Ortho Tribune

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Inside this issue

But whose evidence?

Why clinically derived research shouldn't be ignored

By Larry W. White, DDS, MSD, FACD

It takes only a short time for some popular phrases to transform into clichés. Back in the late 1960s and early '70s, one such cliché that all commentators and writers with "gravis" used too frequently was "living life on the cutting edge." This clearly implied that unless people engaged in unusual, risky and even unproven behavior, their lives lacked conviction and high purpose. Writers and speakers who favored and promoted this exciting call to action also suggested that those who failed to live life on the cutting edge had somehow sacrificed their God-given innovation and curiosity for intellectual and spiritual stupor.

But was this a fair assessment of more socially conservative people who lived comfortable, productive and somewhat predictable lives away from the so-called frontiers of progress? Of course not, and that general appreciation probably contributed to the phrase's quick loss of potency and degeneration into a cliché that no longer holds much relevance.

(Photo courtesy of Dreamstime)

Dentistry has recently coined a phrase that, for me, has quickly turned into a tired, impotent and overused slogan: evidence-based dentistry. This has evolved as a mantra of academia because scientists rule in this environment and have opportunity to engage in objective studies that limit the force of extraneous influences.

Professional journals and organizations have eagerly hoisted this new banner and dedicated entire issues and conferences to its primacy. But the implication remains that prior to this new dedication to evidence, dentistry operated by myth and magic. This impugns the integrity, dedication and usefulness of previous efforts to discover the truth of professional matters and denigrates the developments and applications of our collective experience.

Evidence

OT *see page 5*

Industry Report

Retention you can depend on

New Vivera retainers challenge traditional ways of thinking by offering four sets instead of one

By Joanna Farber

You have just spent approximately 18 months getting Jimmy's teeth perfectly aligned. Now it's time to work on retaining his beautiful smile for years to come.

Orthodontists are in wide agreement that effective retention is a critical factor in maintaining treatment results — so you know you need something that will really work. You could go with a traditional retainer and hope Jimmy wears it as directed. Or you could try something new.

Enter Vivera™ retainers. The subscription-based program introduced by Santa Clara, Calif.-based Align Technology, Inc. in late 2007 challenges the once-held theory that one retainer is enough to prevent relapse. With Vivera retainers, patients receive four sets of fresh retainers over time.

When Align Technology, makers of Invisalign aligners, explored the dental retainer field, its researchers found that retainer materials lose their ability to deliver force over time, and can fail or break down by warping, tearing and cracking after as little as two to three months of normal daytime use.

Retention

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Running an office utilizing human resources management

By Dennis J. Tartakow
DMD, MEd, PhD, Editor in Chief

Part 2

To briefly review the resources management dimension of any organization, which certainly can be applied to our orthodontic office management, an effective administrator must have three basic traits:

1. Technical skills for the mechanical part of the job are often more applicable for larger companies (and/or offices) where the CEO has extensive competent assistance and experienced technical workers in the organization. Older, more established companies typically have operational momentum that affords the CEO the ability to concentrate on strategic issues and planning.
2. Human skills in working with others are necessary for effective and cooperative relationships within a group. These human skills can be further subdivided into (a) leadership ability within the manager's own unit, and (b) skills regarding inter-group relationships. Outstanding capability in one role often is accompanied by mediocre performance in the other.
3. Conceptual skills are necessary for recognizing the interrelationship of factors that led to taking all necessary actions for achieving the maximum good for the organization. This depends upon a specific way of thinking and involves: (a) emphasis and priority on conflicting objectives and criteria; (b) tendencies and probabilities, not certainties; and (c) correlations and patterns of elements, not clear cause-and-effect relationships.

These three skills vary with each administrative level of responsibility. In lower levels, technical and human skills are needed whereas higher levels require human as well as conceptual skills, and in top levels, conceptual skills are most important for successful administration.

These skill requirements also suggest that good administrators are not born, but develop and transform the need for identifying specific traits in order to provide a better way to visualize the administrative process. Identifying such skills that are required at various levels of responsibility can be useful in selecting, training and promoting executives.

