

## Conference article

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# Aesthetic dental procedures: legal and medico-legal implications

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**Abstract:** Dental treatments, as well as simple anatomical and functional repair work, can also be for aesthetic purposes. This is because the anatomical area concerned, i.e. the oral cavity, has a great power of attraction. Aesthetic treatments in general – in particular dental treatments – have been on the rise in recent years, and this has also meant an increase in claims due to patient dissatisfaction with the results obtained. Numerous laws have been introduced that emphasise the need for comprehensive prior information in order to acquire valid consent. This has resulted in the elimination of the distinction between the obligation of means and obligation of result, with achievement of the normally expected result required in any case.

**Keywords:** Information; Dental treatments; Liability; Dentistry

## 1 Introduction

Art. 13 (Regulation for prevention, diagnosis, care and rehabilitation) of the Code of Medical Ethics [1] explicitly states that “The doctor shall not agree to the patient’s

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request for a prescription solely to please him. The doctor shall not use nor endorse diagnostic or therapeutic practices for which there is no adequate scientific and clinical documentation available for evaluation by the professional community or competent authority”.

Furthermore, the following Art. 22 (Refusal to provide professional services) underlines the option of the health professional to refuse to provide his services where “services are demanded that go against his conscience or technical-scientific beliefs,” provided that such a refusal will not result in immediate and serious harm to the health of the patient.

Furthermore, the regulations of professional ethics become increasingly compelling, in consideration of the fact that health professionals have been criminally prosecuted in the past for not having refused to operate. This is despite the operations being requested by the patient, in the absence of valid technical justification, where the operation result was unsatisfactory.

Therefore, within the context of a requested cosmetic treatment, a prior careful psychological approach goes beyond being a mere opportunity to form part of a modern form of medicine that is sensitive and attentive to the psychological problems that are inextricably interwoven with traditionally physical issues. There is clear need to include this prior psychological assessment as an essential part of the semiological pathway to a precise diagnosis of the psychophysical state of the patient, with the consequent choices of the most appropriate therapeutic action.

## 2 Discussion

It should be highlighted that recent years have seen a proliferation of medical procedures and cosmetic surgery to change local anatomical features subjectively believed to be unattractive [2], within which all dental treatments are included due to the precise anatomical area on which the medical acts are performed [3].

In fact, the anatomical limits of dentistry, as defined by Art. 2, Par. 1 of Law no. 409/85 include an area of the body (the oral cavity, with teeth, lips and cheeks and supporting tissues) known for its great power of attraction. Due to both its particular topographical location (in the middle of the face) and for its changeable expressive characteristics, it is the subject of frequent requests for more or less visceral remodelling.

A telling example of this is the ever-increasing number of requests for face-lifts with the removal of excess skin and fat from the cheeks, lip lifting and augmentation, application of veneers to the front teeth, or oral and maxillofacial surgery or orthodontic treatments to correct issues of late development, prognathism or uneven teeth.

Without doubt, a significant proportion of dental treatments are undertaken for both functional and cosmetic purposes. The cosmetic element being most important in certain cases and often the primary motivation for the patient contacting the dentist.

Moreover, requests for cosmetic dental treatments have taken on much greater importance in relation to the meaning attributed for some time now by the World Health Organization to the concept of health. It is recognized, not simplistically as the absence of illness, but rather as a state of complete physical, psychological and social well-being.

Now, the data in scientific literature, albeit with some disagreement, indicates a constant increase in legal disputes in dentistry in civil courts [4].

Although failure due to incorrect design and/or installation of prosthetics and prosthodontic implants is the main cause of disputes in this area (prosthetics: 30-70%; implantology: 20-25%), the areas of conservative-endodontic therapy (15.5-30.4%), oral surgery (5-20%) and orthodontics (5-10%) are not exempt from such risk, being most frequently involved in association with prosthetic issues [5].

In this context, there is also the role played by the psychological behaviour of the patient who frequently blames the health professional for the failure to achieve the expected cosmetic result (especially if overstated to him before treatment).

It must also be recognised that this expected result has been supported, or at least promoted, over time by frank uncertainties and not differing views of doctrine and law. In this sense, it is understood to refer to the controversial issue of the degree of obligation – of means (diligence, behaviour) or of results – to which the health professional is bound in his service, a particularly delicate issue in dentistry and totally controversial in activities for cosmetic purposes [6].

