Medicolegal Considerations



Richard L Small and Myron R. Tucker

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SUMMARY

In recent years there has been an increase in the number of malpractice claims brought against dentists. This trend has had a profound impact on several aspects of dentistry. Some of the most common lawsuits are related to extraction of the wrong tooth, failure to diagnose a problem, and lack of proper informed consent. The stress associated with the increased possibility of litigation influences the entire office. Malpractice insurance premiums are high, contributing to increased patient costs. Dentists feel pressured into practicing "defensive dentistry," second-guessing sound clinical decisions based on concerns about potential litigation.

The influence of litigation on dentistry has resulted in an effort by the profession to reduce the risk of legal liability by more closely examining treatment decisions, improved documentation, and better dentist-patient relationships. Reviewing all aspects of dental practice to provide the best possible patient care and to reduce unnecessary legal liability is termed *risk management.*

Although no substitute exists for sound clinical practice, nontreatment issues prompt many lawsuits. These often include miscommunication and misunderstanding between the dentist and patient and poor record keeping which in turn present opportunities for patient's lawyer, to criticize. This chapter reviews concepts of liability, risk management, methods of risk reduction, and actions that should be taken if a malpractice suit is filed.

LEGAL CONCEPTS INFLUENCING LIABILITY

To understand the responsibility of the dentist in risk management, it is important to review several legal concepts pertaining to the practice of dentistry.

Malpractice is generally defined as professional negligence. Professional negligence occurs when treatment provided by the dentist fails to comply with "standards of care" exercised by other dentists in similar situations. In other words, professional negligence occurs when profes-

sionals fail to have or exercise the degree of skill ordinarily possessed and demonstrated by members of their profession practicing under similar circumstances.

In most states the standard of care is defined by that which an ordinarily skilled, educated, and experienced dentist would do under similar circumstances. Many states adhere to a national standard for dental specialists. Malpractice occurs when the patient proves that the dentist failed to comply with this minimal level of care, which resulted in injury.

In most malpractice cases the patient must prove all of the following four elements of a malpractice claim: (1) the applicable standard of care (legal duty), (2) breach of standard of care, (3) injury, and (4) the breach caused the injury. The burden of proving malpractice lies with the plaintiff (patient). The patient must prove by a preponderance of the evidence all four elements of the claim.

First, there must be a professional relationship between the dentist and patient before a legal duty or obligation is owed to exercise appropriate care. This relationship can be established if the dentist accepts the patient or otherwise begins treatment. Second, a breach or failure to provide treatment that satisfies the standard of care must be demonstrated. This standard of care does not obligate the dentist to provide the highest level of treatment exercised by the most skilled dentist or that which is taught in dental school. The standard of care is intended to be a "common denominator" defined by what average practitioners would ordinarily do under similar circumstances. Third, it must be shown that the failure to provide this standard of care was the cause of the patient's injury. Fourth, there must have been some form of damage demonstrated.

Dentists are not liable for inherent risks of treatment that occur in the absence of negligence. For example, a dentist is not liable if a patient experiences a numb lip after a properly performed third molar extraction. This is a recognized complication. A dentist can be legally liable for a numb lip if the patient proves it was caused by negligence (e.g., the numbness was caused by a careless incision, careless use of a bur, or other instrument).

Recently several suits have charged the dentist with *breach of contract.* This charge has traditionally been applied to business transactions and has not normally been used in disputes between patients and dentists. However, some courts have recently ruled that a patient and dentist may actually have a contractual agreement to produce a specific result, and that failure to achieve this objective may result in a breach of contract. In many states an alleged promise or guarantee as to the result is not enforceable unless it is in writing. Overly aggressive marketing can lead to contractual liability.

Marketing pressures sometimes lead to written advertisements or promotions that can be interpreted as guaranteed results. Patients who have difficulty chewing after delivery of new dentures, if originally promised that they would be able to eat any type of food without difficulty, might consider such promises breach of contract. Dissatisfaction with esthetics or function is often linked to unreasonable expectations, sometimes fueled by ineffective communication or excessive salesmanship.

