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THE EDITOR'S CORNER

What's a Doctor to Do?

I recently did a consultation for an interesting case that left me thinking. The patient was an attractive young lady, mid-30s, blonde hair, blue eyes, tall, slender. She had a Class II, division 2 subdivision right with its characteristic deep bite, a compensatory chin button, and a sublabial furrow that actually looked good on her in a Geena Davis kind of way. She also had a mild maxillary constriction that, coupled with her Class II skeletal pattern, resulted in a fairly dysfunctional occlusion. She had no cusp-fossa relationships that I would have considered acceptable, no cuspid rise, and centric occlusion was unstable. When I asked her to pop her teeth together, the resulting sound was more of a sickly "crunch" than a strong, healthy "clump". Her opening stroke was wobbly and asymmetric, deviating to the left on opening. Distinct crepitation was evidenced bilaterally, with pain on intrameatal palpation when biting hard. Asked if there was anything else about her smile or her bite that she wanted to call to my attention, she said, "Oh, yes! When I smile big, my lips don't move up evenly on both sides. I really want that fixed." I thought to myself, "Oh, great—asymmetric activity in the muscles of facial expression." In short, she had a dreadful bite with clear signs and symptoms of temporomandibular dysfunction, in both articular and muscular manifestations.

I went through my usual consultation procedure, delineating my differential diagnosis, informing her of the nature of her malocclusion, taking special care to point out her temporomandibular disorders, and presenting her with the various treatment options, including the polar extremes of orthognathic surgery or no treatment whatsoever, and what to expect from those options. I also emphasized that I wanted her to visit the TMJ clinic here at the university. Through all of this, she seemed genuinely attentive and concerned about the status of her occlusion and the health of her TMJs. Everything went well until the point when we discussed finances. The patient had recently been through a divorce, and her current insurance policy provided only minimal coverage for orthodontics

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and none for a TMJ consultation. Basically, she had no discretionary income. When she learned the cost of orthodontic treatment and the consultation at the TMJ clinic, she replied, "I just want my front teeth straightened. I don't care how my back teeth look or fit together. Can't we just make these two front ones on the top straighter and line up these front ones on the bottom?"

What's a doctor to do in a situation like this? The answer to her question was clearly "yes". With a little air-rotor stripping and some controlled tipping using inexpensive removable appliances, I could have lined up her front teeth. I would have addressed the patient's chief complaint, I might have made a relatively pretty smile even prettier, and I would not have overtaxed her limited finances. I almost had myself talked into this when she raised the question, "Well, if we do that, will it make my joints feel better and make my lips even when I smile?"

"Probably not", I said.

"Well, how would it make my joints feel?"

In all honesty, I could only answer, "I don't know for sure." They might have felt better, they might have felt the same, but since the woman had indicated that the dysfunction in her joints seemed to be getting worse with time, there was every reason for me to believe they would continue to worsen—not because of my proposed limited treatment, but in spite of it. One way or the other, I might have been held accountable for the outcome. Again, what's a doctor to do?

My clinical judgment got the better of me, and I told her that it would not be advisable to do any orthodontic treatment without a full TMJ workup. You can probably guess her response: "Can't you just fix these two? Won't you help me?" I really did want to help this pleasant young lady. She was certainly deserving of help —as are most patients who walk through our doors—but the help she was asking for was not the help that she needed. This quandary faces us repeatedly, day in and day out: What are we to do when the wishes of the patient do not coincide with our best professional evaluation?

Although this conundrum has been around since the dawn of orthodontics, it has surfaced as fodder for debate in several public forums over the past few years. At one such occasion, a meeting of the Angle Society in Pasadena, California, a presenter showed a case in which the occlusal finish was not ideal, but the smile was beautiful. The doctor ended by admitting that he had compromised, "but the patient was happy with the result". This prompted one of the attendees, the legendary Dr. Harry Dougherty, Sr.—who has never been known to back away from an argument—to rise and challenge the speaker: "Since when does a happy patient mean that the case was handled appropriately? This case is a mess, and the patient just doesn't know any better. They may look fine, and they may be as happy as a clam, but you have missed all the basics of a good occlusion! We are supposed to be doctors, not beauticians!"

It's hard to argue with that kind of logic. Just to play devil's advocate, however, let me pose the counterargument: Do we do the patient an appropriate service if we achieve our functional and occlusal goals, but the patient is not happy with the esthetic result? Proponents of what is now referred to as the Soft Tissue Paradigm would say "no". Some would argue vigorously that meeting the patient's primary demands with regard to facial esthetics should be our main objective. After all, don't most people come to us simply to have their teeth straightened?

Both schools of thought have merit. I doubt that any serious orthodontist would argue against the desirability of achieving a good occlusion as classically defined. I also doubt that any would consider it wrong to meet the patient's esthetic expectations. Both are desirable outcomes. It would be naive to suggest that we can always achieve both—but we should always try.

Where do we draw the line when a patient's goals do not coincide with our own? What do we do when a patient insists, as mine did, "I only want my front teeth straightened"? Do we turn them away with the attitude of "my way or the highway"? Or do we adjust our objectives and reach a sound compromise? The ideal treatment, however you define it, is not necessarily the optimal treatment for everyone. There is a difference. Ideal implies a goal of perfection toward which to strive. Optimal implies that which is best in a specific situation when all important factors are considered—the patient's chief complaint; the economic, psychological, and esthetic circumstances; and the occlusal and functional situation. Which factor carries the most weight in any particular case is a function of the orthodontist's professional judgment and personal ethics. It is the doctor's responsibility to hone both of those to a very keen edge. RGK

Next month: More on limited treatment in both the Editor's and Readers' Corners.