

Ethical Marketing in 'Aesthetic' (‘Esthetic’) or ‘Cosmetic Dentistry’ Part 3

Abstract: This, the third and final article in this series on ethical marketing, makes it clear that cosmetic dentistry is not a guaranteed oneway ticket to happiness for either patients or dentists, but it can be for lawyers. In fact, this area of dentistry is fraught with many dangers for the unwary patient and even for the enthusiastic or experienced dentist. In general, it is not at all wise to raise patient expectations beyond that which is definitely going to be easily achievable in his/her particular case.

Clinical Relevance: If things go wrong with extensive cosmetic dentistry, or are judged as being suboptimal, or unacceptable, by the patient, then that dentist may become liable for all the remakes of that elective cosmetic dentistry for the lifetime of the patient, together with all the associated general and specific damages. This is because, if the elective cosmetic dentistry had not been done, the patient would not have needed to have the remakes. Informed consent is a major issue with cosmetic dentistry, as is avoiding any possible claims for breach of contract, which could be verbal, implied or written.

Dent Update 2012; 39: 472–486

Pitfalls and problems: the dangers of creating unrealistic expectations with marketing

There is a very real danger, when seeking to promote one's products or services in aesthetic ('esthetic') dentistry, to use language or images that are likely to create unrealistic expectations in some patients. For instance, showing the very best case on the practice website or practice brochure will be interpreted, understandably, by patients as signalling that the dentist, or their practice, routinely provides that level of improvement for every single patient. That perception, which may be brought about unintentionally in patients, is potentially fraught with great danger. If anything less than an excellent aesthetic outcome is achieved for the patient who has had his/her expectations heightened by such images, or language, and the patient interprets this as having been achieved for someone else, then this could well be a source of disappointment, complaint or possibly litigation.

Advertising often seeks to attract the attention of potential patients and to

convince them to attend that dentist or practice rather than a competitor. The real temptation is to exaggerate a bit and make the aesthetic product or service seem to have benefits that are prettier, more substantial or longer lasting than might actually be the case. Furthermore, an established ploy of some salesmen is to omit 'extraneous negatives'. In other words, such sales peoples' advice is not to dwell on any potentially negative aspects of

Martin G D Kelleher, BDS, MSc, FDS RCPS, FDS RCS, Consultant in Restorative Dentistry, King's College Hospital, London SE5 9RS, **Serpil Djemal**, BDS, MSc, FDS RCS, MRD RCS, Consultant in Restorative Dentistry, King's College Hospital, London SE5 9RS and **Nicholas Lewis**, BDS, MSc, MFDS(Edin) FDS(Rest Dent) RCS, Consultant in Restorative Dentistry, The Eastman Dental Hospital, London WC1X 8LD, UK.

Serpil Djemal and Nicholas Lewis

Figure 1. The seriously instanding upper right lateral incisor was bonded with direct composite 15 years previously and still shows minimal deterioration. Sadly, this is not that usual with composite bonding but it can be re-done at any point without damaging the tooth.

the proposed treatment which might reduce the 'chances of a sale'.

Dentists, however, are under an ethical obligation to draw attention to the weaknesses and inevitable failures of aesthetic dentistry (Figure 1). This is particularly important when this involves substantial destruction of originally healthy tooth tissue.

September 2012 **DentalUpdate** 473

CosmeticDentistry

In such elective treatment situations a balance has to be struck between the commercial reality of running a 'dental business' and the more important demands of ethical behaviour and acting in the patient's best long-term dental health interests.

The dangers of emotive words or making claims of having extra skill or talent in 'cosmetic' dentistry

In the last ten years or so there has been an increase in the influence of business coaches and marketing 'experts' on the dental profession. Many of these 'coaching gurus' have relatively little experience of dentistry themselves but have a lot of experience of commercial selling and promotion. They are usually proficient in slick presentations on how to get patients to accept expensive 'cosmetic' dental treatment and they emphasize the business/financial side of dental practice rather than the ethical care of patients.

Some easily influenced, unwitting or commercially aware dentists may be seduced into using words or pictures that provide unrealistic images to patients. For instance, the word 'perfect' is an absolute term, a bit like sterility or virginity. Things cannot be a 'little bit sterile' or a 'little bit perfect'. One cannot be 'a little bit of a virgin'.

You are, or you are not. Things are either perfect, or they are not. 'Perfect' or 'perfection' would not be used in relationship to aesthetic dentistry by any sane, sensible dentist. 'Perfect' is not the same as 'nice', or 'acceptable', or 'better'. 'Perfect' means that nothing, even in one's wildest dreams, could be better. Sadly, in relationship to cosmetic dentistry, patients are the sole judge of that and, if they start with unrealistic expectations due to the practice promoting unrealistic images and, if there is any shortfall in 'perfection' as judged by the patient or his/her family or friends, then to them the 'cosmetic' product or service is lacking in 'perfection'.

This cautious use of terms should extend to avoiding references to a veneer or a crown as being a 'permanent' veneer, or a 'permanent' crown, or a 'permanent' implantretained crown or a 'permanent' bridge (Figures 2 and 3).

