

# Orthodontic working group report

November 2016

The Dental Council is a responsible authority established by the Health Practitioners Competence Assurance Act 2003. Our primary purpose is to protect the health and safety of the public by making sure that oral health practitioners are competent and fit to practise.

The oral health practitioners that the Council regulates are dentists, dental specialists, dental therapists, dental hygienists, clinical dental technicians, dental technicians and orthodontic auxiliaries. We regulate approximately 5,100 oral health practitioners—with about 4,300 currently holding annual practising certificates.

Section 118 of the Act defines our role and functions.

These include:

- setting accreditation standards and competencies for each of the dental professions and defining scopes of practices and the associated prescribed qualifications
- maintaining the public register of all registered oral health practitioners
- issuing annual practising certificates to oral health practitioners who have maintained their competence and fitness to practise
- receiving and acting on information from health practitioners, employers and the Health and Disability Commissioner about the competence of oral health practitioners
- reviewing and remediating the competence of oral health practitioners where concerns have been identified
- investigating the health of oral health practitioners where there are concerns about their performance and taking appropriate action
- setting standards of clinical and cultural competence and ethical conduct to be met by all oral health practitioners
- promoting education and training in the oral health professions
- promoting public awareness of the Council's responsibilities.

Further information about the Dental Council and the professions it regulate is available on the website [www.dcnz.org.nz](http://www.dcnz.org.nz)

# Contents

---

Executive summary	5
Working group recommendations	6
1. Background	8
The working group	8
Working group process	9
Orthodontic-related complaints	9
Concerns raised by practitioners	10
Advertising complaints	11
Accident Compensation Corporation treatment injury claims	11
University of Otago report on education and competencies	12
Resources	13
2. Discussions	14
Competence of dental graduates	14
Further education and training	15
Quality of courses available	15
Risk of harm	19
Treatment modalities	19
Complaints' consideration	21
Professional relationships	22
The safety, rights and interests of patients	23
Access points for orthodontic treatment	23
Informed consent	24
Patient information	26

Advertising	26
Handling of advertising complaints	27
Patient safety when outsourcing the diagnosis and treatment planning	28
Tools available to address concerns	29
Post nominal qualifications on the Dental Council public register	29
Competence review committee composition	29
Additional investigations or literature reviews	30
3. Conclusions	31
4. Recommendations	34
Appendix A: Working group terms of reference	35
Appendix B: BDS learning outcomes and competencies related to orthodontics, as reported by University of Otago	36

# Executive summary

---

The Council established an orthodontic working group in September 2015 in response to concerns from patients, general dentists and orthodontic specialists concerning the quality and appropriateness of orthodontic treatment provided by general dentists.

The working group comprised subject-matter experts in the area of orthodontics, and independent academic and clinical perspectives from dentists and other dental specialists. One lay member and a children's advocate were to strengthen the deliberations from the perspectives of public safety, patient care and expectations, and patient rights.

The working group held three meetings. Following the first meeting the working group identified the need for further, targeted information gathering. Identified stakeholders were requested to comment on a briefing paper that contained the issues identified in the working group's terms of reference and a summary of discussions from the working group's first meeting. Stakeholders submitted written responses, and some followed this up with a presentation to the working group.

The working group's key conclusions were:

1. The general dental scope of practice allowed dentists to provide orthodontic treatment within the practitioner's competence—similar to other activities performed.
2. Dentists had the base-knowledge to do limited orthodontic treatment. Engagement in further training and gaining relevant experience was required to perform a wider and more complex range of orthodontic treatment.
3. Undergraduate training instilled sufficient fundamental knowledge for dentists to undertake further education and training to perform orthodontic treatment within their level of competence, skills and experience.
4. There was a need for better quality, New Zealand-driven courses available to dentists to upskill in the area of orthodontics.
5. Short courses did not offer comprehensive, stand-alone training programmes that would be sufficient to enable dentists to perform orthodontics in the absence of other education and training. Short courses could have some value in continuing professional development, if the practitioner had the fundamental knowledge to ascertain whether the system and content offered was evidence-based, and appropriate for a particular patient.
6. Orthodontic treatment had a limited risk of serious harm with most procedures being reversible; the risk associated with orthodontic treatment was not significantly greater than other advanced areas of dental practice.
7. The size of the problem with inappropriate orthodontic treatment was small; with the number of practitioners with identified concerns about their orthodontic practice being very small.
8. More independent information must be made available to patients to equip them to ask the relevant questions when seeking orthodontic treatment, and to facilitate informed consent.

9. The tone of some orthodontic advertising was undermining the dental profession at large and potentially not assisting the public to make decisions—in particular, when using comparative advertising techniques.
10. Peer-contact between dentists providing orthodontics, and orthodontists would be beneficial; improved collegial and professional relationships would be more constructive in changing behaviour than the introduction of increased regulation.
11. There was no need for changes to the general dental scope of practice, or a new practice standard related to the practice of orthodontics, at this point in time. It was considered that the Council's *Standards Framework for Oral Health Practitioners* adequately covered the professional and ethical behaviour required from oral health practitioners.
12. To ensure absolute clarity on new dental graduates' capabilities in relation to orthodontics, orthodontic-specific competencies that reflect the current undergraduate curriculum should be developed.

## Working group recommendations

---

The working group recommended the following to the Council:

1. The Council considers developing orthodontic-specific competencies for dental graduates, using the learning outcomes and competencies provided by the University of Otago Bachelor of Dental Surgery (BDS) programme.
2. The Council encourages better quality, New Zealand-driven courses available to dentists in the area of orthodontics.
3. The Council encourages exploring electronic mediums and technology to assist in the delivery of such education, in particular for ongoing supervision.
4. The Council, in consultation with key stakeholders in this area, develops and releases educative information guiding the public on orthodontic treatment. In particular what patients should look for when choosing a practitioner, important questions to ask when seeking orthodontic treatment, and patients' rights—including the right to complain about harm caused or unsatisfactory treatment. The information should be targeted to both young people and their parents/carers, and in plain English.
5. The Council collaborates with the New Zealand Dental & Oral Health Therapists Association and the Clinical Directors Forum on more consistent, comprehensive and transparent information on referral options for patients and parents/carers to access orthodontic treatment, when referred by dental therapists.
6. The Council considers the majority support for mandatory disclosure by a practitioner offering orthodontic treatment to confirm their registered practising status—whether they are a dentist doing orthodontics or an orthodontist.

7. The Council advocates for continuing professional development initiatives on informed consent specific to orthodontic treatment. In particular, on the continuing assent for ongoing treatment, the spectrum of consent and decision-making participation distribution during the extended period of orthodontic treatment, active decision participation by the child, and the shift of ongoing assent from the parent/carer to the child during the duration of the treatment, and young person targeted information.
8. The Council prioritises the review on its communication approach to advertising complaints—in particular to complainants.
9. The Council works with the New Zealand Association of Orthodontists on their concerns about the handling of their advertising complaints.
10. The Council proceeds with its plan to revisit its policy on the publication of post nominal qualifications; with only registerable qualifications to be listed on the Dental Council public register.
11. The Council closely monitors the complaints related to orthodontic treatment, including informal inquiries or questions related to concerns or unsatisfactory outcomes.
12. The Council clearly communicates its expectations of practitioners performing orthodontic treatment, following its consideration of the working group report.

