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PCSO Bulletin

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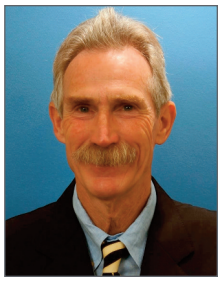

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Biography

Dr. Straty Righellis, a Diplomate of the American Board of Orthodontics, is an associate clinical professor at the both the University of the Pacific and the University of California, San Francisco. He also lectures annually to residents at Boston University, Harvard University, the University of North Carolina, the University of Colorado, and Arizona School of Dentistry & Oral Health orthodontic residents.

Dr. Righellis is a reviewer for the *American Journal of Orthodontics & Dentofacial Orthopedics* (*AJO/DO*); he has written over 35 articles and papers on treatment efficiency and treatment excellence, and has lectured to over 350 groups nationally and internationally. He authored a chapter on treatment efficiency and excellence for the textbook *Goal-Directed Orthodontics*.

In 2014, Dr. Righellis was one of six judges who selected the best paper in the *AJO/DO*. In 2015, 2016, and 2017, the *AJO/DO* acknowledged his contribution as one of its top reviewers (according to the number of reviewed manuscripts).

Dr. Righellis is a faculty member at the Foundation for Advanced Continuing Education (FACE) teaching program, past president of the Edward H. Angle Society of Northern California, and a former PCSO delegate to the AAO. He graduated from UCLA Dental School and received his orthodontic specialty certification from University of California, San Francisco. In addition, he maintains an active private practice in Oakland, CA.

Patrick Turley (PT): Think of the reasons you wanted to become an orthodontist years ago. Do they still hold true today?

Straty Righellis (SR): I was in the sixth grade when I decided to become an orthodontist. I liked what my orthodontist did. He would carry on a conversation with me about school or sports as he shaped some wire on the table near the chair. He had two assistants who helped him with a number of procedures. Also, I noticed he would interact with my parents and other patients in the office. Although much has changed since that time, those same elements are what I truly enjoy in practice today. Of course, diagnostic and treatment changes have evolved as more clearly defined treatment goals have been established.

PT: As a full-time practicing orthodontist, an educator, and a volunteer in organized orthodontics, do you have a perspective on the future of orthodontics?

SR: As an orthodontist with a fee-for-service practice, and as an educator who leads seminars with orthodontic residents from many programs in the U.S. and internationally, I do have a few observations.

First and foremost, orthodontic programs continue to attract the brightest minds in dentistry. These individuals are personable and inquisitive. It amazes me that our specialty continues to attract the top dentists; that's a credit to our orthodontic profession.

However, when I speak to orthodontic residents, I sense a shift in what new orthodontists will do when they graduate. More residents are delaying entering private practice, probably due to student debt. They are not sure where they can afford and/or want to live and work. The opportunities to associate in a fee-for-service orthodontic practice are few, and the number of days per month is limited. As a result, alternative practice modes are enticing to the young graduate.

PT: Can you be more specific about these different modes of practice?

SR: There are alternatives and options not only in healthcare, but in all of consumer life. For example, the neighborhood grocery store must compete with large, corporate grocery outlets. In dentistry, and specifically in orthodontics, this is

so clear. We have the traditional fee-for-service model, the corporate orthodontic model, franchise orthodontics, and now do-it-yourself (DIY) ortho!

PT: Does this concern you?

SR: Not at all. I view this as an opportunity! Throughout my years in clinical practice, the landscape has constantly changed. I recall a time when the name on your sign could be no larger than three inches, and when insurance companies became a part of our practice lives. While the signage and marketing approaches have evolved, and the insurance companies control our fees to some extent, the fee-for-service practice can still thrive.

Orthodontics is becoming layered. We see it with the marketing of corporate orthodontics—such businesses compete using location, extended hours, and price to attract patients; just look at media advertisements!

PT: If fee-for-service orthodontics is to survive and thrive, what do you think must happen?

