JCO INTERVIEWS

Martin L. 'Bud' Schulman on Success Through Sharing

DR. GOTTLIEB Bud, one of the most intriguing things you have done in orthodontics has been your annual meetings of a group of some of the highest-income practices in the specialty.

MR. SCHULMAN Yes, and I believe that forming similar groups would be beneficial to any participants.

DR. GOTTLIEB What is the theme of the meetings?

MR. SCHULMAN The theme is "Success Through Sharing". We share performance information. All members file requested data in advance covering financial analysis, fees, collections procedures, treatment statistics, labor efficiency, and practice development. That data is a basis for our discussions. One of the devices we use is that each year two members "show" their practices. This is usually presented in the form of videos or still photos of the office and an explanation of the patient flow, staff programs, practice-building devices, and many other bases for the continuing success of the practice.

DR. GOTTLIEB If income is a measure of success, how much difference is there between the incomes of your group and the specialty average?

MR. SCHULMAN I'd say that my group's annual income averages more than twice the specialty average.

DR. GOTTLIEB Do your practices charge fees that are higher than the average for the specialty?

MR. SCHULMAN Not really. They may be a little higher. The average child full treatment fee was $4,474 in 2001 and $4,670 this year. The average adult fee was up from $4,956 in 2001 to $5,140 in 2002.

DR. GOTTLIEB They increased fees by 4-5%. Is that a planned annual increase?

MR. SCHULMAN It is not by chance. It is well thought out on a long-term basis.

DR. GOTTLIEB Do they work longer hours?

MR. SCHULMAN No. I think you will find that the hours worked are the same.

DR. GOTTLIEB Do they have a greater profitability?

MR. SCHULMAN No. Expenses are about 52% of gross for the profession as a whole and for our group, too.

Mr. Schulman

Dr. Gottlieb

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DR. GOTTLIEB If the difference is not in hours, fees, or expenses, it has to be in the number of cases under treatment and the number of case starts.

MR. SCHULMAN Absolutely. There are vast differences among doctors in their ability to develop significant practice size. Today, the average number of patient starts for our members is more than twice the national average.

DR. GOTTLIEB It has been said that you just cannot turn out good work while treating such large numbers of patients.

MR. SCHULMAN Some are very critical of large practices, but there is no accepted level of what it should be. Some want it to remain a small, personal professional function, and that's OK if that's what they want. But it doesn't have to be that way, and for those who want it to be something different, a much more broadly based practice is achievable. There are many practices today with such unbelievably high incomes that others might say that they turn out trash. But that is not true. If you have a large practice you can't afford to turn out trash. Trash gets recognized.

DR. GOTTLIEB Does your group make greater use of delegation?

MR. SCHULMAN I don't really think so.

DR. GOTTLIEB What's the secret?

MR. SCHULMAN It's efficiency, teamworking, organization, self-discipline, proper planning, and marketing for patient referrals.

DR. GOTTLIEB Our practice studies have repeatedly shown that more than 50% of referrals come from general dentists. I presume that you have found the same thing in your group.

MR. SCHULMAN Our figure is somewhat higher: 56% come from general dentists.

DR. GOTTLIEB Does your group send gifts to general dentists?

MR. SCHULMAN Almost all do. The gifts are all over the lot—theater tickets, tickets to baseball games, dinners.

DR. GOTTLIEB Do your practices keep a record of the referrals, and if a referral pattern declines or stops, do they call the referring source and try to find out why and try to reinstitute it?

MR. SCHULMAN Most of my crew does. They get a monthly referral report on every referring doctor so they can tell when a doctor shows a decline or stops referring. But most orthodontists don't know.

DR. GOTTLIEB It might be repairable if there is a problem.