It is only recently, on the legal side, that the courts of law have reached a position which, recognising that this distinction introduced by French law of the early 1900s is “totally without regulatory validation and of dubious foundation” (Cass. April 2007, No. 8826) effectively eliminates said division, highlighting the health professional’s position as guarantor, under which he is required to deliver the expected result normally achievable in relation to his level of specialisation and the technical-organisational level of the structure in which the therapy is performed (Cass. Civ., III Sec., Case 8826/07).

An initial legal stance (Magistrate’s Court of Modena, sub-office of Finale Emilia, 9 July 1993; Court of Florence, II Civil Division, 18 October 1998, No. 2932; Court of Cassation of Genoa, 12 May - 18 July 2005) which, in fact, compared dentistry to engineering or architecture, with the constraint, as such of the obligation of result via the undertaking, at the time of preparing and applying a prosthesis, to “create an object that must be perfectly suited to its purpose” (constraint also relevant to slight negligence), was contrasted by the laws of legitimacy (Cass., III Civil Division, Judgment No. 10741, 23 July 2002), which, viewing dentistry as an intellectual profession, subjected it to the obligation of mere diligence, emphasising “the activity, reserved for physician, of diagnosing the patient’s condition, choosing a suitable treatment, with the subsequent application and monitoring of the prosthesis,” with the specification that the performance of the dentist “never gives rise to a material object”.

There lay disagreements in doctrine, sometimes admitting the comparison of dentistry to engineering or architecture, albeit restricted only to the design phase of the prosthetic bridge [7], and sometimes firmly rejecting it, believing that dentistry in general and prosthetics in particular, like any medical discipline, goes through different phases, each burdened by biological variables that make it impossible to predict the outcome of the treatment [8].

This is the position taken by Crinò and Gualneira [9], who accept the dentist’s obligation of means and, therefore, of behavioural diligence, with the result being affected by several variables, such as the individual responsiveness and collaboration of the patient, who is obliged to attend regular check-ups during the application of the prosthesis and during follow-up.

However, other authors believe that the dentist always has an obligation of results in dentistry performed for cosmetic purposes only [10] or in the construction of a prosthesis [11].

There are, however, those who subordinate the nature of the obligation to the overall purpose of the treatment,

tending towards an obligation of means if the procedure has the purpose of curing a functional defect or instead, of result if it has a purely cosmetic purpose [12]; for De Palma, in the case of services for both curative and cosmetic purposes, consideration should be given to which of the two aspects is “most important” [13].

Understandably, it is criticized by Fiori [14], in that “the tendency in legal disputes to equate dentistry with prosthetics (this being the most common discipline in legal dental disputes) and prosthetics with its cosmetic component, from which the absurd equivalence for which, given the requirement of cosmetic surgery to fulfil the obligation of result, the same is proposed for prosthetics, and thus, *ad abundantiam* to the entire dental profession, from which the formulation of a judgment that is incorrect in its conceptual assumptions as well as its analysis”.

Furthermore, should it be desired to insist in admitting an unconditional obligation of result, it would inevitably evoke the deviation of a defensivist dentistry. The high risk of preference of minimal therapies in place of alternative therapeutic methods scientifically valid, but with inherent increased risk of unintended failure, or even more regrettable scenarios, such as the abandonment of treatment by a the patient suffering from illness difficult to cure [15].

In our opinion, obligation of result can be admitted for aspects of quality of materials of the objects used, in the event of optimistic promises, in the absence or significant lack of information, in cases of evident technical simplicity [16].

Concerning the first aspect, in a globalised society characterised by the wide distribution of imitation products even in the health sector (at reduced cost, but of questionable quality, with poorer performance and with a negative impact even on the aesthetic aspects of the treatment), it is essential to emphasise that the patient must be guaranteed the use of medical devices compliant with the European Community directives, such as the guarantee of sterility and technical reliability requirements.

Nor should we overlook the fact that failure to comply with this regulatory requirement would imply a charge of professional medical liability with specific negligence profiles pursuant to Art. 43 of the Penal Code, with the possibility of additional charges of general negligence if their technical conduct deviated from the regulations of due diligence, care and competence in relation to the nature of the activity undertaken (Art. 1176, Par. 2 of the Civil Code).

