CHAPTER

3

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Developing the Treatment Plan

CHAPTER OUTLINE

Having established the patient's diagnoses and problems, the dentist is prepared to begin developing a treatment plan. This process can be rather simple for patients with few problems and relatively good oral health. Treatment can commence quickly, especially when the patient is knowledgeable about dentistry, harbors little anxiety toward dental treatment, and has the necessary financial resources available. More commonly though, the patient has many diagnoses and problems, often interrelated and complex, that require analysis before treatment can begin. The dentist may wonder whether an individual problem can or should be addressed, and what treatment options are available. Would a crown, for instance, be better than a large direct restoration to restore a carious lesion? Would an implant be a more satisfactory option than a fixed partial denture to replace a missing tooth? Which treatment should be provided first, and which procedures can be postponed until later? What role should the patient have in any of these decisions? Is he or she even fully aware of the individual dental problems? How successful, overall, will the planned treatment be?

Although all dentists struggle with these questions, experienced practitioners know when to address each issue individually and when to step back and look at all aspects of the case as a whole. They are also aware that treatment planning cannot occur in a vacuum and must involve the patient. This means educating patients about their problems and making them partners in determining the general direction and the specific elements of a proposed treatment plan.

The purpose of this chapter is to provide the reader with the fundamental skills necessary to begin creating treatment plans for patients. This includes developing treatment objectives, separating treatment into phases, presenting treatment plans to patients, sequencing procedures, consulting with other practitioners, obtaining informed consent, and documenting the treatment plan.

Much of the material is presented as guidelines, which must be modified by the circumstances of each patient. Few, if any, rules are ironclad when treatment planning, and like many other aspects of dentistry, clinical decisions improve with experience.

DEVELOPING TREATMENT OBJECTIVES

As we discussed in Chapter 1, the practitioner first determines what patient findings are significant and then creates a list of diagnoses and problems that formally document why treatment is necessary. After assessing the patient's risk for ongoing and future disease (discussed in Chapter 2), the next step towards devising a treatment plan is to articulate, with the patient's assistance, several **treatment objectives** (Figure 3-1). These objectives represent the intent, or rationale, for the final treatment plan. Treatment objectives are usually expressed as short statements and can incorporate several activities aimed at solving the patient's problems. Good treatment objectives articulate clear goals, from both the dentist's and the patient's perspective. Objectives evolve from an understanding of the current diagnoses and problems and provide the link to actual treatment (Table 3-1).

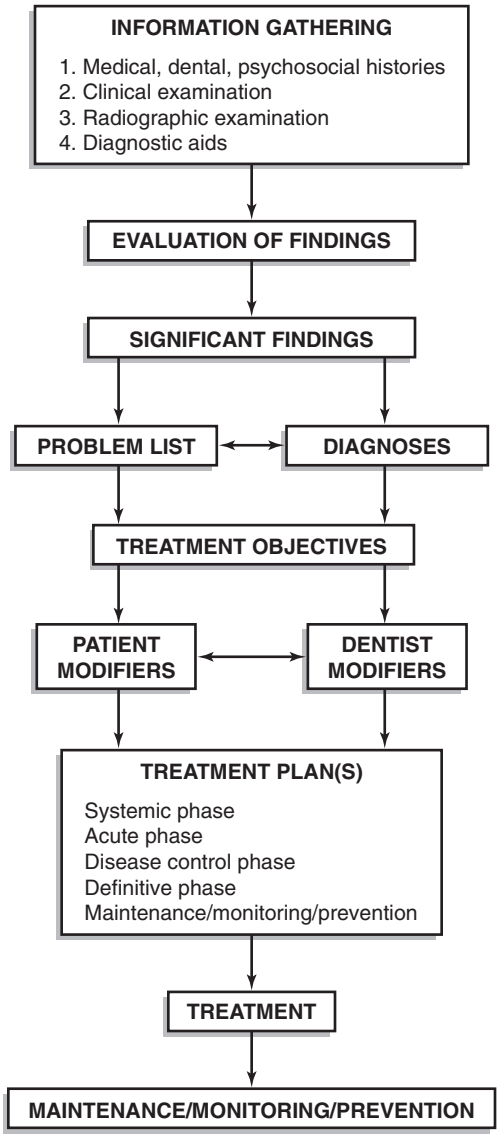


Figure 3-1 The treatment planning process in dentistry.

Patient Goals and Desires

Before creating any treatment plan, the dentist must first determine the patient's own treatment desires and motivation to receive care. Patients usually have several expectations, or **goals,** that can be both short and long term in nature. The most common short-term goal is the resolution of the chief complaint or concern, for instance, relieving pain or repairing broken teeth. Long-term goals are usually more global and can be more difficult to identify, especially if the dentist only considers his or her own preconceived ideas of what the patient desires. For example, an understandable long-term goal would be maintaining oral health and keeping the teeth for a lifetime. Most dentists would extol this expectation, as would many patients, especially those who come to the dentist with good oral health. But for patients with a history of sporadic dental care, poor systemic health, or extensive (and potentially *expensive*) dental needs, individual goals can be quite different. A patient with terminal cancer may only wish to stay free of pain or to replace missing teeth to be able to eat more comfortably. On the other hand, a physically healthy patient with recurrent caries around many large restorations may be frustrated with past dental treatment and want any remaining teeth extracted and full dentures constructed.

Determining patient goals begins during the initial interview and can continue throughout the examination process. Careful probing of the patient's past dental history provides an indication of past and future treatment goals. The practitioner should avoid asking leading questions about treatment expectations. Such questions may instead convey the dentist's own personal goals, opinions, and biases and inhibit the patient from expressing his or her own goals and views. Some examples follow:

"Do you want to keep your teeth for a lifetime?"
"Isn't it worth the time and money to chew better?"
"Wouldn't you like whiter teeth and a prettier smile?"

Table 3-1 The Relationship Between Diagnoses, Problems, Treatment Objectives, and Treatment

Signs and Symptoms: *Ms. Smith, a 45-year-old patient, requests an examination. She has been diagnosed with Sjögren's syndrome. Her last visit to a dentist was 2 years ago for teeth cleaning. She reports symptoms of sore hands and wrist joints and a dry mouth. Her gingiva is red, and extensive plaque covers the necks of the teeth. Several teeth have small, dark areas on the facial enamel near the gingival margin, which are soft when evaluated with an explorer. The patient works in a convenience store and consumes an average of 1 liter of naturally sweetened carbonated beverage per day.*

Diagnoses	Problems	At Risk for	Treatment Objectives	Treatment
Sjögren's syndrome	Reduced salivary flow, symptoms of xerostomia (dry mouth)	Caries, poor prosthesis retention, discomfort	Investigate ways to increase salivary flow and/or reduce symptoms of xerostomia	Consider prescribing medication to promote saliva production; saliva substitute products
Rheumatoid arthritis affecting the hands	Unable to use a manual toothbrush	Poor oral hygiene, gingival and periodontal disease	Look for aids to improve oral hygiene	Suggest an electric toothbrush
Gingivitis	Poor plaque control	Periodontal disease	Restore gingival health	Prophylaxis and oral hygiene instruction
Caries on seven teeth	Increased caries susceptibility resulting from a high-sucrose diet; poor oral hygiene; and reduced salivary flow	Pain, tooth loss	Reduce refined carbohydrates in the patient's diet; restore cavitated lesions	Diet analysis and counseling; begin a caries control program; prescribe topical fluoride; glass ionomer restorations
Acute apical abscess	Constant pain #3	Infection, swelling	Relieve pain	Emergency endodontic therapy #3

It is better to use open questions that elicit the patient's thoughts and feelings and encourage the sharing of genuine concerns, especially regarding the chief complaint:

"Are you having any problems in your mouth right now?"

