LETTERS

Economics and Ethics of Two-Phase Treatment

The recent Management & Marketing column by Dr. Robert Haeger ("Statistical Analysis of Two-Phase Treatment Compared with Single-Stage Comprehensive Treatment," JCO, March 2008) supports the contention of many orthodontists that two-phase care is not recommended to patients in order to maximize profits. Of course, one could increase the fee to cover the differential vs. one-phase care, but a market economy efficiently mitigates against fees that are out of line with perceived benefits. We have found, in our market, that the extra costs of doing two-phase care are only slightly recoverable to non-recoverable. We have also found the treatment of cleft-plate patients is not cost-effective. And we have found that pro bono treatment is even more of a financial non-starter.

We will continue to offer all these financially inefficient treatments, however, because we can. It seems to come down to this: are an orthodontist's Phase I results good enough to justify the effort? Our particular experience has made it clear—patients who receive treatment early enough are healthier and have more stable results. And if they need braces, treatment proceeds more smoothly. We see other significant advantages for patients. Unfortunately, the value of this is not as well perceived by patients (and some orthodontists) as it will be in the future.

The author's study is similar to the case studies I have seen in business school. The study of profitability is central. On the other hand, business school has not been exemplary in education regarding social responsibility and integrity. One should consider that someone outside health care might be offended to read the words, "To achieve the same revenue as for full treatment, I would have had to charge at least $3,000 more than the full-treatment fee." It could be supposed that the recommended treatment would be based on the most profitable course of action. Good for business—bad for perceived integrity.

The author has apparently found that his two-phase treatment is not effective enough and thus is not financially efficient. On the contrary, we have found that two-phase care is best for patients—the way we do it. And we have chosen to accept less, because we believe it is the right thing to do.

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Dr. Haeger replies:

I appreciate the comments from Dr. Hayes, but I believe he has missed the point of the article. The primary conclusions regarded consideration of patients' and parents' time, trips to the office, and time spent in braces. Financial considerations for the orthodontist were included to document that two-phase treatment is also unproductive for the practice, and therefore should not drive the decision to recommend Phase I treatment.

I am not aware of any study documenting that "patients who receive treatment early enough are healthier and have more stable results". Dr. Hayes's comment, "Good for business—bad for perceived integrity", couldn't be farther from the truth. I believe parents and patients should be made aware of the extra costs, time, patient visits, and inconvenience involved in two-phase treatment without any guarantee of improvement in the results. It is our responsibility as orthodontists to make the parents, as decision makers, aware of these additional costs before proceeding with any kind of treatment. It would be unethical not to share such information. Considering the information available today regarding two-phase therapy, I believe the ethical challenge falls on the orthodontist who recommends Phase I treatment. In the article, I included a list of possible indications and justifications for such treatment that I use to guide my own decisions.

Regarding Dr. Hayes's comment that "the author has apparently found that his two-phase treatment is not effective enough and thus is not financially efficient", I continually monitor all

debonded patients in my practice to evaluate bracket types, bonding methods, assistants, techniques, and treatment timing, as well as the effectiveness of two-phase treatment. I am constantly changing my treatment methods based on the results of this analysis, and would certainly have considered increasing the number of Phase I patients had the data indicated comparable overall treatment times, numbers of visits, or results.

I hope Dr. Hayes will evaluate his own patients in a similar way and show us how two-phase treatment works in his office. Based on my analysis, however, a large percentage of such treatment is driven more by patients' and parents' perceptions than by clinical need. ❑

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