Dental malpractice: Practical tips on avoiding a dental malpractice claim

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Abstract:
With a few simple strategies, dentists can avoid the expensive trauma of malpractice litigation. Sometimes it's just a matter of maintaining good records.

Obviously, no dentist ever wants to be sued for malpractice. Beyond these strong sentiments, however, few dentists take the time to analyze their own practice for risk exposure and take affirmative steps to minimize the chances of a malpractice suit. There are numerous proactive measures which every dentist should consider to help reduce the chance of a lawsuit.

Outlined below are several practical measures which reduce the risk of possible exposure for malpractice. In general, the following suggestions are organized under six major themes dealing with patient selection, treatment objectives, dental records, the importance of x-ray, consent to dental treatment, and the agency issue.

Avoid problem patients

The first thing you can do to reduce the risk of exposure is exercise caution in selecting patients. A dentist-patient relationship is a voluntary relationship. Other than in an emergency situation, in most instances you can refuse treatment provided prudent follow up steps are taken.

Most problem patients have a number of similar characteristics. The key is to identify these "red flags" before treatment begins. As a part of the initial patient interview and questionnaire, you should obtain some information regarding the patient's prior history of dental services. If a patient has seen numerous dentists over a relatively short period of time, there is an increased chance that the patient will be dissatisfied with your services. Secondly, inquiries should be made regarding the patient's expectations concerning the services and the fees. If a patient makes negative comments about a prior dentist's charges, there is an increased likelihood the patient will also find your fees or services disagreeable. Thirdly, problem patients often stem from providing services to relatives. In my experience representing dentists, dentists who perform services for relatives tend to let their guard down a bit. The dentist is less apt to keep complete records. Office visits are sometimes not recorded in the chart and the diagnosis, treatment plan and the actual services rendered are frequently omitted because of the familiarity with the patient. This problem also comes about when the patient is a close friend.

Before agreeing to treat a patient, you should have a clear understanding of the patient's prior history of recent dental treatment and whether the patient has any complaints of the prior treatment or fees. Also, if you do provide services to a close friend or relative, be sure to treat that person the same as you would treat any other patient, especially with regard to record keeping, despite the tendency to adopt a more informal manner. If you decide not to treat the patient, be upfront with the patient and send the patient a short note confirming you declined to render any services and suggest they contact a local dental society or their PPO for referral to another dentist. Never forget that in the end, unless there is an emergency situation, you do have a choice whether to agree to the dentist-patient relationship.