"Tell me about how important you feel your teeth are."

"How well are you able to eat with the teeth you have?"

"How do you feel about the appearance of your teeth?"

The dentist can influence a patient's treatment goals. This often occurs when the patient has expectations that are difficult or even impossible to achieve, considering the condition of the mouth. For instance, the patient may want to retain his or her natural teeth, but is unaware of severe periodontal attachment loss. Ultimately the dentist needs to educate the patient about the dental problems and begin to suggest possible treatment outcomes.

Patient Modifiers

Treatment goals are frequently influenced by patient attributes, often referred to as **patient modifiers.** Positive modifiers include an interest in oral health, the ability to afford treatment, and a history of regular dental care. Commonly encountered negative modifiers include time and financial constraints, a fear of dental treatment, lack of motivation, poor oral health, destructive oral habits, and poor general health. Many patients are understandably concerned about the potential cost of care, especially when they know they have many dental problems. Whether the fees for services will function as a barrier to treatment depends on several variables, including the patient's financial resources, the level of immediate care necessary, the types of procedures proposed (i.e., amalgams versus crowns or partial dentures), the feasibility of postponing care, and the availability of third-party assistance.

Poor motivation, a lack of good oral hygiene, or a diet high in refined carbohydrates can significantly affect the prognosis of any treatment plan. Nevertheless, occasionally such patients may still want treatment involving complex restorations, implants, and fixed or removable partial dentures. Before treatment is provided, the dentist must inform the patient of the high risk for failure and record this discussion in the patient record.

Dental Team Focus

The Treatment Plan and the Oral Health Team

After the dentist has developed a treatment plan, other members of the dental health team may have some responsibility for helping the patient understand the plan for treatment, confirming treatment objectives, and reiterating the goals of the planned treatment. The administrative staff will schedule a series of appointments, answer questions about treatment sequence, develop a financial payment plan if extensive work is to be scheduled, and submit claims to dental insurance companies for reimbursement.

Patients often feel comfortable bringing concerns and questions to clinical staff members. By incorporating supportive communication and attentive listening skills in interactions with the patient, the clinical staff may help explain procedures, provide literature about relevant dental treatment options, and facilitate further communication between dentist and patient.

Dentist Goals and Desires

Dentists also aspire to certain goals when creating treatment plans for patients. Several are obvious, such as removing or arresting dental disease and eliminating pain. Other goals may be less apparent, especially to the patient, but are just as important nonetheless. Examples include providing the correct treatment for each problem, ensuring that the most severe problems are treated first, and choosing the best material for a particular restoration.

In gathering these altruistic goals together, the dentist would likely want to create an **ideal treatment plan.** Simply put, such a plan would provide the best, or most preferred, type of treatment for each of the patient's problems. Thus, if a tooth has a large composite restoration that requires replacement, placing a crown might be considered the ideal treatment. If the patient has missing teeth, then the dentist might consider replacing them. The goal of ideal treatment planning provides a useful starting point for planning care. Unfortunately, such a plan may not take into account important patient modifiers or may fail to meet the *patient's* own treatment objectives. In addition, one dentist's ideal treatment plan can differ significantly from another's, depending on personal preference, experience, and knowledge.

Creating a **modified treatment plan** balances the patient's treatment objectives with those of the dentist's. For instance, a patient with financial limitations may not be able to replace missing posterior teeth. The dentist needs to explain (and document) what may happen without ideal treatment (i.e., in some instances, tipping and extrusion of the remaining teeth). Another example is the patient with several periodontally involved teeth that should be removed even though they are not excessively mobile or symptomatic at the present time. An appropriate treatment objective might be for the dentist to observe the teeth for the present, but be prepared to extract them if mobility increases or if the patient reports symptoms.

Incorporating the patient's wishes into a treatment plan can be difficult to implement at times. A classic example is the patient with rampant dental caries involving both the anterior and posterior teeth. For esthetic reasons, the patient may be interested in restoring the anterior teeth first, but the dentist, after interpreting the radiographs, may detect more serious problems with the posterior teeth, such as caries nearing the pulp, and wish to treat these teeth first. Another example is the patient with poor oral hygiene and severe periodontal disease who wishes extensive fixed prosthodontic treatment begun immediately.

Dentist Modifiers

Every dentist brings factors to the treatment planning task that can influence goals for patient care and ultimately the sort of treatment plans that he or she creates. The astute dentist is aware of these modifiers, especially when they limit his or her ability to devise the most appropriate treatment plan to satisfy the patient's dental needs and personal desires.

Knowledge The dentist's level of knowledge and experience can influence the selection of goals and objectives for patient care. At one extreme is the beginning dental student, with a limited knowledge base and little experience in treating patients. Such early practitioners may not recognize the patient's treatment desires and modifying factors. As a result, they may create only ideal treatment plans, ignoring more appropriate solutions. At the other extreme is the complacent dentist who has been in practice for many years and has substantial clinical experience, but a knowledge base that has changed little since graduation. Such dentists may lack knowledge of new treatment modalities that could be offered to patients, preferring instead to limit what they do. For these clinicians the adage, "If all you have is a hammer, then everything is a nail," unfortunately may be true. The conscientious practitioner is a lifelong student who is never complacent and who learns not only from his or her own experiences, but also from those of others. This dentist keeps up with current developments in the profession by attending continuing education courses, interacting with peers, and critically reading the professional literature.

Technical Skills In addition to a sound knowledge base, the dentist must also have the technical ability to provide treatment. Many dentists choose not to provide certain procedures, such as implant placement, extraction of impacted third molars, or endodontic treatment for multirooted teeth. This is not necessarily a limiting factor *per se* when treatment planning, but it can be if the dentist does not consider referring the patient to another dentist who has the expertise to provide the treatment.

Treatment Planning Philosophy Finally, each dentist develops an individual treatment planning philosophy that continues to evolve over years of treating patients. The dentist's philosophy regarding treatment planning may vary considerably because of differences in his or her knowledge base, technical skills, clinical experience, and judgment. Treatment planning in a dental school environment is often different from treatment planning in a private practice. Students are often frustrated when instructors differ in treatment philosophies because of different educational backgrounds. Dental schools and dental practices may also control or recommend which treatment options practitioners can provide to patients. The recent graduate, starting out in practice, is often motivated to incorporate new techniques and materials different from those used in dental school. Dentists who have been in practice several years also try to keep up with new developments in the profession, which in theory can influence how they develop treatment plans for patients. For the most part, patients benefit from new materials and techniques. But patient care suffers when experienced or inexperienced practitioners adopt treatment philosophies that are unproven or empirical in nature. A good example is the unwarranted removal of sound amalgam restorations and replacement with gold or composite resin under the premise that the amalgam affects the patient's systemic health. Such treatment can be unethical and may be a disservice to the patient by exposing teeth to the risk of pulpal damage or removal of additional tooth structure.

