



Understanding
the Changing
Dentist-Laboratory
Relationship

by Mark Murphy, DDS, FAGD

THE FUTURE IS NOWHERE

Most people decode this un-spaced word and see “The Future is Nowhere.” What I meant to say is, “The Future is Now Here.” Quite a different interpretation of the same input to your brain – an instantaneous paradigm shift that allows us to see the problem and/or solution differently. By looking at it with new eyes we can see it in a fresh way. The same goes for the dentist-laboratory relationship.

If I asked you what exactly the dental-laboratory relationship is, the automatic functionality of your interpretive brain might say, “They make my restorations.” However, if that was all we could “see,” we might be blinded to all of the possibilities the relationship holds, and the benefits it provides.

The dentist-dental laboratory relationship has changed and continues to evolve dramatically and rapidly. No longer is a lab just the place you send your impressions to get restorations made. The communication channels are more robust, materials and technology have advanced and the roles we bring to the restorative process on behalf of the patient have changed.

The landscape of our profession has evolved as well (perhaps devolved would be appropriate). This paradigm shift is huge and it creates risk to the status quo of how we do business. Competition is waxing. Patient demand is waning. Expenses are zigging while profitability is zagging. The population is aging, requiring shift in types of services

and solutions we provide. All this technology requires more capital expense. DSO (Days Slaes Outstanding) proliferation and insurance reimbursement discounts are changing the power structure and more!

Let's take a deeper look at the various components of the dentist-laboratory relationship communication, clinical materials/technology and roles, and see how looking at it with a new paradigm can reduce your stress, improve predictability and make you more profitable.

Communication

Long, long ago, in a place far away (1981), I had no cell phone, fax, intra-oral scanner, 3D cone beam, digital camera, Easy Shade or computer in my dental practice. Neither did my lab. I took analog impressions made from goopy materials that gagged the patient. I shot Kodachrome 64 slides that I had to wait a week to have developed. I wrote out labs slips by hand and called my lab guy on a landline. I trusted my colorblind dental assistant and my own eye for shade and didn't need 3D imaging because we didn't place or restore implants. It was the dark ages, but now it has shifted.

Today, Lee Culp CDT, our Chief Technology Officer at Microdental and all-around incredible technician/artist/ceramist, and I share images in real time about cases using the Internet clouds and our iPhones. Implant placement guides,

contour and shade issues, as well as overall facial aesthetic characteristics are all commonplace nuances to how we communicate. I don't think Lee even has a landline or slide projector anymore. Our only language barrier is that he speaks Apple-ease while I use a broken Apple/PC dialect. When we lecture and present together, he needs a special dongle to

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hook his thin-air-cloud-Apple thingy to the projector. Our presentations are going to the cloud soon and a bluetooth interface will help us project them holographically in the middle of a space right in front of each attendee (just kidding).

Another friend of mine from Virginia, Dr. Chong Lee, an incredible dentist and LVI faculty has developed an application for the iPad that lets the patients describe what they see using video capture, sets expectations for results, is used to communicate with the laboratory and serves as a "before" to compare to after the work is done.

We have come a long way, baby!

These broader, deeper and more precise communication tools may feel challenging to apply and use at first, but they

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do make life, our dentistry and our practices more predictable and less stressful. They cost money, but they do usually provide a solid return on investment. If you own an intra-oral camera and use it less than once a day, try setting a goal of 25 percent of your restorative and hygiene patients. You will be amazed at the improved case acceptance and hygiene retention. The collaboration between specialists and laboratory technicians on cases is far more patient-centric, timely and successful. Patient health is improved, we get to do more of the dentistry that fulfills us and we can be more productive per hour.

Clinical Materials and Technology

Porcelain fused to metal, full gold and all Ceramic feldspathic jacket crowns were pretty much all we had back then. Today, lithium disilicate, nano-ceramics, nano-composites, improve Lucite reinforcements and materials like Vita's Enamic dominate the landscape. Monolithic zirconia is running PFMs out of town (can't wait to cut some of those off down the road) and there are more millable, printable and pressable options today than you can imagine. PFMs that are still being done are more often scanned and laser sintered than waxed and cast like we did in dental school. Digital dentures are almost here and digital impressions will replace goop in a few/several years.

Materials selection, appropriate use and application are real challenges today. It usually takes an intense collaborative effort between technician and restoring clinician to arrive at the best material choice, application and final restoration for the patient. What material? Over what framework or coping material? Milled? Pressed? Waxed then cast? Waxed then pressed? Pressed monolithic? Layered porcelain? Over what coping or framework material? Here we go again...! You need a PhD in metallurgy or ceramics to figure this out alone. Today we need our lab technician to be much more involved when we plan a case. Once I have prepared and impressed the case, it is hard to go back and change materials if a better one is suggested. Measure twice, cut once. Just like carpenters.

