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THE PROFESSIONAL RELATIONSHIP BETWEEN THE DENTAL PHYSICIAN AND THE PATIENT

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ABSTRACT. The physician-patient relationship is the core interpersonal relationship staying at the base of the contemporary medical ethics, most clinical issues causing ethical dilemmas being centered around it. This relationship can be analyzed from four main perspectives: legal, social, psychological and moral.

In medical ethics literature, there are numerous models of physician-patient relationship, which are based, on variable degrees, on the legal, psychologic, sociologic and moral principles that will be briefly summarized here, the most well-known being the models developed by Szasz and Hollander, Roter and Hall, Ben-Sira, Thomasma, Mead and Bower, and especially Emanuel, whose models are currently considered the standard models and are being presented as such to medical student and residents in many countries (including Romania).

However, the dental profession has some particularities that require, at least in some circumstances, some additional models that will be presented briefly in this unsystematised review.

We will begin by performing a brief analysis of the professionalism of the dental-patient relationship, followed by a discussion regarding the most often cited models of relationship, namely those developed by Ozar, Coleman and Burton, Friedman and Bedos.

Keywords: *dental patient relationship, Ozar, professionalism*

REZUMAT. ***Relația profesională dintre medicul dentist și pacient.*** Relația medic-pacient este una dintre interacţiunile profesionale esenţiale ale medicilor, stând la baza eticii medicale contemporane, majoritatea dilemelor de etică clinică fiind centrate de aceasta. Relația medic-pacient poate fi analizată din patru perspective fundamentale: legală, socială, psihologică și morală.

În literatura de specialitate sunt descrise numeroase modele de relație medic-pacient care sunt bazate, în grade variabile, pe principii legale, psihologice, sociologice și morale ce vor fi sumarizate aici, cele mai cunoscute fiind cele dezvoltate de Szasz și Hollander, Roter și Hall, Ben-Sira, Thomasma, Mead și Bower și mai ales

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Emanuel, ale cărui modele sunt considerate de mulți autori drept modelele standard și sunt predate ca atare studenților medicinişti şi rezidenţilor din multe țări (inclusiv România).

Medicina dentară are o serie de particularităţi care fac absolut necesară utilizarea, cel puțin în unele circumstanţe, a unor modele adiţionale, care vor fi prezentate succint în acest review nesistematizat al literaturii de specialitate.

Vom începe această analiză cu o scurtă discuţie despre profesionalism în contextul relaţiei medic dentist-pacient, după care vom analiza cele mai citate modele de relație, respectiv cele dezvoltate de Ozar, Coleman și Burton, Friedman și Bedos.

Cuvinte cheie: *relația medic dentist-pacient, Ozar, profesionalism*

1. Introduction

The physician-patient relationship is the core interpersonal relationship staying at the base of the contemporary medical ethics, most clinical issues causing ethical dilemmas being centered around it. This relationship can be analyzed from four main perspectives: legal, social, psychological and moral.

From a legal point of view, in most countries this relationship is contractual, and it has to fulfill four main conditions to be valid: the existence of a capacity to enter in civil contracts (usually occurring automatically during adulthood), a valid consent of all parties, a determined object a licit cause. Within this legal relationship, the physician has some fundamental obligations, such as the duty to care, the duty to obtain the informed consent, the obligation to inform the patient truthfully, to respect the confidentiality of the medical act, and many other obligation specific to particular contractual relationships (such as respecting reproductive rights, rights determined by the presence of an HIV positive status, etc.).

From a psychologic point of view, the physician-patient relationship is usually analyzed through four main models: obedience, domination, aggressivity, and positivity, with the mention that often in clinical practice there are mixed models, and that these models tend to vary in time, depending on the disease, the particular psychological state of the patient in a particular moment, etc. [1].

