The phone call comes one evening as you are reviewing an interesting article in the latest issue of the Journal. It’s your neighbor, who tells you that his wife Susan is now in braces. You swallow once, wondering why Susan didn’t seek your opinion. Evidently, Susan had responded to a mailed advertisement from an orthodontist who practices in a nearby dental group. After a brief examination, Susan left the orthodontist’s office that same day with full brackets on both arches and an archwire in place. You ask whether x-rays and images or casts of the teeth were produced at that appointment. Your neighbor responds that only a few photographs and a radiograph of the teeth were made, but the brackets went on even before the radiograph was brought to the operator for the doctor’s review. A treatment coordinator told Susan that she “needed full braces as soon as possible.” The financial contract was signed, and the brackets were placed. The entire appointment lasted less than an hour. Susan said that the staff assured her that she was doing the right thing, so she decided to proceed with immediate treatment to minimize lost work time.

As your neighbor recounts the story, you recall that Susan had lost a few teeth several years ago because of periodontal involvement. Your neighbor is concerned that no collaboration with her periodontist occurred. Susan said that the informed consent discussion was too brief to be understood, and her idea of her overall treatment plan was sketchy at best. Your neighbor asks whether this is the new standard of orthodontic care.

There appear to be several concerns associated with this style of orthodontic care delivery. The patient is not only denied a thorough diagnosis and thoughtful treatment planning, but also deprived of dental or medical collaboration when needed. The time spent with the doctor is minimized given the priority of accomplishing multiple procedures in a short time, limiting the opportunity to establish trust and confidence in the doctor. The patient can barely discuss her case and assert her autonomy regarding her treatment choice—including her ability to decline treatment altogether. Perhaps that is this orthodontist’s greatest fear.

There are additional concerns. Nothing trumps a carefully documented, thorough clinical examination. However, our mental recall of the intricacies of a case, even those that appear to be routine, can become vague. Documentation of the patient’s initial presentation can reveal nuances that are too subtle to determine at first glance. Consider pretreatment internal root resorption or a significant centric occlusion-centric relation discrepancy that is initially undetected. Either might become critical once treatment proceeds. Visual and tactile recalls are thus essential for comparison of the future status and case progress—or lack thereof.

Pristine records also provide an introspective evaluation of a treatment result for pretreatment and posttreatment comparisons. The patient’s metamorphosis in treatment and growth is sometimes too gradual and subtle to recognize. This can be especially true when control of a case falters or growth proceeds unfavorably.

As most boarded orthodontists know, self-assessment can be an enlightening educational experience. And in the clinical research arena, treatment outcome fully depends on access to quality records. From a forensic perspective, complete diagnostic and treatment records documenting the orthodontist’s attention to the patient’s needs and desires are key in legal defense, if questions arise. The value of quality diagnostic records has even more expansive consequences. One of the most common reasons for rejection of case reports submitted for publication to the AJO-DO is inadequate quality or content of the records (Rolf Behrents, personal communication, February 26, 2016). Publication of case reports depends on several factors, but accurate and thorough documentation of pretreatment and posttreatment conditions is indispensable.

Diagnostic orthodontic records for publication in the Journal must include, but are not limited to, the following: (1) extraoral and intraoral photographs; (2) a panoramic radiograph and periapical radiographs where indicated; (3) diagnostic casts, either plaster, digital, or stereolithic; (4) diagnostic setup casts, created from either

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secondary initial casts or digital setups; (5) lateral cephalograms and cone-beam computed technology images when diagnostically indicated; and (6) initial and final cephalometric tracings with superimpositions.

Your reply to your neighbor might include your recognition that it is indisputable that business philosophies vary among practitioners. However, the fundamentals of patient care are immutable and have not changed appreciably since we were educated in the delivery of orthodontic specialty care. Patients will always be entitled to the presentation of a thorough diagnosis, followed by treatment options ranging from the most optimal to no treatment at all. Informed consent must be delivered in a relaxed atmosphere with ample time for questions and answers. Collaboration with other practitioners on behalf of many adult patients is imperative before a single tooth is moved. This should be followed by thorough disclosure of surgical, restorative, and periodontal needs, including costs. A bit of prudence before treatment begins might avert a big surprise after treatment.

**REFERENCE**