CNA

DENTIST'S ADVANTAGE

Dental Professional Liability Claim Report

3RD EDITION

For decades, The Dentist's Advantage Program and CNA have remained steadfast in their commitment to supporting dental professionals through education, risk mitigation, and comprehensive insurance solutions. As the landscape of dental care continues to evolve, so do the challenges and responsibilities encountered by practitioners across all practice settings.

The Dental Professional Liability Claim Report: 3rd Edition reflects our ongoing dedication to helping dentists understand the circumstances that may lead to professional liability claims. By analyzing closed claims and identifying patterns in patient outcomes, we aim to provide actionable insights that can inform clinical decision-making and enhance patient safety.

The Academy of General Dentistry (AGD) is honored to have provided input and suggestions on this important initiative. AGD's commitment to lifelong learning and excellence in general dentistry aligns with our shared goal of empowering dental professionals to deliver safe, effective, and compassionate care. Together, we recognize that understanding risk is a critical component of professional growth and patient advocacy.

As partners in this endeavor, we extend our sincere appreciation to the dental community for its resilience, professionalism, and unwavering support to patients. It is our hope that this report serves as a valuable resource for dentists in solo, group, academic, and institutional settings, helping them to navigate the complexities of modern dental practice with confidence and clarity.

CNA

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DENTIST'S ADVANTAGE

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Key Findings of the Dental Professional Liability Claim Report

Since the prior report, the **average total incurred** for professional liability closed claims **increased 10.5 percent**, from $134,497 **to $148,655**. (Page 4)

Although **failure to diagnose** is associated with various conditions, the **severity** primarily results from claims associated with **cancer or other tumorous growths of bone or soft tissue**. Such claims **represented 41.0 percent** of failure to diagnose claims, with an average total incurred of **$403,614**. (Page 6)

Swallowed/aspirated object – a dental never event – now represents a larger proportion of dental claims (7.5 percent) and has **increased in severity (24.1 percent)** since the 2nd Edition report. (Page 7)

The average total incurred for all claims in which **procedural sedation** was administered is $248,821. For claims in which the **sedation caused an injury or death**, the average total incurred is **$437,116**. (Page 9)

Professional conduct complaints **increased by 3.4 percent**, and the **average defense/expense payment** rose substantially by **77.5 percent**. (Page 10)

Dental Professional Liability Spotlights

In the months ahead, please access the Dentist's Advantage Prevention and Education Web page to download the report and Spotlights on key risk topics:

- Protecting Your License
- Informed Consent and Refusal
- Patient Termination and Referral
- Procedural Sedation
- Crowns and Bridges

Terms

- **Average Total Incurred** – Also referred to as "claim severity" within the report, refers to total paid indemnity and expense payments (total incurred), divided by the total number of closed claims.
- **Distribution** – Refers to a specific group of closed claims with categories expressed as a percentage of the total.
- **2nd Edition** – A reference to the prior report, entitled 'Dental Professional Liability Claim Report: 2nd Edition,' which includes claims that closed from 2015-2019.

Introduction

CNA and the Dentist's Advantage program strive to educate our insureds, and the healthcare industry at large, on risks associated with patient care in dental practice. This 3rd Edition of the report provides a prioritized analysis of key claim types, interspersed with case study summaries. Future Spotlights will be produced to delve deeper into selected topics of interest. Our goal is to help dentists enhance their practice and minimize professional liability exposures by identifying loss patterns and trends.

Dataset and Methodology

There were 836 professional liability closed claims and 1,719 closed license protection matters attributed to insured dentists from January 1, 2020, through December 31, 2024. Dataset inclusion criteria are as follows: 1) an insured dentist or dental practice with 2) professional liability closed claims resulting in an indemnity payment ranging from $10,000 to $1,000,000; or 3) license protection matters that resulted in claim expenses of $1 or more. Since elements of the inclusion criteria in this report may differ from that of previous CNA/Dentist's Advantage claim analysis and claim reports issued by other organizations, we suggest readers exercise caution when comparing these findings with other reviews. Similarly, due to the fundamental uniqueness of individual claims, the average total incurred amounts referenced within this report may not be indicative of the total incurred amounts attributed to any single claim. Furthermore, due to the limited number of claims in some claim categories, the presence or absence of one or two high-severity claims may cause a substantial increase or decrease in the average total incurred from the 2nd Edition to the 3rd Edition. This may not be indicative of any significant risk trend.

