Part 5- Legal issues

Chapter 1 Current conflicts related to implants, and prospects for solutions

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I. The medical standards expected of medical and dental practitioners under trial

(1) Various arguments have surrounded the definition of standards of medical practice required of medical and dental practitioners. A series of recent Supreme Court precedents have helped in finding solutions for these issues. In the past, the main consensus regarding medical standards for dentists was the so-called “practice as a clinician (on site)” (Supreme court, Precedent 30th March 1982, Hanrejihou, Vol. 1039, p 66 and Precedent 30th May 1986, Harei Times, Vol. 606, p 37). This led to emphasis being placed on the clinical practice of medical and dental practitioners, and resulted in limiting their obligations and indemnifying them from responsibilities).

Current practice asks the question “What should the standards of medical practice be?”, implying that medical practice should not only entail clinical aspects but also that both medical and dental practitioners should act as a clinician within their own practice, in accordance with what is expected of medical practice (Supreme court Precedent 9th June 1995, Hanreijihou, Vol. 1537, p 3). This approach should result in a shift in the direction of expansion of the scope and extent of duty of care.

With such changes, the standards of medical and dental practice that were previously varied in accordance with disparities in the community, hospital, and specialties, and whether the treatment was performed under insurance or in private, became standards that were decided in the context of the individual patient and the medical environment of the clinic.

(2) Furthermore, the Supreme Court Precedent of 25th February 1999 became an example where the Court acknowledged a consequential relationship between malpractice (a mistake) and the result (death). Even though the presence of a hepatoma was an initial cause that worsened the prognosis of the patient, the fact that years of life could have been added by earlier discovery cannot be disregarded. Therefore, as long as the affirmation could be established that failure to identify the hepatoma (a technical error) led to shortening of a patient's life (life-prolong benefit), a possible causal relationship existed between the misdiagnosis of hepatoma, (malpractice) and death (bad outcome, a 'worthless result'). The Court affirmed the malpractice of the medical practitioner. On 22nd November 2006, the Tokyo District court acknowledged that had the doctor not overlooked (malpractice) the hepatoma and treated it instead, the cancer would nevertheless have caused the patient to die eventually, but her life was shorted by the hospital-acquired infection. The mental anguish felt by the patient (a 71-year-old female) due to inability to put her affairs in order before the end of her life (violation of her right to prolongation of survival) was great. Compensation of ¥1,300,000 was authorized.

Another precedent set in a Supreme Court case on 27th November 2001 (Hanreijikou Vol. 1769, p 56) ruled malpractice of a medical practitioner with regards to informed consent. The doctor was said not to have fully informed the patient of the various treatment options. Conservation treatment for breast

cancer had not yet been established and was at the clinical trial stage. The Court ruled that, “even if this treatment option had not yet been established, or the practitioner had not been adequately trained to carry out the operation, the patient had the right to choose, and if this treatment option had been advantageous to the patient, the professional had the duty to inform the patient of the treatment (expectation rights). Not giving out sufficient information is a violation of the right of the patient.” The Court acknowledged the malpractice of the medical practitioner.
This is an example of the infringement of the patient’s right to choose conservation treatment for their breast cancer, with misconduct by the doctor.

(3) Recent precedents, as shown in these examples, have placed emphasis on the patients’ right to self-determination. To acknowledge the standard of medical practice as “what it should be”, (Sendai High Court, precedent 31st March 1987, Fukuoka District Court, precedent 26th December 1994 “Loxonin case”, Tokyo District Court precedent 25th December 2000, “arthrosis of temporal mandibular joint (TMJ) case”) which does not demand that medical and dental practitioners perform miracles, but the law is inclined towards the right of the patients to choose.
This approach should act to improve the national IQ with regards to the medical aspects of treatment coupled to the dramatic development of medical equipment and methods of surgical treatment. In addition, this should encourage medical and dental practitioners to strive to meet the demands of the required medical standard of “what it should be”, not only in treatment of the patient, but also in terms of practice that is in accordance with their duty of care, including continuing education, recommendation of other doctors, and accurate explanation. This is also becoming expected of medical interns (Tokyo High Court 27th Jan. 2005). (Sankei Newspaper 28th Jan. 2005).
(4) In addition, in the Supreme Court precedent 8th Sept. 2005 (Filed case No. 989, the final appeal was accepted by the civil court in 2002) a case was filed where the patient had a strong wish for Cesarean section, however, the medical practitioner decided to allow vaginal delivery. The practitioner was unsuccessful in the breech extraction, and the woman gave birth to a neonate with severe asphyxia who died three hours later. This accident was acknowledged as, “The practitioner should have acted upon his/her duty of care and discussed with the patient the dangers of vaginal delivery, and should have given her the opportunity to decide whether she should continue with this method” (violation of expectant rights).
This is an example where the practitioner should have acted in accordance with the duty of care and given a treatment explanation that is relevant to the medical inquiries of the patient, aiming to ensure the patient’s right to self-determination.