MR. SCHULMAN A mea culpa approach has been most helpful. "I must have done something that upset you, and I am terribly unhappy that I haven't gotten any patients from you." It has been effective. Let me tell you there is another source of patients that is highly valuable, and that is the hygienist. A hygienist will refer patients directly to an orthodontist. They see that there is a malocclusion and suggest they go see Dr. So-and-So. "He treats most of our patients, and your son needs orthodontics." And that's all it takes. That can be as good a source of patients as many dentists.

DR. GOTTLIEB Do you need the dentist's approval to approach the hygienist?

MR. SCHULMAN No. Hygienists are licensed practitioners. Many practices will have the treatment coordinator take hygienists to lunch. Also, hygienists are always seeking continuing education credits. The orthodontist can sponsor an evening with a little light refreshment and with an orthodontic speaker who is accredited to the hygienists' association, who can put on an hour or two-hour program and talk about malocclusions and how to recognize them. This group has capitalized on that, and we find that we can generate hygienist referrals that way.

DR. GOTTLIEB How do your doctors express appreciation to hygienists for referrals?

MR. SCHULMAN Some orthodontists give them a discount for themselves and their kids.

DR. GOTTLIEB Do your doctors reward families who refer patients?

MR. SCHULMAN Most do, with cards, gift certificates, flowers. Movie tickets have been popular.

DR. GOTTLIEB In internal marketing to patients and parents, are there ways of asking for referrals?

MR. SCHULMAN Some orthodontists may be more forward in that regard. They may say, "If you think we have treated you well, I hope you will refer us to your friends." There are other ways. Publishing a newsletter gets some general appreciation. Some are setting up scholarships in the orthodontist's name at the local high school for $1,000 toward a college education.

DR. GOTTLIEB Is there a place for advertising?

MR. SCHULMAN There is some direct mail being done, but it isn't terribly effective. One thing I have just seen that seemed to be rewarding in bringing in new calls was a direct-mail piece that offered a free exam to tell you whether someone needs orthodontics.

DR. GOTTLIEB Are telephone ads effective?

MR. SCHULMAN Some practices set up a blind phone number to be used in the telephone ad to check on its effectiveness. You know when that phone rings that the call came from the telephone ad. But telephone advertising hasn't been very rewarding.

DR. GOTTLIEB There has never been great enthusiasm for patient satisfaction surveys and patient newsletters. Are they irrelevant?

MR. SCHULMAN One of our group prepares the best practice newsletter that I have encountered. Let me describe it in more detail. It is published quarterly. The doctor decides on the articles to be prepared and assigns each article to a staff member. The doctor reviews each article with the employee. The newsletter is typeset on the office computer and sent to a printer. The printing cost is just over $300. The newsletter is handed out at the next patient appointment. This program creates pride for the staff members in their efforts and contributes to their learning more about orthodontics.

DR. GOTTLIEB Is it a practice builder to be open for some evening hours or some Saturday hours?

MR. SCHULMAN Yes, particularly for adults. One practice builder I am seeing more of is that some doctors are setting up a Bracemobile or a Brace Bus, which might be an SUV or a station wagon with their name on it. They take it to the high school and junior high and pick the patients up after school. I don't know whether afterward they take them home or to a shopping center near their home. There are quite a few now in use.

DR. GOTTLIEB Do your practices have satellite offices?

MR. SCHULMAN Most of them do. They have become so efficient and so effective that they can't get one office to develop enough patients to maintain the level they would like to be at. Sometimes the branch offices are shared with a periodontist or an endodontist. They do fine because they are cheap to operate. Some have a satellite office close enough that they can have the patients go to their primary office for taking records at the initial visit. You don't put all the diagnostic equipment in the branch office.

DR. GOTTLIEB As far as I know, you were the originator of the idea of seeking case acceptance at the first visit. I seem to recall that when you introduced this idea years ago, the rationale was that the patient is never more ready to accept

treatment than at the first visit.

