CNA DENTIST'S ADVANTAGE

Dental Professional Liability

Risk Management Program

Contents

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.

Any references to non-CNA Web sites are provided solely for convenience, and CNA disclaims any responsibility with respect to such Web sites.

Dental Professional Liability

Dental Claims: Information, Experience and Management

Upon completion of this section, you should be able to:

- **List the primary reasons why dental professional liability claims are alleged.**
- **Understand claim-related terminology and the claim/lawsuit process** described in this section.
- **Describe the steps involved in reporting a dental professional liability claim** and/or how to proceed in the event of dental licensing board complaint/investigation.
- **Understand the purpose of the National Practitioner Data Bank** and how to conduct a self-query.

Dental Claim Experience and Reporting

One of the world's greatest scientists said, "The only source of knowledge is experience" (A. Einstein). In the case of dental liability claims, a slightly modified version is a reasonable alternative: "The preferred source of knowledge about dental professional liability claims is the experience of other dentists!" This maxim can be reduced to one word that all dentists embrace: prevention. Learn from the claim experiences of your colleagues and use that knowledge to improve patient safety and risk management in your dental practice.

The combination of collective claim data and the individual dentists' claim experiences facilitates the assessment and management of risk exposures in dentistry today. A study of dental malpractice claim data provides an understanding of claim types, frequency and monetary value.

Beyond monetary value, patient complaints, dissatisfaction and claims also may affect the psychological well-being of the dentist and dental team members. Not all complaints lead to a "claim," as defined below, yet these issues remain important to address and understand. Non-claim issues, therefore, are also addressed in this manual, primarily in the Patient Management section. When claims arise, dentists must know the steps to take, and this important information is covered later in this section.

Note that CNA publishes claim reports that provide additional information and detail on professional liability claims and licensing board actions. These reports focus on various segments of the healthcare industry, including dentistry, pharmacy, nursing and others. The most recent dental claim report may be accessed in the risk management section of the Dentist's Advantage website.

Definitions

A few definitions will help to better understand claim terminology and information presented in this section of the manual.

Allegation. An assertion that the healthcare professional or organization has done something wrong or illegal

Average total incurred. Indemnity plus expense costs paid by CNA, divided by the number of closed claims

Claim. The receipt of a demand for money or services, naming the insured and alleging a dental incident, which also includes covered dental licensing board complaints

Dental procedure. The dental procedure that contributed to the patient's alleged injury.

Frequency/distribution. The percentage of closed claims with a common attribute, such as a specific allegation or injury.

Paid expense. Monies paid in the investigation, management and/or defense of a claim.

Paid indemnity. Monies paid by the insurance company on behalf of an insured for the settlement, arbitration award or judgment of a claim. (All indemnity payments are required by federal law to be reported to the National Practitioner Data Bank. Various state laws also require similar reports be made to licensing boards or other state agencies.)

Total incurred loss. The costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim

Beyond monetary value, **patient complaints, dissatisfaction and claims** also may **affect** the psychological well-being of the dentist and dental **team members**.

Additional Perspective on Claims

Dental professional liability insurance policies generally define a claim as "the receipt of a demand for money or services which names you and alleges a dental incident."

- A demand may be made in writing, in person, or by telephone, facsimile or email. It may be made informally in the form of a letter or telephone call (often from the patient directly), or formally entered as a filed legal action. Claims may be asserted by the patient, the patient's guardian, a patient advocate, such as a spouse, sibling or attorney, or emanate from a court or peer review committee.
- "Money or services" may mean a refund, a payment in excess of a refund, providing free care, or paying for the care of another healthcare provider.
- "You" is generally defined as you personally, as the named insured in the policy, anyone who works for you, or anyone the patient believes may be employed by you, or acts as your agent.
- A "dental incident" relates to what "you" did or failed to do with respect to your professional dental services in the course of patient care.

In addition, most professional liability insurance policies also will provide defense coverage related to state licensing board investigations or for injuries or damages allegedly resulting from a dental incident otherwise covered under the policy. Defense coverage may include attorney fees and related expenses. The dentist is typically responsible for any fines, restitution, continuing education costs or other expenses related to disciplinary actions. Moreover, the highest expenditures involving a licensing board complaint involve the legal costs associated with its defense.

A dental licensing board complaint represents a simple and inexpensive means for a patient to seek a remedy from, or retribution against, the dentist. In many states, the number of dental licensing board complaints far exceeds the number of civil negligence lawsuits against dentists. The dental board (or in some states, the Board of Health or other agency) is authorized and/or mandated to investigate all complaints.

Whether or not a claim arises is determined by the allegations in the patient complaint, rather than by what you believe may or may not have occurred. For example, a patient sends you a letter demanding a refund for a denture you made for her. Your records show that she never paid for the denture. Therefore, you believe that she cannot demand money or services, since you cannot refund what you were never paid. The patient also may claim other damages such as lost wages, pain and suffering. Nevertheless, the patient has made a claim as defined by the policy.

While virtually all professional liability policies impose a duty on the insured to report claims, dentists sometimes opt to address minor patient demands on their own, without engaging their professional liability insurer. Although dentists may be successful at addressing the patient's concerns and/or demands, consult with your professional liability agent, claim professional, or risk management professional to discuss the matter before proceeding. You also may wish to consult with your own attorney on these matters. While certain situations are able to be managed effectively by the dentist, others may become more complex and difficult to defend. Moreover, failure to report a claim could affect your coverage. Your insurance representative will assist you in determining how best to proceed.

Why Claims Are Alleged

Many dental professionals believe that a patient's pursuit of a malpractice claim should be permitted only when the practitioner has made an error or omission that constitutes malpractice as judged through the eyes of the dental professional. In the civil justice system, however, malpractice allegations are pursued in accordance with recognized principles of state tort law.

Our data indicates that clinically unacceptable dental treatment is not the major reason why patients allege malpractice. If it were, then a far greater percentage of the claims we receive would involve a compensatory payment to the patient, either in the form of a settlement or a jury verdict. From 2009 through 2018, approximately 85 percent of our dental professional liability claims closed *without* a payment being made to the patient. So if it's not substandard dentistry, then why are the majority of claims being instituted?

The motivation for a patient's malpractice claim can sometimes be a mystery. Often, money is the primary reason. It may be fees the patient paid to you or fees the patient owes and doesn't want to pay you. It may be about an outstanding balance that was referred to a collection agency. The patient may need money to fix a dental problem, money for which the insured dental professional is named in a lawsuit. It is also possible that the money is "needed" for some purpose other than dental care.

The only tangible benefit a patient can gain from a malpractice claim is money. A malpractice claim cannot turn back the clock to prevent the alleged injury from occurring. Nor can it ensure that any corrective treatment for the alleged injury will return the patient to his or her former condition. So, the law permits the award of monetary damages to compensate for the inability to be made "whole" again, or otherwise returned to one's former condition.

Disputes over money are inevitable in the practice of dentistry. How you handle those disputes is one of the most significant factors in the likelihood of encountering a malpractice allegation. In one state, for example, our claim professionals estimate that malpractice claims alleged in retaliation for a dentist's collection action comprise approximately 20 percent of the total claim volume. While other states may reflect a lower percentage of retaliatory claims, the volume remains significant. Clearly, claims often arise from circumstances other than dental malpractice, and dentists should thus consider the implications of office financial policies upon the dentist/patient relationships.

In addition to monetary disputes, we have identified the following issues as underlying patient motivations for malpractice allegations. Many relate to various aspects of patient dissatisfaction. Recognize that patients will rely on their own perspectives and criteria, however biased, erroneous, or unfounded, when determining their level of satisfaction with the dental care and your practice.

Poor communication

Good communication is the foundation for good dentist-patient relationships. A patient who believes issues may be discussed openly with a dentist and his or her staff will be less likely to pursue a malpractice claim in the event of a dispute or less-than-ideal outcome. The adage states, "people don't sue people they like."

Some individuals are naturally good communicators who easily develop relationships. Others must work hard to improve and maintain their communication skills. Although staff communication with patients may be impeccable, their abilities can never fully overcome the inadequacy of a dentist's communication. Dentists have been characterized by some claimants as lacking compassion and concern for their needs. These characterizations may be accurate, but it is also possible that a dentist who is perceived to lack compassion may instead possess poor communication skills.

In addition, communication issues between staff members and patients also may lead to claims. Just as some dentists are poor communicators, so too are some dental staff. Moreover, dental team members are often delegated difficult communication tasks, such as collections and rescheduling of patient appointments at the doctor's request.

Poor communication also may arise from language barriers, especially when the dentist and patient speak different native languages. Other communication barriers confronting the dental profession include limited oral health literacy, a lack of understanding of oral health, oral disease, and the terminology used to describe those conditions.

Every dental practice has experienced a communication breakdown at one time or another. Such breakdowns may irreparably damage the dentist-patient relationship such that either the patient leaves the practice, or the patient is asked to leave the practice.

Unmet expectations

Patients have certain expectations when they present for treatment. These expectations may be related to cost, time, function, appearance, comfort, courtesy, or convenience, to name just a few. Patients lack the clinical knowledge of how to assess the treatment you provide, so they use other criteria to judge you, your staff, and their dental experience based upon how well you fulfill their expectations.

Revenge or spite

Some patients insist on retribution for their alleged injuries, while others pursue retaliation for trivial offenses. The mere perception of having being slighted may lead some patients to institute a malpractice claim or dental board complaint. Collection actions thus become a frequent source of these claims.

Treatment errors

Treatment errors, including clinically unacceptable results, are usually preventable events. Every dentist must be knowledgeable and exercise skill and due care when performing treatment. Increasing one's skills and knowledge base may be achieved through personal commitment and continuing education. Moreover, dentists must honestly and critically evaluate their own decisions and clinical results in order to recognize errors or omissions and take appropriate corrective action. A team approach to corrective action development is important to help eliminate bias in the process and to maximize effectiveness and buy-in for new or modified policies or procedures

Accidents

Accidents can and do occur. While it would be ideal if they were completely preventable, it would be an unreasonable expectation to assume that inadvertent errors may never happen. Accidents such as "wrong tooth" extraction or treatment and other similar occurrences represent a small proportion of the total volume of claims received.

Other

Other situations should be considered in the context of why claims are alleged. No dentist intends to overlook disease signs or symptoms during an examination. Yet, "failure to diagnose" is asserted in dental claims. Similarly, patients also may assert that the dentist or other office personnel failed to take adequate safety precautions, causing injury. Do these incidents represent "accidents", a "treatment error", or something else? Do dentists intend to injure patients? No, the dentist always intends to prevent patient injuries.

Irrespective of the claim category, oversights related to clinical care, processes and procedures are commonly the source of alleged claims. Developing a practice philosophy focused on patient safety represents an important strategy to help prevent such errors. Implementation of an incident or "near miss" review and corrective action process is a critical part of an effective patient safety program.

Treatment errors, including clinically unacceptable results, are usually **preventable events**. …dentists must honestly and critically **evaluate** their own **decisions and clinical results** to recognize errors or omissions and take appropriate corrective action.

Factors in Claim Assessment, Outcome, and Valuation

At any given time, the claims on file in computer databases represent a compilation of recently reported claims of which all facts are not well known, claims which have been pending for some time where more is known, and claims which are closed, for which the most information is known. In all three categories, some of the claims have required or will require monetary payment to the claimant, and some will be closed without payment. The value of a pending claim can change (up or down) as more information becomes available.

Estimated value

When a claim is first reported, a monetary value is placed on the claim as a case estimate, and the information is entered into a database. The case estimate is meant to be an accurate evaluation of claim value, considering all the facts known at that time. As more facts become known, the estimate is adjusted up or down, as necessary, to reflect the claim professional's evaluation of potential liability.

Generally, claims about which little is known will have low estimates. Claims about which more is known will have higher estimates if liability and damages are probable, or lower estimates if diminished liability or damage is perceived. Ultimately, when the claim is paid, dropped by the claimant, or otherwise resolved, the true value of the claim becomes clear. The case estimate is then adjusted to the actual amount paid, or to "zero dollars" if no amount is paid, but the claim has been dropped.

When a dental incident is reported, a minimal case value estimate may be established. If no demand is made upon the insured within a reasonable timeframe, the claim is considered dropped, and the case estimate is adjusted to zero.

Once a demand has been made and/or suit has been filed, a thorough investigation of the case is undertaken. If a lawsuit has been filed, this investigation will include a more formal process, including the exchange of "written discovery" (questions which will be answered by both parties to the litigation, under oath). Of course, a review of all pertinent dental and medical records will be necessary. Eventually, if the lawsuit continues, oral depositions will be taken of all parties and witnesses, including prior and subsequent care providers.

As the investigation continues, the claim will be evaluated based upon numerous factors: the purported misconduct of the practitioner, the nature and extent of the damages alleged and confirmed, the jurisdiction in which the suit has been filed, the sympathetic (or unsympathetic) nature of the claimant, as well as the demeanor and veracity of witnesses. Each of these elements will play a role in determining the reasonable case value.

Expert opinion

Of the many factors to be considered in evaluating a claim, expert opinion (both supportive and not supportive) can play a major role. While jurisdictions may vary in terms of the procedures involved in maintaining a lawsuit, almost all require expert input before the case can be presented to a judge or jury. Generally, a layperson may not sustain a claim against a healthcare professional without expert opinion. Indeed, the valuation of the claim will include considerations of the expert's qualifications, training and background, knowledge of the procedure or treatment at issue, understanding of the standards of practice, credibility, prior experience as an expert, whether or not the expert is impartial or delivers expert testimony based upon the professional engagement, and the rationale for the expert's opinions. In fact, the strength of a claimant's lawsuit often can be measured, in part, by the credibility of his or her expert.

Similarly, the assessment of the claim will include the opinions of our own experts. How will he or she defeat the claims of plaintiff's expert? Are the opinions of our expert sound, are they credible, will they be understandable and acceptable to a lay juror? Does our expert have difficulty in supporting some or all of the care of our insured? Are we able to obtain a credible expert?

Dental records

The dental records also will play a major role in the evaluation. In some instances, textbook care may have been provided, but the records lack the documentation to that they will not support the defense of the claim. Post-procedure complications and their treatment must not only be acted upon but also noted. Most claimants do not have a series of malpractice claims pending or a host of substandard results. Consequently, it is natural to assume (and the plaintiff's attorney will argue) that the claimant will have a much clearer recollection of the events than will the practitioner, who sees multiple patients each day. It is difficult for a jury to believe a practitioner's rendition of events which are not properly documented.

Other factors

As suggested previously, the evaluation itself may consider elements of the claim which do not bear directly upon the clinical practice of dentistry. Is the claimant likeable and credible? What about the insured? Would the average juror wish to have the insured as his or her dentist? Although it may not be sound from an academic perspective, will the plaintiff's claim appeal to the jury? What are the damages? Are they so devastating that they will overwhelm any type of liability defense?

Analysis of Claim Data

How can we gain meaningful information from claim data? First, we can collectively assess the percentage of all claims with similar allegations, such as "failure to diagnose." Second, we can evaluate the cumulative monetary value placed upon claims in similar categories. For example, since we know the frequency of claims for a specific dental procedure or a type of injury, as well as the total dollar value (payments plus case estimates) of all claims associated with the procedure or injury, we are able to study an individual claim in relation to all reported claims in the same category. Available data, however, does not identify details such as how many of our insured dentists perform a procedure, such as endodontic or root canal procedures, nor how many root canal procedures each dentist performs during a month or a year.

Importance of Claim Data to Risk Management

To maximize the potential benefit of risk management techniques, the factors most susceptible to a claim must be identified, as well as the risk management techniques applied to those areas of risk. A review of claim data is an important part of risk management so that priorities can be established for implementation of new methods of control. Neither the frequency nor the severity of each type of loss should be overlooked when evaluating the relative value of various risk management techniques.

Every claim, even if later closed without a payment made to the claimant, will require significant time from the dentist. At best, the time spent will involve reviewing a chart and reporting the incident to the professional liability insurer. But the amount of time spent could be considerably greater. For example, if an incident leads to a lawsuit that is successfully defended in court, the dentist will have spent many hours in consultation with the claim professional, with defense counsel and in court. Most claims fall somewhere between these two extremes. Some risk management techniques are directed at minimizing the number of claims made, which, in turn, reduces the time needed to respond.

Claim Data

Dental professional liability claim data can be sorted, classified and evaluated in many ways. The most useful risk management aspects are derived by studying the injuries that patients allege, the probable cause of the alleged injury, and the dental procedure that resulted in the injury. The following tables provide a snapshot of aggregate data for closed dental claims from 2009 through 2018. More claim analysis is available in the latest dental claim report referenced previously in this section.

Frequency Trends for Closed Dental Claims 2009-2018

In the following three tables, these subdivisions are assessed by the percentage of the total number of closed claims and by the percentage of the total dollars spent on closed claims.

Frequency vs. Total Claim Cost by Dental Procedure

Comparison of Countrywide CNA Claim Data – January 1, 2009–December 31, 2018 Notice Date; Closed Claims Only

Percentage of Closed Claims	Dental Procedure	Rank	Dental Procedure	Percentage of Total Claim Cost
13.2%	Crowns	1	Extractions Surgical	15.3%
9.5%	Root Canal Therapy	2	Crowns	11.2%
8.7%	Extractions Simple	3	Implant Surgery–Placement	11.1%
5.8%	Extractions Surgical	4	Extractions Simple	9.3%
5.3%	Implant Surgery–Placement	5	Root Canal Therapy	8.7%
4.4%	Composite Restorations	6	Other Restorative Services	6.3%
4.1%	Clinical Oral Examinations	7	Clinical Oral Examinations	5.4%
2.6%	Fixed Bridges–Tooth Supported	8	Fixed Bridges–Tooth Supported	2.4%
2.0%	Partial Dentures	9	Comprehensive Orthodontics	2.0%
1.7%	Complete Dentures	10	Prophylaxis	1.5%

Frequency vs. Total Claim Cost by Cause of Loss (Allegation)

Comparison of Countrywide CNA Claim Data – January 1, 2009–December 31, 2018 Notice Date; Closed Claims Only

Percentage of Closed Claims	Cause of Loss (Allegation)	Rank	Cause Of Loss (Allegation)	Percentage of Total Claim Cost
17.0%	Board Complaint / Investigation	1	Inadequate Precautions To Prevent Injury	19.0%
16.1%	General Patient Dissatisfaction	2	Treatment Failure	15.1%
15.1%	Inadequate Precautions To Prevent Injury	3	Unnecessary Treatment	9.7%
12.4%	Treatment Failure	4	General Patient Dissatisfaction	7.9%
4.9%	Procedure Performed Improperly	5	Failure To Diagnose	7.6%
4.0%	Improper Procedure Performed	6	Procedure Performed Improperly	6.3%
3.0%	Failure To Diagnose	7	Improper Procedure Performed	5.6%
1.9%	Failure To Complete Treatment	8	Anesthesia Complication	3.1%
1.8%	Equipment Failure	9	Board Complaint / Investigation	2.8%
1.6%	Wrong Tooth (Teeth) Treated	10	Failure To Refer	2.5%

Frequency vs. Total Claim Cost by Type of Loss (Injury and Additional Loss Types)

Comparison of Countrywide CNA Claim Data – January 1, 2009–December 31, 2018 Notice Date; Closed Claims Only

Percentage of Closed Claims	Type of Loss (Injury and Additional Loss Types)	Rank	Type of Loss (Injury and Additional Loss Types)	Percentage of Total Claim Cost
16.3%	Corrective Dental Treatment Required	1	Corrective Dental Treatment Required	19.1%
4.6%	Infection	2	Injury To Nerve/Paresthesia	13.6%
4.2%	Swallowed Object	3	Death	7.3%
3.8%	Injury To Nerve/Paresthesia	4	Infection	6.3%
3.5%	Lost Tooth (Teeth)	5	Unauthorized Restraint	5.6%
3.5%	Corrective Surgical Treatment Required	6	Corrective Surgical Treatment Required	5.6%
2.4%	Wrong Tooth (Teeth)	7	Broken/Fractured Bone(S)	3.9%
1.9%	Pain And Suffering	8	Lost Tooth (Teeth)	3.6%
1.7%	Laceration	9	Tumor/Cancer	3.1%
1.4%	Retained Foreign Object	10	Brain Damage	2.2%

Average Total Cost Analyses for Closed Dental Claims

The following two tables provide further context in presenting "average" total cost per claim for selected dental procedures and types of losses (injuries and additional loss types). While averages may be skewed by a small number of large payments, the tables help to provide a clearer picture of dental claims.

Comparison of Average Total Cost per Claim by Dental Procedure

January 1, 2009–December 31, 2018 Notice Date; Closed Claims Only

Dental Procedure	Average Total Cost Per Claim
Osseous Surgery	232,136
Extractions Surgical	130,035
Complete Overdentures	121,924
Clinical Oral Examinations	110,540
Implant Surgery–Placement	96,189
Fixed Bridges–Implant Supported	89,647
Comprehensive Orthodontics	84,574
Fixed Bridges–Tooth Supported	73,755
Extractions Simple	65,528
Crowns	57,412
Root Canal Therapy	50,587
Partial Dentures	50,041
Complete Dentures	49,633
Crowns–Implant Supported	48,030
Composite Restorations	17,608

Comparison of Average Total Cost per Claim by Type of Loss (Injuries and Additional Loss Types)

January 1, 2009–December 31, 2018 Notice Date; Closed Claims Only

Type of Loss (Injuries And Additional Loss Types)	Average Total Cost Per Claim
Tumor/Cancer	338,556
Broken/Fractured Bone(S)	193,834
Injury To Nerve/Paresthesia	154,163
Loss of Impant	113,073
Tmj Problem	92,247
Infection	88,867
Corrective Surgical Treatment Required	77,254
Corrective Dental Treatment Required	75,008
Pain and Suffering	57,406
Lost Tooth (Teeth)	54,182
Sinus Perforation	43,152
Retained Foreign Object	42,207
Wrong Tooth (Teeth)	35,167
Laceration	29,154
Swallowed Object	14,952

Reporting and Handling Claims

Effective implementation of risk management techniques help to reduce the likelihood and severity of dental professional liability claims. Analyzing claim data helps you to weigh the relative value of potential risk management techniques. An over-arching consideration includes "patient safety" and "risk management" as *preventive* concepts: implementing processes, procedures, staff training, patient education and other approaches *before* issues or injuries occur is always preferable to a reactive response. When necessary, however, the actions you take after you become aware of a claim situation can have a significant effect on the final outcome of that claim.

Consider following the steps outlined below, if a professional liability claim is asserted against you. You may not be able to follow each step in every claim situation, but this reporting approach will help your claim professional provide prompt, efficient claims service, including timely legal defense, if necessary. If you are insured for professional liability insurance with a company other than Dentist's Advantage/CNA, we recommend that you contact your agent or insurer for further direction. Dentists insured by a surplus lines policy, either with CNA or a company other than CNA also should check with their agent regarding coverage, as policy language may vary.

Role of the Dentist

In the event you receive a dental professional liability claim, you are advised to:

1. Immediately report to your insurance agent any information you have. In some cases, you may be asked to contact dental risk management personnel. Depending upon the circumstances, risk control efforts may help to mitigate the possibility of a claim or lawsuit.
2. When appropriate, the information provided by you will be reported to the designated CNA claim office. A CNA professional liability claim professional will be assigned to discuss the claim with you. Information included in the incident report will be provided to the claim professional. This information typically will include: date of the incident, name of the patient, circumstances of the occurrence (procedure performed, injury incurred by patient, etc.), and copies of any correspondence received relating to the incident. Dental licensing board complaints *must* be reported to CNA by the dentist within 30 days of receipt of notice to avoid jeopardizing coverage.
3. Don't discuss the circumstances or merits of the claim with anyone other than your claim professional or appointed legal counsel. In addition, consult your CNA claim professional or appointed legal counsel before you agree to attend any conferences arranged for the specific purpose of discussing the claim.
4. Obtain approval from your CNA claim professional before you accept a release from any party, or present a release to any party.
5. Document in writing, at the request of your CNA claim professional or defense counsel, the circumstances surrounding the claim. This documentation should be completed as soon as possible, because time may cloud your memory and obscure details. Since this narrative will become an important part of your defense, be prepared to spend the necessary time to prepare a complete and concise report. *Do not place this narrative in the patient record.*
6. Assemble, in chronological order, all pertinent dental records, consent forms, radiographs and other diagnostics, lab reports, correspondence, memoranda, and other information related to treatment offered and given to the patient in question.
7. Maintain all original dental records. *Do not make any alterations, deletions, or additions to the dental record.*
8. Accept all letters, memoranda, lawsuit papers, and related documents without comments or arguments. Do not admit liability and do not attempt to place blame.
9. Be prepared to spend time to aid in the investigation, defense, or settlement of the claim.

Role of the Insurer

In the event of a dental professional liability claim, CNA will:

1. Evaluate the facts provided to determine if a claim file should be established.
2. Contact the insured dentist to begin investigation of the claim. A CNA claim professional will coordinate and manage the defense of the claim.
3. Assign an attorney experienced in the defense of dental professionals whenever a lawsuit is filed, or in other circumstances, where necessary, to serve as the dentist's legal counsel.
4. Direct, monitor, and assess the course of the investigation.
5. Keep the insured dentist advised of the status of the claim, as necessary. A dentist who has questions about the claim is encouraged to contact his or her CNA claim professional or appointed legal counsel.
6. Evaluate the dentist's potential liability to determine the courses of action available. CNA will then make a recommendation to the insured dentist on the defense or settlement of the claim.

It is very important for a dentist to *report his or her claim promptly and accurately.* The sooner the dentist's insurance agent or broker and the insurer have the necessary information, the easier it will be to manage the claim.

Assessing and Controlling Claim Costs

As already described, an initial monetary value, or case estimate, is determined when a claim is first reported to CNA. The case estimate is the best evaluation of claim value, considering all of the facts known at the time. As more facts become known, the estimate will be adjusted up or down to reflect the claim professional's evaluation of changes in potential liability. The true value of the claim is clear only when the claim is paid, withdrawn by the claimant, or otherwise resolved.

It is important for both insurer and dentist to keep claim costs to a minimum. CNA rigorously defends non-meritorious claims. Claims where liability is evident, or where a successful defense is unlikely, will be quickly evaluated and recommended for settlement. This approach helps CNA to maintain premiums at competitive levels, but never at the expense of claim service—a dentist's paramount need and concern.

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) or "the Data Bank" was created through the *Health Care Quality Improvement Act of 1986* (HCQIA) and is operated under the auspices of the U.S. Department of Health and Human Services (HHS). It was created to serve as a flagging system to facilitate a comprehensive review of healthcare practitioners' professional credentials. The information contained in the NPDB is used by healthcare entities, state licensing boards, and professional societies in conjunction with information from other sources for decisions involving clinical privileges and credentialing, employment, affiliation, or licensure. This section provides a brief summary of the NPDB: dentists should review the Data Bank website and *NPDB Guidebook* for complete information at: www.npdb.hrsa.gov.

Two separately operated Data Banks: the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) existed before May 2013. The HIPDB was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted on August 21, 1996. As part of a required national health care fraud and abuse control program, the HIPDB was created to receive and disclose certain final adverse actions against health care practitioners, providers, and suppliers. Due to overlap in some reporting and querying requirements, Section 6403 of the *Affordable Care Act of 2010* (ACA), Public Law 111-148 consolidated the NPDB and HIPDB operations. Information previously collected and disclosed by the HIPDB is now collected and disclosed by the NPDB.

Regarding dental and medical malpractice, HHS recognizes that not all paid claims are meritorious. This view is reflected in the October 2018 version of the *NPDB Guidebook*, where it states:

> "Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. **Thus, as specifically indicated in title IV, a payment made in settlement of a medical malpractice action or claim should not be construed as a presumption that medical malpractice has occurred.**"

There are three types of reports submitted to the NPDB:

- Medical Malpractice Payment Reports
- Judgment or Conviction Reports
- Adverse Action Reports

Medical Malpractice Payment Reports

Each insurance company or other entity that makes a malpractice payment for the benefit of a dentist must submit a report when the payment meets the following criteria:

- There is an exchange of *money*.
- The payment must be the result of a *written* complaint or claim demanding monetary payment for damages, based on a dentist's provision of, or failure to provide, dental services. Payments made in response to *oral* complaints are not reportable.
- The payment is made as a result of a demand against an individual dentist. Payments made solely on behalf of an incorporated group practice or clinic are not reportable, as entity reporting is not required under the law or the regulations promulgated under HCQIA.

NPDB defines a "malpractice payer" as an "entity that makes a medical malpractice payment through an insurance policy or otherwise for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment against that practitioner."

Examples of a "malpractice payer" as defined above include:

- CNA and other professional liability insurers
- Dental professional services corporations, including those comprised of a solo practitioner (e.g., John Q. Smith, D.D.S., Inc. or John Q. Smith, D.D.S., P.C.)

Therefore, a professional corporation of any size that makes a payment for the benefit of a named dentist (including an incorporated solo practitioner) must report that payment to the NPDB.

A payment made by an individual dentist from personal funds on his or her own behalf is *not* reportable, whether or not the dentist does business as a professional corporation. The NPDB *Guidebook* clarifies that "A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner should not be reported to the NPDB."

Judgment or Conviction Reports

Judgment or conviction reports are to be submitted to document "health care-related criminal convictions and civil judgments in federal or state court. Reports include convictions, injunctions and "no contest" pleas involving the delivery of healthcare items or services. Federal, state or local prosecutors are required to file such reports, whether or not there is a pending appeal.

Adverse Action Reports

Adverse action reports originate from three sources. Hospitals and other healthcare entities, such as dental preferred provider organizations and other managed care entities, must report professional review actions related to professional competence or conduct that meet certain criteria.

State licensing boards are required to report disciplinary actions such as revocation, suspension, censure, reprimand, probation, and surrender of license. Revisions, such as reinstatement of a license, also must be reported.

Professional societies must report professional review actions that adversely affect professional association memberships and revisions to such actions. (Peer review committee decisions do not affect a dentist's professional association membership, and, therefore, are not reportable.)

Other Points

A fee refund for services rendered is not uncommon in dental practice. The NPDB also addresses the fee refund situations. The *NPDB Guidebook* states that if a refund is made by an entity (including solo incorporated practitioners), a report must be filed. However, no report is required if a refund is made by an individual. The *Guidebook* also goes on to state that a refund is reportable if it "results from a written complaint or claim demanding monetary payment for damages" that is based on a dentist's "provision of or failure to provide, health care services."

It is also important to note that many state licensing boards routinely query the NPDB to identify practitioners who may potentially pose a threat to the public. Many such boards will initiate their own investigation if a routine query to the NPDB identifies a new report of a malpractice payment, an adverse licensure action in another jurisdiction, or an adverse clinical privileges action.

Notwithstanding the efforts of numerous consumer groups seeking a modification to the HCQIA to permit access by private individuals to the information contained in the NPDB, the public is not authorized to obtain information about healthcare professionals from the NPDB. However, many state dental licensing boards disclose their disciplinary actions to the public either through online postings or publication.

Although the NPDB reflects a self-reporting requirement for malpractice payers, the occasions on which an insured dentist has contacted CNA for information or assistance to self-report may have been rare. Moreover, we are unaware of any instances in which the U.S. Department of Health and Human Services (HHS) has pursued an action against a dentist for failing to self-report.

For most dentists, a report to the NPDB has no adverse consequences to their income or their ability to practice dentistry. Unless a dentist is planning to move to another jurisdiction and obtain licensure, seek hospital medical staff privileges, or enroll in a credentialed provider organization, the impact of an NPDB report has been negligible. Nevertheless, the report of a dental malpractice payment to a federal regulatory agency understandably has an emotional impact on the healthcare professional who is the subject of the report.

Self-query of the NPDB

Dentists may query the NPDB at any time to determine what information, if any, is maintained about them. For additional information, dentists may contact The Data Bank Customer Service Center: navigate to the website provided previously in this section and select the "Contact Us" hyperlink for further information.

Dental Licensure Complaints

Dental licensure complaints may result when a patient's concerns with treatment are not addressed. A complaint may result from a simple misunderstanding or miscommunication. Patients also may seek to pursue a licensing complaint when they are unable to obtain legal counsel to represent them in a malpractice suit.

Licensing board complaints may also be submitted by non-patient third parties, such as other healthcare providers, including dentists and dental insurance companies. States may also allow anonymous complaint submissions. And while states may have some flexibility regarding the investigation of license complaints, many state legislatures have enacted legislation that *requires* the state dental board to investigate every complaint filed against a dental licensee.

Irrespective of the source, a licensing complaint begins when a complaint is received by the dental licensing board about a licensed dentist or other licensee within the board's purview. State law or administrative rules provide the details of the process, which may vary significantly by state. Dentists should, therefore, review and understand both the standards to which they will be held and the process their state board will follow in the event that a complaint is filed.

Another important issue that dentists often overlook is a state requirement for self-reporting. Self-report requirements may apply to criminal convictions and other legal actions not directly related to the delivery of healthcare services. Self-reporting also may be required for patient care scenarios, such as a patient death or hospitalization, whether directly related to dental care or not. Again, understand and comply with your state requirements.

If a complaint concerns patient care, the dental board will typically request a copy of the dental information patient record as a first step. Dental or other professional license complaint investigations may be the responsibility of a state agency other than the professional licensing board. Closely review any communication from a state agency and ensure that dental team members understand when to inform you about important communications.

The Need for Representation

Regardless of the investigating agency or investigation process in your state, the next step is the same. As soon as you receive a request for records from a state agency or other notice of investigation, immediately contact your insurance agent and report it as a claim under your policy. Most dental professional liability policies provide coverage for attorney fees and costs associated with defending a licensure complaint if it arises out of injury or damage from a dental incident. Typically, the highest expenditures involving a licensing complaint are the legal costs associated with its defense. Note that most dental professional liability policies exclude reimbursement for any fines, restitution, costs of continuing education, or other disciplinary measures that may be imposed.

Response and Process

Pay close attention to the required response date in the notice. The deadline is often very short, requiring swift action and in many cases, a request to extend the deadline may be appropriate. You should begin to compile the requested information, but it is best to discuss the investigation and response with your assigned claim professional and/or attorney before proceeding.

You also should be aware that many dental licensing boards may require you to submit original radiographs and will not accept copies. If originals are required, duplicate the radiographs and maintain copies in your chart. Do not send any original records without first creating acceptable copies.

When the investigating agency receives the requested records and/or other documents, it will determine whether or not additional steps are necessary, in accordance with the process in your state. If the response effectively substantiates that no violation of the dental practice act or other health code occurred, then the case may be closed. However, further investigation activities may be pursued depending upon state protocols (typically as set forth in the dental practice act). Examples of requirements may include: (i) requests for further documentation; (ii) narrative reports from the dentist; (iii) patient and/or dentist interviews; (iv) on-site assessment of the dental practice; and/or (v) a hearing.

Unless participation is required by state law, a dentist should never submit to an interview with the state licensing board or state investigator without first consulting with legal counsel. If the dental licensing board suggests an interview, settlement conference or other type of conference or hearing, a dentist should be accompanied by an attorney. There are numerous examples of dentist interviews and written statements submitted without advice of counsel that have severely compromised or defeated any viable defense, resulting in serious disciplinary consequences.

If a violation is found, a number of different sanctions can be imposed. These sanctions may include: (i) a fine; (ii) completion of prescribed continuing education or academic training; (iii) dental license/dental practice restrictions or probation; (iv) license suspension/revocation; or (v) restitution (repayment to a patient or third-party payer). While license revocation is rare, dental licensing complaints are a serious matter. Unfortunately, many dentists erroneously believe this to be an "informal" process which they can handle themselves. In some cases, a dentist may try to settle a complaint without advice of legal counsel in an attempt to complete investigation rapidly as possible.

Even a simple board matter may take many months or longer to conclude, resulting in anxiety for the dentist. Nevertheless, the best advice is to report any investigation upon notification and work closely with your insurer and attorney to resolve the matter.

Dental Professional Liability

Risk Management Overview

Upon completion of this section, you should be able to:

- **Understand the purpose, benefits and procedures** that are part of an effective dental office risk management program.
- **Examine and assess risks specific to your dental practice** and identify risk management techniques to address them.
- **Consider and identify factors important to the dentist and team members** that will influence future risk management issues and decisions.

The primary goals of every dentist's risk management efforts should focus upon: (i) improving patient safety; (ii) reducing the risk of patient injury; and (iii) enhancing patient dissatisfaction. Such efforts diminish the potential for the filing of a malpractice claim or a complaint submitted to the state dental licensing board. CNA recommends a preventive risk management approach for dentists and the dental team. The methods and actions pursued may be characterized as your office Risk Management Protocol. Protocols and standard procedures help to ensure predictability and consistency in effecting processes. These important elements, applied to dental procedures, patient communication and clinical documentation will help to reduce the risk of professional liability exposure.

There are different ways to practice dentistry based upon each dentist's education, perspective, ethics, and preferences. Each method has an inherent level of risk. Similarly, there are many different forms of risk management based upon individual preferences. Your challenge is to minimize your risk as much as possible within the framework of your own practice setting and the choices you make. Some risk management efforts will be more effective than others. Regardless of the techniques you use, a strategy and process to manage your risks must be developed. By prudently and intelligently deciding to limit, avoid, control or transfer identified risks in accordance with the principles presented in this resource, you will be utilizing the prevention tools necessary to avoid allegations of malpractice.

Risk management is considered a specialty within the management field. Thus, many of the principles you have learned that produce sound practice and personnel management results also can be applied to the patient/clinical risk management process. Just as "preventive dentistry" is the key to limiting or eliminating the damage caused by diseases such as dental caries, risk prevention or "preventive risk management" will help dentists practice safely, satisfy patients and limit the anxiety and stress resulting from malpractice claims and related lawsuits.

Terms

A **loss** can be any occurrence that has a negative impact on your objectives. Loss typically refers to a decrease in assets in the form of property or money, often resulting from a claim for damages. In dentistry, loss represents a transfer of money from you to a patient. It also may represent decreased production, a diminution in the value of your dental practice, restriction of your professional dental license, and/or damage to your professional reputation.

A **loss exposure** arises when a situation presents the possibility of loss, regardless of whether or not the loss actually takes place. Anesthesia or paresthesia following the extraction of a severely impacted mandibular third molar represents an example of a loss exposure. It may or may not occur, but the possibility exists.

Risk is the possibility that a specific event, or set of events, will occur that will result in a loss. Risk management involves reducing the likelihood that an adverse event will occur and reducing the severity of damage to the patient as a result of the adverse event. Loss exposures can vary greatly in the potential risk they present.

Risk management involves reducing the likelihood that an adverse event will occur and **reducing** the severity of **damage to the patient** as a result of the adverse event.

The Risk Management Process

The risk management process consists of four simple steps outlined below. To strengthen your office risk management strategies, consider integrating these steps into your dental office team meetings on a regular basis. Conducting an initial "risk management team meeting" to focus attention on this area represents a sound first step, followed by including the topic in all future team meeting agendas. Depending upon the needs of the practice, scheduling weekly or monthly meetings solely dedicated to risk management principles for a period of time may be appropriate in order to more efficiently address current or emerging issues and trends.

1. Identify and analyze potential adverse events

There will always be risks associated with dentistry. In clinical practice, as well as in the business of dentistry, potential loss exposures can take many forms.

- **Patients** — injury or dissatisfaction resulting in a malpractice action, as well as slips and falls
- **Property and equipment** — theft, fire, water damage, vandalism, destructive acts of nature
- **Personnel** — illness, disability, embezzlement, staff attrition, employment practice issues
- **Operations** — sanctions arising from regulatory violations, such as those involving OSHA, HIPAA, and dental licensing board actions

These losses can affect patient care as well as practice profitability. A single incident may negatively influence many aspects of a dental practice, including the emotional health of the employees. Office morale often suffers following a large malpractice settlement or verdict, or a natural disaster such as a fire, flood, or hurricane.

The ability to identify potential losses before they occur is gained through knowledge, experience, and education. Resources may include your personal experience, malpractice attorneys, professional publications, professional study clubs, continuing education programs, and peer review groups. You also should refer to information compiled through your own quality assurance programs, patient questionnaires, and flow charts.

The sources from which you draw your knowledge of potential risks are not as important as your ability to use that knowledge to identify risks. You can begin by listing the clinical procedures you perform, and ask yourself, your colleagues, your staff, and your patients about adverse events encountered relative to each procedure. For example, adverse extraction events include unanticipated tooth fracture, inadequate anesthesia, postoperative bleeding, excessive swelling, pain, wound infection, and residual paresthesia and anesthesia. Awareness of potential problems permits you to proactively manage the risks.

Once identified, risks must be analyzed to assess a number of factors. The analysis should include the likelihood that a risk will result in a loss (risk frequency) and the extent to which such a loss would affect the practice (loss severity). Risk analysis will assist in determining the best use of the human, physical, and financial resources of your practice. For example, an orthodontist may identify root blunting and resorption as a risk of treatment. This exposure may not occur frequently, but can result in severe consequences when it does happen. The doctor opts to manage the risk because of its potential severity, rather than how often it may occur.

2. Evaluate possible risk management techniques

Once risks have been identified and analyzed, the dentist must determine the risk management technique(s) that will minimize the frequency and severity of a loss. There are three primary techniques available to manage risk.

Avoidance — Dentists can opt against performing certain clinical procedures, thereby eliminating the risk of a patient injury (and possible subsequent claim) arising from that procedure. Avoidance also may be practiced by opting not to accept certain individuals as patients. For example, you may decline to accept new patients who are rude or demanding, those who have unreasonable expectations, or those who refuse radiographs.

Control — You can endeavor to control the *likelihood* of a malpractice claim by using the following *loss prevention* techniques:

- High quality dentistry that meets or exceeds the standard of care
- Good communication with patients and staff
- Appropriate documentation of care
- Adequate education and training of the dentist and staff

The *severity* of a loss can be controlled by using *loss reduction* techniques, including:

- Timely and appropriate response to adverse events, documented thoroughly
- Maintaining intact, unaltered dental records
- Early reporting of adverse incidents to your professional liability insurer
- Seeking expert professional advice prior to responding to a potential claim

Implementation of loss reduction techniques helps minimize the risk of malpractice liability and also may reduce the amount of any payment made to the claimant.

Transfer — A dentist can transfer risk by shifting the risk to someone or something else. Dentists transfer financial risks by purchasing various insurance policies. Types of coverage include professional liability, general liability, property, workers' compensation, and employment practices liability. Hold harmless agreements represent another risk transfer vehicle. However, third party benefits agreements signed by dentists typically transfer risk *from* the plan *to* the dentist.

3. Implement selected risk management techniques

The selection and implementation of techniques to prevent, control, and minimize losses that may arise from professional activities is a personal decision. Numerous risk management approaches to an exposure may present themselves, some of which will reduce the risk more than others. Select the techniques that best suit the level of liability exposure you are comfortable assuming.

4. Reassess and improve techniques

Regular reassessment and, if necessary, improvement of your risk management practices and techniques is recommended. In today's rapidly changing business and healthcare environment, risk analysis and mitigation plans should be reviewed on a routine basis, as for any important protocol or clinical technique. Reassessment should be conducted with the input of the entire dental team. The use of patient and staff questionnaires, quality assurance audits, checklists, and continuing education courses are important strategies in this effort.

Compare your results with your original lists of potential adverse events and reevaluate any areas requiring improvement. Don't forget to celebrate successes as well. It is important to discuss positive outcomes that result from the risk management process overall, as well as to recognize individual efforts by office personnel that have helped to improve patient safety and/or avert professional liability claims or other adverse outcome.

Benefits

The potential benefits of the risk management process apply to both individual dentists and to the dental profession.

Dentists enhance the overall quality of patient care through improved decision making and better dentist-patient relationships. Improved documentation and other record keeping techniques provide a more organized approach to treatment planning and completion. Well documented records also aid in the defense of malpractice claims.

The dental profession benefits from the risk management efforts of its members. Successful risk management, because it minimizes the frequency and severity of adverse events, also may affect both the affordability and availability of insurance products.

Decision-making Considerations

Decision making within the risk management process requires the assessment of numerous factors unique to the dentist, patient, and fact pattern. We are often asked by dentists confronting a difficult situation with a patient to "just tell me what to do" to resolve the matter. Unfortunately, the process is not that simple. What may be a reasonable option for one dentist may be untenable for another. However, the use of a basic approach to decision making in disputes with patients is often successful in helping dentists determine what is individually appropriate for them.

A great majority of the allegations against dentists, both founded and frivolous, are traceable to financial issues. Therefore, we'll apply a decision-making methodology to a common scenario among dentists who have contacted CNA with a risk management issue: an unhappy patient demands a refund of fees, believing that the dentist has done poor quality work. Moreover, the patient has threatened to pursue a licensing board complaint and/or a malpractice lawsuit if the dentist does not comply with the refund request within a specified period of time.

Should the dentist refund the money? That depends on a number of important individual factors, including, but not limited to:

- What you would want from your dentist if the events in question had happened to you as a patient?
- Opinions of the dentist regarding the patient and the request
- Defensibility of the treatment in adhering to the standard of care
- Thoroughness and accuracy of the dental record
- Amount of the demand
- Financial position of the dentist, and his or her ability to pay the requested refund
- History of dental licensing board complaints (and judgments) against the dentist (dental boards generally are not favorably disposed to receipt of second and third complaints against a licensee)
- Aggressiveness of the state dental licensing board
- Dentist's health and the impact of the stress created by the dispute
- Dentist's opinion of the patient's motivation, resolve, and willingness to be reasonable
- Dentist's opinion of the patient's willingness to negotiate the amount in question

As you have recognized, there is no single solution that reasonably applies to every dentist, or every situation for a given dentist. However, we can offer some insights that will aid you in making the best choice for your situation. Ultimately, the decision becomes a determination of the more satisfactory outcome for you: resolving the dispute and putting the matter behind you, or declining to meet the patient's demand and confirming your position. A variety of reasons may support either decision, and we encourage dentists to examine the larger picture and assess the risks of each course of action as part of their decision-making process. It is important to note the anxiety, stress and emotion that a claim, lawsuit or even a request for a fee refund may elicit. Preventive risk management can help by permitting the doctor to consider various scenarios in advance, before emotion and defensiveness cloud one's judgment.

Why would a dentist who knows treatment was performed properly consider giving a refund? Re-examine the previous list of factors to consider and you'll find a number of good reasons. A dentist may simply believe that patient satisfaction is a cornerstone of good practice, and that the amount of the refund is a reasonable price to pay to achieve that satisfaction. A dentist currently on probation with the dental licensing board does not want to have another complaint alleged. Or, a dentist might not be able to physically or emotionally withstand the stress of the conflict, if it progresses to a board complaint or civil action. Perhaps the treatment was performed well, but the dental record fails to properly document key aspects of treatment, such as the informed consent process. Whatever the reason, giving the refund often satisfies the patient and represents a plausible solution for many dentists.

Conversely, some dentists would opt not to give a refund. That is their right. Those who choose this path usually base their decision on "principle" or their own distaste for the "extortion" the patient has thrust upon them. These individuals must remember that the likelihood the patient will then pursue a dental board complaint or lawsuit will increase with their refusal. If you select this course of action, ensure that you have thorough chart documentation, a willingness to cooperate in your own defense, and a great deal of patience. Be prepared to take the time to speak with your claim professional, meet with your attorney, and attend all depositions and legal or administrative proceedings.

Many dentists who decline to meet the patient's demand are later exonerated in dental board proceedings as well as in malpractice actions. But how much time away from the office will it cost; and how much production will be lost? If a dentist knew in advance that the risk of a claim would be greatly reduced by simply refunding a procedure fee, would that option be worth the financial cost to that dentist? In most situations, there is neither a right answer nor a wrong answer, solely a personal decision for each dentist. Considering these factors before a problem arises may help the dentist confront accusations and "difficult" patient situations in a more objective and efficient manner, while mitigating the risk of a claim or legal action.

If a dentist knew in advance that the **risk of a claim** would be greatly **reduced by** simply **refunding a procedure fee**, would that option be **worth the** financial **cost** to that dentist? In most situations, there is neither a right answer nor a wrong answer, solely **a personal decision** for each dentist.

Dental Professional Liability

Effective Patient Communication

Upon completion of this section, you should be able to:

- **Understand the key aspects of good communication** including the role of emotional intelligence and empathy, and recognize potential communication barriers.
- **Identify challenges and potential solutions** for the identification and management of patient expectations.
- **Understand the benefits and risks of using and communicating via social media;** identify processes and procedures to mitigate risks and enhance benefits for your practice.
- **Understand and develop methods to address common communication concerns** such as treatment guarantees, angry patients and conflict resolution.

The Importance of Communication

Good communication is the foundation of a healthy and effective relationship between a patient and a dental practice. A solid relationship is built through verbal, nonverbal, and written communication. It is based on mutual trust and respect, which must be developed at the first encounter and continuously reinforced. The primary cause of many dental professional liability actions relates to breakdowns in communication.

A successful practice does not depend entirely on the clinical skill of the dentist. In fact, clinical skills may vary among both highly successful and less successful practices. Patients, and sometimes staff, have little ability to evaluate your clinical skills. Even other dentists may have a difficult time assessing the technical quality of your treatment, especially when they're not familiar with the circumstances under which it was provided.

Instead, patients evaluate your practice based upon their own criteria and their level of satisfaction within those criteria. The communication skills of you and your staff, combined with the quality and effectiveness of your office communications, represent major factors used by patients in determining their own levels of satisfaction. Patients evaluate these skills during personal conversations with you and your staff, while listening to discussion between you and your staff, and through written documents. You also communicate indirectly to patients via the décor and cleanliness of the office, the respect you have for their time, the care with which treatment is delivered, and the attire and personal hygiene you exhibit.

Improving the quality of communication between the patient and you and your staff will result in greater levels of patient satisfaction. Patient satisfaction tends to diminish the likelihood of malpractice allegations. As you pursue your professional obligations, consider the following basic concepts:

- Patients assess clinical excellence by evaluating your communication style.
- Patient satisfaction is based largely on the perception of communication, primarily its quality and effectiveness.
- Patients won't and don't tell you everything.
- Patients will leave your practice even if they don't complain or tell you why they're leaving.
- Patients who believe they have a constructive doctor-patient relationship are less likely to allege malpractice.

Both you and your patients can benefit from good communication. When you communicate clearly and effectively with patients, they tend to be:

- More compliant with your clinical recommendations and instructions
- Less fearful of treatment
- More satisfied with their dentist-patient relationship
- More understanding of you and your staff
- More likely to refer others
- Less likely to allege malpractice

What Is Communication?

Communication is an irreversible process. We can never undo what we have communicated. We may try to qualify, negate, or somehow reduce the effects of our message. However, once the message has been sent and received, it cannot be reversed. This fact underscores the importance of effective communication — sending the intended message every time using every means available to you.

Communication is the transmission of a message from one person, the sender, to another person, the receiver. Unfortunately, intended messages are frequently blocked, overlooked, or quickly forgotten. Interestingly, most of our words are never forgotten because they are never really received. Noted psychologist Albert Mehrabian found that only seven percent of communication is verbal, or relayed through the actual words we speak. The remaining 93 percent was based on how the words were presented. He found 38 percent of communication to be vocal, using characteristics such as volume, pitch, and rhythm, with the remaining 55 percent conveyed by body movement, mostly through facial expression. In truth, it's not what we say; it's how we say it that is remembered.

Effective communication in dentistry requires credibility and empathy. The strength of the dentist-patient relationship will reflect the patient's assessment of your competence and empathy. Patients will feel positive about dentists and staff who:

- Make them feel comfortable
- Seem genuinely empathic and care about them as individuals
- Seem experienced, relaxed and capable
- Appear organized, efficient and respectful of their time
- Seem open to their questions
- Are good listeners
- Give good, understandable explanations
- Look at them when they speak
- Give them the time they need
- Appear open and honest
- Talk to them personally
- Return their phone calls

Patients with whom **you cannot communicate** present **significant risks**, both to themselves and to you. In addition to precluding the **vital exchange of information**, language barriers are also an impediment to the legal requirement of **obtaining** a patient's **informed consent**.

Patient Barriers to Communication

There are numerous potential barriers to a patient's understanding of your intended message. Communication barriers negatively affect patients in every aspect of dental practice, including appointment scheduling, compiling the medical and dental history, understanding your diagnosis, making informed consent decisions, and complying with instructions. An uninformed patient presents risks to himself and to you. Two of the most significant communication barriers are language and human nature.

Language

America continues to be a diverse nation with regard to language. The U.S. Census Bureau has indicated that nearly one in five people, or 60.4 million U.S. residents age five and older, spoke a language other than English at home. While many of these individuals also spoke fluent English, the Bureau's report, *Language Use in the United States: 2009-2013*, noted that 41 percent of this group spoke English less than 'very well'. This data represented approximately 25.1 million Americans, or 8 percent of the U.S. population. This patient population clearly presents an increased risk of communication failure due to a language barrier.

Patients with whom you cannot communicate present significant risks, both to themselves and to you. In addition to precluding the vital exchange of information, language barriers are also an impediment to the legal requirement of obtaining a patient's informed consent. A patient who cannot understand your words about the nature, alternatives, and risks of treatment may contend that he was uninformed, making any consent invalid.

Be aware that depending upon circumstances and your state law, you may be required to provide translation services free-of-charge for patients with limited English proficiency (LEP). If your practice accepts federal funds (e.g., treatment of patients covered by Medicaid), federal law may require providing translation services for LEP patients.

Also note that Section 1557 final rule of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of:

- Race
- Color
- National origin
- Sex
- Disability
- Or age in certain health programs and activities.

Under Section 1557, dentists must take reasonable steps to provide meaningful access to patients with LEP, which may include translation services free of charge. If any bilingual staff person serves as a translator, that individual must meet the criteria established for other interpreters/translators. Stay up-to-date on these requirements by seeking legal advice from a qualified attorney, or contact your state/national dental society or association for further information. The U.S. government also provides an extensive amount of information on the Department of Health and Human Services website, including responses to frequently-asked-questions, information for providers and information for individuals.

Document in the patient's chart the name, address, and telephone number of the interpreter in case additional communication is necessary. The final rule prohibits use of adult family and friends as interpreters except in an emergency, or if a patient insists that an adult family member/friend interpret for them and they agree to do so. In this case, document the information in the patient healthcare record. Note that using minor children as interpreters or to facilitate communication is prohibited, except in an emergency when no qualified interpreter is immediately available.

Human Forgetfulness

"The only thing faster than the speed of thought is the speed of forgetfulness. Good thing we have other people to help us remember." – Vera Nazarian, *The Perpetual Calendar of Inspiration*

In addition to the language barrier, some messages never get conveyed simply due to human nature. An examination of information retention provides some remarkable statistics about verbal communication. Researchers have found that humans retain 83 percent of what we see but only 11 percent of what we hear. Other studies have confirmed that verbal discussions supported by the use of written or visual material produce better communication results than verbal discussions alone, particularly in low literacy patients.

Applying this information to clinical dental situations implies that patients who are only having verbal informed consent discussions or are given only verbal postoperative instructions are remembering minimal information. Providing written documents to accompany the verbal discussion would enhance retention of the information and improve patient compliance. The next time a patient insists you did not provide certain information you recall giving, your verbal message probably was never understood or simply forgotten.

Be a Better Communicator

Interpersonal skills, those which promote a good relationship between individuals, do not come naturally to all healthcare professionals. Individual methods and styles of communication are primarily learned responses to how we have communicated in the past. Many individuals were taught to communicate poorly by well-intentioned individuals who also may have been taught inadequate ways of relating. Fortunately, communication skills can be improved at any age through education and practice.

Effective communication involves more than talking. It also encompasses empathic listening, nonverbal forms of communication such as gestures and body posture, and the way in which you speak the words you've chosen.

Emotional Intelligence and Empathy

Emotional intelligence (EI) may be defined as the capacity for recognizing our feelings and those of others, for self-motivation and for managing emotions and relationships. EI allows individuals to understand and effectively respond to the emotions and moods of others; manage stressful situations; adapt to change; and work well with teams.

Empathy is the ability to recreate another person's perspective and appreciate the world from his or her point of view. Without empathy, communication loses much of its effectiveness. Increasing one's level of empathy involves caring and concentration — how much we can empathize is directly related to how much we really care about a person. Responding empathically means conveying an accurate understanding of how the other person feels, without implying judgment about whether the feelings are justified.

Malpractice claimants often state that the dentist or dental staff "just didn't seem to care about me" as a significant reason for their feelings of dissatisfaction. The underlying message: EI and empathy are an important part of an overall theme: healthcare is about helping people and *understanding and relating to their emotions* may enhance communication, clinical success, and support effective risk management.

Understanding a patient's emotional reaction or expressing more empathy toward patients can be difficult. Dentists and staff occasionally find themselves questioning the sincerity of patients and the veracity of the information they provide. Do your best to set aside any personal judgments about patients and build each patient relationship with as much empathy as possible.

These suggestions will help both dentists and staff members express greater empathy and enhance efforts to communicate effectively.

- Improve your emotional intelligence (and your decision-making abilities): by focusing on controlling and managing stress and improving communication skills, including nonverbal communication and conflict resolution.
- Adopt an attitude of caring for the patient.
- Try to recall or imagine how you would feel in similar circumstances.
- Using the behavioral cues supplied by the patient, speculate on what emotions they are feeling.
- Respond in a way that indicates your sensitivity to, and validation of, the feelings and concerns you perceive.
- When listening to what a patient is saying, concentrate on both the verbal and nonverbal messages.

