

# Patient Knowledge in regard to Injury from Dental Treatments and the ways to Seek Legal Remedy in Ouagadougou, Burkina Faso

Wendpoulomé AD Kaboré<sup>1,3\*</sup>, Raoul Bationo<sup>2</sup>, Carole DW Ouédraogo<sup>3</sup>, Seydina O Niang<sup>4</sup>, Mathieu Millogo<sup>1</sup>, Khaly Bane<sup>4</sup>, Mouhamed Sarr<sup>4</sup> and Babacar Faye<sup>4</sup>

<sup>1</sup>Unité de Formation et de Recherche en Sciences de la Santé (UFR/SDS), Université Ouaga I Pr Joseph Ki Zerbo, 03 BP 7021 Ouagadougou 03, Burkina Faso

<sup>2</sup>Centre Médical Camp Général Aboubacar Sangoulé Lamizana 04 BP 8105 Ouagadougou, Burkina Faso

<sup>3</sup>Centre Municipal de Santé Bucco-Dentaire (CMSBD) de Ouagadougou, 01 BP: 85 Ouagadougou 01 Burkina Faso

<sup>4</sup>Service d'Odontologie Conservatrice Endodontie/Université Cheikh Anta Diop de Dakar, BP: 5005 Dakar-Fann, Senegal

\*Corresponding author: Kaboré WAD, Unité de Formation et de Recherche en Sciences de la Santé (UFR/SDS), Université Ouaga I Pr Joseph Ki Zerbo, Burkina Faso, E-mail: [dr\\_kabore@yahoo.fr](mailto:dr_kabore@yahoo.fr)

Received date: 29 Jul 2016; Accepted date: 16 Aug 2016; Published date: 22 Aug 2016.

Citation: Kaboré WAD, Bationo R, Ouédraogo CDW, Niang SO, Millogo M, et al. (2016) Patient Knowledge in regard to Injury from Dental Treatments and the ways to Seek Legal Remedy in Ouagadougou, Burkina Faso. Int J Dent Oral Health 2(7): doi <http://dx.doi.org/10.16966/2378-7090.214>

Copyright: © 2016 Kaboré WAD, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

## Abstract

**Introduction:** In Burkina Faso, oral diseases are exacerbated by poverty. The question of dentist's responsibility in malpractice is particularly pertinent in light of the largely illiterate population that pays scant attention to their rights and whose priority is having access to adequate care. It also needs to be viewed in the context of the low standard of equipment in dental practices. This study was conducted to assess the level of knowledge by the patients in regard to the concept of prejudice and remedies in case of a dispute with a dentist.

**Patients and Methods:** A printed questionnaire was provided to patients being treated at the unit of Conservative Dentistry and Endodontics at the Municipal Center for Oral Health of Ouagadougou over the period from March 1<sup>st</sup> to March 31<sup>st</sup> of 2016.

**Results:** The results showed that 38.8% of the patients were familiar with the concept of prejudice. But the majority of the patients (59%) were not aware of how to seek redress for damages incurred. For 65% of the patients, God was thought to be responsible for what might happen to them during treatment. Diagnostic errors were reported by 2 patients (1.6%). Only 28% of patients were aware of informed consent.

**Conclusion:** The present work has shown that despite the precarious situation, individuals are nonetheless aware of medical errors and the harm they may cause.

**Keywords:** Prejudice; Legal remedies; Dental surgeon; Conservative dentistry and endodontics

## Introduction

Burkina Faso is an African country with a low Human Development Index (HDI), and it is ranked 181 out of 187 countries [1]. Performing dental surgery, like all medical practices, entails a degree of professional responsibility. Articles 1382 and 1383 of the civil code [2] and the code of ethics [3] define this responsibility. The therapeutic aims of the practitioner must match what the patient requests. The practitioner must ensure that the patient is adequately aware of the nature of the therapy and its aims so that the outcome at the end of the treatment will not have a negative psychosocial impact [4]. The practitioner and the client form a tacit or synallagmatic contract [5]. Conditions under which responsibility comes into play occur with a mistake, a prejudice with a link to causality. Civil liability is contractual in principle, tortious or quasi-tortious in specific circumstances [6]. Yet a country's, or its population's, precarious setting appears to make medical responsibility of practitioners a secondary consideration. In light of this, a technical appraisal aimed at determining the consequences of harm suffered by an individual by performing several medico-judicial actions is almost never requested in our setting. This study was undertaken to assess the extent to which patients who received conservative or endodontic dental treatment (CEDT) at the Municipal Oral Health Center (MOHC) of Ouagadougou were knowledgeable of the notion of prejudice and of the ways to seek redress.

