A Paradigm Shift in Orthodontic Marketing

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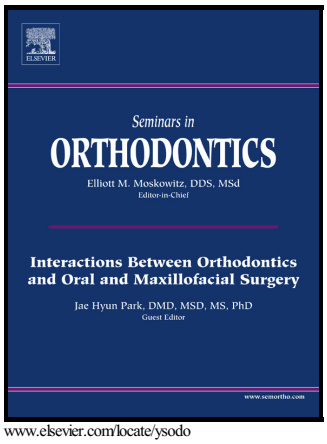

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Abstract

The increase in primary care dentists who are providing their own orthodontic care has caused orthodontic specialists to change their marketing strategy. Recently, a paradigm shift in marketing has occurred from dentist-based referrals to direct-to-consumer advertising. Orthodontists are now choosing to advertise to patients directly, rather than solicit primary care dentists to refer patients when they deem ready. In essence, primary care dentists have forced the orthodontist's proverbial hand to become independent. The reach of this independence will likely extend well beyond current direct-to-consumer methods to orthodontists soon owning pediatric and general dentist offices in the future. The purpose of this paper is to review these current and future trends in orthodontic marketing.

KEYWORDS – Marketing in Orthodontics, Paradigm Shift

A recent increase in primary care dentists (PCDs) being convinced that they can provide some semblance of orthodontic, combined with the disconcerting emergence of patient mail-order, do-it-yourself (DIY) treatments, and the rise of corporate offerings seems to be resulting in more advertising by orthodontic specialists. Orthodontists seem no longer able to rely solely on referrals from neighboring primary care dentists, but have adopted a strategy to market (in some fashion) and educate prospective patients directly. This strategy is referred to as direct-to-consumer (DTC) advertising. The result is that in some quarters, orthodontists have had to become savvy and serious marketers, in an attempt to gain some independence from those dentists that they once heavily relied upon. The old guard's adage "don't step on your referring dentist's toes" has now sadly become the modern cry in dentistry of "every man for himself;" even as the code of ethics and professionalism is sometimes breached.

This paper will review the history of direct-to-consumer adverting, the old methods of orthodontic marketing and their validity today, as well as current and future trends in orthodontic marketing.

Dental Marketing Time Capsule

The term marketing is occasionally nothing more than a politically correct synonym for advertising, dressed-up to veil a spiel to entice the unsuspecting public. Edgar R.R. "Painless" Parker (1872-1952) is often credited for the downfall of advertising within the profession as this flamboyant "street dentist" hired one of circus magnate, P.T. Barnum's former managers to take his "practice on the road" (The Parker Dental Circus) and publicize it.

In efforts to battle the quackery that arose concurrent with aggressive advertising in dentistry and during infancy of its specialties, the career of Rodrigues Ottolengui (editor of Dental Items of Interest for 35 years, novel writer, and regarded entomologist) stands in stark contrast to "Painless." He was an example of someone who was regarded as a champion of professionalism and ethics that even did battle Edward Angle, leading to Angle's resignation from the organization that he formed (American Orthodontic Society). Curiously enough, despite their differences, Parker employed "mesmeric passes" while Ottolengui dabbled in "hypnotherapy."

Despite being described as a "menace to the dignity of the profession" by the American Dental Association, "Painless" Parker did promote did auspicious the concepts of patient advocacy and increased access to dental care; however, he regarded the pathway to achieve those positive initiatives was directly through overt marketing. A balance between professionalism, ethics, and advertising has been a perilous endeavor at best in the subsequent century in the professions since Ottolengui and Parker. Can equipoise be achieved in a climate of corporate, practitioner, and best-of-the-patient interests?

It was barely a generation past that the only advertising permitted by a professional was that of a single "shingle" of specified dimensions. There once was a time when various professionals regularly acted collegially, often practicing independently in one large professional building, but always available to help one another. Today, it seems that rather than spend time reviewing the literature and improving one's acumen in clinical orthodontics, we compulsively and interminably click on internet websites to determine our Google rating as it compares to our "competition." And the beat goes on.

Traditional Marketing: Diffidence and Gifts

The traditional model of orthodontic marketing has been to appease and appeal to PCDs, who would in turn refer their patients when they deemed them ready for treatment. Orthodontists would make muffin-runs (i.e., donuts-for-dollars), provide staff lunch-and-learns, and purchase gifts (sometimes lavish) to get into their benefactor's good favor. If a question or concern regarding a patient's treatment ever arose, the orthodontist would be reserved, diffident, and all too often apologetic regardless of the situation so as not to upset a potential referral source. This has especially been true as the controversies of extraction/nonextraction, TMJ/occlusion, and early treatment raged (and now apparently with the bizarre advents of snore devices and facial fillers). The old method was perhaps one of subservience and bootlicking, "I really wanted to take out teeth for this patient, but I knew of course that I simply couldn't."