Before sending **written communication to a patient**, consider how you would feel if you were the recipient. Any letter or email written in **anger should be set aside** for a day and re-examined when you are feeling less emotional. Even **patient termination/dismissal letters** should be written with an **empathetic perspective** and tone.

Nonverbal Communication

No words are as clear as the language of body expression. Nonverbal communication can send a message as forceful as any words you may speak. Your posture, your gestures, the way you look, dress, and move, your facial expressions and eye contact, or lack thereof — all convey continuous, highly believable messages about you. People believe more of what they see than what they hear.

In addition to body language, nonverbal communication permeates your practice through inanimate objects. It starts the minute a patient arrives at your office. Your office location, size, layout, and décor communicate a lot about you. So do the magazines (and the dates on them) and other reading materials in your reception area. Even the car you drive sends a message to your patients.

Other informational tools can be used to get your message across. These may include DVDs, brochures and pamphlets, photographic displays, computer-enhanced predictive imaging, study casts, and demonstration models.

The goal of nonverbal communication is to present an open, positive message with your body language and to make it comfortable for the patient to converse with you. The following suggestions will help you send positive nonverbal messages with your body language.

- Position yourself at an eye level equal to that of the patient.
- Maintain good eye contact, focusing on the patient's eyes whenever you are speaking or listening.
- Face the patient squarely. Sit with arms and legs uncrossed and your shoulders and hips toward the patient in an upright posture with your feet on the floor.
- Lean toward the person speaking to you.
- Give positive feedback with facial expressions and gestures.
- Do your best to be relaxed and natural. Nonverbal communication works best when it's done automatically, which requires practice to feel comfortable.
- In clinical settings, remove your mask and seat the patient upright. Return the patient to your eye level when important information must be discussed.

A good way to assess and improve your nonverbal communication is to videotape yourself during a conversation. Then, replay it without the sound and assess the messages you've conveyed, either deliberately or inadvertently.

Listening

Listening — the process of receiving, constructing meaning from, and responding to verbal and nonverbal messages — is a cornerstone of effective communication. One of the greatest attributes a dentist or healthcare provider can possess is being a good listener.

Poor listeners often interrupt in mid-sentence, finish sentences for others, or change the subject to fit their agenda. Their nonverbal cues include signs of impatience, such as fidgeting or looking at their watch, at papers, or around the room. They fail to make direct eye contact and often have their arms folded or legs crossed.

Instead, position your body to be an attentive listener using the nonverbal suggestions outlined. Once your body is in position, place your mind in the proper reference. Follow these suggestions to improve your listening skills.

- Be a patient listener. Avoid interrupting at all costs and limit your own talking.
- Tune out distractions and concentrate intently on what the speaker is saying.
- Suspend judgment. Don't dismiss the value or importance of what is said by a person speaking in a monotone voice, or with a foreign accent.
- Listen for the feelings behind the facts.
- Clarify by asking questions and paraphrasing.
- Make positive comments.
- Focus on both verbal and nonverbal messages. Recognize both consistent and inconsistent messages and discern the meaning the patient is trying to communicate.
- Be aware that your posture affects your listening.
- Maintain control over your emotions.

Speaking

How you speak often says more than the words you say. There are vocal components of speech apart from the verbal content that affect others' perceptions of your intended message. These factors include your volume, pitch, and tempo, and the emphasis you place on certain words.

Everyone wants to be clearly understood when speaking. Here are some suggestions to improve the effectiveness of your communication with patients and others.

- Control the volume and tone of your voice to help convey your intended message.
- Shorten your sentences, eliminating unnecessary words.
- Speak about things you know first, and then move to the unknown.
- Present only a few main ideas.
- Talk using pictures and action language.

Choosing Your Words

Although other aspects of communication are clearly important, it is essential your words are an accurate expression of what you intend to convey. Accuracy is important when informing patients of your clinical findings, your diagnosis, and your treatment recommendations; informing your staff of treatment or communication directives for patients; and informing colleagues of referral specifications.

To maximize your communication power, we suggest the following:

- Use plain language — accurate, straightforward words that are easily understood. Limit your use of dental jargon and clichés.
- Whenever possible, be specific rather than vague. For example, state "You have an infection" rather than stating "It appears you might have signs of an infection".
- Don't overstate or understate important information, such as the risks or goals of treatment. For example, tell patients about *numbness* rather than *paresthesia*; *pain* rather than *discomfort*; *disease* rather than *condition*. Another example is "We hope to *improve* your periodontal health" rather than "*cure* your periodontal disease".
- Explain yourself thoroughly. Rather than simply state "That tooth might need a root canal," give the patient an understanding of why you believe that statement to be true. What do you see? What other factors are involved? In what time frame might this occur? Under what circumstances?

Accurate, consistent word usage not only improves a patient's understanding of your message, it also minimizes the potential development of unrealistic expectations.

Written Communication

Dentists often underestimate the damage a poorly worded letter or email can do to an otherwise positive dentist-patient relationship. Many well-meaning dentists, office managers, and billing coordinators have corresponded with patients in an attempt to convey an important concept or explain an issue. Unfortunately, many of those communications have had the opposite effect, offending the patient or exacerbating the situation.

Before sending written communication to a patient, consider how you would feel if you were the recipient. Is the content professional in its tone? Does it convey the message you intended to communicate? Does it express empathy for the patient's point of view? Any letter or email written in anger should be set aside for a day and re-examined when you are feeling less emotional. Even patient termination/dismissal letters should be written with an empathetic perspective and tone.

Dental practices also correspond with physicians and other dental practices. The need for clarity in such professional communication is of great importance. An error in a referral letter, for example, could lead to improper or unnecessary treatment or treatment of the wrong tooth or area.

Be certain to check all correspondence for correct spelling, grammar, and punctuation. Errors such as these imply that you are careless, lazy, or inattentive to detail. Most word processing programs have spell- and grammar-checking capabilities built into the software but the feature may require activation if not set to "on" as a default.

Communication Styles

People vary greatly in their style of verbal communication. Some are very open and effusive — they will sit in the dental chair and recount all of their previous dental experiences with little or no prompting. Others are far more reserved and will only give as much information as your question required. Because each dental team member possesses his or her own style of communication, it is not surprising that certain personality types or communication styles do not mesh well together.

From a professional liability perspective, all dental team members should be well-versed in understanding and communicating with a variety of communication styles. This competency facilitates not only a more open exchange of information, from expectations to patient education, but also gives patients a greater sense of personal attention and understanding. It would be ideal for both dentist and staff to be able to converse in the communication style in which each patient feels most comfortable.

To that end, we encourage dentists to become knowledgeable regarding personality and communication styles, and to include their staff members in the process. After all, in most practices it is the dental staff — receptionists, dental assistants, and hygienists — who have the greatest amount of contact and communication with patients. Understanding personality and communication styles can be gained through dental continuing education courses, books, workshops, and other forms of training. The method of learning is far less important than the end result of imparting and receiving important information that affects clinical treatment in addition to patient satisfaction.

Communication During the Initial Appointment

Establishing a relationship

As the saying goes, you only have one chance to make a first impression. The patient's impression of you at the initial appointment will be shaped by what you say and how you say it, combined with your nonverbal body cues. You can create a positive impression and promote effective communication in this new relationship by incorporating the following suggestions into your initial patient encounter.

- Introduce yourself by name while making eye contact. "Hello Mrs. Jones, I'm Jack Smith."
- Do not wear gloves, a mask, or safety glasses when first meeting with the patient.
- Initiate the discussion by asking an open-ended question such as, "How can I help you?" or "What can I do for you today?"
- Be confident, cordial, empathic and compassionate.
- Express an interest in the patient's interests, family, occupation, and hobbies.
- State the purpose and approximate length of the appointment.
- Assess the patient's expectations and any misconceptions regarding treatment.
- Listen carefully to the patient's needs, desires, and problems: confirm that you have heard and understood important points with the "tell-back" method by re-stating and summarizing.
- Ask patients to help in defining treatment needs.
- Say something complimentary or positive.

Obtaining information from the patient

When questioning the patient during the initial appointment, use your communication skills to obtain answers for the following:

- How he or she wishes to be addressed
- Reasons for seeking treatment at this time
- Chief complaint
- Patient's perception of present dental condition
- Fear or anxiety about treatment
- Patient's expectations (see Managing Patient Expectations, on the following page, for more on some areas of expectations to consider)
- Review and clarification of the medical and dental history

Managing Patient Expectations

Many risk management problems and their subsequent solutions have their roots in how well a dental team can assess and actively manage patient expectations. Unfortunately, failure to meet patient expectations continues to be a major cause of professional liability actions. Through careful communication with patients and staff, you can discover and understand what patients know about dentistry and what they expect from you and your practice. Then you can assess if their expectations are reasonable.

Most patient expectations are satisfied through the course of routine dental care. However, unstated or unreasonable expectations may often present a significant malpractice risk, especially when undetected by the dentist during the course of treatment. Our experience has shown that failure to meet a patient's expectations can be a significant factor in a patient's decision to file a claim alleging professional liability.

Dental professionals often mistakenly believe that their patients are informed about dentistry. However, most patients do not possess such information: their health literacy level (and their *oral or dental* health literacy) is typically inadequate. Assumptions about a patient's ability to separate fact from fiction in all the dental information he or she has previously acquired are simply conjecture. What patients know or think they know about dental treatment affects their expectations of the dentist and his or her staff. Therefore, the dentist must determine the level of dental knowledge of each patient and also educate the patient through a variety of methods. Providing educational services and opportunities via brochures, articles, in-office audio and video media and/or via a practice website represent sound approaches in the process of helping to manage patient expectations. These efforts support the doctor's role as "teacher", but equally important, are education and improving oral health literacy directly support risk management activities such as informed consent. And while patient education and improvements in oral health literacy will not solely improve treatment outcomes, the likelihood of a satisfactory treatment result is enhanced. Clearly, informed and knowledgeable patients who understand and accept treatment risks and possess reasonable treatment expectations will be better able to respond to your professional services.

Patients may have expectations regarding a variety of issues, including reception room waiting time, the cleanliness and presentation of the office, financial and insurance considerations, as well as clinical care outcomes. You may have heard of the term "gap analysis" in the business world: a comparison of actual performance versus potential performance or an industry benchmark or expectation. In this case, the distance between a patient's expectations and your ability to meet those expectations (actual performance) constitutes what we refer to as a "malpractice gap". There may be a number of strategies to address and then close the malpractice gap. Ultimately, the dentist should effectively adjust, re-set or lower the patient's expectation to a reasonable level, or raise his/her level of performance to meet or exceed it. By reducing or eliminating the gap, reducing your risk of patient dissatisfaction that may lead to malpractice claims, serves both patient interests and that of your practice.

Patients expect to have a courteous and **professional relationship** with everyone associated with your practice. **How you and your staff interact** with one another and with patients **communicates** your level of courtesy and **professionalism**.

Sources of Expectations

Patient expectations of you and your practice are derived from many sources. A primary source is your own practice, whether directly or indirectly, in the form of:

- Advertising, including your Internet web site, practice brochures, promotional mailings, telephone directory
- Discussions or telephone interaction with you or your staff members
- Word-of-mouth referrals from existing patients
- Intraoral imaging and computerized predictive result planning

Patients also develop expectations based on factors that are external to you and your practice. These expectations are often derived from media sources, such as television shows, the Internet, print media, and news reports. A patient's interaction with prior dental offices, immediate and extended family, as well as his or her own personal experiences — both good and bad — are also factors.

The increasingly consumerist view of the American public has greatly affected patient expectations. Many patients have taken the retail marketing principle of "satisfaction guaranteed or your money back" and extrapolated it to dental care. If dissatisfied with the end result, they are not shy about asking for a refund, regardless of how hard you worked to please them, your laboratory costs, or the number of hours they spent in your chair. They view dentistry as a commodity rather than a service, and thus believe the finished product should conform to their expectations. These views have created significant functional and cosmetic expectations from the perspective of patients. Can every dentist in the U.S. deliver on these expectations? It is unrealistic to believe so. What matters is whether *you* can assess, fulfill, or manage and *adjust* the expectations of the patients that seek your services.

Patients expect to have a courteous and professional relationship with everyone associated with your practice. How you and your staff interact with one another and with patients communicates your level of courtesy and professionalism. Seemingly simple and routine components of a practice, such as telephone protocols, staff interaction, appointment scheduling, dissemination of information, and answering patients' inquiries are critical factors which can improve patient satisfaction if well managed.

Criteria of Judgment

Patients generally lack the knowledge and experience to objectively evaluate a dentist's clinical skills. As a result, patients judge their dental care experiences based upon different criteria than dentists and their staff. Patients use a basic approach to judge their dental experiences, basing their satisfaction on:

- How long did it take?
- How much did it cost?
- How much did it hurt?
- How do I look?
- How long did I wait for an appointment?
- How long did I wait in the waiting room?
- Was I treated courteously and professionally?
- Was my financial account handled properly?
- How well was I kept informed?

Although these criteria may not accurately measure your clinical skills, they form the basis of patient satisfaction.

Dissatisfaction also may result from misunderstandings about the technical clinical limitations of treatment. You may provide high quality dental care. However, if a patient expects a result beyond the limitations of clinical dentistry, then he or she is likely to be dissatisfied. A classic example is the elderly patient who requests replacement dentures. She has brought to her first appointment the seven sets made in the past five years, each by a different dentist. None of the dentures fit to her satisfaction or make her look young enough, although all appear clinically acceptable. Can you make a new set of dentures that will satisfy her?

Patients also judge your practice, in part, by the quality of the staff you employ. Hire individuals who can project the image you desire and train them accordingly. It is often said that tasks can be taught, but kindness, empathy, and concern are qualities that cannot be learned.

Controlling the risks

Patient selection

- It is important to not only address reasonable patient expectations but to consider and effectively communicate the expectations that *you and your office have of all new patients.*
- Accept only those patients who understand and accept responsibility for their own oral health status and conditions, and who understand your role to help them achieve improved oral health.
- Accept only those patients who understand and accept that achieving "improved oral health" is a shared responsibility of both the patient and dentist.
- Accept only those new patients whose clinical needs and expectations coincide with what you believe you can reasonably provide. Educate and help patients to understand realistic outcomes: don't succumb to patient pressure or accept unreasonable expectations.
- Accept only those new patients who meet your expectations for patient cooperation. Be cautious when patients are unwilling to discuss their past dental history or provide a copy of past dental records.
- Accept only those new patients whose financial expectations are compatible with the financial protocols and philosophy of your practice.

Communication

- All dental personnel should be courteous, sympathetic, and empathic.
- Provide new patients with informational brochures or handouts that include your office policies regarding billing, canceled appointments, after-hour emergencies, and other protocols. Review policies with the patient periodically, especially before undertaking a major new treatment plan.
- Provide patients with consistent information about your practice.
- Discuss the patient's expectations of you and your staff, beginning at the initial visit.
- Determine your patient's level of knowledge about dentistry and assess his or her oral health literacy.
- Describe billing practices to each new patient.
- Ask patients their expectations concerning proposed dental treatment and the possible treatment outcomes. Address functional, esthetic, and financial expectations in the discussion.
- Educate your patient about why certain expectations cannot be fulfilled, and that dentistry has its limitations. Covering the treatment *prognosis* as part of informed consent is an important part of addressing potential unrealistic outcome expectations. Delineating the possibility of treatment failure and its possible causes may help the patient to understand and accept that no dental treatment option is perfect, though there is usually a preferred option, depending upon the patient's condition and priorities.
- Regularly re-assess the expectations of your patients, especially when you are in the midst of a long-term (greater than three months) treatment plan. Have expectations shifted or become unrealistic? The patient's family situation, career plans, medical conditions, financial priorities and many other factors may change at any time and significantly affect expectations.
- When staff members learn of specific patient expectations or concerns that could become a barrier to patient satisfaction, they should inform the dentist. The dentist, in turn, must be tactful in his or her discussion of the matter with the patient. If the subject is broached, such discussion should not compromise the quality of the relationship between the patient and the staff member.
- Inform all new patients of the general circumstances under which they should expect you to refer them to a specialist.
- Train your staff in your preferred manner of answering questions from prospective patients.
- Ask patients who have been referred to you by another dentist or a current patient what they were told about you and your practice, so you may correct any misinformation before it interferes with your new dentist-patient relationship.

Office issues

- In and around the office, keep all areas, including the reception area, clean and neat in appearance. Patients expect healthcare offices to be clean and sanitary, and the level of cleanliness of your practice influences patient opinions of your practice.
- Similarly, make at least some infection control practices obvious and observable to patients. Inform and educate patients about how your office protects their health through infection control practices.
- Make the names of all staff members known to patients (introductions, name tags, etc.).
- Hire individuals who can project the practice image you desire and train them accordingly.

Consider sending an introductory brochure to prospective patients informing them about your practice. Communication of such information immediately begins the process of molding a prospective patient's expectations to conform with how your practice functions, while also informing and educating them about your expectations of patients. It also serves as a framework for further communication between the patient and the practice regarding important issues and policies. Patients are more likely to comply with office policies when they know them from the outset.

The brochure could include information such as:

- A short description of you and your staff
- The services you provide, including specialty information and educational services/opportunities
- Any special dental procedures you perform, such as implants or cosmetic procedures
- Office hours and days of practice
- Location, transportation, and parking
- Office appointment policy, including emergency care
- Insurance plans accepted
- Billing and payment procedures
- The phone number of your practice
- Broken appointment fee policy, if any
- The importance of providing a complete and accurate medical/dental history
- Shared responsibility for oral health: improved health requires a patient-dentist/dental office team approach

Keep in mind that your patient has a specific set of expectations when coming to your office. You must assess those expectations by carefully listening to and communicating with your patients in order to manage the expectations accordingly. Educating and communicating with patients to improve their oral health literacy, and gaining acceptance of their responsibility for their own oral health are strategies that will help to manage expectations, improve patient satisfaction and reduce professional liability risk.

Electronic and Social Media

Electronic media — including email, blogs, social networking sites, websites, texting and instant messaging — have become a primary means of self-expression for many individuals, including dentists and dental practice personnel. The ever-growing volume of electronic communication has created a new sense of connectedness and a new cluster of risks.

A growing number of dentists are now expanding their networking ability by linking their practice-based Web sites to the following types of media platforms:

- Social networking sites, such as Facebook, which promote mutual sharing of news and information, as well as marketing messages.
- Video and photo sharing sites, including YouTube, Flickr, and Instagram.
- Micro-blogging sites, such as Twitter, which encourage interaction via short published messages and links.
- Weblogs, including corporate and personal blogs, as well as blogs hosted by traditional media publications, which communicate ideas and opinions in journal format.
- Business networks, such as LinkedIn, connect job seekers and potential partners to the practice or organization, and colleagues with each other.
- Numerous forums and discussion boards support sustained dialogue among their community members.

The risk exposures associated with electronic and social media use in healthcare continue to evolve and expand with increased usage. The following cases demonstrate a few ways in which electronic communication is increasing dental office risks. Although the examples are specific to dentistry, all areas of healthcare are increasingly affected.

- A dentist who advertises the availability of cosmetic procedures "tweeted" that she achieves "outstanding results" without substantiating data to support the remarks. Some of her patients, who were dissatisfied with their treatment outcomes, complained to the state board of dental examiners. The board sanctioned the dentist for false and exaggerated representations under federal and state truth-in-advertising laws.
- While on his dental practice Facebook page, a dentist accepted a patient's online "friend" request and began communicating with the patient regarding her current course of care. The patient relied on the dentist's advice in lieu of seeking onsite care, eventually suffering serious complications from an apparent delay in treatment. Subsequently, a lawsuit was filed against the dental practice, asserting unethical conduct on the part of the dentist, among other allegations.
- Under an adopted "username," a dentist blogged about why he preferred not to treat patients who carried a certain type of dental insurance. Shortly thereafter, a patient with the specified insurance coverage sued the dentist, alleging a missed diagnosis and negligence. The plaintiff's attorney was able to obtain and produce copies of the blog postings, making the case more difficult to defend.

These exposures could have been avoided had proper social media safeguards been implemented. Dentists should be aware that litigation discovery requests may go beyond the traditional scope of patient treatment and financial records, and may now encompass text messages, blog entries and social media postings. Consequently, dentists must understand the exposures associated with these media and create practice policies that recognize their benefits while minimizing the risk potential due to carelessness or misuse.

Recognizing risk factors

The use of social media and electronic devices by dental personnel may result in the following risk exposures, among others:

Patient privacy. Workplace emailing or text messaging may violate privacy and security requirements imposed under the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the regulations promulgated under these laws. While unencrypted email for treatment-related communications is not prohibited for direct communication to a patient, reasonable safeguards must be taken to protect patient information when communicating electronically. However, the potential exists that protected health information (PHI) may be inadvertently transmitted to an unauthorized third party, which would represent a breach of unsecured PHI and thus a violation of HIPAA. Therefore, the use of HIPAA-compliant encrypted email systems and other methods to protect electronic patient/provider communications and thus help to ensure compliance. If PHI is revealed on practice-owned equipment or employee-owned devices used for healthcare-related purposes, this may constitute a breach of the HIPAA Privacy and Security Rules and related state laws. Also, the use of cellular telephones to take and share photographs or audio and video recordings relating to a patient has significant privacy implications. HIPAA privacy and security requirements (and technology systems) are complex and enforcement activities continue to increase. From a risk management perspective, legal and regulatory compliance is critical in today's healthcare environment to protect patients from improper disclosure of PHI. Implementation of a HIPAA compliance program, including ongoing staff training, to remain current, represents an important element of your practice protocols. Many resources and tools are available to help you comply, and many are freely available government resources. Several resources are provided in the manual bibliography for reference and further study.

Organizational liability and impact on litigation. Harassing, threatening or otherwise inappropriate messages posted by employees from workplace computers or texted from employer-issued mobile telephones can create vicarious liability exposure for a dental practice. And as seen in the previous examples, improper litigation-related postings and text messages can undermine legal defense efforts.

Workplace productivity and patient safety. Texting and conversing on cellular telephones in patient care areas may decrease staff efficiency and lead to distraction and error, thereby endangering patients. Even the use of MP3 players and other headphone devices can create a sense of disconnection from the environment, impairing communication and slowing response time.

Network security. Unregulated web browsing and emailing on networked computers can introduce viruses or spyware into the system, resulting in possible data loss, theft or damage. In addition, sharing of passwords and other security lapses can compromise confidential information, with potentially serious regulatory and liability implications.

Risk to reputation from external use. Patients' use of electronic media, especially through blogs and online rating sites, creates reputational risk exposures for the dentist and the practice. Many states have enacted laws that affirm the patient's legal right to offer a public opinion, even if that opinion is considered inaccurate or offensive to the dentist. Moreover, a number of legal cases involving a dentist's challenge to the patient's statements have not resulted in a favorable outcome for the dentist.

Risk to reputation from internal use. Utilizing social media forums to recruit new patients or build practice loyalty may damage a practice's reputation, unless the effort is managed in accordance with best practice guidelines. Risk exposures include, but are not limited to, jurisdictional issues and allegations of fraud and defamation.

The virtual dental practice?

Expanding on the concept noted above regarding internal use, launching your own social media site requires preparation, planning and attention to a number of risk management considerations. Before initiating a social media project, dentists should fully consider its implications from a strategic, marketing, liability and information security perspective. The following questions can help focus the planning process:

- What is the underlying purpose of the social media activity?
- Does the proposed social media presence complement the business strategy of the dental practice?
- Who is the intended audience for the site, page or profile?
- Which topics, activities and forms of interaction will be promoted, and which will be excluded?
- Are adequate human and financial resources available to maintain and update the project on an ongoing basis?
- Which media platform, tool or application is best suited to the intended purpose and audience?

Dentists may wish to retain a social media specialist to answer these initial questions, as well as to assist in the planning and implementation of the following essential activities:

- Establishing practical boundaries and guidelines for electronic media use
- Promulgating sound operating rules and security controls to protect against infiltration and other external threats
- Negotiating with vendor platforms regarding terms of use, such as requirements for separate login pages and written notice of changes in privacy conditions and provisions assessing platforms, applications and/or vendors regarding capabilities, consumer familiarity, costs, convenience and security considerations
- Reviewing insurance policies for potential cyber liability coverage gaps and recommending portfolio changes, where necessary

Once the site goes online, the social media consultant also can help educate staff, patients and other users on rules and etiquette; advise on updating guidelines; assist legal counsel in reviewing and updating vendor contracts and site controls; and ensure that all social media tools have a consistent identity and appearance, including appropriate use and placement of the practice logo.

Controlling the risks: general social media use

Dental office policies should directly address the issues raised by the proliferation of electronic media, in order to clarify the expectations of employees and reduce liability exposure. The strategies that follow are designed to help dentists effectively manage the widespread use of these communication tools.

- Create and enforce a formal policy governing personal use of networked computers, with provisions that strictly prohibit all messages and activities of an offensive, threatening, harassing, defamatory or unprofessional nature.
- Request that employees sign a form confirming that they understand the rule and the consequences of noncompliance. Signed forms should be retained in employment files.
- To maintain morale, consider installing non-networked computers for personal use during lunch and breaks.
- Provide staff with written copies of the electronic monitoring policies. Explain that employers have the right to monitor email messages and other communications on practice-owned computers and that inappropriate conduct may have disciplinary consequences, up to and including termination.
- Regulate cellular telephone use by staff members, specifically addressing such key issues as personal calls while at work, confidentiality, conversational volume and etiquette, talking while driving and utilization of the camera feature.
- If you provide employees with practice-issued cellular telephones, issue separate, more stringent policies that reflect the vulnerability of your practice to vicarious liability.
- Regularly revisit the privacy and confidentiality policies of your practice, taking into consideration the risks of posted and texted messages containing PHI or other sensitive material.
- Convey to staff the possible implications of careless use of social media, including the permanence and recoverability of deleted messages, limits of anonymity and realities of e-discovery. Clearly describe both the nature of the risks and the consequences of policy violations in the employee handbook, and reinforce the importance of sound judgment through staff training.
- Remind all personnel that, as a threshold requirement, they must receive written authorization from patients prior to discussing their cases on blogs or web sites. Postings should not include individually identifiable information.
- Encourage appropriate etiquette and a mature attitude. Remind staff members that they are viewed as ambassadors of the practice, and their posture on the Internet should reflect this fact. Consider assigning mentors to coach less experienced staff in understanding the nuances of professional conduct.
- Regularly underscore cyber security rules and concerns, using orientation and training sessions, posters, supervisory reminders and other means.
- Ensure that both legal counsel and information technology staff review all social media-related policies for regulatory compliance and technical relevance.
- Foster constructive use of social media. Many dental practices and other healthcare organizations creatively utilize this technology for purposes of outreach, reputation management and emergency communication. Written policy should address the following important considerations: guidelines for engaging e-patients; protocols for managing online conversations; parameters for giving patients both personal medical advice and general medical information; procedures for combining social media with personal health records; and criteria for disengaging e-patients (e.g., publishing derogatory statements or falsehoods about the organization).

Launching your own **social media** site **requires preparation, planning and attention** to a number of risk management considerations. Before initiating a social media project, dentists should **fully consider** its **implications** from a strategic, marketing, **liability** and **information security** perspective.

Controlling the risks: dental practice social media sites

The following measures can help limit liability exposure associated with developing and launching your own practice social media site:

Draft formal policies and procedures. Written guidelines should be designed to protect patient privacy, prohibit misleading and harassing statements, and specify the individuals authorized to speak on behalf of the practice. Guidelines also should mandate review by legal counsel of internal protocols, vendor operating policies, and contract provisions regarding privacy obligations and security controls.

Incorporate social media issues into staff training. Sessions should cover such key concerns as social networking protocol and expectations, parameters for use during working and non-working hours, potential legal pitfalls, patient confidentiality issues and disciplinary consequences of misuse. Offer training to all new employees upon hire and annually thereafter, documenting session content and attendance.

Establish standard terms of use. Inform users that they are subject to the site's terms and conditions and that repeat violations will result in termination of access. The "click agreement" with users should be written in clear and unambiguous language and include these basic provisions, among others:

- Users understand the risks associated with participating in online communication and acknowledge that postings by dentists and staff are not intended to be interpreted as a dental diagnosis or treatment.
- Service marks and trademarks of the practice are the sole property of the organization, and no copyrighted text, image, video or audio content may be distributed, modified, reproduced or used, in whole or in part, without prior consent of the practice.
- Blog postings may be edited or deleted by the practice without prior notice, and abusive, illegal, disruptive or medically misleading communications are subject to immediate removal.
- Disclosure of patient health information shall be governed by patient privacy policies, as well as relevant federal and state privacy laws. Solicitation of confidential or proprietary patient information is strictly prohibited.
- The practice is indemnified against any damages, liabilities, judgments or expenses arising from any third party claim involving posted material.

Prepare disclaimer statements. Sites should include the following standard disclaimers:

- All content and information are of an unofficial nature and are not intended to be interpreted as dental advice.
- The views expressed are those of users and do not necessarily represent those of the practice.
- The sponsoring practice is not obligated to monitor chat rooms, Facebook pages, bulletin boards or other interactive areas where visitors post their comments.
- Institute strict editorial controls. Written guidelines for user-posted comments should include the following restrictions:
  - Postings cannot contain specific patient data or other confidential information.
  - No unlawful material can be posted on the site, nor any content that could be considered obscene, defamatory, threatening, harassing or malicious.
  - No material can infringe on the rights of any third party, including rights to intellectual property, privacy or branding.
  - Superlative and absolute phrases are to be avoided, such as "best care," "highest quality" or "state of the art," as they may be used in a legal action alleging breach of an express or implied warranty.
  - Messages may not entice prospective patients to expect care beyond the practice's capabilities, nor rely on falsely promised accommodations.
  - Any off-topic material may be deleted, including the promotion of outside products, services, groups or organizations.
  - The practice reserves the right to remove posts advertising commercial products, including business solicitations, chain letters or pyramid schemes. Platform settings should disable advertisements and "pop-ups," when possible.
  - Users may not impersonate another individual or share their identity and password.

Develop an incident response plan. The written response plan should address violations of site rules, such as password compromise, hacking, or posting of unauthorized patient images or other inappropriate content. At a minimum, the plan should encompass removal of objectionable material, notification of offenders, documentation and reporting of incidents, staff follow-up action and disciplinary standards, drafted in compliance with relevant employment laws.

In conclusion, electronic media define connection in today's world. Dentists and dental practices should establish a balance between their own and staff members' reliance on these ubiquitous communication tools and the perils posed by their misuse. The measures described can help minimize risk by providing practices with the needed guidance.

Communication Concerns

Schedule Delays

Be respectful of the patient's time. Lengthy waiting time implies that the patient's time isn't as valuable as the dentist's. Delays upset the patient's schedule and contribute to decreased patient tolerance when something goes wrong in the course of treatment. If the practice is behind schedule, tell all affected patients. Those who will be seriously inconvenienced by a long wait should be offered the opportunity to reschedule their appointment. In addition to staff apologizing for any delay, the dentist should offer his or her apologies and explain the reason for the delay. Have the staff check on the patient on a regular basis to ensure that the patient is not left alone for long periods of time. In effect, staff may serve as the patient's advocate, a technique that can greatly enhance the communication process and the patient's satisfaction.

Guarantees and Warranties

Treatment guarantees and warranties expose dentists to breach of contract claims, which, in many jurisdictions, have a longer statute of limitations than malpractice claims. Additionally, breach of contract claims do not require the plaintiff to prove that the dentist breached the standard of care. Rather, the plaintiff must prove only that the treatment outcome did not achieve the guaranteed result.

Some dentists clearly intend to guarantee their work and expressly state that fact to patients. Others inadvertently offer guarantees through their words (or those of their staff) or due to misunderstandings by patients.

Superlative words offered by dentists may seem to patients to be a promise of more than what can be delivered. Words such as "best, finest, fastest, smoothest, cleanest, whitest, strongest, most comfortable, most aesthetic, quickest, cheapest, highest quality" can imply a guarantee. Phrases such as "I'm certain you'll be happy with your new veneers," "Don't worry, this treatment will solve your problem," and "I've done that procedure dozens of times without a problem" may suggest a warranty or guarantee.

You may know that the patient was never promised anything. You or your staff members were just being reassuring. From the patient's perspective, however, simple words may reverberate as pain, frustration, and dissatisfaction increase. You need not hesitate on every word you say to your patients for fear of misleading them. However, it is optimal to clarify your intention as much as possible.

Managing the Angry Patient

Patients may become angry about a variety of issues or activities within your practice. Remember though, that an angry outburst may also be completely unrelated to you or your practice. The patient may be "on edge" due to personal/family problems, conflict in the workplace, or someone may have cut them off in traffic on their way to their dental appointment! Remaining calm in this situation is an important clinical skill to develop and refine. When communicating with an angry individual, keep the following in mind:

- Inform your staff that you will take care of angry patients. Ask them to immediately inform you about these patients.
- Speak with the patient immediately, if possible. Strive not to defer the patient's concerns until a later time.
- Take the patient to a private room to discuss the matter.
- Allow the patient to vent without interruption. Sometimes, allowing the patient to express his or her concerns is all that is necessary.
- Validate emotions to help disarm the patient and de-escalate their anger ("I understand your frustration" or similar validation).
- Do not belittle the patient's concerns. If an issue has caused the patient to become angry, take it seriously no matter how trivial you may regard the issue.
- Do not get caught up in his or her anger.
- Do not feel compelled to defend every aspect of your practice. No practice is perfect and there is strength in admitting it.
- Address reasonable concerns. If you cannot fix the problem, make sure another staff member attends to it. If you cannot address a problem immediately, tell the patient when you will respond.
- Disregard unreasonable criticism. Do not even respond.
- Summarize the issue after the patient has vented. Clearly state what you will do and when to help resolve the problem.

There are numerous approaches to managing an angry individual: many share the same or similar points emphasized here. Additional resources are included in the bibliography for further review and study.

An Approach to Problem Solving

Even good communication can occasionally break down. That's when problem-solving skills are needed. Regardless of your role on the dental team, you never know when you may find yourself in the midst of a conflict regarding clinical care, financial issues, appointment scheduling, or staff concerns.

As the risk management process has a specific sequence of steps, it is also useful to analyze and address conflict in a stepwise manner. One point to remember is that conflict may arise for any number of reasons, but are typically both factual and emotional aspects to disagreements. Considering both the nature of the disagreement and the feelings associated with the conflict is important to a mutually-agreeable resolution.

1. Define the conflict, remembering to use EI and empathy to connect with what is felt, not only what is said.
2. Analyze the situation.
   - Who is involved?
   - What is the problem? What is its nature and scope?
   - When did the problem occur? How much has the problem escalated?
   - Where did the conflict occur? In what context, situation, or place did the problem surface?
   - Why did the problem arise?
   - How did the problem occur?
   - What occurred that precipitated the conflict? Does anyone have a hidden agenda?
3. Focus on resolving the conflict and mutual respect, rather than blaming, being right or winning and argument.
4. How important is the issue? Does it represent a challenge to personal or practice core values or a minor, negotiable point?
5. Generate alternative solutions.
6. Project the possible outcomes of implementing each alternative solution.
7. Ask the patient what he or she believes is a reasonable solution before offering a solution yourself.
8. Select and agree on a plan. If you can't come to an agreement, know when to let something go. Is it possible to agree to disagree?
9. If agreed to a solution, implement the plan.
10. As with the risk management process, assessing and evaluating results is an important final step.

Dental Professional Liability

Pre-treatment Issues

Upon completion of this section, you should be able to:

- **Develop and implement procedures to document and update** a comprehensive medical history for all patients.
- **Recognize the importance of both comprehensive and limited patient examinations,** and the documentation methods that may be applied to mitigate their associated risks.
- **Describe the risks involved and actions to consider** when patients refuse dental radiographs.
- **Identify and apply the current recommendations for patients related to pre-treatment concerns** such as: infective endocarditis; orthopedic implants/joint replacements; and pregnancy.

Medical History

An accurate, thorough, and current medical history represents an essential tool in providing quality dental care. It also protects both the patient and you from unnecessary risks. Failure to obtain, update, and investigate the patient's medical history have all been alleged in professional liability claims asserted against dentists.

The primary purpose of a written medical history is to inform you of the patient's past and current physical status, reducing the likelihood of injury. By taking and regularly updating the patient's medical history, you can prevent drug interactions, identify oral manifestations of systemic diseases or pharmacotherapy, and better manage patients with such medical conditions as heart disease, high blood pressure, cancer, and diabetes. Evidence of a dentist's lack of diligence in asking for and distributing vital medical information would strongly support a patient's claim of professional negligence.

An accurate, thorough, and current **medical history** represents an **essential tool** in providing quality dental care. It also **protects** both the **patient and you** from unnecessary risks.

New Patient Medical Histories

- Have each patient complete a thorough, written medical history at the initial visit.
  - Consider using forms that require a specific "yes" or "no" response from the patient.
  - Ask about allergy to latex, drugs, and nickel, as well as any other allergies.
  - Document all prescription drugs, over-the-counter drugs, dietary and herbal supplements, and non-prescribed drug and alcohol use.
- Have access to a current drug reference manual and use it frequently or contact a pharmacist, if needed. Review for possible ramifications with dental procedures and possible drug interactions, if dispensing or prescribing. Electronic drug reference manuals represent an excellent supplement to or replacement for a hard copy manual. Electronic drug resources are typically updated regularly or continuously to provide the latest information available.
- Before beginning treatment, orally review the medical history with the patient using everyday language the patient can understand. An oral review is essential, since many patients do not fully understand medical and/or dental terminology.
- Visually assess the patient, noting physical and/or psychological problems that may not be evident from the written history.
  - Check and record the blood pressure. This is especially important for patients with a history of hypertension or other cardiovascular conditions. Recording initial blood pressure and pulse for dental patients over 12 years of age is *required* to meet the standard of care in Texas (Rule 108.7(2)(B)). Make sure to investigate and comply with any similar requirements in your state.
- When the entire medical history interview is complete, the form should be physically or electronically signed by both the dentist and the patient. *Throughout this section, note that recommendations for signature, initials or other validation refers to use of acceptable validation methods for paper and/or electronic records.*
- Important health history information should be displayed in a prominent location *inside* the dental record, allowing all providers and staff to be aware of drug interactions, allergies, infectious diseases and other potential complications.
- *Never* place medical alert information on the outside of a patient chart, as this may be construed as a violation of patient confidentiality. Caution must also be exercised with such information if displayed on a computer screen.

Updating the Medical History

Good dentistry depends upon always having the most current information about your patients' health and checking their medical history before beginning treatment.

- The following steps should, therefore, be taken at *each and every visit*:
  - Review the written medical history.
  - Check the patient's current medications, remedies and dietary supplements.
  - Ask your patient, "Have you had any changes in your medical history since your last visit?"
  - Document the patient's response, especially affirmative responses and changes in medication and supplement regimens.
- At least annually, ask patients to review their most recent medical history questionnaire and note in writing on the form on in the electronic record any changes that have occurred since it was originally completed.
  - Have the patient initial and date the changes, if any, then re-sign and date the form near the patient's original signature.
  - After the patient has reviewed the form, review it orally with the patient, then sign and date it yourself. When the form becomes crowded with notations, the patient should be asked to complete a new questionnaire.
- Any changes revealed on the questionnaire also should be documented in the progress notes section of the patient record. In addition, visually assess the patient, noting physical and/or psychological problems that may not be evident from the written history.
  - Document the updated information in the progress notes section of the patient record, specifying any changes noted on the questionnaire. A typical record entry might read "MHR: now taking Inderal 180 mg daily, up from 100 mg. Remainder neg."
  - Consult your current drug reference manual and/or a pharmacist to check current medications for possible ramifications with dental procedures and possible drug interactions.
- At recall visits, when the patient has *not* completed or revised a medical history questionnaire, ask the following questions:

  Since your last dental visit,
  - Have you seen a physician or other healthcare professional for any treatment or consultation?
  - Have you suffered any illness or injury?
  - Have you stopped, started or changed any prescription or over-the-counter medication or remedy or dietary supplement?

Proper documentation is essential after *every* inquiry, even if there are no changes. Entries such as "Reviewed MH, pt. reports no changes" or "MHR neg" indicate that the health history was reviewed and found unchanged since the last visit.

The importance of compiling complete, accurate health history information cannot be overstated. Failing to obtain and distribute vital data endangers patients and increases the liability risk for you and your staff. Remember that even a small oversight may cause significant patient injury.

Proper **documentation is essential** after every inquiry, even if there are no changes. Entries such as "Reviewed MH, pt. reports no changes" or "MHR neg" **indicate** that the **health history was reviewed** and found unchanged since the last visit.

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. In this patient, 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." "Snowbirds" is the term commonly used to describe them.

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 certain 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: telephone or write 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 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 manual 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.

Radiography

The following allegations have been reported for claims involving radiography:

- Failure to obtain a radiographic image
  - Preoperatively — extractions, endodontics, periodontics, crown and bridge, implants, etc.
  - Intraoperatively — to evaluate excessive apical resorption of anterior teeth during orthodontics or identify separated instruments or perforations
  - Postoperatively — following completion of endodontic treatment or implant placement
  - In response to a postoperative complaint — failure to fully investigate the patient's complaint
- Failure to obtain an image of diagnostic quality — radiograph taken, but image has no diagnostic value (too dark, too light, blurry, poor angulation, cone cut, overlapping structures)
- Failure to obtain the proper image — periapical taken when panoramic was warranted and vice versa
- Failure to review radiographs taken in the dental office or those forwarded to you by other providers

Radiographic screening for the purpose of detecting disease **before** clinical **examination** should **not be performed**. A thorough clinical examination…of the patient should precede radiographic examination.

Radiographic Examination

At this time, the guidance entitled, *Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure (2012)* is current. The American Dental Association (ADA), in conjunction with the U.S. Food and Drug Administration (FDA) and the U.S. Public Health Service (USPHS) produced this revision, with input from a number of other stakeholders, including dental specialty and other organizations. The guidance document provides patient selection criteria, recommendations and methods to limit radiation exposure in dentistry, as well as an explanation section that includes clinically relevant scenarios and examples to aid decision making at the point of care. Dentists should monitor the professional literature and the ADA and FDA websites: with a 2012 publication date, updated recommendations may soon be developed and published. The current guidance document is available on both the ADA and FDA websites. Within the document is a chart entitled, *Recommendations for Prescribing Dental Radiographs*, listing suggested radiographic examinations and exposure intervals for specified clinical parameters. While it provides guidance in selecting radiographic intervals, the document ultimately recommends that each dentist use his or her professional judgment to evaluate each patient's needs and make appropriate recommendations.

The standard of care for obtaining radiographic images continues to be what a "reasonable and prudent dentist would do under the same or similar circumstances." Yet it's difficult to say how many radiographs a reasonable and prudent dentist would take for any given patient and how often they should be taken. Your guide must be what your professional knowledge and judgment determines is in the best interests of your patient.

A fairly common practice in dental offices is to have the dental auxiliary obtain radiographs prior to the clinical examination of the patient by the dentist. *The Recommendations for Patient Selection and Limiting Radiation Exposure* suggest such a protocol is ill-advised, stating, "Radiographic screening for the purpose of detecting disease before clinical examination should not be performed. A thorough clinical examination, consideration of the patient history, review of any prior radiographs, caries risk assessment and consideration of both the dental and the general health needs of the patient should precede radiographic examination."

Radiography as Part of the Dental Record

Radiographic images are considered a component of the patient's dental record. Many dentists have moved to the digital radiograph format, rather than conventional film radiography, as their imaging method of choice. Whether film or digital, radiographs are an important part of the clinical record and original radiographs should always be maintained as part of the clinical record.

On the subject of film vs. digital, *The Recommendations for Patient Selection and Limiting Radiation Exposure* state, "Radiographic examinations can be performed using digital imaging or conventional film. The available evidence suggests that either is a suitable diagnostic method. Digital imaging may offer reduced radiation exposure and the advantage of image analysis that may enhance sensitivity and reduce error introduced by subjective analysis."

Digital radiography, including cone beam computed tomography (CBCT), is admissible in dental malpractice cases. If electronic images become part of the defense of a malpractice claim or dental board complaint, the dentist would be required to attest to the validity of the radiographic image. Using systems that comply with the Digital Imaging and Communications in Medicine (DICOM) standard for handling, storing, printing, and transmitting medical images can help to confirm the validity and security of digital radiographs and other clinical images.

Our experience indicates that the format of the radiographic image — emulsion versus electronic — is insignificant relative to the issues of:

- Was a radiographic image obtained when clinically necessary?
- Is the radiographic image of diagnostic quality?
- Did the dentist interpret and use the radiographic image appropriately?

Whether in the form of a conventional radiographic film, DR image, or CBCT scan, diagnostic images must be handled carefully, guarding against accidental loss or damage. Radiographic images that are lost, misfiled in the wrong chart, accidentally deleted, or damaged may have a direct impact on patient care as well as professional liability exposure.

We encourage dentists using conventional radiographs to date and label all radiographs (or mounts) with the patient's name. We have also found that plastic sleeve style radiographic mounts provide greater protection against accidental displacement and fluid spills than mounts that hold only the film borders. For dentists using electronic formats of radiography, we encourage regular backup of your image files, with off-site storage of the backup medium.

Radiographs also should be retained in accordance with any state requirements for dental record retention, similar to retention of medical histories, progress notes, and prescription records. Digital radiography users should retain all originally captured images as well as any that have been manipulated (adjusted contrast, reversed field, etc.) for diagnostic or treatment purposes.

Radiographic Safety

Dentists always must weigh the benefits of exposing a patient to dental radiography versus the risks of not exposing a patient to radiography. Fortunately, it is rare that a dental malpractice claim arises from allegations of excessive exposure to ionizing radiation through radiography.

The Recommendations for Patient Selection and Limiting Radiation Exposure offer the following regarding patient safety during radiography for all individuals:

> "Once a decision to obtain radiographs is made, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure." Examples of good radiologic practice include:
>
> - use of the fastest image receptor compatible with the diagnostic task;
> - collimation of the beam to the size of the receptor whenever feasible (rectangular collimation reduces radiation dose up to fivefold over round collimation);
> - proper film exposure and processing techniques; and
> - use of leaded aprons and thyroid collars, when appropriate;
> - limiting the number of images obtained to the minimum necessary to obtain essential diagnostic information.
> - protective aprons and thyroid shields hung or laid flat and never folded
> - protective shields evaluated for damage (e.g. tears, folds, and cracks) monthly

A dentist following these safety guidelines provides the most patient protection and assumes the lowest risk of radiologic injury.

Refusal of Radiographs

A frequent refusal heard in dental practices is, "Doctor, I don't want any X-rays taken." While it may seem that the refusal of radiographs is no different than the refusal of endodontic treatment, there is a significant difference between the two situations.

Let us assume the patient in need of endodontics has been examined, both clinically and radiographically, and that his dentist has explained the nature of the proposed treatment (necessity, benefits, prognosis, time, cost), the reasonable *alternatives* to the proposed treatment (including specialty referral and extraction), and the *risks* and potential complications of the proposed treatment (due to a pulp stone in the canal or dilaceration of roots). This patient has been presented with sufficient information to be considered *informed* regarding his decision-making process.

Conversely, the patient who refuses radiographs will never be able to consider some of these factors because his dentist is unable to identify and disclose them. The patient may give his consent for endodontics in the absence of a radiograph, but it would not likely be deemed an *informed* consent. This omission would be problematic if a claim arose.

Additionally, the standard of care in dentistry requires a preoperative radiograph for most forms of treatment. To test this assumption, we have asked thousands of dentists at our risk management seminars if they believe it is necessary for a dentist to radiographically evaluate a tooth before treatment such as endodontics, an extraction, or a crown is performed. Their answer has always been a resounding "yes," since the failure to obtain necessary diagnostic information would constitute a breach of that standard by the dentist.

Therefore, a reasonable and prudent dentist should decline to treat any patient who refuses *necessary* diagnostic radiographs, rather than jeopardize the patient's health. The refusal of *necessary* radiographs is also a valid reason for dismissing an existing patient from your practice.

Even if the patient offers to sign a waiver of liability absolving you of responsibility, the most prudent action is to refuse to treat the patient. If you decide to proceed, you — not the patient — will be taking the responsibility for any poor outcome. Numerous defense attorneys have opined that dentists who have obtained such releases have simply documented their poor judgment in a written form for use by the plaintiff.

Consider this important information in such situations:

- A patient cannot consent to a negligent act and thereby waive the dentist's professional duty to practice at or above the standard of care. If a dentist knows that a sequence of treatment, such as the omission of preoperative radiographs, does not meet or exceed the standard of care, proceeding with that treatment would constitute negligence, regardless of any consent or assurances given by the patient.
- When a dentist has insufficient diagnostic information, such as when a patient refuses radiographs, any consent granted by the patient is generally not considered informed consent. Because the dentist lacks the information necessary to determine and disclose the risks and possible alternatives specific to that patient, the patient cannot be considered reasonably informed.
- A patient cannot waive his or her right to bring future legal action against a dentist for treatment that has not yet been performed. Individuals are precluded from waiving their legal rights as patients. No statement or signature provided by the patient can protect the dentist from liability for his or her future actions.

If you decide to perform treatment without a necessary diagnostic radiograph or test, document all of the diagnostic information you used (patient symptoms, periodontal evaluation, hot and cold test, percussion, palpation, observation, electrical stimulation, etc.), your complete differential diagnosis, and all circumstances surrounding the failure to secure the required diagnostic. Proceeding with treatment is riskier than declining to treat the patient, making your documentation more significant.

Ownership of Radiographs

The dentist owns the dental record and all diagnostic information, including radiographs. Regardless of what your patient believes, *you* own the films. The patient, however, has the legal right of access to all information in the record, including radiographic images. The patient is entitled to a copy. Again, state legal requirements govern in this area.

Radiographs that were given to a patient, lost in the mail, or misplaced in an insurance or specialty office can never be used in subsequent patient treatment or to defend a malpractice claim against you. It is important that you and your entire staff carefully guard against the accidental loss of radiographs.

It is recommended that you never release original records or radiographs, only copies, unless required by subpoena. If you use film-based radiographs consider purchasing an X-ray duplicator or make arrangements for the use of another dentist's duplicator. Keep in mind that many state dental practice acts mandate that you retain the original records, including radiographs. Giving originals to a patient or an insurance company may violate the dental practice act in your state.

Sharing Radiographs Among Dentists and Across Formats

The handling of original radiographs may become an issue in referrals to specialists. On occasion, the copies of films sent to specialists are not of diagnostic quality and are not useful in patient care. Receipt of such copies places the specialist in a position of requiring the exposure of an additional radiograph (or radiographs) in order to meet the standard of care in providing treatment. Of course, patients often object to additional films, both from radiation and cost perspectives.

One possible solution is for the referring dentist to take double pack films whenever a referral is likely. This permits both the referring and referral dentists to each have a set of original films. A cost sharing agreement would be advisable in such situations to prevent the additional expense from being borne solely by one dentist or another.

Another option, though riskier for the referring dentist, is to retain a copy of the original films while permitting the referral dentist to use them. After treatment has been completed, the originals are returned to the referring dentist who then forwards the duplicates to the referral dentist. The risk is that the originals will be lost in transit or in the referral dentist's office.

Duplicating digital radiographs of course do not pose the same issue as for film, since an electronic file copy is identical to the original file. Nevertheless, the use of both film and digital radiography formats present challenges to information sharing. Users of one format may be uncomfortable with the images forwarded to them in the other format, most often because the image seems less diagnostic than what they are accustomed to seeing. If you believe the radiographic copy or printout you receive hinders your ability to properly treat the patient, it is suggested that you obtain a better image. Contacting the prior dentist for a clearer copy, or obtaining a new original image achieves this goal. It is generally inadvisable to treat the patient with radiographic images you believe are not diagnostic.

Refer also to the section on Record Keeping and Documentation for more on sharing/exchanging digital radiographs, images and other electronic records.

Cone Beam Computed Tomography (CBCT)

Introduced in dentistry in the early 2000s, CBCT is an incredibly useful tool. The three-dimensional volume of information produced can be viewed in various ways to provide important diagnostic and treatment planning capabilities. However, CBCT uses ionizing radiation and, therefore, is subject to the same safety and risk management issues described previously in this section of the manual.

The use of CBCT has seen rapid growth in dentistry and applications for the technology are anticipated to evolve in the coming years. Typically, clinical and diagnostic advances often progress much faster than legal and regulatory systems are able to respond. Clinical guidelines also lag behind new procedures and technologies, since research and clinical experience form the basis for guidelines.

Dentists should remain current as CBCT clinical guidance and regulatory or legal requirements continue to develop. In the absence of specific clinical guidelines (and even with them), base your recommendations and decisions for the use of CBCT on the patient's best interests, and document the rationale. For CBCT or any radiographic examination, one size does not fit all. Patient safety and good risk management require that imaging be considered and selected for an individual patient, in accordance with clinical need. Adhering to this concept will help to address many professional liability risk management questions that may arise with CBCT or other technologies that emerge in the future.

Controlling the risks

A complete review of CBCT technology and its applications are beyond the scope of this manual. However, a number of resources are included in the bibliography for further reference and information. If CBCT is part of your office armamentarium, if you plan to add this capability in the future, or if you refer patients for CBCT imaging, it is essential to remain abreast of the technology on many fronts.

- **CBCT ownership.** Determine if your state has acted or plans to take action on CBCT ownership and use in dental practice. Some states may require a "certificate of need," or other requirements may apply. Your state dental association or the board of dentistry may be the best sources for up-to-date requirements for your state. Monitor changes closely and comply with state mandates or recommendations.
- **Training and continuing education.** It is incumbent on every dentist to be knowledgeable and competent in the use of any product or technology, or in the application of any technique or procedure that is employed in the provision of patient care. Most dentists in practice today began their careers before the advent of CBCT imaging in dentistry. Years ago, the same could be said about panoramic radiographs. But while panoramic images presented a new challenge for dentists, three-dimensional

CBCT imaging technology presents and even greater challenge to existing skills for many dentists. Seek out educational opportunities that will address your level of involvement with CBCT: the American Academy of Oral and Maxillofacial Radiology (AAOMR) now offers CBCT training courses. Another practical approach is to establish a local or regional CBCT/radiology study club, where general dentists and/or specialists with CBCT experience may serve to mentor others. The club also may sponsor continuing education programs, based upon the needs of the member dentists.

- **Accreditation requirements.** If a patient's medical insurance will be billed for a CBCT image, dentists must understand that accreditation is now required for "advanced imaging services" billed to Medicare and other medical insurance carriers. The Medicare requirement became effective in January 2012, as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPAA). Other insurance carriers have adopted or plan to adopt the requirement as well. Providers may apply for accreditation to one of several accrediting bodies and must demonstrate: compliance with certain standards; acceptable operator and staff training/qualifications; acceptable quality assurance and safety measures. One organization from which CBCT accreditation is available is the Intersocietal Accreditation Commission (IAC).
- **Professional recommendations.** Guidelines and recommendations on CBCT use and safety are developing in dentistry and documents have been published by the ADA, dental specialty organizations and others. The professional literature continues to expand rapidly on CBCT so awareness of new and developing information is essential. It is especially important to monitor information from the AAOMR on this topic. ADA publications may have broad implications for this technology as well, and guidelines for specific uses from other specialty areas such as endodontics, orthodontics and oral and maxillofacial surgery are also important for dentists who undertake these procedures.
- **CBCT interpretation (and waiver of liability).** Clearly, CBCT volume must be reviewed and interpreted by an individual(s) with appropriate skills and competency. Whether a dentist sends a patient to another facility for imaging, or imaging is completed within a dentist's own office, the volume must be reviewed. The prescribing dentist must ensure that the image is interpreted for abnormalities and pathologic findings, when appropriate. The prescribing dentist may review the volume or refer to a dental specialist for review. The prescribing dentist and/or the specialist are responsible for interpreting the dental/oral and maxillofacial structures, according to their expertise and scope of practice. As for any image that includes structures outside of the dentists' scope of practice (lateral head/cephalogram, panoramic image, etc.), review of the full image for potential abnormalities is necessary, followed by referral to qualified providers for interpretation and diagnosis, as appropriate. Questions have been posed by dentists in risk management seminars and via the CNA risk management support telephone line on this topic. For example: "A dentist friend of mine said I should have the patient sign a waiver of liability form related to "non-dental" areas of a CBCT scan that will not be interpreted. Is this a good idea?" Some dentists also have proposed providing the patient with a copy of the CBCT scan on DVD media and recommending that the patient take the copy to a radiologist for evaluation, if desired. These practices are not recommended and may result in significant liability if the patient is later diagnosed with a condition or disease that could have been detected in the CBCT volume. The practitioner has a duty to serve the patient's best interest by making sure that all diagnostic test results and information are appropriately reviewed and interpreted. These two functions may be performed by the prescribing dentist alone, by others via referral, or a combination of the prescriber and other qualified providers.
- **Referral for interpretation and teledentistry.** CBCT images may be copied to a DVD and mailed or carried to another office or facility for interpretation. Follow all appropriate security and privacy requirements to protect this patient record in the process of referral. Similarly, sharing this or other electronic health records over the internet requires that the information be protected. Ensure that you are in compliance through the use of appropriate security measures and encryption. In addition, if images are transmitted across state lines for interpretation, investigate and comply with all applicable laws and regulations. While telemedicine and teledentistry are expanding, state laws and regulations related to this area vary widely. Both the referring and interpreting doctor may be liable for non-compliance.
- **Offering CBCT imaging services.** Risk management questions on this topic are often received. Dentists who are currently offering or plan to offer this service, should investigate state laws or regulations that may apply to imaging centers. Also check with your insurance agent to determine if the services you plan to provide will have any impact on your professional liability coverage. You may also want to discuss the risks and benefits involved with your personal/practice attorney to make a decision that is right for your situation. Some dentists have established an imaging business/corporation separate from their dental practice for this purpose.