The *statute of limitations* generally provides a time limit for filing a malpractice suit against a dentist. This limit, however, varies widely from state to state. In some states the statute of limitations begins when an incident occurs. In other states the statute of limitations is extended for a short period after the alleged malpractice is discovered (or when a "reasonable" person would have discovered it).

Several other factors can extend the statute of limitations in many states. These include children under 18 or the age of majority, fraudulent concealment of negligent treatment by the dentist or leaving a nontherapeutic foreign object in the body (e.g., broken bur or file).

RISK REDUCTION

The foundation for all dental practice should be sound clinical procedures. However, properly addressing other aspects of patient care and office policy may considerably reduce potential legal liability. These aspects include dentist-patient and staff-patient communication, patient information, informed consent, proper documentation, and appropriate management of complications. Additionally clinicians should note that patients with reasonable expectations and a favorable relationship with their dentist are less likely to sue and more likely to tolerate complications.

Patient Information and Office Communication

A solid dentist-patient relationship is key to any risk management program. Well-informed patients generally have a much better understanding of potential complications and more realistic expectations about treatment outcomes. This can be accomplished by providing patients with as much information as possible on proposed treatment, alternatives and risks, and benefits and limitations of each. If done properly, the informed consent process can improve rapport. Patients are given this information to help them better understand their care so they can make informed decisions. The information should be communicated in a positive manner and not presented in a defensive way.

Patients value and expect a discussion with their dentist about their care. Brochures and other types of informational packages help provide patients with both general and specific information about general dental and oral surgical care. Patients requiring oral surgical procedures will benefit from information on the nature of their problem, recommended treatment and alternatives, expectations, and possible complications. This information should have a well-organized format that is easily understood and is written in nonprofessional's language. Informed consent is discussed in detail in the following section.

When a dentist has a specific discussion with a patient or gives a patient an informational package, it should be documented in the patient's chart. Complications discussed earlier can be reviewed if they occur later. In general, patients with reasonable expectations create fewer problems (a theme repeated throughout this chapter).

INFORMED CONSENT

In addition to providing quality care, effective communication and good rapport should become a standard part of office management objectives. Dentists can be sued

not only for negligent treatment but also for failing to inform patients properly about the treatment to be rendered, the reasonable alternatives, and the reasonable benefits, risks, and complications of each. In fact, in some states, treatment without a proper informed consent is considered battery.

The concept of informed consent is that the patient has a right to consider known risks and complications inherent to treatment. This enables the patient to make a knowledgeable, voluntary decision whether to proceed with recommended treatment or elect another option. If a patient is properly advised of inherent risks and a complication occurs in the absence of negligence, the dentist is not legally liable. However, a dentist can be held liable when an inherent risk occurs after the dentist fails to obtain the patient's *informed consent.* The rationale for liability is that the patient was denied the opportunity to refuse treatment after being properly advised of risks associated with the treatment and reasonable options.

Current concepts of informed consent are based as much on providing the patient the necessary information as on actually obtaining a consent or signature for a procedure. In addition to fulfilling the legal obligations, obtaining the proper informed consent from patients benefits the clinician in several ways. First, well-informed patients who understand the nature of the problem and have realistic expectations are less likely to sue. Second, a properly presented and documented informed consent often prevents frivolous claims based on misunderstanding or unrealistic expectations. Finally, obtaining an informed consent offers the dentist the opportunity to develop better rapport with the patient by demonstrating a greater personal interest in the patient's well being.

The requirements of an informed consent vary from state to state. Initially, informed consent was to inform patients that bodily harm or death may result from a procedure. It did not require discussion of minor, unlikely complications that seldom occur and infrequently result in ill effects. However, some states have currently adopted the concept of "material risk," which requires dentists to discuss *all* aspects material to the patient's decision to undergo treatment, even if it is not customary in the profession to provide such information. A risk is material when a reasonable person is likely to attach significance to it in assessing whether to have the proposed therapy.

In many states dentists have a duty to obtain the patient's consent; they cannot delegate the entire responsibility. Although staff can present the consent form, the dentist should review treatment recommendations, options, and the risks and benefits of each option; the dentist must also be available to answer questions. Although not required by the standard of care in many states, it is advisable to get the patient's written consent for invasive dental procedures. Parents or guardians must sign for minors. Legal guardians must sign for individuals with mental or similar incapacities. In certain regions of the country, it is helpful to have consent forms written in other languages or have multilingual staff members available.

