EDITORIAL

ORTHODONTICS: A THEMED ISSUE

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Guest Editors, *BDJ* themed issue on orthodontics

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BDJ UPFRONT

When the National Health Service was formed in 1948 orthodontics and oral surgery were designated as consultant-led specialties. It is interesting to consider what has happened to orthodontics since then. This themed issue explores most of the important areas in orthodontics and will undoubtedly raise some pithy comments and observations. It sets out what we believe are important messages for the general dental practitioner in terms of treatment timing, methods and delivery of orthodontics. The themed issue is grounded in the best interests of patients and the specialty.

Who does what in the orthodontic workforce is probably the start of what has been the biggest change in orthodontics over the last three decades. When we arrived in Bristol at the beginning of the 1990s the local view was that service delivery of orthodontics in general dental practice was the right model. Our view differed and we built an orthodontic training programme for specialist orthodontists in the belief that the majority of service should be delivered by specialists. Bristol still runs an excellent orthodontic undergraduate training in orthodontics, including instruction in the placement and management of fixed appliances. From this we feel the students benefit from seeing what can go wrong, as well as what can go well and therefore the need for specialist training.

In postgraduate training we were always anxious that students understood the complexities of research and so wished to minimise the time spent acquiring knowledge in order for them to spend more time on their research. To do this we built an online virtual learning environment and also published *'Postgraduate notes in orthodontics'*, the latter being updated every three years for our new intake of postgraduates. Where our postgraduates have ended up has been driven by market forces. The majority work in specialist practice, a number have become NHS consultants and two are currently undertaking academic training. The latter has until recently been a less attractive option, but since 2006 and the end of fee-for-item payments, the introduction of the new individualised contracts and the need for retendering, an academic career with some freedoms is now perhaps more appealing.

> 'So why suddenly the surprise that the orthodontic workforce might now be too big?'

We also ran a pilot study for orthodontic auxiliaries in Bristol which shaped the UK training programmes. The advice we gave on how many of these courses should run until the impact on the workforce had been assessed was unfortunately ignored. So why all the surprise when we suddenly start to consider that the orthodontic workforce might be too big? Workforce planning is nearly always wrong and the consequences are often not recognised. The expansion of undergraduate training numbers and dental schools only eight years ago is now being reversed with a 10% cut of student numbers. Not surprisingly vice-chancellors and teaching trusts take a fairly dim view of the decision makers who take none of the risks or indeed the financial consequences.

The increase in demand for adult orthodontics was predicted in the last century and courses are now springing up offering supposedly quick treatments to be carried out by those with little training or experience. The obvious reason is that it is lucrative. It is also dangerous and accounts for the increased litigation in this area and thus indirectly to the rise in General Dental Council registration fees. This themed issue will not stop this wave, but why do we think it takes three years to train a specialist and a further two years to train to the level of a consultant? Orthodontics is complicated, it can go wrong and you need adequate training to demonstrate competence and be able to deal with the unpredictable.

Our final comment is on the research base in orthodontics. Almost any systematic review of research in an area of orthodontics will tell you the primary data is inadequate and further research is needed. Proof is then needed through randomised controlled trials and subsequent meta-analysis to support clinical approaches. Those with little or no research training have taken a polarised view on research in that they have their hypotheses and instead of them having to prove they are right they expect it to be shown that they are wrong! Many of these theories are unlikely and untestable without vast amounts of money and time. There is also sufficient evidence (albeit low level) to suggest these are not areas to pursue. What we do need to prove is the absolute benefit of orthodontics and the value of someone having perfectly straight teeth.

We hope you will enjoy reading the articles in this themed issue on contemporary aspects of orthodontics.

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