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Why patients sue — and how effective communication can help avoid a lawsuit

No healthcare provider welcomes being on the receiving end of legal action from a patient. A lawsuit can leave providers feeling frustrated and disappointed. After all, as a dentist, you are likely committed to delivering quality care and likely pride yourself on your positive relationships with your patients.

Unfortunately, sometimes situations emerge that prompt patients to file lawsuits. But by understanding the reasons behind why patients often file lawsuits can help you take steps to prevent them.

Why a lawsuit?

Based on an analysis of several articles, Huntington and Kuhn identified four reasons why patients file a lawsuit: (1) a desire to prevent similar (adverse) incidents from occurring; (2) a desire for an explanation as to how and why an injury occurred; (3) a desire for financial compensation to make up for monetary losses, pain, and suffering or to cover the cost of future care for the injured patient; and (4) a desire to hold providers accountable for their actions.

Huntington and Kuhn noted that the dominant theme in the studies was a breakdown in the patient-provider relationship because of unsatisfactory communication. (Although these studies focused on physicians, it's likely the findings would apply to other providers as well, including dentists.) Examples of communication issues included patients feeling providers did not listen to them, did not talk to them openly, did not warn them of future problems, did not understand their perspective, devalued their views, and even misled them.

Establishing a positive relationship that includes effective communication can go a long way to help prevent legal action. Huntington and Kuhn noted that patients tend not to pursue legal action against providers whom they "like and trust."

Notably, protection from legal action is not the only reason to hone your patient communication skills. According to the Institute for Healthcare Communication, effective communication has several other benefits, such as better diagnostic accuracy, greater patient adherence to the plan of care, higher patient satisfaction, and reduced risk of patient harm.

Here are some suggestions for improving your communication skills with patients.

Establish rapport

Rapport helps create a positive relationship with a patient. You and all dental office staff can establish rapport by first greeting patients warmly. Smile, make eye contact, and if appropriate, shake hands.

During the encounter, be sure your interaction with the electronic healthcare record (EHR) or your documentation does not overshadow your interaction with the patient. Sit rather than stand to indicate you are not in a hurry. Avoid crossing your arms, which can be off-putting.

Humor, if used appropriately, can help establish rapport. However, do not overuse humor and be aware that what humor is considered to be appropriate vary considerably from one person to another.

A critical contributing factor to rapport is respect. Demonstrate respect by engaging patients in conversation. Ask them for their input and thoughts on your ideas for treatments or strategies for following treatment instructions. Be sure to check for understanding, particularly when delivering patient education. Align your interactions with the cultural background of the patient. (One resource improving your ability to communicate with those of different cultures is the "Guide to Understanding Effective Communication and Language Assistive Services," published by Think Cultural Health. Access the guide at https://hclsig.thinkculturalhealth.hhs.gov/).

Finally, and probably the most important way to establish rapport, is to listen. Focus on what the patient is saying and not on what you plan to say next or on other tasks you still have to complete.

Set expectations

Few people like to be surprised, particularly when it comes to their oral healthcare. That's why dentists need to ensure patients know what to expect from the plan of care, including any procedures that may be necessary, or changes to medications, activities, or diet. Be realistic in what you say. Don't make statements such as, "You'll be fine." Instead, Huntington and Kuhn suggest saying something like, "Barring any unforeseen problems, I see no reason why you shouldn't do very well. I'll certainly do everything I can to help you."

Be clear with patients about the next steps. For example, a patient scheduled for a root canal needs to know what will happen in each phase of the procedure: removing the inflamed pulp, cleaning and disinfecting the surfaces inside the tooth, and filling and sealing the tooth. It would be important for the patient to know that they will likely continue to be numb for several hours after the procedure and that they may experience some sensitivity or discomfort for a few days (though some patients may expect to be pain-free).

Patients also should know what is expected from them. In the case of the root canal example, this could include taking any antibiotics or anti-inflammatory medications as prescribed, avoiding smoking and drinking alcohol, and eating a healthy meal a couple of hours before the appointment. Be clear on any consequences related to not meeting expectations, such as the need to postpone the procedure if the patient fails to take all antibiotics as prescribed. Dentists and dental hygienists should utilize the teach-back method throughout the patient encounter to ensure all information and instructions are explained properly, in a manner the patient understands and will remember.

