

EmPRO
BASIC RISK MANAGEMENT HOME STUDY COURSE
FOR
DENTISTS

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Introduction

The EmPRO Home Study Course has been developed to help our insured dentists become more conversant with many of the risk management issues which often lead to, or contribute to, a dentist being the target of a medical malpractice suit or may result in a less than favorable outcome of such suits. The basic material presented in this course has been utilized over a number of years as part of EmPRO's ongoing Risk Management program, and has had a positive impact on many of our insureds' practices. It is our sincere hope that you will find this information useful.

In order to obtain the premium credit, you are required to pass the test with a minimum score of 80%.

The answer sheets must be completed and returned to EmPRO, postmarked or faxed as indicated on the accompanying letter, in order for you to receive the premium discount. A 10% premium credit is awarded for 36 months for successful completion of the test.

To receive credit, please mail the answer sheets to:

EmPRO
Dental Risk Management
Department 1800 Northern Boulevard
P.O. Box 9007
Roslyn, NY 11576

Answer sheets may also be faxed to: (516) 684-2365.

EmPRO's Basic Risk Management Study Course for Dentists

Educational Objectives

1. The course will:

Aid the dentist's understanding of the role of good documentation in improving patient care, as well as methods to improve their documentation.

Provide information as to the legal and practical aspect of informed consent to better enable the dentist to comply with the requirement to obtain an informed consent.

Aid the dentist's understanding of the need for improved provider/patient communication and its effect on patient care.

Aid the dentist's understanding of the need for improved communication among health care providers.

Provide information to dentists on methods and techniques for improved tracking and follow-up systems in their private office.

Provide updated information as to the legal environment and legislative changes which impact upon a dentist's practice.

Table of Contents

	<u>Page</u>
Introduction	
Chapter I - Record Keeping	5
Chapter II - Informed Consent	19
Chapter III- Legal Environment	24
Chapter IV- Communication	36
Chapter V- Office Procedures: Administrative Systems	45
Chapter VI- Office Procedure: Tests/Surgery	54
Chapter VII- Coverage Issues	65
Chapter VIII- Managed Care Issues	69
Test Questions	72

CHAPTER I

Record Keeping

A. Introduction

Patient charts, logs, message slips, appointment books and many other documents are the usual records maintained in the dental office. While they reflect the day to day patient encounter, fundamentally, those records provide a continuous and general accounting of the dentist's care and treatment of the patient. That is the primary reason that records are prepared and maintained. Therefore, it is incumbent upon the dentist to maintain complete and accurate records, if the quality patient care and maximum protection from liability are to be ensured. This section will highlight several aspects of record keeping which are important to dental practice.

B. Elements of a Good Dental Record

A good dental record contains comprehensive documentation of all patient care encounters. Basically, that information should include:

1. The Date

Every chart entry must begin with a complete date, including the year. The date that treatment was rendered, or a prescription renewed, is always important.

2. A Complete Patient History

The following basic areas should be covered in a dentist's documentation of a patient's history:

- Dental conditions
- Surgical conditions
- Medical conditions
- Allergies and/or untoward reactions to drugs
- Currently or recently used medications
- Conditions that could significantly influence future care, e.g. family history, social history, etc.

Where the patient denies any of these, the record should specifically document that.

3. Chief Complaint/ Purpose of Visit

Findings at every visit should be prefaced with a statement of the reason that the patient presented and any symptoms or complaints that are reported to the dentist, including a history of the present complaint.

4. Details of the Physical Examinations/ Clinical Findings

In recording the findings of the physical examination, the dentist must be specific in his/her recording of all areas examined. Where the findings are negative, that fact must also be recorded. It is also beneficial to utilize diagrams to record abnormal findings.

5. Diagnosis/ Medical Impression

It is important that the dentist's note includes a diagnosis or dental impression, relative to the patient's complaints and the dentist's findings.

6. Studies Ordered

Where diagnostic studies are required, a note to that effect should be entered into a patient's chart, so that it is clear as to the plan for arriving at diagnosis.

7. Therapies/ Treatments Prescribed

Documentation regarding any treatment that is prescribed (whether it is a prescription or over-the-counter drug), must be entered into the dental record. Documentation of the prescription should include:

- the name of the drug
- the dosage
- the amount
- any instructions given to the patient
- the duration of the therapy

8. A Plan of Care (Disposition/ Recommendations)

The plan of care for the patient, as well as any recommendations and instructions given to him/her must also be charted. This should include the time frame within which the patient is expected to return to the office.

9. Signatures

Especially where there is more than one dentist in the practice, it is important that dental record entries are signed. This practice should also be followed where hygienists and other staff make entries in the chart. This also becomes important where notes are dictated and transcribed. These notes should be read prior to being incorporated into the dental record. This is important because, on occasion, a typist may not record the information as the dentist intended. Also, the re-reading of the note gives the dentist an opportunity to ensure the accuracy of the note.

C. Documentation of Specific Patient Care Events

It is important that all patient care encounters are adequately documented; however, there are certain specific events with which dentists should be particularly careful:

Telephone Advice

Advice given to patients by telephone should be noted in the chart. In many instances, the crux of a dental malpractice case is the information that may or may not have been given to the patient, in the course of a telephone conversation. Without this documentation, these cases are more difficult to defend. This includes the documentation of medications and other treatments prescribed by phone. A note as to the phone call should be recorded in a phone log by office staff. The dentist's response should be placed in the chart, and the call checked off of the phone log.

Informed Consent

As you will note in the upcoming chapter on Informed Consent, the requirement to obtain a patient's informed consent for a procedure, does not consist solely of obtaining his/her signature on the appropriate form. Rather, the basis of informed consent is a discussion between patient and treater. This discussion must be summarized in a note in the patient's chart; however, listing multiple specifics should be avoided since one can never enumerate all possibilities. The legal doctrine, generally, is what a reasonable person would do vis-à-vis the patient and nature of the procedure.

Refusal of Treatment and Patient Non-Compliance

Dentists often see patients who, for one reason or another, will refuse treatment. There are also those patients who will either have poor compliance with a prescribed treatment regimen or will be totally non-compliant. If the dentist is assured that the

patient fully understands his/her recommendation for care,

then (s)he is obligated to fully discuss the consequences of non-compliance with the patient and make a comprehensive chart entry regarding the discussion. In these instances, it is often helpful to state the patient's reason specifically.

Should this delay prove detrimental to the patient's ultimate diagnosis and treatment and a professional liability case results, the proof of the reason for the delay will coincide with the dentist's note. He will then be in a better position to refute any claim that he did not make a timely recommendation.

D. Tools to Aid the Dentist in Documentation

Many dentists find it helpful to utilize certain documentation aids such as forms, in their practices. Some dentists purchase commercially prepared forms while others develop their own, in an effort to include all the areas they consider necessary. Where dentists develop their own forms, the forms should have a caption and should also be appropriately labeled with the dentist's/practice's name and address.

Forms

Some dentists find that a form is beneficial to them in maintaining a comprehensive record. However, these forms should neither be check lists nor forms that provide very limited space. They should leave room for recording of important clinical findings and discussions; 5" x 8" index cards, for example, usually do not provide adequate space for notations.

Forms are also particularly helpful for documenting comprehensive examinations, they help to serve as a reminder to the dentist of the various items for review and documentation. Also, where a dentist fully utilizes a standard form, such that his/her documentation is complete, it makes it easier to defend that dentist's professional liability cases.

A problem arises where a dentist chooses a form for his/her practice and then subsequently fails to complete that form. In essence, the message is that although (s)he considers the information important and therefore, chose the form, (s)he didn't find it necessary to ask the patient of the certain questions, or to include certain aspects of the examination in the notes. Forms, like notes, should be complete.

Other Forms

In some practices, first-time patients are asked to complete forms that require significant health history information. These forms should be designated specifically for the patients, and should be printed in language that the patient will understand. It is important that the dentist takes the time to review the information provided by the patient and

incorporate it into his/her own documentation of the patient's history. This may be done by initialing the form or by simply noting that it has been reviewed with the patient. Care should be taken to ask of the patient regarding sections that (s)he may have left blank, and to include that information in the dentist's note.

Telephone Message Slips

In order to help standardize the information documented by the office staff when a patient telephones the dentist, and also, to help ensure that these messages reach the dentist, some practices use telephone logs. Logs that have "tear off" slips with space for the dentist's response and that can be mounted directly into the chart as well as providing a carbon copy, reduce the need for additional documentation, but also help ensure that the telephone communications are documented. The carbon copies should be retained and filed chronologically. (This issue will be discussed further in the Chapter on Communication).

