Not meeting standards of care

**Medical and dental negligence in India discussed. By Dr George Paul**

Several definitions for medical negligence exist. Baron Anderson defined “negligence” in the course of the famous case of Blyth v. Birmingham Waterworks Company (1856) as “The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do. The defendants might have been liable for negligence, if, un-intentionally, they omitted to do that which a reasonable person would have done, or did that which a person taking reasonable precautions would not have done.”

The operative word in the definition is “reasonable”. This sets the benchmark in determining “standard of care”, the breach of which is the quintessence of negligence. We therefore understand that, for an act to be considered negligent, a doctor, who owed a certain standard of care, must have not fulfilled all four criteria mentioned above. In understanding negligence, one must also grapple with the exceptions to negligence. A review of decided cases shows that some of the situations mentioned below do not fall under medical negligence. For example, absence of informed consent in an emergency or patient dissatisfaction with progress of treatment or even causing excessive pain are not considered negligence.

A professional standard of care is generally that standard of care or skill that is determined by a body of professionals on behalf of the medical profession. It does not have to be of the highest level though. It is here that the term “reasonable care” is exercised. The test of the standard has traditionally been the Bolam test, which is used to determine scientific validity and accommodates two or more differing opinions in the treatment of a particular condition.

In this context, one must also deal with two important aspects of treatment or care, customary practice and accepted practice. Customary practice may be a common practice. However, if it is not validated by science, it is not recognised in law. Accepted practice is generally an evidence-based practice and is accepted in law. For example, many people do not use rubber dams during root canal treatment. It may be a customary practice, but it is wrong. Using rubber dams is, however, an accepted practice even if it is not applied universally. In the event of accidental ingestion of an instrument, only the accepted practice will prevail.

Contributory negligence is a mitigating clause in liability for negligence. If the patient has contributed to an undesirable outcome, the defendant doctor can claim exemption from negligence, for example, if a patient has not taken a prescription as instructed.

In India, there is yet another liability as a result of medical services being rendered within the ambit of the Consumer Protection Act (1986). This was the result of a prolonged legal battle inIMA v. VP Shantha (1997), which finally decided that medical service was clearly within the definition of service envisaged under the Consumer Protection Act, which is a quasi-judicial legal premise to render swift justice in the event of a deficiency of service. It generally comes under civil or tort liability.

If charged with civil liability, the defendant is made to compensate the complainant with liquidated damages, which may be simple or exemplary as decided by the judge (or jury in many parts of the world).

Some instances of negligence may invite punitive actions under criminal law and may include imprisonment, fines or both. However, in India, there are decided cases, as in Jacob Mathew v. State of Punjab (2005), in which strict guidelines have been laid down for criminal action against doctors. They cannot be arrested for death or disability caused during treatment unless a medical board determines that the negligent act was indeed criminal in nature. The relevant sections in the Indian Penal Code are Sections 337, 338 and 304A (a rash and negligent act causing simple injury, grievous injury or death, respectively).

Like several other countries, India has statutory bodies in the form of its medical council and dental council, which can institute enquiries into negligent acts by medical or dental persons who are registered under these bodies. They can prescribe punitive action, ranging from removing the doctor’s name from the register to imposing retraining before being permitted to return to practice. It is important for doctors and dentists to be aware of medical negligence so that they can take adequate care to prevent unnecessary litigation.
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Winning a competition is usually something to celebrate. The Global Burden of Disease 2020 study ranked untreated caries in permanent teeth first on the prevalence list of 295 diseases and injuries, with severe periodontitis ranked sixth and untreated caries in primary teeth tenth. Not exactly a cause for celebration, I would say, but more a profound wake-up call for the dental profession worldwide to analyse the structures through which it currently manages dental diseases to determine realistic and feasible means of improving the situation.

Before the Global Burden of Disease 2020 study was even published, we already knew that too many cavities all over the world went untreated. We also knew that the prevalence of this condition differed significantly on a global scale, with many countries, such as those in Scandinavia or even my home country, the Netherlands, just to name a few, having done extremely well in this regard. In addition to a restorative-rehabilitative care system, they have a well-functioning oral health infrastructure, including state and private health insurance systems, and, most importantly, a good communication system with the public, through which the adverse effects of sugar consumption and the beneficial effects of regular brushing with a fluoride toothpaste are discussed and monitored through a well-established recall system, and public communication measures, such as television promotions.

After all, dental caries is a biofilm-induced behavioural disease that, supported by preventative measures, can be controlled through personal behaviour, as recently reported.7 Children attending educational and preventative programmes at university clinics 2.8 times on average per year since their birth showed a 9% prevalence of dental caries and a mean DMFT (decayed, missing or filled teeth) score of 0.25 at age 4, compared with similarly aged children whose mothers had elected against attending such a programme. Their caries prevalence was 8.5% with a mean DMFT score of 4.1.

Dental caries is a dynamic disease and does not always progress from a lesion in the enamel to the dentine and further into a dentine cavity. A carious lesion can be halted by preventive treatments and, by positive changes in a person’s oral health behaviour. This indicates that, in contradiction to what is being taught, it is not always necessary to drill into a carious lesion that has just reached the dentine without causing a clear cavity. If performed too early, drilling would be an unethical treatment that contributes to the restorative cycle, which is known to lead to the early death of a tooth.²

Nowadays, life expectancy has reached up to 100 years in a few countries and this number may increase further in the future. People are expected to live much longer than they were 50 years ago. This means that teeth need to function for a much longer period. It was inevitable that the dental profession would begin changing its restorative-driven approach for managing dental caries into a preventative communicative and community-driven approach, backed by education, that considers restorative intervention as a last resort instead of a primary measure, as advocated by organisations such as the FDI World Dental Federation¹ and World Health Organization.³

It is not news that the development of carious lesions can be prevented. This has been known for 30–40 years, although there was not as much information available then as there is now. The philosophy of minimal intervention dentistry (MID) is an attempt to serve the public in the current century, and to keep their teeth healthy and functioning into old age. Its goal is to preserve as much sound and remineralisable tooth tissue as possible, starting right from infancy. While MID makes use of evidence-based preventive and restorative measures, it is also open to alternative treatments. It consists of five principles: proper diagnosis and caries risk assessment at regular intervals, optimal evidence-based measures for the prevention and arresting of carious lesions, an individualised recall system for reinforcing behavioural actions and for providing preventive care, minimally invasive operative interventions based on biofilm eradication and the use of adhesive dental materials, as well as the repair rather than replacement of faulty restorations.⁷

Since dental caries forms part of the common risk factors for general health, dental professionals will have to cooperate more closely with medical professionals. At health care centres with mother-and-child care facilities, nurses need to be trained to inspect the mouths of infants, give advice to the caregivers and, if necessary, refer them for treatment. Why should these nurses counsel mothers about all other paediatric diseases, but not about dental caries as the most common child disease? The same applies to paediatricians.

Many Western countries can no longer balance their health care and oral health care budgets, and as a result they have exploded. If we feel collectively responsible for the first-, sixth- and tenth-ranked items on the list of the most prevalent diseases and injuries, then urgent action is necessary. The MID approach is a good step forward. It is applicable not only to cariology and restorative care, but also to periodontology and rehabilitative care. Dental professionals should not rely on high-tech devices and sophisticated equipment to the extent that they do when it comes to the treatment of carious lesions. If dental curricula worldwide embraced this philosophy and dental professionals worked more closely with medical professionals and the public, then we might create a future scenario in which a different disease will be first on the list in the next systematic analysis on global diseases and injuries.

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