Informed consent consists of three phases: (1) discussion, (2) written consent, and (3) documentation in the patient's chart. When obtaining informed consent, the clinician should conduct a frank discussion and provide information about seven areas: (1) specific problem, *(2)* proposed treatment, (3) anticipated or common side effects, (4) possible complications and approximate frequency of occurrence, (5) anesthesia, (6) treatment alternatives, and (7) uncertainties about final outcome, including a statement that the treatment has no absolute guarantees.

This information must be presented so that the patient has no difficulty understanding it. A variety of video presentations are available describing dental and surgical procedures and the associated risks and benefits. These can be used as part of the informed consent process but should not replace direct discussions between the dentist and patient. At the conclusion of the presentation, the patient should be given an opportunity to ask any additional questions.

After these presentations or discussions, the patient should sign a written informed consent. The written consent should summarize in easily understandable terms the items presented. Some states presume that if the 1 information is not on the form, it was not discussed. It should also be documented that the patient can read and speak English; if not, the presentation and written consent should be given in the patient's language. To ensure that the patient understands each specific paragraph of the consent form, the dentist should consider having the patient initial each paragraph on the form.

An example of an informed consent document appears in Appendix V. At the conclusion of the discussion, the patient, dentist, and at least one witness should sign the informed consent document. In the case of a minor, both the patient and the parent or legal guardian should sign the informed consent. In some states, minors may sign the informed consent for their own treatment if they are married or pregnant. Before assuming this to be the case, local regulations should be verified.

The third and final phase of the informed consent procedure is to document in the patient's chart that an informed consent was obtained after the dentist discussed treatment options, risks, and benefits. The dentist should record the fact that consent discussions took place and should also record other events, such as videos shown, brochures given, and so on. The written consent form should be included.

Three special situations exist in which an informed consent may deviate from these guidelines: First, a patient may specifically ask not to be informed of all aspects of the treatment and complications (this must be(specifically documented in the chart).

Second, it may be harmful in some cases to provide all of the appropriate information to the patient. This is termed the *therapeutic privilege* for not obtaining a complete informed consent. It is somewhat controversial and would rarely apply to routine oral surgical and dental procedures. Third, a complete informed consent may not be necessary in an emergency, when the need to proceed with treatment is so urgent that unnecessary delays to obtain an informed consent may result in further harm to the patient. This also applies to management of complications during a surgical procedure.

It is assumed that if failure to manage a condition immediately would result in further patient harm, then treatment should proceed without a specific informed consent.

Patients have the right to know if any risks are associated with their decision to reject certain forms of treatment. This *informed refusal* should be clearly documented in the chart, along with specific information informing the patient of the risk and consequence of refusing treatment. Patients who do not appear for needed treatment should be sent a letter warning of potential problems that may arise if they do not seek treatment. Copies of these letters should be kept in the patient's chart.

RECORDS AND DOCUMENTATION

Poor record keeping is one of the most common problems encountered in the defense of a malpractice suit. When the quality of patient care is questioned, the records supposedly reflect what was done and why. Poor records provide plaintiff attorneys with an opportunity to claim that patient care also must have been substandard. Even though a perfect record is neither possible nor required, records should reasonably reflect the diagnosis, treatment, consent, complications, and other key events.

Adequate documentation of the diagnosis and treatment is one of the most important aspects of patient care. A well-documented chart is the cornerstone of any risk management program. If dentists do not document fundamental clinical findings supporting the diagnosis and treatment, attorneys may question the need for treatment in the first place. Some argue that if an item is not charted, it did not happen. The following eleven items are helpful when recorded in the chart:

1. Chief complaint
2. Dental history
3. Medical history
4. Current medication
5. Allergies
6. Clinical and radiographic findings and interpretations
7. Recommended treatment and other alternatives
8. Informed consent
9. Therapy actually instituted
10. Recommended follow-up treatment
11. Referrals to other general dentists, specialists, or other medical practitioners

