bromly in Kent. These visits to the Royal Dental Hospital were the start of my formal orthodontic education.

Dr Lee: Which year was this?

Dr West: Well it was in 1958 that I went to England. I kept up my association with the Royal Dental College even after I had got my Dip. Orth. and my D.D.O. in Glasgow because I enjoyed the experience and the continued association with Professor Walther and other students from around the world. I returned to Melbourne in January, 1964.

Dr Lee: On your return to Melbourne did you come straight back to the Hospital?

Dr West: Yes, to the Orthodontic Department.

Dr Lee: Was there a university department established at that time in its present form.

Dr West: Not in its present form. There was, in 1964, teaching at faculty level at the University which was under the control of Dr Adamson. The situation at that time, as I recall, was a little unusual, since prior to becoming a faculty of the University, the teaching of Orthodontics, along with all the other dental subjects was done by the Dental College where, I believe Dr Adamson was Head of the Orthodontic Department.

Dr Lee: So you came back to the Orthodontic Department in the relatively new Hospital. Were you involved in teaching at that stage?

Dr West: Yes, I started teaching undergraduates fairly informally. In those days, Orthodontics was a full fourth year subject with a practical examination. I was involved in that role until December 1968 at which time I was offered a position as Senior Lecturer in the University.

Dr Lee: In 1968?

Dr West: Well the actual appointment began in January 1969 so this is my twenty-fourth year with the Faculty, but including my hospital years, it gets close to 30 years of teaching.

Dr Lee: In your time here, you have probably seen four graduates a year

come through.

Dr West: Not quite. We began with only one or two students a year in the early days of my responsibility. In fact the late Peter Botting, who died shortly after graduation as a result of an accident, was my first formal graduate student. There were others already in the system that was operating when I took over. Then, as now, it was possible to obtain an M.D.Sc. by full thesis alone. However, it was also attainable by examination; but there was no formal course of instruction as we know it today. However, as well as being examined in Orthodontics, the M.D.Sc. required the candidates to be examined in considerable detail in Oral Pathology; a fact I see, in retrospect, as having more relevance to historical precedent than to clinical needs. It was almost par-for-the-course that candidates were not successful in their first attempt to pass the Oral Pathology component, despite the considerable time devoted to it by most candidates.

Dr Lee: So you are saying that there were people presenting for their Masters Degree who had not been full-time students?

Dr West: Well, the first Masters candidate I examined was somebody whom I had never seen until he presented for his clinical examination. He had been in the previous system, had completed part one of the requirements in one or other of the basic sciences – which usually included Metalography – and had completed his written papers in Orthodontics.

Dr Lee: So his clinical training was in private practice?

Dr West: Yes, as it turned out in that case.

Dr Lee: So he was doing a preceptorship in fact.

Dr West: Something wasn't right about it.The thing that precipitated a change was that we had one candidate who was in that old system and who was a great student; he came to grief over the Oral Pathology, as mostly we all did, and I thought this is' ludicrous'. People were spending more time on the Oral Path than they were on Orthodontics. So fortunately – I can remember it as if it were yesterday – I was driving home from an undergraduate examination, risking my life and limb with professor Storey in his Morris Minor, and I said to him: "Look, I'm a bit concerned about what's happening with the Masters and how much time is not being devoted to clinical matters in what ought to be a clinical training programme". To my delighted surprise he agreed with me and said: "Yes, I think we ought to change it". From that time we brought about some changes, not without, I might add, a little bit of resistance from some members of the Faculty.

Dr Lee: I'm not at all surprised. Vic, as an educator you've worked during the age of an evolving system. Do you feel that the present system, which came in some years ago, where the students are full-time is the best that we can do? Do you think that we can improve on, or make any changes to that system?

Dr West: Yes, there are two aspects to this. Administratively it's frequently difficult to merge a full-time Masters Degree with a variation of it. But I have expressed the view many many times, that if I were designing a course and had no limitations, I would attempt to do something similar to that which was done by one or two people during those twenty-four years: that is one year full-time and then two more years on a half-time basis; but in an orthodontic practice. Those who did it this way weren't necessarily from an orthodontic practice. The ideal would be to take students in, give them the essential grounding in that first year, and then, in the second year and third year, keep them coming back just to keep the didactic aspects where they ought to be. The very desirable clinical benefits are obvious: most patients could be treated to completion by the student who began the treatment.