ESTABLISHING THE NATURE AND SCOPE OF THE TREATMENT PLAN

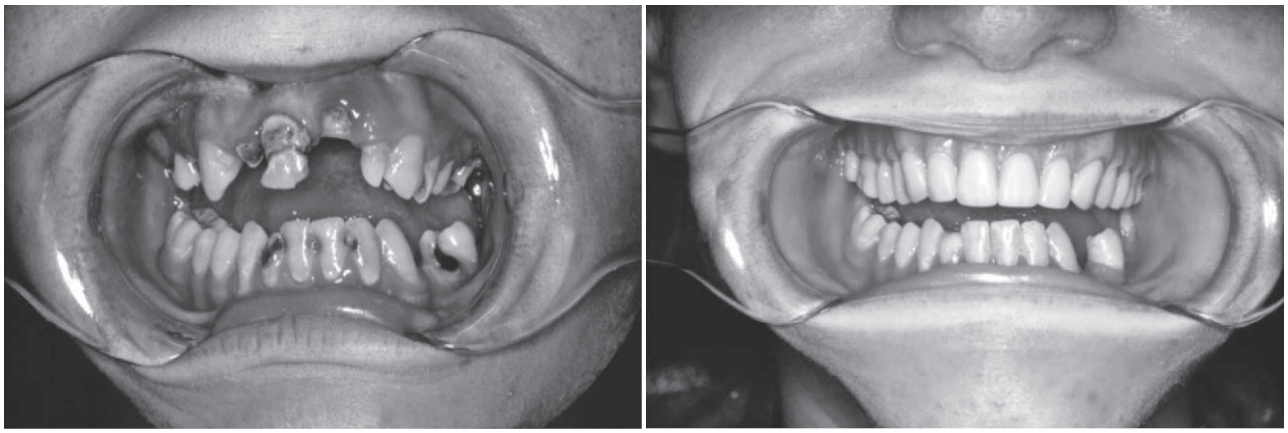
With the examination finished and the dentist confident that he or she has gained an awareness of the patient's treatment desires, it is time to develop the treatment plan. The dentist has the responsibility to determine what treatment is possible, realistic, and practical for the patient. In many instances, this is a relatively straightforward process, especially for those patients with few problems and the resources and interest in preserving oral health. At the other end of the spectrum, the process is more complex for patients with many interrelated oral problems and a high degree of unpredictability regarding the final treatment outcome. For such cases, the dentist has at his or her disposal several useful techniques for developing treatment plans: visioning, identifying key teeth, and phasing procedures.

Visioning

Dentists naturally contemplate treatment options while examining patients. The experienced practitioner will also develop a **vision** of what the patient's mouth will look like when treatment is completed. The concept of having a vision of the final result could be described as analogous to deciding on the destination before starting a journey. Imagining one or more end points for the completed case is beneficial when evaluating different treatment approaches. For the patient with many severely decayed teeth in both arches, the dentist might see the patient ultimately wearing complete dentures or, alternatively, consider retaining some teeth and placing a removable partial denture, or even restoring more teeth and using implants to support fixed prostheses (Figure 3-2, *A* and *B*).

Further exploration of each option requires the dentist to identify what steps are necessary to reach the treatment goals. Experienced dentists commonly use this technique of "deconstructive" thinking to explore each option. In the first example, the dentures can only be made after the remaining teeth have been extracted. Will all the teeth be extracted at the same time? The patient will need time to heal and might be without teeth for several weeks. On the other hand, possibly only the posterior teeth should be removed first and the anterior teeth retained to maintain a good appearance. After healing, dentures could be constructed for immediate placement after the remaining anterior teeth have been extracted. Thinking ahead again, the dentist considers the fact that immediate dentures often require relining 6 to 12 months after placement. Is the patient prepared to accept the additional cost?

Considering the second option, the dentist might envision the patient with removable partial dentures and again begin the process of deconstructing the final result. Which teeth will serve as abutments for the removable partial denture? A surveyed crown may be necessary on some or all of the teeth to achieve adequate retention of the prosthesis. For the teeth needing such crowns, insufficient tooth structure may remain and a foundation restoration or post and core will have to be provided. Endodontic therapy must be performed first before a post and core can be placed. The dentist may determine that



A B

Figure 3-2 Visioning skills are useful when trying to arrive at treatment options for a patient with many problems. **A,** This 20-year-old woman had extensive dental caries, nonrestorable teeth, and limited financial resources. **B,** Of the several options presented, the patient chose to have the maxillary teeth removed and mandibular teeth restored.

the periodontal condition of several abutment teeth is poor, calling for a new treatment plan designed around different abutment teeth. Can a suitable partial denture be made using these alternative abutment teeth?

Experienced dentists perform this mental dance of forward and backward thinking almost automatically, constructing and deconstructing various treatment plans. Such practitioners can simultaneously vision proposed changes in the treatment plan at three levels: the individual tooth, the arch, and the overall patient. Dental students and recent graduates who lack experience and visioning skills need to work harder at coming up with various options and testing their clinical validity. Even for straightforward cases, it may be advantageous to construct mounted study casts and make diagnostic waxings to help evaluate possible options. Having a network of experienced dentists with whom casts and radiographs can be shared and cases discussed can be helpful. The dentist who practices alone may need to join a study club or develop relationships with experienced general and specialist dentists.

Key Teeth

When developing a treatment plan for the patient with a variety of tooth-related problems, such as periodontal disease, caries, and failing large restorations, a first step may be to identify the important or **key teeth** that can be salvaged. Such teeth often serve as abutments for fixed and removable partial dentures, and their position in an arch may add stability to a dental prosthesis. Retaining key teeth often improves the prognosis for other teeth or the case as a whole. Conversely the loss of a key tooth can limit the number of treatment options available to the patient.

Key teeth can be characterized as having several qualities. If enough of these qualities are present, the teeth may be important enough to make an extra effort to retain them.

- Key teeth should be periodontally stable. Although some loss of bone or periodontal attachment may be evident from radiographs and during periodontal probing, the tooth usually should have little mobility. Of the anterior teeth, the canines have the most favorable crown-to-root ratios and are especially valuable as abutments. Similarly, posterior key teeth, such as multirooted first molars, have a better prognosis as abutments—especially if the roots are divergent—than do single-rooted teeth or those with tapered and fused roots.
- Key teeth are usually favorably positioned in the arch. For example, imagine the patient who has many missing or nonrestorable maxillary teeth. The dentist would like to identify several key teeth, ideally spread throughout the arch, to secure a fixed or removable prosthesis, or to be used as overdenture abutments. Hopefully the maxillary canines and at least one posterior molar can be retained for stability of the prosthesis. In addition to being favorably located in the arch, key teeth should not be excessively extruded from the occlusal plane (supraerupted), tipped into edentulous spaces, rotated, or located in an extreme buccal or lingual position. Third molars and often some second molars are not suitable to serve as key teeth because of their position in the arch and the difficulties involved in restoring them. The dentist can evaluate the position of individual teeth directly during the examination, with mounted casts and by surveying study casts.