The sociological models of the physician-patient relationship are analyzed through the interrelation of the subjects with their social environment. How is this done, depends heavily on the historical and geographical context. Classically, in Europe, the model was one based on the power of the physician (as a representative of the state) and obedience of the patient, which was considered the passive recipient of a certain disorders. Foucault has described the appearance, starting with

the 18th century, of state-related power structures that were effectively centered on the body, the body of the citizen [2]. The purpose of this approach was to survey, organize and arrange the body of citizens in order to increase their productivity (and associated with it reproductivity), a process called the disciplinary technology of labour [2]. In the US, the approach was opposite, medicine being seen as a profession, and the physician [3] – as a professional. Initially, the patient was seen as a passive recipient of the medical procedures and approach that mimics the European way in method (but not in purpose); this approach was however replaced with a more contract-based approach [4], with clear delineations of the right and obligations of each party, and with the patient seen as an active participant to the professional relationship [5,6].

The morality-based models of the physician-patient relationship are based primarily on respecting principles and virtues of the medical profession. To this purpose, there are many theories, with variable degrees of applicability in various medical professions, each based on a fundamental/ a few fundamental principles or virtues. From a historical point of view, there were two main models – one based on beneficence (older historically, directly derived from Hippocratic principles), and one based on autonomy (currently being considered the base of most physician-patient relationships in developed countries) [3,7]. Others, such as the model based on trust, promoted by Edmund Pellegrino [8], even though important and heavily debated, failed to reach the widespread of the two main ones.

In medical ethics literature, there are numerous models of physician-patient relationship, which are based, on variable degrees, on the legal, psychologic, sociologic and moral principles that were briefly summarized above, the most well-known being the models developed by Szasz and Hollander [9], Roter and Hall [10], Ben-Sira [11], Thomasma [12], Mead and Bower [13], and especially Emanuel [14], which are currently considered the standard models and are being presented as such to medical student and residents in many countries (including Romania).

However, the dental profession has some particularities that require, at least in some circumstances, some additional models that will be presented briefly in this unsystematised review.

2. The profession of dentist

Each profession is defined by a series of characteristics appertaining to the following categories: prestige, innate abilities, acquired abilities, knowledge, protected marked, control, common identity and values, ethical norms, interrelations

with the members of other communities. These characteristics taken together transform the practitioners in a community that is different enough from other communities, unlike crafts, which are not clearly differentiated one from another. An advocate is a professional, as it has unique characteristics that separate them from the practitioners of any other type of occupation. A carpenter is a craftsman – he produces something unique, but his occupation is not clearly separated from others such as glazier, watchmaker, skinner, etc. – these occupation do not have unique codes of ethics, protected marked, common identity and values, etc. (even though they have some unique characteristics, they are not enough to clearly differentiate them). According to Goode, there are seven characteristics that have to be fulfilled in order for an occupation to be considered a profession, namely: (1) a common identity of all members of the profession, (2) common values, (3) the ability to retain its members, (4) a strictly defined relationship with the non-professionals appertaining to that group, (5) unique lexical constructs, which are difficult to be fully comprehended by non-specialists, (6) mechanisms of control to which all members are subjected to and (7) mechanisms to limit the entrance in the profession[15].

Dentistry is one of the few true professions (together with physicians or lawyers), and its members for a unique guild, having unique characteristics that clearly separates them from physicians, significantly more compared to the differences between various medical specialties; therefore, dentistry is a distinct profession, while plastic surgery is not. Ozar defines eight main categories of professional obligations that clearly differentiates dentistry from the medical profession, those being: (1) obligations toward the client (patient or group of patients), (2) an ideal relation between dentist and patient, (3) central values, (4) competency, (5) a relative prioritization of the beneficence of the patient, (6) an ideal relation with other dental practitioners, (7) a relationship between the dental practitioner and the community and (8) integrity and education [16,17].

One of the unique characteristics of the dental-patient relationship is its strong ties with commercial relationships between client and provider, as dentistry is (mostly) a private enterprise. The Dental Ethics Manual of the FDI states that "As noted above, dentistry is a recognised profession. At the same time, however, it is a commercial enterprise, whereby dentists employ their skills to earn a living. There is a potential tension between these two aspects of dentistry and maintaining an appropriate balance between them is often difficult. Some dentists may be tempted to minimise their commitment to professionalism in order to increase their income, for example by aggressive advertising and/or specialising in lucrative cosmetic procedures. If taken too far, such activities can diminish the public's respect for and trust in the entire dental profession with the result that dentists will be regarded as just another

set of entrepreneurs who place their own interests above those of the people they serve. Such behaviour is in conflict with the requirement of the FDI International Principles of Ethics for the Dental Profession that 'the dentist should act in a manner which will enhance the prestige and reputation of the profession'." [18]

Another characteristic of this profession is a strong emphasis on the technical part of the practice, similar maybe with orthopaedics from general medicine. Due to these unique characteristics, there have been developed a series of particular models of the dental-patient relationship.

