Professional ethical standards between orthodontists and general dentists – **improving the relationship between the two groups** Part 1

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As a general dentist trained in orthodontics, have you ever had a patient come back to you claiming that a specialist or another general dentist mentioned your treatment plan or treatment to date is not acceptable – and has criticized you?

Or perhaps you have seen patients who have completed their orthodontic treatment with another practitioner and wondered why the case has been finished that way and believe the case should have ended with a better result?

The patient or parent asks for your opinion – how do you handle this situation?

These are ethical questions and we need to understand the concept of ethics and how it applies to our profession.

Let's start with a definition of ethics

Ethics is defined as: "The science of the ideal human character and behaviour in situations where distinction must be made between right and wrong, duty must be followed in a good moral way and interpersonal relations maintained."

Professional ethics is hence defined as: "The code by which regulates actions and set standards for its members."

Dental ethics may further be classified as: "The moral duties and obligations of a dentist towards his/her patients, professional colleagues and society"

The ADA code of ethics with regards to attitudes towards one's colleague states:

14. Dentists should refrain from disparaging their dental colleagues whether to patients, to other dental practitioners, or to the world at large, except as required by law.

15. Dentists should be reasonably willing to assist their colleagues, including other dental practitioners and dental staff, by the provision of professional services and in the furtherance of the principles set out in this Code of Ethics.

16 (2) If the patient is seeking an opinion about their oral condition, the dentist should endeavour not to say anything which calls into question the integrity of their usual dentist.

The American Dental Association takes professional ethics one step further and states:

"On no account do anything harmful to the interest of the members of fraternity"

The Australian Society of Orthodontists (ASO) Code of Ethics states

1 b 1 Providing guidance for Members of the Society in the conduct of their relationships with their patients, the public in general and their colleagues.

(xiv) Within Australia, members of the ASO should only be involved in the teaching and administration of postgraduate specialist training in ASO Accredited Courses.

I assume all orthodontic specialists were first general dentists – then I ask, "Why should members of the ASO (who obviously are trained orthodontists) be directed not to educate general dentists in the areas of orthodontics – unless it is an ASO accredited course?"

I believe we need transparency and understand why this is so and what are the requirements to have an ASO accredited course, and how would that course differ from a course an experienced and well-educated orthodontist can provide.

In an article by Naidoo SADJ 2013 Jun; 68(5):236-7. Titled: "How do I comment ethically on the work of colleagues?"

The abstract reads, "Patients are entitled to know about their dental and oral health, and practitioners have an ethical duty to inform them on an honest and factual basis. If this can be done without denigrating one's colleagues in any way, both patients and practitioners can benefit.

"As professionals, our first obligation is to place the well-being of our patients ahead of our own interests. First and foremost, and for patient autonomy, we must give patients complete and truthful information regarding their current oral health status. When asked to comment on another dentist's treatment, it is not unethical or unprofessional to remember that there is a significant burden of proof regarding claims of faulty or bad treatment. This demands a prudent dentist must exercise great caution before making comments about other dentist's treatment.

"Uninformed and unjustifiable criticism is disparaging and can lead to unpleasant consequences for the unwary professional. Comprehensive and full accurate records and case history including all notes would be needed by both dentists to support their clinical judgement, if this case ever resulted in a complaint."

I too have been on the receiving end of my specialist colleagues. I would like to share two stories.

The first occurred in the early 2001, soon after two Victorian colleagues and I brought the Herbst appliance to our shores. A 10-year-old boy presented to my practice, with a severe class II skeletal/dental malocclusion, with a retrognathic mandible, 14 mm overjet and was missing two lower incisors. He was told by two previous orthodontists that he would require orthognathic surgery to resolve his malocclusion. We proceeded with a

