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Risk Management Reference Guide

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Risk Management Introduction

Risk management is the practice of identifying and analyzing loss exposures and taking steps to minimize them. Dentists who commit to protecting their patients and the integrity of their profession may also do a better job of protecting themselves against allegations of malpractice. Incorporating risk management into a dental practice means being disciplined and continually:

- Assessing what could go wrong
- Determining which issues are important to address and doing so right away
- Implementing policies to address risks
- Documenting informed consent and other discussions with patients

Use this Risk Management Reference Guide as a reference document only for effective risk management practices and more complete recordkeeping. It is not intended to represent absolute standards of professional conduct, nor is it meant to replace absolute standards of professional care.

You will find many suggested checklists, step-by-step instructions and important tips throughout. For quick and easy reference, these items are **denoted in bold face.** Access various letters and forms referenced throughout this document by clicking on the links provided.

Limitation of Liability — In developing this guide, TDIC researched and talked to experts in the field of dentistry, law and insurance claims. However, the ideas and suggestions contained in this guide represent experience and opinions of TDIC. There are no guarantees that any particular idea or suggestion will work in every situation. The ideas and suggestions contained in this guide are not legal opinion and should not be relied on as a substitute for legal advice. For legal advice specific to your practice, you must consult an attorney.

1.1 Advice and Assistance

TDIC's risk management staff gives free, one-on-one advice for members of sponsoring associations seeking assistance with questions or concerns about liability. Our risk management staff is available to assist dentists and their employees who have questions or concerns about potential claims or patient and employee situations that are troublesome. **Whenever you are in doubt about handling a difficult patient or employment issue, contact an analyst at the Risk Management Advice Line at 800.733.0634.**

A call to TDIC does not constitute the reporting of a claim. Risk Management analysts refer callers to the TDIC Claims department when it is appropriate.

1.2 Claims and Risk Management

A claim is a demand for money or services brought by the patient to the dentist. You probably have had a claim brought against you but never recognized it as one. You simply remade the crown when the patient was dissatisfied with the color or refunded the patient's money for a denture that did not fit. This is a good example of how a proactive response (or practicing risk management) can avoid formal claim allegations.

Claims can be quite costly and time consuming. If a patient requires retreatment in another office or if rampant infection requiring hospitalization occurs, you may be legally responsible if the treatment you delivered fell below the standard of care and resulted in an injury to the patient. The out-of-pocket costs as well as the time and knowledge required to defend yourself may be beyond your capabilities. If a treatment plan is not going as you had planned or a patient has made allegations against you or is acting in a manner that is disturbing, contact the Risk Management Advice Line for assistance. Often the risk management analyst can help diffuse a situation before the patient claims negligence.

When a patient looks to you to cover expenses for retreatment, a medical hospital bill or additional dental treatment, you have several options regarding your course of action. You can:

- Deny responsibility and refuse to pay for anything
- Accept responsibility and pay the costs out of pocket
- Reach a compromise with the patient to share expenses
- Turn the claim over to your professional liability carrier

Because each case is unique, it must be handled individually. Many variables influence which option is appropriate for the resolution of a patient's claim. It is also important to remember that not every patient allegation is legitimate, and those that are legitimate do not always result in a malpractice suit decided by a jury.

The first step in handling a claim is to determine whether the

injury is perceived or actual. The dentist determines how to handle the situation. You might consider refunding the patient's money for the contested treatment and continue with the patient's future care. Or, you might refund the patient's money for the contested treatment then withdraw from continued patient care.

If there was an actual injury (e.g., failure to diagnose oral cancer), your role and what the patient wants from you may go beyond business and goodwill decisions. Seek advice from your professional liability carrier right away.

1.3 Types of Claims

There are three types of malpractice claims.

Peer review is a process offered by local dental societies that resolves disputes arising from the delivery of dental services to the public; in particular, disputes regarding the quality or appropriateness of dental treatment, utilization (problems related to dental insurance benefits when treatment is questioned), or potentially irregular billing practices.

Small claims (also known as conciliation court actions against healthcare providers) are becoming increasingly popular. Many patients see the small claims forum as a way to avoid paying for treatment or obtaining funds for future treatment without having to share any proceeds with an attorney. Whether a matter is appropriate for small claims court depends on the amount the patient claims.

Professional liability is considered civil litigation. The following table explains how individual states approach these type of claims.

State	Description
Alaska North Dakota	Depending on the amount of damages, claims alleging professional negligence by magistrate judges, in small claims, district or superior courts. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
California Nevada New Jersey	Depending on the amount of damages, claims alleging professional negligence are heard in small claims, municipal or superior court. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
Arizona	Claims alleging professional negligence are heard in superior court. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
Hawaii	Cases are heard in the Circuit Courts for the State of Hawaii, which include the mandatory Court Annexed Arbitration Program (CAAP). The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
Illinois	Depending on the amount of damages, cases are heard in small claims court, mandatory arbitration or circuit court. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
Minnesota	Claims alleging professional negligence are heard in district court. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.
Pennsylvania	Depending on the amount of damages, cases are heard by magistrate judges, the court of common pleas or superior court. The patient asks the court to award monetary damages to compensate for alleged wrongdoing. This litigation revolves around the concept of negligence or breach of the standard of care.

1.4 Standard of Care

The standard of care is a relative standard, not a strict legal prescription. It is what a reasonable and prudent practitioner would do under the same or similar circumstances. Since the conduct of a reasonable person varies with the situation he or she is confronted with, negligence is, therefore, defined as the failure to do what this reasonable person would do under the same or similar circumstances. In other words, the standard represents a minimum level of conduct below which members of society must not fall. Persons with a higher level of knowledge, skill or intelligence, such as dentists, are held to a correspondingly higher standard. The conduct of any dentist will be judged by the conduct of other dentists practicing under the same or similar circumstances. General dentists performing specialty procedures are held to the same standard of care as that specialist.

1.5 Vicarious Liability

Vicarious liability is the legal responsibility that occurs when one party is liable for the actions of another party. In professional liability claims, questions arise as to the degree of responsibility the practice owner and the treating dentist have to the patient. Practice owners have a vicarious liability and responsibility for the credentials, licensing and competency of any associates, partners or independent contractors who treat patients.

An example of vicarious liability involves practice partners. A partner's assets are vulnerable for any acts that his or her partner may conduct when treating patients. This can occur when a patient sues both partners and one partner has never seen a specific patient or participated in that patient's care. Another form of vicarious liability exists when a dentist refers a patient to another dentist for an evaluation. Once a dentist takes on the obligation and duty of rendering dental care and attention, he or she is not released of that duty by delegating to others. The dentist is generally referring to another dentist with greater knowledge in a particular area. If the referral dentist performs his or her duty incorrectly, the original referral dentist could be responsible for sending the patient in the first place. This is known as a negligent referral.

A dentist could also be vicariously liable for acts done by an employee. If an assistant or hygienist gives erroneous advice resulting in an injury to a patient, the dentist may be liable. Generally, if the staff person is acting outside the scope of his or her job description or license without the dentist's knowledge, the dentist may avoid liability. However, if a dentist conducts him or herself in a way that leads patients to believe the staff person is acting within the dentist's authority, the dentist may be held liable.

1.6 The Dental Practice Act

One of the keys to successful risk management in the dental office is practicing within the scope of your state's dental practice act. Obtain a copy of your state's dental practice act and review the American Dental Association's *Principles of Ethics and Code of Professional Conduct* as well as your state dental association's code of ethics. For a nominal fee, you can purchase a copy of your state's dental practice act from your state dental licensing board or access it online.

Effective Communication

Studies have shown that the cost of obtaining a new customer is more expensive than retaining an existing one. It makes sense for dentists to do whatever they can to satisfy and retain existing patients. Satisfied patients are more likely to stay in your practice and less likely to be the source of a professional liability claim.

But satisfaction is not enough, especially in today's world. A merely "satisfied" patient may not be a loyal one. To ensure patient loyalty, dentists have to distinguish themselves from other providers by offering added value that others do not. This can be done by communicating effectively, performing reliably, and taking care to respond quickly and effectively when an untoward result occurs. Patients who feel that they were treated respectfully by their dentist will, in turn, respect their dentist.

2.1 Communicating Untoward Results

When your treatment does not go as planned, be open and honest with the patient. Taking immediate steps to resolve the situation ensures the patient's dental needs are met and may help sustain the doctor-patient relationship. When unexpected outcomes happen:

- Talk to the patient or family as soon as possible
- Inform them, in a professional and solution-oriented manner, about what has occurred
- Be compassionate, but avoid using terms that can be construed as admitting guilt, such as, "I'll do whatever it takes to fix this error," or "That should not have happened," or "This is my fault"
- Document what happened and your course of action to resolve the problem
- Notify your professional liability carrier for advice on managing the situation. Do not put notes from these calls in the patient record

Patients appreciate honesty. When an untoward result happens, inform the patient as soon as possible. This may mean stopping treatment, sitting the patient upright, and discussing the issue. If the mistake is discovered after the patient leaves, call him or her right away. Unexpected outcomes and surprises frustrate patients and often lead to anger. Patients file lawsuits because they believe they have been wronged. Giving an explanation and answering questions in a timely manner may be enough to quell anger and avoid a lawsuit altogether.

2.2 Communication with Colleagues

Just as the doctor-patient relationship affects a patient's course of treatment and satisfaction, so too do the relationships among dental staff and colleagues. With the increasing importance placed on technology and the corresponding emphasis on referrals, today's dental professionals must be able to communicate effectively to manage a patient's care. For that reason, it is important that everyone shares ideas, handles disagreements and reaches consensus.

Most often, the general dentist initiates the treatment plan. For that reason, the general dentist should be the coordinator of the team and treatment plan. As the team leader, the general dentist should facilitate understanding of expectations and course of treatment among all practitioners.

Problems or unexpected outcomes may occur over differences of opinion about treating a particular clinical situation. A difference of opinion on a clinical issue does not mean a colleague has practiced below the standard of care. When a colleague chooses a different treatment approach, discuss it with him or her. Stating, "I noticed you chose a different approach to treating the patient. Can we talk about it?" demonstrates collaboration and ensures the best care for patients. Stating, "Why did you do that?" may put a colleague on the defensive and does not foster the team approach. When there are definite quality concerns, address the issue with all practitioners involved. Discussing the situation with the other practitioners and reaching an agreement to remedy a bad outcome ensures that the patient's best interest is met.

2.3 Justifiable Criticism

What do you say to a new patient who asks about the status of her mouth? Remain unbiased in your discussions with a patient about previous treatment and avoid criticizing your peers when giving the patient his or her clinical status. Without pointing fingers, use lay terms to objectively describe the clinical situation and your recommendation. Be as clinical, factual and objective as possible, and work to keep subjective comments and opinions out of such discussions. This approach may prevent a patient from perceiving that another dentist is to blame for a negative dental experience. Document your discussion with the patient as well as the results of that discussion.

The American Dental Association's *Principles of Ethics and Code of Professional Conduct,* section 4-c-1 states:

"A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements."

Therefore, inform patients of their present oral health status without disparaging comments about prior services. **Even if the patient probes you for comments on the prior dentist's work, do not make unknowing, unsupportable or unjustified comments regarding the previous dentist or the work performed by him or her.** Before discussing treatment concerns with the patient, contact the previous treating dentist(s) to learn all aspects under which the treatment was performed. This opens the door to improving patient and professional relations. When responding to inquiries by a patient, talk to the patient about not wanting to comment on other dentist's treatment without benefit of the treatment history. When you discuss another dentist's treatment with your patient, be sure the comments are based on objective facts and not merely a difference of opinion.

