Improving Patient Safety – An Analysis of Dental Risks and Liability
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• A nationwide malpractice insurance company
  — Owned and operated by dentists
  — EXCLUSIVELY for dentists
  — Offers complementary Risk Management resources
    • Phone consultation with Risk Managers (800-522-6675)
    • Courses: Live and Web-based

Here To Serve You

Fortress Online
Risk Management Resources

www.dds4dds.com

Policyholders
User ID: Policy number (begins with 3)

Staff & Others
Register with “Guest User Registration”
Improved Website Navigation

Direct links to our most popular resources now available!

New Informed Consent Forms

• Standard template
• The forms are...
  – Procedure specific
  – Consolidated for ease
  – Efficient and patient – friendly
    • Initial line at the bottom of each page
    • Ideal for the transition from paper to electronic

Online Risk Management Courses

• 3 Part HIPAA Series
• Electronic Medical Records
• Managing Social Media Risks
• Anatomy of a Malpractice Suit
The Course Objectives

• Identify common risk factors in implant, extraction, and failure to diagnose cases.
• Understand how to implement key clinical risk management strategies to help mitigate associated risk factors, improve patient safety, and reduce untoward outcomes and malpractice claims.
• Gain knowledge about opioid management, including considerations for prescribing and securing opioids in the dental practice.
• Learn effective policies and procedures to help improve HIPAA/HITECH compliance in the dental practice.

Common Reasons Patients Sue Other Than Malpractice

• Not happy with results
• Financial incentive
• Criticism from a professional colleague
• Unreasonable expectations
• Communication issues
• Personality conflicts

The “Unhappy” Patient

• 78 year old male
• Presented for denture consultation
  – Promised “top of the line” dentures
• A temporary denture was seated
• Small claim and board complaint were filed
  – Allegations: “top of the line” dentures were promised, but temporary (“flimsy”) dentures remained in place for “too long”
  – DDS provided a refund and claim was dismissed
The “Financial Opportunist”
- 60 year old male
- Crown work was performed: 16 teeth
- Patient was not pleased with the “time it took to complete” the crown work
  - Was told 4-6 visits but it took 9 visits
  - No complaints regarding the care and treatment rendered
- Patient requested a refund of $2,500
  - DDS provided a refund; no claim was filed

The “Bad Mouthing” Colleague
- 29 year old female
- Needs orthodontics, but wants restorations only
- Veneers and crowns placed at #4-13
  - Patient rejected ideal plan, and was unhappy with the limitations of the alternate plan using restorations
- Patient sees another dentist
  - Very critical of the 1st dentist based on patient’s story
- Suit filed against the 1st dentist
  - Settled at mediation

The “Great Expectations” Patient
- 63 year old female
- Seen by a number of different dentists
  - Recommended root canals and implants to restore poor dentition
  - She would only consent to bridges that came with some limitations
- Her DDS agreed to fabricate bridges
- She didn’t like the wax-up
- Suit filed: Defense verdict
The “You Never Told Me” Patient

- 35 year old male
- Presents with pain and decay of tooth #4
  - Root canal therapy performed
- The RCT failed one month later
- Her DDS referred her to an OMS for extraction
- Patient demands the dentist pay for the extraction, refund the root canal fee and threatens litigation
  - Complaint: "I was never told the RCT could fail"

The “Bad” Attitude

- 15 year old female
- Presented with superficial caries of #30
  - Apprehensive about dental treatment and local anesthesia
  - Treatment attempted without local
  - Patient began crying
  - “Stop acting like a child”
  - Eventually agreed to a Local anesthetic: filling completed
- A board complaint was filed
  - Allegations: The dentist became impatient and rude
  - The Board dismissed the claim: PT seemed unreasonable

"Do you swear to spin the truth, the whole truth, and nothing but the truth?"
Risk Management Goals

- Increase patient safety
  - Improve the quality of care; Avoid patient injury
- Reduce claims exposure
  - Mitigate damages
- Create valuable defense tools
  - Make a claim more defensible; Buffer your defense
- Minimize financial loss
  - Reduce the monetary impact; Time out of office

Core Risk Management Principles

- Communication
- Informed Consent
- Documentation

Communication
Communication: Setting the Stage

- In-office
- Phone
- Website
- Word of Mouth
- Online Reviews
  - Yelp, Facebook, Angie’s List, etc.