# 1. Background

---

## The working group

- 1.1 The Dental Council ('the Council') established the orthodontic working group ('working group') to consider and explore the following points and related issues:
  - The Council had received an increasing number of expressions of concern and complaints from orthodontic specialists, general dentists and patients concerning the quality and appropriateness of orthodontic treatment provided by general dentists.
  - The Council agreed there were issues concerning the standard of competence of general dental practitioners taking on complex orthodontic treatment that was beyond their knowledge and skill, and in doing so, the safety of patients could be compromised.
  - The Council was concerned that some practitioners were straying beyond the limits of their training and skill level, and were not fulfilling their professional obligation to "know when to refer", possibly influenced by financial business considerations.
  - The Council had questions about the value generally, of short course orthodontic programmes for general dental practitioners in advancing their competencies to safely deliver an enhanced range and depth of orthodontic procedures to patients.
  - The importance of practitioners understanding their own competence and limitations within their scope of practice, and knowing when to refer.
- 1.2 The composition of the working group was considered in detail by the Council as it sought a balance between the subject-matter experts in the area of orthodontics, and independent academic and clinical perspectives from dentists and other dental specialists. One lay member and a children's advocate were included to strengthen the deliberations from the perspectives of public safety, patient care and expectations, and patient rights.
- 1.3 The working group members were:
  - Robin Whyman – Chair, Dental specialist (public health)
  - Paul Brunton – Senior dental academic
  - Winifred Harding – Orthodontist specialist
  - Brett Hawkins – Dentist performing orthodontic treatments
  - Sue Ineson – External lay member
  - Andrea Jamison – Children's advocate
  - James Talbot – Dentist not performing orthodontic treatments
  - Chris Waalkens – Dental specialist (periodontics).



## Working group process

- 1.4 The working group had two face-to-face meetings on 15 February 2016 and 13 June 2016, and a teleconference on 10 October 2016.
- 1.5 Following the first meeting the working group identified the need for some further, targeted information gathering. The identified stakeholders were requested to comment on a briefing paper that contained the issues identified in the working group's terms of reference and a summary of discussions from the working group's first meeting. The stakeholders were requested to submit a written response, with an invitation to support their submission with a presentation to the second working group meeting.
- 1.6 The following groups were included in the targeted information process, and all provided valuable input to the working group:
  - New Zealand Association of Orthodontists (NZAO) (written submission & presentation)
  - New Zealand Dentists' Orthodontic Society (NZDOS) (written submission & presentation)
  - New Zealand Dental Association (NZDA) (written submission & presentation)
  - New Zealand Dental & Oral Health Therapists Association (NZDOHTA) (supplementary information)
  - University of Otago staff involved in orthodontic training (written submission & presentation)
  - Accident Compensation Corporation (ACC) (written submission)
  - Health and Disability Commissioner (HDC) (written submission).
- 1.7 The working group considered that the above groups represented all the key stakeholders, and sufficient levels of information across the various areas were obtained to inform the working group's deliberations.
- 1.8 It was considered that should there be any proposed changes to standards or compliance obligations as a result of the working group's recommendations, the Council will consult with its stakeholders. That would provide an opportunity for feedback from all practitioners and other stakeholders.
- 1.9 The working group wants to acknowledge the abovementioned groups for their participation in this process, and those practitioners that provided information over time that was used to inform the working group meeting papers.

## Orthodontic-related complaints

- 1.10 In preparation for the working group's initial discussion, the formal complaints considered by the Council in the area of orthodontics were identified and summarised. An anonymised overview of the complaints was presented to the working group.
- 1.11 Seven complaints concerning orthodontic treatment outcomes were received in the last three years—four in 2014 and three in 2015. There were no complaints relating to orthodontic treatments in 2013 or 2016. Of the complaints received, three were from patients, through the HDC and the ACC. The four remaining complainants comprised one dentist and three orthodontists.
- 1.12 In comparison, a total of 298 complaints about oral health practitioners concerning other issues were received by the Council during the period April 2014–March 2016; 48 of those complaints related to competence concerns.

1.13 In summary, the outcome of the inquiries into the orthodontic-related complaints were:

- Two inquiries resulted in concern about the practitioner's level of competence, with a potential of risk of harm to patients.
- One of the practitioners voluntarily removed themselves from the register.
- For the second practitioner, a risk of harm notification was issued to certain relevant parties<sup>1</sup>. A competence review (including a supervision requirement) was initiated, but the outcome of the review concluded that the practitioner was practising to the required standard of competence, and the supervision requirement was subsequently removed.
- In one case the parents of the patient were led to believe the dentist was an orthodontist. The practitioner received a cautionary letter.
- Following an inquiry about a treatment modality adopted for a young patient, concerns about compliance with other professional standards, such as informed consent, were identified. No evidence of a competence deficit was found. A cautionary letter was issued.
- An individual recertification programme was established for one of the practitioners to address the shortcoming identified in the practitioner's practice.
- Two inquiries resulted in no further action—one of the complaints could not be substantiated during further inquiries; and the other was not associated with a specific practitioner's care.

### Concerns raised by practitioners

1.14 The Council had received complaints from three orthodontists, expressing general concern in the area of orthodontic treatment. The three orthodontists' main concerns related to<sup>2</sup>:

- i. A perceived increase in the number of patients seeking specialist revision of orthodontic treatment carried out by general dentists.
- ii. An increase in the complexity of orthodontic cases being attempted by general dentists, straying outside their level of training, knowledge and skill.
- iii. Treatment options offered by dentists limited to preferred treatment modality or available systems, compared with more comprehensive range of options.
- iv. The sometimes misleading justification of orthodontic treatment by reference to disease process, rather than the mostly cosmetic motivation for orthodontic treatment.
- v. A rise in the number of short courses in orthodontics.
- vi. Public misinformation and poor science behind 'quick' orthodontic treatments.
- vii. The long-term dental and emotional impact on the patient undergoing unsuccessful treatments, as well as the financial impact on the parents.

---

<sup>1</sup> Section 35 of the Health Practitioners Competence Assurance Act 2003

<sup>2</sup> The issues raised in the complaints were summarised on a principle level, and reported to the working group anonymously

- viii. A perceived trend from a patient-centred profession to increased focus on marketing and advertising.
- ix. The need for greater attention to public education to enhance understanding of the difference between a specialist orthodontist and a general dentist undertaking orthodontics.
- x. Improvements required in the HDC complaints' process, and in particular, its understanding of specialists and experts.
- xi. Misleading advertising with increased discount offers advertised or available online for purchase.

## Advertising complaints

- 1.15 An overview of advertising complaints relating to orthodontic practice for the January 2014 – October 2016 period was provided to the working group.
- 1.16 A total of 54 advertising complaints related to orthodontic treatment has been received over that period. This includes multiple complaints about the same practitioner using different advertising mediums, or the same issue arising at different times.
- 1.17 The Council has received a number of complaints from the NZAO and individual orthodontists, relating to the advertising of orthodontic services by dentists, comprising 85 percent of the total advertising complaints received on orthodontic treatment.
- 1.18 The complaint from one of the orthodontists mentioned in the previous section also raised concerns about practitioners' ability to advertise non-prescribed qualifications that could potentially mislead the public as to the practitioner's registered scope of practice.
- 1.19 A significant and repeated issue raised was the concern that individual practitioners were deliberately causing public misinformation about orthodontic treatment options and specialist practice through their advertising (particularly via practice websites and internet advertisements/listings).