2.4 Dental Labs

Patients often misunderstand the role of the lab technician. Many mistake the technician for a dentist who specializes in laboratory work. Patients know that an impression was made at the dentist's office, sent to the lab and returned as their bridge. What the patient does not see or hear is the instruction, customization and detail the dentist gives the technician prior to the appliance being fabricated. Patient confusion arises when the final product is not ideal and has to be sent back to the lab for improvements or possibly to be redone. Especially in challenging aesthetic cases, the patient may begin to see the dentist as the intermediary. In some cases, patients may go directly to the lab either on their own or at the dentist's request. When this happens, liability exposures may arise.

Once the patient sees the lab technician directly, the dentist risks losing control of the case. The technician will discuss treatment with the patient and may even recommend or embark on alternative treatment without the dentist's knowledge. Additionally, allowing the patient to go directly to the lab may be an invitation for the patient to begin dictating his or her own course of treatment. In demanding cosmetic cases, the patient may have requested a movie-star look to which the dentist persuaded him or her to pursue a more natural and functional solution. If the lab technician fulfills the patient's wishes without the dentist's supervision, the dentist may be exposed to allegations of negligence, should the course of treatment not be optimal for the patient. At the very least, the dentist is in an awkward position when the time comes to cement the appliance. Further, cost issues may arise. When at the lab, the patient may choose a more expensive material than he or she had previously chosen in the dentist's office and expect the dentist to pay the additional lab costs. Or, the patient may request a referral from the lab technician for another dentist or specialist. If the referral is given, the original treating dentist has lost control of the case and the patient's care.

2.5 Working with Angry or Dissatisfied Patients

A professional liability case has two components: injury and negligence. But it is often the patient's anger that propels him or her to the attorney's office. Patients come in many forms with many different states of emotion including fear, anxiety and worry. Any miscommunication on your part or your staff's part can create a chain of events that can lead to serious consequences. Your attitude goes a long way in conveying cooperation and genuine commitment to the patient. Human beings have a need to understand and to be understood. If that need is frustrated, anger is a likely and predictable response.

Be skilled in recognizing and dealing with patient anger. Your adeptness will help manage miscommunication before it escalates into problems that are more serious.

Warning signs of an angry patient

- Overt expressions of dissatisfaction
- Disproportionate distress
- Failure to return for appointments
- General noncompliance
- Hostile statements made to staff
- Complaints about a bill or billing techniques
- Patient suddenly accompanied to office by relatives or friends
- Negative statements about another dentist

Documenting interactions with an angry patient

- Keep a written record of all your interactions with difficult patients
- Use quotation marks for patient's actual words
- Use objective rather than subjective language
- Do not add to or delete from the patient's chart

2.5.1 Diffusing Anger during Face-to-Face Conferences

Sending a withdrawal-from-care letter to terminate the doctor-patient relationship should be your last choice when handling a difficult patient. Allowing your patient to become another dentist's problem can open the door to criticism of your work, without the benefit of your response.

When a patient criticizes or expresses dissatisfaction with your work, the problem can block successful treatment. This must be addressed sooner rather than later, and a mutual resolution must be reached. Is the complaint justified and can it be clinically corrected? Or, is it based on disappointment arising from the patient's unrealistic expectations, a poor result, an unexpected surprise result (not covered in the informed consent discussion), a ploy to get out of paying a bill or true financial hardship? Whatever the reason, criticism or accusations are not easy for most practitioners to accept and are almost impossible to accept without becoming defensive or angry. Anger must be recognized, addressed and neutralized.

2.5.2 Controlling Anger or Frustration

First, take a deep breath, count to ten and say nothing until you are under control. Understand that hearing the real issues are difficult when emotions are charged with anger. Often anger is the patient's means of gaining control of a situation, which seems frightening or unfair.

Next, create an atmosphere that promotes partnership with the patient to bring about a mutually satisfactory conclusion. Extend an invitation to the patient to join you for a consultation at no charge, at the patient's convenience. Rather than holding the discussion in the operatory, your office may be a more comfortable setting. Keep the dialogue courteous and honest.

Listen attentively and allow the patient to vent his or her anger. Invite the patient to describe how he or she feels (e.g., "Would you like to tell me why you are upset? I can see that you feel angry.") Repeat back to the patient the issues as you hear them. By doing this, the patient will understand the importance you give to his or her perspective. Keep eye contact and comment occasionally with remarks such as, "I see," or "Oh."

This method of communication can reestablish trust and create the necessary partnership to proceed successfully with future treatment. Most important, it affords the dentist the opportunity to educate and explain to the patient the reasons behind your methods and to answer the concerns the patient has identified. It leaves nothing to assumption.

A perceptive dentist notices subtle cues and prevents further damage by prompt and direct intervention. Prompt response requires the doctor to take the initiative to confer with the patient and offer recommendations, thereby shortening the time the patient has to mull over or exaggerate the problem. At the same time, it precludes the patient from addressing the problem on his or her terms only. If a mutual solution cannot be reached from a face-to-face conference, encourage a second opinion or peer review before the patient seeks satisfaction with an attorney or the state dental board.

Being an active listener works in most anger situations. If patients feel they are being heard and that the problem or issue is truly being addressed, their anger can be mitigated. Your tone of voice, body language, attitude and appropriate resolution will convey you listened and you acted, not reacted.

Addressing an angry patient does not include taking abuse, physically or mentally. You should not tolerate name-calling or foul language. Simply tell the patient you cannot discuss the situation until he or she has calmed down and can talk to you civilly. If you feel threatened physically by a violent patient, do not hesitate to call the police for protection.

2.6 Working with Difficult Patients

All dentists face difficult patients during their careers. Patients may continually question treatment recommendations, request second opinions or require more time to decide which option to take. Perhaps they experienced poor results from another office, are concerned about financial constraints or have anxiety about dental treatment in general. Communicating with or treating a difficult patient may require a little more patience from you and your staff. The key is knowing when to draw the line between a patient being difficult and being impossible to please.

2.6.1 Not Complying with Treatment

Often when things go wrong, it is because patients do not adhere to your treatment plan. They may discontinue medication or simply refuse to follow treatment recommendations. Patients have the right not to follow instructions or the treatment plan. However, if doing so is not within their best dental interest or could compromise their health, explain the consequences and, if possible, help them decide to change their decision. When a patient still refuses to comply with the previously agreed upon dental plan, it is time to decide whether to continue seeing the patient or dismiss. As mentioned previously, if you decide to allow the patient to stay in the practice and act in a non-compliant manner, you may be at-risk for future allegations of supervised neglect.

2.6.2 Refusing Diagnostic Radiographs

Patients often believe that "X-rays" are dangerous and question their necessity or frequency. Patients do not understand the importance of radiographs in dental diagnosis and treatment. It is the dentist's responsibility to ensure patients understand the importance of radiographs and have them taken regularly. Take the opportunity to educate patients that radiographs diagnose more than areas of decay. Radiographs are useful tools in determining the presence and degree of decay, periodontal disease and abscesses or abnormal growths, such as tumors or cysts. They can also show the location of impacted or unerupted teeth. Without the use of radiographs, dentists only make their diagnoses and base their treatment planning on visual exams and may potentially miss critical issues, not apparent to the naked eye.

For these reasons, determining the standard of care for how often to take radiographs can be confusing. Many dentists rely on patients' insurance coverage or even the patients themselves to dictate how often they take radiographs. Relying on insurance or the patient to determine the frequency of radiographs is a recipe for problems. It can also be a violation of the standard of care, because dentists are obligated to recommend appropriate diagnostic tests, regardless of the method of payment. Do not postpone radiographs due to finances or the availability of insurance. If a periodontal patient requires individual radiographs every three months, the fact that the insurance company will only pay for them once a year does not change the standard of care for the use of that diagnostic tool.

If you are unsure as to how frequently to take radiographs, contact fellow dentists in your area to determine what most of the other reasonable practitioners are doing. Your peer group can help determine what is a reasonable standard. Most general dentists agree that for a healthy dental patient a full-mouth set of radiographs should be taken every three to five years. Many patients may require periapical radiographs in the interim. Additionally, the consensus is to take bitewing radiographs at least annually. Many also agree that in some situations it is acceptable for patients to refuse radiographs. For example, a patient who believes she is pregnant should not be exposed to radiation. However, it is then your responsibility to take the radiographs at the next appointment when it is safe to do so. You may also reference the American Dental Association's *Guidelines for Prescribing Dental Radiographs* at ada.org.

As a professional, you are bound to provide patients the best care reasonably possible. Let patients know in advance that although their insurance may not cover the additional radiographs, they are still needed for you to properly diagnose, recommend and perform treatment.

Patients may be willing to sign a form releasing you from responsibility should an untoward result occur from failing to have the suggested radiographs. Remind the patient of their importance and the risks involved in not taking them. Let patients know that as a professional, you cannot allow them to consent to substandard care, even if they sign a release form. Explain to your patients that they have the right to refuse radiographs; however, if they do, you will have to dismiss them from your practice, as not taking radiographs is practicing below the standard of care.

When you have a patient that regularly refuses radiographs, send them the **Diagnostic X-rays are Required letter,** which emphasizes the importance of diagnostic radiographs. Should the patient continue to refuse the radiographs, consider dismissing him or her from your practice.

2.6.3 Failing Appointments

Whether it is a failed standard hygiene appointment or an appointment to complete treatment, consider the following as standard office protocol:

- Call the patient to determine why the appointment was missed and reschedule
- Document the conversation in the patient's chart
- When you are not successful in reaching the patient, record the number of attempts you made including the date, time and telephone number you dialed in the chart
- Note any messages you may have left and with whom

The next step is to follow up with a letter to the patient. A **Failed Appointment letter** should include the date of the missed appointment, your attempts to contact the patient, the consequences of not following the treatment plan, and a request to reschedule the appointment. Also, include a date by which the patient should contact your office. Consider sending the letter certified mail, return receipt requested. Place the signed receipt and a copy of the letter in the patient's chart.

Should the deadline come and your office has not heard from the patient, consider sending a second letter. This letter can be short, asking the patient to contact the office for an appointment by a certain date to complete the treatment in accordance with the treatment plan previously agreed upon. Include a copy of the first letter, and send it certified mail, as well. Again, retain the signed receipt and keep a copy of the letter in the patient's file.

Hopefully, you will hear from the patient and resume treatment. If you do not, now is the time to consider withdrawing from the patient's care for noncompliance. Although this seems like an arduous process, the time and effort you expend may become your saving grace should the patient initiate a professional liability lawsuit.

2.6.4 Dictating Treatment

Dentists are responsible professionally and ethically to present treatment options that are most appropriate for the patient's clinical need. Document when a patient demands treatment you believe to be inappropriate, especially when the patient's decision is based on finances. Make clear that the decision is the patient's, not yours. In cases where the patient is dictating treatment that is below standard, even with the patient's consent, you may still be liable. If the patient's request is suggesting you to practice below standard or is against your better judgment, consider withdrawing from the patient's care. Alternatively, consider referring the patient to a clinic or dental school where he or she may be able to obtain the optimum recommended treatment without incurring the fee you may be charging. Execute either option in writing to the patient.

