# consumer-provider conflict in health service recommendations

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VIRTUALLY from its inception, the Office of Economic Opportunity (OEO) has endeavored to implement the idea of participation of consumers in its service programs. Through OEO Neighborhood Health Centers, services were made more accessible to community residents and furnished in a manner most responsive to their needs and with their participation. The varying degrees of success in achieving these goals in different health centers have been documented, and so have some of the difficulties which have attended the social experimentations.

As a contributor to health services, dentistry has been fully integrated in the care afforded patrons of the centers, and there is tangible evidence to support the contention that dental serv-

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ices, dental health instruction, and preventive education have been appreciated by the consumers (*1*).

Recently there have been reports from a few dentists on the staffs of OEO Neighborhood Health Centers to the effect that patients from disadvantaged communities have come to the dental clinics requesting "gold caps" on their anterior teeth. Such reports have revived long-dormant discussions about the assets and liabilities of these particular replacements. Furthermore, clinicians are being asked whether they can reconcile their professionally based refusals to construct such appliances with consumer insistence on health services being furnished in a manner most responsive to their needs, especially when such "responsiveness" is equated with patients' desires to procure what they consider esthetic, vital to feelings of self-esteem, and important for their own mental health.

A brief review of dento-auric replacements might serve to put "psychological justification" and "contraindicated type of replacement" in the proper perspective.

## Historical Review

Dental history reveals that gold has been used in the mouths of human beings as far back as 4,500 years. Egyptian artisans were very skillful in designing and fashioning gold to stabilize teeth as well as to adorn them. Although the main use of gold in the mouth was probably functional in character, there was a closely related esthetic appeal which often became indistinguishable from the practical considerations of operator accessibility, cost of construction, and social status of consumer.

The Etruscans, Greeks, Romans, and other peoples adopted the practices, updated the techniques, and expanded the functions of oral metallic appliances. The first known gold shell crown is reputed to be of Roman origin. Anthropological records place its initial appearance as a unit of bridgework in the first century B.C. Regarded as the prototype of gold shell crowns, the restoration completely covered the clinical crown of the anchor tooth and was attached to gold ribbon loops holding several artificial teeth. Shell crowns thus afforded an easy way to fasten artificial teeth securely, and in addition, they could be used to camouflage unsightly teeth affected by dental caries and dystrophy.

It is interesting to note that the practice of dental adornments with gold has been popular at some time in the history of practically every civilized nation, as well as among relatively primitive peoples. The loss of international popularity of anterior gold shell crowns is a comparatively recent occurrence.

Modern dentistry is said to have had its beginnings in France, where for a brief period in the early 18th century there was a revival in use of gold shell crowns with some modifications.

In the United States the gold shell crown was reintroduced in the middle 1880s. (*2*). The purpose was to hold false teeth to the remaining natural ones, thereby lessening the need for use of large amounts of vulcanized rubber in the palatal region.

The popularity of dento-auric replacements reached a peak in the late 1890s and early 1900s. It was considered fashionable to display one or several gold teeth in talking, smiling, and laughing, and many of the people of that period seemed to place a higher priority upon oral "elegance" than they did upon dental therapeutics. Periodontal discomforts, if and when encountered, were resolutely endured and superseded by whatever constituted "odontauric modishness," which in turn ranged from the conservatively unembellished to the ostentatiously ornate. Among popular styles were the single gold shell crown; a series of anterior crowns; the open-faced crown with several designs which included circle, star, triangle, square, heart, club, diamond, spade, and cross; and crowns embossed and embedded with diamonds, pearls, rubies, and other precious stones (fig. 1).

There was a sharp decine in the popularity of gold shell crowns after 1910 when it became increasingly stylish to have normally appearing teeth. Naturally white, well-shaped, and perfect teeth became the mode, and dental clinicians directed their professional advice and technical efforts toward achieving this goal. The desire for naturally appearing teeth has continued uninterruptedly to the present day. Health educational materials and the communication media all tend to reinforce this concept.