In describing the resources management dimension of the typical orthodontic office, we, too, develop and provide a combination of managerial and CEO attributes. As orthodontists, we are (a) leaders, supervisors and managers, who should be able to achieve high productivity with low cost, turnover and absence, as well as striving to gain the highest level of employee satisfaction. Such leaders often demonstrate a different pattern of management from those who achieve less impressive results; and (b) managers who are high-producers, sometimes deviating from existing theories by creating improved technical procedures and integrating individual principles into a management theory of practice. Orthodontists are often aware of how our practices differ, but understanding the reasoning of such differences is what makes them successful.

In 1967, Dr. Rensis Likert published "The Human Organization," describing (a) how to understand the difference in styles of various companies, and (b) how these styles affected the bottom line. He coined the term "organizational climate," and it was later revised as "culture." According to Likert, the most important behavioral issues in all organizations are supportive relationships and making sure the people involved have self-fulfillment. When not fulfilled, people will avoid doing their jobs. For example, a company manager may be sucessful in his or her department, but the overall result may not as be good for the organization as a whole; the same principle applies to the practice of orthodontics.

Dr. Peter Senge's "Five Disciplines" are basic to understanding all individuals, communities or groups, and apply to the orthodontic office:

1. *Systems thinking* — the cornerstone of organizational learning: the ability to comprehend and address the whole, as well as to examine the interrelationship between the parts, provides both the incentive and the means to integrate all disciplines.
2. *Core disciplines* — four component technologies, or a series of principles and practices that we study, master and integrate into our lives as one of three levels: (a) practices — what you do; (b) principles — guiding ideas and insights; and (c) essences — the state of being a leader with high levels of mastery in the discipline (Senge, 1990, p. 373).
3. *Mental models* — deeply ingrained assumptions, generalizations or even pictures and images that influence how we understand the world and how we take action (p. 8).
4. *Shared vision* — the position that if any one idea about leadership has inspired organizations for thousands of years, "... it's the capacity to hold a shared picture of the future we seek to create. Such a vision has the power to be uplifting — and to encourage experimentation and innovation." (p. 9).
5. *Team learning* — the process of aligning and developing the capacities of a team to create the results its members truly desire, building on personal mastery and shared vision. People must act together in concert, not only for the best interest of the organization or office, but those same individuals will develop into better employees much more rapidly (p. 10).

In describing the resources management dimension of organizations, Dr. James Caraway stated that the "Sixth Discipline," known as "relational reality," added a necessary dimension to Senge's "Five Disciplines," being basic to the outcome, *sine qua non*, for greater understanding of individuals, communities or groups, or even our orthodontic practices. It brings the assurance that the individual-in-relation and the organization as a whole are dialectally considered; both the individual and the organization are understood as necessary and necesssarily related partners. The sixth discipline confirms the importance of the individual and personal fulfillment within the group or community.

According to Caraway, Senge observed: "The five disciplines now converging appear to comprise a critical mass. They make building learning organizations a systematic undertaking, rather than a matter of happenstance. But there will be other innovations in the future ... perhaps one or two developments emerging in seemingly unlikely places, will lead to a wholly new discipline that we cannot even grasp today" (Caraway, 2003, p. 87).

(For more, read Part 3 in November's issue of Ortho Tribune.)

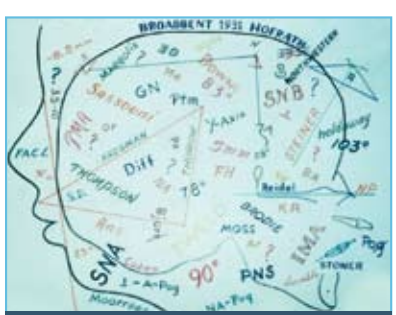

Image courtesy of Dr. Earl Broker.

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BPA WORLDWIDE BUSINESS

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AAO confronts crisis in education

ST. LOUIS — Through its Task Force on Recruitment and Retention of Faculty, progress is being made in the American Association of Orthodontists' (AAO) quest to seek long-term, sustainable solutions to the crisis in orthodontic education.

