A child's need, a parent's wish, an orthodontist's responsibility

David L. Turpin, DDS, MSD

Your first exam of the day happens to be an 8-year-old child who was born with a unilateral cleft lip and palate. She had been seen initially by a craniofacial team and underwent primary lip closure at 3 months and primary palatoplasty at 12 months. Following that, her attendance at the hospital clinic was sporadic and the family did not return for all the recommended dental care. Your examination of the child reveals that she is in the early mixed dentition with some crowding and collapse of the maxillary arch. She is almost ready for an alveolar bone graft and will require some presurgical orthodontic preparation.

Her parents say that it is more convenient for them to visit your office. Should you insist that they return to the craniofacial program at the pediatric hospital, or do you have the expertise to know exactly when the bone graft should be placed to allow for eruption of the permanent canine through bone? What if the family ignores your advice and fails to complete the needed orthodontic treatment in time for the all-important bone grafting procedure?

These questions and the lack of appropriate care this child could receive raise a number of ethical concerns for the orthodontist. For a full discussion of these topics, see the first two articles in this issue, "Ethics for orthodontists" and "Making decisions for children," by Wendy Mouradian. Along with coworkers Lena Omnell and Bryan Williams, she references ethical codes of the American Dental Association as well as the American Medical Association to assist the busy clinician. "Making decisions for children," notes Mouradian, "is part of everyday orthodontic care. But when conflicts arise between provider and parents, articulation of the ethical and legal principles guiding the process can be helpful." In the first paper, she reports on a case similar to the one described above, and discusses the orthodontist's responsibility. In the second, she continues to explore how a child's decision-making ability changes as he or she matures. "A child's competency is a function of age, cognitive abilities, and personal experiences." The concepts of informed consent, parental permission, and child assent are compared and contrasted.

On another subject, how many times have you heard a parent say, "My daughter has a speech problem. Will that disappear when her teeth are straightened?" For a good answer to this frequently asked question, you will want to read "Tooth position and speech—is there a relationship?"a review article in this issue by Johnson and Sandy. Although it is widely accepted that teeth play an important role in speech production, the exact relationship between tooth position and speech remains largely unexplored. Valid research in this area is difficult to accomplish. After all, speech is an activity unique to humans, and animal experimentation has almost no place in the study of speech production. Comparisons between different populations and different linguistic areas also present special difficulties. The authors make it very clear that most patients have the ability to adapt their speech to compensate for abnormal tooth position, but the mechanisms for this adaptation remain poorly understood. The overall conclusion is that while certain dental irregularities show a relationship with speech disorders, there does not appear to be a correlation with the severity of the malocclusion. Neither is there definitive proof that alteration of tooth position can improve articulation disorders.

I hope you enjoy reading the original articles selected for this issue of *The Angle Orthodontist*.

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