The profession and business of orthodontics

As a student, teacher, and clinician in the orthodontic profession for 35 years, I have observed the comings and goings of many trends in orthodontic delivery systems (appliance design) and treatment approaches. The observations over this time demonstrate the many fundamental changes the profession has undergone. When I was a resident in the late 1970s, the straight-wire appliance was the newest and hottest thing. As graduate students, we focused on the didactic basics, such as growth, diagnosis, and biomechanics. In the clinic, we were initially taught the skills of creating ideal archwires in three dimensions (in today's world, we might refer to that as custom archwires). At about that time, straight-wire concepts were introduced and incorporated into the clinical curriculum. We then concentrated our efforts on learning how to use these appliances and deciding on the appliance prescriptions we would use when we graduated. In the 1970s, the goals of treatment were more narrowly focused on attaining a Class I functional occlusion; we had only a vague concept of esthetics as we know it today. As a dental student on the way to becoming an orthodontist, the amount of information required to absorb in residency was so overwhelming that I naturally retained more knowledge in the area most familiar to me—the teeth. The more comprehensive issues such as facial, smile, and dental esthetics were developed later in my career. Once in practice, I gained a greater appreciation of other important and unexpected issues, such as how I was perceived by patients and what they expected of me in terms of outcome. In the practice model of that era, the doctor was in charge and we knew what was best for the patient. Many of us remember that in the early 1980s, we did not even require patients to give informed consent. But today's medicolegal and market environments require a full description of the patient's problems and treatment alternatives. As Ackerman and Proffit stated in a classic paper on informed consent, ". . . the doctor now must talk *with* the patient, not *to* the patient."[1] For me, this concept evolved only over time.

As parents, we strive to teach our children to use proper manners, to maintain respect for others, to educate them, and to get them prepared for the world. Parents of current patients who were patients themselves give me great insight into the importance of orthodontic treatment in their lives. They articulate openly and consistently that the most important service provided for them was enhancement of their appearance that resulted in the improvement of their self-image, self-esteem, and confidence. The role of the orthodontist has clearly become part of that important process in preparing children for competing for jobs, spouses, and all the things that come with a positive appearance and a beautiful smile.

This evolution of the doctor-patient interaction is important because our primary role as orthodontists is to serve the patient. The way that we present

or market our services has changed dramatically over the years for two major reasons: *(1)* the decrease in patient demand and therefore increased competition and *(2)* the introduction of orthodontic manufacturers' direct marketing to the public mirroring the success of pharmaceuticals. First, I very much believe that the orthodontic companies are a vital part of how our profession is able to function. I can say from firsthand experience that many educational meetings, constituent meetings, and continuing education courses are sponsored or in part funded by our partners in the Orthodontic Manufacturers Association. The importance of their investment in developing products that improve our ability to provide better care to our patients cannot be understated. One cannot fault the orthodontic manufacturers for wanting to market their products as effectively as possible, and we actually benefit because of the heightened awareness their marketing creates in the pool of consumers who may be unaware of the choices and benefits of orthodontic treatment. That is the good news. The bad news is the tendency for orthodontists to market the products we have available instead of the services and benefits we can provide. In my opinion, this trend tends to defocus patients and parents from our primary message, which should be what we, as orthodontists, can offer in terms of this enhancement of quality of life. Bob Circostas, also known as Billion Dollar Bob, is a successful entrepreneur. Bob was television's first home shopping host. He acquired over $1 billion in personal product sales on live television and is considered one of the pioneers of the home shopping industry. What does that have to do with orthodontics? Bob's basic philosophy is "features tell; benefits sell." Let's use an example—power steering on a car is a feature. What is the benefit? The car is easier to steer. The corollary is that orthodontists often talk to patients about cephalometric measurements, Angle classifications, brackets, wires, and aligners—the **features** of orthodontic treatment. The **benefits** of orthodontic treatment are a beautiful smile and face and all the positives associated with these characteristics. Most orthodontists spend a lot of time talking about the facts and findings (**features**), but they don't spend enough time talking about the **benefits** of treatment. If the orthodontist doesn't have a clear picture of the outcome (the **benefits**), then the latest bracket, archwire, etc, will not be maximized.

Years ago in my practice, I completed a treatment presentation to a family. The father was employed in the retail business, a business that works on the principle of buying products, marking them up for the desired amount of profit, and then establishing a price. When I finished discussing the orthodontic concerns and treatment goals for his child, he asked the obvious question, "How much does this cost?" I gave him the figure, and he pointed to a set of demonstration models with brackets and wires mounted. "How much do those things cost?" he asked. I replied, "You mean the brackets?" and he answered, "Yes, what is your markup on those?" My response was simple, "If it is brackets you want to buy, I can sell you a cup of them for $100." Now, that may not have been the answer my practice consultant would have me give, but here is the point: The father saw all the things that we had talked about in his child's treatment in the wrong terms. He thought he was buying braces (how many times does your front desk receive a phone call inquiring how much braces cost?), but what I was selling was my knowledge, vision, and treatment. If it were just the braces, the orthodontist is only somewhat necessary.

Surely, the technology we have in terms of computers and the vast improvement in appliances and customized appliances are a great leap forward in our ability to treat patients. But in my opinion, these technologies should not be the focal point of how people see us as to what our value is to them.

So let's finish with our topic of the separation of the professional practice and the business of orthodontics. Let me ask you a basic question—as a profession, are we defined by what we sell? Our biggest value is not the mechanical system, but the knowledge we have to see and establish treatment goals. The point is that while our education is rigorous in science and medicine and very mechanically oriented, the fact is that by far the most important thing we do is to visualize our treatment goals, see what we (you and I) want for an outcome, and then know what to do. Being able to see is greatly enhanced if the doctor can see as an artist would see and carry out treatment as the trained clinician would to reach that end. People remember more of what they both see and hear as opposed to what they see or hear alone. Therefore, it is not just the words that are important, but the images that we digitally create for them to see or the ones we paint in their minds.

Technology is an incredibly useful tool, but it is an adjunct that facilitates our ability to establish treatment goals with the patient and maximize our chances of achieving that outcome. Our focus has been and always will be on achieving the best result we can possibly achieve.

David Sarver, DMD, MS
Private Practice
Birmingham, Alabama

REFERENCE

1. Ackerman JL, Proffit WR. Communication in orthodontic treatment planning: Bioethical and informed consent issues. Angle Orthod 1995;65:253–262.