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THE EDITOR'S CORNER

The Case Against Two-Phase Treatment

A number of topics in orthodontics have generated controversy for many years and will probably continue to do so, no matter what evidence is presented. These include extraction therapy, gnathologic occlusion, and functional appliances. But the subject most likely to stimulate heated debate at any orthodontic meeting is probably that of early treatment. On one hand, the proponents of two-phase treatment list benefits including the need for fewer extractions, the potential for achieving more stable results, and the ability to take maximum advantage of the patient's growth, possibly avoiding later surgical treatment. On the other hand, those who do not believe in early treatment contend that overall treatment time is increased—that the sum of Phase I time plus Phase II time is more than would have been required to treat the case in one phase, after the patient had reached the full permanent dentition. Although few would argue the need for early treatment in cases where a malocclusion is causing some kind of damage, either physical or psychological, my take on the truly scientific data available to date is that there is no physical, medical, or dental advantage to treating a routine case early, in either the primary or the mixed dentition.

Unfortunately, to the best of my knowledge, there is simply no evidence with regard to psychological outcomes. The patient's well being should always be our most important consideration in treatment planning. Still, if there is no patient-related reason to choose one treatment modality over the other, it makes sense to choose the one that is most efficacious from a practice-management point of view. I have heard one well-known (and rather acerbic) lecturer state, "Early treatment is bad for the patient, but good for the practice", implying that those who recommend early treatment may be doing so for economic rather than treatment-planning purposes. The hypothesis is that early, two-phase treatment is more profitable for the practice than single-phase treatment. In this issue of JCO, our Management & Marketing columnist, Dr. Robert Haeger, puts that hypothesis to the test.

Dr. Haeger and his consultant, Dr. Roger T. Colberg, have been using statistical analysis to examine various aspects of his orthodontic practice, and have been presenting their results to our readers in a series of columns. In August 2007, they evaluated the effects of bracket failures and missed appointments on practice profitability. This month, they turn their attention to two-phase treatment. Their conclusions: Two-phase treatment required about eight months more active treatment time, on average, than was needed for comprehensive treatment. This added up to about 13 extra appointments per patient. Furthermore, although Dr. Haeger was charging 22-25% more overall for two-phase treatment than for single-stage treatment, his revenue per appointment and revenue per clinician minute were at least 20% lower. In other words, two-phase treatment can actually reduce profitability.

In a recent series of lectures, I argued long and loud against drawing general conclusions about any research findings that come out of one office alone. So it's only fair for me to repeat that these results were derived from a single practice. I'm looking forward to a future article in this Management & Marketing series, which will examine the economics of two-phase treatment across the entire population of the Super Schulman Group. In the meantime, Dr. Haeger's column should provide ample impetus for each one of us to analyze the data from our own practice. All of us should emulate his objective, analytical approach to making decisions about practice management.

As Dr. Haeger points out, there is no doubt that treatment is indicated during the mixed dentition in cases of traumatic posterior or anterior crossbite, severe anterior open bite, and a few other detrimental situations. In routine cases, however, there is little evidence to support the idea that early, two-phase treatment is beneficial to either the patient or the practice. RGK