Wait, there is more! Does my lab make the material themselves or are they small and have to outsource? Does it go overseas or just across the country or street? Does my lab have certified dental technicians and are they a Certified Dental Lab? The odds are very low on that one. According to the National Association of Dental Laboratories there are only approximately 400 certified dental labs in the United States today, out of some 7,000 labs total. The majority of dental labs today are still small, one-to four-person operations and some work out of a basement or garage (go to DentalLabs.org to view more information about certifica-

tion and material verification). Only six states even require dental laboratories to register with the state. In Canada, every province is required to have at least one Registered Dental Technician per lab (equivalent to our CDT).

And more still! The chairside milling of restorations (bypassing the lab all together) has grown to about 12 percent of dentists since the launch of the initial CEREC almost 30 years ago. Dr. Gordon Christensen, at a recent meeting in Chicago, stated that he believes the final market penetration may approach 25-30 percent. The majority of dentists simply do not want to do lab work to reduce their lab bill. The ones who do often utilize auxiliaries to help. At \$400-\$500 per hour chairtime, spending 30 minutes designing and milling a crown may be the most expensive lab bill you don't think you pay! If you like doing lab work (I do) have at it. If not, find a good lab.

Changing Roles

As a dentist in the early '80s, I saw my lab as the provider of the restorations my patients needed. They sometimes made recommendations or helped me treatment plan (especially partial denture design) but not intentionally. I didn't reach out to them as collaborative restorative design partners that enhanced patient outcomes. In fact, if they did suggest too much change, improvement or new materials, I would get mad and change labs. They were subservient providers of a commodity-like solution for my patients. A crown was a crown was a crown... as long as it had acceptable fit, form and function.

Today we see the incredible cannibalization of the PFM business by full-contour zirconia as a business solution to the rising cost of precious alloys. Your lab helped manage your cost of goods sold (business language) by using an alternative material that still met your goals and objectives. Labs provide continuing education that can enhance my practice growth, development and financial success. No longer do labs simply host manufacturer-sponsored techno-clinical training events that often seem like sales events disguised as CE. Smart labs in this millennium provide business and practice development as well as leadership opportunities to help us be more successful and less stressed. Last time I checked, the dental school curricula still lacked adequate business education, leadership training and practice management modules that we need so much. When labs are involved in clinical education programs, the engagement is usually of a much higher order. At Microdental, we have a lab on the campus of LVI and I serve as visiting faculty at the Pankey Institute in Key Biscayne, Florida. Scott Ward from Ward Dental Lab in Michigan was recently awarded the Ida Gray award from the University of Michigan Dental School. He is the

first non-dentist to do so. Chris Morris, the manager of ADL Dental Lab in Louisville is on site at a surgical all-on-four implant placement at least once a week!

The dental laboratory and dental landscape have evolved and continue their rapid change. More than 13 percent of dentists now practice as part of a dental service organization. This “consolidation” of dental practices into huge 300 and 400 practice groups like Aspen Dental and Pacific Dental Services is mirrored on the laboratory side. When I graduated from dental school there were more than 12,000 laboratories and 60 accredited dental lab programs in the United States. Today, there are less than 20 schools and less than 7,000 labs. Consolidation, although slow to start, is accelerating rapidly. Glidewell is the largest dental lab in the U.S. today followed by National Dentex and Microdental, which are laboratory groups. Most labs have created an economy price line of products to help manage the reduced reimbursement we

often see with PPO insurance. Many of those labs (not Microdental) have turned to an off-shore solution where the labs are made in China, Costa Rica, the Philippines or elsewhere. Some dentists resent this and the fact that they are often not informed of the country of origin even though it is required by law.

So, What are We to Do?

Find a lab you can trust that is certified, technicians you can communicate with and make sure you all have the patients’ best interests as your goal. Look for partners who will help *you* solve *your* clinical and practice problems, not theirs’. Stay informed; take meaningful continuing education that balances your growth clinically and behaviorally. As Dr. Pankey used to say, “Don’t be the first on your block to try everything new that comes along.... but don’t be the last either.” ■



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Dr. Mark Murphy is the lead faculty for Clinical Education at Microdental/DTI Dental Technologies, Inc. He also serves on the adjunct faculty at the University of Detroit Mercy and Michigan Schools of Dentistry and Board of Directors and visiting faculty at the Pankey Institute. He practices general dentistry on a limited basis in Rochester, Michigan, and lectures internationally on leadership, practice management, communication, case acceptance, planning, occlusion and TMD.