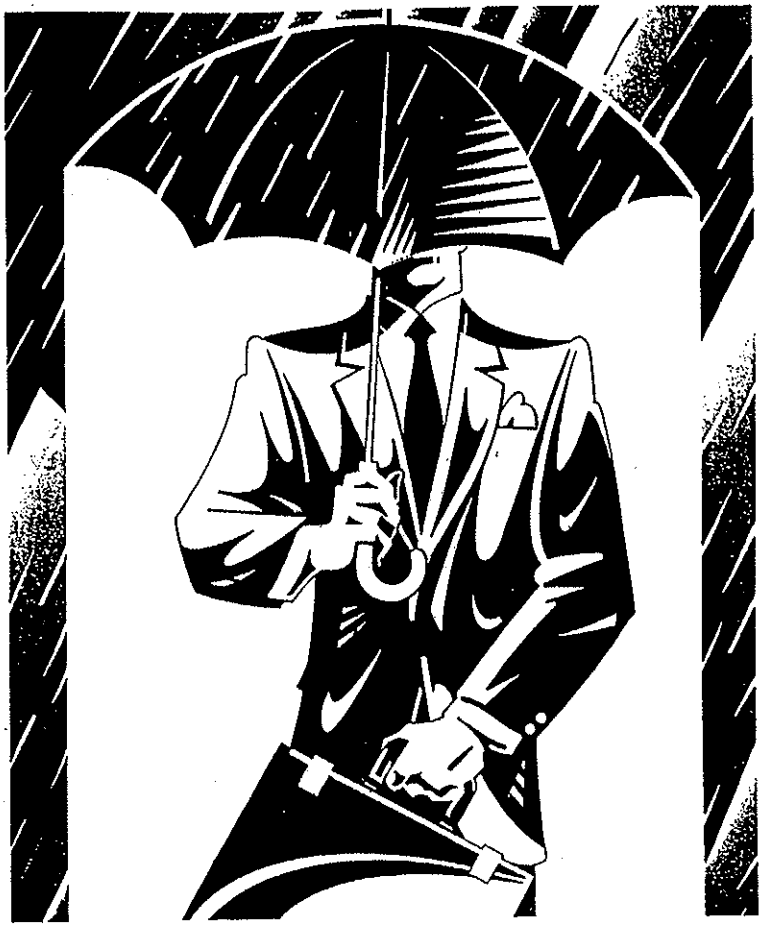
Define clear treatment objectives

Many dental malpractice claims result from the simple lack of communications between the doctor and the patient. Before treating a patient, be sure the patient understands the objectives for treatment so there is a guide post to measure the result. Also, if you have a relationship with the patient over a long period, you need to make sure that at each stage of treatment the patient understands what it is you plan to do and why. If you recommend six month recalls for cleaning and the patient fails to follow up—document this in your chart. Ultimately the patient is responsible for their dental health, but you may need to be able to

show later on that the patient dropped the ball.

When explaining a treatment plan to a patient, avoid the problem of over promising results. If the result is uncertain give the patient your best judgment concerning the chance of success but don't guarantee a positive outcome. Clearly outline the goals of your treatment.

For example, if you are a general dentist and the patient is on a recall program with a periodontist, be sure the patient understands that you are relying upon the periodontist to monitor the ongoing periodontal condition. If you are an orthodontist and the patient is also seeing her general dentist for check ups, be sure the patient understands that the scope of your duties does not generally include monitoring a patient's dental health for any carries or periodontal concerns. Likewise, if you are a periodontist and you are following the patient over a period of time and you detect caries, be sure the patient understands that you do not consider it within your duties to treat the patient for this condition if that is in fact the case. And again, document all of these discussions in your chart.



Protecting yourself from malpractice litigation begins from the moment you choose to treat a patient, continues through every phase of the doctor-patient relationship and relies on clear communication and accurate record keeping.

Doctors are often accused of failing to take x-rays particularly where the patient is seeing more than one dentist. If you are assuming that the patient's other dentist, such as a general practitioner, is periodically taking x-rays, be sure the patient understands this and remind the patient that he or she needs to follow up with their general dentist.

Finally, when you explain to the patient your treatment objectives and the scope of the services which you plan on rendering, it is important to convey to the patient a sense of their own responsibility for their dental health. You should adopt a team approach and stress that you are only one member of a team effort to maintain the patient' s dental health.

Defining the goals of treatment with the patient at each stage of treatment helps avoid a misunderstanding with the patient and reduces the chance of a malpractice suit.

Accurate records

The most frequent cause of dental malpractice claims, and dental malpractice settlements once a claim has been filed, stem from poor record keeping. Dentists in general have a poor track record of keeping adequate records. As someone who has represented numerous dentists, more often than not, the case would otherwise be defensible if the dentist had maintained proper records. Records must be detailed, accurate, concurrent and complete no matter how tedious and time consuming.

Good record keeping begins the moment the patient walks in the door. If you don't use the dental history form at this time, you should immediately start doing so. Also, make sure the patient completes the form in his or her handwriting. The form must be completed in its entirety. Don't leave any area unanswered by the patient. Typically the form will have many questions requiring a yes or no response. Make sure each question is answered. Adopt a custom and practice in your office to review the form with the patient. Initial the form in your handwriting after having done so. If you are sued, you can then refer to your initials as an indication you reviewed the information on the form with the patient even though you may not be able to recall at the time of the later lawsuit.