E. Document Pitfalls

There is a variety of documentation pitfalls about which the dentist should be mindful. They include the following:

1. Lack of Specificity

Probably to reduce the amount of time spent in documentation, many healthcare providers will write notes that are essentially mere conclusions, for example:

“Patient OK”
“Feeling better”

There is sometimes very little additional information provided which will aid in deciphering what is meant by this phrase, by anyone who will read it. Even the authors of these notes are hard-pressed, a year or two later, to remember what they meant. If that entry really means that the patient is now healed, and the patient is experiencing no further pain, and may return to work, that is what should be charted. The note should be as complete as possible, including all salient facts as well as proposed therapeutic plans, if any.

2. Lack of Completeness

A good example of this is where a patient presents with a chief complaint which is documented by the dentist, but where the dentist’s documentation of the physical exam bears no evidence that the examination focused on this complaint.

Incomplete documentation is always a handicap in the defense of professional liability cases. The dentist should not assume that some of his thoughts will be “understood” if they are not documented.

3. Failure to Show Reasoning

The law holds that a dentist’s error in judgment is not malpractice. However, in order to prove an error in judgment versus a negligent omission, it is essential that the dental record shows clearly what the dentist’s thought process is concerning the patient’s treatment; e.g., why he is choosing the conservative approach over the more aggressive route.

Notes discussing therapeutic intervention possibilities are most important. They should be clear and comprehensive.

4. Untimely Entries

It is best that any health care provider make the appropriate chart entries immediately after treatment/care has been provided. To delay documentation until the end of the day or any other further time, is to increase the possibility that the provider may forget to make an entry or forget the details to be included in that entry.

5. Illegibility

Illegible records, especially those illegible to the authors themselves, are of little value. Many instances have been reported where the illegibility of records has caused delays in care or appropriate treatment to be rendered. If the basic reason for keeping records is to benefit patient care, then illegible records are useless. If the dentist's handwriting is illegible, then the dictation and transcription of his/her notes should be considered.

6. Lack of Consistency

There are many cases in which a patient is seen with a specific complaint, treatment is instituted or further diagnostic tests are recommended; subsequently, the patient returns with a new complaint and no mention is made as to the patient's current status, relative to the earlier complaint which required intervention. What often occurs is that the patient develops a problem relative to the earlier complaint which was not resolved. It is difficult to defend such a case, since the record shows inconsistency on the part of the dentist, in providing comprehensive care.

7. Corrections in the Dental Record

If an error is made in a dental record entry, it may be corrected soon thereafter by drawing a single line through the information to be deleted, and initialing and dating the error.

This method allows for the corrected information to be read, and makes it clear as to when the correction was made. The use of correction fluid or complete obliterations of the dental record will give rise to charges of record alterations. Therefore, it is best to use the method described above. If at a subsequent time, it becomes necessary to make a correction or addition to the record it should be done with the use of an addendum.

8. Additions to the Record (Addenda)

In many instances, dentists will recall or obtain information at a later date and add it to a pre-existing record. Such an addition should be entered as an addendum with the actual date on which the new entry is being made. This will avoid the allegation that these additions were made to cover up omissions in the actual care of the patient.

9. Rewritten Records

The practice of rewriting records, whether they are portions of the records or entire charts, is one that usually results in charges of record alterations. Regardless of the motive, it is inadvisable for dentists to prepare dental records other than those that were compiled in the ordinary course of patient care. Original entries should not be destroyed.

Plaintiff's attorneys utilize handwriting and ink-aging experts to aid in establishing the authenticity of records, knowing that to prove that a record has been altered makes a defensible case, indefensible. This occurs because the author of that record is now cast in the light of a dishonest person with no credibility. This is perhaps the worst of offenses that can be committed in the area of charting, and will surely cost the defendant dearly.

10. Unprofessional Remarks/ Jousting

Many professional liability cases are generated by off-handed comments (written or verbal) by a co-provider or subsequent treater. For example, a dentist sees a patient who is considering revision of previous procedure that was performed by another local dentist, the results of which are not to the patient's liking. The second dentist writes in his chart:

In my many years of practice, I've never seen a root canal with this kind of result.

Certainly, this statement will not benefit the original dentist and may even affect the subsequent treating dentist who may very well be sued in this case. Often, those who author such notes find themselves caught up in a time-consuming professional liability action. Dental record entries are to be written in an objective manner.

F. Maintenance of the Dental Record

1. Record Format

A chart that is put together in a haphazard fashion is often equated with haphazard care. Time and effort expended in establishing specific format for the various components of the chart, will also yield results in the decreased time taken to locate specific information when it is needed.

It is also recommended that the pages in the records be secured to the record jacket since loose pages are, of course, more easily lost. It is best to use mechanisms (clasps and binders) that allow for expansion.

2. Storage of the Record

Both active and inactive dental records should be stored in a secure place, in an easily retrievable fashion. Some practices will attempt to reduce the bulkiness of records by removing items such as laboratory reports, or by cutting the reports to remove all information on the reports except the lab values. Parts of the chart that are removed should only be those that are so old as to be of little value to the current care. However, they should not be discarded but should be secured securely where they can be retrieved if necessary.

Trimming the reports is not a good idea since it usually removes vital information such as the name of the lab, the date etc. The patient's record is the primary piece of evidence in most malpractice cases. Every effort should be made to preserve it in its original and complete form.

Dx/Imp

Rx.

Chief Complaint:

Subjective: Patient complaints or absence of complaints in each diagnostic area

Objective: Physical and laboratory findings (+ and -)

Assessment: Your opinion of the problem- improved, worse, etc.

Plan:

1. List any changes in plan or treatment
2. Changes in medications
3. New procedures
4. Referrals

CHAPTER II

Informed Consent

A. The Legal Perspective

Under New York Law, a dentist has a duty to obtain a patient's informed consent before performing a non-emergency treatment, procedure or surgery, or a diagnostic procedure which involves invasion of the integrity of the body.

1. Dentist's Obligations

- a. Explain the procedure in terms understandable to the patient.
- b. Explain what (s)he proposes to do.
- c. Explain the risks, benefits and alternatives to the proposed procedure.
- d. Explain those facts that a reasonable dentist would explain, so the patient can consent with awareness of:
 - his existing condition
 - purpose of submitting to the procedure
 - risks of submitting versus not submitting to the procedures
 - available alternatives

2. Separate Claim from Malpractice

- a. Even if the procedure or surgery is properly performed, but damages result from a complication or risk not properly disclosed, a dentist may be responsible for monetary damages.
- b. The statute of limitations in New York for a cause of action for lack of informed consent is 2 ½ years.

3. Documentation is Required

a. Claims involving lack of informed consent always involve questions of fact between the dentist and patient. Therefore, it is essential that a dentist document the following information in their dental record, when consent is obtained:

- date, time and place where informed consent is given
- name(s) of person(s) present
- risks, alternatives and benefits of procedure discussed
- whether any diagrams, models, brochures were used
- any questions asked by the patient or family

4. Consent Forms

a. If a consent form is used, it should be routinely reviewed and updated as necessary. The consent form must be completed before being signed by the patient. The form must be signed, dated and witnessed, preferably by someone other than a member of the patient's family.

b. The dentist must make sure the patient can read and understand, not only the form, but all other educational material distributed. If the patient's native language is not English, suitable alternatives must be used.

c. The mere fact the form is signed is NOT evidence of an informed consent.

5. Capacity

Minors (generally under age 18 except in pre-natal circumstances) and those mentally incompetent are generally unable to consent. Those patients who have been sedated pre-operatively might also claim they lacked the requisite capacity to consent.

6. Exceptions to Informed Consent Rules

Under New York Law, an informed consent need not be obtained under the following circumstances:

- a. Emergency situation- if the patient is unconscious or in extremis, the law implies consent.
- b. Where the risk which is not disclosed, is too commonly known to warrant disclosure.
- c. The patient assured the dentist (s)he would undergo the procedure regardless of risk.
- d. The patient assured the dentist (s)he does not want to be informed of the risks.
- e. It was not reasonably possible to obtain consent from the patient.
- f. The dentist, after considering the patient's overall condition, used reasonable discretion in limiting the risks, alternatives and benefits disclosed to the patient because (s)he reasonably believed the disclosure would adversely affect the patient's condition.

Due to the difficulties involved in proving these defenses, they are rarely asserted and used at trial. The better position is to discuss, disclose and document the risks, alternatives and benefits of the proposed procedure.

