Original Research

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Dentists' and patients' preferences for paternalistic, consumerist, and partnership models in the doctor–patient relationship: a cross-sectional study

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Abstract

Background. The doctor–patient relationship plays a central role in treatment adherence, satisfaction, and therapeutic outcomes. In dental practice, this relationship is commonly conceptualized through paternalistic, consumerist, and partnership-based interaction models.

Objective. To evaluate dentists' and patients' preferences for paternalistic, consumerist, and partnership doctor–patient relationship models, and to assess the influence of sociodemographic variables.

Methods. A cross-sectional study was conducted between June and December 2020, including 107 dentists and 157 dental patients. Participants completed three author-developed structured questionnaires, each designed to assess one doctor–patient relationship model. Preferences were analyzed according to age, sex, place of residence, and educational level (patients), using descriptive statistics, Pearson's Chi-square test, and internal consistency analysis (Cronbach's alpha).

Results. Both dentists and patients demonstrated high levels of preference for paternalistic and consumerist relationship models. Preference for the paternalistic model was stable across all sociodemographic categories and showed no statistically significant associations with age, sex, place of residence, or educational level. The consumerist model was also widely endorsed; however, inferential analysis did not reveal statistically significant associations with demographic variables after categorical consolidation. By contrast, the partnership-based relationship model showed low levels of explicit preference and high levels of uncertainty, with no sociodemographic variable significantly influencing its endorsement. The questionnaires demonstrated acceptable internal consistency (Cronbach's $\alpha = 0.79–0.84$).

Conclusions. In this sample, paternalistic and consumerist relationship models were preferred more frequently than the partnership model. Partnership-based relationships were characterized by greater uncertainty, suggesting that shared decision-making remains incompletely integrated into routine dental practice. These findings support the need for context-sensitive communication strategies and further research using validated instruments.

Keywords: doctor–patient relationship, paternalism, consumerism, shared decision-making, dental ethics

Introduction

The doctor–patient relationship is a fundamental component of healthcare delivery, directly influencing communication, trust, treatment adherence, patient satisfaction, and therapeutic outcomes [1]. Throughout their personal and professional lives, individuals develop interpersonal relationship patterns that shape the way they communicate, cooperate, and make decisions. In healthcare, these relational dynamics become particularly important because clinical encounters frequently involve asymmetries in knowledge, authority, and vulnerability between physicians and patients [1,2]. Dentistry further accentuates these asymmetries, as patients often experience anxiety, fear of pain, and uncertainty regarding diagnosis and treatment, making effective communication an essential component of high-quality care [3,4].

Bioethical and sociomedical literature traditionally describes three principal models of the doctor–patient relationship: paternalistic, consumerist, and participatory (partnership-based) [5,6]. The paternalistic model is founded on the physician's professional authority and responsibility to determine what is considered to be in the patient's best interest [5]. Within this model, communication is predominantly unidirectional, and clinical decisions are primarily made by the physician, while informed consent often consists of providing information rather than engaging in genuine deliberation. Although frequently criticized for limiting patient autonomy, paternalism continues to play an important role in clinical practice, particularly when patients actively seek guidance, reassurance, and professional expertise [6,7].

The consumerist model, also referred to as the patient autonomy model, emerged as a response to traditional medical paternalism [5,6,8]. In this framework, the physician primarily serves as a provider of medical information and services, whereas the patient assumes responsibility for evaluating available options and selecting the preferred therapeutic approach [5,8,9]. This model emphasizes informed choice, transparency, and respect for individual autonomy. However, it may oversimplify the complexity of the clinical encounter by reducing the doctor–patient relationship to a transactional exchange that insufficiently addresses its interpersonal and emotional dimensions [8,9].

The partnership (participatory) model seeks to reconcile professional expertise with patient autonomy through shared decision-making. Rather than emphasizing authority or individual choice alone, this model promotes dialogue, negotiation, mutual respect, and shared responsibility. Physicians contribute scientific knowledge and clinical experience, while patients provide their values, preferences, and expectations, allowing therapeutic decisions to emerge from a collaborative process. Despite its ethical and clinical advantages, successful implementation of this model requires effective communication skills, sufficient consultation time, and active engagement from both physician and patient [10,11].

Previous research has demonstrated that these relationship models are not merely theoretical concepts but have practical implications for patients' perceptions, emotional responses, communication experiences, and acceptance of treatment [5,6]. Studies in dentistry have shown that paternalistic interactions are more frequently associated with communication of diagnostic findings, whereas consumerist approaches are linked to patients' awareness of treatment options and rehabilitation needs [12,13]. Partnership-based relationships, by contrast, appear to facilitate patient involvement throughout the diagnostic, therapeutic, and follow-up stages of care, supporting greater collaboration between dentists and patients [5,6,8].

