Editorial

What is Our Standard of Care?

This seemingly obvious question lies at the heart of the definition of orthodontics. We would all like the answer to be high quality, or excellence or the best. These subjective and idealistic terms have a definite meaning in our own hearts and consciences, but their precise meaning is hard to convey to another dentist, much less to a layperson. It is safe to say that this traditional view is clearly at risk in today's world.

Perhaps the problem with the traditional definition is that it tends to be absolute. Like dental school we see ourselves, perhaps naïvely, as able to make perfection out of any problem. This is a worthy goal, but it is not the same as the reality of doing the best possible treatment for any given problem under whatever circumstances are present. Clearly, value lies in how much you receive with consideration for what you had to give up to get it.

We all know good care and it is obvious that good care does not necessarily equate with perfection. It is very possible to have 2 finished cases and have one of them more ideal than the other. It is also possible that the one with the less ideal outcome may have received far more value and, in fact, more benefit than the other. It depends on the problems associated with the treatment.

Since value is the operational word, how do we tell the consumer what value we offer? This is especially critical when the consumer is a third party who demands accountability. Orthodontics has no fear of being held accountable, but no gold standard exists for assessing the goodness (or badness) of orthodontic treatment.

One standard of care is that which you have established for yourself and exists in your office. All practices show a variation in treatment outcomes. We would all like to have our usual and customary treatments meet the very idealistic standard of care of the American Board of Orthodontics. The standard of care demonstrated by Board cases is without any economic concerns and represents a heavily filtered sample standard of care showing the most ideal the candidate can offer.

In contrast, the standard of care required to maintain a state license is very different. We want no treatments to fall below the standards of care required to keep a state license. This standard of care is what the State Board perceives as the level of care available and what the public has the right to expect. It has no economic overtones, and it has no reproducible standards.

Standards of care cannot be separated from the economics of practice. After all, value lies not only in what you receive, but also in what you had to give up to get it. For example, if a patient's care is paid by a third party, and a fixed fee paid by that provider is 25% lower than your usual and customary fee, is the standard of care the same for the reduced-fee patient as it is for the usual and customary-fee patient? One position argues that professionalism requires that fees should make no difference and the standards of care should be the same for all. Another view argues that that is unfair since either the doctor or the higher-fee patient is subsidizing the care of the lesser-fee patient. This scenario is not unlike the practice of a hospital that subsidizes the costs of indigent care with the charges made to full pay patients. Either the higher-fee patient's charges cover part of the treatment of the lesser-fee patient, the lesser-pay patient receives lesser care, or the doctor reduces the gross income to the office. Somebody has to give up something to have the value occur.

And what of the consumer? Should we passively allow the consumer to establish the standards of care for orthodontics? Will competition in the marketplace result in someone willing to meet the standards of care of the patient who wants minimal treatment? This may be below your standard of care, but when a marketplace exists, expect someone to meet it and to offer this service. What will be our position when this becomes an issue? What will be our rationale to justify our position?

The more alternative systems of delivery enter our marketplace, the more variations we will see in what is offered to the public. The more direct advertisements are made to the public, the more likely we will see variations in the standards of care. There are no easy answers, and the absence of any agreed-upon minimum standards of care is mute testimony to the complexity of the question.

The fact that it is hard to define our standards of care must not prevent us from addressing the question. Which standard of care will we use to define our services to a nonorthodontic person in the future? If we are ambiguous or unclear on what is proper orthodontic treatment, how can we expect a nonorthodontic person to see our ambiguity as anything other than the fox guarding the henhouse? Our professional credibility will be on the line.

It is past time for us to begin defining what constitutes acceptable standards of orthodontic care. We all know what ideal looks like and we all know all treatment outcomes are not ideal, but we have no definitions of what constitutes minimally acceptable care. We are the most qualified to ask this hard question, and we should do it before it has become a hot button issue. The legal overtones are obvious. It is important for us to document what we consider acceptable even if the answer is not absolute and necessarily includes caveats for multiple patient variables. It is important to the future of orthodontics. Standards of care do make a difference.