For time to time, orthodontists might complain to their orthodontic colleagues about the frustration of maintaining this equilibrium. After all, managing relationships with difficult PCDs can be incredibly stressful. For example, the hypocrisy of a PCD who demands that "canine rise" occlusion be achieved for a referred patient while they treat a patient with some "canned" braces for six months but completely ignore the occlusion. Ultimately, orthodontists continued this method of marketing because it was expected by their referral sources to maintain a stream of new patient exams. This occurred has occurred upon

occasion even at the cost of ethics when lavishing gifts or trips on top referrers, as this is not simply frowned upon, but in many States is considered “fee-splitting” or “kick-back” activity. When is the last time you took a moment to read the AAO, ADA, or your own State’s code of ethics and board regulations. It might be an eye-opening experience for many and perhaps time better spent than reading this missive.

So what happened? Simply put, in the past decade, the rate of referrals from PCDs dropped as marketing to them focused on courses increasing their “profit-centers” by offering specialty services. For example, PCDs began treating many more patients in their offices with clear aligners, limited “doc-in-box” fixed appliances, or “so-called” myofunctional appliances. Once again, ethics and professionalism are often ignored. In fact, state speciality licensing laws may be of concern as only there are only 9 recognized specialties approved by the Council on Dental Education and Licensure of the American Dental Association. In some places, it may be illegal for a dentist to offer any of these services without first disclosing to the public that they are not a licensed specialist. Interestingly enough, at the date of this writing, a Federal Court in Texas as ruled that the Texas State Board of Dental Examiners couldn’t prevent dentists from advertising themselves to the public as “specialists.” The national consequences of this ruling are likely to reverberate throughout our profession.

How often do you see a laundry listing of specialty services on dental websites? Even as seemingly innocuous as the listing of Invisalign might be construed as soliciting as a specialist. Without an accompanying clear disclosure, the public may be unknowingly at risk.

But specialists are not immune to these “errors” as well. It may seem harmless to advertise that you “*specialize”* in adult orthodontics, lingual orthodontics, TMJ treatment, sleep disorders, or wiring people’s mouths shut.” But, to state that you are a specialist in a specialty is just plain inappropriate at best. Even publicizing seemingly innocuous remarks

such as you are “state-of-the-art” is crass and unprofessional because it implies that your colleagues may not be. But, who is policing these “violations?” The profligate proliferation of seemingly unregulated (everyone else is doing it) advertising does smack more of Painless Parker than Rodrigues Ottolengui’s vision of a profession.

Orthodontic product manufacturers began to overtly solicit sales to dentists (rather than selling “on-the-sly”) and initiated Direct-to-Consumer advertisements of trademarked orthodontic services (i.e., products that are tasked as unique “services” offered only by “special” providers who “signed-up” as believers or simply purchased more of their products) to the unwitting general population. As a consequence of these behaviors, orthodontists in some regards have been forced to rethink their referral relationships and marketing strategy.

The History of Direct-To-Consumer (DTC) Marketing: From Prescription Drugs to “Branded” Orthodontists

To understand current DTC marketing of orthodontic products, we must first examine the complex history of this type of advertising for prescription drugs. Prior to 1980, information that patients received about prescription drugs was primarily handed to them through patient packet inserts and physician instruction. The Food and Drug Administration (FDA) required that patient packet inserts were provided to the patient, accompanying the medication, and not before. Any advertisements (or drug rep. marketing) regarding prescription drugs were directed at educating the health care professional to give consideration to prescribing their products, not the patient.

In 1983, Boots Pharmaceuticals aired the first broadcast television commercial in the United States for a prescription drug, Rufen—an ibuprofen product. Though relatively innocent considering today’s standards (e.g., I don’t know what the “purple pill” is for, but it sure seems like I should want one), the FDA felt the 22-second commercial was inappropriate and in 1982 imposed a moratorium on DTC advertising for all prescription drugs. The moratorium was lifted in 1985, and by 1997 the FDA lightened its regulations on television

commercials, but with caveat of allowing voice-over to provide brief summaries of side effects. DTC marketing of pharmaceuticals soared immediately with spending rising form $12 million in 1989 to over 1 billion in 1998. In 2009, DTC spending was nearly 5 billion dollars.

Proponents of DTC advertising argue that these advertisements empower consumers with information; however, opponents worry that consumers do not receive the full disclosure of necessary information and much of it is knowingly misleading. Evidence suggests that DTC advertising stimulates patient demand for pharmaceuticals, which in turn influences the physician's prescribing habit. Does this sound familiar to orthodontists?