## Accident Compensation Corporation treatment injury claims

- 1.20 On the Council's request, ACC provided data related to treatment injury claims. The following represents a summary of the information provided.
- 1.21 From 1 January 2011 to 31 December 2015 ACC made cover decisions for 52,586 treatment injury claims. Of those treatment injury claims, 33,346 (63%) were accepted and 19,240 (37%) were declined. For the same period the total number of treatment injury cover decisions made in the context of dental were 2,460, of which 1,416 (58%) were accepted and 1,044 (42%) were declined.
- 1.22 A data search for all orthodontic related injury claims was performed for the period 1 July 2005 – 2 April 2016. There were 61 claims, with 36 approved. Of all the claims recorded over the ten year period, only 4 – 6 could be classified as serious, the rest were minor and well known risks associated with orthodontic treatment. The serious cases were all orthodontic treatment provided by dentists.
- 1.23 "While very distressing for the patients and their parents the overall risks from ACC's perspective is that orthodontic treatment in New Zealand appear to be safe and achieving acceptable outcomes".<sup>3</sup>

---

<sup>3</sup> ACC submission to the working group, dated 28 April 2016

- 1.24 Under section 284 of the Accident Compensation Act, during the course of processing claims, if ACC believes there is a risk of harm to the public, then it has an obligation to report the treatment that caused the personal injury to the authority responsible for patient safety. ACC determines that the authority is the Director General of Health. Only where there is potential risk for a sentinel or serious consequence may a treatment event be reported.
- 1.25 Sentinel and serious events may (in addition) be notified to a responsible authority if ACC reasonably believes they pose a risk of harm clearly related to an individual registered health practitioner and has peer advice regarding the appropriateness of care from either:
- The HDC's office
  - The Coroner's office
  - An ACC external clinical advisor.
- 1.26 While the responsible authority receives the name of the health professional, the Director General of Health receives a copy of the report with only a service facility identifier.

## University of Otago report on education and competencies

- 1.27 To inform the working group's deliberations, the Council engaged the University of Otago orthodontics department to report on:
- The curriculum and learning outcomes associated with orthodontics in the BDS programme.
  - Orthodontic-related competency standards for a graduating BDS student and a postgraduate MDS/DClinDent (orthodontics) graduate.
  - Comparable international jurisdictions' orthodontic modules and standards associated with orthodontic treatment by general dentists and orthodontic specialists.
- 1.28 The report from Professor Mauro Farella was considered by the working group.

## Resources

In addition to the information provided to the working group already reported in the background section, the following additional resources were available to the working group during its deliberations:

- i. Dental Council. General dental scope of practice and orthodontic specialist scope of practice  
<http://dcnz.org.nz/i-practise-in-new-zealand/dentists-and-dental-specialists/scopes-of-practice/>
- ii. Dental Council. *Competency standards and performance measures for dentists*  
<http://dcnz.org.nz/i-practise-in-new-zealand/dentists-and-dental-specialists/scope-of-practice-competencies/>
- iii. Dental Board of Australia, in partnership with the Dental Council (New Zealand). Specialist competencies – orthodontics  
<http://www.dentalboard.gov.au/Registration/Specialist-Registration/Specialist-competencies.aspx>
- iv. Dental Council. *Standards Framework for Oral Health Practitioners*  
<http://dcnz.org.nz/assets/Uploads/Practice-standards/Standards-Framework-for-Oral-Health-Practitioners.pdf>
- v. Health and Disability Commissioner. *Code of Health and Disability Services Consumers' Rights*  
<http://www.hdc.org.nz/the-act--code/the-code-of-rights>
- vi. Andrea Jamison. Background paper prepared for the Orthodontic Working Group meeting *Overview of Children and Young People's Rights*, 15 February 2016
- vii. Various practitioners provided information over an extended period of time and was used to inform the working group meeting papers

## 2. Discussions

---

The discussions by the working group will be reported according to the working group terms of reference. The items are re-ordered and grouped together for ease of reading.

- i. The information provided by the University of Otago Faculty of Dentistry, primarily regarding the learning objectives and competencies achieved in orthodontics by a general dentistry graduate and a specialist orthodontic graduate.
- iv. Further education and training post-graduation, in extending knowledge, skills and competencies beyond graduation level, but not a formal dental specialist postgraduate qualification.
- v. General dentist competencies associated with orthodontic treatment.

### Competence of dental graduates

- 2.1 The BDS programme was described as a “launchpad” for dentists to undertake simple orthodontic cases after graduation.
- 2.2 Graduates were able to:
  - Identify normal and abnormal occlusions
  - Prioritise treatment needs
  - Take on simple orthodontic cases
  - Develop appropriate, evidence based treatment plans for those cases.
- 2.3 The amount of clinical orthodontic experience was very limited in the undergraduate programme. This was primarily due to the extensive time that orthodontic treatment took. In most cases a minimum of two years was required to follow a patient’s treatment through, and then at least another year for follow-up to monitor retention.
- 2.4 In contrast, the postgraduate orthodontic students were exposed to over 200 cases during the three years of postgraduate study, under on-site supervision by an orthodontist.
- 2.5 The University of Otago reported its model of orthodontic education for dental students was similar to other international models, including Australia. The United Kingdom dental undergraduates had more hands-on clinical experience, with greater focus on removable appliances.
- 2.6 The University of Otago indicated it would consider it very difficult to incorporate an increased level of clinical exposure to orthodontics into an already very full BDS curriculum.

- 2.7 There was agreement that the general dental scope of practice allowed dentists to provide orthodontic treatment, within the practitioner's competence—similar to activities performed in other areas of the general dental scope of practice.
- 2.8 There was agreement that dentists had the base-knowledge to do limited orthodontic treatment. Engagement in further training and gaining relevant experience was required to perform a wider and more complex range of orthodontic treatment.
- 2.9 The working group noted that the current dental graduate competencies did not define orthodontic-specific competencies, and considered this was a gap that needed to be addressed. The working group considered the learning outcomes and competencies reported by the University of Otago, based on the BDS curriculum (Appendix B).
- 2.10 The working group proposes that the Council uses these learning outcomes and competencies to develop orthodontic-specific competencies for the Council competencies for dental graduates.

## Further education and training

- 2.11 As expected, there was a significant difference between the level of orthodontic education in the undergraduate and the postgraduate programmes. It was recognised that not all dentists who perform orthodontic treatment want to limit their practice to orthodontics, or be a dental specialist.
- 2.12 There was consensus by all participants that the undergraduate training instilled sufficient fundamental knowledge for dentists to undertake further education and training to perform orthodontic treatment within their level of competence, skills and experience.
- 2.13 However, it was recognised that even with further education and training, dentists would not be able to practise at the level of a specialist orthodontist. As with any part of practice, dentists offering orthodontic treatment should refer to orthodontists when a case fell outside their knowledge, skills and experience.
- 2.14 It was acknowledged that there were a variety of orthodontic-related courses available in the market place for continued learning, with different levels of scope and quality.
- 2.15 The working group members were made aware of at least three extensive courses available for dentists to advance their education in orthodontic treatment, all of them were based overseas.
- 2.16 An increasing number of short courses, mostly product-driven, were available and marketed to general dentists in New Zealand.

## Quality of courses available

### Longer courses

- 2.17 There were differing views on the quality of the longer courses (18 months to two years).
- 2.18 Some stakeholders held the view that these courses were generally of good quality. However, this view was not shared by all.

2.19 Concerns raised with the longer, part-time, orthodontic course included:

- The course did not provide the same level of knowledge and skills compared with postgraduate training. The level of knowledge obtained by dentists doing these courses limited the practitioner's ability to provide comprehensive orthodontic treatment, to anticipate associated risks, and to adjust treatment accordingly.
- The quality of content of some of these courses was questioned.
- Limited direct supervision by appropriately qualified and experienced supervisors.
- Logistical issues with "residency based" training, in particular to assure appropriate on-site supervision throughout the duration of the programme.

2.20 However, it was agreed that the longer courses offered provided greater opportunity for dentists to upskill in the area of orthodontics. The courses provided dentists with an increased level of orthodontic knowledge and skills beyond graduation. This could enable dentists to perform simple orthodontic treatment within their knowledge, skills and competence levels; or refer to an orthodontist if safe treatment could not be provided.

