Ethics for orthodontists

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Abstract: When treating children, important ethical issues may arise relating to the best interests of the child and decision making for minors. The case of a child with a cleft lip and palate whose parents failed to bring her in for medically indicated orthodontic care is presented. Ethical features of the case are discussed, including the need to benefit the patient, avoid harm, and respect the preferences of the parents. Ethical codes of the American Dental Association and American Medical Association are referenced. Ethical dilemmas include the conflict between the orthodontist's obligation to the child and the need to respect parental autonomy. Parental autonomy is respected up until the point at which significant harm to a child may result. The orthodontist's primary ethical responsibility is to the child, not the parents. The orthodontist providing medically indicated care should involve the craniofacial team or hospital social worker when parental decision making is in question.

Key Words: Best interests standard, Children, Cleft lip and palate, Craniofacial team, Decision making, Ethics, Orthodontics, Patient autonomy, Surrogacy

Although there are ethical dimensions to all medical and dental care, orthodontic interventions have rarely been the subject of specific ethical inquiry. Orthodontists do encounter ethical dilemmas at many levels. Although orthodontists rarely deal with life-or-death decisions, important human values are at stake in the course of treatment. These include preventing pain, preserving and restoring oral function for normal speech and eating, preserving and restoring the patient's physical appearance, and promoting a sense of control over and responsibility for his or her own health.[1] Finally, orthodontists work, to a great extent, within the pediatric population, and they encounter ethical issues that relate to the best interests of the child, surrogate decision making, and access to care.

This article consists of a case example and a discussion of the ethical features present in every clinical encounter and ethical problems arising in particular encounters. Ethical problems arise when there is moral uncertainty or conflicting moral obligations.[2] The case example has been chosen to illustrate some of the dilemmas the orthodontist may face when advocating for the best interests of a child. Throughout this discussion, the approach to clinical ethics and decision making follows that outlined by Jonsen, Siegler, and Winslade.[2]

Case example

This child was born with a unilateral cleft lip and palate (UCLP). She underwent primary lip closure at 3 months and primary palatoplasty at 12 months. She was followed by the craniofacial program at a tertiary care pediatric hospital, but her attendance was sporadic, and the family did not return for all the recommended follow-ups.

She was evaluated by an orthodontist on the craniofacial team at 8.5 years. She had received substantial dental care at an early age,

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Submitted: July 1998, **Revised and accepted:** January 1999

See companion article: Making decisions for children, by Wendy E. Mouradian, MD, 69(4):300-306.

Angle Orthod 1999;69(4):295-299

but otherwise her general medical history was unremarkable. She had received no previous orthodontic intervention. The exam revealed that she was in early mixed dentition with some crowding and collapse of the maxillary arch. She was almost ready for an alveolar bone graft, but required some presurgical orthodontic preparation.

The family lived in an area with limited access to orthodontic care. The team orthodontist outlined two treatment options: (1) care by the craniofacial orthodontic section in the hospital, or (2) treatment by a private orthodontist in the family's home community. The child needed limited maxillary preparatory orthodontic treatment and extraction of the primary canine in the cleft area so that the graft could be performed in about 6 months. The oral and maxillofacial surgeon discussed plans for the graft with the family. They were in agreement with the orthodontic preparation and the alveolar bone graft, but stated they preferred to receive orthodontic care locally.

The team orthodontist was aware that there was no orthodontist with particular interest or expertise in the treatment of children with craniofacial disorders in the family's home community. In view of this fact, and the family's history of inconsistency in following the recommended treatment plan, the team orthodontist encouraged the family to return to the craniofacial program for the presurgical preparation. However, the family insisted that they wanted to seek care locally. The names of several orthodontists closer to their home were provided, and the family was counseled to ask the community orthodontist to contact the team orthodontist after an appointment had been made.

About 5 months later, the family returned to the craniofacial clinic in anticipation of scheduling the alveolar bone graft surgery. However, no orthodontic treatment had taken place. The primary canine was extracted, but the bone graft could not be performed at the optimal time.

Ethical analysis

Medical indications

The first step in assessing the ethical aspects of a case is to have a clear view of the medical indications. This includes the benefits/burdens of possible interventions, as well as the consequences of no treatment.[2] In this case, orthodontic intervention was a necessary prerequisite for the alveolar bone graft. When performed at the optimal time, an alveolar bone graft allows the permanent teeth to erupt into the cleft area, thus ensuring their viability. The combination of appropriate pre- and postsurgical orthodontic treatment and an alveolar bone graft improves occlusion, alignment, and appearance of teeth. The bone graft closes the oronasal fistula, stabilizes the maxillary segments, and creates bony support for the nose,[3] thereby lessening the nasal deformity.