## Attitudinal Changes

Prominent among factors which helped to sustain the generally unpopular practice of fabricating anterior gold shell crowns for unblemished

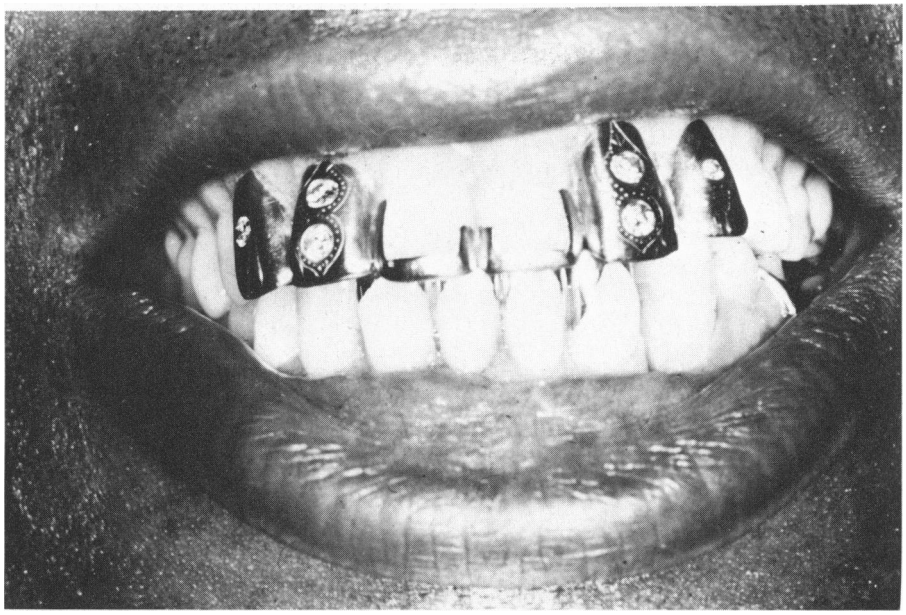

*Figure 1. Full gold shell crowns on central and lateral incisors with embedded diamonds and precious stones. Gold inlays comprise restorations on remaining maxillary and mandibular teeth.*

teeth were the ease and rapidity of construction and the lucrative value of these restorations. Additionally, there continued to be a limited public demand for these restorations from many people, who for reasons of their own still considered the crowns desirable. The persistence of the demand influenced some dentists to fabricate the crowns and justify their decisions by rationalizing that "if they didn't make them, other dentists would." Then there were a few dentists, confident of their own skills in fashioning "serviceable" open-faced shell crowns without any of the traditional technical disadvantages, who insisted that it would be preferable for them to furnish these restorations rather than for patients to be compelled to patronize laboratory technicians or mechanically inept professionals.

It is significant to note that dental educational institutions through the years have been content to denounce the construction of gold shell crowns on anterior teeth as inimical to the image of a health profession and a detriment to dentistry's ideals. This author vividly recalls that in the early stages of his teaching career, he maintained an uncompromising stand against the mutilation of sound teeth for the purpose of constructing anterior gold shell crowns, and advised his students that it was their duty to accomplish for their patients only professionally acceptable and approved procedures (*3*). Furthermore, it was emphasized that they should not accede to patient demands for such replacements under any circumstances. Schools did not advocate their usage, and would seldom, if ever, include in their curricula the technical instructions about how to construct these appliances.

Access to health care used to be considered a privilege for those who were able to pay for it, a situation that contributed to the generally authoritarian attitudes which medical and dental practitioners were encouraged to develop as integral parts of the health professional mien. Patients grew to expect these personality characteristics and submitted to "just whatsoever the doctor ordered." In dentistry, this acquiescence often extended to having gold shell crowns on anterior teeth if and when so prescribed.

Important changes in patients' attitudes have occurred, and no longer is there the customary blind submission to medico-dental authority.

There has been some shift of "power" to the consumer. In the belief that access to health care is the right of everyone, today's consumers feel that the relationship between them and health providers is one of interdependence, and so there must be mutual appreciation and cooperation. All health services are currently receiving the attention of community residents, who look upon these services as being just as important to them as to the health professionals. People have become very vocal and insistent upon their being intimately involved with formulating and finalizing decisions about everything which affects them. This applies with equal emphasis to both privileged and disadvantaged persons.

