Whistleblowing or scaremongering?

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We live in a society of free speech but we, as dentists, are also privileged to be members of a self regulated profession and, as such, have responsibilities to fulfil. Dentists must be responsible for supplying balanced information to the public, based on the best evidence available.

The Government's NHS act, passed in July 1999, is a clear indication of intent to improve quality in the NHS. The National Institute for Clinical Excellence (NICE) is part of this process and will have a key role in co-ordinating evidence based clinical practice and disseminating information.

Among the principles expressed by the Health Secretary is the following: 'Clinical decisions should be based on the best possible evidence of effectiveness'. It is therefore important that clinicians use therapies based on the best possible evidence, and that efforts continue to develop our knowledge base to identify what we need to treat, how to treat it and when to treat it. Professional accountability is an inherent part of clinical governance and it is incumbent on all health professionals to behave responsibly towards each other and in the best interests of patients. It is in this context that 'whistleblowing' is an acceptable aspect of professional behaviour in cases of poor performance. It is also important, however, that this is done in a non-threatening environment, and without the glare of media publicity, to facilitate remedial training where appropriate.

The claims

Many readers will have watched the *Dispatches* TV programme on orthodontics in December 1999. This presented a series of orthodontic scenarios which suggested that orthodontics as practised 'conventionally' in the UK was damaging. It went on to advocate 'alternative' therapies promoted by a minority group of dentists. The clinical issue is not one of appliance types but frequency of use and case selection. Removable arch widening appliances to increase the space available for crowded teeth, and functional appliances to reduce Class II discrepancies have been used by orthodontists for several decades and are taught routinely on M.Orth three year full time courses. British orthodontists are trained to be selective whilst some dentists who attend occasional two or three day orthodontic courses may be less discriminating, being persuaded by claims of far greater therapeutic potency than has ever been proven. The implied ease with which facial proportions can be manipulated at will and by any amount, using expansion and functional appliances, is not supported by current evidence.

It may well be claimed that the opening statement in the programme, that 50 per cent of the children who undergo orthodontic treatment suffer facial damage, was an act of whistleblowing. This might imply that the programme was a way of identifying, and if possible helping, individual colleagues who are under-performing in some way. It must however be deemed irresponsible to attempt to blow the whistle on an entire discipline without robust scientific evidence.

The need for evidence

The resurrection of a treatment philosophy and techniques similar to those used in the first quarter of the last century (but later rejected) should be treated with great caution, at least until fresh evidence is produced to demonstrate definite advantages in terms of aesthetics or dental health while at the same time providing long term stability. After 25 years of being lobbied, are we not entitled to ask where are the clinical trials that would be necessary to provide convincing evidence?

There is undoubtedly room for improvement in the way that orthodontics is administered and carried out in the UK. However, it is a mature specialty with a strong academic base and respect for scientific evidence. The inference in the programme that specialist training supported by research is of doubtful relevance or validity confronts all dentists who value structured training and evidence based clinical practice. The message enshrined in the 'alternative' treatment philosophy is well known to all orthodontists. If this consistently delivered what it promises, there would be no controversy as orthodontists would all recognise the benefits.

No, this was not whistleblowing but an act of scaremongering, causing unwarranted anxiety in the minds of many thousands of parents and children. Scaremongering is not new to dentistry, as the media handling of the amalgam, frequency of dental examinations and fluoridation controversies has shown. In all these issues, scaremongering tactics continue to be used selectively to manipulate the vulnerable without any solid scientific evidence.

Responsibilities

We live in a society of free speech but we, as dentists, are also privileged to be members of a self regulated profession and, as such, have responsibilities to fulfil. However, the principle of self regulation is threatened by the irresponsible behaviour of some of its own members. Through its elected representative bodies, the profession must consider the issue of professional accountability when some of its members create unwarranted anxiety in the general population by engaging in negative campaigning and scaremongering.

Dentists must be responsible for supplying balanced information to the public, based on the best evidence available. Where there are new therapies, these should undergo rigorous scientific investigation. Regrettably, in the case of those who advocate the alternative approach to orthodontic treatment, attempts to gather the clinical records required for scientific scrutiny have been unsuccessful. Collaboration with research institutions thus remains elusive.

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