Understanding how dentists and patients perceive and prefer these relationship models is essential for optimizing communication strategies, improving patient satisfaction, and enhancing treatment adherence [5–10]. Moreover, evaluating these preferences provides valuable insight into the extent to which contemporary dental practice reflects current ethical principles emphasizing patient-centered care and shared decision-making.

Accordingly, the present study aimed to evaluate and compare dentists' and patients' preferences for paternalistic, consumerist, and partnership-based doctor–patient relationship models. In addition, the study investigated whether these preferences were associated with selected sociodemographic characteristics, including age, sex, place of residence, and educational level. By quantifying these preferences, the study seeks to contribute to a better understanding of contemporary dentist–patient interactions and to support the development of communication strategies that better align professional practice with patients' expectations and ethical standards of modern dental care [13–21].

Methods

Study design

A cross-sectional, questionnaire-based study was conducted between June and December 2020. The research design aimed to quantify preferences for three models of the doctor–patient relationship—paternalistic, consumerist, and partnership (participatory)—among dentists and dental patients, while assessing the influence of selected sociodemographic variables.

Ethical considerations

The study protocol was reviewed and approved by the Ethics Commission of the University of Medicine and Pharmacy, Science and Technology of Targu Mures (Decision no. 929/26.05.2020). All procedures complied with the principles of the Declaration of Helsinki. Participation was voluntary, and all subjects provided written informed consent, including agreement for personal data processing in accordance with GDPR.

Study population

Participants were recruited by convenience sampling. Because this was an exploratory cross-sectional study, no formal sample size calculation was performed. The study population consisted of two distinct groups:

- Dentists: 107 respondents, aged between 24 and 69 years (mean age 33.42 years), recruited during scientific meetings and continuing professional education events.

- Patients: 157 respondents, aged between 18 and 74 years (mean age 39.14 years), recruited from the private dental practice CMI Dr. Josan Lucian and the university dental clinics affiliated with the authors' academic institutions.

Participants were further categorized according to age (≤30 years / >30 years), sex (male/female), and place of residence (urban/rural). Age was dichotomized at 30 years because this threshold approximately corresponded to the median age of the study population and allowed balanced subgroup comparisons. For patients, the level of education was additionally recorded and classified as pre-university, university, or postgraduate.

Inclusion and exclusion criteria

Inclusion criteria were: age ≥ 18 years; completion of the GDPR data processing form; and signing of informed consent for participation in research and scientific data use.

Exclusion criteria included: age < 18 years and failure to complete informed consent or GDPR documentation.

Research instrument

Data were collected using three structured questionnaires specifically developed for this study to evaluate preferences for the three classical doctor–patient relationship models:

(1) the paternalistic model

(2) the consumerist model

(3) the partnership (participatory) model (Supplementary Files).

The questionnaires included both positively and negatively worded items to reduce acquiescence bias. Reverse-worded items were reverse-scored before statistical analysis.

The questionnaires were developed based on the theoretical characteristics of the three relationship models described in the bioethical and healthcare communication literature. Item generation was guided by the conceptual features defining each model, to ensure that the questionnaires adequately reflected their respective theoretical constructs. Before administration, the questionnaires underwent expert review to assess content relevance, conceptual clarity, and consistency with the theoretical framework of the study.

Each questionnaire comprised 10 items (A–J). Reverse-worded items were reverse-scored to address similar concepts using different wording to evaluate the consistency of participants' responses. Responses were recorded using a five-point Likert scale (1 = *to a very small extent*, 2 = *to a small extent*, 3 = *to a moderate extent*, 4 = *to a large extent*, and 5 = *to a very large extent*), with higher scores indicating a stronger preference for the corresponding doctor–patient relationship model.

The psychometric properties of the questionnaires were evaluated by assessing their internal consistency using Cronbach's alpha coefficient. The reliability analysis was performed separately for each questionnaire, corresponding to the paternalistic, consumerist, and partnership relationship models.

Data collection procedure

Before questionnaire administration, participants received standardized verbal instructions regarding the purpose of the study and the method of completing the questionnaires. Confidentiality and anonymity were emphasized. Participants received standardized written and verbal instructions before independently completing the questionnaires. Investigators were available only to clarify procedural questions when necessary. Only fully completed questionnaires were included in the final analysis.

Statistical analysis

Data were entered into a dedicated database and analyzed using GraphPad Prism version 9.5 (GraphPad Software, San Diego, CA, USA). Descriptive statistics were used to summarize participant characteristics and questionnaire responses and are presented as absolute frequencies and percentages.

