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. On what percentage of cases are you using esthetic brackets?

Forty-five percent of the respondents used esthetic brackets on 5% or fewer of their cases. Another 40% used them on 6-15% of their patients. Only 7% used esthetic appliances on 15-30% of their cases, and a smattering of clinicians used them on 40% or more. Seven percent did not use any type of esthetic bracket.

Which esthetic brackets do you prefer?

In general, the clinicians used ceramic brackets—particularly polycrystalline brands such as Allure and Transcend—more than other types of esthetic appliances. However, those who had tried more than one type of esthetic bracket tended to prefer the plastic types with metal inserts, such as Spirit and Elan.

Where do you normally place esthetic brackets?

In the maxillary arch, the majority of respondents (52%) used esthetic brackets from cuspid to cuspid, closely followed by those bonding from second bicuspid to second bicuspid (46%). Six percent of the clinicians used esthetic brackets from first bicuspid to first bicuspid.

Only 5% used any esthetic brackets in the mandibular arch—primarily from cuspid to cuspid, with a few bonding from second bicuspid to second bicuspid. Several clinicians said they used porcelain brackets on mandibular anterior teeth.

Do you use the same etching and bonding technique with esthetic brackets as with metal brackets?

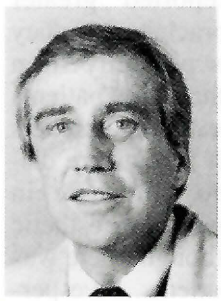
Fully 85% of the respondents used the same bonding procedure. Comments from those who used a different technique included:

- "We use light-cured composite with ceramic brackets."
- "I like to use a one-paste system with metal brackets and a two-paste system with ceramics."
- "I use a shorter etching time with plastic brackets."

What problems have you encountered with esthetic brackets?

The most criticism by far centered on breakage and bracket friction (82%). Discoloration was noted by 6% of the respondents, and enamel damage by 3%. However, most of those who had encountered enamel damage noted that the problem was not as prevalent with newer materials. Other problems included bracket distortion, difficulty in debonding, difficulty in positioning the brackets, wear on plastic brackets, sharp edges, difficulty of ligation, and the poor esthetic appearance of discolored elastomeric ligatures.

What do you like best about esthetic brackets?



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The two outstanding categories were appearance (61%) and patient appeal (29%). Some clinicians noted that the initial appeal did not last, because the brackets (especially plastic) and elastomeric ligatures eventually discolored. Most of the respondents said they usually limited the availability of esthetic brackets to adults. On the other hand, 4% of the orthodontists liked nothing about esthetic brackets.

Comments included:

- "Cost and effort are much less than lingual appliances for those adults who are looking for an esthetic alternative to metal."
- "It opens the market to adults, who can feel more comfortable with treatment."
- "I only use them if the patient will not accept metal."
- "Virtually 100% of my adult patients are in esthetic brackets."

What do you like least about esthetic brackets?

This question engendered the most robust response, with multiple complaints from some clinicians. The most frequent complaint involved breakage, especially of bracket wings, followed closely by difficulty of removal and thickness or bulk of the brackets. Also noted, but to a lesser extent, were friction, discoloration, increased treatment times, poor torque control, difficulty of bracket positioning, and lack of a vertical slot.

Some individual responses:

- "I don't like anything about esthetic brackets except the patient appeal. They are a biomechanical joke."
- "There are no stain-resistant elastic ties, and patients look like they have cheese on their teeth."
- "The inability to induce appropriate torque without fracturing the wings of ceramic brackets."
- "Treatment times are further extended in the adult, exasperating both me and the patient."

What improvements would you like to see in esthetic brackets?

Durability was the most wanted improvement (31%), followed by a lower profile (17%), less friction (14%), and easier removal (12%). Other items on respondents' wish lists included easier ligation, development of non-staining elastomeric ligatures, reduced discoloration of plastic brackets, incorporation of a vertical slot, and smoother edges.

Some comments were:

- "Slenderize the bracket, reduce the coefficient of friction, and develop some plastic ligature modules that don't stain."
- "Develop a less bulky bracket that would resist staining and wing fracture."
- "The biggest improvement would be their disappearance."

Have you stopped using esthetic brackets, and if so, why?

A solid majority of the respondents had not stopped using esthetic brackets. Only 8% said they had nearly stopped, and 4% said they had stopped completely. Reasons for discontinuing the brackets included increased treatment time, breakage, decreased torque capability, and lack of patient requests for them. The following observations were made:

- "They are not esthetic. The patients look like they have gunk on their teeth."
- "I haven't stopped using them, but unless significant improvements are made, it's just a matter of time."
- "Increased chairtime and treatment times, resulting in a reversal of the initial enthusiasm about their esthetic value."

How would you compare patient acceptance of ceramic and plastic brackets with that of miniaturized metal, gold, titanium, or other materials?