As previously stated, the ADA, FDA and the AAOMR are important sources for the latest information on dental radiography guidelines and safety information. Note that the AAOMR website also includes a web page with links to each state's radiation regulations: consult the bibliography for the URL.

Treatment Plans

A written treatment plan should be part of every dental record. Beyond being a good idea, some state dental practice acts require a written treatment plan in every patient record. Written treatment plans play an important role in patient care, as well as in practice documentation, since patients generally do not remember what they are told verbally.

For dentists, written treatment plans represent an excellent means of coordinating and prioritizing patient care, documenting your recommendations for care, estimating the cost and time involved in a treatment, and managing professional liability issues.

For your staff, written treatment plans aid in scheduling appointments, managing referrals and consultations with other providers, preparing properly for each treatment visit, and processing insurance benefits and billing statements.

For patients, a written plan serves as a reminder of the treatment sequence, organizes informed consent discussions to help ensure that they receive all necessary information, and helps them develop and keep track of their financial arrangements with your practice.

In the event of a peer review or professional liability action, written plans also can be introduced as evidence in your defense. If you consistently provide a patient with a copy of the written treatment plan, it will be difficult for the patient to prove a *failure to diagnose* allegation, as long as the condition is addressed in the plan.

Short and simple treatment plans (e.g., those involving just a few operative restorations) can be included in the body of the dental record, rather than on a separate form. They can easily be incorporated into the progress note for the exam during which you diagnosed the need for the restorations.

The more lengthy or complex the treatment, the greater the need for a formal written treatment plan separate from the progress notes. If you have a "paperless" office, there is no need to rewrite a document by hand. Simply print out a copy of the patient's treatment plan from your electronic patient management system.

Irrespective of the form your written treatment plan takes, treatment recommendations and alternatives must be presented in accordance with accepted standards of care and clearly reflect the best interests of the patient.

When developing treatment plans, consider the following:

- Present and perform the treatment plan in a reasonable sequence. Performing treatment in an unusual or aberrant sequence may constitute malpractice, even if the patient suggested or consented to that sequence. If you have a sound clinical rationale for an unusual sequence of treatment, fully document that reason in the record.
- Present your patients with treatment plans that you believe best address their treatment needs. If a patient declines, document the declination and offer reasonable alternative treatment options that the patient may accept. (See further details about "informed refusal" in the Legal Concepts section of the manual.) Every patient has the legal right to be told all reasonable alternatives, even if those alternatives differ from what *you* expect the patient to agree to and/or are more expensive than what *you* believe the patient can afford.
- Fulfill your professional duty by diagnosing pathology, informing the patient, and recommending appropriate treatment. The *patient* must decide whether or not to proceed with the treatment you have recommended.
- You have the same duty to perform at the standard of care for *all* patients in your practice, regardless of the level and/or method of financial reimbursement. Financial considerations and dental benefit plans do not control your professional duty to the patient.
- Always give your patients a copy of the treatment plan. Seeing the plan in writing helps them better understand the scope of care, the time frame involved and the estimated cost. They can refer to it, as needed, to refresh their memory or to check off treatment as it is completed.

Present and perform the **treatment plan** in a reasonable sequence. Performing treatment in an **unusual or aberrant sequence** may constitute **malpractice**, even if the patient suggested or consented to that sequence.

Infection Control

The following allegations have been reported for claims pertaining to infection control:

- Use of inappropriate or unacceptable sterilization techniques
- Lack of an infection control plan
- Lack of proper infection control training
- Lack of proper sterilization monitoring
- Lack of proper patient or employee protection

Dentists should know about and comply with current infection control protocols and regulations and document that compliance, where appropriate. In addition to the Center for Disease Control and Prevention (CDC) guidelines for infection control in the dental office and the Occupational Safety & Health Administration (OSHA) regulations, dentists should review their state dental practice acts and related rules and regulations. State requirements may be more stringent and/or states may incorporate infection control practices into state law or regulations.

In a malpractice case, deviations from federal, state and local rules and regulations may be presented as evidence of a lack of diligence concerning infection control. Another important aspect of infection control is how your patients perceive your infection control procedures.

The American Dental Association (ADA), the Centers for Disease Control and Prevention (CDC), and the Organization for Safety, Asepsis and Prevention (OSAP) have numerous resources available for dental practices. Check their websites for specific infection control information.

Recognizing risk factors

Many factors can make developing and implementing an effective infection control program more difficult. Consider how these situations would affect proper infection control procedures:

- Infection control is not considered a high priority issue in the office
- Lack of knowledge by dentist and/or staff regarding proper infection control protocols
- Poor or inadequate or inadequately documented staff training
- Negative patient perceptions of the office's infection control measures and cleanliness

Controlling the risks

As an employer

- Have a comprehensive, written infection control policy and train all staff members to understand and follow it.
  - Use appropriate personal protective equipment.
  - Provide hepatitis B vaccinations and maintain proper documentation.
  - Provide bloodborne pathogen training and maintain proper documentation.
  - Implement appropriate work practice and engineering controls.
  - Develop a standard operating procedure for disinfecting and sterilizing dental instruments and equipment, using accepted methods and techniques.
  - Document the monitoring of sterilizing equipment.
  - Have non-absorbent floor and wall coverings.
  - Use hands-free faucets, soap dispensers, chairs.
- Keep all equipment in your office in good working order and practice preventive maintenance. Retain all service and repair information.

As a provider of patient care

- Manage patient expectations about infection control through patient education and discussion.
- Allow patients to see that your infection control procedures are organized and carried out consistently.
- Open disposable supplies and wrapped, sterilized instrument bags and cassettes in a conspicuous manner, in plain view, so that the patient may observe your actions.
- Discuss infection control safeguards openly with patients, keeping in mind that as patients have become more aware of infection control issues, they are more likely to notice deviations from standard practice.
- Use a rubber dam for all endodontic procedures and when clinically appropriate for other procedures.
- Have patients wear safety glasses with side shields while in the dental chair. Such safety glasses also help prevent accidental eye injuries from dropped instruments and material splatter.
- Know how to proceed in the event of an infection control breach. Dental offices periodically call the CNA risk management support line when, due to equipment failure or human error, a breach of infection control practices occurs. The CDC has a number of useful resources available in its patient notification toolkit.
- Monitor the professional literature and announcements from the ADA, CDC and OSHA for updates or new information on infection control to remain current and in compliance.

Antibiotic Premedication

The following allegations have been reported for premedication claims:

- Failure to premedicate
- Failure to premedicate with the proper drug
- Failure to use an appropriate dosing or timing regimen
- Failure to obtain an accurate medical history
- Failure to consult the physician
- Negligent prescribing of antibiotics when not clinically warranted

The antibiotic premedication of dental patients has primarily focused on the prevention two specific adverse outcomes: infective endocarditis and late prosthetic joint infection. Recommendations for antibiotic premedication continue to evolve: dentists are strongly encouraged to stay abreast of the latest evidence and recommendations.

In collaboration with other appropriate professional and healthcare organizations, the American Dental Association (ADA) acts on behalf of the dental profession to participate in the development, publication and dissemination of these and other clinical guidelines. Many, but not all guidelines important to the profession are published in the *Journal of the American Dental Association (JADA)*. If not published in *JADA*, guidelines that affect dentistry and dental patients are typically accessible on either the ADA website or the website for the ADA's Center for Evidence-Based Dentistry.

Compliance with these or any other clinical guidelines does not guarantee a positive outcome or prevent all adverse outcomes. However, appropriate consideration of and adherence to applicable guidelines may reduce the likelihood of an adverse health outcome, and provides you with a strong defense in the event of a related malpractice allegation. In some cases though, a guideline may NOT apply to an individual patient or set of circumstances or a patient may refuse the recommended treatment. Seek medical input, if necessary, to support and confirm the clinical direction. Then, document the decision and rationale.

Infective Endocarditis

In the April 2007 issue of its scientific journal, *Circulation*, the American Heart Association (AHA) published updated guidelines for the prevention of infective endocarditis (IE). In 2008, dental-specific recommendations were published in a *JADA* supplement entitled, *Prevention of infective endocarditis: Guidelines from the American Heart Association: A guideline from the American Heart Association Rheumatic Fever, Endocarditis and Kawasaki Disease Committee, Council on Cardiovascular Disease in the Young, and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and the Quality of Care and Outcomes Research Interdisciplinary Working Group* (*JADA*, Vol. 139, January 2008, Supplement 1). Also note that in 2017, the AHA and the American College of Cardiology (ACC) published a focused update to their 2014 guidelines on the management of valvular heart disease. The 2017 publication supports and reinforces the earlier guidelines. See the bibliography and/or www.ada.org for access information.

The 2008 guidelines represented a significant change for many dental patients who had taken prophylactic antibiotics prior to that time. The AHA Committee on Rheumatic Fever, Endocarditis and Kawasaki Disease analyzed scientific literature and also solicited input from "national and international experts on infective endocarditis."

Based on the scientific evidence reviewed, the AHA concluded the following, presented in the guidelines as "Table 2: Primary Reasons for Revision of the IE Prophylaxis Guidelines":

- "IE is much more likely to result from frequent exposure to random bacteremias associated with daily activities than from bacteremia caused by a dental, GI tract or GU tract procedure." The term "daily activities" as used in the guidelines includes tooth brushing, flossing, use of toothpicks, use of irrigation devices, and chewing food.
- "Prophylaxis may prevent an exceedingly small number of cases of IE, if any, in individuals who undergo a dental, GI tract, or GU tract procedure."
- "The risk of antibiotic-associated adverse events exceeds the benefit, if any, from prophylactic antibiotic therapy."
- "Maintenance of optimal oral health and hygiene may reduce the incidence of bacteremia from daily activities and is more important than prophylactic antibiotics for a dental procedure to reduce the risk of IE."

Patients at risk for IE

Based on these conclusions, the AHA recommended that only those patients with the highest risk of an adverse outcome from endocarditis receive antibiotic prophylaxis. Box 3 of the guidelines lists the affected patient groups. Premedication is recommended for patients who have:

- "Prosthetic cardiac valve or prosthetic material used for cardiac valve repair
- Previous infective endocarditis
- Congenital heart disease (CHD)*
  - Unrepaired cyanotic CHD, including palliative shunts and conduits
  - Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure**
  - Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)
- Cardiac transplantation recipients who develop cardiac valvulopathy"

The AHA recommendations also discuss the types of dental procedures for which antibiotic prophylaxis is required for those patients who meet the aforementioned cardiac criteria. However, the recommendation defers largely to the judgment of the clinician. Prophylaxis is indicated for:

> "*All dental procedures* that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa. The following procedures and events do not need prophylaxis: routine anesthetic injections through non-infected tissue, taking dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, placement of orthodontic brackets, shedding of deciduous teeth and bleeding from trauma to the lips or oral mucosa."

* Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

** Prophylaxis is recommended because endothelialization of prosthetic material occurs within six months after the procedure

For completeness, the following provides similar content from the AHA/ACC 2017 publication mentioned earlier in this section.

"Prophylaxis against IE is reasonable before dental procedures that involve manipulation of gingival tissue, manipulation of the periapical region of teeth, or perforation of the oral mucosa in patients with the following:

1. Prosthetic cardiac valves, including trans catheter implanted prostheses and homografts.
2. Prosthetic material used for cardiac valve repair, such as annuloplasty rings and chords.
3. Previous IE.
4. Unrepaired cyanotic congenital heart disease or repaired congenital heart disease, with residual shunts or valvular regurgitation at the site of or adjacent to the site of a prosthetic patch or prosthetic device.
5. Cardiac transplant with valve regurgitation due to a structurally abnormal valve."

Prophylaxis regimens

The suggested antibiotic prophylaxis regimen for adult patients warranting IE prophylaxis who are not allergic to penicillin is 2.0 grams of amoxicillin orally. The timing of the dosage was modified slightly, allowing it to be taken 30–60 minutes prior to the dental procedure. Recommended alternate regimens for adult patients allergic to penicillin, also to be taken orally 30–60 minutes prior to the dental procedure, include:

- cephalexin (2.0 grams), or
- clindamycin (600 mg), or
- azithromycin or clarithromycin (500 mg).

Risk management implications

The AHA recommendations for the prevention of infective endocarditis have been in existence in various forms for more than 50 years. Keep in mind they serve as guidelines, rather than stringent rules. Both the AHA and ADA recommend that the dentist exercise his or her own judgment in assessing the application of the guidelines to each patient. However, the long-term acceptance and use of AHA guidelines by both the dental and medical communities has led to their frequent citation as the standard of care in dental professional liability litigation.

Adherence to the current guidelines is recommended by the AHA, ADA, and other healthcare organizations.

Some dentists may believe they are "damned if they do, damned if they don't" when it comes to prescribing prophylactic antibiotics. Fortunately, the incidence of claims arising from either the act or omission of prescribing a prophylactic antibiotic regimen is low.

Prosthetic Joints

The AHA guidelines for the prevention of infective endocarditis are specific to patients with cardiac conditions and do *not* apply to patients with prosthetic joints or other orthopedic implants. However, patients who present with a medical history that includes *both* cardiac and total joint considerations will necessitate a greater degree of investigation, communication, and documentation by the treating dentist.

After expiration of the 2003 ADA/American Academy of Orthopaedic Surgeons (AAOS) advisory statement on the antibiotic premedication of patients with prosthetic joints in 2008, the AAOS published its own opinion-based information statement that deviated significantly from the 2003 guidelines. The AAOS statement recommended "that clinicians consider antibiotic prophylaxis for all patients with prosthetic joint replacement." The statement created conflict between dentistry and the orthopedic community, and uncertainty regarding the risk implications for dentists.

The AAOS and the ADA later agreed to an evidence-based guideline development approach and the organizations collaborated with several other healthcare groups to conduct a new systematic review of the literature. This resulted in publication of an evidence report and evidence-based guidelines in November 2012 and March 2013 (references available at www.ada.org). The guidelines advised that there is insufficient evidence to recommend the routine use of antibiotics before dental procedures for patients with orthopedic implants to prevent infections. They further stated that there is no direct evidence that dental procedures cause prosthetic joint infections.

The ADA Council on Scientific Affairs (CSA) convened a panel in 2014 to update the systematic review and clinical recommendations from 2012-2013. This resulted in publication of the latest guideline in the January 2015 issue of the *Journal of the American Dental Association* (see the URL in the Antibiotic Prophylaxis section of the manual bibliography and/or at www.ada.org). A chairside guide on use of this guideline is also available on the ADA website.

The January 2015 guideline states that *prophylactic antibiotics are not recommended* prior to dental procedures to prevent prosthetic joint infection. Consistent with past guidelines, antibiotic prophylaxis is not indicated for dental patients with orthopedic pins, plates or fixation screws. The guideline states that dentists and patients should consider clinical circumstances if the presence of a significant medical risk in providing dental care without antibiotic prophylaxis exists. This should be weighed against the known risks of widespread antibiotic use (resistance) and adverse events.

To follow up on the recommendation to consider significant medical risk circumstances, a February 2017 commentary published in *JADA* and authored by ADA-appointed experts, provides information about the use of "appropriate use criteria" (AUC) published by the American Academy of Orthopaedic Surgeons in January 2017. The AUC are described as "a decision-support tool to supplement clinicians in their judgment" and it emphasizes discussion of available treatment options between the patient, dentist and orthopedic surgeon, weighing the potential risks and benefits. The AUC pertain to a limited group of patients for whom antibiotic prophylaxis might be considered (i.e., medically "high risk" or "immune compromised" patients). The commentary encourages dentists to continue to use the January 2015 guideline, consult the AUC as needed, and respect the patient's specific needs and preferences when considering antibiotic prophylaxis before dental treatment. According to the ADA Chairside Guide, in cases where antibiotics are deemed necessary, it is most appropriate that the orthopedic surgeon recommend the appropriate antibiotic regimen and, when reasonable, write the prescription.

Other Concerns

In some cases, physicians will choose to set aside prophylaxis guidelines and recommend a different course of treatment. And although the current guideline does not recommend that prophylactic antibiotics be prescribed, many orthopedic surgeons may continue to hold the opinion that the medication should be taken before dental procedures. The surgeon's decision and recommendation may be reasonable, based on additional medical information with which the dentist may not be conversant. Good communication between healthcare professionals is essential in these cases.

However, dentists also may encounter physicians who recommend continued premedication based on reasons not related to additional medical history information or scientific information. It is still appropriate and prudent for the dentist to discuss the benefits and risks of the dental procedures and antibiotic premedication in this situation, since the patient is under the dentist's care. Again, communication will be critical to your attempts to reach a consensus with the physician. In some cases, an impasse will occur, resulting in continued disagreement regarding the proper course of action for the patient. In such cases, a dentist may suggest to the patient and/or physician that the physician write the antibiotic prescription. This approach will distance the dentist from the risk of allergic reaction to an apparently unnecessary antibiotic. Other options include a recommendation that the patient receive a second physician opinion, or withdrawal from the dentist-patient relationship.

If a dentist is uncertain about the applicability of a guideline to a patient's specific medical condition, consult the patient's treating physician and request a written consultation report. Within that process, do your best to educate the physician about the recommendations and the scientific rationale for the recommendations. To best protect your patients from potential injury, be knowledgeable about the recommendations and follow them accordingly. To ensure that you are using the most recent guidelines, check the ADA website in the section titled Oral Health Topics: Antibiotic Prophylaxis.

The Pregnant Patient

Few patient populations elicit a greater fear of litigation among dentists than pregnant patients. The thought of a patient alleging that a birth defect or other complication of childbirth resulted from negligent dental care is indeed worrisome. It is not uncommon for oral health professionals to be reluctant to treat pregnant patients. However, the current body of knowledge suggests that most dental care presents little, if any risk to either the mother or her unborn child. This perspective is supported through publication of a consensus statement in September 2012. The statement and a number of other useful resources are available on the National Maternal and Child Oral Health Resource Center website. A hyperlink is available in the Medical Emergencies/Medically Compromised section of the bibliography.

The purpose of the consensus statement is to help healthcare professionals and other stakeholders understand the need for improvements in the provision of oral health services during pregnancy and respond accordingly. The statement provides guidance for dentists and other healthcare professionals to help ensure that women receive the care they need during pregnancy. The statement covers information on oral disease management and treatment, including an overview of pharmacological agents that may be used. There are also tips for good oral hygiene during pregnancy, nutrition and on taking care of the baby's mouth after birth. The bottom-line message for dentists and patients: "oral health care, including use of radiographs, pain medication, and local anesthesia, is safe throughout pregnancy."

The current body of knowledge suggests that **most dental care presents little, if any risk** to either the **mother or** her unborn **child**.

Managing the Risks of the Pregnant Patient

Recognizing risk factors

The following considerations must be evaluated when treating a pregnant patient:

- Number of weeks pregnant ("Normal" human pregnancy lasts 40 weeks.)
- Urgency and risks of treatment
- Risks of not receiving treatment
- Maternal systemic health
- Patient's dental knowledge

Controlling the risks

Communication

One of the keys to successful care of the pregnant patient is good communication between the dentist and both the patient and her obstetrician. The dentist must be willing to educate the patient about evaluating risks and benefits. Access and use the information and educational resources available on the consensus statement website previously described to help in this process.

Dentists know the risk of not having an abscessed tooth treated is greater than the hazards associated with the treatment itself or with supportive antibiotic and other pharmacologic therapy. However, some pregnant women, understandably cautious, may focus only on the risks of recommended treatment, rather than on the benefits of the treatment or the various risks of *not* undergoing the treatment.

Clearly, a pregnant patient must fully understand the rationale supporting the doctor's treatment recommendation. If provided information in an empathic and understanding manner, many women will follow through with care once they understand its importance.

Good communication between the dentist and obstetrician is also essential. Dentists should request a medical consultation whenever a question arises for specific patients that may present higher risk during pregnancy, such as those with concomitant medical conditions or a complex medical history. Thoroughly document consultations in the patient record, including written entries for phone consults, and place all original written correspondence in the chart.

Medications

The 2012 consensus statement includes a useful reference table for commonly-prescribed or administered medications related to oral healthcare. Highlights include:

- Antibiotics: Penicillin, amoxicillin, cephalosporins, clindamycin, and metronidazole are acceptable for most patients unless allergic to a specific drug. The quinolone antibiotics, such as ciprofloxacin, moxifloxacin and others should be avoided and tetracycline should not be used during pregnancy.
- Analgesics: Acetaminophen alone or in combination with codeine, hydrocodone or oxycodone may be used. Codeine, meperidine and morphine are also included for single agent pain relief. Aspirin, ibuprofen and naproxen should be avoided in the 1st and 3rd trimesters but may be used in short duration (up to 72 hours) otherwise.
- Local anesthetics with epinephrine: lidocaine, mepivacaine and bupivacaine may be used. Nitrous oxide 30% may be considered, if needed, in consultation with the patient's obstetrician.

Radiographs

Take radiographs for the evaluation and diagnosis of oral diseases and conditions when indicated. Explain the need to your patient and always consider the "as low as reasonably achievable" (ALARA) principle:

- Use a fast film technique or digital imaging.
- Use collimation and good radiographic technique.
- Use lead aprons and cervical (thyroid) collars.

The pregnant patient may be hesitant to proceed with radiographs and treatment, especially since the recommendations and practices for oral health care during pregnancy may be different from her past experience. Consider the patient's perspective and wishes and understand that the patient's condition is time-limited. Will delaying the radiograph(s) and/or treatment place the patient or fetus at risk? Regardless of the decision, appropriately document the discussion and supporting rationale.

If a patient refuses clinically necessary radiographs, proceed as you would for any patient in this situation. Do not treat the patient without required information. Patient dismissal may be the most appropriate action.

Chair Posture

- In late pregnancy, there is a risk of developing supine hypotensive syndrome while in the supine position in the dental chair, caused by pressure from the fetus on the vena cava. If this occurs, turn the patient on her left side to remove the venous occlusion and return the blood pressure to normal.
- Regularly monitor the blood pressure, pulse, and respiration of your pregnant patients.

Oral hygiene

- Increased gingival inflammation and bleeding, caused by hormonal changes, is the most common dental complication of pregnancy.
- The hormonal changes during pregnancy do not *cause* periodontal disease but can modify and worsen conditions that are already present.
- Instruct patients in plaque control techniques and encourage them to maintain meticulous oral hygiene.

Emergency care

- Inform patients of the need to promptly address any dental problems that arise. Emergency dental care usually presents fewer fetal risks than the continued consequences of the pathologic condition.
- Inform patients that, if left untreated, abscessed teeth and periodontal infections can cause bacteremias that might affect the fetus. Even the increased stress from a very painful carious lesion can be detrimental to the pregnancy.

Good dental care can play an important part in a successful pregnancy. By emphasizing communication with both the patient and her physician, and carefully documenting discussions and consultations, dentists can do much to reduce the risks associated with treating pregnant patients.

Protective Stabilization for Pediatric Dental Patients

The use of passive protective stabilization devices in dentistry has been the subject of unfavorable media coverage in recent years. Images of crying children, trapped in restraint systems while being "subjected" to apparently painful dental procedures, have suggested that practitioners may value efficiency and profit over compassion and good patient care. Modern restraint systems are often comprised of soft cloth and Velcro® and offer an effective method to protect an uncooperative child-patient from harm. Use of these devices is not confined to the dental office as various forms of passive protective stabilization are found in emergency rooms and urgent care facilities across the United States.

Most practitioners are skilled at using basic behavior guidance techniques, which include tell-show-do, voice control, nonverbal communication, positive reinforcement, distraction, parental presence/absence (as appropriate) and the judicious use of nitrous oxide. These techniques are not always effective, however, with patients who are too young, have special needs or are highly anxious. In these cases, more advanced techniques of behavior guidance, such as protective stabilization, sedation and general anesthesia, are indicated. Unfortunately, the high costs and risks of sedation and general anesthesia often render these alternatives unattractive. Protective stabilization, alternatively, offers a low risk and low cost approach to addressing the challenges presented by difficult pediatric patients, especially when compared to the health risks of general anesthesia and sedation.

Controlling the risks

- Informed consent for the use of passive restraints is essential — both to prevent potential litigation and to encourage parental acceptance of their use. Typically, only one parent must provide consent and it is recommended that informed consent be discussed and secured in a separate appointment.
- If a change in behavior management is needed due to deteriorating behavior, additional consent must be obtained.

The American Academy of Pediatric Dentistry offers indications, advice and contraindications for use of protective stabilization and behavioral guidance: consult the guideline for complete information (see the bibliography for a link to the 2017 guidelines):

- Patients who require immediate diagnosis and/or limited treatment and cannot cooperate due to emotional and cognitive developmental levels, lack of maturity, or medical and physical conditions.
- Patients who are sedated or have special health care needs, or for whom urgent care is required and the safety of the patient, staff, dentist or parent require limited stabilization to help reduce untoward movement and/or injury.
- An uncooperative patient who requires treatment and for whom sedation or general anesthesia are not acceptable options due to the patient's health, financial issues and/or parental preferences after options are fully discussed.
- In no event should protective stabilization be used to discipline a child or in retaliation for unruly behavior.
- Proper use of the technique should not induce pain.

Contraindications include:

- Patients with a history of physical or psychological trauma due to restraint (unless no other alternatives are available);
- Cooperative non-sedated patients;
- Non-emergent treatment needs in order to accomplish full mouth or multiple quadrant dental rehabilitation;
- Patients who cannot be immobilized safely due to associated medical, psychological or physical conditions; or
- Use of protective stabilization for the practitioner's convenience.

The AAPD guideline also includes recommendations on practitioner education, consent, parental presence in the operatory, techniques for the management of uncooperative patients, protective stabilization equipment, patient monitoring, and for patients with special health care needs.

Importantly, the guideline states that "advanced didactic and hands-on mentored education beyond dental school is essential to ensure appropriate, safe and effective implementation of protective stabilization of a patient unable to cooperate." Note that according to the guidelines, at least one state (Colorado) requires training beyond dental school to use stabilization devices. Dentists should ensure compliance with any state requirements where they are licensed to practice.

Obtaining and documenting parental informed consent is also essential. Use of a written consent form, in addition to the required discussion of the benefits, risks and alternatives to protective stabilization, is strongly recommended. And while many dentists may not allow or do not recommend that parents be allowed to be present in the dental operatory during treatment, the guideline states that dentists should consider parental presence or direct visual observation of the patient, unless the health and safety of the patient, parent or the dental staff would be at risk. Parents have the right to terminate the use of restraint: if requested, dentists should immediately take the steps necessary to safety to bring the procedure to a safe conclusion.

Two additional areas covered in the guideline to emphasize here are the risks associated with protective stabilization and recommended documentation. Risks considerations include:

- Most injuries associated with the use of restraint methods consist of minor bruises and scratches, though more serious injuries have been reported and are possible.
- Fewer injuries result from the use of passive stabilization (use of restraint devices) than for active stabilization (restraint by a person).
- Risks associated with use of a rigid stabilization board include:
  - Patient overheating during treatment
  - Inadequate neck extension, compromising airway patency
- Patients may experience agitation and significant release of endogenous catecholamines, which may sensitize the heart and cause rhythm disturbances.
- The patient's emotional, cognitive and physical development levels may increase risks for an individual patient: consider these factors in all cases and base recommendations on the principle of "do no harm."

Regarding documentation, the following points should be addressed in the patient record:

- The indication for stabilization
- The type of stabilization used
- Informed consent
- If the parent(s) are not present while using stabilization, document the rationale
- Stabilization duration of use
- Evaluation/assessment of the patient's behavior during stabilization
- Any/all adverse outcomes
- Implications for future treatment appointments

When indicated, proper use of protective stabilization permits dental treatment to be provided to the uncooperative patient in a safe work environment for everyone concerned — patient, dentist and staff.

Please refer to page IX for information about access to a sample form on "Discussion and Consent for Use of Protective Stabilization."

Dental Professional Liability

Clinical Treatment

Upon completion of this section, you should be able to:

- **Identify risk management considerations** that are common to all clinical treatment and procedures.
- **Understand and implement risk management techniques** that will reduce the likelihood of adverse events and unsatisfactory clinical outcomes.
- **Identify key risk factors for various clinical procedures** as they apply to patient safety, scope of practice and referral decisions in patient care.

Common Risk Management Considerations

This section of the manual addresses a number of clinical topics and procedures from a risk management perspective. Irrespective of the procedure or topic, some general principles typically apply throughout the clinical treatment section. For example:

- Communication: has effective communication about the procedure/situation, prognosis, and financial requirements occurred? Is the communication documented?
- Informed consent: Has a discussion been conducted with the patient, parent or guardian, rather than simply documenting a signed form? Is the depth and content of the consent discussion adequate for the procedure/situation AND the individual patient needs/circumstances? Has the patient had an opportunity to ask questions and expressed understanding? Is the discussion documented?
- Informed refusal of recommended treatment: Has the immediate need to inform the patient about the benefits and risks of treatment, no treatment and alternative treatments been met? If the patient will continue in the practice following refusal of treatment, is there a reasonable plan to meet the ongoing needs of the patient, as well as for ongoing re-assessment and patient management regarding the treatment refused and the associated condition? (For an excellent example, see the section on periodontics.)
- Patient safety: Has the procedure, process or issue been assessed and optimized from a patient safety perspective? What are the most likely adverse events and are appropriate controls in place? Did an adverse event occur? Was it documented and reported, if appropriate? Has a root cause been established? Corrective action implemented?
- State of the science and appropriate care: Are clinical treatment procedures and recommendations current and in conformity with clinical practice guidelines that may apply? Does the practice implement a mechanism or protocol to actively monitor the state of the science and evidence-based clinical guidelines for dentistry and related fields?

Irrespective of the procedure or topic, some **general [risk management] principles** typically **apply throughout** the clinical **treatment** section.

Scope of Practice

Before deciding whether or not to perform a clinical procedure, a dentist must ensure that the procedure falls within the scope of practice of his or her dental license. The scope of dental practice is defined by the dental practice act and related positions or opinions of the state dental licensing board. If a dentist provides services to a patient outside the defined scope of practice, the dentist has violated the state dental practice act. To obtain a copy of your state dental practice act, contact either your state's board of dentistry. Many states post their practice acts online, making them easily accessible.

Violations of the dental practice act may result in disciplinary administrative penalties (loss of license, monetary fines), criminal penalties (assault or battery), and/or other civil sanctions (malpractice related to negligent or intentional acts or omissions).

In recent years, there has been an increasing focus on providing non-dental services as a means of easing patient fears, making dental visits more pleasant. The provision of these services by dental practices is generally categorized as "spa dentistry" and is characterized by amenities such as scented pillows, virtual reality glasses, hot paraffin hand treatments, manicures, aromatherapy, audio/video selections, and various teas, juices, and other beverages.

These comforts present a low risk exposure for the dentist, the most serious risks being a scald or burn from the hot wax or a respiratory reaction to certain scents. Some dentists have taken the spa concept further by expanding their practice to include services provided by other licensed personnel, such as massage therapists, estheticians, and nurses. The presence of other licensees, whether working as employees or independent contractors, increases the vicarious liability and apparent agency risks for the dentist. Consequently, dentists should thoroughly investigate the risks and verify insurance coverage for both the licensee and the practice before utilizing other non-dental licensed personnel. In some states, there may be specific regulatory requirements applying to these activities that should be reviewed for mandatory compliance as well: check and confirm with licensing boards.

Another evolving professional liability exposure regarding a dentist's scope of practice is the facial injection of botulinum toxin and dermal fillers, such as collagen and hyaluronic acid, for purely cosmetic purposes. Are such uses within the scope of a dentist's license? Each state board of dentistry issues its own determination on this issue. Some have affirmatively declared that botulinum toxin injections are within the scope of dental practice. Others have categorically determined that they are not. Some dental boards have limited cosmetic use to oral-maxillofacial surgeons, or have stated that any use of these products must have a direct relationship with a dental condition. Other licensing boards have issued vague, non-committal opinions or have not yet addressed the issue. Therefore, before engaging in the administration of these preparations, first check with your state dental board for a determination and/or guidance. Further, verify whether your professional liability insurance provides coverage for injuries arising from cosmetic procedures.

In the event of a professional liability claim against you arising from the cosmetic use of botulinum or hyaluronic acid, the plaintiff's expert witness will probably be a board certified plastic surgeon or dermatologist. His or her medical knowledge and expertise in facial cosmetic treatments and procedures will be presented to a jury in a manner that disparages your knowledge and experience. Therefore, the claim may be difficult to defend.

Managing the Risks Associated with Scope of Practice Claims

Recognizing risk factors

A dentist who performs the following is practicing outside the scope of dental practice:

- Procedures that are not authorized by your state dental practice act
- Procedures or prescribed medications without any therapeutic purpose in dentistry
- Procedures to which a reasonable patient would object

Controlling the risks

Certain treatment performed by dentists may fall outside the scope of dental practice as defined by a state dental practice act. Be cognizant of the practice parameters of the dental practice act in your state.

- Prescribe only those medications with a therapeutic purpose in dentistry and for which you hold a valid license.
  - Dentists are licensed only to prescribe medications related to the practice of dentistry. A dentist who is writing prescriptions for drugs unrelated to the practice of dentistry is practicing outside the scope of the dental license — whether the prescription is for a patient or a family member, or whether the dentist believes he or she is qualified to make the diagnosis and prescription. If a condition is not dental-related, prescribing drugs for such a condition is not within the practice of dentistry.
- Do not practice medicine unless you are also licensed as a physician.
  - Amalgam removal — Dentists have been accused of practicing medicine when they remove dental amalgam as a purported method of curing medical conditions such as multiple sclerosis. The question in these administrative actions is not whether the treatment will cure the condition, but whether a dentist is licensed under the dental practice act to treat an underlying medical condition.
  - Sleep apnea diagnosis and treatment — The fabrication of a sleep apnea appliance based on the prescription of a qualified physician would generally be considered an acceptable activity for dentists. However, many states view the *diagnosing* of sleep apnea and prescription of treatment for this condition as transcending the scope of dental practice. There is no accredited dental specialty in this area. Nevertheless, some dental organizations focus on supporting the dentist's role in the treatment of sleep disordered breathing. One organization, the American Academy of Dental Sleep Medicine (AADSM) works closely with the American Academy of Sleep Medicine on education, practice parameters, and other issues. Dentists who wish to pursue patient care in this field should review, understand and comply with appropriate state statutes, rules or regulations. Also refer to information, treatment parameters or applicable guidelines, so that care provided is consistent with current professional standards. Clinical practice guidelines from the AADSM support the use of custom titratable oral appliances over other types of appliances. Continuous positive airway pressure device therapy is superior to oral appliances and is remains the treatment "gold standard." However, oral appliances can be offered to patients with obstructive sleep apnea (OSA) who strongly prefer alternate therapies due to side effects or the inability to use CPAP. Oral appliances may be effective and they present little evidence of harm. See the bibliography for related resources (Evidence-Based Practice/Clinical Guideline section).
- Limit your examinations to structures of the head and neck. (An exception is the oral surgeon with hospital admitting privileges performing a history and physical on a surgical patient.)
  - Examinations by dentists should not involve axillary lymph node palpation, genito-urinary examinations, or the patient partially disrobing. Including such activity in a dental examination is objectionable to reasonable patients, typically unnecessary for dental examinations, and invites allegations of sexual assault.
- Do not perform or facilitate piercings and tattoos.
  - A dentist who agrees to anesthetize the lips or tongue of a patient to receive permanent lipstick tattooing or a lip or tongue piercing creates additional potential liabilities. Although a dentist is both trained and qualified to administer local anesthesia, most states do not consider the practice of dentistry to include the tattooing of lips or piercing of orofacial structures. Therefore, a dentist who performs this service would be deemed to violate the dental practice act. Moreover, if the patient is dissatisfied with the piercing or lip tattoo, the dentist probably would be named in any subsequent malpractice action.
- Do not permit auxiliaries to perform tasks not authorized by your state dental practice act.
  - Permitting — or more seriously, directing — an auxiliary to perform an unauthorized task can lead to disciplinary action by your state licensing agency. The action may be in the form of a fine, probation, suspension, or even revocation of your dental license. A plaintiff also may assert that permitting or directing unauthorized tasks constitutes evidence of negligence in a malpractice action.

The distinction between dentistry and non-dental healthcare is not always clear. The dental practice act definitions provide some degree of latitude. However, dentists must understand the state-specific limitations of their license, recognize and evaluate the risk exposures and consult available resources before making decisions to offer new services. Resources available to assist in this decision-making process are the state department of professional regulations staff, representatives of the local, state and national dental associations, colleagues, and legal professionals.

Local Anesthesia

Claims involving the administration of local anesthetic agents are uncommon. However, the alleged damages can be significant. These complaints typically contend that the dentist performed the injection using an improper technique, administered an excessive dose, or selected an inappropriate agent, and have included the following injuries:

- Adverse reaction to a local anesthetic injection
  - Syncope, shortness of breath, dizziness, lightheadedness, chest pain
  - Hematoma, swelling, trismus
- Toxicity from overdose — seizure, respiratory failure, cardiac arrest, death
- Nerve injury — paresthesia, dysesthesia, pain
- Needle breakage during the injection

Managing the Risks of Local Anesthesia

Local anesthetic agents are the only drugs that most dentists will ever inject into a patient. While dentists administer hundreds of millions of injections each year, continued diligence is required regarding the use, risks, and management of local anesthetic adverse responses. We recommend that dentists and all auxiliary personnel licensed to administer local anesthetic injections remain abreast of current information regarding drug use and dosing information. The package insert/prescribing information should be reviewed regularly to refresh your knowledge and monitor the documentation for significant updates.

Recognizing risk factors

The most common complication of local anesthetic administration is syncope. Syncope may be preceded by many symptoms, including nausea, vomiting, sweating, pallor, yawning, and bradycardia. Allergic reactions to local anesthetic formulations are not common, but do occur. Allergies are more commonly associated with the metabisulfite preservative used for the vasoconstrictor than with the anesthetic itself. Some patients will mistakenly report a history of allergy to local anesthesia when the actual event was syncope, usually due to stress. An allergy may be manifested by urticaria, as well as the pallor, nausea, and vomiting also associated with syncope. Anaphylactic responses also are possible.

A less frequent occurrence, but one of greater concern, is anesthetic overdose. High blood levels can be caused by a number of factors, including a single inadvertent intravascular injection, repeated injections, and rapid absorption in the absence of a vasoconstrictor. Local anesthetic agents are both central nervous system and cardiovascular depressants. Toxic levels of local anesthesia will affect the brain first, then the heart. The brain (central nervous system) is more sensitive to local anesthetics than are peripheral nerves, and local anesthetics readily cross the blood-brain barrier.

It also should be noted that opioid analgesics are additive with local anesthetics in central nervous system depressive activity. This issue has been raised in cases involving pediatric sedation with opioids, during which local anesthetic doses should be adjusted downward.

Signs of mild overdose usually develop between five and ten minutes after injection, but may take longer. Symptoms of mild overdose may or may not include an excitatory phase exhibited by talkativeness and excitability. Symptoms include sedation, analgesia, slurred speech, euphoria, sweating, vomiting, elevated heart rate, and elevated respiratory rate. A more severe overdose may manifest itself rapidly — in a minute or so — or may take up to 15 minutes. Symptoms of severe overdose include disorientation, seizure activity, respiratory depression, and unconsciousness. Death can occur.

For patient convenience, office efficiency and other reasons, "quadrant dentistry" is a common approach to providing restorative care for both children and adult patients. Since adequate local anesthesia may require multiple injections in these situations, it is important to consider the maximum dose *before beginning a procedure*. Maximum dose based on weight (mg/kg or mg/lb) for children and adults of smaller stature must be evaluated prior to commencing treatment. Once treatment is initiated, the dentist is properly focused on ensuring that the patient is comfortable and pain-free. The need to manage acute discomfort may obscure other factors, as presented in the following case report.

Case Report

A 40 pound six year old female patient was given two cartridges of 2% Lidocaine with 1:100,000 epinephrine for the restoration of 4 maxillary teeth. The patient was feeling discomfort, and two more carpules of anesthetic were given. Thirty minutes later, the patient appeared apprehensive and resistant. The dentist thought the anesthetic was wearing off and gave an additional carpule for the remaining tooth to be treated. The patient developed a hand tremor, and the muscles began twitching. Within minutes, the child lost consciousness. The child's skin was ashen, and the lips and nail beds became dark. The dentist instructed staff to call 911. The dentist opened the airway and began positive pressure ventilation. Although the patient's color improved, she was still unconscious when the paramedics arrived. The child was taken to the hospital but never recovered. The cause of death was local anesthetic overdose.

Discussion

The dentist made a key mistake when he failed to recognize an early warning sign of overdose when the patient became resistant and apprehensive at about thirty minutes into the appointment. Instead, he administered additional anesthetic. The maximum recommended dose for 2% lidocaine with 1:100,000 epinephrine for a 40 pound child is approximately 2 carpules (see "controlling the risks" in this section). However, 5 carpules were administered.

Paresthesia Claims

Claims involving prolonged or permanent paresthesia can arise from non-surgical dentistry in the mandibular arch, where a local anesthesia injection is the only plausible cause of the injury. The precise mechanism of these injuries remains unknown. Direct trauma to the nerve sheath by the needle tip has been cited as a proximate cause of the injury. Based on the small needle bore size used in dentistry and other factors, some investigators question whether trauma from the needle could be the primary reason for nerve injury after local anesthetic injection. Other possible causes include intraneural hematoma, permanent disruption of the biochemical process of nerve conduction, contamination of the anesthetic solution by alcohol or sterilizing agents, and the inherent neurotoxicity of local anesthetic agents.

While most cases of paresthesia resolve within a few weeks, the problem may persist. See the "Nerve Injury" section in the "Managing Adverse Events" chapter of this workbook for more detailed information on managing nerve injury cases. Note that some experts have published recommendations that referral to a specialist should occur immediately. or at four weeks from the time of injury, depending upon the type of injury and the course of the patient's signs and symptoms. Although each patient injury is unique, it is clear that early intervention is a key factor related to successful outcomes for both surgical and nonsurgical nerve injury treatments. Claims and indemnity payments in this area are trending upward in recent years. Therefore, from both a patient safety and risk management perspective, if there is any question about the course and speed of the patient's recovery, referral to a nerve injury specialist, sooner rather than later, is strongly recommended.

The factors affecting a patient's risk of an adverse response to local anesthesia include the following:

- Dosage of local anesthetic agent
- Properties of the local anesthetic agent
  - Concentration, lipid solubility, pKa
  - Presence or absence of vasoconstrictor, concentration of vasoconstrictor
  - Preservatives in the preparation
- Regional anatomy
  - Nerve morphology
  - Localized blood flow
- Patient age and weight
- Patient health
  - Poor hepatic, renal, cardiac, pulmonary function
  - Current medications — prescribed or illicit
    - Premedication with or concurrent use of narcotics
    - Cocaine potentiation of vasoconstrictor
  - Level of anxiety
- Clinician controlled factors
  - Extent of review of medical history
  - Selection of appropriate local anesthetic agent
  - Speed of injection
  - Operator technique
- Biologic variation, including metabolic/biotransformation and drug clearance variations

Controlling the risks

Clinical

- Obtain a comprehensive medical history, including prior responses to various local anesthetic agents and current medication/drug use.
  - Opioid analgesics and other nervous system depressant medications may significantly increase the central nervous system depressive activity of local anesthetics.
- Perform and document baseline blood pressures at new patient and recall examinations.
- Know your patient's approximate weight and calculate safe anesthetic dosages. Have a scale available to weigh pediatric patients, whose margin of safety is narrower.
- Know the involved anatomic landmarks and use proper techniques. Always aspirate.
- Inject very slowly. An entire 1.8 ml cartridge should take about 60 seconds to inject.
- The relationship between an "electric shock" felt by the patient during an injection and paresthesia or other neurosensory disturbance (NSD) is tenuous. However, if the patient feels an electrical shock, pain, or other untoward sensation during the injection, it is reasonable to withdraw the needle completely, re-establish your correct position, and reinject. Then, document in the patient's chart that you followed this procedure once the patient expressed discomfort. This clinical protocol minimizes the risk of traumatic nerve injury and places the patient's well-being at the center of the dentist's actions. It demonstrates an appropriate response by the dentist to the patient's report of an untoward situation. Moreover, the documentation of the dentist's actions creates a more defensible position in the event of a claim.
- Since some evidence points to the neurotoxicity of local anesthetic drugs as a cause of paresthesia or other NSDs, the choice of anesthetic solution should be considered for both patient safety and risk management. Hillerup notes that more than 90 percent of local anesthetic-related trigeminal NSDs involve mandibular blocks, and the vast majority involve 4 percent anesthetic formulations. Consider use of less concentrated formulations for mandibular block anesthesia (Hillerup S. *Trigeminal Nerve Injuries*. Springer 2013; chapter 4; p 71).
- *Use the least amount of drug necessary to achieve anesthesia, always staying below the recommended maximum dose.* (Maximum dose recommendations can be found in the product package insert (prescribing information), as well as in various local anesthesia textbooks. Note however that some authors have recommended dosage maximums below the FDA limit stated in the product package insert. For lidocaine with epinephrine 1:100,000 for example, 4.4mg/kg (2mg/lb) up to a total dose of 300 mg has been recommend, whereas the FDA-approved package insert recommendation is 7mg/kg (3.2mg/lb) up to a total dose of 500 mg.)
- Never insert the entire length of a needle into soft tissue whereby the tissue touches the hub. The weakest part is where the needle enters the hub.
- Stay in the room (or have an assistant do so) after the injection to monitor the patient's response.
- In case of an allergic reaction, have antihistamines (such as Benadryl®) and epinephrine (Epi-Pen®) available, and be knowledgeable in their administration.
- If you are unable to retrieve a broken segment of needle, refer the patient to an oral surgeon or appropriate physician specialist immediately.

Communication

- Seek physician (allergist) consultations and written reports for patients who report anesthetic allergies.
- For inferior alveolar blocks, advise patients that they may feel a transient stinging, burning, or shock type of sensation.
- Advise patients that they may feel differently after the injection. (This response is due to the general central nervous system depressive nature of local anesthetic agents.)
- Diligently follow up with patients who have had adverse responses.

Documentation

- Always document the local anesthetic agent given, its concentration, the volume given, the presence or absence of a vasoconstrictor, and the name and concentration of the vasoconstrictor.
- Document any adverse patient responses and your corrective action taken.

Periodontics

Most professional liability claims pertaining to periodontics allege a failure to diagnose, failure to inform, failure to refer, or failure to treat. Adverse events during treatment and the failure of either surgical or non-surgical therapy produce few claims. The majority of periodontal claims are alleged against general dentists. As the majority of the dentists we insure are general practitioners, this data is anticipated. Claims against periodontists reflect the surgical nature of their practices and include claimed injuries such as post-surgical infection and paresthesia.

Claims based upon periodontal disease frequently have a number of characteristics in common. First, the claimant has already left the practice or been seen by a subsequent treating dentist. It is often the diagnosis of periodontal disease by a new dentist, accurate and correct as it may be, that leads the patient to conclude that the diagnosis also should have been made by the former dentist.

Second, the alleged act or omission did not occur recently. Most periodontal claims involve an alleged delay in diagnosis or treatment that led to the claimed injuries. Although the patient may have had a recent recall exam, allegedly at which no diagnosis was made, the claim will typically focus on an exam performed years earlier as the beginning of the dentist's culpability. Not surprisingly, most dentists have no recollection of the discussion from the prior appointment years ago. Therefore, the dentist must rely on the comprehensiveness and accuracy of clinical records and notes. Remember that the statute of limitations, the patient's legal window in which to file a lawsuit, varies by state and can extend for many years.

These characteristics differ from claims arising from many other procedures, such as extractions, whereby patients become aware of their condition soon after treatment and without an evaluation, diagnosis, or commentary from a subsequent dentist.

Other periodontal claim allegations include:

- Improper treatment performed — the periodontal treatment performed was not appropriate for the patient's periodontal case type or status
- Procedure performed incorrectly
  - Post-surgical infection
  - Post-surgical bleeding
  - Post-surgical paresthesia/dysesthesia
  - Inadequate osseous reduction or recontouring
  - Need to repeat root planing or surgical treatment

Theories of Liability

Although there may be only slight differences of opinion within the dental profession as to how to appropriately treat certain conditions, wide disparity among practitioners about the diagnosis and treatment of periodontal disease may exist. The standard of care is a legal term, rather than a clinical description. It may include not only one treatment modality but a variety of treatments which may be practiced by reasonably prudent dentists for the same condition.

Failure to diagnose

The expectation of every patient is that the dentist will thoroughly examine both the hard and soft tissues of the mouth, formulate a diagnosis, inform the patient of his or her clinical findings, and recommend appropriate treatment. The American Academy of Periodontology describes a number of clinical factors that must be assessed for the dentist to arrive at a periodontal diagnosis. They include:

- Presence or absence of inflammation (usually exhibited by bleeding upon probing)
- Probing depths
- Extent and pattern of loss of periodontal attachment and bone
- Medical and dental history
- Other signs and symptoms, such as distribution of plaque and calculus, pain, and mobility

Additional contributing factors are the patient's age, the presence or absence of purulence upon probing, proximal tooth contact relationships, the presence or absence of malocclusion, and the condition of dental restorations and prosthetic appliances.

A contemporaneous patient record documenting that the examination corresponded to the clinical findings listed above provides a strong defense that the dentist performed an acceptable periodontal examination. Documentation in the patient's record concerning any additional clinical information and that all findings were discussed with the patient, including the patient's response to the findings, would further strengthen the defense in the event of a professional liability claim.

In most failure to diagnose cases, the dentists insist that they made a complete and accurate diagnosis, that they tried to refer, and that they attempted to treat. They also state that the patient was informed at every stage and that the patient knew about the deteriorating periodontal condition. Dentists note that the patient refused to see a periodontist. As a result, they continued to examine the patient at each recall, but that the patient eventually stopped listening. Then, at some later time, the patient's condition deteriorated, and the patient seemed incredulous. Or, the patient visited another dentist and suddenly became willing to participate in a comprehensive course of periodontal treatment.

Notice that the preceding paragraph indicated that the dentist made various statements about the treatment and the patient. However, it does not indicate that the dentist's record supported the statements. The reason that *many "failure to diagnose" claims result in a settlement or judgment against an insured dentist is the dentist's failure to document.* The best defense to a failure to diagnose claim is a comprehensive patient record that reflects the patient's periodontal status.

The current standard of care for oral examinations includes a periodontal diagnosis, well supported by documentation of clinical findings, including recall and initial examinations. A comment about the patient's oral hygiene habits, such as "OH fair," does not reflect the presence or absence of periodontal disease, nor your diagnosis. It represents a good supplemental note, but a comprehensive periodontal examination and diagnosis with supporting documentation (periodontal probing, presence or absence of disease signs and related clinical findings), is required to comply with current professional standards.

Failure to refer

The duty owed to each patient includes a timely referral whenever the required care is beyond your training, experience or expertise. Concerning periodontal disease, the referral dentist would most likely be a periodontist. If you wish to refer a patient with periodontal disease to someone who is not a periodontist, you should inform the patient that although your referral is not a periodontist, you commonly refer to him or her. However, the patient should be given the option of seeing a periodontist.

The timing of the referral is often of great importance in a lawsuit. Was the patient referred immediately when it was believed that the patient's needs exceeded the dentist's professional skills, or was there procrastination, allegedly causing the patient's condition to further deteriorate?

Your referral discussion with the patient should be documented thoroughly, emphasizing your message to the patient as well as the patient's response and understanding of his or her condition. Patients also may wish to hear what you believe the periodontist will do.

No rule demands patient referral out of your practice. If you feel competent treating periodontal disease, no law or ethical standard prohibits you from doing so. However, in a lawsuit asserting that your periodontal care breached the standard, expect your care to be held to the standards of a periodontist. The expert who will testify in court on behalf of the plaintiff will probably be a periodontist, subject to applicable expert witness requirements of the venue in which the case is tried. Therefore, it is a prudent practice to treat only those cases within your clinical expertise.

Improper procedure performed

A periodontal claim alleging an improper procedure was performed typically arises after a subsequent dentist informs the patient that he or she was mistreated in some way. Some patients will seek a new dentist if they believe your treatment was too expensive or simply unsuccessful. Others may seek a second opinion of diagnosis and treatment options to enhance their understanding even during your successful treatment. Claims may arise after surgical or non-surgical periodontal therapies.

This allegation often surfaces after the patient is told by a subsequent dentist that non-surgical therapies, which you were directing, are less effective than a surgical approach. The patient feels cheated or misled, especially if the patient's relationship with you was less than perfect. Although numerous studies have been published demonstrating the strengths and weaknesses of these conflicting therapeutic approaches, the patient has little access to this research and limited understanding of the concepts and principles involved. Informational pamphlets may be helpful in assisting the patient to better understand periodontal disease and its treatment options.

A number of risk management strategies can be utilized. These include keeping abreast of current scientific knowledge, maintaining good communication with your patients, practicing informed consent principles, including a discussion of the available treatment options, and fully documenting your rationale, treatment, and communication in the patient's record. Also, be diligent when considering *new* diagnostic or treatment methods for periodontal disease or other conditions. Such advances are critical to improving patient care. Nevertheless, you should understand the evidence (or lack of evidence) available for the products and/or techniques being promoted or proposed. Informed consent should address this information so that the patient is able to understand the benefits, risks and prognosis associated with proposed options.

Refusal of Periodontal Treatment or Referral

A patient who refuses either your periodontal treatment recommendation or your periodontal referral presents you with two choices. You may continue to treat the patient — within certain parameters — or you may dismiss the patient from your practice due to noncompliance. There is no right or wrong decision, simply a matter of preference that is informed by your assessment of the risks.

Each choice presents some level of risk to your practice. If you decide to continue treating, you risk the possibility that at some point in the future, the patient's periodontal condition may not be adequately evaluated or documented. If you dismiss the patient, you risk alienating him and having his ill will spread to other patients he knows. Base your decision on factors such as the quality and longevity of your dentist-patient relationship, the nature and urgency of the recommended periodontal treatment, and the overall financial impact on your practice.

The dentist who opts to retain the refusing patient in his or her practice and continue with care must be aware of several additional duties that emanate from the patient's informed refusal. These duties apply in addition to having informed the patient regarding the risks of refusing the recommended periodontal treatment.

They include:

- A continued duty to *examine* and *diagnose* the patient's periodontal condition for the duration of the dentist-patient relationship and as long as the patient continues to refuse either periodontal treatment or a periodontal referral
- A continued duty to *inform* the patient about his or her periodontal status and the associated risks throughout the dentist-patient relationship, the presence of the periodontal condition, and the patient's continued refusal of treatment
- A heightened duty to tell the patient how the refusal of periodontal treatment may affect treatment of other structures or the overall treatment plan
- Refusing to agree to a patient's ill-advised demand for other dental treatment may be necessary and/or prudent from a risk management perspective. For example, placing crowns or bridges on teeth with poor periodontal support may breach the standard of care, depending upon specific circumstances. In any event, restoration failures in these situations often lead to a patient demand for a refund, or the filing of a professional liability claim.
- The failure to meet these obligations has resulted in *failure to diagnose, failure to inform,* and *failure to treat* allegations. A claim of this nature may involve a patient who refuses scaling and root planing but is agreeable to return on a regular basis for debridement by the hygienist. Since the patient has not demonstrated an interest in improving his periodontal health, the dentist does not emphasize periodontal concerns during periodic recall visits. As the periodontal condition worsens over time, he neither probes the periodontium nor documents in the progress notes anything about the patient's periodontal status.

CNA claim professionals have noted that the patient records in these claims typically lack periodontal chartings and/or documentation of having informed the patient of disease status. The risk to the dentist lies in the absence of regular evaluations and disclosure to the patient, and/or the lack of documentation of these actions, even if performed. These claims are based upon the patient's lost opportunity to reconsider a treatment refusal decision based upon updated information from the dentist.

Periodontal care refusals represent an increased liability risk and require greater diligence on your part to manage that risk. The most effective technique is to thoroughly document the informed refusal process as outlined in the "Informed Refusal" section of this workbook. It includes the use of an informed refusal form in conjunction with comprehensive note writing. *Please refer to page IX for information about access to risk management forms.*

Managing the Risks of Periodontal Treatment

Recognizing risk factors

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

- Patients who are noncompliant with home care, treatment recommendations, or referrals
- Patients with whom you have encountered prior treatment difficulties, whether surgical or non-surgical
- Patients with significant medical conditions or co-morbidity factors, such as cardiac disease, diabetes, tobacco use, eating disorders, and bruxism
- Patients who present other patient management difficulties, such as failure to follow medical advice and failure to keep follow-up appointments
- Patients with unusual periodontal topography
- Refractory cases
- Patients with significant esthetic concerns and expectations

Please refer to page IX for information about access to a sample form on "Discussion and Refusal of Periodontal (Gum) Treatment."