2.7 Working with Patients of Divorced Parents

You may wonder who is able to give consent for a minor's treatment when working with patients of divorced parents. Only the legal guardian (commonly the parent with custody) can consent to treatment. If it is not clear which parent has custody, you have the right to ask for proof of custody in the form of court documents. In joint custody situations, decide with the parents which one will be the primary decision-maker regarding their child's treatment and put the agreement in writing.

There are times when one parent contests custody of the children. That parent may request his or her child's treatment records. You cannot deny a parent access to their child's dental record and information. You must provide copies of the child's treatment record to either parent, unless the custodial agreement states otherwise. Remember to obtain a signed authorization for release before releasing any information.

Divorced parents regularly disagree about their child's treatment. While you are not a counselor, sometimes sitting both parents down and explaining how they are placing their child's oral health at risk inspires a compromise. Invite both parents in for a meeting. Discuss your concerns; tell them that you are considering postponing treatment until they can come to an agreement. Remember you should be responding to a pattern of behavior, not a single incident. It is important to document all occasions where the parents' disagreements have compromised your ability to treat the child.

If you have an office policy in place designating one parent responsible for both financial and treatment decisions, gently remind the parents of this signed agreement and why this policy keeps their child's best interests in mind. If you do not have a policy in place, send a letter to both parents asking them to clarify which parent will make decisions about the child's care, emphasizing that this is in the best interest of the child. Consider following up by scheduling a meeting with them.

If these efforts fail and you cannot get them to agree, consider withdrawing from care. If you do, do so in writing. Remember that you cannot withdraw from care if doing so would cause injury to the patient. Complete any course of treatment you have begun before withdrawing. If you have only diagnosed treatment, you may withdraw from care and do not have to treat. In the withdrawal letter be sure to include the treatment you diagnosed and that you will see the patient for 30 days only for emergency visits. Contact the Risk Management Advice Line for a sample withdrawal-from-care letter.

2.8 Partnering with Other Practitioners

When referring patients to a specialist or accepting a patient already under the care of another dentist, make sure you know the other treating practitioner. Knowledge of other practitioners' training and experience may assist you when deciding where to refer your patient. Consider observing the other practitioner prior to referring to him or her. As mentioned previously in Vicarious Liability (section 1.5), you may be liable for the actions of those to whom you refer. Please reference Referrals (section 10.7) in this guide for further guidelines regarding referrals.

2.9 Discussions with your Professional Liability Carrier

Keep documentation of discussions between you and your professional liability carrier separate from the patient's record. If these discussions are included in the patient file, they are part of the patient record and can be used against you.

Initial Patient Appointment

The initial appointment is critical to establishing a strong doctor-patient relationship. It is the ideal time to gather all non-clinical information necessary to conduct business with your patient. It is also the time to get an idea about dental care the patient has received in the past as well as discussing the patient's dental treatment goals and gathering as much treatment history as possible from the former treating dentist.

3.1 Personal and Financial Information

Capture the patient's full name and address, current telephone numbers along with employment, payment, and insurance information. You should also obtain identification of patients with special circumstances: minors with divorced parents, non-traditional families or patients with financial difficulties. In the event of an emergency, note emergency contacts with names and telephone numbers. Consider gaining permission to leave voice messages at the patient's home or office. Be sure to document if the office has that permission. Note identification of other persons with whom you may share the patient's condition (e.g., spouse, adult child, sibling). If there is a language barrier, record who will act as the translator.

3.2 Health History

It is important that offices establish a system for collecting medical history information. A Health History form can assist a dentist in determining whether a patient has an illness, condition or allergy that might impact dental treatment. These forms should have sufficient space available for recording and updating patient information. Make sure to note any conditions requiring premedication, history of infectious disease or illness, allergies and any tobacco, drug or alcohol usage. Note this information conspicuously inside the patient record, not on the front. Be sure you can read the name, address, and telephone number of patient's primary care physician and any specialist treating the patient's current medical problem(s). Occasionally, there may be required changes to a health history form. TDIC recommends checking with your local dental society every two years to see if there are any changes required.

Have patients review and update their Health History form at every visit as well as sign and date it. You should also initial and date the form. Both signatures serve as evidence that the information is current and that you discussed their health with them.

When reviewing the health history with the patient, question the patient regarding any areas of concern or speculation. Write the clarifications on the health history form itself along with the date of the discussion. Many patients, especially those who are elderly, may not remember certain medications or illnesses they have had until they are questioned. Asking open-ended questions may elicit this information when updating the health history.

Additionally, if you are concerned about treating a patient with medical concerns, send a Fax Transmission: Medical Clearance for Dental Treatment form to the patient's physician. Follow the physician's recommendations and keep the physician's response in the patient's file.

3.3 Treatment Information

Finally, you will need to collect treatment information. Examples of pertinent information include the patient's current dental complaint, current oral condition by examination and radiograph findings. You should also have complete records including copies of radiographs and models from the previous treating dentist. Document the patient's expectations and whether those expectations are realistic. Also note conversations with the patient's previous dentists and any patient complaints about a previous dentist's treatment.

To complete the initial evaluation:

- Document the patient's baseline condition, including existing restorations, oral health status, periodontal condition, occlusion and TMJ evaluation, blood pressure, and pulse rate
- Orally review the health history. Follow up on any section left blank
- Have the patient sign and date the Health History form The signature serves as evidence that the information is current and that you discussed the patient's health

Treatment Planning

4.1 Diagnosis and Treatment Planning

Before initiating any treatment, the patient record should reflect a diagnosis of the patient's problem based on the clinical exam findings and the medical and dental histories. Documentation of the treatment plan for the diagnosed condition includes all radiographs and models used, and a summary of what you learned from them. Also, include a complete description of the dental treatment to be performed and how the treatment plan will address the problems identified in your diagnosis. Address whether the diagnosis indicates more than one treatment alternative, with all alternatives noted in the record. Last, incorporate whether or not you chose to consider a common alternative (e.g., an implant in a restorative case), summarizing your reasons for that decision, and whether all or any part of the planned treatment requires referral to one or more specialists, along with the names and specialties of those involved.

Specific items to note when documenting the treatment plan include:

- The patient's expectations: costs, esthetics, level of pain, longevity
- The patient's concern(s) or needs about a specific treatment outcome (e.g., when a fashion model receives restorative treatment or a professional musician who plays a wind instrument receives orthodontic treatment)
- When finances affect the patient's treatment decisions, consequences and risks should be noted

4.2 Communicating the Treatment Plan

When communicating with patients about a proposed treatment plan, be sure to provide the appropriate justification of the treatment you are recommending. Patients who understand the rationale for treatment are often more compliant and experience better treatment results. Tell the sequence of events for the entire treatment plan. Encourage questions. This gives patients the impression you do care about their feelings and concerns. Above all, communication is teamwork. Patients today expect more from their dentist and want to be accepted as an active participant in their care. Keep your communication open about how you are going to proceed.

4.3 Unrealistic Expectations

It is important to explain the realistic expectations of proposed treatment and to make clear to the patient that there may be no assurance of a perfect result. Before beginning treatment, address the patient's expectations and ensure that the patient understands the realistic outcome. Most lawsuits occur when the dentist inadequately addresses the patient's expectations and the patient is led to believe that a million-dollar smile is attainable.

Patients with unrealistic expectations may ask you to restore original whiteness to their teeth, provide treatment that will prevent teeth and gums from deteriorating further, create fillings that will last forever and prevent all pain and discomfort. Other unrealistic expectations include making their fear of dentists disappear, re-doing all procedures at your cost until the problem is solved and making dentures that will look and feel perfect.

Always perform a thorough examination and take radiographs. It's important to sit down with the patient early on and explain very clearly what is reasonable to expect as an outcome from the treatment and what is not reasonable and have a thorough informed consent discussion. Document the discussion including treatment limitations. If the patient still has doubts or lacks trust, offer to send the patient for a second opinion before frustration and anger set in. A written report could help to support the dentist. As a last resort, you may have to discontinue the relationship if the patient is not in the middle of treatment. If the patient is still in treatment, referral to a specialist may be the best option.

4.4 Guaranteeing Treatment

Patients often want to know how long their dental treatment will last. Answering this question is akin to telling them how long their natural teeth will last. There is really no reliable way to estimate the longevity of a tooth or restoration. Telling patients, "This bridge will last at least 10 years," or "I guarantee my bridges for 10 years," gives false expectations about the treatment. When guarantees are made, the patient assumes that any problems related to the treatment must be due to faulty dentistry. Patients do not take into account other issues that may play a role in treatment failure. The condition of the teeth, bone and gums, before and after treatment, impact how long

restorations will last. Patients' home care, eating habits, general health, medications and stress levels are also important factors that affect the lifespan of restorations. Guaranteeing or assuring treatment longevity will likely put the dentist into a position of having to honor such a statement as a guarantee because it may be considered a verbal contract.

Since there are many factors that may contribute to the failure of dental treatment, avoid guaranteeing, assuring or promising how long treatment may last whether it be verbally or in marketing material. When patients ask about longevity, advise them that many factors influence treatment success and longevity. Further, explain to them their part in the success of their treatment, emphasizing good home care and the importance of regular exams and cleanings. Finally, tell them to contact the office at the first sign of problems or concerns with the treatment. Addressing problems early can minimize treatment needs. Be sure to document in the chart all discussions regarding future treatment needed, including any request for a guarantee of treatment and your response.

4.5 SOAP

The simple recordkeeping system, SOAP, is a good way to document each visit. This method provides for patient complaints, the nature of the examination, significant findings, diagnosis and planning. Formatting records in this fashion not only helps in the defense of a dentist's treatment but also makes for a more thorough record upon which to evaluate a patient's condition over time.

S **Symptoms and subjective observations or the patient's chief complaint**
This is information that the patient gives, including the patient's chief complaint or obvious symptoms.

O **Objective findings or the dentist's observations**
Evaluate the patients condition. This includes health history, vital signs, diagnostic aids and other dental or medical consultation.

A **Assessment and advice, i.e., the diagnosis and informed consent discussion**
This includes the diagnosis, alternatives to recommended treatment and informed consent discussion.

P **Plan or procedure, the actual treatment plan, and the treatment performed**
This states what you will do to address each complaint. This needs to include materials, anesthesia, tooth number, medications and any referrals.

This method facilitates a systematic approach to the thorough and logical collection of all pertinent information. SOAP is not necessarily a replacement for your own recordkeeping system. Rather, it is a useful method for evaluating your records.

Below is an example of how to chart properly, using the SOAP method.