Even though the concept of white teeth is the current norm to which most people aspire, there are instances in which individuals desire anterior gold shell crowns on their own teeth as well as on the teeth of members of their families. There are people, by no means disadvantaged or underprivileged, who have obtained such crowns and wear them proudly. The open-faced gold shell crowns with stars on the anterior teeth of nationally known basketball players Gus Johnson and Dave Stallworth have been well publicized. In a recent issue of a national weekly magazine (*4*), a society news item called attention to the "diamond-studded" dental replacements of a Philadelphia married couple who decided to "brighten their smiles with diamonds in their teeth." The late Pablo Picasso is reputed to have had a gold shell crown on an anterior tooth. From time to time photographs and presentations in the news media have shown many persons, prominent in national and international public affairs, with gold shell crowns on their anterior teeth.

## Characteristics of the "Disadvantaged"

Reasons for the implied increase in the number of requests for gold crowns from disadvantaged persons who patronize OEO Health Centers are open to speculation. It has been suggested that the apparent popularity of the gold crown may be evidence of social defiance and a resistance to the concept of naturally appearing white teeth. This latter may even have been rationalized as an imposition of majority group standards worthy of repudiation. There have been no similar case reports from private practitioners who have been serving increased numbers of disadvantaged persons because of the financial assistance afforded the latter through public health and social programs.

It would seem appropriate to review some of the characteristics which have been attributed to the poor and disadvantaged, many of whom have frequently been labeled as being "different." The reactions of the poor to many situations and circumstances are generally different from the responses of those fortunate persons who have had economic and cultural advantages. Those who have worked with the underprivileged in ghetto areas can attest that people from lower socioeconomic communities tend to share similar attitudes, superstitions, and value judgments concerning their own health and the health of their neighbors. Very often their beliefs about sickness and how it should be handled set them apart from other elements of the population with more up-to-date, scientifically based, sophisticated attitudes toward health and disease.

The matter of dissimilarities between the poor and nonpoor was examined at two 1969 workshops sponsored by the American Dental Association's Council on Dental Health (*5*). The workshop faculty devoted the entire first day of the sessions to the identification of some of the seemingly minute but nevertheless actual differences, contrasting the attitudes and values of the underprivileged child with those of the dentists who would treat him. Specifically highlighted were hypersensitive attitudes and behavior, overreactions to imagined grievances, testing of persons whose motives are not clear, resentments and reactions to certain physical contacts, communication gaps, fears about dental treatment, and health concepts.

Among the factors which deter many members of low-income groups from seeking dental care are ignorance about dentistry, folk beliefs, superstitions, and presentiments of dental fatalism (*6*). There is a commonly held opinion that since teeth are going to be lost regardless of what one does, it is hopeless to save them when affected and just as futile to try to prevent oral diseases. Consequently, treatment is usually a last resort, and dental services are sought mainly for emergency dental care.

Common among folk beliefs is resistance to having teeth removed because "the sign was not right" and because "one's manhood would be affected" (*7*). Not so well known are the positive interassociations of opulence, gold teeth, and con-

cepts of self-importance. The brilliant flashing of the gold in artificial light is regarded as a particularly desirable characteristic. There may have been the impression that if wealthy people requested these emblems, then it was desirable for poor people to have them too. There was also the commonly held opinion that the wearing of gold crowns on anterior teeth was a racially associated custom, welcomed by nonwhites but denigrated by whites. It was in the rural South that these associations were most rife. White dentists of the region were unapologetic for their decisions to construct these crowns voluntarily for black patients, while discouraging and refusing to fabricate similar appliances for white patients. Besides the social and racial connotations, the possession of gold teeth was regarded as a sign of "good luck." Generally ineffective at dissuading the practice were criticisms that defacing sound teeth in order to fit gold crowns was an atrocious, atavistic barbarism desired only by savages. A somewhat more successful approach was the unemotional presentation of sound professional reasons and procedures for maintaining the mouth in good repair. The author can recall a number of instances in which he was able to convince nursing students to have their anterior gold shell crowns replaced. Many of these had been constructed as high school graduation gifts!

## Health Services and Cosmetology

The skin, hair, and nails are the parts of the human body that are usually distinguished in cosmetology. Defined as the study of the proper care of the body from the point of view of cleanliness and comeliness, cosmetology may involve other parts of the anatomy and should be regarded as an important facet of the health sciences. The art of increasing and preserving attractiveness utilizes beautifying substances and preparations as well as techno-scientific procedures.

There is probably a need to distinguish between dento-oral procedures which are bona fide health services and dental intervention that can be classified as a luxury intended merely to satisfy the patient's concepts of cosmetics. The distinction is not easy to substantiate, especially if a patient's personal satisfaction is equated with the status of mental well-being that psychiatrists testify is as an important a facet of health as are physical and social health.

