Implant Dentistry at the Focus of Liability Lawsuits

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Purpose: *In recent years, the growing readiness on the part of dental patients to take legal action has resulted in an increasing number of medical liability lawsuits. The aim of this retrospective analysis was to highlight aspects of these lawsuits of special significance, to subject them to both qualitative and quantitative analysis, and to show how conflicts can be avoided.* ***Materials and Methods:*** *Forty relevant court decisions from the year 1984 onwards were found in online databases and through direct inquiries at the courts. These were supplemented by 21 reports prepared by experts at the University of Muenster, Department of Dental Medicine, commissioned by courts in connection with ongoing lawsuits. Analysis was initially based on formal aspects of the cases and reports. It was later supplemented by differentiated assignment of the questions addressed by the courts to the expert consultants. The principles underlying the judgments as to the liability arising from the terms of the contract were also assigned to the expert consultants in a differentiated manner.* ***Results:*** *The results revealed marked differences in the frequency of liability-prone aspects of treatment. While the majority of judgments referred to the obligation to take due care during the preparatory and treatment phases, infringement of the obligations to provide information and to keep records played more than a minor role. Moreover, 90% of all cases represented combined charges covering various aspects, including those related to consequential failings.* ***Discussion and Conclusion:*** *The detailed qualitative analysis of the grounds quoted and of the lines of reasoning can therefore be summed up in clearly defined recommendations aimed at helping the clinician avoid conflicts by observing the judicial requirements.*
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Key words: *court decisions, implant dentistry, lawsuits, liability litigation, treatment obligations*

The status of implant dentistry has been greatly enhanced in recent years. This is related in part to its application to new indications, such as the use of extraoral implant systems as a basis for facial epitheses or the use of implants for more extensive anchorage potential for tasks within the fields of orthodontics and osteogenic distraction. Concurrently, the information available to patients has increased, as has the public's awareness of the field and its expectations with respect to quality. Today, maximum treatment success is expected in terms of both function and esthetics, partly because of the increased financial involvement on the part of the patient. Patients and their legal representatives are becoming increasingly aggressive in asserting their claims, so it is hardly surprising that the number of founded and unfounded claims for compensation has increased in recent years. What is surprising, however, is the casual, carefree approach taken by many dentists[1] in grasping and assessing the significance of liability lawsuits.

The aim of this retrospective analysis was to determine starting points for liability claims in the field of implant dentistry, to subject aspects of liability lawsuits to qualitative and quantitative analysis, and to show how conflicts can be avoided.

MATERIALS AND METHODS

To determine the most liability-prone aspects, a search was made for relevant court decisions from the year 1984 onward in 3 online databases—Juris, Saarbrücken, Germany (www.juris-online.de), Medizin-Recht, Frankfurt, Germany (www. medizinrecht.de),

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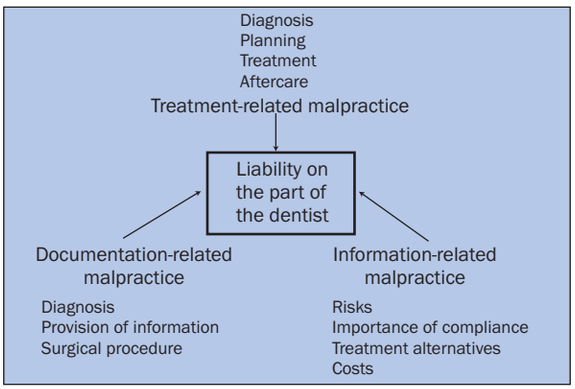


Fig 1 Classification of liability bases.