MR. SCHULMAN I think that is generally a true statement. They wouldn't be there if they hadn't been told to see an orthodontist or if they didn't have some real concerns that orthodontics was necessary. Or they might be seeking reassurance that it was not necessary. They might be put on a waiting list if the orthodontist doesn't think they are ready to start, but if a child needs treatment and if the orthodontist is properly prepared, acceptance of treatment can be completed at the first visit. The patient is prepped in advance, usually with a brochure in the mail explaining something about orthodontics to develop a sense of confidence in the practice, and records are taken before the orthodontist sees the patient.

DR. GOTTLIEB As you probably know, the chief criticism of the one-visit entry is that it denigrates the diagnosis. It assumes that the doctor can know everything that is needed to know about a case from a look at the x-rays and a brief clinical exam, and make a diagnosis on the spot.

MR. SCHULMAN I believe in some cases, possibly 80% of the cases, they can tell immediately that orthodontics is called for and what the approach may be. In other cases they may need a more thorough diagnosis in order to plan treatment. I believe that the tendency throughout the profession is to reduce the entry-visit procedure. Time is not working in the doctor's favor. It may encourage negative thoughts. If they come in and orthodontics is necessary, I see no reason not to take entry as far as the patient is prepared to go at the first visit. Why would you do other than that?

DR. GOTTLIEB It stems from the concept that the most important professional activity of the doctor is diagnosis, and that time is needed to study the records, even for cases that appear routine. Do all of your doctors have only one-visit entries?

MR. SCHULMAN Most seek entry at the first visit, but let me tell you what the experience in our group is this year. For case acceptance on the first visit, the mean is up from 49% to 50%. On the second visit, it's up from 30% to 31%, and on the third visit, it is down from 21% to 19%. So the pattern is to have fewer pre-acceptance visits.

DR. GOTTLIEB The person who comes in with the child often is not prepared to say "yes" at that first visit. They'll say, "Well, I'll have to go home and talk to my husband." How is that handled?

MR. SCHULMAN It's the treatment coordinator who determines that, and she will say, "Now when can I call you for your decision?" "Tell your husband to call me if he has any questions." She's the one who follows it up. It isn't the doctor. The doctor is a kind of sweet, gentle soul who is so busy making patients well that he or she isn't money-related, and shouldn't be.

DR. GOTTLIEB Does the doctor do the case presentation?

MR. SCHULMAN Normally the doctor makes the case presentation, but doesn't talk about money or how it will be paid. The treatment coordinator will take it from there to ascertain that they are prepared to go ahead and discuss choices for payment.

DR. GOTTLIEB Another way to separate the doctor from the money is to use a fiscal intermediary such as Orthodontists Fee Plan. Do you favor that?

MR. SCHULMAN Yes, I do, and a large majority of our practices offer it. About 5% of their patients use OFP for payment.

DR. GOTTLIEB Is the use of credit cards now generally accepted?

MR. SCHULMAN Yes. The patient authorizes the office to put through a charge the first of every month against their credit card. That seems to be gaining because that costs them nothing. There is no added fee to the patient for that unless they don't pay off the credit card, but that

is none of the doctor's business. About 7% of the patients use credit-card or bank-draft payment. But most of the practices still use the traditional 20-33% down and the balance in 20-36 months at no interest.

DR. GOTTLIEB But the doctor has to pay the credit-card company a percentage that may vary from 2-4%, depending on the size of the account. Does the doctor absorb that just for the convenience of collecting fees in that way?

MR. SCHULMAN Yes.

DR. GOTTLIEB Can making more lenient fee arrangements, such as not charging for an initial visit, be practice building for some orthodontists?

MR. SCHULMAN Yes, I think it is. As a matter of fact, a lot of advertising says, "Come in at no charge, and we will tell you whether your child needs orthodontic treatment."

DR. GOTTLIEB What about reducing or eliminating the down payment?

MR. SCHULMAN I think that may appeal to people with bad credit. A majority of our practices do it, but only on occasion.

DR. GOTTLIEB You were one of the first to advocate paying the full fee in advance with a discount.