2.21 It was also acknowledged that in the current New Zealand market no university-based or other provider-based longer course in orthodontics apparently exists. Given this situation, dentists interested in gaining greater skill and competence in orthodontics, but not wishing to specialise, had little option other than to source courses overseas.

### Short courses

2.22 Overall, the quality of the short courses (two-three days) was questioned, including by all professional bodies.

2.23 The concerns expressed about short courses were:

- Limited opportunity to expand theoretical knowledge to the required level.
- Participants did not develop the necessary skills to discern accurate scientific evidence.
- Focused mostly on techniques; and were mostly aligned with specific products.
- These courses were heavily marketed, and did not particularly focus on the potential risks or limitations of the various treatment modalities. The obligation to disclose these risks was left to the practitioner.
- No independent quality assurance.
- These courses could lead to overconfidence by dentists in their abilities to undertake orthodontic cases beyond their knowledge, skills and experience.
- Some of the short courses that linked to specific products did not provide adequate fundamental knowledge and skills. This can result in the reliance of the dentist on a third-party dentist/orthodontist (could be an oral health practitioner not registered in New Zealand) to oversee the proposed treatment plan and tracking of treatment outcomes. It was considered that a competent practitioner should be able to develop their own treatment plan, track treatment outcomes, and be able to adjust the treatment plan accordingly if outcomes were outside of expected norms.



- The availability of New Zealand-developed short course training for general dentists is currently very limited.

- 2.24 It was acknowledged that some recent improvements had been made by some of the course providers, with the employment of orthodontists to remotely monitor the treatment plans of dentists who had completed the short course, as a means of providing greater support to their training.
- 2.25 It was also noted that it could be argued that these systems were filling a gap in the market, and appropriately meeting some patients' expectations. Patients often asked about these techniques—so having attended a course related to them was not necessarily a negative.
- 2.26 There was agreement that these short courses did not offer comprehensive, stand-alone training programmes that would be sufficient to enable dentists to perform orthodontics in the absence of other education and training. It was considered that short courses could have some value in continuing professional development, if the practitioner had the fundamental knowledge to ascertain whether the system and content offered was evidence-based, and appropriate for a particular patient.

### Quality assurance of courses

- 2.27 Multiple participants raised concern about the lack of quality assurance of the course content of these courses offered to dentists.
- 2.28 None of these underwent a formal Council quality assessment process—such as accreditation of prescribed qualifications.
- 2.29 Some of these courses were approved by the NZDA as meeting the Council's continuing professional development policy criteria.
- 2.30 The working group posed the question whether it might be necessary to accredit orthodontic-related courses?
- 2.31 The working group had little appetite, and saw limited value in a formal quality assurance/accreditation of orthodontic courses for general dentists. Such an initiative would also have implications on all other areas of dental practice, and the regulatory burden that would be imposed did not appear proportionate to the risk. It was considered that similar to other areas of practice, practitioners should apply their professional judgment on continuing professional development undertaken, and how that contributed towards their competence.

### New Zealand-developed courses

- 2.32 The lack of quality orthodontic education available to dentists wanting to upskill in the area of orthodontics, driven from within the New Zealand profession—rather than by the market, was raised as an area that needed addressing.
- 2.33 The unique difficulties related to the education of orthodontics were acknowledged. The primary difficulty was the extended duration of orthodontic treatment, in particular with the ongoing supervision of orthodontic cases. Other specialist areas were also discussed as having potentially similar complexities, for example, special needs dentistry was considered as having some differences in treatment philosophies and complexity with timeframe for some care plans.
- 2.34 Furthermore, it was acknowledged the number of dentists that would take up such courses would likely be small, and this presented a potential barrier for the development and sustainability of New Zealand-driven orthodontic courses. In particular, as orthodontics education requires a lot of resources.

2.35 The working group identified the following opportunities to address the current deficiency in quality, New Zealand-driven education for dentists in the area of orthodontics:

- Electronic mediums and technology could be used to relieve some burden on continuous, on-site supervision of trainees—through remote supervision of orthodontic cases during study.
- It was acknowledged that technology was generally being used more and more in education. The new dental school and the potential Auckland satellite clinic would have more technology available to facilitate such opportunities.
- It was recognised that there was a uniqueness to dealing with a patient in the chair, and to experience and manage individual responses to treatments by patients.

2.36 The working group considered that the University of Otago Faculty of Dentistry, the NZAO and the NZDOS all had roles to play to explore avenues to develop quality orthodontic courses for dentists.

2.37 The University of Otago indicated its willingness to explore developing a postgraduate training programme, not at a specialist level, for dentists who want to undertake further education in orthodontics. The potential Auckland satellite clinic could offer opportunities to achieve this. Again, appropriate on-site supervision was emphasised.

## ii. The potential risk of harm to patients undergoing orthodontic treatment

2.38 The working group considered that the majority of orthodontic procedures would likely be reversible.

2.39 There was consensus that, from a clinical perspective, the potential for serious risk of harm was limited, but not excluded; and that the risk was not substantially greater than in other areas of advanced dental practice.

2.40 However, the working group considered that the greatest risk of harm was the emotional impact of adverse orthodontic experiences due to:

- The young age of patients—they were in a developmental phase with a high level of self-consciousness
- Children's sense of time was different to adults—that was particularly relevant where patients' active participation was required over an extended period of treatment (and for ongoing informed consent).

### Treatment modalities

2.41 The working group recognised that there were different views held on the appropriateness of certain treatment modalities used in orthodontic treatment. The consideration of the appropriateness, or not, of specific treatment modalities fell outside of the ambit of the working group. The working group report will not make any commentary in this area.

2.42 However, to understand the tension that exist between some groups within the profession delivering orthodontic treatment, the working group explored this area from a principle perspective, but did not consider any scientific evidence on the benefits, or otherwise, of specific orthodontic treatment modalities.

2.43 The primary areas of concern raised on different treatment modalities include:<sup>4</sup>

#### **Orthodontists' perspective:**

- It was argued that there were no different treatment philosophies. All treatments should be evidence-based, informed by scientific research. Treatment approaches could differ, but the knowledge base and scientific evidence for quality orthodontic care and predictable outcomes were the same.
- Modalities not supported by evidence and experience could not be considered safe and appropriate for patient care.
- It was important that the patient's expectation and opinion be taken into account in developing the treatment options. The practitioner needed to determine whether the patient's expectations could be met. Compromised positions by both parties (patient and practitioner) might have to be accepted.

---

<sup>4</sup> This does not necessarily represent the views from all practitioners practising in the respective areas, but reflects the points made by the representative bodies from these groups

- In relation to specific approaches the representatives considered that early orthodontic treatment was only appropriate in certain cases (cross bites, displacements, teasing and trauma due to a large overjet—i.e. prominent teeth).
- In the opinion of some orthodontists, most orthodontic treatment could be covered in a single, comprehensive treatment plan rather than two stages, and that in the absence of evidence-based indicators, the decision by some dentists to treat early was financially driven.

**Dentists' perspective:**

- There were different positions on whether one or two phases for orthodontic treatment were most appropriate.
- The starting age for orthodontic treatment was a point of conflict between dentists and orthodontists; with a large number of dentists preferring to start orthodontic treatment at an earlier age.
- There were different interpretations of research by the two practitioner groups.
- Some dentists placed more emphasis on developmental and/or environmental factors, plates, tongue posture, and airway development in their treatment plan; with less focus on tooth extractions.
- Measurement of successful treatment outcome had to include consideration of whether the patient deemed the treatment a success, and therefore, met their needs and expectations. This means that an “interim outcome” could be appropriate for a particular patient. For example, an interim target for a young child might be to focus on the aesthetics, with further treatment undertaken when the patient was older.