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Defuse anger

Fear is usually the root cause of anger. Try to determine what the patient is afraid of by listening closely. For example, a patient may say they are upset because a dentist didn't tell them a procedure might cause some temporary numbness or discomfort, but they are really afraid the discomfort may indicate a serious condition or that the treatment isn't working. Once you identify the real issue, you are better able to resolve it.

After hearing the patient out, Huntington and Kuhn recommend expressing empathy, and then apologizing that things have not gone the way the patient hoped or expected. Above all, do not respond defensively nor avoid the patient.

The next step is to address the issue. Ask the patient what they want and explain what can and can't be done. The goal is to re-establish a positive relationship.

Be honest

The dentist-patient relationship must be built on trust, and trust depends on honesty. Being honest includes providing information related to diagnosis and test results, as well as sharing possible adverse outcomes of procedures.

Honesty needs to be maintained when a complication occurs. The dentist should explain why it occurred and how it can be managed.

If the complication occurred because of an error, Huntington and Kuhn recommend disclosing this fact to the patient and offering an apology. In some professions, disclosure is seen as an ethical responsibility. The Patient Safety Network notes that the components of disclosure most important to patients include an explanation as to why the error occurred, how the error's effects will be minimized, and steps that will be taken to prevent the error from happening in the future.

The American Dental Association (ADA) offers a free on-demand program, *Communicating with Patients When Things Go Wrong in Dentistry*, that may aid in these disclosures. Access the course at https://ebusiness.ada.org/education/viewcourse.aspx?id=635.

Fears of a lawsuit often make dentists reluctant to disclose. However, patients are more likely to change providers or take other non-legal actions rather than file a lawsuit, especially when the provider is honest about what happened. In addition, some organizations, such as the University of Michigan Health System, have reported that having a structure for responding to and being transparent about errors reduces the number of malpractice lawsuits.

Dentists also should remember that not all complications and errors are the result of negligence. For instance, *Clostridioides difficile* may occur as a result of antibiotic administration, but that doesn't mean it was wrong to prescribe the antibiotic.

Before disclosing an error, talk with your risk management department or attorney to understand how to best approach the situation. It is also critical to notify your professional liability insurance provider.

Communicating for success

A communication breakdown is a common reason why patients choose to take legal action against providers. By using effective communication techniques (sidebar), you can create a positive relationship that reduces the likelihood of lawsuits and benefits both you and the patient.

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4 Es of communication

The 4 Es communication model is an easy way to promote positive interaction at each patient encounter:

1. **Engage.** Invite patients to share their health stories. Ask open-ended questions to help you find out what matters most to the patient.
2. **Empathize.** Show patients that you see and hear them. Accept their values even if they are different from your own.
3. **Educate.** Ask patients what they know and what they want to know. Answer their questions, provide written information, and ask questions to confirm their understanding.
4. **Enlist.** Forge a partnership by collaborating with patients to make care decisions. Seek agreement on treatment plans and monitor progress.

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Treatment of Diabetic Patient Allegedly Results in Infection and Sepsis

Although medically complex patients may be treated safely and successfully in the dental office setting, the dentist must consider the potential impact of a patient's medical status on dental treatment recommendations and decisions. This process begins with obtaining a comprehensive medical history and, when necessary, further investigation of the patient's condition and co-morbidities in an effort to determine whether treatment benefits will outweigh the risks.

This case involves the treatment of a patient with a history of type 1 diabetes mellitus (T1D). More than 37 million individuals are living with diabetes in the United States, including approximately 2 million with T1D. The Centers for Disease Control and Prevention (CDC) reports that co-existing conditions and complications may be significant, involving major cardiovascular disease, kidney disease, lower extremity amputation, vision loss and other health challenges.

CLAIM CASE STUDY

Practitioners: General practitioner dentist (GP)

Claimant: Male, aged 38 years, diagnosed with T1D since age 9. Diabetic-related co-morbidities (not known at the time of treatment) included diabetic retinopathy with macular edema of the right eye, cardiovascular disease and kidney disease. The patient also failed to disclose certain details of his medical history, including a past dental infection that resulted in hospitalization.