MR. SCHULMAN Yes, usually 6-8%. Many people prefer it that way, particularly if they can get a discount. The experience in our group is that 15% of the patients do this. I think many orthodontists never ask.

DR. GOTTLIEB Is there a separate charge for diagnostic records?

MR. SCHULMAN Our doctors are pretty evenly divided on that question.

DR. GOTTLIEB What is the average charge if there is one?

MR. SCHULMAN For records and treatment plan, the average charge is about $250.

DR. GOTTLIEB Should one fee be charged for two-phase treatment, or should it be divided?

MR. SCHULMAN Some years ago I started the idea of what I call Comprehensive Treatment. This combines Phase I and Phase II. Acceptance means that you never have to ask whether they wish to proceed into Phase II. Some parents, when given the choice, will say, "Well, doctor, I think she looks good enough", and elect not to go forward into Phase II. A further benefit when offering Comprehensive Treatment is that the payments continue while the patient waits for the cuspids to erupt before entering the second phase. Essentially, they agree to enter treatment and are never offered a choice of leaving after Phase I is completed. The whole concept of offering two separate phases is of no value and shouldn't be used.

DR. GOTTLIEB What is the number of visits in the average full-treatment case?

MR. SCHULMAN The mean is 24—two for entry, two for strapup, 16 for tooth movement, four for retention.

DR. GOTTLIEB One thing that has changed is the interval between visits. Does lengthening the interval create collection problems?

MR. SCHULMAN I don't think so. I have never heard of it being a problem.

DR. GOTTLIEB Broken and canceled appointments can prolong treatment if they are not managed properly. Do you find they do prolong treatment?

MR. SCHULMAN I have not heard that they do. The chairside assistant monitors that, and I think they motivate patients pretty well.

DR. GOTTLIEB What is the average percentage of broken appointments in your group?

MR. SCHULMAN It is 6% for active treatment visits. It is much higher for retention visits—15%.

DR. GOTTLIEB It seems to me that there has never been an extensive use of post-treatment conferences, and that it has even been declining. Do your practices have post-treatment conferences?

MR. SCHULMAN I can't think of anybody who does not have post-treatment conferences. There is always a conference when the bands and brackets come off. I think it is important at that point to ask the question, "How do you think they turned out?" You ask it of the parent and then of the patient because, if they have regression sometime later, in many cases they will remember that when the appliances came off they felt that they were fine. The more you impress on them that they like what happened, what they looked like when the appliances came off, the less likely you are to have a problem with regression. At that post-treatment conference many doctors make a celebration out of the occasion.

DR. GOTTLIEB Is a charge made for retreatment?

MR. SCHULMAN Yes, almost all offices charge for retreatment and, again, it is easier to charge for retreatment if the parent and the patient have acknowledged that they looked good when the appliances came off.

DR. GOTTLIEB With permanent bonded retainers there is a possibility of limiting or preventing relapse, but they require continuing responsibility for maintenance. You could wind up with a huge amount of retainer checks. But you can't really dismiss a patient who still has an appliance in the mouth.

MR. SCHULMAN I don't think you can. You have to have them back at least every six months. Eventually, the appliance must be removed, or you are responsible as long as your retainer is in the patient's mouth. There has got to be a day at which you say, "I am through", and you remove the retainer. You can give them a removable and say, "Take this along with you, and I think it wouldn't hurt if you put it in every night when you go to bed, and it will keep the teeth in good order. But I am actually done moving your teeth." You might say they can come back for adjustment if they wish, and you won't charge them anything for that. But you have got to end the relationship.

DR. GOTTLIEB Are your practices using e-mail to make and confirm appointments and for communication with patients?

MR. SCHULMAN Yes, some do.

DR. GOTTLIEB Are you in favor of the paperless office?

MR. SCHULMAN Yes. I know one orthodontist who has a great system. When a patient comes in, the models are pulled up on a screen, and the image can be altered or looked at it from any angle. All the patient records are in the system. It's terrific.

