Dento-legal considerations about an MI approach

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In brief

Provides understanding of legal issues surrounding MI dentistry.

Provides a checklist for record keeping and consent in relation to MI dentistry in general practice.

Provides guidance on the standards expected from the GDC.

Over the years there have been many conceptual changes in how dental disease is prevented and managed. What is now the norm and standard practice was at some earlier time considered to be at best pioneering, and at its worst, heresy or negligent. When we look, for example at how we conservatively manage periodontal disease when less than a generation ago we were wielding surgical knives far more frequently than we do now, we can see how research and evidence-based dentistry has influenced our thinking. We are very much at that tipping point now with minimum intervention (MI) dentistry. This article will discuss the impact of MI dentistry from a legal viewpoint, covering such aspects as consent and record-keeping.

Introduction

There is an ethical imperative to promote what is best for patients and this beneficent approach to care is balanced with the non-maleficent desire to avoid harm where possible. In applying these important biomedical principles[1] we should also ensure the patient understands what we are doing, and why we are doing it in order to obtain their consent for the treatment.

And here is where we have a problem. In order to explain the risks and benefits of different modalities of treatment, as clinicians we must first know about them and believe that they will work. It is well recognised that treatment decisions by clinicians are influenced by a complex and varied range of factors which are not solely based on knowledge and technical skills but include cognitive behaviour, perceptions and individual attitudes.[2]

If patients know about a more conservative approach to their care they are more likely to accept it, particularly if they are told that the restorative cycle, which starts with the first time a drill is applied to the tooth, may lead to further treatment including repairs and replacements.

Our professional duty and clinical care for the patient should also extend beyond the restorative concerns of MI. While spending more of our detailed time assessing the smaller and smaller perimeters of the hole, we also need to plan ways in which we can focus more on the whole of the patient in terms of their general health and well-being.[3]

There are also other factors that drive treatment decisions, one of which is the payment system. In the UK, the NHS payments system in primary dental care revolves around activity payments (either as fee per item or units of dental activity). It is very unfortunate that the current remuneration scheme (unit of dental activity) in health service practice in England and Wales prevents practitioners from adopting a modern biological approach to caries control.[4] Quite simply, if your payment mechanism encourages prevention, then prevention will be provided.[5,6]

Contract reform in England, embedding a preventive pathway cannot come soon enough.[7]

Consent

The information asymmetry that exists between patients and clinicians is a gulf that can only be spanned by a mutual exchange of information – shared decision making. There is a professional and ethical obligation to find out what our patients want to know as well as what you think they need to know.[8] Following on from the supreme court judgement in the Montgomery case[9] there is now a legal obligation to do the same.

Consent is not a matter of bombarding the patient with technical information or a smorgasbord of choices that are neither specifically related to the patient and tossed into the conversation simply to fulfil the edict of 'giving all the options', or appropriate for the clinical situation.

Many definitions of consent have been suggested but the following one is a useful starting point. The best known definition of consent comes from the Department of Health which says it is 'the voluntary continuing permission of the patient to receive particular treatments. It must be based upon the patient's adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and a discussion of any alternative to it including no treatment'.

Montgomery requires that clinicians translate their professional knowledge into something meaningful for the average patient,[10] as well as for the particular patient sitting in front of them. The clinician is required to inform their patient about risks which the individual patient sitting in their chair would be likely to attach significance to.[11]

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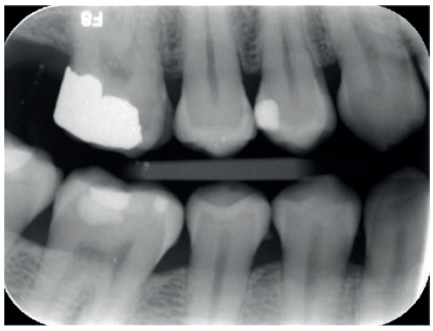

Fig. 1 Radiograph section of bitewing showing glass ionomer and composite sandwich two years after placement. Courtesy of Avi Banerjee

