

# Ethics corner

## Periodontal treatment & allegations of neglect

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### CASE SCENARIO

A long-standing patient attended a practice and said that she plans to report her practitioner to the Health Professions Council for failing to adequately treat her periodontal condition. At her initial examination some ten years earlier, she presented with advanced periodontal disease and radiographs clearly showed the extent of the severe bone loss throughout the patient's mouth. The practitioner did a thorough examination and charting, and discussed at length both the short and long term treatment plans. The patient was fully informed of the situation, given appropriate advice and consented to undergo extensive periodontal therapy. It was recommended that she attend every three months for examinations, scaling and oral hygiene instruction. She agreed to the treatment plan and her progress was carefully monitored and her periodontal status gradually improved over the years.

Although the practitioner saw the patient regularly and carried out such care and treatment as was deemed necessary, the periodontal condition began to deteriorate resulting in mobility of a number of anterior teeth and the patient was then referred to a periodontist for a second opinion. During the visit to the periodontist, a perhaps inappropriate comment was made to the effect that something could have been done to save a number of these teeth had the appropriate advanced treatment been instituted at an earlier stage. The patient was naturally upset by this statement and decided to make a complaint against her dentist.

### COMMENTARY

People are living longer and retaining their teeth into later life. The percentage of individuals with moderate to severe periodontitis, in which the destruction of supporting tissue can cause loosening and even loss of teeth, increases with age. The most common form of adult periodontitis is described as 'general and moderately progressing'. It is characterised by a gradual loss of attachment of the periodontal ligament to both the gingiva and bone, progressing to actual loss of the supporting bone. It is most often accompanied by gingivitis.<sup>1</sup>

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The severity of periodontal disease is determined through a series of measurements, including the extent of gingival inflammation and bleeding, the probing depth of the pocket to the point of resistance, clinical evidence of attachment loss of the periodontal ligament and the loss of adjacent alveolar bone as measured by radiographs.<sup>1</sup> Severity is also determined by the rate of disease progression over time and the response of the tissues to treatment. The prevalence and severity of periodontal disease increases, but does not accelerate with age.<sup>2</sup> The current view is that the disease process may not be continuous but rather progresses in random bursts in which short periods of breakdown of periodontal ligament and bone alternate with periods of quiescence. These episodes occur randomly over time and at random sites in the mouth. Part of the difficulty in determining the pattern of progression reflects variation in the sensitivity of the instruments used to measure the loss of soft tissue and bone.<sup>3</sup>

While there is no doubt that the existence of bacteria plays an important role in the aetiology of periodontal disease, studies suggest that it is the combination of the presence of these bacteria and the host response of the individual that determines the development and rate of progression of periodontal disease.<sup>4</sup> Thus the main risk factors of the disease are often outside the control of the clinician. In addition, familial history, genetic susceptibility, systemic disease and smoking are known to play a part in the aetiology and rate of progression of the disease.<sup>5</sup> Again, the clinician cannot be held responsible for the existence of these factors and patients need to understand that their periodontal disease is also their problem. However, it is an ethical responsibility of the clinician to educate the patients, to make them aware of the condition and assist them to reduce the impact, giving advice, guiding, monitoring and encouraging them patient to maintain the best levels of oral hygiene they can achieve.

Complaints regarding undiagnosed and untreated periodontal disease are on the increase.<sup>6</sup> The most common allegation is that the patient was unaware of the presence of periodontal disease or that the extent and implications of the disease had not been adequately explained to them. In these instances, two questions are usually posed: firstly, did the dentist properly diagnose, treat and monitor the periodontal disease and secondly, was there adequate communication and discussion regarding the diagnosis between the dentist and the patient?

A patient-centred approach is in keeping with the principle of respect for autonomy. Listening to the patient enables the dentist to decide what information the patient needs, how this information should be transmitted to the patient and what the patient's preferences are. Good communication makes it possible to compile a complete and accurate patient history, and makes the patient feel reassured and cared for. Furthermore, good communication is a necessary pre-requisite for responsible decision-making. In order to exercise their right to informed consent, patients must understand their diagnoses, the various treatment options, and the possible consequences of undergoing or refusing treatment.<sup>7</sup> In the above-mentioned case scenario, it is clear that the dentist acted in the best interests of the patient. She was informed at her first visit that her periodontal condition was compromised and that periodontal disease can manifest by years of quiescence and occasional bouts of sporadic activity. Radiographic evidence did not show any major deterioration until the final visit and when a second opinion was required she was referred to a specialist.