## Patients and Methods

### Site, type, and timing of the study

This was a prospective study of a descriptive and analytical nature in regard to patients from the Conservative Dentistry and Endodontics unit of the MOHC. The investigation was carried out between the 1<sup>st</sup> until the 31<sup>st</sup> of March 2016. The MOHC was chosen as it is situated in the central part of Ouagadougou. Its accessible location and not-for-profit nature make it an ideal entity for performing this study. It is frequented by patients of all socio-economic levels.

### Criteria for inclusion and for non-inclusion

All of the patients of legal age, whether literate or not, and who freely agreed to participate in the investigation were included in this study. With all patients who were minors, the inquiries were directed at their parents. Neither gender nor the level of education constituted criteria for exclusion.

### Data collection and processing

The study was undertaken based on a questionnaire using a form that was filled out by the patients with assistance from a healthcare officer who ensured that the questions were adequately understood. Each participating patient was questioned in regard to the following items: their marital

status, profession, level of education, the reason for the consultation, knowledge in regard to personal injury and ways to seek recourse. The inquiry form was drafted using Sphinx version 5 software (ParcAltais 74650 Chavanod, France). An office separate from the unit was set aside for filling out the forms so that the patient's answers were not influenced by the staff. A trial test run that was carried out with ten patients allowed the questionnaire to be validated.

### Statistical analyses

Statistical analyses of the data were performed using Sphinx version 5 software (ParcAltais 74650 Chavanod, France). The  $\chi^2$  (Chi<sup>2</sup>) test was used to compare the two statistical variables. Differences were considered to be significant when  $p < 0.05$ .

## Results

### Socio-economic characteristics of the sample

One hundred and twenty-five patients were interviewed, and 57.6% were female versus 42.4% males ( $p = 0.0892$ ). The sex-ratio was 0.74. The median age was 33.7 years, ranging from 13 to 60 years of age. Assessment of the level of instruction indicated that 21% of the patients were illiterate. Patients who had received a tertiary level education represented 26.3%, secondary level was 29%, and primary level was 23.7%. The majority (85%) of the patients lived in Ouagadougou. Patients with high incomes (e.g. business people and private sector employees) represented 13.5%, while 16.5% had average incomes (e.g. public sector employees and retirees). The majority of the sample (70%) comprised patients with low incomes (e.g. those in the informal work sector, pupils, students, unemployed, domestic employees) ( $p = 0.0001$ ).

### The reason for the consultation and therapeutic indications

A toothache was the reason for a consultation in 71% of the cases ( $p = 0.0001$ ) (Table 1). The most commonly enacted procedure was endodontic treatment (62.4%) followed by dentinogenic amalgam treatments (14%). Treatments with composite resins amounted to 12%. Root posts followed by direct restoration with composites amounted to 5.6%.

### Knowledge in regard to prejudice by the patients

The patients tended to be unaware of the notions of personal injury and incurred harm. The results showed that 38.8% of the patients were aware of the notion of bodily harm stemming from medical risk, although it often appeared to be confused with incurred harm. None of the patients were aware of the notion of direct and indirect harm. For 72%, God was thought to be responsible for what might happen to them in the course of

Reasons For A Consultation		Frequency (%)
Reasons For An Emergency Consultation		
Irreversible pulpitis		20.9
Apical periodontitis		40.5
Pulpal hyperemia		6.9
Dental Traumatism		2.7
Other Reasons For A Consultation		
Restorative dentistry	Dental filling	11.3
	Non-carious lesion	4
	Septum syndrome	1
	Crown destruction	9
Various reasons	Functional discomfort	1
	Halitosis	0.5
	Regular check-up	1.2
	Esthetic reason	1
Total		100

Table 1: Reasons for a consultation

their treatment. None of the patients were aware of the notion of a causal link between the error and the harm incurred. The types of grievances voiced by the patients were in regard to diagnostic errors (3.2%) and pain during the treatment (0.8%) despite it having been brought to the attention of the practitioner. The patients did not have a clear picture of the treatments that they received. The patients claimed to have agreed to the treatment following informed consent in 28% of the cases (Table 2).

### Knowledge of the ways for recourse by the patients

As far as ways to achieve recourse was concerned, the most common was through an amicable settlement (79.2%). Furthermore, the majority of the patients (68%) had no idea of what could be undertaken to request compensation for the harm incurred (Table 3).