Staff Training & Staff Monitoring

Communication Challenges

80% of malpractice claims are attributed to communication issues¹

- Literacy gap
- Social media
- Online reviews
- Seniors & Minors
- Limited English Proficiency (LEP) & American with Disabilities Act (ADA)
- Miscommunication

¹ “Sorry Works”

The Literacy Gap

- National Assessment of Adult Literacy:
  - 32 million adults in the US cannot read
  - 21% of adults in the US read below a 5th grade level
  - 19% of high school graduates can’t read
- Leave out the dental jargon
  - “cavities” versus “caries”

Social Media

- Marketing & communication tool considerations:
  - HIPAA
    - Patient permission (redacted images)
  - Separate profiles
    - Personal vs. Professional
  - Promises
    - “Teeth in a day” (disclaimer)
  - Patient communication
    - Caution patients from reporting health issues

Online Reviews

- Did you get a negative review?
  - Evaluate the options (respond, delete, ignore, hide)
- Things to consider before responding:
  - HIPAA violation
  - Reach out to the patient (not while your upset)
    - Phone or direct messaging
  - Post ONE generic response (no back and forth)
- Encourage positive reviews from other patients
- Monitor your online reputation

Contact Fortress Risk Management for guidance

Case Analysis: Online Review

- 21 year old male
- Presented for extraction of #1
- Tooth extracted without incident
- Patient is upset with the bill he received in the mail 2 weeks later.
- Creates Facebook page: “Dr _ is a Con”
Case Analysis: Online Review

- Facebook page attracts other patients who experienced similar issues
- Patients begin placing comments on wall

Dr. responds to patient’s allegations stating:
“I discussed with you before the appointment what it was going to cost to extract your wisdom tooth. I gave you a discount because you said you couldn’t afford it.”

What Can We Learn From This?

- Consider alternatives to responding
  – Delete, Ignore, “Hide”
- Utilize a generic response
  – Avoid posting identifiable patient information online
  – Request the patient contact your office to resolve the matter
- Contact Fortress Risk Management for guidance

Seniors & Minors

- Seniors
  – Medically compromised/Comorbidities
  – Polypharmacy
  – Consent
    • Power of Attorney
    • Auditory or visual issues
- Minors
  – Compliance
  – Consent
    • Power of Attorney for Minors
    • Divorce/Guardianship Challenges

Check your state dental board for specific regulations
Case Analysis: Minor of Divorce

- 10 year old male
- Presents with rampant decay
- Treatment plan:
  - Extractions, Endodontics, Restorations and Ortho treatment
- Mother requested and consented to hospital treatment under anesthesia
- The dentist agreed to the mother’s request

Case Analysis: Minor of Divorce

- Dentist was unaware the minor’s parents were divorced
  - Per custody agreement: Father was required to pay and consent to treatment
- Father refused to pay
- The case went to court and for several years there was no amicable solution

What Can We Learn From This?

- Identify the patient’s legal guardian before you obtain informed consent
- Determine who is financially responsible
- If necessary, require all parties to agree to consent and financial agreements
- Use forms to document this agreement
American with Disabilities Act (ADA)

- Most prevalent accessibility issues:
  - Lack of effective communication
    - Complicated and interactive communications require a Sign Language Interpreter or translator
    - Family or friends cannot be forced to interpret
  - Lack of accessible equipment & services
    - Health care service, medical equipment and diagnostic tests are accessible to individuals with disabilities
  - Refusal of care
    - Refusal to treat HIV patients (Bragdon v. Abbott)

Limited English Proficiency (LEP)

- Must ensure effective communication at **NO** cost to the patient
- The patient determines if he or she has limited English proficiency
  - Read
  - Write
  - Speak

LEP Frequently Asked Questions

1. Who decides interpretation is needed?
2. Can an appointment be rescheduled if interpreter is not available?
3. Can the patient be asked to bring in a family member?
4. Do you have to use an interpreter selected by the patient?
5. Who pays for the interpreter?
Miscommunication

• The failure to convey relevant dental information to key players in the team
  – Dentist to staff/Staff to dentist
    • Chain of command, Dental emergencies
  – Dentist to referral/Referral to dentist
    • No referral document
  – Patient to dentist/Dentist to patient
    • “The dental shopper(s)”, Medical history omission

Extractions & Implants

Imaging Considerations

• Imaging should add useful information and aid in assessing treatment options, risks & referrals
• Is a traditional radiograph (panorex/periapical) and clinical exam sufficient?
• Cone Beam CT Scans (CBCT) might be indicated and useful in some cases
• Beware of overuse, overcharge, over-radiation
  – William Scarfe “All that Glitters is not Gold”
Dental Extractions: Steps to Success