"We are beginning to realize our goal of putting realistic and lasting solutions in place to address orthodontic faculty recruitment and retention," Task Force Chair and AAO Past President Donald R. Joondeph, DDS, MS, said.

First steps

The Task Force's first initiative, implemented in the AAO's 2006–2007 fiscal year, was disbursement of $2 million to augment salaries of full-time faculty at accredited postdoctoral orthodontic programs in the United States and Canada. One-time awards of up to $30,000 were distributed to 142 orthodontic faculty members in recognition of their contributions to the specialty and as an incentive to remain in orthodontic education.

More measures implemented

AAO efforts during its 2007–2008 fiscal year secured commitments for more than 60 years of teaching through a new initiative: full-time faculty teaching fellowships. Eleven faculty members received two- or three-year fellowships. Fellows receive $30,000 for each year of the fellowship and must commit to teaching a number of years equal to the length of the fellowship. Two-year fellows must teach a total of four years. Three-year fellows must teach a total of six years. The 2008 AAO House of Delegates extended this initiative for new fellowships that will range from two years to five years, yielding four to 10 years of teaching per fellow.

The Task Force is launching a clearinghouse on faculty job opportunities on the AAO's member Web site, *AAOmembers.org*, to make these positions known to a wide audience. A presentation on academic careers was developed for orthodontic students and residents as they consider their post-graduation options.

In addition, the AAO Foundation (AAOF) has made significant contributions to orthodontic education for more than a decade. Since 1994, $6.9 million in endowment earnings from the AAOF's "A Case for the Future" campaign have been awarded to support orthodontic faculty, teaching fellowships and research. The AAOF has made it possible for many educators to remain in the classroom.

(Source: AAO)

OSAP winners announced

ANNAPOLIS, Md. — The Organization for Safety and Asepsis Procedures (OSAP) announced the winners of its I See IC Contest during a red-carpet event at the OSAP Symposium in Palm Springs, Calif., on June 13.

The contest was designed to promote infection control and safety by inviting dental professionals to create attention-getting videos and photos. A DVD is being created that will include the finalists' entries and additional material.

Winners for the contest were:

- *Best Comedy:* "Beauty Pageant for Gloves," submitted by Leslie Canham
- *Best Drama:* "Infection Walks Loose," submitted by Joab Montes Garcidueñas
- *Best Infection Control Message:* "Proper Placement of PPE," submitted by Philip Kim and Jasrit Pahal
- *Most Creative:* "A Long Journey," submitted by Piedad Hernandez Ramirez

In addition, $1,000 in cash was given to the best video and the best still photo. The award for Best Overall Video went to "Are Both the Same," submitted by Rene Rodriguez Romero. The award for Best Still Photo went to "Her Highness," submitted by Sharon Reams.

OT Corrections

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Kristine Colker, managing editor, at k.colker@dtamerica.com.

The missing element to complete care

Part 3

By Joy L. Moeller, BS, RDH, COM
(Certified Orofacial Myologist)

(In Part 2, we discussed how orofacial myologists can assist the orthodontist, and we delved into detail about a habit elimination therapy. Here is a look at four other types of therapy.)

The Mini-Myo program for the young child

Many times, young children can benefit from doing exercises to develop positive growth factors and eliminate negative growth pressures. The young child program has to be fun and fast in order to achieve success. Because the bones are soft, the changes can be remarkably fast. I use a variety of rewards and behavior modification techniques. Parental support at home is essential. The young child program lasts about three to six months and can make a major life enhancing change.

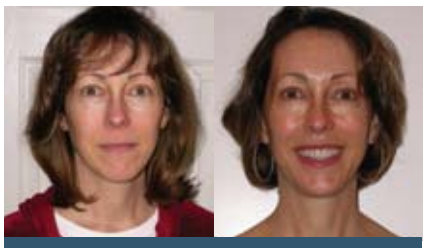
Goals of the Mini-Myo program are:

- encourage nasal breathing,
- develop a lip seal,
- implement a palatal tongue rest posture,
- encourage bi-lateral chewing,
- work on proper sleep posture as well as eating posture,
- introduce the "bite, sip and swallow back" motion,
- keep hands and objects away from the face.

