Dental ethics case 27

The orthodontic dilemma of non-compliance

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CASE SCENARIO

About six months ago, a new patient, a young boy of 13, attended my orthodontic practice with his parents. The child was withdrawn and not very forthcoming when questioned about his oral health. Despite the fact that his parents reported having taken him regularly to the dentist, an oral examination revealed occlusal cavities and poor oral hygiene. The orthodontic diagnosis was a straight-forward Class 1 malocclusion, with no skeletal disharmony and minor overcrowding in both the maxilla and mandible. I anticipated that a 12-18 month treatment with a bonded fixed appliance would correct the malocclusion and agreed to carry out the treatment, provided that the patient took the responsibility to improve his oral hygiene. Treatment was commenced but despite many attempts to provide oral hygiene instructions and to educate him about the dangers of the lack of preventive care and the harm that may result, I have become most frustrated about his total lack of interest in the treatment and the continued neglect of his oral hygiene. I am now inclined to discontinue treatment. Should I have taken on this case?

COMMENTARY

Orthodontics is an interesting specialty involved mainly with treating children and shares some of the risks associated with elective, cosmetic procedures carried out in adults. However, in orthodontics, just as in any other discipline of dentistry, human values are at stake in the course of treatment. This includes preventing pain, preserving and restoring oral function for normal speech and eating, the preservation and restoration of the patients physical appearance and promoting responsibility and a sense of control over his or her own health.[1] Furthermore, all this should be done taking cognisance of the fundamental principle of professional ethics, namely that the best interests of patients should always take precedence over any consideration of profit or personal gain.[2]

The nature of orthodontic treatment is unique in that the orthodontist needs to see patients on a monthly basis over a period of years, and one of the most important aspects contributing to the successful outcome of orthodontic treatment is patient compliance. Compliance firstly with instructions related to the correct use and care of appliances, and secondly with the need for meticulous oral hygiene. Ethical problems often occur when there is moral uncertainty or conflicting moral obligations and since much of an orthodontic practice relates to the treatment of children, situations may become even more morally and professionally complex when issues such as the best interest of the child, surrogate decision making and access to care come to the fore.[3] Adults who have already developed a strong sense of personal identity can still be vulnerable in relation to dental illness and treatment. Such vulnerability may be dramatically increased in children who lack maturity and are in serious need of complex orthodontic intervention. Difficult social and emotional problems linked to the appearance of their teeth make such intervention of fundamental importance to their confidence and well being. Thus for some children, orthodontic intervention may well be a matter of clinical necessity rather than elective choice, especially after the treatment has begun.[4]

A unique aspect of orthodontic treatment is that during the course of treatment, a patient who has a healthy dentition could very quickly cause or accelerate harm to the dentition by 'benign neglect'. This is on account of the fact that any orthodontic treatment with removable or fixed appliances requires ongoing excellent oral hygiene to prevent plaque accumulation, enamel decalcification, caries formation, gingivitis that may eventually lead to periodontitis and loss of alveolar bone.[5] However, interrupting or stopping the orthodontic treatment due to patient non-compliance may lead to increased functional disharmony. Ethical traditions require orthodontists to act in the best interests of their patients, and in the management of children this obligation to the patient becomes even more pronounced. When the patient is a child, the moral and legal decision-making authority rests with surrogates, usually the parents. Parents have considerable latitude, but their authority is not unlimited – parents too must consider the best interests of the child. The 'best-interests standard" includes what a reasonable person may choose under similar circumstances.[6]

Adolescent patients can confound the prognosis of care because of non-compliance and associated neglect of oral hygiene. However, it is not an easy matter to decide how

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to identify patients for orthodontic treatment. Although there is no legal obligation of an OHCW to treat a patient, the issue is complex one, because health professionals have taken the Hippocratic oath, which affirms the ethical obligation to treat as long as no personal characteristics, such as race, colour, creed, sexual identity and culture impinge on treatment planning.[7] Orthodontic care usually involves long-term treatment with ongoing oversight and requires patient co-operation. The issue of non-compliance should be re-iterated as it will have a negative impact on the treatment outcome. Therefore, prior to the commencement of a long treatment plan for children, orthodontists should carefully outline the various treatment options, including the benefits and risks of each, as well as the consequences of no treatment intervention.[1]

As the child patient matures, it is important to involve him or her in the decision-making process, as far as age and abilities allow. Involving the child in the process makes practical and well as moral sense, since the child is more likely to be co-operative when informed and in agreement with intervention and compliant with instructions.[8] The content of information which needs to be given should include the following:[9]

1. What is going to be done?
2. Why is it going to be done?
3. What is the intended outcome?
4. What are the benefits and risks of the treatment proposed?
5. What are the alternatives including benefits and risks?
6. What will happen if nothing is done?

Since most orthodontic treatments are neither emergencies nor life-threatening, every opportunity must be given by the health professionals and parents to nurture the development of a trusting relationship that is based on mutual respect in providing dental care for children. This helps promote the evolving autonomy of the young patients as they develop into responsible members of the society. In addition, orthodontists should take steps to reassure themselves as far as is possible that the child will be able to adhere to the treatment plan and the health education and promotion advice. The patients should also be told as part of obtaining consent for the plan what will happen both clinically and legally if they do not follow instructions. Agreement to a suitably worded treatment plan should also be obtained from a child able to understand and reason about relevant information.[1] Honesty is an important aspect of orthodontic treatment.[10,11] Transparency will place pressure on the parents not to enter into any agreements that they know their the child cannot satisfy but will also enable the child to protest if parental hesitation is perceived by the child as denying the opportunity for the benefits of treatment. On the other hand, children should clearly not be coerced into having orthodontic treatment that they themselves feel insecure or anxious about. The prime duty of the orthodontist is to ensure that all parties are informed, committed and prepared to embark on therapy.

SUMMARY

It is not easy for an orthodontist to consistently achieve a caring, supportive and patient-centered approach when faced with stubborn resistance to cooperation. By acting ethically and professionally (especially when dealing with children whose lives may be dramatically affected by the interruption or cessation of treatment), the orthodontist may on occasion, find this elusive balance, and ultimately the case will be more rewarding and professionally satisfying.

CONCLUSION

Even in the face of sustained non-compliance, treatments that have begun should in some form continue if their cessation would compromise the best interests of patients. For example, every effort should be made to ensure that extraction spaces are closed. All avenues should be explored and it may be that transferring the patient to another practitioner will solve some of the dilemma… perhaps there has been an issue of personal communication problems? Both parents should be consulted and in the event that the decision is taken that treatment should be discontinued, full details of that agreement must be recorded, together with an estimate of the possible consequences. The patient should never simply be abandoned. There is also always the option that treatment may be resumed at a later date, perhaps when the patient is more mature. The management of the orthodontic patient should always be considered in relationship to the ethical principles of beneficence, respect for patient autonomy, do no harm and the special requirements related to the decision making of minors.

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