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THE EDITOR'S CORNER

More on Limited Treatment

Last month, the Editor's Corner touched on the touchy subject of limited treatment, with particular emphasis on those cases in which the patient's wishes may not be in agreement with the doctor's best clinical judgment. Most of us orthodontists are idealistic enough that we would always like to provide the highest quality of care. In an ideal world, we would treat everyone to exacting standards of occlusion, function, and esthetics, and we would provide comprehensive care to all our patients.

Unfortunately, I find that I do not practice in the ideal world—I practice in Los Angeles. Results of this month's informal Readers' Corner survey seem to indicate that most of our readers, like me, are realists as well as idealists. Only 10% of the respondents said they rarely or never provide limited treatment. I am willing to bet that if we were to sharpen our definition of just what constitutes limited treatment, even those 10% might respond differently. There are unquestionably times when limited treatment is the best option; for example, in a preprosthetic case where the loss of a first molar has resulted in mesial tipping of the second molar while the rest of the dentition is in proper alignment and occlusion, limited treatment is called for to upright an abutment or to prepare implant space. Our readers point out a number of other situations in which limited treatment is the treatment of choice: space maintenance or management in children, along with multidisciplinary periodontal and prosthodontic cases that need adjustments of certain tooth positions prior to restoration. I doubt that even the most idealistic among us would deny that limited treatment is indicated under very specific conditions.

The issue becomes less clear when we broaden the subject to include compromise care. Fully 82% of the respondents to our Readers' Corner were reluctant to provide limited treatment to certain patients. In my practice, as I pointed out last month, it is not uncommon for patients, particularly adults, to ask for limited treatment only to straighten anterior teeth. The most frustrating question I get is, "Can't we do just the uppers now and the

lowers later?" I have never acquiesced to that request, because it is relatively easy for me to envision the potential disasters that could result: unstable tooth positions, unretainable results, joint dysfunction—the dark side of my imagination runs rampant.

Many patients seeking limited treatment are in reality seeking only limited cost. They still want ideal results—a beautiful smile and a healthy, fully functional occlusion—but they do not want to pay for full treatment. Computer projections may help us explain the limitations of partial treatment, but none of these is 100% accurate. When a discrepancy arises between the computer prediction and the actual outcome, it is difficult indeed to explain the matter away on the basis of acceptable standard error of estimation.

Our readers have dealt with this situation in creative ways. One interesting solution was to reduce the financial incentive for limited treatment. Actually, the material and labor costs of providing limited care are almost identical to those of comprehensive care. Chairtime and doctor time may be slightly less, but certainly not 25-30% less. In calculating fees for limited treatment, a doctor should estimate how much the overhead will be reduced on a percentage basis. If the total overhead to treat a case goes down by only 5-10%, the fee should be reduced by a similar amount. When presented with a situation in which comprehensive care is only slightly more expensive than limited treatment, most patients would opt for the better outcome.

Informed consent is critical in these cases. Although 90% of our respondents said there was no difference in their informed-consent statements for limited care, most of them said they carefully outlined the potential limitations of treatment in every case. It would also be wise to make clear that if the patient wants further treatment beyond what is spelled out in the limited plan, there will be an additional cost. If a patient wants the results that could only be expected from comprehensive treatment, he or she needs to know up front that a full fee is in order.

It is interesting to note that our respondents' patient-satisfaction rates for limited-treatment cases were similar to those for their comprehensive cases. In almost every situation, when we resolve the patient's chief complaint, the patient is satisfied. We need to take care, however, that the satisfaction expressed at the time the appliance is removed stays that way over the course of time. If a limited treatment addresses the patient's chief complaint while ignoring long-term issues such as occlusal stability or relapse potential, that satisfaction will most likely be short-lived.

Given that we live and practice in the real, rather than the ideal, world, limited treatment is here to stay. Most of us provide limited treatment on a fairly regular basis. If we will implement some of the ideas put forth in this month's Readers' Corner and utilize our own best clinical judgment, we can continue to do so, knowing that we are providing a service that is not only beneficial to our patients and our referring doctors, but professionally sound as well. RGK