From a purely physical health viewpoint, it is not difficult to find fault with the gold shell crown. Periodontists insist that in addition to poor esthetics, there are clinical factors which have contributed to the justified disrepute in which these crowns are held. Faulty dental restorations have been prominently listed among the many causes of periodontal diseases. Particularly indicted have been the overhanging margins of restorations and replacements which trap debris and stimulate bacterial reproduction. The absences of proper anatomical structure, contour, and contact of the restorations are other factors which have merited considerable attention and the criticism of clinicians (figs. 2A–2M). Open-faced and full gold shell crowns have traditionally been included among "faulty" dental replacements, and more often than not these restorations did possess the characteristics that lent truth to the "faulty" designation. The crowns have been etiological factors in traumatic occlusion, gingivitis, incipient periodontal disease, oral fetor, food impaction, and dental caries in adjacent teeth. As a consequence, periodontists insist there is no good dental rationale to support the fabrication of these crowns, especially since specialists in restorative dentistry have demonstrated superior methods of effectuating whatever technical functions shell crowns were intended to accomplish. Moreover, there are newer methods of constructing crowns with built-in color and depth translucency. Restorative dentists regard brilliant flashes of metal in the mouth as highly undesirable and consider it important to eliminate the problem in their fabrications.

The condemnation of gold shell crowns is not as clear cut from the individual mental health point of view. There may be legitimate reasons for conflict when a patient insists upon having a crown because "it looks good to me and I want one." Does the patient have the right to determine what looks good to him or her? Do patients have the right to demand what they want done on parts of their anatomy to improve appearances as they see them? There is precedent in cosmetology for an affirmative answer to such questions. The removal of facial warts, the surgical elimination of wrinkles, facelifting, ear and nasal piercing, and silicone injections of the breasts and buttocks are all cases in point. It would seem feasible to include patient preference of gold shell crown fabrications on anterior teeth in a similar category.

In the past the private dental practitioner re-

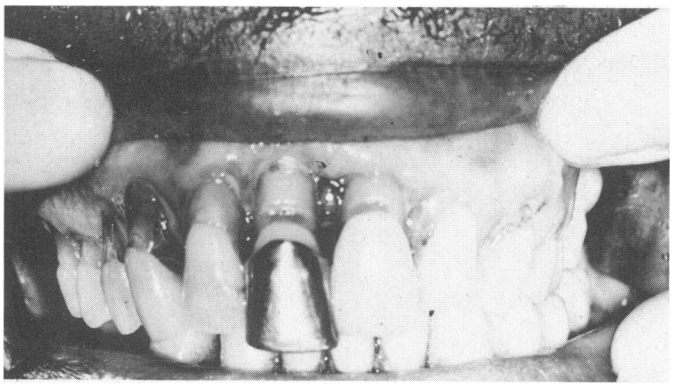

*Figure 2a. Full gold shell crown on extruded maxillary incisor. All teeth are affected by periodontal disease, and there is extensive resorption.*

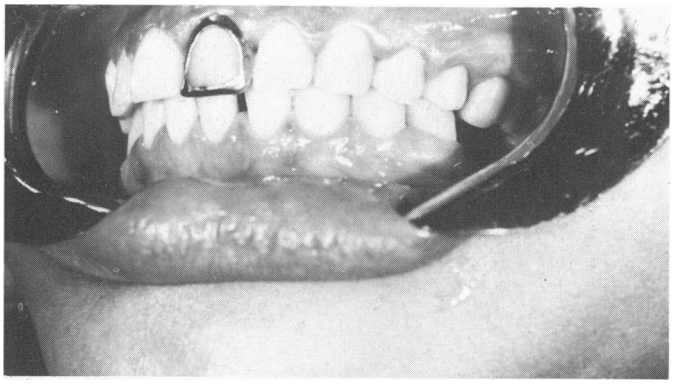

*Figure 2b. Open-faced gold shell crown on maxillary incisor. There is generalized gingival inflammation.*