Orofacial myofunctional therapy

This is my standard program for children 7 through 97. It consists of a year-long program of therapy exercises of the facial muscles and includes:

- noxious habit elimination,
- many different therapy exercises to stretch, tone and develop proper neuromuscular proprioception of the facial muscles,



Patient presented with TMD, many oral habits, headaches and depression. After eight months of myofunctional therapy, all symptoms have subsided. Note the change of facial symmetry.

- introduction of the proper chewing and swallowing patterns,
- development of proper head and neck posture,
- habituation of the new patterns.

The first eight weeks of treatment is the intensive period, followed by habituation of the new pattern.

Special-needs patients and TMD

These patients need an individual program based on their physical limitations, pain factors and ability to cooperate. The treatment plan always needs to be individualized for the best result possible. The goals would be the same as the other programs, but the methods are customized to meet the needs of the patients. The patients really appreciate this help that no other specialty has been able to provide. Some patients with special needs afflicted with incorrect muscle patterns would present:

- TMD,
- autism,
- cerebral palsy,
- Down syndrome,
- attention deficit disorder,
- Bells' palsy,
- orthognathic surgery,
- trauma-induced muscle abnormalities,
- Sturge Weber syndrome.

Cosmetic muscle toning for facial fitness

With age, orofacial posture changes.[7] There are about 40 facial muscles that work in group function. This allows for facial expression. If the patient presents with chronic non-nutritive facial muscle habit patterns, inadequate orofacial postural patterns, orofacial muscle function patterns or orofacial muscle integration patterns, then the overall cosmetic appearance will be compromised in spite of cosmetic surgery or orthodontics.

Plastic surgery patients are tired of having their face cut, burned, injected, creamed and acid etched only to have gravity pull the muscles down again. The more effective way to achieve desired results would be to develop tone and fitness in the facial muscles by changing muscle patterns, habits and postures by a trained orofacial myofunctional therapist and work with both the surgeon and orthodontist before and after surgery.

A personal trainer will tell you that you have to stretch, lift weights and do cardio three to four times a week in order to be fit. Why not exercise your face as well? I feel this type of treatment will be the way of the future for orofacial myofunctional therapists.

Orofacial myofunctional courses, certification

For speech and language pathologists, dental hygienists, physical therapists, registered nurses and other allied health care professionals, there are four or five post-graduate courses available to become an orofacial myofunctional therapist. Certification is available through the International Association of Orofacial Myology. For more information, check out the IAOM Web site, *www.IAOM.com*.

Practicing OMT guides patients to make major life-enhancing changes, which affect their entire body. After 30 years of practicing and teaching courses in OMT, I view the profession of OMT as a specialty of its own, working parallel with orthodontic treatment and being the critical missing element to complete care.

(The reference list is available from the publisher.)

Study OMT

Joy Moeller will teach an IAOM-approved, five-day course on orofacial myofunctional therapy Oct. 19–23, in Philadelphia with Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM. Moeller also will teach a seven-day course Feb. 11–17, 2009, and June 24–30, 2009, in Los Angeles. The course includes two days of internship.

For more information, contact Greene at bgreene@tonguethrust.com or call (805) 452-4302.

OT About the author

Joy Moeller is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in private practice in Pacific Palisades and Beverly Hills, Calif. Moeller is a former associate professor at Indiana University School of Dentistry and an ongoing guest lecturer at USC, UCLA and Cerritos College. She attended the Myofunctional Therapy Institute in Coral Gables, Fla., and the Coulson Institute in Denver, Colo., and studied with Dr. Mariano Rocabado, Santiago, Chile, on head and neck posturing. She is a founding member of the Academy of Orofacial Myofunctional Therapy and has taught courses at USC, the Gutenberg University and Freiberg University, both in Germany, among other locations.