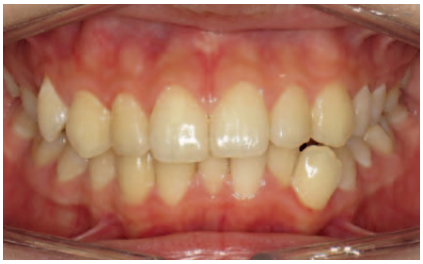

Figure 1 Initial centre

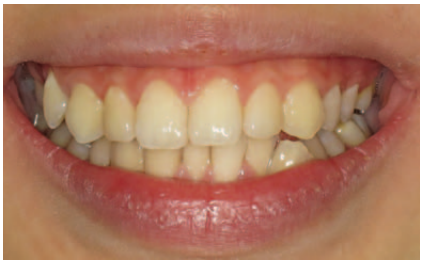

Figure 2 Initial close-up smile

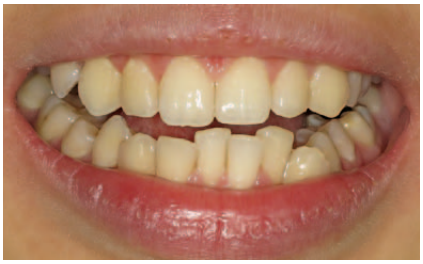

Figure 3 Initial close-up smile open

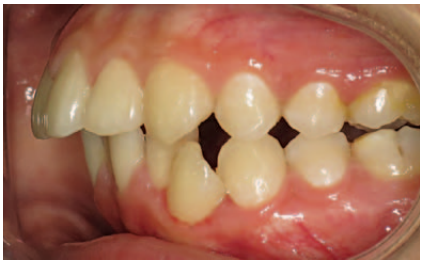

Figure 4 Initial left buccal

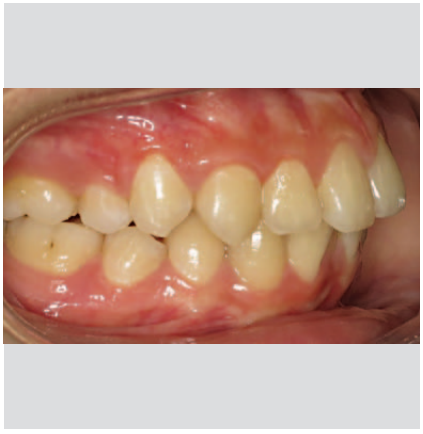

Figure 5 Initial right buccal

Figure 6 Initial profile

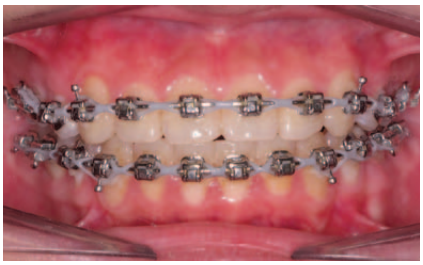

Figure 7 Centre

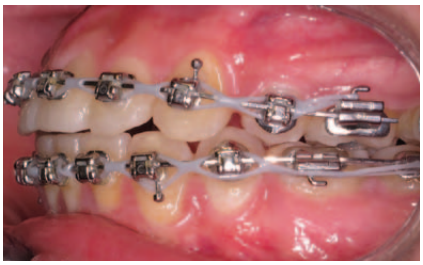

Figure 8 Left buccal

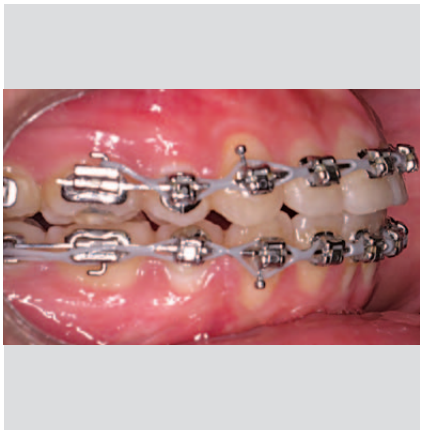

Figure 9 Right buccal

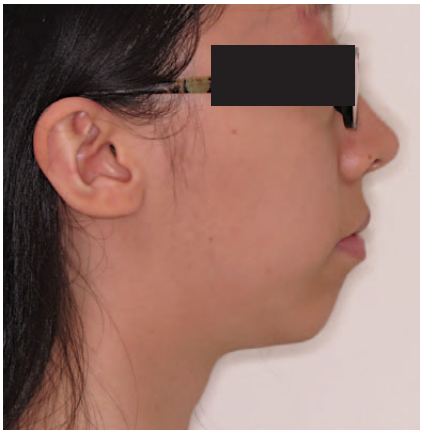

Figure 10 Profile

Herbst appliance and after 15 months of treatment we had reduced his overjet to 4 mm.

Now the interesting part – the child obviously did not like the appliance and decided to go elsewhere for his final braces. Later I received a letter from the ADA, stating the patient had seen five other orthodontists for further opinions and their opinions ranged from 'this was a barbaric appliance,' to 'the Herbst provided no benefit to the patient and all.'

What I find fascinating is that not one of these orthodontists had asked me for the original records and hence I cannot believe they could formulate any proper opinion on the treatment performed. In fact, my treatment saved him from a surgical procedure! Even more interesting today – 4 of those 5 orthodontists who provided further opinions now use this Herbst appliance routinely in their practice for similar types of cases.

The second case was far more recent. A female adult Asian patient presented with severe crowding and a bimaxillary dental protrusion (Figure 1 to 6). My treatment involved upper and lower braces in conjunction with the removal of four premolar teeth to resolve the crowding and retract the anterior teeth to reduce the Bi maxillary dental protrusion.

Unfortunately, I left the practice approximately 18 months after starting her treatment, with her treatment obviously incomplete (Figures 7 to 10) and she was unhappy with the result as the orthodontist taking over the practice was unable to finish her case. Firstly I had offered for the original practice to transfer the patient to me and I would finish the case, as it only required some repositioning of brackets and fine tuning to achieve an acceptable result.

Instead the practice declined my offer and after a further 12 months, the patient attended another private practitioner specialising in orthodontics. He proposed a very elaborate treatment plan – and obviously everyone is entitled to their opinion – but in the report he sent to the patient he suggested, "Nothing had been achieved and the patient should be entitled to a full refund."

Once again, my specialist colleague did not request any of the original records, so I ask the question, "How can one make an accurate assessment of the treatment which has been performed without the original records, a full understanding of the discussion between patient and practitioner and a full understanding of the issues that may have been apparent during the treatment process?" ◆