Achieving the Ideal
How to Create the Best Dentist-Patient Relationship

Is there an ideal dentist-patient relationship, especially when treatment is being determined? What kind of relationship should dentists try to create with each patient?

One response to this question is provided by the law—for example, the informed consent relationship. And all clinicians and researchers know that informed consent, which might more properly be called “informed consent/refusal,” is both a conversational process and, sometimes, a document that offers evidence of either this process, part of this process, or, at the very least, a signature event. But does informed consent constitute the ethical ideal for dentistry in our society? Certainly, it describes the legal minimum; it is, also, the ethical minimum currently required for dentists in our society. That is, any dentist who did not work to achieve at least a relationship of informed consent with patients would not only be at legal risk, but would be violating the ethics of the dental profession as well.

However, we are proposing that informed consent is not the ethical ideal, it is only the minimum. What kind of relationship is the ethical ideal for dentists in our society? We would like to try to make the case that the ideal relationship between dentists and patients is much more collaborative than the one usually understood as informed consent—both in the evolving legal expressions of informed consent that vary throughout the United States, and in the common descriptions of the phrase that vary from person to person.

U.S. dental schools teach the idea of a more collaborative relationship. It is implied, sometimes described, and is continually being refined within documents like the American Dental Association’s (ADA) ADA Principles of Ethics and Code of Professional Conduct and the American College of Dentists’ Ethics Handbook for Dentists. Such a relationship is also discussed or implied in other literature about the dental profession, often with the implication that this ideal collaborative relationship also offers the best practical assurance of meeting the shifting legal minimum of informed consent.

We suggest that this is the relationship for which most dentists strive whenever possible (we will say more about situations in which it does not seem possible below). It is also the kind of relationship desired, even expected, by most patients who have reflected on the professional nature of the dentist-patient relationship.

Because of space constraints, we will not discuss the ethics of treatment decisions for patients who are wholly incapable of decision-
making, or whose partial deficits affect their ability to make important oral health decisions. The ethics of such situations will be the subject of a future column. Nor are we looking here at the ethics of relationships with patients who are, for any reason, not seen by the dentist or other professional. Those doctor/patient relationships are just beginning to be legally defined indirectly, through various legislative efforts such as the Emergency Medical Treatment and Active Labor Act (EMTALA). That discussion also will require a separate column on another occasion.

A collaborative effort
Achieving the legal and ethical minimum of informed consent can be challenging. Successfully educating patients about the condition of their mouths, their treatment needs, and the possible outcome of treatment is complicated from the point of view of accepted dental practice. Even when it seems that the dentist and patient are speaking the same language, it is not always clear whether a patient is fully consenting to a particular treatment. The mere fact that a patient does not refuse or leave the chair does not mean that he or she is a partner with the dentist, in any meaningful sense, while choosing the treatment. Because so many patients can display this passive behavior, dentists can become quite cynical about meeting their own minimal ethical standards of informed consent. A proposal like ours, then, could be viewed even more cynically. Still, we propose that dentists ought to be routinely striving to achieve, as their professional ethical norm, a much more collaborative relationship with their patients.

But why are relationships that barely reach the level of informed consent so frustrating? Why do they breed cynicism about dentist-patient relationships and a more collaborative ideal? We believe that the intimacy of dental diagnosis and treatment is not merely something that should be done by one person to another—it should be a joint enterprise. The patient should be a partner in the process, not only because of the importance of autonomy in our society, but because it is the patient’s body that the dentist is examining and trying to repair and preserve. Therefore, we would like to suggest that when patients behave passively in the chair, many dentists should think, “It’s your body! Don’t you want to be involved in what happens to it? Don’t you care?”

Identifying patterns
Some patients participate in a shared dentist-patient enterprise to such a limited extent that they themselves barely meet any sense of the minimum standard of informed consent or informed refusal. In such cases, success in achieving a more collaborative ideal cannot rightly be expected. However, there are several patterns of distance between patients and dentists that a dentist might overlook during the pressures of everyday practice. Dentists can and should identify and address those patterns with each patient in pursuit of a more ideal relationship.

One of these patterns of distance comes from the obvious fact that dentists know far more about the oral cavity and oral health than patients do. When dentists are educating their patients, it is possible for this huge gap in understanding to turn into a gap in the relationship, creating a barrier to an effective treatment partnership. Obviously, the solution is not to try to educate patients to the dentist’s level, but merely to provide them with a level of understanding necessary to make informed and valuable decisions about their own oral health. (Of course, there are patients who perpetuate this barrier by insisting on more and more information, acting as if facts were the entire story of a professional’s clinical judgment. We are not claiming that every barrier provided by a patient can be overcome; when directly explaining that clinical judgment is not simply a matter of facts does not resolve the problem, then it may not be solvable.)

