Marketing premium restorations in your practice

BY DR MICHAEL C. DITOLLA, DDS, FAGD

Dentists who learn to provide premium restorations for their patients are justifiably proud, and hopefully very excited about the opportunity to present these restorations to their patients. Since aesthetics are a high priority for the community I practice in, these are primarily the type of services I provide, and the type I will describe in this article. Incidentally, I use the term "premium restorations" when referring to gold work as well, but fewer and fewer of my patients are willing to trade the advantage of gold's track record for the disadvantage of its poor aesthetics.

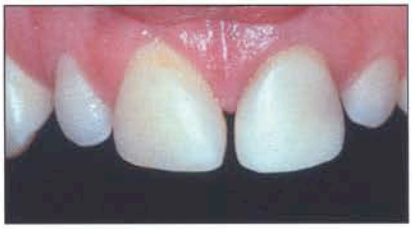
Historically, dentists have had a bad habit of assuming that they knew what their patients wanted, and as a result, patients were rarely involved in treatment decisions. In the past, patients still behaved like the traditional "patient". They found a way to come in Monday through Thursday from 9 to 5, they sat patiently in the waiting room for an hour while the doctor ran late, and they accepted doctor's recommendations without question.

The modern patient, however, has evolved from being a patient to being a consumer. Our patients now view dental purchases much the same way that they view other consumer purchases. They are interested in options, pros and cons, and often would like to know how long it will last. The term "bankers hours" and "doctors hours" used to be synonymous, but banks are now open mornings, evenings and Saturdays. Banks that are striving for the ultimate in convenience have opened branches in supermarkets, and are even open on Sundays. While it

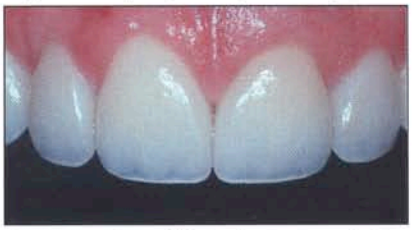
may seem that this increased involvement by the patient would lead to patients trying to talk dentists into always providing the cheapest available treatment, patients who appreciate the benefits of ideal oral health consistently choose higher quality over lower fees.

Apparently the prevailing assumption in dentistry has been that patients want the least expensive treatment with no consideration for aesthetics, longevity, or tooth preservation. Day in and day out, almost every single new patient I meet has one thing in common: all their posterior restorations are amalgam. Once or twice a year, a new patient comes in that has all gold restorations, including occlusal inlays, and my question to them is always the same: "Who is the dentist in your family?" A little surprised, they usually answer "My father, how did you know?" I'll ask you the same question: How did I know?

During my examination with the new patient that has a mouth full of amalgams, I will always ask them why they made the decision to go with the silver fillings instead of the gold. The answer is always



Before and after (below) with Empress



the same: they didn't give me a choice, they just put in the silver ones. Assuming that the patient wants the amalgam, just because it is cheaper, is incredibly unfair to the patient. Of all the factors that should influence a dentist's selection of restorative materials, the only one that the dentist has no business deciding, and is completely unqualified to make, is the cost factor. Yet, cost was the very reason why nearly all patients have mouths full of amalgam and were not given the option of a superior material. The dentist's role is to offer the restorations and materials that fit the parameters of the clinical situation, while the patient's role is to choose a restoration from those suggested by the dentist that fit their aesthetic, financial, and longevity priorities.

Perhaps if this situation was occurring somewhere besides the United States, it would be easier to understand, but freedom of choice is considered a national treasure by the American public. It's as though most dentists have never stopped at a traffic light and looked around to see the amazing variety in make, model, and cost of cars. Why with the amazing variety of people, with an amazing variety in the cost of their homes, cars, clothes and vacations, should all have the cheapest restoration available? The lack of freedom of choice is a treatment planning injustice more shocking to me than the one supposedly revealed in Reader's Digest.

It is my opinion that it is our moral responsibility to give patients options based on the clinical situation, and let them decide what is right for them. Regardless of what they choose, it is one of the treatment options that I presented, and thus I am comfortable with any option they feel comfortable with. As an example, we noticed at a periodic exam that tooth #36 has a large MOD amalgam, with a mid-lingual vertical fracture that is stained, and the existing restoration has failing margins. The patient has two options to choose from: the gold onlay or the tooth coloured onlay. Notice that placing another overextended silver filling poised to break the tooth is not an option. [In my practice,] the tooth coloured onlay will be either Targis or Empress, but that is a decision to be made by the dentist, not by the patient. My inlays and onlays are almost all Targis, while my full crowns and veneers are almost all Empress.

