Dental Professional Liability | Clinical Treatment

Periodontics

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the Dentist's Advantage website.

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

Risk management content and resources are provided for illustrative purposes only. The information is intended to provide only a general overview of the matters discussed and is not intended to establish any standards of care.

The information, examples and suggestions presented in this material have been developed from sources believed to be reliable, but they should not be construed as legal or other professional advice regarding any particular situation.

CNA accepts no responsibility for the accuracy or completeness of this material and recommends the consultation with competent legal counsel and/or other professional advisors before applying this material in any particular factual situations.

Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. All products and services may not be available in all states and may be subject to change without notice. All references to dental claim data refer to CNA claim data.

Any references to non-CNA Web sites are provided solely for convenience, and CNA disclaims any responsibility with respect to such Web sites.

Periodontics

Most professional liability claims pertaining to periodontics allege a failure to diagnose, failure to inform, failure to refer, or failure to treat. Adverse events during treatment and the failure of either surgical or non-surgical therapy produce few claims. The majority of periodontal claims are alleged against general dentists. As the majority of the dentists we insure are general practitioners, this data is anticipated. Claims against periodontists reflect the surgical nature of their practices and include claimed injuries such as post-surgical infection and paresthesia.

Claims based upon periodontal disease frequently have a number of characteristics in common. First, the claimant has already left the practice or been seen by a subsequent treating dentist. It is often the diagnosis of periodontal disease by a new dentist, accurate and correct as it may be, that leads the patient to conclude that the diagnosis also should have been made by the former dentist.

Second, the alleged act or omission did not occur recently. Most periodontal claims involve an alleged delay in diagnosis or treatment that led to the claimed injuries. Although the patient may have had a recent recall exam, allegedly at which no diagnosis was made, the claim will typically focus on an exam performed years earlier as the beginning of the dentist's culpability. Not surprisingly, most dentists have no recollection of the discussion from the prior appointment years ago. Therefore, the dentist must rely on the comprehensiveness and accuracy of clinical records and notes. Remember that the statute of limitations, the patient's legal window within which to file a lawsuit, varies by state and can extend for many years.

These characteristics differ from claims arising from many other procedures, such as extractions, whereby patients become aware of their condition soon after treatment and without an evaluation, diagnosis, or commentary from a subsequent dentist.

Other periodontal claim allegations include:

- Improper treatment performed – the periodontal treatment performed was not appropriate for the patient's periodontal case type or status
- Procedure performed incorrectly
  - Post-surgical infection
  - Post-surgical bleeding
  - Post-surgical paresthesia/dysesthesia
  - Inadequate osseous reduction or recontouring
  - Need to repeat root planing or surgical treatment

Theories of Liability

Although there may be only slight differences of opinion within the dental profession as to how to appropriately treat certain conditions, wide disparity among practitioners about the diagnosis and treatment of periodontal disease may exist. The standard of care is a legal term, rather than a clinical description. It may include not only one treatment modality but a variety of treatments which may be practiced by reasonably prudent dentists for the same condition.

Failure to diagnose

The expectation of every patient is that the dentist will thoroughly examine both the hard and soft tissues of the mouth, formulate a diagnosis, inform the patient of his or her clinical findings, and recommend appropriate treatment. The American Academy of Periodontology describes a number of clinical factors that must be assessed for the dentist to arrive at a periodontal diagnosis. They include:

- Presence or absence of inflammation (usually exhibited by bleeding upon probing)
- Probing depths
- Extent and pattern of loss of periodontal attachment and bone
- Medical and dental history
- Other signs and symptoms, such as distribution of plaque and calculus, pain, and mobility

Additional contributing factors are the patient's age, the presence or absence of purulence upon probing, proximal tooth contact relationships, the presence or absence of malocclusion, and the condition of dental restorations and prosthetic appliances.

A contemporaneous patient record documenting that the examination corresponded to the clinical findings listed above provides a strong defense that the dentist performed an acceptable periodontal examination. Documentation in the patient's dental health information record concerning any additional clinical information and that all findings were discussed with the patient, including the patient's response to the findings, would further strengthen the defense in the event of a professional liability claim.

