



Terminating the dentist-patient relationship

Terminating the dentist-patient relationship can occur for valid reasons such as non-payment, repeated missed appointments, hostile or abusive behavior, irreconcilable differences regarding care, or non-adherence to treatment plans. However, dentists must ensure that termination is not based on any discriminatory grounds prohibited by federal or state law. They also must ensure continuity of care, including making effective referrals to the patient's new dentist, to avoid charges of patient abandonment.

Valid termination

Dentists are legally and ethically permitted to discharge a patient from their practice, but they should first take steps to address the problem and document those steps in the patient's dental record. For example, if a patient is non-adherent to the treatment plan, dentists should document all patient education provided, including the content of the material or conversation, the patient's understanding, and each time education was given.

If efforts are not successful, the dentist can proceed with termination, as long as it does not violate federal or state antidiscrimination laws and regulations. For example, the Americans with Disabilities Act (ADA) protects people with a physical impairment that "substantially limits one or more major life activities" (such as walking, hearing, and speaking). Protection includes people with a "history or record of such an impairment." Examples of disabilities listed on ADA's website include cancer, diabetes, HIV, hearing loss, and intellectual disabilities. A dentist's office is considered a business that is open to the public, so falls under the ADA.

Dentists must also not violate a patient's civil rights as protected by legislation such as the Civil Rights Act of 1964, which makes it unlawful to discriminate against someone on the basis of race, color, national origin, sex (including pregnancy), or religion.

In addition to legal restraints, dentists should know that the American Dental Association (ADA) Principles of Ethics and Professional Conduct states that dentists should not deny dental services to patients because of their "race, creed, color, gender, sexual orientation, gender identity, national origin, or disability."

Termination process

If the dentist has exhausted all efforts to resolve the problem and is not engaged in discrimination, the next step is termination.

The ADA Principles of Ethics and Professional Conduct state that a dentist should not end treatment without giving the patient adequate notice and the opportunity to find another dentist. Otherwise, the dentist could be accused of abandonment.

The dentist can prevent charges of abandonment by having a policy that outlines reasons for termination and the process to follow should termination be necessary. The dentist should first tell the patient that they will be discharged from the practice and follow up with a written letter marked confidential and sent by certified mail.

The letter should include the reason for termination, instructions for accessing the patient's dental records, resources for finding a new dentist, and the effective date of termination. (If a patient has an urgent dental issue, the letter should advise the patient to see another dentist within a specified time frame and list the potential consequences of not doing so.)

Typically, the effective date is 30 days from the letter's date to allow patients time to find another dentist and for records to be transferred. During that time, the dentist should offer to provide any needed emergency dental services.

It can be helpful to have legal counsel review the letter before it is sent (or to assist in creating a template that can be used for different situations). A copy of the letter should be kept in the patient's file. The dentist and staff should avoid further contact with the patient after the termination date.

Reducing referral risk

Once the patient has chosen a new provider, dentists should follow these steps in making the referral.

- Verify that the new dentist has the necessary expertise to care for the patient. For example, a patient with significant molar tooth decay requiring a root canal should be referred to an endodontist, rather than a general dentist. The dentist can point out that a specialist is needed, but ultimately, the final decision rests with the patient, who has the autonomy to select their new provider.
- Provide complete information to the new provider (*sidebar*). Obtain the patient's permission in writing to transfer their records to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Document all communications with the new dentist, including dental records sent and telephone conversations.
- Have the office staff ensure that transferred records have been received and document receipt.

These actions, along with the termination letter, will help maintain continuity of care and avoid charges of patient abandonment.

Patient responses

Some patients may accept (or even welcome) termination, but others may become angry.

The dentist and staff should remain calm if an angry patient calls or comes to the office. Taking deep breaths can facilitate calmness, while active listening can help diffuse the patient's anger. Merritt writes that effective active listening involves making eye contact, avoiding defensive body language such as crossed arms, and paraphrasing the patient's words to ensure understanding.

Personal safety must be a priority in this situation. The dentist or staff member interacting with the patient should position themselves to allow for a quick exit from the room if necessary. In addition, police should be called if the dentist or staff member feels threatened.

Terminating with care

In some situations, dentists may terminate a patient relationship and remain in compliance with laws and ethical principles. However, termination must be a step-wise process that facilitates continuity of care and protects the dentists from litigation.

