EDITORIAL

NEGOTIATION, TREATMENT AND CONSENT

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The BDJ Upfront section includes editorials, letters, news, book reviews and interviews.

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When we were starting to unravel the aetiology of HIV infection and AIDS in the 1980s and 1990s the phrase 'safe sex' came to prominence. Now part of the vocabulary and cultural understanding, in those days it was a rather novel description for an often taboo subject. It was at this point that the notion of 'negotiating' safe sex arose. I have to say that when I first heard it I had a mixed reaction of humour, disbelief and cynicism. How would that work exactly? At what stage in the proceedings? Round a table with glasses of water, a flip chart and someone taking minutes? Under the duvet with torches and a note pad?

In due course, sense kicked in and I understood both the concept and the impetus. It was probably the use of the word negotiation that was initially alien as applied to an otherwise intimate human moment. Yet, once assimilated one realises that the term can actually be applied to all human interactions. We negotiate business, relationships and, crucially for us, treatment plans. In this latter case the negotiation also includes and should always conclude with consent. The agreement of one party, after discussion, to undergo a course of activity as recommended by the other.

Our ability to gain valid informed consent to a particular treatment plan relies not only on the course of action that we propose but also on the possible disadvantages and associated risks to the patient. To date we have attempted to assess the level of importance of a particular risk to any given individual, making a judgement on the extent to which they need to know about risks that are statistically very rare or unlikely and the effects that those risks might have on their lives and welfare. A recent legal case has altered this balance and an opinion piece in a future issue of the *BDJ* will highlight and add further detail to this.

'Good negotiation is about trust and the establishment of trusting relationships...'

Additionally it may in future be necessary to pay far greater attention to explaining to patients details of treatment that is possible but which the particular practitioner does not provide. An example of this arose recently and was highlighted when I attended a seminar on minimal intervention (MI) dentistry. It is a subject that we have published material on in the *BDJ* including two series of papers and an opinion piece on the philosophy and application of the approach.[1,2] Based on prevention it requires both a whole-practice and whole-team orientation in order to successfully deliver the best results. But what if a practitioner does not subscribe to and offer such an MI approach? Is he or she duty-bound to inform the patient that it is a current and acceptable treatment option but one which they will have to seek elsewhere? Taking informed consent to its full definition then the answer must be yes. This can seem like a heavy burden and, as ever, time is a huge consideration for time is also money. But if this is what society requires as a standard of care then the resources must be found to allow this to happen; our practices have to accommodate such changes.

The fear of the law enters into this too. But at the end of the day several things have to happen before such matters get to law or to court. Something has to have gone awry, the patient has to complain and the complaint has to be proven to be upheld. The indemnity organisations will all tell you that the basis of all good treatment planning is good communication (negotiation) and conversely that the basis of all claims is poor communication. But good negotiation is also about trust and about the establishment of trusting relationships. It is a theme that I have written about many times but it remains the bedrock of successful practice.

To illustrate this I recall the wise words of a prosthetic tutor of mine at dental school (not prosthodontics, in those days that was in the USA). 'You will know how successful you are when your patient with full-full dentures returns for a check one week after you have fitted them. The patient who doesn't quite trust you complains that 'your' dentures have rubbed an ulcer on their gums. The patient who trusts you with their life apologises that their mouth has caused a sore patch under 'their' denture.' The outcome may not have the same consequences as safe, or unsafe, sex but the principle is the same and the importance is profound. In order to gain consent we need negotiation, communication and trust.

1. Featherstone J D B, Doméjean S. Minimal intervention dentistry: part 1. From 'compulsive' restorative dentistry to rational therapeutic strategies. *Br Dent J* 2012; **213:** 441–445.
2. Banerjee A. 'MI'opia or 20/20 vision? *Br Dent J* 2013; **214:** 101–105.

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