Date		Entry	Signature
3-29-08		HH n/c, Amox taken per AHA	JLW#8830
4-23-08	S	CC, pain off/on, ↑ rt 2 wks +/-, hot/cold, OK c̄ tylenol until severe pain last night, no sleep. neg swelling, fears RCT.	
	O	? pax ↑ rt, percuss test #2 neg, #3 severe pain, #4+5 neg, #3 sl. mobile. pulp test #2-55, #3neg, #4-45, #5-40, #31-60, #30-55, #29-45, #28-45.	
	A	Dxw - Deital pulp #3, Consult, Rx emerg open/drain today, RCT - Post-Core - Crown to follow. RBAs discussed, endo pamphlet given, accepted.	
	P	#3, Xylo 2cpls, N2O, 50/50, RD, #10 burr into putrescent pulp, Irrig, Xylo + Natty Chl, MB#20 file to 22MM, DB #20 file 20mm, L#30 file 28mm, good drain, apex not reached, left open for drain, Rx Dr. Moawad, ASAP, 10 days max. PO instr. given. Rx call if pain, swelling, etc. Rx Amox 500mg, #40, 1 tab, q 6h until gone, Rx Vicodin, #8, 1 tab q 4-6h, prn dent pain.	DLA #1333
4-24-08		6pm 4-23-08, by phone to, doing well, sore but no pain, took 1 Vicodin started amox. pat. pleased, "easier than I thought." Rx call if pain/swelling, etc.	DLA #1333

At Every Appointment

To ensure continuity of care, be sure to perform the following at every patient appointment.

5.1 Health History Update

The patient should update their health history at every appointment. If the form is old, or becoming difficult to read, have the patient fill out a new one, (e.g., elderly patients with multiple physicians and medication changes). Let the patient see the last Health History form to know if changes need to be made. Be sure to follow up on any question that is not answered and ask the patient if they have seen other healthcare providers since the last visit. Always inquire about pregnancies, surgeries, radiation therapies, trips to the emergency room or hospitalizations; and if they have begun, discontinued or changed (prescribed or over-the-counter) any medications. Have the patient sign and date the health history form and all subsequent updates. The patient's signature serves as evidence that the information is current and that you discussed the patient's health.

5.2 Changes or Additions to Patient Information

Note in the chart any information that will affect either your business or therapeutic relationship. This includes, changes or additions to initial personal or financial information (patients may have changed employers, insurance companies, address or marital status), changes in patient's behavior, patterns of noncompliance or prescription requests and any new dental problems.

5.3 Exam Findings and Treatment Progress

Describe in the chart any problems identified during the examination. Document the general condition of the mouth, including complete examination of hard and soft tissues, oral cancer screening and any findings within normal limits (WNL). You also need to document the treatment progress even when it includes unremarkable progress, no significant findings (NSF). Always document any noncompliance with previous instructions, medications or anesthesia given or prescribed and the informed consent discussion and treatment decision.

5.4 Oral Cancer Screening

Whether the cancer is visible to the human eye or only on a radiograph, dentists are responsible for detecting signs of oral cancer. As part of every patient's oral exam appointment, perform an oral cancer screening. Inspect the head, neck, lips, floor of the mouth, front and sides of the tongue, and soft and hard palates. Perform manual palpation of the related sites. Document your findings in the patient's chart, including the presence of no symptoms. As you perform the oral cancer screening, tell the patient what you are doing and why. This is a prime opportunity to educate the patient about the signs and symptoms of oral cancer.

Dentists must either biopsy any suspicious tissue or refer the patient for biopsy in a timely manner. When making a referral, the dentist has the responsibility to either make the appointment or confirm that the patient makes the appointment to see the referral practitioner. Document and continue to follow up with not only the patient but also the referral practitioner to ensure a definitive diagnosis of an abnormality. If the patient does not follow through with the appointment, send a letter stressing the importance of having the biopsy, outlining potential consequences of not having the biopsy, and include a deadline for the patient to respond. Send the letters via both certified mail, return receipt requested, and regular first class mail. Send the letter to the most current address you have and keep a copy in the patient's chart. Dentists may be accused of supervised neglect when they ignore or fail to act on the patient's symptoms or allow a patient to continually decline a biopsy.

When sending tissue out for a biopsy, be sure to call the laboratory to ensure receipt of the biopsy and document the call. Determine when you can expect results, and note the day. Follow up with the laboratory if you do not receive the results on the agreed upon day. Set an appointment to take another biopsy if something goes awry with the first biopsy and consider not charging for the second biopsy. Call the patient when you get the biopsy results and document the details of the call. If appropriate, refer to a specialist and follow up to ensure the patient went to the specialist, and document those efforts. It may be necessary to obtain a second opinion when pathology reports are inconclusive.

If the biopsy comes back benign, employ an observational approach of the suspicious area. Take measurements and photos of the lesion. Recall the patient in two to three weeks to see whether there are any changes, and photograph the evidence of

no change. Dated digital photos are ideal due to the immediate confirmation of results and ease of storage. If the pathology report indicates malignancy, early detection may give the patient a better chance of survival.

One of the best tools for detecting change in a patient's health is the **Health History form**. It is vital that dentists update a patient's health history at every visit. When doing so, pay special attention to patients with higher risk factors such as prior and current illness or particular health habits and behaviors. Patients are at a high risk for developing oral cancer when they:

- Use tobacco products
- Drink excessive amounts of alcohol
- Have poor oral hygiene and nutrition
- Are exposed to sunlight on a regular or prolonged basis
- Have habits such as lip biting and cheek chewing
- Have irritation from ill-fitting dentures or rough surfaces on teeth

Since auxiliary staff generally take radiographs and spend more time with the patients than the dentists do, be sure your staff knows what to look for. Some cancers can only be detected by radiograph; therefore, it is important to capture the correct and full view of all of the teeth. Even though dentists are responsible for reviewing all charts and radiographs, train your staff to bring any concerns they may have regarding a patient to your attention.

5.5 Vital and Diagnostic Signs

Vital and diagnostic signs can assist in identifying underlying problems. Vital signs measure the functions that are fundamental to life: blood pressure, pulse, respiratory rate and temperature. Take vital signs at every visit, and document the findings in the patient's chart. Prior to each appointment, compare historical readings. When there are noticeable changes, dentists—not the staff—should discuss readings with patients. If the readings are a cause for concern, consider not treating them and referring to their physician for evaluation. Inform the patient of what they are observing but refrain from making medical diagnoses. A patient's level of consciousness, skin moisture and color, eye condition, inability to feel and inability to move, may indicate potential health problems.

5.6 Periodontal Probing

The evaluation and documentation of a patient's periodontal health is part of the comprehensive dental examination as well. Since current standards call for full-mouth periodontal probing at each hygiene recall visit, the absence of that information in the chart might be construed as failure to conduct the periodontal examination. The documentation not only provides record of the patient's current condition, but it provides a record for comparison of any future changes in the patient's periodontal health. At a minimum, the documentation should include:

- The date of the examination
- All pocket depths, including those within normal limits
- Description of gingival tissue health
- Identification of areas of tissue pathology (such as inadequately attached gingiva)
- Areas of bleeding or other pathology noted on probing (e.g. suppuration and tooth mobility)

Also, include a diagnosis of the patient's overall periodontal health. If the patient refuses periodontal probing, describe and document the risks of refusal to the patient. Consider withdrawing from care if the patient continually refuses periodontal probing.

Patient Records and Documentation

Patient records are one of your most important tools for delivering continuous, consistent care and for promoting positive relationships with patients.

6.1 What is the Patient Record?

The patient record is the history of your therapeutic relationship with your patient. It gives you all of the information you need to continue treating that patient appropriately. **Complete records include:**

- A description of the patient's original condition
- Your diagnosis and treatment plan
- Progress notes on the treatment performed and the results of that treatment
- Patient's personal and financial information
- Health history (all questions answered) and regular updates
- Dental history
- Vital and diagnostic signs
- Oral cancer screening
- TMJ evaluation
- Periodontal evaluation
- Diagnostic test findings and exam notes
- Consultant reports, reports to and from specialists and physicians
- Notes describing complaints or confrontations
- Notes about rescheduled, missed or canceled appointments
- Exam notes and treatment notes
- Informed consent discussions and forms
- Models
- All radiographs taken at intervals appropriate to patient's condition
- All written authorizations to release records
- Correspondence to and from patient inclusive of phone calls, e-mails, voice messages, letters and face-to-face conversations

6.2 Why Keep Records?

There are many reasons to keep complete, accurate patient records. Accurate and complete records are indispensable for demonstrating sound clinical judgment and technique and responding to questions and concerns about treatment. Records are your best defense in the event of allegations of malpractice as they serve as credible evidence of discussions between you and your patient as well as the therapeutic treatment provided.

6.3 Radiographs and Models

Note in the chart all radiographs by type and areas of the mouth taken. Label radiographs and models with the patient's name and the date they were taken. If a patient refuses to take radiographs, document his or her refusal and describe the risks associated with failing to have radiographs taken. Have the patient sign and date that notation. Since diagnostic radiographs are the standard of care, no signature relieves you of that duty. Consider sending the patient the **Diagnostic Radiographs are Required letter**, and withdrawing from care if they do not comply.

6.4 Progress Notes

Progress notes tell the story of what happens during treatment. Normal findings, problems encountered and changes to the original treatment plan or prognosis are all items to include in progress notes. Additionally, include the date of treatment and notes about all significant interactions between the patient and your staff members. It is important to use objective rather than subjective language. For example, if you observe what appears to be an intoxicated patient, document "patient exhibits slurred speech" or "is staggering" rather than "patient is drunk." The patient may be exhibiting diabetic behavior rather than intoxication. Be sure to chart only information that is pertinent to the patient's condition.

Document any medications given, recommended or prescribed in the record. Documentation of complete prescription information includes:

- The type and amount of medication (including name, strength, number of tablets, dosage level and time interval, and the number of refills, if any)
- The date
- The name of the pharmacy, if applicable
- The use of anesthetics or analgesics during treatment, including type, amount and any reactions

Staff should document all significant interactions with patients. Of particular importance to note are any discussions about complications or problems. This includes any advice given to them over the phone, by you or any of your staff.

If several dentists are involved in your patient's treatment (e.g., orthodontist, periodontist, prosthodontist, oral surgeon), the record should document your communication with those practitioners and include notes on their progress with the patient and how that progress will affect your work. Similarly, if the patient is undergoing treatment with other healthcare providers, such as a physician or psychiatrist, the progress of that care should be monitored in your progress notes. If, during the course of a procedure, you discover the need for further treatment, this fact, as well as the subsequent treatment plan, treatment options, and discussion with the patient, should be documented. If applicable, also note any new referral or recommendation for referral.

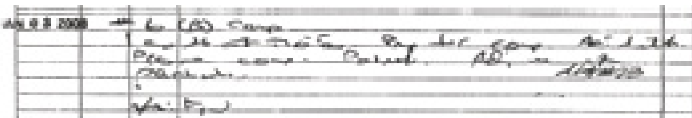
6.5 Insurance Records

Insurance records document your relationship with the insurance carrier and not the patient. Therefore, they are not considered part of the patient record and there is no law specifying how long to retain insurance records. However, insurance carriers may specify how long these records must be kept. Since this information commonly exists in the ledgers or in computerized records, keeping hard copies of the actual insurance forms may not be necessary for verifying payments.

6.6 Legibility

If others cannot read your writing, treatment errors may result. Remember, what you write today may be relied on later by subsequent treating dentists. Write entries neatly and only in dark ink. Pencil is not considered permanent since it can be altered. Do not keep patient information on prescription slips or small scraps of paper that can be misplaced or lost, such as Post-It® Notes. Use preprinted checklists, stamps and stickers to enhance legibility and save time. It is acceptable to use abbreviations, but be sure to maintain a list of all abbreviations in your office policies and procedures manual. This will assist your staff in knowing what abbreviations are acceptable to use.

This entry would be hard for anyone to decipher.