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Evidence

OT from page 1

This insinuation also diminishes clinically-derived formulations because reductive research processes, so useful in the laboratory, prove difficult in clinical settings.

But invoking objective evidence as the *raison d'être* for our professional beliefs and practices can prove harder than its zealous advocates realize. And this provides opportunities for clinicians to add valuable experience to any debate.

Consider the studies of shear bonding strengths of various luting materials. Some researchers found[1-4] composites to be stronger bonding materials, while others[5-9] found resin-reinforced glass ionomer cements equal or superior. Whose evidence should clinicians accept?

At this point, clinicians can certainly lend credibility and clarity to the evidential process by trying them in their own environments. In fact, clinical experience provides the ultimate confirmation doctors need for deciding whether to use a particular product or process. All other evidence assumes a secondary role.

Clinical applications certainly contain fallacies, and many therapies work in spite of themselves rather than because of their efficacies. One need consider only the countless remedies published regarding temporomandibular dysfunctions. Even a cursory examination of many of those cures will reveal the specious physiological and anatomical bases for their applications.

Nevertheless, the profession needs to recognize that not every valid and useful progression has to evolve from an academic research facility. Clinicians, along with dental supply companies, have much to offer, and we need to acknowledge and encourage their collaboration.

Recently, the Journal of the American Medical Association sanctimoniously demonized some technologies and the companies that develop them, further declaring industry-sponsored research untrustworthy and unpublishable unless written by an academic researcher who will take responsibility for it. An editorial from the New York Times also advised physicians to exercise a cautious skepticism about any industry-backed studies

These messages could not have a clearer meaning: Health professionals can trust scientific researchers to display a selfless devotion to discovering the truth, while corporations will devote their efforts to enriching themselves at the expense of those who prescribe and use the products.

However, in a Sept. 8, 2005, article in the New England Journal of Medicine, Dr. Thomas Stossel reported, "No systematic evidence exists that corporate sponsorship of academic research contributes to misconduct, bias, public mistrust or poor research quality."

In orthodontics, no one has a clearer view of what patients and doctors need more than clinicians, and that accounts for a preponderance of the diagnostic and therapeutic processes developed by them through corporations. Clinicians have developed every popular treatment planning protocol orthodontists use today, e.g., The Tweed Triangle,[10,11] The Steiner Analysis,[12,13] The APO Line,[14] The Visualized Treatment Objective,[15-17] The Radney Line[18] and The A Line[19]. Practically every therapy ever developed has had a clinical genesis or collaboration, e.g., headgears, bands, brackets, adhesives, functional appliances and elastics.

I don't offer this screed to excoriate academia — far from it, because I belong to an orthodontic department faculty. All of us profit from the discoveries made in universities, and we need to support those efforts. Nevertheless, we must also acknowledge the roles clinicians and corporations play, and we must promote more cooperation while foregoing exclusion simply on the basis that one doesn't have sufficient statistical evidence.

Bertrand Russell said, "There is an unbridgeable gulf between knowledge by description and knowledge by acquaintance and no way of going from one to the other." (i.e., there is no substitute for experience).

I agree with Russell, and in orthodontics, the clinician supplies the knowledge by acquaintance.

(The reference list is available from the publisher.)

OT About the author

Dr. Larry White received his DDS and MSD in orthodontics from Baylor Dental College. He is a member of the American Dental Association, the Texas Dental Association, the Southwest Society of Orthodontists, the American Association of Orthodontists and the Texas Orthodontic Study Group. He is a diplomate of the American Board of Orthodontists and a fellow in the American College of Dentists. He practices orthodontics in DeSoto, Texas, serves as an adjunct assistant professor at Texas A&M Health Science Center, Baylor Dental College, and is the technology and new product editor for the World Journal of Orthodontics. Dr. White and his wife, Lue Low, have two children and six grandchildren.

