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the editor's corner

Defensive Orthodontics

In light of the fact that TMJ problems can be caused by everyday occurrences such as a yawn, a wide opening, a blow, occlusal changes, stress, bruxing, and many more, it seems extraordinary that the fault is often ascribed to orthodontic intervention. Further, with all the cases that have been treated orthodontically that never had a TMJ problem, and all the cases of TMJ problems that never were treated by orthodontists, it would seem hard to make a case for orthodontic treatment as the cause. Yet, it is happening.

In a recent malpractice suit, a patient was awarded $850,000 plus costs for allegedly causing a TMJ problem with a treatment plan calling for the extraction of upper first bicuspids. The jury was convinced that retraction of the upper anterior teeth following the extractions locked the mandible and forced the condyles back in the fossa. Aside from merits of the case and aside from the question of whether a legal precedent was or was not set, there is a question of how an orthodontist contemplating such a treatment plan should protect himself or herself against a similar suit, assuming that he or she is convinced that TMJ problems do not result from such a treatment procedure—or at least will not in the case at hand.

The point has been made and needs to be made again that orthodontists should be sure to carry a maximum amount of occurrence-basis malpractice insurance, which insures against future suits for present work, as against claims-made-basis insurance, which insures only for the current policy year. (See Jones, C.L.: Long-Term Orthodontic Liability Problems, JCO 19:134, 1985.) The point has also been made that friends do not usually sue friends. (See Larry White's Editor's Corner in the October 1986 issue of JCO.)

It has been suggested that the suit mentioned might not have been lost if the orthodontist had had pretreatment tomograms of the joint to

demonstrate that the condyle position was not changed by treatment. This idea raises the prospect of an expensive defensive tactic, especially when there is no consensus in the profession that tomograms of the joint are diagnostic.

Whether tomograms, in addition to the usual diagnostic records, will improve the chances for a successful defense remains to be seen. Meanwhile, orthodontists would do well to keep in touch with the state of the art in TMJ diagnosis and consider whether axiography, kinesiography, or some other method of measuring mandibular movement and assessing the condition of the TMJ would be an appropriate addition to their diagnostic routine. The chances appear to be good that the answer is "yes".

A second defensive measure would be never to extract bicuspids. Not only is this non-diagnosis unacceptable according to present practice, but it would not necessarily avoid a suit based on alleged TMJ damage. If it were to become clear that there is a better way to handle those cases in which a prudent orthodontist would extract bicuspids today, then orthodontists in the future will follow what they judge to be the better way—as they always have.

A third defensive measure is informed consent. The possibility of TMJ problems following treatment should be discussed thoroughly, and the patient should be given a realistic appraisal of the risk/reward balance in his or her case and the pros and cons of alternative treatment plans. The patient and/or responsible party should sign a consent form that details this discussion. While it is useful and convenient to have a printed consent form, it is important that the points in that form be reviewed in a patient interview and, perhaps, checked off as they are discussed.

We are sometimes reluctant to lay out all the events that could conceivably be related to treatment, when most of them are extremely unlikely to occur in our experience. In some cases, there is a fear that a patient will reject needed treatment because of some far-fetched point raised in the informed consent discussion. This would seem to be a minor risk when weighed against the bringing of or loss of a malpractice suit.

A fourth defensive measure is to collect evidence that will defend the treatment concepts that we customarily use and that will be credible in a court. This might be a specialty group effort or a university group effort, or both. Certainly there ought to be enough cases that have been treated with extraction to remove the question of cause and effect from the anecdotal to the evidential. In the March 1988 issue of AJO, Gianelly et al. published a study that concluded that "neither four-premolar extraction treatment nor deep bites were associated with posteriorly positioned condyles when visualized with corrected tomograms" in the sample studied. More such studies are needed, of cases in which various teeth had been extracted, to establish a body of evidence that might avoid some malpractice litigation and mitigate divisions within dentistry that support such suits.

A final defensive measure is never to dismiss a patient. Orthodontic patients ought not to be transients in an orthodontic practice. They must be educated to the possibility that additional problems related to function and alignment can occur, that they are not necessarily related to prior treatment, and that maintenance of a harmonious stomatognathic system means periodic recall to observe the condition of this complicated system as a person ages, and to treat what needs to be treated to keep the machine running at an optimum level. There are no guarantees that the system will remain in harmony for a lifetime.

Such an approach would introduce a management problem, but not an insurmountable one; and beyond defensive orthodontics lies a conversion of orthodontics from an incidental service to one of ongoing care. ELG