After obtaining the complete history, be sure to document in the chart at each visit, the following information: the patient's subjective complaints;

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Sample letter for termination of care

NOTE: This letter should be typed on the dentist's letterhead and sent to the patient by certified mail. A copy of the letter and the return postal receipt should be kept in the patient's chart. If the certified letter is returned, leave it unopened and place it in the chart.

Date

Dear _____:

You will be requiring further dental care which I will not be providing to you. You should promptly place yourself under the care of another dentist. If you have not received a referral to another dentists or if you wish to contact a dentist who has not previously cared for you, you may call the local dental society for a referral.

(You may wish to tell the patient the reasons for termination of care, particularly if it is for nonpayment of bills or noncompliance with strongly recommended treatment plans and follow-ups.)

To make it easier for you to transfer your care to another dentist, I will remain available to treat you for a short time, which will be no more than 30 days following the date of this letter (for emergencies only). Please try to transfer to a new dentist as quickly as possible within that period.

When you have selected another dentist, please send us a signed authorization so we can forward a copy of your dental chart or summary of its contents to your next dentist.

Sincerely,

_____, DDS

your objective findings; your diagnosis; your recommended treatment; any actual treatment that is rendered; a decision by the patient not to undergo treatment; any medication that was used during treatment; any prescriptions given to the patient and any follow up appointments which were scheduled or recommended. It is particularly important to record the patient's chief complaint as well as your diagnosis.

When recording the patient's complaints, adopt a habit of putting the patient's exact words in quotations on your chart. If you are later sued, the chances are you won't be able to remember exactly what the patient said. If you have that recorded in quotations, you can refer to that statement in your records during your testimony.

For significant dental treatment, it is important to outline a treatment plan on a separate sheet of paper. Provide a copy of the treatment plan to the patient. Record in your chart that the patient received the treatment plan.

For numerous reasons, including financial cost, some patients elect not to undergo elective treatment. In many instances, you are faced in your practice with the situation where you could either continue to treat a tooth with a larger restoration or recommend a root canal and crown. If a patient has adopted a minimalist approach to treatment and elected to continue to pursue continued restoration rather than a crown in a situation where it is basically a judgment call and either treatment is acceptable, you should record in your chart the fact that you explained the various alternative treatments to the patient and the patient's decision. It is unfortunate that many dentists who attempt to work within a patient's financial constraints sometimes find themselves defendants in malpractice actions because they did not take a more aggressive approach and recommend root canals and crowns. Usually this results because the chart is silent on the fact that the dentist explained to the patient various alternative treatments, the relative merits of the various alternatives as well as the patient's decision to forego more aggressive treatment.

Don't forget to chart phone calls with patients. It is easy to simply address the patient's concerns over the phone without following up by recording that conversation in the chart. It is important that any phone conversations with the patient be noted in the chart and that a description of the conversation be recorded.

Even after your relationship with the patient has ended, you should keep a copy of your records. Illinois law requires that you keep your records for 10 years. If your records are later requested by the patient or subpoenaed by his lawyer, be sure to keep a complete copy of all records as well as any x-rays or molds. Again, even though it is time consuming and costly to retain these documents and x-rays, it is imperative that you do so if

your attorney is to provide you with an adequate defense. Often, x-rays or records get lost in the mail. If possible, you should try to keep your original x-rays. If your chart and x-rays are requested, ask the patient or the patient's attorney if they will accept a copy. The same rule applies to any molds or models. If they are subpoenaed, make arrangements to have them duplicated and keep the originals if possible or at least a copy.

If you are ever faced with a situation where you have a request for records from a patient or the records are subpoenaed as part of a pending lawsuit, avoid the temptation to alter the records in any way. Frequently, the dentist's first impulse is to immediately review the records and add notations in the chart of any omitted information. Avoid this temptation. In general, you should never alter or supplement your records after the fact. If there is additional information which belongs in the chart that was omitted for whatever reason, prepare a memorandum to your attorney outlining the additional facts. Don't give the memorandum to the patient or the patient's attorney even if your records are subpoenaed since the document is considered a privileged communication with your lawyer. While this does not become part of your chart, the information will assist your lawyer in defending your case. Attorneys are skilled at spotting altered records. It is very difficult to defend a dentist when it is apparent his or her records were altered. Often lawsuits involve issues of credibility as much as any thing else. Once your credibility is inpuned through facts showing you altered the records, you already have two strikes against you. No matter how strong the temptation, never under any circumstance alter your records in any way. Save the additional information for your attorney.

