CHAPTER

4

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Ethical and Legal Issues in Treatment Planning

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The successful practice of dentistry involves more than the skills required to perform technically excellent dental treatment. It also requires skills that go beyond those necessary to plan and sequence treatment as described in other chapters of this book. A hallmark of a profession is that its members are accorded the privilege of self-governance, primarily because the profession is expected to put the needs of those it serves above the needs of its members. This chapter explores that concept in the light of the laws and other considerations that influence the modern dental practice. Core issues covered are the ethical and legal importance of the treatment plan, the extent of documentation required for the plan and for the treatment rendered, and what constitutes the informed consent required to carry out that plan.

Dental Team Focus

Ethical and Legal Issues and the Oral Health Team

The actions and decisions of the oral health team must be guided by ethical and legal principles. This requires that every member of the team take responsibility for his or her own actions, maintaining confidentiality, doing no harm, and treating each patient fairly.

The administrative assistant begins this chain of basic principles by maintaining confidentiality as the medical-dental health history is obtained and updated at each appointment and by obtaining informed consent from the patient before treatment begins. The clinical staff must follow the standard of care for every patient by performing clinical functions that are legal in the state or country they are practicing in and by maintaining a high level of knowledge. These responsibilities require constant attention to updating skills and maintaining the necessary credentials for certification or licensure.

To be truly skilled in the art and science of dentistry, a dentist must be able to assess the patient's needs, help the patient understand and recognize the need for appropriate treatment, and then perform clinically acceptable dentistry. In addition, the dentist must be able to master the record keeping, legal, and communication skills required by the modern dental office. It is important to recognize at the outset that although the law forms the foundation upon which this aspect of dental practice lies, mastery of the law only is insufficient. Successful professionals exceed the requirements imposed by the law, and furthermore, they appreciate and favorably resolve conflicts that can arise between mere laws or rules and the ethical or moral underpinnings of those laws.

HIPPOCRATIC OATH

The selflessness that grounds the healing professions springs from the Hippocratic oath, first articulated more than 2000 years ago by the physicians of Greece. In that famous oath, the issues of ability and judgment, confidentiality, ethical limits on the boundary of medical practice, and acting only for the benefit of the patient are espoused. Physicians and some dentists continue to swear to that or similar oaths upon their graduation and entry into the healing professions (Box 4-1).

The "golden rule" also supplies an ethical guidepost—treating others as one would wish to be treated. The useful extension of this guiding principle is putting one's self into the patient's shoes when making a treatment choice. If age, gender, or other issues make that transference awkward for patient or practitioner, then the dentist can put the decision in the perspective of what level of care would be provided if the patient were his or her own grandparent, parent, sibling, or child, all the while remembering to put the needs of the patient uppermost in the decision-making process. The clinician should avoid preconceived ideas as to what a particular class of individuals, such as the elderly, desire, need, or are due.

BOX 4-1 Examples of Oaths Taken by Health Care Professionals

A Generalized Medical Oath (Taken by Some Dental Graduates)

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care.

Another Oath Taken by Some Dental Graduates

I, as a member of the dental profession, shall keep this pledge and these stipulations. I understand and accept that my primary responsibility is to my patients, and I shall dedicate myself to render, to the best of my ability, the highest standard of oral health care and to maintain a relationship of respect and confidence. Therefore, let all come to me safe in the knowledge that their total health and well-being are my first considerations. I shall accept the responsibility that, as a professional, my competence rests on continuing the attainment of knowledge and skill in the arts and sciences of dentistry. I acknowledge my obligation to support and sustain the honor and integrity of the profession and to conduct myself in all endeavors such that I merit the respect of patients, colleagues, and my community. I further commit myself to the betterment of my community for the benefit of all society. I shall faithfully observe the Principles of Ethics and Code of Professional Conduct set forth by the profession. All this I pledge with pride in my commitment to the profession and the public it serves.

ETHICAL CODES

In the modern practice of dentistry, these historical guides to good practice have been distilled into the "Principles of Ethics and Code of Professional Responsibility" promulgated by the American Dental Association (ADA). In addressing the very concerns first voiced in ancient times, the Code articulates acceptable professional behavior in upholding patient autonomy, minimizing harm through nonmaleficence, maximizing patient welfare through beneficence, promoting the fair and equal treatment of patients or justice, and maintaining honesty through the principle of veracity. Although the Code states that violations of its provisions may result in disciplinary action, its practical effect is generally limited to standing or membership in the organization itself. Whereas in the not-so-distant past, expulsion from a professional organization, such as the ADA, might have had an effect as devastating as license revocation, the same cannot be said for today's practice arena. Fortunately, in many cases the law has become a substitute for what may otherwise have been lost. Each of the five ethical areas covered by the Code is addressed by the legal system. As will be shown, law, ethics, and morals require a dentist to do what the patient desires, subject to the limitations imposed by law, morals, and ethics. This chapter focuses on the interplay between these often competing themes.

DIAGNOSIS AND TREATMENT PLANNING

The dentist should operate from a patient-centered biologic database that is as complete and well documented as the office's financial database. Patient records that contain diagnoses and tests, a well thought out and clearly recorded treatment plan, written informed consent forms signed by the patient, and coherent progress notes can be seen as excellent evidence of professional competency. Clinicians may also experience ethical dilemmas as seen in the accompanying *In Clinical Practice* box. Preparedness can help the dentist avoid having a suit filed, effectively defend against any suit brought, and minimize compensatory damages in those rare instances when the patient-plaintiff prevails.

What's the Evidence?

The Most Common Types of Disciplinary Actions Initiated by State Dental Boards in the United States

In 2002, 1928 disciplinary actions against dentists were reported by U.S. state boards.[1] The most frequent action, occurring in 25% of cases, was to assess a monetary penalty or restitution (compensating for loss or damage). Approximately 17% of the cases resulted in probation, whereas 16% resulted in reprimand or censure. Remedial education and suspension each accounted for 10% of the disciplinary actions taken. About 4% of the cases resulted in voluntary resignation or retirement, and another 4% resulted in the dentist receiving treatment for substance abuse. The remaining disciplinary actions included: license revocation, practice restriction, controlled license sanctions, and medical or psychological evaluation or treatment.

1. COMPOSITE, ed 15, Chicago, 2004, Publication of the American Association of Dental Examiners.

LEGAL GUIDELINES

Types of Law

The U.S. legal system can be divided into two major divisions—civil law and criminal law. Because our legal system is adversarial in both divisions, attorneys represent clients, acting as advocates who enter facts into evidence and argue the law on behalf of their clients. Commonly, a jury of citizens is impaneled to be the trier of fact, that is, to rule on which party has proved its case. Judges rule on all matters concerning the applicable law and also on the facts in cases not heard by a jury. Civil law governs the private legal relationships between two or more parties, such as in cases of negligent actions or **tort law,** in other words, malpractice. Criminal law operates when a person commits a wrongful act against society or the public, such as driving while under the influence of alcohol. A nonsanctioned act directed toward an individual, such as an assault or battery, may also be a crime. A dental practice may interact with criminal or civil law or even, in unusual cases, both—a dentist could be charged criminally for battery and could be held liable for damages in the same incident. Administrative law, a smaller third division of law, governs the state and federal regulatory areas, such as professional licensing and rules for U.S. Medicare and Medicaid programs.

In Clinical Practice

An Ethical Dilemma

Upon graduation from dental school more than 20 years ago, some classmates kept in close touch as our practices were beginning. One classmate called during the first winter to discuss a new patient. When the patient had presented for his first examination, my friend noticed a lesion on the upper lip that he suspected might be cancerous. He called the lesion to the attention of the patient and suggested a biopsy. The patient declined; he only wanted his teeth restored. When the patient returned 2 weeks later, the lesion had increased in size and my friend's clinical diagnosis was melanoma—a frightening prospect. He again pointed out the extreme urgency of seeking prompt and thorough intervention. He even considered removing the lesion without the patient's consent while the area was anesthetized for a nearby restoration. What a dilemma. He felt strongly that he should intervene, but the patient was adamant in refusing the recommended treatment, even though it might be lifesaving. After the second visit, my friend concluded that he could no longer ethically treat this individual. One could argue that refusing to provide further care could only make matters worse because by the time the patient had found a new dentist, the melanoma might be too advanced for effective treatment should the patient change his mind. The outcome? Unknown. The patient never returned for that third visit. He was, as is so often noted in our professional journals, "lost to follow-up."

