Can I explain?

S Hancocks OBE*

There can be no doubt that treatment planning is an art in a field of its own. But is it an art that everyone appreciates?

The delicious appeal of treatment planning is its apparently flawless logicality. It attracts our absolute delight because it fits so neatly with everything we like to do. Identify that a problem exists, investigate it and quantify it, apply the knowledge we have about how to fix it, and fix it. A dream of a logical process that is at one and the same time both immensely satisfying and eminently useful.

If only.

The fly in the ointment here, or as someone once put it with such spiteful poignancy, the grit in life's vaseline, is our old friend the patient. Same song, umpteenth refrain — how much easier dentistry would be without patients.

To begin with they so often don't appreciate that there is a problem in the first place. In fairness though, sometimes we're not even sure if there's a problem either. The famous daily dilemma of, 'when is a hole not a hole?' crashes uncomfortably into the equation. Is it caries? Is it stain? Does it need watching? Does it need filling? Now? Later? Never? Only when the patient sees another dentist? Well, you get the picture.

However, even this process is not always one-sided. Sometimes patients see a problem that you don't. 'What about this sticky-out tooth here?' they query, pointing to a lower incisor that is about two millimetres outside the ideal arch, 'can you do something about it because I'm sure it's why my last girlfriend dumped me?'

More difficult still is the problem that neither of you sees or recognises it as something that has to be dealt with, such as periodontal disease for example — but that's a story for another day.

Be that as it may, one way or another, let's assume that the problem has been identified and quantified. Radiographs have been taken, pulp testing carried out, blood samples sent off, hair snipped for mercury analysis, toenails clipped for investigation of calcium enzyme-antagonism activity. The whole panoply of modern day science has been brought to bear on the matter leaving no stone unturned and a bewildered patient punctured, balding and putting their tights back on.

Stage three involves applying your not inconsiderable knowledge, skill and years of clinical experience to the diagnostic process in order to suggest ways of solving the problem. Ways, plural? Surely, way, singular is so much less complicated? Why bother formulating all manner of options when you are only going to be able to carry out one of them anyway, and that based on the assumption that the patient ever comes back? The answer is choice. Choice is now the buzzword and it returns us to that unpredictable commodity, the patient, and what they 'want'. Then again, how can they possibly be expected to know what they want without having been through at least five years of dental school and one of vocational training?

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Some are wonderfully compliant and, consequently, a pleasure to treat. Pandering to today's received consumerist wisdom you begin in earnest with a full description of the problem, its derivation and aetiology. Following through, you detail the possible progression and prognosis without treatment, with treatment and with a variety of different treatment modalities. Finally you wrap up the whole oratorical masterpiece with an itemised delineation of the therapeutic approaches that might best resolve the outstanding diagnostically indicated dilemma.

Then, sitting back suitably confident that you have packaged your treatment planning skills in such a way as to satisfy even the most particular of patients, you wait to hear their detailed response, analysis and decision as how best to proceed. Staring at you with a somewhat detached and vaguely glazed look in their eyes which you had not previously noticed, they sigh and say, 'what ever you think doctor, you know best.'

At least the mild irritation of a unappreciated performance is as nothing compared with the downright frustration when they come back with questions about why such-and-such would be 'best' and whether or not something else wouldn't be far more appropriate. How dare they? Then, not only do they question the options that you have so carefully tailored to their particular circumstances, but they want to know about all the possible consequences and risks too. What happens if this, or that, goes wrong, doesn't fit, falls out? How long will it last, what if it comes adrift when they're on a business trip? The neighbour once had a 'screw-in' tooth that made her lip numb for a fortnight after it was fitted and a man in Malta that they've just read about was murdered by a poison capsule secreted in the back of a false tooth. Is this treatment planning or bespoke personality management? And all for a single surface amalgam.

However, when all is said and done, most things are possible. So, the lower incisor showing its two-millimetre rebellion by breaking away from the symmetry of the arch can certainly be fixed. Fixed is the correct term. Extraction of a premolar, a lower fixed appliance and a period of retention should provide an acceptable solution. 'Great,' says the patient, 'I knew you could solve it for me if you really tried. Can you get it done for a week on Tuesday?' Can I explain? Back to the treatment planning drawing board!

* *The author is commissioning editor for the* BDJ.