B. The Risk Management Perspective

It is imperative to obtain informed consent; additionally, there are some practical considerations for the dentist. They include:

1. Explaining to the patient the risks and benefits of the procedure and any alternatives to the procedure. This explanation must be given in language that the patient understands. Remember that this discussion is to help the patient make an informed decision regarding care.
2. Include in your discussion:
 - how the patient may expect to feel afterwards
 - the length of discomfort
 - the recuperative period (e.g., the expected length, how the patient may expect to progress during this time, etc.)
 - when and whether the patient may expect to resume his/her regular activities
3. Testing the patient's comprehension to ensure that (s)he understands your explanation.
4. Allow the patient time to consider the information.
5. Do not give any guarantees.
6. If the patient consents to the procedure/treatment, ask him/her to sign the requisite consent form(s). The dentist should be the person who requests the patient's signature on necessary forms.
7. Summarize your discussion in the patient's dental record making sure to include:
 - a statement of the patient's problem
 - a description of the procedure as given to the patient
 - a statement indicating that the risks, benefits and alternatives were discussed and why the risk/benefits ratio is in favor of the course you have suggested
 - the names and identification (e.g., relative of patient or staff member) of those present at the discussion

- the fact that the patient expressed an understanding of the information given and his/her questions were answered
 - the fact that all necessary forms were completed and signed by the patient
8. The dentist should familiarize himself/herself with the informed consent policies in all of the institutions in which he or she practices, in order to ensure compliance with them.
9. Even if no specific consent forms are in use for the procedures done in that dentist's office, the performance of office procedures still require that steps 1-7 above are followed, and documented in the chart for the specific purposed procedure.

Refusal of Treatment

There are many informed consent discussions and other discussions of health care providers with patients that conclude with the patient's decision not to undergo the recommended treatment/procedure or delay it. These refusals and delays require specific, comprehensive documentation. Frequently, it is a patient who refuses recommended care who later returns to blame the health care provider for any untoward outcome. When treatment is refused, the dentist's note should be detailed as to:

- the reason for the recommended care/treatment
- the risk and benefits as explained to the patient
- the fact that the patient refused the procedure and any reasons given or statements made by your patient regarding his/her refusal. (This is to document your advice and the patient's decision is contemporaneous)

Some dentists choose to prepare a statement for the signature of the refusing patient; where this is done, the statement should be on a separate sheet of paper and not on the same sheet as the provider's own progress notes. The statement must have a date and should be witnessed.

Chapter III

Legal Environment

A. Anatomy of a Dental Malpractice Action

Introduction

In order to prove a prima facie cause of action for dental malpractice, a plaintiff (patient) must prove the following:

- Dentist/patient duty
- Departure from good and accepted practice
- Damages
- Proximate cause (i.e., the damages must be caused by the departure from good and acceptable dental practice)

As with most Civil actions seeking monetary damages, a dental malpractice action usually has three distinct stages. The following is an overview of the three stages of a dental malpractice action.

Pleading Stage

1. Summons and Complaint

In New York, a civil action may be commenced by service of a Summons with Notice or Summons and Complaint and can take place by a variety of methods ranging from personal (hand) delivery to service by publication (in a newspaper). If you do receive a Summons with Notice or Summons and Complaint, you must act immediately as New York Law allows only 20 or 30 days to respond. Upon receipt of a Summons:

- Contact your professional liability carrier immediately.
- Forward copies of all legal papers received (including envelopes in which documents were received) to your carrier.

- Document (not on the patient's record) the date, time and place legal papers received; name of persons receiving papers.
- Forward copies of dental records and x-rays to your insurance carrier.
- Secure all potential evidence (e.g.; your completed dental log, x-rays, appointment diaries, telephone logs and answering service messages).

The Summons identifies the parties (plaintiffs and defendants) and the venue (where the trial will take place). The Complaint sets forth the nature of the cause of action asserted.

There are some common misconceptions concerning the service of Summons and Complaints. You should be aware that:

- The process server does not have to personally hand hand you the Summons. If you refuse to accept it, (s)he can lay it at your feet.
- If you block access to the process server (i.e. close the door- won't come out), (s)he can simply lay the papers at your door.
- Even if you were not properly served, you can be reserved at any time before the statute of limitations expires. You can even be served when you appear for your disposition.

2. The Answer

The Answer is the response to the Summons which is interposed by your attorney, and it will specifically admit or deny each of the allegations asserted in the Summons and Complaint. Once an allegation is denied, the Plaintiff must prove those allegations at the time of the trial.

For example:

If you practiced as a member (shareholder) of ABC, P.C in 1988, but the Complaint alleges:

- Dr. X was a Partner of the ABC, P.C., in 1988.

An answer is interposed which reads, "Dr. X denies the allegations raised in paragraph numbered "1" of the Complaint.

As a result, the plaintiff would now have to prove that you were a partner (which (s)he will be unable to do) at the time of the trial.

The Answer must also include any defenses or affirmative defenses raised on your behalf.

For example, an affirmative defense frequently used is the jurisdictional defense. This is applicable if the plaintiff's process server failed to properly serve you with the Summons and Complaint. In this situation, your attorney will raise an affirmative defense, which states, "This Court lacks jurisdiction over the defendant." If it is not raised in the Answer, it is waived. Therefore, it is important to record (not in your office records) all facts related to the method and manner of your service. To assess whether or not this defense can be raised, your attorney will ask you the following:

- When were you served?
- What did you receive (Summons and Notice or Summons and Complaint)

- How many copies did you receive?
- How were you served? (i.e.; personally given the summons, it was left with someone (who?) on your behalf; it was nailed/taped to your door).
- Did you receive any copies in the mail? If so, were they mailed to your home or office?

Once an answer is interposed, the attorney for the dentist serves a Demand for a Bill of Particulars and makes other discovery demands. It usually takes 3-6 months, once the action is commenced, before the case reaches the next and most prolonged/stage of action, the pre-trial discovery stage.

Pre-Trial Discovery Stage

During the pre-trial discovery stage, both the plaintiff and defendant obtain all the information, materials and evidence which will be used at trial. Since most of this information (old dental records) is not readily available, discovery is the most prolonged stage of action.

1. Bill of Particulars

The receipt of a Bill of Particulars is the first time a defendant dentist is apprised of the real allegations in the lawsuit.

It is a document designed to amplify the claims of negligence, thereby limiting the issues for trial. Plaintiffs are required to set forth the specific departures alleged, the nature of the plaintiff's injuries and the specifics set of the claims for special damages.

The Bill of Particulars will also list the amount of Special Damages (dental expenses, lost earnings, hospital bills, pharmacy expenses, etc.) claimed by the plaintiff. The amount of time the plaintiff was out of work, hospitalized and otherwise incapacitated, will also be specifically listed.

2. Preliminary Conference

Once a Bill of Particulars is received, a Preliminary Conference is usually scheduled by the Court. At this conference, the schedule for completion of all pre-trial discovery is incorporated into a Court Order which provides for:

- a. Exchange of insurance information
- b. Scheduling of all EBTs (depositions)
- c. Scheduling of Dental Examinations
- d. Production of Dental, Employment and Collateral Source authorizations
- e. Compliance with Notices for Discovery and Inspection
- f. Identification of all Eyewitnesses
- g. Miscellaneous Discovery

3. Depositions/Examinations Before Trial (EBT)

This is the most important part of the pre-trial discovery process, as each side has an opportunity to depose his adversary to “lock in” the adversary’s story for trial. The deposition, if used properly, allows each side to prepare for trial by knowing, in advance, how each party will testify. If a witness changes his/her story at trial, the EBT transcript will be used to impeach the witness’ credibility.

The importance of the defendant’s deposition cannot be overemphasized. The dentist must be prepared for his/her deposition as (s)he is for trial. The dentist should review and familiarize himself/herself with each and every entry in the dental record.

The defense attorney must consult with the dentist as often as needed, until (s)he is comfortable with his/her testimony and the “theory of defense” which will be utilized at trial. Your “theory of defense” is your explanation to the jury as to what occurred and why that does not amount to dental malpractice. If you need more time to prepare for your deposition, discuss this with your attorney.

Trial Judges agree that most cases are not won or lost at this stage, based on the degree of preparation expended for the EBT’s.

4. Physical Examination

If a plaintiff’s alleging continues permanent damages, a physical examination will be scheduled with the appropriate specialist to confirm the injuries. Under New York law, a plaintiff cannot be compelled to undergo an invasive procedure to confirm or rule out claimed injuries.

5. Expert Opinions

Once the pre-trial discovery is completed, and sometimes earlier, an expert is retained by the defense to comment on the propriety of the dental care rendered. Where an expert believes that all the claims are defensible, a document is prepared and sent to all parties indicating the qualifications of the expert and the substance of basis of the expert opinion. Under New York law, the identities of the dental experts for all parties are kept confidential.

