**Short-term gains...long-term problems?**

The emergence of STO and its future implications in general practice. By Aws Alani, UK.

The provision of orthodontics can be a life-changing experience for young patients whose "crooked" teeth can affect their confidence and self-esteem. Indeed, where mature patients present with a history of malalignment, equally beneficial and fulfilling results can be achieved. In government-funded systems, patients with congenital abnormalities receive treatment that is essential to their ongoing oral health. Restorative dentists work closely with orthodontists, who can appreciate how small details can aid in achieving positive restorative outcomes.

As a young dentist, I corrected a tooth in crossbite with a simple T-spring appliance. It was enjoyable and brought a different type of delayed gradual satisfaction to the more cerebral but tenuous molar endodontics or the more artistic and instant composite build-up. I was not a specialist, but I managed to do some orthodontics. In contrast to my experience, general dental practitioners are now more routinely providing tooth movement with the emergence of short-term orthodontics (STO). This has resulted in some conjecture as to the methods of achieving “straighter” teeth. Indeed, some may consider STO as an emerging entity competing with specialist orthodontics, but should it be?

The specialist training pathway for orthodontics involves a competitive-entry three-year full-time course linked with the achievement of a master’s level qualification that many may feel daunted by. Indeed, navigating the pathway from start to finish can be difficult academically and financially when factoring in fees and loss of earnings during training. Once qualified, the majority of these specialists reside, like the majority of all specialists, in the south-east of England. With this skewed distribution of specialists and assumed need for access, it might seem prudent for general dental practitioners to contribute to meeting the need for orthodontics.

Indeed, the long-cited managed clinical networks have yet to be fully realised, although all planning and documentation related to managed clinical networks identify general dental practitioners as integral to the function of the network. The number of orthodontic therapists has gradually increased over the last ten years or so since inception of the first courses in Wales and Leeds. Therapists are allegedly more cost-effective to train and employ in a large orthodontic practice; however, unlike their hygiene or therapy colleagues, they cannot practise without a specialist’s treatment plan and supervision. Patients who qualify for orthodontic treatment under the UK government-funded system need to be assessed according to the index of orthodontic treatment need. There will be an obvious shortfall of adults or adolescent patients with minor malocclusions who do not meet the criteria who would like their teeth straightened. This cohort may have to seek treatment privately from orthodontic specialists or general dental practitioners. As such, these minor or straightforward cases may be managed in a number of different settings utilising various techniques with the advent of STO. This may have resulted in some territorial paranoia between the two camps of traditional and short-term orthodontists.
Quick and easy?
Commercialisation has modified the provision of orthodontics in the UK. Indeed, there are now orthodontic brands with courses attached and a faculty of individuals who promote their particular product. Companies tend to boast that their product is the best with limited complications and treatment being low risk, predictable and easy. Some-what surprisingly, courses are being run on how to convert patients into orthodontic clients. There are books describing strategies on promoting and increasing revenue. They outline detailed strategies on attracting more patients than one’s local competitor—tailed strategies on attracting more patients into orthodontic clients. What may cause fear and worry is that the provision of tooth movement set against a backdrop of a focus on increasing revenue and patient conversion may detract from the real reasons we are providing the treatment. The risk and benefit of treatment must remain balanced or be rebalanced in favour of the patient. The best things in life are rarely quick, easy and without reflection. While learning or training, one gains stature from one’s mistakes and learns by way of osmosis from those of individuals one hopes to emulate. Becoming an expert in many a field requires time, effort and experience. Orthodontics is a complicated discipline that is difficult to deliver optimally and efficiently. Treatment planning should be performed in person not only to appreciate the challenges the patient presents with but also to develop a lasting patient rapport. Equally important, patients need to be diligent during treatment and for ever more for purposes of retention. Is it possible that a one or two-day course with a treatment plan lasting half a year or less can provide equally optimal results to a specialist orthodontist utilising traditional means?

In any case, placing a time limit on any treatment could be considered contentious. Patients ask me all the time ‘How long is this treatment going to take Doc?’ I always reply ‘I’ll tell you when its finished’. As such I am rarely wrong.

Advertising cosmetic treatments the fair dinkum way
The Australian health ministry recently examined the provision of cosmetic procedures and in particular the modes of promoting the treatments. The working group found that advertising and promotion more often than not focused on the benefits to the consumer, downplaying or not always mentioning risks. The group went on to identify advertising practices that were not driven by medical need and where there was significant opportunity for financial gain by those promoting these. They identified the need to regulate promotion and advertising ethically with factual, easily understood information from a source that is independent of practitioners and promoters. This is unfortunately not always readily available. In some Australian jurisdictions, there are specific guidelines that need to be adhered to for promotion of cosmetic treatments and they specifically cover before and after treatment adverts, which we know in the UK is a popular practice among the cosmetically driven. This is commonly one ideal, perfect case showed on the front end of the practice website with no mention of any problems, either acute or chronic. Another aspect of the report detailed prohibition of time-limited offers or inducing potential customers through free consultations for the purposes of treatment uptake. The latter is something that has seen STO promoted by way of voucher deals on the Internet or via smartphone applications. Others may consider such a practice as loss leading, one could ask who is losing and who is gaining and at what price?

One important aspect of the report identified the wider social impact of cosmetic procedures in that people may become increasingly dis- satisfied with themselves and their appearance, culminating in deeper concern for the person and reducing scope for individuality. Many dentists throughout the country may have a slipped contact here, a rotation there or a space distal to a canine who are unlikely to be waiting in earnest for the next voucher deal alert on their iPhones. Inducing misgivings or rais- ing concerns about the patient’s tooth position where the teeth are otherwise healthy and the patient presents with no concerns could be considered unethical and worryingly dishonest.

Relapse of confidence
In a recent publication from an independent provider, orthodontics was identified as an emerging area for claims against their clients. This is likely to be the tip of the iceberg, whose size will probably continually grow as more and more orthodontics is provided and the repercussions of which may only become apparent gradually in the future.

In the now highly litigious arena of UK dentistry, the failure of orthodontic treatment against the backdrop of Montgomery v. Lanarkshire Health Board is likely to result in increased litigation. The movement of teeth into what the patient and the dentist feel is the correct position may be possible in the short term, but in the long term complications may arise owing to a variety of soft- and hard-tissue factors that cannot accommodate this new and supposedly “right” position. Indeed, orthodontics requires the appreciation of detail where symmetry and alignment are “king”, but long-term stability is the likely “empress”. Relapse of position is a common complaint and where patients have paid handsomely for a result they may have been happy with, at the time of the cheque clearing, over time tiny tooth shuffles can result in disproportionate and vehe- lent dissatisfaction. Where teeth are moved indiscriminately, recession in the labial segment is a complication difficult to explain and remedy in the high lip line of a conscientious and ambitious corporate female patient. Indeed, more haste, less speed may result in a case being etched longer in the memory of the patient and the cli- nician for the wrong reasons.

Clear steps to business building
A cornerstone of a successful business is the repeat customer who values the dentist and his or her service and returns with no qualms or misgivings about what the dentist feels should be provided. A successful business relies on patients returning in the long term owing to their positive experiences. Focusing on short-term gains without due consid- eration of time-limited offers or inducing potential customers through free consultations for the purposes of treatment uptake. The latter is something that has seen STO promoted by way of voucher deals on the Internet or

make it on to the price list of Sa- mantha’s, a beauty salon in Peckham.

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