Dental Professional Liability | Pre-treatment Issues

Examinations

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the Dentist's Advantage website.

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

Risk management content and resources are provided for illustrative purposes only. The information is intended to provide only a general overview of the matters discussed and is not intended to establish any standards of care.

The information, examples and suggestions presented in this material have been developed from sources believed to be reliable, but they should not be construed as legal or other professional advice regarding any particular situation.

CNA accepts no responsibility for the accuracy or completeness of this material and recommends the consultation with competent legal counsel and/or other professional advisors before applying this material in any particular factual situations.

Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. All products and services may not be available in all states and may be subject to change without notice. All references to dental claim data refer to CNA claim data.

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Examinations

After the preliminary information gathering, subsequent discussions and medical history review with the patient have been completed, the dentist typically begins collecting examination and diagnostic information. A clinical examination is the most common marker of the beginning of a dentist-patient relationship. Numerous claims have arisen from dentist-patient relationships that lasted only one visit, some of which involved indemnity payments. Claims involving examinations have included allegations of:

- Failure to diagnose pathology or abnormalities, such as caries, periodontal disease, oral cancer, pulpal pathology, TM disorders, infections, periapical pathology, malocclusion
- Failure to perform an adequate examination
- Failure to obtain appropriate radiographs
- Failure to perform a periodontal examination
- Failure to perform necessary diagnostic procedures
- Failure to inform the patient of the findings and/or diagnosis
- Failure to recommend appropriate treatment
- Failure to refer for treatment

Limited and Specialist Examinations

As evidenced by the claims, patients expect a dentist's examination to be comprehensive in scope with respect to the oral cavity and masticatory system. This expectation is especially true for general practitioners. If a general dentist intends to perform a less than comprehensive exam, such as to evaluate an emergent complaint, the dentist should clearly explain that the exam will be limited in scope to the problem at hand and that the individual should follow up by having a comprehensive exam. The disclosure and directive also should be clearly documented in the SOAP-formatted progress note written for that visit. The SOAP format is delineated in the Record Keeping and Documentation section of this manual.

In general, specialists perform examinations that are problem-focused and limited in scope. They, too, should inform patients of the limited nature of their evaluation and suggest a more thorough exam, when appropriate.

Specialists often inquire if they can be held liable for failing to diagnose a condition that was not part of their specialty examination. For example, can an endodontist be liable for failing to diagnose periodontal disease in an area of the mouth away from the tooth being evaluated? The answer is – maybe. Suppose an endodontist, while evaluating a painful maxillary molar for endodontic treatment, observes generalized inflammation, puffiness, and loss of stippling of the gingiva throughout the mouth, especially in the lower anterior. These observations would be readily apparent to any dental practitioner of any specialty as signs of periodontal disease.

Under the circumstances noted, the endodontist *would* have a duty to make a general statement about the patient's periodontal disease and to recommend further evaluation and care. The endodontist would *not* be required to pick up a periodontal probe and probe six sites on each tooth throughout the mouth. Because the endodontist would customarily evaluate the periodontal status of the problem tooth in a more thorough manner as a means of assessing the etiology of the patient's complaint, an 8 mm pocket or furcation involvement of that tooth – left undiagnosed – may expose the endodontist to liability.

Conversely, consider a scenario in which a patient with a painful maxillary right molar with no grossly visible signs of periodontal disease is examined by an endodontist. The gingival tissues appear healthy, belying the through-and-through furcation involvement of #19. In this situation, the endodontist probably would not be held liable for failing to diagnose the furcation. As the focused evaluation did not involve the furcation, and it was not readily apparent to a reasonable practitioner during a casual inspection of the oral cavity, liability would not attach.

In general, every dentist, regardless of the nature of practice, should inform the patient of any suspicious condition or overt pathology readily observed in the patient's mouth. This information includes, but is not limited to, caries, periodontal disease, tooth fractures, and suspicious soft tissue lesions. Be sure to document having informed the patient of your findings. Your comments to the patient can be as general as:

- "The puffiness and bleeding I'm seeing are signs you have gum disease. Be certain to come back so I can perform a thorough examination of your whole mouth."
- "The black areas on your teeth that you see when you look in the mirror are cavities. You should follow up soon with your general dentist, because those teeth could become very painful if left untreated."

The "I Don't Want an Examination" Dilemma

On occasion, a patient will inform you or your staff of the desire to schedule a prophylaxis, but an examination is not sought. The request may be based on personal financial issues, ignorance of the importance of an exam, or a fear of knowing one's oral status. Individuals who have dual residences, timing their movements based on the seasons, often say, "My dentist back home does all my exams, so I just want to have a cleaning."

We strongly discourage permitting patients to receive dental services while simultaneously refusing to undergo an examination. In this scenario, a patient may allege a pathological condition existed which was not diagnosed during the visit to your practice, notwithstanding the refusal of an examination. Moreover, unless you have a copy of the clinical record or a report from the dentist "back home," verification of the actual date of the last examination is impossible. In fact, the patient may not have had an examination in years, but fully expects you to comply with his or her wishes.

More importantly, this approach does not represent good patient management. The dentist is expected to assess and facilitate his or her patients' oral health. To do so requires an examination. Most reasonable dentists acting as expert witnesses would agree. Furthermore, some state dental practice acts require the dentist to assess the adequacy of services performed by the hygienist. How can a dentist comply with such a rule without an examination?