Professional Liability Claims Analysis

This report presents an analysis of the top professional liability closed claims by dental procedure, allegation, and injury type, followed by a section describing the impact of procedural sedation exposures.

Since the prior report, the average total incurred for professional liability closed claims increased 10.5 percent, from $134,497 to $148,655. Overall, this is consistent with national trends in medical malpractice and social (tort) inflation where settlements and judgments continue to trend upward, with periodic "nuclear verdicts" now affecting the dental industry.

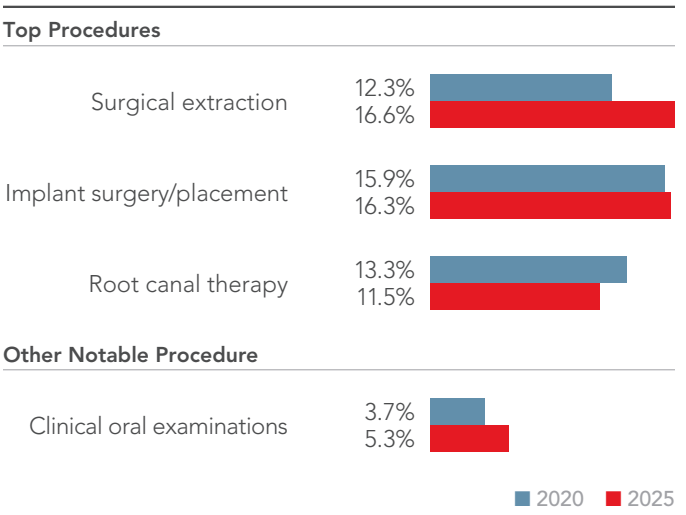
The rise in the average total incurred is primarily influenced by a 9.8% increase in the severity of claims associated with General Practitioners (GPs), from $129,457 to $142,185. Approximately 90 percent of the claims in the dataset are associated with GP dentists. However, it should be noted that, while they are a smaller portion of the dataset, claim costs associated with non-GPs increased 17.2 percent from $170,347 to $199,721. For reference, outside of GPs, the three specialties with the highest claim costs on average include oral maxillofacial surgeons, prosthodontists, and periodontists.

…**settlements and judgments** continue to **trend upward**, with periodic **"nuclear verdicts"** now **affecting the dental industry**.

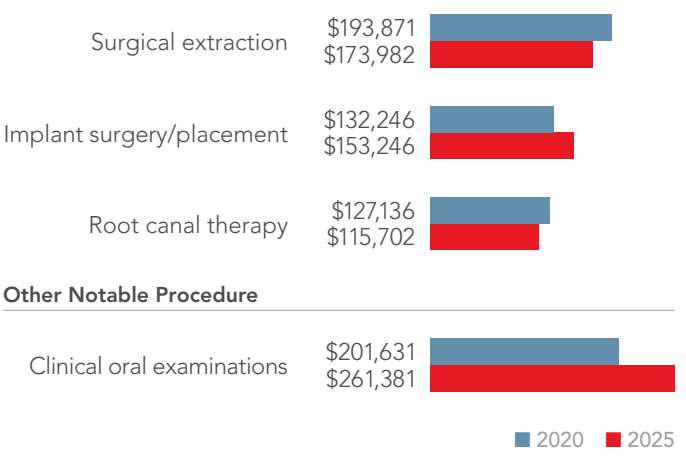
Dental Procedures

- Collectively, the top three dental procedures remained the same as the prior report with an increase from 41.5 percent to 44.4 percent of the total claim distribution as seen in **Figure 1**. Although two of the top three procedures reflected a decrease in the average total incurred (**Figure 2**), their combined severity increased 1.6 percent from $148,876 to $151,300. More significant was the rise of 17.9 percent, from $124,294 to $146,544, for claims outside of the top three procedures. Among the top three dental procedures, the only increase in average total incurred was for implant surgery/placement which was up 15.9 percent to $153,246.
- Historically, incurred costs for claims associated with implant surgery/placement are significantly impacted by cases of nerve injury. In this dataset, nerve injury represents the top injury-related cost driver for implant placement. Other issues also may lead to severe claims with implant surgery/placement, as discussed in Case Study 1.
- An example of a less frequent procedure with a notable increase are claims associated with clinical oral examinations, with an average total incurred of $261,381 up 29.6 percent as compared to the prior report. This is primarily due to cases of failure to diagnose oral cancer or other destructive lesions (Case study 2). Review the Allegations section for more information on claims related to failure to diagnose. Severe outcomes may result from clinical oral examination procedures due to other allegations/injuries. Case Study 3 presents an example.