Ten frequently overlooked pieces of information should be recorded in the chart:

1. Prescriptions and refills dispensed to the patient
2. Messages or other discussions related specifically to patient care (including phone calls)
3. Consultations obtained
4. Results of laboratory tests
5. Clinical observations of progress or outcome of treatment
6. Recommended adjunct follow-up care
7. Appointments made or recommended
8. Postoperative instructions and orders given
9. Warnings to the patient, including issues related to lack of compliance, failure to appear for appointments, failure to obtain or take medication, instructions to see other dentists or physicians, or instructions on participation in any activity that might jeopardize the patient's health
10. Missed appointments

Corrections should be made by drawing a single line through any information to be deleted. Correct information can be inserted above or added below, along with a contemporaneous date. The single-line deletion should be initialed and dated. No portion of the chart should be discarded, obliterated, erased, or altered in any fashion. In some states it is a felony to alter records with the intent to deceive.

REFERRAL TO ANOTHER GENERAL DENTIST OR SPECIALIST

In many cases dentists may think that the recommended treatment is beyond their level of training or experience and may choose to refer a patient to another general dentist or specialist. A referral slip or letter should clearly indicate the basis for referral and what the specialist is being asked to do. The referral should be recorded in the chart. A written referral to a specialist may ask the specialist to provide a written report detailing the diagnosis and treatment plan.

A patient's refusal to pursue a referral should be clearly noted in the chart. If a patient refuses to seek treatment from a specialist, the dentist must decide whether the recommended treatment is within the dentist's own expertise. If not, the dentist should not provide this particular treatment, even if the patient insists. A patient's refusal to seek care from a specialist does not relieve the dentist of liability for injuries or complications resulting from care outside the dentist's level of training and expertise.

Dental specialists should carefully evaluate all referred patients. For example, extracting or treating the wrong tooth is a common allegation in court. When in doubt the specialist should contact the referring dentist and discuss the case. Any change in the treatment plan provided by the specialist should be documented in both the referring dentist and specialist's charts. To avoid informed consent problems, the patient must approve any revised plan or recommendation.

COMPLICATIONS

Less-than-desirable results can occur despite the dentist's best efforts in diagnosis, treatment planning, and surgical technique. A poor result does not necessarily suggest that a practitioner is guilty of negligence or other wrongdoing. However, when complications occur, it is mandatory that the dentist immediately begin to address the problem in an appropriate fashion.

In most instances the dentist should advise the patient of the complication. Examples of such situations are loss of or failure to recover a root tip; breaking a dental instrument, such as an endodontic file, in a tooth; perforation of the maxillary sinus; damage to adjacent teeth; or inadvertent fracture of surrounding bone. In these instances the dentist should clearly outline proposed management of the problem, including specific instructions to the patient, further treatment that may be necessary, and referral to an oral and maxillofacial surgeon when appropriate.

It is advisable to consider and discuss reasonable treatment options that may still produce reasonable results. For example, when teeth are extracted for orthodontic purposes, the first premolar may accidentally be extracted when the orthodontist preferred extraction of the second premolar. Before removing any other teeth or alarming the patient and parents, the dentist should call the orthodontist to discuss the effect on treatment outcome and available treatment modifications. The patient and parents should be notified that the wrong tooth was extracted but that the orthodontist indicated that the treatment can proceed without significantly compromising the result.

The lack of reasonable modifications of the original treatment plan is more challenging. The dentist may have to consider a more expensive plan, such as implants, and should also consider funding additional treatment.

Another common complication is altered sensation following third molar removal. The chart should reflect the existence and extent of the problem. It may be useful to use a diagram to document the area involved. The density and severity of the deficit should be noted after testing, if possible. The chart should reflect the progress of the condition each time the patient returns for follow-up. Ultimately the patient may require a referral to an oral and maxillofacial surgeon with experience in diagnosing and treating nerve injuries. In most cases the referral should occur within approximately 3 months after the injury if no significant improvement is seen. Excessive delays may limit the effectiveness of future treatment. Documentation of the patient's progress helps justify the decision to delay the referral.