Associations between participants' preferences and the investigated sociodemographic variables (age, sex, place of residence, and educational level, where applicable) were assessed using Pearson's Chi-square test. Because some response categories contained a limited number of observations, adjacent categories were combined before inferential analysis to satisfy the assumptions of the Chi-square test. Specifically, the response categories *"to a large extent"* and *"to a very large extent"* were merged into a single category representing high preference, while the remaining response categories were combined into a category representing lower preferences.

The internal consistency of the three questionnaires was assessed using Cronbach's alpha coefficient, calculated separately for each instrument. Statistical significance was established at $p < 0.05$.

Results

Psychometric properties of the questionnaires

The internal consistency analysis demonstrated satisfactory reliability for all three questionnaires. Cronbach's alpha coefficients were 0.82 for the paternalistic relationship questionnaire, 0.79 for the consumerist relationship questionnaire, and 0.84 for the partnership relationship questionnaire, indicating acceptable to good internal consistency (Table I).

Table I. Internal consistency of the study questionnaires.

Questionnaire	Number of items	Cronbach's α
Paternalistic relationship	10	0.82
Consumerist relationship	10	0.79
Partnership relationship	10	0.84

Table II. Proportion of respondents reporting high preference for each doctor–patient relationship model.

Relationship model	Dentists (%)	Patients (%)
Paternalistic	High (>80%)	High (>85%)
Consumerist	High (~85%)	High (~80%)
Partnership	Low (<20%)	Low (<15%)

Paternalistic relationship model

The paternalistic relationship model showed high levels of preference among both dentists and patients. Most respondents selected the response categories "to a large extent" or "to a very large extent".

No statistically significant associations were identified between preference for the paternalistic model and age, sex, place of residence, or educational level (all $p > 0.05$). Similar response distributions were observed across all demographic subgroups.

Consumerist relationship model

The consumerist relationship model was also highly endorsed by both dentists and patients, although response variability was greater than that observed for the paternalistic model.

No statistically significant associations were found between consumerist preference and age, sex, place of residence, or educational level after categorical consolidation (all $p > 0.05$). Descriptively, higher levels of preference were observed among respondents aged over 30 years, urban residents, and patients with university or postgraduate education; however, these trends did not reach statistical significance.

Partnership (participatory) relationship model

In contrast to the paternalistic and consumerist models, the partnership relationship model was characterized by low explicit endorsement and high levels of uncertainty.

The partnership relationship model demonstrated the lowest level of preference among the three investigated doctor–patient relationship models. The most frequent response in both dentists and patients was "I do not know / unable to assess."

No statistically significant associations were observed between partnership model preference and age, sex, place of residence, or educational level (all $p > 0.05$). Similar response patterns were observed across all demographic categories.

Synthetic comparative overview of relationship models

To facilitate comparison, preferences for the three relationship models were summarized by collapsing responses into high preference ("to a large" and "to a very large extent") versus other responses (Table II).

This synthetic overview highlights the predominance of paternalistic and consumerist models in dental practice, alongside the marginal and uncertain status of partnership-based relationships.

Discussion

The present study evaluated dentists' and patients' preferences for the three classical models of the doctor–patient relationship—paternalistic, consumerist, and partnership-based—within the context of dental practice [5,6]. The satisfactory internal consistency demonstrated by the three questionnaires supports the reliability of the measurements and strengthens confidence in the observed preference patterns.

The findings indicate that both dentists and patients showed a strong preference for the paternalistic relationship model, regardless of age, sex, place of residence, or educational level. The absence of statistically significant differences across all investigated sociodemographic variables suggests that clinician-led decision-making remains broadly accepted within the study population. These findings are consistent with previous reports indicating that patients continue to value professional expertise and guidance, particularly in clinical situations characterized by uncertainty, anxiety, or complex therapeutic decisions [5–9].

From the clinician's perspective, this preference may reflect the responsibility associated with treatment planning and the need to make timely decisions during invasive or technically demanding procedures [22,23]. From the patient's perspective, acceptance of the paternalistic model—even among participants with higher educational

attainment—suggests that reliance on professional authority cannot be explained solely by differences in health literacy. Instead, patients may perceive clinician guidance as a source of confidence and reassurance during complex dental treatment [5,6,8].

The consumerist relationship model also received substantial support from both dentists and patients. Although respondents with higher level of education and those living in urban areas tended to report stronger consumerist preferences, these differences did not reach statistical significance after inferential analysis. Consequently, these descriptive trends should be interpreted cautiously and cannot be considered evidence of demographic differences within the present study.

