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THE EDITOR'S CORNER

Primum Non Nocere

"First, do no harm." Although the phrase has traditionally been ascribed to Hippocrates himself, it appears more likely that it was first coined by the Roman physician Galen. Regardless of whether the Hippocratic Oath actually contains those words, or whether we took any such oath when we earned our diplomas, the dictum is a sacred obligation for anyone engaged in health care. Those of us who have been blessed with the fortitude of character, intellectual ability, and family background that permit us to enter the health professions owe a debt of gratitude to society for allowing us to earn our living in the service of others. Orthodontists are particularly blessed with respect to lifestyle, working conditions, and a myriad of other factors. With that in mind, we have a special responsibility to be idealistic in the application of our professional standards. Every single patient we see has the right to expect, at the very least, that *primum non nocere* will be our prime directive. First and foremost, before anything else, we must never harm a patient.

I see no harm in implementing practice management procedures that allow us to maximize our incomes, provided that our primary goal remains the highest possible quality of care. One of the most memorable teachers along my own path of professional development was a prosthodontist who taught the TMJ courses in my residency program. He lived by a simple business philosophy: "Money is a byproduct of good dentistry." Not a bad way to look at it. Do your best, keep the patient's long-term well-being as your primary treatment goal, deliver the highest quality of care possible in an efficient and efficacious manner, and the money will follow.

What constitutes the highest quality of care, however, has always been the subject of debate. We can argue interminably over whether a case should have been treated with or without extractions, or whether a Class II would have been better addressed with Kloehn headgear in the mixed dentition, or by removing upper first premolars and lower second premolars in the adult dentition. Still, although it is difficult to define specific standards of

care that everyone can agree on, I think there are certain fundamentals that we should all live by. The patient should expect to end treatment with a stable occlusion that is both esthetically pleasing and optimally functional.

There are times when a patient asks the doctor to make compromises. In those circumstances, it is incumbent on the doctor to simply say no if, in his or her best judgment, granting the patient's request would in any way compromise the eventual quality of care delivered. If the doctor says no, and the patient walks away from treatment, the doctor will have met the prime directive. *Primum non nocere.*

All too often, I am tempted to allow the rather dominant ol' softy part of my personality to agree to a compromise treatment plan just to satisfy a patient's requests. "Doctor, I don't want extractions!" "Can't you just straighten the upper teeth?" "Can't we do that without braces—maybe just a retainer?" The one I am probably most susceptible to is, "Can't we just straighten my teeth and forget the surgery to align my jaws? All I want is straight teeth!" I have to keep telling myself, "First, do no harm!" Saying no to a patient is sometimes the only way.

Does this mean that we have to treat every patient to a gnathologically correct Class I occlusion? Not necessarily. There are numerous situations in which we may properly opt to treat to an *optimum* result as opposed to the *ideal* result. The most common examples that come to my mind are prerestorative cases. These patients are almost always adults, in their late 40s or 50s or older, who have decided to make the commitment to restore a mutilated dentition that reflects the ravages of time, and perhaps trauma or neglect. Their primary goal is to obtain a healthy dentition that looks nice and works well. They don't really care if they end up with the ideal profile in a Class I relationship. There is no scientific evidence to prove that such a result is actually healthier than a convex profile with a Class II skeletal pattern, even with what would be considered slightly excessive overjet. Treating this type of case to the optimum result of a pleasing smile in a healthy periodontium with good intercuspation and masticatory function, while forgoing the extractions or orthognathic surgery needed to achieve a Class I skeletal relationship, clearly does no harm. Other examples along the same lines would include limited treatment such as the eruption of fractured teeth that have been endodontically treated, to allow for acceptable margins in the final restoration without comprehensive orthodontics. Again, no harm is done in performing this kind of limited treatment.

Deciding between an ideal treatment plan and an optimal treatment plan may pose a difficult dilemma for the orthodontist. The choices are not always black and white. In such a case, it is usually advisable to present the patient or parent with a range of acceptable treatment outcomes and the respective treatment plans needed to achieve them. This forms the basis for informed consent, and the patient then becomes a valuable co-therapist with the doctor. If we keep the prime directive, "First, do no harm", as our guiding principle, we can deliver optimal care while still abiding by the most idealistic professional standards. *Primum non nocere.*

RGK