**Global Ceram • X Case Contest 2008/2009**

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**Under-treatment & Supervised Neglect**

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In the Dentsply Global Ceram•X Case Contest three UK students came out on top and were put forward to the global final. In this issue we take a look at Barts and The London, Queen Mary’s School of Medicine and Dentistry (UK) student Reena Wadia’s presentation.

Introduction to the case

A 59-year-old female patient presented with large fractures of her maxillary right (UR1) and left (UL1) central incisors. These were a result of a traumatic fall and necessitated restorations for aesthetic and functional reasons.

The ULI responded normally to sensibility testing and therefore considered to be vital; the UR1 had been treated endodontically, satisfactorily. This case was restored using Ceram•X™ duo; advanced nano- ceramic technology.

Material and method

Ceram•X™ duo (Shade E3 and D2), Nupro® prophylaxis paste (Dentsply DeTrey), 36% phosphoric acid (DeTrey® Conditioner 56, Dentsply DeTrey), Prime&BondNT (Dentsply DeTrey), Enhance and PoGo™ (Dentsply DeTrey), unfilled resin.

Direct adhesive bonding followed by natural layering technique. Ceram•X™ duo shade E3 used to give enamel-like translucency and shade D2 used to re-place the lost dentine giving the correct opacity and chroma. Final polishing for superior surface gloss and smoothness.

Discussion and conclusion

A very aesthetically-pleasing, ‘life-like’ result was achieved. This material also has excellent handling and placement properties and is understood to have good longevity. This is thus an attractive option especially for anterior restorations. Ceram•X™ duo certainly brings a smile to both the patient and dentist.

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The Patient’s Response

On the one hand, there will be cases where the patient has repeatedly declined the dentist’s recommendations for certain treatment, or perhaps a referral. This may be on grounds of cost, inconvenience, disinterest/apathy or for a variety of other reasons. Whatever the cir-
Furthermore, it is important to record the recommendations that were made (and the patient’s response) very clearly in the notes at the time.

Similarly, it is important to record any and every appointment that the patient fails to attend or cancels at the last minute. Reception and administrative staff should be encouraged to amplify clinical notes to reflect what has been agreed with the patient. For example, “Patient rang to cancel appointment. Offered to rebook, but patient prefers to contact us when more convenient.”

With most (although not all) computerised records and appointment systems, it is relatively easy to record the fact that a patient cancels an appointment scheduled several days or weeks after the booking has been made. This helps to establish a more complete record of the patient’s attendance pattern, and this can become very important if allegations of supervised neglect or excessive treatment delay are made at a later date.

Where manual (paper) records are being used, however, it would be much more unusual for a receptionist to retrieve the patient’s notes, specifically in order to record the fact that the next appointment, a week or two later, had been cancelled by the patient. In the absence of this record, the appointment book itself can sometimes become a valuable additional record—although many receptionists prefer to cancel appointments completely, in order to indicate availability and to legibly insert a new name.

At some stage in their career, most practitioners will have had patients who seem to stagger from one crisis to another, and whose treatment never really feels to be under the practitioner’s control. These patients often present with so many unexpected emergency problems in between their scheduled review appointments, that one course of treatment seems to merge seamlessly into the next. There is a danger that the patient’s treatment schedules can get mixed up on these occasions in a reactive “patch and mend” fashion, rather than a more proactive “what’s happening here, and why?” fashion.

Assessing the Situation

In such cases it is important to stand back from time to time and to make the effort to take a more detailed overview of the patient’s oral health, approaching this in the same logical fashion as one might approach a patient who you were treating for the first time. If the records can demonstrate that this was done, then it becomes much easier to defend subsequent allegations of under-treatment or “supervised neglect.”

The records sometimes tell the story of a patient who was at one stage being treated very diligently and attentively by a practitioner, but gradually this picture changes to one in which medical histories are not being updated, periodontal health is not being monitored, x-rays are not being taken, and so on.

A periodontal problem or a sinus over a root apex is “treated” with a prescription for antibiotics, but with no other details recorded in the notes, and no arrangements made for follow-up. Worse still, the records simply mention that a prescription was given, with no explanation of why this was being done.

Many factors can contribute to a greater or lesser extent in the “supervised neglect” of a patient:

• A dentist who is under stress for reasons unrelated to dentistry (perhaps financial worries, or domestic/personal problems) may be distracted by these outside pressures and become less attentive in the treatment of patients.

• Other dentists are unwell physically or mentally, and may not always realise this at the time; in one instance the explanation was no more complex than that the practitioner in question had not realised the extent to which his eyesight had deteriorated.

• Sometimes dentists are simply too busy, perhaps having been unable to replace a departed colleague, and “supervised neglect” becomes a response to having too many patients in too little time.

A significant number of the “multiple” cases of “supervised neglect”, tend to involve practitioners who are nearing retirement, which is a particular concern, since a large number of the practitioner’s patients will shortly be seen by a second dentist. This is often the means by which “supervised neglect” of a patient has been occurring on a wide scale, over an extended period of time, there have been many instances where this has created a nightmare situation (financially and logically) for any dentist(s) who takes over the care of the patients within the same practice. The worst scenario arises when such a dentist has taken over a “rolling” list of capitation patients, and finds a significant number of patients in need of extensive treatment in return for minimal capitation payments.

When a dentist is treating the patient within a capitation payment system, “supervised neglect” can arise for slightly different reasons. Very occasionally, a dentist appears to have “lost track” of a patient on capitation payments, while carrying out a normal range of treatment for patients who are paying fees on an item of service basis. Clearly, it is difficult to justify and defend the ethics of such an approach; it is clearly abusive of the capitation renumeration system and it is important to appreciate that it is the individual dentist, not the payment system, who is responsible for abuse of this kind.

Assumptions

When a patient actively declines treatment that has been recommended, the situation becomes quite clear-cut. A feature of “supervised neglect” cases, however, is sometimes an assumption on the part of the treating clinician that the patient “wouldn’t worry” about a particular treatment if it was offered on a separate occasion. This has created a nightmare situation, and in many instances this has just one patient out of hundreds where the same situation is encountered. Seen through one pair of eyes this is supervised neglect; seen through another pair of eyes, this is prudent, cautious, minimum-intervention dentistry.

To avoid this situation it is sensible either to make, or not make, a specific treatment recommendation, to discuss the options with the patient and to record the outcome of these conversations clearly in the clinical notes. This becomes particularly important when treating patients with whom you have a less formal relationship—perhaps professional colleagues, staff, friends or family members. There are precisely the situations where conversations that should take place, might not occur.

Summary

All dentists have a duty of care to exercise a reasonable level of skill and competence when treating each patient under their care. Failing to provide necessary treatment is one way in which this duty of care can be breached; recommending or providing unnecessary treatment falls at the other extreme, but is still a breach of a clinician’s duty of care.

Regular and effective communication with patients about their oral condition, and about what treatment is (and isn’t) being proposed, and why, is a valuable protection against an allegation of under-treatment. Full and meticulous records based upon appropriate investigations are equally invaluable. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

About the author

MPS is the world’s largest specialist provider of dental professional indemnity and risk management for the whole dental team. The articles in this series are based upon Dental Protection’s 100 years of experience currently handling more than 8,000 cases for over 48,000 members in 70 Countries.

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