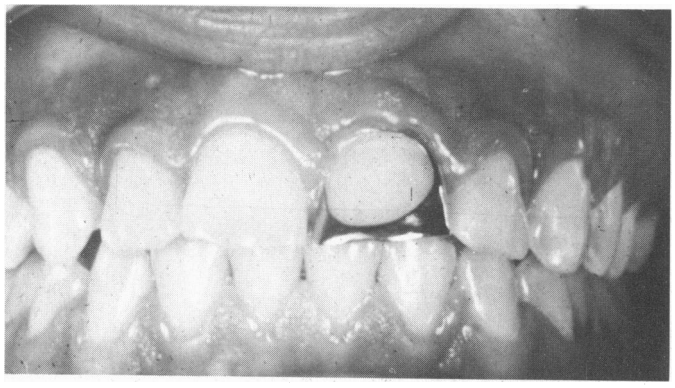

*Figure 2c. Open-faced gold shell crown on maxillary incisor. Hypertrophied tissue completely covers gingival margins.*

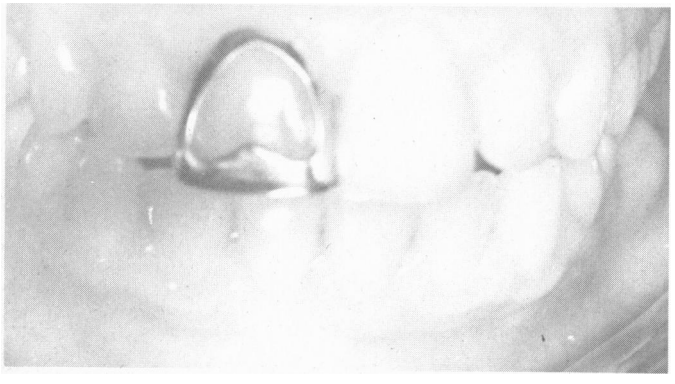

*Figure 2d. Cordate open-faced gold shell crown on unblemished maxillary central incisor. There is marginal gingivitis around the crown, but remaining tissues are normal and healthy.*

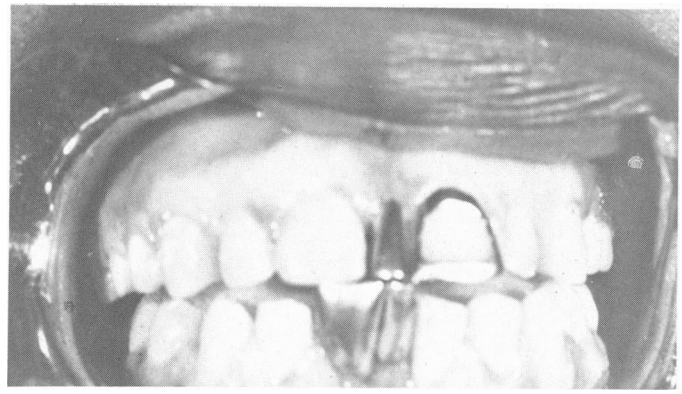

*Figure 2e. Open-faced gold shell crown on maxillary central incisor is in traumatic occlusion with full gold shell crown on mandibular central incisor. A full gold minicrown fills diastema between these incisors. There is generalized periodontitis.*

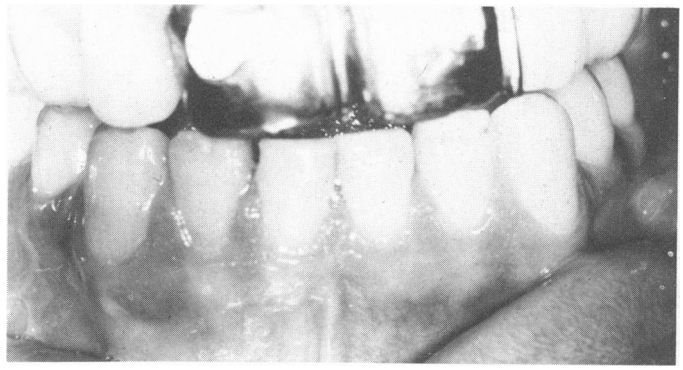

*Figure 2f. Bocallave-shaped, open-faced gold shell crown on maxillary central incisors with full minicrowns.*