• Examine & Develop a diagnosis and treatment plan
  – Exercise professional judgment re: extract or refer
• Manage patient expectations early
  – Communicate the plan and obtain consent
  – Present options, explain common risks
  – Discussed and documented failure to follow up complications until treatment is completed
• Use written referrals
  – Refrain from relying on a layperson’s claim of tooth # or verbal instructions from referrals

Causes of Wrong Tooth Extractions

• Miscommunication among providers
• Counting errors
• Relying on patient to identify tooth
• Rushing
• Failing to take and/or review x-rays
• Failing to review referral form

  Slow down Count accurately Review x-ray

Extraction Documentation:
What is commonly left out

• Radiograph(s)
  – Missing, old or only partial tooth structure
• Documenting Which tooth/teeth?
  – Identify the tooth number & tooth
• Discuss concerns of the DDS and patient
  – Options, evidence of higher risks/complications (i.e. impacted tooth), address patient concerns
  – Referral if complex or complications likely
    • Patient’s decision, but treat within your comfort zone
Case Analysis: The Extraction

- 40 year old male
- History of pericoronitis surrounding tooth #32
- Presented to the dental office requesting extraction
  - Deep vertical impaction with part of the crown exposed
  - X-ray did not show the apex of the root

The Procedure

- Extraction of #32 started
  - Only able to remove crown after half-hour
- Patient referred to an OMS and seen immediately
  - Panorex: Apex of the root millimeters from the inferior border, involving the inferior alveolar canal, possible fracture
  - Pain medication and antibiotics given
  - Further treatment delayed to assess potential nerve damage

Post Procedure

- The next day, the patient returned to the OMS complaining of numbness
  - The remaining root was removed
  - A severed nerve was repaired
  - A fracture was reduced
Litigation

- Patient sued
  - He never regained full sensation
- The dentist conceded a referral may have been a better option during deposition
- Settled before trial

What Can We Learn From This?

- Consider your comfort level and experience
  - Good image helps assess and make decisions
  - Procedures can become more difficult than expected
- Refer to specialist:
  - If too complex, risky after exam and consult
  - When complications develop
- Obtain adequate radiographs before treatment
  - See entire tooth before you begin treatment

Implants: Steps to Success

- **Assess** difficulty of the ENTIRE procedure
- **Develop** an appropriate treatment plan
- **Communicate** the treatment plan: PT & team
  - Who will be involved in the process from start to end
  - Ensure the patient accepts his/her role and responsibilities; manage expectations
- **Execute** “the plan” → **Discuss** a “change in plan”
- **Document** the treatment plan, consent, complications, compliance, patient satisfaction
Common Omissions in Implant Documentation

- Communication with other team members
  - Implant make, type, abutment
  - Respective responsibilities
  - Surgical guide
- Implant size
  - Describe in progress notes
  - Imaging should support the plan
    - Traditional imaging (Pano, PA)
    - Is advanced imaging beneficial? (CBCT)

Case Analysis: Extraction & Implant

- 45 year old female
- Extensive medical & surgical history
- Presented for extraction of “broken” tooth #31
- Treatment plan:
  - Extract #31, place implant after healing
- Tooth #31 removed without issues
- 18 months later implants placed at #30 and 31
  - Antibiotics were prescribed prophylactically

Pre – Procedural Panorex
1 Week Post – Procedure

• Patient disputed consent for implant at #30
  – “This was never discussed with me”
• Post-op pain and swelling continued
  – Antibiotics are changed
• Referred to an OMS
  – Patient has submandibular swelling
• Admitted to the hospital for IV antibiotics

2 Weeks Post - Procedure

• Readmitted to the hospital for submandibular swelling
  – I&D performed
  – IV antibiotics administered
  – Implants were removed

2 Months Post - Procedure

• Third hospital admission for non-healing implant site
  – I&D performed (again)
  – IV antibiotics administered (again)
• Patient now has a perforation of the lingual plate near the implant site
  – Teeth #28 and 29 were extracted
Subsequent Treatment

- Mandible resection performed: 5 cm bone removed
  - After 4 unsuccessful I&Ds
  - IV antibiotic treatment continued
- Bone graft from tibia used for mandibular reconstruction
  - Now there are 2 surgical sites

Litigation

- Suit was filed against the dentist
- Allegations:
  - No Informed consent for #30 implant
    - alleged battery
  - Perforation of the lingual plate led to the prolonged infection and the need for subsequent surgeries

Expert Review & Resolution

- Defense expert review:
  - Liability problem re: informed consent
  - Causation regarding the infection was questionable
  - Were prior medical complications relevant?
  - Was clearance or a consult needed?
- Case settled before trial
What Can We Learn From This?