Controlling the risks

Controlling the risks of periodontal diagnosis and treatment requires a multifaceted approach that includes clinical skill and attention, good communication, and thorough record keeping.

Clinical

- Perform comprehensive initial and recall periodontal examinations on each patient. Document your findings using periodontal charting forms and descriptive, thorough progress notes. Remain current on periodontal disease diagnosis and classification. (Disease classifications updated in 2017-18 by the American Academy of Periodontology (AAP): refer to the AAP website section on clinical and scientific papers.)
- Obtain appropriate radiographs to aid diagnosis. The AAP has stated that intraoral radiographs, such as periapical films and vertical or horizontal bitewings, provide information about the periodontium that cannot be obtained by other non-invasive means. However, the AAP also states that radiographs routinely underestimate bone loss and that the diagnosis of periodontal diseases is almost entirely based upon traditional clinical assessments.
- Treat cases within your clinical expertise.
- Prior to surgery, assess the patient's physical condition and ability to tolerate the procedure.
- For surgical patients, record the patient's blood pressure prior to administering local anesthesia. Patients with dangerously elevated or depressed pressures should have treatment deferred, if possible, and should be referred to their physician for evaluation.
- Refer in a timely manner, when appropriate, to competent clinicians, under the following circumstances:
  - Complex surgical cases
  - Cases with potential complications that exceed your expertise or comfort level
  - When a patient does not respond to your care
- Plan your incision and flap design before picking up the scalpel.
- Use sound clinical judgment during treatment.
- Require patients to return for postoperative evaluation.
- Recall patients for periodontal maintenance therapy in a timely and efficient manner.
- Have a specific protocol for responding to patients who refuse to follow your recall schedule, including the possibility of termination from your practice when the time period between recalls reaches a point that endangers a patient's oral health.

Communication

- Inform the patient of your clinical findings and your recommended treatment.
- Provide the patient with truthful and informative guidance. Don't avoid the issue of periodontal disease or periodontal deterioration in order to avoid upsetting the patient.
- Manage the variety of patient understandings and expectations regarding diagnosis and treatment.
  - Ask patients what they want and/or expect to occur during the course of treatment.
  - Inform patients what to realistically expect during treatment and postoperatively.
  - Inform patients how their periodontal diagnosis and treatment affects their ability to achieve desired restorative treatment goals.
- Perform only those periodontal procedures for which you have the patient's informed consent. Explain the diagnosis, nature of treatment, any alternative treatments, and the risks, benefits and potential complications of the various treatment options.
- Don't make treatment decisions for patients. If you diagnose the need for periodontal treatment or referral, inform the patient and permit the patient to say "yes" or "no," even if you believe you know the answer.
- Provide clearly written postoperative instructions and information, including how to reach you after hours and how you will manage the patient's postoperative follow-up.
- Explain to the patient any reason(s) for referral.
- Use a comparison of recall chartings to baseline chartings to educate patients regarding the necessity for referral upon recall.

Documentation

- Complete a preoperative periodontal chart (*not* only a PSR screening) for *all* patients undergoing periodontal therapy, especially root planing and surgical treatment.
- For repair procedures such as connective tissue, free gingival, and pedicle grafts, document the location of and necessity for the surgical procedure. Document the location of the *donor site* as well, including appearance before surgery and healing after surgery. Clinical photography may be beneficial for before/after images as well.
- Document in the patient healthcare information record that you have informed the patient of your diagnosis of periodontal disease and your recommended treatment.
- At recall and maintenance visits, update your periodontal charting and write a progress note that describes your clinical findings, your updated diagnosis, and your updated periodontal treatment plan.
- If a referral is made, document in the patient healthcare information record the reason(s) for referral and the fact that you have informed the patient of the need for referral.
- Maintain accurate and consistent records. Ensure that your billing and insurance processing descriptions correlate with progress notes.
- Thoroughly document any patient's informed refusal of your treatment recommendation or referral by using an informed refusal form coupled with a comprehensive progress note.
- Make a chart entry concerning refusal of care at *every* subsequent visit when you discuss the issue with your patient, irrespective of the time frame between visits.

Please refer to page IX for information about access to a sample form on "Discussion and Consent for Periodontal (Gum) Treatment."

Thoroughly **document** any patient's **informed refusal** of your **treatment recommendation or referral** by using an informed refusal **form** coupled with a comprehensive **progress note**.

Crown and Bridge

Malpractice claims involving crowns comprise more claims than any other dental procedure.

Our CNA claim files have demonstrated that virtually every reason for which a crown or fixed prosthesis may require replacement has been cited as a basis for a malpractice claim, including:

- Procedure performed incorrectly
  - Inadequate margins — margins are, for example, open, overhanging, short, bulky, or exposed.
  - Incomplete caries removal
  - Violation of the biologic width
  - Poor occlusion
  - Poor esthetics
  - Inadequate preparation — porcelain ground through to metal when adjusting occlusion
  - Excessive preparation — inadequate retention; resultant need for endodontics
  - Wrong tooth treated
  - Unintended pulpal exposure during preparation
  - Damage to neighboring teeth or soft tissues
- Inadequate evaluation — no preoperative radiographs taken; need for endo/perio not diagnosed
- Improper treatment plan — restoration placed despite the need for extraction or endodontic or periodontal treatment
- Improper or unnecessary treatment performed — tooth did not need a crown
- Treatment not completed
- Lack of informed consent — patient would have selected a different treatment if all alternatives and risks had been presented
- Fraud — dentist billed for high noble metal but instead used semi-precious or non-precious metal

Managing the Risks of Crown and Bridge Claims

Recognizing risk factors

Many crown and bridge claims arise from patients who are dissatisfied solely with the esthetics of their restorations, usually due to the shade. Many of these claimants had approved the case during the try-in appointment. Later, they changed their minds after hearing critical comments from a spouse, family member, or friend. In most cases, the patient requests a refund of fees or that the case be redone at no charge.

Dentists vary widely in their responses to this situation. Confident that the standard of care was met, some adamantly refuse to accede to the patient's wishes. Others are willing to redo the case in an effort to please the patient. Others refund the fee and ask the patient to go elsewhere, believing that they will never be able to meet the patient's (or the patient's critic's) esthetic expectations. No option is appropriate for all dentists. The decision making involves business considerations coupled with many personal and clinical factors. Select the path that best suits your personal ethics and views, your perception of risk, and your appetite for further conflict.

Many factors can affect the outcome of crown and bridge restorations. The risk of a poor restorative outcome or a dissatisfied patient is increased in these circumstances:

- Significant and/or unrealistic patient expectations, particularly esthetic expectations
- Untreated periodontal disease or an unstable periodontium
- Poor oral hygiene
- Poor tooth angulation
- Root proximity problems
- Poor occlusion
- Inadequate inter-arch space for the restorative material selected
- Encroachment or violation of the biologic width
- Limited interincisal opening
- Questionable treatment plan
- Limited experience of the dentist
- Inadequate documentation of the diagnosis and need for treatment

Controlling the risks

Clinical

- Select cases within your clinical expertise and refer when appropriate.
- Do not allow yourself to be pressured into performing treatment outside your comfort level, for patients who present with the following issues:
  - Patients with unrealistic expectations
  - Patients with untreated systemic conditions
  - Patients with untreated periodontal disease
  - Patients with untreated oral pathology — periapical lesions, mucosal lesions, etc.

Always have a preoperative radiograph showing the entire root structure and periapical area prior to preparing any tooth, and carefully assess the pulpal, periodontal, and periapical status of the tooth or teeth prior to crown and bridge preparation.

Let's consider the following scenario for the previous bulleted recommendation: One of the common scenarios involves the recall patient who has an exam, prophy, and bitewing radiographs. The dentist diagnoses recurrent decay around an old amalgam restoration on a molar and recommends a buildup and crown. The patient dutifully follows through with treatment, which is completed without complication. A few weeks after cementation, the patient begins to experience prolonged and increasing pain on chewing from the crowned tooth, as well as thermal sensitivity to both hot and cold. He returns to the dentist for further evaluation.

The dentist evaluates the tooth, which also involves a periapical radiograph. The image shows a 5 mm diameter well-circumscribed periapical radiolucency, which the dentist immediately realizes must have been present before the crown preparation was performed. Informing the patient of the need for endodontic treatment does not go well, as the patient believes that the tooth was not in need of a root canal before the crown was done. Therefore, the dentist must have done something wrong to cause the need for the root canal. He expects a root canal, buildup, and new crown on a complimentary basis.

Although the dentist knows the patient's logic is incorrect, he is placed in a difficult position knowing that he should have diagnosed the need for endodontics prior to the crown. The management of this common source of claims is very basic. Before treatment begins, thoroughly evaluate the pulpal, periodontal, and periapical status of all teeth to be crowned or used as bridge abutments.

- Remember to inform patients of their own responsibility to maintain good oral health and comply with self-care instructions and ongoing follow-up requirement, and the consequences of not doing so.
- Do not begin any crown and bridge treatment until the patient demonstrates an interest and ability to meet your requirements for oral hygiene and periodontal health. Any other choice may subject you to liability if the prosthodontic treatment fails.
- Discuss the possible need for endodontic treatment in the future with crown and bridge restorations. This is a foreseeable risk and relatively common outcome, due to the mechanical insult of tooth preparation and may not be avoidable. Where appropriate, recommend endodontic therapy before crown preparation. Document the rationale.
- Refrain from restoring teeth that have an unfavorable or hopeless prognosis.
- Verify the correct tooth to be prepared twice *before* picking up the handpiece.
- Require the patient to have periodontal crown lengthening when clinically necessary due to violation of the biologic width or other reasons.
- Have patients approve esthetics before crown cementation. Ask them to sign an approval. If they are uncertain, provisionally place the crowns with an appropriate temporary cement.
  - Invite patients to have their spouse, family member, and/or trusted friend accompany them and participate in the appointments critical for esthetic success, such as shade selection and try-in.
- Critically evaluate restorations before cementation. Remake at your expense those that do not meet the standard of care.
- When necessary, take a bitewing radiograph to determine the integrity of interproximal margins.
- If you realize that a completed restoration is not as you would like it to be, inform your patient and take corrective action to remedy the inadequacy.

Communication

- Discuss case fees and payment expectations before beginning treatment.
- During the informed consent discussion, advise patients prior to preparing the tooth or teeth if you anticipate that a compromised result may occur. Then, document the disclosure in the patient record.
  - Short clinical crowns generally result in preparations of a less-than-optimal length, compromising the retention of the casting. Inform patients when such a compromised condition exists. It may be appropriate to refuse treatment in such cases unless the patient accepts a plan for crown lengthening or other alternatives if any exist. The treatment plan must meet the standard of care.
- Follow up by calling your patient later on the day of treatment to assess his or her condition, and document all patient complaints and your recommendations.
- Provide clearly written postoperative instructions and information, including what the patient should expect and how to reach you after hours.
- Document a specific warning to the patient that root canal treatment may become necessary after cementation of the crown and state that it is impossible to predict the teeth that may need such treatment.

Documentation

- Have a written treatment plan for all restorative cases.
- Document all pulp test results, including those within normal limits.
- Restore only those teeth for which you have the patient's informed consent.
- Use written informed consent forms whenever possible, especially for extensive or complex restorative cases.
- Thoroughly document the treatment performed.
- Provide clearly written postoperative instructions and information, including what the patient should expect and how to contact you after hours.
- Use a written referral form to reduce miscommunication between dentists.

Please refer to page IX for information about access to sample forms on "Discussion and Consent for Crown Restorations" and "Discussion and Consent for Fixed Bridge Restorations."

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."

Endodontic (Root Canal) Therapy (RCT)

In terms of frequency and claim indemnity costs, RCT-related incidents continue to be a major liability concern for dentists, ranking in the top five procedures for both claim frequency and overall claim costs.

A common theme in many endodontic claims is a patient belief of never receiving information of the costs associated with the buildup and crown necessary after endodontic treatment. Patients assert that they would have chosen to have the tooth extracted if they had been fully informed of the overall cost of treatment.

We recommend including the broader treatment plan options and the costs of each treatment option in the informed consent discussion before any treatment has begun. Therefore, inform the patient of the clinical need for the root canal *plus* any crown lengthening that may be necessary *plus* the buildup *plus* the crown, and the aggregate fee estimate for this treatment sequence. Alternatively, the patient could select the extraction treatment route, which would entail the extraction *plus* placing an implant *plus* placing a crown on the implant, or perhaps the extraction *plus* a fixed bridge instead. In either scenario, the patient should be told the total fee estimate for the extraction *plus* the implant *plus* the abutment/crown, or the extraction *plus* the bridge.

It is important to also inform the patient of the option of having a specialist perform the treatment, whether it is the root canal by an endodontist or the extraction by an oral surgeon. General dentists should note that the American Association of Endodontists (AAE) has published a *Treatment Standards White Paper* on endodontics (2018), which includes detailed "standard of practice" information and a section describing the scope of endodontics in general dentistry. The paper is available on the AAE website in the *Clinical Resources/Guidelines & Position Statements* section.

The patient must be given the big picture of each treatment option and the corresponding fees in order to make the most informed decision possible. Of course, the benefits and risks of each treatment sequence should be discussed as well. Fee information should be documented in the patient's progress note in the context of having informed the patient of the charges for each treatment sequence option. An informed consent form specific to the treatment of choice also is recommended. If the patient was aware of the cost of the root canal but never informed of the need for or the cost of the restorative treatment, a truly informed decision on whether to extract or keep the tooth is not possible.

The following allegations have been asserted for RCT procedures:

- Failure to diagnose the need for endodontic therapy (failure to radiographically evaluate, failure to perform appropriate tests)
- Failure to inform the patient (written/oral) of the need for endodontic therapy
- Failure to refer to an endodontist for treatment, either initially or after difficulties were encountered
- Failure to treat — patient alleges no endodontic treatment was recommended by the dentist, when in fact, treatment was necessary
- Improper treatment performed
  - The tooth did not require endodontic therapy due to a lack of pathology or other clinical indications.
  - The tooth could not be restored and should have been extracted rather than have RCT performed.
- Procedure performed incorrectly
  - Wrong tooth treated
  - All canals in a tooth not treated (usually when canals are missed, sometimes when canal orifices are calcified)
  - Perforation of the root or pulp chamber
  - Obturation is unacceptably long or short, or is insufficiently condensed
- Inadequate precautions
  - Lack of rubber dam
    - Swallowed or aspirated file or other instrument
    - Injury from irrigant use, such as bleach
- Poor outcomes
  - Infection during or after treatment
  - RCT is unsuccessful
    - Tooth is retreated
    - Tooth is extracted
    - Root is amputated/tooth is hemisected
- Separated instrument left in the canal

Managing the Risks of Endodontic Treatment

A general dentist performing endodontic treatment will often be held to the standard of care established by the *specialty*, since an endodontist will probably be the plaintiff's expert witness for any endodontic claim.

Recognizing risk factors

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

- Performing treatment without a rubber dam in place
- Overuse of endodontic instruments (files, reamers, etc.)
- Teeth with dilacerated roots, sclerotic canals, and canal systems of unusual morphology
- Teeth that have been traumatically injured
- Retreatment cases
- Treatment of patients with whom you have encountered prior endodontic difficulty
- Treatment of patients who present other patient management difficulties, such as a difficulty wearing the rubber dam, failure to keep follow-up appointments, and failure to follow medical advice
- Treatment of patients with significant medical conditions
- Treatment of patients who are not fully informed about their treatment options

Controlling the risks

Clinical

- Select cases within your clinical expertise.
- General dentists will be held to the endodontist standard of care in nearly all states: refer when appropriate. Examples of when to consider referral to an endodontist include the following:
  - Teeth with dilacerated roots, sclerotic canals, and canal systems of unusual morphology
  - Teeth presenting difficulty with finding a canal, negotiating a canal, or reaching the apex
  - Patients who are difficult to treat, such as those with limited interincisal opening or a severe gag reflex. The endodontist may be able to complete treatment in fewer visits, perhaps in a single visit.
  - The retrieval of a separated instrument or repair of a perforation
  - Cases involving other difficulties or complications during treatment
- *Always* use a dental dam — it is the standard of care in endodontics, reaffirmed by the AAE in 2017. Unfortunately, this requirement is often overlooked, placing the patient and the practitioner at risk.
- Evaluate the patient for possible latex allergy and use non-latex dams when appropriate.
- Regularly check the rubber dam for patient comfort and to detect breaches in the protection offered by the dam that could lead to chemical burns.
- *Always* obtain a *preoperative* radiograph showing the *entire* root structure and periapical area prior to initiating endodontic therapy on any tooth. Carefully evaluate the pre-operative radiograph for anomalies in tooth morphology and to estimate the tooth length.
- Verify the correct tooth twice *before* creating your endodontic access opening.
- Perform endodontic therapy only on teeth for which you have consent.
- Use written informed consent forms.
- Exercise diligence in finding all canals. If you cannot find the orifice of a canal that radiographically appears patent, refer the patient to an endodontist.
- Verify apex location and working file length radiographically or by another accepted method.
- Carefully inspect files, reamers and broaches before and during use. Discard any that appear defective.
- Follow manufacturers advice on file re-usage. Consider limiting endodontic files and reamers to a single, then discarding, per the current Centers for Disease Control and Prevention (CDC) dental infection control guidelines. While not mandated in the United States, some countries have mandated that endodontic files and reamers be designated as single-use devices, primarily over concern for Creutzfeldt-Jakob Disease (CJD). A joint committee of the AAE and the Canadian Academy of Endodontics in 2011 recommended using "sound clinical judgment" when selecting endodontic instruments for re-use and to select acceptable sterilization methods. Hand and rotary files and reamers selected for re-use would include "those that do not demonstrate surface or flute defects, those that have not lost their cutting efficiency, and those that have not been used on patients diagnosed with CJD."
- Measure every instrument to the correct working length before you insert it into the tooth, check its length when you remove it from the tooth, and irrigate frequently with a standard irrigating solution.

- Use proper techniques during reaming and filing, and take confirming radiographs during treatment, as necessary.
- Use broadly taught and accepted obturation techniques. (Paste fill techniques are more difficult to defend because they are not taught in U.S. dental schools and not advocated by leading endodontic authors.)
- Verify the endodontic result with a radiograph of the obturated canals. Date and retain the radiograph.
- Date and retain all radiographs taken before, during and after the endodontic procedure. They are integral to supporting your treatment recommendation and procedures in the event a claim is brought against you arising from the endodontic treatment.

Communication

- Perform endodontic treatment only on teeth for which you have the patient's informed consent. Disclose the nature of treatment, the broad treatment alternatives (including fees), and the foreseeable risks. Disclose the risks associated with refusal of treatment, and document in an informed refusal form.
- To reduce the risk of a failure to refer allegation, non-endodontists should always offer referral to an endodontist as a viable treatment alternative.
- If you foresee a complication that *is* within your skill level and you plan to accept the case, discuss that risk with the patient as part of the informed consent process before the procedure.
- Manage the patient's expectations.
- Ask patients what they want and/or expect to occur during the course of treatment.
- Inform patients of what to expect during treatment and postoperatively.
- Provide clearly written postoperative instructions and information, including how to contact you after hours and how you address follow-up.
- Follow up by calling each patient the next day to assess his or her condition, and document all patient complaints and your recommendations.
- Disclose a separated instrument or perforation.

Documentation

- Document in the patient record *why* the endodontic treatment 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 the results of percussion, palpation, thermal and pulp testing, and radiographic findings.
- Use written informed consent forms that specify the tooth to be endodontically treated (See sample form in this section of the manual.) Include tooth number and description of tooth if tooth shifting from missing teeth makes tooth numbering difficult.
- Document the clinical procedure, including local anesthesia used (type, concentration, quantity, vasoconstrictor concentration); antibiotic or anxiolytic premedication; file sizes and lengths to reference points on the tooth; irrigation; intracanal medications, if any; material used for provisional seal of access opening; postoperative oral medications prescribed (both over-the-counter and prescription medications); postoperative instructions given; untoward events and their resolution; patient condition upon discharge.
- Document disclosure to patient of adverse event of separated instrument or perforation.

Separated Instruments

One of the more common incidents that occurs while performing endodontic procedures is the separation of files and reamers in the root canal. The risk of a file separation can be reduced by following the clinical suggestions previously listed. A reasonable and prudent dentist should pursue certain safeguards prior to and during endodontic treatment.

Even with safeguards in place, an occasional endodontic instrument may separate in the canal. Assuming the proper safeguards were used, the separation of a file or reamer is typically *not* considered dental malpractice. Once you realize that the file is broken, the follow-up conduct determines if you adhere to the standard of care. A reasonable and prudent dentist will do the following:

- Tell the patient immediately that an instrument has separated. Explain what has occurred and your recommended next steps. Keep in mind that this is much more of a problem for the patient than for you.
- Attempt to remove the piece of broken instrument from the tooth using accepted techniques. Try not to force the broken piece further into the tooth.
- If you can extract the piece, measure it with the remainder of the separated instrument to verify removal of the entire broken instrument. In addition, verify the removal radiographically. Show the radiograph and the retrieved piece of the instrument to the patient and continue with the endodontic treatment. Document the retrieval in the patient record.
- If the separated piece of the file cannot be retrieved, refer the patient to an endodontist for evaluation and treatment. A referral confirms that you advised the patient of the separated instrument and reinforces your efforts in seeking the best care for the patient. If the patient refuses your referral, you are not obligated to attempt to continue treating a situation you believe is beyond your comfort level or expertise. Re-emphasize the need for referral and complete an informed refusal form, documenting the patient's decision.
- If the canal is negotiable past the separated piece and you choose not to refer, you may opt to attempt to obturate the canal up to and around the broken piece as best as you can. Ensure that the tooth has been filed sufficiently and that you continue to evaluate the postoperative result on a regular basis for any signs of case failure. If the obturation around the separated file is unsuccessful, refer the patient to an endodontist or to an oral surgeon for evaluation of retrieval and retreatment, an apicoectomy and retrograde filling, or extraction.
- If the tooth is to remain in place and the file cannot be removed, follow up with the patient regularly to discover any related problems as soon as possible. Encourage the patient to contact you if problems arise.
- Document comprehensively what was done and what was said to the patient and to other providers. In addition, document all follow-up visits, including comments from the patient.

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

Implants

Implant claims consistently involve a greater *severity*, or dollar value, than most other dental malpractice claims due to the expense of implants and the complex and expensive corrective remedies required to return the patient to his or her preoperative condition.

The following allegations have been reported for implant claims:

- Improper placement of the implant into a vital structure, such as a sinus or nerve bundle
- Improper placement of the implant — poor angulation, proximity to a natural tooth, proximity to another implant; unusable fixtures
- Improper choice of implant — too long, too short, too narrow, too wide
- Improper technique causing loss of implant — failure to osseointegrate, periimplantitis, postoperative infection
- Improper fabrication of the implant restoration — poor design, poor occlusion, poor esthetics
- Unnecessary placement of implant fixtures — more placed than clinically needed to support the restoration
- Insufficient number of implants placed — too few placed than clinically needed to support the restoration
- Inadequate precautions — e.g., swallowed or aspirated screw, abutment, screwdriver, impression coping, broken screw

Do not place any **implant fixtures** unless **you, the patient,** and the **restorative dentist have all agreed** on the treatment plan.

Managing the Risks of Implant Claims

Recognizing risk factors

The success of implant dentistry can be affected by many factors.

Patient factors

- Systemic factors
  - The patient's overall health — are there more important systemic disease processes that should be addressed prior to considering dental implants?
  - Underlying diseases such as diabetes, bleeding disorders, or hypertension
  - History of antiresorptive therapy — these patients should be thoroughly evaluated as candidates, and the risk of osteonecrosis disclosed during treatment planning and informed consent discussions
- Local factors
  - Adequacy of bone, oral hygiene, occlusion, ridge morphology, bone quality, sinus or nerve position, periodontal status, extent of interincisal opening, width of keratinized gingiva, distance between proposed endosseous fixture sites
- Other factors
  - Reasonableness of expectations, expense of treatment, ability to financially afford treatment, tobacco use, alcohol use, patient attitude

Clinician factors

- Adequacy of patient evaluation and diagnostics, including radiographic assessment
- Patient selection
- Appropriateness of the treatment plan
- Adequacy of pre-surgical case planning
- Selection of the proper implant fixture — length, diameter, design
- Clinical ability and experience — both surgical and restorative phases
- Communication with other implant team dentists

Controlling the risks

Clinical

- Do not place any implant fixtures unless you, the patient, and the restorative dentist have all agreed on the treatment plan.
- Select for treatment only those cases that you believe have a good prognosis for long term success.
- Say "no" when an inappropriate candidate insists on having implants.
- Obtain appropriate radiographs and diagnostic models to properly assess the implant site(s).
- Review and understand information on nerve injury prevention and post-nerve injury management, especially for implant placement in the posterior mandible.
- Plan the implant restoration, then create a surgical stent to act as a guide during implant placement.
- Follow a *sterile* surgical technique during surgery, not simply a clean technique.
- Irrigate copiously during surgery to prevent overheating the bone, a cause of implant failure.
- Use antibiotics, when warranted, based upon your evaluation of the patient and the surgery itself.
- Select an implant size that is appropriate for the implant site and function.
- Place a barrier, such as gauze, in the posterior of the mouth to block dropped or mishandled items from falling back into the pharynx.
- Use high-speed suction with a filter over the tip to keep the patient from aspirating or swallowing hardware and to keep you from losing it.
- Be cautious when attempting to restore implants that have been placed at an incorrect or overly challenging angulation. The poorer prognosis for case success must be disclosed to the patient.
- Encourage patients to return for routine maintenance appointments even if implants and no natural teeth are present.

Communication

- Closely manage patient expectations throughout treatment. If expectations are unrealistic, do not accept the case.
- Ensure that the patient, implant surgeon, and restorative dentist communicate regularly both when planning and during the course of treatment.
- Have a comprehensive informed consent discussion with the patient.
- Discuss finances before beginning treatment. Once you begin treatment, you may be obligated to continue even in the absence of payment.

Documentation

- Thoroughly document treatment, including patient discussions, in the patient healthcare information record.
- Record all specific identifiers of the implant fixture, such as manufacturer, size, type, and lot number.
- Use a written informed consent form and write a thorough progress note reflecting the informed consent discussion. *Please refer to page IX for information about access to risk management forms.*
- Retain models for full arch and difficult or complex cases at least until the statute of limitations in your state expires for that case. Also consult your state practice act regarding specific requirements for retaining dental casts/models.

Please refer to page IX for information about access to sample forms on "Discussion and Consent for Implant Placement Surgery" and "Discussion and Consent for Implant Restoration."

Pediatric Dentistry

Claims involving alleged injuries to children often elicit great sympathy among juries. Claims involving children have alleged the following:

- Treatment performed without parental consent
- Dentist handled child "roughly"
  - Dentist slapped, pinched, struck, or in some way, physically abused the child.
  - Dentist used excessive force.
- Child restrained without parental consent, such as use of hand-over-mouth or protective stabilization
- Child traumatized by unprofessional treatment

Managing the Risks of Pediatric Treatment

Recognizing risk factors

The following risk factors increase the likelihood of a claim involving the treatment of a child:

- Poor patient cooperation
  - Inability to obtain a radiograph or perform other diagnostic tests
  - Patient will not/cannot remain still for treatment resulting in inability to treat child safely
- Patient behavior that places the child at risk for injury during routine treatment
  - Unfamiliarity with local anesthesia and its effects
  - Unfamiliarity with dental procedures
- An overly emotional or apprehensive parent
- Parents with unreasonable treatment or behavior expectations
- Lack of informed consent or conflicts arising from the informed consent process

Controlling the risks

Clinical

- Always consider referral to a pediatric dentist as a treatment option.
- Have a parent assist with obtaining radiographs.
  - If a necessary radiograph may not be obtained due to behavioral issues, consider how difficult — and risky — treatment will be versus no treatment.
  - Consider a referral to a practitioner with a broader availability of patient management options, including pharmacologic means.
- With local anesthesia, instruct parents as well as children to be cautious until normal sensation returns to the tongue and/or other affected areas.
  - Instruct parents and children to test for numbness using only safe methods, such as with a finger.
  - Instruct parents not to feed their child solid foods until after sensation fully returns.
  - Parents should watch and remind their child to avoid testing for numbness by biting or chewing their cheeks or tongue.

Behavior management of children

One of the most difficult issues in pediatric dental care is parental acceptance of or reaction to child-patient behavior management. Many parents are upset by the manner in which a child's behavior is "handled" in the dental office. This displeasure can often be diminished or alleviated by taking the time to:

- Explain prior to treatment the situations when behavior management is recommended and the techniques to be considered. Describe any equipment and personnel that may be utilized. Additional information is provided on the use of protective stabilization and restraint systems in the manual section on "Pre-treatment Issues."
- Secure the parent's written informed consent for your proposed patient management techniques prior to treatment, including even simple restraint procedures. Only one parent must consent, although both signatures are preferable.
- Explain to the parents when they can and cannot help, and when they can and cannot remain in the room.
- Also obtain the parent's written informed consent for the clinical procedure you plan to perform.

If the parent is not willing to agree to some or all of your policies, you may decline to treat the child. If you cannot practice safely and within your own comfort level, it may be better to refuse rather than to begin treatment.

Divorced or separated parents

A common scenario arises when one parent brings the child in for treatment, but the other parent is responsible for paying the professional fees. The parents disagree on the treatment plan, or perhaps have a disagreement after you begin treatment. The financially responsible parent refuses to pay, leaving you and the child caught in the middle. It is also necessary to discuss and clearly understand who in the family has authority to provide consent for treatment. Do not make assumptions in this area.

In cases involving divorced parents, it is recommended that your office financial policy be clearly communicated verbally and in writing. You may wish to consider a policy requiring that the parent accompanying the child be personally responsible for the fees. In addition, any court-ordered payments or reimbursements expected of the other parent must be pursued by the accompanying parent, rather than your practice. You may decline to treat any patient whose parent is not agreeable to your financial protocols, unless a child presents with a serious dental problem in need of emergent care.

If a payment conflict arises after a sequence of treatment has been completed, you may decide to terminate the dentist-patient relationship due to non-payment of fees.

Orthodontics

Orthodontic treatment is not a significant source of high severity dental malpractice claim activity, though calls to the dental risk management support line regarding financial disputes in this area are relatively common. Aligner therapy claims are increasing as general dentists are offering treatment. Among orthodontic claims, the more frequent allegations include:

- Poor results
  - Patient dissatisfied with orthodontic result; failed to achieve promised result
- Treatment performed incorrectly
  - Improper treatment plan
    - Extraction vs. non-extraction differences of opinion
    - Aligner therapy versus other orthodontic treatment methods
  - Treatment allegedly caused periodontal problems
  - Treatment allegedly caused root resorption
  - Treatment not completed; abandonment
- Treatment not completed according to agreed timeline and/or fees higher than agreed
- Failure to diagnose caries, periodontal disease, or other oral pathology before or during treatment
- Referral errors related to tooth extractions (wrong tooth/teeth) or other referral errors
- Tooth sensitivity after interproximal tooth reductions with aligner therapy

Managing the Risks of Orthodontics

Recognizing risk factors

Many factors affect patient outcomes and satisfaction with orthodontic results, including:

- Patient compliance
  - Orthodontic appliances (elastics, aligners, retainers, etc.)
  - Oral hygiene
  - Failed appointments
  - Withdrawal from treatment
- Tooth size/position
- Periodontal status
- Continued patient growth and development during treatment
- Metabolic factors affecting bone
- Patient expectations (and parental expectations)
- Orthodontic treatment plan
- Lengthy treatment times compared to other dental procedures
- Comments by other dental professionals and/or patient family members
- Parental involvement and/or conflict

The "correct" orthodontic treatment for an individual patient is a frequent subject of dispute among orthodontic care providers, whether specialists or general practitioners. Disagreements over orthodontic treatment planning are manifested when a patient changes practitioners in the midst of treatment. Whether due to patient relocation, withdrawal from a particular benefit program, or other reasons, the subsequent dentist/orthodontist often determines that some or all of the previous treatment should be changed or corrected.

Controlling the risks

Clinical

- Consider/discuss referral to an orthodontist or pediatric dentist if appropriate for the clinical situation.
- Consider orthodontic referral if aligner therapy is not providing anticipated results and conventional orthodontic treatment methods are not offered in the practice.
- Thoroughly evaluate and re-evaluate patients.
  - Probe the periodontium of patients to diagnose, document and monitor periodontal concerns.
  - Carefully examine all radiographs for possible pathology and document the review.
  - Closely monitor oral hygiene and take action to prevent enamel decalcification and dental decay.
- Refrain from discontinuing care until the patient's dentition is reasonably stable.
  - If a patient or parent requests that orthodontic treatment be terminated prior to your professional judgment that the case has been completed to a satisfactory degree, explain the status and the additional treatment necessary. Ask the patient/parent to sign a statement requesting removal of the appliances and confirming awareness that the treatment is not complete.
- Provide adequate retention appliances whenever active appliances are removed, regardless of the reason for removal.
- Remove appliances when treatment is complete, regardless of the payment history or status of the account. Do not wait for the case to be paid in full before removal.
- Be cautious when using tooth numbering systems that are not customarily employed.
  - If quadrant tooth identifications — such as UR1 through UR8 — are customarily used, carefully match the teeth in question when converting to the 1-32 numbering system. Include written descriptions such as "both upper first premolars" or "lower left second premolar" for improved clarity for referrals and other treating practitioners.

Communication

- Emphasize to both patients and parents the need for meticulous oral hygiene to prevent decalcification and decay around bands and brackets.
- Inform patients and parents of treatment options during your informed consent discussions.
  - Encourage patients to seek second opinions.
  - Inform both patients and parents that the patient's rate of growth and development during treatment may necessitate a change in the treatment plan.
  - Inform both patients and parents before treatment begins that changing to a new practitioner during treatment may result in additional treatment costs and/or a change in the treatment plan and/or appliances due to incompatible appliances (slot size, technique) or a difference of professional opinion.
- If the patient/parent changes to a new orthodontic practitioner for any reason:
  - The original dentist/orthodontist should explain to the patient that the new practitioner may decide to alter or change the original plan.
  - The two practitioners should discuss/review the case by phone or by letter.
  - The second (new) practitioner should be tactful when informing the patient/parent of the reason for recommended treatment changes.
  - Do not alarm the patient/parent simply because two professionals have a difference of opinion about treatment.
- Discuss with both parents prior to treatment the action you will take in the event of non-payment or other forms of non-compliance (such as the child failing to keep scheduled appointments). Have such office policies available in written form for distribution.
- Before you begin care, explain all consequences, such as no refund of fees, difficulty, risks and costs related to stopping/restarting treatment, the need for retention and retainer compliance.
  - If your policy is to suspend or terminate care for non-compliance or for other reasons, the parents should be informed of this policy prior to treatment.
  - If payments stop, follow your policy.
  - Deviate from your policy if it would cause immediate harm to the child, such as infection or tooth loss.
  - If dismissing a patient from your practice, follow the recommendations found in the "Patient Termination" section of this workbook.

Documentation

- Make thorough chart entries regarding various treatment options provided to patients/parents.
- Document all patient and parent discussions and all treatment rendered.
- Maintain thorough progress records, including recommending and obtaining appropriate radiographs you deem are necessary for the individual patient. Ensure that the office policy/procedure on reviewing all radiographs is clearly communicated to all staff, rigorously followed and that the review/findings are documented in the patient record.
- Document all aspects of patient non-compliance.
  - Missed and cancelled appointments
  - Poor oral hygiene
  - Misuse or lack of use of elastics, headgear, and appliances, among others.
- Document all referrals, including returning to the general practitioner for prophylaxis.
- Retain all models (preoperative, predictive, intraoperative, postoperative). Review state practice act requirements regarding record retention, including requirements for models.

Discuss with both parents prior to treatment the **action you will take** in the event of **non-payment** or other forms of **non-compliance** (such as the child failing to show up for appointments). Have such office policies **available in written form** for distribution.

Postoperative and Follow-up Care

Proper follow-up is a critical phase of clinical dentistry as well as an excellent patient management technique. The postoperative period is a time that demands scrupulous attention to patient needs and diligent follow-up care. Proper follow-up enhances both patient care and patient satisfaction by identifying clinical problems early and addressing patient concerns and complaints quickly.

A common barrier to sound postoperative care leading to claim allegations is a staff member who acts as an immovable gate-keeper or buffer for the doctor. These individuals often dismiss a patient's concerns as trivial or unimportant, rather than conveying the information to the dentist. This action may compromise the patient's health as well as the ability to seek and receive proper follow-up treatment in a timely manner, and should be avoided.

The following allegations have been reported for claims involving postoperative and follow-up care.

- Failure to follow up
- Failure to examine
- Inadequate examination performed
- Failure to prescribe — antibiotics, analgesics
- Failure to diagnose infection
- Failure to refer
- Abandonment

Managing the Risks of the Postoperative Period

Recognizing risk factors

The following patients are most likely to need clear postoperative instructions and close follow-up:

- Patients with existing infections
- Patients undergoing surgical procedures, including extractions, preprosthetic surgery, periodontal surgery, and implant placement
- Endodontic patients
- Crown/bridge preparation patients
- Patients with heightened or unreasonable expectations
- Patients with a strong need for personal attention
- Patients with limited oral health literacy

Additional risk factors for claims in the postoperative period involve the practice personnel and office activities, including:

- Staff members who impede access to you by not relaying messages and/or not permitting patients to speak with you
- Dentists and staff who do not return patient messages in a timely manner
- Dentists who are unreachable, and whose practices do not direct patients how to access dental care in the dentist's absence

Controlling the risks

Clinical

- Take steps during treatment to minimize potential postoperative complications such as bleeding, swelling, and infection.
- Have patients with complications return regularly for evaluation until the complication is fully resolved.
- Prescribe appropriate postoperative analgesics and antibiotics, when warranted.
- When patients call with postoperative complications, advise them to return to your office as soon as possible so you can perform an examination and fully evaluate their conditions.
- Refer patients that present with complications beyond your expertise or ability to treat.

Communication

- After a difficult visit, contact the patient by telephone to assess his or her status and address any concerns.
- Post operatively, give patients written procedure-specific forms containing clear information that will enable them to recognize what is or isn't a normal postoperative course.
- Verbally review the most important things to expect and monitor.
- If you believe a follow-up appointment is necessary to check healing or otherwise evaluate the patient's condition, clearly explain its importance and insist upon a return visit.
- Refrain from telling patients, "Just call me if you have any problems," unless you have defined what is and isn't a problem through patient education. Examples of helpful education points include:
  - How long will I be numb?
  - How much bleeding is too much?
  - How much swelling is normal?
  - When is the bite too high?
- Return calls to each patient in the postoperative phase of treatment as soon as possible to assess his or her status and intervene in a timely manner. This directive applies to both dentists and staff.
- Staff members should not block access to the dentist. If the patient wishes to speak with the dentist or desires a return phone call, the message should be promptly relayed in a clear manner.

Documentation

- Document having given patients written postoperative instruction forms.
- Document his or her planned return in the chart, indicating that the next visit is for follow-up purposes.
  - A typical entry might read "N/V-F/U to evaluate healing."
- Document missed postoperative appointments and all attempts to reach patients to re-schedule missed follow-up visits.
- If the patient misses or cancels the follow-up appointment, attempt to re-schedule the patient. If the patient fails to respond, follow-up in writing, if necessary.

Give patients written **procedure-specific forms** postoperatively containing **clear information** that will enable them **to recognize** what is or isn't a **normal post-operative course**.

Emergency Treatment

The following allegations have been reported for claims involving emergency treatment.

- Failure to treat
- Inadequate examination performed
- Failure to diagnose
- Improper treatment performed
- Inadequate follow-up
- Abandonment

Managing the Risk of Emergency Claims

Recognizing risk factors

A number of factors contribute to the risk of treating emergency patients, including the following

- Patients with emergencies often have heightened expectations for treatment outcomes due to their emergent circumstances.
- Patients in pain may be very anxious and/or may exhibit difficulty listening. They may not respond rationally to questions or provide needed information to aid diagnosis.
- New emergency patients do not have a relationship with you and your staff — you're strangers to each other. Are they truly in need of dental care, or is there another reason for their presence?
- Dentists typically provide after-hours treatment alone, without the assistance or even the presence of a staff member. The possibilities of assault, robbery, or allegations of professional malpractice, sexual misconduct or molestation all increase after hours when you are alone.
- When the patient's pain subsides, the motivation to follow up or complete treatment often wanes or completely disappears.
- The "dead end" office limits access to care. When a dental practice fails to respond to a patient's message or page, it leaves the patient feeling abandoned and wondering what to do.
- Patients may believe that your staff members prevented access to you by not conveying messages and/or not permitting them to speak with you, compromising their health as well as their ability to seek and receive proper treatment in a timely manner.

Controlling the risks

Office policies

- Determine an office policy and educate your staff.
- Among your options, you may choose to:
  - Avoid treating new patient emergencies
  - Treat new patient emergencies only during office hours
  - Treat only new emergency patients who will pay at the time of service
  - Avoid treating certain types of emergencies, such as surgical extractions.
- Plan for emergency referral situations in advance and know your referral options.
- Build a local network of colleagues to cover emergencies for patients of record: develop procedures/protocols to support one another if unavailable for your patients' emergencies. The protocol may include when you are away from the practice, or for situations when business operations are interrupted (weather disaster; fire, etc.).

If, for any reason, **you believe** that it is in the **best interests of the patient** and in your own best interest **not to begin emergency treatment,** refer the patient elsewhere and provide a **specific referral**.

Message systems and answering services

- When voice mail or an answering machine is used:
  - Provide a clear message with a phone number to call in case of an emergency.
  - Allow ample time for patients to leave a complete message.
  - Monitor it frequently for messages or utilize a system that provides an automated message notice.
- If you are completely unavailable, change your message to inform callers of your lack of availability and any amended directives you recommend, according to your office alternative care options. Your patients of record should have a reasonable option to receive emergency care.
- Answering services must specifically identify themselves as such and not as the dentist's office.
  - Develop a list of questions for the answering service to use to screen emergencies.
  - Have your service promptly report all calls so emergencies can be handled immediately.
- Always state how patients can access emergency care if you are unavailable or do not respond — such as "If you do not receive a return call from me within 2 hours call Dr. Smith at 765-4321." Whenever possible, avoid referring patients of record to urgent care centers or hospital emergency rooms.

Personal safety

- The safest option is to never treat a patient alone after hours.
- If you must see a patient after hours, arrange for a staff member, family member, or friend to accompany you or to meet you at the office.
- If you must go alone, be as cautious as possible, as well as very selective about whom you treat. Be prepared to call for help and have methods in place to do so (alarm system, text to spouse or family member, etc.)

Clinical

- Be judicious about the clinical procedures you're willing to perform during emergencies, especially if treatment occurs after hours without an assistant.
- Refer, as appropriate.
- You have the right to refuse to treat if you believe a patient is fabricating answers to your questions.
- If, for any reason, you believe that it is in the best interests of the patient and in your own best interest not to begin emergency treatment, refer the patient elsewhere and provide a specific referral.
- Require the patient to return for follow-up evaluation and/or treatment until the emergent problem is resolved.

Communication

- Clearly inform emergency patients about your emergency care policies.
- Assess and manage patient expectations.
- As you undertake emergency care and determine the treatment needed, clearly inform the patient of how you intend to proceed and why, engaging the patient in an informed consent discussion of costs, prognosis, time commitments, alternatives and risks.

Documentation

- Consider using the SOAP note format to fully document emergency treatment. The SOAP format is outlined in the manual section on Record Keeping and Documentation.
  - Document all patient concerns and complaints and thoroughly record all diagnostic findings and treatment advice.
  - Document not only the treatment performed, but also your disclosure of the additional treatment required due to the emergency, such as a buildup and crown after root canal therapy.
  - Document all follow-up evaluations and/or treatment, including cancelled and missed appointments and all attempts to contact the patient to reschedule.

Prescriptions and Medications

The most significant and common risk associated with prescriptions and medications involves an injury to a patient arising from an error or omission on the part of the dentist or dental staff.

Patients seeking controlled substances may threaten you with legal action if you refuse to prescribe for them. However, our claim experience indicates that patients rarely follow through with such threats. Those who persist carry the burden of proving the four elements of professional negligence discussed in this workbook, which is substantial. Moreover, engaging with the legal system may expose the patient's drug-seeking behavior: a risk that the patient may not wish to take.

The following allegations have been reported for professional liability claims involving medications.

- Failure to prescribe
- Failure to obtain and document the patient's current medications and steps taken to ensure there is no contraindication or known adverse interaction between the patient's regular drugs and the drug(s) you are prescribing. Contact the patient's primary care practitioner and/or a pharmacist if questions of possible contra-indication and/or interaction persist.
- Prescription of the wrong medication
  - Drug produced an adverse response, such as allergy, side effect, drug-to-drug interaction with another medication, or death
  - Drug was contraindicated for the patient's condition
  - Drug lacked efficacy
- Creating or fostering an addiction
- Failure to inform of side effects, such as driving impairment
- Failure to document drug prescriptions or dispensing of drugs

An additional risk of prescriptions and medications is the intentional acquisition of drugs through theft or fraud. While these illegal actions rarely result in a professional liability claim, they must be addressed by the practice. For situations involving dental practi-tioners, be aware that your state may have adopted mandatory reporting requirements in state law or regulations. Understand requirements for your state.

The theft of property, including drug inventory, is clearly a crime, as are the theft of prescription pads and distribution of false/forged prescriptions. Whether perpetrated by a patient, employee, or a dental practitioner, an individual commits a crime by fraudulently using a DEA or dental license number to obtain prescription medication.

It would be unlikely that a professional liability action would be taken against you, your dental license, or your DEA permit as a result of a patient's fraudulent actions. However, actions against you or your license may occur for failing to report some types of drug diversion or abuse that involve another licensed practitioner.

Managing the Risks of Prescriptions and Other Medications

Recognizing risk factors

Many factors contribute to the risk of injury due to medications. These factors include:

- Patient medical histories with significant findings
- Similar or confusing drug names that lead to the patient being prescribed an incorrect drug
- Poor handwriting on the prescription
- Errors in prescribing (dosage, frequency of administration, etc.)
- Errors related to the use or interpretation of acronyms, Latin or other prescription abbreviations
- Lack of knowledge about a drug you prescribe
- Inadequate documentation in the patient record
- Lack of diligence in investigating information presented by suspected prescription drug abusers

Controlling the risks

Clinical

- Thoroughly review the patient's medical history, including current medications and dietary supplements prior to prescribing.
- Prescribe only when you have a sound clinical reason for doing so based upon your assessment of the patient and his or her condition.
- Prescribe only drugs that have a therapeutic purpose in dentistry.
- Prescribe only the quantity needed as appropriate for the treatment. Follow appropriate prescribing guidelines. For example, many states have adopted limitations and/or other specific requirements related to controlled substance prescriptions. Additional guidance or requirements for minor patients may also be in place.
- Review, understand and comply with state and federal controlled substance prescribing, storage and dispensing requirements.
- Register with and consult your state prescription monitoring system. Some states mandate registration and checking the system prior to prescribing a controlled substance.
- Exercise caution in prescribing drugs with addictive potential.
- Review pain management guidelines and requirements in your state often. In the midst of the national opioid crisis, clinical information and regulations are evolving at a rapid pace. As of this writing, the combination of ibuprofen and acetaminophen are first-line treatment for management of acute pain in dental practice. See the bibliography for selected resources on this topic.

Communication

- Check with a pharmacist or current pharmacologic references if you have questions regarding contraindications and potential drug interactions.
- Advise patients why you are prescribing medication, how long to take it, when to take it, and any precautions that should be taken (e.g., avoid alcohol, refrain from driving). While pharmacists commonly provide drug information to patients when prescriptions are filled, practitioners are responsible for ensuring that patients receive and understand important information about the medications they administer or prescribe. This is the prescriber's *duty to inform*.
- Require patients to have another individual drive them to and from the appointment whenever you prescribe a drug that could impair the ability to drive. Document their acknowledgment in the patient healthcare information record and also ask for a signature on the note.
- Consult prescribing aids, package inserts and drug reference information often and as needed. Both dentists and patients have free access to a plethora of high quality drug and pharmacology resources via the Internet today.
- Communicate often with one or more local pharmacists. Invite them or your local DEA agent to study club meetings to brief you on concerns and local drug diversion challenges.

Documentation

- Document your clinical rationale for prescribing, including patient complaints, examination results, and diagnoses.
- Document all prescriptions in the patient healthcare information record. Your verbal recommendation that a patient take an over-the-counter medication also should be documented, even if you simply advise a widely used drug such as acetaminophen, aspirin, or ibuprofen.
- The chart documentation should indicate:
  - the name of the drug (such as Penicillin V)
  - drug strength (500mg)
  - number of doses (28 tablets)
  - dosage level and time interval (2 tabs stat, then 1 tab four times daily until gone), and
  - number of refills, if any
- Use abbreviations to help record prescription information.
- Maintain appropriate licensing for the drugs you prescribe.
- Maintain appropriate office drug logs as required by your state dental practice act, or the state/federal controlled substances act. You also may be subject to pharmacy practice act requirements if you dispense medication from your office for the patient to take home. Administration of medication (where the patient is given medication in your office) would not typically be subject to pharmacy law. However, storage of medication in your office is subject to pharmacy and controlled substances act requirements.

Drug abuse

- Drug abusers are typically knowledgeable, manipulative, and persistent individuals.
- Do not phone in prescriptions for narcotics or other addictive drugs for patients who refuse to come to your office for an examination, especially new patients whom you have not previously met or examined. To do so constitutes an illegal act in some states and may result in sanctions against your license. Understand your state law.
- Verify the information presented by suspected drug abusers.
  - Verify their identity, address, and telephone number. Photocopy their picture identification or driver's license.
  - Assess the validity of their reported symptoms.
  - Contact their physician and/or usual pharmacy for their prescription history. As a co-treating clinician, you are permitted to share and receive protected health information (PHI) with other co-treaters.
  - Be aware of, understand and use your state's prescription drug monitoring program/system.
- Do not prescribe if the patient is reluctant or unwilling to provide reference information.
- Do not prescribe if the patient is reluctant or unwilling to undergo diagnostic tests or treatment.
- Exercise caution with patients who report that only a specific controlled drug works for their pain, or that they are allergic to non-narcotic analgesics.
- Write prescriptions for appropriate/limited quantities and follow clinical guidelines and/or state law related to dose, quantity or other requirements.
- Use common sense and caution when prescribing addictive drugs to a patient who states that the original prescription or the medication was stolen, misplaced or destroyed.

Drug theft

- Keep all drug inventories in a locked cabinet at all times. Give access only to a limited number of employees. Confirm compliance with state or federal law for controlled substance storage.
- Take regular inventory of your drug cabinet and reconcile current stock with both purchases and distribution to patients, as documented in your drug log.
- If you discover a theft, contact your local police department and/or the local DEA office and file a complaint. Obtain a copy of the police report. Report loss or theft of controlled substances on the DEA Diversion website.

Fraudulent misuse of license

- Do not have your DEA license number pre-printed on prescription pads.
- Keep extra prescription pads under lock and key. Do not leave them lying about the office.
- If the prescription is written for no refills, write out "zero refills" on the script to help prevent prescription fraud. Likewise, write the number of doses numerically and in text: For example, "dispense 10 (ten) tablets."

In the event of a fraudulent prescription under your name or license, it is recommended that you take the following steps. Regardless of whether the individual is charged or punished, taking these actions will assist you in demonstrating and documenting that you did not assist in the commission of the crime or violate any statutes or administrative codes with respect to prescribing drugs.

- Be sure that a copy of all legally prescribed medications is maintained in patient records. If electronic systems are used, ensure that the prescription function is secure and that changes or additions can only be made after secure login by those with designated clearance.
- Thoroughly document the individual's actions in order to establish a defensible position in anticipation of any potential investigation.
- Contact your local police department and file a complaint outlining the fraud and misrepresentation. Obtain a copy of the police report.
- Ask the pharmacy involved to send you a written copy of any investigative findings that may pertain to you.
- Formally terminate your dentist-patient relationship (or employer-employee relationship, if perpetrated by an employee) by sending a written notification of the termination.

Dental Professional Liability

Managing Adverse Events

Upon completion of this section, you should be able to:

- **Recognize the importance of appropriately managing medical emergencies** and implement processes to maintain/improve emergency response skills within the practice.
- **Collaborate with all members of the dental team** to identify risky procedures and/or behaviors.
- **Develop and implement processes and procedures** to reduce the risk of adverse events.
- **Understand the importance of and engage in open and effective communications** with patients when adverse events occur.

Patient Safety in Dentistry

Dentists and other healthcare practitioners have an ethical and legal duty to ensure that both their procedures and their premises are as safe as possible for patients, staff members and visitors. This section focuses on common treatment-related adverse events, but it is important to remember the importance of property risks and overall safety within the dental practice as well.

Research and reports on patient safety issues are becoming more common in the dental literature, but much more work is needed. One paper provides a list of 11 basic procedures and practices for patient safety in the dental office. While the authors are all based outside of the United States, most of their recommendations are consistent with issues covered in this and other sections of the CNA risk management manual. The key points include recommendations to:

1. Develop a culture of safety in the dental office.
2. Focus on the quality of clinical records.
3. Maintain control of procedures and protocols for infection control and instrument sterilization.
4. Exercise extreme caution with the prescribing of medications.
5. Limit exposure to ionizing radiation, by prescribing imaging based upon individual patient need.
6. Never reuse any products intended for single-use with one patient.
7. Protect patients' eyes during dental procedures.
8. Use barriers and other methods to prevent ingestion/ aspiration of instruments, restorations, etc.
9. Use safety checklists for all surgical procedures/.
10. Closely monitor the progression of oral infections.
11. Implement a protocol for medical emergencies in the dental office.

While these 11 points may not be new to any dentist, the frequency with which these topics arise in dental professional liability claims and lawsuits is noteworthy. Therefore, dental practitioners should consider and re-assess even their most basic patient safety practices and procedures.

Medical Emergencies

Medical emergencies in the dental office are relatively rare and most often do not result in significant or permanent injuries. In cases that involve significant or permanent injuries, criticism of the adequacy and timeliness of response on the part of the dentist and dental team may occur.

Dental patients may reasonably expect that dental office personnel receive at least a minimal level of healthcare training and are able to respond to medical emergencies. Consequently, all dental offices should have medical emergency response plans documented in the office policy and procedure manual, as well as regular training and practice sessions to reinforce the roles and responsibilities within the response plan. Failure to create an emergency plan or to adequately train personnel may result in confusion, treatment delays and, patient harm.

Numerous resources, including textbooks, manuals, and CE courses, address the management of medical emergencies in detail. In the interest of quality patient care and sound risk management, we encourage dentists to consult these sources and maintain a reasonable understanding and expertise in the subject.

Managing the Risks of Medical Emergencies

Recognizing risk factors

The key to preparedness begins with knowing those patients at greatest risk and the medical emergencies most likely to occur within your patient population. Patient populations at risk include:

- Older patients
- Patients taking numerous prescription medications
- Patients with significant medical histories (for example, cardiac disease, hypertension, or diabetes)
- Patients under increased stress due to fear, pain, or anxiety
- Patients and procedures requiring longer appointments

The most frequent adverse event reported to CNA is one that may result in a medical emergency: the swallowing or aspiration of a foreign object by the patient. This specific problem is addressed later in this chapter. Among other medical emergencies, those most common in dental practice include syncope, allergic reactions, angina pectoris, sudden cardiac arrest, respiratory distress (often caused by allergic reaction or asthma), and hypoglycemia.

Controlling the risks

The most important component of a medical emergency is its prevention. Prevention can best be achieved by the dentist's thorough physical assessment of the patient. Your assessment should combine the review of a complete, written medical history obtained from the patient, with findings from your clinical examination and evaluation. Allocate time to discuss the medical history with the patient, as well as to investigate further any responses that may be a cause for concern. For example, query diabetic patients about their drug and eating regimens and schedule them early in the day. Hypertensive patients should have their blood pressure recorded at each visit.

Pre-event planning

After the potential emergency conditions for your practice have been identified, the next step is to determine an appropriate office procedure or protocol for each circumstance. Emergency policies and procedures should be based on a realistic assessment of the practice capabilities. These protocols should be tailored to the *type* of dental office, the clinical procedures performed, and the skill level of the office personnel. Access to the emergency medical system (EMS) in your area also represents an important consideration in the development of emergency procedures.

A small general dental office with a responsive EMS may decide to handle all medical emergencies by calling 911 and providing basic emergency measures. However, an oral surgeon may be reasonably expected to be conversant with more advanced resuscitation techniques than a general dentist. Similarly, dentists who provide sedation and/or general anesthesia services will be held to a higher level of knowledge and skill. These dentists are expected to manage medical emergencies due to the additional training they are required to undergo by many state dental boards. In addition, the staff members of different types of practices may have more or less training in medical emergency procedures and access to different types of emergency equipment, depending upon the practice activities and/or state requirements.