The simultaneous endorsement of paternalistic and consumerist models suggests that these approaches are not mutually exclusive. Rather, contemporary dental care appears to integrate professional authority with transparent communication and respect for patient autonomy. This finding supports previous observations that patients value both expert clinical recommendations and adequate information to participate meaningfully in treatment decisions [5–9].

By contrast, the partnership-based relationship model received considerably lower levels of endorsement than the other two models, while uncertainty represented the most frequent response among both dentists and patients. Because no significant associations with the investigated sociodemographic variables were identified, this uncertainty appears to be widespread rather than limited to specific participant groups.

Several explanations may account for these findings. Partnership-based care requires effective communication, mutual trust, and a clear understanding of shared roles and responsibilities [10,11]. In routine dental practice, procedural complexity, limited consultation time, and medicolegal responsibilities may reduce opportunities for fully participatory decision-making [26,27]. Furthermore, some patients may prefer varying degrees of involvement depending on the clinical situation, simultaneously valuing professional guidance while wishing to remain informed about available treatment options [28,29].

Taken together, these findings suggest that contemporary dental practice may be better characterized by a flexible relational framework than by strict adherence to a single ethical model. Rather than replacing paternalism, patient autonomy appears to complement professional expertise, allowing communication strategies to be adapted according to patients' preferences, expectations, and clinical circumstances [28–30]. Such an interpretation is consistent with current concepts of patient-centered care, which recognize that preferences for participation vary between individuals and across clinical contexts [24,25].

From an educational perspective, these findings highlight the importance of strengthening communication training in undergraduate and continuing dental education. Developing competencies related to explaining treatment alternatives, eliciting patients' preferences and values, and facilitating shared decision-making may support the gradual integration of partnership-oriented approaches into routine clinical practice [17,20,21]. Likewise, improving patients' understanding of their role in shared decision-making may reduce uncertainty regarding participatory models and encourage greater engagement in treatment planning.

This study has several limitations. First, the relatively modest sample size, particularly after stratification according to demographic variables, together with the absence of an *a priori* sample size calculation and multivariable analyses, may have reduced the statistical power to detect small associations. Second, participants were recruited using convenience sampling, which may have introduced selection bias and limited the generalizability of the findings. Third, the cross-sectional design precludes causal inference, while the self-reported nature of the questionnaires and their administration following standardized investigator instructions may have introduced social desirability bias. In addition, the response rate was not recorded, preventing assessment of potential non-response bias. Fourth, although the questionnaires demonstrated acceptable internal consistency, they were specifically developed for this study and require further psychometric validation in independent populations. Finally, data collection was conducted during 2020, coinciding with the COVID-19 pandemic, which may have influenced the participants' perceptions and expectations regarding dentist–patient relationships.

Overall, this study provides quantitative evidence regarding dentists' and patients' preferences for different models of the doctor–patient relationship in dentistry. The predominance of paternalistic and consumerist preferences, together with the uncertainty surrounding partnership-based interactions, underscores the need for communication strategies that are responsive to individual patient preferences while supporting the gradual implementation of shared decision-making principles in dental practice.

Conclusions

In this sample of Romanian dentists and dental patients, paternalistic and consumerist relationship models were preferred more frequently than the partnership model. None of the examined sociodemographic variables showed statistically significant associations with preference for any relationship model. The partnership model was characterized by a high proportion of uncertain responses, suggesting limited familiarity with this approach among participants. These findings describe the preferences observed in the present study and should be confirmed in larger multicenter investigations using psychometrically validated instruments.

Author's contribution

L.J. Conceptualization, Methodology, Investigation, Data Curation, Writing – Original Draft, S.M.B. Conceptualization, Methodology, Investigation, Data Curation, Writing – Review & Editing, Supervision, M.P. Methodology, Investigation, Writing – Review & Editing, Supervision, E.T. Investigation, Data Curation, Writing – Review & Editing, A.Ș.Z. Investigation, Data Curation, Statistical Analysis, Writing – Review & Editing, A.O. Methodology, Investigation, Validation, Writing – Review & Editing.

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Questionnaire A. Paternalistic Relationship Model Questionnaire

Participant Information

Variable	Response
Participant ID	_____
Sex	☐ Female ☐ Male
Age (years)	_____
Profession	_____
Place of residence	☐ Urban ☐ Rural
Educational level	☐ Pre-university ☐ University ☐ Postgraduate

Instructions

Please indicate the extent to which you agree with each of the following statements by selecting one response for each item.

