The 'good old days' — were they really so good?

By David L. Turpin, DDS, MSD

Staff meetings to plan public relations or promotional activities are as commonplace today as study clubs were a few years ago. At the conclusion of one such meeting in my office, a glance at my list of jobs to accomplish before the next meeting left me yearning for the "good old days."

When I started practice in the '60s I did not have to work hard to attract new patients. As word spread that there was an orthodontist in town, my practice grew and a waiting list of patients developed. Solutions to my problems then included becoming more efficient, hiring a larger staff and eventually bringing in an associate.

Yes, those were the good old days! But were they really so good, now that I think about it? Would I like to go back to orthodontic practice as it was in the '50s or '60s?

I do not miss pinching bands and welding brackets. I do not miss taking four to six appointments to fabricate and place an edgewise appliance. I know my patients do not miss living with a mouth full of separators, not to mention the effort it sometimes took to fit and cement every band.

Improvements in dental materials have had a positive effect on orthodontic treatment. Prefabricated stainless steel bands, straight-wire appliances and nickel-titanium wires have become invaluable to the clinician. Bonding materials as well as tooth color brackets have greatly enhanced the ability of the orthodontist to handle a number of new challenges. No, I'm not ready to do without the wide range of orthodontic materials available to us today.

I do not miss having to tell an occasional adult patient that he/she could not be treated because of a skeletal disharmony too great to be corrected without surgery. I specifically remember tears being shed at the chair when I tried to explain to a 39-year-old that wearing "braces" for two years would not correct the skeletal relationship sufficiently to warrant treatment. No, I'm not ready to return to a practice that had little to offer the nongrowing person with severe skeletal problems.

"The past is something to be yearned for...not returned to."
—Charles Osgood

The compromised orthodontic patient of today has the opportunity to participate in a multidisciplinary approach to treatment planning. The specialty of orthodontics is now a part of dentistry more than ever before. It is well-documented that several early educators, including Edward H. Angle, favored placing orthodontic education outside the umbrella of dentistry, perhaps as a specialty of medicine. It has taken 50 years to overcome these beginnings and bring the specialty where it belongs. With recent advances in dentistry, it is not uncommon for a general practitioner to coordinate the delivery of care, which may include orthodontics, perio-

dontics and orthognathic surgery. In return for a better educated general dentist, we are no longer aligned with the curse of a secret diagnosis or the magic appliance. There are no secrets in the realm of orthodontic care. Quality treatment results from the proper balance of education and experience. There are no shortcuts to becoming a good orthodontist.

Working as a team

No, I do not want to go back to the day when I could diagnose, plan and treat an adult patient without consulting every member of the dental team. How will the patient's periodontal problems be managed? What type of jaw surgery will accomplish our needs and what about the timing of this procedure? Who will fabricate the temporary pontics and how is it decided where to place the implants?

These questions and others were raised during treatment of the case report published in this issue (Case DM by Dr. John Ive). The patient was in an automobile accident and lost five anterior teeth, and considerable bone. The patient's palatal tissue reacted to the partial denture with anterior inflammatory papillary hyperplasia. The following questions could only be answered by a dental team able to communicate the most current clinical findings in their respective specialties:

- Can osseointegrated implants be used in this case to eliminate the partial denture?
- Will a maxillary anterior bone graft be necessary to fulfill esthetic demands?
- Is it helpful to "load" the endosseous implants to prevent resorption of the bony implant?
- How can the anterior teeth be temporarily replaced to maintain esthetic and functional requirements during this period of periodontal, surgical, orthodontic and restorative care?

These questions are addressed in Ive's report of the successful treatment of a complex case. No, I do not wish to return to the days when we could not deliver this type of dental care. I will continue to face today's challenges — three more lunches with referring dentists are scheduled, our quarterly newsletter is due at the printer this week, etc. — and appreciate the rewards of dental excellence well into the '90s.