- 2.44 There was a view from the working group members that there was a general level of misunderstanding and/or miscommunication between the groups on treatment approaches and philosophies. Early orthodontic treatment formed a large component of the postgraduate orthodontics programme, and two-stage treatment plans were considered appropriate for some patients.
- 2.45 Tension between groups increase when practitioners focused on one treatment modality to the exclusion of any other modality. Also, functional orthodontic practitioners advertised the treatment as a point of difference, or a new treatment modality; whereas functional appliances had been in existence for over 30 years, and were also used by orthodontists, where appropriate.
- 2.46 There were many commonalities between both groups of practitioners; with the primary objective to achieve successful patient outcomes.
- 2.47 Even though there were some areas of philosophical differences on orthodontic treatment options between dentists and orthodontists, the working group considered that there were considerable areas of overlap; and some areas of misunderstanding, or perhaps generalisation, of approaches taken by the different groups.
- 2.48 There was support by members of the working group that patients with syndromic facial abnormalities should not be treated within the non-specialist private sector, and are frequently best treated in a multi-disciplinary public sector environment due to likely vulnerabilities and associated risks.

## Complaints' consideration

- 2.49 Overall, the working group concluded from their experience and the information provided in the papers for the meetings that the majority of practitioners did practise to the required standard, with the intention of providing safe care to patients (do no harm). However, some practitioners may have less insight into their limitations and failed to refer appropriately; or, they failed to properly balance commercial incentives or pressures with patients' best interests.
- 2.50 It was concluded that the number of practitioners with identified concerns about their orthodontic practice was very small, with a low to moderate risk of serious risk of harm to patients.
- 2.51 The NZDA confirmed that in its experience through the peer review and consumer resolution initiatives, and supported by data available through Dental Protection Ltd (DPL) case management, a low number of complaints in relation to orthodontic treatment had been received. DPL also confirmed that concerns associated with orthodontic treatments offered by dentists were not unique to New Zealand.
- 2.52 The vast number of dentists who provided orthodontic advice and orthodontic treatments sought advice from specialist colleagues when required; and had good working relationships, referred appropriately to specialists, and at times were assisted by specialist colleagues to extend the treatment provided to individual patients.
- 2.53 It was considered that the debate on this issue was mainly initiated within the profession, primarily as a consequence of inappropriate advertising from "both sides": dentists performing orthodontic treatment and orthodontists. The ability to facilitate a resolution on complaints was made more difficult by the increasingly tense relationship between some dentists performing orthodontics and some orthodontists.
- 2.54 Most complaints were considered inter-professional, with the majority of complaints in the North Island, particularly Auckland; with the highest number of dentists and orthodontists practising in greater Auckland.
- 2.55 Patients were more willing to make complaints if expected outcomes were not achieved, in particular due to the high costs associated with orthodontic treatment and because the treatment concerned a child/adolescent. Complaints were usually made by the parent.
- 2.56 However, the number of formal complaints received was potentially an under-representation of the level of concern or dissatisfaction with orthodontic treatment, due to the difficult and stressful process of lodging a complaint (and the length of treatment).
- 2.57 It was further acknowledged that some cases would remain unreported due to adverse outcomes being settled between the practitioner and patient—no different to other areas of practice.
- 2.58 Practitioners' ethical obligation to notify the Council of a concern about another practitioner's competence, included as a professional standard in the Council's standards framework, was emphasised.

## Professional relationships

- 2.59 The need for increased professional interaction between the orthodontists and dentists performing orthodontics was raised at various points during the discussion.
- 2.60 It was believed that peer contact between these practitioners would be beneficial, and improved relationships would be more constructive in changing behaviour than the introduction of increased regulation.
- 2.61 The working group identified that some of the representative organisations and their members' views were entrenched—and it would be difficult to bridge those gaps.
- 2.62 However, the working group emphasised that the professional organisations representing these practitioners all had a leadership role to play in building collegial and professional relationships between orthodontists and dentists performing orthodontic treatment.

iii. The safety, rights and interests of patients, particularly of children and young people, in the context of:

- giving informed consent and ongoing assent to orthodontic treatment
- understanding treatment was being provided by a general dentist and not a specialist, and any attendant implications
- understanding the differences between a general dentist and an orthodontic specialist and the treatments they may provide

2.63 The Council's primary responsibility is to protect the safety of patients, by ensuring oral health practitioners are competent and safe to practise. By extension, the working group's primary concern had to be whether patient safety was compromised by orthodontic treatment delivered by dentists.

### Access points for orthodontic treatment

2.64 The working group explored the various mechanisms by which young people were referred to a dentist or orthodontist to access orthodontic treatment, most often within the private sector. Public funding was not available for most orthodontist referrals.

2.65 Dental therapists were identified as a key point of referral, as malocclusion and orthodontic treatment fell outside the dental therapy scope of practice, and because developing malocclusion was commonly identified in growing children—which are the core patient group of dental therapists.

2.66 According to a survey of its members conducted by NZDOHTA, dental therapists most commonly: provided advice to patients and parents about orthodontic treatment by means of verbal discussions; made referrals to an orthodontist; and based their referral choice on a list of practitioners in their area.

2.67 Many adolescent patients seeking orthodontic attention would be seen by dentists in the first instance through the Adolescent Dental Service contracts between the district health boards and private dental practices.

2.68 The 'mum network' was identified as another powerful referral avenue/information point for young people accessing orthodontic treatment.

2.69 Patients and parents were doing a lot more research themselves, mostly online, on available treatment options.

2.70 It was acknowledged that referral was often based on professional relationships, and that this feature was not necessarily unique to the orthodontic area of dental practice.

2.71 It was noted that the availability of referral options for the patient and parents/carers to access orthodontic treatment was not always as comprehensive and transparent as it should be.

## Informed consent

- 2.72 It was acknowledged that 'orthodontics' was a commonly used term and its use potentially created a higher risk of patient confusion on the exact nature of the treatment offered, and the identity of the provider of treatment (i.e. a dentist practising orthodontics vis-à-vis orthodontist). There might also be a lack of general understanding by patients of the difference between a dentist and an orthodontist.
- 2.73 It was believed that in the majority of cases, the parent and patient had implicit trust in the healthcare practitioner to provide them with the best possible advice for their health needs and safe care.
- 2.74 The Code of Health and Disability Services Consumers Rights provides that prior to making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent (Right 4). The HDC in his response to the working group targeted information session advised that: "It is my view that dental practitioners should be meticulous in ensuring that consumers fully understand the proposed treatment including, as appropriate, the qualifications of the practitioner providing the treatment. It is important that general dentists providing orthodontic services, make it clear to consumers that they are not specialist orthodontists and explain the differences between the two types of practitioners."
- 2.75 All participants agreed that ensuring ongoing informed consent was highlighted as one of the most important aspects of orthodontic treatment—in particular, due to the extended length of treatment and vulnerability of young patients.
- 2.76 The ultimate aim of informed consent must be to give the patient sufficient and appropriate information to make an informed choice about the best option for them, and provide an upfront, clear understanding of the expected treatment outcome. To achieve this in orthodontics, information must be age-appropriate for children and young people to ensure understanding and decision participation by minor patients.
- 2.77 Some aspects of informed consent highlighted during the process included:
- How to achieve more active engagement and decision making by young people in orthodontic treatment, especially with taking on a lifelong commitment at such an early age. Information offered must be understandable to the child.
  - Orthodontic patients committed to two or three years of treatment, with significant obligations by the patient. Failed treatment could result in physiological harm and a loss of trust in the practitioner; and patient cooperation for future or remedial treatment was compromised.
  - Informed consent for orthodontic treatment on children or adolescents had the further complexity of third party consent by the parent/carer, on behalf of the patient. It was further recognised that transfer of consent to the patient, if a child or adolescent, could happen over duration of the treatment.
  - Due to the long duration of treatment, other complicating factors, such as family breakdowns, changes in financial positions etc. could impact ongoing consent to treatment.
  - It was recognised that the patient was receiving a lot of information during their first consultation, and that the treatment outcomes would most likely be top of mind.
  - The length and complexity of the consent forms could be a barrier to achieve informed consent. Some were filled with disclaimers and waivers to protect the practitioner. These were often difficult for patients to understand, and did not substitute the practitioner's obligation to ensure the patient understood the proposed treatment plan ensuring valid, informed consent.



