JCO-Online Copyright 2003 - VOLUME 37 : NUMBER 02 : PAGES (81-89) 2003

Efficient and Effective Consultations

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Most orthodontists would agree that patient compliance plays a significant, if not critical, role in the efficacy of treatment. We have all experienced cases that were completed ahead of schedule because patients wore their elastics exactly as instructed, and we have all struggled with patients whose treatment ran much longer than expected due to poor compliance. There is little doubt that our mechanics would be significantly more efficient and effective, and the overall stress level in an orthodontic practice considerably diminished, if a high level of patient compliance could be obtained.

I believe this process begins at the consultation. You have probably heard the oft-repeated phrase, "You don't get a second chance to make a first impression". Think about it in the context of your consultation process. Typically, the child is lying flat on his or her back in a dental chair, while a couple of talking heads hover above as the orthodontist or treatment coordinator earnestly explains to one or both parents the wonders that will be achieved for the child's dentoskeletal complex with braces, headgears, functional appliances, etc. The patient is rarely a party to this conversation. Little wonder that a child's reaction to the talking heads planning a dentoskeletal future of functional appliances and headgears that the child has to wear may well be, "Oh, yeah? Make me!"

In my practice, we have tried to develop a consultation process that enhances patient compliance by making the child an active participant. Somehow, through the lexicon of management experts and consultants, many orthodontists have started calling this initial appointment a "New Patient Exam". I don't know of any other specialists who use that term. When I refer a craniofacial pain patient to a neurologist, that patient is scheduled for a neurology consultation, not a "new patient exam". Couple the terminology with the insistence of many consultants that these exams be done at no charge to lure people in to the office, and the process takes on a commercial tone. I charge for my consultations, and I believe we provide a valuable service for that fee. Indeed, with the possible exception of some plastic surgeons, I have never heard of a specialist in medicine or dentistry who provides consultations at no charge.

If we are to use our time effectively, and if the patients and their parents are to appreciate the value of the consultation, the process should be structured, organized, and extremely focused. Therefore, when patients call my office, it sets in motion a specific series of events designed to allow them to see the amount of effort that goes into a clinical evaluation, diagnosis, and treatment plan, and to leave no doubt in their minds that they will be well cared for by me and my staff.

Initial Phone Call

The preliminary patient information for our computer data base is taken over the phone. Patients are informed of the charge for the consultation and of our policies regarding assignment of insurance. They are also told that we will be sending a clinical history form for them to fill out (Figs. 1A, 1B, 1C, 1D). This is usually mailed the same day, with a cover letter welcoming them to the practice. Feel free to adapt the form for use in your own office. Note, however, that we encourage patients and their parents to write as many notes and to give us as much information about themselves as they wish. You will be amazed at how much you can learn before you have ever seen the patient, and how much more easily you will be able to develop rapport with patients if the parents have already informed you about their apprehensions and concerns.

We generally ask that the history form be returned to us within two weeks, at which time our patient coordinator can check to make sure we have all the information we might need at the consultation. For example, if an adult patient has a history of periodontal treatment, we contact the periodontist in advance. If a child has a history of trauma, we contact the oral surgeon or endodontist who saw the child following the injury. If there is compromising medical information such as a heart murmur or metabolic disorder, we contact the family physician or pediatrician. If the family dentist may have radiographs we can use, we contact the dentist. Most of us have faced the frustration of informing a patient that we need to obtain radiographs as part of the diagnostic workup, only to be told that such x-rays have already been taken at their dentist' s or pediatric dentist' s office. So we refrain from obtaining a panoramic x-ray, on to learn later that the x-rays taken in the other office were bite wings. Then we have to call the patient back for the panoramic x-ray. Such details can all be addressed by obtaining histories in advance and having the patient coordinator do her homework prior to the consultation.

This serves two important purposes. I believe I am able to provide a more thorough consultation because I have the information that I need at hand. Also, most patients are astounded that we went to all that trouble before they even came to our office, and they begin to appreciate the importance of our attention to detail. Let' s face it: most physicians' offices are pretty disorganized, and a lot of patients live with th constant apprehension that their doctor or staff may not know everything they ought to know.

