# Periodontal litigation and the dental hygienist

Omitting to carry out adequate observation procedures, inform patients about their periodontal status and record patient response may lead to negligence claims. **Michelle Mitchell LLB, RDH*** explains how the dental hygienist can avoid litigation.

VERIFIABLE CPD PAPER

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## Introduction

Reports from the USA show that dental hygienists may be included alongside the dentist in periodontal litigation. This article examines the possibilities of legal action against hygienists in the UK. The legal foundations of hygiene practice are discussed alongside risk management procedures that may be implemented in clinical work.

## Hygiene and law

The legal foundations for hygiene practice stem from parliamentary laws. Legislation outlines the scope of practice and training of the dental team. According to these laws the dental regulatory body, the General Dental Council (GDC), is empowered to make rules and regulations regulating professional and clinical conduct of registered dental professionals. All registrants are subject to these rules and regulations. Hygienists and hygiene/therapists need to understand that, as registered professionals, they are in a position of responsibility and with responsibility comes risk. Hygienists in the UK may be held legally liable for the acts they commit and those they omit when treating patients.

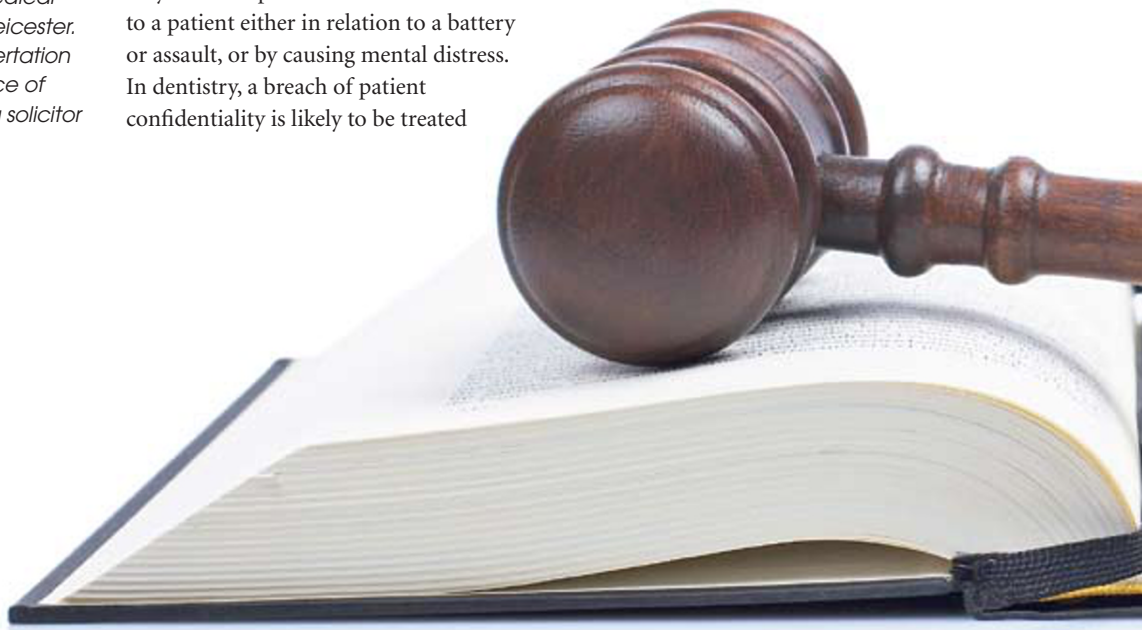
### *Torts*

Not only is the dental team subject to legislation and regulatory rules, but also to Common Law. Negligence claims in dentistry arise in the Law of Tort. A tort (or wrong) occurs when a person has breached a duty to another. Such a wrong may be either intentional or negligent (unintentional). An unintentional tort arises when there is no intention of harm to a person. Catching etching gel on a child’s face when carrying out fissure sealant procedures or incorrect treatment of periodontal disease are examples of unintentional torts. An intentional tort may arise if a person intended to cause harm to a patient either in relation to a battery or assault, or by causing mental distress. In dentistry, a breach of patient confidentiality is likely to be treated as an intentional tort. Dental professionals, by virtue of their professional training, have an automatic duty of care to their patients. Negligence claims under tort law may be settled either in or out of court, with compensation funds payable to the patient harmed. A dental team member must have indemnity insurance, which covers litigation and disciplinary procedures and costs. The GDC insists upon indemnity insurance; it provides a financial means to pay out any damages awarded by the courts and thus acts to protect the patient’s interest.