6.7 How to Amend an Entry

While there are times when a chart amendment is necessary, amendments can seem like attempts to mislead or conceal the truth. To reduce your liability and amend entries properly:

1. Draw a single line through the incorrect portion
2. Add the day's date
3. Mark the new entry "Addendum to" with the date of the entry to be corrected
4. Add the corrected information on the next available line

Do not add or delete from the record and never erase or use correction fluid over previous entries or comments. Do not skip lines because they offer an opportunity for adding to or alternating records later. Each entry should be dated and signed or initialed with a unique number (any number no one else in the office has, i.e., license number, date of birth, or other number). Any staff can write in the chart, but it is the dentist's responsibility to know what is in the chart. File the chart after the dentist has reviewed and approved all entries.

After receiving a patient complaint or, even more so, a notice of a lawsuit, dentists are often tempted to alter or amend records to make sure they adequately detailed what happened and why. Many dentists will attempt to document after the fact in a more detailed way to better explain their thought process or treatment decisions. However, this can often backfire as it may appear self-serving. Plaintiff's attorneys will scrutinize records hoping to prove they were altered. When there is evidence that the records may have been altered, they often add fraud to the list of malpractice charges.

Following is an example of an incorrect chart amendment. Notice the scribbled out tooth number.

1-29-08	EXT #[scribbled] #12 No complications	
	Gave 10 tabs Vicodin + Amox.	
	Post op inst. post op check in one	
	week	DLA#1333
2-5-08	/	

This is an example of a proper chart amendment. Note the single line crossed through the incorrect entry on 1-29-08 with the date, initials and unique number.

	DLA#1333 2/5/08	
1-29-08	~~EXT #11 #12~~ No complications Gave 10	
	tabs Vicodin + Amox. Post op inst. Post op	
	Check in one week.	DLA #1333
2-5-08	Amendment to 1-29-08 Reviewing	
	Chart Realized EXT # 12+13	DLA #1333

6.8 Retention of Records

Ideally, maintain all dental records indefinitely, as they are the history of the patient's treatment. They provide continuity of care for the patient and are the dentist's best defense when called upon to respond to patient allegations. Maintain all parts of the record, including radiographs and models.

If onsite storage of the inactive patient charts is not an option, you may store them offsite in another secured location. An inactive patient is one who has not returned for treatment within the last 24 months and you have formally dismissed them in writing. For easy retention and destruction, separate files of inactive adult patients from files of inactive minor patients, as of last treatment date.

TDIC generally recommends the following for disposing of inactive patients' records:

Adults

- Ten years from the date the patient was last seen, even if the patient is deceased

Minors

- Ten years from the date the patient was last seen or seven years past the patient's 18th birthday (age 25), whichever is longer

Requirements vary by state. Please check with your state's dental board for specific requirements.

6.9 Disposal of Inactive Patient Records

Records may be destroyed after the 10-year retention period in a manner that will preserve the confidentiality of the information in the record. Do not simply throw them in the trash. Since the Environmental Protection Agency does not permit the burning of radiographs, TDIC recommends shredding them.

Keep a log of which records are destroyed and when. This practice will assist you in identifying which records have been destroyed and are unavailable in the event they are requested later. When searching for a records disposal company, look for companies listed as specializing in dental or medical record disposal.

6.10 Copies and Release of Patient Records

The original patient record is the property of the dentist. However, the patient is entitled to the information it contains. Never release any part of the original patient record, including radiographs or models.

Upon receipt of a written request from the patient or the patient's representative, give a copy of the complete dental record to the patient or the patient's representative. However, if the healthcare provider is of the opinion that the release of the records to the patient would be detrimental to the health of the patient, supply the records to the patient's attorney, upon written authorization. Patients can request a copy for themselves or request that you forward a copy to another dentist or healthcare provider.

You cannot deny access to records as a means of collecting on past due bills. It is important to establish reasonable conditions for transmitting records without discrimination against classes or categories of patients. Although you can charge for copies, consider carefully whether charging will inflame an already difficult situation. In addition, do not base your decision to charge for reproduction of records upon punitive, discriminatory or retaliatory reasons. Reasonable costs incurred by a healthcare provider in making copies of medical records shall be borne by the requesting person. However, if the patient refuses to pay copying charges, you are still obligated to provide copies of the patient's records. Contact your state dental board to inquire how much you can charge for the copies.

When your office is faxing confidential patient information to another office, use a **Fax Transmission: Medical Clearance for Dental Treatment form**. In addition, call the receiving office to verify they received the information. Document in the patient's chart what was sent, to whom it was sent, and the date and time it was received. Place a copy of the fax confirmation in the patient's chart.

6.10.1 Authorization to Release Records

Do not release records without an **Authorization for the Release of Dental Records** signed by the patient or the patient's representative. One common exception is when the requesting healthcare provider and the dentist who are both treating a patient directly are sharing medical and dental information for treatment and billing purposes. Dentists often receive subpoenas for records. A subpoena is an order of the court, and you must comply with their request.

6.10.2 Special Confidentiality and Authorization

The Health Insurance Portability and Accountability Act (HIPAA) requires written authorization from a patient before disclosing any personal health information(PHI). PHI includes more than just medical or health records. It also includes mental health information, drug and alcohol abuse records and HIV test results. Be sure not to release this information unless you have express written permission from the patient or the patient's representative.

Dentists often e-mail or fax confidential information to patients, third party payers and other practitioners. Consider adding the following wording to the bottom of your fax cover sheets and e-mail messages:

Notice: This communication, including any attachments, is confidential and may be protected by privilege. If you are not the intended recipient, any use, dissemination, distribution or copying

of this communication is strictly prohibited. If you have received this communication in error, please immediately notify the sender by telephone or e-mail, and permanently delete all copies, electronic or other, you may have. The foregoing applies even if this notice is embedded in a message that is forwarded or attached.

6.11 Digital Records

While manual recordkeeping is still a method of choice for many dentists, computerized recordkeeping is becoming more common in the dental office. There are considerable benefits and risks to ensure digital records have the same integrity as handwritten records.

The core benefit is the organization of patient information. Data is consistently placed into specific sections within the patient record, which makes access easier and saves time by eliminating the need to search for important information in a handwritten chart. Further, problems such as illegible handwriting and misplaced records may also be eliminated.

Also, the software allows individuals to enter identifying information after making an entry in the patient's chart. Since most states require that entries be signed or initialed, this feature ensures compliance for every entry in every chart. As previously stated, TDIC recommends that each entry be dated and signed or initialed with a unique number (any number no one else in the office has, i.e., license number, date of birth, or other number).

While it is easy to enter information into digital recordkeeping systems, ensure that once information is entered it cannot be removed or altered by unauthorized persons. Some systems include a faultless mechanism that prevents the alteration of electronic records. write-once-read-many (WORM) data cannot be re-written or re-formatted, but can be amended. For example, when developing a new treatment plan for a patient, be sure previous plans are not over-written or erased. These precautions reduce the incidence of accidental or intentional erasure of data, enables time and date authentication, and facilitates quick search and retrieval of archived files. These systems would indicate any record alteration that was attempted, and assist in defending against any allegations of record alteration.

Because of numerous forms that require a patient's signature (e.g., health history, informed consent, treatment plans, informed refusal, release of records), many dentists believe a dental practice can never truly be paperless. In fact, many computerized recordkeeping systems utilize signature pads, similar to those in department stores for signing credit card purchases. For those systems that do not include pads, forms can be printed for patients to read and sign, which can then be scanned back into the system.

There are also many misconceptions about digital patient records. One of the most common is that dentists still have to keep the original handwritten chart after converting to a computerized environment. After confirming all information has been converted correctly, scans are of excellent quality, backup data is uncorrupted and retrievable and staff is trained on the system, it is acceptable to properly dispose of the handwritten chart. Another involves their admissibility in court. Just like their paper counterpart, digital records stand as the therapeutic record of the doctor-patient relationship.

Another benefit is the continuity of care these systems offer through forms, templates and alerts. Electronic calendar ticklers and flags alert dentists to health issues, contraindications, missed appointments and prophy recalls, which reduces the possibility of important information falling between the cracks. This ultimately benefits the patient, as the dentist is able to provide more complete, consistent care.

An added benefit of digital recordkeeping is the direct impact on clinical procedures and the standard of care. New technologies like illumination and magnification of digital photographs and radiographs help diagnose disease earlier, which makes treatment less invasive and more conservative. They also educate patients during treatment presentations. With images displayed on a monitor, patients can better visualize the treatment they have received, the treatment that is recommended, and their current dental problem.

The digital record also greatly reduces physical storage needs. All the information contained in handwritten charts is stored in the practice's computer system. While active patient records are kept live on the system, inactive patient records can be transferred or copied to a backup disk or other computerized storage system.

Digital records do not come without risks. One of the main risk management concerns of computerized recordkeeping is security. There are two facets to security: protection and confidentiality. External threats, such as natural disasters, power surges, brownouts or other electrical problems, can cause system failures and loss of data. Hard drives can and do crash. Software can fail. Viruses can enter a system and wreak havoc. Many of these problems can be resolved by implementing regular backups that are stored offsite and installing and maintaining firewalls and anti-virus software.

Develop a proper backup protocol to ensure the integrity of the data. Whether it is a full backup nightly or an incremental backup nightly with a full backup once a week, store the backup data offsite. It is not just enough to store the information offsite.

Regularly test the data to ensure retrievability. Data being stored has to be uncorrupted and accessible when needed.

Federal, state, and case law defines healthcare providers' legal obligations to ensure patient confidentiality. They may not disclose any information revealed by a patient or discovered in connection with treating a patient without the patient's proper authorization. A breach of confidentiality is a disclosure to a third party, without patient consent or court order. Any breach can result in mistrust, and the practice and individuals involved may face federal and state criminal and civil prosecution.

6.12 HIPAA

HIPAA is the federal law establishing comprehensive measures to protect the confidentiality of patients' PHI. Among HIPAA's regulations, the Security Rule addresses the protection of patient information that is produced, used, or stored on an office's computer. The Security Rule does not address patient information that is in a folder and stored in a file cabinet, or which is communicated verbally within the office. This information is protected under the HIPAA Privacy Rule. The focus of the Security Rule is to protect against hackers breaching a computer network's firewall, the interception of viruses that are attached to e-mails, the use of passwords to access electronically stored patient information in office computers and laptops, protection against interception of electronically transmission of patient information through encryption, and the like.

The HIPAA Security Rule requires regulated dentists to:

- Ensure the confidentiality, integrity, and availability of all electronically protected health information that the covered entity creates, receives, maintains or transmits
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information
- Protect against any reasonably anticipated unauthorized uses or disclosures of such information
- Ensure compliance by its workforce

The HIPAA Privacy Rule requires regulated dentists to:

- Adopt a patient privacy policy designed to protect the confidentiality of patient health information in use of that information, and make a copy of that privacy policy available to each patient
- Assess the risk within the practice of release of patient health information, and adopt reasonable measures to address those identified risks
- Use patient information for only the purposes of treatment, payment and health care operations within the practice
- Obtain a patient's specific written authorization for any other use of their health information

6.13 Health Information Technology for Economic and Clinical Act (HITECH)

The federal stimulus bill signed by President Barack Obama contains the Health Information Technology for Economic and Clinical Health Act, known as HITECH, which sets fourth several changes to HIPAA. It includes provisions affecting business associates , new security breach notification requirements, heightened enforcement and increased penalties for noncompliance.