The next step is to train personnel to respond and to *practice* this training on a regular basis. All personnel should know the importance of contacting 911 to activate an EMS response. In addition, the personnel who will respond in a given manner to specific events should be identified. The designated job responsibilities and specific responses also should be documented in the office policy and procedure manual. No matter how simple your response plan, regularly scheduled emergency drills can help staff members develop the habits and reflexes needed to act quickly and smoothly. Contact local EMS personnel as they may be able to assist with conducting mock emergency drills.

Regularly review your system of reacting to medical emergencies in the dental office. The following is a summary of steps for emergency preparedness. The dentist directs and supervises the sequence of actions, but staff members are empowered to take action, according to pre-assigned duties:

1. When an emergency occurs:
   - Notify the receptionist of the emergency. The receptionist calls 911 and activates the EMS.
   - The dental assistant helps to position the patient properly, then brings the emergency kit (if applicable), the portable oxygen, if needed, and assists as directed by the dentist.
   - Monitor vital signs, secure the airway, and begin CPR, if needed.
   - The receptionist notifies the patient's physician. The receptionist also informs a family member that an emergency has occurred and reassures the family that you and your staff are responding to the event.
2. Verify that all staff members have current basic life support (BLS) certification. BLS certification should be renewed in accordance with dental licensing board requirements and current American Heart Association guidelines.
3. Utilize periodic emergency drills to test preparedness, at least on a quarterly basis.
4. Place emergency phone numbers for EMS, police, and local physicians prominently by each telephone.
5. Check oxygen tanks and the oxygen delivery system regularly to ensure that they are in good working order.
6. Check all emergency medications monthly to assure replacement of outdated medications. Designate a staff member to ensure completion and documentation.
7. Be familiar with emergency kit medications as packaging and administration techniques may vary significantly from those with which dentists and office staff are familiar.

In order to ensure the orderly and efficient response to a medical emergency, you and your staff should spend several sessions studying and practicing these procedures so that medical emergencies can be handled calmly and capably.

Equipment and drugs

Emergency equipment should be appropriate for the patient population and nature of your practice, and correspond to descriptions in the policy and procedure manual.

While emergency kits, or "crash carts," are available from a variety of vendors, it may be optimal to create your own kit, tailored to your practice and your abilities. The process of developing your own kit creates a familiarity with both the equipment and the drugs you select for inclusion. If your crash cart contains medications that are not used during an emergency due to your inexperience with them, an allegation may be asserted that you failed to properly manage your patient's emergency care.

Therefore, it is prudent to maintain only those other drugs and instruments which you are comfortable using. Commercial emergency kits often contain equipment and drugs with which most dentists are either unfamiliar or have reservations about using. For example, if you do not plan to start intravenous medication drips in response to a medical emergency, then do not purchase an elaborate kit that includes IV equipment and drugs.

Sources vary somewhat in the equipment, drugs, and supplies recommended for availability during medical emergencies. The following is a sampling of commonly cited items:

- Oxygen tank and the ability to deliver positive pressure oxygen as well as supportive oxygen
  - Positive pressure systems include the bag, valve, and mask device
  - Availability of latex-free equipment for latex-allergic patients
- Blood pressure cuffs of various sizes (automatic or manual)
- Epinephrine (and syringes) and antihistamines for allergic reaction
- Reversal agents for sedatives
- Sugar source for hypoglycemia
- Aspirin for myocardial infarction
- Ammonia inhalant
- Bronchodilator inhaler for asthma attacks
- Nitroglycerin for angina pectoris

You may add additional items based upon your level of competence with the item(s), state laws or regulations, the nature of your practice, and your patients' anticipated emergency needs.

Ensure that all staff members are trained in the use of emergency equipment and schedule routine refresher sessions to maintain a high state of readiness. Also consider cross-training needs, since not all staff members may be working at the time an emergency occurs.

Equipment must be stored in a readily accessible location, and personnel should be assigned to check and maintain the equipment on a routine basis. Medications, for example, must be checked regularly to identify and replace expired emergency drugs. Other types of equipment may need routine calibration. Instruct staff members who examine the emergency kit to initial and date their maintenance checks.

Automatic external defibrillator (AED)

The only treatment for sudden cardiac arrest (SCA), a leading cause of death in the United States, is the rapid delivery of a specific electrical shock within a critical time period. We are often asked if dentists are required to have an AED on hand to meet the standard of care for medical emergency management.

Some state dental licensing boards have instituted a requirement for an AED in the dental office. The requirements vary by state and can also vary by specialty and the types of procedures performed. For example, a state may require all dentists using sedation of any kind to have an AED. Conversely, it may only require certain specialties, such as oral and maxillofacial surgeons, to maintain an AED on the premises.

The first state dental practice act amended to require every dental office to have an AED states, "Any dentist practicing after [the implementation date] without an automatic external defibrillator on site shall be considered to be practicing below the minimum standard of care." In this state, as well as any other state that has instituted the same or similar requirement, all dentists affected by the ruling should comply with the dental practice act and purchase an AED. Dentists practicing in other states that have not adopted similar requirements would be permitted to opt against the purchase of an AED.

If not required to do so, should you purchase an AED? This determination becomes a personal decision for each dentist. When assessing the needs of your patients, some factors to consider are:

- The nature of your practice
  - How often do you treat patients at risk of sudden cardiac arrest?
  - How often do you treat patients who are medically compromised or have significant medical histories?
  - How often do you perform surgical procedures, including extractions?
- How often do you sedate patients?
- How long does it take EMS to respond to your practice location?
- Your perception of risk (both of having an AED *and* not having it)
- Your moral and ethical views regarding the need for an AED

Another consideration: dentists may wish to have an AED available for oneself and all office staff, depending upon their age, pertinent medical/family histories and other risk factors.

Notably, understand that sudden cardiac arrest may occur in individuals with no significant/related medical history. And if you choose to purchase an AED, *all employees* must be trained in its proper use, including non-clinical personnel. According to the manufacturer, the "defibrillator is intended to be easy to use for minimally trained responders." The American Dental Association (ADA) has suggested that "the user should have received training at a recognized course in CPR and AED use, such as those offered by the American Heart Association or the American Red Cross, or be certified in basic life support, advanced life support or other physician-authorized emergency medical response."

Most consumers expect that healthcare personnel are, at least, "minimally trained" to manage medical emergencies. If an average layperson can use an AED properly, you and your staff should be able to do so as well. See the bibliography for a link to further resources for dental office medical emergencies on ADA.org.

Complications During Treatment

Complications occasionally occur during treatment and sometimes result in claims. However, there are steps that can be taken to reduce the likelihood of a complication and also the impact of that complication on both the dentist and patient.

Before a Complication Occurs

- Assess whether or not the procedure (such as an extraction, root canal, or periodontal surgery) *and the foreseeable complications* are within your skill level. If not, refer the patient to the relevant dental specialist.
- Inform the patient that in the event of a complication, you will refer him or her to an appropriate specialist. The risks and potential complications of the treatment must be explained as part of the informed consent process. Therefore, the *possibility of specialist referral* should be provided at the same time. If the patient objects to the prospect of referral, re-evaluate whether or not you wish to proceed.
- *Determine in advance* your office policy concerning charges for procedures during which a complication arises, requiring a referral.
  - It is neither right nor wrong to charge the patient — it is an individual dentist's decision whether or not to do so. However, many dentists decide not to bill the patient for "patient satisfaction" reasons, since satisfied patients generally do not allege malpractice. **Waiving the fee does not constitute an admission of liability.**

Once a Complication Occurs

- Be objective about your ability to address the complication. Use prudent judgment. Ask yourself, "What is in my patient's best interest *at this point in time*?" A referral made following a treatment complication is *not* an admission of negligence in and of itself. In fact, it can often help your defense.
- Be confident about the referral. If you've told the patient of the potential for a referral in advance, there should be no resistance.
- If you refer mid-treatment, follow up with the patient after treatment. Call the specialist as soon as you think the patient has arrived for care. Ask the specialist to contact you when the treatment is complete so you may talk to the patient. Call the patient that evening to ask about his or her condition.
- Document the events thoroughly. Start by collecting your thoughts. Review the events with any staff members who assisted you or the patient, outlining your ideas on a separate piece of paper. Then, write your treatment note, considering the following elements:
  - Factually document what occurred.
  - Focus on what you did that best served your patient's needs.
  - Do not imply that you were careless.
  - Do not rationalize or attempt to defend the complication in the record.
  - Despite a dentist's best efforts to prevent or avert an adverse outcome, a complication may arise. Depending upon the nature and severity of the event, your state board may require filing a report with the board. Contact your state board for information about requirements that may apply.

Once **a complication** occurs **be objective** about your ability to address it. Ask yourself, "What is in my **patient's best interest** at this point in time?"

Post-treatment Complications

Some treatment complications will not manifest themselves until after the patient has left the office. The following suggestions are offered as a post-treatment complication arises.

Clinical

- Insist the patient come to the office for evaluation and/or observation, allowing you a better opportunity to make the correct diagnosis and prescribe the correct treatment and/or medication.
- Have the patient return to the office periodically for your continued evaluation until the problem is fully resolved.

Communication

- Inform all patients of your post-operative protocol before treatment begins, including the manner in which you follow up with post-treatment complications.
- Inform patients in advance that in the event of a post-treatment complication, they will be required to come to the office one, two, or more times for examination, diagnosis and treatment.
- Explain to all patients the possibility of post-operative complications. For example, extraction patients should be informed of the possibility of infection, bleeding, swelling, pain, and paresthesia/dysesthesia/anesthesia, to name a few.

Documentation

- Include information about post-operative complications in your informed consent discussion and in any written patient treatment information or post-operative instruction documents. Review consent form templates available online for useful examples. *Please refer to page IX for information about access to risk management forms.*
- Thoroughly document cases involving post-treatment complications using the SOAP format of record keeping. The SOAP format is outlined in the Record Keeping and Documentation section of this manual.
- Document all pertinent phone conversations and email communications, including patient complaints, return calls to patients, and calls to pharmacies or other practitioners.

Message systems and answering services

- When voice mail or an answering machine is used:
  - Provide a clear message with a phone number to call in case of an emergency.
  - Allow ample time for patients to leave a complete message.
  - Monitor for messages frequently.
- If you are completely unavailable, change your message to inform callers of your lack of availability and provide clear directions on the alternative care plans that you have implemented in your absence.
  - Always state how patients can access emergency care if you are unavailable or do not respond — such as "If you do not receive a return call from me within 20 minutes and you feel you have an emergent problem, call Dr. Smith at 765-4321." Whenever possible, avoid referring patients of record to urgent care centers or hospital emergency rooms.
- Answering services must specifically identify themselves as such and not as the dentist's office.
  - Develop a list of questions for the answering service to use to screen emergencies.
  - Have your service promptly report all calls so emergencies can be handled immediately.

Infections

Infections are potential unwelcome sequelae for almost any dental procedure. Infections often precede or exist concurrently with dental treatment, possibly compromising the treatment's outcome or complicating the health status of the patient.

Therefore, it is understandable that malpractice claims against dentists often cite infection as the claimant's injury. The following are common allegations associated with infection claims:

- Failure to diagnose
- Failure to treat
- Failure to refer
- Inadequate medical history review
- Negligence by the dentist as a cause of the infection

The defensibility of an infection claim is related to the quality and quantity of the dentist's diagnostic efforts — usually in response to the patient's complaint — and the comprehensiveness of the chart documentation. Testimony from plaintiffs and their experts typically allege that a successful outcome would have resulted without injury to the patient if the dentist had properly assessed, diagnosed, treated, or referred.

Managing the Risks of Infection

Recognizing risk factors

Many infections are difficult to diagnose due to a lack of clinical signs, symptoms, or patient complaints. Nevertheless, certain risk factors for infection can be identified, involving variables that relate to the patient, the dentist, and the treatment performed. They include:

- Patients with poor oral hygiene
- Patients who are immunocompromised due to disease, medication, or simply a poor host response
- Dentists who do not employ proper infection control practices
- Dentists who elect to perform procedures that would have a lower morbidity rate if referred to another practitioner

Controlling the risks

Prevention

- Inform patients whenever infection is a risk of treatment.
- Perform thorough diagnostic tests and examinations. Many allegations of failure to diagnose relate to asymptomatic infections that were "missed" during initial or maintenance appointments at which there was no "chief complaint."
- Follow current infection control guidelines.
- Inform patients about recognizing complications and seeking treatment for them. Written post-operative instructions for this purpose should be given to the patient.
- Inform patients about obtaining care outside of regular office hours. Ensure that your patients can access you after office hours (or another practitioner who may be covering emergency calls for you or your practice).
- Follow up with patients you suspect to be at risk of infection via telephone calls and postoperative return visits.

Responding to an infection

- Thoroughly evaluate the patient and assess all possible sources of the infection.
- Clearly inform the patient of his or her condition.
  - Explain the urgency of treatment.
  - Explain the potential consequences of no treatment or delayed treatment.
- Recognize and refer immediately when the patient's condition is beyond your treatment expertise.
- When appropriate, prescribe an antibiotic regimen suitable in dosage, duration, and choice of medication.
- Consider antibiotic sensitivity testing for infections that do not respond to initial therapy. You also may wish to consider medical consultation or referral, if determined to be in the patient's best interest.
- It is prudent to increase follow-up and monitoring efforts for patients that do not respond to initial interventions. Establish and emphasize direct communication for specific/potentially severe signs or symptoms.

Documentation

- Consider using the SOAP format of record keeping described in the Record Keeping and Documentation section of this manual.
- Document the patient's physical appearance and status, and the performance and results of examinations and diagnostic tests.
- Document abnormal radiographic findings by retaining the radiograph and describing your findings in the record.
- Document why you performed a specific treatment and why other alternatives were not selected.
- Document all antibiotics and other medications prescribed and the reasons for the prescription.
- Document any complications as well as corrective action taken.
- If a referral was recommended, document to whom you referred and the patient's response to the recommendation. Follow-up on the referral outcome.
- If the patient refuses the referral, document the referral and re-emphasize the potential consequences of inadequate or no treatment.
- If the patient does not follow through on the referral, document any additional communication you present to the patient, including reminders and reiteration of your position.

Swallowed and Aspirated Objects

Swallowed object claims often demand payment for follow-up radiographs and medical services to initially visualize the object and to track its normal course through the digestive tract. However, some objects, especially endodontic files, have required surgical removal to prevent or correct penetrations in the gastric or intestinal walls. Obviously, claims requiring surgical intervention are much more severe than the average non-surgical claim.

While foreign body aspirations are less common than ingestions, the potential consequences and medical care required are considerably more serious. The injuries alleged by patients who have aspirated objects include mental anguish, surgical removal of the object, and death. Allegations have included an inadequate use of precautions and a failure to exercise due care. Be aware that aspiration may cause choking or severe coughing initially. In some cases, however, the patient may have no immediate reaction to the event. Nevertheless, do not assume that no reaction indicates no adverse event.

Managing the Risks of Swallowed and Aspirated Objects

Recognizing risk factors

A wide variety of dental objects have been ingested or aspirated by patients. The items are usually small to moderate in size, but larger items (such as removable appliances or prostheses) are also rarely involved. Examples include:

- Dental instrument fragments (explorers, periodontal probes, curettes, and scalers), endodontic files and reamers, dental burs, prophylaxis cups and brushes, handpiece heads, ultrasonic scaler tips, mirror heads, implant screwdrivers, rubber dam clamps, rubber dam fragments, suture needles, amalgam restorations, castings, temporary crowns, space maintainers, orthodontic bands, impression materials, teeth and tooth fragments.

In addition to small objects being a risk factor, certain patients can be considered at higher risk to swallow or aspirate an object. They include patients with:

- Strong gag reflexes
- Hyperactivity of the tongue and other intraoral muscles
- Pharmacologically depressed gag reflexes
- A history that includes a previously swallowed or aspirated dental object

Controlling the risks

Prevention of accidental ingestions or aspirations is the primary means of managing the risk. Other methods include maintaining an adequate level of preparedness in anticipation of a swallowed object incident, responding prudently following such an incident, and documenting all measures and actions taken to manage the event. Each of these elements should support the contention that the patient's alleged injuries were not caused by negligence or a breach of the standard of care.

Prevention

A number of clinical techniques can be used to minimize the risk of an object being ingested or aspirated during treatment. They include:

- Rubber dam — arguably the best preventive device. However, it is not always possible or practical to use
- Pharyngeal gauze block
- High velocity evacuator — to remove tooth and restoration fragments
- Dental floss — tied to rubber dam clamps and other small instruments; tied around the pontics of bridges
- More upright chair position
- Modified patient head position — turning the patient's head toward the side of treatment, allowing objects or debris to fall onto the buccal mucosa or into the buccal vestibule

Other preventive steps include patient communication and proper staff training.

- Warn patients that temporary crowns can loosen and unseat.
- Provide written home care instructions to patients who have received a temporary crown or who have been directed to self-administer at-home dental treatment, such as the use of orthodontic keys or elastics. The written instructions should direct the patient to appropriate medical or dental care following any at-home swallowed object incident.
- Train all office personnel in basic life support, including the Heimlich maneuver.
- Develop an action plan to respond to in-office swallowed and aspirated object incidents and train your staff on its implementation. Include in the action plan that a staff member may be required to transport the patient to a medical care facility as part of his or her job responsibility.

Responding to an event

Whenever a foreign object is lost intraorally into the oropharynx, it is prudent to assume that it has been aspirated. Aspirated objects pose an immediate hazard to the patient's health and life.

- Consistent with basic life support principles, first ensure that the patient has a patent airway.
- Initiate appropriate medical referrals unless the patient is certain that the object has been ingested.

If the airway is completely obstructed,

- Initiate the emergency medical system in your area by dialing 911.
- Perform the Heimlich maneuver and cricothyrotomy, if necessary.
- Be prepared to perform additional emergency procedures if the airway becomes patent. Such procedures may include artificial respiration and, if the patient experiences cardiac arrest, cardiac compression.

If the airway is partially obstructed, the patient will likely be able to breathe and to explain his or her symptoms.

- Provide oxygen, as needed.
- Initiate the emergency medical system in your area by dialing 911.
- Be cautious about the partial obstruction moving and causing a complete obstruction.

If the patient exhibits no symptoms of airway obstruction, assume the object has been aspirated, unless the patient expresses absolute certainty that it was ingested. Many aspirated objects have no associated symptoms. If the patient is stable and breathing unassisted, you may choose to quickly transport the patient to a medical care facility yourself, have a staff member drive the patient, or arrange for a family member or friend of the patient to drive. Anyone who transports the patient must be prepared to respond if the patient's condition deteriorates while in route to the hospital. The patient should be accompanied until discharged from medical care.

If the patient has ingested the object rather than aspirated it, refer the patient for medical evaluation and follow-up radiography. Even small objects may irritate or partially obstruct the digestive tract or contribute to gastrointestinal problems.

In every instance, referral to a physician is the most prudent course of action, as it demonstrates that the dentist was acting in the patient's best interest.

Documentation

Whenever an object is swallowed or aspirated, the patient healthcare information record should include the following:

- All preventive measures (rubber dam, pharyngeal drape, etc.) taken to avoid a swallowed object incident
- Copies or notations of any home care instructions or educational materials provided
- Any referrals or discussions about referrals. If the claim is related to a root tip that was lost during an extraction, the patient may allege that the injury would have been avoided if an oral surgeon had performed the extraction.
- The dentist's actions following the swallowed object incident, including:
  - Emergency procedures performed
  - The result of the emergency procedures (for example, did the patient begin to breathe after the Heimlich maneuver was performed?)
  - Any discussion urging the patient to seek a medical evaluation. If the patient refuses to pursue the evaluation, document the reason for the patient's refusal. Also, ensure that the patient understands the potential for acute and chronic complications resulting from the object. Provide the patient with written information and instructions.
  - How the patient was transported for medical evaluation and by whom
  - Any telephone discussions with the medical facility and treating physician, with a copy of the treating physician's report retained in the patient's file.

Report the swallowed or aspirated object incident to your malpractice insurer in a timely manner by first contacting your agent.

Swallowed/aspirated object claims have the potential to be financially severe. Sound risk management procedures can prevent or minimize some claims and provide a stronger defense for those that arise.

Treatment of the Wrong Tooth

Wrong tooth claims usually involve technical errors leading to the performance of dental procedures on the wrong tooth or damage to adjacent teeth. For example, root canal therapy may be performed on the wrong tooth because the rubber dam was incorrectly placed. The reason for this claim can be described as a technical error, which would be discovered immediately upon removing the rubber dam.

Wrong tooth claims also are brought following a dental procedure that was appropriately performed in accordance with the treating dentist's professional judgment. This may occur after a patient consults a second dentist whose philosophy or professional judgment contradicts that of the prior treating dentist. Alternatively, it may occur when patients have not been fully informed of either their dental condition or of the treatment provided.

In certain instances, treatment may be completed on the proper tooth. If more than one tooth in the same area requires treatment, however, the patient may question the necessity of the first treatment if he or she continues to experience symptoms. Although the dentist provided appropriate care for the treated tooth, a wrong tooth claim may arise. A common allegation in wrong tooth claims is that the patient did not provide his or her informed consent for treatment of the tooth in question.

Damages have been requested in wrong tooth claims for:

- Unnecessary past dental expenses
- Future medical or dental expenses to correct the error
- Disfigurement or loss of a body part
- Pain and mental anguish
- Lost wages

Wrong tooth claims resulting from a patient's **perception of error**, either related to the patient's own **opinion** or the opinion of a subsequent treating dentist, can be **defended competently** only with complete and **accurate dental records**…

Managing the Risks of Treating the Wrong Tooth

Recognizing risk factors

Technical errors are typically the reasons the wrong tooth is treated. Technical errors include:

- Inaccurate or incomplete review of dental records
- Lack of concentration
- Incorrect rubber dam placement
- Miscommunication of a referral

These technical errors may lead to:

- Extraction of the wrong tooth
- Initiation or completion of root canal treatment on the wrong tooth
- Preparation of the wrong tooth for restoration
- Incision performed on the wrong side or area of the mouth
- Removal of a crown or other restoration from the wrong tooth
- Errors by a referral dentist based on erroneous or misunderstood instructions from the referring dentist

Controlling the risks

To effectively manage the risk of wrong tooth claims, dentists should minimize the potential for technical errors, obtain the patient's informed consent before starting treatment, and fully document all dental procedures. Proper documentation of all of the above can help defend the dentist against allegations of improper dental treatment.

Also consider protocols to prevent wrong tooth treatments, such as a "time-out" policy, based upon the Joint Commission's Universal Protocol for preventing wrong site surgery. The Universal Protocol is applied in hospitals and outpatient surgery facilities to help prevent wrong site/wrong side surgeries. Integrating components of this approach and involving the entire dental team and the patient in the verification process are important. The online Safety Net Dental Clinic Manual provides information about the "time-out" approach (part of the Universal Protocol) and describes the Joint Commission and American Dental Association (ADA) recommendations for its application in dentistry. See the Adverse Events section of the bibliography for a URL to access this information.

Prevention

In order to reduce the risks of technical errors that result in treatment of the wrong tooth, dentists should:

- Document the reason(s) for extractions at the time of diagnosis. This information may help to prevent mix-ups at the time of surgery, whether in your office or the referral office.
- Review immediately prior to treatment all patient chartings, radiographs, treatment plans, prior treatment progress notes, and medical and dental histories.
- Consistently mount and label all film-based radiographs to minimize the risk of inadvertently misreading them.
- Double check the tooth number and position in the arch prior to initiating any treatment, especially if the intended treatment is irreversible, such as an extraction or endodontic treatment.
- Begin preparation of the tooth before placing the rubber dam to minimize the risk of isolating the wrong tooth.
- Write comprehensive and clear treatment plans, based upon a complete patient charting, examination findings and radiographic interpretation.
- Write progress notes that clearly record the patient's dental needs, identifying those needs that have been treated and those that remain to be treated.
- Provide a clear indication of the treatment to be performed and an accurate identification of the tooth or teeth involved whenever a referral is made to another dentist.
  - Use written referrals and place a copy of the referral in the patient's record.
  - If a referral must be duplicated or transcribed by staff for any reason, require confirmation of the instructions by the prescribing dentist.
  - Engage in a dentist-to-dentist discussion during telephone referrals to minimize communication errors that may occur by using staff personnel as intermediaries.
  - Provide a written follow-up to all telephone referrals. The referring dentist, in addition to the referral dentist, may be subject to malpractice litigation if miscommunication leads the referral dentist to perform dental treatment on the wrong tooth.

Dentists to whom patients are referred also can take steps to minimize technical errors that result in wrong tooth claims.

- Take a new radiograph if the needed diagnostic radiograph is unclear or unavailable from the referring dentist.
- Retain a copy of the radiograph used for treatment, or an original, if available, in the referral dentist's records.
- Contact the referring dentist for discussion or clarification if the treatment for which the patient was referred is unclear or questionable.

Many wrong tooth claims do not allege that the dental procedure was performed incorrectly. Rather, they allege that the patient did not authorize or consent to the procedure. Further, patients may assert that they would not have consented in advance had they been properly informed of the consequences.

In order to reduce the risks of patient misunderstandings resulting in claims alleging treatment of the wrong tooth, dentists should take the following steps.

- Obtain the patient's informed consent prior to treatment. Fully inform the patient or guardian about the recommended procedure and its risks, consequences and alternatives, as well as the ramifications associated with no treatment.
- If additional facts become known during a procedure that dictate a change in treatment, discuss these facts and recommendations with the patient before the treatment change is begun.
  - For example, if the patient has authorized a four-unit bridge, and after preparations have begun it is determined that the bridge should be extended to six units through two additional abutments, the patient must authorize the preparation of two additional teeth.
- Document in the patient healthcare information record all discussions related to informed consent through progress notes and/or informed consent forms. This documentation is especially important when the indicated treatment is irreversible.

Responding to an event

While there is no absolute means of precluding a malpractice claim following treatment of the wrong tooth, the following suggestions will minimize the potential of a claim for fraudulent concealment, which may substantially increase the value of a negligence claim and could result in a punitive damage award.

- If treatment is unintentionally performed on the wrong tooth, *inform the patient* of the error and of any immediate/specific corrective action you recommend or will perform, as well as procedural corrective action(s).
  - The specific treatment corrective action may be to place a restoration in an erroneously prepared tooth or to refer the patient to an endodontist for completion of root canal treatment begun on the wrong tooth.
  - The process of root cause analysis will help lead to procedural corrective action, which should be addressed thoroughly and quickly. This process and the response answers the questions; "what went wrong?" "why did this occur?" and "how will this error be prevented in the future?"
- Do not intentionally withhold information from a patient about a known error. Most patients will eventually discover the error.
- Do not attempt to conceal the error from the patient in the hope that the patient will discover the error only after the statute of limitations has expired. There is no clear statute of limitations for fraudulent concealment.
- Document in the patient healthcare information record what the patient was told about the error and your proposed corrective action.
- Do not bill the patient for a procedure performed in error. Doing so can provide motivation for the patient to file a malpractice claim.

Documentation

In wrong tooth claims, the patient's attorney will request the dentist's records. The patient healthcare information record should thus include:

- A clear, comprehensive examination charting
- The correct treatment plan
- Receipt of the patient's informed consent for the procedure
- Any referrals or discussions about referrals. (If the claim is related to the treatment of the wrong tooth, the patient may allege that the injury would have been avoided if a specialist had performed the treatment.)
- The dentist's actions following the treatment of the wrong tooth, including:
  - Corrective procedures recommended and/or performed
  - The result of the corrective procedures

Wrong tooth claims resulting from a patient's perception of error, either related to the patient's own opinion or the opinion of a subsequent treating dentist, can be defended appropriately only with complete and accurate dental records justifying the treatment performed. Optimally, these records would include medical and dental histories, radiographs, diagnostic casts, laboratory exams, informed consent documentation, charting, progress notes, clinical photographs, documented referral communications, documented recommendations for second opinions and documentation of all pertinent discussions with the patient and other consulting healthcare providers.

Risk management to minimize the frequency and severity of wrong tooth claims is best achieved by proper diagnostic and procedural techniques and thorough recordkeeping.

Nerve Injury

Nerve injuries can result in outcomes diagnosed as paresthesia, anesthesia, and dysesthesia. (The CNA claim data included in your workbook compiles these injuries collectively under the term "paresthesia.") Although nerve injuries can be temporary and reversible, they also can be permanent. Claim demands and costs associated with nerve injuries have increased significantly in recent years. This increase may be due to a number of factors, including heightened awareness of this outcome on the part of both patients and plaintiff attorneys. Unfortunately, it may not be possible to accurately predict injuries that will resolve and those that will not. Moreover, nerve injuries can and sometimes occur following proper and meticulous treatment.

Juries often look sympathetically upon patients with nerve injuries, drawing the frequently erroneous conclusion that an otherwise healthy patient must have suffered a negligent act. Allegations of lack of informed consent regarding the risk of nerve injury associated with surgery often becomes the focus of nerve injury claims.

A common allegation in nerve injury cases is that the dentist failed to refer the patient to an appropriate specialist in a timely manner, and that the referral delay resulted in the loss of any opportunity to pursue the microsurgical repair of the injury. Referral after a period of evaluation/observation may be necessary if the patient is not improving. However, immediate referral to a specialist may be required, depending upon the type of injury, the patient's symptoms, and/or the dentist's ability to effectively manage the patient (see "Controlling the risks" in this section). Although each patient injury is unique, it is clear that early intervention is a key factor related to successful outcomes for both surgical and non-surgical nerve injury treatments. From both a patient safety and risk management perspective, prompt referral to a nerve injury specialist is strongly recommended if there is any question about the course and treatment of the patient's recovery.

Managing the Risks of Nerve Injuries

Proper training, good clinical skills, and timely follow-up are invaluable for quality patient care and to reduce the risk of a professional liability allegation.

Recognizing risk factors

Nerve injury claims are most commonly associated with the following procedures:

- Extractions
- Implant placement
- Periodontal surgery
- Local anesthetic injections

Once a nerve injury has occurred, critical liability risk factors include: the timeliness and quality of the post-injury patient assessment; effective doctor-patient communications; and the timeliness of the referral, if necessary.

Controlling the risks

Dentists can control the exposure presented by nerve injury claims through implementation of the following strategies.

- Avoid performing procedures that lead to nerve injuries.
- Improve knowledge and clinical skills in the procedures that lead to nerve injuries.
- Perform a thorough preoperative clinical and radiographic evaluation of the proposed treatment area. Assess the risks and the advisability of referral for the planned treatment. Note that patient age is a significant risk factor. Patients over 25 years of age are at an increased risk for non-resolving injuries. Some data indicates that the female gender is overrepresented overall and specifically for non-resolving injuries.
- Take appropriate steps once a nerve injury is known.

One system of nerve injury classification describes five degrees based on the extent of the injury. First and second degree injuries are the least severe and can completely resolve or show signs of improvements by one to three months. Complete recovery of second degree injuries may take up to 12 months. Third, fourth and fifth degree nerve injuries are characterized by a three to six month delay in improvement and permanent damage. Neurosurgical repairs of third, fourth and fifth degree injuries have been attempted, often with some level of success. A "successful" repair leads to sensory improvement, rather than a full restoration of sensory function.

A dentist would not be expected to know all five nerve injury classifications. However, a dentist would be expected to know the following regarding nerve injuries that may require surgical or other interventions:

- The recommended window for surgical repair is from one to three months for the lingual nerve and from three to six months after the injury for the inferior alveolar nerve. Because of the location and anatomy of the inferior alveolar nerve, it spontaneously heals more often than the lingual nerve and a longer observation period is appropriate.
- The success rate for surgical repair decreases substantially after six months. If the referral specialist suggests waiting more than six months before evaluating the injury, find another professional to follow the case.
- Surgery is rarely contemplated after one year.
- Surgical repair is not possible for some injuries such as for injuries associated with local anesthetic injection or a known chemical insult (e.g., sodium hypochlorite). Prompt and thorough assessment is recommended and appropriate since the timely implementation of pharmacological and/or behavioral therapy may be indicated.

Microneurosurgeons and/or neurologists are the practitioners who possess the knowledge and skill necessary to definitively treat patients with nerve injuries that do not spontaneously resolve. However, all dentists can perform initial evaluations and ongoing assessments while symptoms continue to improve.

As noted, the potential for improvement via microsurgery diminishes with time. Based upon our experience in managing nerve injury claims, the patient should be promptly evaluated for any opportunity to assess and potentially seek repair of the nerve injury. Recent work on non-invasive therapies show that other treatments also may prove helpful when surgery is not an option or to enhance surgical outcomes. Consider consultation with the patient's physician regarding corticosteroid therapy, which may decrease perineural edema and help in long-term recovery. Sensory retraining may improve patients' perception of altered sensations and administration of vitamin B12 may accelerate functional recovery. More research is needed in these areas specific to trigeminal nerve injuries.

A prudent course of action when a patient reports a nerve injury is presented. Remember to inform your malpractice insurer and check on the availability of new information on the management of nerve injuries.

1. **Examine the patient immediately, if possible, or within one to two days.** Document the patient's description of the nerve deficit as well as all clinical findings of your examination. If the injury is due to extractions, implant placement or other surgical procedures, radiographically assess the area to rule out root tips, foreign bodies or the position of the implant or endodontic filling material as a source of nerve pressure or compression.
   - For patients with an open surgical injury (the treating dentist witnesses the nerve injury), refer the patient immediately to a healthcare professional knowledgeable in treating nerve injuries of the head and neck, such as an oral and maxillofacial surgeon, a neurologist, or an ear, nose and throat physician. If reparative microsurgery is warranted, the rate of success is higher when attempted within the time frames noted previously.
   - For a closed surgical injury (injury not witnessed) or patients whose injury is not related to surgery (local anesthetic injection or a chemical insult (e.g., sodium hypochlorite)), the patient's signs and symptoms should be evaluated as noted above and followed closely for 4 weeks (see below for neurosensory test suggestions).
   - If the symptoms have not resolved or improved significantly in 4 weeks, referral to a nerve injury specialist is recommended.
   - While microsurgery is not an option for nerve injuries due to local anesthetic injection or chemical insult, non-surgical treatments may help as previously described.
   - Note that if symptoms arise after implant placement, the implant could be compressing a nerve (also a type of closed injury). Immediately backing out or removing the implant is appropriate, followed by prompt referral to a nerve injury specialist.
   - Similarly, pressure from an endodontic overfill may cause nerve injury symptoms. Prompt removal of the filling material is indicated to relieve the pressure and prevent long-term damage to the nerve.

2. During the initial evaluation and at follow-up assessments, **map the extent of the sensory deficit and describe or sketch it in the patient healthcare information record.** A neurosensory examination may include a number of tests such as static light touch, two point discrimination, brush directional discrimination, and pin pressure discrimination. These and other tests are discussed in oral surgery textbooks and other sources. Several tests are relatively simple to conduct and provide useful subjective and objective information related to nerve recovery. The tests are repeated at each patient visit to monitor for improvements. They are indicative of the overall injury status and aid in determining the recovery prognosis.
   - Subjective test: ask the patient to rate the sensation in the involved area from zero to ten, with zero being no sensation and ten being fully normal sensation. This test may be conducted using a visual analog scale (VAS), if available, where the patient makes an "X" on a line to indicate the level of sensation.
   - Objective test 1: two-point discrimination. With the patient's eyes closed, the bare wooden end of two standard cotton-tip applicators are held a few millimeters apart and then touched to the skin or mucosa in the affected area. The two applicators are moved progressively closer together until the patient is not able to discern that there are two rather than just one point. This test is performed bilaterally for comparison.
   - Objective test 2: brush directional discrimination. With the patient's eyes closed, use the cotton tip side of a cotton-tip applicator to brush the skin or mucosa in one direction. Move the applicator from right-to-left and then left-to-right (or back-to-front and front-to-back). The patient is asked to determine the direction of the motion. This test is performed bilaterally for comparison.
3. If the patient is referred to a nerve injury specialist, maintain regular contact to follow his or her progress. Document your discussions in the patient's record. After the initial assessment, contact the patient at least every other week during the first month and then re-assess the condition at one month, as noted. Contact the patient at least monthly during the second and third post-injury months, and monthly for the fourth through sixth months if symptoms persist.
4. If the patient refuses to follow through on your referral, advise of the need for early evaluation for both surgical and non-surgical treatments. Also, emphasize the diminished opportunity for surgical intervention, if the patient is deemed to be a candidate. Advise that certain non-invasive treatments may be beneficial as well, depending on the condition.
5. Document all consultant conversations and follow up with written correspondence confirming the information discussed. Retain copies of all patient and consultant correspondence in the patient record.

If the **patient is referred** to a nerve injury specialist, maintain regular contact to **follow his or her progress**. **Document** your discussions in the patient's record.

Dental Professional Liability

Record Keeping and Documentation

Upon completion of this section, you should be able to:

- **Understand appropriate paper and/or computer-based record keeping practices** to enhance patient care and reduce professional liability risks.
- **Adopt techniques and procedures for both doctors and staff members** to improve the accuracy and comprehensiveness of patient records.
- **When necessary, make corrections or additions to patient records** that preserve their integrity as legal documents.
- **Understand the importance of addressing and complying** with federal and state privacy and security laws/regulations in dental practice.
- P**erform risk assessments for paper and/or computer-based patient record systems,** identify issues and implement appropriate corrective actions.

Accurate and thorough records are one of the most powerful risk management tools, as the information captured can support that the professional services provided met or exceeded the standard of care. In addition, comprehensive, timely documentation reduces the opportunity for treatment errors, communication problems and patient dissatisfaction.

Whether in paper or electronic format, the dental healthcare information record ("dental record") serves two major purposes. It preserves your memory about important patient information and facilitates the sharing of vital information, both within and outside your practice. All information critical to the diagnosis, treatment, and continued care of the patient should be documented in the dental record. Paper-based and computerized records are referenced throughout this section of the manual. However, more specific information on computerized or electronic health records (EHR) is included separately under the "Computerized Records" heading.

In the event that you become a defendant in a malpractice action, a comprehensive dental record is your chief defense weapon. It is difficult for a plaintiff to challenge an accurate and unaltered dental record written at the time of treatment. On the other hand, poor records make it very difficult to effectively defend a dentist against a claim or lawsuit, although excellent care may have been provided.

One of the most significant problems in defending professional liability claims occurs when diagnosis, treatment, referral, consultation or patient issues are not supported by appropriate documentation. At a malpractice trial, the jury will be told, and the defendant dentist must acknowledge, that all pertinent patient information — personal and clinical — should be documented in the dental record. If the record is then found to be deficient, the dentist's credibility as a witness is severely weakened. In the subsequent battle of oral testimony, a jury comprised of the patient's peers will believe the patient's version of the events, if that version is credible.

Note however that under the **final Omnibus Rule**, covered entities must **provide an individual** with a **copy of their records** in electronic format, if requested.

Record Organization

There are many acceptable dental recordkeeping systems. Most frequently, dental records are maintained on paper and organized alphabetically by name or account number. Color-coded tabs or file folders are commonly used to further simplify record storage and retrieval.

Notably, the use of computerized patient records continues to expand in dentistry. This trend is being driven, in part, by government regulations, requirements and incentives but also by the potential advantages and benefits attributed to computer-based systems. While computerized records have many advantages, they are not a panacea. In the short term, new risks and risk management considerations typically accompany any significant change. Due diligence is, therefore, required in the preparation for and transition to electronic record systems in order to limit or eliminate potential liability issues, as will be discussed later in this section.

The admissibility of computerized patient records in legal proceedings has been established in numerous healthcare malpractice cases. Therefore, check with your state board of dentistry to ensure that no handwritten mandates apply to any portion of dental records. In the event of a lawsuit, computerized records can be printed to comply with record requests, referral needs or discovery requests. Note however that under the final Omnibus Rule, covered entities must provide an individual with a copy of their records in electronic format, if requested.

Experience with claims that involve computerized patient records show that it can be challenging to compile all pertinent records for the claim investigation. For example, the patient's records may be found in a number of different electronic "buckets". As a result, the process may be much more involved than clicking one "print" button or copying one or two computer files. Discovery may involve standard portions of the electronic health record, as well as:

- metadata (hidden files that may be used to authenticate entries and other information)
- clinical decision support data (system alerts, reminders and similar tools)
- email records
- information stored on smartphones, tablet devices and/or other mobile devices and storage media.

If the record becomes part of the defense of a malpractice claim or dental board complaint, the dentist would be required to attest that the printout or electronic files represent a true and accurate account of the patient's treatment. It is critical therefore to be conversant with your electronic record system design, and the types of data that may be requested/required during the claim or legal discovery process. Our experience indicates that the format of the patient record — paper versus electronic — is insignificant relative to the information contained in or missing from the record.

Certain aspects of "paperless" records can be advantageous in comparison to paper charts. Electronic records are:

- recoverable, because electronic files that have been backed up and stored off-site can be reloaded onto a system following a fire, flood, hurricane, or other loss that would otherwise destroy paper records.
- accessible from many locations via an intranet or the Internet, permitting a dentist to retrieve a chart from a home computer to document a telephone conversation, or send complete records instantly to similarly equipped consulting dentists.
- consistently legible, reducing the risk of miscommunication or disputed entries.

Whatever system you use, it should be employed consistently. Recordkeeping systems should address the needs of the dentist, staff, and patient. Your staff should be well trained in understanding and using your system. Guidelines for recordkeeping should be established and used by everyone. Ensure that your guidelines contain a comprehensive infection control protocol pertinent to handling paper and/or electronic records as appropriate.

Paper records should be maintained in folders or envelopes of similar style and size. Color and other coding systems must be consistent and easily understood to avoid confusion. With electronic systems, the dentist and office staff must be equally comfortable with creating, finding and copying records as they are with opening a file drawer to obtain a patient's paper chart.

Record Elements

It is important to note that some states have codified the elements that must be included in all dental records, which will be addressed later in this section. In the absence of or in addition to any state requirements, consider the following elements that should be included in patient records:

- Patient personal identification and demographic information
- HIPAA-related documents
- Medical and dental histories
- Examination records
- Diagnoses and diagnostic records (including radiographs and photographs)
- Treatment plans
- Informed consent and informed refusal documentation
- Progress notes (see below for further detail)
- Referral and consultation correspondence and reports
- Written patient authorization for each occasion when records are released
- Patient correspondence

Patient financial information should be included in the progress notes only when the financial issue directly relates to the delivery of patient care or a patient's treatment decision. Other financial notations such as daily fees, past due balances, and collection actions should be omitted. An example of a recommended financial reference would be a patient declination of a recommended treatment or pursuit of a less expensive alternative due to financial reasons.

The primary rationale for excluding financial information from progress notes is that the principal function of the progress note is to serve as a repository for pertinent clinical information. Financial account information and notations do not provide clinical insight, except as noted above. In addition, charts that contain financial information, especially when there is more financial than clinical information, give the impression to jurors and dental licensing board investigators that the dentist is more focused on fees than patient welfare.

Who Can Make Record Entries?

Documentation by dental staff is just as important as documentation by the dentist. Any member of the dental staff can enter what they see, what they hear, and what they are told to write by the dentist. The entries of the dentist and the staff are considered equivalent, and what a staff member writes is regarded as representing the report of the dentist.

All staff members should sign or initial their entries. All staff entries must be reviewed by the dentist, who should verify their accuracy, make any necessary changes or additions, and co-sign the entry. This protocol is especially important for those dentists who delegate the task of writing clinical progress notes to their chairside assistant. The data recorded by staff under the dentist's direction remains the dentist's responsibility. If an entry is illegible, incomplete or incorrect, the patient may suffer consequences and the dentist will be held responsible. If litigation arises, a court and jury will not be persuaded by a defense that the staff entries in the records were in error.

Some practitioners transcribe dental record notes from dictation or tape recordings. They find that the time saved using dictation, coupled with the accuracy and comprehensiveness achieved by dictation, offsets the costs involved. Transcribed progress notes should be reviewed for accuracy and initialed or signed and dated by the healthcare provider.

Good Record Keeping Practices

Record Keeping Guidelines

- Write the patient's name on every page of the record.
- Label each diagnostic report or object (radiograph, model, photo, etc.) with the patient's name and date. Digital radiographs and other files that are compliant with the Digital Imaging and Communications in Medicine (DICOM) dental standards incorporate patient information as "meta-data" in each file (see the bibliography for more on DICOM).
- Make a note of every patient visit and telephone conversation.
- Record the date in full (day/month/year).
- Record information during patient visits or promptly afterward, preferably not later that the day of treatment. Understand the documentation time requirements for electronic systems.
- For paper records, write legibly! Also consider the default font style and size for clear and easy-to-read electronic records. Print and evaluate samples from all parts of the electronic record.
- Use dark ink — black ink photocopies best. (Red or blue ink is acceptable on exam forms as long as it copies well.)
- Be factual, objective, and clear.
- Be comprehensive — address who, what, when, where, and why.
- Use appropriate language and a professional tone.
- Use abbreviations and symbols consistently and in accordance with practice-approved lists.
- Do not skip lines in the record.
- Require each entry to be signed (or at least initialed) by the person making it.
- Use quotation marks "…" to accurately record patient complaints and comments.
- Ensure that records document all findings and corrective actions through their resolution.
- Use the SOAP format to document emergency visits and treatment not in the original treatment plan. The SOAP format is delineated later in this section.
- Retain copies of all dental laboratory prescription forms.
- Handle and maintain records in a confidential manner.
- Handle paper records and use electronic equipment in accordance with infection control protocols.
- Train new employees in the recordkeeping methods of the office and document all training.
- Implement a procedure to regularly perform quality assurance record audits to ensure accuracy, consistency, and comprehensiveness.

Determining How Much to Write/Type

A frequently asked question about recordkeeping is "How much do I *really* need to write?" There are two equally important components to that answer. You should write sufficient information in the chart to:

- permit you, your staff, or any other dentist to determine exactly what treatment was performed at each appointment, why that treatment was necessary, and what treatment is next — based solely on your documentation, and
- meet all recordkeeping requirements of your state dental board.

As an aid to meeting the first test, document sufficient information to pass what is commonly referred to as the "amnesia test":

> If you were to *forget* everything you ever knew about each and every one of your patients, but you *remembered* everything you know about how to practice dentistry, would you be able to read any one of your patient charts, and quickly be able to:
>
> 1. know what treatment the patient has had and why, and
> 2. perform whatever treatment is next for that individual and know why it's necessary?

The second component of recordkeeping adequacy varies by state and can present additional risks. A dentist whose records do not comply with dental practice act requirements may be sanctioned by the state dental board (e.g., monetary fine, license probation, remediation), in addition to facing potential professional liability allegations by the patient.

Some state dental boards provide direction regarding minimum requirements for dental records in their states. For example, the Illinois Dental Practice Act (225 ILCS 25/50) states:

> "Every dentist shall make a record of all dental work performed for each patient. The record shall be made in a manner and in sufficient detail that it may be used for identification purposes."

Such a standard lacks concrete parameters either for patient care or risk management purposes. Therefore, we recommend that Illinois dentists, as well as those in other states with similar minimal requirements, use the amnesia test as a guideline instead.

Conversely, other state dental practice acts are more specific in their wording. Although the Florida Board of Dentistry (Sec. 466.018(3)) does not cite a list of what dentists are expected to record, it places the recordkeeping bar rather high by requiring that:

> "Every dentist shall maintain written dental records and medical history records which justify the course of treatment of the patient. The records shall include, but not be limited to, patient history, examination results, test results, and, if taken, X rays."

Thus, in Florida, simply writing what you did would not be sufficient. Your record must *justify* your actions through your documentation. Moreover, the defense of malpractice allegations and dental board complaints typically requires this documentation standard.

Many state boards have adopted dental record requirements and criteria in order to provide further direction for licensees on *how* to justify their treatment. For example, the Minnesota Board of Dentistry Administrative Rules (3100.9600) leads the dentist through a set of very specific items, that must be incorporated in every chart:

> **Subpart 2. Dental records.** Dentists shall maintain dental records on each patient. The records shall contain the components specified in subparts 3 to 10.
>
> **Subpart 3. Personal data.** Dental records must include at least the following information:
>
> A. the patient's name;
>
> B. the patient's address;
>
> C. the patient's date of birth;
>
> D. if the patient is a minor, the name of the patient's parent or guardian;
>
> E. the name and telephone number of a person to contact in case of an emergency; and
>
> F. the name of the patient's insurance carrier and insurance identification number, if applicable.
>
> **Subpart 4. Patient's reasons for visit.** When a patient presents with a chief complaint, dental records must include the patient's stated oral health care reasons for visiting the dentist.

Subpart 5. Dental and medical history. Dental records must include information from the patient or the patient's parent or guardian on the patient's dental and medical history. The information shall include a sufficient amount of data to support the recommended treatment plan.

Subpart 6. Clinical examinations. When emergency treatment is performed, items A to C pertain only to the area treated. When a clinical examination is performed, dental records must include:

A. recording of existing oral health care status;

B. any radiographs used; and

C. the facsimiles or results of any other diagnostic aids used.

Subpart 7. Diagnosis. Dental records must include a diagnosis.

Subpart 8. Treatment plan. Dental records must include an agreed upon written and dated treatment plan except for routine dental care such as preventive services. The treatment plan must be updated to reflect the current status of the patient's oral health and treatment.

Subpart 9. Informed consent. Dental records must include a notation that:

A. the dentist, advanced dental therapist, or dental therapist discussed with the patient the treatment options and the prognosis, benefits, and risks of each; and

B. the patient has consented to the treatment chosen.

Subpart 10. Progress notes. Dental records must include a chronology of the patient's progress throughout the course of all treatment and postoperative visits. The chronology must include:

A. all treatment provided;

B. all medications used and material placed;

C. the treatment provider by license number, name, or initials; and

D. when applicable, the identity of the collaborating dentist authorizing treatment by license number."

This list is substantial, and every item is important. The listing serves to guide dentists toward recordkeeping practices that benefit both the patient and the dental practice. The comprehensive nature of the list and its required compliance also may help explain why our dental professional liability claim experience in Minnesota is consistently better than in most other states.

As one of the primary purposes of state boards of dentistry is the protection of the public, codification of recordkeeping requirements supports this mission. Clearly, dental boards view good recordkeeping as an effective patient safety tool. Similarly, the risk management process seeks to achieve the same goal.

Clearly, dental boards view **good recordkeeping** as an effective **patient safety tool**. Similarly, the risk management process seeks to achieve the same goal.

Documenting in the Patient Record

There is no single standard method or form for writing progress notes. Regardless of your handwritten or electronic system and formatting, include the following information, in addition to criteria cited in the previous section, when documenting patient care. Note that the inclusion of many of these items may be expressly required by your state dental practice act.

- Date (day/month/year) of examination or treatment
  - Cancelled and failed appointments also must be recorded
- Results of your review of the patient's medical history and physical status (includes blood pressure, current medications and over-the-counter remedies)
- Clinical findings and observations, both normal and abnormal
  - If you use a dental examination form, complete all blanks and boxes on the form to verify you have examined those areas or structures. Symbols such as **+** or a check mark may be used, or the abbreviation "WNL" for "within normal limits." However, such symbols or abbreviations may be utilized only if they are formally defined and approved for use by the practice and universally utilized by all staff. With electronic forms, consider eliminating default responses to prevent errors. A default response of "WNL" for example, may result in a "failure to diagnose" allegation in the future.
  - Record all objective findings essential to your diagnosis and treatment plan.
- Clinical findings to be documented include, but are not limited to, size, depth and location of caries; areas of inflammation; periodontal pocketing; furcation involvements; mobility; muco-gingival defects; radiographic findings; pulp, percussion and thermal testing results; root proximity problems; violations of the biologic width; and radiographic results.
  - Document negative findings, when appropriate, or when consistently documented by members of the practice for similar situations. For example:
    - Document when a previously noted soft tissue lesion has healed and is no longer present.
    - Document the absence of fever, despite the presence of infection.
- Diagnoses
- Treatment performed, including
  - Anesthesia used — type, concentration, volume or amount (milligrams, grams, etc.) administered, vasoconstrictor presence or absence, concentration of vasoconstrictor
  - Dental materials and devices used — liners, cements, restoratives, restoration shade, etc.
  - Patient protection, such as rubber dam
- Prescriptions and medications (include confirmation that premedication was taken as prescribed, and any over-the-counter medication) and documentation of consultation with the patient's physician and/or pharmacist, if appropriate
- Patient satisfaction and dissatisfaction, including any complaints and concerns
- Lack of patient compliance
- Treatment complications or unusual occurrences and the corrective action taken
- Pertinent discussions/communications (in person and by telephone or email)
- Informed consent and informed refusal discussions
- Referrals to specialists and consultants
- Postoperative and follow-up instructions
- Plans for next visit
  - The clinical rationale for any deviation from the documented treatment plan, the discussion of the modification with the patient and the patient's consent to the modification

Accuracy Matters

It is essential to write the proper words, and a sufficient number of words, to accurately express yourself. The absence of accuracy in recordkeeping creates a potential for unintended inferences and conclusions to be asserted by plaintiffs and their attorneys.

Below is the chart entry of a patient's initial visit with a new dentist.

> CC: Mild gingivitis due to braces — bleeding probably sometimes. 1-1/2 years with braces — no idea when they will be taken off. Patient has been previously told she had perio disease but was never told to see a specialist. Patient was not told she had bone loss. Moderate amount of plaque and tartar. Patient will be recommended to see periodontist after braces are removed.

Let's evaluate the note to see if we can learn more about the patient's situation. We'll begin with the first line, "CC (chief complaint): Mild gingivitis due to braces — bleeding probably sometimes." Although it is good practice to record the patient's chief complaint, what is the likelihood that the patient expressed her complaint using these words? The categorization of the periodontal status as "gingivitis" appears to be the dentist's conclusion. The phrase "bleeding probably sometimes" is ambiguous and does not have any quantitative meaning.

Which individual has "no idea when" the braces will be removed, the patient or the dentist? The note doesn't say. Perhaps the patient knows but hasn't disclosed that to the dentist. Who told the patient she "had perio disease" — her neighbor, her spouse, her previous dentist? When was she informed? The note indicates she was "never told to see a specialist" but provides no explanation. Perhaps she was not referred because her previous dentist did not believe there was a clinical reason for referral. Or, perhaps that phrase is a criticism of the previous dentist who neglected to provide a necessary referral. The true meaning is impossible to decipher due to the lack of detail in the entry.

Now we move on to the next line, "Patient was not told she had bone loss." Was she not told because there was no bone loss? Or, if there is bone loss, is this another criticism of the previous dentist, who should have informed her but failed to do so? And how would the author know the patient was never told? He didn't accompany this patient to all of her previous dental appointments. Maybe she was told, perhaps many times, but she forgot or withheld the information. Once again, the ambiguity creates more questions than answers. If bone loss is present, it would have been more accurate to write, "Patient reports she was never informed of existing bone loss."

"Moderate amount of plaque and tartar" is a reasonable statement to make. However, if the plaque and tartar are moderate in quantity, it is logical to wonder about their influence on the periodontium, such as the extent of inflammation and loss of attachment. Yet, these aspects are omitted from the note. In the last sentence, we learn of the need for a periodontal referral after the completion of orthodontic treatment. Exactly why is the patient in need of a periodontal referral? The note fails to include a periodontal diagnosis. There is no definitive statement as to bone loss. There is no mention of pocket depths, bleeding, or inflammation. It appears the patient is being referred due to a "moderate amount of plaque and tartar." What wasn't documented was that this patient had generalized pocketing > 5 mm in the posterior, moderate posterior alveolar bone loss, and significant gingival inflammation, all compounded by active orthodontic tooth movement. Her diagnosis was chronic generalized periodontitis, but those words were never reflected in the chart. As a result, it was inappropriate to have recorded "mild gingivitis" as the periodontal diagnosis.

One other troubling aspect of the last sentence is the treatment sequence. The dentist wrote that he planned to refer the patient only after her orthodontic care was completed. What was the reason for waiting? In this case, the dentist who wrote this note was heavily criticized by the plaintiff's periodontal expert for failing to refer her immediately. Because periodontal disease may be exacerbated by active tooth movement and to mitigate the risk of disease progression, the dentist should have considered these factors and referred accordingly.

While there are many ways to write a good exam or progress note, we'll now consider how the note at the beginning of this section could have been improved. Since it contained ambiguities, we will begin by sharing with you the facts that the dentist observed or was told. During his exam, he found moderate plaque and calculus, mild inflammation of the gingival margin, generalized posterior 5-6 mm pocketing, generalized bleeding on probing throughout the mouth, and a loss of 1.5 mm of alveolar bone height in the posterior. Other oral soft tissues were normal in appearance with no signs of oral cancer. Her blood pressure was taken. The patient informed him of the following: 1) she was uncertain when the braces were to be removed; 2) her gums usually bleed when she brushes with any thoroughness; 3) she was on an in-house soft tissue management program at her last dentist; and 4) she does not recall being told by any previous dentist that she had bone loss or that she needed to see a periodontist. Here is one example of a note that includes the necessary information.