When you have completed your study of this chapter, ask yourself what this dentist might have done to better communicate the urgent nature of the diagnosis to gain the patient's acceptance of the recommended treatment. What will you do if faced with a similar circumstance? Although no answer is correct *per se*, this example does not seem to offer many easy choices.

DOCTOR-PATIENT RELATIONSHIP AND PROFESSIONAL LIABILITY

Malpractice claims for damages are civil suits based in tort law. To be successful, claims must satisfy four elements. First, the defendant must owe a duty to the plaintiff and second, the defendant must breach that duty. Third, the breach of the owed duty must result in damage to the plaintiff, and finally, the breach of duty must be shown to be the proximate cause of the damages. Malpractice claims usually allege negligence or fault by the dentist as the breach. The negligent act may arise from either the commission of or the omission of an act during treatment. The plaintiff must provide a preponderance of credible evidence that the alleged wrong occurred, thereby meeting the burden of proof. Each of the four elements must be addressed through evidence; failure to address and to prove each element can result in the case being dismissed in the defendant's favor.

Duty

The dentist owes his or her patient that degree of skill, care, and judgment possessed by a "reasonable" dentist. This is the benchmark against which an alleged negligent act is judged—in other words, the standard of care that must be established by expert testimony. Courts have cited the greatly increased opportunities for communication and education in the dental field as the foundation for a national or prevailing standard of care. In many jurisdictions, a plaintiff cannot use the testimony of a *specialist* to establish the standard of care for a *general* dentist. On the other hand, specialists have long been held to a national standard of care. In addition, general dentists who hold themselves out as specialists (and in some jurisdictions, even those who do not) are held to the national standard when performing treatment that clearly falls into the realm of the specialist. In essence, the courts require all dentists to properly diagnose disease.

The duty to treat arises from the doctor-patient relationship. This relationship may be either an expressed or a tacit agreement. The patient may unilaterally sever it or it may be terminated by mutual consent. The doctor-patient relationship may not be severed arbitrarily by the unilateral action of the dentist, however, without following certain guidelines. An improper termination of the dentist-patient relationship may constitute negligent abandonment of the patient with subsequent liability for damages. In most instances, a patient enters the dental office expecting treatment and does not distinguish between the examination, the treatment plan, and the actual treatment. If the treatment plan is not agreed to for any reason, both the dentist and the patient must clearly understand the next steps to be taken. It is important to realize that even if the relationship is properly severed, the dentist may still owe a duty to arrange for the opportunity of continuing treatment, including providing referrals and a referral source, and making copies of records available.

Breach of Duty

The breach of the duty owed is a negligent action defined as failing to do something that the ordinary, prudent person would do or conversely doing something that the reasonable and prudent individual would not do in the same or similar circumstances. A mere bad result or an unforeseen result does not constitute negligence *per se*. Negligence is established by one of two general methods. The first and perhaps the easiest is through a doctrine known as ***res ipsa loquitur*** in which the deviation from the standard of care is so obvious that expert testimony does not need to be offered to prove the departure. For example, a patient who sustained injury because of a radiographic unit toppling over or because a dental instrument was dropped in the patient's eye need only show that the injury occurred. It is commonly understood that such injuries are not the normal expected results of a dental visit. The extraction of the wrong tooth would also fall into this category of claims, although the services of a dental expert may be required to comment upon the extent of the injury suffered. It is important to note that in this type of case the burden of proof shifts to the defendant dentist to show by a preponderance of the evidence that negligence did not occur. The accompanying *In Clinical Practice* box discusses one such example.

The great majority of cases, however, require a demonstration of the standard of care from which the defendant is alleged to have deviated negligently. The degree of skill, care, or judgment required of the defendant dentist is that of the reasonable and prudent practitioner. As pointed out above, another qualified dentist must testify as to exactly what that means in each case. The standard of care testified to by the expert should not be "what in my opinion I would have done," but rather whether or not the treatment (or lack thereof) at issue is one that the reasonable (average) dentist might have provided under the circumstances. Because errors at the outset have the potential to deprive a patient of the future opportunity for proper treatment, courts have often held that the highest standard of care applies in the area of diagnosis.

In Clinical Practice

Breach of Duty

Some years ago the author was asked to review, before trial, a case of alleged dental negligence from a neighboring state. A woman in her early 20s faced the imminent loss of several molar teeth because of severe periodontal bone loss. Upon her request, her dentist had furnished his complete dental record documenting the treatment that she had received from age 10 through the prior year. The record consisted of a single page form combining an odontogram and progress notes. Numerous bite-wing and periapical radiographs were included in the chart folder. According to the notes, she had been seen every 6 to 8 months throughout the period in question. The notes mentioned that approximately 7 teeth had been restored with Class II amalgams during this time. Additionally, she had received "prophy, BWX, P.A. x 2" at nearly every visit. The record included no charting of or mention of periodontal probing or any other diagnostic testing, nor was there a treatment plan or any updated health history beyond the one completed by her mother at her first visit.

The bite-wing radiographs revealed no calculus, but when viewed sequentially, showed a clear progression over time of generalized periodontal destruction. Bone loss was greatest in the areas between the teeth that had been restored, apparently because nearly every interproximal box restored by this dentist had resulted in overfills with large overhangs. Corresponding maxillary and mandibular periapical views of the incisor teeth were included for each of the bite-wing sets. When questioned at deposition, the dentist maintained that his abbreviation "P.A." actually stood for "periodontal assessment" rather than "periapical." Of course, this case settled before trial. This patient may have had a systemic condition that accelerated her response to the local irritants, or she may have been the victim of an aggressive form of juvenile periodontitis. Nevertheless, this dentist's failure to recognize the progress of the disease, or if he had recognized it, to inform her of her deteriorating oral condition, cost her several teeth and his insurer tens of thousands of dollars. This case illustrates the need to assess and record the findings from current diagnostic aids in the light of previous tests and aids and to regularly update the patient's health history. I suspect that this dentist viewed each session's radiographs in a vacuum as it were, never comparing them with any others beyond the most recent and thereby missing the insidious, but relentless, progress of her disease.

Damages

Next, negligence must be shown to have resulted in damage to the patient plaintiff. This undesired result must be shown to have been foreseeable in the course of events. Although the exact type or extent of damage need not be foreseen, at a minimum, the facts must show that injury could be anticipated under the circumstances. Interestingly, the defendant dentist is said to "take the plaintiff as he finds him"; therefore different plaintiffs will suffer different degrees of damage from the same negligent act. For example, depending on the tooth in question or the number of remaining teeth, the extraction of a single wrong tooth could have vastly different consequences. Similarly the esthetic consequences and method of repair of that mistaken extraction will vary from patient to patient.

The final consideration for damages is that they must be quantifiable, not merely speculative. Commonly, a monetary amount is established that the court may award to a successful plaintiff as compensatory damages, designed to make the plaintiff whole or to restore him to the condition he was in before the negligent act. Compensatory damages include amounts for actual damages, such as past and future medical (or dental) expenses, loss of earnings, loss of consortium (e.g., love and affection), and other damages proved at trial, and noneconomic damages, such as pain and suffering. In certain jurisdictions, an additional damage award, known as punitive damages, may be assessed to punish the wrongdoer or to hold him or her up as an example to others to deter future occurrences. A showing of wanton and willful misconduct by the defendant is required to justify a punitive award. Some jurisdictions limit the total amount recoverable in a malpractice action or may place other limitations on various components of the damage award.