Thirty-seven percent reported greater patient acceptance of esthetic brackets, but they noted that the acceptance was primarily from adults. Twenty percent replied that more patients preferred metal brackets to esthetic brackets when the pros and cons of both types were discussed. Ten percent noted no difference in patient acceptance between metal and esthetic appliances, while another 10% thought there was no difference at all for most patients. Five per-

cent of the clinicians said there was less acceptance of esthetic brackets when their limitations were emphasized.

Individual observations were:

- "Most patients prefer metal when limitations of esthetic brackets are explained. The chief complaint with esthetic brackets is that they look all yellow."
- "Ninety percent of the children want metal. Eighty percent of adults want esthetic brackets."
- "Many adults prefer esthetic brackets, but when the extra cost (about $500), longer treatment times, and limitations are explained, they go with metal brackets."
- "Esthetics involves more than eliminating the obvious; it also has to do with adorning the natural. Gold brackets look terrific on women with blond hair and blue eyes."

2. Have you ever hired an associate or taken on a partner? Have you ever acted as an associate or partner?

Of the orthodontists who responded to this question, 27% had formerly been associates, and 18% were presently employed as associates. Twenty-two percent had taken on current partners or associates, while 8% had entered into previous partnership arrangements.

If you have ever hired an associate or taken on a partner, how did you find this person?

About a third said their new colleagues were personal acquaintances. Slightly fewer said they found their partners or associates in the orthodontic departments of their own schools; some of these said they had also known the people personally. Only a few future partners or associates had been located through classified journal advertising, and none through management consultants. One respondent had found an associate through an orthodontic supply salesman.

Please describe the terms of the current or former relationship.

Those who received monthly compensation reported wages ranging from $4,700-7,500 per month, with the majority in the $6,500-7,500 range.

What percentage of practice income was involved?

The average figure was around 50%. Variations on this theme included 40% of collections, 50% of the gross receipts of patients treated, and 50% of profits.

What were the terms and time periods of the gradual buy-in?

The duration generally ranged from three to six years, with most of the responses at four to five years. One clinician reported a 10-year buyout agreement. The majority of respondents reported a one-to-five-year waiting period before setting a buy-in date, and most favored one year. This was followed by a trial association, usually

of one year, before initiating a buy-in percentage schedule. Nearly all the respondents indicated that the buy-in eventually led to 50% participation in the practice.

What are the advantages of having an associate or partner in your practice?

By far the most frequent reply centered on having more efficient office coverage. This was usually accompanied by comments about the opportunity for more free time to devote to patient relationships and office management. Other advantages included the chance to share responsibility, the appeal of a younger partner or associate to a younger referral base, additional input into diagnosis and treatment planning, increased production, and a new perspective on practice management.

Some individual comments:

- "Less headache of being the boss."
- "I thoroughly enjoy the flexibility on vacations, days off, and someone to consult with."
- "There's great office coverage for emergencies, and I don't get lonely."
- "My young associate brought a fresh new outlook to the practice and helped us get rid of a somewhat musty status quo."
- "I have two partners and two great friends."

What problems have you encountered in hiring or working with an associate or partner?

Seventy percent of the replies focused on disagreements in practice management and treatment philosophies. This was followed by the difficulties in overcoming a junior-partner vs. senior-partner attitude. Some respondents were irritated by a different work philosophy or by the partner or associate not contributing a fair share of effort. A few complaints were related to personality clashes, loss of autonomy, or conflicting patient loyalties.

Interesting responses included:

- "I would like an associate and am actively seeking one, but it's difficult to compete with the salaries being offered to new graduates by orthodontic treatment chains such as Orthodontic Centers of America."
- "Don't do it unless you are related or retiring."
- "It's like being married without the sex. You must give and take for mutual benefit."

What advice would you give other orthodontists who may be considering an associateship or partnership arrangement? What would you have done differently?

Replies to this question were spirited. Two-thirds of the respondents emphasized the need for a legal agreement spelling out responsibilities and financial arrangements. There were many remarks about not rushing into an agreement and making sure treatment philosophies and personalities were compatible. Some mentioned that when hiring an associate, emphasis should be placed on setting a buy-out date, and remuneration should be built on a base salary plus incentives.

Some comments were:

- "Talk more about what happens if the agreement comes apart, rather than hoping that it never will. Or saying, 'Oh, well, we can deal with it if it happens'."
- "Take time to know each other thoroughly. The first year should be non-committal."
- "I should have entered into an arrangement in which only expenses are shared, and income distributed on the basis of production."

If you are now or have ever been hired as an associate or partner, what are the advantages of that relationship?

The most common responses were that the transition from dental school to a practice environment was easier, the difficulties in establishing a solo practice were avoided, and there was an opportunity to become established more quickly in the dental community.

JCO would like to thank the following contributors to this month's column:
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