> Reviewed med hx. No meds, med hx noncontributory. BP 124/76. CC: "My gums bleed whenever I brush real hard." Exam: No decay noted. Oral CA screening neg. Pt in full ortho for past 1-1/2 years, states she doesn't know when tx will be done. Mild inflammation at gingival margin, moderate plaque & calculus, generalized FM bleeding on probing. Pocket depths 5–6 mm in posterior, ≤3mm in anterior — see perio chart. @1.5 mm crestal bone loss in posterior. I asked pt about perio hx. States she started perio tx before ortho began. States previous dentist told her he could treat her without referral because "case wasn't too bad." States she had FM root planing & recalls every 4-6 months. I informed pt about current perio status, new X-rays show existing bone loss. Pt reports she was never informed of existing bone loss. Dx: generalized chronic periodontitis in posterior areas, moderate gingivitis in anterior. Discussed need to stop ortho movement until perio needs are addressed. Referred pt to periodontist.

Of course, you may use abbreviations to make the note easier and quicker to write. And you might choose to sequence or describe the information somewhat differently. An electronic record system may require entry of these data into specified data fields. However written, a note of this type provides the reader with a much better idea of the patient's status, regardless of whether that reader is a periodontist, a plaintiff's attorney, a juror, or simply you, two years from today.

Clearly, accuracy in recordkeeping is important. Good record-keeping involves selecting words that accurately convey what you heard, saw, and considered. To maximize the effectiveness of your documentation, we suggest the following:

- Use words and descriptions that are clearly understood.
- Be specific rather than vague.
  - "Pt. has draining fistula on buccal from periapical abscess #13", rather than "Appears pt. might have signs of an infection"
  - "PA shows distal decay #21 within 1 mm of pulp chamber, likely will need RCT", rather than "D caries #21"
  - "Lesion on R cheek is now 14 mm across, was only 7 mm at last visit", rather than "R cheek spot bigger that before"
  - "Periodontal diagnosis now generalized chronic periodontitis", rather than "Perio worse than before"
- When documenting discussions with patients, accurately record what you told the patient. For example, "Informed pt. of risk of numbness", rather than "Risk of paresthesia"
- Unless you witnessed an event, always record the source of the information or opinion presented to you.
  - "Pt. reports he slipped in shower and broke his tooth", rather than "Pt. slipped in shower and broke tooth"
  - "Pt. stated he thought prior Dr. did RCT poorly", rather than "Prior dentist did poor RCT"
- Thoroughly explain the basis of the clinical decision-making process and evidence that supports the diagnosis and plan of care.
  - For example, rather than simply write "#30 might need endo", document the clinical evidence that the statement is true.
    - What does the dentist see? A large restoration, decay, a periapical lesion?
    - What other factors are involved in the clinical decision-making process? Traumatic occlusion, parafunctional habits, canal calcification?
    - In what time frame might this occur? Tomorrow, next week, next month, next year?
    - Under what circumstances? If decay progresses, if the tooth becomes painful, if the patient continues grinding?

The "SOAP" Format

Lack of documentation is a common problem arising from unscheduled emergency appointments, as well as scheduled visits, when the patient presents with complaints that require a change in the original treatment plan. Consider a patient who returns for crown preparation on tooth #18 three weeks after you've completed emergency placement of a bonded composite for a fractured cusp. The patient indicates that since the emergency visit, chewing is painful and the tooth is sensitive to hot and cold. The radiograph you take shows periapical pathology, and after additional testing, you appropriately recommend root canal therapy.

What error might occur in the record entry for this visit? Your last progress note states "Next visit: crown #18" but in lieu of following the treatment plan, you recommended and performed a completely different treatment. To avoid a failure in documentation, the patient's record should indicate why you deviated from the planned treatment, including patient complaints, diagnostic information acquired, your clinical observations, differential diagnosis, and patient informed consent for a new treatment plan. While that may seem like a great deal to write, it accurately documents what occurred. If the patient has a poor outcome from the subsequent treatment, you'll have documentation that you met or exceeded the standard of care.

Whenever a progress note is made for emergency care or for treatment that reflects a change in the written treatment plan, document the event using the SOAP format. This format uses the acronym SOAP to remind the author to follow the prescribed formula:

- Record the patient's **Subjective** comments, including desires, expectations, and physical complaints. Write the patient's chief complaint in his or her own words with quotation marks around it. Use open ended questions that allow patients to fully describe their problems, such as:
  - "When did you first notice the pain/swelling/loose filling?"
  - "Has the problem changed since you first noticed it? If so, how?"
  - "How have you addressed the problem since you first became aware of it? Did that help?"
- Make note of your **Objective** evaluation. Include the results of your medical history review, physical exam, clinical findings, diagnostic test results, radiographic findings, and all observations.
- Note your **Assessment.** Your assessment of the patient's problem is your differential diagnosis, which may be simple or complex depending on the information collected from the patient's subjective comments and your objective evaluation.
- Outline the **Plan,** the treatment you plan and deliver. All aspects of the actual treatment must be documented, including:
  - Patient preparation (informed consent discussion, NPO status, preoperative medications such as antibiotics and anxiolytics, local anesthesia, rubber dam, etc.)
  - Actual patient treatment (include flap design, type and number of sutures, adhesives, bases, liners, restorative materials and shades, irrigants, impression materials, cements, etc.)
  - Postoperative instructions and medications prescribed (prescription *and* over-the-counter)
  - Plans for the next visit

Make sure each note includes an appropriate level of detail in all four sections, and no section is omitted. Here's a sample SOAP note for the emergency treatment example given at the beginning of this section:

S: "Ever since you put in that big filling I can't drink anything hot or cold or eat on that side of my mouth. Lately it hurts more when I lie down." Chief complaint: pain from hot, cold, and chewing in LL. Pt reports pain began 5 days after last appt. Pain more severe since onset; spontaneous at times; described as "throbbing and deep."

O: Reviewed med hx: pt taking Lipitor for high cholesterol, no other meds. Pt presents w/ large bonded MODBL composite #18 replacing MB cusp. Tender to palpation. Pain on biting, exquisitely painful to even light percussion. Heightened pain responses to both cold and heat. PA shows PDL thickening @ M root w/ slight breakdown of lamina dura. Perio #18 WNL, no pockets >3mm.

A: Irreversible pulpitis #18.

P: Recommended RCT #18. Gave pt endo pamphlet #2 and responded to the patient's questions. Alternatives of RCT by endodontist and extraction also offered. Explained further pain and probable abscess if no tx; risks of tx: pain, infection, separated instrument, lack of healing; that #18 may still require extraction after RCT; need for buildup & crown after RCT; explained fees, answered pt. questions. Pt understands tx and agrees to RCT #18. 2 cartridges Lido 2% w/ epi 1:100,000. #7A clamp, rubber dam, access, extirpated pulp. Established lengths: MB-19.0mm to MB cusp; ML-19.5mm to MB cusp; single Distal canal-18.5mm to DB cusp. All canals filed to #15. Minimal shaping. NaOCl flush. Dried. ZOE temp placed in access. Reduced occlusion. No purulence noted. Rx: Ibuprofen 600mg, 1 tab q6h for pain x 15 tabs. 1 refill. Gave pt endo post-op instruction sheet and reviewed orally. Next Visit: shape & fill.

What Not to Include in Patient Records

Some things are better left undocumented. The following should be heeded in creating records:

- Never use correction fluid such as White Out® or Liquid Paper® to correct errors.
- Do not write disparaging or subjective comments or abbreviations about the patient, such as "patient is rude to office staff," "patient is a complainer," etc.
- Do not write disparaging comments about the prior dentist. ("Patient was improperly treated by Dr. …")
- Never record the patient's daily fees in the progress notes. Fee amounts are not considered as part of a clinical treatment record.
- Do not use words that are ambiguous or vague. "Periodontal diagnosis: poor" does not adequately describe the clinical findings or the true diagnosis.
- Do not record information that requires follow-up action on your part if you are not going to take that action. For example, writing "Patient to be seen in 3 days for re-evaluation" places the onus for evaluating the patient's subsequent status on the dentist.
- Do not use language that suggests carelessness or negligence. ("I hadn't noticed the ulceration at any of the previous appointments.")
- Do not erase decay noted on examination records in order to note completed restorations. This is considered record adulteration. If you wish to graphically display a patient's progress from oral disease to oral health, do so on a form other than the examination record.
- Do not record telephone discussions with attorneys, risk managers, claims specialists, or insurance agents.

Documenting Telephone Calls

A great deal of important information is exchanged during telephone calls. The timeliness and extent of documentation of telephone calls between patients and dentists and their staffs are often the issue that is critical to the defense of a malpractice allegation. The lack of a timely response to a patient's (or patient advocate's) telephone call is often a cause of significant dissatisfaction.

- Document in the patient's record all calls regarding cancelled appointments, medications, emergencies, referrals, consultations, and any aspect of patient care.
- When you are unable to reach the patient by telephone, document the telephone number called and make a notation such as "No answer, left message on machine" or "Spoke with spouse, left message to call back."
- Document after-hours telephone calls at your earliest opportunity. Be certain to clearly indicate any direction provided to the patient and necessary further action, such as patient or dentist follow-up.

To facilitate after-hours access to care, many dentists use answering services, carry pagers or cellular telephones, or use office voice mail or answering machines. When speaking with patients after hours, without access to patient files, it is sometimes difficult to verbally compile and then document all pertinent information regarding his or her call. If problems develop afterward, a terse, cryptic note written on a scrap of paper will not impress a jury. It may even suggest that the dentist failed to take a proper history or convey necessary information to the patient.

Information received during after-hours calls can be documented on a form, or in a log or diary. Such forms should be placed into the patient's record, and logs or diaries should be permanently maintained by the practice as documentation for use in any subsequent litigation. Important information recorded should be transferred or attached to the patient record in a timely manner. If you don't wish to carry items for documentation, immediately call your office and dictate a message on the office answering machine for later transcription. If electronic records are used, notes can be scanned into the patient's records. If you dictate a voice recording or type a note into a smart phone, tablet device or home computer, take appropriate precautions to protect the privacy and security of the captured information. Another option for electronic records is to establish a secure access portal to permit real-time documentation in the patient record. Establish and implement written policies and procedures to address use of personal or practice-owned mobile electronic devices. More information is available on the use of mobile technology on the U.S. government website, HealthIT.gov.

A telephone contact form can guide you in asking the proper questions and capturing essential patient information in an organized and accessible manner. It can be used in any situation where data must be obtained and documented quickly and the patient chart is not immediately accessible. The completed paper or electronic version of the form can be brought back to the office, with the information added to the patient chart or electronic record, saving the original record as well. The result will be an organized, effective system, making follow-up care easier to track and minimizing potential documentation gaps. A number of sample risk management and dental office forms are available that may be modified to suit your own needs. *Please refer to page IX for information about access to risk management forms.*

Information received during **after-hours calls** can be **documented** on a form, or in a log or diary. Such forms should be **placed into the patient's record**, and logs or diaries should be **permanently maintained** by the practice as documentation **for use in** any subsequent **litigation**.

Correcting Dental Records

Occasionally, erroneous information is entered in the record, or important information is omitted. Current hand-written record evaluation methods — such as ink analysis, light reflection tests, transmission analysis, and computerized handwriting analysis — can detect even the most sophisticated attempts to adulterate a paper record. Electronic record entries are generally automatically dated and timed when entered as part of the computer operating system or software program. An adulterated record makes defense of any patient claim extremely difficult. It also raises the issue of fraud, and the possibility of punitive damages or criminal charges, which are not insurable in many jurisdictions. For paper records:

- **Never use correction fluid or other means to obliterate an erroneous entry!**
- If an error is made while making an entry, draw a single line through the error and initial it. Lined-out entries must remain readable so that incorrect inferences cannot be made about their content.
- If an error is discovered after an entry is complete, draw a single line through the error and initial *and date* it contemporaneously. Add the correct information in the next available space in the record, keeping the date of the correction clear. You may also wish to clarify the reason for the correction.
- When making an addition to a prior treatment entry, do so in the next available space in the record, rather than in the margin or the body of a previous entry, and contemporaneously date and time the entry. Information scribbled haphazardly into an old note or added in the margins or between the lines carries the inference of impropriety, even if it was written at the time of service.
- If you receive a notice of peer review, disciplinary or professional liability action, do not make changes or additions to the record in question, even if the additions or changes reflect what actually occurred, although not previously recorded.
  - Any necessary additions, deletions and changes to the record after notice of a peer review, disciplinary or professional liability action can be made in a separate narrative report or by oral testimony. This supplemental narrative report is ordinarily addressed to the defense attorney to maintain confidentiality under the doctrine of attorney-client privilege.
  - Copies of such a report should be kept in a separate file to prevent the material from being inadvertently copied and released to the plaintiff.

Computerized Records

Computers can be helpful in overcoming the problems of internal record keeping conflicts. Good computer systems automatically update ledgers or recall information when a treatment entry is made. Some will automatically add a note in the treatment record when a prescription is written, when a recall card is sent or when a telephone call is recorded. If purchasing a computer system, check for these and similar automation features. If already using a system, be aware of and take full advantage of its features. As previously noted, be aware of any "default" features for examination forms or other parts of the clinical record and consider their risks. It is possible that disabling such features may be advisable.

One drawback to many electronic systems is the challenge of capturing patient signatures on important documents, such as medical histories and informed consent forms. To overcome this problem, you can either have the patient sign a paper form, then scan the form into your computer system; or utilize a form of "electronic signature" (e-signature) that meets applicable legal and regulatory requirements.

Under the HIPAA Omnibus Final Rule, e-signatures may satisfy requirements for a signature "to the extent the signature is valid under applicable law." Although no healthcare-specific requirements for an electronic signature currently exist, healthcare e-signatures may be binding. "Applicable law" at this point in time primarily refers to: 1) the Federal Electronic Signatures in Global and National Commerce Act (ESIGN Act); and 2) the Uniform Electronic Transactions Act (UETA). Note that the ESIGN Act is a federal law and applies in all states. Although it has been adopted by most states and U.S. territories, the UETA is not a federal law. Some states have enacted their own e-signature statutes.

If you currently have an electronic record system in place, or you are in the process of purchasing or developing a system for electronic health records, remain vigilant with respect to legal and regulatory requirements, including e-signatures. Technology continues to evolve rapidly and laws/regulations are not static. Therefore, all dentists and other healthcare providers should confirm e-signature compliance and regularly review the process with experienced legal and information technology personnel. Vendors provide useful information, but consulting with independent advisors is also recommended.

Complete information on e-signature requirements is beyond the scope of this manual. One example is provided since this may initially seem to be a simple solution to dental office e-signatures. Installing an electronic signature pad, comparable to those used for credit purchase procedures at retail establishments will not necessarily comply with legal requirements. In addition to other requirements, the signature image must be securely and automatically added to the form/record by the software/computer system. This form of electronic signature may easily be compromised, unless the system/software prevents altering, moving, or copying and pasting of the digitized signature.

If you decide to scan a signed paper form to capture a patient signature, retain the original signed form. Under what is known as the Best Evidence Rule, original signed documents are preferred to copies or other reproductions. Archive all original documents alphabetically in a master file, rather than creating separate patient charts with each containing only a few pages. This approach precludes the ability to maintain a totally paperless office. However, in today's litigious society, original documentation of the patient's medical history and informed consent represents a critical risk management strategy.

Another potential disadvantage of electronic records is that plaintiff attorneys may attack the integrity of computer records, asserting that they may have been altered without detection. The use of a system that creates audit trails indicating when a record was last modified, coupled with various backup methodologies that prevent alteration of the records, can address the issues of access and security.

Some safeguards that should be incorporated in computer record keeping systems include the following:

- When selecting or developing a computer record keeping system, the system should require a unique username and passwords for each authorized user. Passwords should be sufficiently complex, and changed regularly, such as every 6 months. Office policies should state that usernames and passwords should never be shared.
- Ensure that operating system, software updates and security patches are installed in a timely manner. Also regularly update important third party applications (e.g., Java and Flash).
- Require every individual making progress note entries to type his or her name at the end of each note.
- Review and electronically "co-sign" progress notes entered by staff members.
- Protect against unauthorized system entries. Staff access should be limited to specific portions of the patient record or require review by an authorized staff member.
- Protect against unauthorized electronic intrusion. Your system contains a great deal of confidential patient information that requires protection in accordance with state and federal statutes and regulations. Breaches of this information can result in serious financial liability and reputational harm. Use appropriate software and/or hardware barriers to reduce the risks of "hacking" and "infection" by a computer virus, and train your staff on safe computer usage. These threats are real and becoming more common in dentistry. An example: an online data backup service for dentists in Wisconsin was hacked in 2019, resulting in the encryption of records for approximately 400 dental practices. Be sure to document all training. Use a virus detection program to check all data for viruses before uploading. Consider using a full disk encryption solution on any device (laptop/desktop/mobile) that stores patient data.
- Do not attempt to adulterate records under any circumstances. Nearly all changes to electronic records may be detected. Although the computer screen appears to contain seamless information, data entered at different times is usually recorded in different locations on the storage media. Moreover, the computer operating system and in most cases, the computer application or program create "metadata" on a continuous basis. Metadata is "data about data." The computer system/program creates/records information, including but not limited to: (i) when a document was created or edited and by whom; (ii) when a document

is accessed, even if not edited; and (iii) date and time when saved. Dentists and all healthcare professionals must, therefore, timely document activities and findings, while the details are easily recalled.

- Back up your computer data daily and store the backup data away from the office nightly to prevent the total loss of data in the event of a fire, flood, burglary, or other catastrophic event. Another type of back-up called "mirroring" may represent a viable option for healthcare records. Restoring a system back-up can be time-consuming, especially with large files (images/radiographs, for example). Mirroring creates an exact copy of the records on a separate computer drive or system that is immediately available for use, if the primary system crashes or is compromised. Consult with your Information Technology professional or record system vendor regarding options.
- Check your backup system frequently. Remember that electronic media can eventually fail. Follow advice of Information Technology professionals for media replacement schedules.
- Maintain a signed "backup log" showing completion dates.

Computers are neither foolproof nor immune to accidents and sabotage. To protect your data:

- Keep your electronic storage media away from magnets and excessive heat. Magnets can alter or erase electronic storage media.
- Store back up data off-site, in a secure, waterproof and fire-resistant environment. If "Cloud" back-up systems are considered, work with Information Technology professionals and your attorney to ensure that appropriate security and privacy controls are in place that comply with applicable federal and state regulations.

…suggest typical clinical scenarios in order to **determine how the EHR system** would **help staff** navigate those situations. It is also essential to **assess** the product's **risk management/e-discovery** utility…

Selecting an Electronic Health Record (EHR) Vendor

Successful transition to electronic health records depends on organizational readiness for change, strong planning and communication efforts, an adequate budget, and sound selection criteria. If one of these factors is lacking, a newly acquired EHR system may frustrate users, decrease access to information, compromise patient privacy, fail to achieve regulatory compliance and compromise claim defensibility.

Paying attention to the following steps will help dentists presented with the challenging task of defining system needs and assessing vendors and products.

1. Create an EHR adoption team. To the extent possible in your practice, include staff members with varied responsibilities, such as clinical, risk management, scheduling, and billing and coding. A wide range of experience and expertise will be required to address vendor selection and EHR implementation issues.
2. Identify specific system/compliance goals and system functions. The team should be tasked with establishing realistic goals and priorities, such as the following:
   - **Safeguard patient data** and comply with HIPAA privacy requirements.
   - Satisfy the Centers for Medicare & Medicaid Services (CMS) requirements for "meaningful use", as appropriate
   - **Offer data entry formats** that meet dental practice needs.
   - **Permit remote access** by authorized office staff.
   - **Facilitate secure messaging** between providers using computers and other desired tools, such as wireless tablets and mobile devices.
   - Provide adequate data storage, whether web-based or on-site.
   - **Interface with existing hardware,** including computer networks and servers.
   - Support e-discovery protocols (for liability claims/legal requirements).

3. Determine the quality rating of potential vendors. Consider eliminating systems that lack appropriate certifications for dental and "meaningful use" guarantee. For helpful information on vendor assessment, including a "vendor evaluation matrix tool," visit http://www.healthit.gov and search for "how do I select a vendor." In addition, various independent research bodies — such as KLAS, AC Group and Forrester Research — evaluate IT vendors using a range of criteria, including:
   - Financial strength and industry experience.
   - Technical and training support.
   - Customer satisfaction ratings.
   - Research and development acumen.
   - Implementation plans and procedures.
4. Conduct due diligence. Consider submitting a formal Request for Information (RFI) to vendors:. A sample RFI template is available on the Stratis Health website. (Scroll down to "1.3 Select" and click "Request for Proposal doc.")

   RFIs should include the following information and more:
   - The vendor's profile (i.e., basic information) and years in business.
   - Total monies allocated for research and development.
   - Presence of certified trainers on staff specializing in healthcare applications.
   - Number of similar dental/healthcare systems the vendor has installed.
   - Availability and type of training and customer support resources/options.
   - Software licensing arrangements and user fees.
   - Implementation costs, including hardware and software, staff training, maintenance and upgrades, and patient education (for web-based portals).
5. Request references. Active and past dental/healthcare clients provide a useful perspective on performance, which can aid in determining its suitability for your project. Ask such questions as:
   - Did the vendor listen closely to your needs?
   - Did the vendor keep promises, including costs and time frames?
   - Was the vendor aware of healthcare industry realities and concerns?
   - Did the vendor provide good value, in terms of both products and support?
   - Did the vendor ever disappoint you? How so?
   - How did this installation compare with similar experiences?
   - Has there been adequate post-installation training and follow-up?
   - How did the vendor respond to complaints, concerns, and upgrade or error-correction requests?
   - Should the vendor have done anything differently?
6. Arrange product demonstrations. On-site demonstrations permit providers and health IT implementers to judge the "real life" capabilities of vendors. Administrators should suggest typical clinical scenarios in order to determine how the EHR system would help staff navigate those situations. It is also essential to assess the product's risk management/e-discovery utility, focusing on such capabilities as "footprinting" of entries (footprinting refers to the behind-the-scenes computer record or metadata)

Patient Privacy, Record Confidentiality and Electronic Security

Protecting the privacy of patient health records and other protected information has always been important in dentistry. Electronic records and communications have presented new challenges and requirements with which every dentist should be conversant. Compliance with the Health Insurance Portability and Accountability Act of 1996(HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the regulations promulgated under these laws, is an important aspect of dental practice that should not be minimized or overlooked.

Federal and state legal requirements are stringent with respect to protected health information. All office personnel must be aware of the confidential nature of the information included in a dental record, regardless of whether that record is on paper or in a computer system. The staff must understand the importance of protecting and not disclosing patient information to any unauthorized individual inside or outside the office. Dentists and practice staff must comply with all federal and state laws pertaining to patient privacy and record confidentiality.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to simplify administration, assure portability of health insurance coverage, and facilitate communication of medical records and other information between healthcare providers and health plans. The provisions of the Act that most affected dentistry were the wide range of patient privacy issues and the requirements pertaining to dentists who engage in any manner of electronic claim submission. Dentists who submit entirely paper insurance claim transactions are not subject to the Act, although they continue to be subject to individual state privacy laws and requirements.

In January 2013, the Omnibus Final Rule pertaining to the HIPAA Privacy and Security Rule was published by the U.S. Department of Health and Human Services (HHS), with a compliance deadline for many of the new requirements of September 23, 2013. The Omnibus Final Rule clarified and strengthened various existing requirements under HIPAA Privacy, HIPAA Security, and Health Information Technology for Economic and Clinical Act (HITECH) breach notification laws. Several new requirements were added, as well as a more active enforcement initiative for privacy/security breaches and legal/regulatory compliance.

A few important points regarding the Omnibus Final Rule, which:

- Extends the Privacy Rule and the Security Rule to a covered entity's business associates and contractors
- Establishes new limitations on the use of protected health information for marketing purposes
- Expands patient rights to request/receive copies of health records in electronic format
- Strengthens the ability of patients to prevent disclosure of information to health insurance plans

HIPAA acts as a federal "floor" for patient information security. In states with more stringent privacy requirements than HIPAA, state law will prevail and thus preempt HIPAA requirements. In states where HIPAA would grant more stringent privacy protection than state law, HIPAA will preempt state law. Therefore, you must be aware of the privacy requirements in your state to determine whether state or federal laws or regulations apply.

HIPAA requires healthcare providers to present a written explanation or notice of both your privacy practices and the privacy rights of patients. The notice must be supplied to patients during their first dental visit to your office and to individuals who request the information. Also, a copy must be made available in your patient waiting area. Providers also must make a good faith effort to receive a patient's acknowledgment of the receipt of the privacy notice on the first date that services are delivered to the patient. Retain a copy of each written acknowledgement pertaining to receipt of the privacy notice. Model notice of privacy practice templates are available for download that incorporate requirements of the Omnibus Final Rule. The free model documents are available on the HHS website: search "model notices of privacy."

HIPAA requires the protection of all personal medical records and other individually identifiable health information that is used or disclosed by a covered entity in any form — electronic, paper or oral. It also confers significant rights upon patients to control how their protected health information (PHI) is used. The law ensures patient access to medical records, requires patient consent before information is released in most routine situations and permits recourse to patients whose privacy protections are violated.

HIPAA requires that healthcare providers, including dentists, implement reasonable safeguards to avoid prohibited disclosures. The recommended measures include:

- Designation of a "privacy officer" to develop and implement the privacy policies of your practice
- Staff training to understand and follow privacy policies and procedures
- Establishment of safeguards (e.g., document shredding, locked file cabinets and appropriate electronic safeguards) to protect PHI from prohibited or inadvertent disclosures

The following additional protocols provide privacy safeguards:

- Handle patient records in a manner that precludes other patients from viewing them.
- Never place medical alert stickers containing highly sensitive and confidential patient information on the *outside* of paper charts. Such information must be kept inside the chart.
- Stickers placed on the outsides of charts should be uniform in color and size and should also be blank with no writing. The sticker should serve only as an alert to dental personnel that important information is contained inside the chart.

In addition to safeguards for paper records, care must be exercised with the confidential information in your office computer system.

- Access to confidential information should be password protected, limited to specific portions of the patient record or subject to review by an authorized staff member. Implement strategies to protect against breaches by unauthorized parties.
- Place computer monitors to preclude casual glances by others at a poorly located screen.
- Choose complex passwords and change them regularly.
- Passwords should be written and stored in a safe deposit box or other secure location.
- Covered entities, as defined under HIPAA to include healthcare providers, must conduct a risk assessment of their organization and systems to ensure compliance with HIPAA's administrative, physical, and technical safeguards. A risk assessment and gap analysis reveals issues that may compromise the security of protected health information. HHS now provides a complimentary downloadable tool (software) to assist healthcare providers with this requirement: see the Legal/Regulatory Related Resources section of the bibliography or navigate the HealthIT website and search for "risk assessment tool."

Reasonable safeguards must be taken to protect patient information when communicating electronically, whether sending record copies to other providers or patients, or for purposes of patient communication about dental care via email or text messages. Through exchanges via email and other electronic communications, protected health information (PHI) may be inadvertently transmitted to an unauthorized third party, representing a breach of unsecured PHI and thus a violation of HIPAA. Therefore, the use of HIPAA-compliant encrypted email systems and other methods to protect electronic patient/provider communications are recommended to help ensure compliance.

If PHI is revealed on practice-owned equipment or employee-owned devices used for healthcare-related purposes, this practice may constitute a breach of the HIPAA Privacy and Security Rules and related state laws. Also, the use of cellular telephones to take and share photographs or audio and video recordings relating to a patient has significant privacy implications. HIPAA privacy and security requirements (and technology systems) are complex and government enforcement activities continue to increase. From a risk management perspective, legal and regulatory compliance is critical in today's healthcare environment to protect patients from improper disclosure of PHI. Implementation of a HIPAA compliance program, including ongoing staff training, in order to reinforce current requirements, represents an important element of your practice protocols.

Encrypted email systems/vendors are readily available. Dentists should consult with information technology professionals, attorneys and other experts to understand the advantages and capabilities of systems under consideration. Another option to examine for secure healthcare communications specifically is "Direct Secure Messaging," launched as part of a public-private partnership to facilitate secure point-to-point communications between healthcare providers. Additional details on this topic also may be accessed on the HealthIT website: search for "direct secure messaging" on that website or check for links in the bibliography under the Record Keeping and Documentation section.

The HIPAA legislation and related regulations are voluminous and complex and beyond the scope of this manual. Though many aspects have little or no bearing on most dental practices, various requirements that apply to dentistry are important in today's practice environment. With the new emphasis on enforcement activities, every practice must comply or risk significant monetary penalties. In addition, professional penalties may apply. In November 2014, the Connecticut Supreme Court ruled that patients can sue for negligence if a healthcare office/practitioner violates privacy/patient confidentiality regulations. Other states reportedly have taken similar positions.

Reviewing laws and regulations can be difficult and while dentists are experts in taking care of their patients' oral health needs, most are not experts in the law or regulatory requirements! For a more comprehensive discussion of HIPAA privacy and security requirements and compliance, we strongly encourage you to contact the American Dental Association (ADA) and/or other organizations (such as law firms and practice consultants) that offer complete compliance and staff training programs. Retain and consult legal counsel about privacy requirements and to pursue the technical, legal and regulatory issues that may arise in your practice. Remember that your state may have enacted statutes or promulgated regulations that are more stringent that federal requirements. For more information, you also may wish to access the U.S. Department of Health & Human Services, Office of Civil Rights website.

Releasing Confidential Patient Records

The HIPAA Privacy Rule states that specific patient consent for the use and disclosure of a patient's protected health information (PHI) for purposes of *treatment, payment,* or *healthcare operations* (TPO) is not required.

- **Treatment** pertains to providing or arranging to provide for patient care.
- **Payment** refers to billing (which may involve benefits companies and credit card/financial institutions).
- **Healthcare operations** include quality improvement and assessment, accreditation, credentialing and case management activities.

Apart from these conditions, all personnel must understand that, absent a court order, patient information must not be released to anyone without the patient's written consent. This prohibition includes releasing records to spouses, parents of adult children, children of aged parents, siblings, work associates, and in some situations, insurance companies, and governmental agencies (which may include state dental board investigators). Even attorneys representing patients are required to have written patient authorization to obtain a copy of the record.

The release of information for referrals to, and consultations with, other healthcare providers would probably be construed as *treatment* as defined above. It is important to note that your state laws pertaining to the release of confidential patient information may be more stringent than the federal HIPAA requirements, and may *require* authorization in these circumstances. Therefore, it is optimal to obtain specific patient authorization for disclosure whenever you are uncertain or uncomfortable about sending copies of records.

In addition, the HIPAA Omnibus Rule permits PHI disclosure without patient authorization under four circumstances:

- Pursuant to legal process or as otherwise required by law
- To locate or identify a material witness, missing person, suspect or fugitive
- Under specified conditions regarding a crime victim
- If a covered entity believes PHI constitutes evidence of a crime committed on its premises

Thus, PHI may be disclosed without patient consent under court order, subpoena, in dental malpractice cases, under mandatory reporting laws, or in connection with governmental audits. For example, by filing a dental malpractice lawsuit, the patient will be considered to have waived the privilege against disclosure. If there is a concern regarding the release of records, you may decide to first contact an attorney, while considering the time constraints of the request or legal process.

Another important point on disclosure came directly from Leon Rodriguez, Director of the Office for Civil Rights, U.S. Department of Health & Human Services in a January 15, 2013 letter to health-care providers. In the letter, Mr. Rodriguez stated:

> "I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people."

Here are additional comments and suggestions regarding the release of confidential patient information:

- **The dentist owns the dental record and all diagnostic information.**
- **The patient has the legal right of access to all information in the record.**
- Never release original records or radiographs, only copies. Many state dental practice acts mandate that you retain the original records.
- If you choose to release copied patient records based upon a telephone request from the patient, document the request in the patient's record before photocopying or making electronic copies and obtain a contemporaneously dated, signed consent for the prior release at the next patient encounter.
- Dentists are required to provide the requested records in a reasonable time and manner. Refusing to transfer records because of unpaid dental bills is a violation of the law in most states. While the federal requirement is that healthcare providers act on a request for access to records within 30 days following receipt of the request, it is important to note that some states require a response in a shorter time period. Check with your attorney or state board of dentistry to confirm state requirements.
- You may charge the patient, or anyone the patient authorizes to receive a copy of the record, a *reasonable* amount to pay for duplication costs. If you charge a fee, establish a consistent fee policy for copying records for patients and others. If you don't know what constitutes a reasonable charge, contact a copying or duplicating service listed in the telephone directory and ask for the current rate for copying medical records. Note that some states have adopted specific requirements and limitations on such charges. Again, consult your attorney or state board to confirm state-specific information.
- Document in the patient's chart the request and the date the copy was sent (or picked up). Failure to make such notations could prove embarrassing if, in a professional negligence defense, a copy of the patient record surfaces containing information that differs from what is on file in your office. Maintain all original patient authorizations in the record (release of records, signature on file, etc.). If records are sent by mail, utilize certified, registered mail with a required return receipt and maintain the receipt in the patient's records. If records are picked up by the patient, ask that he or she sign and date a records receipt.
- Staff members who respond to record requests should release only the records specifically requested and should check with the dentist before mailing or sending electronic records to verify that the correct components are being sent.
- In the unlikely event you forward original records from your office, retain for yourself copies of all documents and radiographs.

Record Retention

Record storage and retention are essential aspects of dental practice, whether the patient is in the midst of care or has moved to another practice. Paper and electronic records alike must be maintained, primarily for treatment continuity, but also for risk management purposes.

Ideally, records should be kept forever, whenever possible. On a more realistic level, records should be maintained well beyond any point of legal and/or administrative exposure for the dentist.

State statutes of limitations prescribe the period of time within which a lawsuit can be brought. However, statutes of limitations for filing dental malpractice actions vary from state to state, and many states create exceptions for minors or legally impaired patients. For minors, in many states, the time period doesn't begin to run until the child attains the age of majority, which also varies from state to state. For a patient who is legally impaired at the time an incident occurs, the statutes of limitations clocks generally do not begin to run until the impairment is removed.

Even in cases not involving minors or impairment, other circumstances may result in the statutes of limitations being suspended, or "tolled," permitting plaintiffs to have their cases heard many years after the legal window of opportunity was believed to have closed.

Most states also have enacted record retention statutes which require retaining records for a minimum number of years. (Certain states do not expressly address the issue of dental record retention.) Such laws may be part of various state dental practice acts or other legislation, and often far exceed the time frames of the statutes of limitations. Consult your state dental board or local dental association for specific requirements. Note however that some state record retention requirements may be significantly shorter than the retention period recommended by your insurer or attorney to protect your interests.

In states without record retention laws, ask your attorney for a recommendation. Your attorney may base the recommendations on rulings from legal cases involving record keeping issues, as well as state statute of limitations requirements.

- Keep records forever, if possible.
- If permanent retention is not practical, maintain patient records for *at least* the minimum of time required by state dental practice acts or statutes. In *most* states, 12 to 15 years for adult records is sufficient.
- Dentists using digital radiography should retain, in unaltered form, all original images as well as all manipulated images used for diagnostic or treatment purposes. Such maintenance includes images that have been magnified, field-reversed or contrast-adjusted to better evaluate the patient's condition.
- Dentists utilizing electronic records will require a great deal of electronic storage capacity going forward as well as the ability to access the stored information. When selecting software, consider the long-term viability of the vendor, potential obsolescence of software programs and compatibility with past and future systems or standards. Appropriate and secure system back-ups and/or data mirroring must be in place. Unfortunately, this basic safeguard is often ignored.
- HIPAA requires that patient consents for disclosure and use of PHI be retained for six years from the date it was last in effect.

If permanent retention is not practical, **maintain patient records** for at least the **minimum of time required** by state dental practice acts or statutes. In most states, **12 to 15 years** for adult records is sufficient.

Improving Records Through Self-assessment

Dentists call the CNA risk management support line periodically with questions about audits that have been conducted by dental benefit companies or government agencies. Your own audit program can help to ensure that your documentation not only records events, but also includes appropriate and sufficient information to justify prescribed tests, diagnoses, treatment and third party billing practices. In addition to internal audits, commercial companies/consultants offer dental record audit services. If you do not currently implement an audit system, an audit services firm may provide an opportunity to initiate a program and compile resources/information on how to train staff and implement your own audit process.

While most dentists readily admit that their record keeping practices could be improved, they also acknowledge that they are often too pressed for time to write or type as much as they should. One aspect of managing risk is to recognize those circumstances when additional measures are warranted. In the realm of documentation, the dentist should develop more comprehensive entries for those patients and clinical procedures that present a heightened risk. The risk may be an adverse outcome or simply patient dissatisfaction, which may trigger dental professional liability claims.

Your practice and your patients can benefit from various self-assessment techniques. One option is a record review or quality assurance program. Such a program can be as simple as randomly selecting 10-20 records per month and performing a written review of their organization and the quality of their information. Conduct these audits regularly and have more than one staff member work on it. Upon completion of the review, necessary corrections should be made (in accordance with proper correction methods) to the specific records, and all staff should be alerted to check for similar deficiencies in other records. Audit results should indicate any areas of fundamental deficiency, which can be corrected by policies/procedures and documented training.

Informal record reviews can and should be conducted whenever the records are used. Dentist and staff should actively alert one another to record deficiencies or irregularities whenever discovered, and appropriately entered corrections should be made immediately upon discovery.

Another excellent tool to evaluate the quality of record keeping in your practice is to respond to a series of probing questions. Recognizing your vulnerability to a malpractice claim or to a weak defense in the event that a non-meritorious claim arises reduces the likelihood and severity of malpractice claims. The self-evaluative method of recognizing deficiencies can be effective in helping all dental team members enhance the quality of your practice documentation.

How to Use the Record Keeping Self-assessment Checklist

On the following pages, you will find a self-assessment checklist pertaining to various aspects of record keeping. For each query, determine if you and your staff practice the questioned technique *Always*, *Usually*, *Occasionally*, or *Never*.

The greater the number of *Always* or *Usually responses*, the better your documentation will continue to be. Those questions that you answer *Occasionally* or *Never* should be evaluated for enhanced incorporation into your daily routine.

Consider that this assessment tool does not encompass every possible documentation issue. In Addition, you may find that you use a technique that achieves the same result via a different method.

The purpose of using this self-assessment tool is for each practice to validate the good record keeping practices already employed and to more easily identify areas where documentation can be improved.

Record Keeping Self-assessment Checklist

Record keeping organization

- ☐ Do you maintain a record keeping system that permits you to locate a patient's record quickly?
- ☐ Do you maintain a record keeping system that facilitates finding misplaced patient records?
- ☐ If you utilize electronic records, do you make a system backup daily and store it off-site?
- ☐ Do you have an established office protocol for record handling and record access?
- ☐ Do you have a record keeping system that deters your staff from making unauthorized entries in patient records?
- ☐ Do you have a method for training new employees in the record keeping methods of the office?

Record confidentiality

- ☐ Do you and your employees handle patient records with attention to confidentiality?
- ☐ Do you require a written authorization from a patient to release confidential information?
- ☐ Do you have the original of all patient authorizations in the record (release of records, signature on file, etc.)?
- ☐ Do your records document HIPAA compliance?
- ☐ Do you refrain from placing confidential patient information (including health alert stickers) on the covers of patient files so that protected health information will not be inadvertently disclosed to other patients?

Access to information

- ☐ Do you permit patients to access the information in their dental record?
- ☐ Do you have a written policy for documenting copies of records sent out of the office?
- ☐ Do you have a written record release policy?
- ☐ Have you established a protocol for addressing the cost of copying records for patients and others?

Record retention and record purging

- ☐ Do you retain your records for at least the minimum amount of time of either your state statute of limitations or record retention requirement, whichever is longer?
- ☐ Do you maintain and store all after-hours and telephone logs and diaries?
- ☐ Do you have a system of storing inactive patient records?
- ☐ Have you established parameters for retention of diagnostics and if/when to discard them?
- ☐ If you no longer need a diagnostic, do you document in the patient's record the information on that diagnostic?
- ☐ Do you document whenever an original diagnostic is given to the patient or to a subsequent treater, or otherwise removed from the patient record?

Record review and quality assurance

- ☐ Do you have a system in your office for record review/quality assurance?
- ☐ Do you and your staff perform record audits on a regular basis?
- ☐ Do you discuss the results of your record audits with your staff?
- ☐ Do your dental records include information that mirrors the notations in the following documents:
  - ☐ Patient ledger?
  - ☐ Referral forms?
  - ☐ Consultation letters?
  - ☐ Recall cards?
  - ☐ Patient correspondence?
  - ☐ Telephone communications?
- ☐ Do you include checking the documents against your records during your record audits?

Individualized records

- ☐ Do you have a separate record for each patient?
- ☐ Have you maintained the patient's radiographs in the patient's individual record?
- ☐ Do you have the original of all patient records in your files?

Record keeping practices

- ☐ Do you write the patient's name on every page of the record?
- ☐ Do you make a note of every patient visit?
- ☐ Do you record the date in full (day/month/year)?
- ☐ Do you record information during patient visits or promptly afterward?
- ☐ Are your written entries legible?
- ☐ Do you use dark ink for written records?
- ☐ Are your entries factual, objective, and clear?
- ☐ Are your entries comprehensive, addressing who, what, when, where, and why?
- ☐ Do your entries use appropriate language and a professional tone?
- ☐ Do you refrain from recording disparaging or subjective comments or abbreviations about the patient?
- ☐ Do you refrain from recording disparaging or subjective comments about the prior dentist?
- ☐ Do you refrain from leaving open lines in the record?
- ☐ Do you contemporaneously sign and date any late entry?
- ☐ Is each entry signed (or at least initialed) by the person making it?
- ☐ Do you label each diagnostic (radiograph, model, photo, etc.) with the patient's name and the date it was taken?
- ☐ Do you use quotation marks "…" to accurately record patient complaints and comments?
- ☐ Do you record information in a patient record for all emergency treatment, even new patients seen for the first time for an emergency only?
- ☐ Do you retain copies of all dental laboratory prescription forms?
- ☐ Do you handle records in accordance with current infection control protocols?
- ☐ Do you refrain from routinely recording the patient's daily fees in the progress note?
- ☐ Based solely on your records, can you determine what treatment the patient has had and why it was necessary?

Patient personal information

- ☐ Do you have a comprehensive patient personal information section in the written patient record?
- ☐ Do you update this information regularly, such as at each recall?
- ☐ Do you maintain current emergency contact information, including cellular telephone numbers?
- ☐ Do you have written documentation of guardianship for minors, especially in cases of minors with divorced parents?

Health history

- ☐ Do you take a comprehensive medical history on every new patient?
- ☐ Do you document the patient's current medications and over-the-counter remedies and check for potential interactions (including contacting the patient's physician or pharmacist, if needed) before prescribing any additional medication?
- ☐ Do your records alert you to important medical conditions or other healthcare complications for each patient?
- ☐ Is this information prominently displayed inside the record?
- ☐ Does every provider review the patient's medical history prior to every treatment or consultation visit?
- ☐ Do you complete an abbreviated update of the patient's medical history at every visit and document the results?
- ☐ Do you complete a comprehensive update of the patient's medical history at every recall?
- ☐ Is the health history discussed with the patient at each visit to confirm the written information?

Dental history

- ☐ Do you document a patient's dental history?
- ☐ Do you have a written policy for obtaining the patient's authorization and contacting a prior treating provider concerning a dental history?
- ☐ Do you document the information received?

Diagnostic records

☐ Do you have a policy for determining the diagnostics necessary for each patient?

☐ Do you document your examination of all patients for:

- ☐ Periodontal disease?
- ☐ TMJ problems?
- ☐ Oral cancer?
- ☐ Caries?
- ☐ Defective restorations?
- ☐ Occlusal problems?
- ☐ Other oral health problems?

☐ Does your periodontal examination document areas of inflammation, periodontal pocketing, furcation involvements, mobility, mucogingival defects, root proximity problems, violations of the biologic width, and your radiographic findings?

☐ Do you have a baseline periodontal charting, including pocket depths for each tooth, for all patients who have been diagnosed with periodontal disease?

☐ Do you complete all appropriate blanks and boxes on the dental examination form?

☐ Do you send only copies of radiographs, never originals?

Informed consent and informed refusal documentation

☐ Do you and your staff know the components of informed consent?

☐ Do you know when to have an informed consent discussion with your patient?

☐ Do you document in the patient record the receipt of informed consent when received from a patient?

☐ If you use written informed consent forms, do they:

- ☐ Have a patient-friendly title?
- ☐ Discuss the nature of the proposed treatment?
- ☐ List alternative treatments?
- ☐ Discuss possible complications of the recommended treatment?
- ☐ Use the simplest language possible?
- ☐ Allow you to customize the form for each patient?

☐ If you use written informed consent forms, do you:

- ☐ Also have a face-to-face discussion with the patient?
- ☐ Give the patient as much time as needed to ask questions?
- ☐ Answer all patient questions and document this in the record?
- ☐ Give the form to the patient on a date prior to the treatment date so the patient has time to think about the decision?
- ☐ Give a copy of the form to the patient to retain?
- ☐ Document the use of the form in the patient record, or maintain a copy in the patient record?

☐ Do you document a patient's refusal to follow your recommendations?

☐ If so, do you include that you informed the patient of the refusal risks and the probable consequences of failing to follow your recommendations?

☐ Do you give the patient written documentation of the information he or she was told about the refusal to follow treatment recommendations?

Treatment plans

☐ Do you have a written treatment plan for all patients, when appropriate?

☐ Do you give the patient a copy of the written treatment plan?

☐ Do you notify the patient when there has been a change in the treatment plan during treatment and obtain his or her informed consent for the revised plan?

Progress notes

- ☐ Do you make a note of every patient visit?
- ☐ Does your note include the following:
  - ☐ Date in full (day/month/year) of examination or treatment?
  - ☐ Review of medical history?
  - ☐ Chief patient complaint?
  - ☐ Clinical findings and observations, both normal and abnormal?
  - ☐ Your diagnosis?
  - ☐ Receipt of informed consent?
  - ☐ Referral, if necessary?
  - ☐ Treatment performed, including anesthesia used, materials used, patient protection?
  - ☐ Prescriptions and medications (includes confirmation of premedication)?
  - ☐ Postoperative and follow-up instructions?
  - ☐ Plans for next visit?
- ☐ Do you use the SOAP format to document emergency visits and treatment not in the original treatment plan?
- ☐ If you do not follow a previously documented plan of action, do your records indicate why your treatment plan changed?
- ☐ Do you document cancelled and failed appointments in the patient record?
- ☐ Do you document patient satisfaction and dissatisfaction, including any complaints and concerns?
- ☐ Do you document patients' lack of compliance and discussions with patients regarding the risks of lack of compliance?
- ☐ Do you document treatment complications, unusual occurrences and the corrective action taken?
- ☐ Do you document all pertinent discussions (in person and by telephone)?
- ☐ Do you document all referrals to specialists and consultants?
- ☐ Do you give patients written postoperative instructions?
- ☐ Are your written instructions specifically tailored to the procedure?

Abbreviations and symbols

- ☐ Do you use abbreviations and symbols in the dental record?
- ☐ Do you use the American Dental Association and standard pharmacology abbreviations and symbols?
- ☐ If you use other abbreviations and symbols in your record keeping, do you:
  - ☐ Have a formal policy and list so that others can interpret your notations and ensure that all staff utilize the approved list?
  - ☐ Use the same abbreviation or symbol consistently for the same item?
  - ☐ Refrain from using the same abbreviation or symbol for more than one item?
  - ☐ Use abbreviations that make common sense?

Staff entries

- ☐ Do your staff members write in the dental record concerning treatment they witnessed or in which they participated, as well as pertinent discussions they had with patients?
- ☐ Do your staff members sign, date and time each entry they place in the dental record?
- ☐ Do you read and initial every clinical entry in the record made by one of your staff?

Correcting the dental record

- ☐ Do you correct records without obliterating the incorrect information?
- ☐ When you make an addition to a treatment entry, do you do so in the next available space in the record and date it contemporaneously rather than in the margin or the body of a previous entry?

Consultations

- ☐ If you obtain a consultation over the telephone, do you document in the patient record both the individual to whom you spoke and the information received?
- ☐ Do you retain a copy of all written consultations received from other healthcare providers?
- ☐ Do you explain the pertinent dental information clearly to non-dental professionals from whom you seek consultation?

Referrals

☐ Do you use a written referral form for every referral and retain a copy in the patient record?

☐ Does that referral form contain, at a minimum:

- ☐ The name of the patient?
- ☐ How long the patient has been with the referring practice?
- ☐ What diagnostics are available to the specialist, and the date they were collected?
- ☐ What diagnosis you have made for the patient?
- ☐ What treatment has been completed to date?
- ☐ What treatment you expect the specialist to consider or complete?
- ☐ What treatment is planned when the patient completes specialty care?
- ☐ What information is needed from the specialist?
- ☐ How you want to handle maintenance, if applicable?

☐ Do you require a written referral form from all providers who refer to you?

☐ Do you call the provider to whom you referred a patient to follow up on whether the referral was pursued?

☐ Do you check with the patient to determine if the patient followed your referral recommendation?

☐ Do you inform the patient of the consequences of refusing a referral when the patient does not follow your referral recommendation?

☐ Do you document this information in the dental record?

Telephone calls

☐ Do you have a system in place for alerting you to patient calls for emergency care or information after office hours?

☐ Do you and your staff record all attempts to reach a patient by telephone, including the number called and any message left?

☐ Do you and your staff record all telephone information received in the office concerning a patient in the patient's record?

☐ Do you and your staff record all telephone information received in the office from a patient in the patient's record?

☐ Do you document in the patient record all telephone conversations concerning patient care you have received outside of the dental office?

Computerization

☐ If you record patient treatment notes, medical histories or other patient information on a computer, do you have:

- ☐ An adequate backup system and or mirroring system? ("Mirroring" is an automated process that creates a second original and secure computer record, separate from your primary system. This proves permits immediate access to patient records, if your primary system crashes or become compromised for any reason.)
- ☐ A print-out or electronic storage medium with all patient information on it, labeled, dated, sealed and updated at regular intervals, such as quarterly?
- ☐ A method to detect alteration or deletion of patient information?
- ☐ A method for accessing the patient information before, during and after treatment?
- ☐ Is the software/operating system current and in compliance with healthcare information security requirements?
- ☐ Has a security risk assessment/gap analysis been conducted?
- ☐ Are appropriate controls in place to limit access, such as sufficiently complex passwords and encryption technology?

Documentation of recall

☐ Do you have a patient recall system?

☐ Are recall notifications recorded in the patient record or in a recall system log?

☐ Do you record all missed recalls and patient appointment cancellations in the patient record?

☐ Do you monitor the number of missed recalls for each patient?

☐ Do you establish and implement a written policy to address patients who do not keep scheduled recall appointments?

Insurance documentation

☐ Do you maintain a written authorization from the patient to release information on an insurance form?

☐ Do you have an established office procedure for completion of insurance forms?

☐ Do you always review insurance forms for accuracy before they are sent to the insurance company?

☐ Does your original signature appear on all insurance forms filed on behalf of a patient?

Financial documentation

☐ Do you provide each patient with a written financial plan, when appropriate?

☐ Do you provide a "Truth-in-Lending" disclosure to all patients against whose accounts you may charge interest?

☐ Do you check your patient record for completeness before sending a patient to collection or initiating a court action to collect a debt?

☐ Do you review the relationship you had with the patient before sending a patient to collection or initiating a court action to collect a debt?

Notice of termination

☐ Do you evaluate the stability of the patient's health prior to terminating the relationship with a patient of record?

☐ Do you notify the patient in writing when you terminate a dentist-patient relationship?

☐ Do you offer (and document) to assist the patient in obtaining alternative dental services, assist in his or her transition and document the patient's response to the offer of assistance?

☐ Do you retain a copy of the notification in the patient record when you terminate a relationship with the patient?

☐ Do you document all actions taken to assist the patient in obtaining alternative dental services or his or her refusal of such assistance?

☐ Do you document in writing in the patient record when you terminate a relationship with the patient?

Please refer to page IX for information about access to sample forms on "Patient Authorization to Release Confidential Information" and "Patient Contact After-hours."

Dental Professional Liability

Patient Management

Upon completion of this section, you should be able to:

- **Understand and effectively manage financial dispute issues,** including patient refund requests, in order to reduce malpractice risks and/or the risk of dental board complaints.
- **Implement or improve processes and documentation** related to patient referrals.
- **Utilize and effectively document external consultations.**
- **Employ appropriate patient termination procedures** to assist the patient with the transition and mitigate the associated risks.

Fee Arrangements and Disputes

Financial matters are a frequent cause of breakdowns in the dentist-patient relationship and often lead to feelings of patient dissatisfaction. They can also lead to a professional liability action. Dentists are entitled to establish their own fees and expect that they be paid. However, a patient's personal financial situation will generally have a greater influence on the ability to pay than the reasonableness of established fees or financial policies. Here are several financial risk management guidelines:

- Establish, follow and clearly communicate to patients the payment policies of your practice.
- Provide patients with a written copy of such policies, especially those pertaining to insurance and fee payments.
- When a patient accepts your treatment plan, ensure that he or she also understands and accepts the financial arrangements: how much treatment will cost and when payment is expected. The treatment fees should be included your informed consent discussion. Use this opportunity to ask the patient to commit in writing to a financial plan, as well as a treatment plan.
- Provide each patient with a written financial plan and payment schedule prior to beginning treatment, as appropriate.
- Provide a "Truth in Lending" disclosure to all patients against whose accounts you may charge interest, as required by state statute.
- Require payment at the time of service for most dental procedures. Collect the patient co-payment whenever dental insurance covers only a portion of the dental fee.
- Before undertaking expensive, time-consuming treatment, have the patient establish a pattern of payment with your practice. Alternatively, require the patient to make a sufficient payment in advance of treatment. This approach will minimize the need to pursue the difference if the patient fails to pay the outstanding balance, even if you must complete treatment.
- Whenever a payment is overdue, you or your staff should speak to the patient immediately in a direct manner to determine the problem before it creates a rift in your relationship with the patient. Patients may be dissatisfied in some manner with the care provided, how they were treated, or they may be experiencing financial difficulty.
- Never let non-emergent treatment get so far ahead of payment that you are forced into a collection action. Stabilize the patient's condition. Then, address any payment issues before continuing additional care.
- The individual who makes the financial arrangements with the patient, whether it is you or a staff member, should be comfortable discussing past due accounts.
- Do not cease treatment for a patient in arrears until the patient's condition is stable and you have notified the patient using an acceptable termination protocol. If uncertain of how to proceed, consult a risk management professional associated with your insurer for assistance.
- Educate patients that dental "insurance" should really be identified as dental "payment assistance" because it responds differently than other types of insurance policies. Assist patients in understanding the limitations and exclusions of their dental insurance plans.

Collection Actions

Collection actions against patients frequently result in a retaliatory dental board complaint or a negligence claim against the dentist. The collection actions may involve collection agencies or, in extreme cases, taking the patient to court. It is your legal right to pursue collection action for outstanding debts. However, it is prudent to weigh the possibility of a patient's claim against you before proceeding. If you consider a collection action, be aware that many professional liability claims, as well as complaints to state licensing boards begin as retaliation against a dentist's attempts to recover patient debt.

Before initiating a collection action, review your relationship with the patient, including the quality of the patient's dental records. Ask yourself:

- Do I have any indication from patient discussions or actions that the patient may be withholding payment because of dissatisfaction with the treatment or service?
- Am I aware of deficiencies in patient care that may have contributed to a patient injury or patient dissatisfaction?
- Does the dental record contain all necessary patient care information? Is it legible, complete, and correct? Are all documents, e.g., dental record, ledgers, and insurance forms, consistent?
- Have I documented missed patient appointments and the patient's failure to follow my recommendations?
- Does my staff possess any information from or about the patient of which I should be aware?
- Have I reviewed all of this information in every case before my staff initiates a collection action?

Depending upon the size of the debt and the potential problems revealed by asking these questions, you may find it more practical and economical to forgive the debt than to attempt collection. Answering the above questions will make you aware of the possible professional liability exposure that may accompany collection actions. Balance the cost — of your time, effort, and stress — of potential litigation with the value of the debt you are collecting.

Refund of Fees

Almost every day, dentists contact the CNA risk management support line inquiring about how to correctly respond to a patient's request for a refund. Caller scenarios vary widely, with the following issues often raised by patients:

- Crowns, bridges and veneers: all aspects of these procedures represent common refund request scenarios (shade mismatch, shape or size concern and other areas of dissatisfaction; premature fracture/failure; the need for endodontic therapy; fee dispute; treatment delays; dissatisfaction expressed by family, friends or another dentist).
- Based on claim data reported in the CNA *Dental Professional Liability 2016 Claim Report,* crown and bridge procedures represent those most likely to result in a complaint to state licensing boards. Educating the patient and obtaining/documenting informed consent and cosmetic approval are important to achieving patient satisfaction and mitigating the risk of a board complaint.
- Dental implants: the implant(s) failed to integrate; infection/loss of and implant; cosmetic concerns that may be related to implant placement, tissue position, or the inability to use/restore an implant
- Implant-related issues tend to result in higher cost demands, over-and-above a refund of fees. However, refund demands are common, and board complaints and professional liability claims are increasing for dental implants, while most other procedure-related claims are not.
- Root canal therapy: failure and/or re-treatment; tooth/root fracture; pain and/or infection — extraction needed
- Dentures/removable partial dentures: poor cosmetic result; not stable/poor retention; poor function; cannot wear/tolerate them

Irrespective of the scenario details, the following two questions are commonly raised and the general recommendations help dentists navigate this complex terrain:

Question 1:
"If I refund the money, am I admitting that I have done something wrong?"

