

“In my mouth”: Part 11: Ethical concerns regarding dental over-treatment and under-treatment.

SADJ July 2017, Vol 72 no 6 p281 - p283

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INTRODUCTION

Dental practitioners have been accused of over-treating, failing to treat, or delaying treatment. However, deciding precisely on what constitutes each is not easy or clear cut, and it is often hard to draw a distinct line between necessary treatment and over- or under-servicing. Every dentist will have a different opinion depending on his/her training, clinical perspective, philosophy towards intervention, facilities and personal viewpoints.^{1,2} Much like beauty, this obscurity makes each difficult to define, yet “we all know it when we see it”.¹

OVER-SERVICING

This may take the form of any unnecessary, inappropriate, excessive or fraudulent treatment. It includes supplying, administering or prescribing any diagnostic test, medicine, medical device or therapy which is not indicated, unnecessary or inappropriate to the circumstances, or which is not in accordance with recognised protocols and procedures.³ Over-servicing may also involve increasing the number of procedures provided per patient per course of treatment over and beyond the quantity needed to achieve oral health.⁴ Not only is this unethical, but it also constitutes a breach of the integrity of the profession.⁵ The main motive is usually financial gain. It may be driven by a need to compensate for low medical aid tariffs, a reduction in item fees, delayed payment from funders, high telephone bills arising particularly from calls to medical aids for authorisation, increased medical aid subscriptions and subsequent decreased membership, the weakening economy, oversupply of dentists, increasing costs of materials and equipment and high practice overheads.^{4,5}

In these situations, “over-servicing may occur because treatment decisions are based on the economic needs of the dentist rather than the clinical needs of the patient”.⁵

Over-servicing may also be unintentional, due to professional factors. Clinicians may have out-dated philosophies, inadequate clinical skills, have not maintained their knowledge on current evidence-based approaches, lack diagnostic ability, have no clear criteria defining standards of care, or may have differing clinical opinions.⁵ This may result in their carrying out invasive and dated procedures when current preventive measures may have been better.⁵ This highlights how imperative it is for clinicians to regularly attend continuing education courses.

Over-servicing tends to occur more in patients with few restorative needs where dentists feel that in order to make their work financially worthwhile they have to do a minimum number of procedures per patient session. Naegele *et al* (2010) found this to be on average 3-4 fillings in patients with low treatment needs and 1-2 fillings in those assessed with no actual need. Very often it is the basic services that are exploited as these are more difficult for medical aids to regulate. Examples include refilling of minimally jagged sealants, cosmetic replacement of amalgam restorations, radiographs (especially panoramic) taken with no clinical justification, scaling and polishing on patients with no visible plaque, extraction of asymptomatic third molars, and replacement of restorations with crowns.⁵ On the contrary, the research found that in patients with greater requirements there was less disparity between need and treatment provided.⁵ This may be because dentists feel less compelled to over-treat or they carry out more complex (thus higher paying) procedures.⁴ Clinicians may also be tempted to over-serve patients who arrive in and around the times when there have been last minute cancellations by another patient, in order to compensate for perceived lost clinical time and earnings.

Note: Issues such as charging for a three-surface filling when only one surface was restored is not over-treatment. This is pure FRAUD!

More subtle forms of over-servicing may result from dentists campaigning for patients by promoting

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themselves or their services. This may be via practice advertisements, brochures or web-based posts. It is often accompanied by the use of personal superlatives such as “the best” “top-class” “word-famous”. This form of touting along with the promotion of specific products, use of actors or patient testimonials, fear-mongering, and indirect defamatory comments about competitors is unethical and is prohibited by the HPCSA.⁶

Patient-initiated demands for cosmetic rehabilitation may also lead to over-treatment when dentists “exploit human vanity and ignorance of dentistry and its less costly, more biologically acceptable alternatives”.⁵ In addition to raising the costs of care, this form of treatment often has very few oral health benefits, and may even be detrimental in the long-term.⁵ Other patients seek treatment to “use up their medical funds”. They often ask for purely cosmetic procedures such as bleaching, veneers and replacement of amalgams with tooth coloured restorations, yet there is no actual requirement for these. Many of these cosmetic procedures are not covered by medical aids, and as a result the patients often end up with more extensive (and destructive) restorations such as full coverage crowns which are covered by their funders. They generally have little knowledge of the possible detrimental consequences of these treatment modalities, or are blinded by the brilliance of their shining new A1 smiles! A dentist who concedes to these unwarranted requests could be guilty of over-treating.

Over-servicing, irrespective of the reason, is ethically and legally wrong, and results in conflicts of interest among the patient, the dentist and the medical funder. However, there is no “gold standard” to use for assessing need or determining the necessity of the intervention.⁴

Perhaps, rather than trying to formulate a classification or definition, it can simply be stated that over-treatment is any treatment that has no remediable qualities.¹

While some people may be considered to have “Motor Mouths”, that is still no reason to over-serve them!

UNDER-TREATMENT

Not providing treatment is the exact opposite situation, and is far less often discussed or elucidated. Clinicians may be accused of failing to treat, delaying treatment, of supervised neglect or planned inactivity.² There may be subtle differences and explanations for each, making recognition more complex to determine from a clinical examination alone. Supervised neglect refers to “the situation where a patient’s oral health has been allowed to deteriorate over a period of time, in spite of regular attendance at the dentist for treatment and care”.² This may be due to many reasons. Dentists may be less attentive to patients’ needs if they are under stress, unwell physically or mentally, have not realised their own deteriorating eyesight, are too busy, are understaffed, or have matured with their patients and both become accustomed to settling for minimal intervention dentistry.² Multiple cases of supervised neglect may be seen in the practices of newly retired practitioners after they leave. The patient pool is usually taken over by a new colleague, who will look at all patients with “fresh eyes and without the benefit of knowing their past history”² nor the circumstances

under which the work was carried out. It is common for dentists to be more critical of the work done by others than they are of their own. For example, they may be quick to criticise a less than perfect restoration without knowing that the previous dentist had been monitoring it over the years, and left it untreated because it was deemed to be stable. It’s also tricky deciding whether and how to inform such patients as their responses are unpredictable. The patient may see it as a sign that the previous dentist was negligent, or the exact opposite and suspect that the new clinician is trying to over-serve them!

