Orthodontics

Dento-legal pitfalls for the practitioner and at the specialist interface

For many years orthodontics has been regarded as a relatively low-risk field of dentistry with very few dento-legal problems arising. Times have changed and we are currently seeing an increasing number of claims and complaints involving orthodontics.

Recent experience suggests that these cases are more likely to arise where a general dental practitioner with a particular interest in orthodontics has not had formal specialist training, is undertaking treatment in such cases, most of the problems could be categorised under four headings:

1. **Case assessment, diagnosis and treatment planning**
2. **Consent**
3. **Lack of progress**
4. **Unsatisfactory outcome**

Interestingly enough, shortfalls in respect of (a) and (b) above tend to come to light only when problems have arisen in respect of (c) and (d). Typically the patient becomes frustrated by the apparent lack of progress, or is unhappy with the results that are being, or have been, obtained—as was the case with the patient shown in the adjacent column (left). Sometimes the trigger for this dissatisfaction is a request for an additional fee from the practitioner, because the treatment is taking longer than had been expected at the outset.

**Second Opinions about Progress**

The patient may decide to seek a second opinion about the progress of his or her treatment, and it is often here that the real problems begin. The patient is often prompted to question the appropriateness of the original treatment plan and possibly the training and competence of the first dentist.

If the second dentist is an orthodontic specialist and the original dentist a general dental practitioner with an interest in orthodontics, there can be a variation in approach. The question commonly arises: should the general practitioner have been undertaking the treatment at all, instead of referring the patient to a specialist at the outset?

It may not be obvious at first sight that this raises questions regarding the validity of the consent obtained for the treatment, if the patient had agreed to the treatment without appreciating its potential complexity. Not surprisingly, both orthodontic specialists and general practitioners with a special interest in orthodontics, have strongly held views on this subject. The predictable divergence of these views is actually far less important than the quality of the care itself, and the outcome of the orthodontic treatment.

However, the issue of consent is more complicated than it might appear at first sight. Faced with starting a new course of orthodontic treatment after investing much time, effort (and perhaps, money) into the original treatment, that has not been successful, the patient may well feel angry. The patient might argue that he or she would never have allowed the general dental practitioner to carry out the original treatment had it been fully explained that the orthodontic problem was more appropriate for treatment by an experienced specialist. If the general practitioner did not make it clear that he (or she) was not a specialist, and had not offered the option of a specialist referral for an initial opinion and/or for the treatment itself, then the practitioner can be vulnerable on the question of consent. This would apply even though the patient happily proceeded with the treatment without asking for any such referral. Patients cannot be expected to understand the significance of orthodontic training, or to appreciate the complexity of their own malocclusion; they must be given a balanced and fair explanation of their options (including that of a referral) and allowed to decide for themselves.

When these considerations become central to a claim or complaint, as they often do, the allegation is frequently made that the practitioner failed to assess the case adequately, or perhaps through inexperience, failed to recognise the complexities of a case and to take them into account in the treatment plan. This begs the question of whether an experienced orthodontist who had undergone specialist training, would have assessed the case differently, would have recognised the problems and would have been able to overcome them successfully. Unless this can be shown to be the case, then the all-important question of causation is not established and the case against the practitioner becomes easier to defend. It is in the nature of dento-legal proceedings that experts are called upon to review a patient’s treatment, with the help of clinical records, photographs, models, X-rays etc. Two recurring problems are commonly encountered:

- The clinician appears not to have identified and taken account of certain complicating factors.
- The clinician was too slow to realise that treatment was not progressing as planned, and failed to take steps to reassess the case personally, or with the help of an appropriately trained colleague.

The Specialist/Practitioner Interface

Even when a referral to a specialist is made, problems of a different kind still tend to arise at the interface between the orthodontic specialist, and the referring general dental practitioner. The most common of these are:

- Delayed referral
- Caries and decalcification
- Periodontal problems
- Loss of vitality

Delayed Referral

It is the practitioner’s role to monitor the development of the oral health of a child through the mixed dentition phase. Any variation from the norm whether in terms of occlusal relationship, delayed eruption (or loss) of teeth, the presence of supernumerary teeth, or those which are congenitally absent, hard and soft tissue anomalies and relevant habits (e.g., thumb/finger sucking) should be identified. As soon as any child presents a challenge that exceeds a practitioner’s knowledge, experience and expertise, a duty of care exists to refer the case to a specialist.
It is essential to establish clear areas of responsibility between specialist orthodontists and referring practitioners, and regular communication between the two is paramount. If, perhaps due to a deterioration in the patient’s diet and oral hygiene, areas of early decalcification start to appear (for example, around brackets) or caries develops rapidly, perhaps unseen under a molar band which has become un cemented, the situation requires treatment.

There is always the potential danger that the problem will remain unaddressed with both clinicians assuming that the other is dealing with the problem.

It is essential that an understanding is reached as to who is taking the responsibility for providing the necessary oral hygiene advice and perhaps local remineralisation treatment. The clinical records of both clinicians should show that the problem has been identified and acted upon in timely fashion. Copies of correspondence should always be retained in the patient’s notes to confirm the communication between the clinicians.

Periodontal Disease

Within the last few years, a single case of orthodontic treatment carried out on a patient with juvenile periodontitis, resulted in the loss of 11 teeth, and a settlement which was equivalent to almost 200 times the annual indemnity cost being paid by the dentist concerned, at the time in question. Here again, the orthodontist and the referring dentist need to communicate regularly and closely if there is any deterioration in the patient’s periodontal health during any course of orthodontic treatment. The clinical records kept by all parties must show that the situation has been identified, monitored and treated as necessary, and that the patient has been kept informed of the problem and advised appropriately as to his or her part in resolving it.

Summary
Ten points for the general practitioner to consider when undertaking orthodontic treatment:

1) Is the orthodontic treatment necessary?
2) Does the patient want the treatment and understand what is likely to be involved? (Parents obviously need to be involved in the consent process in the case of minors.)
3) Is the patient prepared to make the necessary commitment in terms of compliance, attendance, oral hygiene, etc?
4) Is the treatment within my competence? Can I demonstrate that I have sufficient training, experience and expertise to undertake a case of this nature?
5) Do I need to enlist the help of a specialist orthodontist to assess the case and to provide me with a treatment plan?
6) Is it then within my own competence to carry out this treatment plan?
7) If I decide not to enlist the help of a specialist colleague, have I made it clear to the patient that I am not myself a specialist?
8) Have I offered the patient a referral to a specialist colleague, and recorded this fact in the notes?
9) If a case is not progressing as planned, should I enlist the help of a specialist to reassess the case and suggest a way forward?
10) Do my clinical records show clearly that I have identified any problems with the progress of a case and taken steps to address them (especially where these problems relate to the patient’s own non-compliance, oral hygiene/diet or failure to attend regularly for appointments)?

Record card audit
Pull out a random sample of 20 or 30 record cards for cases in progress and ask yourself:

- Can I show all the steps of a detailed case assessment, with all appropriate investigations?
- How many of the discussions have I had with the patient (or parents) at key stages of treatment (see points 7, 8, and 10 in the summary) are recorded in detail in the notes?
- Have I monitored orthodontic progress with recorded measurements, models and photographs?
- Do I have copies of all the relevant referral correspondence?
- Have I highlighted any lack of cooperation on the patient’s part (e.g. have all cancelled/failed appointments been recorded?)
- Has any non-compliance been recorded and acted upon?