THE READERS' CORNER

JOHN J. SHERIDAN, DDS, MSD

(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. Do you use miniscrews (temporary anchorage devices) in your office? If not, will you use them in the future?

Seventy-five percent of the respondents were not currently using miniscrews, but a substantial majority expressed a strong interest in the potential of these devices by indicating that they probably will use them in the future. Fewer than 5% of the respondents thought they would never use skeletal anchorage.

If you do use miniscrews, about how many patients have you used them in?

The clinicians displayed some caution about the routine use of miniscrews: More than 85% of those who had used them had tried them in five patients or fewer. Only one respondent reported using these devices in as many as 25 patients, while a few said they had around 10 skeletal anchorage patients.

How do you use miniscrews?

About 8% of the respondents used miniscrews "routinely" for molar intrusion and Class II cases, but infrequently in Class III cases, open-bite situations, and partially edentulous patients. Nearly all the clinicians "occasionally" used miniscrews for molar distalization. Occasional use was also reported, in descending order of frequency, in partially edentulous patients, bimaxillary protrusion cases, and Class II patients. Miniscrews were least frequently used in Class III and open-bite cases.

What types of miniscrews have you tried? What type do you prefer, and why?

Since most respondents had not yet used miniscrews in more than a handful of patients, a pattern of usage was difficult to determine. There was no indication that any one brand dominated the market; the Rocky Mountain Dual-Top, TOMAS, and Imtec screws were sporadically mentioned. One respondent reported having an oral surgeon place rigid intraosseous screws.

Clinicians preferred the self-tapping miniscrews that eliminated the need for drilling initial pilot holes. Smaller and smoother screw heads were also preferred to reduce the likelihood of irritation to patients' tongues or mucosa.

Do you place the screws yourself? If not, who places them for you?

Fewer than 5% of the respondents were comfortable inserting the screws themselves. Two-thirds of the others referred placement to oral surgeons, and one-third to periodontists.

What placement locations do you prefer, and why?

There was no consensus on any particular location for miniscrews; various sites were

Dr. Sheridan is an Associate Editor of the *Journal of Clinical Orthodontics* and a Professor of Orthodontics, Jacksonville University, 2800 University Blvd. N., Jacksonville, FL 32211.

apparently employed to establish the desired tooth-moving vectors. Potential locations included between the second premolar and first molar; in the zygomatic buttress; between the first and second molars in the labial plate; in the attached gingiva, mesial to space closure; and between the abutments of a three-unit bridge. In general, there were four common characteristics of the preferred locations: presence of attached gingiva, adequacy of bone support, avoidance of contact with proximal roots, and ability to establish an efficient force vector.

What are the advantages and disadvantages of miniscrews compared to other anchorage methods?

Three advantages were most frequently mentioned: the availability of absolute anchorage, the reduced need for patient compliance, and the possibility of generating force vectors that would otherwise be difficult to achieve.

There were two predominant disadvantages: the additional cost to the patient and the preference of the vast majority of respondents to refer the patient to oral surgeons or periodontists for insertion. Also mentioned was that patients were sometimes reluctant to accept the miniscrew concept.

What problems have you encountered using miniscrews?

Many of the clinicians said they had no adverse comments about the use of skeletal anchorage. The most common problem was the development of inflammation around the insertion site, with the concomitant necessity of meticulous oral hygiene in that area. Another drawback mentioned was that the implant occasionally became loose before the desired tooth movement was complete.

2. To whom do you extend professional courtesy for orthodontic treatment, and how much of a discount do you normally offer?

As might be expected, referring dentists received by far the highest level of professional courtesy. Nearly every respondent gave 100% discounts to these referral sources. The few clinicians who did not still gave discounts above 50%, except for one respondent who discounted by only 10%.

Staffs of referring dentists always received professional courtesy as well, usually in the range of 20-50%. A few clinicians reported 100% discounts, but they were balanced by those giving 10% discounts.

Family members of referring dentists—with an emphasis on immediate family—received professional courtesy on a level close to that of the dentists themselves. The usual discount was 100%, but a few respondents reported discounts of 10-50%.

More than 60% of the respondents did not extend professional courtesy to other referrers or to their staffs and families. The usual discount, when given, was in the 10-20% range. Several clinicians remarked that the discount would vary according to the referrer's contribution to the orthodontic practice. If a dental specialist sent substantial numbers of patients, a full discount might be extended.