The Consultation Appointment

Our consultation room has a round conference table. When the patient arrives, we deliberately place him or her directly across the table from me so that I am able to establish eye contact (Fig. 2). I have already had a chance to look at the history, of course, and am able to quickly review it with the child and the parents.

Next is the clinical examination, for which I follow a checklist format. Some doctors prefer that the parents not be present for the exam. I disagree. We do a thorough and detailed examination, and I want the parents to see that. Also, the parents of some young children need to feel a level of confidence before they are willing to leave you alone in a room with their children.

When the examination is finished, I usually call the parents over to the chair and hand the child a mirror so he or she can see what I am describing. We do not focus on the esthetic issues, simply because most patients and their parents are already cognizant of them, and these are usually their primary concerns. Our focus is on making sure they understand, on a basic level, the major problems involved with the patient' s occlusion, such as crossbites, blocked-out teeth, and compromised gingival attachments.

This is followed by an explanation that, in order to make a detailed treatment plan, we will need to complete a comprehensive diagnostic workup. If the child needs to stay under observation because it is neither necessary nor appropriate to begin any interceptive or comprehensive treatment, then that is explained to the parents. If there are any specific questions at this point, of course, I will answer them. We generally conclude, however, by explaining to the patient and parents that the information from the diagnostic records will be essential for me to come up with our final recommendations.

At this point, the patient coordinator takes over. She describes the diagnostic workup in considerable detail, so that the child knows what to expect. Since the majority of our patients want to stay for the diagnostic records on the day of the consultation, we pre-block time for them in the records room.

If only one parent is present for the consultation (usually the mother), we strongly recommend that both parents attend the follow-up treatment conference, unless we have already treated one or two children in the family. We find that most parents appreciate this and make an effort to be present, eliminating the frustration of second- guessing by a spouse who wasn' t there, or the problem of a mother who says she can' t make a decision about the child' s treatment without first going home to consult with the father. Having both parents at the conference also saves one of them the trouble of having to explain your treatment recommendations to the other without the benefit of models and x-rays.

Some clinicians might think we are setting up barriers that could discourage patients from coming in for consultations. On the contrary, we find this process can be highly effective if the staff is attentive to the concerns and needs of the patients and their parents. The staff' s function is to act as conduits, not as barriers.

Diagnostic Records

Several years ago, I found that I was doing most treatment plans only a couple of days before the treatment conferences. Now my staff prepares the chart, study casts, and other records within two to three days and places them on my desk for treatment planning. Even though the conference may be two weeks away, I usually do the treatment plan as soon after the consultation as possible.

There are two reasons for this. First, my own recollection of the patient is decidedly fresher than it would be two weeks later. Second, I like preparing my diagnostic report and sending it to the referring dentist well in advance of the conference. A well-organized and lucid clinical report, with appropriate subheadings and titles that avoid having to wander all over two pages trying to find a specific piece of information, is much appreciated by our colleagues. Our patients also appreciate that they can talk to their dentists immediately after our treatment conferences if they have questions about recommended extractions or other matters.

The Treatment Conference

The seating arrangement we prefer for the treatment conference has me facing the child, with the parents sitting on either side of us (Fig. 3). Once the patient coordinator has seated the family and explained to them, briefly, that these are the x-rays, models, and photographs that were taken following the consultation, I prefer to conduct the treatment conference myself. That is not to suggest that a treatment coordinator cannot handle a conference. I simply want to be certain that the parents understand the amount of effort that we put into the treatment-planning process, and I am reluctant to pass up this opportunity to develop rapport with the child and the parents.

As I sit down for the treatment conference, I like to open the patient' s chart and point to a copy of the report that has already been sent to the family dentist. I reinforce the point that a duplicate of the panoramic x-ray has also been placed in the dentist' s files. Should the patient or parents wish to talk to their doctor about treatment recommendations after our conference, they know the necessary information will be there. I want them to be comfortable that the left hand knows what the right hand is doing.