- Key teeth that are decayed or broken should be restorable. Teeth that have caries extending below the level of the alveolar crest may be poor candidates for restorative treatment and subsequent use as an abutment (see Figure 3-2). In situations with less tooth destruction, but with the margin of the final restoration approaching the alveolar crest, the periodontal health of the tooth may be compromised. Orthodontic extrusion of the tooth or clinical crown lengthening surgery can improve the situation, although the loss of periodontal attachment may lead to increased mobility and decreased suitability as a key tooth.

Phasing

When preparing to treat a patient with complex needs, the dentist may find it advantageous to break the treatment plan into segments or **phases.** Sorting treatment into phases helps the clinician organize the plan and improve overall prognosis of the case. In addition, patients often comprehend a complicated treatment plan more easily when it is separated into segments. The five general categories of phasing are: systemic phase, acute phase, disease control phase, definitive treatment phase, and maintenance care phase.

Systemic Phase The systemic phase of treatment involves a thorough evaluation of the patient's health history and any procedures necessary to manage the patient's general and psychological health before or during dental treatment. This may include consultation with other health providers, antibiotic prophylaxis, stress and fear management, avoidance of certain medications and products (e.g., latex), and any other precautions necessary to deliver treatment safely to patients with serious general health problems.

Acute Phase The purpose of an acute phase of treatment is to resolve any symptomatic problems that a patient may present with. Any number of patient problems may require attention during this phase. Common complaints include pain, swelling, infection, broken teeth, and missing restorations. Possible acute phase treatments include extractions, endodontic therapy, initial periodontal therapy, placement of **provisional** (temporary) or permanent restorations, and repair of prostheses. The dentist may also choose to prescribe medications to control pain and infection. Acute phase procedures may be provided before a comprehensive written treatment plan is created.

Disease Control Phase The goal of the disease control phase is to control active oral disease and infection, stop occlusal and esthetic deterioration, and manage any risk factors that cause oral problems. For many patients this means controlling dental caries and arresting periodontal disease before deciding how to rebuild or replace teeth. Common procedures during the disease control phase include oral hygiene instruction, scaling and root planing, caries risk assessment and prevention, endodontic therapy, extraction of hopeless teeth, and operative treatment to eradicate dental caries.

A disease control phase can be valuable when the dentist is uncertain about disease severity, available treatment options, or patient commitment to treatment (Figure 3-3). The success or failure of a disease control phase is evaluated with a **posttreatment assessment examination** before proceeding with definitive treatment procedures. If a patient's dental disease is not controlled or if the patient wishes to limit treatment, he or she may enter a holding period and not proceed to definitive treatment.

Definitive Treatment Phase Definitive treatment aims to rehabilitate the patient's oral condition and includes procedures that improve appearance and function. Depending on the patient, several procedures in the various disciplines of dentistry, such as prosthodontics, periodontics, and endodontics, may be required. Examples of definitive treatment procedures include the following:

- Additional periodontal treatment, including periodontal surgery
- Orthodontic treatment and occlusal therapy
- Oral surgery (elective extractions, preprosthetic surgery, and orthognathic surgery)
- Elective (nonacute) endodontic procedures
- Single tooth restorations

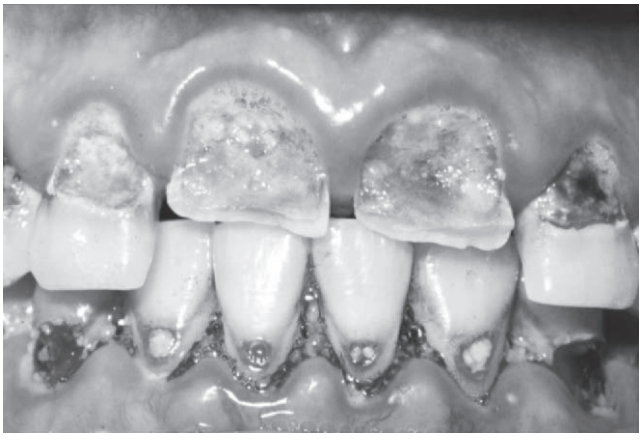


Figure 3-3 This patient had ignored his teeth for many years and has rampant caries and periodontal disease. A disease control phase of care is indicated before any definitive care, such as crowns, can be planned.

- Replacement of missing teeth with fixed or removable prosthodontics, including implants
- Cosmetic or esthetic procedures (composite bonding, veneers, bleaching)

The accompanying *In Clinical Practice* box examines how comprehensive a treatment plan should be.

In Clinical Practice

How Comprehensive Should a Patient's Treatment Plan Be?

When a patient has extensive dental problems it may be difficult, if not impossible, to develop a comprehensive treatment plan incorporating both disease control and definitive phases. This is especially true when the patient has significant periodontal disease or many carious, missing, or broken-down teeth.

Patients often want to know as soon as possible all that will be involved in rehabilitating their oral condition, and the dentist may feel pressured at an early stage to create a comprehensive treatment plan. Unfortunately, with the level of unpredictability that extensive problems involve, this may be impossible. In this situation, the clinician has two treatment planning options available, depending the complexity of the case.

Designing a disease-control-only plan. Such a plan improves predictability by controlling variables, such as rampant dental caries or active periodontal disease, and simplifies the situation by removing hopeless teeth. During this time, it may be necessary to fabricate provisional replacements for missing teeth to satisfy the patient's esthetic and functional needs.

At the conclusion of the disease control phase, the dentist performs a posttreatment assessment. Depending on the level of disease resolution, patient compliance, and desire for further care, the dentist may decide to simply maintain the patient or alternatively may begin designing a definitive phase treatment plan.

Designing a disease control and tentative definitive treatment plan. For patients with greater predictability, it may be possible to control disease while developing a vision for the definitive treatment to follow. For example, by identifying key teeth and planning for a removable partial denture, the dentist might opt to perform endodontic therapy when a carious exposure occurs, instead of simply temporizing the tooth. It may be necessary to prepare mounted study casts and perform some preliminary surveying or diagnostic wax-ups to arrive at a tentative plan. The dentist may also need to consult with specialists, such as orthodontists or prosthodontists, on treatment options.

Having a tentative treatment plan in mind enables the dentist to discuss a possible end point with the patient, while still retaining the flexibility to change directions if necessary. As with the disease-control-only plan alternative, however, it is imperative to have a posttreatment assessment examination before actually beginning further definitive care.

Maintenance Care Phase Unfortunately, many dentists fail to specify a maintenance phase of care to follow after completion of other treatment. Without a plan to periodically reevaluate the patient and provide supportive care, the patient's oral condition may relapse and disease may recur. The maintenance phase is more than a "check-up every 6 months"; rather, it constitutes a highly personalized plan that strives to maintain the patient in optimum oral health. Maintenance phase procedures may include periodic examinations, periodontal maintenance treatment, application of fluoride, and oral hygiene instruction.

