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 UR1 responded normally to sensibility testing and therefore considered to be vital; the UL1 had been treated endodontically, satisfyingly, satisfactorily. This case was restored using Ceram•XTM duo; advanced nano-ceramic technology.

Material and method

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

Direct adhesive bonding followed by natural layering technique. Ceram•XTM duo shade E3 used to give enamel-like translucency and shade D2 used to replace 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•XTM duo certainly brings a smile to both the patient and dentist.

Under-treatment & Supervised Neglect

An interesting contrast between cases that involve dental practitioners and those that involve medical practitioners is that the former tend to involve criticisms of treatment that has been provided, while the latter include a significant number of “failure to treat” or “delayed treatment” allegations described as “under-treatment”. The background to these cases is often more complex than it might seem at first sight.

The emotive phrase “supervised neglect” is often used to describe a situation where a patient’s oral health has been allowed to deteriorate over a period of time, despite regularly attending the dentist who is responsible for the patient’s care and treatment.

It is sometimes confused with a situation in which the patient’s oral health has been deteriorating despite the dentist’s best efforts, rather than because of any lack of effort or attention on the part of the dentist concerned.

The key to this pivotal difference is often to be found in the clinical records, from which it will be clear:

- Whether or not the dentist had identified the relevant problems that existed in the patient’s mouth (for example, defective or fractured restorations, periodontal disease, uncontrolled caries, tooth tissue loss through erosion, abrasion, attrition or fracture, hard or soft tissue pathology, etc.).
- Whether or not the dentist has been monitoring the patient’s condition, and/or carrying out appropriate investigations that would provide the information necessary to reach a proper diagnosis and treatment plan.
- Whether or not the dentist had identified any relevant risk factors that might be contributing to the patient’s deteriorating oral health (for example, oral hygiene, diet, smoking, bruxism or parafunction).
- Whether or not the dentist had informed the patient about his or her oral condition, and communicated effectively with the patient about what was being done and why, or what the patient could do to help, control or improve the situation.
- Whether or not the dentist had explained the available treatment options to the patient, which in some circumstances might include the possibility of a referral for specialist advice or treatment.

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, discomfort or for a variety of other reasons. Whatever the cir...
circumstances, 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 in advance 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 delays 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 legally 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 is left unchecked 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 retreating colleague, and “supervised neglect” becomes a response to having to see 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” has occurred over a wide scale, over an extended period of time. There have been many instances where this has created a nightmare situation (financially and logistically) for any dentist(s) who take 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 at an early stage 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 reduce or “roll back” caries, on capitalisation patients, 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 liberal of the capitation renumeration system and it is important to make sure that it is the individual dentist, not the payment system, who is responsible for abuse of this kind.

Assumptions

When a patient actively denies a clinician’s treatment plan or changes his mind after treatment has been started, the situation be- comes quite clear-cut. A feature of “supervised neglect” cases, however, is sometimes an assumption on the part of the treating clinician that the patient’s “won’t listen, isn’t interested” in a certain treatment option, or that some old and dis-coloured restoration “didn’t worry them”. When there is no confirmation of this in the records, it is easy for a patient to respond along the lines of how did you know— you never asked me?

To avoid this situation it is sensible either to make, or not, 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. It is also very important to be proactive when 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.

Editorial Note: This text should ideally be read in conjunction with the article on history taking to be published in the next edition of Dental Tribune.