- Often international pro-forma consent forms were based on American Law, rather than Crown Law—the basis of the New Zealand’s legal system. This could result in a different focus of intent.
- With more parent and patients accessing online information on treatment options, patients struggle to make a decision and to access quality information. This further necessitates the need for patients to be given accurate and sufficient information to assist them in making a decision.

2.78 The working group asked whether parents and/or young people were well equipped to ask the correct questions that would enable the making of an informed decision—such as, understanding whether the treatment was being provided by a general dentist or an orthodontist, and what that meant; the expected outcome and duration of the treatment; the different treatment options available; the reason for the modality proposed and the potential risks associated.

2.79 For the reasons highlighted above, the working group explored with the groups involved in the targeted information gathering:

- whether it was considered important for orthodontic patients to be informed at the first appointment whether the practitioner was a dentist or an orthodontist
- what the key differences in training between them are
- what that means for their specific proposed treatment plan.

2.80 Mixed responses were received in this area:

- Some believed that there was no need for dentists to preface every orthodontic consultation and/or treatment by advising the patient that they were “not a specialist”. This was not considered necessary in any other area of practice.

It was considered that the patient would be made aware of this as part of the normal informed consent process on occasions when the treatment to be provided approached the practitioner’s competency boundaries, experience or complexity that required such disclosure. If a more complex case or more “experimental” treatment was proposed, the patient would be recommended to seek a second opinion.

Equally it was not expected that as a matter of course orthodontists should have to disclose to patients that “routine” orthodontics (for example, correction of simple cross bites) could be adequately provided by dentists.

- Others held the view that patients had a right to be informed that their treatment was offered by a dentist and not a dental specialist, and for the difference between the two practitioners’ education to be explained.

2.81 There was majority support by the working group on the need for mandatory disclosure by a practitioner offering orthodontic treatment whether they were a dentist doing orthodontics or an orthodontist.

2.82 The rationale for considering mandatory disclosure specifically related to orthodontic treatment were the duration of orthodontic treatment, and direct patient-access to an orthodontist—where other specialist dental treatments were mostly as a result of a referral by a dentist or another oral health practitioner. The concern with this proposal mainly related to potential implications that such a requirement would have on other areas of dental practice.

## Patient information

- 2.83 The working group discussed whether the Council should be more proactive in its communications to practitioners and to the public about orthodontic treatments, providers and risks. Currently, the Council had no guidelines or formal communication in this area of practice.
- 2.84 The working group was of the view that the Council had a role to play in communication for a more informed public and practitioner guidance identifying known issues and risks specific to orthodontic treatment.
- 2.85 The working group believed that the Council should provide educative information guiding the public on what to look for when choosing a practitioner for orthodontic treatment. Also, more information to equip patients to ask the relevant questions when seeking orthodontic treatment, and to facilitate informed consent—for example, know what the treatment is trying to achieve, the expected outcomes and timeframes.
- 2.86 The communication should be supportive (non-punitive towards practitioners), in plain-English, and targeted to both young people and their parents/carers.
- 2.87 This idea was supported by the working group and the majority of submitters. There was comment that such educational material for patients relevant to any area of dental practice would be helpful.

## Advertising

- 2.88 It was acknowledged that there had been a significant increase in advertising of orthodontic treatment.
- 2.89 With the increased demand for cosmetic procedures by patients, increased supply of courses and products related to short term orthodontic treatment, and heavily marketed environment, tension between dentists taking up orthodontic treatment and orthodontists has increased dramatically over recent years.
- 2.90 The working group did not consider this type of tension unique in dentistry. For example, similar tensions arose when dentists began taking up implants within general practice. However, at that point the number of implant courses offered to dentists was limited; this being contrary to the scenario on orthodontic courses.
- 2.91 Marketing of orthodontics currently involves intense direct-to-consumer marketing, including the direct targeting of children and young people. This is different to most other areas of dental practice. Practitioners are reminded of their specific obligations when advertising to children, as described in the Advertising Standards Authority Code for Advertising to Children.
- 2.92 Advertising by dentists offering orthodontic treatment has been the subject of numerous complaints to the Council in recent years.
- 2.93 It does not appear that the level of advertising and marketing is going to slow down in the near future, and could very well increase even more.

- 2.94 The working group acknowledged the role of advertising in informing the public, and the practitioner's right to advertise its services. However, it was considered by some working group members that the tone of some orthodontic advertising undermined the dental profession at large and was potentially detrimental to the public's ability to make informed decisions about accessing dental services and care choices—in particular, where comparative advertising has been used carelessly.
- 2.95 The working group was advised by the NZDA that partly in response to an increased number of advertising complaints, they had established an ethics committee to offer advice to members on whether advertising was considered ethical and responsible, or alternatively, reasons why not—with the intent to positively influence practitioners' behaviour. This initiative is commended.

### Handling of advertising complaints

- 2.96 The Council established an advertising practice standard in November 2013.
- 2.97 As reported in the background section of this report, the Council had received a number of complaints from the NZAO and individual orthodontists, relating to the advertising of orthodontic services.
- 2.98 The working group noted that all complaints received regarding a potential breach in advertising were reviewed against the Council's advertising practice standard. The approach was to first make practitioners aware of a breach of the Council's standard, allowing an opportunity to rectify the issue, where it was in the control of the practitioner. Compliance to any requested changes to a practitioner's advertising are followed up. Ongoing non-compliance, or gross misconduct, could be escalated to a professional conduct committee.
- 2.99 One of the submitters raised concern that the Council had not satisfactorily addressed orthodontic related advertising complaints made by them, particularly as some practitioners appeared to be "repeat offenders", with multiple complaints about the same issue at different times.
- 2.100 Other submitters commented about the Council's responses to the complainants. In particular, that it was not detailed or transparent enough about the outcome of the complaint; and had too strong a legal focus; and the tone of the communication was discouraging. It was proposed that the Council rely more on clinical specialist knowledge and put greater emphasis on professionalism. Some participants offered to work with the Council to address their concerns.
- 2.101 The Council's chief executive advised those submitters, that as part of the Council's strategic plan, greater focus on engagement and effective communication was a priority, and this was one of the areas that would be considered closely in the near future.
- 2.102 The working group emphasised the need for the Council to reconsider the communication approach to advertising complaints—in particular, to complainants.