Under HITECH, patients must be notified any time their unsecured protected health information may have been compromised through unauthorized acquisition, access, use or disclosure. Unsecured protected health information is any protected health information that is not rendered unusable, unreadable or indecipherable. The new breach notification health information requirements became effective for breaches discovered on or after Sept. 17, 2009.

Prior laws did not impose mandatory penalties for noncompliance. HITECH now sets forth mandatory penalties for violations that are due to willful neglect. HITECH also requires the Department of Health and Human Services investigate complaints that are preliminarily determined to involve potential willful neglect.

For more detailed information about HIPAA, visit:
U.S. Department of Health and Human Services
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coverdentities/guidance_breachnotice.html

American Dental Association
http://www. ada.org/2945.aspx?currentTab=1

Remember to remove access privileges of former employees. Have employees sign a disclosure form stating they understand their duty to keep patient information confidential, agree to abide by that duty and recognize they may be liable if they divulge patient information. This employee form should be filed in the employee's personnel file. You may want to include this form in your employee manual.

Finally, doctors are not certain how to handle patient requests for records, a right that is guaranteed by the Privacy Rule. Dental boards require dentists to have the ability to print the entire patient record, if requested by the patient. When patients request copies, print the complete record including radiographs. Do not release the record to the patient without a signed authorization. Be sure to scan the signed form into the electronic record as it becomes part of the record, too.

Informed Consent

Most professional liability claims include an allegation of a lack of informed consent. Patients argue they would have made a different treatment decision had they known of the possibility of a negative outcome. By law, patients must be informed about their treatment. Obtaining informed consent is the best way to protect the patient and the doctor.

7.1 Consent v. Informed Consent

Common law has established that a patient has the right to decide what will happen to his or her body regarding medical care. There are two aspects to that law:

- The right to consent or refuse to consent to treatment (consent)
- The right to sufficient information to make that consent (informed consent)

A doctor who treats a patient without consent may be liable for battery, a criminal offense. A doctor who treats a patient without providing sufficient information to make a meaningful decision (informed consent) may be liable for negligence based on a lack of informed consent, a civil tort.

Informed consent is a discussion between the dentist and patient during which the dentist—not staff—educates the patient about the diagnosis, nature of the treatment, alternative treatment options and the benefits, risks and consequences of each. The patient is allowed time to process the information, ask questions and receive answers. Give all the information necessary for the patient to give his or her informed consent, including the risks of having no treatment. While staff cannot lead the discussion, they can add to it. Patients often feel more comfortable expressing concerns to staff; therefore, train them to answer questions and bring inquiries to your attention.

Higher risk and more invasive treatment are two indicators of how much time and detail should be spent informing the patient. In lay terms, you must discuss:

- The nature of the recommended treatment
- The risks, complications and benefits of that treatment including the likelihood of success
- Alternatives to the recommended treatment, including no treatment, with their risks, complications and benefits
- The outcome and benefits of diagnostic workups including their function in diagnoses
- An explanation of the treatment plans expected sequence of events

The informed consent discussion is a process. However, using a form can expand and enrich that discussion. A printed informed consent form is a useful tool. It can initiate and guide the conversation while reducing the likelihood that points will be forgotten. It can be given to the patient to take home, share with family members, and consider without pressure before signing. Lastly, it can be the material evidence that the patient was informed of the diagnosis and treatment, and the benefits, risks, consequences, and alternatives of the procedure, and had the opportunity to ask questions and have them answered.

The other option is for the dentist to document the informed consent discussion in the patient's chart. Include the date, parties present and issues discussed (nature of treatment, risks, benefits, alternatives and consequences of each). Note in the patient's chart, "RBAs were discussed and patient consented to treatment." If that notation is the only record of the discussion, the patient's and dentist's signatures next to this entry in the chart is a good practice.

7.2 Who can Consent to Treatment?

Without exception, informed consent discussions and decisions should be between the dentist and an adult of sound mind, a minor patient's guardian, a documented emancipated minor or a guardian of an adult who lacks mental capacity.

7.3 Informed Refusal

Just as patients should know the risks, benefits, and alternatives of accepting a treatment recommendation, they should also know the potential consequences of refusing a proposed treatment or procedure (e.g., a patient who refuses a recommendation to extract an impacted third molar must understand the potential for continued symptoms, bone loss and serious, potentially life-threatening infection). All states impose a duty on dentists to obtain a patient's informed refusal whenever refusal holds potentially serious complications.

Depending on the circumstances, dentists should be aware of continuing to treat when the patient's refusal jeopardizes the

possibility for a successful outcome or the patient's health, in which case terminating care may be the only reasonable option. In any case, a patient's refusal should be thoroughly documented in the chart, along with the dentist's attempts to inform the patient of the consequences of refusal.

A patient's refusal for treatment does not allow a dentist to practice below the standard of care (e.g., refusal to have diagnostic radiographs over a long period is unacceptable). Patients cannot consent to substandard care but can refuse treatment recommendations.

7.4 Supervised Neglect

Allegations of supervised neglect can occur when dentists ignore or do not act on symptoms that may be signs of needed patient treatment. Supervised neglect may also result when an informed refusal is allowed to go on too long. There are times when it is permissible for the dentist to continue providing care after the patient signed an **Informed Refusal form**. An example would be if the patient wanted to forgo a referral until his or her insurance benefits are re-established for the next policy year and that timeframe does not compromise the patient's oral health. Supervised neglect would occur when that new year comes and the dentist continues to allow the patient to refuse the referral.

Review charts periodically, and pay attention to and act on recurring patient symptoms and complaints. This shows patients that you care for their well-being. Failure to act may lead to allegations of malpractice. If the patient continues to refuse the referral, it would be wise to consider withdrawing from care.

Withdrawing from Care

Occasionally, circumstances make it impossible to continue the doctor-patient relationship and either party can end the relationship at any time. The dentist can withdraw from the patient's care for any reason that is not unlawful discrimination. Common reasons for withdrawing from care include the patient's noncompliance, ongoing disagreement about treatment goals, chronic nonpayment or the dentist's desire to limit his or her practice.

8.1 When and How to Withdraw from Patient Care

Facts and circumstances of each situation have to be evaluated to determine if a doctor-patient relationship exists. Practically speaking, test the question of its existence by asking yourself if a reasonable patient would expect the doctor to provide care under the circumstances. What would you expect? The relationship could have begun at the time the appointment was made and the doctor agreed to see the patient. Patients may perceive the doctor-patient relationship has begun when a:

- Doctor conducts the initial history and examination
- Patient enters the operatory
- Doctor gives a referred patient an appointment for consultation

If a relationship exists, there is a duty to take care of the patient until the relationship is terminated by one of the parties. When the dentist terminates the relationship, it should be done in writing to allay claims of abandonment, and only after other methods of problem resolution have been attempted.

The dentist has a duty to continue care until notifying the patient in writing. Allow a reasonable amount of time for the patient to find another dentist (e.g., 30, 60 or 90 days). The circumstances for each patient will be different considering treatment status, ability to pay for treatment, access to care and geographical proximity of patient to another dentist. Also, indicate the exact termination date that you will no longer be available for emergency care. Additionally, give two viable referrals, such as the local dental society, local dental schools or a managed care plan; be sure to also enclose an Authorization to Release Dental Records form with instructions to sign and return it to the dental office so their records can be forwarded.

Send the letter via both certified mail with return receipt requested, and regular first class mail. The patient's signed certified receipt verifies that the patient received notification and it should be kept in the patient's chart. An unsigned certified receipt with the undelivered letter will sometimes be held at the post office for 90 days without being returned to the dentist, resulting in the patient not being notified. However, when a letter is sent regular mail, has a visible and legible return address and is not returned, there is a degree of certainty that the letter was delivered. Keep a copy of the letter noting both means of mail delivery in the patient's chart as well as if the letters get returned. Contact TDIC's Risk Management Advice Line. Analysts can provide you with advice regarding your specific situation and with sample withdrawal letters. They can also review your letters prior to you sending them to patients.

8.2 Withdrawal from Managed Care Patients

Verify the withdrawal from care protocol required under the terms of managed care contracts signed by the dental practice prior to dismissing a patient from the practice. Follow that protocol for the patients covered under the contract. If notification to patients is not addressed, be sure to use the preceding protocol for the managed care patients.

Dentists often unknowingly abandon patients when they dismiss them because they no longer accept their insurance plan. For example, a dentist stops accepting ABC Insurance. He then tells all patients currently with ABC Insurance that he can no longer see them because he does not accept that particular insurance any longer. Rather than assuming patients cannot afford your regular rates or will not pay them, give them at least 30 days written notice that you no longer accept their insurance plan. Explain that you will be happy to continue seeing them; however, the rates will reflect a different billing structure. Refer patients to their insurance carrier so they can choose a new dentist within the network, or give them the name and number of the local dental society for names of other dentists in the community. Discuss the current treatment status with patients in lay terms and the necessity of finding a new dentist and risks involved if they do not continue treatment. End the letter with an invitation to call the office with any questions. This type of notification informs patients of the change, offers continued care and provides adequate time for them

to find a dentist who accepts their insurance. Additionally, train staff to respond objectively to patients' questions about why you are no longer a provider of their insurance.

8.3 Withdrawal from Patients who are in Mid-treatment

Before you terminate the doctor-patient relationship, complete any dental treatment in progress to protect yourself from abandonment allegations and to protect the patient from injury should the work go unfinished. You do not have to complete the entire treatment plan, but complete any portion in progress or that which places the patient at risk if not completed (e.g., unfinished root canal, provisional restoration, orthodontics). In extreme situations, you may not be able to complete the treatment yourself (e.g., when a patient is threatening violence). In those instances, it is your responsibility to refer the patient to his or her insurance company, clinic or dental school to complete the work.

8.4 Patient Withdraws from Care

Patients may leave your practice and transfer their care to another dentist for various reasons. They may have relocated, changed insurance plans or simply decided to see another dentist. When a patient withdraws from your care, send a withdrawal letter to the patient via both certified mail, return receipt requested, and regular first class mail (same process as mentioned in previous sections). Advise patients of the importance of continued care and the risks involved for not completing treatment, especially if they are in the middle of treatment.

Financial Considerations

Discussing financial matters with patients can be difficult. Dentists would often prefer not to handle billing, financial arrangements, retreatment and collection issues, but rather "just treat their patients."

9.1 Financial Arrangements

It is important to understand patients' financial constraints and create a financial arrangement that will allow them to receive the recommended dental treatment. Rather than adjusting the treatment to suit the patient's finances, adjust the financial arrangement.

Discuss the financial arrangement and treatment plan with the patient prior to starting treatment. The person responsible for the office's billing procedures should discuss the financial arrangement after the dentist has reviewed or determined the treatment plan. This is also the appropriate time to make any arrangements regarding payment plans and to discuss the office policy regarding financing. This conversation should include the estimated insurance payment. Include a statement in the financial agreement that clearly states that the patient is responsible for the treatment fees regardless of insurance coverage. Have the patient sign both the treatment plan and the financial agreement. Give copies to the patient and keep the originals in the patient's file. Should there be questions about finances, referring back to the signed original agreement is very useful.