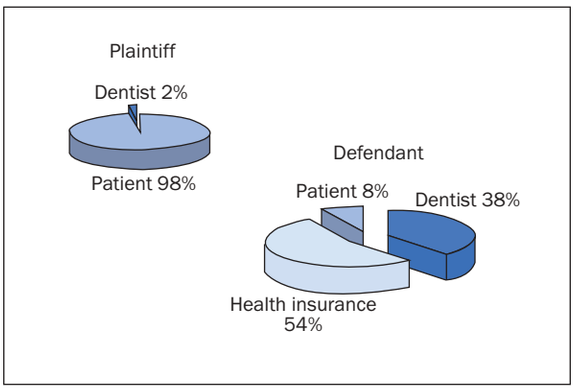
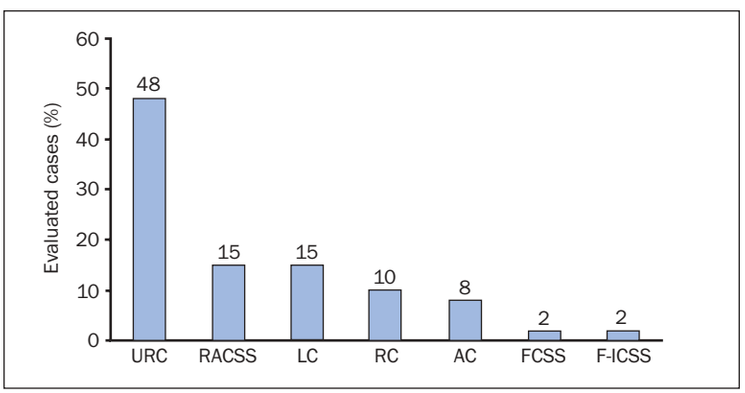


Fig 2 Distribution of plaintiffs and defendants.

Fig 3 Classification of courts passing judgment, German Court System. URC = Upper Regional Court, RACSS = Regional Appellate Court for Social Security, LC = Local Court, RC = Regional Court, AC = Administrative Court, FCSS = Federal Court for Social Security, F-ICSS = First-instance Court for Social Security).



and Jur@t, Erlangen, Germany (www.jurat.de). Direct inquiries to courts were also made. Special attention was paid to the requirements imposed on dental practitioners by courts that had drawn upon the services of an expert consultant. This information was supplemented by expert reports prepared at the Department of Dental Medicine, University of Muenster, Germany, in connection with ongoing lawsuits. An attempt to compare country-specific judgment was not made because of the basic differences in jurisdiction.[2–5]

The basic analysis was based on the following aspects: plaintiff, defendant, type of court, litigation value (ie, the value of the damages awarded by the court), number of occurrences, and duration of litigation. The specific analysis included a precise description of the point at issue, the charges leveled, the questions addressed by the court to the expert consultants, and the principles underlying the decisions. Differentiation and division into groups were based on the liability arising from the terms of the contract, obligation to take due care, obligation to provide information, and obligation to keep adequate records (Fig 1).

The data were analyzed with reference to purely descriptive statistics. The most important perspectives and lines of reasoning given in the legal analyses of the judgments and expert reports were combined and formulated into requirements for the dental practitioner.

RESULTS

The analysis covered 40 judgments and an additional 21 expert reports. The 40 court decisions were selected from the collection of court decisions found in the online databases using the search term "lawsuits and implant dentistry." Owing to the lack of a complete centralized file collection, it was impossible to determine the total number of decisions there have been in Germany. The search revealed a vast predominance of patients on the plaintiff side compared with dentists. More than half of the defendants consisted of patients' statutory health insurance plans, followed by dentists and a very small proportion of patients (Fig 2). The mean litigation value was 16,000 euros (about $18,500), and the mean duration of litigation was 4.8 years. In 25% of the cases, a single occurrence was involved; 67% involved 2 occurrences, and 8% involved 3. The court passing the judgment was a higher regional court in almost 50% of all cases (Fig 3).

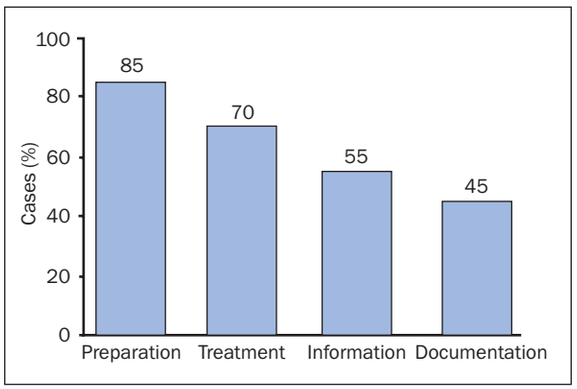


Fig 4 Points at issue.

