THE AUTONOMOUS PATIENT AND HIS COMPETENCE IN ORTHODONTICS PRACTICE

Cristian Romanec*
Valentina Dorobăț**
Irina Nicoleta Zetu***

Abstract
The paper aims at making orthodontists aware of the ethical problems or dilemmas that might occur in their profession. A general discussion and a case study are presented. They try to clarify a number of concepts, patient autonomy, and parent autonomy, the relationship between patient autonomy and parent autonomy, patient’s responsibilities, the concept of informed consent, the competent patient. This is done in order to raise orthodontist’s awareness of some of the pitfalls of their profession regarding the possibility of occurrence of ethical issues.

Keywords: patient and parent autonomy, informed consent for orthodontic treatment, patient responsibilities, competent patient.

* „Grigore T. Popa” University of Medicine and Pharmacy of Iaşi, Faculty of Dental Medicine
** “Grigore T. Popa” University of Medicine and Pharmacy of Iasi, Faculty of Dental Medicine
*** „Grigore T. Popa” University of Medicine and Pharmacy of Iaşi, Faculty of Dental Medicine, email: nicoleta.zetu@gmail.com
It is a generally admitted truth that most of the orthodontic patients, after the treatment, enjoy a significant improvement of the basic functions of oral and maxillofacial complex: mastication, deglutition, breathing, phonation and mainly the esthetic ones. The patient can also enjoy a pleasant smile, a facial harmony and a healthy dentition. However, as in other medical fields, this treatment, with its limits and risks, also remains elective. In this respect in Bioethics – a must in the medical practice, Professor Vasile Astarastoae states that “Bioethics brings hopes of respect and permanent revival of human values, of spiritual revival of man as a unique being, given by his biological individuality and his distinct ontogenic evolution”. In this way, bioethics confers meaning to science in general. This fact turns bioethics in a must for the entire medical profession, including orthodontics [4].

In the Romanian jurisprudence, Law 1995/2006 [8] briefly states that the necessity of obtaining a “written consent in case of subjecting the patient to methods of prevention, diagnosis and treatment with a potential risk for the respective patient after all these risks have been clarified by the dentist”

Similarly, it is required to explain, at a reasonable scientific level for understanding the power of the patient, some information regarding the diagnosis as well as the consequences of the proposed treatment, the viable treatment alternatives, the risks involved and their consequences, and the prognostic of the disease in the absence of treatment.

The orthodontic interventions are not dominant in the dental practice, but starting from the reality of postmodern period we are passing through, - we notice an increasing trend of malocclusions in children and teenagers, amounting now to 70-75% and the necessity of some treatments of complex oral rehabilitation in adulthood which also include orthodontic treatments, - we identify more and more cases in which the orthodontist must deal with certain problems such as:

- The relationship between the professional and ethical aspects on one hand and the economic ones on the other i.e. the large number of patients and their limited possibilities to bear the treatment costs;
- The information to be transmitted to the parents;
- The decision regarding the treatment type, whether uni- or interdisciplinary;
- The delegation of the care to other persons, complementary services for hygiene, pre-orthodontic treatments, etc.;
- Obligation to treat versus treatment refusal;
- Extraction treatment versus non-extraction treatment.

Regarding the treatment plan, the orthodontist must have in view some important elements such as: pain prevention, preservation and restoration of the oral functions for normal speech and feeding, restoration and maintenance of the patient’s physionomy, promotion of control and responsibility for patient health, observance of child’s interest, parents’ decision etc.

This study presents a case and a discussion aiming at developing awareness regarding the possibility of occurrence of important ethical issues in orthodontics. Such cases occur mostly when we feel uncertain or when conflicts over moral obligation develop. The case presents a dilemma that occurs when the interests of the motivated
child are balanced against the opinions or interests of his/her parents. According to classical deontological traditions and to various codes worked out by various professional associations, the orthodontist should act in the interest of his patients [8, 10], irrespective of the financial settlements, sometimes even with certain risks. Unwillingly, the orthodontist comes into conflict with the interest of the parents who usually want, most of the times, a cheap and fast treatment [11]. In spite of this fact, the orthodontist has to respect the patient autonomy [5] and, moreover, to obtain the cooperation of the patient and his family for selecting the optimal strategy. For example, in the Ethical and Professional Code of American Dental Association [2,3], among the primary obligations of the dentist, it is also included the requirement to involve the patient in the treatment in the spirit of the autonomy principle, offering adequate understanding to the young patient, in a constructivist spirit, taking into account the needs of the patient, his/her wishes, obviously as much as it lies in the power and skill of the orthodontist. The orthodontist has to inform the patient, from the very beginning, about the proposed treatment and its alternatives. The outstanding feature of the concept of patient autonomy is the obligation of obtaining an informed consent taking into account the fact that all interventions need the acceptance of the competent, fully aware patient. This concept is not well defined yet as the formation process of the competent patient has not been pedagogically well clarified. Anyhow, when the patient is a child, as in most cases in orthodontics, he/she is incompetent due to his/her age, the morals of the society in which he/she lives, the fact that the legal decision is generally in the hands of his/her parents. In spite of this, the parents’ rights should not be regarded as unlimited as they should also involve the child’s interest [12]. As the child grows, he/she should be gradually involved in the decision making process, starting from the principle that a well informed and well-motivated child becomes an ideal cooperating partner for the orthodontist.

