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Needs, Wants, and Dialogue

Doctor-Patient Collaboration Is Key for Ideal Care

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In "Transforming Patients' Dental Needs Into Wants" (*AGD Impact*, December 2013), dental practice management and business consultant Tim Twigg distinguishes between what patients need and what they want. This is important, he explains, because, "Sometimes, the dentist and dental team need to shift their case presentation from the dentistry patients need to the outcomes they want—and this requires moving from monologue-like conversation to dialogues in which you really hear what the patient wants." This is excellent advice. It's similar to what we wrote in our feature article "Achieving the Ideal" (*AGD Impact*, August 2008): "[T]he ideal relationship between dentists and patients is much more collaborative than the one usually understood as informed consent."

Twigg offers several helpful strategies for achieving this kind of dialogue, and dentists who routinely strive for a highly collaborative relationship with their patients may recognize many of them. We want to build on Twigg's wants/

needs insight by offering a distinction between two kinds of needs. We aim to reinforce Twigg's and our own recommendation that building collaborative, dialogue-based relationships with patients is crucial to providing ideal dental care.

Oral health needs

One meaning of the word *needs*—and how Twigg usually uses this word in his article—concerns the steps that the dentist decides, by applying his or her professional expertise, should be taken for the sake of the patient's oral health. We will refer to these as *oral health needs*—which only can be properly identified by means of the professional expertise of the oral health professional, and this expertise is something the ordinary patient does not have. In addition, the dentist's assessment of the patient's oral health needs always includes a ranking of these needs in comparison with other aspects of the patient's overall health, an assessment that similarly requires professional expertise that the ordinary patient does not

have. See our article "At the Core" (*AGD Impact*, June 2008), in which this ranking is explained in terms of what we have called the dental profession's six "Central Values" of dentistry. These values are life and general health, oral health, autonomy (that is, a patient's self-determination), the benefits of professional habits of practice, esthetic values, and efficiency in the use of professional resources (that is, expertise, time and energy, and material resources).

There is, however, another notion of need that has a lot of impact on contemporary American society. This second idea of need is closely connected to the idea of what people desire, so that is where we will begin. But it is important to note, as we will explain below, that Twigg's notion of patients' wants is different from both need in this second sense and the idea of desire that it builds upon.

People's desires

In the free-enterprise marketplace of American culture, people's *desires* are viewed as the very basis of their interactions. From this commercial marketplace viewpoint, the only reason people act and interact is to fulfill their desires (or *interests*, as they also are called).

We all know that desires can conflict with one another. A person may desire an expensive car or some other expensive item and, at the same time, may desire to hold on to the money that purchasing those things would cost. In the marketplace view, a person resolves these conflicts between their desires by determining which of the conflicting desires is stronger than the other (i.e., in terms of the relevant quantities of we might call *desiredness*). Such conflicts also are resolved by determining which desire is more important in terms of some "higher level" criterion (e.g., security against bad times, or acting in accord with some ideal character). These "higher level" criteria are, from the marketplace perspective, simply even more desired parts of living. And, because they are even more desired, they function more or less as "multipliers" of "lower level" desires when these "lower level" desires come in conflict. To ask if it is "right" or "reasonable" or "admirable" to desire something is, from the marketplace perspective, only to ask if you desire (in one of these "higher level" ways) to be desiring it. For, as was said, from this commercial marketplace point of view, the only reason people ever act or interact is to fulfill their desires. In short, then, resolving conflicts between desires is, in the marketplace view, always and never anything more than a matter of measuring a person's respective quantities of desiredness.

Marketplace needs

How, then, are needs understood in our society's commercial marketplace? From the perspective of the commercial marketplace, saying something is needed says only that it is something that is especially strongly desired. Some things are especially strongly desired (i.e., needed in the marketplace sense) just because they are. Some things are especially strongly desired because these things are necessary for achieving a number of other things that are desired. This is why matters of health are often especially strongly desired

(i.e., needed in the marketplace sense), because they are viewed as necessary for the achievement of many other things that are desired. But in either case, from the perspective of the commercial marketplace, to need something is to have an especially strong desire for it. There is no more to it than that.