In many cases, the levels of periodontal disease in a patient's mouth are due to factors beyond the dentist's control and do not reflect any fault or the part of the dentist. However, it is easier to demonstrate that a high standard of care was provided, if dental records are comprehensively written up.

The Table highlights key issues that need to be documented during the management of patients with periodontal disease. (See table below).

A dentist who is able to communicate effectively and compassionately is able to dissipate fear and allay anxiety. This, in turn, leads to better patient satisfaction and to better treatment adherence. Research has demonstrated a relationship between communication skills and complaints lodged against oral health care workers. Dentists who focus on technical procedures or technology, who spend little time talking to patients and who give minimal explanations to patients are at higher risk of litigation. Risk of litigation appears to be related to "patients' dissatisfaction with their

Clinical audit for patients with periodontal disease	
<b>History</b>	A written medical history has been taken and updated at regular intervals. Systemic diseases and known risk factors for periodontal disease (smoking, diabetes) have been identified and recorded.
<b>Assessment</b>	A full assessment of periodontal status of the teeth including radiographic assessment to gain a clear idea of any bone loss or pathology and to foresee any problems that may arise.
<b>Screening</b>	Appropriate screening (eg. PBE scores, bleeding when brushing) and follow-up investigations (eg. X-rays).
<b>Diagnosis</b>	Establish a clear diagnosis and discuss the treatment objectives with the patient prior to commencing periodontic therapy.
<b>Consider alternatives</b>	It is important to consider periodontal treatment as part of the long term treatment needs of the patient and to consider alternatives that may include extraction of mobile teeth.
<b>Patient information</b>	The patient has been informed of the presence of the disease, given specific information regarding the site(s) and severity generally and warned in respect of any specific teeth that have an unfavourable prognosis.  The patient has received suitable advice/instructions regarding oral hygiene, risk factors (eg. cessation of smoking) to enable the patient to become personally involved in the control of their periodontal disease.
<b>Meticulous measurements</b>	Follow-up measurements of the site(s) and severity of the disease must be made (BPE scores, probing depths, bleeding points, mobility, pathological changes affecting individual teeth).
<b>Initial management</b>	Appropriate levels of initial treatment (scaling, root planning) have been carried out and repeated at suitable intervals. All techniques and procedures used should be evidence-based where possible.
<b>Patient compliance</b>	Any failure on the patient's part with respect to compliance (oral hygiene, risk factors, irregular attendance) has been brought to the patient's attention and the importance stressed.
<b>Review after treatment</b>	The tissue response and patient compliance have been checked and further measurements/monitoring of progression of the disease has taken place.
<b>Monitoring</b>	Records must show that monitoring was been repeated at appropriate intervals, with the necessary x-rays and other investigations.
<b>Failure to keep appointments</b>	Any occasion when the patient has failed to attend appointments, has cancelled appointments at short notice or does not respond to reminders or recall letters.
<b>Failure of treatment</b>	In cases of severe, complex periodontal disease where the patient has not responded to the advice and treatment provided, it must be shown that the possibility of a referral for specialist advice has been considered and discussed with the patient.  Full documentation must be recorded if the patient declined such a referral for any reason or if there was any occasion when the patient declined treatment that was recommended.
<b>Follow up</b>	Follow up is essential especially if there were any problems during treatment.

(Adapted from DPL Riskwise South Africa #10 2006)<sup>5</sup>

physicians' ability to establish rapport, provide access, administer care and treatment consistent with expectations and communicate effectively".<sup>8</sup>

It is worth taking the time to schedule a face-to-face conversation with patients to discuss complex disease like periodontal disease.<sup>5</sup> Such communication goes a long way to encourage the patient to 'internalise' the problem, take responsibility and importantly to adhere to oral hygiene instructions and oral health education messages. These discussions need to be carefully documented in the clinical records, together with copies of any written correspondence. Dentists who do not keep adequate records are placed in an invidious position when a patient makes a claim about the standard of care which has been provided. It has been recommended that a clinical audit be carried out to monitor patients with moderate or severe periodontal disease. Any gaps or weaknesses in record keeping should be identified and improved upon.

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## Postal Strike severely affects Journal



*“Most unfortunately  
the February edition will have  
reached you very late. It was  
delayed nearly three weeks by  
the postal strike!” - Editor*