measuring distance from pogonion to occlusal line perpendicular. This distance was pretty close among the groups, and they were actually homogeneous. The severity of skeletal class must not be defined on the basis of dental measurements such as overjet and mandibular incisor position.

Therefore, selection bias wasn't present. It must be clear that the patients were enrolled by evaluating chin position and not overjet and mandibular incisor inclination. The amount of overjet or mandibular incisor proclination did not influence the probability for a patient to be included in the study. Finally, the differences at baseline in mandibular incisor position and overjet didn't bias patient selection.

Regarding baseline overjet and incisor proclination as confounders, to our knowledge, no data are available in the literature to define incisor position and amount of overjet as risk factors for skeletal correction of Class II and specifically for Herbst treatment effect (outcome, pogonion advancement).

Consequently in our study design, they can't be defined as confounders.

It is only known that mandibular incisor flaring can be a negative side effect; therefore, the use of skeletal anchorage can be beneficial.

Moreover, it is clinical experience, but there is no scientific evidence, that mandibular incisor proclination can be an obstacle for mandibular advancement in this type of malocclusion because it reduces the overjet itself. It is not important what is the baseline position of the mandibular incisors, but rather how much they procline during treatment. This is why skeletal anchorage could be beneficial, and we have considered it as an exposure to take into account. In the same way, it could be hypothesized that a greater overjet favors mandibular advancement. However, our results showed that patients with the narrowest overjet had the best response to treatment.

Regarding the "specific criteria for dividing patients" used in our research, it is difficult to see the connection between this question and the design of our study. In fact, our study was a retrospective observational study (case-control), where we analyzed the effect of a treatment on a cohort of patients. On the contrary, a case report or a case series is a detailed description of unexpected and unusual symptoms, diseases, treatments, and outcomes of individual patients. Then, it is well known that researchers in observational studies are passive and observe the effects of treatment without choosing the type of treatment for each patient (randomization). Lastly, we agree that a randomized controlled trial is the best study design, but observational studies can also help us to understand daily clinical conditions and treatment effects.[1]

Antonio Manni
Lecce, Italy

Sabrina Mutinelli
Trento, Italy

Laura Mazzotta
Cagliari, Italy

Marco Pasini
Massa, Italy

Mauro Cozzani
Cagliari and Genova, Italy

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Do what I say and not what you do

I would like to comment on "Well begun, half done" in the July issue of the *Journal* (Greco PM, Grubb J, Vaden JL. Am J Orthod Dentofacial Orthop 2016; 150:11-2).

The essay presented a hypothetical ethics case study that sought to demonstrate the importance of a full battery of diagnostic orthodontic records before the initiation of treatment and emphasized the orthodontist's ethical duty to separate clinical decisions from practice management considerations. Although the article was well intentioned, how it was written was less than collegial. Two ethics articles previously published in this *Journal* describe more pertinent ethical and legal concepts using a less condescending tone.

In the "Litigation, legislation, and ethics" article in the January 2006 issue of the *Journal* (Jerrold L. Models and the standard of care. Am J Orthod Dentofacial Orthop 2006;129:78-80), the author discussed the 1-visit consultation and the ethical and legal implications of this mode of practice. One conclusion offered was that the need to take models or any other diagnostic record is largely a risk management decision and not necessarily an ethical decision as far as standards of orthodontic practice are concerned. Without a more complete clinical picture of the hypothetical patient, which even the hypothetical narrator doesn't have in the

article by Greco et al, orthodontic treatment may be de minimis as Jerrold describes. So to impugn the 1-step consultation from an ethical and legal standpoint is a dubious argument.

In the "Ethics and orthodontics" article in the June 2015 issue of the *Journal* (Greco PM. A difference of opinion. Am J Orthod Dentofacial Orthop 2015:147: 653), the author discussed the importance of teaching the patient about the specifics of his or her orthodontic problems and placing the patient's best interests above any professional difference of opinion. The clinical theory espoused in the article is that "ideal" treatment that produces "ideal" occlusion (comprehensive treatment) may be preferable to a limited intervention (improving the esthetics of the social 6), and this must be communicated to the patient. Without verifiable facts supporting the concept of "ideal" in orthodontics, the patient's desire for enhancement of the smile must be appreciated. Practitioners who are uncomfortable with this notion do not have to treat the patient. However, they must respect patients' autonomous decisions to elect a course of treatment that fits their needs after weighing the risks and benefits and the alternatives.

In the end, the "Well begun, half done" article does not present an ethical argument and instead presents a series of trenchant opinions.

Marc Bernard Ackerman
Boston, Mass

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