This newsletter is prepared by the staff of the National Society of Dental Practitioners, Inc.

Senior Editor:

Jennifer L Flynn,
CPHRM and President
of the Society.

Associate Editor:

Margaret Surowka Rossi,
J.D.

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The NSDP
1100 Virginia Drive
Suite 250
Fort Washington, PA 19034
800.237.9429

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CRAFTING AN EFFECTIVE REFERRAL

Gorman and Patel provide the following key points to include in a referral.

- Date of referral
- Patient details (e.g., name, date of birth, address, email)
- Medical history (State if there is no medical history. Include items such as medications, learning difficulties, and dental anxiety.)
- Whether or not a translator is needed, and if so, for what language
- Name of the patient's physician and contact information
- Referring dentist's name, practice, address, and phone number
- Reason for referral (Include whether it is urgent or non-urgent)
- Chart that indicates teeth with problems
- Description of previous treatments
- Radiographs (include date)

Additional information will be needed depending on the type of care required. For example, when referring to an endodontist, it is essential to include an assessment of the tooth's restorability. Dentists should make referrals in writing and document that the information was received.

Source: Gorman H, Patel K. Optimising referral letters for the dental practitioner. Br Dent J. 2024;236(9):688-692.

Cynthia Saver, MS, RN, is a medical writer in Columbia, Md

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Extractions Performed in the Dental Office Under Sedation Allegedly Led to Patient Death.

This case involves the unfortunate death of a patient resulting from the administration of procedural sedation. Furthermore, the concepts of apparent agency and shared liability in this case are key points for dentists and dental practice owners/organizations to address to improve safety and mitigate liability risk.

CLAIM CASE STUDY

Practitioner: General practitioner dentist (GP), certified registered nurse anesthetist (CRNA)

Claimant: Male, aged 55 years, history of obstructive sleep apnea (OSA), asthma, COPD, obesity; recent evaluation for bronchitis

Risk Management Topics: Preoperative assessment and case selection; anesthesia monitoring and documentation; medication selection; emergency preparedness

Facts:

The patient sought care at a general dentistry practice for extraction of two mandibular molar teeth (17 and 18) that were non-restorable. The patient expressed a strong desire for “sleep dentistry” due to dental anxiety. After evaluation, the treatment plan called for extractions to be performed under moderate sedation at the office, administered by a CRNA.

Several days before the scheduled procedure, the patient sought care at an urgent care facility for dyspnea, cough and wheezing. He received a diagnosis of acute bronchitis followed by an intramuscular injection of dexamethasone.

On the day of surgery, the patient did not disclose the urgent care visit, and the CRNA initiated sedation with administration of midazolam. Ondansetron and famotidine also were administered. The patient's oxygen saturation readings hovered around 94 percent despite supplemental oxygen via nasal canula. Later in the 50-minute procedure, the CRNA administered labetalol for elevated blood pressure, and airway adjuncts (nasopharyngeal and then oropharyngeal) were placed when oxygen saturation decreased below 90 percent.

Following the procedure, the patient did not respond to verbal or painful stimuli. Flumazenil was given twice without clinical improvement. Shortly thereafter, the patient became combative during emergence and then apneic and unresponsive. Assisted ventilation and resuscitative measures were initiated. After several minutes, the office called emergency medical services (EMS), and they arrived in approximately five minutes. EMS continued resuscitative procedures, and their first monitored rhythm was asystole. Soon after, EMS transported the patient to the emergency department where advanced resuscitation continued until death was pronounced.

The medical examiner certified the cause of death as hypertensive atherosclerotic cardiovascular disease following dental extractions, with contributing conditions including pulmonary hypertension, obesity, and acute/chronic bronchitis.

Key Allegations:

- Failure to obtain and document an adequate preoperative history and physical, including baseline vital signs and targeted airway/respiratory assessment.
- Inappropriate patient selection for office based moderate sedation and failure to refer, given the medical history.
- Inadequate monitoring and documentation.
- Administration of labetalol despite contraindications in patients with reactive respiratory disease.
- Failure to recognize and timely manage evolving respiratory compromise.
- Inadequate emergency preparedness.

Alleged Injury/Damages:

Wrongful death, economic damages (medical expenses; projected future loss of support and services; funeral expenses, and non-economic damages).