Dr Lee: Do you still have a two-year course?

Dr West: Yes.

Dr Lee: Should it go to three years?

Dr West: Only if there is evidence that there is significant advantage from the post graduate's point of view and that the present course, in terms of knowledge and clinical competence, is not satisfying the needs of the students as future specialised Orthodontists. That is not too different an answer to that which I would give to a similar question which asks: 'Would I object to, or have any difficulties with, a three-year programme, the third year of which is totally clinical; and which was designed and directed to satisfy the needs of the student?' I have very strong views about programmes which are to be increased, allegedly in the interests of the clinical experience of the students, but which, in practice, may well operate, without supervision, in the interests of an institution by providing a low cost, or even no cost, specialised work force. It would not be uncommon that the students, in such a situation, may be paying significant tuition fees for the three years of the standard course.

Dr Lee: You accept that many cases take a fair amount of time to treat to the retention stage?

Dr West: Yes, and let's face it, in a teaching institution you don't have the optimum circumstances that you might have in a private practice, where things may be running more efficiently. The upshot of this is that students don't get around to finishing as many cases as we would wish during the course of the two years. What I reject vigorously is the notion that a three-year course is required merely because other schools have increased theirs to three years. I know my views on this are shared by a number of leading academics in U.S.A. Their courses have been increased as a consequence of administrative decisions taken by their governing bodies and the academics responsible for the teaching of the programme. It appears to me that such decisions may not have been made in ignorance of the fact that post graduate students have the capacity to generate income as a consequence of treatment of patients in situations where the patients pay significant fees. I have occasionally been amused over the past twenty-four years at views expressed by demonstrably competent and successful graduates of a two-year programme that, perhaps, there was now a need to increase the programme to three years. The documented support for such a proposal is somewhat less convincing than the support for Parkinson's Law: that is to

say, any given task can be extended to occupy the time allocated for its execution. I am old enough to be allowed to hold the "old fashioned" view that academics in clinical disciplines ought to teach and train; while administrators administer to facilitate that activity. However, I am not so old that I am unaware of the reality of the current financial difficulties being experienced by universities and hospitals alike.

Dr Lee: Yes I know how much the administrators of the old Hospital appreciated the revenue generated by the old Orthodontic Department which contributed to the general running of the Hospital.

Dr West: One very prominent school that I know of in U.S.A. which, by administrative demand, changed its course from two years to three, responded by increasing substantially its vacation and non-teaching periods each year; with a result that virtually the same academic content was being taught over a two year period. Clearly there would be some clinical benefit to the students which I agree would be desirable; but I an not certain that it is the most efficient way of achieving it. An interesting question flows on from a decision to increase the orthodontic programme which is: 'what about the length of the programme for the other dental specialities?' This is particularly relevant in view of recent changes in our School to the education and training of those students aspiring to specialist status in the field of Oral Surgery; or its recent, substantially expanded, field of Facio-Maxillary Surgery. Personally, I have no difficulty with the concept that the different areas of specialisation may require quite different periods; and methods of education and training to achieve their desired goal.

Not surprisingly, on the eve of my retirement as I review my own thoughts on the appropriate duration, content and method of execution of an orthodontic programme designed to fulfil the needs of a future specialist, I still find virtue in a course which embraces a period spent in a functioning efficient orthodontic practice and at the same time, keeps in touch with the more formal aspect of education and training within a university programme.

Dr Lee: But that's a bit of a swing back to the preceptorship system.

Dr West: No, they are not preceptors, because the training that they receive here, under strict supervision of operators of varying clinical persuasions (in terms of techniques that they use), would still expose them to the same teaching that they get now over a two-year period; except that their clinical work would be extended over a three-year period. They would still have to treat the same number of patients, and that under the direct supervision of their supervisors. The virtue of this is that they would then be in a position to evaluate the respective merits of the varying philosophies and modes of treatment of their supervisors; and compare them with those of their employer whose philosophies and approaches to treatment may be vastly different; but which must be followed in the interests of the responsibility of their employer for the outcome of the treatment. May I say that I believe one of the hallmarks of our course, in which I take some pride, is that those orthodontists who have been gracious enough to come into the School as teaching supervisors have been given total clinical freedom to instruct and guide the students in any way they believe to be appropriate. Over the years, both directly and indirectly, former students expressed gratitude for the clinical variation and academic freedom in which they were able to pursue their studies; and for the relatively relaxed but serious environment. Frequently, such favourable comments were made by way of comparison with more rigid approaches which they subsequently became aware of; particularly in other countries.