PRESENTING TREATMENT PLANS AND REACHING CONSENSUS WITH THE PATIENT

During the examination process, the dentist has had a chance to listen to the patient's concerns, evaluate his or her oral and systemic condition, assess the risk for progressive or future disease, and begin mentally envisioning ways to achieve sustainable oral health and function. As discussed earlier, effective treatment plans attempt to address all patient problems and still accommodate the treatment goals of both dentist and patient. Once the dentist has begun to build a relationship of trust and rapport with the patient, he or she must now use communication skills to reach consensus on the final treatment plan. If handled properly, the practitioner will be viewed in a respected, professional manner. If handled poorly, the patient may perceive the dentist as uncertain, lacking confidence, self-serving, arrogant, or even incompetent. The dentist must be prepared to discuss all aspects of the case and remain open to any questions or concerns the patient may have.

The presentation begins by educating the patient about his or her problems and diagnoses. Careful attention should be paid to the chief complaint and other symptoms so that the patient understands *why* treatment is necessary. The clinician should also emphasize the importance of eliminating disease and achieving and maintaining oral health. It is important to use terminology that the patient can understand and to present information in a simple and organized manner. For example, the patient may better understand the intricacies of a three-wall infrabony pocket if described as "a loss of bone around the teeth." Rather than pointing out each carious lesion in the mouth, the condition might be summarized as "decay on six teeth." Extraoral and intraoral photographs, mounted casts, radiographs, diagnostic wax-ups, drawings, and informational pamphlets may be used to educate patients and help them visualize their own

problems. Throughout this discussion, the dentist should encourage questions and periodically verify that the patient understands what is being said.

Next the dentist can begin discussing treatment options. Before presenting this information, the dentist will have evaluated all possible treatment alternatives available to meet the patient's needs. Thinking in general terms facilitates this approach (i.e., large fillings versus crowns, fixed versus removable prosthetics, replacing or not replacing teeth). Once the patient has decided on a general direction for care, the advantages and disadvantages of the individual options should be discussed. The dentist should clearly describe the short- and long-term prognosis for each type of treatment, for the plan as a whole, and what can be expected if no treatment is provided at all. The importance of the patient's cooperation in plaque control, smoking cessation, reducing parafunctional habits, and returning for maintenance therapy should be emphasized, including the impact of that cooperation (or lack of it) on the overall prognosis for treatment. Again, the patient should be prompted for questions.

About this time many patients are beginning to think about the cost for services, the number of appointments, and the length of time involved for treatment. The *What's the Evidence?* and *In Clinical Practice* (p. 62) boxes offer additional information about presenting treatment plans. The dentist should be prepared to discuss some general time and fee ranges, letting the patient know that a more precise estimate will be available before beginning treatment. Many practitioners have chosen to delegate much of this discussion to a business manager or other office staff. If so, the dentist should be available to answer questions if the plan changes.

What's the Evidence?

Improving Patient Acceptance of Treatment Plans

Confronting the patient's health beliefs is a useful technique for gaining acceptance of your treatment plan. Developed to investigate the widespread failure of patients to accept preventive treatment for diseases, the **health belief model** argues that patients must hold four beliefs before they will accept treatment for a particular disease. According to the model, patients must believe:

1. That they are susceptible to the specific disease to be treated.
2. That contracting the disease has serious consequences for them.
3. That the disease can be prevented or limited if the patient engages in certain activities or receives treatment.
4. That engaging in these preventive or disease-limiting activities is preferable to suffering from the disease.

Medical and dental researchers have used the health belief model to better understand why patients accept or reject treatment. Although its ability to predict health behaviors has not been proven, the model does provide a useful framework for explaining why people do or do not engage in health-related activities. Practitioners can improve case acceptance by addressing each aspect of the model during the treatment plan presentation.

- *Perceived susceptibility.* This comes from a thorough discussion of the list of the patient's problems. The patient must understand and believe in the dentist's diagnoses before treatment will be accepted. This is usually not an obstacle if the patient believes the dentist is competent and if a complete and thorough examination has been performed. The practitioner may wish to use educational aids, models, photos, and radiographs to help instruct the patient about his or her problems.
- *Perceived severity.* The patient must recognize that there is some level of severity to his or her oral condition before treatment will be considered. This is especially important if the patient does not have symptoms and has been unaware of a particular dental problem. For instance, the dentist may interpret a large, asymptomatic, periapical radiolucency as very serious, but the patient may not share that perception until the dentist characterizes its significance. Again, patient education is the key, especially discussion of what may happen if the patient chooses *not* to have the problem treated.
- *Perceived benefits.* A patient must believe that the treatment plan will help solve his or her problems. This usually is achieved by spending time discussing the prognosis with the patient. Photographs of completed cases can be a helpful adjunct to this discussion.
- *Perceived barriers.* Surprisingly, it may be necessary to convince the patient that accepting the treatment plan is better than living with his or her dental problems. Patients often have—or perceive that they have—barriers to receiving treatment. The most common barriers are pain, cost, and time. The dentist should make it a point to always address these three issues when presenting a treatment plan.

In addition to the patient's health beliefs and lack of oral health education, patients may not follow professional recommendations because of poor dentist-patient communication. Communication is an interaction that involves the patient and the dentist. Good patient-provider communication in dentistry includes: creating a pleasant interpersonal relationship, exchanging information, and making cooperative treatment-related decisions. A pleasant interpersonal relationship is created when the dentist

What's the Evidence?

Improving Patient Acceptance of Treatment Plans—cont'd

empathetically explains procedures with a calm demeanor and encourages the patient to ask questions. Most patients prefer to receive information in an interaction in which they do not feel that the dentist is attempting to dominate them and in which they can comfortably provide information about themselves. When the patient is calm, trustful, and free of anxiety he or she is more likely to comply with the dentist's recommendations.

Exchanging information allows the dentist to make the diagnosis and create the treatment plan with an understanding of the patient's preferences and expectations. During this time, the dentist not only educates the patient about what good oral health practices involve, but also motivates the patient to incorporate good oral health practices into his or her daily life. When treatment-related decision making is shared with the patient, the patient is more likely to perceive that he or she has a vested interest in the process and will comply with the proposed treatment. Although the dentist is the professional in the relationship and may perform services of the highest quality, if the patient has a negative perception of the relationship, the treatment outcome may be compromised. Because patient-provider communication requires mutual participation, the interpersonal skills of the dentist are as important as the personality and motivation of the patient.

SUGGESTED READINGS

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In Clinical Practice

Tips for Presenting Treatment Plans to Patients

- Sit facing the patient at eye level while presenting the plan.
- Have the patient sitting upright; never present a treatment plan with the patient in a reclining position.
- Use language that the patient can understand.
- Avoid using threatening or anxiety-producing terms.
- Talk to the patient, don't preach. Be aware of your body language.
- Do not overwhelm the patient with the minute details.
- Ask the patient to repeat information back to you to confirm understanding of the treatment plan.
- Use casts, wax-ups, photographs, and radiographs to emphasize key points.

GUIDELINES FOR SEQUENCING DENTAL TREATMENT

Once a patient's problems have been identified and a general course of therapy proposed, the dentist's next major responsibility is sequencing the individual treatment procedures. This process can be particularly challenging when the patient has many interrelated problems and treatment needs. Modifiers, such as patient finances, insurance coverage, time availability, and the need to resolve the chief complaint, can also influence the sequence of treatment.

