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. Which of the following types of digital images do you use: photographs, radiographs, study casts?

Judging by the replies to this question, it is obvious that digital imaging in one form or another is firmly entrenched in our specialty. The vast majority of respondents were currently using digital records—typically more than one kind. Fully 88% took digital photographs, 20% used digital radiographs, and 20% used digital study casts.

A typical comment was:

• "The quality of digital images now rivals our 35mm slides; the cost of digital radiography will go down, and the reliability of the equipment will go up."

If you do not currently use any digital images, do you plan to do so in the future? Why or why not?

Almost all of those who were not using digital imaging indicated that they would be doing so in the near future. Only three respondents said they were not planning to use digital technology because they believed it was still too expensive and bug-ridden.

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If you use digital radiographs, please describe your system. What are the advantages and disadvantages of your system?

Respondents most commonly scanned radiographs into the computer and analyzed them digitally, often with the Dolphin Imaging System. Some used the Sirona system for taking digital panoramic and cephalometric radiographs, but mentioned that this method requires the patient to remain still longer while the images are being taken.

Specific remarks included:

• "I use the Orthopantomograph OP100D. There is no film, no developing, no chemicals to buy or dispose of. Also, the quality of the image is much better than film."

• "We scan conventional radiographs. The advantage is that it's cheaper than direct digital or phosphor plate scanning. The disadvantage is that we still have an x-ray processor, which is the least reliable piece of mechanical equipment ever designed and produced by man."

• "We have a hard copy and digital image for medicolegal reasons. The quality of the image is outstanding. I have not been impressed with digital radiographs."

How would you describe the costs vs. benefits of your system?

Practically all clinicians indicated that the benefits of digital technology far outweighed any drawbacks. The reason most cited was the ability to communicate with patients, parents, and referring dentists using digital photographs and radiographs that could be printed, sent by e-mail, and immediately accessed at chairside monitors. Additionally, clinicians appreciated the cleanli-

ness of digital imaging compared to the chemical solutions used with conventional film processing.

There were many comments about the initial cost of digital equipment. Nearly all of these, however, were modified by remarks to the effect that the advantages more than made up for the start-up expense.

Some representative responses:

• "The cost of scanning conventional radiographs is reasonable. The benefit of pulling up radiographs at my chairside terminal at any time in either office is great."

• "We take standard radiographs and then scan them into the computer. Referring doctors prefer conventional radiographs for extractions, and there is additional labor in scanning the x-rays. We give photocopies to the parents. However, all in all the system is of tremendous benefit."

• "The benefits of having immediate prints and editing photographs as they are taken make the system worthwhile. Once the system is purchased, the cost is comparable to film since I must pay for floppy disks, ink, special paper, etc."

If you use digital study casts, please describe your system. What are the advantages and disadvantages of your system?

Digital study casts were used less frequently than other digital images. OrthoCad and *e*models were the most popular systems, followed by mounting the models and scanning them.

Disadvantages were confined to two categories: the cost and the delay in obtaining digital records. These drawbacks were offset by the advantages of digital cast imaging, including less lab work and mess, immediate availability at chairside terminals, ease of measurement and analysis, elimination of model storage, and reduction of staff time involved in handling casts.

One respondent said:

• "I tried digital models, but we mount all of our cases. I then digitize the cast with Quick Ceph 2000. This is far superior to digital study models."

How would you describe the costs vs. benefits of your system?

There was a general consensus that the initial cost of the system was high, but again, this was outweighed by the savings of not having to construct, store, and work with handheld casts. Clinicians reemphasized the efficiency of digital imaging in communicating with parents, referral sources, and other specialists by e-mail or by printing copies at actual size.

Comments included:

• "It is more expensive to scan and input records into the computer, but storage is simpler and patient acceptance of treatment is greater. It is also far easier to access information."

Did you experience any significant difficulties in implementing your digital system(s)?

The difficulties associated with integrating digital imaging into the office protocol were not generally considered significant, but some learning curve was expected. Those who reported little or no problems tended to use technologies that were independent of their management systems. A few clinicians indicated that the cost of networking more than one office was unexpectedly high. Still, the majority felt that the efficiency of their systems far surpassed any difficulties in implementation.

2. Please list your present age, number of years in practice, and expected age at retirement.

The average age of the respondents was 47, with a range of 31 to 79 years. The average number of years in practice was 22, with a range of three to 40 years. The average expected age at retirement was 66, with a range of 45 to 72 years.

What kind of retirement plan do you have?

Many of the orthodontists had more than one type of retirement plan. The most common was an IRA, followed by profit sharing, 401(k), defined benefit, and defined contribution. Also mentioned were real estate, after-tax index funds, tax-free bonds, separate IRAs, and employee leasing agreements.

What was your last annual contribution to your retirement plan(s)?

The average contribution was $26,000, with a range of $2,000 to $60,000. Those who contributed less than $15,000 generally had newer practices.

What is the planned size of your fund at the time of retirement?

The vast majority of respondents planned to retire as multimillionaires. The average projected retirement fund was $2.7 million, with a range of $750,000 to $4 million.

Does this planned retirement fund include income from the sale of your practice?

Most indicated that their retirement funds did not include income from the sale of their practices. If their practices could be sold at the time of retirement, it would be a bonus.

Have you made any definite plans for the future transition of your practice?

A majority of respondents had not made any firm transition plans, but a minority were considering partnerships or associateships. No one was planning to affiliate with a management service organization. A few clinicians said their children in dental schools or postgraduate programs would be assuming their practices.

Have your plans for retirement changed significantly over the past few years?

More than a third of the respondents said they would have to postpone their retirement plans due to the current downturn in the financial markets. Another 42%, however, had made no definite retirement plans.

Typical comments were:

• "I recently lost much in the stock market. I could have retired three years ago, but 'stayed in'."

• "I don't know what I'll do when it comes time to retire. My focus now is to fund a retirement plan that will allow me to indulge in my interests when the time comes."

• "A few years ago I planned to finish all my patients and close the office. Now, I plan to look for an associate or buyer."

What are your plans for retirement?

For most respondents, retirement plans centered around what they liked to do, including travel, golf, fishing, enjoying the grandchildren, and volunteer work. Still, there were many orthodontists who wanted to stay connected with the clinical or academic aspects of their specialty. These clinicians were amenable to working for an associate or teaching on a part-time basis. Some enjoyed practice so much that they planned on working indefinitely.

Representative remarks included:

• "I will maintain my hospital and teaching positions as well as lecturing—that is, if clinicians will still listen to dinosaurs."

• "I'm uncertain. I can't sit around without losing my mind!"

• "At 55, I'll reduce the days worked per week to three. At age 65, I hope to sell the practice, retire, and continue the lifestyle I have become accustomed to."

• "I have no plans other than getting an associate as soon as I can afford it."

• "I enjoy orthodontics, and plan to work as long as I can. Then I'll become a meeting junkie."

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