Dr Lee: Yes, I have heard such comments from several recent post-graduate students who have been overseas after graduation. I suppose you've seen many changes over the past twenty four years.

Dr West: Do you mean as far as technique is concerned?

Dr Lee: Yes, technique; and, as Orthodontics is evolving, how do you think a course needs to be modified or adapted to what you see might be the demands placed on orthodontists in the future? Can you see anything on the horizon that you consider should be a part of the course, or part of the preparation.

Dr West: I can't see anything specific on the horizon, but I can see clearly that something will inevitably appear. Just as those many years ago, when current techniques utilising computer-assisted analyses, magnetic resonance imaging, x-ray tomography, bonded brackets, variable modulus archwires et cetera, were barely contemplatable, so the future will bring new dimensions into reality which at the moment are still in the realms of science fiction. You would know from your own practice, and the presentations made by our colleagues, how commonplace it is to utilise computer-generated images, either on computer screens or as multi-coloured hard copy printouts. Computer-generated slides are now the benchmark for lecture presentation of data text and graphics. The ability to 'freeze' a computer screen image and utilise it for direct 'off the screen' digitising offers an alternative to the, potentially more hazardous cephalometric radiograph. The use of computers for practice management is now widespread, to a greater or lesser degree. With regard to mechanics and modes of treatment, I am sure you remember in the old University Hospital Orthodontic Department, that we both knew and worked in, there was a heavy bias towards the use of removable appliances. Much of the reason for this was the low cost of removable appliances compared with the significant cost of the extended chairside-time that was required by the orthodontist to "pull up" his own bands, solder the tubes and accessories (such as eyelets for rotation), solder traction hooks and stops onto the archwire and fabricate facebows from huge coils of quite unfriendly wire. It is not surprising that the financial consideration has now swung in favour of fixed appliances considering the advent of seamless bands; bonded brackets with torque; first, second and third order bends incorporated into the brackets rather than into the wires and the ever-increasing range of wires available. I believe that fixed appliances are both more desirable

and more cost effective than their alternatives – the removable appliances. Consider a simple illustration: the jumping of two upper front teeth over the bite. I can't believe that the total cost of fitting two bands and perhaps four, or even six bonded brackets, would exceed the cost of the fabrication and fitting of an acrylic appliance. This does not even take into consideration the potential value of the in-place fixed appliances which may well be indicated for any additional treatment.

Dr Lee: As you have indicated, there are big changes in diagnostic aids. Do you think that it has been overdone?

Dr West: No, I believe that it has contributed to a greater awareness of differences in patients that may be clinically very significant. Thirty or forty years ago, Orthodontics, as widely practised was very mechanistic. It largely consisted of banding all the teeth that were erupted, except those destined for extraction, and attempting to bring them into such a position in the three planes of space that they were in the words of Dr Angle: "in harmony with the face". Unfortunately, there were few guidelines (that were readily communicable) that facilitated or clarified the way such a goal was achieved. There was, then, a significantly different ratio in the art and science of orthodontics to that which I believe now pertains. I believe the use of cephalometrics has contributed to that change. We now appreciate that, by a consideration of craniofacial and dentoalveolar parameters obtained cephalometrically, we are able to describe the head and face of our patients as being mesofacial, brachyfacial or dolichofacial; or a shade of this spectrum of cranio-facial types. The importance of this is that there is an increasing belief that, perhaps, the response to identical treatment may not be the same across the range of facial types. I believe that such variation in response may well explain the dilemma and concern expressed by even the best of our earlier orthodontic colleagues when they could not explain why some of their treated cases held up very well and others, treated equally well, collapsed. There are now many of us who, without criticising our former colleagues, are suggesting that the difference may well have been due to severe brachyfacial patterns in some, while others were equally severely dolichofacial. The use of cephalometrics in enabling us to monitor stability of treatment-induced changes in craniofacial parameters – such as facial axis and lower face height – will allow us to examine such hypotheses. When you can measure something unambiguous, communication about it is facilitated considerably.