## Discussion

This study could have been extended to other facilities in the town of Ouagadougou so as to increase the sample size. It nonetheless provided an indication of the degree of overall knowledge by the patients in regard to the notion of injury incurred over the course of dental treatment.

In Burkina Faso, and in most third world countries, dental surgeons have long been, and still are considered to be medical doctors. Indeed, until 2000 there was an order specific for medical doctors, pharmacists, and dental surgeons. Along with an increasing number of practitioners, more dental centers have been established and the profession has become more widely recognized. Yet universal health cover does not exist and access to dental care remains very limited. Further, our study has revealed that the majority of the patients (70%) had a low socio-economic level. Jaiswal et al. [7] have reported that the most disadvantaged populations in India are the most affected by dental pathologies while they do not have ready access to dental care. Rasteniene et al. [8] have also reported that patients with a substantial income and health insurance had better oral health compared to patients with a low socio-economic level. They pointed out that access to private dental clinics was way out of reach for those without health insurance. Furthermore, they indicated that the resources of public facilities were often limited. In this setting, access to care was considered to be important but not necessarily the quality of the care. The vast majority (72%) of patients had full confidence in their dental surgeon, and they were not aware of the notion of informed consent. They underwent the treatment decided on by the practitioner without understanding the aims or what it involves. The technical errors that this could cause typically go unnoticed or could even be viewed as being normal. There has not yet a documented case in Burkina Faso of a patient taking a

Unclear information/consent was not informed	65 (72%)
Failure of the initial treatment	8 (6.4%)
Tooth eventually extracted	2 (1.6%)
Renewed treatment	3 (2.4%)
Perioperative pain	3 (2.4%)
Persistent post-operative pain	5 (4%)
Loss of a permanent filling in less than a month	2 (1.6%)
Alteration of the treatment	3 (2.4%)
Lip or tongue paralysis	0 (0%)
Persistent tingling of heavy feeling	0 (0%)
Post-operative edema	3 (2.4%)
Perioperative inhalation of liquid items	5 (4%)
Perioperative inhalation of solid items	0 (0%)
Inhalation of instruments	0 (0%)
Perioperative malaise	1 (0.8%)
Post-operative lockjaw	1 (0.8%)
Post-operative allergic reaction	2 (1.6%)
Diagnostic error	2 (1.6%)

Table 2: Causes for a dispute with a practitioner

Ways For Recourse	Yes	No
Are you aware that you can seek compensation in case of a dispute?	40 (32%)	85 (68%)
How would you seek recourse in case of a dispute?		
In Court with a lawyer		0 (0%)
The Police		9 (7.2%)
The mayor and a city councilor		1 (0.8%)
By questioning the dental surgeon on the radio		3 (2.4%)
Amicably		99 (79.2%)
I would not complain, I would go elsewhere		13 (10.4%)
Through an ombudsman		0 (0%)

**Table 3:** Knowledge of ways to seek recourse by the patients

dental surgeon to court for malpractice. However, our study showed that patients are becoming increasingly aware of how to seek legal recourse to make a claim, even though the majority of the patients justified the harm inflicted as being God's will. Yet the practitioner-client relationship has greatly changed over the past two decades around the world [9]. The first malpractice suit for compensation from injury arising from dental care was reported in 1850 in the United States [10]. As with many other professions, dental surgeons are increasingly being sued for damages. [11]. Our study has however revealed a profound lack of knowledge regarding patient rights and the obligations of practitioners. As for now, engaging in legal proceedings appears to be the least of the patient's worries. Taking care of their main basic needs remains a top priority [12]. Despite significant healthcare improvements in Burkina Faso, dental care remains relatively underdeveloped. Indeed, in 2014 the country had 65 dental surgeons on the list of the Burkina Faso National Order of Dental Surgeons [13] for a total population of 14 017 262 inhabitants [14], or one dental surgeon for every 215 650 individuals. Despite all of this, when it comes to their relationship with their patients, dental surgeons are not only subject to moral rules dictated by social life but they must also abide with the laws that are in force [15]. An acknowledged error by a practitioner needs to be addressed only if it results in harm to their patient and if there was a causal link between the error and the harm inflicted [16]. To establish such a link, ways for recourse (amicable or legal) need to be used, which all impose designation of an expert to appraise the situation. The terminology of Dintilhac [17] is the currently accepted and used terminology for in demnization for bodily injury. It distinguishes direct bodily injury to the victim and indirect victims. It can be in regard to pecuniary losses or non-pecuniary damages that can be temporary or permanent, prior to or after assessment of the degree of disability, or even progressive [17]. Most patients (79.2%) indicated that, if the situation arose, they would opt for an amicable resolution. Yet such an amicable resolution would not amount to an evaluation of the harm incurred with the aim of receiving compensation, since it would involve being excused so as to start anew.