A. Medical discretion, the duty to explain, the right to decide

(1) Recent trial examples, including those above, suggest that the discretionary powers of medical and dental practitioners in treating patients are becoming practically limited to acting as a specialist in giving professional advice on the treatment options for patients. The patient has the right to determine (right to choose; personal dignity) his or her own treatment, with the help of the specialist, who is obliged to provide an explanation of the treatment options including directions and methods.
Therefore, the discretionary power of treatment of the patient should occur as a result of mutual

understanding and consent, and be exercised within the framework of the patient's right to self-determination. This seems to be the general, common consensus of the nation regarding medical professionals as a whole.

(2) The issue of defining the patient's right to self-determination needs to be solved, or conversely, how medical or dental practitioners should treat the patient, to ensure that the patient's rights are not abrogated. The key component of correct treatment is to fulfill the "duty to explain" as a standard of medical practice.

Regarding the above, the Supreme Court precedent 27th November 2001, (Hanteijihou Vol. 1769, p56) has stated, "According to the medical contract, where surgery is necessary as the treatment option, except under special circumstances, the patient should be informed of the disease diagnosis (the name and the symptoms), the details and the risks associated with surgery, whether other treatment options are present, these options, their pros and cons, and the outcome, before the procedure."

(3) Concerning the practitioner's duty to explain, factors such as, "who", the subject of the explanation, "to whom", the object of explanation, and, the "means", the "timing", the "number of times", as well as the "scope" of explanation, become an issue. A mere signing off of the surgical consent form by the family is not acknowledged by the Court as the medical or dental practitioner having fulfilled his/her "duty to explain". The dental practitioner must inform the patient of the content and the methods of treatment, individually and in detail. Explanation should be in a form that can be best understood by the patient, using tools such as images, pictures and writing, to enable the patient to come to an informed decision (Tokyo District Court precedent, 25th Dec 1999, arthrosis of the TMJ case, Hanteijikou Vol. 1749, p 4).

Treatment is an active collaboration between the patient and the practitioner against the disease; the patient should not be subjected to authoritarian approach on the part of the practitioner.

(4) A treatment can be defined as reciprocal communication and collaboration on the grounds of "disease". The communication should be recorded as a medical document, to be referred to at each stage of the treatment to verify whether the treatment has been conducted in accordance with this document, and together with the patient, it has to be managed safely and with accuracy. This document should be used as a tool to show directly that the medical and dental practitioners have secured the patient's right to expectation and veto (right to self-determine), and that the professional has fulfilled his "duty to explain". This is what has recently been referred to as the "what it should be" standard medical practice.

B. Medical standards of dentistry as distinguished from medicine

(1) The standard of medical practice that is currently required is as above. However, the differences in risk and content that distinguish medical and dental practices cannot be ignored. The standards of medical practice that are unique to the dental field must be considered separately.

In reference to this point, prior to 1993 examples of dental trials that involved malpractice were due to cases such as intra- and extra-oral damages caused by disc, turbine, or stopping carrier, misswallowing of dental surgical tools such as a reamer or resin, accidental ingestion, inappropriate tooth extraction, bridge prostheses, inappropriate grinding, and inappropriate pulpectomy, as well as anesthetic accidents. These examples were typically factitive cases of malpractice. Such accidents accounted for 33 cases in both civil and judiciary courts.