1 Distribution of Dental Procedures
Closed Claims with Paid Indemnity ≥ $10,000



2 Average Total Incurred of Dental Procedures
Closed Claims with Paid Indemnity ≥ $10,000



Case Study 1. A 70-year-old female with osteoporosis (on alendronate), a history of smoking, alcohol use, and obesity sought restorative care. She had severe mandibular bone loss and agreed to extractions and an implant-retained overdenture. Two of four implants failed due to infection and were replaced. The patient suffered a mandibular fracture, possibly from implant placement. After fracture repair, another implant was placed, causing a second fracture. Experts agreed that this implant was ill-advised and unnecessary. Both fractures required internal fixation and later hardware removal. Experts criticized the treatment plan, noting the patient was a poor candidate and records were confusing and inadequate. The case settled with a total incurred (indemnity plus claim expenses) of $375,000.

Case Study 2. A 50-year-old male, non-smoker and occasional alcohol consumer, presented to an insured general dentist (GP) with tooth pain. A limited exam revealed the need for endodontic treatment on tooth 19, and he was referred to an endodontist who performed root canal therapy (RCT). Two weeks later, he returned to the GP for radiographs and a comprehensive exam.

Over the following year, he received restorative work and was referred to and treated by a periodontist for issues in the right mandibular posterior region. He delayed his one-year recall with the GP by three months due to a family matter. Shortly before the rescheduled visit, he saw an ENT for throat pain and reported a persistent sore on the left side of his tongue, present for over a year. The ENT referred him to an oral surgeon, and a biopsy confirmed stage IV squamous cell carcinoma. Treatment included surgery (with three positive lymph nodes), chemotherapy, and radiation. The patient sued both the GP and periodontist, alleging failure to diagnose or refer for oral cancer. Records lacked documentation of tongue pain or oral cancer screening. The total incurred for the GP was $250,000. Amounts incurred by other providers were not available. The patient survived and was cancer-free at settlement.

Case Study 3. A 60-year-old male with a history of obesity, smoking, type 2 diabetes, ulcerative colitis, hyperlipidemia, and multiple orthopedic surgeries sought dental care. He opted for extractions as needed. Six months later, the patient reported tooth 9 was loose (due to a past RCT). Radiographs and an examination showed mobility and infection. He postponed treatment and agreed to 6-month recalls. Four months later, he experienced sensitivity in tooth 10. The dentist adjusted the occlusion, which initially helped; however, the patient developed pain and swelling within a week. Tooth 10 was extracted at the patient's request. That evening, he became unresponsive and was subsequently diagnosed with sepsis at the hospital. He passed away the following day due to septic shock and multiple system organ failure. A wrongful death suit alleged failure to treat infection, prescribe antibiotics, and communicate the risks of infection for tooth 9, which led to sepsis. The case settled with a total incurred of more than $1,000,000.