If it transpires that there is any problem with any of those restorations, at any point in the future, then clearly the veneer, crown or bridge or implant is lacking in 'permanency'. Lawyers and many patients understand the word 'permanent' as being an absolute term and not a relative term. Dentists often use the word 'permanent' to distinguish it from 'temporary' or 'provisional', eg in referring to a filling or a crown or bridge. Sadly, there is no such thing as a 'permanent veneer' or a 'permanent crown'. Pretty much every restoration or restored tooth fails in the long term, either partially or completely, and it is just a matter of what is left when that failure occurs, unless the patient decides to exercise his/her option to die before the dental failure can occur. 'Death', on the other hand, is an absolute term.

A restoration can certainly stay in position, such as a nicely made and well matched veneer or crown, but if there is significant recession around the veneer or crown and the patient later on finds that unacceptable because of his/her lip line showing this, then the responsibility and financial costs of the replacement of the restoration (particularly if it is placed for elective aesthetic reasons) lies fairly and squarely with the dentist if they have made a claim that this was a 'permanent restoration'. It is unwise to use the word 'permanent' in relationship to dentistry of any sort and the word 'perfect' and 'perfection' should be deleted from any sensible dentist's vocabulary. Much better words or phrases to use when referring to possible future dental cosmetic changes are 'acceptable' or 'reasonable' or 'a bit better' or 'may result in appearance improvements in the medium term' (Figures 4–9).

Advertising one's practice with a crassly stupid name such as the 'ABC or XYZ Perfect Smile Practice' or something similar is simply asking for trouble. Marketing type buzzy or glitzy words used in a practice name

could well attract a substantial number of patients with unrealistic expectations to the practice. Such patients could well have a fastidious approach to even minor dental imperfections, a tendency to have obsessive

Figure 2. A single tooth implant at UL1 is a very good match for the other teeth but it would be unwise to call it 'permanent' or 'perfect'. (Courtesy of Ahmed Al-Khayatt, King's College Dental Institute, London SE5 9RS.)

Figure 3. The main advantage of a single tooth implant is that it avoids damage to the adjacent teeth. It is not a permanent solution and should not be called that. It is a fixed solution rather than a removable one. It is inappropriate to damage adjacent teeth with veneers or crowns just so that the restorations match.

Figure 4. Dead, discoloured, root-filled upper left central incisor with composite restoration.

Figure 5. Composite removed and chamber cleaned with ultrasonics for 10 minutes prior to patient undertaking inside/outside bleaching for 3 days and nights.

Cosmetic Dentistry

474 **Dental Update** September 2012

compulsive characteristics and, in some cases, could be patients with body dysmorphic disorder. Sometimes these sorts of patients will bring in to the dentist magazine images of film stars, actresses, models, or minor airhead celebrities whose teeth they particularly admire. Many will hope that if those types of teeth, or shape of teeth, or colour of teeth are provided for them, then their other physical deficiencies will be minimized. In other words, they can look generally 'ugly' but they may well have a distorted mental image of themselves. As a result of this, they might believe that, if they could just have their teeth changed then, somehow, as a consequence of this dental change, the rest of their bodily imperfections would be minimized.

These expectations are sometimes hugely unrealistic and can be part of a psychiatric problem of 'displacement'. In other words, they feel that if only they could get one aspect of their body 'perfect,' such as their teeth, so that these were made to look extremely white and extremely even, then doing that will somehow produce such a startling improvement that their other problems of being overweight, with a poor complexion, a crooked nose, cross eyes, poor hair, big ears and questionable physical shape, will all be magically abolished by having ultra white, even, gapless teeth. Sadly, they have as much chance of that happening by changing just their teeth in that way as they have of winning the national lottery. Any sensible dentist needs to help them, particularly well in advance of any destructive treatment, to be much more realistic about what aesthetic dentistry might possibly achieve for them in their individual and particular circumstances and also stress the lack of 'permanence' of most of dentistry (Figures 4–9).

Unrealistic claims and negligence in cosmetic dentistry

If 'aesthetic' ('esthetic') or

'cosmetic dentists' hold themselves out to have a particular level of skill and expertise then they have a duty of care to discharge that level of duty of care, skill and expertise. This may well be the standard against which they will be measured if, and when, a question of negligence arises. In determining negligence there has to have been a breach of professional duty in terms of the standards actually achieved in a particular case. A breach of duty is one of the essential requirements in any finding of negligence. In such cases, reference may frequently be made to acceptable professional standards which reflect a 'reasonable, responsible and respectable body of dental professional opinion' in operation at that time. In such a case an 'expert opinion' is usually sought. In litigation involving defending a claim of negligence, the treatment undertaken needs to be able to be presented as being treatment that a representative body of respectable, reasonable and responsible dentists, working in that field, at that time, would have undertaken in similar circumstances. Unfortunately, it would usually be 'specialists' who would be asked to provide such evidence in their report to the court. GDC recognized specialists would usually be judging the treatment in relationship to the benchmark of other specialists working in the same field at that time. General practitioners could be judged against other general practitioners but only if they claimed to be generalists. There is no GDC recognized specialist list in 'Cosmetic Dentistry' and advertising oneself as though one exists is fraught with dangers. Membership of one of various new academies should not be used for dishonest self promotion or to deceive the public at large, either accidentally or deliberately, that this is equal or superior to a legitimate postgraduate university degree or prolonged and accredited Royal College of Surgeons training. The required duty of care and the way in which it might be measured might be affected by the basis on which the dentist entered into the contract in undertaking to provide 'cosmetic dental treatment' for the patient in question at that time. If there was an agreement (or implied agreement, eg based on the self promotional name of the practice) between the patient and the dentist that the dentist would provide 'The Perfect Smile' and a lot of destructive dentistry was then undertaken in order to provide that 'Perfect Smile' and the patient subsequently judges the outcome not to be 'perfect', there can easily be a claim for breach of duty, negligence and, as a consequence of that claim, for all the associated remedial treatment, damages and legal fees. This possible claim isn't limited just to the cost of provision of any new treatment, usually to be undertaken by a

different dentist and often with higher fees than the original fees incurred. Potentially, it also involves compensation for the pain, suffering, psychological distress, loss of amenity, loss of the patient's time and/or income lost, while he/she is having re-treatment.