(2) However, the cases relating to dental implant Tokyo District Court precedent of 21st Dec. 1993, and

30th June 1994 (Hantei Times, Vol. 847, p 238, and Vol. 878, p 253), and of Fukuoka District Court precedent 26th Dec. 1994, the Loxonin asthma attack case (Hanteijikou Vol. 1552, p 99) led to the affirmation that dental practitioners should fulfill their “duty to be devoted to study”; consequently, the standards of dental practice came to be judged individually, and relative to each specific treatment. This trend has recently become more prominent, and cases like the one described below, “questioning the existence of an error in the surgical root treatment of a removed tooth” Tokyo District Court case 4th Oct 2007, (Tokyo District Court, 2006, ordinary civil lawsuit, Vol. 2509, case of damage claim) is an example that defines the current consensus:

1) Previously, the general treatment for dental decay had been to remove the tooth. However, the importance of teeth in functions such as “helping the digestion and absorption of food,” “providing appreciation of texture that improves the sensitivity of taste,” and “improvement in the circulation of the brain by chewing well,” have become widely acknowledged. Therefore, the current consensus on dental treatment is to preserve as many teeth as possible. The original idea behind “treatment of the root canal” was to treat the dental nerve, with the intent of “preserving teeth” as far as possible. With this idea, surgical treatment of the root canal, tooth extraction should still be limited to extremely rare cases.
2) Thus, except in the case where tooth extraction is the last resort, such as in the presence of a contraindication, the dentist has the duty to perform surgical treatment without resorting to tooth extraction. In cases where tooth extraction is absolutely necessary, the practitioner must fulfill his/her duty to explain.
3) In contemplating this predicament, an illustrative case occurred where “the tooth had severe periodontal disease or decay, and the remaining periodontal membrane was extremely limited, likely to represent a contraindication to root canal treatment.” However, due to lack of evidence that proved the subject's tooth met the requirements, it could not be determined with certainty that the duty to explain had been fulfilled. The malpractice of the dental practitioner could not be ruled out.

We will next introduce the current status of medical conflicts, medical standards, and preventive measures against medical conflicts that are associated with the insertion of dental implants, a treatment option that has become increasingly common in recent trial cases. In the rest of this chapter, we will cover the latest examples of trial cases that concern medical malpractice by dentists.

II. Implant treatment that is expected of the dentist

The dental implant is gradually emerging as a category within “advanced medicine”, and there has been a surge in demand from patients who are suffering from lifestyle-related diseases, or other diseases. The provision of implant treatment to these patients is already a common concept in clinical practice. With dental implant surgery, even under the influence of local anesthesia, factors such as inadequate communication with the patient, slight ineptitude, or any error can readily lead to the patient experiencing psychological or physiological trauma (stress), and trigger the onset of other diseases.
Conversely, a successful implant treatment can have such a great effect that the patient may be immensely grateful. Financial returns are an added bonus. However, the potential for slight ineptitude, or an error that can affect the patient’s psychological, physiological and financial (private) outcome,

implies that the risks and returns associated with implant treatment should be of great interest to both the patient and the professional.

The details of the clinical aspects are as follows:

A. The characteristics of conflict that surrounds implants, and the present situation

Implants have their own issues that are distinct from all other dental malpractice. It should be constantly emphasized that faults in implant treatments lead directly to litigation.

During the period from 1993 to 1994, subperiosteal implants or endosseous implants became a common intervention as, at that time, they seemed to be successful. However, due to frequent complications, and with the large compensation costs that were awarded, their use in treatments became the subject of long-term debate. These methods are now infrequently used in the clinical setting. Osseointegration is currently the most common surgical method, using cylindrical implants made of titanium. Nevertheless, there has been a number of litigations concerning dental implants, and the reality of this occurrence is summarized below.

1) Patients that are the subject of disputes are mainly middle-aged, and have already been treated with a number of implants.

2) Initial discussion occurred early on, however, the patients' expectations and the actual treatments gradually diverged. The main reason was due to a sense of discomfort on chewing.

