CNA HealthPro

When Your Patient Refuses

It happens to every dentist from time to time. You provide your patient with a thorough explanation of the treatment he needs and how it will benefit him, only to have him refuse to accept or follow your recommendation. Most refusals are based on finances or fear, although other factors may also be involved.

Not every patient refusal is the same when it comes to managing risk. Some declinations create manageable risks, while others place the dentist in an untenable position. A critical distinction is whether or not it was an *informed* refusal.

An informed refusal is essentially the opposite of an informed consent in that the patient has said "no" to the procedure instead of "yes." The information presented to the patient is the same for both processes, until the patient declines the recommendation. From that moment on, the dentist is required to share even more knowledge with the patient.

Why informed refusal is important

Numerous malpractice lawsuits have been filed against health care providers by patients who claimed that, upon suffering a serious injury after refusing care, they did not fully understand the potential consequences of such refusal. In a typical situation, a patient alleges that the health care provider was negligent in not fully disclosing the risks of treatment refusal. Coupled with this allegation is the assertion by the patient that he would have consented to the procedure or treatment if only the risks of refusal had been properly and completely explained by the health care provider.

Becoming "informed"

Before addressing informed refusal specifically, we must begin with the process through which a patient becomes informed enough to make an educated decision about your treatment recommendation.

All states require that a patient provide a dentist with his or her informed consent before each evaluation or treatment is started. It is also necessary that the consent be given without coercion or fraud, based upon the patient's reasonable understanding of what will take place. Informed refusal requires the same level of information and understanding by the patient as does informed consent.

We encourage dentists to consider the informed consent process an educational experience, with the patient as the student and the dentist as the teacher. (Although staff members, brochures, and electronic equipment can assist in educating the patient, the ultimate responsibility for ensuring the patient is informed rests with the dentist.) To be considered "informed," the patient must be able to pass a "quiz" of understanding and answering three basic questions:

1. What treatment is proposed and why has it been recommended?

2. What other choices do I have?

3. What bad things might happen as a result of the proposed treatment?

These questions relate to the three main components of the doctrine of informed consent, which requires that the patient be given sufficient information about, and consider:

- the *nature* of the proposed treatment, which includes the necessity for treatment (your diagnosis), the benefits of treatment, the prognosis of treatment, time involved, and cost

- reasonable *alternatives* to the proposed treatment, which also includes the alternative of not having treatment (when an option), and the choice of a specialty referral when the proposed treatment falls within what a specialist would normally perform in that specialty

- the *risks* and potential complications of the proposed treatment that have a reasonable likelihood of occurring, and in which a reasonable person would be assumed to take an interest

The quiz questions are intended to measure whether the patient has a sufficient understanding about the proposed treatment to make an informed choice about whether or not to proceed. Consequently, a patient who passes the quiz can generally be considered informed. The next step is for the patient to state his desire to either pursue or decline the proposed treatment.

The patient has a legal right to decline your treatment recommendation and refuse care. If this occurs, you must explain to the patient the consequences and foreseeable risks of refusing treatment. Also ask about the patient's reasons for refusing care. If the patient states, or if it appears, that the refusal is due to a lack of understanding, re-explain your rationale for the procedure or treatment, emphasizing the probable consequences of the refusal.

The dentist's disclosure of the consequences of the refusal is a critical aspect of the informed refusal process. For example, a patient who declines scaling and root planing must be informed of the progressive nature of periodontal disease and that his condition will worsen more quickly without treatment. A patient who declines to have impacted #32 removed must be informed of risks such as follicular enlargement leading to bone destruction, pain, pathologic fracture, and nerve damage. If the patient still refuses to accept your treatment recommendations after you have communicated the risks of refusing treatment, then the patient has given an *informed refusal*.

Retain or dismiss?

A patient who has refused your treatment recommendation presents you with two choices. You can continue to treat the patient – within the outline of the parameters to follow – or you may dismiss the patient from your practice due to noncompliance. There is no right or wrong decision, simply a matter of preference.

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

Continuing duties

The dentist who chooses to keep the refusing patient in his or her practice and continue with care must be aware of several additional duties that stem from the patient's informed refusal. These duties are in addition to having informed the patient regarding the risks of not having the recommended treatment.

They include:

- A continued duty to *examine* and *diagnose* the patient's condition for as long as the dentist-patient relationship exists and for as long as the patient continues to refuse treatment

- A continued duty to *inform* the patient about the condition and its associated risks for as long as the dentist-patient relationship exists, the condition exists, and the patient continues to refuse treatment

- A heightened duty to tell the patient how the refused treatment might affect treatment of other structures

The failure to meet these obligations has resulted in numerous *failure to diagnose* and *failure to inform* allegations. The good news is that we at CNA are seeing fewer of these allegations than we were in 1990. A typical claim of this type involves 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 is not particularly interested in improving his periodontal health, the dentist does not emphasize periodontal concerns during regular 6-month recalls. He neither probes the periodontium nor documents in the progress notes anything about the patient's perio status.

After a few years, the patient complains of a worsening of his periodontal status, including increased bleeding and progressive mobility of teeth. Upon hearing a renewed complaint by the patient, the dentist finally reevaluates the periodontium, only to find it has progressed from a Type II case to a Type IV case. The patient now has severe bone loss and needs multiple extractions. Incredulous at the news, the patient questions how his mouth could have gone from needing a "gum scraping" to multiple extractions without the dentist ever saying a word about it.