Liability in such cases can well extend to all the remakes of the dentistry for the lifetime of the patient and it can also involve general and specific damages. This is because, if he/she had not had the negligent

Figure 6. The patient wore a single tooth bleaching tray all the time and changed the gel in the tooth and in the mouthguard every 2 hours and last thing at night.

Figure 7. The colour changes after 3 days of inside/outside bleaching. No sound tooth tissue was removed with this process, nor were the adjacent bleached owing to the tray being cut back as shown in Figure 6.

Figure 8. Appearance prior to inside/outside bleaching and direct resin composite bonding.

Figure 9. Composite bonding maintained the structure of the damaged teeth. The patient was told that this bonding was not 'permanent' and would need to be re-polished, repaired or replaced in the future.

Cosmetic Dentistry

476 **Dental Update** September 2012

cosmetic dentistry done, the remakes would not have been needed. Many such patients, when they realize that they have been cheated out of their invaluable sound enamel and dentine, as well as their money, by someone they trusted to do the right thing for them can become formidable litigation foes. This dispute can lead to disciplinary action with the regulatory body such as the UK General Dental Council, if the patient or his/her ever helpful lawyer, complains to them.

There is the added risk that the litigious patient's lawyers, or a specialist litigation firm, runs the case for the patient on a 'no win no fee' (conditional fee) arrangement. Such firms have, in the past, having obtained an agreed financial settlement both for themselves and the patient, as an added bonus, thrown in a complaint to the General Dental Council (GDC) against the dentist as a 'sting in the tail' feature of their services, ie providing continued vindictiveness against the defendant dentist involved in the case. In many cases, the contract for the provision of aesthetic or cosmetic dentistry is verbal rather than written, although both dentist and patient may rely on other material to demonstrate their understanding of the nature and extent of the contract. In 'aesthetic' or 'cosmetic dentistry' this may include reference to a dentist's website, practice brochures, information leaflets or internal practice promotion documentation, which may be used to illustrate the discrepancy between what was actually achieved and what had been 'promised' based on such

promotional or other information material (Figure 10).

Records should clearly document that the limitations or negative aspects of the supposedly 'cosmetic' treatment (particularly if it involves serious sound tooth destruction which is often anything but cosmetic) had been discussed in detail and preferably these warnings should be confirmed in writing. The likely, preferably modest, claim for longevity of any restoration to be provided should form a sensible part of any dentist's documentation who regularly, or infrequently, undertakes 'cosmetic dentistry'.

Large entries in, for example, Yellow Pages or flash websites with the dentist's best cases on them, beautifully illustrated for all to see, can attract patients with unrealistic expectations. There is a real and present danger that, intentionally or unintentionally, dentists can enter into a verbal contract to provide a standard of care which is very much higher than a 'reasonable standard'. For instance, a large or flash sign on the practice saying 'The XYZ Perfect Smile Practice' could be considered by some patients as providing an implied contract to achieve 'perfection' for them, regardless of the level of the problem of their dental appearance. By undertaking 'cosmetic' treatment for such patients, in such a named environment, it is possible to open the door to the possibility of being sued for breach of contract (Figures 10 and 11). This could be instead of, or in addition to, being sued for the negligent provision of treatment.

Guarantees and warranties in supposedly 'cosmetic' dentistry

Entering any contract offering guarantees and/or warranties poses particular problems, especially if the treatment proposed includes any terms such as a 'permanent crown' 'permanent implant' or 'permanent veneers' or 'a perfect smile'.

Some dentists, for their own commercial gain or marketing reasons, may make a statement that they will replace or remake any veneer, crown, implant-retained restoration, or implant free of charge if it fails within a defined period of time. Restrictions may, or may not, be placed on that guarantee, such as limiting the offer to only fair 'wear and tear', or imposing other conditions of one kind or another. However, if the restoration fails within a specified time, even by a day, and the circumstances of failure were not specifically excluded by the terms of the guarantee or warranty, a dentist generally would be liable, contractually, to replace the work free of charge, whether or not it was negligently provided or, indeed, irrespective of its quality at the time of provision or delivery. This is a matter of contract law, not one of negligence or tort. Many such cases could be successfully defended were it not for the presence of the 'guarantee' given by the dentist about the treatment provided. Some dentists probably

offer these supposed 'guarantees' in their desire to obtain larger fees for their version of 'cosmetic' dentistry (Figure 11). It is wise to err on the side of caution in any claims for the beauty of the outcome and not to make promises that your hands can't keep.

Maintaining the appropriate records in aesthetic dentistry

If problems arise in a 'cosmetic', or 'aesthetic' case, excellent records are necessary to help the dentist, or anyone else looking at the case subsequently, to understand not only what was done, but also why it was done, when it was done, how it was done and by whom.