6. Possibility of Settlement

Once the expert opinion is received, it will be reviewed by your attorney and the insurance company for any weakness in your defense. If it is determined by the insurance company that the chances of success at trial are compromised, consideration may be given to discussing settlement.

Trial

1. Jury Selection

The first step in trial stage is the selection of a jury. In New York, routinely six jurors and two alternates are selected by the attorneys to decide the claims case. The parties and Judge are not usually present during the jury selection. The length of jury selection usually depends on the number of parties and the local rules governing jury selection.

2. Assignment to a Trial Judge

In those venues where the court's calendar is managed by a Trial Assignment Part (TAP), once a jury is selected, the attorneys report back to TAP to await assignment to a trial judge.

3. Opening Statements

Following preliminary instructions to the jury, each party is entitled to give opening statements. Although these statements are not evidence, they are designed to allow the attorneys to explain to the jury what their proof will show. The plaintiff gives his/her opening statement first, followed by the defendants, in the order in which they are listed in the caption of the case.

4. Plaintiff's Case

The plaintiff, who has the burden of proof, presents his/her evidence first. It is not unusual for the plaintiff to call the defendant dentist as a witness in his/her case. In order to prove a prima facie case, the plaintiff must call an expert to testify to the four elements required to prove a dental malpractice action (refer to Introduction of this Chapter).

5. Defendant's Case

The defendants present evidence in the order they are named in the caption. There is no requirement that the defendants must present any evidence, nor prove or disprove any of the plaintiff's

allegations. As a practical matter, experts are routinely called to dispute the plaintiff's claims.

6. Summations

Summations are also not evidence. However, they are usually very persuasive as the attorneys comment on what the evidence has shown, and what inferences they believe can be drawn from that evidence. Since the plaintiff has the burden of proof, the plaintiff's attorney gets the last word and is allowed to sum up last.

7. Judge's Charges

The judge must instruct the jury on the applicable law and explain to the jury, the mechanics of deliberating. Only 5 of the 6 jurors must agree for there to be a verdict in a civil case. The alternate jurors are excused following the judge's charge.

8. Deliberations

Jury deliberations can vary from minutes to days. Once a verdict is rendered, it is usually read by the foreperson and the jurors are polled.

B. Miscellaneous Legal Issues

1. Jury Psychology

Jurors must be able to rationalize to themselves and others the results of their labors and their reasons. Trial attorneys must work in collaboration with their clients to formulate a theory of defense that is dentally defensible, legally plausible and justifiable.

Since the plaintiff is the only party who comes to court with a claimed injury, dentists and their attorneys must compensate for a jury's natural desire to sympathize with an injured party. Arrogance and callousness on the part of the defendant can and does have a deleterious effect on trial. The dentist must be cognizant that (s)he is being constantly evaluated by a jury. Expensive and trendy clothes, jewelry or an expensive sports car in a conservative venue, can do more damage than a plaintiff attorney's cross-examination.

2. Expert Testimony Required

Since the plaintiff's attorney must present an expert or face a dismissal of his case, it is often mandatory that the defense present an expert witness on its behalf. However, with unusual, eccentric or questionable practices, it is sometimes difficult for an insurer to find experts who can defend such practices. Under those circumstances, since the chances of success at trial are greatly diminished, serious consideration must be given toward a settlement.

3. Dentist/Patient Duty

The dentist has had a legal duty to his/her patients and should bear the following in mind:

- The dentist/patient duty exists whether or not the dentist is paid for his/her services

- The duty is no less because the patient is non-compliant (the patient's non-compliance does not diminish the dentist's duty)
- For the plaintiff to succeed at trial, (s)he must prove that the defendant dentist violated one of the following duties:
 - possessing requisite skill and knowledge possessed by the average member of the dental profession in his community
 - exercising ordinary and reasonable care
 - using his best judgment in the application of his knowledge

Even if the defendant achieves a BAD RESULT, that is not evidence of malpractice if the dentist employed his best judgment.

4. Abandonment

There is no claim which ignites the passions of a jury more than one which alleges that an acutely ill patient was abandoned by a health care provider or hospital. Discontinuing treatment of an acutely ill or injured patient may be deemed abandonment. To insure continuity of dental care, proper procedures must be followed before discontinuing treatment:

- A patient who is in an acute phase of an illness should not be discharged from your care unless another dentist has been identified (either by you or the patient), and it is agreed with the new dentist and the patient, that care is to be transferred.
- Proper communication with the patient, preferably in writing, and documentation in the patient's chart is required.

- Proper notice (not less than 30 days) must be given, with assurances that there will be continuity of care in the interim period.

5. Use of Dental Products and Prescribing Medications

- Although a dentist does not manufacture a product of medicine, (s)he may be liable for failing to properly administer or prescribe such products.
- Product inserts, informational brochures and PDR listings have been held by certain Courts to be evidence of accepted standards of prescribing and dispensing medications.
- Failure to conform to these “suggested” dosages may subject a dentist to liability if damages result.

In order to reduce the risk:

- discuss and document the risks, alternatives and benefits to proposed treatment
- follow all dispensing instructions
- investigational uses of drugs must be within the recognized standards of care in the dental community
- document the name, manufacturer, product and lot numbers of any materials dispensed

CHAPTER IV

Communication

A. With Patients

A dentist's willingness to work at an effective communication with his/her patients can mean the difference between compliance and non-compliance, an enjoyable dentist/patient relationship or an ongoing skirmish, a dental malpractice lawsuit or no malpractice lawsuit.

While communication is a two-way street, it is usually the dentist who must "set the tone" regarding his/her willingness to spend time speaking with and listening to the patient. Clearly, if a patient comes into a practice where (s)he routinely waits an hour and a half to be seen, where there's a waiting room that is always full and a dentist who is dashing from one examination room to another, (s)he is not going to feel that (s)he can take the time necessary to discuss his/her dental problems and have them addressed adequately.

Some claims of dental malpractice cannot be linked to any error on the part of the dentist or other provider, therefore, it is believed that many such claims are the result of a patient's negative perception of the dentist and/or his/her practice.

Additionally, a patient's dissatisfaction is often grounded in discrepancy between his/her expectations and the actual outcome of care. The aim of the dentist should be to bridge that potential gap through effective communication with the patient. If we agree that people utilize suits, to a great extent, to seek redress for their satisfaction, then good communication should serve the Dentist well as a risk management tool.

Of course it is extremely important that the dentist is cognizant of the patient's own observations and feelings about his/her dental condition. A good way to explore that is to ask the patient open-ended questions such as, "What do you think is wrong with you?"; "What do you think caused this condition?"

Effective communication requires:

- that the dentist does more than speak at the patient in lecture style, giving him/her little or no opportunity to ask questions
- that the dentist does more than speak to the patient, probably in language they can understand, but then leaving the room immediately, so again, the patient has no input
- that the dentist is non-judgmental in his/her responses; the patient will thus be encouraged to continue in the discussion
- expression of genuine interest and concern about the patient
- maintaining eye contact with the patient, in a casual, friendly manner
- active listening, i.e., confirming to the patient that the dentist understands what the patient is saying
- avoiding excessive interruptions during your conversation with the patient

The dentist's ultimate goal in effective communication is to engage the patient as an active participant in his/her own care. The path to this is through the sharing of information as described above.

The dentist's demeanor with patients will generally be adopted by the office staff, who should be made aware of the impact of their relationship with patients on the practice, as well as the dentist's likelihood of being sued.

The Telephone as a Communication Tool

In today's dental practice, much of a dentist's communication with his/her patients may be done by the telephone. Therefore, the following should be considered:

The dentist should make every effort to have the patient's chart available for review and reference when returning a patient's call.

It is up to the dentist to set distinct guidelines in his/her practice, as to who will give dental advice, as well as the parameters for that advice. The dentist must always bear in mind that (s)he is liable for

all dental advice disseminated from the practice, regardless of who give that advice.

Diagnoses made and treatment rendered without the benefit of seeing and examining a patient personally, always carries increased risks. Telephone treatment often results in patient care problems. The patient should be advised that this is not the ideal manner in which treatment should be rendered.

The advice given to patients by telephone becomes important to their continued care, and may be critical in dental malpractice cases.

Therefore, it is important to have a system in place to document telephone advice and your response to telephone queries. Telephone logs with carbon copies, in which the top slip goes to the dentist and the carbon copy is maintained are available. The carbon copies should be maintained in chronological order.

The top slip should be inserted into the chart and the dentist's response should be dated and written in progress notes. In this manner, the telephone call and its response are thoroughly documented.

These slips also help in ensuring that telephone call information is included in the proper chronological order, relative to other chart entries.