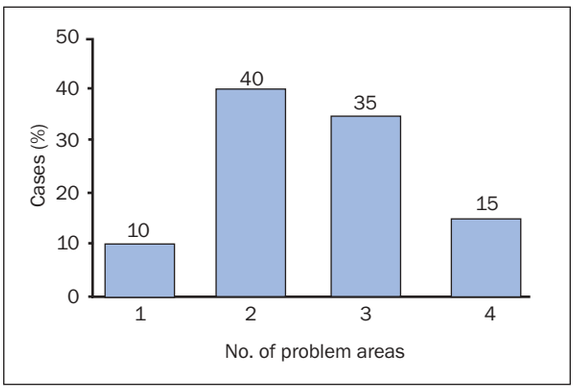


Fig 5 Number of problem areas.

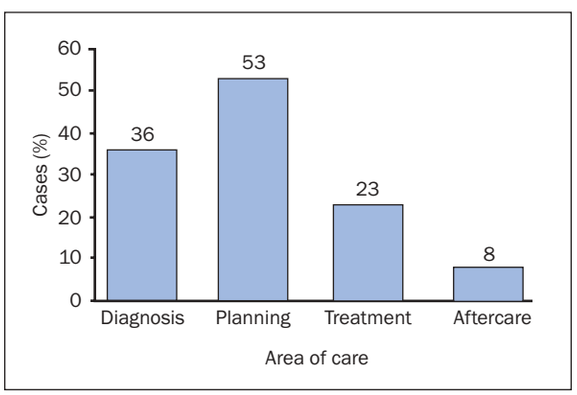


Fig 6 Infringements of the obligation to take due care.

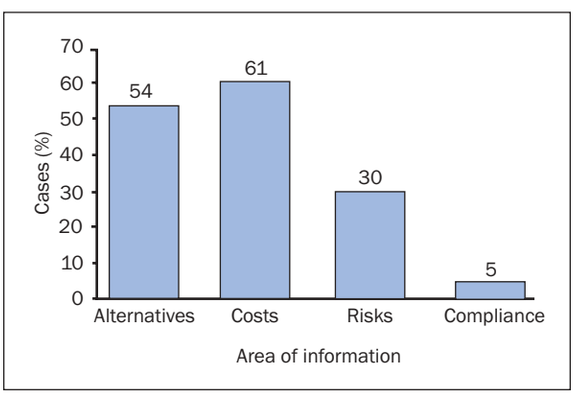


Fig 7 Infringements of the obligation to provide information.

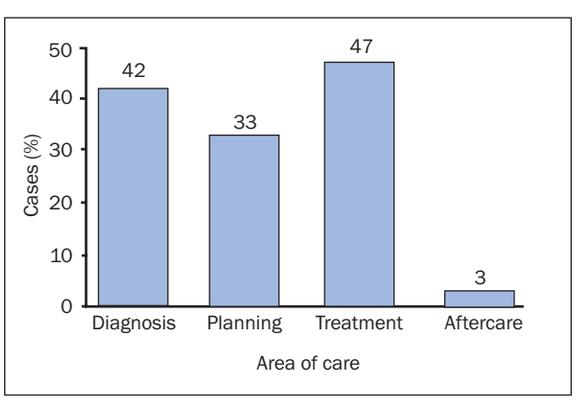


Fig 8 Infringements of the obligation to keep complete, accurate records.

Classification of the point at issue revealed that 85% of the judgments related to the obligation to take due care in the preparatory phase, 70% to the obligation to take due care in the treatment phase, 55% to the obligation to provide information, and 45% to the obligation to keep records (Fig 4). Only 10% of cases were based on a single aspect, while 40% were based on 2, 35% on 3, and 15% on all 4 aspects (Fig 5).

Differentiated consideration of the points at issue showed that infringements of the obligation to take due care arose mainly from planning deficits, followed by diagnostic deficits. Deficits in the course of active treatment and the aftercare together accounted for less than one third of these cases (Fig 6). The points at issue in these cases were all findings of the court and not allegations of wrongdoing. Information deficits related primarily to failure to inform the patient about costs or alternative treatment methods. The risks of treatment were inadequately explained in 30% of the cases, and the need for postsurgical care plus the risk of the potential results of ignoring restrictions in only 5% (Fig 7). The obligation of record keeping, which is not classified directly as a point at issue, was uniformly neglected in the fields of diagnosis, information, and surgery, while fault was found with the records covering the aftercare in only 3% of the cases (Fig 8).