In most failure to diagnose cases, the dentists insist that they made a complete and accurate diagnosis, that they tried to refer, and that they attempted to treat. They also state that the patient was informed at every stage and that the patient knew about the deteriorating periodontal condition. Dentists note that the patient refused to see a periodontist. As a result, they continued to examine the patient at each recall, but the patient eventually stopped listening. Then, at some later time, the patient's condition deteriorated, and the patient seemed incredulous. Or, the patient visited another dentist and suddenly became willing to participate in a comprehensive course of periodontal treatment.

Notice that the preceding paragraph indicated that the dentist made various statements about the treatment and the patient. However, it does not indicate that the dentist's record supported the statements. The reason that *many "failure to diagnose" claims result in a settlement or judgment against an insured dentist is the dentist's failure to document.* The best defense to a failure to diagnose claim is a comprehensive patient record that reflects the patient's periodontal status.

The current standard of care for oral examinations includes a periodontal diagnosis, well supported by documentation of clinical findings, including recall and initial examinations. A comment about the patient's oral hygiene habits, such as "OH fair," does not reflect the presence or absence of periodontal disease, nor your diagnosis. It represents a good supplemental note, but a comprehensive periodontal examination and diagnosis with supporting documentation (periodontal probing, presence or absence of disease signs and related clinical findings), is required to comply with current professional standards.

Failure to refer

The duty owed to each patient includes a timely referral whenever the required care is beyond your training, experience or expertise. Concerning periodontal disease, the referral dentist would most likely be a periodontist. If you wish to refer a patient with periodontal disease to someone who is not a periodontist, you should inform the patient that although your referral is not a periodontist, you commonly refer to him or her. However, the patient should be given the option of seeing a periodontist.

The timing of the referral is often of great importance in a lawsuit. Was the patient referred immediately when it was believed that the patient's needs exceeded the dentist's professional skills, or was there procrastination, allegedly causing the patient's condition to further deteriorate?

Your referral discussion with the patient should be documented thoroughly, emphasizing your message to the patient as well as the patient's response and understanding of his or her condition. Patients also may wish to hear what you believe the periodontist will do.

No rule demands patient referral out of your practice. If you feel competent treating periodontal disease, no law or ethical standard prohibits you from doing so. However, in a lawsuit asserting that your periodontal care breached the standard, expect your care to be held to the standards of a periodontist. The expert who will testify in court on behalf of the plaintiff will probably be a periodontist, subject to applicable expert witness requirements of the venue in which the case is tried. Therefore, it is a prudent practice to treat only those cases within your clinical expertise.

Improper procedure performed

A periodontal claim alleging an improper procedure was performed typically arises after a subsequent dentist informs the patient that he or she was mistreated in some way. Some patients will seek a new dentist if they believe your treatment was too expensive or simply unsuccessful. Others may seek a second opinion of diagnosis and treatment options to enhance their understanding even during your successful treatment. Claims may arise after surgical or non-surgical periodontal therapies.

This allegation often surfaces after the patient is told by a subsequent dentist that non-surgical therapies, which you were directing, are less effective than a surgical approach. The patient feels cheated or misled, especially if the patient's relationship with you was less than perfect. Although numerous studies have been published demonstrating the strengths and weaknesses of these conflicting therapeutic approaches, the patient has little access to this research and limited understanding of the concepts and principles involved. Informational pamphlets may be helpful in assisting the patient to better understand periodontal disease and its treatment options.

A number of risk management strategies can be utilized. These include keeping abreast of current scientific knowledge, maintaining good communication with your patients, practicing informed consent principles, including a discussion of the available treatment options, and fully documenting your rationale, treatment, and communication in the patient's record. Also, be diligent when considering *new* diagnostic or treatment methods for periodontal disease or other conditions. Such advances are critical to improving patient care. Nevertheless, you should understand the evidence (or lack of evidence) available for the products and/or techniques being promoted or proposed. Informed consent should address this information so that the patient is able to understand the benefits, risks and prognosis associated with proposed options.

