ETHICAL MANAGEMENT OF PATIENT COMPLIANCE/CO-OPERATION

Introduction

Compliance can be defined as the act of doing what someone tells you whereas cooperation is synonymous with collaboration or teamwork. Compliance therefore implies an unequal relationship and requires a patient to comply with an orthodontist's instructions.

Successful treatment is reliant upon teamwork between orthodontists, supporting staff, patients, parents/carers and the referring dentist. Clear, effective and sensitive communication is key. This will ensure patients are fully informed and prevents dissatisfied patients/ complaints.

The issue of compliance affects all patients. However, the orthodontist must ensure the patient understands the associated risks if they don't abide by the advice. The challenge is not only in providing the information, but ensuring a patient is able to process and retain the tailored advice.

Orthodontists have a duty of care whereby any provision of treatment must be appropriately justified, completed in a reasonable time frame and within their level of competence.

Patients lacking compliance will no doubt compromise treatment results. Orthodontists are reliant upon patient compliance in aspects such as, but not limited to, oral hygiene maintenance, diet control, appliance wear and attendance. This should be monitored at each visit for all patients.

Record keeping is particularly important when changes to, or discontinuation of the treatment plan is considered for any reason, particularly in cases of non-compliance or non-attendance.

Accepting responsibilities

Orthodontists expect patients to be involved at three levels as defined below:

Implied consent: wearing fixed appliances and managing mild/moderate discomfort.

Discipline: patients are informed to strictly avoid certain foods and drinks, not abuse the appliance and cease habits such as thumb sucking or nail-biting habits

Active participation: Patients are asked to attend appointments at regular intervals, maintain good oral hygiene, use fluoride supplements, report problems when they arise and wear removable appliances and adjuncts such as elastic bands. In addition, patients are expected to maintain cleanliness of their appliance

Parents of patients with children (under 16 years of age), should be involved in the consent process at every stage of treatment. Gillick competency however, needs to be considered.

Gillick competence: originates from the legal case in England It is based on a decision of the House of Lords in the case Gillick v West Norfolk and Wisbech Area Health Authority [1985]. The legal term identifies whether a child can consent to their own medical treatment.

A child is deemed Gillick competent if they can understand the nature, consequences and alternatives of the proposed treatment If a child is Gillick competent, it is however, recommended they discuss the orthodontic treatment options with their parent.

Lord Scarman's comments in his judgment of the Gillick case in the House of Lords summarised the position:

"parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

In Scotland, the Age of Legal Capacity (Scotland) Act 1991 gives the right to a child to consent to any surgical, medical or dental procedure should they be deemed to have capacity. Furthermore, an adult is classified as over the age of 16 in Scotland.

Best practice

From the outset, patients and parents/carers should be made aware of practice procedures and the importance of compliance and the associated risks should advice not be followed. Patient information leaflets are a useful means of supplementing information discussed verbally as part of the consent process. The British Orthodontic Society provides several such leaflets that can be purchased in hard copy (www.bos.org.uk/PILs).

Communicating patient responsibilities

Informed consent relies on patients and parents having the full responsibilities communicated effectively, to be able to make the necessary treatment decision suited to them.Visual aids are useful tools, supplemented with written leaflets to take-away for back-up.

A patient who fully understands the proposed treatment, process and risks is more likely to understand what is required and comply. The use of a consent form, a copy of which is retained by the patient, is highly recommended and should identify the important elements of the patient's responsibilities. However, it is important to be aware that a consent form does not in itself demonstrate valid consent and the GDC guidance clarifies that ethically:

3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether consent is valid.

Discussions should therefore be recorded in the clinical notes and clinicians should not solely rely on provision of patient information leaflets. Explanations do not necessarily have to be provided by the orthodontist but information on compliance can be given by an orthodontic therapist, nurse or an auxiliary. Orthodontists should however, be available to answer questions.

Duty of care

The responsibility of an Orthodontist goes beyond providing information as part of the consent process and expectations relating to compliance. This two-way process should be constantly checked throughout treatment to ensure:

- The treatment plan is realistic in all times to ensure patient compliance
- The most appropriate design is selected for any fitted removable appliance and user-friendly, comfortable and robust
- Eliminate fixed appliance breakages due to inappropriate bracket positioning and wire placement by ensuring the correct procedure is followed.
- Accessory appliances (such as elastics or headgear) are correctly prescribed. Should alternatives be required, instructions must be given for any changes undertaken.
- If treatment has gone beyond the anticipated time-frame, the patient and parents must be made fully aware of the delays and informed of the likely new timescale
- The orthodontist must ensure that the treatment aims are specific, realistic and time-bound.