## vi. How patient safety was ensured when outsourcing the diagnosis and treatment planning, in particular to overseas-based specialists

- 2.103 There was general support by participants that practitioners should have the necessary knowledge to both diagnose and treat their patients. It was offered that if the treating practitioner could not diagnose and develop a treatment plan, appropriately monitor the treatment outcomes, and adjust treatment when required, then the practitioner was considered not competent to offer the treatment; and patient safety was compromised.
- 2.104 It was acknowledged that off-shore collaboration regarding specific cases could be beneficial in the treatment process. However, the dentist should have the ability to identify and manage complications or non-achievement of expected outcomes, or to refer the patient if treatment fell outside his/her competence or level of experience.
- 2.105 The HDC noted in his response to the working group it is his view “that a provider is responsible for ensuring that s/he has obtained all necessary and relevant information before providing treatment to a patient.
- 2.106 “Overall, I consider that if [the provider] becomes aware that it has insufficient information on any aspect of a client’s care to enable [that provider] to support the client adequately, the onus is on [the provider] to obtain the necessary information. Otherwise, [the provider] should not take on the responsibility of providing care to that client. In accepting responsibility to provide care to a consumer, [the provider] must ensure it has sufficient information to provide an appropriate standard of care.”
- 2.107 The working group was of the view that various sources and advice were used by local practitioners on a regular basis to inform their practice. It was agreed that the New Zealand registered practitioner was ultimately responsible for their patient regardless of any external advice or outsourcing of work. While there could be a continuum of shared care, the legal and professional responsibility for a patient’s treatment plan and outcomes remained with the patient’s primary practitioner.

## vii. Tools available to address concerns with undertaking complex orthodontic treatment beyond a practitioner's knowledge, skills and competence

- 2.108 Reflecting on the level of risk of harm to patients, the specific areas of concerns raised, the newly established standards framework, and the identified proposals to address these concerns—the working group did not identify a need for amendment to the general dental scope of practice or a new practice standard for the clinical area of orthodontics, at this point in time.
- 2.109 This view was supported by multiple stakeholders. They believed that the Council's *Standards Framework for Oral Health Practitioners* adequately covered the professional and ethical behaviour required from oral health practitioners. This was supported by a practice standard on informed consent that offered practitioners detailed information on obtaining consent.
- 2.110 It was also noted that there was no specific advice given on other clinical areas of practice such as endodontics, prosthodontics etc.
- 2.111 During deliberations, other areas related to the Council's business, and related to the topic on hand, were raised. These are reported for completeness.

## Post nominal qualifications on the Dental Council public register

- 2.112 The view was expressed that the list of practitioners' qualifications did not facilitate a clear understanding of the extent of the practitioner's training and skillset, or whether the practitioner was a specialist or not.
- 2.113 It was considered that advertising of additional qualifications that were not recognised for registration as a dental specialist should not be permitted on the Council's public register—this was considered misleading.
- 2.114 It was noted that the Council cannot prevent practitioners to advertise valid qualifications obtained, on their own advertising material.
- 2.115 The working group and several groups endorsed the Council's plan to revisit its policy on the publication of post nominal qualifications; and held the view that only registerable qualifications should be listed on the Council's website. This would not preclude practitioners from advertising their qualifications on their own professional material.

## Competence review committee composition

- 2.116 All professional bodies raised the composition of the Council's competence review committee (CRC), when reviewing a competence concern related to orthodontic treatment provided. The principle was extended to reviews completed by other agencies, such as HDC and ACC; and the NZDA peer review system.

2.117 Their reasons put forward for not supporting an orthodontist being part of a competence review committee of a general dentist providing orthodontics were:

- The history of animosity between the two parties that could result in bias.
- A dental specialist not being a true peer of a dentist.
- Differences in treatment philosophies and outcomes.

2.118 An alternative proposal to the above was put forward, being that a dentist with the necessary experience should be the peer appointed to the CRC, but to have an orthodontist's knowledge and expertise available to the committee, when required.

2.119 The counter argument put forward was that there must be an orthodontist on a competence review committee, when concerns of a dentist's orthodontic treatment were reviewed, to ensure appropriate clinical knowledge and experience to evaluate the clinical appropriateness of the treatment plans and outcomes. It was considered that not involving a dental specialist implied different standards for orthodontic care.

2.120 Members of the working group that have recently been on a competence review committee of a dentist performing orthodontic treatment, expressed the view that the different clinical perspectives and expertise brought by the dentist peer and the orthodontist on the same committee, contributed towards a robust review. There were balances in place to ensure a fair and transparent review process. The primary objectives of a review was to consider the quality of care delivered, and whether the Council's standards have been met.

2.121 There was a view that the role of "a peer" was wider than a practitioner registered in the same scope of practice, or one that supported similar treatment modalities. The peer needed to have a higher level of knowledge and greater experience to be able to critically evaluate the appropriateness of the treatment plans and outcomes. A balanced view could be achieved by including both a dental specialist and a dentist, with expertise in the particular area, on the review committee.

#### viii. Identify any additional investigations or literature reviews required to inform the discussion

2.122 No further investigations, beyond what has been reported on, have been identified by the working group.

2.123 The working group understands that the Council will consult with its stakeholders on any proposed changes to any standards or practitioner obligations.

## 3. Conclusions

---

The following reflects the positions reached by the working group:

### Orthodontic treatment by dentists

- 3.1 The general dental scope of practice allowed dentists to provide orthodontic treatment within the practitioner's competence—similar to activities performed in other areas of the general dental scope of practice.
- 3.2 Dentists had the base-knowledge to do limited orthodontic treatment. Engagement in further training and gaining relevant experience was required to perform a wider and more complex range of orthodontic treatment.
- 3.3 Undergraduate training instilled sufficient fundamental knowledge for dentists to undertake further education and training to perform orthodontic treatment within their level of competence, skills and experience.

### Education and training

- 3.4 Longer orthodontic courses<sup>5</sup> provided greater opportunity for dentists to upskill in the area of orthodontics. These courses provided dentists with an increased level of orthodontic knowledge and skills beyond graduation. This could enable dentists to perform simple orthodontic treatment within their knowledge, skills and competence levels; or refer to an orthodontist if safe treatment cannot be provided.
- 3.5 The short orthodontic courses<sup>6</sup> did not offer comprehensive, stand-alone training that would be sufficient to enable dentists to perform orthodontics in the absence of other education and training. It was considered that short courses could have some value in continuing professional development, if the practitioner had the fundamental knowledge to ascertain whether the system and content offered was evidence-based, and appropriate for a particular patient.
- 3.6 There was little appetite and limited value identified in formal quality assurance/accreditation of orthodontic courses for general dentists. Such an initiative would have implications on all other areas of dental practice, and the regulatory burden that would be imposed did not appear proportionate to the risk. It was considered that practitioners should apply their professional judgment on the quality of the courses, and appropriateness of the education offered to assure their competence in a particular area of practice.
- 3.7 There was a need for better quality, New Zealand-driven courses available to dentists in the area of orthodontics.

---

<sup>5</sup> 18-24 months

<sup>6</sup> Up to 3 days

## Risk of harm

- 3.8 Orthodontic treatment had limited risk of serious harm with most procedures reversible; the risk associated with orthodontic treatment was not substantially greater than other advanced areas of dental practice.
- 3.9 The size of the problem of inappropriate orthodontic treatment was apparently small; with the number of practitioners with identified concerns about their orthodontic practice, very small.

## Treatment modalities

- 3.10 Even though there were some areas of philosophical differences on orthodontic treatment options between dentists and orthodontists, there were considerable areas of overlap, and some areas of misunderstanding, or perhaps generalisation, of approaches taken by the different groups.
- 3.11 Patients with syndromic facial abnormalities should not be treated within the non-specialist private sector, and are frequently best treated in a multi-disciplinary public sector environment due to likely vulnerabilities and associated risks.

## Referral by dental therapists

- 3.12 The availability of referral options given by dental therapists to the patient and parents/carers to access orthodontic treatment, was not always as comprehensive and transparent as it should be.