Notes as a result of telephone advice, should at a minimum include:

- the date
- the patient's name (and name of the caller if different from the patient)
- the patient's complaint or reason for call
- information/instructions given to the patient

B. Communication Between Health Care Providers

In the contemporary practice of dentistry, it is not uncommon for a patient to be under the care of more than one dentist simultaneously. Therefore, it is essential that there is effective communication between all of the dentists involved in a patient's care. This section will review various risk management issues related to the prior communication.

Communications Between Partners/Associates in the Same Practice

Some dentists practice in group settings, therefore it is essential that there is effective communication between partners and associates. The dental record is a key tool that allows communication between dentists regarding the patient's status. If the information recorded in the patient's record is incomplete or non-descript, there is an increased probability that the patient's care will not be optimal. For example, if one dentist sees a patient for a new and chronic complaint and inadequately documents the dental examination findings or the history of the present symptoms, it will be difficult for an associate to accurately evaluate changes, improvements or progression of the patient's symptoms.

There is an increased risk that signs and symptoms that present in a progressive pattern will be overlooked or that a change in the clinical picture will not be promptly noted.

When partners or associates alternate night or weekend call, thorough sign-in and sign out procedures are a must. The on-call dentist must be fully aware of the group's patient whom the dentist in the group anticipate may require care (e.g.; patients who recently had surgery) or experience problems in the near future. There should also be a policy for the on-call dentist to report any significant occurrences during the covered time to the other members of the group. This report should include information on any new patients, changes in a current patient's status, or problems that have developed during the covered time. Depending on the nature of the practice, this exchange of information can be accomplished in formal meetings or via informal phone discussions. However, it is important to keep in mind that, as demonstrated, in the game of "telephone", indirect reports can be distorted; therefore, care must be taken to ensure that information is communicated clearly and effectively to appropriate members of the group.

Communication Between Referring Providers and Consultants

Another common situation where good communication between providers is essential, is where a dentist requests that another health care provider evaluates the patient for a suspected diagnosis, or to assist in the development of a treatment plan for a patient with a complicated or unusual condition. In these instances, communication between the providers is a two-way process that requires both the referring dentist and the consultant to establish a dialogue, to ensure that the appropriate information is available to properly assess and care for the patient.

It is always essential for the referring dentist to provide the consultant/dentist with appropriate information concerning the reason for the referral and pertinent information regarding the patient (i.e., significant finding, history, etc.). The referring dentist should not rely on the patient to advise the consultant regarding the indications for the referral. An anxious patient may not accurately recall or relate particular details or significant historical information that would have an impact on the consultant's evaluation of the patient.

The information provided to the consultant should always be conveyed in writing. This can be accomplished in a number of ways.

1. If the patient is hospitalized, hospital consult forms have a section dedicated to this function.
2. In the out-patient setting, a letter to the consultant is advised. If the time permits, the referring dentist should prepare a summary of the pertinent information and send it to the consultant. This will allow the consultant to review the information prior to seeing the patient. If the patient is to see the consultant shortly, the information could be sent by overnight mail or fax.

If the referral is of an urgent nature, the referring dentist may want to contact the consultant by telephone. However, this sometimes results in ineffective communication of significant information, especially if the information is relayed to the consultant indirectly. Regardless of the mechanism used to contact the consultant, the referring dentist should always document contacts with the consultant in the patient's dental record. The referring dentist should also maintain copies of any written information sent to the consultant in the patient's record.

When the dentist who is acting as a consultant completes his/her assessment of the patient, (s)he must provide the referring provider with a written report of his/her findings and recommendations. Copies of these reports should be placed in the patient's record, whether hospital or office.

The consultant dentist should make every effort to ensure that their recommendations are clear and not ambiguous. Any discussion between providers regarding the patient's plan of care should be recorded in the patient's record.

It is also important to ensure that the patient, the dentist and, when applicable, the co-treating dentist or other provider, are each clear concerning who will provide any recommended follow-up care.

If the patient's care is to be transferred to the consultant, that must be clearly communicative to the patient, and the specific date of the transfer must be noted in the record.

Dentists should also keep in mind that reports, letters, and other correspondence between health care providers regarding the patient's care become part of the patient's dental record. Therefore, all documented information (including letters and reports) must be factual, accurate and recorded in an objective manner.

Communication Between Dentists When a Patient Transfers Care to Another Practice

Patients may choose to transfer their care to another practice for a variety of reasons. In some cases, the patient leaves a practice on good terms (i.e., as a result of relocation, change in insurance coverage or a change in health status). In other cases, the transfer of care may be a result of ineffective or unsatisfactory dentist/patient relationship, a billing or financial problem as the result of a poor or unexpected outcome. Regardless of the reason a patient transfers to another practice, effective communication between the former and current provider is essential. In order to ensure continuity of care, when the patient transfers care to another practice, the provider must ensure that upon receipt of a properly executed authorization, exact copies of the patient's dental records are promptly transferred to the new provider. Dentists should be cognizant of the fact that subsequent treating dentists may require prior records to properly evaluate and care for the patient, therefore, every effort should be made to respond to such requests in a timely manner. A patient's

dental record may not be withheld for non-payment of an outstanding bill.

When a new patient enters a practice, the dentist should assess the need to obtain and review the records of prior treating dentists. If it is determined that the records of a prior provider may be important the patient should be asked to authorize the previous provider to release copies to the patient's dentist. It is always best to err on the side of safety and obtain such records.

When the records are received, they should be reviewed. If there is any material or information that requires clarification, efforts should be made to clarify it. The records should then be included in the dentist's chart, or if the record is too bulky, at least summarized therein. In any event, the transferred records should be maintained, even if in a storage area.

C. Communication Between Dentists and Other Providers

Communication with Other Healthcare Professionals

Dentists may occasionally rely on other healthcare providers to help carry out a patient's treatment plan. Therefore, good communication between dentists and other healthcare providers is an integral aspect of providing quality patient care.

In situations where a patient is referred to another provider (e.g., physical therapist, visiting nurse, etc) for treatment, monitoring or care, it is important that the dentist clearly communicates the recommended treatment plan to the provider. This should be done in writing. This will help ensure that the information is accurately conveyed to the provider. The dentist should keep a copy of the orders/prescriptions given to other providers. This will provide the dentist with specific evidence of the instructions/orders given to other providers. The dentist should also ensure that (s)he receives reports from the other provider on a regular basis to evaluate the patient's progress. After such reports have been reviewed, a notation concerning them should be placed in the patient's record to document the review. These reports should then be incorporated into the patient's dental record.

Communication with Facilities That Provide Ancillary Dental Services

There are some occasions when the dentist will rely on the services of ancillary providers such as labs, hospitals or testing centers to provide corollary information which is needed to evaluate a patient. Generally, it is the policy of such facilities to communicate abnormal/urgent findings to the dentist by phone. In those cases, the dentist and/or staff who receive the information, must ensure that the information is properly taken and recorded.

When receiving a verbal report regarding an abnormal finding, it is important to document the following information in the patient's chart:

- the date
- time of call
- the name of the lab/facility
- the name of the lab/facility making the call

- the abnormal finding or value

If a practice receives verbal reports on a regular basis, it may be helpful to develop a telephone report form to facilitate recording of the information in a uniform manner. Whether a separate form is generated or not, there should always be full documentation of these reports in the chart. It is also important for all office staff who may receive such information to understand that the information must be conveyed to the dentist in a timely manner. The record must also include a notation of the dentist's action in response to receipt of this information.

All verbal reports should be followed by a written report, which should also be incorporated into the patient's dental record.

CHAPTER V

Office Procedures: Administrative Systems

A. Introduction

In this section we will highlight several issues which are recurrent themes in professional liability cases. The institution of the systems discussed in this Chapter does not require a great investment of additional resources, but, for the most part, calls for a rethinking of old habits and making a few adjustments within the practice.

B. The Handling of Income Reports

The mishandling of reports has led to a number of a number of cases where a failure to diagnose or a delay in diagnosis is alleged. Many practices refer patients and/or specimens for diagnostic testing. Usually the dentist will note in his/her dental record that the patient is to have certain tests and that the dental record is returned to the file. In the event that a report is never received, the practice may not become aware of it until an inordinate length of time has elapsed. This is especially hazardous, since in many practices patients who have tests performed are told that if they don't receive a call from the dentist's office, it means "everything is OK".

A good method of avoiding this circumstance is to maintain a simple log of patients and specimens sent for testing. This log should be used for ordinary lab tests as well as other diagnostic evaluations for which the patient may have been referred. If incoming reports are checked against this log, an errant or absent report can be identified quickly. The incoming reports should then be placed on the dentist's desk with the patient's chart for prompt review.