3) Close to 90% of the cases under dispute are related to the upper jaw. The bone density and quantity in the upper jaw make it difficult to fix implants. Nerve blocks often have to be used.

4) Recently, there has been a surge in the number of implant treatments due to a rise in demand from patients with loss of teeth, particularly in the elderly or those who suffer from other underling diseases such as periodontal disease. As a result, disputes have become common.

5) An objective guideline that states who should undergo implant treatments has not yet been established. This has caused some difficulties for the unfamiliar patient who wishes to gather evidence to prove that they have been the subject of malpractice if the trial goes to court. The result of this has been that patients present the case as a violation of their right to be informed.

6) The general term "implant" cannot specify the manufacturer due to the presence of several distributors. Treatment differs even among the titanium implants from specific manufacturers.

7) The implant treatment must be paid for privately, as it is exempt from health insurance. Implant treatment is costly (one implant costs, on average, ¥300,000, not including the superstructure), and as there are no price guidelines, the prices vary among dentists, causing further turmoil.

B. Medical standards for implants and trials of medical malpractice

(1) There are examples of cases in the Tokyo District Court where malpractice was ruled to be present, despite infrequent use of implants at the time, and lack of established surgical methods, so judgment at these trials was complicated.

After 1993–1994, dramatic developments occurred in materials used for implants and the associated surgical methods. It was during this period of development, that the first judgment was passed on the medical standards regarding the implants, in the Osaka District Court in 2001. Many other judgments

followed in quick succession. The details of these are as follows:

[Details of Osaka District Court precedent 9th Mar 2001 (Has not yet been written into legislation]
* A treatment to replace lost teeth includes dentures (full/ partial) that can be covered by health insurance. Implants have not yet been established as a treatment as the long-term consequences have not been defined. Thus, an implant could not be covered by insurance. Based on the financial aspects and its invasiveness, implant treatment seemed more demanding of the patient in comparison to dentures. Furthermore, implants placed in the setting of dental practice appeared to have a low level of urgency or necessity, and the prospect of mistreatment leading to irreversible side-effects was not appealing to patients as a treatment option. Considering all these factors, there is an extensive and grave accountability for the dental practitioner.
Regarding this, a case was presented in which there was misconduct of a practitioner who did not fulfill his duty to explain the treatment specifics, including: the surgical contingencies and examples of failure; the risk of infection following surgery; the complexity of implant surgery in the maxillary bone due to its bone quantity, as well as use of penetration, a surgical method used where the maxillary bone appears too thin, and the associated risks of this procedure. The practitioner was ordered to pay ¥2,500,000 (on appeal, in the Osaka District Court precedent 9th May 2002, the figure for damages was increased to around ¥11,070,000).

[Details of Nagoya District Court precedent 11th July 2003]
* At the implantation stage of the implant, the dental practitioner should drill a hole with great care. If the patient complains of pain, the practitioner should use X-ray photograph to determine whether this pain stems from the drill approaching the mandibular canal, and has a duty to insert the implant in a position that does not press into this canal. The dental practitioner had to pay a sum of ¥6,740,000 in compensation. (Hanteijikou Vol. 1852, p 104).

[Osaka Appeal Hearing, First Oral Proceedings, 25th April 2007]
* With implant treatment, a Grade 4 complication was identified, i.e., inability to chew, so the patient is on liquid diet. The patient was unable to work and eat food requiring continuous treatment for eight years. The practitioner was ordered to pay ¥22,340,000 in compensation. (Subject to an appeal hearing in the Osaka District Court)
[Details of Tokyo District Court precedent 26th July 2007]
* A case was presented, regarding mishandling of an implant and its causal relationship with the aftereffects of maxillary sinusitis. The court acknowledged misconduct in handling the implant, but did not consider this misconduct to be the cause of maxillary sinusitis. The court dismissed the claims of ¥40,920,000.
This case is an example where a debate was raised as to whether a fault was present in the technique of drilling into the maxilla. (Civil law suit, 2004, Case no. 18142 Claims for compensation)

