Editorial

It's all in the sequence: Assessment II

Diagnosis

The minimal diagnostic expectation of an attending dentist, both from legal and professional views, is the recognition of diseases and abnormalities of the oral cavity and surrounding tissues. Clinically, this simply means the ability to detect changes from "normal."

To detect these changes, one should recognize: *(1)* the oral signs and symptoms—and understand the disease process—of developmental, inflammatory, immunologic, metabolic, and neoplastic diseases; *(2)* the oral signs and symptoms of systemic diseases and understand the impact of those diseases and their treatment on the delivery of dental care; and *(3)* anatomic or other deviations or abnormalities that compromise oral form, function, health, or esthetics. One should also identify: *(4)* the location(s), extent, etiology, and activity state of *(a)* dental caries, *(b)* periodontal diseases, *(c)* pulpal diseases, and *(d)* occlusal disease or disharmony; *(5)* temporomandibular dysfunction and etiology; *(6)* patient behavior patterns that contribute to oral disharmony; and *(7)* factors that complicate the case to an extent that referral might be warranted.

This list could be continued and refined indefinitely, but it covers the major considerations of oral diagnosis. It isn't even important that a practitioner follow it, but it *is* important that a practitioner have some systematic process for gathering and evaluating data on all contributing factors to oral disharmonies.

As we noted last month: *(1)* factors that contribute to oral disease and disharmony must be recognized before they can be treated; *(2)* it is not necessary to name a lesion, abnormality, or disease once it has been detected; *(3)* the attending doctor need not have full knowledge of all diseases; and *(4)* referral of patients to health care colleagues should be a routine part of one's practice.

Attending dentists should be able to compile differential, provisional, and definitive diagnoses by interpreting the assessment results and the diagnostic findings discussed last month and above (the history, clinical, radiographic, and special diagnostic test results gathered from the patient). The interpretation of these data allows one to decide: *(1)* whether treatment is indicated, and *(2)* if indicated, what form of treatment is best suited to the condition(s); *(3)* likely effects, both local and systemic, of that treatment; *(4)* probable outcome of the proposed treatment; and *(5)* follow-up protocols.

Treatment planning. Having gathered adequate assessment information to formulate a provisional diagnosis, proper sequencing demands the creation of a treatment plan. It has long been my contention that the best treatment plan for any patient is the simplest intervention(s) that adequately meet the needs, wants, and abilities of the patient.

Practical treatment planning requires the development, presentation, and discussions necessary to assist patients in making rational treatment choices that are in their best self-interest. *These choices may not coincide with the doctor's personal choices,* but the right of patients to make their own decisions must be safeguarded.

The generic components of an adequate treatment plan for patients of any age, then, are consistent with the patient's condition, interest, goals, and capabilities.

Those components include the provision for: *(1)* preventive services based on an oral disease *risk analysis* for that particular patient; *(2)* a comprehensive, properly sequenced treatment plan that will ultimately restore form, function, health, and esthetics to the patient; *(3)* communications with other health care colleagues who may contribute additional information or treatment to the case; *(4)* discussion of findings, diagnosis, and treatment options with the patient; *(5)* mutual agreement, based on informed consent, of the preferred treatment option; *(6)* mutual agreement about fees, payment(s), patient responsibilities, time requirements, treatment sequence, alternative treatments, and maintenance issues; *(7)* modification of the primary treatment plan based on changes in patient wants, needs, or circumstances; *(8)* management of doctor-patient conflicts when they arise; and *(9)* follow-up recall, both for maintenance of the therapeutic interventions and for the preventive maintenance that is the hallmark of an attractive, healthy, functional mouth.

Our next topic will be an overview of managing oral disease or dysfunction.

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