Many years ago, the case law in some jurisdictions prevented recovery by patients who had received treatment without charge—a charity exemption. Similar exemptions also once protected nonprofit and government-operated health care organizations from liability. This is no longer the law in most (if not all) U.S. jurisdictions. In today's litigious society, even the dentist who provides treatment at no cost—whether for charity or even as a gift to friends or family—remains at risk should negligence be proved. Regardless of the funding source, the dentist owes every patient the same level of skill, care, and judgment.

Proximate Cause

Establishing **proximate cause** is a factual matter. The evidence must demonstrate that the damages complained of flow directly from the negligent action of the defendant to the plaintiff without any other intervening cause and that, but for that negligent act, the damages would not have occurred. Some cases will fail the proximate cause test because even though the defendant dentist

deviated below the standard of care, the patient did not suffer any injury. Similarly, even if the plaintiff suffers an injury, the results may not be any different from those that would have been likely to occur in the absence of negligence. For example, the negligent extraction of a hopelessly periodontally involved tooth may not result in actual damages. One line of cases has held that failure to refer a patient to a specialist after a negligent injury has occurred, or referring that injured patient to a specialist shown to be incompetent, may constitute proximate cause. In a similar vein, failure to secure informed consent may be shown to be the proximate cause of damages suffered by a patient.

Some jurisdictions substitute a risk-benefit analysis to determine which party should bear the costs of a negligent action. Such an analysis may include an assessment of public policy or may apportion the fault among various entities based on which can best compensate the injured party and modify operating procedure to prevent future occurrences.

Other Factors

In certain situations, even if the plaintiff can meet the four requirements previously described, other factors may preclude the case from being judged. One of these is known as the statute of limitations—the case is just too old and would therefore be complicated by such factors as the possible loss of evidence and witnesses. The judicial system has a valid interest in limiting the time in which a case may be brought to the bar. Many jurisdictions place a 1-, 2-, or 3-year limit on the opportunity to bring suit, dating from when the plaintiff first knew or should have known that a negligent action had occurred. A similar bar to the courtroom is the statute of repose that operates to deny relief after a certain defined amount of time has passed, no matter whether the potential plaintiff has gained knowledge of the negligent act or not.

Conversely, in some situations, the amount of time available to the plaintiff may be increased. The act of fraud, such as concealing a negligent act from a patient, can in some jurisdictions overrule both the statutes of limitation and of repose. The age of the potential plaintiff at the time the negligent act occurs can also extend the amount of time available. For a minor, the counting of time under either statute may not begin until that minor reaches the age of majority. For example, a patient who is 6 years old may have until he or she is 19 (or older) to commence a suit for malpractice. In all states, the minor's guardian can commence a more timely suit if desired, and in some states, the guardian may be required to sue expeditiously or forfeit that right for his or her ward.

An additional consideration, which has been touched upon previously, is the concept of the "reasonable" person. The law uses this standard to judge the actions of individuals considering the facts of the case. The standard of care is established based on a reasonable dentist. The actions (or failure to act) of a patient are also subject to this test. The law does not expect perfect action, merely the action that a prudent person possessing the degree of knowledge, foresight, and discretion attributed to the average individual would be expected to perform.

ACCEPTING PATIENTS INTO THE PRACTICE

Who Must Be Accepted?

Is a dentist obligated to accept all comers as patients? The answer is a qualified *no* based on legal, ethical, moral, and personal considerations. Additionally, a patient can be accepted into the practice on a limited basis. Although the dentist has no legal obligation to accept a patient into the practice, caution must be exercised in this area. The refusal to appoint, examine, or treat a patient cannot be based on a legally impermissible foundation. For example, in the United States, it is illegal for a dentist to refuse to treat a patient if the refusal can be shown to be based on the race, creed, or gender of the patient because such status is constitutionally protected. Laws such as the Americans with Disabilities Act (ADA) have broadened the list of persons with legally protected status to include, among others, persons with AIDS and those who are HIV positive.

Who Must Be Treated?

The dentist has ethical and moral obligations to relieve pain when possible. Therefore, a patient must be thoroughly examined to diagnose the cause of the pain; assess the dentist's ability to render the requisite level of treatment, or at the very least, formulate a minimal treatment plan; and discuss the proposed treatment relative to the overall oral health prognosis. Through the proper use of informed consent, it is possible to limit the care of the patient to the examination only, to only the urgent care necessary, or to a limited-scope treatment plan. Furthermore, at any stage in the treatment of a patient, should personal issues interfere with the ability to care adequately for the patient, treatment may be terminated.

In such cases, the dentist must carefully record the circumstances in the chart. The entry should be factual and nonjudgmental, noting the problem (e.g., failed appointments, the patient's repeated noncompliance with instructions, or failure to honor financial commitments) and any attempts to rectify it. Finally, in those cases in which ongoing treatment is interrupted or suspended, a letter should be mailed to the patient outlining the facts and the options for continuity of care. The patient's oral status must be such that any reasonable delay in accessing continued care would not cause any harm.

When Does Treatment Begin?

Does the examination of a patient imply a duty to treat the disease uncovered or merely a duty to inform the patient of its presence? At what point is treatment considered to begin? Although not always subject to a precise definition, treatment certainly has begun when the dentist moves beyond the examination stage and renders treatment. Although in certain cases as previously alluded to, a dentist may limit the doctor-patient relationship to consultative services only (such as an examination and second opinion, or referral to a specialist for a particular phase of treatment), any other limited care arrangement should be expressly discussed, agreed to, and documented in the record before its performance. One situation in which misunderstanding can arise occurs when the dentist refers a patient for periodontal surgery. Who then has responsibility for the immediate and long-term follow-up care? Another example is when the general dentist has made the diagnosis of an acute problem (e.g., dental abscess) and referred the patient to an endodontist for treatment. In the absence of a comprehensive evaluation and treatment plan by the generalist, who is responsible for the patient if an additional problem (e.g., oral cancer) arises? Similar difficulties may arise in cases in which treatment must be interrupted: how, when, and at whose direction is treatment to be restarted? As noted above, proper documentation in the record is essential in any and all of these situations.

Referring Patients

When referring a patient to another dentist (whether specialist or general dentist) or to a physician for necessary care, it is particularly important that the referral and the reasons for it are noted in the patient record. In cases for which the retention of teeth or potentially life-threatening systemic disease (unchecked diabetes or hypertension, for example) is the focus of the referral, the referral should be made by letter to the agreed-upon entity (Figure 4-1). A copy of the letter should be retained in the record and follow-up phone calls to both the entity and the patient are advisable. Some U.S. clinicians are concerned about the implications of the Health Insurance Portability and Accountability Act (HIPAA) for exchanging patient information with other professionals. HIPAA was not designed to thwart the delivery of appropriate clinical care. The Act makes important exceptions for the exchange of protected health information; the most important of these are referred to as "TPO" or treatment, payment, and operations exceptions. A practice (covered entity) may exchange data that further the treatment of a patient; referral and consultation clearly fall within this exception. It is prudent to advise the patient before making the referral. Should the patient object, the referral should not be made to that particular specialist and other options should be explored with the patient.

The dentist must also consider issues surrounding appropriate referral to specialists. Cases in some jurisdictions have attributed negligence to a dentist for failure to refer a patient if expert testimony can demonstrate that a specialist would have likely had a better result, or even that the patient would have had a better chance at a positive result. Negligence may also be found in cases in which referral to another practitioner was appropriate, but the referring dentist knew or should have known that the dentist referred to was incapable of successfully treating the patient.