Risk management topics: medical/dental history, management of medically complex patients, medical consultation, post-treatment communication and documentation

Facts: The patient presented for a new patient examination and assessment for dental restorations. According to the history provided, it had been 8 years since his last dental visit. The medical history indicated T1D. The patient commented on the medical history form that his health was "good" overall. Although "cardiovascular disease" (CVD) was affirmatively checked on the history form, no further details were provided.

The examination revealed extensive decay on tooth 14, as well as decay on partially erupted teeth 16 and 17. The dentist observed moderate to heavy posterior calculus with bleeding on probing in most pocket areas. The proposed treatment plan included scaling and root planing, followed by extraction of 14, 16 and 17. The patient refused an implant-supported crown to replace tooth 14, opting instead for a 13 to 15 fixed bridge.

The dental hygienist began root planing that day and completed it the following week. The patient scheduled the extractions for 10 days later. After administering anesthesia, teeth 14 and 16 were removed without complication. The partially impacted tooth 17 proved to be more difficult. The doctor exposed and removed distal-buccal bone and began tooth luxation. However, the crown was weakened by decay and loss of tooth structure. After the crown of the tooth partially fractured, the dentist used a handpiece to remove the remaining tooth crown. He then separated and removed the mesial and distal roots, and placed a bone graft. Verbal and written post-op instructions were provided before patient discharge.

Four days later, the patient allegedly contacted the office to complain of persistent jaw pain with swelling and a sore tongue. He spoke with a front desk team member. However, the call was not documented in the dental patient information record. The team member advised the patient to follow directions for warm salt water rinses, which had been included in the written instructions, and to use the pain medications prescribed on the day of surgery. If his condition worsened, the patient was instructed to call back.

One week later, the patient's spouse called the office to advise that the patient had been admitted to the hospital with an infection and sepsis. Upon learning of this development, the dentist contacted the patient's spouse who indicated that her husband went to urgent care two days prior, and the physician prescribed antibiotics. Following two of the first three doses, the patient vomited and his condition worsened, leading him to seek care at the hospital emergency department (ED). Upon admission to the ED, his blood glucose was 320 mg/dl but the patient reported that it had been over 500 a few hours before when the level was checked at home. The patient was admitted to the intensive care unit (ICU) with infection, diabetic ketoacidosis and dehydration. The ED initiated intravenous antibiotics, which continued after admission.

Shortly after the patient's admission, the ICU diagnosed sepsis. Given the recent dental treatment, the medical team requested an oral surgery consult. The oral surgeon's exam revealed a failed bone graft and a suspected abscess near the tooth 17 extraction site. An attempt to drain infection from the area was unsuccessful initially, but successful 24 hours later. After three days, the patient began to improve. Ten days after admission, he was discharged but remained on IV antibiotics for another month via a peripherally inserted central catheter (PICC) line.

Key Allegations: Failure to seek medical consultation; failure to meet the standard of care for extractions and post-treatment follow-up; failure to refer/offer referral.

Alleged Injury/Damages: Post-surgical infection, sepsis and related medical sequelae, current/future medical expenses, lost wages, pain and suffering. Plaintiff demand: $700,000.

Analysis: Dental professional liability case studies often raise interesting and difficult questions. The prudent dentist must consider many factors in order to address such questions, including the patient's best interest, appropriate risk management principles, and balancing these points with reasonable business practices. Possible questions associated with this case (with proposed responses) may include the following:

- **Can (or should) the dentist trust that a patient will provide an accurate medical/dental history?**

  Although every dentist may anticipate that a patient will provide a comprehensive and accurate history, a prudent practitioner may wish to adopt a "trust, but verify" policy. This protocol is especially important for situations such as medically compromised patients, new patients with whom the dentist has not yet developed a working relationship, and/or patients for whom dental and/or medical care reflects extended time gaps and a lack of adherence.