3. Models of dental-patient relationship

The most well-known are the four models described by Ozar, the author of maybe the most influential book on dental ethics at an international level, namely the guild model, the agent model, commercial model and the interactive model [17,19]. In the guild model, the dentist is in total control, a status based on his awareness and fully comprehension of the dental needs of his patient. The patient is a passive recipient, which accepts all the decisions taken by the dentist, as he has neither the theoretical nor the practical knowledge to solve his dental issues. This model is highly similar to the paternalistic model of the physician-patient relationship from general medicine [14] with one notable, but fundamental exception. If, in the paternalistic model, the physician is seen as a reservoir of theoretical, practical and applied knowledge, in the guild model, the dentist is not an independent expert but rather a representative of his profession; knowledge is acquired within his profession, which certifies him, has internal control mechanisms, and establishes how should he manage the patient regarding all aspects of this interaction. The agent model is opposite to the guild model, all control being transferred to the patient, who decides the optimal course of treatment, the physician being only skilled worker. This approach is a more extreme variant of the autonomy model of the physician-patient relationship [14], in which the autonomy of the physician is deposed, him being unable to refuse a treatment with which he does not agree with, and his professional independence is questionable. The commercial model is seen as a middle ground between the guild and the agent model, in which both parties have specific rights and obligations, the autonomy of both parties is respected. The dentist is only a provider of medical services, the patient selecting the best variant, depending on (mostly) his financial potency. This approach does not take into account the professional duties of the dentist and is not allowed, as a pure form, in many countries, including Romania. For example, upon this model, the dentist cannot be obliged to treat dental emergencies, as there

is not a contractual relationship established within fully agreed terms between the contractual parties. The last model is the interactive one, which was developed later by Ozar (his first theory containing only the first three models). In this mode, the dentist and patient are in a state of equilibrium – each has a set of values that the other has to respect, each is involved in the decision-making process and the autonomy of both members of the therapeutic alliance is respected [17].

Coleman and Burton have developed four models of dentist-patient relationship, depending on who initiates the dental consultation, namely: (1) consultations initiated by the patient (in which the patient is in informational control, the dentist not knowing anything about him), (2) consultations initiated by third parties (other colleagues, physicians), in which the patient knows almost everything about his disease, and the physician knows little about him (what his colleague told him), (3) periodic consultations, initiated by the dentist, in which both parties have partial knowledge about the dental status of the patient, and (4) consultations for the continuation of the treatment, initiated by the physician, in which the dentist is in informational control [20].

Friedman et al have developed a iatrosedative model, which is useful in anxious/depressive patients who need extensive dental procedures (the model has been developed on patients needing total restorative therapies) [21]. According to this model, dental patients have four types of responses to extremely anxiogenic situations: correct adaptation, type 1 maladaptation (patients who see dental loss as a severe decrease in quality of life, causing difficulties in the psychologic adaptation to the new dental status), type 2 maladaptation (which adds physical inability to cope with the new dental status), and type 3 maladaptation (patients not wanting to wear dental prostheses, never come again to the dentist, generating chronic depression secondary to their edentulous status [21].

Bedos has developed a model for dentists working specifically with vulnerable patients from a socio-economic point of view [22]; his approach is mostly deliberative, the professional interaction having five main axes: (1) awareness regarding the social context of the patients, (2) allowing more time and increasing the empathy, (3) avoidance of moralistic attitudes, (4) removal of social distances and (5) favouring a direct contact with the patients.

These models allow a proper management of the vast majority of dental patients, both adult and children, irrespective of their social status or economic power. However, physicians should be able to properly identify which model best suits a particular patient, and use it accordingly, and to shift it depending on particular circumstances or new events. This is one of the most difficult part in the social interaction with the patient, but is essential to build trust in the professional relationship, to increase therapeutic compliance and, in the end, to maximize the medical benefit for the patient.

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