All incoming reports should be reviewed by the dentist. Each report should be initialed (or signed) and dated by the dentist, so that the review is documented; this documentation also helps mitigate against reports being filed before they are reviewed. This means that all office staff must be advised that unsigned reports are not to be filed.

If preliminary reports are obtained by telephone, these results must be noted in the chart indicating that they were obtained verbally from the laboratory. The date of this report as well as the name of

the laboratory representative is to be noted. Verbal reports from consultants usually are an indicator of a problem or a need for further investigation. Routine findings are rarely reported by phone. Therefore, telephone reports should be brought to the attention of the dentist, as soon as possible.

Some practices leave it up to the patient to contact them regarding test results. However, especially where the results warrant treatment or other action, the dentist should make contact with the patient. Any information, recommendations, treatments etc., given to the patient must be documented.

C. Patient Referral/Follow-Up

In dentistry, some patients are referred to specialists for further diagnosis and treatment. In the ambulatory setting, the patient should leave the referring dentist's office fully aware of the reason for the referral, how quickly (s)he needs to see the other dentist and what the next step is after (s)he has seen the dentist. As previously noted in the Chapter on Communication, a note covering this discussion should be included in the chart. It is preferable that the referring dentist sends a note to the consultant, giving any relevant information that will be of value in his/her assessment of the patient. If the consultation is required the same day, a telephone call to the consultant is mandatory.

In many professional liability cases where the issue of referrals has arisen, it has to do with the lack of follow-up on referrals to consultants where the patient never sees the consultant or significantly delays the visit.

Generally, in the aforementioned cases, the courts have held that providers who make the referrals have an added responsibility to try to ensure that the patients are seen in a timely manner. In some practices, this takes the form of office staff making appointments for the patients. Where an appointment is made, it should be noted in the patient's chart.

However, what is of even greater importance is that, for urgent referrals, a tracking or follow up mechanism should be instituted, so that these patients do not "fall through the cracks". A log (or "tickler system") such as that demonstrated on the following page, could be a helpful tool for this purpose.

SAMPLE
Referral Log

<u>Date</u>	<u>Patient</u>	<u>Consultant</u>	<u>Report Rec & Reviewed</u>	<u>Comments</u>
1/10/99	Jane Doe	Dr. Periodontist	1/15/99	Discussed with patient 1/16/99 with full Explanation
1/10/99	John Public	Dr. Endodontist		Patient called 1/25/99- Says he rescheduled Appointment for 2/2/99
1/12/99	Mary Smith	Dr. Oral Surgeon	1/19/99	

The log should be checked periodically to ensure that a report has been received for each patient. As in the sample log, a patient for whom no report is received should be contacted and his/her response noted. Especially, if "Mr. Public's" referral was an urgent one, it is important to make a more complete note in the patient's chart. For example:

1/25/99

Spoke to Mr. Public since consult report not yet received. States he rescheduled appointment for 2/22/99 due to work schedule. Reminded of urgency to consult.

Should this person's delay have an adverse effect on the outcome of his care, this type of tracking and documentation will be of great importance to the dentist's defense.

D. Missed Appointments

In any dental practice, patients miss scheduled appointments for a variety of reasons. In many cases where patients claim injury due to dental negligence, the issues of appointments that were not kept arise. Sometimes, the missed appointment has no significant bearing on the case. In other instances, an appointment that was missed, exacerbated by the dentist's being unaware that the patient had not returned for the recommended treatment, may further complicate the case and lessen the chances of a successful defense.

In some practices, patients who miss appointments are called routinely or sent letters asking them to contact the office to reschedule. It is also reported, that in practices where appointments are reconfirmed a day or two prior to the appointment, the incidence of missed appointments is decreased.

The following points are suggested in the handling of missed appointments:

- The dentist should be made aware of all missed appointments on a daily basis, so that (s)he can decide whether further follow-up with the patient is necessary.
- If the dentist decides there is no need for further follow-up then a simple note in the chart, documenting the missed appointment, is sufficient.
- If the patient was scheduled to be seen for re-check on a problem that the dentist does not consider to be serious, but concerning which (s)he will not be satisfied until the patient is seen, it is in order to send a brief note to the patient, requesting that the patient call to make a new appointment, or to contact the patient by telephone.

In the aforementioned case, the note in the chart should at least contain the following information:

2/10/99- Patient did not keep appointment. When contacted, said he had to work this afternoon and forgot to call. New appointment- 2/15/99- 2:30 p.m.

If a note is sent to a patient, a copy must be kept in the patient's chart. In some of these cases, when the patient is contacted (s)he may say (s)he doesn't wish to see the dentist as his/her condition has improved. These responses must also be documented. In addition, if the dentist still feels that the patient should be seen, the patient must be so informed, and the chart entry should include that fact.

- In instances where the dentist may consider it critically important that the patient is seen, a call should be made to the patient advising of the urgent need for care, with appropriate documentation made in the chart. If the patient cannot be reached by phone, then a letter should be sent. Especially, if it is a patient who has a history of non-compliance, that letter should be sent by "return receipt requested" mail. again a copy if the letter is to be retained in the patient's chart along with the signed delivery receipt.
- It is also suggested that a person's name not be erased from the appointment book, but rather that some indication be made next to their name, that the patient did not show up for the appointment.

Where the record is left open-ended, showing no contact with the patient after a missed appointment and further, no indication that the dentist is made aware of missed appointments so that an informed decision is made regarding follow-up, the dentist is often hard-pressed to prove the patient's non-compliance in a malpractice action. Moreover, the effort to contact the patient may very well make the difference in that patient's receiving the necessary care.

E. Fee/Billing Issues

This section will deal briefly with the key issues of fees and billing that, if not adequately provided for in a practice, could increase risk. The following recommendations are worthwhile considering:

1. Have a designated person/persons responsible for handling of fees/billing in the practice. This person will be well-versed in the fee schedule and billing arrangements, and will, therefore, lessen the chances that a patient will be misinformed, giving rise to friction. Questions as to fees and billing should generally be directed to that person.
2. Especially, where there may be extraordinary fees for a visit (most importantly for an initial visit), the patient should be given as close an estimate as possible of what (s)he will expect to pay, when the appointment is made. This will help eliminate the element of surprise and possible unhappiness on the part of the patient, and will also increase the chance of the practice's receiving the required payment at that visit.
3. The practice should have clear policies as to the requirements for payments, acceptance of insurance assignments, payment methods, etc. If the practice has a patient information brochure, that is a good place to include these policies.
4. The practice should develop clear guidelines regarding billing frequency and the steps to be taken with regard to delinquent payers.
5. When a delinquent payer meets the criteria for their account to be referred to a collection agency, a mechanism should be in place for the dentist's input. This should include the dentist's review of the patient's dental record, to ensure that this is a case that (s)he believes, should be turned over for collection.
6. The practice's contract with the collection agency should include a requirement for written permission from the

dentist before collection efforts are escalated to a suit. Billing and collections must be closely monitored as this is an area that often precipitates a malpractice action against the dentist.

F. Administrative Systems in Large Group Practices

In some large practices, each provider manages his/her own administrative systems. A uniform plan that is in force throughout the practice helps to ensure that each provider does have effective systems in place to address these various situations. Moreover, uniform systems allow for greater flexibility with staff. A secretary who usually works for Dr. A will not be at total loss when she must fill in for Dr. B.

CHAPTER VI

Office Procedures: Tests/Surgeries

Introduction

Historically, dentists perform most procedures in the office setting. This section will review some basic loss prevention information concerning office procedures.

A. Deciding Which Procedures to Perform in the Office

The types of procedures performed in the office setting will vary. There are a number of factors that must be considered when a dentist decides which (if any) procedures (s)he will perform in the office. A key factor in the decision making process, is an assessment of the conditions necessary to provide optimal patient care that meets or exceeds the community standard for that procedure.

Each dentist should assess his/her office environment to ensure that it is appropriate for the procedures being performed. The physical environment should meet applicable requirements for infection control, sterility, safety and patient comfort. For example, the dentist should consider if the area where procedures are performed is easily accessible to emergency services personnel. That is to say, if a patient requires emergency evacuation, will the transport team be hampered by the physical design of the procedure area? Dentists may want to reconsider difficult procedures in areas that have limited emergency access.

Dentists should ensure that the equipment being used to perform office procedures is in keeping with what is currently being used in the community. If the equipment being used for procedures is antiquated, the dentist may expose himself/herself to liability if a diagnosis is missed or not observed as a result of inadequate equipment. Equipment should be maintained and upgraded in accordance with current technology.

It is also important to understand that a dentist who performs a procedure in the office will be held to the same standard as other dentists who commonly perform that procedure in the community. Therefore, dentists should not perform procedures which they are not qualified to perform.