Analysis by Allegation

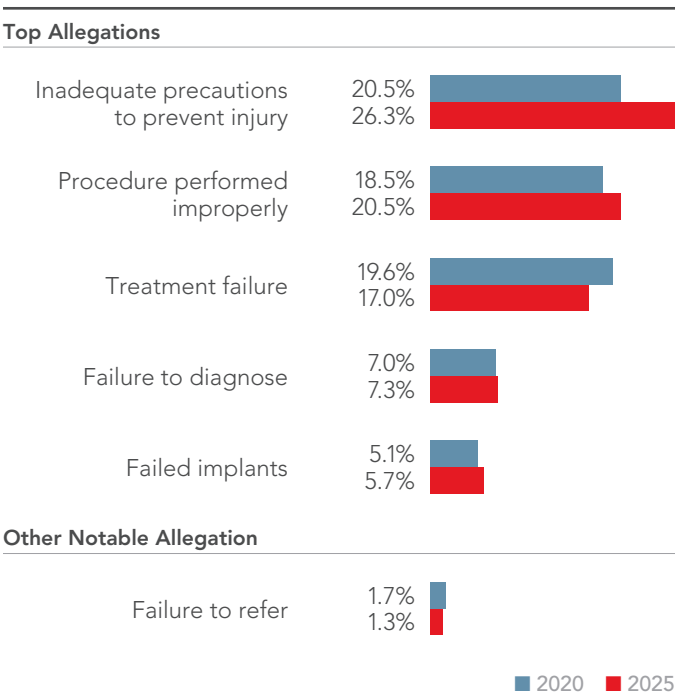
The top five allegations by distribution accounted for 76.8 percent of all claims, as shown in **Figure 3**. Although all but one of the top five experienced an increase in average total incurred since the 2nd Edition report, as seen in **Figure 4**, the change for one allegation stands out (failure to diagnose).

- Severity for failure to diagnose increased by 47.1 percent to $250,151, which is now 68.3 percent higher than the overall average total incurred.
- Although failure to diagnose is associated with various conditions, the main contributor for the increase in severity is from claims associated with cancer or other tumorous growths of bone or soft tissue. Such claims represented 41.0 percent of failure to diagnose claims, with an average total incurred of $403,614.
- Outside of the top five allegations, a similar alleged lapse in dentists' duty to the patient is failure to refer. The average severity for claims associated with this allegation increased by 30.8 percent. For purposes of this claim report, all cancer/tumor related claims are captured under failure to diagnose, whereas failure to refer is primarily comprised of claims associated with periodontal disease, nerve injuries, RCT and infection.

Case studies 4 and 5 present examples of failure to diagnose/refer.

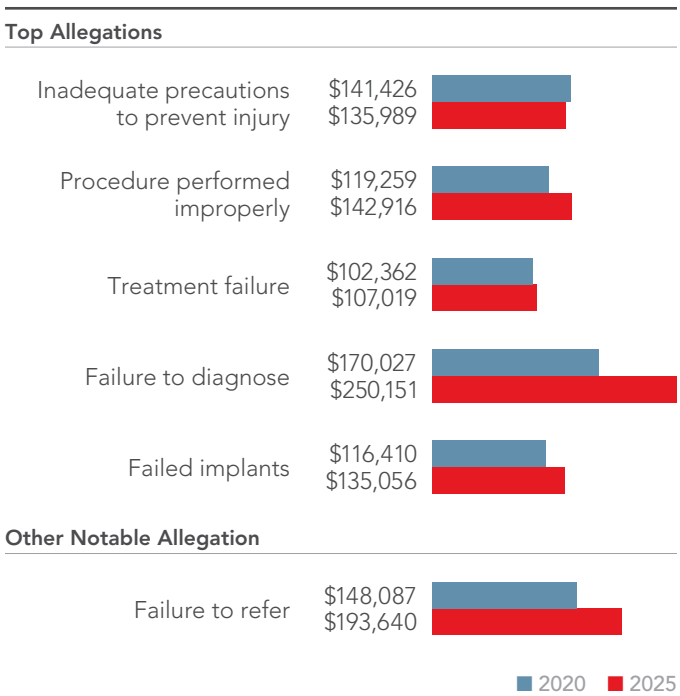
3 Distribution of Allegations

Closed Claims with Paid Indemnity ≥ $10,000



4 Average Total Incurred of Allegations

Closed Claims with Paid Indemnity ≥ $10,000



Case Study 4. A 76-year-old male sought care for loose upper teeth. Due to decay and bone loss, the dentist recommended an implant overdenture, but the patient chose a traditional immediate denture. After the patient's diabetes was controlled, treatment began for an immediate maxillary denture. Over the 14 months of treatment and follow-up visits, the patient had ongoing complaints of poor fit and was treated for thrush without resolution. When he stopped wearing the denture and reported radiating pain from his palate, the dentist referred him for a biopsy of suspicious palatal tissue, resulting in a diagnosis of advanced squamous cell carcinoma. Aggressive treatment followed, including radiation, surgical excision, neck dissection and autogenous bone and soft tissue grafts. Experts criticized the treatment and inadequate records, noting no documented performance of a comprehensive exam or cancer screening. The case settled with a total incurred of approximately $1,000,000.

