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THE EDITOR'S CORNER

A Void in the Practice

Like a great many JCO readers, I enjoy the benefits of a group practice. There are two common management structures for orthodontic groups. In one, every patient is a patient of the entire practice, and all the doctors use the same appliance systems, with minor individual variations. The same auxiliary support staff serves the entire group; all business affairs are handled by one central office. I practice in the other type, in which each orthodontist basically has an individual practice within the larger group. The scheduling, billing, and insurance functions are still handled by a common office staff, but each doctor pretty much does things his or her own way. In my group, for example, I use an .018" × .022" preadjusted appliance system with loop mechanics. Another orthodontist is a devotee of a popular .022" × .028" preadjusted appliance, using only sliding mechanics. Another one of our clinicians has favored a Begg-type system for years. The fourth doctor uses an .022" × .028" system with a Roth prescription, augmented by vertical auxiliary slots. We are all proficient in our chosen systems, but we are also somewhat familiar with the other appliances used in our practice. Due to our differing professional, academic, and family schedules, I and one other doctor in the group have each treated about 40% of the patients, with the remaining two doctors accounting for about 20% of the patients between them.

This system was put to the test last month when the other doctor who sees about 40% of the total patient base suffered a devastating cardiac dysrhythmia, which seems to be refractory to any effort to convert it back to a normal sinus rhythm. The dysrhythmia has been a chronic problem for my partner, but just recently and quite unexpectedly, the condition took an abrupt turn for the worse, making it impossible for him to practice. Of course, for all of us in the group, our first thoughts and deepest concerns were for the rapid recovery of our friend and colleague. We were incredibly relieved when we learned that he would indeed survive this latest downturn, albeit in a state of what will probably be a permanent disability. After we

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issued our prayers of thanksgiving, however, we had to deal with the sizable void that his departure has left in our practice. Since my two other colleagues are only part-time, their ability to absorb extra patients is limited. Fortunately, my ailing friend is an extraordinary orthodontist, so his cases are well under control, and I have been able to pick up where he left off. The other clinician in the practice who uses an .022" appliance feels the same way, but the one who uses the Begg-type system is having some difficulty adjusting.

Because our partner is a meticulous clinician, his cases have tended to run over the time allotted for the patients' accounts to be paid in full. In addition, he is a generous and kind-hearted humanitarian who does a considerable amount of pro-bono care for the needy. I doubt that any of the rest of us will decline to continue these pro-bono policies, although they could easily have become a point of contention. But it remains to be seen how we will be compensated for finishing the cases of our partner's "paying customers".

Another problem is that each doctor in our practice has had a tendency to work with particular chairside assistants. Whenever small groups of people work together consistently, an efficient teamwork dynamic evolves. When those small teams are disrupted due to circumstances such as we are experiencing now, the overall efficiency of the entire practice drops, at least temporarily.

Now that we are returning to what might be called a normal pace, with the initial crisis behind us, we can pause for a moment and ask ourselves what lessons there are to be learned. First of all, we should have had a crisis-management plan in place from the outset. You can be sure that we will soon have a manual with specific policies concerning the unexpected departure of any of the practitioners—including emergency patient reallocation, pro-bono care, management of accounts receivable, and compensation for completion of cases with zero balances. Another lesson we have learned is that it would be better if all of us used the same appliance system. At this point, it seems unlikely that any of us will switch, but we at least might put PowerPoint presentations together to demonstrate our biomechanical idiosyncrasies to the others. One seemingly minor issue that has made matters more complicated is that none of us knew where the others stored their supplies. The solution to this problem is self-evident. Lastly, I have discovered that it is critical for every chairside assistant in a group practice to be cross-trained to work with not only every doctor in the group, but with every other assistant as well.

The biggest lesson I have learned is that the worst possible time to find out how to deal with an unexpected departure from a group practice is after it has happened. Plan things out well in advance. It may be impossible to anticipate every possible contingency associated with an unexpected void in the practice, but you should write down everything you can think of in an emergency manual. A good reference is an article by Dr. Fred Fink, "Use of a mutual protective agreement after a heart attack" (JCO, April 1993). Get all the doctors and all the staff in the practice together on this project.

At last word, thankfully, my friend is doing better. Chas: Hang in there, buddy. We've got you covered.

RGK