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Structuring dynamic meetings

By Scarlett Thomas
President, Orthodontic Management Solutions

Take your practice to the next level of success by working *on* the practice, not just *in* it. If you no longer have staff meetings because of complaints ("We're too busy," "Nothing was ever prepared," or "The meetings were just gripe sessions."), see what a little structure can do.

Meetings are the most efficient way of making sure that everyone is on the same page. Productive meetings can be used to resolve issues, implement new ideas, minimize gossip, encourage staff to take a more proactive role in the business, engender buy-in for practice values and, generally, make coming to work each day more enjoyable.

There are five meeting types — morning huddles, evening huddles, goals and budget reporting, training and business development. Because everyone is responsible for practice success, everyone should attend all meetings to understand where the practice is headed and areas that may need improvement.

Each meeting must have a facilitator and someone who takes notes. Facilitators develop meeting agendas and run meetings. One week prior to meetings, facilitators should type agendas based on topics the staff and orthodontists submit. During meetings, note takers document major ideas and decisions on flip charts so everyone can agree to the outcomes.

Daily morning huddles

Convene morning huddles 10 to 15 minutes prior to the start of business. Have each staff member report on assigned items related to that day's activities, e.g., delinquencies, cases overtime in treatment, difficult patients, medical alerts, starts and consultations scheduled, scheduling availability and lab appliances due. Having everyone report on an item keeps staff members interested.

Daily evening huddles

Convene evening huddles immediately after patients leave. Reflect on the day's challenges and achievements. Cover charting, new patient starts, resolved delinquencies, number of care calls that need to be made, how problem patients were handled, daily production and collection activity, etc.

Twice-monthly training meetings

Hold separate training meetings twice monthly for front office and clinical staff. The front desk should review patient service policies, proper phone protocol, return call timeliness, ways of managing difficult parents and scheduling, etc. The back office should continually review proper impression taking, radiography, photography, and bonding techniques and wire sequencing, etc.

Monthly goals and budget meetings

Hold this meeting for roughly two hours during the first week of each month. The first part is for information sharing: the previous month's success versus goals and the current month's goals, including departmental budgets, collections, production, case acceptance, new patient starts, referral sources, etc. Transition the meeting to idea-generating to address challenges. Deliver bonuses and awards during this meeting.

Quarterly business development meetings

Business development meetings should cover all major issues. Hold them quarterly and use their outcomes as the game plan for continued achievement. Topics should cover marketing, patient service, new equipment, team-building, remodeling, systems implementation, consulting services needed, fees and upcoming conferences.

Conclusion

Keeping everyone in the practice apprised of how the business is doing is the best way to ensure continued practice viability. Involving staff in problem solving puts everyone's experience to use and helps create loyalty and dedication.

To learn more about how to structure meetings or implement effective practice systems, attend Orthodontic Management Solutions workshop Nov. 7–8 in San Diego. Visit *www.orthoconsulting.com* for more information and to register.

OT About the author

Scarlett Thomas is an orthodontic practice consultant who has been in the field for more than 23 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, she has an exceptional talent to inform, motivate and excite. Contact her by phone at (858) 435-2149 or by e-mail at scarlett@orthoconsulting.com.

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The right way to market an ortho practice

By Roger P. Levin, DDS

How do you know if you are implementing the right ortho marketing strategies? Could you be doing more? In today's sluggish economy, how can you maximize your efforts?

Talking with a new client, I was dismayed to learn he'd spent several years and tens of thousands of dollars on external marketing efforts that generated only minimal results. The proper program, along with excellent management systems, can predictably increase practice production by 30 percent or more. By marketing to referring doctors and patients, you can attract new patients and experience unprecedented growth.