Refusal of Periodontal Treatment or Referral

A patient who refuses either your periodontal treatment recommendation or your periodontal referral presents you with two choices. You may continue to treat the patient – within certain parameters – or you may dismiss the patient from your practice due to noncompliance. There is no right or wrong decision, simply a matter of preference that is informed by your assessment of the risks.

Each choice presents some level of risk to your practice. If you decide to continue treating, you risk the possibility that at some point in the future, the patient's periodontal condition may not be adequately evaluated or documented. If you dismiss the patient, you risk alienating him and having his ill will spread to other patients he knows. Base your decision on factors such as the quality and longevity of your dentist-patient relationship, the nature and urgency of the recommended periodontal treatment, and the overall financial impact on your practice.

The dentist who opts to retain the refusing patient in his or her practice and continue with care must be aware of several additional duties that emanate from the patient's informed refusal. These duties apply in addition to having informed the patient regarding the risks of refusing the recommended periodontal treatment.

They include:

- A continued duty to *examine* and *diagnose* the patient's periodontal condition for the duration of the dentist-patient relationship and as long as the patient continues to refuse either periodontal treatment or a periodontal referral
- A continued duty to *inform* the patient about his or her periodontal status and the associated risks throughout the dentist-patient relationship, the presence of the periodontal condition, and the patient's continued refusal of treatment
- A heightened duty to tell the patient how the refusal of periodontal treatment may affect treatment of other structures or the overall treatment plan
- Refusing to agree to a patient's ill-advised demand for other dental treatment may be necessary and/or prudent from a risk management perspective. For example, placing crowns or bridges on teeth with poor periodontal support may breach the standard of care, depending upon specific circumstances. In any event, restoration failures in these situations often lead to a patient demand for a refund, or the filing of a professional liability claim.
- The failure to meet these obligations has resulted in *failure to diagnose, failure to inform,* and *failure to treat* allegations. A claim of this nature may involve a patient who refuses scaling and root planing but is agreeable to return on a regular basis for debridement by the hygienist. Since the patient has not demonstrated an interest in improving his periodontal health, the dentist does not emphasize periodontal concerns during periodic recall visits. As the periodontal condition worsens over time, the dentist neither probes the periodontium nor documents in the progress notes anything about the patient's periodontal status.

CNA claim professionals have noted that the patient health information records in these claims typically lack periodontal chartings and/or documentation of having informed the patient of disease status. The risk to the dentist lies in the absence of regular evaluations and disclosure to the patient, and/or the lack of documentation of these actions, even if performed. These claims are based upon the patient's lost opportunity to reconsider a treatment refusal decision based upon updated information from the dentist.

Periodontal care refusals represent an increased liability risk and require greater diligence on your part to manage that risk. The most effective technique is to comprehensively document the informed refusal process as outlined in the "Informed Refusal" section of this workbook. It includes the use of an informed refusal form in conjunction with comprehensive note writing. *Please refer to page IX for information about access to risk management forms.*

Managing the Risks of Periodontal Treatment

Recognizing risk factors

The risk of a poor periodontal outcome, or a dissatisfied patient, is increased in these circumstances:

- Patients who are noncompliant with home care, treatment recommendations, or referrals
- Patients with whom you have encountered prior treatment difficulties, whether surgical or non-surgical
- Patients with significant medical conditions or co-morbidity factors, such as cardiac disease, diabetes, tobacco use, eating disorders, and bruxism
- Patients who present other patient management difficulties, such as failure to follow medical advice and failure to keep follow-up appointments
- Patients with unusual periodontal topography
- Refractory cases
- Patients with significant esthetic concerns and expectations

Please refer to page IX for information about access to a sample form on "Discussion and Refusal of Periodontal (Gum) Treatment."

Controlling the risks

Controlling the risks of periodontal diagnosis and treatment requires a multifaceted approach that includes clinical skill and attention, good communication, and comprehensive record keeping.

