Medico-legal aspects of periodontics

Reena Wadia and Neesha Patel discuss one of the fastest growing areas of litigation in dentistry – periodontal claims

On a typical busy day in general practice, it is very easy to consider hands-on clinical care to be more important than record keeping. The trouble with this is that if we fail to write adequate records of the treatment completed or discussions had with our patients then, legally, it didn’t happen.

Poor record keeping makes dealing with complaints and professional liability claims extremely difficult to defend. According to Dental Protection, periodontal claims are one of the fastest growing areas of litigation in dentistry and take up a vast amount of the organisation’s time and resources.

Taking a closer look, we find that not all clinicians are equally susceptible to claims: the minority of dentists are responsible for the majority of claims.

Why do dentists get into trouble?

As dental practitioners, we have a duty of care to our patients to exercise a reasonable level of skill and care. In order to recover compensation for negligence, a number of criteria need to be met. If the claim of negligence progresses to court, the outcome essentially rides on the quality of the clinician’s record keeping.

The General Dental Council (GDC) emphasises that it is an essential requirement to keep contemporaneous, complete and accurate patient records. It also highlights that patients expect their records to be up-to-date, complete, clear, accurate and legible.

Allegations are particularly likely to occur in specific circumstances (Table 1).

To elaborate, the scenario may be that a patient who regularly visits the same dentist for many years, for one reason or another, sees another dentist. It may be that the second dentist simply describes the periodontal condition in terms that the patient has not heard of previously, or in a way that the patient is better able to understand.

In this situation, the patient may come to resent the previous dentist as they may wonder why the condition has gone undetected for so long.

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

The patient’s legal window to file a lawsuit from the time a problem is identified is normally three years; each claim is also assessed on a case-to-case basis.

Not surprisingly, most dentists have no recollection of the conversation from an appointment several years ago. Therefore, the dentist must rely on the accuracy of their clinical records. Without these, it is extremely difficult to defend against any allegations that the diagnosis or disease process was not explained or specific advice and treatment was not given.

Professional liability claims pertaining to periodontics most commonly allege failure to: diagnose; inform; treat appropriately, or refer. Some of the hallmarks of cases involving allegations of untreated periodontal disease are the patient’s assertion that:

1. They were unaware of the presence of disease
2. They were unaware of the extent and severity of the disease
3. The dentist failed to explain the implications of disease – eg, tooth migration, recession and mobility.

Adverse events during treatment itself and failure of either non-surgical or surgical therapy produces far fewer claims. The majority of periodontal claims are alleged against general dental practitioners. Claims against periodontists, on the other hand, reflect the surgical nature of their practices and include claimed injuries such as post-surgery infection or paraesthesia.

What has driven the increase in claims?

From a dento-legal perspective, times have certainly changed. The rise in periodontal litigation may be associated with a level of expectation that tooth loss is avoidable.

As many of our patients retain their teeth...
into later life, the loss of teeth due to periodontal disease is no longer seen as inevitable. Furthermore, the general public’s perception of the healthcare profession being infallible is no longer the case.

Patients are much more health savvy in the current Google era, so are less likely to take what we advise at face value. At a time when evidence-based dentistry is emerging as an ethical consideration in clinical practice and there are readily available published guidelines with respect to treatment protocols and guidelines for specialist referrals, failures are difficult to defend.

What do dentists need to focus on?

Comprehensive dental records are the best way of defending allegations. A key question that needs to be asked is how we are communicating specific information to our patients. We all have our own unique ways of communicating with patients but it is important to remember that it is imperative that they understand us.

Layman’s terms are easier to understand, rather than explanations that are too scientific or clinical. When it comes to understanding periodontal disease, it is useful to use visual aids such as diagrams, photographs, radiographs and models to explain the hallmarks of the condition, such as inflammation, attachment loss as well as bone loss.

A vital component of a successful defence, when it has been alleged that a dentist has failed to diagnose or treat periodontal disease, includes an up-to-date medical history.

There are a number of factors that could arise from the patient’s medical history, such as diabetes or certain medications, that are known to be associated with placing patients in the high-risk category for periodontal disease.

When considering the social history, smoking is a well-recognised and significant risk factor, so a full smoking history should be recorded. Clinical records should continually reflect your awareness of risk factors. This will show that, as a clinician, you have not lost sight of them over time.

The next important requirement is to show from the patient’s records and radiographs that any periodontal disease has been identified, recorded and monitored appropriately.

From a medico-legal perspective, a clear written record of your diagnosis is an essential requirement. Periodontal records may vary depending on the circumstances of each case, but a ‘basic periodontal index’ is a reasonable starting point.