In any case, this investigation has revealed that some patients are aware of how to get recourse even if they would not use it. To that end, dental surgeons could benefit from establishing their duties [18] and the nature of their obligations [19]. Furthermore, the responsibility of the entire medical team comes into play in the sequence of treatments for the patient [20].

## Conclusion

Legal summonses for bodily injury linked to a treatment are becoming more and more common in recent years in Burkina Faso, particularly in regard to general medicine. Patients often threaten to sue the implicated practitioners, although these disputes are often settled out-of-court. Patients have little idea when it comes to the ways to seek recourse and the possibility of receiving compensation. There will continue to

be plentiful harm from dental procedures that will not be accounted for until clear groundbreaking standards are devised and made widely available to protect the afflicted individuals. The all new Order of Surgical Dentists should take rapid action in this regard to protect patients and the profession alike.

## Conflict of Interest

The authors have no conflict of interest to declare.

## References

1. United Nations Development Programme (PNUD) (2014) World Report on développement humain. Sustaining human progress: reduce vulnerabilities and build resilience. New York 1-239.
2. Civil Code 1804 (Burkina Faso) Offenses and quasi-offenses. Chapter 2, 52-62.
3. DECRET N°97-051/PRES/PM/MS (1997) Wearing Code of Ethics Dental Surgeons of Burkina Faso.
4. Mauhourat S (2011) Patient's right and responsibility of the practitioner: Information and consent. *Orthod Fr* 82: 59-66.
5. Béry A (2004) The source contract obligations. *Rev Orthop Dento Faciale* 38: 371-372.
6. Prado CED, Kanunfre LDF, Feistler AP, Zaitter W (2013) Criminal liability in dental practice. *RSBO* 10: 96-101.
7. Jaiswal AK, Pacahva S, Sanikommu S, Rawlani SS, Pydi S, et al. (2015) Dental pain and self-care: a cross-sectional study of people with low socio-economic status residing in rural India. *Int Dental J* 65: 256-260.
8. Rastenienė R, Aleksejuniene J, Puriene A (2015) Dental treatment needs and health care-seeking behaviours of patients with acute odontogenic infections in Lithuania. *Int Dental J* 65: 188-195.
9. Goel K, Goel P, Goel S (2014) Negligence and its legal implications for dental professionals: a review. *TMU J Dent* 1: 113-118.
10. Rai JJ, Acharaya RV (2014) Dental negligence and its liabilities in a nutshell. *IJDS* 6: 084-088.
11. Pérez PB, Sáez SA, González LME, Juan MEA (2011) Professional liability in oral surgery: Legal and medical study of 63 court sentences. *Med Oral Patol Oral Cir Bucal* 16: e526-e531.
12. United Nations Development Programme (UNPD) (2012) MDG Acceleration Framework (CAO) in Burkina Faso, Eradicate extreme poverty. 18-20.
13. National College of Dental surgeons Burkina (ONCDB) (2015) National Congress, Moral Report 2014. 1-16.
14. National Institute of Statistics and Demography (INSD) (Burkina Faso) (2008) Preliminaries General Census Results of Population and Housing (RGPH) of 2006. 1-52.
15. Romdane H, De Mello G (2009) The implantologie in the legal and ethical field-1. The obligations of the dentist. *Med Buccale Chir Buccale* 14: 85-95.
16. Sargos P (2011) Medical Civil Liability: the major changes case law of the Court of Cassation. *AOS* 218: 137-149.
17. Dintilhac JP (2007) The working group responsible for the work to develop a classification of bodily injuries. *J Med Right Leg Med*. 50: 161-174.
18. Devadiga A (2012) Informed Consent and the Dentist. *OJHE* 8: 1-20.
19. Abbasi M, Salehi H, Mashayekhi B (2012) The Nature of Medical Obligations in the Light of Comparative Study. *Iranian J Med Law* 1: 7-24.
20. Straka J (2013) The issue of civil legal responsibility of medical and therapeutic entity associated with hospital infections. *MBS* 27: 57-61.