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Periodontal Disease: Pitfalls and Strategies

Professional liability claims pertaining to periodontics most commonly allege 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. This is statistically expected, considering that the majority of U.S. dentists are general practitioners. Claims against periodontists reflect the surgical nature of their practices and include claimed injuries such as postsurgical infection and paresthesia.

Claims based on periodontal disease frequently have a number of characteristics in common. The first is that 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 should also have been made by the former dentist.

The second is that the alleged act or omission did not occur recently. Most perio 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 conversation 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 to file a lawsuit – varies from state to 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.

Theories of liability

A patient that alleges malpractice must show that the dentist fell short of the standard of care, no matter how comprehensive or current the diagnostics and therapies were. The standard of care of periodontal diagnostic and treatment techniques is established in the same way as standards for other types of procedures. A jury, after listening to experts, determines the appropriate standard as that which a reasonably prudent dentist would do.

Although there may be only slight differences of opinion within the dental profession as to how to appropriately treat certain conditions, there can be wide disparity among practitioners about the diagnosis and treatment of periodontal disease.

The standard of care is a legal term. 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 your clinical findings, and recommend appropriate treatment. The American Academy of Periodontology's *Position Paper: Diagnosis of*

Periodontal Diseases (Journal of Periodontology, August 2003) lists 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, mobility

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

Should a dentist be charged with failure to diagnose periodontal disease, a contemporaneous patient record documenting that the examination corresponded to the clinical findings listed above should provide a strong defense that the dentist performed an acceptable periodontal examination. Documentation in the patient's record concerning any additional clinical information would further strengthen the defense.

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 insist that the patient was informed at every step and that the patient knew about the deteriorating periodontal condition. They say that the patient refused to see a periodontist. The dentists say that they continued to examine the patient at every recall, but that the patient eventually stopped listening. Then, at some later time, the patient's condition deteriorated, and the patient seemed shocked. 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 "said" all of these things about the treatment and the patient. What it does not indicate is that the dentist's record supported the statements. Many failure to diagnose claims actually involve a failure to document. The best defense for a claim of failure to diagnose is a comprehensive patient record that documents the patient's periodontal condition.

Today's standard of care for oral examinations includes complete diagnosis and documentation of the periodontal status. This includes recall as well as 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 is a good supplemental note, but it fails to suffice for the complete treatment note.

Be certain what you say to the patient is truthful and informative. Don't avoid the issue of periodontal disease or periodontal deterioration in order to prevent upsetting the patient. It is also important that you let the patient make his or her own treatment decision. Once you diagnose the need for periodontal treatment or referral, explain the reasons and treatment plan to the patient and let the patient decide yes or no, even if you think you know the answer.

Patients will have a variety of understandings and expectations regarding their diagnosis and treatment. The patient desiring anterior veneers likely doesn't have periodontal treatment high on her wish list, if at all. Consequently, it is important that patients be asked what they want as an end result and what they expect to occur during the course of treatment. This is your chance to manage their expectations by informing them what to realistically expect during treatment and postoperatively and how their periodontal diagnosis affects their chance of being able to achieve the desired treatment goals.

Failure to refer

Each dentist has a duty to provide appropriate care to patients of record. This responsibility includes the timely referral of a patient whom you believe requires care that is beyond your training, experience or expertise to a dentist who can appropriately treat the patient. Concerning periodontal disease, the referral dentist would most likely be a periodontist, or, on occasion, a general dentist with an affinity for and advanced expertise in periodontal therapies. Should you wish to refer a patient with periodontal disease to someone who is not a periodontist, you should inform the patient that although your choice is not a periodontist, you commonly refer to him or her. It would be prudent to give the patient the option of seeing either a periodontist or your referral dentist.

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 may also wish to hear what you believe the referral dentist or periodontist will do.

There is no absolute rule that demands referrals to specialists. If you feel competent treating periodontal disease in your practice, there is no law or ethical standard that prohibits you from doing so. However, in a lawsuit alleging that your care breached the standard, expect your care to be held to the standards of the appropriate specialist that customarily provides similar care (in this instance, 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 good practice to only treat those cases within your clinical expertise.

Develop protocols to assess when a referral recommendation would be appropriate. A common determinant is the need for periodontal surgery, a procedure most general practitioners refer out. Other patient presentations to consider for referral are refractory cases, cases with potential complications that exceed your expertise or comfort level, patients with complex medical histories, and those patients that do not respond to your care. You might also choose to refer certain patients based on non-clinical factors, such as their level of pain tolerance or their expectations for treatment outcomes.

Whenever a referral is made, document in the patient record the reason(s) for referral and the fact that you have informed the patient of the need for referral. It is often helpful to use a comparison of recall chartings to baseline chartings to educate patients regarding the necessity for referral upon recall.