This is not the same as that situation where a patient’s oral health has deteriorated due to their own lack of effort or concern despite of the dentist’s best efforts to intervene. This makes it crucial for dentists to keep accurate records which would highlight that they had identified the problems; carried out the necessary investigations needed to make a proper diagnosis; formulated a treatment plan with options; identified any associated risk factors that may have contributed to the poor oral status; informed the patient about the condition and how it could be improved; explained whether treatment had been offered; and had noted how monitoring had been conducted. Many times this is done but not documented.² Even informal treatment discussions with more familiar patients should be entered into their records.

Another situation that may lead to “supervised neglect” is that of patients who frequently present at unscheduled times with dental emergencies. They tend to get treated with patch-work dentistry, and never progress to having definitive pro-active treatment plans formulated or completed.²

Similarly if a patient declines treatment for whatever reason, this should be recorded, as well as late / repeated cancellations or failure to arrive for scheduled appointments. It is good practice to always offer such patients an alternative date and document this, so they cannot later claim that the dentist could never fit them in. Appointment books are seldom useful to defend supervised neglect on the grounds that the patient had repeatedly cancelled, as many times names are written in pencil and erased to accommodate changes. Clinicians must also take note there is a difference between a patient who actively declines treatment and one that they “assume would not be interested”. The latter poses a risk of being undertreated if the dentist never actually asks or confirms their suspicions.

Finally there is the issue of under-treatment due to cost barriers. Is this neglect? Many patients who cannot afford treatment don’t ever go to a dentist, so their needs will not be detected. However what about those who do present with urgent and / or necessary needs, but who cannot afford the recommended procedures. Is it neglect to make a decision not to treat based on economic grounds? It surely goes without saying that no patient can be turned away while still in pain, but what are the dentist’s obligations legally and ethically beyond this?

ETHICAL PRINCIPLES

Hartshorne and Hasegawa presented an excellent overview of the ethical issues and moral rules related to over-servicing which is well worth re-visiting.⁵ They stressed

that clinical ethical decision-making requires practitioners to be constantly judging themselves, asking questions such as: Would it be unethical not to do this treatment, and could that inactivity result in any harm? Will the treatment benefit the patient? Is the decision to treat being governed by financial incentives? Has the patient been educated as to the risks, benefits and consequences of treatment? Has the patient given informed consent? Thereafter they should select the choice of action that best answers all of these questions and that is in the best interests of the patient.

CONCLUSION

Assessing need and suitability of treatment is a complex issue based on differing opinions, dental and patient-related factors, and always carries with it an element of subjectivity. Not only do opinions vary, but there may even be individual inconsistencies when the person commenting is also responsible for providing the treatment as opposed to when they are only evaluating need. Personal financial gains, business profits or economic survival can never justify over-servicing.⁵ At the same time, the risks of neglect are minimised if all patients are presented with an accurate diagnosis, a list of possible treatment options, a recommended plan, time and cost implications, and alerted to the risks and benefits of each option. They must also be afforded the opportunity to accept or decline the proposed treatment based on an educated understanding of the consequences of their choice. Ultimately, regardless of the circumstances, all clinicians have an ethical duty to provide the best and most appropriate treatment for their patients, based on current thinking and up-to-date knowledge of diagnostic and therapeutic interventions, keeping the patients best interests as the driving motivation behind their actions (or planned inactivity).

Perhaps the ultimate deciding factor in each situation is for the clinician to ask themselves "What would I do IN MY MOUTH?"

REMEMBER

Treatment-based Guidelines of SADA state:

"The Dental Association respects the clinical freedom and judgement of every practitioner to institute whatever treatment he or she considers appropriate in given circumstances, provided it is based on a sound clinical diagnosis and the patient is given informed choice regarding the treatment options available".⁷

References

1. Gutkowski S. Overtreatment? What's overtreatment?: Accessed at: www.rdhmag.com/.../overtreatment-whats-overtreatment.html; Accessed on: 11-01-2017.
2. The Young Dentist. Undertreatment and supervised neglect - The Young Dentist. Accessed at: www.theyoungdentist.com/.../512-undertreatment-and-supervised-neglect; Accessed on : 07-11-2016.
3. HPCSA. Guidelines on Overservicing, perverse incentives and related matters. Accessed at: <http://www.hpcsa.co.za>; Accessed on: 07-11-2016.
4. Naegele ER, Cunha-Cruz J, Nadanovsky P. Disparity between dental needs and dental treatment provided. *J Dent Res.* 2010;89(9):975-9.
5. Hartshorne J, Hasegawa TK. Overservicing in dental practice - ethical perspectives. *SADJ.* 2003;58(9):364-9.
6. HPCSA. Guidelines for Good Practice in the Health-care Profession. Booklet 2. Accessed at: <http://www.hpcsa.co.za>; Accessed on: 07-11-2016
7. HPCSA. Guidelines on Overservicing, Perverse incentives and Related Matters. Booklet 5: Accessed at: <http://www.hpcsa.co.za>; Accessed on: 07-11-2016 Additional site: <http://www.sada.co.za/component/zoo/item/booklet-5-guidelines-on-overservicing-perverse-incentives-and-related-matters.html>; 2008.