For the same reason, avoid using pencil or white-out in your records. Pencil can easily be erased opening you to the charge that the entry was altered or made at a latter date. White-out also suggests to an attorney that the records were altered. If you make a mistake as part of your record entry, draw a single line through the mistaken entry so it is apparent you were not trying to hide the information, initial and date the correction, and then continue on with the correct information.

There is one exception to the rule that the record should be as complete as possible. Irrelevant data should be omitted. For example, you should generally avoid recording any negative or subjective comments about a patient unless it directly relates to the treatment or its success. If a patient is not following your instructions, that should be recorded. This sometimes arises where the patient refuses to practice proper home hygiene. On the other hand, subjective thoughts and feelings regarding the patient should not be recorded in the chart.

To consistently keep good records, you must adopt a specific manner of record keeping that you follow with each patient. Often it is simply too time consuming to record all the required information between patients. One way to increase your efficiency is to adopt the practice of using a Dictaphone. Before seeing the next patient, you can simply dictate all the required information into a small hand

Letting a patient go—2

Sample letter for termination of care

NOTE: This letter should be typed on the dentist's letterhead and sent to the patient by certified mail. A copy of the letter and the return postal receipt should be kept in the patient's chart. If the certified letter is returned, leave it unopened and place it in the chart.

Date

Dear _____:

The relationship of patient and dentist is a very special one and should continue only so long as both parties are fully confident that a continuing relationship will contribute to the dental care which will provide satisfaction to both parties. When either of the two parties has less than complete confidence in such a relationship, then it is necessary to terminate that relationship.

Unfortunately, I find it necessary to advise you that it will be necessary for you to establish a new relationship with a new dentist as soon as reasonable. If this office can be of assistance to you in locating a suitable dentist, please do not hesitate to call us. In the meantime, please be assured that we will handle any emergencies that arise within the next 30 days. Once you have selected another dentist, please return the signed authorization and we will send a copy of your dental chart or summary of its contents to your next dentist.

Sincerely,

_____, DDS

Frequently, general dentists are accused of failing to recognize and refer for treatment, patients with periodontal disease. Typically the next allegation is the dentist failed to take sufficient x-rays to recognize progressing bone loss.

held recorder which your secretary or receptionist can then type into the record the following day or shortly thereafter. If you use this method, however, you should be sure to review the typewritten entry for accuracy and initial and date the typewritten chart after it has been approved.

If you do write out your entries, try to make your writing as legible as possible. The first thing a former patient's lawyer will do after obtaining your records is to send them to another dentist for their review. If the reviewing dentist can't read the entries, they will be more apt to criticize your treatment. If your handwriting is lousy, try printing. Legible entries are also a great help to your lawyer later on.

The primary reason dentists are sued is because they don't maintain adequate records. When a plaintiff's attorney is reviewing a case to determine whether to bring a lawsuit against the defendant, the attorney will typically have the case reviewed by an outside dentist consultant. All that a consultant has to go by at that point are your records and your x-rays. If the required information is not in the chart or the x-rays have not been taken, the consultant will typically conclude that your treatment was inadequate. Even if you later are able to explain at your deposition the rationale for your treatment and even if it is eventually shown you met the standard of care during your treatment, you will still have been sued. On the other hand, if your records are accurate, thorough and complete, the chances dramatically increase that you will never find yourself a defendant in a malpractice case.

Dentists as well as patients naturally forget over time what was discussed during a visit as well as the details of the visit. Typically the records end up being the deciding factor. You should adopt the motto that if it isn't in your records, it never happened. Unfortunately, when it comes to defending your conduct in a malpractice case, that is often the standard with which you are judged at least initially by the plaintiff's attorney and the plaintiff's expert witness.

