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THE READERS' CORNER

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Topics are bracket slot size and telephone answering systems.

1. What bracket slot size do you use routinely?

There was an even split among the respondents, with about one-half preferring the .018" slot and the other half favoring the .022" slot. A few of the clinicians used both slot sizes--for example, one size on the upper anterior teeth and another in the buccal sections.

Would you favor a single standardized slot size? If so, what size, and why?

Thirty-two percent of the respondents did not favor a single standardized slot size. More than twice the remaining respondents preferred the .022" slot over the .018" slot, but 8% of the clinicians believed a slot size between .018" and .022" should be developed. This group felt that an .020" slot would allow the use of a sturdier archwire than with the .018" slot, while allowing the use of a more flexible wire when filling the slot than with the .022" size.

Those who favored a standardized slot size believed it would facilitate transfer cases. Proponents of the .022" size listed stability and torque control as their principal reasons. Those who favored the .018" slot as a standard frequently mentioned that heavier archwires were no longer necessary because of the development of superelastic wires.

A typical comment was:

λ "The .022" allows you to close space on an .018" or .020" round wire without arch collapse and bite deepening. Also, I can use larger wires to open bites and adjust arch width on adults with denser bone. The original advantage of lighter forces with the .018" slot has been negated by the use of nickel titanium and braided archwires."

Do you aim to fill the slot from the beginning of treatment? Eventually?

Very few of the respondents reported that they filled the slots from the beginning of treatment. These clinicians usually stated that they did so only in cases where significant torque would be required on the incisors.

Of the remaining respondents, the majority said they did fill the slots eventually. Nevertheless, there was a significant group that did not fill the slots at all, finishing most of their cases with slightly undersize wires--for instance, an .019" × .025" wire in an .022" slot. It was also noted that filling the bracket slot often accentuated the effects of somewhat faulty bracket positions that would not be problematic with slightly undersize wires.

Representative remarks included:

λ "I routinely fill the slot because you can only achieve the benefit of the preadjusted system by filling the slot. If you don't, it really doesn't matter what system you use."
λ "I don't fill the slot from the beginning of treatment, but eventually I will fill the slot on the

anterior teeth only."

How do you choose a particular set of preadjusted bracket specifications?

More than half the respondents indicated that they made their decisions based on what they believed to be correct for the majority of their patients. The word "experience" was often used to explain these decisions. In addition, many clinicians noted that they preferred prescriptions with significant lingual root torque on the upper incisors and distal root tip on the cuspids, especially in extraction cases.

About 47% of the respondents used preadjusted bracket prescriptions based on specific techniques, most of these favoring the Roth formulation and a few using Andrews or Ricketts.

One typical comment was:

λ "I must have the tips and torques that I find work in most cases. Ultimately I expect only averages and that I will have to place offsets or do some torquing in the wire in most cases. Preadjusted brackets are rarely right on. One size does not fit all."

Is interbracket width a consideration in your technique?

About half the respondents indicated that interbracket width was a consideration; 35% did not consider it to be a factor, and 15% believed it to be somewhat of a factor. Those who said it was not a consideration often stated that with the availability of superelastic wires, bracket width is not as critical as it once was. Still, there were clinicians who believed that interbracket width was crucial when bonding narrow teeth such as lower incisors.

A specific reply:

λ "I definitely believe that interbracket width is a consideration. I use a midsize bracket to get the interproximal space that is necessary for wire flexibility, and still control rotations well. Larger-width brackets, especially in the lower anterior, can make it quite difficult to tie in even an .016" nickel titanium wire."

2. How would you describe the telephone answering system in your office during regular office hours?

Three-fourths of the respondents indicated that the phone was answered by the same staff member as often as possible. The remainder said the phone was answered by any available staff member. No practice used an automated message that routed the caller to an appropriate department.

If a live person answers your calls, do you have scripts for responding to particular situations?

Most of the clinicians did not use prepared scripts. Many of these mentioned that they preferred having well-trained staff members speak to the callers. There were also a few comments to the effect that scripts were too impersonal. Those who did use scripts (about 25%) employed them mainly for initial contacts and emergency calls.

Pertinent responses included:

- "We have scripts to commonly answered questions. But more important, we have a well-trained team member who can handle most situations."
- "We have people who are ranked in order of answering performance, from first to fifth. They all undergo script training to handle virtually any question."

When a caller is placed on hold, what is heard?

Half the respondents reported that there was silence when their callers were placed on hold. Twenty percent indicated that information about the practice was heard, while a smattering of respondents used recorded music or a radio station. One practice played an entertaining message skit. No one used a message asking the caller to keep holding.

What kinds of calls will the doctor take routinely during regular office hours when not at the chair?

Nearly all the respondents indicated that the doctor would routinely take calls from referring dentists, referring specialists, and orthodontic colleagues, as well as personal calls. Additionally, 82% would take calls from patients or parents, and 84% would take calls from non-patients seeking information. A few remarked that although the doctor would take most calls when not at the chair, the practice did make an effort to have the person answering the phone respond to the caller without interrupting the doctor. There were no respondents who indicated they would never take calls when not at the chair.

What kinds of calls will the doctor take routinely during regular office hours when at chairside?

Again, nearly all respondents said the doctor would routinely take calls from referring dentists, referring specialists, and orthodontic colleagues. Fewer practices, however, said the doctor would take personal calls or calls from patients, parents, or non-patients seeking information. Ten percent said they would not take calls from anyone on a routine basis.

Some comments were:

- "I will take calls at the chair about a mutual patient, but not personal stuff."
- "I take personal calls while at the chair on an emergency basis only."
- "I will take calls from parents if I' ve called them, or if they' ve previously let my staff know they need to talk to me. I do not want to be inaccessible; however, I try to empower my staff to handle as much as possible."
- "I do not want to take any calls when bonding or cementing, or during initial exams."

How would you describe your procedure for responding to telephone messages?

The vast majority of respondents indicated that telephone messages were answered by a single staff member as much as possible. Twenty percent said their messages were answered by any available staff member, and 10% said the messages were answered by the persons in whose voice-mail they were placed.

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