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the editor's corner

Look What They've Done to My Song

In 1967, when JCO was started, the United States was deeply involved in fundamental changes that seriously altered the social fabric of this country and that will have political, social, and economic reverberations for years to come.

The greatest impact on orthodontics has been a change from independence to dependence. Until the 1960s, there were more than enough patients to go around and orthodontic practices in much of the country were able to feel independent—independent of patients, dentists, and staff. Orthodontists were content to be generic. There was no need to create a distinction between one's practice and other practices. Happiness, Vic Benton said, was being a wirebender.

Today, many of the tasks formerly confined to the orthodontist are delegated to auxiliaries, producing a greater dependence on staff. Today, there are more than twice the number of orthodontists than there were 20 years ago, and many general dentists and pedodontists are doing a significant amount of orthodontic treatment. At the same time, we have also seen a decline in the number of annual births—the national fertility rate is at an all-time low. There has been a significant rise in adult orthodontics and in the number of patients receiving insurance benefits, but case loads in the average practice have not increased and the dependence of orthodontists on general dentists and patients for referrals has increased. In light of this, there is now a greater need for creating a practice distinctiveness in the minds of referrers and potential referrers, and a need for greater attention to practice building and practice management.

Much of the change in orthodontic practice has been the result of government intervention. Expanded delegation of tasks to auxiliaries resulted from changes in state dental practice acts. Some state "sunset" committees are

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making deregulatory moves aimed at independent practice of dental auxiliaries and lab technicians. The federal government has subsidized HMOs and supported PPOs and other alternative arrangements for the provision of dental care. The federal government went further than that in advancing concepts of deregulation of dental practice—attacking dental organizations as being in restraint of trade, and promoting efforts to reduce the cost of health care through increased competition by permitting professional advertising. The traditional professional code of ethics was destroyed in the process, and the concept of self-policing of professions seriously compromised.

All of this is changing the standing of the professions in fundamental ways, but the government made one additional intervention that may have had the most profound effect of all. That was its support for the idea that there was a shortage of dentists, and that the way to create more dentists was to subsidize the dental schools and, as a quid pro quo, prescribe quotas for the numbers of students. The program was highly successful in creating more dentists, but the need for all the additional dentists never materialized. The justification was changed to a concept that increased numbers of dentists would result in increased competition, which would result in lower fees.

The increased number of dentists has not resulted in lower fees. It has done more than any other single factor to decrease the busyness of the average dentist and to increase the amount of orthodontics being done by general dentists. While the increased number of dental graduates was accompanied by an increased number of orthodontists, the consensus in the specialty is that the amount of orthodontic treatment that is being shared with general practitioners is having more effect on the economics of orthodontic practice than the increased number of orthodontists.

How does the orthodontic specialty look after these 20 turbulent years?

Orthodontic treatment has improved. Our armamentarium has improved. There have been significant improvements in brackets and the attachment of brackets, and in the ability to control tooth movement, and in surgical orthodontics, and in our understanding of growth. The changes in our ability to correct malocclusions during the past 20 years can only be decribed as exciting.

It would obviously be a mistake to think that orthodontics has not been dramatically affected by all the changes noted, but orthodontic treatment is still essentially a one-on-one form of health care—strongly rooted in cosmetics. It still depends on patient cooperation and the use of brackets, wires, elastics, headgears, and removable appliances. It still takes approximately two years of active treatment. It still depends on retention for post-treatment stability. Furthermore, orthodontic practice is still almost entirely a fee-for-service, referral-source enterprise conducted by solo practitioners.

Orthodontics has probably been affected less than general dentistry by advertising and alternative forms of delivery of dental care. Few orthodontists have advertised, and the number does not appear to be increasing. There is no question that orthodontists' average standard of living has declined, but the average orthodontist still has a substantial annual income. The most recent JCO Practice Study shows that orthodontists are holding their own as far as income is concerned.

What does the future hold for orthodontists? So far, the referral-source, fee-for-service, solo practice of orthodontics is surviving virtually intact, and there is nothing on the horizon to indicate that will change very much in the next five years. What may happen in the next 20 years is unpredictable—but whatever it is, you can be certain that JCO will be reporting it to you as it happens. ELG