VIEW POINT

Michael C. DiTolla, DDS, FAGD

Giving patients freedom of choice

Historically, dentists have had a bad habit of assuming that they knew what their patients wanted and, as a result, patients rarely were involved in treatment decisions. The "traditional patient" found a way to come in Monday through Thursday from 9 a.m. to 5 p.m., sat patiently in the waiting room for an hour while the doctor ran late and accepted the 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 now are open mornings, evenings and Saturdays. Banks that are striving for the ultimate in convenience have opened branches in supermarkets and are open on Sundays. And 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 esthetics, longevity or tooth preservation. Day in and day out, almost every new patient I meet has one thing in common with all my other new patients: all their posterior restorations are amalgam.

Once or twice a year, a new patient comes in who has all gold restorations, including occlusal inlays, and my question to him or her always is the same: "Who is the dentist in your family?" A little surprised, the patient usually answers, "My father. How did you know?" I'll ask you the same question: How did I know?

Give patients a choice

During my examination with the new patient who has a mouth full of amalgams, I always ask why the decision was made to go with silver fillings instead of gold. Inevitably, the answer is the same: the patient wasn't given a choice; the dentist just put silver fillings in. Assuming that patients want amalgams, just because it is cheaper, is incredibly unfair to them. 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 weren't given the

Dr. DiTolla operates two strictly fee-for-service practices, one in Downey, Calif., and the other in Tustin, Calif. Since 1994, he has addressed numerous study clubs and groups of dentists, as well as being a presenter at the California Dental Association Spring Scientific Session. He can be reached for seminars at (714) 633-9647 or at his office at (714) 505-4867.

Why should we give people — with different levels of income and different priorities on how it should be spent — the same cheap restoration? To me, this is a treatment-planning injustice more shocking than the one supposedly revealed in the Reader's Digest.

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 fits his or her esthetic, financial and longevity priorities.

Treatment-planning injustice

Perhaps if this situation were occurring somewhere other than 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 should we give people with different levels of income and different priorities on how it should be spent the same cheap restoration? To me, this is a treatment-planning injustice more shocking than the one supposedly revealed in the *Reader's Digest*.

In my opinion, it is our moral responsibility to give our patients options based on the clinical situation and then let them decide what is right for themselves. Regardless of what the patient chooses, it is one of the treatment options that I presented and, thus, I am comfortable with any option this individual chooses.

As an example, we notice during a periodic exam that tooth #30 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-colored onlay. Notice that placing another overextended silver filling, poised to break the tooth, is not an option.

As dentists, we must make certain clinical decisions for our patients that they are unable to make due to a lack of experience and knowledge. It is unfair to give the patient a choice between a $750 crown and a $195 three-surface amalgam. The patient thinks, "Heck, I can have the silver amalgam done three times over and it still will be cheaper than the crown!" What the patient doesn't understand is that by the third time you reprep the tooth for another amalgam, it now needs a crown, a build-up and possibly a root canal due to the coronal destruction.

Why I quit doing amalgams

I made another decision for my patients three years ago when I stopped doing amalgams. I thought back over my first six years in practice and realized that 99 percent 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" and then wait for the tooth to break. It makes no sense when I could, instead, bond a lab-processed restoration into place at a good fee, knowing this tooth now is bagel and popcorn-proof.

My treatment presentations always are done with the intraoral camera and a laboratory model that 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 margin, the filling expands and contracts at a rate greater than that of the tooth and that's why the patient's MB cusp broke off or there is a marginal-ridge fracture, etc. I tell the patient that since we have a variety of superior materials, we don't even use the amalgams anymore.

I take the amalgam inlay out of the oversized model tooth and toss it to the side. I then place the gold restoration in the tooth and 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 the tooth to its original strength. But, if the tooth is in an area that shows, you can see the gold from about 30 feet away.

I then put the porcelain restoration into the model and explain to the patient that porcelain hasn't been around as long as gold and it probably doesn't last as long as gold. But, it can be bonded to the tooth and can return the tooth to its original strength. Once in place, the porcelain restoration is essentially invisible.

Give them a choice

I tell patients that I would be happy with either the gold or the tooth-colored restoration in my own mouth (unless it's an esthetic area) and it is really up to them to make the choice. I hand them the model

continued on page 87

continued from page 12

with the gold and tooth-colored inlays and 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.

Having just finished my speech about gold having the most research and lasting the longest, what restoration do nine out of 10 of my patients choose? The overwhelming choice is the tooth-colored restoration, with the notable exception being men over the age of 55 and/or engineers.

The value of esthetics

You need to realize that just because you might place a premium on longevity and would, therefore, prefer to do gold, the vast majority of patients value esthetics over longevity. Look at it this way: a 55-year-old woman receiving a gold MOD only on tooth #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 a tooth-colored 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! Look outside of dentistry for a minute. Everyone who has a face lift or breast augmentation knows that these enhancements don't last forever and frequently need to be redone over time, but that doesn't stop them from having theses services performed and subsequently redone. 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.

Most of my patients could not afford to have 12 tooth-colored inlays done. But as a result of the intraoral-camera tour and our commitment to only providing the highest-quality dentistry, nearly all of my patients still are quality-conscious enough to choose the bonded tooth-colored onlay, even if it means we do three inlays a year for the next four years.

Since we no longer do amalgams, the patient's decision comes down to doing the bonded restorations with me or seeing another dentist to have the amalgams placed. To date, we have had only two patients leave the practice in three years because of the amalgam issue. I believe strongly in my commitment to only do the highest quality dentistry.

DE