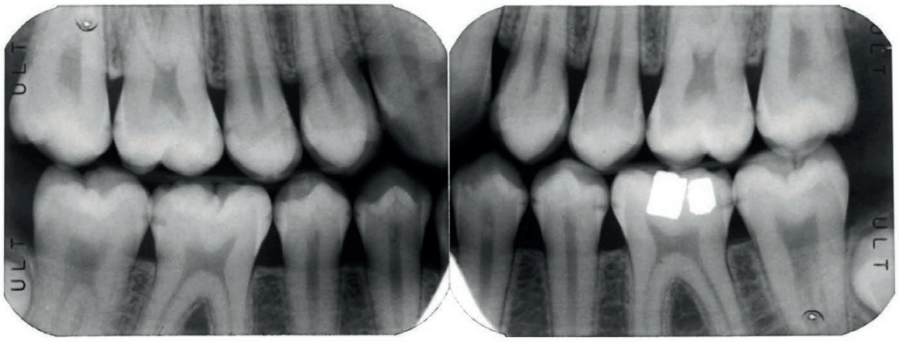

Fig. 2 Bitewing radiographs showing multiple early lesions. Courtesy of Louis Mackenzie.

Unless the patient is informed of the comparative risks of different procedures they will not be in a position to give their fully informed consent to one procedure rather than another.[12]

In the context of MI dentistry,the risks of other options may be more interventive.

Paradoxically it is also the risks of utilising an MI approach which relies on the patient compliance and consent to embark on a prevent approach that carries its own inherent risks.

The patient needs to know what part they will have to play in this and this is the classic example of shared decision making where the patient is more empowered, informed and autonoumous.[13]

Where the patient is in a high risk category for caries for example, the need for the patient to understand what their role is in managing their own personal situation with an MI approach becomes absolutely imperative with an MI approach becomes absolutely imperative. If the patients does not want to engage with the philosophy or the clinician does not feel they fully accept it or understand it then it may not be worth pursuing.

Consent checklist

- Is the patient old enough and capable of making a decision?
- Have I given the patient sufficient information about the treatment?
- Does the patient understand what treatment they have agreed to?
- Does the patient know their risk susceptibility/status?
- Does the patient know what their own involvement is?
- Does the patient understand the risks and benefits of the treatment?
- Has the patient been given alternatives?
- Does the patient understand all the costs involved?
- Have I provided any written information about the treatment and preventive procedures?

If the preventive regime requires the daily routine of cleaning, flossing, application of preventive mousses or pastes, dietary control and regular attendance, the patient should know this in advance and agree to it. If it means there is a risk that future treatment that you are trying to avoid, such as root canal therapy in a deep carious lesion, may still be required, they should know this along with the attendant costs.

The GDC point out that it is the clinician's responsibility to make sure the patient understands the decision they are being asked to make and that you should check and document that the patients have understood the information you have given them.[14].

Knowing all this, the patient may well decide not to do this and have the cavities restored or the definitive treatment provided rather than opting for a 'wait and see' approach. They have the right to do this.

Record keeping

Record keeping assumes a greater significance when an important part of the success of MI dentistry is patient compliance and choice. What a patient was told about their particular condition and the reasons a particular approach was taken becomes more important, and information leaflets utilised to help the patient understand the options will be useful to refer to.

A minimally invasive approach helps to preserve pulpal health when there are deep cavities. By isolating a lesion and incarcerating the bacteria under a sealed restoration, the clinician will be judged by some to have adopted an effective modern biologically sound approach. To the uninitiated, it may appear to resemble recurrent caries or a failure to remove all the caries.[15]

In Figure 1 the challenge would be to establish whether the radiolucency under the glass ionomer part of the restoration is active recurrent caries, residual inactive caries or a leakage defect. Without sight of the records or an understanding of the operative procedure in placing this restoration, it is purely guesswork for the next practitioner who sees the patient to decide how to proceed. The tragedy here of course is that if it is a stable inactive lesion then treating it as active recurrent caries undoes all the biological healing that has been taking place and subverts the MI process which may have gone undisturbed and asymptomatic for some years.