### *Periodontal claims*

A periodontal claim often arises when a patient attending a dentist for several years had no periodontal diagnosis, treatment or referral to a hygienist or periodontist. A change of dentist results in a diagnosis of advanced disease. The original dentist would be the obvious person facing a potential negligence claim or disciplinary action. A recent GDC disciplinary case outlined a situation involving a patient, who despite having seen the dentist and hygienist as a regular patient, was not informed of his periodontal disease or referred to a periodontist. Only the dentist faced disciplinary action in this instance but one must speculate on the hygienist’s role and responsibility here. American hygiene websites discuss how hygienists are involved as co-defendants in periodontal litigation or disciplinary actions. Key clinical omissions that may involve hygienists in such litigation are:

1. Lack of observation (as in recording periodontal pocket depths, state of gingival tissues, discussions with the patient, and the patient’s response to their state of periodontal disease)



2. Lack of informing the patient or dentist of periodontal disease
3. Lack of periodontal referral for further treatment and advice
4. Inadequate documentation.

***Scale and polish trap***

The majority of UK hygienists would consider their observations to be recorded in full. However, the 'routine scale and polish trap' may lull dentist and hygienist into a false sense of security and allow a wise litigation lawyer to include the hygienist in any negligence claim. Discrediting the dentist **and** the hygienist can result in a higher compensation claim for the client. The 'scale and polish trap' assumes that regular appointments for calculus removal with basic oral hygiene instruction, and recording areas of bleeding on probing, with associated pocket depths, are adequate to avoid litigation. Such appointments may be classed as maintenance programmes, especially under managed care schemes. However, these regular 'cleaning' appointments may simply be maintaining a level of disease in the mouth, leaving the patient unaware of the true risk to their systemic and oral health.

Hygienists have a legal and ethical duty to inform patients concerning their oral health status. In addition, the GDC considers that all dental professionals should work in the 'best interests' of the patient. Developing a proactive approach to treatment means examining potential risk factors in the clinical environment and working to reduce these. Two main areas of risk management for hygienists to examine are:

1. Thorough recording of observations
2. Recording of **information given to the patient**, and the **patient's response** to such information.

## Record keeping

Adopting an individual approach towards each patient, the hygienist should record the following at every appointment:

1a) The level of oral hygiene visible, stating the amount of plaque and calculus present (with indices and scores if possible)

b) The visible state of the gingival tissues, describing areas of controlled periodontal disease and healthy gingival areas

c) Areas of obvious advanced periodontal disease such as furcation involvement and pocketing should be noted

d) Pocket depths and bleeding areas should be charted accurately

e) Any failed appointments for treatment or refusal of treatment should be noted.

It may be prudent to check that hygienists' and dentists' BPE scores correspond; otherwise a lawyer will argue that they were carried out incorrectly.

2a) The discussion with the patient regarding the state of their gingival health, the risks to oral and systemic health and benefits of any referral or non-surgical treatment offered

> 'Developing a proactive approach to treatment means examining potential risk factors in the clinical environment and working to reduce these.'

b) Of great importance is the patient's reaction to being informed of their periodontal problems, and to oral hygiene instructions and possible referral

c) At all times the patient's responses should be recorded. An objective manner is required and is best written using the patient's own words, ie 'the patient said, "I know I should floss daily, but I don't have the time"'.

## Communication

Not only is good record keeping important to avoid litigation; communication is a key risk management factor. Vital to avoid litigation is the need to inform the patient of their role in controlling periodontal disease. It is important to allow the patient to 'own' the periodontal problem thus putting the responsibility on the patient to control it.

Hygienists should be encouraged to develop a practice protocol to monitor patients, possibly establishing criteria to band patients into low, moderate or high-risk cases. Holding regular clinical meetings with the dentists will establish good patient care and allow the team to discuss individual cases. Assess when advanced treatment or referral may be required.

Hygienists and therapists today have an automatic legal and ethical duty of care to each patient. Omitting to carry out adequate observation procedures, inform patients about their periodontal status and record the patient response may lead to negligence claims. A risk assessment/risk management approach to treatment will better protect both dentist and hygienist and provide better patient care. Treatment patients receive is more individualised and appropriate to particular patient needs.

**Further reading and useful websites**

General Dental Council. Standards of Guidance. *Scope of practice.* April 2009.
Brazier M, Cave E. *Medicine patients and the law*. Penguin Books, 2003.
Kimbrough V J, Lautar C J. *Ethics jurisprudence and practice management in dental hygiene*. Prentice Hall, 2002.
Jackson E. *Medical law text, cases and materials*. Oxford University Press, 2006.
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