However, to be most effective, the alveolar bone graft must be performed before the permanent teeth erupt into the cleft.[4] Maxillary expansion and necessary extractions must precede the surgery, making the issue of timing critical. If the optimal timing for the alveolar bone graft is missed, the procedure is generally delayed until after facial growth is complete, when it is typically combined with orthognathic surgery, a more extensive procedure with a higher rate of complications.[5] This delay may be a significant factor for a child with a cleft, as these children often become more sensitive about their appearance in adolescence. If the bone graft is *never* performed, the maxilla remains unstable and the patient is at greater risk for tooth loss.

The burden of the proposed treatment includes inconveniences such as travel to the craniofacial center, costs of care, and the discomfort and possible complications of surgery. However, when performed by experienced surgeons, the alveolar bone graft provides definitive repair of the cleft with high rates of success, low incidence of complications, and modest levels of discomfort that resolve quickly in the postsurgical period.[6]

The recommended treatment procedures are likely to benefit oral function, appearance, and quality of life for this child, and the burdens of treatment seem worth the potential benefits. Failing to provide these interventions will delay attaining these benefits, and will almost certainly mean more extensive surgery at a later date. Timely orthodontic treatment and alveolar bone grafting were considered the best treatment for this child, and these procedures were medically indicated.

Ethical commentary

Like physicians and other dentists, orthodontists have a moral obligation to promote the patient's interests and protect the patient from harm. Although many physicians and most dentists function as independent entrepreneurs, individually or in groups, medical and dental care are not viewed as ordinary commodities in the marketplace, where interactions are governed by contracts and laws of commerce.[1] Doctors and dentists possess special training and expertise, which patients and their families do not. This special knowledge and skill, with the potential for benefiting (or harming) patients, places on the medical and dental professional the moral obligation to act in the interests of the patient. This concept of dedication to the inter-

ests of the patient is what distinguishes a profession from a purely commercial venture and is expressed in the moral principles of *beneficence* and *nonmaleficence.* These principles are outlined in the codes of ethics of the respective professional organizations.[7,8]

The historical origins of these beliefs include the Hippocratic tradition, dating back to the 5th century B.C., and the Judeo-Christian ethic of care of the sick.[9] These tenets recognize the vulnerability of patients with respect to their illness or disability, the professionals' special knowledge and expertise that the patient has sought out, and the potential for conflict of interest when doctors are paid for their services. These moral obligations require the effacement of the doctor's self-interest for the sake of the patient.[10] While the implications of these ethical norms have been emphasized more for physicians than dentists, it is clear that the same stringent ethical requirements apply to both.

Similarly, questions also arise as to how doctors and dentists honor their duty to their patient in the changing models of healthcare delivery. Fee-for-service medicine and dentistry have always had an inherent conflict of interest, since professionals stand to profit by treatments recommended, which may favor overtreatment. This conflict is mitigated, if not eliminated, by the professional's obligation to the patient's best interests. In managed care models, a different conflict of interest arises when doctors and dentists are rewarded financially for *not* providing care. On this point, the ADA is clear: "The same ethical considerations apply whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first."[7]

The AMA has issued similar guidelines.[11]

In summary, the ethical traditions and codes of conduct of medicine and dentistry require doctors and dentists to act in the interest of their patients, regardless of financial arrangements, and even at times with risk to themselves. In the case of children, this obligation to the patient becomes even more pronounced, and may conflict with the dentist's obligations to respect the wishes of the parent.

Patient preferences

If the most beneficial course of treatment was clear for this child, the means to accomplish it were not. The craniofacial orthodontist wished to respect the family's preference and did not wish to appear self-serving by overemphasizing the expertise of the tertiary care center. However, the orthodontist knew that finding the appropriate care locally might be difficult. Finally, the orthodontist had concerns about the family's history of missed appointments.

When the family continued to insist on seeking care locally, the names of local orthodontists were provided. The family was counseled to set up an appointment and then have the community orthodontist contact the craniofacial orthodontist, in the hopes that a good treatment alliance could be formed.

Ethical commentary

The craniofacial orthodontist wished to respect the family's autonomy. Respect for patient autonomy is another cardinal ethical principle. "Under this principle," the ADA guidelines state, "the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given the patient's needs, desires and abilities. The dentist should inform the patient of the proposed treatment, and any reasonable alternatives."[7] This discussion should also include the likely outcomes without any treatment. The backbone of patient autonomy is the *doctrine of informed consent,* which states that all interventions require the free, informed consent of the competent patient. When the patient is a child and deemed incompetent due to age, moral and legal decision making authority rests with surrogates, usually the parents.[12] Parents have considerable latitude in the exercise of this authority, but their authority is not unlimited.[2] Parents must consider the best interests of the child. The medical and dental team must also formulate plans with the child's best interests in mind, and hold these as a "reality check" on family decision making.[17] The "best interests" standard includes what a reasonable person might choose under similar circumstances.[2] This is in contrast to the situation with adults, whose decisions must be respected even when they do not seem to be in the individual's best interests.