Score	Response option
0	Not at all
1	To a very small extent
2	To a small extent
3	I do not know / Unable to assess
4	To a large extent
5	To a very large extent

Questionnaire

Item	Statement	0	1	2	3	4	5
A	A healthcare professional with greater expertise than mine is better able to determine what is in my best interest.	☐	☐	☐	☐	☐	☐
B	Another person may understand my interests and goals in a particular situation better than I do.	☐	☐	☐	☐	☐	☐
C	I feel comfortable when someone else makes important decisions on my behalf.	☐	☐	☐	☐	☐	☐
D	My inability to make decisions reduces my decision-making autonomy.	☐	☐	☐	☐	☐	☐
E	I readily accept decisions made by others on my behalf.	☐	☐	☐	☐	☐	☐
F	The physician can objectively determine what is in the patient's best interest.	☐	☐	☐	☐	☐	☐
G	The physician is able to understand what is in the patient's best interest regarding his or her health.	☐	☐	☐	☐	☐	☐
H	I am comfortable allowing the physician to make treatment decisions on my behalf.	☐	☐	☐	☐	☐	☐
I	I need to make my own decisions whenever possible.	☐	☐	☐	☐	☐	☐
J	I generally agree with the physician's decisions regarding my health care.	☐	☐	☐	☐	☐	☐

Questionnaire B. Consumerist Relationship Model Questionnaire

Participant Information

Variable	Response
Participant ID	_____
Sex	□ Female □ Male
Age (years)	_____
Profession	_____
Place of residence	□ Urban □ Rural
Educational level	□ Pre-university □ University □ Postgraduate

Instructions

Please indicate the extent to which you agree with each of the following statements by selecting one response for each item.

Score	Response option
0	Not at all
1	To a very small extent
2	To a small extent
3	I do not know / Unable to assess
4	To a large extent
5	To a very large extent

Questionnaire

Item	Statement	0	1	2	3	4	5
A	I want the information provided by the healthcare professional to be accurate, complete, and clearly communicated.	□	□	□	□	□	□
B	I prefer to interact with competent healthcare professionals who respect my opinions and decisions.	□	□	□	□	□	□
C	It is appropriate for healthcare professionals to exercise professional autonomy when providing information within their area of expertise.	□	□	□	□	□	□
D	I believe I am the person best qualified to decide what I want to achieve regarding my health care.	□	□	□	□	□	□
E	The decisions I make are always consistent with my own best interests.	□	□	□	□	□	□
F	I want my physician to provide clear, relevant, and comprehensive information about my condition and treatment options.	□	□	□	□	□	□
G	The physician is responsible for providing complete and accurate medical information.	□	□	□	□	□	□
H	The information provided by the physician should enable me to make informed decisions independently.	□	□	□	□	□	□
I	As a patient, I should have the final authority in choosing the treatment I will receive.	□	□	□	□	□	□
J	Because I pay for healthcare services, I believe I should be able to choose the treatment option that best meets my preferences.	□	□	□	□	□	□

Questionnaire C. Partnership (Shared Decision-Making) Relationship Model Questionnaire

Participant Information

Variable	Response
Participant ID	_____
Sex	□ Female □ Male
Age (years)	_____
Profession	_____
Place of residence	□ Urban □ Rural
Educational level	□ Pre-university □ University □ Postgraduate

Instructions

Please indicate the extent to which you agree with each of the following statements by selecting one response for each item.

Score	Response option
0	Not at all
1	To a very small extent
2	To a small extent
3	I do not know / Unable to assess
4	To a large extent
5	To a very large extent

Questionnaire

Item	Statement	0	1	2	3	4	5
A	Collaboration is based on establishing a partnership between individuals who share the common goal of successfully achieving mutually agreed objectives.	☐	☐	☐	☐	☐	☐
B	Before making a joint decision, I prefer to collaborate and negotiate with the other person.	☐	☐	☐	☐	☐	☐
C	Making important decisions requires a partnership between all those involved.	☐	☐	☐	☐	☐	☐
D	Responsibility for decisions made within a partnership should be shared equally by all partners.	☐	☐	☐	☐	☐	☐
E	When entering into a partnership, I prefer to collaborate with someone who has expertise relevant to the shared objective.	☐	☐	☐	☐	☐	☐
F	As a patient, I want to establish a partnership with my physician to improve my health.	☐	☐	☐	☐	☐	☐
G	Before deciding on a treatment plan, the physician should discuss all appropriate therapeutic options with me.	☐	☐	☐	☐	☐	☐
H	The physician and the patient should participate equally in making treatment decisions.	☐	☐	☐	☐	☐	☐
I	Both the physician and the patient should share responsibility for the treatment decisions that are made.	☐	☐	☐	☐	☐	☐
J	I view my physician as a partner with expertise in his or her professional field.	☐	☐	☐	☐	☐	☐