Understand the importance of x-rays

A close second to the importance of records is the importance of x-rays. Today, an increasing number of dentists are joining capitation plans. Frequently, these plans attempt to dictate the frequency of x-rays. If you are ever sued for malpractice, you will not be able to rely on the frequency with which the insurance plan would pay for the x-ray as the basis for the standard of care. Don't let the frequency with which you take x-rays be dictated by the capitation plan guidelines.

In my experience, many dentists are hesitant to take x-rays. I am not aware of any instance where a dentist has ever been accused of taking too many x-rays. The first thing an attorney will ask for if you are sued for malpractice is to review the x-rays. X-rays provide objective information concerning the patient's dental condition at a very specific time. On the other hand, many lawsuits stem from the dentist's failure to recognize and treat an on-going dental problem as a result of the lack of adequate or frequent x-rays.

Frequently, general dentists are accused of failing to recognize and refer for treatment, patients with periodontal disease. Typically the next allegation is the dentist failed to take sufficient x-rays to recognize progressing bone loss. A surprising number of dentists are not able to explain what their office procedure was regarding x-rays, how often they would take full mouth x-rays and under what circumstances. My recommendation is that your office procedure comply with current American Dental Association guidelines. If there is some reason to vary from the guideline in a particular patient, then it is a good idea to explain that in the chart.

X-rays will not do you any good in a lawsuit if you don't keep a copy. It is worth repeating that you should always retain the original of your x-rays if possible and, at a minimum, a copy. If you release any x-rays to a patient or pursuant to a subpoena, document in your chart the date and description of the x-rays which have been provided.

When you take an x-ray, be sure the name of the patient and the date the x-ray was taken is recorded on the x-ray. Dating the x-ray makes it a lot easier for your lawyer later on.

Sometimes x-rays are misleading. In some cases, to justify a malpractice suit, the plaintiff's reviewing doctor may rely on an apparent condition which is shown on x-ray but which is not supported by clinical examination. If this occurs, it is usually because the doctor failed to record in the chart the clinical findings which contraindicate the need for treatment. Just as x-rays can help prevent you from being sued, they can also further the chances of a lawsuit if you don't keep complete records which indicate that you followed up on any apparent pathology through a thorough clinical exam.

Document consent to procedures

Many dental malpractice suits involve allegations of lack of consent. Even if actual consent to a procedure is given by a patient, the plaintiff's attorney often charges that "informed consent" was not obtained since the relevant risk factors were not explained to the patient prior to treatment.

Obviously, you should obtain informed consent to all your dental procedures. It is not always necessary to require a patient to sign a separate

consent form, however, at a minimum, record in your chart the patient's verbal consent to the procedure as well as a list of all the disclosed risks. While it is not the standard of care, it is a good idea to obtain written consent for any procedure other than routine dental work including third molar extractions, apicoectomies, crown and bridge (particularly in the anterior area) as well as any osteotomy surgeries. Because of the varying schools of thought regarding the proper treatment plans, thorough informed consent to all treatments relating to jaw or facial pain should also be obtained in writing; particularly if there is a risk of nerve damage, necrosis or tooth loss. If a separate document is not signed, it is a good idea to require the patient to initial the chart confirming the disclosure of the relevant risks. Often patients claim after the fact that they were never told about the risks of the procedure even when they are outlined in the chart.

The manner in which you obtain written informed consent is also important. Be sure to allow the patient time to read the consent before asking for the patient's signature. In many instances, patients later claim that they were simply handed a consent form and told to sign it without having read the document.

Without detailed records relating to consent, it is difficult to defend the defendants in a malpractice claim involving the charge of a lack of informed consent since usually it amounts to the former patient's word against yours. Particularly in instances where you can't simply recall what was discussed with the patient because a treatment occurred a number of years earlier, your custom and practice and your records become even more critical.