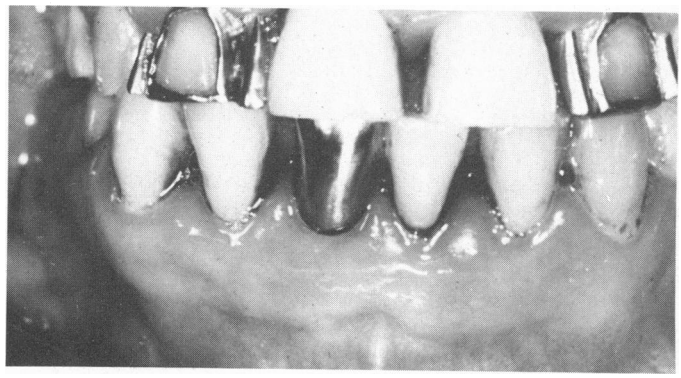

*Figure 2g. Open-faced gold shell crowns on maxillary incisors; mesial and distal full gold minicrowns and full gold shell crown on mandibular central incisor. There is generalized periodontitis.*

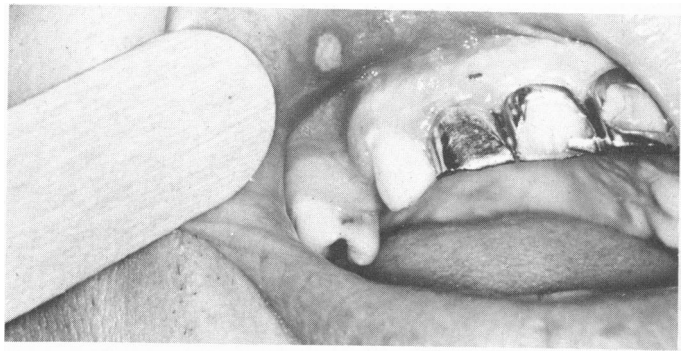

*Figure 2h. Full gold shell crown on lateral incisor and open-faced shell crowns on central incisors. Note generalized gingivitis and aphtous ulcer.*

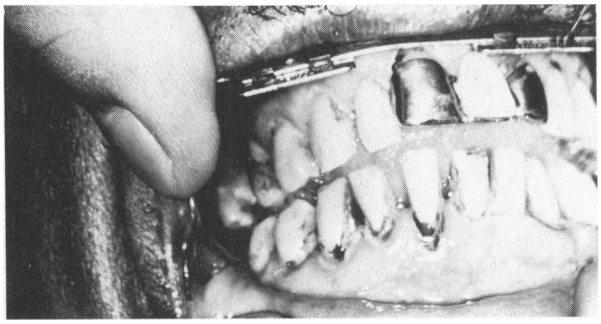

*Figure 2i. Three-tooth anterior bridge with full gold shell crown on central and lateral incisors. There is generalized periodontitis.*

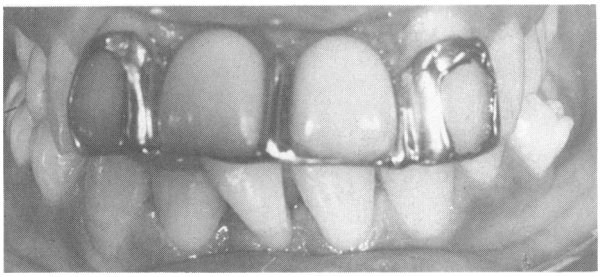

*Figure 2j. Four-tooth anterior bridge with ill-fitting open-faced gold shell crowns on lateral incisors.*

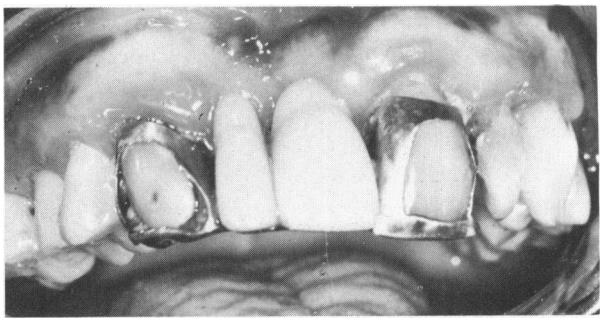

*Figure 2k. Four-tooth anterior bridge with deficient open-faced gold shell crowns on central incisor and cuspid. Extensive periodontitis affects these abutment teeth.*

