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THE EDITOR'S CORNER

What Price Compromise?

There are cases in which it may be prudent to follow a compromised plan of orthodontic treatment when the doctor and the patient agree on such a plan. These might include an adult Class I case with crowded lower anterior teeth for which extraction of one lower incisor is recommended, or an adult case with a so-called "mutilated dentition". There are cases in which there are sufficient reasons to recommend extracting two upper bicuspids and leaving the case in Class II instead of extracting four bicuspids and aiming for a Class I result. Compromise is frequently involved in cases of non-cooperation. Surgical-orthodontic cases may be the most frequently compromised in percentage terms; often, neither the patient nor the orthodontist is eager to see the surgery done. Compromise might also be valid in certain questions of esthetics.

But to what extent should compromise come into play when the patient's conditions and goals for treatment are at odds with the orthodontist's? How is the orthodontist to react if the patient's decision to undertake treatment is based on cost or on prejudices outside the rationality of an orthodontist's diagnosis, such as no extractions, no surgery, no visible appliances, no headgear, or "I just want my front teeth straightened"?

If a patient will not accept visible appliances and that is all the orthodontist has to offer, the question is moot. But if a patient refuses extractions in a case in which the orthodontist thinks they are required, should the orthodontist treat the case nonextraction? Even if it is a borderline extraction case, should the orthodontist go along and try to treat the case nonextraction for a while to see how it goes? If the diagnosis calls for a headgear to support maximum anchorage, should the orthodontist proceed without it if the patient refuses to wear a headgear? Should an orthodontist do less than comprehensive treatment because the patient cannot afford full treatment?

Many prospective orthodontic patients present with two malocclusions, one they can see in the front of the

mouth—crowding, protrusion, diastemas, anterior open bite—and one they cannot see—posterior malocclusion. They are only interested in correcting the one they can see. If this can be done in a manner acceptable to the patient, is that acceptable to an orthodontist? It may be argued that orthodontics is a service, and that the patient has a right to choose whatever treatment he or she desires. It could even be said that orthodontics is a cosmetic service, and that partial treatment for cosmetic improvement is justified. On the other hand, does an orthodontic standard of care preclude making compromises to satisfy a patient's desires?

At one time, orthodontists were viewed by general dentists and the public as being uncompromising. We were accused of wanting to turn out only Cadillacs, only perfect full-treatment cases—and the accusation was true. Correcting malocclusions is what an orthodontist did, and there was an unwillingness to exchange one malocclusion for another. The orthodontist would not set out to achieve a partial or imperfect result. The orthodontist was a master craftsman, and the one-on-one doctor/patient relationship made the perfect result a matter of pride in workmanship for the orthodontist and of expectation for the patient.

This concept of orthodontics was based in part on the belief that the perfect result was also the most stable and the most healthful. As reports of frequent long-range instability of results were published, and as the relationship of occlusion to oral health became less certain, the primacy of perfect occlusion also became less certain. The cosmetic aspects of orthodontic treatment increased in importance. In addition, delegation moved the orthodontist a half-step away from the position of master craftsman, and there has been a sociological change in the doctor/patient relationship that has diminished the authority of the doctor figure. Under these circumstances, orthodontists have become more willing to compromise.

If partial treatment for cosmetic reasons would do no harm and accommodate a patient's need, many orthodontists today find justification for compromise, especially with the possibility of permanent retention. If the patient wants to try nonextraction treatment in an out-and-out extraction case, and is willing to pay for potentially extended treatment, orthodontists today may be more inclined to go along. In borderline cases, they may even suggest such a solution. If a patient will not wear a headgear, many "non-compliance" alternatives are now available. Although many private offices provide charitable treatment to some who cannot afford orthodontics, there may be more of a tendency nowadays to provide lesser significant treatment for a lesser fee if patients so desire.

To keep things in perspective, it may be well to keep in mind that while the emphasis lately has been placed on patients' rights, orthodontists have rights, too. There is no question that an orthodontist has the right not to make a compromise and not to treat a particular case. Even with the protection of informed consent, how often can the orthodontist accommodate patients' wishes and compromise his or her own decision-making without creating a professionally unrewarding practice? Is it possible to get so caught up in the numbers game that no prospective patient is willingly let go? Both orthodontists and patients might be better off if many treatment compromises were left unmade and the cases left untreated.

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