SR: The fee-for-service orthodontist must have more to offer his/her patients, and I'm not referring to swag. Fee-for-service care must offer enhanced services and expanded treatment goals. We have to be more than just "tooth straighteners." We must be experts in occlusion, facial balance and symmetry, smile design, periodontics, and airway analysis. This means we must learn all we can from restorative dentistry, oral surgeons, periodontists, and ENT specialists. We must learn from each other to provide comprehensive dental care.

Corporate dentistry is here; it will serve the needs of some, but the future of fee-for-service care will be bright as long as there is interaction with other specialists. That is how we will provide comprehensive dental care.

PT: Let's shift gears. Your résumé notes that you are a long-standing reviewer for the *AJO/DO*. Can you tell us how you keep up with reading journals, and how you integrate new information into your clinical practice?

SR: This is a challenge. As a busy clinician, I cannot possibly read every article that is published. Everyone has their own learning style, but I find the best approach is to read the topics in the journals, specifically in *The Angle Orthodontist* and the *AJO/DO,* then highlight (i.e., tear them out of the journal, old school style) and read them a few days later.

My process is to read the abstract first, then jump to the conclusion section. I connect the question asked and the conclusions provided; if I think the article has value to me and my patients, I move to the methods and materials section to see if any bias has been inlaid into the paper. If you only read summaries or abstracts, you may just get the particular reviewer's interpretation of the question.

Reading the methods and materials section is key. This is the recipe. If you and I independently repeat the study using the same recipe (methods and materials), we should have similar conclusions.

Integrating what I read is the challenge, as it is easy to keep doing things the same way. It helps to be self-critical about the care we provide and to realize that there are ways to constantly improve in order to enhance our outcomes. That is when I integrate the new idea into the practice.

PT: When a client comes to your office with questions about various treatments based upon unfiltered internet information, how do you deal with it?

SR: Great question.

We all have had parents arrive with preconceived ideas about a child's orthodontic treatment. The clearest example is when the parent insists upon non-extraction care regardless of the amount of crowding or excessive facial protrusion that might exist.

For example, when a parent is resistant to extractions, a complete set of records is a great educational tool. These include mounted study and diagnostic models showing the amount of expansion needed along with facial computer visualizations. They will clearly show the effects of excessive expansion on the facial balance and the periodontal tissues. Showing this evidence plus verbally sharing your vision or goals for occlusion, facial balance and symmetry, smile esthetics, and respect for the long-term health of gum and bone tissue is helpful. The parent's value system or preconceived notions may not change, but at least you have presented what you stand for.

Keep in mind that part of our responsibility to our patients is to teach them, guide them, and give them the benefits and consequences of a particular approach. The time you spend may not sway your parent, but they may share your tactic and highly recommend you to others who share your approach to orthodontic diagnosis and treatment.

Pat, you and I have both practiced long enough to see this happen many times over. And our commitment to clear goals has helped us to create practices where patients and parents feel the same way.

PT: For the past three years, you have been acknowledged by the *AJO/DO* as one of its top reviewers. In 2016, you reviewed the same number of articles as Kate Vig and only a few less than Kevin O'Brien from the UK, which puts you in special company. What type of articles do you most commonly review, and how does that complement your private practice and teaching responsibilities?

SR: When I graduated from my orthodontic program, I was planning a small private practice and a half-time teaching position. My passion was—and still is—teaching, so reviewing articles is pure pleasure.

The editors with whom I have had the pleasure to volunteer ask me to review research papers that have clinical implications. The topics range from facial balance/symmetry, to effects of extraction/non-extraction treatment on the face and occlusion, to the effects of palatal expansion on the face and airways—to name a few.

Reviewing these articles makes me a much better clinician, as I must look critically at what our colleagues are researching and what effect that may have on all our practices, assuming we practice evidence-based orthodontics. It also makes me more conversant with my clients when they introduce other approaches.

PT: Dr. Righellis, let's talk about the subject you most commonly discuss in your lectures: treatment efficiency and excellence. Tell us about what you think is most important in achieving excellent clinical results?

SR: Achieving an optimal outcome with efficient use of treatment visits has three components.