A simple response to a patient who requests a prophy but no exam is, "I understand your request, but my goal is to maintain, if not enhance, the oral health of my patients, and I simply cannot do that unless you permit me to examine you. If you insist on not having an examination, I will have to respectfully decline to provide the cleaning and ask you to find another dentist."

Baseline Examination and Documentation

Appropriate baseline chart entries, made during the initial examination of the patient, are essential in record keeping. In addition to written notes, diagnostics such as dental radiographs, intraoral and extraoral photos, and study models further document the patient's status by confirming information compiled through visual and instrument examination. Use of these baseline records at later visits allows you to determine whether a patient's oral conditions have improved, worsened or remained the same. Notes concerning these comparisons should be carefully entered in the dental treatment record. Without baseline records, you and your staff have no reliable method of documenting comparative changes in a patient's condition.

An examination form documents the patient's condition at a specific point in time. It thus becomes a snapshot of the patient's mouth. Therefore, the record should not be altered or amended after its creation. We strongly discourage dental practices from erasing notations of decay on the exam form and replacing them with notations of restorations as treatment is completed. Such action destroys the information originally recorded. If you opt to graphically represent the progress of the patient's treatment, another form should be used, rather than the examination record.

We strongly **discourage permitting patients** to receive **dental services** while simultaneously **refusing** to undergo **an examination**. In this scenario, a **patient may allege** a **pathological condition** existed which was not diagnosed during the visit to your practice.

All patient comments and clinical findings which influence and/or support your diagnosis and treatment plan should be documented.

- Inquire about the patient's chief complaints and symptoms and document the responses in the record.
- Perform a comprehensive examination of all new patients and document your findings.
  - Teeth – present or missing; presence and location of caries and other pathology of the teeth and supporting tissues
  - Restorations – existing restorations and appliances and their condition
  - Occlusion – normal or malocclusion, including classification
  - Oral cancer screening and evaluation of all intraoral soft tissues (lips, cheeks, tongue, floor of mouth, hard and soft palate, gingiva, salivary glands, etc.) and soft tissues of the head and neck, including lymph nodes
    - On your exam form, document either a positive or negative response for each structure listed on the form that you examine, even if it's an abbreviation as simple as "WNL" for "within normal limits" or a mark such as + or a check-mark. The omission of documentation can be alleged to imply that no examination of that oral structure was ever performed.
  - Periodontal examination – document your probing depth findings using a periodontal chart
  - Temporomandibular joints
- Obtain appropriate radiographic images and document your findings
- Obtain diagnostic records and perform diagnostic tests, as clinically appropriate, and document your findings
- Inform the patient of your findings and diagnosis. Many state dental practice acts *require* a written diagnosis for each tooth or condition treated. The failure to document a specific diagnosis has resulted in dental board fines, as well as sanctions against dentists' licenses.
- Document your findings – if it isn't in the record, it didn't exist. Keep accurate, legible records to support your actions.

Assessing a Prior Dentist's Treatment

There are few situations in dentistry more difficult to address than informing a patient about or answering patient complaints concerning dentistry completed by another dentist. When confronted with these situations, consider these priorities:

- Explain to patients their current treatment needs by assessing current oral health conditions, arriving at a diagnosis and recommending appropriate treatment. *You are not obligated to judge the supposed negligence of a prior provider.*
- Don't guess about another dentist's treatment. Your best response to questions about why a prior treatment turned out the way it did, or why a prior dentist didn't diagnose an oral condition, is to answer that you weren't present. Therefore, you don't know the circumstances under which the prior treatment was performed or a diagnosis not made. You also may suggest that the patient contact the prior dentist directly for such answers.
- If you have your own questions about prior dentistry, go to the source. Contact the dentist who performed the treatment to obtain his or her views. If your efforts to ascertain what happened are thwarted by the prior dentist, then use your professional judgment in a difficult situation for which no perfect answer exists. If you determine what happened and believe that the prior dentist's treatment failed to meet the standard of care, referring the patient to the local peer review or mediation committee may be advisable.
- In cases where insufficient information exists, *you are under no obligation to guess at the reason why the dentistry appears as it does*, irrespective of the patient's insistence.
- Never be dishonest with a patient, even to protect a colleague. You have a responsibility to your patient and your profession not to ignore questionable dental care. Avoid drawing conclusions about the circumstances under which work was performed or the dentist who performed it. *You protect your patient by prescribing correct treatment after a thorough diagnosis. You protect yourself by remaining neutral regarding a prior dentist's treatment.*
- You may also wish to consult the American Dental Association's Principles of Ethics and Code of Professional Conduct on the matter of assessing a prior dentist's treatment. Note that some states have officially adopted this document into their Rules and Regulations. See the Legal/Regulatory section of the Bibliography for URLs.

Recall Examinations

The standard of care for evaluating a patient during an examination is identical for both initial and recall exams. The dentist must complete an examination, determine a diagnosis, and inform the patient. In addition, many state dental practice acts require dentists to perform an examination whenever a patient is seen by a hygienist.

The patient's record should clearly document your clinical findings, any diagnoses made, and any treatment recommended.

For more information call Dentist's Advantage at 888-778-3981, or navigate to the Dentist's Advantage website Risk Management section.

In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

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