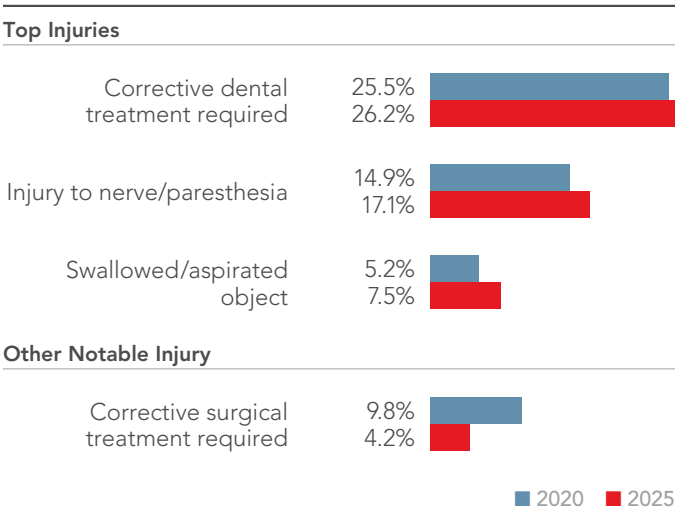
Case Study 5. An adult female patient was treated by the dentist over a 10-year period, receiving infrequent restorative care and RCT on two teeth. Despite periodic exams and imaging, progressive alveolar bone loss and periodontal disease signs were not documented. There was no documentation of a diagnosis, doctor-patient discussion, or treatment for periodontal disease in the records. After moving and seeking alternate care, the patient learned of her severe condition from a new dentist. Defense experts agreed that the case was indefensible, leading to a settlement with a total incurred of nearly $300,000.

Analysis by Injury

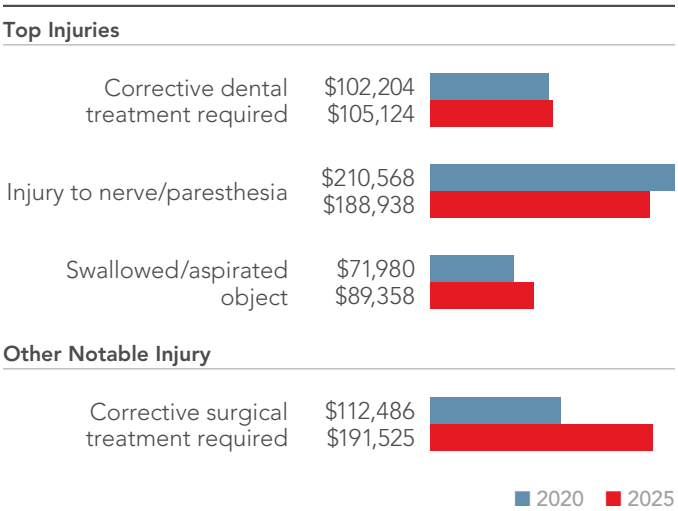
Similar to other areas of this report, the change in the distribution of the three most common injuries has remained relatively flat compared to the prior report. While the order of the three most common injuries remains unchanged, they now account for just over 50 percent of the total claims. The following points highlight several notable changes relevant to clinical safety and the incurred severity of loss.

- Swallowed/aspirated object – a dental never event – now represents a larger proportion of dental claims (7.5 percent) and has increased in severity (24.1 percent) since the 2nd Edition report, as represented in **Figure 5**. Case studies 7 and 8 present examples.
- Despite a decrease in severity of 10.3 percent, nerve injury (Case Study 6) remains a frequent and severe dental patient injury, with an average total incurred of $188,938. This is 27.1 percent greater than the overall average severity of $148,655.
- Although it dropped out of the top five injuries due to a relative decrease of 5.6 percent, the average total incurred for corrective surgical treatment increased 70.3 percent (**Figure 6**). A review of these claims indicates that issues associated with complex implant-supported restorative care are primarily responsible for the increase.