As dentists we must make certain clinical decisions for our patients that they are unable to make due to lack of experience and knowledge. It is unfair to give the patient a choice between a $750 Empress crown and a $195 three surface amalgam. The patient thinks "Heck, I can have the silver done three times over and it will still be cheaper than the crown!" Except for the fact that by the third time you re-prep it for the amalgam, it now needs a crown and a build-up, and possibly a root canal due to the coronal destruction.

I made another decision for my patients three years ago when I stopped doing amalgams. I thought back over my first six years

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in practice and realised the 99% of the teeth that required crowns all had silver fillings. Every time a patient called with a cusp that had broken off, there was a large silver filling present that was responsible for the fracture. I enjoy doing crowns as much as the next dentist, but why would I plant this amalgam "crown seed" now, and wait for the tooth to break, when I could bond a lab-processed restoration into place at a good fee, knowing this tooth is now bagel and popcorn proof.

Since we no longer do amalgams, the patient's decision is to do the bonded restorations with me, or see another dentist for the amalgams. To date, we have had two patients leave in three years because of the amalgam issue. The reason I am so strict about my "no-amalgam" policy is to demonstrate that I believe so strongly in my commitment to only do the highest quality dentistry that I am willing to have a patient leave the practice rather than compromise my commitment. Remember: Quality is a lot like local anesthetic, you never have to apologise for insisting on it, and patients rarely complain about too much.

My treatment presentations are always done with the intraoral camera and the Empress laboratory model which shows an amalgam, gold and porcelain restoration that can be placed in the tooth. I always start with the amalgam in place and explain how, due to the high mercury content of the amalgam, the filling expands and contracts at a rate greater than that of the tooth, and that is why their MB cusp broke off, or there is a marginal ridge fracture, etc. I tell them that since we have a variety of superior materials, we do not even do the amalgams anymore, and I take the amalgam inlay out of the oversized model tooth, and then toss it to the side. I then place the gold restoration in the tooth. I tell the patient that gold has been around forever, it's the longest lasting material we have in dentistry, it can't break, it can be bonded to the tooth and return it to its original strength, but if it is in an area that shows, you can see the gold from about 30 feet away.

I then put the Empress restoration into the model and tell them porcelain hasn't been around as long as gold, it probably doesn't last quite as long as gold, it can be bonded to the tooth and return the tooth to its original strength, and once in place it is essentially invisible. I tell them that I would be happy with either the gold or tooth coloured restoration in my mouth (unless it is in an aesthetic area), and it's really up to them which one they want to have. I hand them the model with the gold and tooth coloured inlays. It is amazing how many of them pick up the two inlays and try them into the tooth model. This is exactly the level of involvement I want the patients to have while making treatment plan decisions. And, having just finished my speech about gold having the most research and lasting the longest, what restoration do 9 out of 10 of my patients choose? The overwhelming choice is the tooth-coloured restoration, with notable exceptions being men over the age of 55 and engineers. You might think dentists fall into this group as well, but as a result of lecturing, I am lucky to have several dentists and their staff as patients, and approximately 60-65% of the dentists are choosing the tooth coloured restorations over the gold.

The diagnostic skill of a dentist is the ability to recommend acceptable treatment options based on the clinical factors affecting the teeth in question as the patient is not able to make those decisions. Likewise, as the dentist examines a patient's mouth, assumptions about what the patient wants based on the expense of the treatment is at best presumptuous, and at worst malpractice.

You need to realise that just because you might place a premium on longevity and would therefore prefer to do gold, the vast majority of patients value aesthetics over longevity. I Look at it this way: a 55-year-old woman receiving a gold MOD onlay on #14 may get it to last a lifetime, but hate how it looks every time she smiles or looks in a mirror. If she has an Empress onlay, she may have to have it replaced once in her remaining years, yet she smiles proudly and confidently on a daily basis. Are patients willing to risk having to redo a restoration to have it be beautiful? Absolutely!

Dr Michael DiTolla received his D.D.S. from the University of the Pacific in San Francisco in 1988. Upon graduation, he purchased a 20 year old practice in Downey, California. Within four years, he had built up the practice so that its production and collection statistics placed it in the top 1% of all dental practices across the U.S. Dr DiTolla has been asked to share his successful fee for service strategies through a wide variety of venues. He has published articles in Dental Economics, The Profitable Dentist Newsletter, Dental Products Report and Dental Surgery Products as well as several state and local journals. Dr DiTolla has addressed study clubs and groups in more than 50 cities with audiences ranging from 40 to 800 dentists.

Michael DiTolla be speaking in Australia from 11th June until 17th June in most capital cities. The one day seminar is titled "Creating Value for Comprehensive Aaesthetics." For information, contact Jenny on (03) 9533 1992.