Records should contain clear records of conversations including any implicit or explicit promises that were made at any point. It is important to use moderate language in relationship to any promises that are given to a patient which could later be seized on by the patient, or their legal representative, if there is a dispute about the eventual appearance outcome.

Pre-operative photographs are an invaluable record. Study models can give a good long-term record of the position of the teeth before treatment. Clearly, they can't illustrate colour, which is why digital images need to be taken from a variety of angles, preferably with the teeth in the intercuspal position, but also from a variety of angles,

Figure 10. This patient was unhappy with this 'cosmetic' outcome because she had been promised 'the perfect smile'. She did not agree that it was perfect and sued her dentist and reported the matter to the GDC.

Figure 11. Failed extended ceramic veneer on a previously intact tooth which resulted in the death of the upper right central incisor. The veneer lacked the 'permanence' and 'perfection' that the patient had been promised.

September 2012 [DentalUpdate 477](#)

CosmeticDentistry

including those with the lips widely retracted and the teeth not in contact with one another. This frequently helps to profile the irregular dark spaces around teeth, which are often the source of the patient's unhappiness about his/her dental appearance. In other words, often it is not the shape of the teeth themselves that is the problem but rather the irregular dark spaces around the teeth which patients actually complain about. This is often the case even if they cannot always describe the real source of their specific aesthetic unhappiness (Figure 12 and 13).

Baseline information should obviously record patient identification data, as well as a comprehensive medical history and dental history. The records of the clinical examination should reflect appropriate detail and the justification for, and the diagnostic yield of, any radiographic examination, especially if there were any discoloured front teeth involved in the possible treatment options (Figure 14)

It is important that a diagnosis

of the 'cosmetic' problem or problems is entered in the records. This is often missing from 'aesthetic' or 'cosmetic' treatment notes or plans. There needs to be clear reference in the notes to a sensible consent process. This should include details of what aesthetic changes were proposed or discussed or shown to the patient, eg with a walking diagnostic composite temporary bond up (see Part 2 in this series *Dent Update* 2012; **39**: 406, Figures 21–24 for details).

This needs to be recorded clearly, as well as the relevant advantages and disadvantages of the various lines of possible treatment offered. The patient's preference for a particular type of treatment that was chosen also needs to be recorded, together with the agreed reasons for doing such treatment, especially if the dentist has, or had, any reservations about carrying out this particular treatment. Progress notes should also be detailed as to what was undertaken at each visit. It is also helpful if each of these 'cosmetic' stages are photographed. If there is any dispute which causes the patient to consider leaving the practice, particularly in the middle of treatment, this should be recorded in great detail because, at that stage, it is reasonable to assume that the patient is now 'in the market' for something very different from what has been achieved so far in changing his/her facial or dental appearance.

Every effort should be made to maintain contact with such patients, particularly if they are unhappy about some aspect of their appearance. It may be prudent under these circumstances that an experienced and reliable receptionist or nurse has the conversations with the patient and documents these conversations, because the treating dentist can often become frustrated by the apparent 'limitless demands' from the 'nightmare patient'.

In any such disputes it is prudent to remember that patients have access to their health records under the Access to Health Records Act 1990 and under the Data Protection Act 1998, as well as the Freedom of Information Act 2000. It is wise, therefore, to keep the notes sympathetic in their tone, regardless of any perceived 'aggravation' or 'irrationality' in the patient's apparent position. A note such as 'Mad Cow Disease' or 'Barking' does not look quite so funny in court.

Obtaining consent in aesthetic dentistry

If a treatment is elective in nature, as most of aesthetic or cosmetic dentistry is, then obtaining proper consent for it is a vital component of the process. The patient has to be competent to give consent. They have to be able to give it voluntarily and consent has to be based on adequate information and knowledge of what is **really being proposed**.

Consent is not a single event but rather a process and is defined by the UK Department of Health as follows: 'The voluntary continuing permission of the

patient to receive a particular treatment. It must be based on 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.¹

In a 'cosmetic' or 'aesthetic' case, when deciding on what is in the patient's best interest, the 'Bolam Test'² will usually apply. In the 'Bolam Test' a dentist must act in accordance with a responsible and competent body of relevant professional opinion at that time when making decisions about any such treatment. A dentist who is in any doubt about any aspect of the 'cosmetic' treatment should probably consult another, perhaps more experienced, dentist, and record any discussions that took place with that

Figure 12. Following an accident, the UR2 had a root fracture and was discoloured. The upper right central was dead. The broken tips were also a source of unhappiness for the patient because they are profiled against a black background. This is a sensible pre-treatment photographic record of the problems.

Figure 14. Following root-fillings and bleaching the back teeth and the broken front teeth were bonded with direct resin composite to help reduce the dental irregularities and protect the damaged teeth. The patient was told that the composite was not 'permanent' and would need to be re-polished, repaired or replaced at some stage in the future. This approach involved minimal biological damage.

Figure 13. The root fracture at UR2 and the three dead, root-filled teeth prior to bleaching and bonding.

Cosmetic Dentistry

478 Dental Update September 2012

colleague about that particular patient's problems in that patient's records.