- Document
  - Why implant was needed at #30
  - Patient’s consent to add #30 implant
  - Possible increased risks
- Prior medical conditions may raise issues:
  - Establish DDS was aware and considered medical issues
  - Was a medical consult or more information needed?
- A patient should be informed of risks before consenting to treatment
- Consider an OMS referral in complex or difficult cases

The Informed Consent Process

- How judges define it to jurors
- Elements
- Benefits and minor limitations

Example of Jury Instruction

“Negligence may consist of... failure on the part of the dentist to reasonably inform Plaintiff of risks or hazards which may follow treatment contemplated by the dentist. "Reasonably inform"... means information must have been given timely and in compliance with accepted standards of practice among members of the profession with similar training and experience...."

“There are risks inherent in medical treatment that are not within a doctor’s control. A doctor is not liable merely because of an adverse result. However, a doctor is liable if the doctor is negligent and that negligence is a proximate cause of an adverse result.”
Informed Consent: The COMPLETE Process

- Discuss, use a good form, chart discussions & consent
- Use layman’s term, simple wording based on patient’s education level

  • Include:
    – Diagnosis/Prognosis
    – Proposed treatment, reasonable options
    – Benefits and risk of each (incl. no treatment)
    – Signatures: patient, witness (if applicable) and doctor

  • Give the patient time to review the form
  • The DDS should ensure all questions are answered
  • Avoid negating by saying “one in a million” or it has never happened to my patients: use stats accurately

Informed Consent Goals

- Enhance rapport, trust & reasonable expectations
- Document patient’s acceptance of reasonable risks
- I.D. Limitations: When your PT only wants TX likely to cause unacceptable results/risks
  – Risks of letting PT “accept” substandard care?
- A valuable defense tool
  – In lawsuits, peer review, board of dentistry complaints
  – Negates false claims by patients

Case Analysis: Implant Placement

- 72 year old female
- History of thyroid problems
- Presented for implant consultation
- Treatment plan:
  – CT scan
  – Implant placement at site #13, 14 and 20
Pre – Procedure CT Scan

The Procedure

• Implants were placed
• Vicodin was prescribed
• Four months later restorative work was done
  – 3 unit bridge (12-14) was seated, adjusted and cemented
  – A crown was placed on #20

Post – Procedure

• Complaints of food getting stuck under 12-14 and difficulty flossing around 20
  – Bite Wings: Implant #20 intersected the root tip of #21
Post - Procedure

• 1½ months later bridge was redone
  – Patient did not like the way it looked
  – Looked “fake”

Post – Procedure

• 4 months later, the patient still had complaints:
  – Can’t clean the bridge
  – Food gets stuck
  – It’s bloody and smelly
  – Request for a FULL refund
  – A partial refund was offered
  – The patient left to seek a second opinion

The Second Opinion

• Second DDS opinions:
  – The bridge was fabricated incorrectly
  – #20 implant is in the root of #21
• New treatment plan:
  – Extract tooth #21
  – Remove implant at #20
  – Place new implants in the areas of #20 and #21
The Third Opinion

- The patient saw a periodontist — Agreed with the second opinion
- DDS denied second request for compensation

- The subsequent treaters wrote reports critical of the original DDS, supporting the patient
  - Given to the original dentist
  - The dentist followed up with 2 letter to the patient

The Dentist's Response to the Patient

“I am sorry you feel my bridge is inferior. I feel it is just fine.”

“I want another Dentist — any Dentist you chose to tell me my Bridge is not right and that he can do better. I want a 2nd opinion if indeed my bridge is inferior — have him call me and I will pay for it.”
The Second Letter

“Your lawyer broke protocol by calling my office – twice. Therefore I don’t feel bad about writing you this letter…”

“…I want you to go to another implant Dentist. If you choose not to – then it’s courts, lawyers, motions being filed… I have malpractice. My lawyer is paid for. Please consider going to a Dentist I met a week ago [I already shared your treatment plan with him].”

The Outcome

• The patient’s attorney wrote the dentist
  – The DDS provided substandard care with upper bridge and lower implant
  – The DDS violated HIPAA by discussing private information with a stranger, without permission
  – Damages will include: Re-doing dental work, pain and suffering, punitive damages, legal fees, and will pursue HIPAA violation
• The case was settled before litigation

What Can We Learn From This?