Although the order in which treatment should proceed may vary, some general guidelines can be followed initially to sequence procedures (Box 3-1). In general, these guidelines parallel the recommendations for phasing treatment. The practitioner begins by assigning procedures to each phase, and then sequences the procedures within each phase according to the level of problem severity. The resulting list of procedures addresses the patient's most severe problems first and concludes with those of less consequence.

Because it may be difficult to create a linear, step-by-step prescription for addressing all of the patient's problems, the dentist must remain flexible throughout this process. In some situations, it may be helpful to group treatments together, or to create a cluster within a phase and not specify a specific order. For instance, a patient may need a number of teeth restored to control caries. By clustering the planned restorations into groups such as "treat early" and "treat later," sequencing is achieved, but the practitioner retains some flexibility to decide later which restoration to do first, second, etc. As discussed earlier, although the dentist can follow

BOX 3-1 Guidelines for Sequencing Dental Treatment

I. Systemic Treatment
  A. Consultation with patient's physician
  B. Premedication
  C. Stress/fear management
  D. Any necessary treatment considerations for systemic disease
II. Acute Treatment
  A. Emergency treatment for pain or infection
  B. Treatment of the urgent chief complaint when possible
III. Disease Control
  A. Caries removal to determine restorability of questionable teeth
  B. Extraction of hopeless or problematic teeth
    1. Possible provisional replacement of teeth
  C. Periodontal disease control
    1. Oral hygiene instruction
    2. Initial therapy
      a. Scaling and root planing, prophylaxis
      b. Controlling other contributing factors
        (1) Replace defective restorations, remove caries
        (2) Reduce or eliminate parafunctional habits, smoking
  D. Caries control
    1. Caries risk assessment
    2. Provisional (temporary) restorations
    3. Definitive restorations (i.e., amalgam, composite, glass ionomers)
  E. Replace defective restorations
  F. Endodontic therapy for pathologic pulpal or periapical conditions
  G. Stabilization of teeth with provisional or foundation restorations
  H. Posttreatment assessment
IV. Definitive Treatment
  A. Advanced periodontal therapy
  B. Stabilize occlusion (vertical dimension of occlusion, anterior guidance, and plane of occlusion)
  C. Orthodontic, orthognathic surgical treatment
  D. Occlusal adjustment
  E. Definitive restoration of individual teeth
    1. For endodontically treated teeth
    2. For key teeth
    3. Other teeth
  F. Esthetic dentistry (i.e., esthetic restorations, bleaching)
  G. Elective extraction of asymptomatic teeth
  H. Prosthodontic replacement of missing teeth
    1. Fixed partial dentures, implants
    2. Removable partial dentures
    3. Complete dentures
  I. Posttreatment Assessment
V. Maintenance Therapy
  A. Periodic visits

certain guidelines when sequencing treatment, exceptions can and will arise. Many of the challenges in sequencing are associated with the issues described in the following sections.

Resolution of the Chief Complaint

New patients usually have specific concerns or complaints. To help build rapport, the dentist should sequence the treatment for these complaints early in the treatment plan when feasible. Obviously, it makes sense to provide treatment immediately when the patient has pain or swelling, but occasionally the solution to the patient's problems is complicated, and from the dentist's point of view, should be addressed later in the plan. For example, a patient may request that missing teeth be replaced so that he or she can function better. However, it would be inappropriate to fabricate a fixed partial denture if the patient has active periodontal disease or more immediate restorative needs. When this situation occurs, the dentist must carefully explain the significance of the disease control phase and its relationship to the success of future treatment. One solution may be to provide a provisional removable partial denture. Another example is the patient with rampant caries who, for esthetic reasons, wants the anterior teeth restored first before treating the often more severely decayed posterior teeth. Again the dentist will need to discuss the situation with the patient and reach some consensus. Perhaps treating the most severe posterior tooth and one or two anterior teeth at the next appointment will be an acceptable compromise. Occasionally, as discussed in the *In Clinical Practice* box on p. 64, a dentist will refer a patient to a specialist to resolve certain problems.

In Clinical Practice

Referring Patients to Dental Specialists

General dentists refer patients to specialists for several reasons. Most commonly, the practitioner wants the specialist's assistance in diagnosing or treating a patient's problem. Many general dentists choose not to provide certain types of treatment procedures or do not possess the skills necessary to perform them. Treatment complexity may also be a concern. Occasionally the generalist's treatment of the patient's problem is not progressing well or has resulted in an unfavorable outcome. Examples of the second situation might include the inability to extract an impacted third molar or complaints of pain by a patient 6 months after completion of root canal therapy.

The patient's well-being should be first and foremost when deciding whether to refer for treatment. Most patients look favorably on the dentist who seeks assistance for their problems. The referral process flows more smoothly if the dentist observes the following guidelines:

- Inform the patient of the reason for the referral, including any pertinent diagnoses or problems from prior treatment rendered. Make sure the patient understands the consequences of *not* seeking specialty treatment.
- Familiarize the patient with the specialist's area of expertise and in general what types of treatment will be provided.
- Assist the patient in making contact with appropriate specialists by providing names and telephone numbers. Some practices choose to make the first appointment for the patient.
- Provide the specialist with copies of any radiographs, casts, or other diagnostic aids before the patient's first appointment.
- Communicate the particulars of the case to the specialist, especially the reason for referral, a summary of the overall treatment plan, and any special concerns regarding patient management. Many specialists provide dentists with referral pads for conveying this information, but often a short letter is better. In the event of an emergency referral, the dentist should speak first with the specialist on the telephone before arranging the patient's visit.
- Maintain a referral log to assist with follow-up of referred patients. Specialists often send an acknowledgment after their examination or completion of treatment. If the general dentist recommends and makes a referral, but the patient does not follow up by contacting the recommended clinician, this should be documented in the patient record.

The general dentist is responsible for coordinating overall patient care between specialists and the general dental practice. On occasion, the dentist may need to consult with the patient when specialty opinions or changes to the treatment plan conflict. The general dentist must also confirm with the specialist any need for future treatment or reevaluation. A classic example is the orchestration of periodontal maintenance treatment between the periodontist and the general dentist. Other examples include periodic evaluation of implant therapy and treatment for pathologic oral conditions.

Periodontal Therapy

In a dental school environment, initial periodontal therapy often is sequenced first in a treatment plan. Although this may be appropriate for the individual with few additional treatment needs, it may not be appropriate for others, especially those who are having some discomfort. To ensure appropriate care, periodontal therapy should occur as early as possible in the plan, but it can be delayed for several reasons. One frequently encountered justification is the decision to first resolve a simple complaint, such as replacing a lost restoration or extracting symptomatic impacted third molars. Another example is the patient with large carious lesions, especially those located subgingivally. Restoring such teeth with a permanent or provisional filling should make periodontal treatment more comfortable for the patient, and begin to resolve the gingivitis that accompanies subgingival lesions. Lastly, teeth that are nonrestorable or are periodontally hopeless are often extracted before beginning scaling and root planing procedures.