A large part of the consent process ('consent') is informing the patient properly and in detail of any reasonable options available to him/her. These might include a referral to a specialist. It is sensible to record in the notes the details of any important conversations that actually took place. These should confirm what option the patient chose at that particular time (Figures 12–14). This is particularly important because subsequently the patient may claim that he/she was not informed adequately, or at all, of the range of options. They, or their lawyers, may state later on that they never had, or never declined, the offer of an earlier referral to a specialist.

Consent is really about treating patients with courtesy and recognizing their dignity and rights as individuals to make their individual choices. Consent should be part of an ongoing dialogue between the patient and the treating dentist. For consent to be informed the following information needs to be made available to the patient:

- The 'aesthetic' treatment that is

being proposed and what is involved in undertaking this in general terms;

- Why the treatment is deemed to be necessary;
- What viable alternatives exist for the management of the 'cosmetic' problems and the benefits and risks associated with those options, eg inside/outside bleaching;³
- The adverse anticipated risks that are likely to be encountered in the short term, the medium term and the longer term with the various different treatments;
- What the costs are likely to be in terms of tooth tissue, time and, lastly, money (Figures 15 and 16);
- The consequences of no treatment.

Ethical duty to disclose information when things go wrong with aesthetic dentistry

It is important that the patient is fully informed of any problems, no matter how embarrassing such a disclosure is likely to be to the treating dentist. The patient has a legal right to know that a particular problem has occurred, even if it was unforeseen, or even if it may potentially undermine the patient's confidence in the dentist.

Confidentiality

There is an understandable temptation for dentists to show their best cases to other potential patients in order to convince a new patient of one's technical skills and cosmetic/aesthetic artistic talents. More often than not such 'before' and 'after' pictures of cosmetic or full-mouth rehabilitations are actually a demonstration of the dental technician's skill.

The real biological damage to the teeth involved in achieving these outcomes is often glossed over or omitted from the presentation in order to present the most attractive case.

However, such information about already treated patients is confidential, particularly if it involves a change in their appearance. Images should not be used on promotional material, eg websites, without anonymizing the photographs and only if patients have given written consent for their use. Each patient's information and records are confidential and can only be used for the purpose for which it was given. This information needs to be kept secure. A doctor or dentist is under a duty of care not to disclose information of anything which has been gained in a professional capacity without the consent of the patient.

Misleading messages about 'cosmetic improvements'

It is not unusual for some dentists to edit out selectively the more gory clinical pictures of what is actually involved in the preparation of the teeth, or the gingival surgery, or anything else that the potential patient might find off-putting if he/she was thinking about having 'cosmetic' dentistry. However, doing so may not present an honest

picture to patients of what is actually involved in achieving these desirable results, and such omissions may have legal and advertising implications (Figure 11 and Part 2 in this series *Dent Update* 2012; **39**: 394, Figures 11–14 for details).

It is particularly dangerous to use beautiful images of other dentists' work or to seek to 'pass off' such pictures as being a reflection of one's own work. Computer generated, or computer enhanced images (eg Photoshop) are a real and particular danger in producing unrealistic expectations in patients. Patients often do not realize that clinical dentistry is variable, tricky and difficult to reproduce precisely. Furthermore, human beings are under no obligation at all to behave like computer software, so it is foolish in the extreme to give patients a printout of a computer-simulated aesthetic improvement as they may well wish to use this in any subsequent dispute of what they believed that they were going to get as a result of the treatment.

It is also unwise to use claims based on the outcome figures for longevity of restorations done by talented and experienced specialists as though these automatically apply to every dentist undertaking those procedures. One's own audited figures should be quoted instead to give patient's a fairer picture. If in any doubt, it is wise to err on the side of caution and modesty in one's claims about cosmetic improvement or longevity of restorations and to try hard to 'underpromise and overdeliver'.

Figure 15. The upper left central incisor had a serious extrusion luxation injury but was monitored by the patient's former dentist for 4 months. The tooth should have been root-filled much earlier. Failure to treat appropriately, or to refer to someone else to do so, was an act of omission with possible clinical and legal consequences.

Figure 16. The upper left central incisor was root-filled and subsequently bleached with inside/outside bleaching and shortened. A composite tip was added to the upper right central incisor. This minimally destructive approach cost very little sound tooth structure.

September 2012 **DentalUpdate** 481

CosmeticDentistry

Duty of care

The standard of care in the general law of negligence is ascribed to the apocryphal 'Man on the Clapham Omnibus' but the duty of care expected from a dentist is greater than this. The 'Bolam Test' sets out the standard of care required by dentists in clinical negligence cases.² This is 'the test of the standard of the ordinary skilled man or woman exercising and professing to have that special skill. A man or woman need not possess the highest expert skill. It is sufficient if he/she exercises the ordinary skill of the ordinary competent man or woman exercising that particular art. A doctor is not guilty of negligence if he/she has acted in

accordance with the practice accepted as proper by a responsible body of medical men or women, skilled in that particular art'.

In other words, a doctor

(dentist) is not negligent if he/she is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view.

Clinical judgement and differences of opinion in aesthetic dentistry

If you were to ask 10 different dentists about an aesthetic problem you would probably get 11 different treatment plans and options. In view of those acknowledged differences of opinion, it is scarcely surprising that there would be at that time, and there will be in the future, a body of opinion which would take a contrary view of the treatment actually undertaken.

