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Ewen McColl

Who's to blame?

We live in an ever increasing 'blame culture', which manifests in wider society and ever increasingly in the field of clinical dentistry. While patients may look to blame clinicians when things go wrong, increasingly clinicians look to blame each other. These *'blue on blue'* disputes may be over not just clinical matters, but business and contractual disputes. In both cases, some sort of compensation or punitive action may be sought, rather than a focus on how to resolve the matter or prevent a re-occurrence.

When things do go wrong and complications arise, it is perhaps human nature to look to appropriate blame to either someone or something, sometimes both. In the close confines of the oral cavity, where scalpels, instruments and high-speed drills are used daily, it is perhaps surprising that the vast majority of procedures are undertaken safely and without incident. This is testament to the training and skill of clinicians, with safety being paramount, while often dealing with very challenging clinical scenarios.

So when things do go wrong in dentistry, who's to blame? I recall at dental school an experienced and highly thought of restorative professor advising my class to never judge anyone else's crown preparations until you have treated the patient yourself. Having completed many crown preparations in the simulated environment I perhaps naively expected every tooth to start from a similar base point and consistent preparation should not be too challenging. I soon realized the start point is always slightly different at tooth level, and at patient level. In many respects the same, but different, with patient movement, salivary flow rate, and existing ferrule making every situation slightly different, with the aspirational endpoint of a functioning crown the same.

Over the years the professor's words have often rung true. When you realize that the patient's tongue has a great attraction to the rotating drill tip, or Wharton's duct in full spate has no respect for you trying to cut a challenging lingual finish line, one may then reflect that perhaps the colleague's crown preparation was not so bad after all, and passing judgement may not have been so clear cut. Even applying standards, guidelines and best evidence to determine whether an expected outcome met the expected standard, this will not take into account the individual circumstances the clinician faced on that particular day.

Clinically, I have seen a number of cases where an extraction goes entirely to plan, the compromised tooth is removed, and all seems well. After 3 days the patient presents in pain, is apyrexic and requests a prescription of antibiotics, because these worked previously in similar circumstances. Whether the patient had or had not followed the post-operative instructions is by now irrelevant with the patient in pain.

The dentist does the right thing, managing the suspected dry socket and reassuring the patient that antibiotics are not indicated. The patient then develops swelling overnight, attends A&E and is managed accordingly. The complaint letter follows. From the patient's perspective, the dentist is to blame, but in all probability biology is to blame, if it is possible to blame biology!

Similarly, I recently reviewed two implants in the central incisor positions. At review, one was in perfect health and the other failing. All clinical and occlusal parameters were the same beyond those associated with the now failing implant. The patient's oral hygiene and compliance was good, placement procedure uneventful, so it was difficult to discern why one implant was failing. Was the clinician, implant, or biology to blame, it was difficult to ascertain.

Last week I attended a peer-review session where a range of successful and a small minority of not so successful cases were presented. While the successful cases were most informative, there was often more to be learned from these cases where things did not go quite according to plan. For example, a lower molar endodontic case had been treated to a technically high standard. However, despite the clinician's best efforts, the peri-apical radiolucency increased in size at radiographic review. Consideration was given to an apicectomy, but weighing up the risks and benefits, the tooth was extracted. The patient may consider this a failure, but who's to blame? The bacteria beyond the apex? Reference to the evidence, guidelines and standards would demonstrate that the clinician had provided a high standard of care, but in some cases the patient's perception may differ despite careful explanation.

By the nature of carrying out dental treatment, complications and their management are part and parcel of daily life. Good patient communication, with time spent discussing the procedure and associated benefits, risks and alternative treatments, good record keeping, goes a long way to mitigate against complaints and litigation in the event of complications. As ever, reflecting on what can be learned, and how to best mitigate against future recurrences is a crucial part of being a reflective practitioner.

So, who's to blame?

Sometimes nobody, but in a blame culture where there's a perception of blame, a claim may follow.

In many issues of *Dental Update,* a range of clinical complications and their management are presented. This acts not only as continuing professional development, but also as a reference source for all of the dental team so that we can inform consent appropriately and explain that on some occasions no one's to blame despite assertions to the contrary.