Has the ‘golden-age’ of orthodontics left the building?

By Dennis J. Tartakover, DMD, MEd, PhD, Editor in Chief

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T here once was a time when an orthodontist was required to learn how pinch-lapping bands, spot-welding brackets, bend loops, hooks and first- and second- and third-order bends in wires as well as various auxiliary appliances work. Diagnosis included drawing our own cephalometric X-rays and trimming our own diagnostic casts — putting the “plaster-on-the-table” as the saying goes.

What has happened to change history? Are we better educated with greater expertise to serve the public, or are we restrained by the many technological advancements? For those who were privileged to have known or were taught by some of the great orthodontists of the past, you know how truly special it was. We were trained to provide services to the patient without any help from specialty companies.

Today, clinicians have the luxury of sending out X-rays and casts — we don’t even have to bend wires any more with the current trends of out-of-the-box treatment. At some point, we must ask ourselves whether or not (a) technology is inhibiting or enhancing progress, (b) patients are better served or are we delusional? Difficulties are sometimes encountered in finding high-dependency treatment results from the so-called “advanced technological improvements.”

High-dependency treatment relates to the close proximity of observed results; low-dependency treatment occurs when accompanied by ignorance and is unrecognizable when we have no means of comparison or assessment. Issues of dignity and privacy may be compromised in order to give priority to the seriousness of the patient’s care, especially in today’s modern society.

Our decisions about patient care are often influenced by media and sales representatives rather than by our own sophisticated intelligence. It is sometimes difficult to find the accommodation appropriate to a specific patient’s needs, health and safety. The question is, “Will delusion become implanted in the legacy of orthodontics?”

Decisions to maximize efficiency can be a double-edged sword, and we must be careful about what we wish for, as modernization may become our Achilles heel.

Although the process of patient care being delivered with dignity and privacy is in a sensitive environment, these issues are not confined to the delivery of care, particularly when the decision is to provide the “best” care; it also relates to management decisions for personal gains or advantage.

There is no question that technology cannot be ignored, but neither can it stand in the way of care or progress. However, appropriate application of standards for dignity, privacy and excellence to our patients should be aimed at avoiding gimmicks or attention-grabbers and confined to what we know in our hearts is righteous.

Suggesting that it is exceptional for an orthodontist to have an attitude problem or lack the necessary training regarding issues of patient dignity and privacy is not intended, and neither is it implied that the problem lies with teachers who have failed to acknowledge deficiencies in the fabric of the environment in which care is being offered.

However, it is incumbent upon educators not to be in denial of the structural inadequacies of technology, but rather to encourage individual thinking that is appropriate to achieve patient care with the supreme quality.

Hopefully the present “golden-age” of orthodontics does not have a tarnished halo, and care for our patients is held first and foremost in our minds as well as our hearts.