Consideration of the detailed contents of the legal analyses and of the underlying lines of reasoning in the chronologic context revealed a tendency to ever-closer definition and to increasingly exacting requirements. The present results showed clear-cut differences in the frequency of liability-prone

aspects. The detailed qualitative analysis of the grounds quoted and of the lines of reasoning used in the expert reports can be summed up in clearly defined recommendations aimed at helping the practitioner avoid conflicts by observing the judicial requirements:

1. Exact, reconstructible records must be kept of the initial findings.
2. Prior to implantation, complete and adequate pretreatment (conservative, periodontal, orthodontic, surgical, medical) must be carried out and documented if it is of significance with respect to the subsequent implant treatment.
3. It is not the clinician's responsibility to clarify matters associated with the insurance coverage. Rather, the clinician must provide the patient with information required for such clarification (eg, cost estimates).
4. The indication for implantation must be clarified with the patient. Economic feasibility as well as all therapeutic alternatives and medical aspects must be taken into account.
5. Comprehensive information on costs, treatment alternatives, risks, and the necessity for patient compliance must be provided and recorded.
6. Irrespective of the severity and complexity of the case, the planning must meet recognized standards regarding scope and intensity.
7. The surgical measures must be backed by reliable presurgical planning and postsurgical examination measures, and they must be performed correctly from the technical aspect. Materials and systems used must be in line with the current state of the art as evidenced by scientific studies.
8. A systematically structured record must be kept of the course of the surgical intervention and postsurgical care. It is crucial to record reasons for deviation from the planned sequence and for modification of the diagnosis, together with their timing.

DISCUSSION

Analysis of the present data identifies 2 problem fields: the crucial importance of the preparatory phase and the high proportion of cases involving combined charges or consequential failings. It is not intraoperative malpractice, so often assumed and alleged by patients, but rather the consequences resulting from deficits in preparation and planning that represent the crucial factors underlying legal disputes. One example in this context is the attribution of the unfavorable axial inclination of an implant supporting a prosthesis, to an unfavorable bone situation (eg, atrophy or traumatic bone loss). In view of the scientifically proven success rates of bone augmentation, which has been deemed a routine procedure, this reasoning is no longer acceptable with respect to the currently specified standard.[6]

Therefore it should be ensured that care decisions are in keeping with standards based on the current state of the art,[1,7] an undertaking fraught with difficulty in everyday practice in view of the dynamic transformation process to which the factors determining the standard are continuously subject.[8] Nevertheless, it should be noted that scientific societies have long since turned their attention to the problem of standardizing the individual processes and have already evolved guidelines in many fields[9–13] based on the results of scientific longitudinal or basic studies.[14–17]

The term "equivalent treatment alternative"[18,19] remains a matter of dispute. In view of the virtually unlimited number of crucial factors, it will continue to be impossible to stipulate an unequivocally secured indication favoring one therapeutic strategy.[8] In this context it is absolutely essential to respond to the conceptual principles of health insurance plans, which are frequently reflected in the questions addressed when ruling on the evidence. Performance characteristics such as "adequate," "expedient," "economic," "medically necessary," and "the medically necessary extent"[20,21] derive from the German Social Insurance Code, whose origins dated back to 1911, and are certainly not appropriate to the therapeutic opportunities offered by modern dental medicine.[22] In the field of implant dentistry, however, an assessment of what is medically necessary or a consideration of conventional versus implant-supported treatment is often demanded from the aspect of adequate, expedient therapy. It seems virtually impossible for questions to be correctly answered by expert consultants in a way that meets the needs of present-day cost-reimbursement practice unless the principles are newly formulated. At present, the given answers tend to lead to virtually incomprehensible, contextually confusing differentiations and definitions.

CONCLUSION

The recommendations are aimed at helping to avoid sources of error by means of a structured sequence[23] and at encouraging the clinician to review his or her own standards continuously and to update them if necessary to develop an individual quality assurance concept.[7,24]

Techniques and methods should be secured by scientifically based and documented longitudinal studies. The dentist should not be tempted to regard techniques as adequately secured and perfected on the basis of case reports, pilot studies, or preliminary results.[25] Such therapeutic approaches fall within the scope of experimental therapy and call for separate informed consent as well as for special precautionary measures (insurance for the patient, approval by an Ethics Committee in the event of larger numbers of cases).[26]

The observation and implementation of standards should not be seen as red tape, but rather as a help in the clinician's routine work. It is only on this basis that unexpected and unfounded accusations can be countered with well-founded lines of reasoning.

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