There is no guarantee that a patient is going to pay for treatment in a timely manner. Even if the patient has not fulfilled the financial obligation, the dentist must complete the treatment in progress. Treatment can be postponed for pending payment only when withholding treatment does not place the patient at risk. Should a permanent crown not be cemented due to an unpaid balance and the patient's tooth fractures while in the temporary, the dentist could be liable for patient abandonment.

When establishing financial arrangements with patients:

- Base financial arrangements on treatment recommendations rather than treatment planning based on finances
- Have the patient sign both the financial agreement and the treatment plan
- Place the originals in the patient's chart and give the patient copies
- Complete treatment regardless of payment status
- Once the patient's treatment is completed, pursue any balance due

9.2 Refunding

When a refund is the mutually acceptable solution to an untoward result, you must determine whether a dental insurance company participated in paying the fee. If so, it is the dental office's responsibility to refund the insurance portion to the insurance company. A phone call to the carrier's customer service department or quality review department should provide you with the protocol for refunding the insurance company's portion of the fee.

Generally, when a dental insurance carrier receives a refund from a dentist the benefit is made available again to the patient. Patients may object to not getting all of the money refunded to them, but when they consider the advantages it affords them, they often see the wisdom in returning the insurance portion directly to the insurance company. In the case of a denture, the benefit usually is only available every five years. If the insurance portion is not refunded to the company, the patient will be unable to claim coverage for the new denture sooner than five years. However, if the refund goes back to the insurance carrier, the benefit is available again and may cover the difference in price or at least a percentage of it.

Refunding to the patient and to the dental insurance company prevents any suspicion of fraud that comes with discounting or forgiving the patient's portion and not the insurance company's. It is possible that if the dental office refunds all monies to the patient, the office will still owe the insurance company its portion.

When refunding a patient's money, be sure to phrase your reasoning as being in the "interest of goodwill and compromise." It is a good idea to have patients sign a release of liability confirming their acceptance of a refund to compromise or settle the matter.

Because every patient situation is different, it is necessary for you to contact TDIC's Risk Management Advice Line for the appropriate forms (e.g., release of liability, forgiving balance), information or advice prior to offering a refund.

9.3 Release of Liability

When refunding a patient's money, it may be appropriate to have the patient sign a release. While a release cannot stop patients from suing the dentist, nor relieve dentists of their professional responsibility to the patient, a signed document may show that the patient intends to accept the refund as final resolution of the matter. However, in some cases, presenting the patient with a release to sign may inflame the situation to the point of litigation. If a patient accepts the refund and signs the release, or accepts the refund without signing the release, document the outcome and keep the original release form in his or her chart.

9.4 Forgiving Balances

Does forgiving a patient's debt mean the dentist is admitting he or she is wrong? Not when the message sent is clear that the dentist is extending goodwill and compromise. Every patient situation is unique, as are reasons for writing off a balance. Reasons could include the treatment did not meet either the dentist's or the patient's expectations, the doctor has tried to adjust treatment and the patient is still unsatisfied, or the patient has developed a serious financial hardship since the original treatment plan was initiated.

Prior to writing off a balance, decide if you are interested in retaining the patient in your practice. Determine if all efforts have been made to address the patient's complaint, if the balance owed is worth fighting over or if writing off the balance will solve the problem. While forgiving a patient's balance may seem like an easy solution, be wary of writing off a balance as the only solution to an uncomfortable situation. The last thing you want to do is develop a reputation for writing off balances the moment a patient complains about a treatment plan or cost. If a dentist is too quick to zero out accounts, some patients may begin to wonder what else they can get if they wait a little longer or complain a little louder.

Also, make certain you understand what the patient is asking for. You may think the patient wants to write off the entire bill for full-mouth reconstruction when all the patient is talking about is reimbursement for one bad filling. Clear communication between the dentist and patient is essential.

Once a course of action has been decided, certain guidelines are recommended:

- Document all discussions between you and the patient
- Decide on an identifiable amount to be written off Example: *"Take $700 off the bill and we'll call it even."* Although it sounds easy, this is not a desirable position. Define exactly what the patient is asking for and proceed with exact figures to back up your decision. *"You have stated you are happy with the bridge, but not the crown. That crown cost $700. In the interest of goodwill and compromise, I am willing to take $700 off of the balance due"*
- Obtain a written release with the patient's signature
- Give the patient a copy of the signed release and a copy of his or her statement reflecting the adjustments and new balance
- Retain copies in the patient's chart, along with objective and professional notes as to why you wrote off the balance. Be aware that any notations in the chart are a part of the patient's record

9.5 Billing Disputes

Billing is rarely the focus of a liability claim; however, it often serves as a catalyst for litigation. While dentists usually regard billing as the final phase of the treatment process, patients perceive it differently. For them, receiving the bill is the first opportunity to consider the value of the treatment received. Disputing the fees or withholding payment are ways for a patient to express dissatisfaction with the quality of care. How you handle the situation depends on your ability to distinguish patients who have legitimate concerns from those who simply do not pay their bills.

Once a patient expresses dissatisfaction with treatment when pressed to pay a past due balance, send a letter to inquire whether the past due amount is a result of concerns about the treatment or unresolved questions. This letter will make it harder for the patient to argue later that you "...just didn't care." In the letter, offer to bring that patient into the office at no charge and determine if there are legitimate complaints during the meeting. If the complaints are legitimate, correct the problem(s) yourself or refer the patient to a specialist for a second opinion. Should there be any additional fees, let the patient know immediately. The fee may have to be negotiated with the patient depending on the circumstances and the cause of the problem. It is customary to retreat or correct a patient's complaint about treatment without additional fees. This is a matter of patient satisfaction as well as practicing within the standard of care. If complaints are not legitimate, a face-to-face meeting with the patient should be conducted to identify what is truly getting in the way of payment.

These decisions can only be made by the treating dentist, not a staff member. There comes a time when the dentist must interact with the patient regarding dissatisfaction issues and complaints about treatment in response to collection efforts at this time.

For example, to the patient who is withholding further payment until the dentist resolves problems with the fit of a new denture, a collection action may suggest that the dentist is more interested with money than with the patient's concerns. In this case, the

collection action may send the patient out of the treating dentist's office to another practitioner preventing the treating dentist from satisfying the patient. This dissatisfied patient complains to a new dentist about the "unsuccessful" denture and criticisms start to fly. Before long, talk of abandonment and substandard care fills the patient's mind. Completing treatment without satisfying a patient is a poor position to be in when trying to collect on an unpaid bill.

Office Policies and Procedures

It is good risk management to develop a policies and procedures manual to maintain continuity of care and assist you in running a smooth practice.

Consider including the following when developing your policies and procedures manual:

- Communicating dental charges and payment options
- Purchasing protocols
- Billing and collections protocol
- Insurance filing and follow-up
- Scheduling
- Patient registration protocol
- Setting up a dental record
- Closing and reconciling the day's activities
- Sterilization techniques
- Samples of all forms used in the office
- Samples of all patient education materials
- Releasing dental records protocol
- Recordkeeping protocol

Require employees to review the manual. Place it in a common area and use it as an ongoing reference for the practice.

10.1 Telephone Communication

Train all staff members who answer the phone to distinguish the nature of a call and its urgency. Most calls are routine, such as appointments, scheduling and prescription refills. However, some may be more urgent and require immediate action. Train staff to bring emergency calls to your attention immediately. Make a point of returning calls promptly. Staff should triage calls properly and tell the patient when to expect a call back. The Emergency Telephone Screening form helps staff determine appointment immediacy. Otherwise, the patient may be waiting for a call that does not come, thinking your staff is inefficient or you do not care.

Document all telephone communications to, from or about the patient in the patient's chart. The documentation should include date and time of the call, patient's chief complaint or concern, advice given, necessary follow-up, symptoms that will require patient to call back and the name of the person who handled the call. If you take or make a call while you are not in the office, document your conversation in the patient's chart as soon possible. In the event of a claim, it is extremely hard to defend details of undocumented discussion with the patient. Usually, if a phone call is not documented and the claim goes into court, it becomes your word against the patient's word as to what happened. Without documentation, the patient's memory may carry more credibility than yours or that of your staff who may have spoken to a lot of patients that day.

10.2 After-Hours Calls/Vacation

Establish procedures by which you can be reached after-hours, while on vacation or in case of an emergency. You are obligated to make reasonable emergency care arrangements available to your patients of record. Arrangements may include referring patients to their local emergency room, another colleague who has agreed to fill in for you, or answering machines or answering services directing callers to on-call emergency resources.

When using an answering service, occasionally test the system for accuracy. The service should have written protocols for screening phone calls appropriately. Provide the service with a current call schedule and current telephone numbers. The service should identify itself as such: "Dr. __________'s answering service" and let the callers know what to expect: "Dr. __________ is on vacation, but I will notify the doctor on-call and he or she will contact you shortly." To facilitate documentation of after-hour's patient contacts, most services provide daily listing of the calls to the practice.

When you use an answering machine or voice mail, check the system frequently to ensure that it is working, the message is clear and that it records all the messages. The opening statement should instruct the caller what to do in case of an emergency: "You have reached Dr. __________'s office, and we are currently closed. If this is a true emergency, go to the nearest hospital or call 911. Otherwise, please leave a message and your call will be returned."

Be sure to follow up promptly with the patients who attempted to reach you with an emergency while you were out as well as contact the colleague or any emergency room doctors involved in treating the patient's emergency. It is important to remember that documentation of after-hours calls is as important as any telephone conversation.

10.3 Scheduling

Patients perceive long waits as a lack of concern, and they quickly become dissatisfied. Dissatisfied patients may choose to go to other dental offices and increase the risk of a professional liability claim. Consider setting aside one or two appointments each day to adjust for extended or emergency appointments. Consider having staff informing patients about the delays via telephone or when they first arrive for their appointment. Not only may this help to defuse their anger, it also demonstrates respect for their time.

While there are no regulations requiring a dentist stay on time, it makes good business sense to honor the daily schedule. When you keep patients waiting, you risk losing them. Certain situations may call for adjustments in your schedule. For example, if you find it difficult to make 8 a.m. appointments, instruct staff to schedule patients starting at 8:30 a.m.

10.4 Office Protocol for Emergency Patients

After identifying an emergency patient, he or she must be worked into the schedule immediately, the same day, or within a few days depending on the nature of the emergency. If this cannot be done, advise staff to notify you immediately. Minimal delay for other patients must also be considered.

Staff should schedule the patient on the front office appointment book, verbally notify the clinical staff of the scheduled time and name of the emergency patient, and post an Emergency Telephone Screening form on the outside of the patient's chart.

If the patient is new and the severity of the emergency allows it, have the patient complete a Health History form before treatment and any other forms as time and circumstances allow. Have patients of record update their health history form before treatment if possible.

10.5 Telephone Prescription Refills

Periodically, patients may call your office for a refill of their prescriptions. Medication errors occur because of failure to review the patient's health history prior to prescribing. Train staff to ask patients whether they are taking any other medications, including over-the-counter drugs. Be sure to review the patient's chart and review their health history for any known allergies, before giving an answer to the patient. Dentists may authorize staff to approve refills, but such authorization should be documented in the office policy and procedures manual. After your approval of the refill, have a staff member contact the patient to let him or her know that the refill was approved. Document all refills in the patient's chart including the name of the drug, dosage, amount, strength, the date of the refill and the name of the person who authorized the refill. Document the information even if the refill was not approved. Dentists should not prescribe or refill prescriptions over the phone for non-patients.