Our claims specialists find these claims commonly are without any recall perio chartings or documentation of having informed the patient of his status. The risk to the dentist lies not in the continuation of the dentist-patient relationship, but in the absence of regular evaluations and disclosure to the patient and of documentation of these actions.

Documentation of informed refusal

Refusals of care represent an increased liability risk and require greater diligence on your part to manage that risk. The most effective technique is to thoroughly document the informed refusal process. Criteria for documenting informed refusals are similar to, but go beyond, those for informed consent. Following a discussion of the consequences, we strongly recommend a comprehensive progress note as well as the use of a written form documenting the refusal. Your progress note should document:

- What treatment was discussed

- What educational documents, brochures, handouts, or presentations were given to or viewed by the patient

- What questions were asked and what answers were given (by both parties)

- That the patient refused the recommended care

- That the patient was informed of the risks of not following your recommendations

- The patient's reasons for refusal

- That the consequences of refusal were re-explained and that the patient still refused the recommended treatment. Emphasize that the patient understood the risks of refusing care.

- Who was present

As noted, we also encourage the use of an informed refusal form, as shown on pages 6-7. Most patients do not remember all that they were told during the informed consent/refusal discussion, making written forms a valuable reminder to both the patient and the dentist. A written form also helps manage patient expectations, provides further documentation of the disclosure of information, and deters claims of negligence alleging a lack of informed consent or informed refusal.

Fill out the form, paying particular attention to the section titled "Risks Of Not Having The Recommended Treatment." Then ask the patient to sign it. Some patients will change their minds and agree to treatment when presented with a written document and an insistence on their signature. Although the documentation process is not necessarily designed to persuade patients into accepting treatment, these individuals will ultimately be better off for having received the proper care.

Of the patients who still refuse your treatment recommendation, some will sign the form, while others will not. While it is preferable to have the patient's signature, don't fret if you can't obtain it. Sign the form yourself and have the staff member who witnessed the discussion and disclosure sign it as well. Regardless of whether or not the patient signed the form, place the original in the patient's chart and give a copy to the patient. Your signatures on the form, along with your progress note, will demonstrate that a discussion took place and an informed refusal was given.

The documentation process for informed refusal doesn't end after the first refusal. You should make a chart entry concerning refusal of care at *every* subsequent visit when you discuss the issue with your patient, no matter how much time has elapsed between visits. If your findings and recommendations are the same as when the informed refusal form was last filled out, simply sign it again with the new date. If your findings or treatment recommendations have changed, then fill out a new form that includes the updated information.

Refusing radiographs

A common refusal heard in dental practices today is, "Doctor, I don't want any x-rays taken." While it may seem that the refusal of radiographs is no different than the refusal of endodontic treatment, there is a significant difference between the two situations.

Let us assume the patient in need of endodontics has been examined, both clinically and radiographically, and that his dentist has explained the nature of the proposed treatment (necessity, benefits, prognosis, time, cost), the reasonable *alternatives* to the proposed treatment (including specialty referral and extraction), and the *risks* and potential complications of the proposed treatment (due to a pulp stone in the canal or dilaceration of roots). This patient has been presented with enough information to be considered *informed* regarding his decision making process.

Conversely, the patient who refuses radiographs will never be able to consider some of these factors because his dentist is unable to identify and disclose them. The patient may give his consent for endodontics in the absence of a radiograph, but it would not likely be deemed an *informed* consent. This fact would be problematic if a claim arose.

Additionally, the standard of care in dentistry requires a preoperative radiograph for most forms of treatment. To test this assumption, we have asked thousands of dentists at our risk management seminars if they believe it is necessary for a dentist to radiographically evaluate a tooth before treatment such as endodontics, an extraction, or a crown is performed. Their answer has always been a resounding "yes," since the failure to obtain necessary diagnostic information would constitute a breach of that standard by the dentist.

Therefore, a reasonable and prudent dentist should decline to treat any patient who refuses *necessary* diagnostic radiographs, rather than jeopardize the patient's health. The refusal of necessary radiographs is also a valid reason for dismissing an existing patient from your practice.

Even if the patient offers to sign a release of liability absolving you of responsibility, the most prudent action is to refuse to treat the patient. If you decide to proceed, you – not the patient – will be taking the responsibility for any poor outcome. A patient cannot consent to a negligent act and thereby waive the dentist's professional duty to practice at or above the standard of care. If a dentist knows that a sequence of treatment, such as the omission of preoperative radiographs, does not meet or exceed the standard of care, proceeding with that treatment would constitute negligence, regardless of any consent or assurances given by the patient. Numerous defense attorneys have opined that dentists who have obtained such releases have simply documented their poor judgment in a written form for use by the plaintiff.

If you decide you must perform treatment without a necessary diagnostic radiograph or test, document all of the diagnostic information you did use (patient symptoms, periodontal evaluation, hot and cold test, percussion, palpation, observation, electrical stimulation, etc.), your complete differential diagnosis, and all circumstances surrounding the failure to secure the required diagnostic. Proceeding with treatment is riskier than declining to treat the patient, making your documentation all the more important.

Summary

Refusals of care are a fact of life in dentistry. Following the above risk management guidelines will not guarantee that you will never be sued for failure to properly inform the patient of the risks of refusing care. However, the adequate quantity and good quality of your documentation will greatly benefit your defense of any claim.