"In the ideal patient-dentist relationship, the patient and the dentist judge together what ought to be done and choose together to do it."

We will call this second category of needs, then, *marketplace needs*. We will contrast this with *oral health needs*, as previously discussed. Marketplace needs are determined by what a person happens to desire and how strongly he or she happens to desire it. Whether a person has marketplace needs, in short, is determined by the person doing the desiring. Oral health needs are determined through the expertise of the dental professional—expertise that the ordinary patient does not have. (A more detailed analysis of the two notions of need examined here can be found in an article by David T. Ozar, PhD, "Ethics, Access, and Care," *Journal of Dental Education*, November 2006.)

From this explanation, it should be clear that Twigg's reference to patients' wants is something very different from marketplace needs (i.e., especially strong desires). When Twigg talks about patients' wants, he is talking about patients having actual *reasons* for choosing something, not just desires that are stronger or weaker than others. These reasons serve, then, as the bases of patients' decisions to proceed with the dentist's recommendations for oral health care. At a minimum, Twigg is presuming that patients can base their decisions on reasons. He also is presuming that the dentist can, through respectful dialogue, guide them to see that there are good reasons for deciding to accept the oral health care that the dentist recommends. What the dentist brings the patient to understand—through careful dialogue—is that he or she has an oral health need (as determined by the dentist's professional expertise), that the recommended care is the best response (in relation to the patient's overall health) to that need, and that the oral health need is a good reason for deciding to accept the recommended care.

There probably are patients whose desires and needs fit so perfectly with the commercial marketplace picture of desires and needs that no amount of careful dialogue will bring them to think that their oral health need is a good reason to decide to accept care (i.e., something they should have or should *want*, in Twigg's sense of the word). There probably also are patients who so thoroughly have lost touch with the idea that dentistry is a profession—and therefore that the dentist has the expertise to give them good reasons for accepting oral health

care—that they interpret all efforts at exchanging dialogue about their oral health needs as nothing more than advertising for the sake of selling. Twigg is an optimist in believing and hoping, however, that respectful dialogue can guide patients—who do not already do so—to recognize that they should want a dentist’s recommended care because their oral health needs are, indeed, good reasons for them to accept it.

Twigg’s advice to dentists takes for granted, as we do, that dentists already know that a dentist’s relationship with every patient is, first of all, a professional relationship and that, in a professional relationship, things can work differently from how they would work in a marketplace relationship. The marketplace views the patient and the dentist as being no different from each other in how each makes decisions. Both are viewed as making decisions solely on the basis of their desires, as described above. The dentist and the patient are simply sellers and consumers like everyone else interacting in the marketplace. There is nothing to differentiate the relationship of dentist and patient from that of seller and consumer. If this actually was the case, the dentist’s notion of what the patient needs simply would be what the dentist desires or needs (in the marketplace sense of these words) the patient to purchase. There is no other possible meaning, from the marketplace perspective, for the dentist’s treatment recommendation to the patient. This is not, though, how a dentist understands the patient’s needs. And for us, as for Twigg, this is not how we want the patient to understand his or her need for health care, either (see “Dental Professionalism,” *AGD Impact*, August 2011).

Good salespeople in the marketplace work hard, of course, to match their recommendations for purchase to what the consumer desires or needs (in the marketplace sense) or, if possible, to shape the consumer’s desires or needs to match what they hope to sell. But any interest the seller may appear to have in the consumer’s well-being is, from the point of view of the commercial marketplace, nothing but a means to achieve what the seller most desires/needs, which is a profitable sale.

Point of dialogue

Twigg is urging dentists, then, to exchange dialogue with patients to make sure their relationship is a professional relationship rather than a marketplace relationship. The point of the dialogue that Twigg recommends sharing is to make sure, as much as this is possible, that the patient participates in the relationship in terms of wants/reasons rather than in terms of the marketplace’s desires/needs.