• Listen to patient complaints, review the entire case and try to resolve problems before your patient seeks other treaters or lawyers
• Patients should not feel their complaints are ignored
• Consider how this case will look to peer review, a dental board or jury
• Avoid continued, escalating arguments with your patient, especially in writing
• Don’t have other DDSs review your patient’s case without your patient’s permission
In the News

Dental patients’ info dumped outside building on Detroit's east side

Indiana Dentist Fined by State for HIPAA Violations

Three top-3 lists for using HIPAA compliant email in your dental practice

What is HIPAA & HITECH?

• Health Insurance Portability and Accountability Act (HIPAA)
  – Standardizes confidentiality requirements for health care information, reduce fraud and abuse
• Health Information Technology for Economic and Clinical Health Act (HITECH)
  – Advances safe and secure use of electronic medical records (encryption, security measures)
What’s a violation?

The Health Record Should...

• Be secured
  – Take reasonable steps and precautions
  • Failed to protect personal information and properly dispose of records containing personal information
  • Violated Indiana Privacy Laws and HIPAA

Examples of Fines (HHS site)

• $1.5 million for stolen unencrypted laptop
• $150,000 stolen unencrypted thumb drive
• $1.2 million for returning copiers without wiping clean
• $1.7 million for allowing unauthorized access to network during software upgrades
• $800,000: Hospital employee left 71 boxes of records on driveway of retired MD to “assist him”
HIPAA/HITECH “Compliance”
- MANDATORY Security Risk Assessment
  - www.healthIT.gov
- Designate a HIPAA Officer
- Train Staff
- Create office and sanction policies
- Establish: BA Agreements, Encryption, Usernames, Passwords, Screensavers

HIPAA/HITECH “Compliance”
- Credible document destruction process
- Secure the server
- Secure the wireless network
- Data “backup” restoration
- Have a plan

HIPAA/HITECH series in the e-Learning Center

Documentation
Health Record: The Story

- History
- Exam
- Diagnosis
- Treatment
- Consent
- Follow Up & Progress (including the result)

*Good records tell a story of the care provided*

Charting Basics: History

- Health history form
  - All pertinent medical/dental conditions (TMJ symptoms)
  - Medications (i.e. Aspirin, Plavix, Bisphosphonate)
  - Dietary Supplements, Herbals, Vitamins, etc.
  - Allergies
  - A comment section
  - Signatures (including doctor)
- Ensure all questions are answered
- Audit for relevancy routinely

Sample Health History

<table>
<thead>
<tr>
<th>PATIENT MEDICAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, emphysema of heart, chest pain, severe coughing)?</td>
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<tr>
<td>Intestinal issues?</td>
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<td>Intestinal issues?</td>
</tr>
</tbody>
</table>

*Note: Sample Health History is for demonstration purposes only.***
Sample Health History

MEDICATIONS
Are you taking any of the following:
Antihistamines?
Antidepressants?
Heart drugs?
Medications (prescriptions, over-the-counter, etc.):
Please list any other medications you have taken in the past 12 months:

ALLERGIES
Are you allergic to or have you had an adverse reaction to:
Food products?
Medications?
myModalLabel

Sample Health History

I understood the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Signature of patient, parent, guardian

Printed name of patient, parent, guardian

Date

Relationship

HEALTH HISTORY UPDATE

Date

Comments

Signature

Charting Basics: Exam & Diagnosis

• Exam
  – Subjective: Patient’s chief complaint, etc.
  – Objective:
    • Oral exam findings
    • Lab results (if applicable)
    • Imaging (films, scans)

• Diagnosis (Assessment, Plan)
  – The differential diagnosis
  – Prognosis considerations & Plan
Charting Basics: Treatment

- Treatment Note:
  - Informed Consent discussion
  - Include recommended intervention(s), advice & patient response
  - Any changes to treatment plan based on exam
  - NPO status (if applicable)
  - Use of surgical guide, pre-medication, etc.
  - Medication(s) provided during the treatment
  - Complications

Charting Basics: Follow Up & Progress

- Follow Up & Progress Notes:
  - The suggested return date
  - Referral to specialist(s)
    - Be specific and clear (include “who” and “why”)
  - Clinical correspondence
  - Test results & patient notification
  - The patient’s progress & status
    - Include the good news (“healing well”, “lesion gone”)
  - Patient compliance
    - Cancellations, No-shows, etc.