PATIENT MANAGEMENT PROBLEMS

Noncompliant Patient

Dentists and staff should routinely chart lack of compliance, including missed appointments, cancellations, and failure to follow advice to take medications, seek consultations, wear appliances, or return for routine visits. Efforts to advise patients of risks associated with failing to follow instructions should also be recorded.

When the patient's health may be jeopardized by continued noncompliance, the clinician should consider writing a letter to the patient, which identifies the potential harm and advises the patient that the office will not be responsible if these and other problems develop as a result of the patient's noncompliance. If the patient's care is eventually terminated, the accumulation of detailed chart entries documenting the noncompliance should justify why the dentist is unwilling to continue care.

Patient Abandonment

A legal duty is owed to the patient once a doctor-patient relationship is established. This occurs when a patient has been accepted by the office, the initial evaluation has been completed, and treatment has begun. The dentist is usually obligated to provide care until the treatment is completed. There may be instances, however, when it is impossible or unreasonable for a dentist to complete a treatment plan because of several problems. Such problems include the patient's failure to return for necessary appointments, follow explicit instructions, take medication, seek recommended consultations, and stop activities that may inhibit the treatment plan or otherwise jeopardize the dentist's ability to achieve acceptable results. This may include a total breakdown of communication and loss of rapport between the dentist and patient.

In these cases it is usually necessary for the dentist to follow certain steps before discontinuing treatment to avoid being accused of patient abandonment. First, the chart must document the activities leading to the patient's termination. The patient should be adequately warned (if possible) that termination will result if the undesired activity does not stop. The patient should be warned of the potential harm that may result if such activity continues and the reason why the harm may occur. After being told why the office is no longer willing to provide treatment, the patient should be given a reasonable opportunity to find a new dentist (30 to 45 days is common). The office should continue treatment during this period if the patient is in need of emergency care or care is required to avoid harm to the patient's health or to treatment progress.

When it has been decided that the dentist-patient relationship cannot continue, the dentist must take the following steps to terminate the relationship:

A letter should be sent to the patient, indicating the intent to withdraw from the case and the unwillingness to provide further treatment. It should include five important pieces of information:

1. The reasons supporting the decision to discontinue treatment
2. If applicable, the potential harm caused by the patient (or parent's) undesired activity
3. Past warnings by the office that did not alter the patient's actions and continued to put the patient at risk (or jeopardized the dentist's ability to achieve an acceptable result)
4. A warning that the patient's treatment is not completed; therefore the patient should immediately seek another dentist or go to a hospital or teaching clinic in the area for immediate examination or consultation. {The clinician should include a warn ing that if the patient fails to follow this advice, the patient's dental health may continue to be jeopar dized and any treatment progress may be lost or worse.)
5. An offer to continue treating the patient for a rea sonable period and for emergencies until the patient locates another dentist

This letter should be sent by certified mail to ensure and document that the patient did in fact receive it. If other dentists are treating the patient, the clinician should consider advising them of this decision. The clinician should consult local counsel if any concerns of confidentiality or a particularly sensitive reason behind this decision exists.

The dentist must continue to remain available for treatment of emergency problems until the patient has had adequate time to seek treatment from another dentist. This must be communicated in the letter outlined previously.

The dentist must offer to forward copies of all pertinent records that affect patient care. Nothing must be done to inhibit efforts of subsequent treatment to complete patient care.

Patients who are positive for the human immunodeficiency virus (HIV) or who have similar diseases cannot be terminated because of their disease, because this action may violate the Handicapped Civil Rights Act and other federal or state laws. These patients cannot be refused treatment based on their disease. Patients who are HIV-positive or have acquired immunodeficiency syndrome (AIDS) are considered handicapped under these laws.[1] Legal counsel should be consulted if the clinician has another valid reason to terminate such a patient.

Exceptions do exist to these suggested guidelines. Dentists must evaluate each situation carefully. Occasions may occur when the dentist does not wish to lose contact with a patient or lose the ability to observe and follow a complication. Terminating treatment will often anger a patient, who may in turn seek legal advice if experiencing a complication. The office may elect to complete treatment in such cases.

If treatment continues, the chart should carefully reflect all warnings to the patient about potential harm and the increased chance that acceptable results may not be achieved.

