I’ve been practicing for almost four years, and at one of the offices where I work, I see a lot of older patients who used to see a now-retired DMD. I think he has been somewhat lax with periodontal diagnosis and treatment, and many of his patients come in with radiographically visible bone loss and 6mm (or so) pockets. They have been having their teeth cleaned every six months for a long time, and when I see them and we do a full charting I discuss their perio status with them, inform them that they have perio disease, discuss the consequences of no treatment, and go from there.

Some patients accept SRP; some don’t. I’m wondering how the rest of you handle this. I feel like on the one hand, if I inform patients of the recommended treatment and consequences of no treatment and they choose not to do SRP, then they are making that informed decision. On the other hand, we’ve all heard about supervised neglect, and how perio disease is underdiagnosed. Honestly, I’m afraid someone will go after me at some point because I let him or her continue to get “cleanings” done, rather than stressing the importance of further treatment.

In situations like this, do you refuse to treat further? Do you dismiss the patient, and how? I write very detailed progress notes but I haven’t actually dismissed someone with a certified letter or anything like that.

There’s several threads on this already. It’s a constant issue. In my practice (and in yours), patients have autonomy and, once properly informed, can choose the treatment they want. So even though we have a high percentage of SRP in our hygiene practice (30 percent), we continue to have some perio patients who have chosen routine cleaning.

It’s more of a problem when you’ve just taken over a practice and trust is an issue. Most clinicians will respond to this initially by gently informing the patient of the problem and possible treatments, then letting the patient decide what he or she wants to do. I find that all new patients know what “deep cleaning” is, but don’t understand the term, “scaling and root planing.”

Remember, once they’ve been informed and made a decision and you’ve documented that, you are not at risk. So don’t go throwing any patients away. Best of luck.

I actually have patients sign off that they have been informed of a periodontal condition and they understand the risks of non-treatment. Patients refuse treatments for all sorts of reasons, even in medicine, so we are not unique. As long as you document that they were informed of the advantages and disadvantages, benefits and risks of treatment, you have done your job. Communication is key, and having a signed document is important in case patients forget about the conversation.

By the way, with the hygienist having conversations with the patient at re-care appointments, I find that very often patients will come around, in time. They read and hear stuff and they build trust over time and one day they finally say, “OK, let’s do it.” I have seen this happen,
so we dentists have to be real. Sometimes it’s fear, money or lack of understanding. Our job is to show them the way to a higher level of dental care and that takes time. ■

This is a constant issue and one that is ever evolving as the years go on. My take on issues like this one centers on diagnosis-based recommendations. The short version of this is, I can make a diagnosis, then I can:

• recommend treatment that is consistent with that diagnosis
• provide “alternative” treatment options (including no treatment) that are also appropriate within that diagnosis.

However, I can’t recommend “wrong” treatment, i.e., treatment that is not appropriate for the diagnosis.

It’s that last part that causes the trouble. That’s the risk point. It’s when push comes to shove, one might have to say that one was supervising treatment that was not consistent with the known diagnosis…or the diagnosis that should have been known.

That pushing and shoving tends not to happen too often, and thus many practices have avoided the risk event. If it happens, it seems to be more likely to happen when a patient comes under the care of another diagnosing doctor.

This is compounded by the nature of our scope—also being able to provide elective treatment. We can freely provide treatments that don’t require a diagnosis (esthetics, elected ortho, whitening, sports guards, etc.).

The thread of logic could suggest that an elective coronal polish would, in theory, be plausible. The thought being, if we can whiten teeth by professional protocol, why couldn’t we electively polish them for the same reasons?

However, usually if and when this issue would make an appearance in a dispute or risk event, it is unlikely those involved would be ultimately successful in that argument. ■

This is something every practice faces. Some have higher acceptance than others, and just like anything else, the better your hygienist is at communicating and educating, the higher the acceptance.

Use trigger words. We have found that the implementation of trigger words has been a great help. Trigger words like “pus,” “blood,” “infection” or “pain.” Show them the blood and pus and tell them there is infection. Verify that this is being done in your practice. ■

Yes, or get that camera out and show them! Pictures say it all. You may not notice a gum problem yet!

“Yet” is a key word in any conversation. In the case of periodontal disease: You haven’t lost any teeth—yet! But you will eventually and then you will need an implant or a partial or a denture. It’s amazing how many hygienists don’t use a camera to effectively communicate disease and need for restorative to patients. It is a disservice to your patient. When people see how gross their mouth is, they get it.

We don’t dismiss a patient over refusal of SRP. It doesn’t happen too often that I have a patient refuse. They key is patient education and let them own the problem. Here’s what I do.

Give the patient a mirror. Grab your perio probe. Show him (or her) a diagram with the probe and
what it means as the numbers go beyond 4mm and the significance of BOP. Have him hold the mirror and let him watch in the mirror as you probe. Very effective and undeniable there is a problem.

There are a couple of tools that we use, albeit not every day since most folks who come to us have an idea as to what’s going on.

One is Previser. You can test the consumer version on my website. Click the “What’s my Dental Score” tab. The subscriber version is much more detailed and gives you very clear talking points that you can show/print/email to patient. If the patient elects not to pursue recommended treatment, then this is pretty sound informed refusal.

The other is the DDS-GP app. Short animations as to what is happening and what treatment options there are. Again, show/print/email to patient.

Most of the elections to not pursue treatment in our area are due to economic reasons. Circumstances change and many who could not see their way to have treatment may do so at a later date. Periodontal maintenance is something we offer to try, and help them until definitive treatment can be undertaken. If chronic periodontitis is their main issue and they don’t want that, then I encourage them to see their family dentist more frequently. You are not doing them a disservice by cleaning their teeth—as long as they know their status.

I am thankful I never heard this advice. For 54 years I had a perio- and preventive-oriented general practice. I helped tons of reluctant perio patients gradually improve and at the same time I developed treatment and communication skills that are still working.

I gradually learned to be more aggressive with smokers, some diabetics and patients with immune problems. The biggest problem I have now is the interference of insurance companies. In my opinion, refusing all treatment for reluctant patients itself violates the minimal standard of care. It is classic all-or-nothing, distorted thinking.

I am a new practice owner and am currently (and slowly) building a periodontal program in my office. It has not been an easy process for me. Many of my perio patients have had prophies for many years. Like many have stated, I inform my patients of their condition and let them make the decision on perio tx or not.

A few things I am really noticing with this whole process: tx of perio disease is not cookie-cutter, just doing SRP is not enough sometimes, grafting may be necessary, getting an appropriate recall schedule (three months, four months, six months) to help keep a patient stable may be more important than the SRP is. Patient expectations and goals must be set.

Also, my hygienist and I are really working to get everyone in the office on the same page. When I only have five minutes with a patient and they have 45, their discussion is so important. Building trust in our team is essential to any tx.

There seems to be so many ways to skin a cat with this topic. Just trying my best to help my patients.