In the spirit of respecting the autonomy, most of the times, we managed to convince the family as in the case presented here, mainly with the help of the child, showing that the interest of the little patient means in fact to act in due time for his/her physical integrity and esthetical welfare. Let us not forget, in this respect, that any difficult medical situation involves delicate cultural issues and social relations which are not always simple.

Aims of the paper

In order to exemplify the concepts of informed consent, the patient autonomy, the parents’ autonomy, the informed consent and the competent patient, we identified a sensitive case in order to make orthodontists aware of the possibility of occurrence of some unsolvable issues in orthodontic practice. In this respect, we selected the case of patient C. D., male, who called for our help at the age of 13. The reasons for the orthodontic assistance included: physiognomic type disorders generated by the pronounced convex facial profile and the fact that his smile was affected by the malposition of the incisor-canine group.

Discussions and case presentation

The presence of the parents allowed us to find out on the spot that father had a similar malocclusion. We compared
the two malocclusions and told the
parents that during the period of
growth, the malocclusion of the child
would worsen in the absence of
treatment.

The extended family investigation on
four generations demonstrated that the
malocclusion was an autosomal
dominant disorder. It is unanimously
known that the dental-maxillary
malocclusions that admit in their
etiology the genetic factor (as it is the
present case – 2\textsuperscript{nd} class/2 Angle) are
responding with difficulty to treatment,
and the risk of recurrence is
significantly high. The chance to obtain
a good and permanent result depends on
the way the orthodontist uses the
growth potential and the treatment
method on one hand and the
cooperation of the patient during the
therapeutic program on the other hand.
The family investigation carried out by
the geneticist followed by a discussion
of the clinician-orthodontist-geneticist
team allowed us to offer the patient and
his parents a thorough and correct
account of the prognosis of the case in
the presence vs. the absence of
orthodontic treatment.

Based on clinical and complementary
examinations, the patient was diagnosed
with 2\textsuperscript{nd} class malocclusion Angle, sub-
division 2, with agenesis of premolars 2
mandibular, and a tendency to inclusion
of M3 of hereditary nature.

Regarding the treatment, we favoured
a mixed surgical-orthodontic treatment.
We indicated the extraction of
premolars 1 maxillary (a balanced
extraction to the agenesis of premolars
2 mandibular) practiced in the treatment
of 2\textsuperscript{nd} class Angle, followed by
orthodontic treatment by a poly-
aggregated system.