Non-referring professionals and their staffs and families did not usually receive professional courtesy. Those who did were generally given discounts of 10-25%, with the professionals themselves receiving the highest discounts, followed by family and staff.

Relatives of current and past patients were given professional courtesy by all respondents, but the discounts were relatively modest, ranging from 5-10%. Rather than discounting a percentage of the fee, some clinicians deducted a specific dollar amount, usually about $200.

The orthodontists' own staff members and their immediate families were typically given 100% discounts. Several respondents noted that the discounts would become effective only after one year of employment, or that the cost of lab

fees and supplies would be excluded. Discounts for relatives were generally reduced according to their closeness to the staff member on the family ladder.

Friends were given various degrees of professional courtesy, depending on the depth and length of the friendship. Discounts ranged from 0-100%, but most were in the 10-25% area. Overall, the clinicians' friends received a slightly higher level of professional courtesy than their relatives did.

Some interesting comments were:

• "Over a period of time, I have limited the discounts to the extent that there has to be a definite 'good will' or marketing benefit for my practice. On close scrutiny, it's not that common."

• "I help those who can help me."

• "After many years in private practice, I realize that giving people discounts has no effect on the vigor of my practice, and there is minimal appreciation for the favor. Let them pay. Maybe they'll appreciate it more."

How many cases did you treat on a pro bono basis in the past year?

Nearly all the respondents were treating pro bono cases, generally between two and five in the past year. A few clinicians reported no pro bono work at all, while 15% treated significantly more than the average, with some treating twice as many and one reaching out to treat 20-30 patients over the previous year.

What were your reasons for extending this courtesy?

The primary reason for treating pro bono cases was that these selected patients were in financial distress. Other reasons included appeals from churches or other charitable groups, or working in conjunction with other specialists in a team approach. Also mentioned was that the orthodontist wanted to join in the charitable spirit of the community, especially when the breadwinner of the family had died.

The need for pro bono work was often brought to the attention of the orthodontist by the referring dentist. This not only allowed the orthodontist to fulfill a moral commitment by helping the less fortunate, but also reinforced a humanitarian bond with the referring dentist.

Specific remarks included:

• "When you say 'pro bono', I consider these to be people who have financial needs and can't afford the cost of care. These are not the referral sources or their kids and family."

• "Referring dentists would contact me and explain that a child needed care for a severe malocclusion, but had no way of paying for it. Also, certain clergy would call with the same situation."

• "I certainly treat some pro bono cases and I feel I should. However, I will make the final decision to treat these cases, not a third party."

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Dr. Steven A. Appel, Philadelphia, PA
Dr. Susan Arnold, Randolph, NJ
Dr. Daniel A. Avant, Colorado Springs, CO
Dr. Joseph F. Coniglio, Corpus Christi, TX
Dr. Joseph M. Crisham, Dixon, IL
Dr. Willy Dayan, Toronto, Ontario
Dr. Michael J. Delgado, Hurst, TX
Dr. John P. Doley, Williamsburg, VA
Dr. Brett Eckley, Beckley, WV
Dr. Joel Glovsky, Topsfield, MA
Dr. Daniel Haberman, Sacramento, CA
Dr. Robert D. Heitzman, Rancho Bernardo, CA
Dr. Robert G. Hicks, Orlando, FL
Dr. William E. Hoffman, Leawood, KS
Dr. Michael L. Jacobsen, Victorville, CA
Dr. Brett Johnson, Wichita Falls, TX
Dr. Douglas A. Jolstad, Minnetonka, MN
Dr. Jene F. Jordan, Archdale, NC
Dr. Jeffrey LeBlanc, Laurel, MS
Dr. A.S. Marko, Orleans, Ontario
Dr. Maston R. McCorkle, Jr., Roanoke, VA
Dr. Randal D. Morita, Aiea, HI
Dr. Steven A. Nerad, Pleasanton, CA
Dr. Kenneth W. Norwick, Dearborn, MI
Dr. Michael D. O'Leary, Wisconsin Rapids, WI
Dr. Anthony R. Peluso, Virginia Beach, VA
Dr. C. Edwin Polk, Stillwater, OK
Dr. Kendra J. Remington, Guilford, CT
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