Case study

Jim was a 31-year-old orthodontist who had been in practice for four years. He had engaged a general marketing firm to create his corporate identity through business cards, stationery and a practice brochure. The firm also provided advertising and direct mail services and charged Jim a retainer on an annual basis of approximately $50,000. Jim was one of only three orthodontists in a fairly non-competitive area that was growing with numerous young families. He was disappointed he had not exceeded a $600,000 level after four years and was frustrated he had not grown at all in the previous 12 months. In talking to the people at his marketing firm, they simply explained they were doing everything they could and that he should be more patient.*

Jim called me to talk about his situation, and I immediately realized he was making one of the classic mistakes we often see in orthodontics. Jim had done absolutely nothing in regard to meeting or getting to know his referring doctors and was attempting to build his practice strictly on corporate identity, direct mail and advertising. I immediately explained to him that I doubted the approach he was taking was going to be completely effective. Here's why:

• ***Corporate identity marketing doesn't work by itself.*** The development of a corporate identity — business cards, stationery and a brochure — is necessary, but will almost never attract patients. I have always contended and still believe that the simplest logo in the world will attract almost the same number of patients as the one that costs $10,000 and takes six months to design.

Am I saying you don't need a corporate identity? Of course not. These materials are a necessity for any orthodontic practice, but they represent a *passive* approach to marketing and should be used in conjunction with more active forms of marketing, especially referral marketing. In our Total Ortho Success™ Referral Marketing programs, our consultants work with clients to create attractive corporate identities, but more importantly, they emphasize that referral marketing is the key approach.

• ***Direct mail is ineffective.*** Direct mail firms will tell anyone that there is a 1.5 percent or greater return on direct mail and that the customers will gain a return on investment. While that sounds good, in the last 23 years, I have seen most of these campaigns in orthodontics fail. Direct mail also can be extremely expensive in terms of design, printing, address lists and postage costs. And still, after spending a lot of money, there is no guarantee you will achieve the coveted 1.5 percent response rate either, which still means 98.5 percent of your marketing efforts are being wasted.

For orthodontic practices, direct mail is a risky way to attract new patients and can waste a great deal of time and money.

• ***No referral marketing was being done.*** Jim was not doing any marketing directed at his referring doctors. The one, almost guaranteed, approach to building orthodontic practices is marketing to referring doctors combined with marketing to patients. When I use the term "referral marketing," I am referring to using proven strategies in a consistent marketing program managed at all times by a professional relations coordinator (PRC).

Predictable marketing, dependable results

Orthodontics is different from other types of businesses. Companies such as L.L. Bean and Land's End live and die by catalogs and Internet marketing. Orthodontists, on the other hand, depend on referrals from doctors and patients.

What's the best way to gain new patients? Identify current and potential referring doctors in your area and begin marketing to them. As I discuss in my Total Ortho Success Seminars, the secret of referral marketing lies not only in the quality of marketing but also in its quantity. Most referring doctors do not respond to one or two attempts to gain their referrals. Instead, it's a gradual process of attracting doctors over a six-month period.

The potential for dynamic growth

Jim, the doctor in our case study, had been wrongly advised by another orthodontist to not bother with referring doctors. He was told referring doctors are uninterested, unappreciative and have already decided on certain specialists.

Jim was misinformed.

Referring doctors are more than willing to establish new relationships. Practices that engage in referral marketing can grow dynamically after five or six months. Referral marketing, when done consistently, is highly predictable. When proper systems are put in place, more than 98 percent of practices experience growth in less then 12 months.

After several years of trying unsuccessfully to build a practice that met his vision and goals, Jim was ready to try a new approach. Spending far less, he implemented a complete referral-based marketing program, and within 12 months, practice production jumped 27 percent. Now, in his second year, Jim is on track for 31 percent additional growth.

Conclusion

A consistent, ongoing, referral-based marketing program is the key to growing your practice. With the right program in place, you will gain new patients, dramatically increase production and achieve breakthrough profitability.

** Based on actual Levin Group client information*

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OT About the author

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, Inc., the leading orthodontic practice management firm. Levin Group provides Total Orthodontic Success™, the premier comprehensive consulting solution for lifetime success to orthodontists in the United States and around the world. A third-generation dentist, Dr. Levin is one of the profession's most sought-after speakers, bringing his Total Orthodontic Success Seminar Series to thousands of orthodontists and ortho professionals each year. For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of orthodontists. Levin Group may be reached at (888) 973-0000 and customerservice@levingroup.com.

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