1) The duty of care exists to ensure that an implant is placed with all due care, without penetrating the antral mucosa. However, in this case, the fact that penetration of the antral mucosa occurred was not

considered to be an error. Even though the implant did not penetrate the antral mucosa, an error was acknowledged for penetrating the maxillary bone and making it in contact with the antral mucosa.
2) The dental practitioner argued his case based on the existence of a surgical method that does not penetrate the antral mucosa, the socket-lift method. However, since this surgical treatment had not been employed in this case, the fact that the method was chosen on the grounds that it would not penetrate the maxillary bone cannot be ignored. Therefore, the fault in the drilling technique that led to penetration through the bone, and the lack of any attempt to prevent this (by sinus-lift) were acknowledged.
3) However, the issue of misconduct stated in (2) was not acknowledged to be related to the aftereffects of maxillary sinusitis, based on the time-course regarding the onset of the disease. It was concluded that there were other causes for the disease.

(2) Dental practitioners who adopt implants as one of the treatments they use should learn from these past precedents. The outcomes of decisions in these trial cases clearly stem from the judicial decisions of the Supreme Court cases of 9th June 1995, and 27th Nov 2001.

C. Preventive measures against conflicts concerning implants

(1) Implant surgery is distinct from the conventional dental prosthetic surgery using, partial dentures, solid bridges, or removable bridges, and is characterized by placement of artificial dentures on the supposition that invasion should be made in the jaw bone or the full body. Therefore, even higher medical standards and medical ethics (including a duty to explain) are required regarding structures such as the interior of the jaw bone. It goes without saying that it is necessary to take into consideration other concomitant diseases including lifestyle-related illnesses or other disorders that affect organ systems or the whole body.
Therefore in handling implants, “establishing patient safety is imperative”. The implant specialist should act to improve the “dental IQ” of the patient, along with fulfilling the duty of care in areas of pre-, intra-, and post-surgical tests, diagnosis, and surgery itself. Furthermore, specialists are expected to be trained so they are capable of performing not only standard and customary medical and dental procedures, but are also expected to be expert in the areas of anesthetics, psychological, internal (circulatory and digestive system) medicine and surgery that are outside the scope of everyday treatment. Under a broad and high level of medical standards, it is essential that the dental practitioner be trained as a specialist. This is considered one of the most effective methods for prevention of conflict associated with the insertion of dental implants.
(2) For a specialist in the field of clinical implants, medical practice standards should be to establish patient safety before, during and after surgery; to increase his/her knowledge of pathology, periodontal disease, and radiography; and make a commitment to study, in order to improve techniques, and guarantee appropriately structured treatment.
1) Basic techniques
Improve knowledge, judgment and techniques of incision designing, drilling, implantation, fenestration (secondary) surgery.
2) Applied techniques
Sinus lift (lateral approach or alveolar crest approach), selecting indications for alveolar bone

augmentation, reconstruction of the jaw bone with the aid of titanium mesh (ridge reconstruction, lower jaw reconstruction) and implants, and lower jaw reconstruction with the use of implants.

3) Dealing with concomitant diseases

Damage to the antral mucosa, involvement of the maxillary sinus, damage to the mandibular canal, bleeding (local and systemic causes) and infection (especially for patients with diabetes)

4) Treatment by the medical team.

Current implants are expected to have a natural look, more indications, and close to 100% functional satisfaction. For this to be possible, coordinated action is required by specialists from the fields of oral medicine, prosthetics, periodontics, dental anesthetics, and radiology — a team of professionals needs to be developed that can oversee the dental treatment of a specific patient.

(3) The Ministry of Health, Labor and welfare published a “Medical advertisement guideline” on 1st April 2007, where the specifics of advertisements for private consultations (Medical service law No. 5 of 6 , p 1) were defined. Following this, on 19th Sept 2007, a detailed medical advertisement guideline was published. The ban on advertising implants was removed, but restrictions were applied instead. The advertisements must state, 1) the product name of the implant and its Pharmaceutical Affairs Registration number, 2) the type of private treatment, and 3) the standard price. Practitioners should note that if any of these is missing from any postings, leaflets or on web pages, this would be a breach of conduct, in terms of the Medical Services Law, and consequently could be penalized.

