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THE EDITOR'S CORNER

The Dilemma of Transfer Cases

Given that my private faculty practice is adjacent to the main campus of the University of Southern California, which is predominantly a residential university with few commuter students, I get a disproportionately large number of transfer cases. It is rare for an August to go by without my receiving 10 or more calls, letters, or e-mails from concerned parents whose orthodontic patient-freshmen are off to college and away from home for the first time. The parents are all rightfully concerned about how their teenagers will continue treatment so far from home. Typically, these students are in the finishing stages of comprehensive orthodontics, but I have had everything from cases that have just been bonded to patients in the immediate presurgery phase, just waiting for semester break to come around as a convenient time for orthognathic surgery, to patients needing only replacement retainers.

The orthodontic faculty practice is considered by many parents of incoming USC students, rightly or wrongly, to be a service provided by the university. As such, we are "encouraged" to accept these incoming transfer cases—which has both advantages and disadvantages. On the plus side, we get to see practically every appliance manufactured in the world today. Because USC draws students from all points of the globe, I have had transfer cases come in from every continent except Antarctica and have seen every conceivable fixed appliance and every flavor of self-ligating bracket on the market. I have even seen some devices that I simply did not recognize. The downside is that I am rapidly approaching the "old dog" phase of life, in which it is getting harder and harder for me to learn new tricks.

This uninvited experience with myriad types of cases probably explains the sinking feeling I get in the pit of my stomach whenever I see the word "transfer" on the daily schedule. Even though every practicing orthodontist in this and other developed countries has been through a rigorous specialty training program, each with a similar grounding in the scientific literature, we all have our own way of doing things. That inter-individual variation applies not

only to actual treatment, appliances, and biomechanics, but to every aspect of orthodontic practice—financial management, collection policies, third-party payment options, records procedures, diagnostic and treatment-planning methods, appointment scheduling, retention protocols, even transfer policies. Some orthodontists simply refuse to accept transfer cases. I have always admired those who have enough fortitude of character to insist on doing everything their own way and no other. Unfortunately, I don't have that option.

We all know how difficult it is to pick up in the middle of a case and try to second-guess the original diagnosis and treatment plan. A number of seasoned practitioners will accept transfer cases only if the patient or parents are willing to consider it a "start-over", with brand-new records and diagnosis, removal of any existing appliances, and implementation of the receiving orthodontist's treatment philosophy. Fees are usually prorated based on the estimated time left in treatment, using the new orthodontist's customary fee schedule. Problems arise when a patient wants to transfer to a practice in the same town, due either to financial problems with the first office or to some vague rationale of not being able to see eye-to-eye with the previous doctor. To avoid the potential for unneighborly relations, many an orthodontist will refuse to accept a transfer unless the patient is moving a considerable distance.

Having long ago recognized the difficulties associated with patients moving from one orthodontic practice to another, the AAO has developed standardized transfer forms that address many of these issues. Still, individual practices insist on completing even the standardized transfer forms in their own way. The fun with transfer cases never stops.

In my campus practice, there are a few procedures that I have found beneficial in making patients' transitions from their home orthodontists to me as smooth as possible. By far the most productive is *always* calling the previous orthodontist. Establishing a personal contact helps minimize miscommunication as the case progresses, thus averting potential problems with treatment plans, appliance choices, and patient expectations. It also allows for an open discussion of the financial situation. Another mandatory procedure for any case is obtaining transfer records. Preferably, I want to see the starting records (high-quality duplicates are acceptable), but if that is not possible, the most recent progress records (or good copies thereof) are required. I also make a point of obtaining full records representing the state of the case at the time I take over. These are followed by a consultation with the patient, which works best if the parents are able to join in by conference call.

Of course, one of the best ways to cope with any challenge of everyday practice management is to find out how your colleagues are dealing with the same problem. In this month's Readers' Corner column, Dr. Jack Sheridan addresses the topic of transfer cases. The recommendations made by JCO readers from across North America should help me cope with the frustration that I feel when I see "transfer" on the daily schedule.

RGK