## Informed consent

- 3.13 Ensuring ongoing informed consent was one of the most important aspects of orthodontic treatment—in particular due to the extended length of treatment and vulnerability of young patients.
- 3.14 More independent information must be made available to patients to equip them to ask the relevant questions when seeking orthodontic treatment, and to facilitate informed consent.
- 3.15 This included educative information guiding the public on what to look for when choosing a practitioner for orthodontic treatment; what questions to ask—for example, what the treatment is trying to achieve, the expected outcomes, and the timeframes.
- 3.16 The communication should be supportive towards all parties, in plain-English, and targeted to both young people and their parents/carers.
- 3.17 The Council had a role to play in formulating and making such communication available.
- 3.18 Practitioners should not rely on lengthy pro forma documents, particularly documents based on American legal systems, as basis for achieving informed consent.
- 3.19 The majority of the working group supported the need for mandatory disclosure by a practitioner offering orthodontic treatment whether they were a dentist doing orthodontics or an orthodontist.



## Advertising

- 3.20 Advertising had a role to play in informing the public; and practitioners had a right to advertise their services.
- 3.21 However, the tone of some orthodontic advertising was undermining the dental profession at large and potentially not assisting the public to make decisions—in particular, when using comparative advertising techniques.
- 3.22 The Council's plan to revisit its policy on the publication of post nominal qualifications was endorsed; only registerable qualifications should be listed on the Dental Council public register.

## Outsourcing diagnosis and treatment planning

- 3.23 Various sources and advice were used by local practitioners on a regular basis to inform their practice. It was agreed that the New Zealand registered practitioner was ultimately responsible for their patient regardless of any external advice or outsourcing of work. While there could be a continuum of shared care, the legal and professional responsibility for a patient's treatment plan and outcomes remained with the patient's primary practitioner.
- 3.24 A competent practitioner must be able to diagnose and develop a treatment plan, appropriately monitor the treatment outcomes, and adjust treatment when required—to protect patient safety and achieve good outcomes.

## Professional relationships

- 3.25 Peer-contact between dentists providing orthodontics and orthodontists would be beneficial; improved collegial and professional relationships would be more constructive in changing behaviour than the introduction of increased regulation.
- 3.26 The various professional organisations representing these practitioners all had a leadership role to play in building better relationships between these practitioners.

## Regulatory intervention

- 3.27 Reflecting on the level of risk of harm to patients, the specific areas of concerns raised, the newly established standards framework, and the identified proposals to address these concerns—the working group did not identify a need for amendment to the general dental scope of practice or a new practice standard for the clinical area of orthodontics, at this point in time. It was considered that the Council's *Standards Framework for Oral Health Practitioners* adequately covered the professional and ethical behaviour required from oral health practitioners.

## 4. Recommendations

---

The working group recommended the following to the Council:

1. The Council considers developing orthodontic-specific competencies for dental graduates, using the learning outcomes and competencies provided by the University of Otago BDS programme.
2. The Council encourages better quality, New Zealand-driven courses available to dentists in the area of orthodontics.
3. The Council encourages exploring electronic mediums and technology to assist in the delivery of such education, in particular for ongoing supervision.
4. The Council, in consultation with key stakeholders in this area, develops and releases educative information guiding the public on orthodontic treatment. In particular what patients should look for when choosing a practitioner, important questions to ask when seeking orthodontic treatment, and patients' rights—including the right to complain about harm caused or unsatisfactory treatment. The information should be targeted to both young people and their parents/carers, and in plain English.
5. The Council collaborates with the NZDHOTA and the Clinical Directors Forum on more consistent, comprehensive and transparent information on referral options for patients and parents/carers to access orthodontic treatment, when referred by dental therapists.
6. The Council considers the majority support for mandatory disclosure by a practitioner offering orthodontic treatment to confirm their registered practising status—whether they are a dentist doing orthodontics or an orthodontist.
7. The Council advocates for continuing professional development initiatives on informed consent specific to orthodontic treatment. In particular, on the continuing assent for ongoing treatment, the spectrum of consent and decision-making participation distribution during the extended period of orthodontic treatment, active decision participation by the child, and the shift of ongoing assent from the parent/carer to the child during the duration of the treatment, and young person targeted information.
8. The Council prioritises the review on its communication approach to advertising complaints—in particular to complainants.
9. The Council works with the NZAO on their concerns about the handling of their advertising complaints.
10. The Council proceeds with its plan to revisit its policy on the publication of post nominal qualifications; with only registerable qualifications to be listed on the Dental Council public register.
11. The Council closely monitors the complaints related to orthodontic treatment, including informal inquiries or questions related to concerns or unsatisfactory outcomes.
12. The Council clearly communicates its expectations of practitioners performing orthodontic treatment, following its consideration of the working group report.

# Appendix A

## Working group terms of reference

The working group terms of reference required the following to be considered and reported on:

- i. The information provided by the University of Otago Faculty of Dentistry, primarily regarding the learning objectives and competencies achieved in orthodontics by a general dentistry graduate and a specialist orthodontic graduate.
- ii. The potential risk of harm to patients undergoing orthodontic treatment.
- iii. The safety, rights and interests of patients, particularly of children and young people, in the context of:
  - Giving informed consent and ongoing assent to orthodontic treatment;
  - Understanding treatment was being provided by a general dentist and not a specialist, and any attendant implications; and,
  - Understanding the differences between a general dentist and an orthodontic specialist and the treatments they may provide.
- iv. Further education and training post-graduation, in extending knowledge, skills and competencies beyond graduation level, but not a formal dental specialist postgraduate qualification.
- v. General dentist competencies associated with orthodontic treatment.
- vi. How patient safety was ensured when outsourcing the diagnosis and treatment planning, in particular to overseas-based specialists.
- vii. Tools available to address concerns with undertaking complex orthodontic treatment beyond a practitioner's knowledge, skills and competence.
- viii. Identify any additional investigations or literature reviews required to inform the discussion.
- ix. The working group was required to submit a report to the Council with recommendations on a way forward regarding orthodontic treatment provided by general dentists.

# Appendix B

## BDS learning outcomes and competencies related to orthodontics, as reported by University of Otago <sup>7</sup>

### Learning outcomes

Describe and explain orthodontic problems and the implications on the patient's health status and society.

Describe the range of normal dental development and recognise a developing malocclusion and methods for determining possible treatment modalities.

Demonstrate orthodontic diagnostic procedures for developmental problems and outline rudimentary treatment plans.

Perform simple orthodontic therapy at the general practitioner level and describe principles of comprehensive treatment.

Explain the basic biomechanical principles involved in orthodontic tooth movement.

Understand the basic mechanisms and indications/contraindication for orthodontic treatment

Understand the principles, design, fabrication, and activation/adjustment of a limited number of orthodontic appliances.

Have some experience handling orthodontic appliances in a non-clinical environment.

While some appliance therapy is taught at the undergraduate level, students are also taught the clinical scenarios where referral to an orthodontist is indicated.

It is essential that general dental practitioners are able to identify when treatment of a patient is beyond the scope of their practice, training and skills.

### Competencies

Following completion of their course, general dental practitioners should be competent with the following aspects of orthodontic treatment:

- Recognition of dentofacial problems in children and adults with an understanding of the implications associated with their management whether by:
- Provision of removable orthodontic appliances for simple tooth movement including dental expansion of selected teeth. Simple appliances normally contact teeth at a single point and produce tipping movements. Treatment objectives are limited to moving a small number of teeth. Examples include; the correction of one or two teeth in crossbite, space opening for a partially impacted tooth and use of an elastomeric separator to dis-impact a mildly impeded tooth.

---

<sup>7</sup> Excerpt from University of Otago report by Prof Mauro Farella, prepared for the orthodontic working group (August 2015)

- Provision of a limited range of fixed orthodontic appliances which include passive space maintenance appliances following early loss of deciduous (baby) teeth, fixed anti-habit appliances (thumb or tongue interposition appliances), and minor orthodontic alignment in carefully selected cases.
- Referral to, and interaction with, specialist practitioners for treatment which is in the best interests of the patient.