Confidentiality

Patients enjoy a reasonable expectation that the disclosures made to health care professionals will not be made public. U.S. federal law upholds the right to nondisclosure of certain aspects of health care, such as mental health records. HIPAA further specifies these rights. State laws may also place a higher burden of privacy on health care providers and on the records they maintain. Employees of the dental practice are also required to honor the confidential nature of both the dental record and other health care information revealed concerning patients. This information may include utterances by the patient that are not recorded in the chart or information gathered through the normal course of business in the office. Under the legal theory of ***respondeat superior,*** the dentist as employer and master under the law can be found liable for damage to a patient resulting from breach of confidence. Office policy, ideally expressed in

August 30, 2006

Dr. John Doe

Oral and Maxillofacial Surgeon

3344 A Avenue

Anytown, USA

RE: James Roe

Dear Doctor Doe:

Please accept this referral of my dental patient, James Roe, to your practice. Mr. Roe has been a patient in my practice for some 10 years having been seen on regular recall for minor restorative treatment as well as for prophylaxis. Recently, he has complained of a recurring swelling in his lower lip, sometimes lasting for several hours and at other times for mere minutes. The swelling is painless and bluish in color, its size never exceeding 4 mm.

My clinical diagnosis is that the swelling is a mucocele. I have explained to Mr. Roe the cause and prognosis associated with a mucocele as well as listing the differential diagnoses that I excluded in reaching that conclusion. In an abundance of caution, Mr. Roe has requested that it be surgically removed and sent to pathology for biopsy/histopathology.

Please discuss the biopsy procedure with Mr. Roe. Should he elect to continue with the surgery, please send me a copy of your operative note as well as a copy of the oral pathologist's report. In the event he elects not to have the surgery, please indicate that fact in your consultation letter to me.

Thanking you in advance for your prompt attention to this matter, I remain

Sincerely yours,

Robert E. Barsley, D.D.S.

Figure 4-1 Referral letter.

an office manual, should address this issue. Not only should knowledge of private health care information not be shared among staff who have no need to know the information, but other private nonhealth related information, such as financial data, should also be given the same protections.

Certain health-related disclosures are mandated by various states to be made to particular agencies. Most states require notification of specific sexually transmitted diseases to the health department. HIV/AIDS is a notable exception because some states require disclosure and others specifically forbid disclosure. In every state, the disclosure of suspected physical abuse and neglect (both child and elder) is required of any licensed health professional privy to information from which neglect or abuse could be reasonably inferred. In some instances, difficult questions arise, such as whether information should be (or can be) shared with the parents, guardians, or other family members. In many states, guidelines are permissive, rather than directive, and the dentist must determine whether disclosure is appropriate given the particular circumstances of the case.

DENTAL RECORD

Who Owns It?

Although the dental record is owned by and made for the benefit of the dentist, the patient also enjoys certain privileges relative to these documents. The patient (or a legal representative) may request copies of their own records and these must be provided at a nominal (or no) fee. Because financial records, accounting, and reconciliation or forgiveness of debts serve different purposes, unrelated to health care *per se*, such records should be maintained apart from the clinical dental record. Similarly the dentist has a legal right to maintain an "incident

report" or separate file for litigious or potentially litigious patients. Such a report or file can contain personal reflections or judgments that would not be appropriate to include in the patient record. This information, however, may be invaluable to the dentist's insurance carrier and/or attorney. As long as such a report is not attached to the patient record or referenced in it, it is "nondiscoverable" and is subject to dentist-client-attorney privilege.

What Is Included?

The dental record includes documentation of the general health and dental history questionnaires and notes, all database information and radiographs, diagnoses, treatment plans discussed, the course of treatment, progress or treatment notes, consent forms, patient complaints and their resolutions, information about patient noncompliance and missed appointments, and records of follow-up and periodic visits. Copies of written postoperative instructions should also be included either by reference or by the insertion of the document(s).

Patient noncompliance with provider requests or treatment requirements should be documented. Should a patient continue to demonstrate failure to follow the dentist's recommendation, at some point the provider must decide whether he or she can continue to treat the patient. A copy of any letter of dismissal must be kept in the record and the letter should enumerate the reasons for dismissal and describe any arrangements for continuing care that were provided (Box 4-2; Figure 4-2). Items such as the appointment book and telephone log are also considered to be valid and legal documents and should be preserved. Notes summarizing telephone conversations with the patient and any consultations with referring or referral dentists should also be appended to the patient record.

One other area of record keeping deserves special mention—the prescribing and dispensing of medications. Specific federal requirements for documentation must be followed when controlled drugs are prescribed for patients of record. State laws may also affect these requirements. Finally, agreements with health or dental insurance companies and/or with Medicare/Medicaid agencies often impose additional record keeping requirements on the dental office in terms of documenting treatment claimed for reimbursement.

The progress (or treatment) note is generally considered to be among the most valuable of the many parts of the record. The SOAP (subjective findings, objective findings, assessment, and plan for treatment) note format described in Chapter 6 represents the preferred method of writing progress notes for the acute care patient. Documenting treatment for the patient undergoing active care is described in Chapter 1. Progress notes for the periodic visit are described in Chapter 9.

BOX 4-2 The Four Paragraph Dismissal Letter

First paragraph: Establish the facts—indicate the diagnosis and the agreed upon treatment, stressing the role the patient was to play. State that the patient's cooperation (active participation) was a vital part of success.

Second paragraph: Document the patient's failure to uphold his or her end of the bargain. State that this noncompliance has both affected the prognosis for care and created a situation in which the dentist can no longer continue treatment.

Third paragraph: Sever the relationship. Suggest realistic alternatives for care. Point out the need for action on the patient's part, such as scheduling an appointment.

Fourth paragraph: Discuss the availability of records and record forwarding (duplicates only). You may wish to offer emergency care on an interim basis. Close politely.

How Should the Information Be Recorded?

In the written record, all entries must be legible and should be in ink (in the past black was preferred; today many prefer blue ink because it allows copies to be readily distinguished from the original), and should follow in chronologic order. Explanations for any out-of-sequence entries should be included. Any incorrect entries should be struck through with a single line so that they remain decipherable and should be initialed by the person making the change. The correct entry, including the reason for the change, should be made in the next available space. These notes do not need to be handwritten by the dentist; however, if written by office personnel, the note should be initialed by the writer, and the office should have some method of later identifying the initials should the need arise. If notes are dictated and transcribed, the date of dictation and of transcription should be made a part of the record, and the dentist should have the opportunity to review, correct, and sign the chart copy. Electronic records are increasingly widely used in health care. Although there is no relevant dental case law as yet, it is clear from business and criminal cases that forgeries and alterations to electronic documents remain detectable.

John Doe

123 A Street

Hometown, USA

July 7, 2005

Dear Mr. Doe:

Upon reviewing your case with Nancy Smith, our office hygienist, after your last appointment failure on June 30, 2006, it became obvious to us that our philosophy of dental care and yours differ significantly. As you and I discussed in our first few visits together, the success of the treatment plan I outlined to you and that you accepted was dependent upon keeping your teeth and their supporting structures clean and healthy. Due to the aggressive nature of the periodontitis in several areas of your mouth, there was an understanding that you would follow a schedule of frequent recall and cleaning appointments.

You have repeatedly failed to keep scheduled appointments and, when contacted after the failures, you have avoided our efforts to reschedule these missed appointments. Your noncompliance with the agreed upon treatment has created a situation in which I can no longer be responsible for your treatment.

Therefore, as of today, July 7, 2006, I am severing our professional relationship. I am confident that you can find a dental office in which you can place your confidence and through which you can receive treatment. The local dental association, which can be reached at (555) 555-5555, can supply you with a list of local dental offices that you can contact.

Please have your new dentist contact our office to facilitate the transfer of your duplicated records should they be needed. Wishing you success in your future oral health, I remain

Sincerely yours,

Robert E. Barsley, D.D.S.

Figure 4-2 Dismissal letter.

How Long Should Dental Records Be Kept?

