“Patients tend to go to court more often nowadays”

An interview with Dr Andy Wolff, Israel

...Be it a careless error or a case of misjudgement, even the most experienced practitioner can make a mistake. In fact, statistics indicate that it is likely that every general dentist will be involved in a malpractice suit at some point in his or her career. Israeli-based dentist Dr Andy Wolff has worked as a medical expert in dental malpractice litigation for many years and has seen almost everything, ranging from slight negligence to severe overtreatment. Dental Tribune International had the opportunity to speak with him recently about the steady increase in litigation in the field and simple measures that can help prevent many malpractice incidents in the first place.

Dental Tribune International: Dr Wolff, you have been a medical expert in dental malpractice litigation for many years now. Why is it so important to increase awareness of this topic?

Dr Andy Wolff: So much literature out there tells dentists how to do things—whether it is placing implants or improving efficacy with the newest technology—but there are no books on how not to do things or, more precisely, what can happen when something has gone wrong. This aspect is no less important, both for the patient affected and for the clinician, who might be facing legal consequences.
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Many may think that it is not relevant to them, but every smart physician knows that things occasionally go wrong and no one is immune. By documenting dental malpractice incidents and by talking and writing about these, I aim to raise awareness and therefore help prevent future incidents.

In your experience, what types of malpractice are most common?
There are definitely many cases in the neurological field. As a medical expert, I am confronted with many instances of damaged nerves caused while placing an implant, during tooth extractions or through an injection. It is common and it happens quickly. Typically, it is an inadvertent mistake, because the clinician was either in a hurry or impatient. However, the consequences for the patient are mostly very dramatic and often beyond repair.

Aside from nerve damage, is there an area where mistakes are more likely?
If I had to choose one, I would say it is implants. I recently had a very disconcerting case where an oral surgeon did all the preliminary examination work meticulously, the CT scan, the radiographs, everything. For that reason, he knew for certain that he was working with a bone structure of 11 mm, yet he used an implant that was 13 mm long in the treatment. Maybe he was just mistaken or the assistant handed him the wrong implant and he did not recheck it, but the result was that he hit a nerve.

In this particular case, the dentist was a specialist, an experienced surgeon. Without raising the question of guilt—although the surgeon was without a doubt responsible for the damage—cases like this show that mistakes really can happen to anybody.

So expertise does not preclude mistakes, but there are undoubtedly also cases that result from negligence and hubris.
I certainly see many cases in which dentists have carried out a treatment for which they were not qualified. I remember an incident in which a general practitioner injured nerves on both sides of the mouth during an implant treatment. That is truly unbelievable. I have seen many cases over the years, but nothing quite like that.

In another case, a dentist extracted a third molar without the requisite training. He should have referred the patient to a specialist, but he chose to do it himself—possibly because it earned him another US$200 to 300 (£130 to 190)—with the result that the patient now has to live with chronic pain for the rest of her life.

Can injured nerves regain normal function eventually?
Mostly, damage is irreversible. There are exceptions, of course, either if the damage was not too severe or if the nerve was inside a canal. Potentially, an injured nerve can regain function over time. However, if it is an exposed nerve, such as the lingual nerve, the damage is generally irreversible, although there are some microsurgery procedures that may improve the situation. Interventions like this, however, carry extremely high risks themselves and might even aggravate the situation.

With the consequence that patients partially lose sensation in the mouth or face?
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Yes. Another consequential damage, of which I only recently learnt, is loss of sense of smell. Patients whose sinus has been injured often lose their ability to smell. Sometimes, they may not even realise it initially, because the sinus runs on both sides of the face and the unaffected side often functions normally. Imagine losing your sense of smell completely owing to a defective bilateral sinus lift procedure—that would be a fairly serious impairment of a person’s quality of life.

_Have malpractice incidents become more common over the last decades?_

I would say so. At least, litigation has increased. Of course, there have always been cases of malpractice, but patients tend to go to court more often nowadays. Perhaps you could call it an “Americanisation” phenomenon: almost every problem is taken to court, with the result that dentists are paying increasingly higher insurance fees because the treatment risks are so high today.

_How common is legal action in dentistry and what is the compensation amount paid compared with other medical disciplines?_

It is perhaps comparable to plastic surgery. There are many complaints filed for cases in which the result was not what the patient expected it to be. Compensation payments range from US$10,000 to 100,000, which is much lower than those in other medical disciplines.

_Do more cases of overtreatment or cases of error on behalf of the dentist end up in court?_

These cases have an almost equal occurrence. Of course, overtreatment leaves the dentist in a bad position. It raises the question of why he or she treated the patient unnecessarily in the first place and did so poorly in the second; it leaves him or her doubly guilty. If a mistake occurred after a reasonable treatment plan had been formulated, it is comparatively less bad. Sometimes, even if a patient dies while undergoing therapy, this does not need to involve a distinct fault of the clinician.