With shared decision making, the patient will be aware of this approach and engage with any future practitioner about the decisions made. This protects the clinician adopting an MI philosophy but also ensures the biological advantages gained are not squandered through ignorance.

Record keeping objectives

- Who was present?
- What was said?
- What was done?
- Why it is being done?
- How is it being done?
- What was paid?
- What is being planned for the future?

Specific record card entries for MI

- Patient shown radiographs/intra-oral images
- Radiographic report – extent of carious lesions E1,E2, D1,D2, D3

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- Aetiology of problem explained
- Specific details of prevention regime
- Treatment carried out, eg, MI approach taken – patient aware and agrees
- Explained options, partial caries (infected caries) removal versus complete carries removal
- Advised of risks
- Note of patient's acceptance/reluctance/concerns
- Assessment of risk – high/medium/low
- Recall interval
- Any specific leaflets given.

The records for the patient in Figure 2 need to identify the lesions and their extent, tooth by tooth, and record the specific advice given to the patient, for example, the use of floss, reinforced oral hygiene, strength of toothpaste if prescribed and review interval. Even if they do not progress, these cavities will not look appreciably different. It is important therefore that the patient is told that what another dentist might think are active lesions, are in fact inactive and are being managed.

There is no doubt that whilst a clinician may discuss things at length with a patient and the conversation may be free flowing during an appointment, the essence of that discussion is sometimes difficult to capture succinctly and efficiently enough unless we all had all the time in the world.

Many practitioners are now using custom screens with their computerised notes or cutting and pasting favoured paragraphs into the notes to save time. This is a pragmatic approach but one that needs to be exercised with care. The notes need to accurately reflect what was said and done and there will always be a little variation between patients. This needs to be carefully undertaken so the notes do not all look the same for every entry and between patients as it potentially undermines the specificity of the record keeping for those patients.

Clinical photography, either done with an intra-oral camera or a digital SLR, is very relevant for MI dentistry and assists in note taking and recording the type of treatment provided.

Transfer of risk

Where patient compliance is needed as part of an MI approach in a particular clinical situation, for example in a patient who has early enamel lesions occlusal or interproximally, their commitment should be assessed early on and patient selection is important.

Unlike the non-surgical management of periodontal disease which also requires patient compliance, there is an alternative to the MI approach which is simply to do the restorative treatment and not rely on the patient's compliance.

Getting this wrong could end up with the clinician transferring the risk back to themselves. If the patient fails to comply with the advice given, those early lesions may well progress, making the restorative care more interventive than it otherwise would have been had the lesions been treated at an earlier stage.

Standard of care

To successfully bring an action of clinical negligence, a patient must prove there was a breach of duty of care in failing to reach the standard of care expected and they suffered harm/losses as a result (causation), and that harm was foreseeable and not too remote.

The key issue is what the standard of care pertaining to the time for that particular clinical situation was and whether the dentist did something a reasonable dentist would not have done, or alternatively, did not do something a reasonable dentist would have done in that particular situation. This is the Bolam test[16] and is still the relevant standard that applies some sixty years after the judgement was handed down.

The law does not expect a dentist to be aware of every recent development in medical science,[17] but they would, however, expect that where a procedure or technique has become 'well proved' and 'well accepted' it is adopted.

There have been many publications[18,19] and conferences on the issues of MI, and the concepts form part of undergraduate teaching and textbooks,[20] including this series.

The GDC expect clinicians to provide good quality care based on current evidence and authoritative guidance advising that if you deviate from established practice and guidance you should record the reasons why and be able to justify your decision.[21]

The tipping point of the MI philosophy would suggest that a clinician who does not now adopt or consider this approach may well find themselves vulnerable to a claim in negligence as well as challenge by the regulator.

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