5 Distribution of Injuries
Closed Claims with Paid Indemnity ≥ $10,000



6 Average Total Incurred of Injuries
Closed Claims with Paid Indemnity ≥ $10,000



Case Study 6. A 49-year-old male sought treatment for decayed and missing mandibular molars. Tooth 31 and opposing tooth 2 were missing. Non-restorable teeth 18, 19, and 30 were extracted and replaced with grafts and implants. The patient experienced left and right paresthesia, progressing to total loss of sensation in the lower lip and chin, with intermittent severe dysesthesia on the right side. The dentist delayed action, leading the patient to seek second and third opinions before filing suit. Liability was probable due to inadequate imaging (pre-operative, intra-operative and post-operative), failure to refer for nerve evaluation, and documentation issues. Defense efforts to challenge claimed damages reduced the settlement significantly, resulting in a total incurred of $650,000.

Case Study 7. A 68-year-old male with asthma and chronic obstructive pulmonary disease had failed bridgework replaced with implant-supported restorations. Bridge sectioning, extractions and maxillary implant placement were completed under moderate sedation with no complications. After surgery, he experienced increased coughing. He visited his pulmonologist, but coughing persisted despite medical treatments. Twelve months after dental surgery, a chest X-ray revealed a foreign object in his right lung. Bronchoscopy under sedation failed to remove it; however, it was successfully extracted under general anesthesia using a rigid bronchoscope. When the object was determined to be a porcelain fused to metal bridge retainer, the patient filed a lawsuit. Although the dentist indicated that a throat pack and high-volume evacuation were used during surgery, and that he inspected the extracted teeth and restorations before ending the procedure, these points were not documented. Given these facts, the defense pursued and reached a settlement, with a total incurred of $250,000.

Case Study 8. A 62-year-old male required endodontic treatment on a mandibular second molar. During the procedure, the dentist removed the dental dam frame to take a file length radiograph. After completing the radiograph, the assistant began removing files before replacing the frame. During the process, the assistant inadvertently dropped a file, which the patient reflexively swallowed. Without the dental dam frame in place, part of the oral cavity and tongue was exposed, leading to the adverse event. At the hospital, imaging confirmed that the file was in the patient's stomach. A gastroenterologist recommended removal. After two failed endoscopic attempts, the patient underwent laparoscopic surgery involving four abdominal portals and incisions in both the stomach and small intestine. The patient, representing himself, sought compensation for medical costs, lost wages, pain, and psychological distress. After rejecting an unreasonable demand near policy limits, the defense team negotiated a settlement aligned with the actual injuries and losses. Total incurred was approximately $110,000.

Dental Nerve Injuries

1 Severe Claims Primarily Associated with:

Mandibular third molar and other surgical extractions (IAN*, lingual nerve)

Mandibular posterior dental implant placement (IAN, mental nerve)

Mandibular posterior RCT (IAN)

*Inferior alveolar nerve

2 Common Outcomes

Paresthesia, dysesthesia, hyperesthesia, anesthesia

Functional deficits (e.g., drooling, impaired speech, difficult chewing/ swallowing)

Accidental self-inflicted trauma

3 Essential Management Steps

Anticipate/recognize adverse or unexpected outcomes

Evaluate immediately or as soon as possible

Prompt specialist referral

Timely treatment for severe and/or persistent injuries

Frequent/effective communication with patients and specialists

Maintain detailed records

Focus on Procedural Sedation

Procedural sedation represents a new area of analysis in the 3rd Edition report. Although procedural sedation is only associated with 8.1 percent of claims included in this analysis, the injuries and costs associated with these claims are often severe. The average total incurred for all claims in which procedural sedation was administered is $248,821. For claims in which the sedation caused an injury or death, the average total incurred is $437,116.

- For claims associated with moderate sedation, 31.3 percent resulted in a sedation-related injury or death, while 21.4 percent of deep sedation/general anesthesia cases resulted in a sedation-related injury or death as noted in **Figure 7**.
- Although there were no sedation injuries associated with minimal sedation, it is important to note that when minimal sedation was intended by the provider, 45.5 percent of cases resulted in moderate sedation by definition, according current ADA Sedation Guidelines.* This set of cases represents one third of the moderate sedation cases associated with sedation injuries
- Of note, multiple claims associated with sedation injuries were cases in which the practitioner did not possess a valid sedation permit as required by state law, or whose permit did not apply to the administered sedation level.