After that, it is a simple matter to point to salient items on the radiographs and the study casts, outline the nature of the clinical problem, and inform them of the specific correction that is necessary. I prefer to present the treatment plan to the child. The average 8-, 10-, or 12-year-old is pretty intelligent. These children have no difficulty grasping the intricacies of a crossbite, an excessive overjet, or crowded teeth

when demonstration models are used. I don' t want the parents to feel slighted or ignored, however, so I generally turn to them and ask their permission to do the presentation in language that is simple and straightforward enough for the child to understand. Then I absolutely ignore the parents and present the problem and the solution to the child (Fig. 3).

The general tone is, "Susie, can you see how your teeth are crooked?" or "you have an overbite", or "you have a crossbite because the upper teeth are fitting inside the lower teeth". Once the child acknowledges, sometimes verbally and sometimes with a nod of the head, that she understands the problem, I show her what a finished orthodontic correction should look like and ask if she would like her teeth to look that way and to fit that way. Another verbal agreement or nod of the head. "Good. Now, Susie, I can do this, but I cannot do it without your help. Will you help me to get this result for you?" Another verbal agreement or nod of the head. "Good. Well, then I need you to help me by wearing the functional appliance", or whatever is appropriate to the case. If I want the child to wear a functional appliance or a headgear or intermaxillary elastics, I think it is important for her to know why I am asking for this effort. After all, her mother isn' t going to wear the appliance, she is.

We often use open-ended questions to solicit responses. Eye contact with the child is imperative, as is acknowledging the importance of the child in the process. I want that child to feel like the most important person in that room, for the simple reason that she is. At this point, I usually extend my hand across the table and shake the child' s hand to obtain a promise that the two of us are going to work together. Now, finally, I can turn to the parents and say, "Mr. and Mrs. Jones, are you comfortable with your understanding of what needs to be corrected and how we are going to do it?" Usually the parents have a few additional questions, which I am happy to answer. But a fair number of times, there aren' t ar questions, and the patient coordinator can take over. After I have bid good-bye and left the room, the patient coordinator reviews the necessary home-care information, explains the fees, and schedules the needed appointments.

Conclusion

Much of what I have described here can hardly be a revelation to most orthodontists. Individual practitioners have individual preferences on how to manage their consultations and their patient interactions, and no particular technique is going to work for everyone. I really want to emphasize only two major points.

Instead of focusing on trying to "sell" treatment to children and parents, I believe a lot of the time spent tearing our hair out over problems with patient compliance could be saved if the children were made partners in the consultation process. I have found that treatment plans can be presented effectively to children as young as 7 or 8 years old, and certainly to children 12 or 13 years old. If the child is really small, I sometimes get down on my knees to talk (Fig. 4). Try it, it won' t hurt. Avoid making yourself and the parents disconnected talking heads hovering over the child in a treatment chair.

My other main argument is in favor of a two-step consultation process. I know this may seem antiquated to some, but I question the ability to establish as much rapport at the first consultation, when the child is still apprehensive and likely to view you as more of an authority figure than a partner. Because some of my colleagues believe this process takes up entirely too much doctor time, we have videotaped and timec our consultations. With a little practice and organization, a consultation can be completed in no more than eight to 10 minutes of doctor time. The follow- up treatment conference rarely takes more than six to eight minutes of doctor time for a routine case, and eight to 10 minutes for a more complex treatment plan.

Since we changed our methods and started presenting treatment plans to children, our problems with compliance have diminished considerably. The kids wear their appliances because they understand why. A positive doctor/patient relationship has been established prior to treatment, and patient compliance is likely to remain higher throughout the treatment process. Back this up with some positive reinforcement at subsequent visits, and you might be surprised at the results. •

FIGURES

SONDHI-BIGGS ORTHODONTICS

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Orthodontics and Temporomandibular Joint Disorders

Patient's Clinical History/Family Information

(please complete in ink)

Name ______ Age ____ Sex ____ Date of Birth ______
Last First M.I.