In certain cases the patient may be asked to sign a revised consent form that includes three important points:

1. The patient realizes that the patient has been noncompliant or has otherwise not followed advice.
2. The previously mentioned activities either jeopar dized the patient's health or the dentist's ability to achieve acceptable results or have unreasonably increased the chances of complication.
3. The dentist will continue treatment but makes no assurances that the results will be acceptable. Com plications may occur requiring additional care, and the patient (or the patient's legal guardian) will accept full responsibility if any of the above events occur and will not hold the dentist responsible.

COMMON AREAS OF DENTAL LITIGATION

Litigation has involved all aspects of dental practice and nearly every specific type of treatment. A few types of dental treatment have a higher incidence of legal action. Removal of the wrong tooth usually results from a communication breakdown between the general dentist and oral surgeon or the patient and dentist. When in doubt the dentist must confirm the tooth to be extracted by radiograph, clinical examination, or discussion with the referring dentist. If opinions differ regarding the proposed treatment, the patient and the referring dentist should be notified and the outcome of any subsequent conversation documented. A short follow-up letter confirming the final decision may also be helpful in documenting this decision. If the wrong tooth is in fact extracted, this should be handled in the manner described earlier in this chapter.

Nerve injuries are often grounds for suits, with attorneys claiming that the nerve injuries resulted from extractions, implants, endodontic treatment, or other procedures. These allegations are usually coupled with allegations of insufficient informed consent.

Because nerve injuries are a known complication of mandibular extractions or mandibular implants posterior to the mental foramen, patient advocates claim the patient had a right to accept these risks as part of treatment. If the dentist can visualize conditions that increase this risk, the patient should be advised and the condition documented. An example would be to specifically note the relationship of the inferior alveolar nerve to the third molar tooth to be extracted, when these appear to be in very close proximity.

Failure to diagnose can be related to several areas of dentistry: One of the most common problems is a lesion that is seen on examination but is not adequately documented and no treatment or follow-up is instituted. If the lesion causes further problems or a subsequent biopsy documents long-standing pathology or a malignancy, this may be viewed as negligence. This problem can be avoided by following up on any potentially abnormal finding. The clinician should chart an initial diagnosis or seek a consultation from a specialist. If the lesion has resolved by the next visit, the clinician should record that fact so the issue is closed. If the patient is referred to another doctor, the referring clinician should follow up to document the patient's progress, including whether or not the patient's condition was successfully treated.

Failure to diagnose periodontal disease is often the area of criticism and legal action. A periodontal examination should be a part of routine dental evaluations and therefore becomes the primary responsibility of the general dentist. The status of the problem, suggestions for treatment, referrals, and progress or resolution of the problem must be clearly documented.

Implant complications or failure is another common area of litigation. As with any procedure the patient should be informed of the complication's associated reconstruction and long-term outcome. The need for careful long-term hygiene and follow-up should be explained. The potential detrimental effect of patient habits such as smoking should be explained and documented. Dentists placing implants should consider using a customized consent form, summarizing common complications, and stressing the importance of patient follow-up care and oral hygiene.

Failure to provide appropriate referral to another dentist or specialist can be a source of legal problems. Dentists usually determine the appropriate time to refer a patient to a specialist for initial care or management of a complication. Failure to refer patients for complicated treatment not routinely performed by the dentist or delayed referral for management of a complication frequently becomes the basis for litigation. Referrals to specialists can greatly reduce liability risks. Specialists are

accustomed to treating more difficult cases and complications. Specialists with whom the dentist has a good relationship can also diffuse patient management problems by being objective and caring and by reassuring angry patients. The general dentist and specialist may discuss ways of relieving the expense of addressing a complication and completing treatment.

Temporomandibular joint (TMJ) disorders sometimes become more apparent after dental procedures requiring prolonged opening or manipulation, such as tooth extraction or endodontic treatment. It is important to document any preexisting condition in the pretreatment assessment. The risk of TMJ pain or other dysfunction as a result of a procedure should be included in the informed consent when indicated. If the patient is in dire need of care that may aggravate or cause a TMJ condition, a customized consent form should be drafted and signed. It should clearly define the problem, giving the patient options and confirming the patient's authorization to proceed.