Clinical

- Perform comprehensive initial and recall periodontal examinations on each patient. Document your findings using periodontal charting forms and descriptive, thorough progress notes. Remain current on periodontal disease diagnosis and classification. (Disease classifications updated in 2017-18 by the American Academy of Periodontology (AAP): refer to the AAP website section on clinical and scientific papers.)
- Obtain appropriate radiographs to aid diagnosis. The AAP has stated that intraoral radiographs, such as periapical films and vertical or horizontal bitewings, provide information about the periodontium that cannot be obtained by other non-invasive means. However, the AAP also states that radiographs routinely underestimate bone loss and that the diagnosis of periodontal diseases is almost entirely based upon traditional clinical assessments.
- Treat cases within your clinical expertise.
- Prior to surgery, assess the patient's physical condition and ability to tolerate the procedure.
- For surgical patients, record the patient's blood pressure prior to administering local anesthesia. Patients with dangerously elevated or depressed pressures should have treatment deferred, if possible, and should be referred to their physician for evaluation.
- Refer in a timely manner, when appropriate, to competent clinicians, under the following circumstances:
  - Complex surgical cases
  - Cases with potential complications that exceed your expertise or comfort level
  - When a patient does not respond to your care
- Plan your incision and flap design before picking up the scalpel.
- Use sound clinical judgment during treatment.
- Require patients to return for postoperative evaluation.
- Recall patients for periodontal maintenance therapy in a timely and efficient manner.
- Have a specific protocol for responding to patients who refuse to follow your recall schedule, including the possibility of termination from your practice when the time period between recalls reaches a point that endangers a patient's oral health.

Communication

- Inform the patient of your clinical findings and your recommended treatment.
- Provide the patient with truthful and informative guidance. Don't avoid the issue of periodontal disease or periodontal deterioration in order to avoid upsetting the patient.
- Manage the variety of patient understandings and expectations regarding diagnosis and treatment.
  - Ask patients what they want and/or expect to occur during the course of treatment.
  - Inform patients what to realistically expect during treatment and postoperatively.
  - Inform patients how their periodontal diagnosis and treatment affects their ability to achieve desired restorative treatment goals.
- Perform only those periodontal procedures for which you have the patient's informed consent. Explain the diagnosis, nature of treatment, any alternative treatments, and the risks, benefits and potential complications of the various treatment options.
- Don't make treatment decisions for patients. If you diagnose the need for periodontal treatment or referral, inform the patient and permit the patient to say "yes" or "no," even if you believe you know the answer.
- Provide clearly written postoperative instructions and information, including how to reach you after hours and how you will manage the patient's postoperative follow-up.
- Explain to the patient any reason(s) for referral.
- Use a comparison of recall chartings to baseline chartings to educate patients regarding the necessity for referral upon recall.

Documentation

- Complete a preoperative periodontal chart (*not* only a PSR screening) for *all* patients undergoing periodontal therapy, especially root planing and surgical treatment.
- For repair procedures such as connective tissue, free gingival, and pedicle grafts, document the location of and necessity for the surgical procedure. Document the location of the *donor site* as well, including appearance before surgery and healing after surgery. Clinical photography may be beneficial for before/after images as well.
- Document in the patient healthcare information record that you have informed the patient of your diagnosis of periodontal disease and your recommended treatment.
- At recall and maintenance visits, update your periodontal charting and write a progress note that describes your clinical findings, your updated diagnosis, and your updated periodontal treatment plan.
- If a referral is made, document in the patient healthcare information record the reason(s) for referral and the fact that you have informed the patient of the need for referral.
- Maintain accurate and consistent records. Ensure that your billing and insurance processing descriptions correlate with progress notes.
- Thoroughly document any patient's informed refusal of your treatment recommendation or referral by using an informed refusal form coupled with a comprehensive progress note.
- Create a chart entry concerning refusal of care at *every* subsequent visit when you discuss the issue with your patient, irrespective of the time frame between visits.

Please refer to page IX for information about access to a sample form on "Discussion and Consent for Periodontal (Gum) Treatment."

Comprehensively **document** any patient's **informed refusal** of your **treatment recommendation or referral** by using an informed refusal **form** coupled with a comprehensive **progress note**.

For more information call Dentist's Advantage at 888-778-3981, or navigate to the Dentist's Advantage website Risk Management section.

In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

Republished 12/25.