If members of the dentist's staff are assisting with a procedure, the dentist must ensure that they are properly trained and credentialed in accordance with the community standards. Where specific training is required, the dentist should maintain documentation of the staff's training in their personal files. Credentials and certificates should be updated as necessary.

B. Emergency Preparedness

Dentists must ensure that they are prepared for any foreseeable emergency that may arise during, or as a result of, an office procedure/diagnostic evaluation. The amount and type of emergency equipment maintained should be in accordance with the anticipated needs for the practice's patients and the predictability of an adverse event. For example, dentists who perform procedures that require sedation or anesthesia should be prepared in terms of equipment and training, to provide emergency support to a patient who suffers an adverse event. In these practices, it is also important to ensure that staff members are trained and currently certified in CPR. This will allow the dentist to direct the resuscitation efforts and provide additional care as appropriate, if a patient arrests in the office.

Emergency equipment should be reviewed and inspected on an ongoing basis to ensure that it is complete and in good working order. It is recommended that the practice maintains a master list of emergency equipment and medications which can be used on a regular basis. The intervals of the checks should be based on the frequency and type of procedures performed in the office. Medications must be reviewed periodically to ensure that they are current. Practices should maintain a log of the equipment and medication checks and all such reviews should be dated and signed.

This will provide the practice with a record of the efforts made to ensure adequate preparation for emergencies. Emergency kits are available from dental supply services.

Each practice that performs procedures should also establish a plan for handling an emergency which necessitates that the patient be transferred to an acute care facility. Each staff member should have specific tasks to be performed if a patient required transfer. For example, a specific staff member should be designated to call 911 (or whatever mechanism is used) to access emergency response. If there are other calls to be made (e.g., to the hospital or to a consultant), the staff should understand who is to be contacted and in what sequence. In all cases, the dentist should communicate with the emergency facility involved and give necessary information. If at all possible, the dentist should accompany the patient to the hospital or independently arrive at the hospital at the time the patient arrives.

In some practices, it may be helpful to plan "mock codes" or drills to reinforce each staff member's role in an emergency. This becomes especially important in a practice with a large physical plant. It is

also important to make alternate plans for occasions when specific staff members are off or away, to ensure that the duties of that individual are not overlooked in their absence.

C. Obtaining Consent for Office Procedures

Many dentists fail to realize that it is necessary to obtain the patient's consent for procedures performed in the office. It is important to understand that the same guidelines that apply to obtaining a patient's consent for an invasive procedure in the hospital setting, also apply in the office setting. Whenever a patient undergoes an invasive procedure, regardless of the location, it is important to document that the dentist has discussed the proposed procedure with the patient and that the patient understands:

- the indications for the procedure
- the risks of the procedure
- the benefits of the procedure
- the alternates to the procedure

It is essential that the dentist includes a summary of his/her discussion with the patient (and if appropriate, the patient's significant other) in the office record.

Note: Please refer to Chapter II for a more detailed discussion regarding Informed Consent Issues.

D. Documentation of Office Procedures

It is essential for dentists to ensure that they maintain documentation of procedures performed in the office. The level of detail required will depend on the procedure. For example, a procedure requiring IV sedation should be documented with the same level of detail as if the procedure were performed in a hospital or ambulatory surgery unit. Lesser procedures requiring local or no anesthesia, do not necessarily require a full operative report. However, the note recorded in the office chart should not be limited to a phrase such as, "Extraction done". When procedures are performed in the office, the dentist must record a note in the patient's chart that provides the following basic information:

- The indications for the procedure
- The fact that the patient has consented to the procedure
- Sedation given (if any)
- Findings/outcome of the procedure
- How the patient tolerated the procedure
- Any post-procedure observations of the patient
- Instructions given to the patient regarding post-procedure care and follow up visit
- Condition on discharge from the office

Practices that perform certain procedures on a regular basis may find it helpful to develop an appropriate form to document procedures. The use of graphics or diagrams that will enhance the documentation of the findings is recommended.

The use of standard operative reports is not recommended. It is important that the report of an operative procedure reflects the facts regarding the care and treatment of the particular patient.

It is also important to document any instructions given to the patient regarding follow-up care. When possible, it is preferable to provide the patient with written instructions regarding post-procedure care. Again, if there are procedures that are performed on a regular basis, it may be helpful to have pre-printed instructions that can be given to patients. It is not necessary to place copies of pre-printed instructions in each patient's file. If pre-printed forms are being used, the dentist or a member of his/her staff can enter a note in the

chart that the instructions for a certain procedure were given to the patient. The practice should retain a master copy of the instructions, in its original form, in a permanent office file. The original should include the date the form was implemented. This will ensure that a copy of the information provided to the patient following a procedure will be available if it is needed for the defense of a claim.

Practices that give patients sedation or anesthesia should have a policy to ensure that the patients who receive sedation are discharged in the company of a responsible adult. It is important to document that fact in the patient's dental record. Where possible, the identity of the person with whom the patient was discharged should be specifically noted in the file.

It is appropriate, and to the patient's and dentist's advantage, to have a policy to contact patients following invasive procedures. When the dentist or a member of the staff contacts a patient following a procedure, (s)he should ensure that those contacts are comprehensively documented. If the patient reports (s)he is feeling well, that should be noted.

If the patient reports any complaints or problems, they should be noted along with any additional advice or instructions that are given to the patient.

E. Loss Prevention Issues Related to Office Laboratory Testing

When a practice obtains laboratory specimens or performs laboratory evaluations in the office, there are a number of loss prevention policies that should be in place. The following is an overview of issues dentists should consider regarding laboratory testing.

1. Specimens should only be obtained by someone qualified to do so.
2. All specimens must be identified immediately after they are obtained. This will help prevent the possibility of a specimen being mislabeled, lost or confused with another.
3. Where specimens are being stored, ensure that they are being stored properly.
4. Equipment used for in-office testing must be maintained and calibrated in accordance with the manufacturer's guidelines. (The dentist may also wish to periodically run controls comparing results on his/her equipment with those maintained at an outside source.) The practice should maintain documentation of when the equipment was calibrated or serviced. This will provide evidence that it was reasonable to rely on the equipment's accuracy.
5. The dentist must ensure that the staff performing in-office lab tests are properly trained and qualified to do so. Where staff has received special training, documentation of the training should be maintained in the employee's personal file.
6. In-house lab test results should be documented in the patient's dental record in a uniform manner. Results can either be entered directly into the progress notes or recorded on a report form. If a report form is used, it should include:
 - the patient's name
 - the date the specimen was obtained
 - the date the result was available, if it was not the day the specimen was obtained (e.g., culture results)
 - the identity of the person who performed the tests

If the results are recorded in the progress note, the same information should be recorded. If the machine used to

analyze a specimen prints out the test results, the dentist should ensure that the printout is identified with the patient's name and the date of the test and incorporated it into the patient's record. The printout must also be permanently affixed into the patient's record to ensure that it does not get lost or separated from the record.

7. Reports received from outside laboratories should be maintained in their entirety. They should not be trimmed, cut or modified to conform to the size of the dental records in the practice.
8. Laboratory reports should not be discarded even if the information has been transcribed into the progress notes of the patient's chart.
9. If an outside laboratory is being used, make efforts to ensure that the laboratory is reliable and adheres to appropriate quality assurance standards.

F. Radiology Issues

Practices that provide radiology services to patients must also be mindful of loss prevention in that area. The following is a summary of loss prevention recommendations for dentists who provide radiology services to their patients:

1. Equipment used for radiology evaluations must be capable of providing the quality of studies equivalent to the community standards. In cases of professional liability, this issue is most often raised when the quality of diagnostic study obscured a finding, resulting in a delayed diagnosis. Care must be taken to ensure that the quality of the studies performed in a practice is in keeping with the current state of the art.
2. Dentists should ensure that radiology equipment is maintained and inspected in accordance with applicable laws.
3. Staff who is performing diagnostic radiologic procedures must be properly trained and credentialed. The dentist should maintain updated documentation of the staff's credentials in the employee personnel file.
4. X-ray films should always be identified with the patient's name and date of examination. When the anatomical landmarks are not readily apparent, it is necessary to read right from left on the film.
5. It is necessary for the dentist to formally document his/her interpretation of x-ray studies obtained in the office. The interpretation (including views obtained, where applicable) can be incorporated into the progress note or can be documented in a separate record; in either case there must be evidence in the dental record that the dentist reviewed and interpreted the study.
6. Where appropriate, the dentist should obtain copies of previous films for comparison purposes. Where it is not possible to obtain prior films, the reason the films could not be obtained should be noted in the patient's record

7. Under ordinary circumstances, original x-rays should not be released to patients. Original x-rays are often irreplaceable, and the defense of many claims rests on this invaluable piece of evidence. Many malpractice claims allege improper treatment as a result of a dentist's failure to properly interpret an x-ray.

