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. What change or changes in your office have been most traumatic for your staff? How did the trauma manifest itself? What was the solution to the problem?

The vast majority of replies involved converting the office to a new or different computer format. These difficulties were usually resolved through patience, professional advice, and refusal to give in to the temptation to sink back into the comfortable but antiquated system that had previously been used.

Another frequently mentioned trauma centered around the loss of a key employee, especially an office manager. Such problems were overcome by aggressive searching for and careful training of new employees.

A number of respondents described the acquisition or loss of a partner or associate as traumatic. These problems usually worked themselves out with patience on the part of the participants and the staff.

Comments included:

• "Changing to a new (our first) computer system. The staff did not want to let go of the 'hard' appointment book to utilize the online scheduler. I found them hiding the appointment book in various places. I had to physically remove it. They finally accepted the new technology and are now loving it. However, I'm having trouble with the computerized schedule. I find myself running late with new exams or consults. I just love to talk. The staff is doing their best to keep me on schedule—that's their job."

• "I had difficulty changing from a 35mm camera system to an electronic digital camera. The difficulties with the utilization and integration of this technology required an extensive learning curve. However, I'm sure the time invested will eventually give me superior documentation of my cases."

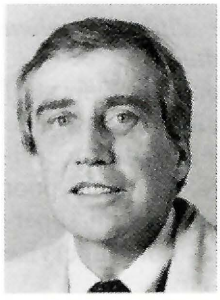
• "Switching orthodontic suppliers on the basis of an enthusiastic sales promotion, involving sizable discounts and reportedly better products. I switched 100% of my business to this company. However, the representative was not very attentive, the service was not crisp, and the products were no better than what I had abandoned. The solution was obvious: I went back to my old supplier."

Do you make appliance changes that were not originally planned after a case has been treated for awhile?

More than 92% of the orthodontists said "sometimes", and the remainder said "often". There was not a single reply indicating that incourse appliance adjustments never occurred.

Do you find it necessary to change your treatment plan for a case? What was the usual cause for such changes?

All of the respondents said they "some-



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times" had to change treatment plans. Nearly two-thirds cited non-cooperation as the main reason. Other factors included lack of dental or skeletal response (18%), orthodontist's change of mind (9%), and patient request (6%). Some individual remarks:

• "I usually try to treat nonextraction, but may have to remove teeth later in treatment."

• "I know kids will grow. I just can't predict when, in what direction, and by how much. So I'm not all that surprised when I have to alter my treatment plan—it goes with the territory."

• "When non-cooperation is evident, I often change to some sort of a fixed Class II correction device (Jasper Jumper or bonded Herbst). Breakage of these appliances is occasionally frustrating, but they get results that would otherwise be impossible."

Do you ever elect to use a form of retention not originally planned? If so, why?

Nearly all of the clinicians answered "sometimes", with only a few responding "often" or "never". The primary reasons for changing were lack of cooperation, patient or parent requests after repeated loss of retainers, and requests for clear plastic retainers. Comments included:

• "I don't plan retention until three months prior to debonding. Even so, some patients request a different type of retainer after I have delivered the one of my choice."

• "Restorative plans by dentists often necessitate interim retainers. When this happens, we offer to make a new Essix type at no charge if the patient comes to our office immediately after receiving new veneers."

• "I feel we'll get better compliance if the patient is given an opportunity to select from appropriate retention devices."

• "If the progress ceph shows that the lower incisors were flared more than anticipated or were difficult to align, a fixed retainer is used. If a Class III shows excessive growth, a positioner is used."

2. Do you have a toothbrushing center in your office? Do you have a separate area for adults?

A substantial majority (81%) of the respondents had toothbrushing centers, with the rest indicating that instructions were given at chairside. Eighty-nine percent said they did not have separate areas for adults, but a few of these said adults could use the private rest rooms in their offices. One comment:

• "Rarely do I have to give brushing instructions to an adult. It's the kids who need constant monitoring."

Do patients have their own brushes, or do you provide disposable brushes?

Most of the clinicians used disposable brushes. A few who provided individual brushes for patients noted that the patients sometimes used disposable brushes as well.

Do you provide a separate tube of toothpaste for each patient?

About three-fourths of the respondents did not provide individual toothpaste tubes, but 14% said they provided preloaded disposable toothbrushes. Some individual remarks:

• "Manufacturers' sample sizes are available for those who want a separate tube."

• "I don't have a separate tube for each patient because we use disposable brushes that incorporate toothpaste. We leave these in an accessible area, and the patients or parents can help themselves. If they want to take a few home, that's fine with me."

• "I don't use separate tubes for patients. However, we put a small portion on a tongue depressor, and this is given out at the front desk when the patients check in."

Do staff members supervise children when brushing? Do they supervise adults?

Two-thirds of the clinicians said their staff members did not supervise children when brushing. Ten percent commented that staff supervision was warranted in cases of obviously poor hygiene. Even most of the practices that supervised children's brushing did not supervise adults. One explanation:

• "I had a separate toothbrushing area for adults,

but it was rarely used. Some adults seemed to be offended, and I felt awkward when adults were instructed to brush. I think they felt they were being treated like children. We give adults a hygiene lecture and demonstration prior to starting the case, but we don't press the hygiene issue unless it's obvious that they need guidance."

Do you give toothbrushing instructions to patients? If so, how?

All the respondents said they gave toothbrushing instructions, usually involving a variety of techniques such as model demonstration, video instruction, disclosing tablets, and demonstrations of perio aids, floss, and oral irrigators. Most also had the patients clean their teeth under supervision after the instructions.

One clinician described a thorough, four-part toothbrushing program:

• "1. We show a video on the day of the case presentation.

"2. We review toothbrushing on the day the brackets are placed.

"3. A three-minute egg timer is given to the patient to encourage the proper length of time required to brush.

"4. Each month we have a 'Brace Buck' lottery for all good brushers."

Do you have a dental hygienist on your staff? If so, is it a full- or part-time position?

Only one respondent had a hygienist on his staff, and that was because he was in a practice with a pediatric dentist. His response indicated the potential benefits of an in-house hygienist:

• "We recommend many patients have a prophy/fluoride treatment as many as three or four times a year. The frequency is dependent upon the oral hygiene, gingival status, precarious lesions, etc."

An orthodontist who had previously employed a hygienist commented:

• "An additional duty that could be relegated to the hygienist is to do a thorough cleaning at the time of debonding, and ensure that all bonding composite has been removed."

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