If in the future, patients are attracted by misleading advertisements, resulting in malpractice, there is bound to be an increase in discontent about “unjust, fabricated, misleading advertising”. As a minimum, advertisements should comply with the guideline, to prevent such problems from arising.

III. Examples of recent trials relating to dental malpractice

There has been a recent rise in the number of published reports of cases similar to the 2001 trials about misconduct related to implant treatment. And most of these are due to malpractice by omission.

First is a case that is both old and new: a reamer was misplaced by the dentist who was ordered to pay ¥600,000 for this error by the Tokyo District Court on 21st march 2001 (Hanrei Times, Vol. 1089, p 238). In another case, a claim was made for the return of a treatment fee after poor correction of occlusion following a traffic accident. Here, the case was dismissed by the Tokyo District Court, on 21th June 2001, as no fault could be found with the dentist (Hanrei Times Vol. 1088, p 217). There was a claim that a dentist violated his obligation to explain the treatment of pulpectomy for a molar prosthesis, and 12 crowns. The case was dismissed by the Tokyo District Court on 20th Dec 2001 as no fault could be found with the dentist (Hanrei Times Vol. 1160, p 182). In one case, the practitioner mistook the maxillary bone for the palatal root, and dug into the maxillary bone, causing perforation. The practitioner continued the treatment, without verifying that the impression agent had not seeped through this hole, and without revealing the truth. The claim for neglecting his duty to report and not explaining to the patient was upheld by the Yamaguchi District Court on 18th Sept. 2002, and the dentist was fined ¥1,520,000 for his misconduct and based on a claim regarding lack of monitoring after the use of resin. This claim was partly upheld as the dentist had not fulfilled his/ her duty to monitor, but as there was no proof of any risks the court only partially upheld the claim. In the Okayama District Court on 14th Jan 2004

(Okayama District Court 2002 Civil Court lawsuit Vol. 1078) regarding use of arsenious acid in a patient in whom use of this agent was contraindicated, a claim was made regarding lack of sufficient examination and verification of the position of the tooth root, to avoid drug leakage in a patient in whom arsenious acid was contraindicated. The dentist was ordered to pay ¥25,250,000 by the Yamaguchi District Court, on 17th March 2004 (Yamaguchi District Court 1999 Civil Court lawsuit Vol. 249). A case was reported where death of a patient resulted from administration of xylocaine as local anesthesia. The claim that there had been a lack of consultation and faulty injection technique was dismissed by the Aomori District Court on 16th Oct 2004 (Aomori District Court 2001 Civil Court lawsuit Vol. 227). The court upheld a claim regarding the frequency of dosage and the quantity of administration of APS because of a third administration, and a payment of ¥4,090,000 was ordered by the Kyoto District Court on 26th May 2005 (Kyoto District Court 2003 Civil Court lawsuit Vol. 3665). A claim of unnecessary pulpotomy, and incomplete treatment of the root of the tooth was rejected by the Tokyo District Court on 25th Feb 2006, (Tokyo District Court 2003 Civil Court lawsuit Vol. 21196). In another claim, a practitioner was found at fault for breaking a needle at the time of administering anesthesia for a surgical tooth extraction. The broken needle entered the tissues of the right maxilla and the Sapporo District Court ordered the dentist to pay ¥17,170,000 on 2nd Nov 2006, (Hanreijihou Vol. 1923, p 77). For excessive inappropriate grinding of 24 teeth for treatment of periodontal disease, a practitioner was ordered by the Yamaguchi District Court on 22nd Dec 2006 to pay ¥9,680,000 on the grounds of violation of the obligation to explain, and misconduct with respect to treatment methods (Hanrei Times Vol. 1223, p 240). In a case where prosthetic treatment was used with the main objective of aesthetic improvement, a dispute arose as to whether this agreement was a contractual agreement or a time and material/ standard commissions contract. In this case, it was judged to be a standard commissions contract, therefore, the Tokyo District Court ordered the practitioner to return ¥240,000 out of the upfront payment of ¥1,320,000 (Tokyo District Court 2007 Civil Court lawsuit vol. 9883, Case seeking repayment for the pre-payment for prosthesis; Tokyo District Court, 29th Jan 2008). In yet another case where the duty of care was violated due to inappropriate tooth extraction for treatment of a tooth root, the misconduct was confirmed regarding the tooth removal, however, the claim regarding the replacement of the tooth using a bridge instead of an implant was dismissed. The practitioner was ordered to pay ¥1,640,000 from the claimed ¥9,300,000 (Tokyo District Court 2007, Civil Court lawsuit vol. 2509, a case seeking compensation, Tokyo District Court 4th Oct. 2008). The above examples are a sample of medical malpractice lawsuits in which sentences have been handed down.