DR. GOTTLIEB What are the most important administrative records an office should keep?

MR. SCHULMAN How effective the practice is in two areas: one is patient generation, and the other is cost control, efficiency, and staff productivity. Those are the areas that I think are really important.

DR. GOTTLIEB How do you measure staff productivity?

MR. SCHULMAN We record the number of patients seen per chairside assistant per day. In our group it averages 16. In regard to staff productivity, a current trend that I favor and I think is gaining stature rapidly is to assign each patient to a chairside assistant who will see that patient at every visit. Every chairside assistant has a computer work station behind her chair, and she will schedule the patient for all future visits with

her. That chairside assistant will also have a business card with her name and home telephone number, which she will give to the parent at the first visit and say, "If you have a problem at any time or have any questions, don't hesitate to call me." It has resulted in a number of improvements. In the first place, it takes a lot of the scheduling away from the front desk, and it has relieved the doctor of many telephone calls for minor conditions. Now, if there is something significant, she will discuss it with the doctor and the doctor will deal with it. But otherwise, she will take care of most conditions on the telephone. That's good because it gives the family a secondary personal relationship with someone they can feel comfortable calling at home and talking with about their treatment.

DR. GOTTLIEB Do the doctors also give the patients their home phone numbers?

MR. SCHULMAN They give them an emergency number, which is their home number. The chairside assistant has also given them her card. They might call the doctor first, but if they can't reach the doctor they will call the chairside assistant, who is their primary off-hour contact. I'm sure if it's something serious, they'd call the doctor.

DR. GOTTLIEB What motivates orthodontic employees? Is it money? Is it fringe benefits? Is it the work environment? Is it the relationship with the staff or with the doctor? Is it job security?

MR. SCHULMAN All of the above. It varies because people are different. Some women work because they need the money. Others work because they are bored at home and they love kids. I would say the orthodontists by and large have quite good staffs and they pay them quite nicely. By the same token, I think the staffs are quite competent and capable and like to work with young kids. Many have their own young kids.

DR. GOTTLIEB In hiring, what sort of person should orthodontists be looking for?

MR. SCHULMAN Are they compatible with the doctor? Are they compatible with the office atmosphere? Do they fit the practice personality? Some doctors don't require more than a high-school education. Others want some education beyond that. Some like youngsters and some like mature people.

DR. GOTTLIEB Are psychological tests used on job applicants?

MR. SCHULMAN There is little such testing used in the selection process. But there are quite a few good dexterity tests. I think they are more commonly used than a personality profile.

DR. GOTTLIEB Many offices limit training to on-the-job training. Does your group have a formal in-house training program for new hires?

MR. SCHULMAN Not many. It's pretty much on-the-job training. I don't know anybody who makes them go through any special training program.

DR. GOTTLIEB Are they using a trial period?

MR. SCHULMAN Some are and some aren't. I don't believe many have methodized it.

DR. GOTTLIEB What is their basis for pay increases?

MR. SCHULMAN Most of the time it's done on a methodical basis, either once or twice a year. Usually once a year.

DR. GOTTLIEB Is it based on profitability?

MR. SCHULMAN Yes, and on whatever is driving their economy—inflation or competition. Many have incentive plans, predicated on number of patients seen per day per chairside assistant.

DR. GOTTLIEB Do they believe in profit sharing?

MR. SCHULMAN Very few do. If I were an orthodontist, I wouldn't want to reveal to my employees what my profitability is. Some reward staff with gift certificates at department stores.

DR. GOTTLIEB That seems more in the line of bonuses.

MR. SCHULMAN Not necessarily. A gift certificate could be predicated on the number of patients seen per day.

DR. GOTTLIEB Do the doctors in your group offer bonuses?

MR. SCHULMAN Some do it annually based on overall practice profit, and others base it on individual performance.

DR. GOTTLIEB If an orthodontist has little or no turnover of employees, which is desirable, and if employees are given an annual increase, staff salaries can become a large expense. How can that be controlled and still be equitable for a loyal and competent staff?