If more extensive breakdown has occurred, there are indications to complete a six-point pocket chart. Additional clinical information would further strengthen the case.

Alongside this, the records should clearly show that the patient has been informed of the nature and extent of their disease. Be specific and avoid vague statements such as ‘trouble with your gums’, as patients tend not to understand the significance of such comments and disregard them.

Expectations

For many patients suffering from periodontal disease, their primary concern following diagnosis is tooth loss. If one of more teeth has a doubtful prognosis, then this should be explained carefully to the patient. If tooth loss is inevitable, the apprehension is centred on when this will occur and how the missing teeth will then be replaced.

The patient needs to be questioned on what they expect to occur during the course of treatment and what they expect as an end result. As clinicians, this is our opportunity to manage our patients’ expectations appropriately.

An ‘improper procedure performed’ claim involving periodontal disease typically arises after a subsequent dentist informs the patient that he or she was mistreated. The allegation often surfaces after a subsequent dentist tells the patient that the non-surgical therapy that has been directed is less effective than a surgical approach.

Although many studies have been published demonstrating the strengths and weaknesses of these approaches, the patient has little access to this research. Risk management to minimise the potential for
these claims would include: keeping abreast with current scientific knowledge; maintaining good communication with the patient; practising informed consent principles; providing patient information leaflets, and fully documenting your rationale for treatment.

**When to refer**

It can often be confusing as to when one should refer a patient for a specialist consultation and possibly treatment. The British Society of Periodontology (BSP) has created guidelines for referral, which are summarised below:

- **Complexity one** cases may be treated in general practice – BPE scores one to three in any sextant
- **Complexity two** cases can either be referred or treated by the general practitioner – BPE score of four in any sextant or surgery involving the periodontal tissues
- **Complexity three** cases should mostly be referred. It is worthy to note that apparently simple periodontal treatment may have to be delivered by specialists as part of a more complex integrated treatment strategy. Complexity three includes BPE score of four in any sextant as well as one or more of the following factors:
  - A concurrent medical/oral factor that is affecting the periodontal tissues, such as diabetes
  - Complicating root morphologies and anatomical factors that adversely affects prognosis
  - Diagnosis of aggressive periodontitis
  - Non-response to previous optimally-performed treatment
  - Patients requiring surgical procedures, such as regeneration, crown lengthening or osseointegrated implants.

There are a number of other modifying factors that can increase the complexity by one increment (not cumulative). Examples include:

- Medical history that significantly affects clinical management
- Regular tobacco smoking (10+ cigarettes a day)
- Concurrent mucogingival disease, such as erosive lichen planus.

The timing of the referral is often the most important aspect in a lawsuit. Was the patient referred immediately when it was felt that the patient’s needs exceeded the dentist’s skill or was there a delay? The latter opens the door for the patient to allege that their condition was allowed to deteriorate further.

If your patient refuses to follow through on your referral, you are left with a choice of either dismissing the patient from your practice or continuing to treat but keeping in mind that you have already determined the extent of your care does not fully meet their treatment needs.

Both decisions require thorough documentation to defend against potential claims in the future. It is important to ensure that you document that the patient has been informed of the potential consequences of their refusal and any additional attempts to persuade the patient to reconsider their refusal at each subsequent visit should be clearly documented.

There is no absolute rule that demands referrals to specialists. If you feel competent in treating complex cases, 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 a periodontist.

The GDC’s Standards for the Dental Team emphasises that dental professionals should maintain and work within their professional knowledge and skills. Thus, it is good practice to refer a patient whom you believe requires care that is beyond your training, experience or expertise.

**References**

For the list of references that accompany this article, please email pd@fmc.co.uk.

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**Figure 2:** An example of a ‘good’ periodontal record

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalised chronic periodontitis</td>
<td>BPE 4/2.5</td>
</tr>
<tr>
<td>Glenrose</td>
<td>1.5</td>
</tr>
<tr>
<td>Initial treatment</td>
<td>4</td>
</tr>
<tr>
<td>Full mouth植</td>
<td>4</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>4</td>
</tr>
<tr>
<td>Radiographs</td>
<td>4</td>
</tr>
</tbody>
</table>

- **Medical history**
  - Hypertension
  - Diabetes

- **Smoker**
  - 25 cigarettes/day x 35 years

- **Occupation**
  - Banker (‘9 to 5’)

- **Dental history**
  - Oral hygiene: twice weekly, no plaque, no calculus

- **Medical history**
  - Hypertension

- **Periodontal status**
  - Narrowing of interdental spaces
  - Hard tissues: gingivitis
  - Soft tissues: gingivitis, sulcular, limited mobility

- **BPE score**
  - 4/2.5 |

- **Other findings**
  - Erosion, abrasion

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