Part of the reason for dialogue between patients and dentists is that patients hold certain values and judgments that dentists can learn only if patients share them. Thus, dentists may be able to reduce the “information gap” by making it clear that patients have valuable ideas to contribute toward their shared judgment about treatment. It is vital for patients to understand that treatment is not based solely on some fact about symptoms—which are of value only when interpreted through the lens of the dentist’s technical knowledge and clinical experience. Patients must understand that treatment is also based on their relevant values and their oral and overall health priorities, pain concerns, fiscal resources for dental care, ability to make future appointments, and so on. These are not science or clinical technique considerations, of course, but they are central to the patient’s role in the judgment and the choice of what ought to be done, so not only should they be accepted as part of the dialogue, they are an essential element of it. If dentists can convince patients that both parties are equal contributors to the process, the huge and unavoidable gap in information about diagnosis and treatment may be bridged.

Cost-effectiveness decisions
Some practice management teams may limit their descriptions of this dialogue between patients and dentists to such terms as balancing costs and effectiveness, or balancing costs and benefits. These are useful terms to describe the balance between what dentists bring to this conversation and what patients bring to it. But it is not just cost/effectiveness or cost/benefits; it is both. Furthermore, different patients balance cost/effectiveness and cost/benefits differently from each other. Recognizing this is critical to the ideal doctor-patient relationship and, because of this, it is worth saying a little more before describing a few other barriers to the ideal collaborative relationship.

Costs in terms of benefits and effectiveness are not just monetary; they also can be measured in terms of time, resources, and non-tangible values. As important as these quantitative or qualitative statistics are, they still require the dentist’s knowledge and statistical interpretation skills, gained through extensive experience and observation. The patient also can have multiple values and may not know how to express all of them effectively.
Recognizing and communicating this fact is another way in which dentists can overcome the significant gap that prevents patients from joining with dentists in an ideal relationship. A third barrier that limits the collaboration between dentist and patient occurs when patients accept the dentist’s expertise regarding proper treatment as being definitive without asking for or listening to an explanation. It would be easy for dentists to consider a patient’s silence to be a compliment: He or she has accepted the dentist’s diagnosis without question.

However, this is a dangerous scenario, one in which dentists are left completely in the dark about the patient’s understanding of the matter being discussed and how it fits into the patient’s values and priorities. Certain patients react this way because they feel there are no other options available to them. Other patients have been acting this way with doctors for most of their lives, and the factors hindering the ideal doctor-patient relationship have never been addressed. Some patients come from cultural settings in which the doctor-patient relationship is still defined by “doctor’s orders.” Other patients, who frequently possess high intelligence and sophisticated health knowledge, genuinely trust the expertise of the dentist without question. All of these patients invariably expect dentists to be able to identify a single best modality of treatment, no matter how complicated the proposed treatment seems to be. Not only is this not the case in many situations for which competing acceptable treatments are possible, but it also overlooks the possibility that the patient may have alternative values—which, in principle, the dentist should include in the final judgment—that are not being considered.

The following case report illustrates the challenge of working toward the ideal relationship with patients who accept dental expertise as final and unchanging.

“Do whatever you think is best”

Donna Robertson is an emergency room nurse at the nearby hospital. She is in her early fifties and is in good health. She has been Dr. Snyder’s patient for more than a decade, had received high quality dental care before joining this practice, and shows the benefits of excellent oral hygiene. As a young teen, however, Donna had orthodontia with band braces. The orthodontia was successful, but she grew up in an area that had not yet fluoridated its water; also, her family, for all practical purposes, had not been able to discourage frequent sipping and snacking. Consequently, the toll her braces took on her enamel required numerous amalgam restorations, all of which are now at least second- or third-generation replacements.

During her most recent visit, everything looked fine except for a three-surface MOB amalgam on No. 30, which clearly

“Dental relationships are not, first and foremost, a partnership made of one helpless person in need and a powerful fixer; rather, they should be seen as a partnership that cannot achieve the patient’s goals without each member participating equally.”
was leaking. Radiographs showed a thin area of enamel between this filling and a sound two-surface OD third-time replacement amalgam on the same tooth that Dr. Snyder had replaced eight years prior.

“We have another old amalgam filling here, Donna, in the lower right first molar,” Dr. Snyder told her. “The seal between the amalgam and the enamel has opened and it needs to be replaced or that space will develop caries in no time.”

Before Dr. Snyder could say more, Donna replied, as she had many other times, “Do whatever you think is best, doctor. You know that I trust your judgment.”

“Well, there is more to say, Donna,” said Dr. Snyder. “Doctor, I work with patients all day in the ER and I know what I am doing there, just as you do here. I want my patients to respect that in me and I respect it in you.”

“It isn’t that simple,” said Dr. Snyder, forging ahead. “It’s a choice between treating the tooth conservatively and risking that there is not enough sound enamel to hold it together. Even if there is enough tooth structure for that, it will need to be capped. There also is the risk that simply removing this large old filling might traumatize the nerve enough that it could require a root canal and a cap anyway. Even though the tooth is still vital, it might be worth considering doing the root canal if we think it might go that way in the end.”

