Letters to the Editor

'Nothing personal, it's just business'

I read with some sardonic amusement the recent guest editorial on 'The "Uberization of orthodontics" – or how low can you go?'[1]

Mention was made of both the growth of limited, so-called short-term orthodontics (STO), as well as the more recent development of do-it-yourself (DIY) orthodontics, namely one that requires patients to acquire their own smart-phone diagnostic dental photographs, take their own dental impressions, and subsequently self-administer a series of clear aligners that have been digitally fabricated to the prescription of a clinician who has never personally consulted with the patient.

In relation to STO, this approach is acknowledged as being an ethical treatment option, but only if it constitutes one of a range of those for a patient to choose from, together with an informed discussion of the various risks, benefits, limitations, anticipated outcomes, commitments and costs for each of them, as reported previously.[2-4]

When it does not, it potentially leaves the clinician in jeopardy of having to defend a General Dental Council (GDC) Fitness to Practice allegation of not obtaining valid consent, not to mention letting the patient down by not putting their interests first.[5]

In this type of situation, those who fall foul of the GDC seem more frequently to be non-specialists,[5] and some may have succumbed to the alluring commercial enticements of speed, simplicity, aesthetics and profit. Perhaps these registrants may also be the product of an undergraduate dental education that inadequately covered the acquisition of critical reading skills, simple statistical assessments, ethics and jurisprudence in its curriculum. Otherwise, more discerning evaluations would be being made about the unsubstantiated claims that are often propounded by those with a vested interest in selling their aesthetic treatment products.

In relation to DIY orthodontics, I have seen one of these television adverts that have been aimed directly at the public. They are professionally produced and to the eye of an innocent they certainly appear to be straightforward, safe and relatively inexpensive. However, the lack of direct clinical contact and supervision is a major cause for concern that leaves much to be desired.[1,6]

For both STO and DIY orthodontics, perhaps the origin of why they now prevail is because of the freedom to advertise directly to the public, a freedom that arose in 1988 when the elected GDC Council had to submit to the Office of Fair Trading Director General's directive of relaxing the profession's former advertising restrictions.[7]

While the consequential descent into the gutter of the dental profession that was predicted by many did not materialize, the overly aggressive marketing of cosmetic techniques by some dentists and dental groups has nevertheless been noted, together with the potential for this to undermine the profession's integrity, a perception that seems to be lost on a growing number of dentists who regard dentistry as a business rather than a profession and who see it as just doing another job.[8]

Even if the relaxation of dental advertising has not resulted in a gutter descent, since familiarity breeds contempt, one could argue that it may be partly responsible for the pendulum swing of the personal attributes that seem to currently prevail amongst some professionals, that is, a shift from those of altruism and vocation towards those of business and profit.

In relation to the dentists who facilitate the provision of DIY orthodontics, for those who come under the jurisdiction of the GDC, they risk falling foul of its Fitness to Practice Committee on several counts, not least of which would include failing to undertake an adequate orthodontic assessment, not carrying out sufficient treatment planning, not providing the patient with a written treatment plan, not obtaining written consent, not maintaining an adequate standard of record-keeping and not adequately monitoring the progress of the orthodontic treatment.[5]

It is a sad indictment, but ultimately it may take a public outcry from disaffected DIY orthodontic patients to enforce a change, once the problems associated with their remotely prescribed and produced orthodontic treatments eventually manifest.

As far as dental advertising is concerned, the genie is definitely out of the bottle[8] and there will be no putting it back.

So, to answer the rhetorical question posed in the second part of the recent guest editorial's title of 'how low can you go?'[1] the answer may be found in the Sicilian mantra of the Cosa Nostra, which is that it's 'Nothing personal, it's just business'.

But surely, isn't that the crux of the whole problem and, if it is, how can the creeping slide of the practice of dentistry be reversed from being a profession towards merely being a trade?

References

1. Kelleher M. The 'Uberization of orthodontics' – or how low can you go? *Dent Update* 2016; **43**: 606–607.
2. Chate RAC. Truth or consequences. *Br Dent J* 2013; **215**: 551–553.
3. Chate RAC. Short term orthodontics. High profitability and low risk. *Br Dent J* 2014; **217**: 107.
4. Chate RAC. Short-term orthodontics debate. *Br Dent J* 2014; **216**: 388–389.
5. Singh P. Orthodontic allegations raised against registrants by the General Dental Council. *Br Dent J* 2016; **221**: 291–294.
6. O'Brien K. Do it yourself orthodontics revisited: Invisalign and SmileDirectClub and others. **www.kevinobrienorthoblog.com** (Accessed 30 August 2016).
7. Lawton F. President's address to the General Dental Council. *Br Dent J* 1988; **164**: 305–307.
8. Newsome PRH, Langley PP. Professionalism, then and now. *Br Dent J* 2014; **216**: 497–502.

Mr Robert Chate
Vice-dean, The Royal College of Surgeons of Edinburgh

A case report of an unusual presentation of a keratocystic odontogenic tumour in the anterior mandible

Keratocystic odontogenic tumours (KCOTs) are commonly seen in the posterior mandible. They can also rarely occur in the anterior mandible and mimic