COMMENTARY

Practitioner and Patient Perceptions of Orthodontic Treatment: Is the Patient Always Right?

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This is an important study and article because it directly addresses the fundamental conflict, which exists among the various groups and specialties of dentistry regarding who determines what aspect of treatment outcome is most "important." This research was conducted and written by orthodontists, and as an orthodontist myself, I congratulate the authors in addressing these essential topics. My comments will also be from the orthodontic perspective. In clinical practice, the orthodontist serves "many masters." We want to please our referring dentist, of course. The dentist may have the firm view that the most important thing for an orthodontist to provide for their patients is an excellent occlusion and harmonious joints. Another dentist may value esthetics as the major objective of their referral. Most want both of these for their patients, of course. But the patient may have other objectives for their treatment, usually esthetic improvement. Thus a potential conflict exists that has to be navigated thoughtfully and professionally. Then there is another master—the orthodontist himself. All of us as professionals have personal standards and goals we want for our patients. What will the clinician be happy with and sleep well at night with? The final and most significant master is the patient. So this article addresses the issue and a critically important question-who is right? This is the basic question that this article addresses.

It is our professional obligation to address treatment in a scientific and informed manner. But how do we keep up with the evidence or decide what is legitimate? For example, we have journals that publish the best of evidence-based material, the refereed journal. We have prosthodontic journals, cosmetic dental journals, periodontal journals, surgery journals, orthodontic journals—you get the picture. Add to that the number of non-refereed journals and other organs of information such as peer groups, study clubs, sponsored internet chat rooms, and "Angie's List." Did I just say Angie's List? More than ever we are being drawn into the need to recognize that patients have a growing confidence in the information gathered from the Internet. Each clinical presentation may have many options. In our own professional ranks, then, there are diverse opinions as to who is right on any particular topic.

This article speaks immediately to what on the surface may appear to be a practice management issue, the issue of the "doctor-centered" practice versus the "patient-centered" practice. As the authors state, "is treatment success now more related to patient satisfaction than time-honored, clinician-centered goals?" and "traditional measurements have not been designed to consider the patient's values." This is an important aspect of this study: are we sensitive to patient desires? In reality, what is at issue is a fundamental bioethical and informed consent matter. In an excellent treatise on patient autonomy versus paternalism in orthodontic practice, Ackerman[1] states: "Previously, the doctor was the sole decision-maker in the treatment planning process. Now a shift was occurring toward the patient as a co-decision-maker. Bioethecists across the country and the jurisprudence system in many states have concluded that the doctor as sole decision-maker is paternalistic and an abuse of professional authority. Thus it is now the doctor's legal as well as moral responsibility to advise a patient of the risk/benefit considerations of a contemplated treatment and to discuss alternative treatment possibilities."

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The conclusion of this study is that patients consider their outcomes significantly more favorably than do general dentists, prosthodontists, or orthodontists. Orthodontists are generally more critical of treatment results than either prosthodontists or dentists. I see this as simply a function of the relative level of understanding of the complexities of orthodontic treatment. The authors very correctly acknowledge this does not excuse subpar treatment simply because the patient would not recognize it anyway. But it does mean that professional judgment must be exercised as to what amount of "burden of treatment" a patient should endure to reach what may be unrewarding to the patient or dentist.

Let me finish and illustrate the relevance of the study with a good example. As an orthodontist I am constantly asked by my patients, "When are they coming off?" I will coach them in the fact that if they are happy, I can take them off now! They invariably will backtrack a little and ask, "Am I ready?" The patient, having paid for and undergone treatment "wants it right." So they ask me do I think it's "right." In the end I have to ask myself the question, "Am I treating the patient, the referring dentist, or me?" If I want every case to be perfect regardless of level of difficulty, then I am certain I will exceed the "burden of care" in a number of cases.

This article demonstrates the differences between the patient's, the dentist's, and the orthodontist's evaluation of treatment result and success and the discussion amplifies the importance of mutual understanding and communication for the outcome to satisfy all three participants in the therapeutic enterprise. The patient may decide in favor of "going the extra mile" if they are apprised of the doctor's concerns and at that point; however, in the final analysis, the orthodontist must grant the patient their rightful autonomy to decide what is really "best" from their point of view.

REFERENCE

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