Insufficient information provided to patient undergoing functional orthodontic treatment (03HDC03104, 25 May 2004)

Dentist ~ Standard of care ~ Information about treatment options ~ Information about risks and side effects ~ Rights 4(1), 6(1)(a), 6(1)(b)

A 39-year-old man complained about the treatment and information he received from a dentist practising functional orthodontry, specifically that the dentist:

1 had not assessed him adequately or correctly diagnosed him, and treatment was inappropriate;

2 did not adequately inform him about alternative treatments, the risks and side effects of the proposed treatment, or other options to termination of the treatment;

3 did not adequately supervise his employees, leading to the inappropriate instalment of an occlusal plate on two occasions;

4 did not identify a pre-existing infected wisdom tooth;

5 did not provide remedial treatment to repair the broken occlusal plate in a timely manner.

The man consulted the dentist about teeth-grinding and pain in the joint of his jaw, which was causing headaches. Following a clinical examination, joint vibrational analysis and X-rays, the dentist diagnosed an overbite causing abnormal contact between the upper and lower teeth, incorrect jaw posture, and dysfunction in the joint, and proposed treating this with appliances made of acrylic and fixed orthodontic wires. He informed the man that success of the treatment depended on the patient wearing the appliances at all times as instructed, that the patient must be responsible for taking care of the appliances, and that the appliances might cause discomfort and problems with speaking. A few days later the dentist provided the man with a report detailing these and other points.

The man experienced problems with the appliances, finding he was unable to wear them all the time; the dentist made modifications on several occasions, and repaired broken wires. During routine checks the man was seen briefly by the dentist, and then dental assistants carried out the treatment. The problems continued and the man advised the dentist that he was wearing the appliances only at night. Eventually the dentist installed fixed splints between some of the teeth because of the problems using the removable appliances. However, the occlusal plate holding the splints broke one hour after placement and, over the next few days, the man experienced discomfort from a loose wire. The dentist was unavailable over the Christmas/New Year period, and there is dispute about when the breakage was reported and whether emergency treatment from other staff was offered; in the event the man visited an after-hours dentist elsewhere.

Early in the new year the man visited the dentist and complained about progress of the treatment. The dentist explained that the current treatment was a compromise, and undertook to carry out future appliance repairs and checks himself. However, during a consultation two weeks later the man stated that he was unable to continue with the appliances and asked about alternative treatments, such as a night splint. The dentist advised that a night splint would be unsuitable, but he did not suggest alternative treatments. The man asked for the appliances to be removed, and was told that this

might cause his teeth to return to their former positions and that the headaches might return. An assistant removed the appliances, and the dentist observed that the man's bite had improved and would be functional, if not quite correct, within a month. He wanted to take further impressions of the teeth and carry out another joint vibrational analysis, but the man declined further treatment, and the consultation became somewhat heated.

Some time afterwards, the man found that he had an impacted (and infected) wisdom tooth, which had not been picked up by the dentist. He sought advice from an oral and maxillofacial surgeon on his treatment by the dentist, and subsequently made a complaint directly to the dentist and to the Commissioner.

It was held that the dentist breached Rights 6(1)(a) and 6(1)(b): in not informing the man about his impacted wisdom tooth, and not advising him of possible problems with the treatment offered; in not providing him with information (either verbally or in his written report) about alternative palliative treatment options for his teeth-grinding symptoms, particularly as the proposed treatment was lengthy, expensive and demanding; and in not advising him of alternative options at the final consultation when treatment was terminated. It was further held that the dentist breached Right 6(1)(b) by not fully explaining the expected risks and side effects of the treatment.

While opinions regarding functional orthodontics vary in the orthodontic community, it was held that the dentist's clinical practices were appropriate, and he did not breach Right 4(1). He exercised reasonable care and skill in relation to his diagnosis, treatment plan, delegation of duties to other staff, the tests and radiographs taken prior to treatment, and the steps taken to repair the broken occlusal plate.