Dr Lee: Do you ascribe much of this to Dr Ricketts?

Dr West: Yes indeed! I believe the record will show that he has been one of the great innovators in Orthodontics; whether it be in regard to seamless bands, bracket design, approaches to segmental mechanics; or the full utilisation of cephalometrics in diagnosis, treatment planning, forecasting, monitoring and clinical research. Notwithstanding the many years he has been teaching Orthodontics, he is still utilising his own current research in the development of prescription brackets which recognise and allow for the variations in stable inter-incisal angles many years out of retention, and which are associated with the variation in cranio-facial patterns that we have just been discussing. With regard to the question of changes that I have seen and those that I may yet see, I am obliged to say that: in my view, not all change is synonymous with undisputed progress. I am concerned that many of the changes that occur are industry-driven for predominantly commercial reasons. I can understand and accept that such activity is legitimate and frequently results in significant progress. However, my concern is that, unless the training of the members of the dental community in general, and the Orthodontic Specialty in particular, has provided them with the necessary discernment to evaluate the virtues and possible disadvantages of the new product, there may well be widespread use of these products based only on the manufacturers' claim that they are "miraculous" additions to an orthodontist's or a general practitioner's armamentarium. The acquisition of such discernment is an area of responsibility which falls on people in my position, and one which I myself take quite seriously; even at the risk of being seen as an arch-conservative and as an impedance to progress. Remember the big surge to lingual orthodontics? Much to the horror of most recent postgraduate students, I have still insisted that they fully band a certain (decreasing) number of cases. To do otherwise, would allow a person to leave this place with a post-graduate qualification undermined by a significant deficiency. Such a person would fall a long way short of what I call a 'well-trained' orthodontist. I have a similar attitude to the exclusive use of prescription brackets on the basis that the hallmark of a competent orthodontist is the ability to control the forces produced by the interaction between a bracket and an activated archwire. To produce graduate students who believe that they can rely on the prescription in the brackets and tubes to achieve this control, is to encourage the belief that the difference in skill between an Orthodontist and a minimally trained General Practitioner is a reducing quantity which has, or is about to, disappear.

Dr Lee: Clearly,the point you are trying to establish is that: if plain Edgewise brackets with zero tip and torque are used, there is a need for students to learn to control the archwire. In other words, you require them to be competent in wire bending.

Dr West: Yes, that's the object. I remember being invited to attend a course very early in the introduction to Australia of the prescription bracket system. The two overseas Orthodontists who were instructing made the point in their introductory remarks that these new brackets still required considerable wire bending skill to achieve a good result.

Dr Lee: Now, briefly in conclusion, two or three points: have there been any advantageous or deleterious effects following the combining of the Dental and Medical Faculties as far as your Department is concerned? Do you see any major benefit?

Dr West: I'd have to say that we've gone on pretty much as before. There may have been to me, as Senior Lecturer and then as Reader,

bureaucratic processes that have given us a little less flexibility than when we were a full Faculty; but they would be pin-pricks in the fabric. It would be unfair to say that we have had great upheavals; and I am sure the students don't even know whether we are a Faculty or a Department.

Dr Lee: You mentioned the other day that the Dawkins' changes to the large campi were not affecting you here.

Dr West: Not at all, no, not very much.

Dr Lee: Is there anything that you would like to pass on to members as a result of your experiences here as an educator?

Dr West: Only to state the obvious: that I've derived incredible enjoyment and pleasure out of the activity. One doesn't stay in this sort of job for financial reasons. So, therefore, I stayed in the job for other compensations. The great stimulus that I have obtained over the years – and it might sound trite, but it is, in fact, true – has been the opportunity to mix with young folk. To be stimulated by their enthusiasm and their intellect challenges somebody in my position to stay with them. There is an amount of pride involved.

Dr Lee: It sounds as if you have enjoyed your time.

Dr West: Yes there is no question about it! There are certainly no regrets, at this stage, as I get ready to leave the job.

Dr Lee: Well good luck in your retirement. I hope you enjoy it. Thank you for the interview.