WHEN A PATIENT THREATENS TO SUE

Whenever a patient, the patient's attorney, or any other representative of the patient informs the dentist that a malpractice suit is being considered, several precautions should be taken:

First, all such threats should be documented and reported immediately to the malpractice insurance carrier. The dentist should follow the advice of the malpractice carrier, institutional risk management team, or the attorney assigned to the case. These individuals will usually respond to the threat. Because the first indication of a potential claim is usually a request for records, the office should comply with state law regarding what must be provided (usually copies of care and treatment records, not the originals).

Patients sometimes request the original chart and radiographs for a variety of reasons. The law in many states indicates that the dental office owns the records and has a legal obligation to maintain original records for a specified period. Patients are entitled to a legible copy, and dental offices are entitled to a reasonable reimbursement for the same. Patients do not own the records merely because they paid for care and treatment.

Second, the dentist and staff should not discuss the case with the patient (or representative of the patient) once a lawsuit is threatened or made. All requests for information or other contact should be forwarded to the carrier or attorney representing the dentist. All arguments with the patient or representative should be avoided. The dentist must not admit liability or fault or agree to waive fees. Any such statement or admission made to the patient or patient's representative may be used against the dentist later as an "admission against the dentist's interest."

Third, it is imperative that no additions, deletions, or changes of any sort be made in the patient's dental record. Records must not be misplaced or destroyed. The clinician should seek legal advice before attempting to clarify an entry.

During the process of malpractice litigation, dentists may be called to give a deposition. This may be as the defendant in a case or as an expert witness. Although this is quite common for attorneys, the procedure is often unnerving and emotional for dentists, particularly when testifying in their own defense.

The following are six suggestions that should be considered when giving a deposition related to a malpractice case:

1. The clinician should be prepared and have com plete knowledge of the records. All chart entries, test results, and any other relevant information should be reviewed. In complex cases, the clinician should consider reviewing textbook knowledge of the subject; however, an attorney should be con sulted before anything other than the clinician's own record is reviewed.
2. The clinician should never answer a question unless it is completely understood. The clinician should listen carefully to the question, provide a succinct answer to it, and stop talking after the answer is given. A lawsuit cannot be won at a deposition, but it can be lost.
3. The clinician should not speculate. If a review of the records, radiographs, or other information is necessary, the clinician should do so before answer ing a question, rather than guessing.
4. The clinician should be careful when agreeing that any particular expert author or text is "authorita tive." Once such a statement is made, the clinician may be placed in a situation in which the clinician did something or disagreed with something the "expert" has written. In most states a clinician can be impeached by anything an author states, once the clinician agrees that the author is "authoritative."
5. The clinician should not argue unnecessarily with the other attorney. The clinician's temper should not be shown (this will only educate the clinician's adversary as to what will upset the clinician in front of a jury, who will expect the dentist to act professionally).
6. The advice of the clinician's lawyer should be fol lowed. (Even if retained by the insurance company, the attorney is required to represent the clinician's interests, not that of the insurance company or anyone else.)

Most anxiety related to litigation comes from the fear of the unknown. Most dental practitioners have limited or no exposure to litigation. It must be kept in mind that dentists prevail in most cases. Only about 10% of cases go to trial, and dentists win well over 80% of these cases.

Unfortunately, a malpractice trial requires a tremendous investment of time, energy, and emotion, all of which detracts from patient care. Most dentists have no choice; they must defend themselves. Dentists who are prepared and who possess reasonable expectations of each step of the litigation process usually experience less anxiety.

MANAGED CARE ISSUES

The influence of managed health care has greatly changed many aspects of dentistry. This includes the doctor-patient relationship and the way decisions are made regarding which treatment alternatives are most

appropriate. Dentists are often placed in the middle of a conflict between a desire to provide optimal treatment and a health care plan's willingness to approve appropriate, needed care.

Traditionally, the patient chose whether to elect a compromised treatment plan or even no treatment. Under managed care, however, some patients are being forced to accept compromised treatment or no treatment, based on administrative decisions that may be driven more by cost containment pressures than sound dental judgment.

