OrthoAccel Technologies joins Houston venture company

OrthoAccel Technologies, a Texas-based orthodontic product startup company out of the University of Illinois at Chicago contract-ed with Simplexity MD to provide it with management personnel as well as shared services. Michael Long, President and CEO of Simplexity MD, a global market-ing, brand and product manager with Phillips Oral Healthcare, will serve as the company’s president.

OrthoAccel is developing the Celerect 1000, an orthodontic sys-tem that moves teeth at twice the rate of traditional orthodontic pro-cedures. This proprietary technol-ogy has three issued patents.

OrthoAccel is partnering with Texas-based dentistry schools to continue the development, clinical trials and commercialization of the technology. The product is a re-movable device that fits inside the mouth – similar to a retainer – and attaches to any orthodontic archwire, complementing all traditional orthodontia treatments and tech-nologies. It is expected to be available in 2009.

www.houston.bizjournals.com

Reader Response

January’s edition of Ortho Tribune featured an article by Ortho Tribune editorial advisory board member Dr. Elliott Moskowitz entitled, “Let’s revisit the ‘single-visit consult.’” We always welcome reader responses, and here we have our first set.

I enjoyed Dr. Moskowitz’ article about single-visit consults. As is usually the case in our specialty, practitioners tend to present concerns in black or white. I respectfully disagree with his premise that a thorough and complete exam and consult cannot be present in a single visit. I consider my office to be typical of a lot of ortho-dontic practices. I see a vast majori-ty of straightforward adolescent or-thodontic cases; with complex adult, growth and crowding cases making up a small percentage of patients. In the straightforward cases, any experienced orthodontist has seen hundreds of times, presenting the treatment plan, potential problems and the requisite compliance of the patient and parent in a single visit is not only simple, but also reflects well on the orthodontist’s experi-ence and confidence. Labeling that confidence and experience as being “detrimental to the integrity specialty” is both unfair and belittling.

A practitioner who can draw on past experience, excellent interpersonal skills and the ability to commu-nicate well with patients at all edu-cational levels is not “dumbing down” his or her consultation. That practitioner is simply presenting what orthodontists around the world have to offer – experience and effi-ciency. While I feel very comfortable providing “single” visit initial consult-ations for approximately 85 per-cent of my new patients, there are the 15 percent who require much greater investigation. Those patients are scheduled for a full consulta-tion at a future date when all the question marks that they present can be investigated.

As is usually the case in our specialty, there is a large gray area in this regard, and that needs to be respected. If an orthodontist feels more confident, and can present his or her rational more comfortably by breaking the diagnosis and consult-ation up into two or even three patient visits, then they should not be ostra-cized for being slow, uncommunicative and unsure. Conversely, those of us who have both the benefit of experience and the ability to commu-nicate clearly and concisely and are comfortable in providing “one step” new patient exams and treat-ment plans, should not be accused of contributing to the “detriment of the quality of orthodontic treatment or sound risk management proto-cols.” There is room for both styles. But please do not consider my treat-ment planning and case presenta-tion concerning a normal growth, non-extraction Class II division I 15-year-old to be deficient if I can present that in a single one-hour appointment. And please do not consider that to be a problem when the patient who presents for a sec-ond opinion in my office begins treatment because my staff and I seemed very confident and ex-pressed well what we wanted to do for that patient.

Tim A. Auger, DMD Monterey, California

Response:

I welcome Dr. Auger’s response to my article that critically examined the single-visit consultation in orthodontic practice upon patient care and the level of risk management an ortho-dontist might choose to consider in his or her own practice.

Without question, Dr. Auger’s views on this subject, indeed, repre-sent a profound difference in both philosophy and practice than my own. We agree, however, that we re-spectfully disagree with each other on this entire matter. It is okay for all of us to employ different proto-cols in our office. However, in the absence of credible evidence-based information (regrettably, in so many instances), we must rely upon logi-cal, empirical, and in some in-sances, intuitive reasoning on a daily basis. Such is the case with the manner in which our orthodontic colleagues choose to structure their initial examination and consultation appointments.

Attributing the ability to perform a “single-visit consult” in the vast majority of cases to “a practitioner who can draw on past experience, excellent interpersonal skills and the ability to communicate well with patients,” as you have written, is more like the campaigning politi-cian, who campaigns in poetry and then must govern in prose. In other words, while I do agree that instill-ing confidence to patients and par-ents of our patients is a needed skill for all of us, the single-visit consult based upon your criteria is more of an exercise in exquisite salesman-ship, practice management expedi-ency, and professional and academ-ic hubris. Furthermore, the range of extraordinary variation (both the obvious and the very subtle) in the patients and respective malocclu-sions that we are called upon to treat, demand at the very least, a fresh and unbiased evaluation for each and every patient. It is very comforting, indeed, to know that you can discern that “95%” of your cases somehow remind you of so many of your previously treated cases that have resulted in success-ful outcomes (I think that you have referred to them as the “simple ones”). And you can easily recognize the other 15 percent that do not.

If I was bringing my child to your office, I would hope that he or she would have fortuitously found himself/herself to be included in the 15 percent of cases in your office “who require much greater investiga-tion,” and not the former “slam dunk” category that so remind you so much of the case that you might have completed previously.

I never meant to “belittle” any of my colleagues who choose to expe-dite their consultation experience with the single-visit consult. How-ever, the manner in which we “aca-demically pinheads” (either full-time or part-time) struggle to educate our orthodontic residents with respect to their obligations to each and every patient includes (as does the American Board of Orthodontics, for those who have actually presented cases), the most careful scrutiny and contemplation of problems lists and treatment options. You seem to indicate that this ever so important consultation task can be achieved with a Dale Carnegie course and accompanying pamphlet. I simply disagree.

Elliott M. Moskowitz, D.D.S., M.S.d Clinical Professor Department of Orthodontics New York University College of Dentistry

Dear Dr. Moskowitz,

I appreciate the article you wrote regarding the misuse (or lack) of the orthodontic diagnostic process. After 20 years of practice, I can count on one hand the number of times I have found the circumstance appropriate to shortcut the process.

Thanks to careful diagnosis, treatment planning and thorough patient consultations, I have been able to avoid most mid-treatment surprises and minimize extended treatment times. It has been my im-pression that those who subscribe to the single-visit consult are far more concerned with starting the case than finishing the case. Referring dentists, most patients and those orthodontists in it for the long haul truly understand the difference.

Dr. Gerry Phipps
Spokane, Washington