_An American dentist was recently charged because his patient died after he extracted 20 teeth in one procedure._

I have performed such extensive treatment in the past; it depends on the need for the treatment and how it is done. Probably, that case in the US was the result of a combination of many things. For instance, did the dentist act in accordance with state-of-the-art practice? If not, he is at fault. If he did, one has to remember that dentists cannot rise above today’s level of knowledge and technology. Let us say an impaired patient files charges for something that happened to him 20 years ago that would have been preventable with the latest medical treatment. He can, of course, make a claim, but the dentist could not be sued for it if he or she treated the patient according to the best knowledge available at that time.

That is a very important aspect when writing expert reports on dental malpractice: did the dentist act to the best of his or her ability and according to the current knowledge or with gross negligence? That is what makes the difference.

_What can medical professionals do to protect themselves against legal disputes arising from high-risk procedures they intend to perform?_

Patients should not only be warned of the possible consequences of a certain procedure, but also be advised of the alternatives—and one of those alternatives is not proceeding with treatment at all. In my opinion, the patient should always understand both options: the risks of a particular treatment and what could happen.
if nothing is done. Only then should the patient
be asked to sign a declaration of consent.

Unfortunately, the reality is often quite differ-
ent. Patients are often asked to sign declarations of
consent on their way into surgery or while already
on the dental chair. Even if they had questions then,
there would be no time to answer them properly.
Although it should be of major concern for every
dentist to thoroughly inform the patient of the
risks, as well as alternative treatment methods,
before he or she is asked to sign a consent form,
I am constantly confronted with the opposite.

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So, you are saying that consultation should
be of similar importance to treatment?

Absolutely. In my opinion, building mutual
trust between doctor and patient is key for avoid-
ing malpractice and consequential charges. If pa-
tients feel that their condition is being properly
treated, and that money is not the dentist’s first
concern, this alone can prevent litigation in many
cases. Of course, if a nerve is damaged, there
needs to be a settlement of some kind, but if a
bridge fails, for example, instead of filing charges
the patient will return for further treatment if
there is a solid, trust-based relationship.

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Time, communication, trust—what else is
important when it comes to preventing mal-
practice?

One more basic rule every dentist should
follow is adhering to evidence-based dentistry.
This means not performing a certain treatment
just because in the dentist’s experience it is con-
sidered to be right. External scientific evidence
should be implemented. Also, every single finding
should be taken into account in determining how
to treat the individual patient: diagnosis, radi-
ographs, periodontal analyses, age, health status,
literature and so on. Neglecting these related
aspects can very likely lead to misconduct.

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Do you see basic problems in dentistry that
need to change?

Nowadays, we face the problem of “cheap”
dentistry. Owing to the amount of competition
with the large number of dentists in the market,
there are many cases of overtreatment. Cheap
dentistry needs to be fast, yet I have documented
cases in which patients have returned for retreat-
ment of a simple problem up to 70 times in two
years. If you add up the time those patients invest
only to have a poor outcome, it is striking. How-
ever, it is not possible for there to be elite dental
practices solely. For legal purposes, dental treat-
ment does not need to be exquisite, but it has to
be reasonable.

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Maybe it is a problem of today that patients
have increasing expectations regarding the
service or technologies their dentist should be
using.

That is certainly part of the same problem. Ad-
vertising that promises people a new Hollywood
smile in 2 hours forms the basis of patients’ beliefs
or expectations regarding treatment. Dentists
should not be tempted to involve themselves in
this kind of misguided pressure. Honest com-
munication is key when aiming to avoid dis-
appointing patients.

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Measures to prevent malpractice should
begin as early as possible, but where should
prevention start?

Personally, I think legal regulation should be
extended, such as specific laws or by-laws con-
cerning the amount of experience and training,
for example, required in order to perform certain
procedures. Basically, it is just what common
sense calls for and everybody will agree with if

“I am confronted with many
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through an injection.”

they think about it: should one be allowed to place
an implant after attending a speakers’ corner talk
or looking over a colleague’s shoulder? No, yet
this is often what happens.

A second measure could focus on under-
graduate education. Dental schools should devote
more time to prevention of lawsuits. This aspect
is neglected in the curriculum, although it is
an essential part of dentistry. General awareness
of the subject needs to be raised and this alone
would help prevent mistakes. As I said earlier,
mistakes are not always avoidable, but they
should at least not arise out of negligence, hubris
or greed. Apart from that, there will always be
cases of medical malpractice. Dentists are hu-
mans too; only he who does nothing makes no
mistakes at all.

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Thank you very much for the interview...