As the child matures, it is important to involve him or her in the decision making process, as far as age and abilities allow.[13] Involving the child in this process makes practical as well as moral sense, since the child is more likely to be cooperative when informed and in agreement with the interventions.

In this case, the orthodontist felt that allowing the parents to exercise their autonomy might not be in the best interests of their child. The important question to ask is what the impact would be if the family neglected to provide this care for the child.

In summary, the orthodontist respected the family's autonomy

about treatment choices, although not without considerable misgivings about whether the child's best interests would be best served by this course of action. Considering the elective nature of the interventions, the child would not be in any grave or immediate danger if the interventions were not provided.

Contextual features

Every medical situation is influenced by the larger issues of culture, social relationships, and financial concerns, and these factors inevitably influence patient care and treatment decisions.[2] In this case, several contextual issues need to be explored.

First, why did the family have difficulty following through with previously scheduled appointments and recommended treatment plans? There could be multiple reasons for this, including a lack of understanding of the importance of the treatment and the costs of care and travel. The family appeared to be in agreement with the recommended treatment plan, although they did not carry it out. Why? Had a family member had a bad experience with dental or orthodontic care, or had someone experienced a surgical complication? Were there other social or cultural factors impacting their attitude toward dental care? Did this fit into a pattern of neglectful and or abusive caretaking for this child? Were they struggling with significant family dysfunction due to marital conflict, domestic violence, or substance abuse? These and related issues should be explored by the craniofacial team, hospital social worker, or other appropriate professional. Once these barriers to care are better understood and family goals clarified, appropriate interventions and services can be proposed to help the family achieve the goal of bringing their child in consistently for care. In fact, if these issues are not explored, this family may not return for care at the appointed times anyway.

The craniofacial team orthodontist could also take specific actions to pave the way for the family to receive care locally. For example, the orthodontist could call one of the community orthodontists and set up an appointment, or at least make a referral, and then call the family personally with this information. The family's primary care physician could be contacted and his or her help enlisted in seeing that the family gets in for care. A tickler file could be organized at the craniofacial clinic or in the dental clinic for callbacks to families who seem to require such reminders, especially when timing of interventions is critical.

Although the potential role of social issues is particularly apparent in cases like these, assessment of psychosocial status is indicated in all cases of families of children who have complex and chronic health conditions, such as cleft lip/palate. Published standards of care emphasize the importance of coordinated, multidisciplinary care for these children and families, including the need for regular attention to psychosocial and family issues.[14-16]

A second contextual feature relates to how the craniofacial team orthodontist relates to the community orthodontist. How can he or she honestly present the care option of receiving orthodontic care at the craniofacial center without seeming to be self-serving? While there are no simple answers to this question, diplomacy and openness that recognize the unique advantages of both tertiary level and community-based care are needed. However, clarity of thinking and honesty can be very helpful. The orthodontist should not hesitate to state his or her interpretation of the child's best interests in this case, even if this does entail returning to the craniofacial orthodontic section for care. A false sense of modesty may be harmful when the best interests of the child are at stake.

Summary and conclusions

Ethical problems in this case arose from conflicts between the craniofacial orthodontist's obligation to the child and the need to respect family autonomy, and between the orthodontist's desire to respect community-based care and the need to advocate for the best interests of the child. These problems should be understood in relationship to underlying ethical principles of beneficence, respect for patient autonomy, and the special requirements of decision making for children. Review of these principles in the context of specific clinical situations can help orthodontists clarify their obligations in these cases.

In all clinical work, the orthodontist should carefully outline indicated treatments, including their benefits and burdens, as well as the consequences of no treatment. Information should be shared in an open fashion that allows patients to participate in decision making. In the case of children, this information must be shared with the parents, but should also be shared with the child as he or she matures. The best interests of the child should drive the medical/dental recommendations, and doctors and dentists must strive to clarify what these are in each case. Based on these, they should make explicit recommendations to the family.

The orthodontist providing children with medically indicated care should take specific steps to ensure that needed care is actually received. The consequences to the child if the treatment is not received determine how strongly the parents' preferences must be opposed when there is disagreement

or failure to follow through with medically indicated care. The orthodontist should take responsibility for involving the team social worker, pediatrician, or other appropriately trained member of the craniofacial team when concerns arise about the family's ability to provide appropriate care for their child. For these and other reasons, the needs of the child with chronic medical conditions such as cleft lip and palate should be managed by a multidisciplinary craniofacial team that includes a social worker or professional with a similar background.

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