There is usually more than one reasonable way to provide treatment in any given aesthetic/cosmetic situation. The law recognizes that a genuine difference in clinical opinion or treatment does not mean that it was necessarily negligent. In the Hunter v Mann case, Lord Clyde stated 'In the realm of diagnosis and treatment there is ample scope for genuine differences of opinion and one man (for which read 'woman') clearly is not negligent merely because his conclusion is different than those of other professional men. A true test for establishing negligence in the diagnosis or treatment on the part of the doctor (dentist) is whether he has been proven to be guilty of such a failure, as no doctor of ordinary skill would be guilty of, if acting with ordinary care'.

In other words, a dentist would not be found negligent if he/she was able to demonstrate that there were two or more schools of thought existing in a given situation, one of which was allowed at that time.

It might be comforting to a dentist to think that he/she could rely in any possible dispute on some of his/her peers to determine what an 'adequate standard of care' really is and that this aspect of a claim is not going to be left to a judge. However, in 1999 in the UK, the Civil Procedure Rules (CPR 1999) changed matters in relationship to the 'Bolam Test'.

The Civil Procedure Rules(CPR) state clearly that the duty of the expert in clinical negligence cases is to the Court and not to the person who pays him/her. Such 'experts' therefore cannot be used as a 'hired gun' to support dubious, supposedly 'cosmetic' dental practices or procedures. A significant change in UK

law relates to what is called the 'Bolam Test'. This resulted in a modification of the 'Bolam Test' in that having a responsible body of opinion to support the actions of a doctor (or dentist) is now not enough. That professional opinion must now be able to

stand logical analysis. If a judge finds that the opinion of one expert doesn't stand up to logical scrutiny, then the 'Bolitho Test' allows the judge to choose the opinion of the other expert. The use of these adjectives – responsible, reasonable and respectable – all show that the Court has to be satisfied that the exponents of the body of medical (for 'medical' read 'dental') opinion relied upon can demonstrate that such an opinion has a logical basis. In particular, when cases involve, as they often do in 'cosmetic' dental cases, the weighing of risks against benefits, the judge, before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, when forming his/her view, that the experts have directed their minds to the question of **comparative risks and benefits** and have reached a defensible conclusion on the matter.

A new definition of a 'responsible body of medical opinion' must be that the opinion is now 'logically defensible'. ***Many extreme treatments in cosmetic dentistry undertaken for relatively minor problems would struggle to be 'logically defensible' especially where 'ear to ear multilectomies' have been involved.***

Contributory defences to claims in negligence

It is clear that the dentist has a duty of care towards any patient that he/she treats, but patients also have certain duties and responsibilities to provide correct information, follow reasonable instructions and generally act in their own best interests. In such situations, the standard that needs to be met is that of a 'reasonable patient'. This is important when seeking to establish whether the actions, or inactions, of patients have contributed to their problems. If it can be proved that, on the balance of probability, the patients' actions contributed to their problems, then there could be a defence to a claim of negligence.

For instance, if a patient were to open a bottle of beer with his/her new porcelain veneered teeth and, in doing so, broke one or more of them, this adverse outcome would probably be deemed to be due to the patient's actions. However, this very much depends on the facts of the case and whether sufficient written information was provided for the individual patient to allow him/her to make a reasonable decision (eg were they specifically warned not to open beer bottles with their teeth?).

Records reflecting an understanding of the information given to patients about possible 'cosmetic' treatment

Giving information to patients is one thing, but whether or not they understand any, or all, of such information is an entirely different matter. The law places a strict duty on the clinician to explain to the patient, in words or language that the patient can readily understand, the essential nature

and purpose of the 'cosmetic' treatment that he/she is to undergo.

To avoid the question of negligence and consequent liability, the dentist must have taken 'sufficient care to convey to the patient the gravity, nature and extent of risks specifically attendant on the procedure'. The dentist also needs to be reasonably certain that the patient understood this before undertaking any irreversible or destructive 'cosmetic' treatment.

Particular care is advised, in view of possible problems of communication between people from different countries,

Cosmetic Dentistry

482 **Dental Update** September 2012

especially if either the dentist or the patient has any difficulty due to language skills or, possibly, their accents. A skilled interpreter may be required from time to time, for either the dentist or patient, to help convey the subtleties of language about any proposed elective 'cosmetic' dentistry. Under such circumstances, written confirmation of these discussions is a sensible option to avoid misunderstanding becoming a major problem.

Advertising and 'cosmetic' or 'aesthetic' dentistry

'Aesthetic' or 'cosmetic' dental treatment is often undertaken with the best of intentions in an effort to provide a benefit to the patient ('beneficence'), preferably without doing any real damage to the teeth ('non-maleficence'). However, such interventions do not always go as the patient or dentist hoped that they would at the outset. Ultimately, the patient is the sole arbiter of whether an 'aesthetic' or 'cosmetic' treatment is in line with his/her expectations. In fact, the result may not be the greatest possible clinical outcome but, if it is generally in line with the patients' expectations, or even a little better than their expectations, it is unlikely that there will be much complaint.

The real difficulties occur when there is a serious mismatch between the 'cosmetic' outcome that is actually achieved and what the patient was hoping, or expecting, the supposedly 'cosmetic' treatment was going to achieve. This is particularly a danger if the expectation of an improvement was largely based on any advertisement of any type by the dentist (such as 'ABC Beautiful Teeth Practice' or 'XYZ Perfect Smile Practice' or the 'XXXX Best Dentist Spa' or 'Emporium'). It is often at this stage, unless the history has been very well documented, that disputes arise and are difficult to defend.