Address ______ Tel. # ( ) ______
Street City Zip

School ______ Grade ____ S.S. # of Patient ______

Best telephone number to call for appointments **(During Business Hours)** ______

Best Fax # ______ Best Cell Phone # ______ Best E-mail Address ______

Father's Name ______ Father's SS # ______
Last First M.I. **(for accounting purposes only)**

Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Home Address ______ Home Tel. # ( ) ______

Employed by ______ Occupation ______ Position ______

Office Address ______ Work Tel. # ( ) ______

Does Father have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company ______

Does Father have Medical Insurance? ____ Yes ____ No Name of Insurance Company ______

Mother's Name ______ Mother's SS # ______
Last First M.I. **(for accounting purposes only)**

Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Home Address ______ Home Tel. # ( ) ______

Employed by ______ Occupation ______ Position ______

Office Address ______ Work Tel. # ( ) ______

Does Mother have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company ______

Does Mother have Medical Insurance? ____ Yes ____ No Name of Insurance Company ______

Patient's Family Dentist ______

Patient's Family Physician ______ ______

Whom may we thank for referring you to our office? ______

If responsible party is other than the patient's parents, please give information: ❑ Not Applicable

Name ______________________ S.S.# ______________ Relationship to patient __________

Address ______________________________________ Tel. # (   ) ______________

Does responsible party have Orthodontic Insurance? ___ Yes ___ No Name of Insurance Company ______________

Does responsible party have Medical Insurance? ___ Yes ___ No Name of Insurance Company ______________

Fig. 1A Clinical history form used to prepare for consultation (continued in next figure).

MEDICAL HISTORY:

Has patient had or does patient have any of the following?

	Yes /	No		Yes /	No
Rheumatic Fever	❑	❑	Persistent Headaches	❑	❑
Heart Murmur	❑	❑	Neck Pains	❑	❑
High Blood Pressure	❑	❑	Nerve or Brain Disease	❑	❑
Heart Attack/Stroke	❑	❑	Migraine	❑	❑
Blood Vessel Disease	❑	❑	Epilepsy	❑	❑
Blood Disorder	❑	❑	Mental Health Problems	❑	❑
AIDS/HIV Infection	❑	❑	Bone Disorders	❑	❑
Hepatitis	❑	❑	Arthritis (Any type)	❑	❑
Diabetes	❑	❑	Sleep Apnea	❑	❑
Ulcers	❑	❑	Ear Disorder	❑	❑
Herpes (Any type)	❑	❑	Sinus Infection	❑	❑
Psoriasis	❑	❑	Swollen Glands	❑	❑
Cancer	❑	❑	Allergies	❑	❑

Comments ______________________________________

Please list any other significant information about the patient's medical history:

____

____

Yes	No	
❑	❑	Is patient under a physician's care at present? If yes, reason ______________
❑	❑	Is patient presently, or has patient ever been, under the care of a psychiatrist or psychologist? If yes, describe ______________
❑	❑	Is patient currently taking any medication? If yes, describe ______________
❑	❑	Is the patient allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, what? ______________
❑	❑	Has patient ever had any general anesthesia? When? ______________

DENTAL HISTORY:

Yes	No	
❑	❑	Do any of your teeth hurt? If yes, upper right ❑ upper left ❑ lower right ❑ lower left ❑
❑	❑	Have any wisdom teeth been removed? How many? ______________
❑	❑	Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe ______________
❑	❑	Have you ever had any previous orthodontic treatment (braces)? If yes, when ______________ If yes, doctor's name and address ______________
❑	❑	Have there been any injuries to your mouth or teeth? If yes, describe ______________
❑	❑	Have you ever had any injury in the head and neck area? If yes, describe ______________
❑	❑	Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe ______________
❑	❑	Have you ever had any surgery in the head and neck area? If yes, describe ______________
❑	❑	Do you clench or grind your teeth? If yes, while sleeping ❑ under stress ❑ other ______________
❑	❑	Do your jaw muscles ever feel tired? If yes, when ______________
❑	❑	Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe ______________
❑	❑	Does it hurt to chew? If yes, where does it hurt? ______________
❑	❑	Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
❑ Clicking:	❑	❑	________	______________
❑ Grating:	❑	❑	________	______________