The first component is an accurate and complete diagnosis. Do we really see everything we need to know about the patient? Do we look at every aspect of the occlusion, facial and smile symmetry, airway, jaw joints, gum and bone tissue? Do we listen to the patient's chief concerns? For example, are there occlusal wear facets on the teeth, and can the wear patterns be related to specific jaw movements? What about the health of the jaw joints? Are there pops, clicks, or crepitus? Do we ask the right questions about

breathing? Are there subtle smile and facial asymmetries noted prior to treatment? These are just a few questions that we need to investigate prior to treatment. We all have had experiences in which those subtle findings surfaced and become more obvious during treatment. Sometimes these unexpected occurrences require extended treatment time, an alteration of the original treatment plan, and/or even an unexpected result.

The second component is a clear vision of our expected outcome. Is there visualization for the occlusion, facial balance, and smile attractiveness? Will treatment enhance or detract from facial esthetics? And of course, for completeness we need similar visualizations for periodontium, jaw joint, and airway health.

The third component is organized mechanic sequencing. All orthodontists have their approach to efficient mechanics. As an educator, when a student brings a case to me that may have finishing challenges, I often view it as a diagnosis problem or an unreasonable expectation.

PT: Can you describe your protocols for achieving treatment efficiency?

SR: Our office has protocols for a complete diagnosis, techniques to visualize the expected outcomes (using Visualized Treatment Planning software), and a direction for efficient mechanical sequencing.

In the fixed appliance treatment for the growing patient in the permanent dentition, the first step is accuracy of bracket placement.

After the brackets are placed, treatment sequencing begins. Each clinical staff member and I see what must be done at each office visit and know what to expect from the outcome from that visit. Treatment is divided into three stages; each stage has specific objectives and a timeline of expectations. Stage 1 is primarily leveling and aligning the brackets. However, we also look to initiate midline corrections and begin closing open bites.

Stage 2 is the working stage, when A-P, transverse, and vertical changes are made. We have specific expectations for achieving these changes. If not, there might be patient cooperation issues and/or misdiagnosis of facial growth expectations.

Stage 3 is the finishing stage—or, as we learned in school, "detail and retain." This used to be very tedious, with ad nauseam wire bends and a timeline of six to nine months. However, with preadjusted bracket systems, initial use of flexible wires, and alert and timely bracket repositions at the end of Stages 1 and 2, Stage 3 should only take three to four months. If not, I was inefficient in Stages 1 and 2.

In addition to an attentive office crew who makes every office visit meaningful, there are other modifiers for clinical efficiency such as well-designed bracket prescriptions, self-ligating brackets, office motivational techniques, and the use of accelerated tooth movement techniques. My passion for efficiency was demonstrated in four cohort studies of 100 consecutively started patients over 15 years, and graded by an independent orthodontist. These cohort studies documented that the three above efficiency components reduce treatment time and produce better occlusal outcomes, as scored by the independent graders.

Time limits all the protocols we use; however, if any of your readers would like more information, they may email me at **straty.er@gmail.com**, and we can set aside time to discuss.

PT: Who were your mentors, and what have they contributed to your professional career?

SR: Countless orthodontists have shaped who I am and what I do. However, there are a few special part-time instructors at UCSF that had an early and lasting impact!

First, Dr. Wayne Watson instilled in me the balance between being a strong clinician and having an active academic mind as I integrate new technology and/or ideas into my clinical practice. To this day, Wayne and I still have great conversations!

Dr. Bob Scholz, or Uncle Bob, as many knew him, gave me guidance and confidence as I pursued my passion to teach others. Dr. Kleve Johnson, another part-time instructor, demonstrated the balance between a successful private practice, family, travel, and the outdoors.

And lastly, I must mention Dr. Ron Roth! His passion for orthodontics, his principled convictions, and his ability to produce predictably high-quality outcomes are most impressive. He too was a friend, and an incredible and passionate mentor. Like the other role models mentioned here, he was unselfish about using his time to teach others.

What these mentors taught and lived constantly laces my professional life. To them, I say thanks! ◈