Dentists are often reluctant to entertain a patient's request for a refund of fees because dentists believe the refund would be tantamount to an admission of liability. As long as the dentist makes no admission of wrongdoing, it can be argued that the refund is based solely on a dentist's business decision to mollify the dissatisfaction of an unhappy patient and retain them, their family members and/or their friends in the practice.

Question 2:
"I did nothing wrong. Why should I refund the fee?"

A refund for anything other than "complete satisfaction" is a common promise today, and many patients come in expecting nothing less. From a preventive perspective, consider discussing the nature and limits of dentistry and healthcare outcomes with patients at the outset, during the initial assessment of expectations. Explain to them how obtaining dental treatment differs from purchasing consumer goods or services, and why perfect results cannot be guaranteed. This discussion will help patients understand why a refund request may not be automatically granted. Once a refund request or demand is made, consider that a refusal to refund fees may result in a malpractice claim or dental licensing board complaint against the dentist as an alternate avenue for the patient to obtain a refund. The dentist must weigh the value of the refund against the risk of a claim and its potential to disrupt the practice. The dentist also may decide that other reasons for a refund may apply to specific patient situations, such as poor material or product performance (including an unexpected dental material or product defect), or simply the desire to maintain a satisfactory doctor-patient relationship.

It is preferable to have the patient sign a release of claims document in exchange for any refund. A release of claims may preclude the patient from pursuing legal action against the dentist for the treatment specified in the document. Two release of claim document templates are available online. *Please refer to page IX for information about access to risk management forms.*

Some patients may refuse to sign such a release, instead escalating the dispute into a dental board complaint or malpractice allegation. Their rationale has often been based on a belief that they were relinquishing more in the form of personal legal rights than the value the refund held to the dentist. Due to the potential for anger, as well as intensifying the patient's resolve, it may be advisable to omit the release form and simply comply with the refund request. This approach may serve to appease the patient and circumvent legal action. Only the dentist can make this determination, based upon his or her assessment of the patient, the treatment, its outcome, and his or her level of risk tolerance.

Please refer to page IX for information about access to sample forms on "Release of All Claims" and "Refund/Fee Waiver Release."

Referrals

Dentists refer patients to other practitioners when treatment or patient management is beyond their personal experience and expertise, or when a second opinion is desired. By referring the patient to a dental specialist or to another dental practitioner with advanced experience in a non-specialty discipline, the dentist provides patients with an opportunity to receive appropriate care while reducing the risk of a potential dental malpractice lawsuit.

Many referral problems can be avoided by assessing and correcting referral methods, and improving communication with both the patient and the referral dentist.

Claims involving referrals have alleged:

- Failure to refer to a dental specialist
- Failure to refer in a timely manner
- Unnecessary treatment performed by the specialist, based upon referral, without independently verifying the need for care
- Advising treatment of the wrong tooth by the referring dentist, or treatment of the wrong tooth by the referral dentist
- Advising inappropriate treatment on the correct tooth, such as endodontic therapy on a non-restorable tooth
- Negligent referral to a dentist who practices below the standard of care

In failure to refer cases, typical allegations include that the adverse consequences would have been avoided if the dentist had referred the patient to a specialist with additional training and experience in a timely manner either for further evaluation or to perform necessary treatment.

Managing the Risks of Referrals

Recognizing risk factors

Dental procedures customarily performed by specialists are most often associated with dental malpractice claims alleging a general dentist's failure to appropriately refer the patient to a dental specialist. These procedures include: endodontic therapy, extractions, treatment of periodontal disease, oral surgery, implant placement and/or restoration, treatment of temporomandibular disorders, and orthodontic treatment. Analysis of current professional liability claim trends indicate that three procedures are the most common and costly: molar tooth root canal therapy, impacted third molar extractions and placement of dental implants.

Controlling the risks

Avoidance

A basic technique of risk management is avoidance. Refuse to provide treatment that is beyond your skills, regardless of the patient's demands. Insist upon the referral. Do not permit your professional judgment to be altered by a patient's emotional plea for you to personally perform treatment.

Communication with the patient

- Explain to patients at the outset of your dentist-patient relationship why and when you refer to various specialists. Emphasize that you appreciate the patient's trust in your clinical skills, but also request that the patient trust your judgment to recommend referral when it is in the patient's best interest.
- Don't assume your patient understands the need for referral. Explain clearly and simply why you believe referral is indicated. Often, patients believe that their dentist is capable of performing all of the required diagnostic and treatment services.
- Whenever possible, refer patients to specific practitioners based on the specific needs of the patient. Give the patient the selected specialist's name, address, and telephone number.
- If you prefer to present patients with a list of specialists and allow them to exercise freedom of choice, select only well qualified practitioners with whom you are familiar to offer as options.
- Advise the patient of what to expect from the specialist.
- Clearly explain to your patient that you will continue providing treatment for problems outside this referred procedure.
- Track patients and ensure that they actually see the specialist. Follow-up calls to both the patient and the referral dentist may be needed in some cases.
- General dentists who provide treatment commonly performed by dental specialists should inform the patient during the informed consent discussion whenever specialty care is an available treatment option.

Communication with the referral dentist

In a referral, both providers are responsible for ensuring that appropriate treatment is performed. It is not advisable to rely on the patient to serve as the conduit of information to the referral dentist, as patients are not qualified to provide the required technical information. Never send a patient for referral care without appropriate communication to the specialist. If referral communication is inadequate, the referral dentist may inadvertently duplicate diagnostic tests or may give the patient information that contradicts, or at least fails to support, the information given by the referring dentist. In some cases, a treatment may even be unnecessarily duplicated. For example, root planing and scaling could be recommended after completion of this procedure at the referring dentist's office.

A written referral is the best vehicle for avoiding problems with referral communication. Written communication between dentists promotes the necessary exchange of referral information and serves as a foundation for a dialogue between dentists when either party has questions. A referral letter or email should include the following information:

- Introduction of the patient (name, length of time in the practice)
- Diagnostic information and/or test results available and date collected (To reduce the risk of miscommunication, you may wish to use a wax pencil to indicate the tooth to be evaluated or treated on the radiograph that will be sent to the referral dentist.)
- Describe the tooth if tooth numbers are confusing due to shifting or missing teeth.
- Treatment completed to date
- Your diagnosis (or provisional diagnosis) and prognosis for success
- Description of the treatment you expect the specialist to complete
- Your treatment plan after the patient completes specialty care, including alternate options (The specialist may have insights and/or suggestions that are meaningful to your treatment plan.)
- Request for status and postoperative reports, and how follow-up will be managed

Confirm that the referral information is accurate prior to sending the letter or email and follow up with the specialist to ensure that communication is complete.

When emergency mid-treatment referrals are necessary, such as a sinus communication, fractured mandible or when a sizable portion of a root remains after your attempts at an extraction, it is advisable to draft a written referral that the patient can take to the specialist. If a telephone referral is made, a comprehensive note must be placed in the record documenting the treatment rendered and the reason for referral. In either case, request the specialist to send a written treatment summary and include it in the patient file.

Documentation

- Document in the dental record why, when, and to whom the referral was made.
- Document all pertinent communications, including telephone conversations with the patient and specialist, requests for records release, and your follow-up care.
- Place a copy of the referral letter in the dental record. Referral/treatment errors and claims have resulted when patients lose or misplace the referral documentation and request a replacement. A duplicate letter eliminates this risk while providing accurate referral documentation.
- If the patient decides not to follow through on the referral, document that the patient was counseled regarding the potential risks of refusing the referral and the patient's decision to confirm refusal. If possible, have the patient sign and date the refusal.

Refusal of Referral

When a patient refuses a referral, he or she must be informed of the potential consequences. A detailed note should be made documenting the discussion and the patient's informed refusal. If you elect to proceed with treatment after the patient has refused the referral, you will ordinarily be held to the standard of care of the dentist to whom you intended to refer. If you are liable to treat to this standard, it would be prudent to avoid beginning treatment. See the "Informed Refusal" section of this workbook for more information.

The Specialist's Role

Regardless of the treatment requested by the referring dentist, dental specialists have an independent professional duty to assess the patient and determine an appropriate treatment plan. Occasionally, a referring dentist or his or her staff member will request treatment that is deemed inappropriate by the specialist, such as endodontic therapy on a non-restorable tooth, or indicate treatment for the wrong tooth. By taking the time to verify the need for care, you can help avoid errors and resultant patient injuries that may expose both you and the referring dentist to liability.

If the treatment plan expressed by the referring dentist is questionable, the specialist should contact the referring dentist to discuss the matter. Only when the two practitioners agree should treatment commence. Do not discuss the issue with the patient before contacting the referring dentist. Such professional consultation will prevent confusion or distress to the patient, which may result in a refusal of treatment and ultimate patient harm.

If the specialist and the general dentist cannot agree on a course of treatment, each must pursue a course of action that he or she believes is in the patient's best interest. On occasion, an additional referral to another specialist may be necessary to help the treating dentists reach agreement.

Negligent Referral

A negligent referral occurs when a patient is referred to a dentist who is known to be unqualified due to a lack of skill or judgment. In some cases, the lack of skill or judgment may be due to impairment such as drug abuse, alcoholism or local or systemic disease. In others, it may simply be due to general carelessness or apathy on the part of the clinician.

Claimants injured while under the care of a referral dentist often cast a wide net, alleging that the treating dentist committed malpractice and that the referring dentist also made a negligent referral that placed the patient in harm's way.

Negligent referral can be very difficult for patients to prove in cases where the referring dentist had no prior knowledge about the referral dentist's alleged lack of skill or judgment, or impairment. For this reason, negligent referral is not a frequent cause of action in the CNA dental claim environment. However, such cases arise, and certain precautions should be taken.

Keep in mind that your first duty is to protect your patients. If you note a pattern of inferior care provided by a dentist to whom you have previously made referrals, you are professionally obligated to exercise due care and avoid that provider for future referrals. A reasonable guide when making referrals is to ask yourself, "Would I consent to be treated by the dentist I am recommending?" Use good judgment when selecting specialists or consultants for referrals and avoid referring patients to any dentist who fails to practice according to the standard of care.

Managed Care Referrals

Some dental plans restrict the available referral choices of a participating patient or dentist. If you are not familiar with any of the plan's participating specialists and feel uncomfortable blindly referring to any of the listed specialists, you should refer the patient to your specialist of choice. Inform the patient why you customarily refer to that specialist, as well as the potential limitations of the patient's benefit plan if the patient pursues your referral.

If the patient opts to remain within the benefit plan for financial reasons, the choice of a specialist becomes entirely his or her own. You need not offer a recommendation from the list. However, you may wish to direct the patient to the plan administrator for more information about the participating specialists. Remember that if there are specialists listed whom you believe do not practice within the standard of care, you are obligated by professional duty to avoid recommending them, irrespective of the managed care contract provisions.

Thoroughly evaluate referral protocols and the roster of participating specialists before agreeing to participate in any plan that potentially restricts your referral options. Reduce your risks by joining only those plans in which you feel comfortable.

Please refer to page IX for information about access to a sample form on "Patient Referral Letter."

Keep in mind that your **first duty** is to **protect your patients**. A reasonable guide **when making referrals** is to ask yourself, "Would I consent to be treated by the dentist I am recommending?"

Consultations

Consultations with physicians or other non-dental healthcare providers are an important part of treating and protecting the health of patients with special medical conditions. Dentists have both an ethical and legal duty to be knowledgeable about the non-dental consequences of the treatment they perform, as well as the medications they prescribe. Ignorance is not a valid defense to a malpractice action.

Consultations are an opportunity to better serve the patient. Whenever possible:

- Send a specific consultation letter tailored to the needs of the patient.
  - Indicate the pertinent findings in the patient's medical history.
  - Describe the dental procedure you intend to perform, including presenting conditions of the patient, the length of treatment time, the expected amount of bleeding and other pertinent information. Use lay terms and don't assume that all healthcare providers have a working knowledge of dentistry, or that they understand the difference between a surgical and non-surgical dental procedure.
  - Briefly specify your reasons for concern (e.g., potential for excessive bleeding, site infection, or infective endocarditis).
  - Indicate the medications you intend to give the patient (including anesthetics), by what methods and in what quantities. This treatment summary will aid the consultant in determining an appropriate protocol for patient management, including pharmacologic needs, if any.
- Obtain a written report from the consulting physician/healthcare provider in advance of the date of patient treatment. Maintain all consultation reports in the patient's chart. A written report will document that you have taken the necessary course of action to protect your patient from potential harm.

Communicating with the consultant by fax, scanning, or other electronic methods, using a tailored letter with these elements may elicit a quicker response than a mailing. To further facilitate a timely response to simple consultative questions, consider placing check boxes and a signature line on the letter. Ask the consultant to check the appropriate box, sign it, and fax or scan it back to you. The letter can be emailed as well, as long as the consultant prints, signs, scans, and emails back the form. This process ensures that you have the signature of the consultant or a specific designate on the form. Remember to consider and use appropriate secure electronic communication methods, such as encryption, to protect patient privacy.

If you must make a consultation request by telephone, spend sufficient time to adequately address all of your patient care concerns. Make a comprehensive notation in the dental record, including the name and telephone number of the individual with whom you spoke, as well as all pertinent information and recommendations obtained during the conversation. Send a confirmatory written summary of the discussion to the consultant and place a copy of the summary in the patient's chart.

If, after receiving a consultant's report, you feel uncomfortable with the information, contact the consultant. Such communication will enable you to determine if you're correctly interpreting what has been written, and if necessary, to ask for sources that support the information. If you remain unsatisfied, ask another consultant for an additional opinion. It is neither in the best interest of the patient, nor yours, to proceed with care unless you are satisfied that the information you received from the consultant makes sense for this patient. Moreover, it will not constitute a defense to a malpractice suit that another healthcare practitioner told you to do something if you knew or should have known that the recommendations contained in the consultation were incorrect or unsubstantiated.

Patient Termination

The standard of care for dentists includes the legal duty to continue caring for patients of record. If an irreconcilable dentist-patient conflict results in a determination that you cannot continue to care for the patient at or above the required standard of care, you are obligated to end the relationship in an appropriate manner. Improper termination of the dentist-patient relationship may lead to allegations of abandonment or failure to treat.

Managing the Risks of Terminating the Dentist-Patient Relationship

The dentist-patient relationship simply does not end when the patient leaves your office or your care. It continues until one party properly ends it. *Unless the relationship is legally terminated, the courts may consider it to exist even years after the last communication between the patient and dentist.* You may terminate the dentist-patient relationship for many reasons, including when patients become unreasonably demanding, stop paying their bill, miss and/or cancel numerous appointments, refuse your treatment recommendations, or are otherwise difficult for you and your staff.

Abandonment

Abandonment involves the unilateral dismissal of the patient by the dentist in the absence of ample and proper notice to the patient. Abandonment allegations are based upon the patient's belief that he or she has suffered an injury due to the dentist's failure to continue to perform his or her professional duty. In addition, laws restrict a dentist from refusing treatment to or dismissing a patient from the practice solely on the basis of a disability, race, color, creed, ethnicity, gender or age. While you may terminate a relationship with a patient who is disabled or otherwise protected by anti-discrimination laws, all patients must be treated equally. Any patient who cannot or will not comply with office policies or treatment recommendations can be dismissed, if the reasons for doing so are fair and the process adequately documented.

Caution: if you refuse to treat a patient of record in need of emergent care simply because the patient owes you money, you may become liable for a charge of abandonment.

Recognizing risk factors

Certain patients whom you terminate may be more likely to allege abandonment than others, including those with:

- Poor or adverse clinical outcomes
- Unmet expectations
- Billing disputes
- Argumentative personalities
- Litigious personal histories
- Poor compliance with postoperative care and follow-up appointments

Controlling the risks

Clinical

- Evaluate the stability of the patient's health prior to terminating the relationship, and ensure that the patient's health is never compromised, including during any termination period.
- Treatment should be terminated or transferred at a logical point during care when the patient no longer requires emergent care.
- As a general guideline, complete multiple visit procedures which you have started, such as root canal therapy (obturation), crown and bridge procedures (cementation), orthodontic treatment or postoperative care following surgical procedures.
  - The exception to the general guideline occurs when the relationship is terminated due to the patient's failure to return for unfinished treatment. In such cases, the dentist may terminate in the midst of active care, following a documented good faith attempt that has been made to get the patient to return for care.
    - **Ensure that you have documented in the patient record all attempts to contact the individual before terminating the relationship.** This documentation shows that every reasonable and prudent step to continue patient care was taken and helps to defend against abandonment claims.
    - A minimum of three documented attempts to contact the patient regarding the completion of unfinished treatment is recommended. One attempt should take the form of a letter sent to the patient. The others may be documented through telephone calls and/or telephone messages.

- In most situations, the dentist is legally obligated to assist the patient during the termination of care, even when the patient terminates the relationship.
- Before terminating care, ask yourself the following questions:
  1. Have I met the required standard of care in my past treatment and management of the patient?
  2. If not, has the patient failed to allow me to provide care that adheres to the required standard of care?
  3. Have I provided care to the point where the patient has no immediate need for emergent dental treatment?
  4. If not, has the patient refused to return for care?

If you answer "yes" to the first and third questions, or "yes" to the follow-up questions, a court would probably decide that your responsibilities were fulfilled.

Communication

- At the outset of the dentist-patient relationship, inform patients of your practice rules, including reasons why patients may be asked to leave the practice. A practice brochure should suffice for this purpose.
- Make reasonable attempts to resolve patient conflicts and document those attempts.

Documentation

- **Document in the patient record all attempts to contact the individual before terminating the relationship.**
- If a *patient* terminates the dentist-patient relationship for any reason, clearly and fully document the patient's decision in the dental record, including verbatim comments from the patient or copies of patient correspondence.
- If the *dentist* terminates the relationship, notify the patient in writing by mail. Send two copies of your letter: one via certified mail, return receipt requested, and the second via standard first class mail. Even if the patient refuses to sign for the certified letter, the first class mailing will be delivered. The letter should include the following information:
  1. Clearly state that the dentist-patient relationship is being terminated and indicate the specific date that the relationship will end.
  2. Indicate the current status of care and any further treatment needs of the patient, including the risks of not receiving the needed treatment.
  3. Offer to provide emergency care to the patient for a reasonable period of time, which must be sufficient for a reasonable person to secure an appointment with a new dentist (30 days is generally sufficient in most areas).
  4. Indicate how the patient can find a new dentist, such as the telephone directory or the local or state dental society referral service, if one exists where you practice.
  5. Offer to forward copies of records to the patient, or to the patient's next dentist, upon written request of the patient. Be sure to retain the original records. *You may not refuse to supply copies even if the patient has an outstanding balance.*

Although you are entitled to charge a "reasonable fee" for duplication and mailing, we strongly encourage you to provide a copy of the record free of charge when terminating a patient. This approach avoids any (additional) ill will between you and the patient that may trigger a malpractice action or dental board complaint.

- Keep a copy of the letter and any related correspondence or documented discussions in the patient's dental record.
- Retain the certified mail receipt as part of the file whenever you send correspondence by certified mail.
- If your certified letter is returned to you unopened, retain it unopened in the patient chart. Your previously sent first-class letter will serve as notification for the patient.

Other Issues

Dentists often ask, "If a patient still owes a large sum of money, calls during the 30-day emergency period and requests to be seen, do I have to treat him?" The answer: yes. You cannot refuse access to emergency care due to an outstanding balance. You may, however, minimize the risk of nonpayment by informing the patient of the anticipated fees *for that day's services* and insisting on same-day cash payment for the care. This protocol does not abandon the patient because it does not *deny* access. It merely *arranges* for patient care on your terms.

You also may opt to limit your emergency treatment to stabilizing the problem at hand. For example, if a patient you are terminating presents with a missing mesiolingual cusp of #30, consider placing a direct placement restoration to replace the missing tooth structure, rather than preparing the tooth for a crown. Of course, you must inform the patient of the limited nature of the emergency treatment you provided and that additional treatment is necessary upon finding a new dentist.

Sample Letters

The patient termination scenarios and examples of termination letters may be considered for use in effecting the patient termination. Keep in mind that circumstances vary from patient to patient and dentist to dentist. The case scenarios are representative of situations that you may encounter in your office and are not intended to be comprehensive, to constitute legal advice, or to determine what should or should not be written to a specific patient when a relationship has ended. The scenarios are provided in response to questions from dentists concerning possible formats for this type of communication. What is important is that you make appropriate contact with the patient, based upon your personality and your knowledge of the patient, and provide the patient with the required information. The samples are intended as references to provide direction for you to draft your own letters. The scenarios topics include:

- Nonpayment of fees
- Unreasonable Patient Demands/Expectations
- Missed Appointments
- Failure to Return for Recall Visits
- Failure to Return for Ongoing Treatment
- Inactive Patient
- Failure to Return for Treatment (Managed Care Organization)
- Termination — Specific Reason Not Required

Please refer to page IX for information about access to sample patient termination letters.

Ceasing Practice

The decision to discontinue practicing is often difficult, involving many personal and professional considerations — including potential liabilities. Ceasing practice, however, does not necessarily end all associated liabilities. Fortunately, with a little time and effort, you can protect yourself against many of these risks.

Selling a dental practice can be challenging depending on many factors, including the practice location, building and/or equipment age, the local economy, and many more. Though it is a difficult decision, dentists sometimes decide to close their doors. Whether you sell your practice or close it outright, various risk management considerations must be addressed. Some of these issues are easier for the dentist who is able to find a buyer for his or her practice.

Unfortunately, we periodically receive questions on the risk management support line from associate dentists and insurance agents when an owner-dentist has suddenly died. While it would be rare for this situation to lead to a professional liability claim or lawsuit, not planning for this possibility may be costly to the insured dentist's estate and very stressful for patients, employees and surviving family members. Consult with your attorney and other practice advisors to ensure a smooth practice transition for the benefit of everyone associated with your dental practice.

Managing the Risks of Ceasing Practice

Recognizing risk factors

The primary professional liability risk considerations for a dentist planning to discontinue clinical practice are:

- Claims emanating from comments and criticism offered by subsequent treaters, including a purchaser of your practice
- Retention of, and access to, patient records
- Concerns regarding abandonment allegations
- Gaps in insurance coverage

Controlling the risks

Selling the practice

If you are trying to sell your practice, look for a purchasing dentist whose standards of care and philosophy of practice are very similar to your own. The reason is that comments about your work — even honest differences of professional opinion — made by the purchasing dentist may encourage malpractice litigation by your former patients. If possible, observe your potential buyer's clinical and communication skills to evaluate that individual's potential fit with your patients. Before completing the transaction, retain an attorney experienced in negotiating dental practice sale agreements.

Informing patients

Fortunately, abandonment allegations arising from a dentist's retirement are not a frequent source of malpractice claims. Patients are entitled to reasonable notification that a dentist's services will no longer be available. Therefore, notify *all* patients of record of your plans to cease your clinical activity, except those you have already formally terminated or who have previously contacted you to do so. This step is more critical if you close your practice outright, since patients will not be able to access dental care by simply returning to your current practice location.

The ways in which a patient can be notified of a dentist's impending retirement include direct correspondence, office postings, emails and public announcements. Your state may have specific rules or regulations in place: consult with your state dental licensing board to confirm requirements and how to comply.

Direct correspondence

Patients should be alerted to your retirement by a simple, clearly written letter sent to their current mailing address on file. The letter can be sent via first class mail and does not require certified mail. The letter should inform patients of your last date of practice, explain how they can obtain a copy of their treatment record, and specify who, if anyone, will continue to provide care in the office.

If the office will be closing, inform patients as to how they can find a new dentist, for example, by advising them to consult the telephone directory, giving them the names of colleagues or directing them to a referral service. If you are selling your practice or have made arrangements regarding the retention or storage of patient records, include a form in your mailing that authorizes transfer of the dental records to a subsequent dental provider.

A two- or three-month notice period before you cease practice is usually sufficient to permit your patients to make necessary arrangements, such as finding a new dentist, having their records transferred and resolving billing issues. It also allows you adequate time to finish treatment or if that is not possible, to stabilize patients' oral health condition before the practice closes.

For patients requiring ongoing care, follow up your letter with a discussion, either face-to-face or by telephone, informing them of their remaining treatment needs. This protocol will help protect patients from potential harm and further reduce your risk of abandonment allegations. Document the list of letter recipients and make chart entries of all such discussions with patients.

Occasionally, an unexpected injury or illness forces the decision to stop practicing and may lead to closure or sale of the practice. As noted previously, the untimely death of the owner-dentist is another possibility. Under circumstances where no advance notice can be given, notify patients as soon as practicable. Developing a plan to facilitate short-term practice operations, practice transition and/or closure will benefit those charged with clinical, legal and business responsibilities in your absence — whether that absence is temporary or permanent.

Office postings

In addition to sending letters to patients, post a notice conspicuously in your office stating the same basic information. In case someone who presents for treatment overlooks the notice, discuss the matter personally with each patient. Also, have your staff inform patients calling for appointments of your upcoming retirement.

Public announcement

A public announcement satisfies the notice requirement for any patient of record who may not receive your written notification. The public announcement of your retirement can be as simple as a notice or advertisement in your local newspaper(s) stating the closing date of your practice. Similar to the mailing, it should direct patients to contact your office prior to the date of closure for access to care and records. For public announcements of planned closures, a minimum of 30 days' advance notice is needed and 60 days is recommended.

When a practice is sold rather than closed, it further reduces the risk of abandonment, as patients will have continued access to care, albeit with a different provider. In this case, the various notice forms should advise patients that their records will be left with the purchasing dentist as of the date of sale. The forms also should inform patients that, if they choose not to continue care with the purchasing dentist, they may contact you in advance of the sale date for a copy of their record.

If claims arise later, these measures serve as documentation that a good faith effort was made to inform patients of the change.

Saving and transferring records

Ideally, original patient records should be kept forever, if possible. At a minimum, keep records well beyond any timeframe for legal and/or administrative risk exposure — that is, for a duration sufficient to protect you from potential malpractice actions and to satisfy any state requirements that may exist. Check your state dental practice act for any specific requirements on mandatory record retention or consult an attorney for guidance in this area.

If you are selling your practice, you will need continued access to your dental records in the event of a peer review or professional liability action. To that end, ensure that your sales contract contains a provision requiring the buyer to maintain all of the records you transfer for a specified period of time. The time frame should satisfy state record retention requirements as well as the statute of limitations for malpractice actions. In addition, the contract should contain a provision stipulating that you or your estate has the right to access those records in defense of a malpractice claim or similar legal action.

Keep in mind that state laws vary, especially with respect to healthcare provider malpractice actions pertaining to minors. In some states, minors have until their 23rd birthday to bring a malpractice claim against their dentist. These timeframes should be considered when drafting the provisions pertaining to a purchase and sale agreement of your practice. You can specify a retention period of "forever," but a more practical time frame would be 12 to 15 years for patients who were adults at the time of treatment.

Even if you are unable to find a buyer and must close your doors, you may be able to reach an agreement with a local dentist to serve as custodian of your records. In exchange for the goodwill value of the records and the potential for an influx of new patients, he or she may agree to maintain the records for a specified length of time, similar to the sales agreement described above.

All record requests should be in writing and filed in the patients' charts. Most states permit you to charge patients a "reasonable" duplication fee. Check the dental practice act in your state to determine if such a clause is included and if "reasonable" is further defined. Many dentists do not charge for this service, since a dentist's decision to sell or close the practice is the cause of the potential record request.

If you close your practice and retain your own records, you will need duplication methods available following the last date of practice. As one option, if record requests are received after a set date, you may arrange for and inform patients that a medical records duplicating service will create dental record copies and that any charges for the duplication costs must be paid directly to the vendor.

If you are storing records yourself, beware of the danger of water damage, fire and related risks of home storage. Consider alternative storage methods, such as microfilming, warehousing or transferring to a computer database. Also make sure that computer records are appropriately backed up and securely stored. Understand and comply with HIPAA requirements and any state-mandated electronic record requirements.

Please note that the above guidelines are general in nature, and do not necessarily reflect the record retention laws of any specific state. For specific legal advice, contact an attorney in your state with expertise in this area. You may also wish to investigate resources available through your state and national dental association. The American Dental Association (ADA) publishes "A Guide to Closing a Dental Practice." Check with the ADA or your state dental society for more information on this resource.

Insurance coverage

If you have been covered by claims-made professional liability insurance, you can obtain coverage pertaining to late-emerging claims by acquiring so-called *tail coverage*, known formally as extended reporting period (ERP) coverage.

In a *claims-made* policy, tail coverage extends the time period within which a claim may be reported if the claim arose from an incident that occurred while a policy was in force but is reported after policy expiration. Therefore, the terms and conditions of tail coverage should be discussed with your insurance representative.

Without tail coverage, claims-made policies will generally not cover claims that are reported after the policy has terminated. Although most states have a statute of limitations on malpractice actions, the limitations clock may not begin ticking until years after an incident. The long tail of malpractice claims arises when the plaintiff becomes aware of a problem long after the treatment ended or was a minor at the time of treatment. For this reason, dentists should consider the purchase of an unlimited extended reporting period.

Under certain conditions, a dentist may be entitled to free tail coverage from his or her malpractice insurer upon retirement. It is a good idea to discuss tail coverage and other insurance issues with your insurance representative, who can explain the risks and coverage options available through the extended reporting period.

Retirement should be a time to relax from the pressures of professional life. By paying close attention to the issues of patient notification, record retention and insurance coverage, you can substantially decrease your exposure and increase your peace of mind.

Please refer to page IX for information about access to a sample form on "Patient Authorization to Transfer or Forward Dental Records."

Dental Professional Liability

Legal Concepts

Upon completion of this section, you should be able to:

- **Understand the legal concepts that directly relate to clinical practice** such as standard of care, professional liability and negligence.
- **Implement effective risk management procedures and techniques** to address informed consent and informed refusal for all patients.
- **Tailor your practice management techniques to mitigate risks** related to vicarious liability issues.
- **Understand the importance of engaging staff in the risk management process** and provide appropriate staff education.

Legal Liability

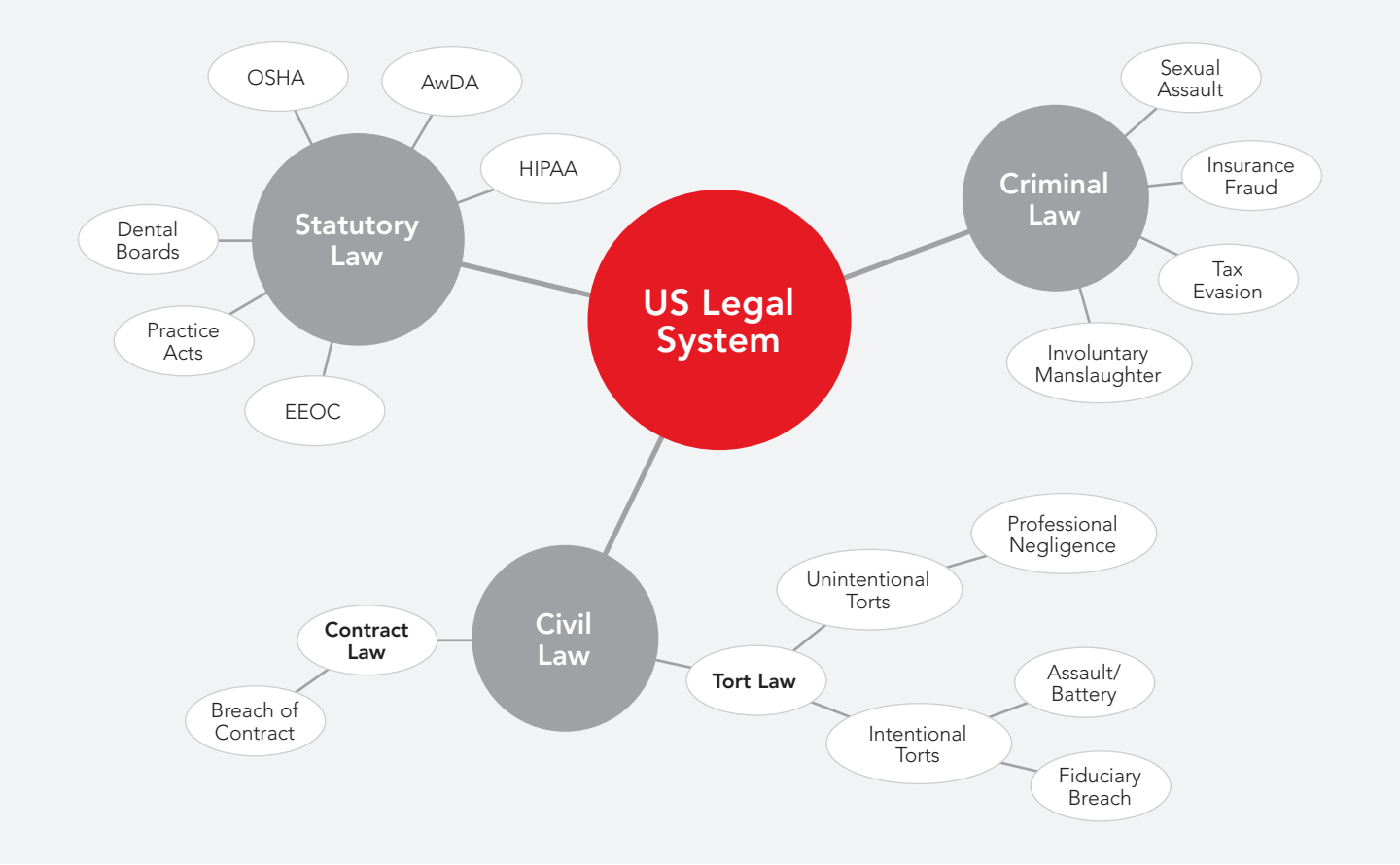
Dentists face a myriad of risk exposures pertaining to legal liability. These exposures arise from various aspects of civil, criminal, and administrative law at both the federal and state levels. The chart below highlights some of the risks dentists must address.

The Americans with Disabilities Act (AwDA)

A complete discussion of the Americans with Disabilities Act is beyond the scope of this manual. Nevertheless, the AwDA is referenced due to the numerous inquiries received regarding application of the law to dentistry. Typical questions involve hearing impaired patients; the presence of service animals; patients with mental health diagnoses; and more.

Signed into law on July 26, 1990 by President George H.W. Bush, AwDA essentially prohibits discrimination against disabled individuals. The law guarantees equal rights related to employment opportunities, access to commercial goods and services and to governmental programs and services. "Disability" is defined by the AwDA as a physical or mental impairment that substantially limits one or more major life activities. It should be noted that the definition also encompasses a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment. Moreover, the definition may be applied to groups of individuals NOT expressly referenced in the law.

Due to the complexity of various scenarios, dentists should consult an attorney conversant with the AwDA and any similar state laws. In addition, a number of resources are available on the AwDA website. In addition, the U.S. Department of Justice provides a toll-free information line (see http://www.ada.gov) staffed by personnel who can help callers understand the law and how it may apply to specific situations.



Section 1557 of the Affordable Care Act (ACA)

In May 2016, the U.S. Department of Health and Human Services (HHS) published a final rule under Section 1557 of the ACA to protect individuals from discrimination in health care on the basis of race, color, national origin, age, disability, and sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. Section 1557 is enforced by the HHS Office for Civil Rights, the federal agency that enforces HIPAA.

Dental practices may be required to comply with Section 1557 if they receive certain kinds of government funds, such as Medicaid or CHIP funds, or "meaningful use" payments. Non-compliance may result in fines, and the Section 1557 final rule allows an individual or entity to bring a civil action (lawsuit). The specific requirements of section 1557 of the ACA are complex. CNA recommends that dentists consult their attorneys and refer to resources available from the American Dental Association (ADA.org) or other sources for further information. Note that in mid-2019, organized dentistry voiced support for proposed revisions to Section 1557. Stay up-to-date to understand the potential impact on dental practice.

Establishing Professional Negligence

Malpractice lawsuits in the United States are civil causes of action based upon the principles of tort law. In the broadest sense, a tort is any civil wrong, other than a breach of contract, for which the law will provide a remedy in the form of an action for damages.

A patient must establish four elements to prove negligence on the part of a dentist:

1. **Acceptance of a Patient (Creation of Duty).** When a dentist accepts or undertakes to render care to a patient, a dentist-patient relationship is created and the dentist incurs a legal duty to employ the requisite skill, care and knowledge ordinarily possessed by members of his or her profession. This duty is known as the "standard of care."
2. **Breach of Duty.** A dentist who fails to possess or exercise the skill, care and knowledge ordinarily used by reasonably qualified dentists practicing under the same or similar circumstances fails to adhere to the standard of care and breaches the duty owed to the patient.
3. **Causation.** In addition to establishing breach of duty, the plaintiff must show both an actual and foreseeable causal connection between an act or omission of the dentist and the resulting injury.
4. **Damages.** The plaintiff must prove an actual loss or injury incurred due to the dentist's breach of the standard of care. Such losses frequently include disability, lost wages, disfigurement, pain and suffering, past and future medical expenses, and other financial losses.

When responsibility begins

As stated previously, a dentist-patient relationship must exist in order for a dentist to be legally liable for a professional error or omission. Audience discussions at risk management seminars reveal that many dentists may not understand when their legal responsibility to a patient begins. Interestingly, some dentists may fail to consider their initial evaluation or examination of a patient to establish the creation of the dentist-patient relationship. However, seminar attendees understand that a dentist can be held liable for failing to diagnose a cancerous lesion or other pathology during the first examination. This incongruity leads many practitioners to harbor the incorrect view that an individual is not a "patient of record" if the patient was only seen on one or two occasions or never accepted a treatment plan.

For risk management purposes, dentists should consider their legal responsibility, and the dentist-patient relationship, to begin when the dentist first:

- Examines a patient
- Provides a diagnosis or treatment to a patient
- Offers professional information or opinion that a reasonable person relies upon to one's own detriment.
- The formation of this relationship pertains to any "bad advice" given by the professional, irrespective of the location (your office or otherwise) or circumstances under which it is given.

Regardless of whether the dentist-patient relationship abides for twenty minutes or twenty years, the dentist is responsible for practicing at or above the standard of care throughout its duration.

When a **dentist accepts** or undertakes to render **care** to a patient, a **dentist-patient relationship** is created and the dentist **incurs a legal duty** to employ the requisite **skill, care and knowledge** ordinarily possessed by members of his or her profession. This duty is known as the "**standard of care**."

Standard of Care

The standard of care is what a reasonable and prudent practitioner would do under the same or similar circumstances. Although the *concept* is widely understood, there are no definitions of what is or is not "reasonable and prudent" for each dental procedure.

A reasonable and prudent dentist should act with skill and due care when treating patients. Exercising due care involves:

- Informing the patient of the diagnosis
- Referring when indicated
- Obtaining the patient's informed consent prior to treatment
- Completing treatment that has been started
- Schedule any necessary follow-up visits

The standard of care is a dynamic concept, changing over time with new technology, research and advancements in clinical methods.

In a malpractice action, the standard of care is articulated through the opinion testimony of expert witnesses. Expert witnesses are professionals with background and training similar to the defendant, typically from the same practice community, who give their opinion to the court regarding the allegations in the complaint. Since the testimony given by experts is *opinion testimony*, the courts afford expert witnesses immunity from liability with respect to their testimony. This immunity promotes the free exchange of ideas permitting experts to testify without fear that a plaintiff or defendant could sue them for their testimony.

In cases involving treatment that falls within the scope of what a specialist would ordinarily provide, the plaintiff (patient) customarily retains a member of that specialty as an expert witness. As a result, the standard of care is defined by the specialist, regardless of whether the defendant dentist is another specialist or a general practitioner. Thus, if you are a general practitioner who performs endodontic therapy, you will be held to the standard of care as defined by an endodontist in claims arising from such treatment. The specialty standard of care applies to treatment ordinarily performed by other specialists.

There are exceptions, however. In some states, only a dentist with similar training and experience to that of the defendant dentist is permitted to testify as an expert witness. In such states, for example, a defendant general practitioner would be confronted with another general practitioner as the plaintiff's expert. Specialists would be barred from testifying as expert witnesses. Therefore, consult with your attorney regarding specific laws and rules governing expert witness testimony in your jurisdiction.

Another factor that juries consider when determining the standard of care is educational curricula, including what is taught both in dental schools and in continuing education courses. If you use unproven or outmoded procedures, materials, or techniques, a jury may question whether you are practicing within the professional standard of care. For example, the omission of a rubber dam during an endodontic procedure would prove difficult to defend, as all U.S. dental schools teach that a rubber dam should always be employed. Conversely, treatment of an experimental or investigational nature is often portrayed by plaintiffs' attorneys as failing to meet the profession's standard of care. Such treatment may include therapies that have not obtained regulatory clearance or approval for marketing in the United States.

It is very important to understand your state dental practice act, since these statutes often include express specific language addressing the standard of care. Also note that the current American Dental Association Principles of Ethics and Code of Professional Conduct is incorporated into many states' dental regulations or professional requirements: see the Legal section of the manual bibliography for a link to the Code on the dental association website. In a dental professional liability cause of action, a violation of the dental practice act is often presented as a *per se* breach of the standard of care.

Vicarious Liability

The legal theory of vicarious liability holds employers responsible for the acts and omissions of their employees. Vicarious liability is based on the legal concept of *respondeat superior*, which holds the "master" (employer) responsible for the acts or omissions of its "servant" (employee). When a person employs another for his or her own profit, fairness demands that the person also bear responsibility for managing the risks and paying for the damages associated with the employee's work. Dentists, as employers, are, therefore, vicariously liable for the negligent conduct of employees acting within the scope of their employment. Such individuals include employee dentists, clinical auxiliaries, and non-clinical staff.

Vicarious liability risks are typically clinical in nature, although they can be based upon errors or omissions of communication. For example, the patient asserts that he or she was given incorrect clinical information, or was never told the correct clinical information by a staff member. Fortunately, such claims are not common. Far more frequent are claims arising from a patient's dissatisfaction with staff interaction, especially when the patient believes the employee has impeded the ability to see or speak with the dentist.

Vicarious liability is an important concept in both risk management and patient management. Even when the services provided by the dentist meet the standard of care, an employee in the office may do or not do, say or not say something that will negligently cause a patient injury. Employee conduct thus significantly expands the risk to both the patient and to the dentist.

Vicarious liability for the actions of others is not limited to employees. In general, patients can reasonably expect all of the personnel they see in your office to be supervised by you. The fact that a dentist, hygienist, dental assistant, massage therapist, nurse or esthetician is an independent contractor (IC) may have tax and benefit consequences distinguishing him or her from employees. However, the independent contractor status may be irrelevant in terms of vicarious liability. For example, a dentist who enters into a contract with an independently contracted hygienist will be subject to vicarious liability exposure for the conduct of the contracted individual. Once you have assumed a certain degree of authority over your personnel, employed or contracted, you also share their risk.

Is this just? The courts and legislatures have tended to reinforce the concept of vicarious liability through judicial decisions and statutory measures, even if it seems unfair to the dentist employer. The law in all states is clear that an employer is responsible for the negligent actions of his or her employees within the scope of their employment. Courts have stated that if the law was not structured in this manner, employers would be more likely to delegate responsibility for making important healthcare decisions to unqualified employees — without any recourse or redress available to injured patients. The concept of vicarious liability creates potential repercussions, motivating most employers to delegate only to responsible employees, to appropriately train employees, to hire skilled employees and to replace those who will not follow established policies and procedures.

If vicarious liability did not exist, patients who suffered identical injuries under slightly different circumstances would not receive comparable compensation. The patient who received bad advice directly from the dentist would be able to pursue compensation under such a tort system. However, the patient who suffered an identical injury from the same advice given by the dentist's employee would be unable to pursue a cause of action.

Independent contractor and employee dentists also may be liable for the actions of dental personnel whom they supervise, but do not employ. In an analogous scenario, consider the independent contractor general surgeon who performs an appendectomy in a hospital operating room, surrounded by nurses and support staff who are not his employees. The surgical nurse is a hospital employee and thus creates vicarious liability for the hospital. During the surgery, however, the nurse also is working under the direct supervision of the independently contracted surgeon. The surgeon performing the procedure is responsible for ensuring that the nurse's actions, such as counting surgical sponges, are performed properly and meet the requisite standard of care. If a sponge is mistakenly left inside the patient, both the surgeon and the hospital will be vicariously liable on the claim.

Similarly, an independently contracted or employee dentist may be the only dentist in the office at a particular time, and is practicing with the support of the staff employed by the owner dentist. Then, imagine a patient is injured by the actions of a dental assistant or hygienist during this time. Which dentist is responsible? The answer is both. Both risk and responsibility are shared in this situation. Independent contractor and employee dentists cannot assume they are immune from legal responsibility simply because they do not pay the salaries of those whom they supervise.

Managing the Risks of Vicarious Liability

Recognizing risk factors

The risk of vicarious liability claims is higher in practices that have:

- Inferior leadership by the dentist-owner and/or delegation to unqualified personnel
- Poor selection of staff
- Inadequate office policies, procedures and staff training programs
- Poor supervision and/or staff evaluation
- Poor understanding among staff of duties and responsibilities

Controlling the risks

Vicarious liability can represent a significant area of vulnerability for dentists. Nevertheless, the techniques used to reduce vicarious liability risks also provide a higher quality of patient care. The following suggestions can help you minimize vicarious liability risks:

- Consider the professional conduct of your employees as extensions of your own — and ensure that staff also view their actions in this manner.
- Foster a positive attitude and open communication in your practice. Do not encourage staff members to obstruct patient access to you.
- Hire qualified staff members with good communication, interpersonal, and technical skills who can project the desired image of the practice.
- Establish thorough, written policies and protocols that give direction to your staff. Review policies at least annually, or as needed to remain compliant with clinical, legal or regulatory changes.
- Clearly document the duties and responsibilities of each staff position in a written job description.
- Examine the job and employment credentials of all applicants, including salaried employees, hourly employees and independent contractors. Check with the references listed on résumés.
- Background checks may be considered, though it is important to understand and comply with state and/or federal anti-discrimination laws. Consult an attorney experienced in employment law for professional advice in this area. Useful information also may be obtained on the U.S. Equal Employment Opportunity Commission website. See the Legal section of the manual bibliography.
- When evaluating prospective job applicants, keep in mind that tasks can be taught, but kindness, empathy, and concern are qualities that are not easily learned.
- Verify current credentials of all employees whose job responsibilities require licensure or certification.
- Establish clear, written performance expectations for staff.
  - For example, instead of informing your receptionist that a job function is answering the telephone, direct her to answer the telephone in three rings or less, stating the words or script you desire, using a pleasant tone of voice.
- Review your state dental practice act — you and your employees must practice within the limitations imposed by this statute.
  - Do not assign duties to auxiliaries that fail to comply with the dental practice act.
- Conduct performance reviews at least annually.
- Provide adequate training for staff members.
- Encourage and financially support staff attendance at continuing education courses that update their knowledge and skill.
- Certify your staff in CPR (cardiopulmonary resuscitation).
- Supervise each employee from the outset of employment to ensure that the employee has adequate knowledge and skill to perform assigned duties.

Vicarious liability can be a significant **area of vulnerability** for dentists. The **techniques used to reduce** vicarious liability **risks** also provide a **higher quality of patient care**.

- Hold regular staff meetings to strengthen office policy and improve staff communication.
  - Use staff meetings to discuss office successes and/or shortcomings, resolve problems or other office practice situations that need improvement, and educate your staff. Incorporate patient safety and risk management topics in all staff meetings.
- Respect and show confidence in your staff, especially when patients are present.
- Review your professional liability insurance policy to determine whether it includes vicarious liability coverage. (For example, professional liability policies for dentists and dental specialists issued through CNA include this coverage.)
- Through the use of surveys and evaluations, ask patients for feedback about your practice and include your staff as an evaluation subject. This tool will assist in gaining insight into patients' perceptions of your staff and the quality of staff-patient interactions.
- Require a certificate of insurance from all independent contractor dentists. Confirm that you are listed as an additional insured on each of the other dentists' policies.
- Ask independent contractors or other dentists sharing your space to sign a hold harmless/indemnification provision, which indemnifies you against any losses arising from their activities. (As these clauses are varied and complex, consult with your personal attorney before signing any contracts containing a hold harmless provision.)
- Ensure that the other dentists' insurance policies cover contractually assumed liability.

The Importance of Staff in Managing Risk

Dentistry is a team business. No matter how or where you look in a dental practice, dental staff are vitally important to every aspect of the practice. The ability of staff to help manage risk is critical to an effective patient safety and risk management program.

Chairside dental assistants make clinical procedures safer for patients and increase dentist productivity. Dental hygienists provide clinical care and also educate patients. Front desk staff represent the public face of the practice, the first office representatives to whom the patient will speak by phone or meet in person. Patients' first impressions of them can have a profound effect on the practice. Financial personnel are charged with ensuring the cash flow of the practice and are given the task of managing accounts receivable. Whatever their role, staff members influence patients' opinions of the practice as well as their sense of satisfaction.

Why is this important? We know patient dissatisfaction is a significant factor in dental professional liability claims. Approximately 80 percent of CNA closed dental claims do not result in a payment to the claimant. Although exceptions exist, the majority of these claims probably were not instituted solely because of poor dentistry. Rather, they were pursued due to patient dissatisfaction arising from non-clinical issues. With multiple patient contacts in a variety of interactions, the dental staff has a profound ability to improve patient satisfaction and reduce the likelihood of a professional liability claim. The ability of your staff to positively affect patient views is a separate, yet related, risk management issue from that of vicarious liability.

Apparent (Ostensible) Agency

Vicarious liability is not limited to liability resulting from the actions of employees or independent contractors (ICs). It also may arise from the actions of anyone with whom the dentist has, *or appears to have*, a supervisory relationship. This application of vicarious liability involves the legal theory of apparent agency, also called ostensible agency.

The theory of apparent agency applies, for example, when an owner dentist utilizes an independent contractor (IC) associate dentist in the practice. Ultimately, the IC leaves the practice for another professional opportunity and the care of his patients reverts back to the owner dentist. The owner dentist then either receives complaints from patients about the care of the former associate or directly finds evidence of inadequate care. In either case, the owner dentist had not performed the treatment himself and directs the patient to pursue correction of the problem by the former IC at his new location. The former associate likewise tells the patient to pursue the matter with the owner dentist, since the payment check was made out to the owner dentist's practice entity. As each dentist attempts to deflect responsibility to the other, the patient is dissatisfied with the failure to respond to his or her concerns. So who must accept responsibility for the work performed?

State legislatures typically do not enact laws that address who has primary liability in this type of case. Therefore, who is accountable depends upon the parties the patient opts to pursue. The patient may pursue correction and/or reimbursement from the clinician who actually provided the care, the IC who has left the practice, or the business entity to whom professional fees were paid, the owner dentist. Or the patient may pursue all of these parties. Therefore, a shared responsibility exists for the two dentists, both for clinical outcomes and the financial costs. Both have potential liability, and it is in the best interest of each dentist to try to address the patient's needs.

Some dentists mistakenly believe that they can insulate themselves from liability in such cases by paying the associate as an IC rather than as an employee. Regardless of Internal Revenue Service or other accounting tests for independence, an important liability consideration depends upon whether the patient had a clear understanding of the independent status of the IC. If a patient held a *reasonable belief* that the other practitioner was associated with your practice, or that you were in some way a supervisor or manager of the IC, that practitioner may be considered your "apparent agent." Thus, it would become difficult for you to fully extricate yourself from responsibility.

The closer the apparent connection between the dentists, the more reasonable the patient's belief and the greater the potential for apparent agency liability. For example, the fact that fees are billed by and paid to the owner dentist's practice, rather than directly to an IC, would be one aspect of apparent agency. The payments to the owner would lead a reasonable person to believe that the IC worked for his practice. A common practice telephone number and shared support staff also fail to support the claim of separate entities. In addition, is there signage on the wall or an information sheet given to patients that explains the separate nature of the practices? If not, a reasonable patient may believe the IC works for the owner dentist's practice.

By identifying the independent status of the dentist in question, you may be able to reduce the risk of liability under the theory of apparent agency. A clear disclaimer of responsibility may reduce your risk in such circumstances. Some additional strategies to diminish the risk of apparent agency liability include:

- Place IC names in a separate location on the building marquee. The more obvious the separation, the more likely a reasonable person would question whether the two practices were affiliated.
- Include a demarcation between the primary dentists' names and the IC's name on entry and exit doors. Again, a reasonable person should observe an apparent separation between the practices.
- Produce a brochure that lists the practice hours, the services performed, and the names of the dentists in your practice. Inform readers of the brochure that the IC is not associated with your practice. The IC also could produce a brochure for his or her patients with corresponding information.
- Add a clause to the agreement between you and the IC requiring the independent dentist to inform each patient of the separate nature of the practices. This procedure would limit the potential for an apparent agency liability claim.
- Ensure that brochures and other information concerning the IC's practice are not available to your patients, and vice versa.
- Expressly inform patients at the time of any referral to the IC that his or her practice is independent of yours, even though that dentist leases your office space.

Informed Consent

Informed consent represents the exclusive right for patients to determine what is done to their bodies. In the United States, it has developed primarily over the past century from the legal concept of battery, which is the unauthorized touching of another person. Through the years, numerous legal cases have affirmed the healthcare provider's duty to obtain a patient's informed consent before treating.

Informed consent is the process through which a patient is provided sufficient information to make an informed, reasoned decision regarding the proposed treatment or procedure. The consent must be given without coercion or fraud, based upon the patient's reasonable understanding of what will take place.

Except in an emergency situation, whenever you ignore the wishes of a patient and proceed with treatment without the necessary consent, you may be subject to malpractice litigation. Litigation may ensue notwithstanding your professional opinion that treatment was in the best interest of the patient. By pursuing the treatment, you also may have committed the criminal offense of battery.

Most patients have a reasonable idea of some dental procedures that occur during routine examination or treatment. Thus, patients imply their permission to have work performed when they visit an office for routine care. Implied consent. However, the concept of implied consent has severe limits as a legal defense. Dentistry is a highly technical profession, and patients often have a limited understanding of the procedures to be performed. The law employs the concept of informed consent to protect patients from making uninformed decisions about their welfare.

We encourage dentists to consider the informed consent process as an educational experience, with the patient as the student and the dentist as the teacher. Although staff members, brochures, and electronic equipment can assist in educating the patient, the dentist bears ultimate responsibility for informing the patient.

The informed consent process involves two main components:

- Discussion, including disclosure and patient education
- Documentation in the patient record, which often includes the use of a written informed consent form

Although some dentists may consider the informed consent process burdensome and time consuming, it has a number of positive risk management effects. The informed consent discussion represents the first step in managing the patient's expectations for treatment outcomes and reducing the possibility of a misunderstanding. Patients who have an understanding of the risks of treatment will be less likely to institute a malpractice claim if one of the described risks actually occurs. In addition, healthcare information record documentation of the informed consent process provides the best defense against a patient's allegation that he or she was inadequately informed about the proposed treatment, the treatment options available, or the potential for injury. Furthermore, a patient instituting a claim based upon "lack of informed consent" must prove that informed consent was not provided. Good communication and documentation by the dentist will increase that burden and act as a deterrent to allegations of a lack of informed consent in the event that a claim arises.

Many claims of professional negligence are accompanied by an allegation of a lack of informed consent. In such an action, the patient may contend that the dentist was negligent in not properly educating the patient. Moreover, if the patient had known in advance of the treatment or procedure that a bad result was possible, he or she will further allege that consent would have been withheld.

Typically, claims do not solely allege lack of informed consent, without other claimed damages. In many instances, the dentist has met the standard of care in the delivery of services, yet the patient was dissatisfied, often due to a lack of communication. In today's consumerist environment, the informed consent process assumes greater importance as a vehicle for patient education, dentist-patient communication, and sound risk management.

Informed Consent Discussion

Informed consent is a process, not a specific document. The process requires a verbal component regardless of whether a written form is used. As such, a patient can give an oral informed consent. An exclusively oral informed consent is valid in most jurisdictions. However, individual state requirements govern and a number of states require written informed consent. As a practical matter, a written informed consent form memorializes and thus documents that the protocol was implemented. The goal of informed consent remains the same whether you have an oral discussion exclusively or also use a written form: the patient must have an adequate understanding of the proposed treatment to provide you with the consent necessary to begin treatment.

Your diagnosis and treatment plan should serve as the framework for your informed consent discussion with the patient. The information provided as a basis for informed consent will differ based upon the complexity of treatment and on the degree of risk presented by the proposed treatment. For example, the information for orthognathic surgery consent should, therefore, be significantly more detailed than for a facial composite resin discussion. Treatments which are within the understanding of the patient, either through past experience or general knowledge, require a less detailed explanation.

Components of informed consent

The doctrine of informed consent requires that the patient be given sufficient information about, and consider, three major components, which you are required to disclose and discuss with the patient. They are:

1. Nature of the proposed treatment

The discussion regarding nature of the proposed treatment should include the:

- necessity for treatment
- anticipated benefits of treatment
- prognosis of treatment
- time involved
- cost involved

Information pertinent to the *nature* of the proposed treatment should explain why your diagnosis justifies the *need* for treatment. State your diagnosis and indicate the *benefits* of your recommended treatment, including comparison with other treatment options.