Retaining records as long as practical is advisable, perhaps using off-site storage and/or imaging for later retrieval. Many jurisdictions specify a minimum number of years for which records must be retained. Additional requirements concerning record retention may be imposed by contracts with payer entities or by employment or affiliation contracts. For example, Medicaid regulations require that records be kept a minimum of 3 years from the date the claim is filed for reimbursement. In a practical sense, because federal income tax issues can arise up to 6 years after taxes are paid, many experts advise keeping records a minimum of 7 years. Finally, as noted earlier, because many jurisdictions toll (suspend) the statute of limitations during a child's minority, a case of alleged negligence involving a very young patient may arise as much as 16 to 18 years after treatment.

What Is the Value of the Dental Record?

One can readily appreciate that this confidential dental record is potentially valuable in several ways and must be safeguarded. Dentists can be liable for damages in the event that a patient's record is left in a public place or its contents are made visible to other patients or noncare providers. As noted earlier, unauthorized disclosure, even by a member of the staff, would constitute a negligent breach of a duty owed the patient.

The successful defense of a malpractice claim often hinges on the clinician's ability to produce all of the original radiographs or other test results for the case in question. The original copies of these irreplaceable items should never be separated from the patient chart. Juries tend to rule against dentists who cannot produce records, whose record keeping is sloppy or lax, or who have been shown to have altered the patient record. For an illustration of these issues, see the *In Clinical Practice* box.

In Clinical Practice

The Importance of Good Records

Louisiana law requires that before most cases alleging negligence against a health care provider can proceed to trial, the allegations must be submitted to a panel of three practitioners for review. Several years ago, the author was asked to be the third member of such a panel by two other dentists—one chosen by the plaintiff and one by the defendant. A nonvoting attorney serves as chairperson and coordinates the procedure. The defendant dentist had removed a lower third molar, and the patient now complained of temporomandibular joint (TMJ) dysfunction secondary to the extraction. The extraction had been done on an emergency basis on a Saturday morning. The fact that the patient had called the dentist at his home and that he had made a special trip to meet her at his office was undisputed. Unfortunately the dentist's record was incomplete, to say the least, and doubt entered into every other aspect of the treatment. The record contained no SOAP note, only the notation that the patient had a toothache (in her handwriting and only on the dental/medical questionnaire–patient registration sheet) and no dental charting. An abbreviated progress note referred to the tooth number, the charge, and the amount and brand of local anesthetic injected along with the abbreviation "EXT." The only diagnostic material, a single preoperative radiograph, was unreadable because of silver deposition resulting from incomplete fixation. A postextraction radiograph was available, but it was unclear whether it had been taken during or at the conclusion of the extraction, or at a follow-up visit. Reference to a follow-up visit and to a telephone prescription completed the record. No telephone log or notation in the appointment book had been made for any of the visits.

The patient alleged that the tooth was only chipped and that she merely wanted it filed smooth. She also alleged that this molar had been her sole remaining occluding posterior tooth on that side of the mandible, and that its extraction had led to loss of vertical dimension and TMJ dysfunction. She maintained that the extraction had taken an extraordinary amount of time; that the tooth had fractured during the procedure; and that the dentist had failed to remove all tooth fragments from her jaw, resulting in an infection. The dentist had a differing recollection: the fracture had extended into the pulp; the patient had been in extreme pain; he had performed several tests, including percussion, which demonstrated that the tooth was not salvageable without root canal therapy and that it was not the sole remaining occluding tooth. Finally, he maintained that because of the difficult extraction, he had telephoned the patient that evening and that he had willingly seen her for several follow-up appointments until she missed two scheduled ones. His lax record failed to substantiate this version of events.

Because the sole preoperative radiograph was unreadable, the three-dentist panel concluded that a material question of fact existed, therefore the case went to trial—twice. The first trial resulted in a hung jury. Before the second trial, the defense team made an exhaustive effort, employing an expert in dental radiography who rendered the preoperative radiograph readable. Defendant's deposition testimony revealed her past dental history, and the records from other treating dentists were then used to show that only a single other tooth had been extracted from the affected side before the visit in question. This combination allowed the defense experts at the second trial to conclude that the plaintiff's recounting of the experience was more likely than not untrue.

Although the dentist can be said to have "won" this case, in reality he lost. The verdict came some 6 years after the incident, and there was extensive local publicity about the case and the trials. Although the dentist's liability insurance paid the direct costs of his defense, indirect costs such as the stress involved and the costs of the many days he was out of the office were not covered.

Had there been an adequate record, such as a SOAP note, or had the radiograph been properly stored, this case would never have gone to trial. This dentist learned an expensive lesson.

Dental records also have economic value as part of the "good will" upon the sale of a practice. In the event that the practice and the records are sold, the seller should arrange a mechanism that will ensure his or her continued access to the records of prior treatment if necessary, for example, to assist in the defense of a malpractice claim filed after the sale is final. The sale of a practice also requires that patients be permitted to object to the transfer of the records to the new owner. In such an instance, those patients may request that their records be transferred to a dentist of their own choosing rather than to the new owner.

CONSENT TO TREATMENT

What Is Consent?

Courts have long recognized the right of a competent adult to decide what may happen to his or her own body.

It follows that the dentist has an affirmative duty to disclose to the patient the risks attendant on any contemplated procedure. Most jurisdictions have adopted a "reasonable patient" approach to this disclosure. In other words, the patient must be given sufficient information about the condition and the recommended treatment to allow a reasonable person to make a voluntary and informed decision. This has become known as informed consent. Some commentators call this process informed decision making, the purpose being to make certain that the patient has enough information at hand before he or she commits to what may be an irreversible course of treatment.

How to Gain Informed Consent

Although the dentist ultimately is responsible for recommending a course of treatment, the patient would not be expected to know and understand all of the factors to be taken into account in that process. To fulfill this duty, the dentist must disclose all risks and benefits of the proposed treatment, including any complications that might reasonably be expected to occur, any alternatives (including the alternative of no treatment) to the proposed course of treatment, and the risks and benefits (if any) of nontreatment. Some jurisdictions address consent in such detail that the statutes specify the required disclosures. Under certain circumstances, information that could be harmful to the patient need not be mentioned. A few jurisdictions use a "reasonable dentist" approach, that is, the dentist need only disclose the information that a reasonable dentist would reveal to secure the consent of the patient.

To ensure that the patient meets the criteria for informed consent detailed above, the dentist should explain the treatment plan, potential complications, alternatives, and any implications of nontreatment. The patient must be allowed to ask questions and receive comprehensible answers. A written consent form should be viewed as supplemental to the discussion and should not replace the conversation between dentist and patient. Meaningful informed consent cannot be obtained under less than ideal circumstances, for example, after the patient has been sedated before surgery or for other reasons cannot ask questions or understand the responses (See *Ethics in Dentistry* Box). Usually the provider cannot delegate this duty to a less qualified employee because the provider alone has the full intimate knowledge of the case and the treatment objectives.

Documenting Informed Consent

Because proof that informed consent was obtained can be a crucial factor in a malpractice allegation, preprinted consent forms have been developed that outline the elements of consent and provide blanks for the clinician to complete as each item is discussed (Box 4-3). The patient (or the patient's representative) is asked to sign the form indicating that each element has been discussed and understood, and that all questions have been satisfactorily answered. It is important to recognize, however, that a signed consent form does not automatically prove that valid and voluntary informed consent was obtained. The patient may still allege that insufficient information was provided and that if the facts at issue had been known, then consent for the treatment would not have been given. It is often advisable to supplement the consent form with entries in the progress notes, detailing the treatment alternatives discussed, the questions asked and answered, and even the reason (if given) that a particular treatment recommendation was accepted or declined (Figure 4-3).

Ethics in Dentistry

Informed Consent

The patient's formal written consent for treatment is based on the information the practitioner gives to the patient about the diagnosis, prognosis, and treatment options. In practice, the practitioner is sometimes uncertain about the diagnosis or the risks of treatment. For example, during a planned restoration the dentist may discover that caries is more extensive than had appeared during the assessment phase. Now, faced with a carious exposure, the dentist changes the treatment plan from a surface restoration to root canal therapy with a probable crown.