“Doctor, I would not be sitting here if I did not believe that you know what you are doing,” said Donna. “You can make a much better decision about this than I can. Again, that’s how I want my patients to respect me and that is how I respect you. It’s late and you are probably as eager to go home as I am. Just make your best clinical judgment and proceed; that is what I want.”

Commentary
Dr. Snyder described the patient’s oral condition, explained the treatment alternatives (including no treatment and possible sequelae), but he cannot predict how likely these sequelae are until he opens the tooth, and very possibly not even then. In response, the patient has affirmed her choice that whatever treatment Dr. Snyder judges best is her preference. Arguably, the legal ideal of informed consent has been fulfilled, especially since current state laws usually do not require formal documentation of even the general sense of this conversation. As Donna noted, it was late and Dr. Snyder probably was tired and eager to go home. Should Dr. Snyder work harder to establish a more collaborative relationship with Donna, or is it professionally acceptable for him to proceed according to his best clinical judgment?

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Here are two suggestions for how the conversation with Donna might proceed, although Dr. Snyder might need to adjust the tone and the wording of these points to increase the likelihood that they will sink in. Also, we are taking advantage of the fact that the patient is an educated and experienced health care professional with a high opinion of other health care professionals’ expertise, which may not be true of all patients.

Dr. Snyder’s response: Option A

“Donna, many dentists favor a conservative approach, removing the least possible amount of material from a vital tooth. They believe that it is better to save vital tissue from the start, and they accept the risk that, once the tooth is prepared for a filling, it may need a crown preparation. In other words, what they were trying to save may need to be removed anyway. Or, in the worst case scenario, the process of cleaning out the old, defective filling will traumatize the tooth’s nerve and destroy so much enamel and dentin in the top of the tooth and so much of the root toward the bottom that the entire tooth will need to be removed.

“Other dentists would look at your tooth, whose only sound filling is a third-time replacement, and which has minimal enamel and dentin left between the filling and the pulp chamber, and simply do the endo immediately. They would consider that to be the safest, most stable long-term approach. Each of these approaches is justifiable and clinically acceptable; the differences between them are simply a matter of the dentist’s preferred philosophy of treatment and his or her personal comfort based on past experiences.”

Dr. Snyder’s response: Option B

“But, Donna, each treatment philosophy involves different value issues from the patient’s point of view. I have to ask you how much are you willing to risk needing further, possibly extensive, and certainly expensive work in order to try the less extensive and less expensive treatment first? Does it matter to you that you will need to make additional appointments if the conservative approach does not succeed? Moving straight to a cap may bypass this issue, but it’s possible that the cap will not keep the tooth from needing a root canal. It also is possible that by going straight to endo and later receiving a post and a cap (an approach that still would risk causing harm to the tooth), you might have little or no pain from this tooth, now or for years to come.

“If the tooth collapses after it is cleaned or prepared for a cap, it will probably be painful. My question to you, Donna, is really about our relationship—now and in the future. Do you want me to make an important decision about your body based on my preference for a particular treatment philosophy? Another dentist might make a different decision because of a different treatment philosophy. Some dentists might even offer another option, extracting the tooth and placing an implant. Don’t you want your views about risk, pain, time commitments, and expense to play a role in a decision that is not clinically cut-and-dried?”
"I can listen to your initial request and follow my best judgment according to my own philosophy of treatment without your involvement. But this is your mouth, and ultimately your body to which I am administering care. That is a matter of high trust. I would prefer that we communicate and make this decision together. I am asking you if we can collaborate instead of me simply accepting your mandate that I go it alone when it is your body and your health at stake."

Engage the patient
Donna’s actual response is not necessary here, nor is Dr. Snyder’s final decision. What is significant is that the very nature of the ideal dentist-patient relationship—the most important factor in any healing relationship—is at stake. This is so important that it is worth engaging the patient in a discussion if a dentist recognizes that a patient may not be aware of this ideal relationship and its importance. It also needs to be addressed with surrogate decision-makers when a patient is wholly or partially incapable of recognizing the importance of this collaborative relationship.

We have never taken the view in these columns that our position is the last and final word. Our job is to prompt our readers’ reflection, encourage conversation with colleagues and patients, and invite feedback. We hope that this discussion, concerning the kind of relationship that every dentist should try to achieve with every patient, to the greatest extent possible, will have this effect.◆

Donald Pathoff, DDS, MAGD, is a general dentist who has practiced in Martinsburg, W.Va., since 1974. He has been a member of the American Society for Dental Ethics (ASDE), formerly known as Professional Ethics in Dentistry Network (PEDNET), since 1988, and has served as its president. He served as chair of the Ethics Committee of the Academy of Laser Dentistry from 1996 to 2003 and since 2006, and has been a member of the American College of Dentists ethics committee since 2001.

David Ozar, PhD, is professor and co-director of graduate studies in health care ethics in the Philosophy Department of Loyola University Chicago. He is an Honorary Fellow of the American College of Dentists and was the founder and first president of the American Society for Dental Ethics in 1987. He served as president again in 1998, as its unofficial executive director from 1989 until 1993, and formally as its executive director from 1999 until 2005.

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