7 Distribution of Claims Associated with Sedation Resulting in Sedation-Related Injuries

Closed Claims with Paid Indemnity ≥ $10,000

Level of Anesthesia	Percent of Sedation Cases with Sedation-Related Injury
Minimal sedation	0.0%
Moderate sedation	31.3%
Deep sedation/ General anesthesia	21.4%

8 Average Total Incurred for Claims Associated with Sedation-Related Injuries

Closed Claims with Paid Indemnity ≥ $10,000

Level of Anesthesia	Average Total Incurred with Sedation-Related Injury
Minimal sedation	$0
Moderate sedation	$428,155
Deep sedation/ General anesthesia	$481,924

Case Study 9. A 55-year-old male required extraction of a mandibular second and third molar. He desired sedation and it was agreed upon by his dentist due to surgical difficulty. His medical history included smoking, obesity, type 2 diabetes, and cardiovascular disease. On the day of surgery, midazolam was administered intravenously to achieve the desired moderate sedation level. Near the end of the 40-minute procedure, the patient's oxygen saturation dropped, and he became unresponsive. Flumazenil was administered, arousing the patient who then became combative. However, his oxygen levels continued to drop. Emergency medical services (EMS) was called, and resuscitation efforts were attempted, but the patient expired approximately one hour later. The family filed a lawsuit alleging inadequate medical assessment, failure to consult the patient's physicians, inadequate monitoring, and failure to timely contact EMS. Defense experts were unsupportive for several of these reasons, leading to a settlement at policy limits, with total incurred costs exceeding $1,000,000.

Case Study 10. A 42-year-old male with a BMI >40 and severe dental anxiety presented for an extraction and anterior restoration. The dentist administered triazolam, morphine, and promethazine at or above FDA maximum doses for unmonitored home use. Although minimal sedation was intended, the medication combination, and doses greater than the FDA maximum for unmonitored home use, meet the ADA sedation guideline definition for moderate sedation. The patient became apneic and non-responsive during treatment. EMS transported the patient to the hospital, where he later expired. The spouse filed a lawsuit, alleging over-sedation, failure to seek medical consultation, and non-compliance with sedation guidelines. Discovery revealed that the patient failed to disclose a cardiac condition with accompanying treatment by a cardiologist. Defense experts stated that office sedation was contraindicated due to BMI and presence of a cardiac condition. Despite the patient's withholding of information, the experts opined that a prudent dentist should have ruled out significant health issues (diabetes, sleep apnea, cardiovascular disease, and others) via medical consultation. The dentist was unaware of state permit requirements for oral sedation and did not comply with current clinical guidelines or state requirements for patient monitoring and emergency care preparedness. The total incurred cost after settlement was $1,100,000.

* Review the ADA 2016 Guidelines, page 2 for situations in which intended minimal sedation is categorized as moderate sedation (moderate sedation recommendations apply). All sedation cases were categorized as minimal, moderate, or deep sedation by one reviewer, consistent with ADA and other applicable clinical practice guidelines.

Analysis of License Protection Matters

In this analysis, there were 1,719 closed license protection (LP) matters in the 3rd Edition dataset. License protection matters involve the defense of the insured dentist before a regulatory agency or state dental board. License protection matters include the cost of providing legal representation to defend the dentist during the investigation, whereas professional liability claims may include an indemnity and/or settlement payment. A Spotlight on License Protection Matters will expand upon this overview.

- The average defense payment increased 9.5 percent since the 2nd Edition report from $4,428 to $4,847.
- The top four license protection allegations by distribution in the 3rd Edition dataset are represented in **Figure 9**, highlighting limited variation from the 2nd Edition. By far, the most frequent license protection complaints involve improper treatment/care. The top examples of this allegation include improper or negligent restorative treatments or surgical techniques.
- Dental crowns represent the procedure most often associated with improper treatment/care allegations, at 31.0 percent of restoration complaints. For complaints involving surgical treatment/care, implant placement surgery is the most frequent procedure cited, at 30.7 percent.
- Professional conduct complaints increased by 3.4 percent, and the average defense/expense payment rose substantially by 77.5 percent from $3,328 to $5,906. Professional/personal misconduct and other regulatory/legal noncompliance (e.g., failure to release patient records) comprised the majority of these complaints. Only complaints associated with clinical oral examination and diagnosis experienced a greater increase in the average defense/expense payment from $3,684 to $7,527 (104.3 percent). The top complaints related to examination/evaluation/diagnosis include wrong diagnosis, failure to diagnose and failure to complete a proper patient assessment.