If the treatment plan changes during active treatment, the dentist has several options for obtaining the patient's consent to proceed. Although it may be tempting to simply explain the problem to the patient and continue with little or no discussion, most patients cannot give truly informed consent while reclined in the dental chair with a rubber dam in place. The patient should be given the opportunity to ask questions and to consider additional options, such as extraction. This can best be achieved by removing the rubber dam and allowing the patient to sit up for a face-to-face discussion with the dentist. The revised treatment plan should be documented.

When the dentist enters into a treatment plan with uncertainty, questions about informed consent may be avoided by a thorough discussion of the possibilities before initiating treatment. If the dentist obtains consent for a straightforward restoration, but explains that the decay might be more extensive, the patient's preferences for further discussion or proceeding immediately with more extensive treatment can be established before treatment is begun.

BOX 4-3 Designing a Consent Form

Although the elements of consent remain generally the same across all disciplines of dentistry, certain procedures (perhaps entire disciplines) are better served with more detailed consent forms. To demonstrate that the consent is a freely given informed consent, every consent form must include the following:

Patient name, date, dentist's name, and the office location or location of proposed treatment.

The diagnosis (or the disease/deformity) that led to the procedure being undertaken; the procedure itself explained in simple terms (i.e., "cutting" rather than "incision" and "stitches" rather than "sutures").

The risks and possible complications associated with the treatment (including the risks associated with nontreatment); the alternatives to the treatment (again, including nontreatment); and the types of medications, materials, and anesthetics that may be used during the treatment along with their associated risks.

Supplemental areas include listing the possibility that the dentist will be assisted by staff or students and that it may be necessary to consult other health care providers; that the disease or deformity may be greater or lesser in scope than originally thought, requiring more or less treatment; postoperative instructions and duties for the patient; and a release to use photographic images.

The final section should state that the patient acknowledges that all of the foregoing has been explained to his or her satisfaction, that he or she has read the consent form, all questions have been answered, he or she understands that dentistry/medicine is not an exact science and that results cannot be guaranteed, and that authorization for the treatment to be provided by the named dentist is willingly given. The patient or legal guardian must sign the document. Although much of the form can be preprinted, the areas for listing the disease, treatment/procedures, risks, and alternatives should consist of blank lines to be filled in as necessary before the patient reads and signs the consent.

In addition to using a consent form, informed consent can be documented in the progress notes by making a **PARQ note,** an acronym taken from the first initial in each of its four components. The components are as follows:

Procedure: This is a summary of the proposed treatment plan or procedures and why the plan or procedures are necessary.

Alternatives: This includes a list of possible alternative treatments.

Risks: What adverse outcomes are possible as a result of the treatment plan or procedures? What are the risks of *not* having treatment?

Questions: This section documents any patient questions (or that the patient had no questions).

Although written evidence of consent is preferred, the court can attribute consent in certain cases. For example, a patient who has had his or her teeth cleaned at earlier dental appointments gives consent by action when he or she returns to the practice, sits in the dental chair, and opens his or her mouth for the current prophylaxis procedure to begin. This lowest level of agreement or assent is used when patients are established in a practice and undergo a routine procedure, such as examination and cleaning. This informal agreement is acceptable if the dentist ensures that the patient has an ongoing understanding of the purpose of the procedure, the benefits, risks, and alternatives, although these may not be made explicit at each visit. Changes in the patient's oral or general health status necessitate a return to verbal and/or written consent. When the dentist chooses not to use a signed consent form—as with a "simple" restorative treatment plan with no notable alternatives to the treatment proposed—it is still advantageous to have documented in the dental record that the procedure was discussed, the elements of consent were covered, and the patient gave verbal consent to the treatment.

Competence and Capacity to Consent

In the United States, legal competence is granted to adults over the age of 18 who have not been declared incompetent through a legal hearing. An informal evaluation of decision-making capacity is more often used to determine whether a patient is capable of giving informed consent for a particular procedure. Through the process of obtaining informed consent, the dentist should assess whether the patient shows evidence of understanding the proposed treatment, the risks and benefits of the treatment, the options available, the consequences of nontreatment, and whether the patient shows evidence of rationality in weighing the options (Appelbaum & Grisso, 1987). Capacity is assessed for each treatment proposed because patients may have capacity for some decisions, yet lack sufficient decision-making skills for more significant or irreversible decisions, such as orthognathic surgery.

When a Patient Lacks Decision-Making Capacity

Adults with developmental, acute, or chronic cognitive disorders may lack the capacity to make their own dental and other health care decisions, while still retaining *legal* competence. In cases in which a judge has found a patient to be incompetent for all decisions, a legal guardian is usually appointed by the court. In the United States,

CONSENT TO DENTAL TREATMENT
Office of Dr. Robert E. Barsley
Anytown, USA

Patient Name: _____ Date: _____

I hereby authorize Dr. _____ to perform the dental procedures discussed below in order to correct the following conditions in my mouth:

Bone loss associated with advanced gum disease

I understand that this treatment will consist of the following procedures including:

Cutting through my gum tissue around the teeth in the upper right sides of my mouth on both the tongue side and cheek side; peeling the cut gum tissue back to expose the bone, roots and other supporting structures; scraping and cutting some of the bony areas between and around these teeth; scraping and cleaning the exposed roots of these teeth; the possibility that some bone tissue may need to be replaced with an artificial bone material; and, repositioning the gum tissue back around the teeth with stitches.

I further affirm that the following benefits of these procedures have been explained to me as follows:

The procedure may arrest the progress of my gum disease and allow me to retain the use of the affected teeth for an additional period of time than might otherwise be available should I not elect to undergo this procedure.

The risks commonly associated with this procedure include the following, each of which has been satisfactorily explained to me:

The treatment may not achieve the desired results: one or more of the target teeth may need to be extracted during the course of the procedure or shortly thereafter; the repositioning of the gum tissue may cause the teeth to appear longer; and one or more teeth may be sensitive to hot or cold temperatures.

I understand that the doctor will be using a local anesthetic solution that may contain a vasoconstricting drug that will be injected into my gums and around the jawbone and that other types of anesthetic including _____ may be used. I further understand that various personnel may assist the doctor in parts of the treatment. I understand that the practice of dentistry is not an exact science and realize that no guarantee of specific results can be or is hereby made by the doctor or by any member of his/her staff. I also realize that unforeseen conditions may arise during this treatment thereby altering the situation and calling for an exercise of the doctor's best professional judgment in selecting procedures in addition to or different from those presently contemplated; in such a case I request that the doctor do whatever is determined to be in my best interest. I acknowledge that the long-term success of this treatment is dependent upon actions I undertake during the healing phase of this treatment and hereby agree to refrain as much as possible from detrimental activity such as smoking, drinking alcohol, failing to receive adequate nutrition, and other activities such as: _____.

I further acknowledge that long-term success is dependent upon effective oral hygiene habits practiced at home and by professional follow-up visits scheduled with the doctor.

I consent to the photographic, videographic, and/or radiographic recording of these procedures by the doctor or his/her associates for scientific and educational purposes and agree to the use or publication of those materials with the following limitations:

By my signature below, I agree that I have read this form, that I understand its contents or have had them explained to me, that I agree with each of the statements made, that I have been given an opportunity to ask questions about the treatment, and that my questions have been answered to my satisfaction.

I am signing this consent document in New Orleans, LA, on this the _____ day of _____, 2006.

_____ (signature)

Patient's printed name

If signing for a minor, the minor's name is _____.