An approximation of the *prognosis* of the treatment is required. No dental provider can, or should, promise a specific prognosis to a patient. Indicate the prognosis in general terms such as excellent, good, fair, or poor. Give the prognosis for the "big picture," not simply for the procedure at hand, as the patient has a right to consider all pertinent information when determining a course of treatment. More extensive discussions with the patient about any treatment recommendation with only a fair prognosis would help the patient make a more informed decision. Treating patients with a poor prognosis is a risky proposition and should be avoided. Moreover, patient demands for and consent to treatment options that are not in the best interest of the patient may breach the standard of care. Refuse to provide care in these circumstances as the dentist must always practice in conformity with the standard of care, regardless of patient demands.

Advise the patient of an approximate *cost* of the treatment, and estimate the *time* involved. Cost is not an element of the informed consent doctrine, *per se*, but more patients tend to make treatment decisions based on finances than on any other single factor. Therefore, the expenses should be included in the discussion. Always update the patient whenever there is a change in cost, time or prognosis.

Financial issues are the most common reason claims are instituted against dentists. Patients who believe they were not provided full disclosure of their treatment fees in advance of the treatment often feel deceived. They may perceive the lack of full fee disclosure as tantamount to a "bait and switch" tactic to lure them into a costly commitment to the dentist. Clearly, these perceptions are potentially damaging to the dentist-patient relationship, as well as the patient's oral health in circumstances in which the patient cannot afford to continue with care.

Consequently, we recommend that dentists disclose the cost of the informed treatment decision at hand (e.g., RCT vs. extraction), as well as the approximate cost to complete the various treatment alternatives available. For example, inform the patient of the cost of the root canal, including the buildup, the periodontal crown lengthening, and the crown as one option. Treatment option two includes the cost of the extraction, plus the bone graft, plus the implant fixture, plus the implant abutment hardware, plus the crown. Option three includes the cost of the extraction, plus the cost of the bridge. By fully disclosing the fees, you minimize the likelihood of a financial misunderstanding that leads to frustration for both you and the patient.

2. Alternatives to the proposed treatment

The discussion of the reasonable alternatives to the proposed treatment should include the following:

- when the proposed treatment falls within what a specialist would customarily perform in that specialty, the alternative of specialty referral should be offered
- the alternative of no treatment, when appropriate

You are not ordinarily required to list every available alternative procedure. However, the alternatives must contain those procedures most relevant to specific patients and their oral and overall health conditions. The alternatives presented are typically those that have a better prognosis, are less costly, involve less time, require less follow-up care, or are less irreversible. Patients should be told why the recommended treatments are preferred over the alternatives. Patients should understand at what point in the treatment certain alternatives will no longer be available.

It also may be necessary to discuss alternative treatments that you do not personally perform. For example, a patient is congenitally missing tooth #7 and wears a flipper partial denture. You do not place or restore implants in your practice and would customarily treatment plan a bridge from #6 – 8. However, an implant and crown may be the preferred alternative to a fixed bridge, depending on the clinical circumstances and other factors. Therefore this option should be offered as a potential treatment option, while acknowledging the need for referral to another dentist for this alternative.

3. Foreseeable risks

The discussion of the foreseeable, material risks and potential complications of the proposed treatment should:

- define a foreseeable, material risk as one which has a reasonable likelihood of occurring and about which a reasonable person would be assumed to take an interest.
- advise the patient of the risks of refusing the recommended treatment

Similar to the discussion of alternative treatments, the list of potential risks need not be all-inclusive, but it should be pertinent to the patient's oral and overall health. Concentrate on risks likely to occur, such as swelling after an extraction or root sensitivity after scaling, or those with high severity, such as postoperative infections, tooth loss, and nerve injury/paresthesia.

To be considered "informed," the patient must be given sufficient information upon which to base a decision *and* understand that information. In order to assess both your level of disclosure and the sufficiency of the patient's understanding, you may wish to determine whether the patient is able to pass a "quiz" about the proposed treatment. The patient should have the ability to answer three basic questions that relate to the main components of informed consent. Ask the patient:

1. What treatment is proposed and why has it been recommended?
2. What other choices do you have?
3. What negative consequences may occur as a result of (or lack of) the proposed treatment?

The next step is for the patient to state his desire to either pursue or decline the proposed treatment. The patient has a legal right to decline your treatment recommendation and refuse care. (See the "Informed Refusal" section later in this chapter for more information.)

To be considered **"informed,"** the **patient** must be **given sufficient information** upon which to base a decision and **understand** that information.

Informed consent discussion suggestions

Lawyers and judges have noted that how something is said is equally as important as what is said. We recommend that the treating dentist lead the informed consent discussion when obtaining informed consent.

- The oral discussion with the patient should be approached with empathy and reason, and should be tailored to the needs of each individual.
- Use basic, uncomplicated language that the patient will understand. If you use technical terms, provide explanations. Limited oral health literacy is a significant barrier to effective informed consent discussions.
- Present your need to obtain informed consent as a benefit to the patient. When patients understand that the discussion is for their own best interests, they will be more receptive and cooperative with the process.
- Treatments that are within the understanding of the patient, either through past experience or general knowledge, need not be explained in as much detail.
- Provide information based upon the complexity of treatment and on the degree of risk presented by the proposed treatment.
- Use brochures, pamphlets, models, educational DVDs and discussions with your staff to provide the patient with additional information about the proposed treatment.
- Give the patient every opportunity to ask questions. You should answer the questions as clearly and thoroughly as possible, and evaluate — and correct, if necessary — the patient's understanding of your replies.
- Where appropriate, encourage the patient to have a family member present in the room during the informed consent discussion, both for emotional support and to assist in achieving an understanding of the information.
- On occasion, it may be desirable for you to have a staff member present during the informed consent discussion to witness the discussion and make the patient feel more at ease.
- When treating a minor, obtain the informed consent of the parent or guardian prior to beginning treatment. A minor cannot consent to his or her own treatment unless legally declared emancipated by the court or determined to be emancipated pursuant to state law.
- Secure the patient's informed consent at an appointment prior to the treatment visit whenever possible. The return on the date of treatment is further validation of the desire to receive the recommended treatment.
- Although staff members can assist in the informed consent process by helping to educate the patient, the patient *must* be given an opportunity to speak with, and ask questions of, the treating dentist before treatment begins.
- It is ultimately the responsibility of the treating dentist to ensure that the patient understands what has been presented. Always ask the patient, "Do you have any questions about the information you have been given or about the proposed treatment?"
- Ask for the patient's approval to perform your recommended treatment. Remember that any treatment rendered without the patient's consent may result in allegations of battery or other charges.

Communication problems

- If your patient cannot understand the informed consent process due to language or other barriers, then you cannot obtain the necessary *informed* consent.
- If you or a staff member do not speak the patient's language, invite the patient to bring a family member or friend to translate, when needed. Be aware that depending upon circumstances and your state law, you may be required to provide translation services free-of-charge for patients with limited English proficiency (LEP). If your practice accepts federal funds (e.g., treatment of patients covered by Medicaid), federal law may require providing translation services for LEP patients.
- Thoroughly document who translated and what was said. Include the translator's name, address, and telephone number in the body of your progress note for that day.
- If you routinely treat patients who speak the same foreign language, have your consent forms translated into that language to facilitate the informed consent process.

Informed Consent Documentation

In dental professional liability litigation, the defendant dentist often must present documented (verbal, written, or recorded) evidence in court to prove that an informed consent discussion was conducted. There are two important elements to informed consent documentation:

- Verification that the discussion occurred, and
- Evidence that the patient understood and agreed to the treatment procedure.

Whether supplied orally or in writing, receipt of the patient's informed consent must be documented in the patient record. A written description of the informed consent discussion, signed and dated by the patient, serves as the best evidence of this discussion. Typically, a pre-printed form that permits the dentist to insert specific information, where appropriate, is used.

Regardless of whether a written informed consent form is used, the dentist should write a progress note that reflects the specific consent process for that patient. Your entry should include:

- What was discussed
- What questions were asked
- What answers were given
- Who was present, including staff and friends and/or family members of the patient
- What documents, brochures, or handouts were given to the patient and/or what patient information videos were viewed
- That informed consent was given by the patient

Your level of documentation should correspond with your assessment of risk for the recommended treatment and your comfort level with both the patient and the procedure. While it may be efficient to write a simple progress note that includes the abbreviation "RPIC" for "received patient's informed consent," both a detailed progress note and a written customized document are preferable. Another brief and often-used progress note is, "informed consent signed." While this may be an accurate statement, it fails to document that the required discussion took place.

An alternative documentation method includes a notation in the patient's chart stating the important elements of the informed consent discussion, with a patient signature on the record entry. Examples of customizing the entry to the patient include listing additional important information regarding alternatives and risks ("patient understands the possibility of numbness...") and specific questions answered ("patient asked about possible swelling; I advised her that moderate swelling was likely…").

Be aware that a cursory entry reading "risks, consequences, and alternatives were discussed" has significant limitations. The dentist would still be required to explain in court the express discussion, without being able to refer to a comprehensive record of the specific points and topics covered.

Whenever adjunct aids are used, their use should be documented in the patient's healthcare information record. Documentation can easily be completed with abbreviations or short notations, such as "Pt. and mother viewed RCT DVD #3" or "Pt. given implant pamphlet #12-B." Then, you can refer back to the DVD or pamphlet if questions arise in the future. Such substantiation also serves to document your education of the patient. Keep in mind that an informed consent form is also an excellent tool for educating patients.

Ultimately, if a "lack of informed consent" claim is heard in court, a jury will determine the adequacy of the informed consent. A signed form does not guarantee that the defendant dentist will win a case of this nature. However, documentation of the informed consent discussion and the patient's admitted understanding of the discussion will aid in the defense of a "lack of informed consent" malpractice allegation.

Risk management topics such as informed consent are still uncommon in the dental literature. However, at least two systematic reviews on informed consent have been published recently in the Journal of the American Dental Association (August 2016 and April 2017).

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

Written Informed Consent Forms

Developing a written informed consent form

Written informed consent forms are used to supplement, but not replace, informed consent discussions. Most patients do not remember all that they were told during the informed consent discussion, making written forms a valuable reminder to both the patient and the dentist.

Effective informed consent forms should be customized to both the patient and the procedure. Following the informed consent discussion, the patient is asked to sign the form. An effective form will help direct the discussion and serve as a reminder to the dentist to cover certain important points. Think in the context of educating the patient to pass the 3-question quiz noted earlier. In addition, the dentist should sign the form and retain a copy in the patient's chart.

Written informed consent forms should:

- Use simple, plain language that the patient will understand.
- Specify the name of the dentist who will be providing care.
- Specify the name of the treatment(s), procedure(s), or test(s).
- Discuss the nature of the proposed treatment, its necessity and benefits.
- List available alternative treatments to the recommended treatment.
- Discuss potential complications and general risks of the recommended treatment and any specific risks for this patient.
- Permit you to customize the form for each patient using checklists and/or fill-in blanks.

Some dentists also include blank areas for patients to describe, in their own words, their understanding of the discussion. Written patient comments serve to verify that the patient has understood the information presented.

Suggested dental procedures for using a written informed consent form

We recommend written informed consent forms for procedures with high claim frequency, a significant risk of injury, and those having the potential for patient misunderstanding. The informed consent protocol should be implemented for various procedures, including but not limited to, procedures such as:

- Extractions
- Root canal treatment
- Crown and bridge
- Implants (both placement and restoration)
- Surgery involving incision and flap reflection (perio, endo, preprosthetic, etc.)
- Pediatric dentistry, including behavior management
- Cosmetic dentistry
- Orthodontics
- TMD treatment
- IV sedation or general anesthesia (use a separate consent form)

We also recommend that you employ a written informed consent form with patients who may present an increased risk, perhaps due to an argumentative nature or forgetfulness. In practical terms, you may use a written informed consent form for any procedure you choose. For simple procedures, such as operative dentistry, an informed consent form may seem impractical. But what if you're placing a large direct MODB composite on #30 due to deep recurrent decay around a 30-year-old amalgam? It is an operative procedure, but one with a significant risk of a pulpal exposure or pulpal trauma that could lead to root canal therapy and a crown. Does the patient know of these risks and accept them?

Written informed consent form suggestions

Procedurally, the use of written informed consent forms should include the following protocol:

- Give the form to the patient on a date prior to the treatment date so the patient has time to think about the decision. (Due to emergency treatment needs, it may not be possible to pursue this timeframe.)
- Ask the patient to sign the form, although a patient signature is not necessary to prove that an informed consent discussion took place.
- Retain the original form in the patient's chart to document the specific information given to the patient, then document the use of the form in the progress notes.
- Give the patient a copy of the form.

Informed Refusal

An informed refusal is essentially the opposite of an informed consent in that the patient has said "no" to the procedure instead of "yes." The information presented to the patient is the same for both processes, until the patient declines the recommendation. From that moment, the dentist is required to provide more information to the patient.

The patient has a legal right to decline your treatment recommendation and refuse care. If this occurs, you must explain to the patient the consequences and foreseeable risks of refusing treatment. Also ask about the patient's reasons for refusing care. If the patient states, or if it appears, that the refusal is due to a lack of understanding, re-explain your rationale for the procedure or treatment, emphasizing the probable consequences of the refusal.

The dentist's disclosure of the consequences of the refusal is a critical aspect of the informed refusal process. For example, a patient who declines scaling and root planing must be informed of the progressive nature of periodontal disease and that his condition will worsen more quickly without treatment. A patient who declines to have impacted #32 removed must be informed of risks such as follicular enlargement leading to bone destruction, pain, pathologic fracture, and nerve damage. If the patient again refuses to accept your treatment recommendations after you have communicated the risks of refusing treatment, then the patient has given an *informed refusal*.

Numerous malpractice lawsuits have been filed against healthcare providers by patients who asserted that, upon suffering a serious injury after refusing care, they did not fully understand the potential consequences of such refusal. In a typical situation, a patient contends that the healthcare provider was negligent in not fully disclosing the risks of treatment refusal. Coupled with this allegation is the patient's assertion that he or she would have consented to the procedure or treatment if the risks of refusal had been properly and completely explained by the healthcare provider.

Informed Refusal Options

A patient who has refused your treatment recommendation presents you with two choices. You can

- Continue to treat the patient — within the outline of the parameters to follow
- Dismiss the patient from your practice due to noncompliance

There is no right or wrong decision, simply a matter of preference. Your decision may vary from patient to patient, depending on your risk assessment for continuing to treat each individual.

Each choice presents some level of risk to your practice. If you decide to continue treating, you risk the possibility that at some point in the future, the patient's condition or treatment recommendations may not be adequately evaluated or documented. If you decide to dismiss the patient, you risk alienating him and spreading his ill will to other patients he knows. Your decision will be based on a myriad of factors, including the quality and longevity of your dentist-patient relationship, the nature and urgency of the recommended treatment, and the overall financial impact on your practice.

Continuing Duties

The dentist who retains the refusing patient in his or her practice and continues with care must be aware of several additional duties relating to the patient's informed refusal. These duties are imposed in addition to the informed refusal discussion.

They include:

- A continued duty to *examine* and *diagnose* the patient's condition for the duration of the dentist-patient relationship and as long as the patient continues to refuse treatment
- A continued duty to *inform* the patient about the condition and its associated risks while the dentist-patient relationship exists, the condition exists, and the patient continues to refuse treatment
- A heightened duty to tell the patient how treatment refusal might affect future treatment options, other oral/body structures and/or overall health.

The failure to meet these obligations has resulted in numerous *failure to diagnose* and *failure to inform* allegations. A positive trend has developed inasmuch as fewer of these allegations have arisen in recent years. A typical claim involves a patient who refuses scaling and root planing but is agreeable to return on a regular basis for debridement by the hygienist. Since the patient has not demonstrated an interest in improving his periodontal health, the

dentist does not emphasize periodontal concerns during regular recall appointments. The dentist neither probes the periodontium nor documents in the progress notes any facts about the patient's periodontal status or diagnosis.

After a few years, the patient complains of a worsening periodontal condition, including increased bleeding and progressive mobility of teeth. Upon hearing a renewed complaint by the patient, the dentist finally re-evaluates the periodontium, observing progression from a moderate to a severe case. The patient now has severe bone loss and needs multiple extractions. Incredulous at the news, the patient questions how his mouth could have gone from needing a "gum scraping" to multiple extractions without the dentist ever discussing this situation.

CNA claim professionals find that the patient records in these claims often lack updated periodontal probing records, clinical observations, diagnoses, or documentation of having informed the patient of the disease status. The risk to the dentist lies not in the continuation of the dentist-patient relationship, but in the absence of regular evaluations and disclosure to the patient, and of documentation of these actions.

Documentation of Informed Refusal

Refusals of care represent an increased liability risk and require greater diligence on your part to manage that risk. The most effective technique is to thoroughly document the informed refusal process. Criteria for documenting informed refusals are similar to, but go beyond, those for informed consent. Following a discussion of the consequences, we strongly recommend a comprehensive progress note as well as the use of a written form documenting the refusal.

Your progress note should document:

- Who was present
- The treatment discussed
- The educational documents, brochures, handouts, or presentations given to or viewed by the patient
- The questions asked and answers given by both parties
- The patient's refusal of the recommended care
- That the patient was informed of the risks of not following your recommendations (list the specific risks you stated)
- The patient's reasons for refusal
- That the consequences of refusal were re-explained and that the patient continued to refuse the recommended treatment. Emphasize that the patient understood the risks of refusing care.

Using an informed refusal form

As noted, we also encourage the use of an informed refusal form, such as the sample form made available with use of this manual. Few patients remember all that they were told during the informed consent/refusal discussion, making written forms a valuable reminder to both the patient and the dentist. A written form also helps manage patient expectations, provides further documentation of the disclosure of information, and helps to deter negligence claims alleging a lack of informed consent or informed refusal.

Complete the form, paying special attention to the section titled "Risks of Not Having the Recommended Treatment." Then ask the patient to sign it. Some patients will change their minds and agree to treatment when presented with a written document and an insistence on their signature. Although the documentation process is not necessarily designed to persuade patients into accepting treatment, these individuals will ultimately benefit from receiving the proper care.

Of the patients who persist in refusing your treatment recommendation, some will sign the form, and others will not. While it is preferable to have the patient's signature, don't fret if you can't obtain it. Sign the form yourself and have the staff member who witnessed the discussion and disclosure sign it as well. If the patient has refused to sign, write "Patient refuses to sign this form" on the patient signature line. Regardless of whether or not the patient signed the form, place the original in the patient's chart and give a copy to the patient. Your signatures on the form, along with your progress note, will demonstrate that a discussion took place and an informed refusal was given.

The documentation process for informed refusal does not end after the first refusal. At *every* recall visit — after re-examining the patient, updating your diagnosis and informing the patient of his or her status — make a chart entry concerning the continued refusal of care. If the patient's condition as well as your treatment recommendation is the same as the last visit, re-sign and date the informed refusal document and ask the patient to do so as well. If the patient's condition, your diagnosis, or your treatment recommendation has changed, complete a new form reflecting the updated information.

Finally, note the refusal of care in the progress note for any visit during which you discuss the issue with your patient, notwithstanding that the time period between visits was brief.

Please refer to page IX for information about access to a sample form on "Discussion and Refusal of Treatment."

Special Issues in Informed Consent

Consent for Minors

As a general rule, consent for treatment offered by an unemancipated minor is not valid. The informed consent of a parent or legal guardian must be obtained before treatment is rendered. Adult siblings, grandparents, and other adult caretakers are not legally authorized to provide consent unless they have been granted legal guardianship by the court.

Regardless, dentists too frequently accept the consent of the adult party who brought the child rather than defer until the proper consent can be obtained.

Consider the situation where the parent does not accompany the child to a six-month recall appointment. If, during the clinical exam, the dentist decides that X-rays are required or that one or more carious lesions should be restored, is the consent of the parent (or legal guardian) required before such routine procedures are performed? If the parent cannot be reached by phone, is it prudent to proceed, or should the treatment be deferred until consent can be obtained?

From a liability perspective, this is a gray area. Some may contend that by allowing the child to present alone at the office, the parents have given their implied consent to any such routine procedures. More conservative risk managers would disagree, countering that while the exam and prophy might fall within an implied consent, the radiography and restorative care do not. In today's litigious environment where "lack of informed consent" is a common allegation, proceeding without consent may create a conflict between you and the child's parents. The conflict may arise even if the parents object solely to the additional professional fees.

Establishing and communicating an office policy related to unaccompanied minor patients will help to clarify this issue for all concerned and prevent misunderstandings. If you are presented with an unemancipated minor, unaccompanied by a parent or legal guardian, we recommend the following steps to minimize potential conflict and reduce liability risks:

- First, make a professional judgment as to whether any delay in treatment will be detrimental to the minor patient's dental or systemic health. Ask yourself whether it is in the patient's best interest to proceed with the treatment immediately, or whether treatment can wait until a parent or legal guardian can be contacted.
- Next, make a reasonable effort to contact the parent or legal guardian. To that end, patient charts should be updated with cellular telephone numbers. The dental record should contain documentation of all attempts to reach a parent or guardian.
- If you cannot reach a parent or guardian, defer routine treatment or, if necessary, palliate the patient's condition until a parent or guardian's informed consent can be obtained.
- Generally, it is acceptable to intervene without parental consent when immediate intervention is warranted due to traumatic injury or other truly emergent conditions.

If an unaccompanied minor child presents for an appointment for simple or routine treatment that has already been discussed and consented to by the parent or guardian, it is permissible to proceed with treatment. Be certain you do not perform any treatment transcending the limitations of the prior consent.

Although you may have obtained consent, certain appointments may arise when the planned treatment is rather involved and you wish to have a parent accompany the child. You may institute an office policy that requires a parent to be present for treatment to proceed. If you have such a policy, clearly inform parents that their presence will be necessary at that time.

The age of majority varies from jurisdiction to jurisdiction, as does the law concerning when a minor is deemed emancipated. The treatment of adolescent patients can be uniquely challenging. The hallmarks of adolescence are physical changes, increasing autonomy and sometimes a proclivity for risky behavior, as those situated between childhood and adulthood seek to understand themselves and explore the larger world. Dentists and staff members who treat adolescent patients establish a professional relationship, allowing them to develop a mutual trust and thereby gain insights into an adolescent's state of health.

During the course of care, a dental examination may signal certain sensitive health issues that, in turn, present a range of clinical, legal and ethical concerns. Contact an attorney in your area who specializes in malpractice defense for clarification of these issues.

Children of divorced parents

Obtaining informed consent from one parent is adequate. However, it is essential that the parent granting consent be legally authorized to do so. Divorces can often be highly contentious, such that some divorce decrees stipulate that a non-custodial parent is stripped of parental rights. If a natural parent has no parental rights, that individual is precluded from granting consent on behalf of his or her child.

The right to legally grant consent for a minor child is independent of any financial obligations or arrangements that may have been made during divorce proceedings. Consequently, the parent paying your fees may or may not be legally authorized to grant consent. In the best interest of the minor patient, discuss and probe these issues, as necessary, before treatment begins to effectively mitigate miscommunication risks.

Occasionally, divorced parents will disagree regarding the granting of consent for their child's treatment. From a practical perspective, it would be inadvisable to proceed until someone — a parent, grandparent, aunt, uncle or other party — first assumes financial responsibility for the care. Keep in mind that one of the most effective risk management techniques is to simply say "no" to unreasonable requests from patients and parents. Empathetically inform parents (divorced or otherwise) that you understand that disagreements may occur, but that it is essential to obtain clear direction and informed consent before proceeding with treatment of a minor patient. The dentist's role does not include arbitration of family disputes.

Decision Making, Consent, and Mental Capacity

As the number of older Americans continues to grow, dentists will be faced with an increasing number of dental, medical, ethical and legal questions when treating mentally incapacitated patients and those with impaired mental capacity due to aging or disease. This issue also pertains to patients of any age where mental capacity issues arise. Healthcare decisions, including informed consents and refusals, are valid only when patients have the capacity to comprehend and consent to treatment — and patient capacity can be difficult to assess.

There are no hard-and-fast rules to assure a dentist that the patient possesses or lacks capacity to consent to treatment. However, emergency procedures may be completed regardless of the capacity issue in life-or-death situations, provided that the urgent need for intervention is clearly determined and documented. What may seem to be a "dental" emergency from the perspective of the dentist, patient, or patient's caregiver, such as the extraction of a mobile and painful tooth, might not be deemed a true "life or death" emergency that would vitiate the requirement to obtain the consent to treatment from an individual who lacks capacity to consent. Thus, dentists involved in capacity situations must be cautious about decision making and treatment until all capacity and informed consent issues have been resolved.

There are several basic tenets that a dentist should consider when capacity is at issue:

1. All adult patients are assumed to be capable of consent unless proven otherwise.
2. Only a court can officially designate someone as legally incapacitated.
3. Evidence of a good faith effort by the dentist to determine capacity will assist a dentist if the capacity issue arises after initiation of treatment.
4. There is no standard procedure that a dentist can utilize to evaluate and unequivocally prove capacity.

However, there is information that can assist the dentist. A 1982 report issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research continues to offer excellent guidance in this area. The report included a three-pronged test for decision-making ability. According to this study, to be considered to have the requisite capacity, the patient must:

- Possess a set of values and goals
- Be able to communicate and understand information
- Have the ability to reason and deliberate about choices

The following questions may assist a dentist in determining and documenting a patient's capacity to understand and consent to treatment.

Does the patient possess a set of values and goals?

- Question the patient about his or her daily routine. Ask why the patient does certain things (eating meals, taking medication, reading, watching television, discussing information with a caregiver).
- Ask the patient to list the five most important things he or she does every day.
- Ask the patient to describe his or her most pressing personal issue.
- Ask the patient to describe the most pressing issue for the country.

Is the patient able to communicate and understand information?

- Ask the patient to describe the reason for the visit to your office.
- Give the patient a simple explanation of treatment needs, and ask the patient to repeat the information to you.
- Ask the patient for the following information:
  - Date of birth
  - Age
  - Current address (the patient may not know the street address, but may know the location, e.g. "my daughter's house," or "All Care Nursing Home")
  - The name of his or her closest relative
  - The name of the person who should be contacted in an emergency

Does the patient have the ability to reason and deliberate about choices?

- Before you suggest any treatment, ask the patient for any suggestions about the treatment needed. Evaluate the sensibility of that information.
- Ask the patient to describe one or two problems that may arise if treatment is not completed.
- Ask the patient to list one or two positive benefits of the treatment you have recommended.

Patients whom you believe understand and can respond adequately to these questions may be considered of adequate mental capacity to proceed with the informed consent discussion and subsequent treatment. Treatment of patients who do not fully comprehend the questions or do not provide cogent answers should be deferred until mental capacity and/or decision-making authority are investigated and resolved.

Even in situations when the patient is of sound mind, the patient's spouse, siblings and/or children may insert themselves into the informed consent process and attempt to override the patient's wishes and demand specific treatment. In these circumstances, you may choose to provide the patient with written information regarding treatment options, as well as a written informed consent form, and suggest that the parties discuss the matter further before proceeding with treatment.

Legal status of proxies

Traditionally, patients' family members were relied upon to make treatment decisions for mentally incapacitated patients. The family was considered the proxy, even without formal designation. This view was endorsed in the 1976 New Jersey Supreme Court decision, *In the Matter of Karen Quinlan, 70 N.J. 10 (1976,)* in which Karen Ann Quinlan's father was allowed to serve as his comatose daughter's surrogate decision maker.

In the aftermath of the *Quinlan* decision, several states enacted statutes addressing proxy designation through the appointment of a durable power of attorney for healthcare decision making. These statutes permit adults with the requisite capacity to appoint a proxy authorized to give or withhold consent for healthcare treatment if the designator becomes incapacitated. Dentists were legally bound to recognize the surrogate's authority unless the appointment was nullified by a court.

In 1990, however, the U.S. Supreme Court limited the authority of families to end life-sustaining treatment for incapacitated patients. The Court's decision in *Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990),* held that, while competent patients have the right to refuse unwanted treatment, states are not constitutionally prohibited from enacting laws mandating continued

treatment to incapacitated patients when there is no "clear and convincing" evidence, such as a living will, to document that the patient would refuse life-sustaining care or treatment. Thus, states are not required to follow undocumented dictates from family members acting in the name of an incapacitated patient.

Following the *Cruzan* decision, undesignated family members may not always serve as healthcare proxies. *Cruzan* did not address the issue of whether a state would be compelled to defer to the decision of a surrogate where substantial evidence exists indicating that this would reflect the patient's wishes. However, the decision supports the view that incapacitated patients who have previously prepared a written document addressing their treatment choices and naming a healthcare decision maker are more likely to have their instructions implemented than those without such a document. (In some states, courts have accepted oral statements as compelling evidence of patient desires.)

The *Cruzan* decision and its progeny have encouraged patients of sound mind to write advance directives prior to any decline in mental capacity. It is in both the dentist's and the patient's interest to encourage the preparation of such advance directives, whereby important decisions are made and preferences discussed early in the relationship, prior to patient incapacity.

When the treatment relationship begins subsequent to incapacity, contact the patient's previous treating dentist and/or physician to discuss any advance directive arrangements the patient may have implemented during previous treatment. Obtain copies of any documentation he or she has of those arrangements, and make notes of these discussions in your own patient healthcare information records. If no advance directives exist, discuss with the patient and the patient's family members the need to pursue designation of a healthcare decision maker.

Dental Professional Liability

Claim Scenarios

Upon completion of this section, you should be able to:

- **Assess the various claim scenarios and clinical procedures** and their relevance to your practice and patient population.
- **Consider and discuss with staff members the ways in which the doctor-patient relationship could have been modified and improved** to prevent patient dissatisfaction, harm and/or professional liability claims.
- **Work with the entire dental team to implement practices and procedures** that will improve patient safety, risk management and clinical patient outcomes.

Claim Scenario 1: Medication and Related Medical Complication

Practitioner: General practitioner
Claimant: 84 year-old female; 15-year history of warfarin anti-coagulant therapy

Risk management topics

Medical consultation; recordkeeping; clinical best practices or guidelines

Facts

On the initial appointment, the patient indicated that she had a history of pulmonary embolism, hypertension, stroke, cancer, heart murmur, heart attack. She had undergone open heart surgery to place an artificial mitral valve and pacemaker. The patient was taking a number of medications including warfarin. On examination, teeth 4 and 5 had Class II mobility. One year later, the dentist recommended extraction of teeth 4 and 5. He recommended that the patient stop taking all medications, including warfarin, seven days prior to the extraction appointment. The dentist also requested that the patient consult her physician prior to doing so. Eight days later, teeth 4 and 5 were extracted with little bleeding and without complications. On the day following surgery, the patient suffered a massive cerebrovascular accident and died 6 months later.

Key allegations

Failure to obtain medical consultation; improper medication advice; failure to request appropriate diagnostic tests, including INR to evaluate coagulation time

Claimed injury/damages

Massive debilitating stroke, followed by death

Analysis

- Accurate documentation. The chart note to "stop Warfarin 7 days prior" appeared to be a directive to the patient to stop taking the medication. The dentist stated that this was a question for the patient and that she was to ask her physician about discontinuing the anticoagulant. However, there were no quotation marks (if a patient question) and no question-mark (if a question from the patient to the dentist, or vice versa.)
- Medical consultation. Dentists should not rely upon a patient's communication to the medical professional. The dentist should directly contact other practitioners about proposed treatment, pertinent medical history and appropriate related medical advice.
- Clinical best practices or guidelines. A hematologist and two general dentists were deposed as expert witnesses. The hematologist stated that the risk of clot development and stroke for this patient far outweighed any risk of bleeding for uncomplicated tooth extractions. He estimated that the cessation of warfarin increased the patient's risk of stroke by 10 times. He described the patient's stroke as "massive," affecting the middle cerebral artery, one of the main arteries to the brain. Death within one year of such an event is not uncommon. The dentists opined that for most patients, anticoagulant medication should continue during dental procedures, due to the risk of thromboembolism and related morbidity.
- Proximate cause. There was an apparent causal relationship between the discontinuation of the warfarin and the patient's stroke, as the stroke occurred one day after the dental procedure.
- Damages. Although elderly, the patient was self-sufficient prior to the stroke. At deposition, the patient's daughter effectively described her mother as vital and active prior to the incident — in contrast to the last six months of her life during which she was languishing, and unable to speak or move.

Outcome

Defense experts recommended against going to trial: settlement and expenses totaled more than seven figures.

Claim Scenario 2: Wrong Tooth Treatment (Extraction)

Practitioner: General dentist
Claimant: 10 year-old healthy female

Risk management topics

Wrong tooth extraction; effective referral communications; orthodontics

Facts

In September and December, the patient's orthodontist referred her to the general dentist for the extraction of multiple primary teeth, including tooth G. The general dentist treated the patient the following January and mistakenly extracted tooth 10. Two years later, the orthodontist took a panoramic radiograph and recorded in the chart, "Tooth 10 not visible on today's panorex. Previous extraction referral asked for extraction of tooth G. Dentist possibly extracted tooth 10." The orthodontist did not disclose this information to the parents but advised them that he would review the radiograph and contact them with any findings. The orthodontist called the general dentist to discuss the possible wrong tooth extraction. The parents were then informed of the error and various treatment options.

Key allegations

Wrong tooth extraction of permanent upper lateral incisor (10)

Claimed injury/damages

Loss of tooth 10

Analysis

- Referral communications. In a referral, both providers are responsible for effective communications and ensuring that appropriate treatment is performed. The dentist performing treatment has the ultimate duty to verify the diagnosis and perform the correct treatment.
- Current diagnostics. The dentist did not view or did not have the latest panoramic radiograph, which would have revealed that tooth G had exfoliated and was no longer present. If a current radiograph was provided by the orthodontist, then the treating dentist has a duty to request one, or to take new radiographs, as necessary, to meet the standard of care.
- Damage calculation. As this is a 10 year old patient, the replacement cost for an upper anterior tooth will be calculated for the reasonable life span of the patient. Damages may, therefore, be greater than for a similar wrong tooth extraction error involving an adult patient.
- Disclosure. The orthodontist decided to discuss the situation with the general dentist before explaining his findings to parent. While this decision may not have affected the outcome of the claim in this case, immediate disclosure of adverse findings is recommended. The general dentist and orthodontist did not blame each other and shared liability in this claim.

Outcome

Claim costs: general dentist — in the low 5 figures; orthodontist — in the high 4 figures

Claim Scenario 3: Failed Endodontic (Root Canal) Therapy

Practitioner: General practitioner
Claimant: 42-year-old male

Risk management topics

Recordkeeping; specialist treatment/referral process; abandonment/emergency care

Facts

The patient presented with pain from biting pressure related to a mandibular second molar. The dentist obtained an intraoral periapical radiograph and recommended root canal therapy (RCT). Following the completion of the RCT, the dentist placed a composite restoration at a subsequent visit. The patient sought care from another dentist several months later for two painful areas — one in the posterior maxilla and the other in mandible, near the prior RCT. The second dentist recommended that the root canal filling in the mandibular second molar be removed and that the tooth be re-treated. The patient then returned to the original dentist's office and completed a number of visits over the next several months for preventive and restorative care before the RCT re-treatment was initiated. The day after the re-treatment procedure, the patient had pain and presented to the second dentist, since the first dentist was not available. Dentist number two administered a local anesthetic for pain relief, removed occlusal contacts from the molar tooth, prescribed an antibiotic and suggested referral to an endodontist or extraction of the tooth. A few days later, the patient sought care at a local hospital for infection with substantial swelling and fever. The swelling required open drainage in the operating room and removal of the offending mandibular second molar. The diagnosis: lateral pharyngeal abscess with hematoma, extending into the floor of the mouth. Post-surgery, the patient continued to seek treatment for ongoing paresthesia, hyperalgesia and other complaints.

Key allegations

RCT treatment below the standard of care; inadequate records, including inadequate diagnostic work-up and radiographs; failure to obtain needed consultations or refer for care; abandonment/inadequate emergency care

Claimed injury/damages

Infection, tooth loss/disfigurement, medical expenses, pain and suffering, mental anguish

Analysis

- Recordkeeping. When RCT or any other treatment is recommended, objective clinical findings, test results and diagnosis must support the treatment plan and be adequately documented. However, while a radiograph was taken to aid in the diagnosis, the findings were not recorded. Moreover, as RCT may be complex, it should be performed only after obtaining and documenting the patient's informed consent, including disclosure of the nature of treatment, treatment alternatives and foreseeable risks, as well as the risks associated with no treatment. The patient record included no written/signed consent form and no supporting progress note.
- Specialist treatment/referral. While all dentists may perform root canal therapy, non-endodontists should always offer referral to an endodontist as a viable treatment alternative to reduce the risk of a "failure to refer" allegation. Dentists must honestly assess their own skill and experience and discuss the alternatives with the patients. In this case, file sizes and file lengths were not documented, and no post-fill radiograph was produced or documented in the records. Later radiographs revealed radiolucent areas associated with root canal fillings that were well short of the root apices. These findings led dentist number two to recommend that the patient seek re-treatment of the molar RCT from an endodontist. When the patient returned to his original dentist, re-treatment was delayed for unknown reasons, and other treatment needs were addressed instead. If a referral was made to a specialist, it was not documented.
- Abandonment. Dentists should inform patients how to access care in the event of a dental emergency, whether it occurs during customary business hours or after hours. Treatment may be provided by the dentist or by colleagues with whom the dentist has made such arrangements. The dentist was not available to manage the patient's pain and swelling immediately after the root canal re-treatment and he did not inform the patient of emergency care options. He also subsequently failed to examine the patient, who later sought care at a local hospital. Failure to effectively manage the patient's posttreatment emergency care needs left the dentist vulnerable to an allegation of abandonment.

Outcome

The claim costs were in the in the low six figures.

Claim Scenario 4: Surgical Implant Placement

Practitioner: General practitioner
Claimant: 66-year-old female

Risk management topics

Informed consent; diagnostic information and risk assessment; response to adverse outcomes

Facts

The patient reported a history of frequent headaches, head/neck/jaw injury, grinding/clenching (for which an oral appliance had been worn in the past) and bleeding gums. After examination, the dentist recommended extraction of a mandibular first molar (non-restorable) and other restorative care. The patient agreed to proceed, beginning with the first molar extraction and replacement. Extraction and immediate placement of a dental implant occurred at the next visit, with a post-placement radiograph. One week post-surgery, the records indicate that while the observable tissues were healing well, the patient reported post-surgical "numbness." The doctor reassured the patient that he would monitor her progress. Approximately three weeks post-surgery, the healing continued, but a new periapical radiograph revealed that the implant seemed to be impinging on the mandibular nerve. One month post-surgery, the patient reported about half as much numbness compared to the immediate post-surgical period. After taking another radiograph, the doctor contacted an oral surgeon, who recommended removing, replacing or backing out the current implant to relieve nerve compression. The doctor and patient agreed to back out the implant and monitor symptoms. One week later, the patient reported continued numbness and "tingling."

Approximately three months post-surgery, the dental office contacted the patient to schedule a follow-up visit. The patient, who reported feeling frustrated, instead sought care from a periodontist, who removed the implant and placed a bone graft approximately five months post-surgery. A suit was filed three months later. The patient opted for a fixed bridge restoration and continued to report numbness and altered sensation.

Key allegations

Failure to obtain necessary radiographs, including cone beam computed tomography (CBCT) imaging, in order to prevent nerve impingement/injury and diagnose impingement post-surgery; failure to place a dental implant properly/safely; failure to take appropriate actions and/or refer during post-surgical follow-up.

Claimed injury/damages

Mandibular nerve damage, medical expenses and lost wages

Analysis

- Informed consent. Paresthesia is a known risk of extractions and/or implant placement. While the patient agreed to the surgery and implant placement, she was not informed of the foreseeable risks related to the recommended treatment, including the possibility of nerve injury and paresthesia.
- Diagnostic information/risk assessment. The adequacy of the pre-extraction radiograph was questionable, showing the extent of the tooth roots but not the mandibular nerve canal. Additional intraoral/extraoral images (including CBCT) would have shown the nerve position, thus facilitating a more accurate assessment of the procedural risks, as well as guiding placement and preventing injury. While the two-dimensional periapical radiograph later appeared to reveal impingement, CBCT imaging would have provided additional useful information, either before or after the implant was backed out.
- Response to adverse outcomes. Nerve compression from implant placement or endodontic overfill requires swift action (i.e., decompression) to minimize the risk of permanent nerve injury. While the dentist diligently followed the patient until she left his care, delays in assessing the damage and taking necessary counter-measures breached the standard of care. These delays, combined with the failure to obtain informed consent and poor record-keeping practices, led to settlement of the claim before trial.

Outcome

Claim costs totaled in the low six figures

Claim Scenario 5: Crown & Bridge Challenges

Practitioner: General dentist
Claimant: 51-year-old healthy female patient

Risk management topics

Impossible-to-satisfy expectations; informed consent; guarantee/warranties; refunds; dental materials and treatment options

Facts

The patient, who was missing upper lateral incisors, presented with anterior crowns: she felt that the embrasure spaces were too large and the crowns were too square in shape. After a thorough diagnostic work-up, including examination, radiographs, intraoral photographs, and mounted models, the dentist obtained the patient's informed consent to proceed with treatment. A diagnostic wax-up and temporary restorations were completed. This treatment was followed by four years of continuous treatment and re-treatment, including full mouth crowns, veneers and a lower left fixed bridge. Some restorations were remade 3-5 times with the assistance of multiple dental laboratories. This occasionally included office visits by laboratory technicians to help insure that the patient's expectations were clearly communicated. The patient's approval was secured prior to the cementation of each restoration. The patient insisted on ceramic bridges, but after three bridge fractures on the lower left, the patient consented to fabrication of a porcelain-fused-to-metal bridge. On the final appointment with the insured, various crowns and a new lower left bridge were placed. The patient was informed that the restorations required return to the laboratory for porcelain glazing. When the practitioner left the operatory for a moment, the patient left the office with the restorations. A subsequent practitioner refused to cement the restorations, but was willing to proceed with new restorations. The patient then requested a full refund from the insured.

Key allegations

Dissatisfaction with anterior restoration esthetics and occlusion of lower left bridge, leading to both a professional liability claim and dental licensing board complaint

Claimed injury/damages

Replacement of multiple restorations

Analysis

- Unrealistic patient expectations. Determining when a patient is impossible to please is far easier to detect in hindsight. When should the dentist have terminated treatment? When the first restorations were rejected? The second round of rejections? Of course, each patient scenario is unique. While we all know that it is impossible to please all of the patients all of the time, it is often challenging to know when to discontinue treatment and dismiss a patient. The dentist printed photographs, which permitted the patient and the dentist to effectively communicate with the laboratory about desired cosmetic changes. Laboratory technicians also observed the patient/restorations in the operatory. While the patient remained dissatisfied, these methods may help to achieve patient satisfaction when faced with cosmetic challenges.
- Informed consent. In this case, the patient was informed of the benefits and risk of treatment, and she also approved the aesthetics at each cementation appointment. The patient insisted on all ceramic porcelain bridges, even after detailed discussion of the associated increased risk of fracture. One point to consider is whether or not the all-ceramic bridge was an appropriate alternative in this case. In hindsight, perhaps not. We know that the patient later agreed to a porcelain-fused-to-metal restoration. As the dental professional, you have the ability and responsibility to say "no" to a patient's treatment demands if you believe the treatment option is not in the patient's best interest.
- Guarantees/Warranties. The patient was not charged for any of the replacement restorations. The dentist provided a warranty, promising free restoration replacement for five years. Some dentists provide guarantees and warranties that require patient compliance with recall appointments, night guard use, etc. While it is reasonable to stand behind the quality of one's work, understand that treatment guarantees and warranties expose dentists to breach of contract claims, which may have a longer statute of limitations than malpractice claims. Breach of contract claims require only proof that the outcome did not achieve the guaranteed result, regardless of whether the standard of care was met.
- Refunds. If the dentist had terminated the relationship due to unrealistic patient expectations, a refund would allow the patient to seek treatment elsewhere. In some situations, a refund may represent the most advisable course of action for the dentist as well as the patient.

- Dental materials/restorative options. Relatively new ceramic materials were used for the first three bridges. The dentist insisted that the fourth replacement be a porcelain-fused-to-metal bridge. The long-term success of bridges constructed with new ceramics is unknown. However, ceramic bridges continue to experience higher rates of failure due to fracture compared to porcelain-fused-to-metal bridges. It was, therefore, prudent to inform the patient of the risk. The dentist also placed very thin veneers on multiple anterior teeth, which experienced a high fracture rate. With a known history of bruxism, were other options preferred? At what point should the dentist alter the treatment plan? Dentists should consider that a patient's insistence on a specific dental material or treatment option does not defend sub-standard treatment. Each dentist must assess the needs of the individual patient and decide whether the material/treatment demanded by the patient will meet the standard of care. If not, the dentist should decline the patient's request.

Outcome

Licensing board investigation — closed without action; professional liability claim — denied and closed without payment

Dental Professional Liability

Appendix

In this section, you'll find:

- Bibliography
- Index

Bibliography

CNA has compiled the following list of additional resources for reference and continued learning. Website URLs were current as of August 15, 2019. Access to some website content may be limited to organization members, such as for certain American Dental Association web content.

NOTE: Any references to non-CNA Web sites are provided solely for convenience, and CNA disclaims any responsibility with respect to such Websites.

CNA and Dentist's Advantage Websites

- CNA Website
- Dentist's Advantage Website

Adverse Clinical Outcomes/Adverse Events

- *Classifying Adverse Events in the Dental Office*. J Patient Saf. Published online 2017 Jun 30.
- Dentistry's List of "Never Events." Dentist's Money Digest. Published online 2018 Jun 14.
- *Safety In Dentistry.* Agency for Healthcare Quality and Research (AHRQ), Patient Safety Network.
- What are incident reports and how are they used? Safety Net Dental Clinic Manual, Unit 4, Administrative Operations
- What is a time out policy: does the clinic need one? Safety Net Dental Clinic Manual, Unit 4, Administrative Operations

Anger and Conflict Resolution Resources

- Conflict Resolution; Anger Management and more. HelpGuide Website: see Relationships>Communications
- Calm, Empathetic Reaction by Physicians Best for Handling Angry Patients. ENT Today. April 2013.
- Turning the Heat Down on Patient Anger. Pharmacy Connection. May-June 2008. pp. 20-22.
- Workplace violence resources. OSHA Website
- Active Shooter Resources. Ready Website — Department of Homeland Security

Antibiotic Prophylaxis

- Prevention of endocarditis and orthopedic joint infections. American Dental Association resources: hyperlinks to clinical guidelines and many other resources
- Chairside Guide—management of patients with prosthetic joints undergoing dental procedures. Guideline resource
- American Dental Association guidance for utilizing appropriate use criteria in the management of the care of patients with orthopedic implants undergoing dental procedures. *JADA* 2017 148(2):57–59.

Communication/Health Literacy/Education Resources

- Health Literacy Universal Precautions Toolkit. The AHRQ toolkit aids in assessment of health literacy services.
- Quick Guide to Health Literacy, US Department of Health and Human Services
- The Patient Education Materials Assessment Tool (PEMAT). Systematic evaluation of patient education materials
- Health Literacy Measurement Tools. Tools to measure reading comprehension as an aspect of health literacy
- Tips for Effective Listening/Communication. HelpGuide Website: see Relationships>Communications. Includes non-verbal communication and emotional intelligence

Dental Risk Management/Professional Liability

- Mukherjee A et al. Informed consent in dental care and research for the older adult population. *JADA* 148(4) pp 211-220. April 2017.
- Managing Professional Risks. ADA Center for Professional Success (some content available to ADA members only)
- Liability Protection and Risk Management. Safety Net Dental Clinic Manual (see Unit 4, Administrative Operations)
- Sorry Works! Content on disclosure for health professionals and their organizations.

Emergency Preparedness/Disasters

- Natural Disasters and Severe Weather. Centers for Disease Control and Prevention
- Disaster Recovery Resources. American Dental Association
- Ready Business Website. Federal Emergency Management Agency (multi-hazard preparedness programs)

Evidence-Based Practice, Clinical Guideline/ Standard of Practice Resources

- ADA Center for Evidence-Based Dentistry™. The site includes access to clinical practice guidelines and implementation tools, EBD tutorials and a database of systematic reviews/critical summaries.
- *JADA* Series on Practical Evidence-Based Dentistry, 11/2014 to 5/2015 (first article of a 7 article series)
- ECRI Institute Guidelines Trust™. A publicly available resource for healthcare evidence-based clinical practice guidelines (replaced the AHRQ National Guidelines Clearinghouse).
- Agency for Healthcare Research and Quality (AHRQ) and its Patient Safety Network (PSNet) provide a broad range of information on healthcare research, quality, guidelines and safety for both professionals and consumers.
- Health Resources at National Center for Biotechnology Information. Clinical practice and research databases regarding diseases and treatments
- Current periodontal disease classification, guidelines and other resources. American Academy of Periodontology.
- Endodontic Case Assessment Form. American Association of Endodontists (AAE)
- *Colleagues for Excellence*, Fall 2014. The Standard of Practice in Contemporary Endodontics
- Treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy. AADSM Clinical Practice Guideline
- Consult dental specialty organization websites for additional information on various guidelines.

Infection Control

- Infection Control in Dental Settings. Centers for Disease Control and Prevention
- Patient Notification Toolkit (infection control breach). Centers for Disease Control and Prevention
- Sharps Safety for Healthcare Settings. Centers for Disease Control and Prevention
- Management of Occupational Blood Exposures to HBV, HCV, and HIV. Centers for Disease Control and Prevention
- DentalCheck Mobile App. Centers for Disease Control and Prevention
- Infection Control Breach Assessment. Centers for Disease Control and Prevention
- Postexposure Prophylaxis Resources (including a PEP clinician hotline). Centers for Disease Control and Prevention
- OSAP—The Organization for Safety, Asepsis and Prevention

Legal/Regulatory Related Resources (including HIPAA)

- State Dental Practice Statutes/Regulations
- Brach C. Making Informed Consent an Informed Choice. Health Affairs Journal/Blog. April 2019.
- Americans with Disabilities Act (ADA) information and assistance. US Department of Justice, Civil Rights Division
- Implementing Section 1557 under the ACA of 2010. HHS Final Rule: summary and training materials
- Heath Information Privacy home page. US Department of Health and Human Services. Information for individuals and professionals, including frequently-asked-questions (FAQs); enforcement; breach notification rules; and more.
- HIPAA – FAQs: Use of email with patients
- HHS Facts on Individuals' Right to Access Medical Information
- 2013 Omnibus Rule (final)
- Sample Notice of Privacy Practices to comply with 2013 Omnibus Rule
- Video and other resources (tip sheets, FAQs, etc.) related to mobile device/smart phone security
- HIPAA/HITECH Security Risk Assessment Tool for practitioners
- HHS Cyber Security Checklist
- HHS Cyber Security Infographic
- American Dental Association 2013 Privacy and Security updates. Information, resource links and online CE course.
- ADA Principles of Ethics and Code of Professional Conduct information page
- Background Checks: What Employers Need to Know. EEOC resource

Medical Emergencies/Medically Compromised

- ADA online resources for dental office emergencies
- 2017 American Heart Association Focused Update on Adult Basic Life Support and CPR Quality.
- 2017 American Heart Association Focused Update on Pediatric Basic Life Support and CPR Quality.
- Malamed, Stanley F. *Medical Emergencies in the Dental Office*, Seventh Edition. Elsevier-Mosby, 2015. Available online from various booksellers.
- National Maternal and Child Oral Health Resource Center—Pregnancy (includes consensus statement on oral healthcare during pregnancy and related resources)

Medications (General and Drug Diversion/Abuse)

- ADA Dental Drug Handbook: a Quick Reference.
- The Prescribers Letter and related Therapeutics Research content.
- Malamed, Stanley. *Handbook of Local Anesthesia, 6th* Edition. Elsevier/Mosby, 2013. Available online from various booksellers.
- Controlled Substances
- American Dental Association: resources/information on the opioid crisis
- What Dentists Should Know: select opioid-related articles from *JADA*
- Academy of General Dentistry: resources/information on the opioid crisis
- Prescribers' Clinical Support System for Opioid Therapies (PCSS-O). A consortium of professional organizations (free webinars are available)
- Opioid Overdose: Understanding the epidemic. Centers for Disease Control and Prevention, August 2017.
- Opioid Overdose: What States Need to Know—PDMPs. Centers for Disease Control and Prevention, October 2017.
- Dental Guideline on Prescribing Opioids for Acute Pain Management. Washington State Agency Medical Director's Group, September 2017
- Prescribing Policies: National Conference of State Legislatures. June 2019.
- Screening, Brief Intervention, and Referral to Treatment (SBIRT). Substance Abuse and Mental Health Services Administration, September 20, 2017.
- Facing Addiction in America. Office of the Surgeon General, HHS, November 2016.

Nerve Injury/Dysesthesia-Surgical/ Non-surgical

- Spencer, Klasser. Oral dysesthesia: a perplexing problem for practitioners. *JADA* 2017; 148(12):941-45.
- Pogrel MA. Nerve damage in dentistry. Gen Dent 35(2):34-41. March/April 2017.
- Bagheri SC, Meyer RA. When to refer a patient with a nerve injury to a specialist. *JADA* 2014; 145(8):859-861.
- Comment re Bagheri and Meyer article. Comment 2—author response. *JADA* 2014; 146(1):6-8.;
- Trigeminal Nerve Injuries (Springer, 2013). Miloro M, editor.
- Hillerup, Jensen, Ersbøll. Trigeminal nerve injury associated with injection of local anesthetics: Needle lesion or neurotoxicity? *JADA* 2011; 142(5): 531-539.
- Hillerup S et al. Concentration-Dependent Neurotoxicity of Articaine: An Electrophysiological and Stereological Study of the Rat Sciatic Nerve. Anesth Analg 2011; 112:1330–8.

Oral Cancer

- American Dental Association Oral Health Topics: Oral Cancer (multiple references and resources)
- Academy of General Dentistry Oral Cancer Screenings (multiple references and resources)
- Evidence-Based Clinical Practice Guideline for the Evaluation of Potentially Malignant Disorders in the Oral Cavity.
  - Evidence-Based Clinical Practice Guideline Chairside Guide

Patient Safety/Safety Culture

- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network (PSNet—an AHRQ website with patient safety news and resources)
- A Just Culture Guide/Toolkit. AHRQ, PSNet
- Team Strategies and Tools to Enhance Performance and Patient Safety, TeamSTEPPS® 2.0, AHRQ
  - TeamSTEPPS® dental module
- Curtis DA, et al. Patient-centered risk assessment in implant treatment planning. Int J Oral Maxillofac Implants. 2019 March/April; 34(2):506-520.
- Perea-Perez B et al. Eleven basic procedures/practices for dental patient safety. J Patient Saf, 2016.
- AAPD Guideline on Protective Stabilization. AAPD Council on Clinical Affairs, adopted 2017
- Maramaldi P et al. How dental team members describe adverse events. *JADA* 2016:147(10):803-811.
- Time-out policy/procedure (wrong site/wrong tooth procedure or surgery): University of WA procedure (Sept 2016).
- The Inside of a Time-out (wrong site/wrong tooth procedure or surgery): AHRQ article
- Obadan EM, Ramoni RB, Kalenderian E. Lessons learned from dental patient safety case reports. *JADA* 2015:146(5):318-326.
- In Conversation with...Bernardo Perea-Perez, MD, DDS, PhD. PSNet, Agency for Healthcare Research and Quality.
- Hupp JR. Creating a Culture of Safety. *JADA*, 145(4), April 2014, pp. 321-324.
- Christman A et al. Designing a safety checklist for dental implant placement: a Delphi study. *JADA* 2014;145(2): 131-140.

Practice-Based Research

- The National Dental Practice-Based Research Network. (NDPBRN)
- National Institute of Dental Craniofacial Research. NDPBRN page

Radiographic References/Resources

- Image Gently® Campaign. What Can I Do as a Dental Professional?
- American Dental Association: X-rays/Radiographs: includes link to Recommendations for Patient Selection and Limiting Radiation Exposure — ADA/FDA Guidelines.
- FDA — Information for Dental Professionals (hyperlinks to a number of resources)
- AAOMR/AAE position statement on CBCT. J Endon, Sept 2015.
- AAOMR position papers
- CBCT Accreditation Resources
  - AAOMS
  - ADA
  - Intersocietal Accreditation Commission (IAC)—Dental CBCT

Record Keeping and Documentation

- Dental Records ADA Center for Professional Success (members-only content)
- HealthIT.gov: Safer Guides (guides to electronic record safety)
- Dental Informatics Standards and Technical Reports (ADA)
- Electronic Health Records (EHR) Systems—General Considerations Before You Buy. ADA Center for Professional Success (members-only content)
- Direct Project/Direct Secure Messaging (website and overview)
- DirectTrust overview

Social Media Resources

- Getting Started in Social Media. U.S. Department of Health & Human Services
- CDC's Social Media Toolkit
- Emmet, L. Protecting Patient Rights on Social Media. AGD online resource
- Guidelines for Practice Success: Managing Marketing—Best Practices. ADA Catalog, item P553BT.
- The Danger of Social Media for Healthcare Professionals. Health Careers Website
- Ventola, CL. Social Media and Health Care Professionals: Benefits, Risks, and Best Practices. PT. 2014 Jul; 39(7): 491-99, 520.

Index

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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