Overtreatment

Allegations of overtreatment take many different forms, but the majority of such allegations usually imply an improper motive on the part of the clinician.

Consent

Whenever any kind of professional service is being delivered to a member of the public by someone who is highly trained and knowledgeable in a professional field, an almost inevitable feature of the relationship that develops will be an inequality in the levels of knowledge and understanding between the professional on the one hand, and the lay person on the other. Patients are more likely to assume, for example, that treatment either needs to be carried out or it does not; as a result, they can find differences in clinical opinion very difficult to understand.

In the healthcare setting this imbalance has fundamental consequences for the patients’ ability to decide for themselves whether or not to proceed with any particular treatment that has been suggested to them. The provision of medical and dental treatment is a very personal experience, and often the procedures are irreversible. Healthcare providers have a very privileged relationship with the patients under their care; patients have the right to expect that their best interests will remain uppermost in the thoughts and actions of the healthcare professional.

The consent process is a fundamental aspect of patient autonomy. Patients have a right to decide what treatment they wish to undergo or to decline, and the role of the clinician in this situation is to assist the patients in such choices by providing sufficient balanced information expressed in simple terms so that patients can understand the explanation.

A defining and high profile case in the UK a few years ago involved the provision of excessive and unnecessary treatment by a dentist (and to make matters worse, treatment of a poor standard). The dentist was found not only to have acted negligently, but to have committed an act of trespass (a wilful assault) upon the patient, on the grounds that the dentist would, or should, have known that the treatment was not necessary. Because of this, the patient’s agreement to the treatment had been obtained in bad faith and on the basis of deliberately misleading information and guidance provided by the dentist concerned.

Aggravated (punitive) damages were awarded against the dentist in a substantial sum—excessive and unnecessary treatment which was not clinically necessary and which resulted in irreversible damage to the patient’s oral health. Patient after patient, when asked whether they had experienced any doubts or reservations or even surprise at the considerable amount of treatment carried out, replied they had not. They believed that the dentist was the expert, totally qualified to advise them and that he would carry out only such treatment as was in their best interests. Such implicit confidence and unwavering trust are part of the privileges granted to members of a caring profession. They place an incalculable responsibility on members of the profession to justify that confidence and trust and never to allow their conduct, knowledge or clinical competence fall below that which the public and their professional colleagues are entitled to expect.

The allegation of overprescribing takes many different forms, including:

1) The provision of treatment which is inappropriate to the patient’s needs, ie, complex treatment where simpler treatment may have achieved a comparable or an even better outcome for the patient.

2) The deliberate provision of excessive amounts of treatment, or unnecessarily complex treatment for individual patients.

3) The provision of a certain treatment at unnecessarily frequent intervals.

4) The provision of unnecessary treatment to sound teeth or restorations which need no such treatment.

5) The elective provision of certain kinds of treatment in clinical situations where most other dentists would not feel it to be necessary or appropriate.

It has been well documented in the scientific literature over many years that clinical opinions will always vary, and...
sometimes by wide margins. One dentist might recommend more treatment, or more complex or extensive treatment, based on clinical views developed over many years and sincerely held, in most cases. A very small minority of dentists might knowingly provide unnecessary or excessive treatment, but in most other cases, a dentist’s treatment decisions might simply reflect an outdated treatment philosophy and a lack of awareness of less invasive techniques that have replaced the more radical operative approaches of the past.

In situations where treatment is funded wholly or partly by the State, or by a third party (for example, Health Funds), or other insurance schemes, these external agencies will put systems in place to monitor unusual or abnormally high levels of prescribing certain types of treatment by individual dentists or groups of dentists.

**Statistical Comparisons**

Any such monitoring relies upon the statistical comparison of an individual dentist’s treatment pattern with that of other dentists locally, regionally or (in some cases) nationally. Statistics may point in one direction when common sense points in another.

One of the problems of single-handed practice, particularly in rural or isolated areas, is that one can easily lose touch with changes that may be affecting the clinical practice of one’s peers and other colleagues. In such a situation it becomes all the more important to remain involved in professional activities to keep up to date by whatever means are available and practicable.

It is not unusual to find that dentists prefer certain aspects of clinical practice to others. Reflecting this fact on the one hand and the patient base of the practice on the other (i.e., the patients’ age, needs, demands, etc), many dentists polarise their activities towards the provision of certain types of treatment, and/or away from the provision of other kinds of treatment. Specialisation is the ultimate expression of the former trend, and referral of patients to specialists or other colleagues is a logical consequence of the latter.

In time a dentist may progressively start to recommend or carry out more of the kinds of treatment that are found to be enjoyable or less stressful, possibly Procedures that an individual dentist finds enjoyable are often done more regularly, more effectively and to a higher standard. It is not unusual to find that they are also more profitable, and it is here that the seeds of overtreatment can be sown.

**Summary**

When carrying out a lot of a certain kind of treatment, several questions need to be asked:

1) Is this treatment always being provided in the patient’s best interest?
2) Has proper consideration been given to alternative forms of treatment, and proper time and effort to the consent process to allow each patient the opportunity to consider all of these alternatives and decide whether or not to proceed with the treatment?
3) Can the necessity for this treatment be clearly demonstrated? Are the records and any investigations carried out (including radiographs) sufficient to justify the provision of this treatment?
4) Am I keeping up to date with the professional literature, and if so, does it support the provision of the treatment I am providing, and will it support the present scale on which it is provided? 

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