_____ (signature)

Printed name of legal guardian: _____ relationship: _____

Figure 4-3 Consent form.

when a patient clearly lacks decision-making capacity, the dentist should check to see whether the patient has named a surrogate decision-maker through a Durable Power of Attorney for Health Care document. Otherwise, decisions are usually obtained from a proxy or surrogate decision-maker, most often using a "next of kin" hierarchy. Although a patient who lacks capacity cannot give fully informed consent, the essential elements of the treatment plan should be explained and the patient should have a chance to ask questions, much like the model for obtaining assent that is promoted in pediatric and adolescent care. Most dental care requires cooperation from the patient, and including a patient with dementia or developmental delay in the discussion may improve cooperation. When the patient's mental capacity is unclear, the dentist should seek further guidance from the patient's physician or other health professionals involved in the patient's care, such as a social worker or nurse, before initiating treatment.

Is Informed Consent Always Necessary?

The only exception to the necessity to obtain consent is the existence of a life-threatening emergency, an event that is relatively rare in dental practice. Cases in which the provider's actions exceed the consent obtained or in which consent is found to have been given without full information are considered negligence. Failure to obtain any consent at all is considered a battery, a form of unprivileged touching, and may be actionable under law as an intentional tort.

Although patient consent does not provide a defense in the case of treatment that does not meet the standard of care, a patient can give informed *refusal* in rejecting a recommended course of treatment. Like informed consent, a dentist should clarify that the patient is fully informed, the refusal is voluntary, and the patient demonstrates the components of decision-making capacity. Blanket consent to an unspecified course of dental treatment is not considered valid. Patients must be advised of changes in the status of their disease and of any modifications that might be advisable or undertaken. A long, continuing course of treatment may require periodic renewal of consent.

NEGLIGENCE AND THE DENTAL PRACTICE

Liability Insurance

Although a dentist may believe that the primary reason for purchasing professional liability insurance is to cover the payment of any judgment of liability, in fact, by far the most important benefit of such coverage is the provision of a legal defense should a claim be brought. Why? Very few claims ever reach trial and of those, in only a small percentage is the dentist ruled liable. The failure to file a timely answer to a legal claim of negligence, however, represents an admission of liability, and an attorney is vital to crafting the answer to the claim. In that light, the costs of even the "simplest" defense of a claim continue to escalate annually and may exceed the "value" of many claims. These costs include monetary items such as attorneys' fees and expert witness costs along with nonmonetary costs such as the necessity to be absent from the practice to attend to matters associated with the case. Enormous personal and professional costs can also accrue, including the potential for negative publicity that may surround the case if tried in court (or in the local press). Psychological costs may also accrue—no professional enjoys having a patient, or more realistically the patient's lawyer, call into question the quality of his or her services.

The professional liability insurer serves as a valuable resource in the prevention of liability claims. A forthright discussion with the agent about actual, potential, and hypothetical cases can help point out shortcomings in the office setting, which may then be corrected. Many professional liability insurers offer courses and materials on risk reduction, with some even offering a reduction in the cost of policies for successful completion. Finally, in difficult situations, the agent and/or the defense attorney can serve as an additional ear, perhaps even recommending a third party to serve as a resource. It is important to recognize that the insurance carrier should be contacted at the slightest hint of the possibility of a suit or even the suspicion that an unusual office occurrence may lead to a suit. Advice concerning documentation of the incident, communication with the patient, and instructions to staff could have a substantial impact on the final resolution of the matter.

Malpractice reform has resulted in a wide variance among the states concerning professional liability. For example, some states (Louisiana, for one) *require* that a dentist participate in a professional liability insurance coverage plan (or else provide a bond) to enjoy statutorily imposed limits on liability. Other states impose limits on the amount of damages that can be awarded and some require that before a lawsuit claiming negligence against a health care provider can be filed, the potential plaintiff must meet certain procedural standards.

Suit-Prone Patients

What are the chances that a particular dentist will be involved in a lawsuit alleging professional misconduct?

Commentators cite an approximate annual risk of 5% to 15% and this risk has increased substantially over the past 2 decades. Patients have become more consumer oriented in their approach to health care at the same time that the practice of dentistry may have become less personal for many patients. Dentistry seems to be slowly evolving from the solo practitioner, relatively inexpensive, patient-centered practice of the past to an office setting in which more than one professional may be involved in the diagnosis and treatment of oral problems. These changes move toward what must seem to many patients to be a more expensive, third-party–dependent series of financial transactions. As some practice management advisors stress administrative "improvements," such as multipatient scheduling to reduce the impact of cost centers (i.e., operatories) on the bottom line, the personal aspect of dentistry continues to diminish.

Although the overall risk of suit has increased, it remains probable that the increase has not affected all practitioners. Primarily at risk are those who are technically competent in dentistry, but who lack competence in interpersonal skills—sometimes called a "bedside" or "chairside" manner. Mastery of the ability to interact well with patients includes the ability to recognize quickly those individuals with whom the dentist may develop a notable personality conflict. Certain individuals telegraph their propensity for becoming dissatisfied patients. Many practice management guidelines identify various types, such as the "shopper," the "complainer," and others. One cardinal warning sign is the patient who immediately complains about the care, price, attitude, office condition, and so on of the last dentist "fortunate" enough to have treated the patient and/or who encourages the dentist to find fault with previous treatment.

If the dentist feels stressed, anxious, and tense while treating a patient, the likelihood of saying or doing something inappropriate, or of being left with a less positive outcome, is increased. Recognizing these potential pitfalls, the wise practitioner will, at the outset, either refer the patient elsewhere, or develop a thoughtful and professional coping strategy in which the entire office staff plays an informed role. But even in the presence of a reasoned and orchestrated coping strategy, many dentists seem to have a knack for getting themselves in the middle of these issues by virtue of their own, unsolicited comments. A dentist clearly has a duty to disclose failed or failing dentistry performed by another dentist, but should do so in a nonjudgmental fashion. Often the full story is not known at the point of initial discovery—the patient may have been noncompliant or may have refused a recommended "better" treatment. At the very least, a telephone call should be made to the previous dentist to understand more fully the situation before making a hasty proclamation alleging substandard care. Many lawsuits have commenced and many dentists have found themselves unwilling witnesses because of a hastily uttered comment made while examining or treating the patient. The accompanying *In Clinical Practice* box takes a closer look at the three situations that may lead to a clinician ending up in a courtroom.

Common Causes for Litigation

Textbooks and legal casebooks are filled with malpractice cases decided against dentists or in favor of dentists (see,

In Clinical Practice

Courtroom Issues

The three situations that may lead to a dentist testifying in court or being deposed by counsel in a malpractice suit include: appearing as a defendant, appearing as an expert witness for either the plaintiff or defendant, or appearing as a treating (either previous or subsequent) dentist. The first and last situations are most often not of the dentist's own choosing. Only the expert witness, has in effect, volunteered to testify (although for a fee).

Whatever the reason for an appearance in court or at a deposition, the dentist would be well advised to heed certain maxims.

- First, be aware that the law is unfamiliar territory, operating subject to rules that the dentist may not fully comprehend. Legal procedures move at their own pace, with the final outcome often not readily apparent.
- Second, the dentist must be able to fully trust his or her attorney. This implies full and complete communication in both directions. As a defendant, it is difficult for a dentist to present a strong case if communication is lacking in either direction.
- Third, the dentist should accept the advice of counsel who will be responsible for providing guidance through the labyrinth of the law. Often counsel will advise the client to avoid answering hastily, sometimes to not answer at all, and to never volunteer information—advice that may prove difficult to comply with.
- Fourth, remember that, as a witness, the dentist seeks to educate the trier of fact (judge or jury). To do so successfully, the dentist should strive to be certain that distracting behaviors do not cloud the presentation of testimony (e.g., casting answers in unnecessarily confusing technical terms or dressing inappropriately).
- Finally, resist the temptation to engage in arguments or word games with the attorneys, particularly with opposing counsel. Remember, words are their stock in trade.

for example, Morris, 1995). Data from one large national liability insurer point to the "failure to diagnose, treat, or refer" as a frequent source for litigation. Some of the largest monetary recoveries have been for failure to diagnose conditions, such as abscesses and other infections, which in several cases led to death. Recently an increasing number of claims have alleged the dentist's failure to diagnose head and neck cancer. Because modern treatment modalities offer an increasingly excellent prognosis when coupled with early detection, the question then becomes at what point should the reasonable dentist have included cancer in a differential diagnosis and referred the patient for a biopsy or other definitive treatment.