Electronic Health Records

- Beneficial
- Risks
  - Templates
  - Copy & Paste
  - Cyber Issues
- Considerations
  - “Lock” system
  - Backup system daily
  - Conduct audits of the system
- There are a number of different EHR Systems
- General Principles:
  - All staff documenting should have a log-in and “signature”
  - “Time Stamp”
  - Meta Data
  - Do NOT delete/alter notes
    - Amendments/Addendums should maintain the original note
REMEMBER:
Your best defense in a claim is your chart notes

Failure To Diagnose

Oral Cancer: Incidence & Survival
- In 2014: over 43,000 Americans diagnosed with oral cancer
- Rates increased for 8 consecutive years
- Every year:
  - 30,000 new cases diagnosed
  - 8,000 deaths
  - 5 year survival rate 76% if local CA, but only 19% if metastasized
  
  Early detection saves lives

National Oral Cancer Foundation
Oral Cancer: Contributing Factors

Traditional risks: smokers, alcohol, age, compromised immune systems

- Significant rise in SCC of the tongue, base of tongue, and tonsils in white patients between 20-44 years of age

“New” Carcinogens:

- Marijuana (debatable)
- Human Papillomavirus (HPV)

Oral Cancer: “New” Carcinogens

80% of women are HPV+ by the age of 50
50% of American males are HPV+

Case Analysis: Oral Cancer

- 67 year old female
- History:
  - Diabetes, COPD, and Hypertension
  - Smoker & Alcohol use
- Referred by the DDS to an OMS for “small yellow lesion on posterior, top of tongue”
The OMS Visit

- Exam findings:
  - 4 mm triangular white striae on left tongue, ulceration pseudo-membrane, present for 1 year, improving, no nodes
- Diagnosis: Erosive lichen planus posterior tongue
- Plan:
  - No biopsy, benign
  - Kenalog orabase
  - Refer back to DDS to follow up during 6 month prophylaxis

The Follow Up Visits

Over the next 14 months:

- The patient had 8 visits with the DDS
  - No chart notes about the tongue lesion, exam, etc.
- Patient returns to OMS on her own (no referral)
  - Complaint: Lesion increasingly painful for months
  - Exam findings: 10 mm ulcer at left tongue base (was 4 mm)
    Tender enlarged submandibular node
  - Plan: Refer to ENT for suspected SCC

The ENT Visits

- Patient sees an ENT 1 week after OMS referral:
  - A biopsy was performed
    - Diagnosis: Infiltrating keratinizing SCC
    - Classification: Stage 3 SCC: T2, N1, MO
  - Treatment Plan: Glossectomy & Radiation
    - Patient had one malignant node
  - Prognosis: 85% chance it will grow back
“Benign” lesion → Post-op scar
Went from benign 4 mm lesion to 10 mm, SCC stage 3

The Outcome

• The patient filed suit against the DDS & OMS
• The DDS claimed:
  – Didn’t follow up because of benign diagnosis by OMS
• The OMS claimed:
  – Thought the DDS would monitor and refer back if no improvement
  – Relyed on the patient to keep regular appointments with DDS (she did) and DDS to monitor and refer back

What Can We Learn From This?

• The GP: Even if a diagnosis is benign...
  – Examine, monitor progress, chart findings
  – Refer back if it does not improve in a few weeks/months
• The OMS: If you rely on someone else to evaluate, or the patient to follow up:
  – Advise all involved in writing: avoid communication breakdown
  – Follow up in an appropriate & timely manner
What Can We Learn From This?

- Develop a differential diagnosis; can you rule things out?
  - Detailed history: how long was it present, possible causes, etc.?
  - Appropriate exams or referrals until you can rule things out and timely diagnose
  - If patient no-shows for follow up, document efforts to get PT back & consequences
  - When in doubt... REFER OUT

Cancer: Details to Document

- Details about the onset or other causes:
  - History of onset? Trauma, burns? Treatment & result?
- Note specific symptoms and complaints
- Chart specific exam findings & changes:
  - Location, size, characteristics (Pictures)
- Differential Diagnosis (if appropriate)
- Document Instructions to patient:
  - What to do? When to return? What to look for?
- When a suspicious lesion is gone: CHART IT

Oral Cancer: Suspected?