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

If your patient refuses to follow through on your referral, you are left with the choice of either dismissing the patient from your practice or continuing to treat, notwithstanding the fact that you have already determined the extent of your care does not fully meet their treatment needs. The former decision requires thorough documentation to defend a potential abandonment claim. The latter requires thorough documentation that you did your best to persuade the patient to follow through with the referral, and that the patient refused. An informed refusal form, signed by you, a witnessing staff member, and the patient is recommended in such cases. Be certain to document that the patient has been informed of the potential consequences of their refusal. Additional attempts to persuade the patient to reconsider his or her refusal should also be documented in the patient's chart at each subsequent visit. See the accompanying article "The Refusal of Periodontal Treatment and Periodontal Referrals" for more information.

Improper procedure performed

An improper procedure performed claim involving periodontal disease typically arises after a subsequent dentist informs the patient that he or she was mistreated. Some patients will seek a new dentist if they believe your treatment was too expensive or unsuccessful, while some may seek a second opinion of

diagnosis and treatment options to enhance their understanding and sense of self-determination, even during your successful treatment. Claims may arise after surgical or nonsurgical periodontal therapies.

This allegation often surfaces after the patient is told by a subsequent dentist that nonsurgical therapies, which you were directing, are less effective than a surgical approach. The patient may feel cheated or misled, especially if the patient's relationship with you was less than ideal. Although numerous studies have been published demonstrating the strengths and weaknesses of these opposing 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.

Risk management to minimize the potential for periodontal disease claims alleging improper procedure performed includes keeping abreast of current scientific knowledge, maintaining good communication with your patients, practicing informed consent principles, and fully documenting your rationale, treatment, and communication in the patient's record.

Recognizing risk factors

Our experience handling professional liability claims arising from periodontal treatment (or lack thereof) provides insight regarding cases that present a heightened risk. We have found 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
- Surgical treatment of patients with whom you have encountered prior surgical difficulty
- Patients who present other patient management difficulties, such as failure to follow medical advice, failure to keep follow-up appointments, etc.
- Patients with unusual periodontal topography
- Refractory cases
- Patients with significant esthetic concerns and expectations

Controlling the risks

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

Among the most effective steps you can take to control your risk is to perform comprehensive initial and recall periodontal examinations on each patient and to document your findings. A critical aspect of the evaluative process is obtaining appropriate diagnostic radiographs. (The American Academy of Periodontology has stated the position that a panoramic and bitewing survey is not diagnostic for periodontal disease.)

Every patient undergoing periodontal treatment should have a diagnosis based on a preoperative periodontal charting, *not* just a PSR screening. 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. Also document in the patient record that you have informed the patient of your diagnosis of periodontal disease and your recommended treatment.

Noncompliant patients and those with a deteriorating periodontal condition require especially thorough documentation. Also, your records should reflect your consistent and continual communication and recommendations and include the patient's responses. The more thorough and accurate the patient's record is, the stronger the defense will be, if needed.

Each periodontal patient must give his or her informed consent prior to treatment. An informed consent discussion pertaining to periodontal treatment should include an explanation of the diagnosis, the proposed treatment, any alternative treatments available, and the risks, benefits and potential complications of the various treatment options. The patient should be given the opportunity to ask questions. The discussion should also include the importance of good oral hygiene, and the discussion of fees. The goal of an informed consent discussion should be a well-informed, compliant patient who agrees with the proposed treatment. All aspects of the informed consent discussion should be thoroughly documented in the patient's chart, or on an informed consent form, or both.

Prior to performing periodontal surgery, assess the patient's physical condition and ability to tolerate the procedure. Be certain to 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. Following treatment, give patients clearly written postoperative instructions and information, including how to reach you after hours and how you deal with postoperative follow-up.

Patients that have had active periodontal treatment should be required to return for postoperative evaluation and maintenance. Recall patients sometimes fall through the cracks of a busy practice, so be certain to recall patients for periodontal maintenance therapy in a timely and efficient manner. Failure to recall is another, less common theory of liability. Periodontal maintenance visits should reassess the patient's periodontal status and be well-documented, including an explanation of the patient's level of continuing compliance with home care instructions. Objective clinical findings, such as "decreased pocket depth measurements," make better entries than vague notations such as "OK" or "improving."

Develop a specific protocol for dealing with those patients who refuse to follow your recall or periodontal maintenance schedule, including the possibility of termination from your practice when the time period between recalls reaches a level that endangers a patient's oral health.

Periodontal disease claims continue to focus on alleged omissions by the dentist. These alleged omissions most frequently encompass failure to diagnose and failure to refer. Dentists and hygienists can reduce their risk by practicing good risk management techniques that include thorough clinical examinations, clear treatment plan discussions, and detailed documentation. Remaining current in periodontal disease diagnostic techniques and treatment modalities will enhance patient care and contribute to a stronger defense against a charge of malpractice.

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