Failure to diagnose periodontal disease remains a common claim by patients who have lost teeth or who have undergone extensive periodontal therapy. Recent advances in periodontal therapy treatment modalities have increased the likelihood that what once may have been only a weak claim could be judged meritorious today.

A second class of lawsuits involves the dentist's failure to interpret (or sometimes even to solicit) the relevant health history of the patient. The *In Clinical Practice* box discusses a rare but serious consequence of failing to obtain information about the patient's health history. Prescribing practices that disregard possible medication interactions or involve the improper prescribing of medications invite risk. The systemic effects of such errors can include long-term disability for the patient or even death.

Areas of dentistry that most often generate litigation include treatment for temporomandibular joint problems, difficult extractions, and treatment involving implants. An increasing number of cases have involved orthodontic treatment, including orthodontic relapse, root resorption, and a lack of informed consent on the part of the adolescent patient.

What's the Evidence?

The Most Common Types of Dental Malpractice Cases/Suits and How Complaints Are Distributed Among the Various Categories of Dental Care

There is little information in the public domain concerning dental malpractice cases. The available information is reported either by dentists through voluntary surveys, or by governmental complaint boards. A survey of U.S. dentists found that 55% of malpractice claims resulted from treatment errors, 17% from errors in diagnosis, 8% were a result of failure to consult, and 6% were a result of a lack of informed consent.[1] Information from the Medical Responsibility Board in Sweden identified faulty treatment performance (32%) and unsatisfactory technical or esthetic quality (30%) as the most common complaints in malpractice cases.[2]

The most common categories of dental care reported in malpractice cases varies by country. In England and the United States, the majority of reported malpractice cases relate to oral surgery or restorative dentistry (mainly fixed prosthodontics).[1,3,4] A review of legal claims in England found that 28% of the cases related to oral surgery procedures and 24% to restorative procedures.[3] A survey of oral surgery and fixed prosthodontic procedures performed by English dentists accounted for 20% each of patient complaints.[4] A survey of U.S. dentists found similar results, with 22% of the cases relating to oral surgery procedures and 20% to prosthodontic procedures. Endodontic procedures were also quite high, however, and were cited in 18% of the cases.[1] Complaint boards in Sweden and Denmark reported different results, with only 9% and 6% of the claims, respectively, associated with oral surgery procedures.[2,5] Instead, prosthodontic procedures generated the most common malpractice

Continued

In Clinical Practice

Health Questionnaires

A briefly described but truly frightening case involves a dentist who commonly made the "one-stop painless" denture—inviting the prospective patient to come in with natural teeth and leave with dentures. The dentist made an unbelievable blunder. He failed to take a health history on a patient who in fact had myriad systemic complications, including untreated hypertension. As was the dentist's practice, he sedated the patient for the many extractions needed. Before the extractions could be begun, the patient had to be rushed to the hospital with a suspected heart attack. He was released the next day. Unbelievably, the patient returned to the dentist the following week and, even more unbelievably, the dentist again did not ask him to complete a health questionnaire or query him orally about his general health. Once again the dentist began to sedate the patient for the requisite extractions. Again the patient coded, but this time he did not survive. The civil law implications of failing to take an adequate history, apparently failing to secure an informed consent, and performing admittedly risky procedures in an office setting paled next to the criminal implications—this dentist was charged with negligent homicide.

What's the Evidence?

The Most Common Types of Dental Malpractice Cases/Suits and How Complaints Are Distributed Among the Various Categories of Dental Care—cont'd

complaints in Sweden (60% of the claims)[2] and Denmark (58%).[5]

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The dentist has the affirmative obligation to disclose to the patient any misadventures that occur during treatment, for example, a broken endodontic file or reamer. Failure to disclose leads to several undesirable results. First, when the patient discovers that the misadventure occurred, he or she will naturally think that the dentist was less than honest and if less than honest about that, then what else was the dentist dishonest about? The patient may feel betrayed and will be more likely to ascribe any bad result to the misadventure and may potentially seek litigation. The law in many states views the purposeful nondisclosure of such acts as a form of fraud. Alleging fraud in litigation may lessen the patient's burden of proof (i.e., no need to prove violation of the standard of care) and lengthen the time in which to file a claim (statute of limitations and/or repose). Misadventures should be fully documented in the chart, and the patient should be informed as soon as practicable. If proper informed consent was obtained, the discussion of risks will have envisioned many of the misadventures that may occur in dental treatment. In any case, the dentist should be forthright, should explain what can be done to mitigate the situation, and should never refer to the event as an accident, error, or mistake. The office staff should be equally cognizant of the importance of avoiding use of the terms accident, error, or mistake.

The dentist and all of the office staff should practice preventive ethics to lessen the risk of both misadventure and litigation. Policy and procedure manuals should be updated and followed by all staff, including the dentist. Documentation in the patient record should parallel the events that are chronicled. Chart notations should be contemporaneous and complete. In addition to including the SOAP elements discussed earlier in this chapter, notations concerning oral instructions to the patient and questions from the patient along with answers in response should be noted. Never include derogatory information about the patient in his or her own chart, or in another patient's chart. It may be useful to prepare an "incident" form that is kept separate from the dental record. Such a form is not discoverable by a plaintiff's attorney and can contain information that would not be included in the patient record.

CONCLUSION

The authors hope that those reading this book will recognize the importance of proper diagnosis and treatment planning. These skills form the cornerstone of excellence in dental practice and constitute an integral factor in quality assurance. A foundation of the trust patients place in their health care professionals is the belief that each professional accepts the responsibility to monitor the outcomes of treatment and to use that feedback to improve areas noted to be deficient. This too is a part of the self-governance granted to professionals. Outcomes evidence, especially long-term outcomes, should be the bedrock upon which treatment recommendations are anchored. Too often, dentists in practice, dental educators, and dental patients are most interested in the short-term results. In this era of changing patient expectations for dentistry, and rapid advances in dental technology and materials, one must not lose sight of the primary goal—long-term oral health.

It is also important to recognize that once a problem (or a potential problem) has been identified, correction should begin immediately. Recognition and mitigation do not imply legal responsibility. In fact, just the opposite is true. Failure to recognize and to take adequate measures to lessen the chances that the same unwanted results will recur can be seen as negligence. In the end, the successful dentist is the one who communicates his or her findings to the patient and documents those findings and the resulting dental treatment in the patient record. The dentist owes every patient a thorough and careful diagnosis and a well-founded treatment plan. Unfocused treatment planning, accomplished in a piecemeal fashion at each subsequent visit, has the potential to compromise the patient's oral and general health. The dentist who grounds patient care in the ethical principles

and practices cited at the beginning of this chapter is more likely to provide better care and develop a stable practice and less likely to encounter legal problems.

Because of the changing nature of the law, no case citations are included in the text. Any case referenced may be overruled or amended, or a new case may supplant it at anytime. A citation to valid case law in one jurisdiction may have no validity in another jurisdiction. Readers are cautioned to contact legal counsel in the event a claim is made against them or in the event they are concerned about the possibility that a claim may be brought in the future.

This chapter is not intended as legal advice by the author, the editors, or the publisher. Readers are strongly cautioned to discuss such matters with their own legal counsel.

REVIEW QUESTIONS

How do ethical codes and the law help shape the treatment planning process? What are their limitations?

To be successful, malpractice claims must satisfy what four elements?

Must the dentist accept every patient into the practice? What are the patient's rights? What are the dentist's rights?

What are the uses of the dental record? Whose property is it? How should information be recorded in it?

What are the legal and ethical standards for informed consent?

List some of the "do's" and "don'ts" in dealing with a potentially litigious patient.

What are common causes of dental malpractice litigation?

SUGGESTED READINGS

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