Regular cancer exams are important

- If you note suspicious lesions, assume it could be cancer unless and until you rule it out
- Refer to specialist for consultation, biopsy or monitoring
- If suspicious lesions don’t resolve in a few weeks, refer to specialist for biopsy and definitive diagnosis
- DOCUMENT! DOCUMENT! DOCUMENT!
Oral Cancer: Conclusions

• Keep up with the literature and assess high risk patients:
  – Traditional: Smokers, drinkers, older people with compromised immune systems (classic risk factors)
  – Newer: HPV associated oral cancers largely occur among nonsmokers and nondrinkers

• Assume it’s cancer until proven otherwise
  – Get a diagnosis: communicate with PT and treaters
  – If patients fail to follow up: contact PT to avoid delays

• Documentation is critical:
  – Credibility will help counter sympathy in jury trials


REMEMBER:
  Screen Early
  Screen Thoroughly
  Screen Routinely
Did we mention DOCUMENT??

Prevalence of Gum Disease in the US

**Adults over 30**
- Healthy Periodontium: 53%
- Gum Disease: 47%

**Other Risk Groups**
- 65 or older have perio disease: 70%
- More men than women: 56% to 38%
- Below federal poverty level: 65%
- Non-high school graduates: 67%
- Smokers: 64%
Periodontal Disease: Steps to Success

- Assess patient risk factors
- Document Baseline, note changes
- Develop office protocol for screening for periodontal disease; use it religiously
- Regularly update imaging
- Document patient non-compliance, warnings
- Modify diagnosis, treatment plan, referrals
- Refer to specialists when necessary

Case Analysis: Periodontal Disease

- 33 year old male
- Dental history includes extraction of 4 wisdom teeth, 4 bicuspid (orthodontic treatment plan) and tooth #18
- Patient presented for routine exams and cleanings
  - Moderate to severe recession observed on the lingual side of the maxillary arch
  - No periodontal charting done

The Visits

- Two years after initial presentation
  - Patient was referred to a periodontist for “implant consult”
    - The patient did not go
- Over the next 3 years the patient kept regular prophy visits (exams & cleanings)
  - “great OH”; “flosses daily and wears NG faithfully”
  - No chart references to earlier recession or perio
The “Problem”

- Patient presented for a limited evaluation of a loose mandibular anterior tooth after biting a carrot
  - An x-ray showed bone loss on teeth #22-26
  - The second referral to a periodontist was made

The Periodontist Treatment Plan

Thank you for referring [name] to our practice to evaluate his overall periodontal condition. With your permission, I have recommended the following treatment:

- Phase 1:
  - Osseous Surgery UR and LR

- Phase 2:
  - Osseous Surgery UL and LL

The Next Visit

- The patient returned to the dentist for a prophy and perio charting
  - This first perio charting was performed after the periodontist’s diagnosis, 5 years after recession
  - Probe depths: 2-6mm
  - This was the last visit to this dentist
- The patient sought a second periodontist opinion
  - He discontinued treatment with the 1st periodontist
The Second Periodontist

- The findings: Periodontal disease
  - Some pockets over 7mm, some exceeded 9mm at the lower anterior
  - Recession at #3 (2mm), 4 (3mm), 14 (3mm), 15 (3mm), 20 (3mm), 28 (3mm), 30 (2mm) & 31 (2mm)
  - Bone loss in all four quadrants
- Recommended osseous surgery in all 4 quads

Litigation

- The allegations:
  - Despite routine dental care over a number of years...
    - He had progressive periodontal disease for 5 years, but was never informed about it
    - No periodontal screening was performed and no baseline documented before referral to a periodontist
    - Surgery on all four quadrants was required to treat the disease; was preventable

The Outcome

- The patient had surgery
  - #22-27 were splinted
- The patient improved after several periodontal treatments over 2 years
- The case was settled before trial
What Can We Learn From This?

- Perform routine periodontal evaluations, document
- If you identify a potential problem (focal or systemic) chart it, advise the patient and follow progress timely
- Treat within your training & comfort level
- Refer early when appropriate
- Make specific referrals and ensure patient goes
- Note non-compliance along with warnings of harm
- Document all findings, progress and conversations with your patient!
  - “If it wasn’t documented... It was never done”

Was There Supervised Neglect?