Record keeping

It is essential to record all information provided to patients prior to, and during treatment. If the relationship between the orthodontist and patient breaks down, the treatment outcomes are compromised. The only remaining defence may be detailed and comprehensive record keeping.

Managing non-compliance

These generally fall into one or more of the following categories:

Poor oral hygiene and diet control

Establishing optimal oral hygiene is an essential pre-requisite for orthodontic treatment. This minimizes the risk of damage to dental enamel and the surrounding tissues. The longitudinal nature of appliance therapy, there may be a decline in standards that could prejudice the health of the dentition and gingivae. Every attempt should be made to discuss the problem openly with both the patient and the parents/carers. Concerns, discussions and the efforts made to modify patient behaviour should be clearly recorded in the clinical notes. The issue of discontinuing treatment should be discussed with the patient and parents/carers with adequate forewarning as to the risks and consequences of stopping treatment with any warnings recorded in the notes.

Poor wear of appliances and continued breakages

Discontinuing treatment may need to be considered in situations where patients regularly attend with damaged appliances, or they poorly comply with wearing the appliances/ accessories. The clinician must demonstrate all efforts have been made to eliminate the possibility that breakages/poor wear are not attributed to clinical errors. A careful, clear written record should always be kept of any action taken or recommendation made. The orthodontist must be able to justify the decision to discontinue treatment and should inform the referring dentist and, when appropriate, notify the relevant commissioning authorities.

Poor attendance
Patients that are wearing orthodontic appliances and do not attend are not receiving supervised care. Frequent non-attendance compromises the patient's oral health and therefore action should be under taken by the orthodontist. It is good practice that every attempt to contact the patient is made to continue orthodontic care and ensure any risk of damage is minimised. It is also important however, to consider issues such as chronic illnesses and/ or any safeguarding concerns. Communication with the referring clinician is essential in these circumstances. Consideration can also be given for a direct referral for safeguarding issues if felt appropriate following local safeguarding procedures. The British Dental Association (BDA) offer advice on safeguarding and have an outline of a 'Was Not Brought' protocol to assist clinicians with the pathway. This information is freely available on their website and is accessible to BDA members and non-members.

Continued failure to attend would suggest the patient has withdrawn consent for completion of orthodontic treatment. In these circumstances, clinicians should inform the parents/carers and GDP in writing of the risks to the dentition with continual unsupervised wear of an orthodontics appliance. No responsibility will be taken for any harm that may follow.

Charges

Within the current NHS funding system within England and Wales, it is not permissible to charge for failed appointments or broken appliances (unless removable appliances or retainers require replacement). The Statement of Dental Remuneration details the charges for the repair/replacement of appliances in Northern Ireland and Scotland. It is essential that any costs are made clear in any written information provided to all patients at the start of treatment (including if such charges are NHS or private).

Booking of future appointments should not be reliant upon receipt of payment prior to the appointment or settlement of non-attendance charges. For payments in arrears, the child's treatment should continue while debt recovery measures are in progress.

NHS regulations on discontinuation of treatment
In England and Wales, the National Health Service (Personal Dental Services Agreements) Regulations 2005 clarifies the grounds on which NHS treatment may be discontinued which are limited to three areas:
Violence which is reported to the police
Refusal to pay NHS charges
Irrevocable breakdown in the professional relationship between the orthodontist and patient

Reference should be made to the NHSE Guidance on the completion of FP170 forms within the NHS (www.nhsbsa.nhs.uk/DentalServices). Recent changes to FP17Os 'Orthodontic assessment and de-bond- Overseas patient' is introduced as a new item from 1 October 2022. https://www.nhsbsa.nhs.uk/fp17-and-fp17o-changes-1-october-2022
In Scotland and Ireland readers are advised to refer to the Statement of Dental Remuneration for clarification. There is a distinction between where the responsible clinician decides to discontinue treatment versus when consent is effectively withdrawn and the patient wishes to abandon their care.

Websites for further information
General Dental Council: https://www.gdc-uk.org/
NHS rules and regulations: https://www.nhsbsa.nhs.uk/nhs-dental-services
BOS advice sheets: https://www.bos.org.uk/professionals-members/advice-sheets-and-guidelines/

Updated by the Clinical Governance Directorate of the British Orthodontic Society December 2023.
Recommendations may change in the light of new evidence.

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