Did these joint sounds begin gradually or suddenly? gradually ❑ suddenly ❑

❑ ❑ Was there some specific event that started the joint sounds? If yes, describe ______
❑ ❑ Have you ever experienced difficulty in opening or closing your jaws? If yes, describe ______
❑ ❑ Have your jaws ever "locked" closed? If yes, describe ______
❑ ❑ Have your jaws ever "locked" wide open? If yes, describe ______

Fig. 1B Clinical history form used to prepare for consultation (continued in next figure).

Yes No

❑ ❑ Do you have pain in your jaw joints? If yes, right ❑ left ❑ Since when? ______
Did your pain start gradually or suddenly? ❑ gradually ❑ suddenly
During what activity? ______ Describe nature of pain ______
What increases the pain? ______ What decreases the pain? ______

Do you have any of the following habits?

Yes No

❑ ❑ Finger/Thumbsucking
❑ ❑ Lip Biting
❑ ❑ Nail Biting
❑ ❑ Gum Chewing
❑ ❑ Ice Chewing

GROWTH AND DEVELOPMENT:

❑ ❑ Has patient reached adolescent growth? ______
❑ ❑ Girls –Has monthly cycle started yet? If so, when ______
❑ ❑ Boys – Has voice changed yet? If so, when ______
❑ ❑ Is the patient adopted? Does the patient know? Yes ❑ No ❑
❑ ❑ Are there any learning disabilities? If yes, explain ______
Patient's present height ______ Expected height of patient______
Father's height ______ Mother's height ______
❑ ❑ Are there other children in the family?
Names and ages ______
❑ ❑ Has any other member of the family had orthodontic treatment?
❑ ❑ Has any other member of the family been a patient in this office?
Name ______

Please describe why you sought this consultation ______

❑ ❑ Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment ______

Any information you can give me concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

______

______

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

______ ______
(Signature of Responsible Adult) Date

Doctor's Notes ______

______ ______
(Doctor's Signature) Date

Fig. 1C Clinical history form used to prepare for consultation (continued in next figure).

PATIENT COORDINATOR CHECKLIST AND NOTES

Contacts with other doctors:

1. ______________________________
2. ______________________________
3. ______________________________

Special notes ______________________________

Additional doctor's notes ______________________________

PATIENT ____________ CN ____________ PARENT ____________

DATE	TODAY'S PROCEDURE	AST	DR	NEXT PROCEDURE

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Fig. 1D Clinical history form used to prepare for consultation.

Fig. 2 Child is seated directly across from doctor to allow eye contact during consultation. Note opportunity to establish relationship with younger sibling, who may later become a patient.

Fig. 3 Eye contact and attention paid to child during treatment conference.

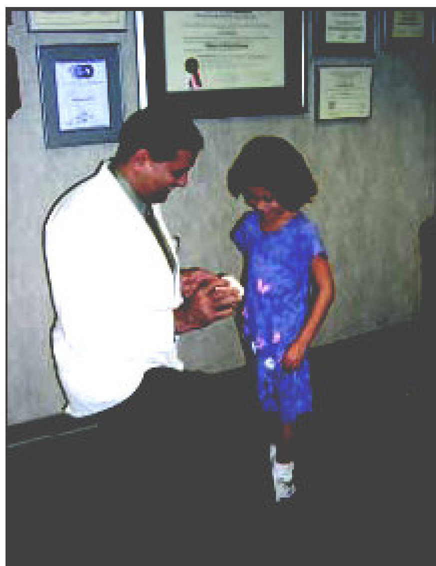

Fig. 4 Getting down to child' s level.