The patient may very well claim that he/she was led into having 'cosmetic' treatment by the dentist's advertisements, but that the dentist, before doing this treatment, did not point out in any real detail, or with any great force, that there

was a significant chance of failure of the elective treatment, either early on with the treatment, or later on in his/her life. For instance, a multiple porcelain veneer case can look very good initially and form part of a dentist's advertisement or website but, as often happens when these are placed on top of previous composite restorations, or when there is more than a third of the tooth missing, failure of porcelain veneers is not infrequent.⁴ Once a veneer or more than one veneer produces problems or comes off, it involves acute embarrassment to the patient, and often the dentist, particularly if the patient seeks care elsewhere. If there are frequent failures of de-cementation, or pain, or the matter is not dealt with appropriately, sympathetically, or in a timely manner, then the potential for complaint or litigation is considerable (Figure 17).

It is not ethical, not fair nor reasonable to withhold relevant information which could be later construed as cheating the patient out of his/her sound enamel and dentine, as well as money, largely for the benefit of the treating dentist.⁵

Under such circumstances, patients often maintain that they 'would never have agreed to have' the orthodontic, surgical, prosthodontic or other 'cosmetic' procedure undertaken if they had been made aware earlier on, or during the discussions, or the treatment planning stage, of the fact that there was any potential for longterm problems (Figures 17 and 18). In such circumstances, they can allege that these balancing negative aspects of the treatment were deliberately withheld from them and that it was this lack of knowledge of possible further complications that finally influenced their decision to go ahead.

Many patients, like dentists, have 20/20 vision with a 'retro-specto-scope'. In other words, with the benefit of 'hindsight' it is easy to be wise. In such disputes about 'cosmetic' surgery or dentistry various allegations can, and are, made by unhappy patients such as:

- The materials and/or techniques advertised, or recommended to them, had little or no long-term scientific evidence base to support their use and they were not told of this fact before they agreed to have the destructive preparations undertaken to their teeth, jaws or gums to receive these supposedly 'cosmetic' interventions.

(Some dentists use new experimental

Figure 17. Three intact teeth were killed by this supposedly 'cosmetic' intervention to produce whiter teeth. When the dentist failed to repay the money the patient took legal action. Unfortunately, the money received as financial compensation can't buy back the enamel and dentine that was destroyed by this cheating of the patient out of his/her sound tooth tissue.

Figure 18. This full-mouth rehabilitation followed elective, orthognathic surgery which failed to position the teeth correctly. The teeth were largely intact prior to this prolonged orthodontic major elective facial surgery and the prosthodontic treatment. The surgery and prosthodontic destruction

caused the endodontic problems and probably contributed to the disastrous loss of the teeth. Who was responsible for this? CONSENT ISSUES?

September 2012 **DentalUpdate** 485

CosmeticDentistry

materials or technology with little serious attempt at research or any real evidence, other than what the sales representative told them, that it 'was new and better'. New and better is an oxymoron. Things cannot be 'new and better'. Either they are 'new' in which case there was nothing like them before or they are 'better' in which case there was something inferior there before and this is supposedly a 'better' version. For 'better' in dental materials, many cynical but experienced dentists read 'experimental or unproven' and are careful not to do human experimentation without licence on their trusting patients. Such experimentation in proper clinical trials with informed consent is the work that dental manufacturers should have done before launching their new products in order to gain market share with a 'lookalike' product or crossover technology).

- That they had been 'sold' the 'cosmetic' benefits of the treatment to be delivered via advertisements, information leaflets, websites or in the surgery but had not been informed in any real detail about the disadvantages, problems, or risks, which might be involved later on with these elective treatments;⁵

- They were not told in advance of the viable alternative approaches which might not have been as expensive in terms of their tooth tissue, time or money;

- They were not informed that any such treatments were not 'permanent', and/or that they therefore lacked the necessary balancing information that would have enabled them to make a properly informed choice.

Patients often allege that they felt that they were under no obligation themselves to seek out any or all of this balancing information. Instead, some litigious patients can contend that it was the ethical, or moral, responsibility of the dentist who was providing the elective 'cosmetic' treatment to draw their attention early on to any potential, or possible, problems. This, they claim, is because the 'professional dentist' should have been in possession of those balancing facts. It is not infrequent for patients to suggest that the dentist advertised his/her skills, or products, in a particular way in order to induce them into having treatment but, in so doing, conveniently neglected to inform them of those potential longer term problems in order to 'make the sale' of the 'cosmetic' treatment largely for the dentist's own financial reasons.

In such disputes, it is sometimes alleged that the dentist advertised him/herself, directly or indirectly, or claimed to be a 'specialist' or 'expert' in the 'aesthetic' or 'cosmetic' field when, in truth, this was not

the case. In fact, he/she may well not actually have been as highly talented, qualified, brilliantly artistic, or experienced, as the patient was led to believe via advertisements, websites, practice name or with any other information supplied to the patient generally or specifically in any discussions.

