Dental Professional Liability | Clinical Treatment

Extractions

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.

Extractions

Closed claim data reveals that for overall claim costs, extraction malpractice claims are more costly than for any other dental procedure. In fact, costs associated with surgical and simple extractions combined are about twice the amount of the next most costly procedures for claims (implant placement/surgery and crowns). The following allegations are commonly reported for extraction claims:

- Failure to diagnose the need for extraction (failure to radiographically evaluate, failure to perform appropriate examination and/or tests)
- Failure to refer to an oral surgeon, either before treatment or after difficulties were encountered
- Failure to treat — patient alleges extraction was not recommended by the dentist, when, in fact, treatment was necessary
- Improper or unnecessary treatment performed
  - The tooth did not require extraction due to pathology or other clinical indications
- Procedure performed incorrectly
  - Wrong tooth extracted
  - All roots of a tooth not removed
  - Postoperative paresthesia/dysesthesia/anesthesia
  - Damage to neighboring teeth or soft tissues
  - Failure to prescribe antibiotics when indicated
  - Antibiotics prescribed unnecessarily
- Inadequate precautions
- Poor outcomes
  - Infection following the extraction
  - Broken instruments (e.g., elevator, root tip pick, suture needle)

Managing the Risks of Extraction Claims

A general dentist performing procedures that fall within the scope of practice of an oral surgeon will be held to the standard of care established by the *specialty*, since an oral surgeon will probably be one of the plaintiff's expert witnesses in any oral surgery claim. There are exceptions, however. Check with your attorney regarding specific laws and rules governing expert witness testimony in your jurisdiction

Recognizing risk factors

The risk of a poor outcome or a dissatisfied patient is increased in these circumstances:

- Extraction of impacted teeth
- Extraction of teeth with divergent, dilacerated, or unusually long root structures
- Extraction of ankylosed teeth
- Extraction of teeth with roots close to the sinus or the inferior alveolar nerve
- Extraction of badly broken down or non-restorable teeth which may be difficult to remove
- Surgical treatment of patients with whom you have encountered prior surgical difficulty
- Surgical treatment of patients who are tobacco and/or alcohol users
- Surgical treatment of patients who present other patient management difficulties, such as failure to keep follow-up appointments or failure to follow medical advice
- Surgical treatment of patients with significant medical conditions, such as hypertension and diabetes

An uncommon but noteworthy risk for extraction patients with a history of antiresorptive therapy for osteoporosis is antiresorptive agent-induced osteonecrosis of the jaw (ARONJ). Clinical and patient management information on the subject of ARONJ is available on the American Dental Association (ADA) web site in the section on Oral Health Topics: Osteoporosis Medications and Oral Health). Information also may be available on the American Association of Oral and Maxillofacial Surgeons (AAOMS) website. Note that other acronyms may be used for this condition, including "medication-related osteonecrosis of the jaw (MRONJ) and "bisphosphonate-related osteonecrosis of the jaw" (BRONJ).

Controlling the risks

Clinical

- Select cases within your clinical expertise and refer, when appropriate. If you foresee a complication that exceeds your expertise or your own comfort level, refer the patient to an oral surgeon *before* attempting the procedure.
- Assess the patient's medical history, physical condition and ability to tolerate the procedure.
- Record the blood pressure and pulse prior to administering any local anesthesia. Patients with elevated or depressed pressures should have treatment deferred, if possible, and should be referred to their physician for evaluation.
- Confirm and document that appropriate premedication or pre-treatment regimens have been followed (e.g., antibiotics as needed for infective endocarditis, anxiolytics, diabetic management, etc.).
- *Always* obtain a *preoperative* radiograph showing the *entire* root structure prior to extracting any tooth.
- While evidence is limited, the dentist may consider preoperative use of an antimicrobial rinse to reduce the risk of infections related to surgery.
- Review and understand information on nerve injury prevention and post-nerve injury management, especially for extraction of mandibular molar teeth.
- Plan your incision and flap design before picking up the scalpel.
- Verify the correct tooth to be extracted twice *before* picking up an elevator or forceps.
- Use sound clinical judgment during the extraction.
- If you encounter significant difficulties or complications during the extraction or surgery, stabilize the patient and make a referral to an oral surgeon. The clinical needs of your patient come first.
- Require patients to return for at least one postoperative evaluation.

Communication

- Extract only teeth for which you have the patient's informed consent. Disclose the nature of treatment, the alternatives, if any, and the foreseeable risks.
- If you foresee a complication that *is* within your skill level and you plan to accept the case, discuss the risk with the patient before the extraction as part of the informed consent process.
- To reduce the risk of a failure to refer allegation, non-oral surgeons should always offer referral to an oral surgeon as a viable treatment alternative.
- Manage the patient's expectations.
  - Ask patients what they want and/or expect to occur or not occur during the course of treatment.
  - Inform patients what to expect during treatment and postoperatively.
- Provide clearly written postoperative instructions and information, including how to reach you after hours and how you address follow-up.
- Follow up by calling each patient later on the day of surgery to assess his or her condition, and document all patient complaints and your recommendations.

Documentation

- Document in the patient record *why* the extraction is warranted, beginning with subjective patient complaints. We recommend that subjective patient complaints and comments, such as "this tooth is killing me" and "I haven't slept for three days," be documented in the progress note using quotation marks.
- Document your objective clinical findings, such as mobility, periodontal probing depths, occlusion, caries, radiographic findings, and the results of percussion and digital palpation.
- Use written informed consent forms that specify the tooth or teeth to be extracted. Besides referring to tooth numbers, consider describing the tooth. For example, in addition to writing tooth15 also include the upper left second molar with missing occlusal filling in the case of tooth shifting or missing teeth.
  - On the form, circle the most significant risks; draw a line through those that do not apply.
- Document the clinical procedure, including: local anesthesia used (type, concentration, quantity, vasoconstrictor concentration); antibiotic or anxiolytic premedication; incision and flap reflection; bone removal; tooth sectioning; socket curettage; irrigation; clotting agents; sutures (material, number, and location); postoperative medications prescribed (both over-the-counter and prescription medications); postoperative instructions given; untoward events and their resolution; patient condition upon discharge.
- At the postoperative visit, document your clinical findings and the patient's postoperative course.

Please refer to page IX for information about access to a sample form on "Discussion and Consent for Extraction."

For more information call Dentist's Advantage at 888-778-3981, or navigate to the

Dentist's Advantage website Risk Management section. To access the Dental Professional Liability Claim Report: 2nd Edition click here.

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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