Analysis:

From a clinical risk perspective, several red flags were present preoperatively: a history of OSA and asthma, obesity, and recent and undisclosed evaluation for bronchitis with hypoxemia and wheezing. Collectively, these factors increased the likelihood of airway obstruction and hypoventilation during sedation and heightened the risk that even modest respiratory depression might precipitate significant decompensation in an office setting.

Monitoring deficiencies were central to the case. Records lacked a comprehensive preoperative history and physical with respiratory assessment, baseline vital signs, and complete intraoperative monitoring tracings. In the absence of robust contemporaneous documentation, it is difficult to demonstrate adherence to the standard of care — even when portions of care may have been clinically reasonable.

Emergency response sequencing and role clarity were additional concerns. The record reflected delays between the onset of unresponsiveness and the call to EMS, as well as uncertainty about the timing of airway interventions. Although anesthesia was administered by a CRNA, the GP and office personnel must be well-prepared to respond to an emergency. A well-rehearsed procedure is necessary, including but not limited to pre-assigned staff roles, stopping the dental procedure, calling EMS, initiating resuscitation, and documenting all actions and medications in real time to minimize delays and cognitive overload.

Medication selection also drew criticism. Expert reviewers opined that labetalol was contraindicated in patients with asthma/COPD because beta-blockade can precipitate bronchospasm. In a patient already demonstrating borderline oxygenation, the risk-benefit assessment weighed against its use. Additionally, experts believed that the patient was not an appropriate candidate for office-based sedation and would have been better managed in a hospital setting with a secured airway.

A final analysis point involved the question of liability. Readers may believe that the CRNA was primarily responsible for injuries related to sedation administration and management. Although sedation and patient monitoring were the responsibility of a contracted CRNA, the general dentist retained shared risk under theories of vicarious liability and apparent agency. Plaintiff experts argued that the dentist had a duty to ensure appropriate patient selection, confirm the qualifications and preparedness of the anesthesia provider, and oversee the overall safety of the procedure. In cases where the patient perceives the contracted provider to be part of the dental office team, courts may find the dentist and/or the practice liable for that provider's actions or omissions.

Outcome:

Given negative expert reviews for both the anesthesia provider and the practice, coupled with substantial wrongful-death exposure, the defense evaluated resolution options. The estimated verdict range was assessed to be substantially more than the policy limit, for which a time-limited demand was made. The defense team and dentist agreed to accept the demand, and the case settled with a total incurred (settlement plus expenses) in excess of \$1,000,000. The outcome of the case against the CRNA was not available

Risk Control Takeaways:

- Strengthen preoperative evaluation. Obtain a focused medical history, targeted airway/respiratory assessment, baseline vital signs, and review of recent illnesses or urgent-care visits. When recent respiratory infection, OSA with obesity, or unstable comorbidity is present, defer elective care or treat in a higher acuity setting.

- Use structured screening tools for OSA and respiratory risk when considering sedation. Document screening results and your clinical rationale for the treatment setting and depth of sedation.
- Match monitoring to risk, and document continuously. Ensure complete anesthesia records (including time-stamped vitals and significant events) and consider capnography for early detection of hypoventilation when using moderate/deep sedation.
- Choose medications with comorbidities in mind. Avoid or use extreme caution with beta-blockers such as labetalol in patients with asthma/COPD. Coordinate with the anesthesia provider and consider alternatives.
- Develop and implement emergency protocols. Perform — and document — mock drills annually at a minimum, preferably more often. Preassign roles, and keep emergency equipment, reversal agents, and a step-by-step checklist immediately accessible.
- Adopt a conservative threshold for terminating a procedure when persistent desaturation occurs, and escalate to advanced airway management and contact EMS without delay.
- Ensure regulatory compliance with sedation permits and maintain training records for all team members, with regular audits of documentation. Note that your state may require sedation permits, office inspections, and more, even if the treating dentist or practice owner does not administer sedation.

This case represents an example of the risks that may be involved with in-office sedation or general anesthesia. Offering sedation services provides certain benefits. Nevertheless, inherent risks exist even for patients that do not present with significant diagnosed medical conditions. Patient assessment and medical consultation, when appropriate, are important considerations before deciding to treat, engage with an anesthesia specialist, or refer.

Article by: Ronald Zentz, RPh, DDS, FAGD, CPHRM
CNA Dental Risk Control

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