Occasionally, it may be appropriate to begin periodontal treatment *before* completing the patient's dental examination. This typically occurs when the patient has not seen a dentist for many years, and the dentition is covered with plaque and calculus. The dentist may decide to begin gross scaling of the teeth to permit visualization and exploration of tooth surfaces during the examination.

Caries Control

For the patient with many carious lesions, treatment consists of restoring lost or decayed tooth structure and preventing caries from occurring in the future. Preventive strategies, such as reducing refined carbohydrates, improving the patient's plaque removal technique, and the application of fluorides, should commence immediately and be regularly reinforced, ideally at every appointment.

The following guidelines should be followed when triaging treatment for caries:

- Address any symptomatic teeth first. Extract those that should not be retained for obvious periodontal

or restorative reasons. For other symptomatic teeth, remove all caries, begin endodontic therapy if necessary, and place a permanent or provisional restoration.
- Treat any asymptomatic carious lesions that may be nearing the pulp as determined clinically or interpreted on radiographs. The goal is to prevent symptoms for the patient and avoid irreversible injury to the pulp.
- Remove caries to determine restorability. For teeth with caries at or below the alveolar crest radiographically, remove the caries and decide whether the tooth can be restored (Figure 3-4). Endodontic therapy should not be provided until the tooth is deemed restorable and periodontally sound.
- Finally, remove caries from asymptomatic teeth and when possible restore with a definitive restoration, such as composite resin or amalgam. For efficiency, sequence first by severity and then by quadrant.

Endodontic Therapy

Endodontic therapy consists of a series of treatments, including removing pulpal tissue, filing and shaping root canals, obturation of the root canal space, and placement of a permanent restoration for the tooth. For some patients, it may be appropriate to do each step in succession, especially when no other problems have been identified. For patients with many deep carious lesions or pulpal pain, simply removing the caries and pulpal tissue followed by rudimentary filing and shaping and placement of a provisional, **sedative restoration** is preferred. After establishing some level of disease control, endodontic therapy can then be completed. To prevent fracture, permanent restorations for endodontically treated teeth should be sequenced before those for vital teeth if at all possible.

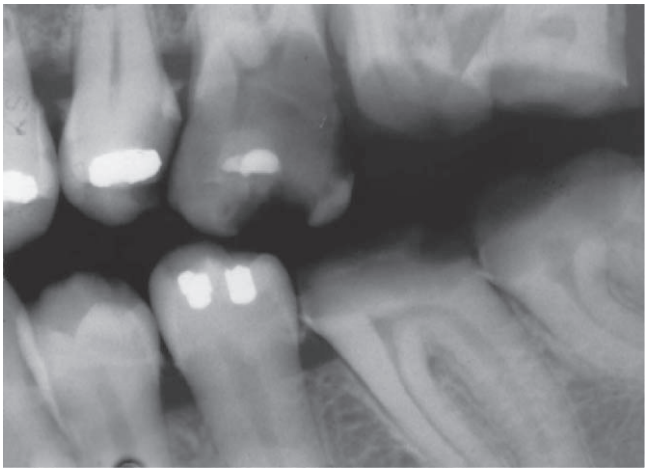

Figure 3-4 Bite-wing radiographs are especially useful for evaluating the extent of caries in relation to the alveolar crest. In this patient, the maxillary and mandibular molars are probably not restorable.

Extraction

When possible, tooth extractions should be sequenced early in the treatment plan to permit healing to take place, especially before tooth replacements are fabricated. The dentist should attempt to limit the number of surgical appointments and extract all hopeless or nonrestorable teeth at the same time. It may be necessary to delay the extraction of asymptomatic teeth so that provisional replacements can be fabricated to preserve appearance, to maintain the position of opposing and adjacent teeth for short periods of time. The classic example of this concept involves planning to place immediate dentures. The process begins by removing the posterior teeth, leaving the anterior teeth for esthetic reasons. Impressions for the dentures are taken 6 to 8 weeks later, after some healing of the posterior segments has occurred. Dentures can be fabricated using altered casts and delivered when the anterior teeth are extracted.

Sequencing removal of third molars in a treatment plan may vary. When symptomatic, they should be removed immediately. Asymptomatic or impacted teeth may be removed at the end of the disease control phase or during the definitive treatment. If the treatment plan includes extracting and fabricating a complex restoration, such as a crown, for the second molar anterior to it, the third molar should be removed first because of the potential to damage adjacent teeth during the oral surgery.

Occlusion

Achieving a stable occlusal relationship represents an important goal when developing a comprehensive treatment plan. During the examination, the dentist will have identified any occlusal problems, such as malocclusion, tooth mobility, loss of vertical dimension, malposed teeth, or signs of parafunctional habits, such as bruxism. Study casts mounted in centric relation are essential for evaluating and planning occlusal relationships, especially if multiple crown and bridge restorations are planned.

The practitioner should have a clear vision for what the final occlusion will be like before beginning definitive care, especially when the plan involves prosthodontic treatment. Treatment for occlusal problems would normally begin after the disease control phase and may involve orthodontic treatment, comprehensive occlusal adjustment, or altering the vertical dimension. In some instances occlusal therapy, such as a limited occlusal adjustment, may be part of the initial therapy. When

restoring or replacing teeth with crowns or fixed or removable prosthodontic appliances, procedures should be sequenced to develop the anterior occlusion first, followed by the posterior occlusion.

Removable Partial Dentures

Patients who eventually will need to have teeth replaced with removable partial dentures typically have several dental problems. Controlling caries and periodontal disease should begin immediately. It may also be necessary to fabricate provisional partial dentures to satisfy the esthetic and functional needs of the patient during this interval. The practitioner should also begin identifying key teeth during the disease control phase, particularly those that will serve as abutments for the removable partial denture. It may be necessary to do a preliminary removable partial denture design on study casts with the help of a dental surveyor. At the same time, the dentist should be evaluating the need for preprosthetic surgery, especially torus removal and maxillary tuberosity reduction.

Key teeth should receive special attention during the posttreatment assessment, especially their response to disease control procedures and their suitability as abutments. The partial denture design should be finalized before beginning definitive care. This is particularly important so that the dentist can incorporate occlusal rests, guide planes, and retentive areas into the restoration design. Preprosthetic surgery, endodontic therapy, post and cores, survey crowns, and fixed partial dentures will precede fabrication of the removable partial denture.

Third Parties

The most fundamental dental relationship involves just two parties, the dentist and the patient. Ideally, in such a relationship, outside interference with treatment planning decisions is minimal because all aspects of the plan will be decided upon between the dentist and the patient. Frequently, however, **third parties** participate in treatment planning decisions and affect how we practice dentistry. Although dental insurance companies are generally thought of as the major third-party influence on dental care, it is important to remember that other individuals, such as a patient's parent or guardian, may modify the dentist-patient relationship and function as a third party (Figure 3-5).