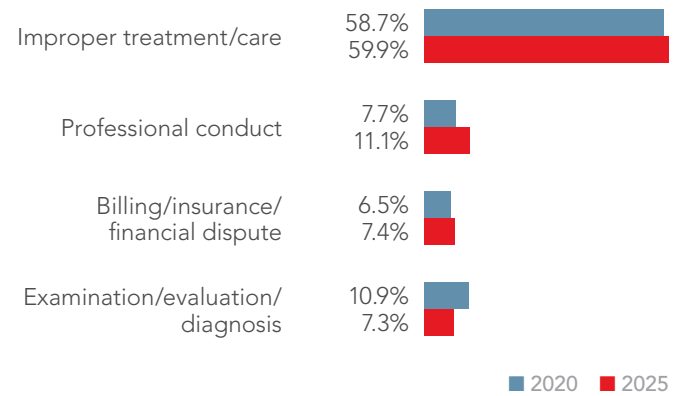
Licensing Board Actions/Outcomes

The Licensing Board outcomes by distribution are displayed in **Figure 10**. There was an increase in the outcomes of closed – no action as well as fines in the 3rd Edition of the report.

- The proportion of LP matters that closed with board disciplinary action decreased from 25.4 percent to 20.0 percent.
- Although the percentage of LP matters that closed with no action increased by 5.4 percent by distribution, the average defense payment for those matters increased by 22.1 percent, from $3,180 to $3,882.

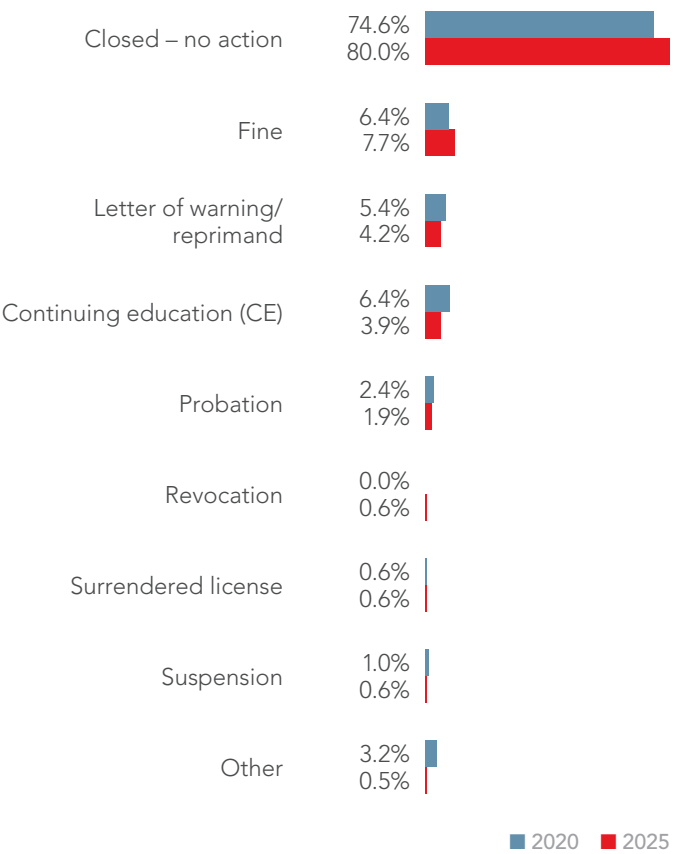
9 Distribution of License Protection Matters by Top Allegations

Closed License Protection Matters with Paid Expense ≥ $1



10 Distribution of Licensing Board Outcomes

Closed License Protection Matters with Paid Expense ≥ $1



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Published 10/2025.