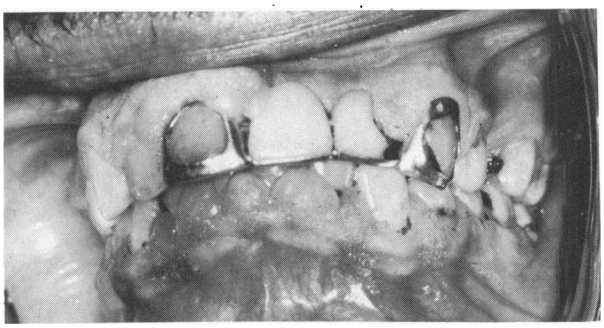

*Figure 2l. Four-tooth anterior bridge with open-faced crowns on lateral incisors and massive dilantin sodium hyperplasia covering gingival margins.*

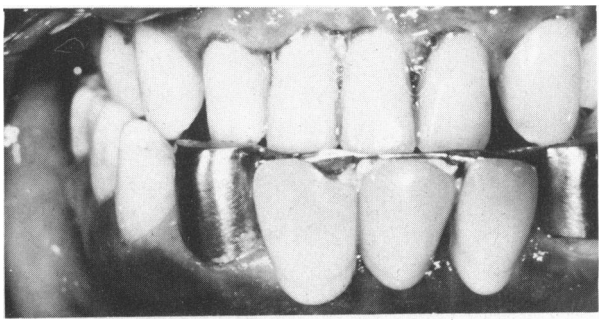

*Figure 2m. Defective bridge with full crown on cuspid and lateral incisor involved in generalized periodontitis. Improperly positioned cuspid facing in central incisor position demonstrates total lack of esthetic cosiderations.*

sented being told how to practice dentistry. Today's clinicians are equally indignant. Current consumers of health services are antipathetic to being denied services which they want to have performed and tend to become excited at having their wishes rejected. What many patients desire for themselves is in conflict with that which health providers consider professionally advisable. Unfavorable publicity usually attends the provider's unwillingness to accede to consumer wants.

## Resolving the Dilemma

Section 2 of the Principles of Ethics of the American Dental Association states (*8*): "The dentist's primary duty of serving the public is discharged by giving the highest type of service of which he is capable, and by avoiding any conduct which leads to a lowering of esteem of the profession of which he is a member." The implication is clear that anything contrary to the highest type of service is a disservice to patients and therefore should not be rendered. It would be unethical to accomplish for patients that which the private practitioner would not, under ordinary circumstances, condone either for himself or his family.

There does appear to be an acceptable way to resolve the provider-consumer conflict based upon the "to construct or not construct gold shell crowns" dilemma. First, the dental practitioner does have the obligation to listen attentively to whatever the patient has to say about his personal dental desires. Such an effort concedes the patient's right to express his wants and wishes.

Then it would be the indicated procedure for the dentist to explain in detail, and as comprehensively as possible, the liabilities of shell crowns. If every reasonable effort at dissuasion fails, the clinician would then have the responsibility to seek professional assistance and may suggest patient consultations with a psychiatrist or social worker.

Continued difficulties in persuasion would pose the problem as to whether a clinician should accomplish the dental procedure merely to satisfy the patient's fancy or refuse to compromise dental professional standards and quality care. In the latter eventuality, he would explain his decisions to the patient and refer him to a specialist in restorative dentistry for further opinions and disposition. This would in turn satisfy the dentist's right to adhere to the highest professional standards in safeguarding the welfare of his patients.

For the dental practitioner who believes so firmly that it is his responsibility to be responsive to patient needs that he is obligated to fabricate the crown, there may still be justified criticism, based upon an absence of patient confidence in the ability and professional recommendations of the dentist. It is an essential of good dentist-patient relations that there be a mutual respect between the patient and whomsoever the latter chooses to render professional services.

If this respect is lacking—and a patient's refusal to accept the considered recommendations of a dentist is indicative of such a lack—then the dentist is within his prerogatives to refrain from further service to this patient.

## Summary

Recent requests for gold caps on anterior teeth from a few patients patronizing O.E.O. Neighborhood Health Centers have revived discussions about the assets and liabilities of these appliances. A brief review of the use of gold shell crowns in the mouth and a summary of their effects on the periodontium have been presented. Dental schools have denounced these appliances as inimical to the image of a health profession. Because there have been remarkable changes in patient attitudes toward the providers of general and oral health services, many patients now feel that it is their right from a public health standpoint to demand and receive cosmetic services on parts of their anatomy to improve physical appearances as they view them. There are acceptable ways to resolve the provider-consumer conflict in this particular instance, and these should be used whenever necessary.

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