IV. Reconstruction of preventive measures against conflict common in dentistry

The demand for private dental treatment will rise dramatically, as was seen with “the generation of baby boomers” (generation born after the Second World War) who demanded free clinics with expectations of improvement in dental QOL, alongside further distribution of information over the Internet, the increased “dental IQ” of the nation, an aging population and fewer children, and the development of advanced medicine.

Dental treatment should be different from the past, as treatment should meet the standard that requires medical practice to be “what it should be”, and in keeping with the diversity of the population. To achieve this, discretionary power to decide on the treatment is required, a treatment that should naturally

accommodate the various features of individual patients, including their age, sex, medical problems to which they are predisposed, lifestyle, social context, and financial background (ensuring the right of the patient to self-determination). Furthermore, treatment should be provided timely and meet the needs of the patient.

Recent trends have shown that in addition to the cases described above, including various examples of cases related to technical errors with implants that occurred during the period from 2002 to 2005, there has been an increase in the number of cases that previously would not have been brought to court. These include violation of the obligation to consult, of the duty to explain, and the duty to monitor progress. The conflicts have been of a highly diverse nature, as shown here. As these cases have become more open to the public, other episodes of malpractice have also been increasingly brought to the courthouse.

What does the nation (patients) expect of dental care? The rise in the standards of medical practice, where misconduct can lead directly to de-licensing, supports the contention that high levels of dental care are expected by patients.

V. Securing the bidirectional exchange of medical information and treatment

The patient must be enlightened and made to recognize the fact that, in order to meet this rising demand for dental care as a whole, there is a limit to what the dentist alone can do. The mutual enemy of the patient and the dentist is illness, often termed “disease”, and therefore the “treatment” to fight this enemy should become the objective of both parties. Understanding should be created that this objective cannot be the sole task of the dentist. This understanding should be as stated below:

1) At the consultation, the patient has an obligation to provide accurate medical information (e.g., medical history) to the practitioner at all times, and play a proactive role in the treatment.

2) During treatment, both medical and dental information should be readily provided regarding the physiological and psychological condition of the patient, including any lifestyle-related diseases, concomitant disease, and any history of disease. The patient has the obligation to manage his/her own symptoms (comply with treatment, take care of his/her person).

3) Lastly, during the course of treatment and after treatment, the patient is obliged to report any vital signs of pain, discomfort or distress immediately, without hesitation.

Information obtained from the patient should be received in a timely manner by the dentist, who in return will provide information about medication and treatment options, and supply medicines. This reliable, two-way exchange of information should preferentially result in understanding and acceptance between the two parties and establish a relationship founded on trust. It can be said with conviction that medical treatment built on this foundation is what is required of medical care, including dental care.

VI. Human and physical abilities to reduce human error

It must be noted that in the drive to obtain medical practice that conforms to the idea of “what should be”, and to secure and maintain two-way trust in the relationship, there are huge obstacles that include the large number of cases of misconduct as regards swallowing of foreign objects, removal of teeth, administration of the wrong drug, drug overdosing, unskilled treatment techniques, and misconduct

and human error that lead to problems such as infection. Therefore, overcoming human error (diminishing human error) should be the number one priority, through reconstruction of the medical system, regarding both its human and physical aspects. Tackling this problem should be the simplest route and one that should always be practiced in order to prevent conflicts that arise from medical misconduct.