Patients can also then contend that there were other, more talented, more experienced or more highly qualified clinicians to whom the dentist ought to have referred them, given the full extent or complexity of their initial presenting clinical problems (eg the dentist should have sent them to a 'bondodontist' or an appropriately trained orthodontist or orthognathic team rather than the dentist doing 'immediate orthodontics' with a diamond bur, eg for extensive porcelain veneers or other experimental CAD CAM ceramics.^{5,6}

It is also sometimes suggested that the dentist should have known, if he/she had been as experienced as claimed, that the prognosis for the treatment undertaken was actually quite limited (Figure 17 and see Part 2 in this series *Dent Update* 2012; **39**: 391, Figures 1–4, 10). They may allege that the dentist did not bother passing on that information, or that the dentist neglected to discuss, in advance, the future prognosis or potential problems, or the possible later costs to the patient of that treatment.⁶

Not infrequently, such patients state that, had they known that the prognosis was so guarded, they would have chosen a different option, including not having that particular treatment, or any treatment at that particular time, or not involving that large amount of money (Figures 17 and 18).

Most or all of these possible points need to be considered by the dentist early on at the enquiry, or discussion, stage. What is key to avoiding such problems is being able to determine accurately a specific patient's desires, ie for what exactly is he/she in the market to get, because this is a minefield for the unwary. Many enthusiastic, or over enthusiastic, or egotistical dentists may well have a great deal of self confidence in their aesthetic talents, clinical skills and dental ceramic technician back-up but some, perhaps, lack the necessary balancing self criticism. Such 'Decent Doubt' is sometimes referred to as an 'Internal Critic'. This requires a dentist to be honest, reflective and self critical before and after treating patients for elective 'cosmetic' dentistry. Sadly, nauseatingly self congratulatory advertisements are now commonplace on websites, in commercially driven trade publications, with some ghosted testimonials and pseudo-scientific articles proliferating well beyond the point of what sensible dentists would call frank cheating of patients out of their enamel, dentine and money.

That tacky over commercialization does little good for the

dental profession at large and needs to be curtailed voluntarily by the profession before regulators act as they have done in a draconian way in Australia.

Good photographs of 'aesthetic' or 'cosmetic' cases, if reviewed regularly as part of personal or group audit or clinical governance, will frequently show areas for potential improvement and help participants to learn from their mistakes or sub-optimal treatment results. Such photographs should also help to stop some dentists from selectively deleting from their memory those problems, treatments, complications and details of patients that they would much rather forget and thereby continue to advertise or draw attention to their more successful outcomes in a possibly misleading way.

On a more positive note, regular review of the problems in delivering cosmetic dentistry frequently teaches one a great deal more than the successful cases. Experience is a great teacher and, considering what it costs, it jolly well should be! The old adage that 'experience is something you get shortly after you really needed it' remains true, especially in the field of cosmetic dentistry. Mistakes, sadly, are the usual bridge between inexperience and dental wisdom.

Summary

Planning cosmetic restorative dentistry requires time, experience, judgement, caution and balancing benefits against risks while obtaining continued informed consent ('consense'). Patients must be fully aware of the implications of the supposedly 'cosmetic',

Cosmetic Dentistry

486 **Dental**Update September 2012

but often risky, destructive, or unstable treatment being offered to change their appearance, and the merits and drawbacks of the other viable alternatives, including no treatment.

Ideally, a patient declaration that he/she really understands what is involved should be obtained in writing and retained in the patient notes. The importance of accurate dental records cannot be over emphasized. It is vital to recognize the patient's level of expectation(s) and to challenge these expectations early on, as appropriate, in order to counterbalance those expectations with what probably could be achieved in the individual case. Failure to do so early is a common pitfall. Patients are continually exposed to software improved images in various media, many promoting a certain form of unrealistic or enhanced dental or facial appearance.

It is important to be modest and realistic about what can probably be achieved in any given clinical scenario and to consider carefully any lesser destructive alternatives

to help avoid subsequent professional, financial, or dento-legal consequences.

Acknowledgements

Much of this material draws on the publications of Dental Protection Limited but were modified by the authors with additional material to emphasize some pitfalls and problems specifically in the field of 'cosmetic dentistry'.

Many of these articles and modules were written by past and present members of staff of Dental Protection Limited and their help is gratefully acknowledged.

Main Source: **www.dentalprotection.org**

Riskwise modules 1-12 and module 37.

Dental Protection Ltd.

Dental Protection Record Keeping

Module **www.dentalprotection.org**

References

1. *Reference Guide to Consent for Examination, Treatment or Care.*

Department of Health, Social Services and Public Safety. March 2003.

<http://www.dhsspsni.gov.uk/consentreferenceguide.pdf>

2. *Bolam v Friern.* Hospital Management Committee. High Court: 1957, WLR 583.

3. Kelleher MGD. *Quintessentials: Dental Bleaching.* London: Quintessence, 2008. Ch.3: pp40–41.

4. Dumfahrt H, Schaffer H. Porcelain laminate veneers. A retrospective evaluation after 1 to 10 years to service. Part II. Clinical results. *Int J Prosthodont* 2000; **13**: 9–18.

5. Fordham N, Lewis M, Naeem S. Aesthetic midline re-alignment using CAD CAM technology and Straumann Zerion. *Dentistry* (Suppl) 2012; Spring: 10-11.

6. Kelleher M. Porcelain pornography. *Fac Den J* 2011; **2**: 134–141.

**offering flexible postgraduate
training to dentists everywhere**