# Stop! Look and Listen

To many of us who are involved with university or hospital centers that treat the TMD patient, the frequently recurring potential for iatrogenesis is sobering. Two recent examples that illustrate the issue are recounted here.

One involved a young woman who had originally presented to her dentist with joint sounds and a single incident of locking. She stated that her physician had referred her to a dentist to have her "TMJ checked." At that time, she had had no previous jaw movement problems nor jaw/head pain, and she emphasized this to the practitioner.

The dentist, on the basis of a panoramic radiograph, advised her that she had a "displaced disc with condylar degeneration." He recommended an orthotic device, orthodontic therapy for "misaligned jaw relation," and potential surgery. The patient was referred to our clinic because insurance would not cover the thousands of dollars required for treatment.

We questioned her, in light of her acceptable jaw function and absence of pain, as to her chief concern. She replied she was concerned with future "disability and facial deformity" if the problem was not addressed. These were the terms given her by the dentist who made his diagnosis from the panoramic radiograph and a short consultation/conversation with her. We had requested all records for our opinion and learned that there was only a cursory clinical examination, without written observations or even a record of range of motion, muscle palpation, or a general health assessment. There was merely the panoramic radiograph, which we found to be esssentially normal without evidence of asymmetry or condylar remodeling.

We advised that she not pursue the treatment regimen that was recommended. Furthermore, we explained in detail her symptoms and cited the possible sequelae she could expect if pain and functional symptoms were to occur. We also instructed the patient on certain home care procedures she could utilize regardless of the presence of symptoms. All in all, we gave her approximately 30 minutes of our time after completing our examination and history resume. The patient thanked us for our time and explanation and stated in leaving that she appreciated the fact we would listen to her concerns. The original dentist had not given her the opportunity to express those concerns and had made his diagnosis in 5 minutes after seeing her panoramic radiograph without so much as a brief intraoral or extraoral examination. I personally believe an iatrogenic situation would have occurred if the patient had had insurance coverage and not had to seek a second opinion.

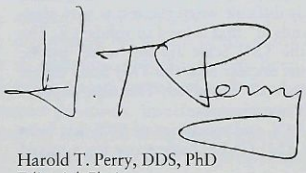
In the second situation, the practitioner had initiated extensive diagnostic tests in conjunction with tomograms, MRIs, facebow-mounted study casts, objective intraoral and extraoral examinations, and even a personality assessment. A diagnosis was rendered and the patient or insurance company sought a second opinion.

The mere presence of infrequent functional joint sounds had prompted the diagnosing practitioner to recommend an extensive regimen of therapy that would cost the patient (or insurance company) several thousands of dollars. The input from the patient relative to his thoughts or questions on the matter seemed not to have entered into the professional recommendations. Our belief was that a more comprehensive understanding by the patient, as in the aforementioned case, was primary to management. After providing the patient with a rather detailed explanation of the symptoms and possible self-care that might be required, the patient was satisfied. Now, nearly a year later, the patient is functioning well and accepting the infrequent functional sequelae; sans the major therapy recommendations. Many times, when re-evaluating the records and the patient, we learn that the practitioner sought little input from the patient or did not listen when the patient expressed concerns or asked questions.

Tennyson once wrote that "Knowledge comes but wisdom lingers." Our knowledge comes from the thoughts and writings of others. Our wisdom, however, is nurtured and expanded by application and interpretation of daily experiences blended with our basic knowledge.

Too frequently, in our modern high-tech professions we have too many "toys" with which to "play," while we neglect two of our finest sets of personal diagnostic instruments — our eyes and ears. We must listen to our patients, exhibit empathy, and observe their movements and expressions as we take their history. It is tempting, with our knowledge, to preempt a patient's presentation with a dogmatic snap diagnosis. Such a superior attitude is folly and often results in an erroneous diagnosis because all the possible information was not gathered and evaluated.

Many of us, after years of graduate education, years of clinical experience, and the ego salving of realizing more successes than failures, too often incorrectly believe that we are infallible and that our knowledge and wisdom are sufficient to render a correct diagnosis with a casual review of a radiograph, MRI, or set of study casts. Sometimes we get lucky, but many other times we may iatrogenically affect a patient, causing long suffering and pain. I have a very good friend in southern Illinois who is a topnotch practitioner and, in addition, has a very solid understanding of people and events. One of his more succinct statements rings true on this issue: "It's what you learn after you know it all that really counts."



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