Public Assistance Plans This type of insurance plan is often restrictive and is commonly associated with such programs as Medicaid in the United States. Here, the third party limits both the *type* of treatment covered and the *level of payment* for particular dental procedures. If the dentist's fee is higher than what the program pays, the dentist cannot charge the patient the difference. Medicaid programs are controlled at the state level, with coverage varying from state to state. Although the programs provide many individuals with some access to dental care, they often do not pay for the ideal or most appropriate type of treatment. For example, if the patient has an ill-fitting maxillary partial denture, the program may only pay for extractions in preparation for a complete denture regardless of the condition of the abutment teeth.

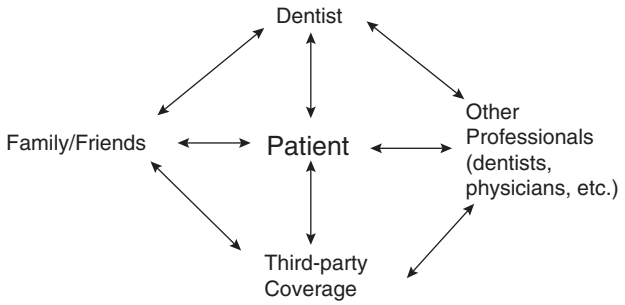

Figure 3-5 A number of relationships may need to be considered when treating a patient.

When the program dictates an extremely limited treatment plan that constitutes irrational or poor dental care, the dentist is faced with an ethical dilemma. To render the optimal treatment at no charge is usually not economically feasible; yet to perform the "approved" treatment may constitute substandard care. The dentist and patient must decide on a course of treatment that represents the best available option under the circumstances. In some cases, the dentist may decide not to accept the patient for treatment under the third-party restrictions. More often, however, at least minimal disease control can be carried out within the limitations of the program. Patients may later choose to pay for further treatment on their own. Providing informed consent regarding what public assistance will and will not cover is critical before beginning treatment.

Private Fee-for-Service Dental Insurance Policies

With private fee-for-service insurance, the third party is more generous with treatment covered and the levels of payment, as compared with public assistance programs. The insurance companies control reimbursement for services by:

1. Limiting the types of treatment covered
2. Paying only a fixed amount or a percentage of the dentist's fee for each service, with patients often expected to pay the difference
3. Setting yearly or lifetime maximum benefit limits

For the patient with limited treatment needs, this type of third party may cover all of the proposed treatment at a high level of payment. When a patient has extensive oral health needs, he or she may ask the dentist to provide treatment in stages to coincide with annual benefit limitations. Sometimes treatment can be begun at the end of one policy year and concluded into the next, thus taking advantage of two benefit years. The dentist will often want, and may be required, to ask for authorization from the third party before beginning treatment to determine the patient's benefit levels, particularly for prosthodontic treatments.

Occasionally an extensive treatment plan may be extended for 3, 4, or even 5 years to take maximum advantage of the insurance benefits. Such long-term treatment planning is challenging and assumes a stable dentist–patient–third-party relationship. For such a plan to work, the current insurance coverage must remain in effect during the entire treatment period, the patient must remain employed to be eligible for benefits, and the patient must not move or change dentists during the course of treatment. If any of these conditions are likely to change, this type of extended treatment planning is contraindicated.

The dentist must also consider whether the treatment can be safely spread out over several years without jeopardizing the final result. Typically, with an extended treatment plan, the dentist performs disease control therapy first, placing interim restorations and building up teeth while postponing more costly rehabilitation of the dentition. In some cases, for example when restoring several endodontically treated teeth that should have full crowns placed for protection, this may be impossible. Although patching large, defective amalgams or composites instead of providing full coverage restorations, such as crowns or onlays, may save the patient money, such a strategy may only postpone the inevitable. When teeth need to be replaced, transitional removable appliances may be attempted to preserve appearance in lieu of definitive removable or fixed partial dentures. Unfortunately, many patients cannot or will not tolerate these interim prostheses for very long.

OBTAINING INFORMED CONSENT AND DOCUMENTING THE TREATMENT PLAN

Informed Consent

The treatment plan presentation appointment is the appropriate time to discuss the risks of the planned procedures, a discussion that can serve as the basis for obtaining informed consent from the patient to begin treatment. This type of discussion not only helps reduce the threat of malpractice claims, but also serves to better educate patients and prepare them for treatment. The topic of informed consent is discussed in greater detail in Chapter 4, but a brief review is presented here.

In general, for the patient to make an informed decision regarding treatment, the dentist must describe and discuss any diagnoses and problems, treatment alternatives, and the advantages and disadvantages of each alternative. The consenting individual must be mentally competent and of majority age (usually 18 years of age or older). The consent must not have been obtained by fraudulent means or under a situation of duress.

Specifically, the dentist must disclose:

1. The nature of the condition being treated (i.e., the diagnosis and problem list)
2. The proposed treatment
3. Any risks involved in undergoing the proposed treatment
4. Any potential complications or side effects
5. Any consequences or risks of *not* undergoing the proposed treatment
6. Any alternative procedures that might be employed
7. The prognosis for the treatment

When obtaining informed consent, the dentist should use lay terms as much as possible. In addition, the patient must have the opportunity to ask, and have answered to his or her satisfaction, any questions regarding the intended treatment. It may be helpful to draw sketches or use casts and radiographs to assist in the explanation and to add these to the patient record. Patients will also want to gain some idea about the cost for treatment.

Treatment Plan Documentation

In addition to examination findings and problem lists, the dentist must also document the proposed treatment plan and any alternatives presented to the patient. Besides the obvious risk management benefits, a clear treatment plan is a useful practice management tool. With a clearly written plan, the dentist, staff, and patient are all aware of what procedures will be performed, the sequence of care, and the fees to be charged.

Depending on the nature of the case, treatment plans can be simple or extremely complex documents. For patients requiring only one or two procedures, a short entry in the record, often in the progress notes, can provide sufficient information. When more documentation is necessary, various forms are commercially available for the dentist to use in listing procedures and fees. Many office computer systems include software functions for entering treatment plans that integrate into the appoint-

ing and billing systems. Some clinicians have used word processing and spreadsheet software on personal computers to create their own professional-appearing documents. Regardless of how the plan is documented, the following issues should be addressed:

- Good treatment plans have procedures sequenced in the order they will be provided.
- Although the listing of fees is optional from a legal standpoint, they are often included to provide the patient with a fee estimate.
- It is a good idea to write treatment objectives on the plan, especially for disease control and limited treatment patients.
- Consider adding diagnoses and problem lists to the treatment plan and use the document for informed consent.
- A disease-control-only treatment plan should clearly state the need for reevaluation and further definitive care.

CONCLUSION

The well-constructed treatment plan provides a foundation for the long-term relationship between dentist and patient. A functional treatment plan is dynamic, not static, evolving in response to changes in the patient's oral or general health. A sound and flexible treatment plan facilitates communication and strengthens the doctor-patient relationship. Its contribution to good patient care and effective practice building makes it well worth the time and thought required to develop it.

REVIEW QUESTIONS

How are treatment objectives developed with and for a patient?

What role does "visioning" play in establishing the nature and scope of the treatment plan?

What are the five treatment plan phases? What is the purpose of each?

Identify "do's" and "don'ts" when presenting treatment plan options to a patient.

What is the importance of sequencing in dental treatment planning? Create a list of sequencing guidelines.

What constitutes informed consent, and how is it achieved?

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