- **Based upon the proposed treatment plan, what serious adverse events may be most likely to occur with this patient? Is more information needed to make this determination?**

  Although the patient indicated that he was in "good" health overall, his T1D was diagnosed at a relatively young age. Even with controlled T1D, the patient is at higher risk for a number of co-morbidities that may lead to a dental incident. As in this case study, patients with T1D may exhibit compromised healing, with a higher risk for infection, especially if the diabetes is uncontrolled. Based upon the early disease onset, this patient also may be vulnerable to serious cardiovascular outcomes.

  Discovery during the claim investigation led to a number of concerning facts. The patient's hemoglobin A1c (HbA1c) test results while hospitalized and other healthcare information records clearly indicated poor patient adherence to medical recommendations to manage his T1D. In fact, his diabetes had been uncontrolled for most of the previous 8 to 10 years. The uncontrolled diabetes probably contributed to his previous and undisclosed hospitalization associated with dental treatment.

  The discovery process also provided information on the patient's cardiovascular disease history. For several years, he had been taking a "statin" (adherence to the statin protocol was unknown) to lower cholesterol. Statins are a commonly prescribed medication for T1D patients with retinopathy and nephropathy. Although he quit 5 years before this dental incident, an undisclosed history of cigarette smoking may have also increased the patient's medical risk profile.

  The patient certainly bears responsibility for undisclosed conditions and history. However, it may be asserted that a prudent dentist would suspect potentially significant co-morbidities and that even a limited doctor-patient medical history discussion would have led to further investigation and increased awareness of the patient's health status and risk profile.

- **What additional information is needed, and at what cost? (Cost considerations may include topics such as: treatment delays, with associated dental disease progression and/or pain; new diagnostic tests or second opinions, leading to additional patient expense; or referral to a dental specialist for treatment, resulting in reduced dental practice income.)**

  Although the patient did not experience an adverse cardiovascular outcome, understanding the complete patient history would have provided the dentist with important information for risk assessment. At his initial dental visit, the patient did not require urgent care. Therefore, it is unlikely that a short treatment delay to obtain a medical consultation would lead to significant cost or dental health consequences. Had the dentist tried to obtain contact information for the patient's primary care physician or endocrinologist, a phone call may have revealed important details about the patient's poor adherence and HbA1c history. Notably, many dentists now have the ability to check a patient's HbA1c in the dental office. Although defense experts opined that diabetes testing was not required to meet the standard of care, performing the test or requesting records from the patient or his physician at the time of the new patient visit may have prevented a serious adverse outcome and malpractice lawsuit.

- **Is medical consultation required in order for dental treatment to safely proceed?**

  The response to this question is, of course, "it depends" on many factors, including the individual patient history and the practitioner's knowledge and experience. An accurate, comprehensive and current medical history represents an essential tool in providing quality dental care. Moreover, it is the starting point for a discussion that will ultimately reveal whether or not the benefits of dental treatment will outweigh the risks to the patient - and the dentist.

Outcome: Defense experts generally supported the dental treatment provided. However, they were concerned about recordkeeping issues, including the failure to conduct and document a medical history discussion to clarify or expand upon the information in the patient history form. In addition, the office failed to establish and implement a protocol for the professional assessment of post-treatment patient complaints. Not only did the front desk team member fail to document the patient phone call and discussion, she did not advise the dentist of the call or patient complaint. A dentist-patient discussion may have revealed early signs of the developing infection, as asserted by the plaintiff's experts.

The case proceeded to depositions and then mediation. Although the defense case was strengthened by the patient's history of non-adherence to medical recommendations and his failure to disclose important medical history details, the defense team and insured dentist agreed that going to trial would present an inordinate risk. Mediation resulted in settlement significantly below the plaintiff's demand, with a total incurred (indemnity plus defense expenses) of approximately $250,000.

Risk Control Comments: In addition to the hyperlinks included throughout the case study, dentists may wish to review content and resources available on the American Dental Association website regarding dental care for patients with diabetes.

By taking and regularly updating the patient's medical history, dentists may identify significant treatment risks, prevent drug interactions, identify oral manifestations of systemic diseases or pharmacotherapy, and better manage patients with medical conditions such as heart disease, high blood pressure, cancer, and diabetes. Evidence of a dentist's lack of diligence in asking for, investigating and distributing vital medical information could support a patient's claim of professional negligence.

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