Avoid exposure for your agents

A principal is liable for any act or omission of his or her agent. In the dental malpractice scenario, not only are you potentially liable for the conduct of your actual agent, such as your partner or employee, you are also potentially liable for any act or omission of someone who is your "apparent agent."

Practicing dentistry as part of a dental clinic increases the risk of your exposure for malpractice. Not only are you potentially a defendant for your conduct but you also might find yourself named in a lawsuit due to the conduct of another dentist in your office. This occurs even if you both practice as independent contractors because of the risk of exposure as a result of apparent agency.

If you are a partner in a dental clinic that retains independent contractors, be sure to obtain written independent contractor agreements with each independent contractor. Often the written agreements have a limited term of one year or more. If this is the case, be sure to update the written agreements periodically. Also, outline in the document itself that you have no control over the independent contractor's professional judgment regarding treatment of his or her patients.

Even if your status at the office where you work is an independent contractor and not an employee or partner, you are still potentially liable for the acts or omission of other dentists under the doctrine of apparent agency unless you take specific steps to avoid this exposure. If it appears to a patient that another doctor in your office was your employee or partner and the patient testifies he or she relied upon this appearance in a manner consistent with ordinary prudence, you may be liable for that dentist's acts or omission even if the person is an independent contractor.

To avoid exposure based on the doctrine of apparent agency, you should adopt a practice of disclosing to your patients the nature of the relationship with the dentists who practice at your clinic. If for example you have an oral surgeon on staff who is an independent contractor and not a partner or employee, require that the oral surgeon disclose this to the patient before rendering treatment. One easy way of doing this is to amend the initial patient history form to add a paragraph disclosing that the particular doctor is an independent contractor and not an employee, agent or partner of the clinic, followed by a sentence above the patient's signature confirming that they read the document prior to signing the form. Another alternative is to attach to the history form a separate document titled "Disclosure of Independent Contractor Status." You can then attach the form if applicable to the history sheet when it is given to the patient for completion. Using a separate form, which the patient should also sign, will reduce the chance the patient will claim that they didn't read or understand the disclosure provision.

I have represented numerous dentists in malpractice cases where the only connection to the lawsuit was their having practiced in the same office as the treating dentist. The plaintiff's attorneys typically name all the dentists who are affiliated with the office and include a charge of either actual or apparent agency. If you have a signed disclosure form in your file showing the patient was informed prior to treatment that no actual agency relationship existed, the chances dramatically decline that you will ever be named as a co-defendant in the lawsuit for the conduct of another dentist.

Be sure to allow the patient time to read the consent before asking for the patient's signature. In many instances, patients later claim that they were simply handed a consent form and told to sign it without having read the document.

Conclusion

It is impossible to completely avoid the risk of a malpractice suit. There are, however, a number of very practical steps you can take as pro-active measures to reduce your risk of exposure. It begins by being careful who you select as patients. Once you agree to provide a patient services, you should define the clear objective for treatment. The most important thing above all is to keep detailed, accurate, concurrent records and adopt a consistent and reasonable policy regarding x-rays. Once treatment is recommended, be sure to pay close attention to the need for informed consent which should always be documented in the chart if not acknowledged by the patient through a separate consent form.

Finally, you can greatly reduce the risk of your potential exposure if you are mindful that you can not only be sued for your own conduct, but also the conduct of other dentists who may be your actual or apparent agents.

Every individual dentist has a unique practice. Some of the above suggestions may not apply in every instance for one reason or another and you have to ultimately use your own professional judgment regarding which measures to adopt. The key is that you take the time to analyze your practice for malpractice exposure and take affirmative steps to minimize the risk of being sued. Some dentists find it helpful to consult with attorneys who represent other dentists in malpractice suits to provide pro-active recommendations regarding office procedures and policies which help reduce the chance of a lawsuit. Since the number of dental malpractice claims in Illinois continue to increase each year, it is likely this trend will continue.

Rolwes is a Partner in the law firm of Hinshaw & Culbertson in Chicago. He has represented numerous Illinois dentists