Invisalign followed a marketing path somewhat similar to prescription drugs with a DTC campaign that has disrupted the orthodontic industry. Not surprisingly, in 2002, Align Technology, Inc. hired Tom Prescott as CEO, who previously worked in the medical device sales industry. Today, Invisalign DTC marketing spans from full-page ads in popular woman's magazines to prime time television commercials.

And like DTC advertisements for prescription drugs, there is legitimate concern whether Invisalign advertisements could be misleading. According to Invisalign's ads, seemingly everyone is a potential candidate, which may not be the case. It may be implied that brackets and wires are painful and outdated technology; whereas clear aligner therapy is easy and simple. What's worse, these ads blur the line between an orthodontic specialist and a primary care dentist provider. Demand for orthodontics may have increased as a result of this aggressive marketing, but not without some cost to the specialty.

Like the prescription drug companies, Invisalign took their marketing directly to the customer, causing some patients to present to offices expecting Invisalign before even receiving a comprehensive evaluation to determine if the product is right for them. A further complication has been that primary care dentists with inadequate diagnostic skills and training believe changing clear plastic trays can correct any malocclusion, in fact, without

any experience or knowledge of tooth movement. In addition, skilled orthodontists are then pressured to prescribe Invisalign treatment even when they also have limited experience or even interest in the product, simply due to fear of losing the patient to colleague. In such a *folie à deux*, clear aligners are prescribed by a reticent specialist who would rather not, in order to prevent the patient from being treated by the PCD. None of these scenarios are in the public's best interest.

Though DTC marketing of orthodontic appliances began with clear aligners, but the strategy became more targeted in advertising approach with Damon braces. This took the form of marketing to consumers that the practitioners who use their product as able to provide treatments with special benefits beyond those achievable with similar orthodontic products (e.g., the wider so-called, "DamonSmile due to bone-growing jaw expansion). Unfortunately, this tactic alienated orthodontists who chose not to use the product. This apparent conflict between appeasing corporate shareholders versus serving the best health interests of the public has persisted.

Accompanying the astounding growth of social media, (such as Facebook and YouTube), unsubstantiated claims are pushed to the public in the form of infomercials and campaign ads. For example, Six-Month Smiles claims "orthodontic treatments" can be completed in 3-6 months. The public may understandably equate a unique innovation is at work that can cut treatment time for any orthodontic issue while at the same time, the patients assume that the results will be the same as those achieved from a longer, more traditional approach. This also further misleads the public regarding the difference in training and experience between dentists and specialists providing actually dissimilar treatments.

So, does the specialist simply relent and also offer treatments for just the social six front teeth and bite-be-damned? If the consumer cannot differentiate between the 2 types of services (and those providing them) to be able to make an informed decision, they are perhaps being deceived. Ethics in some locales dictate that a PCD must at least *offer* the

option of a referral to a specialist when they are suggesting “specialty” treatments as part of informed consent.

More readily disconcerting for the public is the rise of Do-It-Yourself orthodontic treatments *trending* in social media. Recently, Smile Care Club began advertising DIY at-home clear aligner treatment: sending prospective patients some putty and impression trays with instructions to submit their own impressions and some “selfie” photos for treatment planning by a practitioner who is unlikely to ever see the patient personally or professionally. Those orthodontists that provide clear aligner treatments realize from experience that this endeavor is unlikely to result in consistently successful results—but how is the consumer to know?

So far, it seems that telemedicine has only made limited in-roads into orthodontics as patients seem to need to at least meet and decide if they like and trust the person they are entrusting their care (and money) with. “Office check visits” done on FaceTime or Skype have not taken off.

The New Method of Marketing: Go Right to the Source and Hold No Punches

Rather than stay silent and accept the changing competitive landscape, orthodontists took a page directly from the pharmacy & clear aligner playbook and began overt marketing to patients directly. If PCDs were to prescribe orthodontic treatment while not disclosing the fact that they are not specialists, than orthodontists began to bypass them in the referral chain. Remove the middleman or gatekeeper, so to speak.

Orthodontists have employed numerous methods of both external and internal marketing as DTC advertising increased from simple branded tokens, trinkets, office newsletters to discount coupons, and patient “gifts” for referrals of new patients (both considered unethical in most precincts). However, it seems that the best marketing is still recommendations from patients that are satisfied with your services and the positive experience in your practice given to friends and acquaintances. Nothing can beat that type of marketing in the long-term.

The most powerful form of external marketing, at least in more competitive urban environments, currently appears to be the orthodontic practice website. Though standard websites have been popular for the past 15 years, orthodontists now commonly invest $10,000-20,000 in more elaborate websites. These websites are becoming increasingly more artistic and interactive, including videos, games, and links to social media outlets such as Facebook, YouTube, Pinterest, and Twitter to interact with the local community or friends of current patients. With the increasing popularity of tablet and smart phones, mobile-friendly sites are essential.