**Classic case:** “it happened on his watch”:

- The chart included evidence of a perio problem but no evidence the DDS diagnosed it or offered a treatment plan early
- The problem progressed despite regular appointments, without a diagnosis or referral.
- Another DDS diagnosed periodontal disease
- Unnecessary surgery, tooth loss, etc. was caused by supervised neglect
- Easy cases for lawyers:
  - Neglect and delay caused avoidable damage

Supervised Neglect

- Proper follow up & charting or a referral should be considered after evidence of a problem
  - serves the patient’s best interests
- When non-compliant patients no-show or refuse needed periodontal referrals putting their health at risk, consider:
  - Informed Refusal
  - Patient Termination
Informed Refusal: Patient and Dentist’s Rights & Duties

- **Patient autonomy**: Patients have the right to refuse treatment, elect alternative treatment, or change their mind.
- **Dentists have the right not to provide sub-standard care likely to cause unreasonable results or risks**.
- **Patients can be asked to accept reasonable risks and limitations** associated with refused care or selection of an alternative: get it in writing!

Informed Refusal Process

- **Document**
  - your recommendation, care or refused referral
  - the patient’s treatment choice & limitations and risks
- **Patients should accept reasonable risks and complications** associated with their choice; chart discussion of those risks
- **Assess the risks/limitations**: Are they reasonable, in the DDS’s professional opinion?
- **Offer referral or second opinion if appropriate**
- **Use Informed Refusal Forms** signed by the patient and DDS

What is “reasonable”?

- **Patients who refuse X-rays**
  - Healthy 20 year old v. 65 year old smoker, ETOH?
- **Patients who refuse referrals**
  - Periodontal care? (minor problem v. facing tooth loss)
  - Biopsy of suspicious lesion?
- **How the legal system/jurors analyze**:
  - **Legal Test**: would a “reasonable DDS” allow a patient to accept these risks?
  - **Jurors** hear opinions from “Experts” and lawyers
Last Resort: Withdrawal

- When your patient will only consent to substandard care you are unwilling to provide
- Send a certified letter & regular mail documenting:
  - Prior conversions about options and risks, reasons for withdrawal, treatment needed, where to seek it (i.e. a dental clinic, dental school or other opinions)
  - Give reasonable time to find new DDS
  - Don’t delay transfer: Don’t hold records hostage
- Call Fortress Risk Management before proceeding

Additional Information - DDS 401: Treating Challenging Patients

Opioid Management

Prescribers of Immediate Release Opioids

- Dentists: 12%
- Family Practice: 30%
- Internal Medicine: 15%
- Orthopedic Surgery: 12%
- Osteopathic Medicine: 12%
- Others: 10%

IMS Institute for Healthcare Informatics
Opioid Considerations

- Follow responsible and tailored prescribing practices
  - Secure prescription pads when not in use
  - Consider lowest dose possible, alternative medications
  - Be aware of patient’s substance use history and take precautions; pharmacy inquiries?
- Be aware of suspicious staff actions
  - Lockdown narcotics; limit access and monitor
    - Including orders

Case Analysis: The Recovering Addict

- 22 year old male
- Recovering heroin addict but said he was “clean”
- Extraction of #24 and #25
- Prescribed 15 tablets of Vicodin 5/500mg with 1 refill
- Outcome: Patient died 16 days later from a heroin overdose. Claim is filed. Family alleges the reintroduction of opioid medications caused relapse

What Can We Learn From This?

- Prescribe with caution, lowest dose possible
- Involve responsible family members and PCP’s when appropriate (comply with HIPAA)
- Educate patients on safe disposal of unused medication
- Consider available resources when patient abuse is suspected
  - Treatment Referral Hotline: 1-800-662-HELP
Case Analysis: Staff Stealing Narcotics

- Office manager is only other person with keys to medication storage
  - Hinges pried open (from inside), fentanyl stolen
  - OMS fires office manager, prosecutor files criminal charges but doesn’t pursue (evidence issues)
  - Office manager files wrongful discharge & malicious prosecution charge after she completes 2 week drug rehab program
- EPL claim settled for minor amount

What Can We Learn From This?

- Ensure staff with access to narcotics can be trusted
- Monitor orders, supplies and employee access
- Collect and document sufficient evidence necessary to terminate an employee
  - Get assistance from counsel, local authorities if necessary
  - Being an “at will” employee is not the only issue
- If you get involved in criminal prosecution, understand what prosecutors need
- Talk to your agent about EPL coverage

Recognizing Drug-Impaired Co Workers

- Excessive amounts of time spent near a drug supply
- Heavy “wastage” of drugs
- Sloppy recordkeeping, suspect ledger entries and drug shortages
- Inappropriate prescriptions for large narcotic doses
- Missing scripts... don’t wait for call from pharmacy
Thank You