The phrase “as much as this is possible” in the previous sentence is crucial in this context. This is because, as Twigg discusses, the patient may have other reasons—especially reasons of other resource priorities and costs in the patient’s life—which the patient also must take into account for his or her part of the decision-making process. It would be a serious mistake, then, for the dentist to assume that the patient should have the dentist’s view of the patient’s oral health needs as his or her only perspective. This complicates the dialogue between dentist and patient. It is a key reason why Twigg stresses that if

the dentist’s focus is wholly on the patient’s oral health needs, then this “entire experience is doctor-driven. [T]he dentist dictates the conversation and, likely, the outcome. This doctor-patient interaction occurs as a monologue, not a dialogue.”

However, as long as the expertise of the professional that is embodied in the dentist’s treatment recommendation (based on the patient’s oral health needs) continues to play a significant role as an important reason in the patient’s decision-making process, the relationship can still be considered a professional—rather than a marketplace—relationship. Twigg’s recommended strategy for making this happen is to make the conversation want-based—that is, based on the reasons why the patient has come to the doctor’s office in the first place, what Twigg calls the patient’s wants.

Language of needs

Worth noting in Twigg’s article is that all but one of the references to what patients need are about patients’ oral health needs. The one exception occurs in a sentence in which Twigg explains his conviction that patients can be guided to think about dental care from the perspective of wants/reasons rather than desires/marketplace needs: “People often do not like to spend money on things they *need*; instead, they like to spend money on things they *want*.”

What Twigg is referring to here is that most humans recognize that they do not have a lot of control over their desires, neither over what they desire, nor over how strongly they desire these things. One of the main things that humans are trying to do in their decision-making process, however, is to determine how their lives should go. They are, among other goals, trying to control what they do and what happens to them. Our ability to do this as humans is limited; nevertheless, insofar as people can make their decisions on the basis of wants/reasons (i.e., things that they have thought about), to that extent, humans can increase their control over their lives, thus overcoming the uncontrollable vagaries of what they might happen to desire or how strongly they happen to desire it.

Twigg’s advice assumes—as we do, and as we believe oral health professionals are committed to believing—that humans ordinarily prefer to make their decisions on the basis of wants/reasons rather than desires, even when these are especially strong desires (i.e., marketplace needs). There is another strategic reason, however, for Twigg to note that, “People often do not like to spend money on things they *need*; instead, they like to spend money on things they *want*.” For whenever what is being discussed is called a need—whether the reference is to a marketplace need or an oral health need—many people respond to such talk with the feeling that they no longer have a choice about whether or not to respond, that they are being pushed into something, because things that are needed feel as if they automatically “outrank” every other basis for action. In other words, as soon as the notion of something being needed arises, many people want to resist, because such language feels like it is removing one’s control of the situation.

Therefore, even though the needs that Twigg is focusing on in his article are oral health needs—which are very good reasons for accepting the recommended care—Twigg advises the dentist not to talk of them in the language of needs, but rather to talk about them in terms of the kinds of wants/reasons that have brought the patient to the dentist’s office in the first place. The questions he offers as examples of the required dialogue in the “Thinking about wants” section all point in this direction, as does the advice Twigg offers in “The cost conversation” section. The goal of the dialogue, in other words, is that the professional’s expert judgment about the patient’s oral health need be grasped by the patient as being both a reason for accepting the recommended care and a way that the patient can control what happens and achieve what he or she wants.

In the ideal patient-dentist relationship, the patient and the dentist judge together what ought to be done and choose together to do it. The only way to achieve this on a regular basis is for the dentist to focus on respectful dialogue between patient and dentist or, as Twigg puts it, to follow a wants-based model of interaction.

The advice Twigg offers is important, because respectful

dialogue is the best way to produce treatment decisions that are based on a correct understanding of the patient’s oral health needs, and it is the best way to produce shared decisions—rather than passive, or even begrudging, decisions on one side or the other. In addition and equally important, building such collaborative, dialogue-based relationships with patients is crucial to preserving the professional character of the dentist-patient relationship. It must not be allowed to become simply a commercial, marketplace exchange between a consumer and a seller. ♦

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