If the x-ray is not available, it is impossible to say with certainty if an abnormality was identifiable on the film at the time of the examination.

We have experienced difficulty in retrieving films that healthcare providers have given to patients. There is no guarantee that a film will be returned, even when the dentist has asked the patient to sign for the film or leave a deposit. Moreover, if the film is lost or damaged while in the care of the patient or other provider, it will be unavailable for review.

Dentists who perform x-rays on a regular basis may want to purchase x-ray copiers for their practices. Copy machines are available at nominal cost and reasonable copying charges to the patients are proper. If this is not feasible, an alternative solution to this problem is to make arrangements with a local hospital or radiologist to make copies if necessary. If the practice requires notice in order to maintain copies, it may be helpful to advise patients of your policy in advance. If the dentist feels that the copies of x-rays will not be adequate for a subsequent treader to properly evaluate the patient, then (s)he should consider retaining the copy and forwarding the original. This will at least provide the referring dentist with some record of the information that (s)he relied on when caring for the patient.

CHAPTER VII

Coverage Issues

A. Introduction

After-hours, emergency and vacation coverage are issues that require adequate and ongoing attention by the dentist. If a patient who is experiencing an urgent or emergency event has difficulty contacting his/her dentist, the groundwork for a negative and perhaps even a hostile encounter has been laid. This section will discuss coverage issues that should be addressed by dentists in order to mitigate against allegations that the dentist abandoned the patient in his/her time of need.

B. After-Hours Coverage

Dentists who performed surgical procedures should have a mechanism for patients to reach them after hours. Traditionally, dentists have engaged answering services for this purpose. Obviously, it is the dentist's obligation to ensure that the answering service can contact him/her in the event of an emergency. The service must also know how and where to reach the dentist. It is also wise to continually monitor and periodically assess the manner and efficiency with which the service is handling the patient's calls. The dentist should also ensure that the service operators do not independently assess whether or not the dentist should be contacted.

In many practices, service can be reached directly through the regular office number. If patients cannot access the answering service directly through the regular office number, the mechanism to reach the service must be clear.

When a healthcare provider develops an indirect system for patients to contact him/her, the provider should be mindful of the fact that patients attempting to contact him/her after hours may be experiencing a great deal of stress; therefore, the system to reach the provider should be as simple as possible.

If the dentist has an indirect system for patients to reach his/her service, it is important to recognize that this is an impediment to easy communication and may undermine good patient relations.

If an answering machine is used, the message on the machine must provide specific information as to what patients are to do if they are experiencing an emergency or an urgent problem. This will ensure that they do not leave messages expecting the dentist to contact them. Also, if the machine takes messages, there should be a mechanism to preserve the messages left on the machine, as they become important in professional liability cases.

Dentists who choose not to engage in an answering service, should ensure that there are no gaps in their accessibility to patients. For example, if the dentist wishes to have patients contact him/her directly via a home number, provisions must be made to ensure that there is a foolproof system (i.e., call answering, call forwarding, etc.) for occasions when the dentist may not be at home or is unable to take calls.

If the nature of the dentist's practice is such that no after-hours coverage is available, that should be clearly communicated to the practice's patients at the time of service. A conspicuously posted sign in the waiting area would be appropriate. If the practice has an informational brochure and/or provides patients with post-surgery instructions, the fact that there is no after-hours coverage should be clearly noted in these documents.

C. Coverage for Vacations and Days Off

On occasion where the dentist will be unavailable for patient care, it is necessary to ensure that appropriate arrangements are made to cover his/her practice.

It is important to make sure that the dentist who will cover the practice is capable of doing so. Obviously, that dentist should have similar training and expertise and be competent to care for the patients in the practice during the dentist's absence (e.g., patients who recently had procedures).

The dentist should have a formal sign-out procedure to ensure that the covering dentist is aware of the current status of patients who may require special attention in his/her absence.

The date and time the covering dentist will begin and end coverage should be clear to the following persons:

- the covering dentist and his/her staff
- the dentist who is being covered and his/her staff
- the answering service of the dentist being covered
- any patient who the dentist anticipates will be seen by the covering dentist (e.g., patients who may require special attention in the dentist's absence)

The dentist should also have a sign in procedure that includes contact with the covering dentist to obtain information regarding care rendered in his/her absence. Where necessary, the dentist should obtain reports and summaries concerning patients treated in his/her absence. When these reports are obtained, they should be made part of the patient's dental record. The dentist may also want to contact patients who were seen by the covering dentist to ensure that any follow-up recommended by the covering dentist is arranged.

D. When You Are The Covering Dentist

On occasions when you cover another dentist's practice, you should follow the same steps regarding sign-in/sign-out procedures. If another dentist's patient is seen in your office, you should record a comprehensive note of your findings, evaluation and treatment. Where necessary, you should obtain and document significant information concerning the patient's history. Although it is not necessary to create a formal chart for patients seen in the capacity of the covering dentist, the record of this encounter should be maintained in a file that will be accessible if needed at a later date.

When a covering dentist has cared for another dentist's patient, (s)he should ensure that the primary dentist is provided with all of the necessary information regarding their evaluation and treatment of the patient, so that the patient's care can be continued without interruption.

Chapter VIII

Managed Care Issues

It is a reality of current dental practice that many health care providers enter into arrangements with managed care entities. Many patients benefit from these arrangements and they are also beneficial to many practices. As with all aspects of medical and dental care, there are risks associated with being a managed care panel provider. The following is not meant to be an exhaustive discussion of these issues or to dissuade our policy holders from entering into these agreements. Rather it is meant to serve as a reminder to our insureds that even in these relationships, they bear the responsibility for providing patient care and therefore, also bear the associated risks.

Review of Contract and Provider Panel Lists

Generally, providers who enter into agreements with managed care plans are required to sign contracts with these organizations. As with any contract, it is advisable that the provider reviews this documentation carefully with his/her personal attorney. Since there is a wide variation amongst these contracts, some of the areas for which the provider should direct particular attention are:

- the restrictions that may affect his/her ability to obtain screening examinations that are considered to be standards of dental care, consultations or other diagnostic tests
- the appeal mechanism where coverage for a particular test or course of treatment is denied
- the provisions as to his/her ability to retain the authority to ultimately determine what is dentally necessary for his/her patients
- the specific requirements of the organization for patient care documentation, relative to reimbursement

The provider should also review the list of panel members, laboratories, etc., especially for his/her geographical area, since

(s)he should feel comfortable about referring patients to these other providers. This is important since they essentially become the provider's "partners" in caring for his/her patients.

Request for Authorization

Under the terms of most managed care plans, the healthcare provider is required to obtain the managed care organization's authorization to perform many tests, procedures, etc.

Generally, the provider is responsible for submitting the requisite information to the organization. The provider should ensure that (s)he does the following:

- provides all necessary information that the managed care organization will need in order to process the request for authorization
- emphasizes, where necessary, the urgency of the procedure
- follows up with the managed care organization if a timely response is not received

Denial of Coverage

The provider's standard of care must be uniform regardless of the restrictions, etc., which the managed care organization may proffer. If a recommended test or course of treatment is denied by the managed care organization, it is important that the provider:

- advises the patient of the denial, restating his/her opinion that the test/treatment is important
- follows the appeal procedure set forth by the organization
- fully informs the patient of availability of care outside of the system at his/her expense

If coverage is not obtained, the availability of other services must be made very clear to the patient.

From a liability perspective, proper documentation of all of the above is doubly important in these cases, since if the managed care organization becomes involved in litigation with the patient, the organization may cross-claim against the provider. The provider's defense in such a small matter will be based on documented evidence that (s)he has exhausted all avenues to obtain the requisite care for the patient.

Even though a provider may have previously treated a patient who was denied a specific test/service, (s)he should still pursue coverage for subsequent patients and if denied, follow the steps as recommended above.

While there have been cases in which health insurance payers/managed care organizations have been held liable for decisions which resulted in care being withheld from patients, providers should be aware that they are usually included in such cases as defendants. Documented evidence of provider's efforts to help the patient obtain what they consider to be required/necessary care, will be critical to their defense.

Documentation/Treatment Guidelines

Many managed care entities have their own documentation and treatment guidelines which may be helpful to the provider. However, in some instances managed care organizations require chart entries that may not be prudent from a risk management perspective. For example, a requirement that a provider documents a full dental exam at each visit may result in entries being made in the chart, for examinations that did not occur.