Other forms of external marketing have included more aggressive direct mailing campaigns, billboards, grocery-store advertisements (or at least free, local publications that you might find there or at your hairdresser or gym). Where there are families or Mom's, there will inevitably be orthodontists advertising. Recently, orthodontists have become increasingly aware of the importance of community sponsorship and support for school activities and interests. Financial contributions to schools, town proprietary events, religious institutions, youth sports teams, and afterschool activities, provide powerful and lasting DTC marketing opportunities as well as goodwill.

Though orthodontists are just beginning to tap into the immense potential of external marketing, they have always been internal marketing to their existing patients. Popular forms of internal marketing include a variety of methods to "engage" patients such as adding new technology, in-office promotional posters, typodonts with appliances on them for patients to "touch", a photographic book of before-and-after treated cases, refer-a-friend cards, in-office contests, a display wall of finished smile photographs, patient recognition events such a movie-day or a pool party, complimentary tooth bleaching, family discounts, in-office video games, massage chairs, coffee stations, WiFi, computers or tablets, waiting room displays such as Kaleidoscope in-office signage, wooden nickel rewards, and more recently, Patient Rewards Hub and Kids Club programs. Once the flood-gates opened to advertising and this type of marketing, it is astonishing what has been unleashed by

orthodontists competing with their "colleagues." Patient engagement costs have become more elaborate and costly. But, the best source of new referrals remains existing patients.

Regardless of the type of marketing today, orthodontists are now using these opportunities to educate patients more than ever. Direct mailers, in-office posters, or even seminars for patients often contain information regarding the right time for a first visit or the benefits various types of orthodontic treatment. Many orthodontists are diligently trying to inform patients of the difference between a PCD and an orthodontic specialist. Simply put, orthodontists are becoming more vocal about encouraging orthodontic treatment by a trained specialist, not simply as a self-serving measure, but to insure the public is best served by the best-trained and experienced practitioners.

The Emergence of DSOs and Corporate Orthodontics

In the past decade, the explosion of dental support organizations (DSO), whose business model strongly encourages orthodontic care by their contracted PCDs or specialists, has only contributed to the competitive landscape. Though state laws instruct DSO's to operate as a managing partner in charge of only *nonclinica*l business activities, the realty is that these corporations provide clinical oversight and strongly encourage the use of non-traditional approaches like myofunctional appliances, clear aligners and Six-Months Smiles by their PCDs. Unfortunately, limited education on these methods is provided by PCDs in a handful of courses. The information presented is often quite limited and anecdotal, distorting the challenges of orthodontic treatment. Rather, the emphasis is placed on quotas and collections. The result is often a selling of orthodontic appliance therapy first with little understanding of diagnosis and actual tooth movement biomechanics, limitations, and alternatives. The thought of referring to an orthodontic specialist outside the corporation for comprehensive brackets and wires is discouraged.

The latest entries into the specialty have been corporate groups purchasing strictly specialty practices and operating them in franchise fashion. The appeal of the sale price of a practice

for an eager seller and the debt load of recent graduates are a perfect storm in the growth of this model in coming years. It perhaps may be a challenge for private practitioners to compete with the marketing, purchasing, and management power of these conglomerates soon.

The Future of Orthodontic Marketing

The marketing trends toward independence from PCDs will likely evolve in the future to orthodontists attempt to develop and cultivate referrals sources by owning pediatric dental clinics or perhaps even employing associate PCDs and hygienists. Historically, it's been the other way around. Pediatric dentists or PCDs interested in "keeping everything in house" had been the ones to hire orthodontic associates. Orthodontists likely did not pursue ownership of pediatric dental offices sooner because they did not need the added revenue and they did not want to upset other referral sources. Rather, they choose to form alliances within a group of PCD colleagues and specialist in their vicinity. Alternatively, they may hire an orthodontic associate whose spouse is a PCD or pediatric dentist to cultivate referrals. Perhaps, the creation of orthodontist-owned, orthodontic-pediatric group practices is on the horizon. More likely are corporate owned, full service, one-stop, self-contained locations.

Conclusion

A number of factors have influenced the type and amount of marketing in orthodontic specialty practice. This has included the increase in number of PCDs offering some type of orthodontic treatments, the seemingly lax restrictions on ethics and advertising, the increased use of direct-to-consumer ads, and changes in referral patterns and sources: competition instead of collegiality. The current DTC marketing trend from orthodontists has been the primary outgrowth of these factors. A healthy supply of PCD referrals will always be integral to an orthodontic office; however, more marketing directly to the consumer aims to gain greater independence, but must be approached with serious concern for professional ethics.