MR. SCHULMAN Well, two other things are happening. Fees go up, and there are improvements in techniques that tend to reduce the number of visits. So there are compensating factors. Incomes keep going up.

DR. GOTTLIEB Do your doctors do performance reviews?

MR. SCHULMAN Oh, yes. Every one. Usually a couple of times a year.

DR. GOTTLIEB If an employee is not performing in a satisfactory way, how is that handled?

MR. SCHULMAN Fire her.

DR. GOTTLIEB They don't withhold a raise or give them a warning?

MR. SCHULMAN They might warn them.

DR. GOTTLIEB Do your people hold staff meetings?

MR. SCHULMAN Most of them will have staff meetings once a week or every other week. They talk about where they are going, cases they will be treating, plans for the future, opening a branch, bringing in a partner, changing some equipment, some technique. Some practices have a staff meeting before they open every morning. They talk about how many patients are scheduled and what the day is going to be like.

DR. GOTTLIEB What creates stress in a practice, and how do you deal with it?

MR. SCHULMAN Running late is probably the greatest single cause. Sometimes it is caused by the doctor taking telephone calls.

DR. GOTTLIEB Do staff conflicts enter into it?

MR. SCHULMAN Not really, because there should be a clear-cut chain of command. Someone in the practice other than the doctor is the boss of the staff and deals with it. It shouldn't be the doctor, except in a small practice.

DR. GOTTLIEB It used to be that a practice was built on the reputation, skill, and personality of the orthodontist. How do those factors come into play in a practice where the contacts with the patients and parents are by someone other than the doctor?

MR. SCHULMAN Every practice develops a personality. It usually is the personality of the principal. If the doctor is a quiet, recessive person it could be the treatment coordinator, and she'd better be a good one. But normally, the doctor sets the tone in the treatment center. He or she could be a happy, joking, pleasant, gung-ho sort of person. In my group I can pick out the individuals who are dominant in their practices, in their communities. They are just good leaders.

DR. GOTTLIEB The treatment coordinator is a key person in the practice. What size practice needs a treatment coordinator?

MR. SCHULMAN I think when a practice reaches an income of $600,000 it can and should use a treatment coordinator. Exactly what that role is varies. It depends on the person and the size of the practice. It may be the person who guides the patients through the entry. It could be the treatment room manager who controls the staff. It also depends upon the doctor and what he or she is looking for. Some don't have the person who supervises the clinical area be the treatment coordinator. Their treatment coordinator would have more to do with patient entry and patient flow. They may be PR persons concerned with practice development, such as seeking out the hygienists. Some might be hygienists themselves and go into the schools. They go into third grades in certain school districts and survey the kids, and they might give them toothbrushes with the practice name on them. We have one meeting a year just for the treatment coordinators. We have motivational speakers talking about the wonderful profession these people are working in, and the treatment coordinators share information and experiences.

DR. GOTTLIEB Are there many partnerships in your group?

MR. SCHULMAN Not many. Many doctors go to partnerships merely because they are inefficient and have never really developed their practices.

DR. GOTTLIEB We have never found that a two-doctor practice will generate twice the income of a one-doctor practice.

MR. SCHULMAN I agree with that completely. It never does.

DR. GOTTLIEB So what do your practices do? Do they hire one or more associates?

MR. SCHULMAN The practices in the group reported that they employ an average of two orthodontists. In many cases, the associate does not want the responsibility and authority. They want to come in, treat the patients, and go home and forget about it. In all likelihood you would not wish an associate to start patients, because you wish the patients to be yours.

DR. GOTTLIEB Are these mostly recent graduates?

MR. SCHULMAN Some are, but some are retired orthodontists who want to continue working. It might be they want to work two days a week, and that is all the practice needs. He or she is a nice person, capable, maybe 60-65 years old. Both parties are happy with the arrangement. The hiring doctor might want to take a two-week vacation, and the semiretiree fills in for that time.