With regard to optimistic promises, it must be agreed as argued by the Supreme Court, that, despite it not being included under the obligations of the doctor/dentist

to ensure a certain result for his service, he accepts the role of guarantor of the result for which they expressly assume responsibility. However, the patient is responsible for demonstrating the role of guarantor assumed by the health professional (Cass., III Civ. Div., Ruling no. 16394, 13 July 2010).

The same applies to the total or partial lack of information given to the patient in order to acquire informed and valid consent to the medical procedure. In this situation, given that his fundamental right to self-determination has been violated by failing to indicate possible risks and complications that may affect the expected result, the health professional, in fact, undertakes to attain this result, whilst fully responding to any unexplained adverse events, even if they are not operator-dependent (Cass., III Civ. Div., Ruling no. 7237, March 30 2011).

The need to provide detailed information [17] is essential, so as to put the patient in a position in which he is able to choose whether or not to have the proposed treatment [18].

The quality of the information process is considered key to ensuring the truly informed consent of the patient [19].

Therefore, in cases of dental treatment with a primarily cosmetic purpose, it is of the utmost importance to give detailed information [20], in association with, moreover, specific technical skills and in-depth scientific knowledge, given that there are fairly frequent failures at the hands of poorly trained operators and insufficiently organised environments [21], with immediate repercussions on the practicality of professional liability insurance policies offered by the insurance market [22].

In this respect, it should be noted that the patient signing the “cost estimate” agreement or providing the patient with a generic pre-printed document with no indication of the treatments to be carried out do not constitute proof of properly informing the patient.

Moreover, as effectively underlined by the judges at the Court of Milan during the ruling on a claim of the incorrect application of a partial prosthetic device to the upper dental arch, “the signing of any pre-printed form can never be reduced to a formal act, provided as the most important element in pre-preparing a disclaimer; the signing of these forms should instead be at the final moment of review and revision of the detailed information process that the health professional should have undertaken to make the patient aware and inform them of the decision he/she would take by authorising the treatment” (Court of Milan, 18 June 2003).

This aspect should be taken into particular consideration with regard to patients who are about to undergo

dental treatments for cosmetic purposes precisely in relation to the reported possible psychological problems because information that is faithfully detailed, precise, exhaustive, unambiguous, clear and timely balances out the risk of misunderstandings in situations in which the psychological conditioning not infrequent among those patients who resort to cosmetic surgery may be engaged, capable of undermining not only the amplitude of the outlined horizon of information but also the effectiveness of the consent given, in terms of the effective, informed assertion of the individual's self-determination.

The varying differences of position in the doctrine position on the type of obligation assumed by the dentist in operations for cosmetic purposes and those of the law referred to above seem, however, to be superseded by the aforementioned Ruling no. 8826/07 of the Supreme Court. It should be added here that elements reinforcing such a proof to be given, in general and in principle, by the subsequent Ruling no. 577 of 11 January 2008 of the United Divisions Civil Court of Cassation, which affirmed - for the sake of interest - that the distinction between obligations of means and obligations of result, if it may have a descriptive function, is categorically overcome, given that the doctor is contractually committed to the normally obtainable result, in relation to the set circumstances of the case.

In the same ruling, it is stated, *inter alia*, that the fulfilment of the professional obligation involves observing the diligence qualified as standard competence for the category and that the failure to improve is also seen as a deviation of result from the agreed outcome of the service.

This does not give rise to objective liability by default (i.e. responsibility for the event, irrespective of fault) [23], but to the immediate consequence of the reversal of the legal burden of proof, with the service provider (health provider) (a fortiori in the case of simple or routine procedures) of proving that failure to achieve the result was due to things beyond his control due to an unforeseeable event that cannot be overcome with the due diligence the achievement of which this event prevented.

### 3 Conclusions

The future practical impact the breakthrough Ruling no. 577 11 January 2008 of the United Divisions Civil Court of Cassation, which would seem to mark the end of the legal distinction between obligations of means and obligations of result, though already registering observations contrary to the judges in question, is as yet unknown.

The fact remains that it offers a significant contribution to an increasingly demanding interpretation of dentistry, even beyond the simple facts of biological knowledge that – vice versa - would impose positions of greater flexibility of behavioural demands.

However, it cannot be denied that in clinical areas characterised by possible psychological uncertainty and in activities not yet fully free from particular ethical aspects that make them in some respects autonomous, as compared to other areas of medicine, cautionary measures and technical-ethical behavioural precautions are no threat to the respect of the dignity and protection of the health of the patient.

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