PULLING TEETH

Robert Mills explains negligent dentistry claims

Litigation concerning negligent dentistry is an area of clinical negligence claims that continues to expand.

Although perhaps often taken for granted, a person's dentition is undoubtedly one of their most sensitive physical features. The loss of a good smile is something that can cause significant embarrassment and a loss of confidence in personal and professional situations. This is one reason why dental claims will commonly have an associated psychological injury claim attached.

Coupled with this, dental pain can be one of the most invasive, prolonged and difficult forms of pain to treat. Where the damage is treatable with restorative work, it is often very expensive, with a single dental implant to replace one missing tooth costing anything from £2,500 to £3,500.

It is therefore unsurprising that when dentistry goes wrong, it is an area of medicine where people feel particularly affected, and so are minded to make a claim.

Identifying the defendant in dental negligence claims is not as straightforward for claimant solicitors as it once was. The conventional approach was to proceed against the individual negligent treating dentist, who would be indemnified by a defence organisation.

The progression of the law surrounding vicarious liability and non-delegable duties has opened the door for claims against the dental practice, partnership or practice principle, for the negligence of the associate dentists or staff. The vicarious liability approach is now commonly used when a treating dentist cannot be identified or is uninsured. Some firms now use the approach as a first port of call, given the advantages in multiple defendant cases, where the alternative would be to pursue each dentist individually with different defence organisations.

In such a scenario, the defendants may struggle to constructively engage and collaborate in settlement proposals, particularly if their assessment of liability or quantum is materially different. Care must be taken, as with all areas of clinical negligence, to stay up-to-date with the law surrounding vicarious liability, in order to ensure that the scenarios in an individual claim indicate that such an approach has merit.

Common claims

There is a wide range of different dental negligence claims. Data from one major dental defence organisation, the Dental Defence Union, indicated the following breakdown of the most common type of claims:

(i) Extractions (likely leading to nerve injury): 24%

(ii) Root canal treatment: 20%

(iii) Caries and fillings: 17%

(iv) Periodontal disease: 10%

(v) Implants: 9%

Periodontal disease is an area that commonly attracts high value claims due to the fact that multiple teeth are often lost, and complex restorative requirements ensue. Claimant solicitors are well advised to be on the look-out for periodontal claims, even when the initial complaint may be unrelated.

A close analysis of bitewing radiographs and Basic Periodontal Examination (BPE) scores in a patient's records are often the most reliable indicator of the presence of disease by either bone loss or pocketing of the gums. In the absence of such assessments in the records, liability is likely to be established if a patient went on to develop the disease without appropriate treatment.

Defendant solicitors will be on the look-out for causation defences in periodontal disease cases. In particular, consideration of the extent of the disease at the start of the treatment period, together with other restorative compromise of the tooth, can provide an effective defence to a causation of tooth

loss argument. If negligence has led to acceleration of loss only, the defendant may avoid a high-value implant claim.

Root canal treatments are another common area of negligence. Claimant solicitors should be on the lookout for root canal treatments where there has been no previous filling. There may be concerns about whether caries has been missed in its early stages, or whether the root filling was necessary at all.

Where a root filling has failed, practitioners should be alert to looking for the documented use of a rubber dam and appropriate irrigant to prevent bacterial contamination of the canals or the swallowing or inhalation of instruments.

A close examination of the radiographs of the filling itself can also form the basis of a claim if it can be seen that the canals are filled well short of the apex of the root, or indeed through the apex and into the soft tissues.

Crowns and veneers are a common area of restorative (and potentially) aesthetic dentistry that forms the subject of claims. When screening for claims, solicitors should look carefully at crowns which fail in a short space of time (1-2 years or less). In particular, an examination of radiographs can pay dividends in identifying caries that has been left in situ, or poor margins on the crown that have acted as a magnet for further development of decay.

Where multiple teeth are crowned to a poor standard, claimants can find themselves in very difficult situations, with complex treatment requirements. Complications such as temporomandibular joint (TMJ) pain, occlusal difficulties or simply a poor aesthetic can be invasive injuries.

Often a review of the records in such cases will reveal poor treatment planning, a lack of pre-operative photos and study models, or simply poor surgical technique in undertaking the dental work.

Consent claims

As with other areas of clinical negligence, the field of dentistry also sees its fair share of consent claims following the clarification of the law in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 and subsequent litigation, which has been seen by many as raising the bar for medical professionals obtaining appropriate informed consent. Dentists have to be clear when undertaking any course of treatment that the patient is well appraised of the alternative treatments that may be suitable for them, and the risks and benefits of each option.

In the dental sphere, it is relatively uncommon to see consent claims relating to restorative treatment such as root canals and fillings, for the simple reason that the alternative is usually to let decay progress untreated and lose the tooth.

The exception to this is to look carefully at decisions to extract teeth, to ensure that a claimant has been given all appropriate options for treatment or referral which may have saved or prolonged the life of a tooth.

The more common consent claims in dentistry relate to prolonged elective courses of treatment. Often these relate to aesthetic work such as crowns / veneers to multiple teeth, or orthodontic work where the patient ultimately had a realistic option as to whether to undergo the treatment.

Before such courses of treatment are embarked upon, professionals would be well advised to prepare thorough written consent documentation to illustrate that the *Montgomery* requirements are fulfilled. In the absence of this and with a claimant who can provide credible evidence as to why further information would have changed their decision, a successful consent claim may ensue.

Picking experts

Whether acting for claimants or defendants, solicitors are well advised to pick their experts carefully in dental negligence litigation.

Breach of duty evidence should come from a practitioner in the same field as that under scrutiny (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582). If a general dentist is at fault, this is the field in which the expert should practice. If a restorative dentist is criticised, the same field of practice should provide the expert analysis. Mixing the two is a dangerous strategy, and risks the other side arguing either that an excessively high standard is being applied by the expert, or that the expert simply does not have the level of expertise to comment on a specialist area. If the other side has a more appropriately qualified expert for the liability subject matter, they will be at a significant advantage at trial.

Similarly, in the field of condition and prognosis, practitioners should avoid the temptation to think that a dental negligence claim simply requires a dental expert to comment on both liability and condition and prognosis.

Often with complex restorative work such as implants following tooth loss from periodontal disease, a general dentist may have no experience