DR. GOTTLIEB How is the semiretiree paid?

MR. SCHULMAN They get a per diem.

DR. GOTTLIEB Practice today is easier than it used to be in many ways. Does that make you feel that retirement can be postponed?

MR. SCHULMAN That's an entirely personal thing, related to one's position in life. Are you happy? Is your health good? What is your relationship with your spouse? Do you get vacations? Do you work too hard? Some doctors work until they are well into their 70s. Some are ready to retire in their 50s.

DR. GOTTLIEB At what age should an orthodontist start planning for retirement?

MR. SCHULMAN Not later than their late 40s or early 50s.

DR. GOTTLIEB They should be setting money aside annually?

MR. SCHULMAN Unquestionably.

DR. GOTTLIEB An orthodontic practice itself is a significant asset.

MR. SCHULMAN Yes, many are sold for over a million dollars. If a doctor retires and sells the practice for over a million dollars—and most large

practices will sell for over a million dollars—the selling doctor will receive a quite comfortable retirement income from the proceeds.

DR. GOTTLIEB What are the usual arrangements for selling a practice?

MR. SCHULMAN The depreciated value of the tangible assets plus two times the last year's profit as the measure of good will are commonly used as the basis to measure the total value of the practice. The good will is paid in the form of a consultantship and includes a restrictive covenant. This will carry no interest. It will be paid out over a good many years—up to nine or 10 years. Of course, in many practice sales the good will is sold as good will, which is a standard asset subject to interest on the unpaid balance. There is great variance in the valuation and the basis for sale of an orthodontic practice.

DR. GOTTLIEB What is the best option for a young graduate starting out—start one's own practice, buy into a practice, or get a job?

MR. SCHULMAN I see practically no graduating doctors opening new offices. The best thing is to buy into the practice of a doctor in his or her late 50s or 60s who is planning to retire in a few years. The bigger the practice is, the better their future life will be, because the senior will teach them how to operate, generate, and treat a practice of that size. They must not be afraid of the price. It just scares them to death when the price gets up to $750,000 or a million or a million and a half or more. I can understand that, but it is a wrong viewpoint because that senior is going to teach them how to run that practice successfully. Otherwise, he or she won't be paid. So it is in the seller's own best interest if they want to retire in three to five years, and there is no better training than to get it from someone who is truly successful at patient generation, treatment flow, mechanics—the whole ball of wax.

DR. GOTTLIEB Could practices continue to grow in size almost indefinitely by opening more satellite offices, employing more orthodontists, working more days, working longer hours, delegating more? Not only delegating more tasks to operatory employees, but even by delegating management responsibilities?

MR. SCHULMAN I can tell you about one practice with three owners that grosses nine or 10 times the average for the profession as a whole. Sometimes they buy practices of doctors who want to retire. Techniques have improved so much that incomes, if not unlimited, are vastly increased without working any harder.

DR. GOTTLIEB Still, the doctor must see each patient. Does that itself not place a limit on the size of a practice?

MR. SCHULMAN Well, in our group the average number of patients seen by the doctors per day is 70, but there are doctors in the group who see more than 100 patients per day.

DR. GOTTLIEB With the number of practicing orthodontists leveling off or declining and the number of graduates remaining low, and the number of patients likely to increase, it looks as though practices will be growing for the foreseeable future.

MR. SCHULMAN They sure are. You know, Gene, I have done consulting in many dental and medical specialties, and there is absolutely none that is as blessed as orthodontics. Your patients are not sick. You have a long-lasting relationship with them. The techniques have vastly improved. The fees have continued to improve. Your patients suffer little pain or discomfort during treatment, and they will think kindly of you all of their lives. I guess my message to orthodontists is: Count your blessings. Build your practices. Inspire your staff to be more productive, more helpful. Work to build your dentist referral program. Stimulate your patients to send their friends to your office for treatment. ❑