In some cases a "gag provision" is included in a dentist's contract with a managed care organization. This prevents the dentist from criticizing managed care organizations and sometimes prevents a dentist from presenting an alternative for care not covered by the third party provider. This obviously creates a conflict between a contractual agreement with the company and the ethical and professional responsibility of the dentist to the patient. In some states this provision is illegal and unenforceable.

In 1995 the American Dental Association (ADA) Council on Ethics, Bylaws, and Judicial Affairs issued the following statement underscoring dentists' obligation to provide appropriate care:

> Dentists who enter into managed care agreements may be called upon to reconcile the demands placed on them to contain costs with the needs of their patients. Dentists must not allow these demands to interfere with the patient's right to select a treatment option based on informed consent. Nor should dentists allow anything to interfere with the free exercise of their professional judgment or their duty to make appropriate referrals if indicated. Dentists are reminded that contract obligations do not excuse them from their ethical duty to put the patient's welfare first.[2]

Dentists may have a responsibility to advise patients that a "compromised" treatment plan has been approved by the managed care organization. The dentist should seek the patient's consent to provide such treatment after the pertinent risks, complications, and limitations have been reviewed, along with an explanation of more optimal treatment options. Dentists should consider advising in written form both patients and third party payers of reasonably expected outcomes when the appropriate treatment is not available because of improper decisions by third providers.

Telemedicine, Electronic Records, and the Internet

Recent technologic developments have induced changes associated with medical and dental practices. The increasing popularity of computers and the Internet has given birth to new potential duties and liability concerns. Digital imaging and radiology, combined with the Internet capabilities for communication and even video conferencing, has created situations where patients may receive advise without the traditional doctor-patient interaction. The conversion to electronic rather than paper charts is a growing technology, with many potential applications for a modern dental practice.

A dentist's legal duty to a patient is currently linked to the existence of a doctor-patient relationship. Determining whether this relationship exists, however, is no longer a simple task. The advent of internet marketing, telemedicine and other modes of providing information or advice through an electronic media, without the direct ability to examine, diagnose, and recommend treatment, has clouded the issue of whether a doctor-patient relationship (and a legal duty owed to a particular patient) exists. Courts in several states are beginning to make decisions that may provide some guidance related to these evolving issues, although controversy still exists. For example, a recent court decision has determined that a physician who consults with a treating physician over the telephone owes no legal duty to the treating physician's patient when treatment options were relayed during a telephone call.[3] However, another court recently ruled that a doctor-patient relationship could be implied when an on-call physician is consulted by telephone by an emergency department physician who relied upon the consulting physician's advice.[4]

Defining clear rules that can be relied upon by practicing dentists who provide direct or indirect advice over the telephone, Internet, or through web sites, will not be an easy task. Many questions remain unanswered. Do the laws of the state in which the patient lives or those in which the dentist practices actually control this issue? Is the dentist practicing dentistry in another state without a license? Is the advice offered by electronic means intended for general information and not intended to be relied upon by patients or the treating dentist for specific care? Will the electronic transfer of the information such as the patient's chart or billing information violate state or federal privacy laws? Can the dentist protect the information from manipulation or misuse if sent electronically?

Over the coming years it, will be extremely important for practitioners to monitor trends in dental care as the Internet, information storage and transfer, and doctor-patient relationships are affected by advancing technology. Current federal rules governing the electronic maintenance and transfer of records are provided in detail in the Healthcare Insurance Portability & Accountability Act (HIPPA).

SUMMARY

In addition to providing sound technical care, the dentist must address several other aspects of patient care to minimize unnecessary legal liability. The dentist should develop the best possible rapport with patients, through improved communication and by providing any information that may enhance patient understanding of treatment. Adequate documentation of all aspects of patient care is also necessary. Clinicians face a constant struggle to document quality care and advice to the patient. The law only requires that such efforts be reasonable, not perfect.

This chapter is intended to provide suggestions to be considered by individual dentists. It is not intended to establish, influence, or modify the standard of care. Medical and dental malpractice laws vary from state to state. When confronted with medicolegal issues, all health care providers should consult local counsel familiar with the laws and regulations that apply in their jurisdiction.

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