THE READERS' CORNER

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(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)

1. Please rate the effectiveness of various methods you have tried to increase the appeal of your practice and to distinguish it from others (effective, somewhat effective, or ineffective).

Saturday, evening, or early-morning appointments

Seventy-seven percent of the respondents felt these appointments were effective or somewhat effective. The remainder thought them ineffective. Comments indicated that early-morning appointments were particularly sought after, especially by working adults. Evening appointments, although in demand, interrupted the clinicians' home and private time. Saturday appointments were frequently broken, especially when the weather was good. Individual comments included:

• "Early-morning appointments are helpful for two-income families. Evenings are another story. The percentage of broken and cancelled appointments was too high to tolerate. People seem to have too many other commitments during the evening."

• "Saturday appointments would appear to be a great service to patients with busy lifestyles, but they're not appreciated. The cancellation/missed/late notations in our appointments registry was too excessive to continue this policy."

• "Adapting our hours to working parents' schedules has definitely produced positive results in our teen-age and adult patient populations."

No down payment on treatment fee

About three-fourths of the orthodontists thought this method was effective or somewhat effective, while the rest believed it to be ineffective. Some of the latter group stated that the issue of down payments was moot now that third parties such as Orthodontists Fee Plan will prepay the complete fee. Some specific comments:

• "No down payments achieved its objective—starts—but there's still the problem of keeping the patient's accounts paid in full and on time."

• "When we banded all the teeth, down payments made sense. There was a lot of up-front time—it took a few hours just to get all the hardware on. Now, a case can be strapped up in a fraction of that time. The only rational justification for a down payment is to reduce the monthly payment as a service to the patient. Other than that, it doesn't make sense."

No charge for examination

Nearly 65% found this method to be effective, more than 20% thought it somewhat effective, and only 15% felt it was ineffective in increasing the appeal of their practices. Some individual comments were:

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• "We do not charge an initial exam fee. This seems to make the patient or parent more comfortable and willing to schedule at least a consultation, enabling them to meet with myself and the staff and to visit our office without any financial commitment."
• "No charge for examinations gives families time to think and plan. Also, the referring dentist can get an opinion without worrying about additional charges for a patient who may not be ready for treatment."
• "Not charging for initial exams encourages shopping. It cheapens the value of a professional opinion. We're probably the only specialty in medicine or dentistry to do this. Since most of the orthodontists in my area (except me) offer free exams, there is no competitive edge for them anyway."

Lowering fees

Only one respondent thought lowering fees was effective. About 20% found it somewhat effective, but the substantial majority believed it to be an ineffective way to promote a practice. This was the most powerful negative response in the present survey. A few specific comments:
• "That's the dumbest way to promote a practice, because there's always someone who will go lower than you. And how can you take pride in your work when the only reason patients select your office is to save a buck?"
• "Quality is not equatable with price."
• "I do not strive to do the best I can just to satisfy the lowest bidder."

Raising fees

Although 64% of the clinicians indicated that raising fees was an effective or somewhat effective method of practice building, as many respondents rated this method ineffective as rated it somewhat effective (36% each). Pertinent remarks included:
• "It's very simple: charge a reasonable fee for your work and increase it periodically for the ever-increasing cost of doing business. Doing otherwise simply doesn't make sense."
• "Raising fees just to test what the market can bear is a bit on the amoral side for a health professional. Raising fees in proportion to office expenses and the standards of the community would seem to be the more ethical choice."

Monetary rewards to patients for referrals

Only a few respondents felt monetary rewards improved their practice appeal. About a third found them somewhat effective, while two-thirds said they were ineffective. Selected comments were:
• "Don't try this in California; it's illegal."
• "How tacky can you get? A letter or thank-you card is in line with courteous and professional conduct. Cash or presents may give you a marketing advantage, but no matter how you cut it, it's seedy."

Active promotion of general dental referrals

This method elicited the strongest response in the effective category (76%), and an additional 22% of the orthodontists thought it somewhat effective. Only one respondent felt it was an ineffective strategy. Some responses:
• "Always, always, always keep up your contact with referring dentists and spend a little money on them. It goes a long, long way."
• "Ignoring the general dental referral source is perhaps the most catastrophic thing a specialist can do to a practice."
• "I appreciate the confidence a dentist expresses in me when a patient is referred. It makes me feel good, it contributes to my practice's success, and it makes me want to deliver the very best service I can to warrant continued referrals from the same source."

Advertising or external marketing

Fewer than 10% of the respondents thought newspapers, magazines, or TV were effective methods, and no one believed radio was effective. The largest positive response (53%) was that newspapers and magazines were somewhat effective. However, 45% of the practitioners

indicated that all advertising and external marketing was basically ineffective. Individual comments included:
• "Ooh, the wasted money!"
• "The best external marketing is TV. However, a professionally arranged presentation is outrageously expensive. The most effective and economical way to use this medium is to get invited to participate in talk shows or interviews. Whenever I speak on TV, I receive at least five to 10 phone calls from prospective new patients."
• "I will never, ever use external marketing. I am a health-care specialist. I choose not to become a cartoon character by commercializing my profession."

2. Which of these responses (don't use them, use them occasionally, use them frequently) describes your current use of orthopedic appliances, and which type do you prefer?

More than 50% of the respondents reported using orthopedic appliances occasionally, about 25% used them frequently, and the remainder did not use them.

Removable functional appliances were used less frequently (38%) than the fixed types (62%). Of the removable appliances, the bionator, twin block, and headgear to the maxilla were most popular. The Herbst was by far the most commonly used fixed functional appliance (65%), with bite jumpers attached to archwires a distant second (25%). A few clinicians preferred the Mara or Hamilton appliances.

Explanations of these preferences included:
• "We only use fixed functional appliances and have controlled the compliance problems of the past. We use a rigid fixed functional appliance (Herbst) for Class II corrections greater than 4mm and a flexible Jasper Jumper appliance for corrections of less than 4mm."
• "If the patient is in the mixed dentition, I will use a twin block appliance. If the patient is in the permanent dentition, I won't waste additional treatment time and will go right to fixed appliances and probably headgear."
• "I use fixed and removable appliances, usually letting the parent and patient choose which they prefer."

What is your understanding of how orthopedic appliances function (stimulation of condylar growth, remodeling of condyle and fossa, acceleration of condylar growth, dentoalveolar adaptation, or temporary bending of the mandible)?

Most of the respondents checked off multiple *modus operandi* to explain the effectiveness of these devices. Nevertheless, the vast majority (85%) believed at least part of the appliance action was attributable to dentoalveolar adaptation, closely followed by remodeling of the condyle and fossa. Stimulation of condylar growth was thought less likely to have an influence (17%), and inducing acceleration of condylar growth even less likely (10%). Only 5% of the clinicians thought the orthopedic response was due to bending of the mandible.

General comments included:
• "Functional appliances do not grow mandibles. They work to encourage remodeling, achieve dentoalveolar changes, and position the mandible so that as growth does occur, it will be in a favorable direction."
• "The data indicate that the 'functional' correction with all these appliances is so pitifully small that it's pragmatically irrelevant. However, the dentoalveolar changes can be dramatic. In many cases, that's enough to get an acceptable result."
• "Any appliance that can take cooperation out of the patient's hands and put it into mine is a godsend. The Herbst, although frustrating to work with, fills the bill."
• "I don't use them. They cause a 'habit bite' with the condyle out of the fossa."

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