

Unanticipated treatment complication and legal recourse

SADJ March 2015, Vol 70 no 2 p76 - p77

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SCENARIO

A middle-aged, partially edentulous Caucasian female patient presented to a general dentist for extraction of a mandibular tooth. The tooth was removed by the dentist, but following incomplete resolution of pain the patient returned three months later for a consultation. The dentist diagnosed an abscess following radiographic investigation and referred the patient to a specialist who diagnosed a fracture of the mandible. The fracture had occurred unbeknown to the dentist and was consequently treated by a reduction procedure. The patient has since pursued legal action against the dentist.

BACKGROUND

The extraction of teeth is a routine part of daily clinical dentistry, and while practitioners may choose to refer the patient to maxillofacial and oral surgeons, the removal of teeth remains a treatment modality that can be carried out by any general dentist. Removal of teeth requires the severing of periodontal tissues and its forceful dislodging from within the tooth socket. Periodontal disease, loss of clinical attachment and bone, existing infection and necrosis of the tooth socket may all contribute to the tooth's mobility, rendering it easier to remove. In some instances, extraction of a tooth requires extreme and considerable surgical intervention to ensure that it is entirely removed – roots and all.

Force applied to a tooth during extraction may be dissipated and transferred to the surrounding bone, to the temporomandibular joint, and throughout the masticatory apparatus. Isolating this applied force solely to the tooth and its immediate periodontal tissues may not always be possible. In addition, anatomical structures may negatively contribute to the strength of the jaw tissues, making them susceptible to injury or even fracture, to dislodging of the tooth and/or parts of it into neighboring anatomical spaces. The mandible exceeds the maxilla in terms of strength of cortical bone, but nevertheless has anatomically weak

areas liable to damage and fracture. With the loss of posterior lower teeth, considerable mandibular resorption may occur. The bone flattens and thins posteriorly as the mylohyoid groove and submandibular fossa continue to the ramus – a point of anatomical weakness. The third molar is typically located at this posterior location within the angle of the mandible, may occupy a considerable volume within the bone and when removed may leave a defect that significantly weakens the jaw. The clinician should be aware of these anatomical idiosyncrasies, ensure that pre-operative investigations are carried out and that the patient has been duly informed of the risks and of possible complications prior to treatment.

Complications and mistakes are inevitable in the practice of dentistry and while in many instances are not permanently harmful, some certainly may be. Mistakes turn into negligence when it is confirmed by a reasonable body of expert opinion that they are harmful, that the harm was caused by the dentist in question and that the mistake did not conform to good professional conduct (i.e. was not the sort of mistake that is unavoidable in the circumstances). Negligence may be defined as a "failure to exercise reasonable skill and care" or the "omission to do something which a reasonable man guided by those considerations which ordinarily regulate conduct of human affairs, would do, or something which a prudent and reasonable man would not do".¹ Every qualified dentist is expected, by virtue of his or her qualification, to possess a degree of skill and to appreciate that care must be exercised to the same standard as by the majority of his/her colleagues. A general dentist is not expected to possess the skills of a specialist, but more importantly, should not attempt any treatment which should be provided by a specialist and any attempt to do so could be construed as a failure to exercise reasonable care. That said the general practitioner in this scenario was not practising outside of his or her scope *per se*.

In general, when a patient is accepted for treatment by a dentist it is an implicit, though unstated, condition of the contract thus established that reasonable skill and care will be exercised. Any patient can initiate legal action to recover damages by way of compensation against a practitioner on the grounds of negligence but for this to succeed it has to be proven that

- (i) the dentist owed a 'duty of care' to that patient in the prevailing circumstances,
- (ii) there was a breach of that duty and
- (iii) damage was sustained as a result.¹

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ETHICAL CONSIDERATIONS

Respect for a patients' autonomy is reflected by good communication. Rendering appropriate clinical care (beneficence) requires effective communication and failure to do so can result in harm to the patient (maleficence). This in turn can have legal consequences (justice). From an ethical perspective, the patient-centered approach used in health care is in keeping with the principle of respect for autonomy. Respecting patient autonomy requires dentists to be honest with their patients, but it is not always easy to disclose to a patient that something has gone wrong and in your efforts to improve their condition you have inadvertently caused them harm. Nor is it always possible to disclose to a patient every possible complication or adverse effect of a proposed treatment modality. Disclosure requires a strong moral character and while moral and legal principles may guide us through ethical dilemmas and identify basic standards for decision making, they do not define what makes someone a good dentist. Personal attributes of compassion, trustworthiness, integrity and discernment - sometimes referred to as moral 'virtue'- are of especial importance, together with the added virtues of courage balanced by the virtue of prudence. That said, even the good, moral dentist may encounter complications, and unfortunately - legal recourse.

Informed consent must be obtained prior to the delivering any treatment. It is the patient's autonomous authorisation of the clinical intervention or treatment.² Giving thorough information regarding the treatment is implicit and according to the National Health Act³ this is to include the:

- Range of diagnostic procedures and treatment options available
- Benefits, risks, costs and consequences associated with each option
- User's right to refuse care after having received explanations of the implications, risks and obligations of such refusal
- Furthermore, this information must be provided in a language that the patient understands and in a manner that takes into account the patient's literacy level.

To protect both patient and the clinician, these tenets are best provided in writing, and for the patient to autonomously sign agreement or disagreement against each item and to select the treatment after having had the time to consider alternative options, understanding the implications, risks and benefits of each option, as well as that of non-treatment. Obtaining such consent is an ethical and legal requirement and any coercion negates the voluntariness of the obtained consent. Clinicians aware that a certain operation carries a particular risk may inform that patient accordingly and obtain consent for the operation. The potential damage may still occur and the patient, despite the informed consent provided, may go on to sue the clinician for negligence. To succeed in such a claim the patient would need to prove that although aware of the risk, the clinician failed to exercise reasonable skill and care, either in the manner of his or her operating or even by attempting the operation him or herself instead of referring the patient to a more experienced colleague or a specialist. However, the clinician who attempts such an operation without informing the patient of the known risk places him or herself in a much worse situation and risk

of subsequent legal action than when informed consent is obtained.

The following may be useful to prevent possible disagreements and miscommunication:

- Have educational material available to patients – pamphlets, booklets, electronically
- Invite your patient to pursue a second opinion if need be
- Keep concise records, written notes, radiographic imaging etc.
- Ensure explicit and informed consent and record it
- Be adequately prepared for complaints and legal challenges
- Ensure thorough follow-up after more advanced and complicated procedures
- Investigate and address unusual postoperative symptoms
- Consult regularly with specialists and consultants and refer if necessary
- Keep updated with best practice care by attending continued professional education courses

CONCLUDING REMARKS

The reasons for and risk factors following dental surgical complications may not be well known and understood by patients and therefore it is important that the time is taken to communicate these prior to any treatment proposed. In addition, supplementary patient information such as take home pamphlets may better protect and prepare both patient and clinician. Complications may occur at any time, even to the most experienced clinician and should be managed effectively and efficiently. Paramount is an expression of empathy and concern toward the patient. Effective two way communication may prevent the deterioration to a disagreement involving legal proceedings. If the clinician is aware that a mistake or complication has arisen, then it is prudent for the patient to be immediately informed and told what steps are going to be taken to rectify it.

References

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3. South African Parliament. National Health Act of No 61 of 2003, Chapter 2 Section 6. Pretoria

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