The treatment decision was discussed
with the patient and his parents,
thoughly explained on plaster models
and orthopantomography. The
advantages of treatment and the
necessity of carrying it out at the
presentation time were described in
details. The parents did not accept
dental extraction considering that to a
natural loss (agenesis of premolars 2)
which will take place, a therapeutic loss
will be added (by extraction of
premolars 1 maxillary). In order to re-
establish the coordination of dental
arches, extractions could be necessarily
but only with the patient’s consent.
Moreover, this strategy, in their
opinion, could lead to the lengthening
of the treatment period. The parents’
argument was based on the fact that the
patient’s father did not follow any
orthodontic treatments and was not
concerned about his physiognomic
aspect. Moreover, he was proud that his
son perfectly resembles him. The
mother was pessimistic regarding the
success of the treatment stating that, a
detail not disclosed initially, the patient
began a treatment at a private medical
practice in the near past but the absence
of progress determined them, after a
while, to abandon the treatment. The
patient, in his turn, seems to be decided
to observe and follow all the conditions
imposed by the treatment strategy,
mostly because he has many classmates
who follow orthodontic treatments.
Obviously, we may identify here a clash
between the aesthetic aspirations of the
child and the pragmatic spirit of the
parents. The parents came back after a
while and proposed us to carry out a
non-extraction treatment. The
discussion was resumed and we
objectively demonstrated, based on the
previous examinations, that the dental
extraction was a necessity. They were
asked to have a family meeting and
come with a decision. For various
reasons and mainly from a more obvious awareness in relation to the aesthetic aspect in contact with other classmates and friends, who faced the same problem, and last but not least, the decision of the patient to choose a future profession in which appearance, especially the facial one, has an important role, at the age of 14 he has shown a strongly motivated interest for the orthodontic treatment in spite of the family opposition that did not believe in the possibility of improving the physiognomic aspect. Nonetheless, the patient was determined to carry out the treatment to its completion, even though a member of the family was to bring him to the orthodontic practice from a longer distance. After 3 years of treatment, the young man left the practice with a good facial balance, a functional occlusion and a pleasant smile. Nowadays, our patient has a successful career in law. It is obvious that, in this success story, communication played a fundamental role mainly in the light of recent developments in medical ethics that tend to become significant for our profession too, mainly the concepts of patient autonomy, patients’ informed consent, and, generally, of the tendency to abandon paternalism in the process of decision making. The authentic motivation of the patient contributed to making the skeptical parents believe in the real chances of success, that the malocclusion without treatment would worsen, that pain could occur, all leading to a later treatment with higher costs. Obviously, we also had to admit that the treatment length could be extended. The orthodontist, in our century, has to cope with some tendencies and obligations imposed by the Professional Ethics Code that underlies the importance of some quality services within the limits of maximum possibilities of the orthodontist, on the one hand, and the obligation to take into account the patient’s right to decide on the treatment alternative that is an option as long as he gets an explanation regarding the risks, on the other hand. This attitude is approached in the spirit of John Dewey’s pragmatism that promoted, in a democratic spirit, the instrumental function of ideas and judgments in sorting out the problems. The application of John Dewey’s constructivist ideas to the issue of informed consent involves the presentation, using an accessible discourse for the patient [1], of diagnosis, treatment plan, treatment procedures and their performance, a presentation of possible treatment alternatives, parent and child awareness of the treatment, the potential risks of treatment, a realistic presentation of treatment benefits and success possibilities, including the invasive treatments such as anaesthesia, extraction, complications resulted from orthognathic surgery. Obviously, in the absence of some objective criteria, the orthodontic treatment, as a way of promoting a higher quality of life, is an issue of personal decision. The orthodontist should offer the patient essential information about treatment risks. Some of these risks can be identified through a careful examination even from the first appointment with the orthodontist: impacted teeth, supernumerary teeth, missing teeth, gingival recession, ectopic eruption teeth etc. Thus, the decision to use an orthodontic appliance should be presented to both the patient and parents, within a broader context that aims at improving the quality of life in a functional, aesthetic and
psychological context. This interactive model of communication answers the aesthetic, functional and psychological needs of the patient, offering an effective and efficient clinical treatment in the conditions of observing the patient’s autonomy according to the informed consent doctrine. Obviously, the patient’s autonomy is considered to be the individual’s capacity of critical reflection based on receiving complete and complex information that might make the patient capable of independent action. We may say, consequently, that the contemporary orthodontic practice is rather an interactive process between patient and clinician aimed at sorting out issues regarding diagnosis and treatment with the purpose of defining and carrying out the mutual objectives of the treatment coupled with a selection of the most adequate mechanic therapy meant to reach the mutual final goals. The clinician-patient interaction includes the ranking of problems, taking into account the therapeutic changes, in a word the capacity of foretelling the course and the outcome of the treatment, the potential relapse risk and its anticipation, for example, by informing the teenager about the status of the third molar which needs extraction as it was necessary in our case. Briefly, every day, the orthodontist is required to integrate the ever increasing scientific developments in the orthodontics practice, without which an authentic informed consent could not be obtained. In this respect, the patient should be made aware not only about the risks of wearing the orthodontic appliance but also about the responsibilities he has during the treatment and which he has to consciously undertake. In other words, this process should not only involve the child but also respect him/her. Consequently, we should not use our power and take advantage of the child’s patience causing him discomfort by lengthening a session to 2-3 hours for fixing all the brackets. This easy way is comfortable for the orthodontists but is rejected by children. We should focus more on the child’s comfort and not on the orthodontist’s easiest way to achieve this. An orthodontist will be more appreciated by a patient for his moral attitude and communication abilities and less for his skillfulness. Similarly important are the knowledge and observance of the growth periods of the dental-maxillary complex accompanied by the selection of the best treatment time. In this respect, the orthodontist should carefully evaluate the orthodontic force he applies by taking into account that the appliance should not be required to achieve more than it was designed for. Moreover, the used forces should be low, bearable, avoiding the engagement of high forces that apparently fasten the treatment. In one word, the individual treatment procedures for extraction and non-extraction cases should be observed together with the characteristics and the length of contention.
Conclusions
All the issues and problems presented in this paper aim at identifying some compulsory requirements to be included in a complex record on the informed consent, surpassing the formalism present in most of the cases in day-to-day practice. In this respect, we consider that it is the duty of the College of Romanian Dentists, as an institution protecting the interest of the patients and dentists, to recommend a number of elements to be included in the informed consent record. The development of awareness, in this respect, is in fact an educational act, in the spirit of constructivist theories that might lead to the formation of a competent patient, prepared to face life.

Bibliography
[4]. Astărăstoae Vasile, Bioetica – o necesitate a practicii medicale în: Irina Zetu, Ortodonție, Tehnica arcului drept, ed. Tehnopress, 2010;
[5]. Ciucă Aurora, Conceptul de "demnitate" a ființei umane în bioetică și biodrept (II). Revista Română de Bioetică vol 8, nr.3, 25-28, 2010;
[9]. Legea 95/2006, publicată în MO 237/05/04/2007;
[13]. Vicol Mihaela Cătălina, De la vulnerabilitate la discriminare în sistemul de sănătate, Revista Română de Bioetică, vol. 9, nr.2, 3-4, 2011;