10.6 Medical Clearance for Dental Treatment Fax Form

There are times when a patient's medical condition necessitates communication between the dentist and the patient's physician prior to a dental treatment. Similarly, a patient may be taking medications that contradict with medications the dentist will be prescribing. In these instances, a Fax Transmission: Medical Clearance for Dental Treatment form can save time and increase communication between the treating practitioners while ensuring patient receives the best care possible.

When requesting a medical clearance for a patient from another practitioner, be sure to include all information including any prescription and over-the-counter medications you anticipate using during the dental treatment. Medical release forms should have an area that allows physicians to comment on the patient's overall health and alert dentists of potential issues. When the patient's health is severely compromised, having a conversation with the treating physician before initiating treatment of any kind is necessary.

10.7 Referrals

Referrals are an essential element to ensure patients with extenuating circumstances receive complete dental care. Base referrals on the unique needs of the patient and the skill level of the specialist. **Dentists should know the specialists to whom they are referring.** This includes how they react to unclear recommendations and how they communicate with the referring dentist after the treatment is completed. When referring a patient to another office for treatment, inform the patient of the reason for the referral and any available alternatives. Encourage discussion about the referral and respond in lay terminology to ease apprehension associated with unfamiliar treatment or providers. This encourages the patients' involvement in treatment decisions.

Any of the following situations provide appropriate rationale for referring for additional treatment:

- Level of training and experience of the dentist
- Extent or complexity of treatment
- Medical complications
- Behavioral concerns
- Patient preference

The dentist should write the referral letter and not delegate the task to a staff member. Mail the original referral letter to the referral dentist and keep a copy in the patient's chart. It is up to

each individual office whether to give the patient a copy of the referral letter.

It is the referring dentist's responsibility to follow up (preferably in writing) with referral practitioners and the patients themselves, regarding the status and progress of each referral. Preprinted forms can be an easy way for practitioners to communicate about a patient's progress. The chart should also reflect the referral process, including:

- Why and to whom was the patient referred?
- Did the patient agree to the referral?
- What is the time frame for the referral?
- Did the patient follow through with the referral?
- When was the treatment completed?
- What was the treatment outcome?
- Were there complications or modifications to the requested treatment? Why?
- Has the patient been scheduled for follow-up treatment?

During subsequent visits, note whether the patient followed through with the referral as well as the progress of that treatment. It may be necessary to maintain a reminder file to follow up with the specialist who has not responded to your office in a timely manner. TDIC developed a Referral letter for evaluation and/or treatment as well as a Referral Reply letter that provides a summary of findings and/or treatment to ensure all treating dentists maintain continuity of care for a patient they are treating.

10.8 Miscellaneous Forms

The following forms can also help you document other aspects of the doctor-patient relationship.

10.8.1 Allergy Warning Labels

These labels can be a tool to help prevent medication errors. The template is suitable for reproduction on a copy machine using an 8½" x 11" sheet of six labels approximately 3" x 4" each (for example Avery® 5164). Bright color labels are best to draw the eye to the information, and the self-stick labels are easy to apply to the chart.

- Place the label **inside** the patient's chart in a standard place where the dentist and staff know to look in order to identify patient's allergies, premedication needs, and physician's name and contact numbers
- Cross out old information with a single line, and replace it with the new information and date the change

10.8.2 Authorization for Agent to Consent to Dental Treatment of a Minor

There are times when parents cannot bring their child to the dental appointment. In these instances, have the parent or guardian with legal custody complete the form in advance. This completed form authorizes another adult to accompany the minor and consent to treatment in the parent's or guardian's absence. *(This form is only allowed for use in Alaska, Arizona, California, New Jersey or Pennsylvania.)*

10.8.3 Caregiver's Authorization Affidavit

Often there are situations where a minor lives with an adult who is not the minor's parent or legal guardian. This person is referred to as an "informal guardian." This is not a legal term but is used when parents let their children live with someone else. When adults complete a Caregiver's Authorization Affidavit, it documents that the minor lives with them and permits them to act as the informal guardian, enabling them to enroll the minor in school and seek medical care. *(This form is only allowed for use in California.)*

10.8.4 Compromised Personal Information Letter

Patient information collected by dentists may include names, addresses, Social Security numbers, credit card numbers, and health and other personal information. If the computer hard drive containing this information is stolen, those patients can be at risk for identity theft. The Federal Trade Commission (FTC) has outlined basic steps business owners should take when faced with information compromise.

The FTC recommends notifying all persons possibly affected by the theft. Alaska, Arizona, California, Hawaii, Illinois, Minnesota, Nevada, New Jersey and Pennsylvania have enacted laws where notification of a security breach is mandatory. Make sure to consult with law enforcement about the timing and content of patient notification to avoid impeding the investigation. Designate a contact person for releasing information. Sending this letter may be the most realistic way to notify patients. Make sure you:

- Describe clearly what you know about the compromise. Include how it happened, information that was taken and what activities you have already taken to remedy the situation, such as notifying law enforcement and credit reporting agencies
- Explain appropriate responses for the type of information taken. For example, people whose Social Security numbers were stolen should contact credit bureaus and ask that a fraud alert be placed on their credit reports
- Provide the contact information of the law enforcement officer working on the case and the case number. Patients can request a copy of the police report to give to creditors who have accepted unauthorized charges. This report is evidence that can help absolve a victim of fraudulent debts

10.8.5 Consent to Dental Screening

This form is for dentists who volunteer their services at screenings. Use of it supplements and summarizes the evaluation and informed consent discussion nicely for the patient. The same documentation requirements apply when volunteering dental services. Be sure to complete and maintain patient records, including copies of any signed forms.

10.8.6 Photograph Authorization

TDIC claims data show that advertising lawsuits do occur and reveal unauthorized use of photos as the most common claim. Because dentists take great pride in their work, especially when they achieve good results, it may be tempting to use that perfect patient's smile in an ad. However, a dentist may be susceptible to an advertising injury claim when the dentist uses a patient's photo without the patient's explicit permission. The patient may file a claim against that dentist for invasion of privacy. Obtain the patient's explicit permission in writing prior to using his or her photo.

10.8.7 Self-sufficient Minor Status

Minors are considered self-sufficient when they are at least 15 years old, living separate from their parents and managing their own financial matters. Use this form to document that fact which will allow them to obtain dental treatment. *(This form is only allowed for use in Arizona and California.)*

10.9 Emergency Kit

One medical emergency kit should be adequate for each dental office. Its contents will depend on the level of training of the dentist and office staff as well as the modalities of anesthesia administered in the office and whether the emergency is related to dental treatment. An emergency kit should be prepared by the dentist and be consistent with the dentist's training in emergency medicine. It should not include drugs or equipment that the dentist is not trained to use. Having equipment and medications that no one is trained to use or that are not regularly tested and updated, is useless and can be a liability. Calling 911 may be the best solution for employees and patients when the emergency does not involve dental treatment. Consider assembling medical emergency kits that address the various types of emergencies that can occur in the practice and including:

- Oxygen
- Blood pressure monitoring equipment
- Antihistamine
- Epinephrine 1:1000 (injectable)
- Aspirin
- Nitroglycerin
- Bronchodilator
- Syringes
- Tourniquets
- CPR pocket mask
- High-volume suction and aspiration tips or tonsillar suction
- A quick source of glucose (orange juice or non-diet cola beverage)

The dentist should regularly check all drugs that are included in the emergency kit (weekly, monthly) to ensure they have not expired. Regularly perform maintenance on any equipment that is included in the kit.

Office emergencies can include staff as well as patients. OSHA requires that an emergency kit for employees be physician-approved.

10.10 Office Emergency Protocol

The most important aspect of treating emergencies is maintaining your composure. Many medical conditions progress to urgent situations quickly and require a dentist's expert recognition and action. Competence in treating an emergency comes from having office protocols, regularly reviewing and updating them, and being in a constant state of preparedness. Train all staff in basic life support and be sure each knows his or her role on the in-office emergency response team. The critical few minutes the dental team has to recognize that a patient is in distress could mean the difference between life and death.

Think about emergency scenarios and how your office will react. Be ready because there will be little or no warning when emergencies happen. Consider these suggestions when developing your office emergency protocol:

1. Be prepared (doctor and staff) with an established plan
2. Regularly improve medical and emergency knowledge
3. Review basic life support and take advanced cardiac life support training
4. Practice resuscitative techniques
5. Learn to recognize when a patient is in distress
6. Keep your composure
7. Call 911
8. Prepare for and initiate CPR, if necessary
9. Assess the patient's condition and prepare for emergency medical personnel and patient transfer
10. Thoroughly document the emergency and how your team reacted
11. Follow up with your patient and the treating physician, and thoroughly document the conversations
12. Make sure licensed personnel keep their required certifications current

10.11 Handling a Medical Emergency

When a medical emergency happens in your office, have the person with the best medical background remain with the patient. The person who calls in the emergency must remain calm and be able to articulate pertinent information to the operator. Preparation, planning and a calm review of information saves critical minutes allowing the operator to quickly assess the medical emergency. It affords the patient the best care possible while providing evidence of a responsible, professional reaction to a medical emergency. Remember, 911 calls are recorded and could be referred to if there is a subsequent investigation into the events surrounding the emergency.

Place the 911 call from the office's phone not from a cellular phone. Emergency operators are able to identify the number and location of the call if it is made from the office's phone. They cannot obtain this information when the call is placed from a cellular phone. The operator will ask for the following information:

- Location where assistance is needed
- Name of the caller and phone number (If you have to use a cellular phone, be sure to keep the phone 'on' the entire time. Do not hang up unless the operator instructs you to do so)
  - Nature of the emergency (e.g., "Patient has lost consciousness in the dental chair.")
- Patient status
  - Seizures, vital signs, etc.
  - Gender, race, age, height, weight
  - Medications/prescriptions given or taken (including local anesthesia if given)
  - Empty vials or containers as evidence of what was given as well as the amount
  - Brief health history (Have the chart handy during the call)
  - Procedure being performed, if any, at the onset of the emergency

Once the emergency team arrives and begins attending to the patient, the caller may document the time the 911 call was placed and the time the EMS arrived and departed. Make sure all team members refer to an "official" clock for consistency and that the time is routinely calibrated to match that time given by the phone company, which will match the time used by 911.

If a call is placed to 911 in error, do not hang up. Most emergency response policies on hang-up calls require a call back to verify whether there is an emergency. If nobody answers the call back, most police departments will dispatch an officer to the location. Explain to the operator that the number was dialed in error, and there is no emergency to report.

Establishing and regularly practicing 911 call protocols is good risk management practice:

- Keep a list of emergency telephone numbers by all phones in the office
- Assign emergency roles to staff and cross training employees so roles are interchangeable and then practicing mock emergencies
- Incorporate 911 calls into emergency response drills
- Follow one "official" calibrated clock for consistency
- Prepare a copy of the patient's chart for the paramedics. (EMS will routinely ask for a copy to give to the ER doctors.)
- Follow up with the patient or the patient's family to inquire about the patient's status
- Document the event factually and as soon as possible while the event is fresh in everyone's mind
- Contact your professional liability carrier after the patient is stabilized
- Meet with your staff to answer their questions or concerns

10.12 Incident Reports

Assessing the situation is the first thing to do when someone gets injured while in the office or on the premises. The appropriate action depends on the incident. If the person has sustained injuries, evaluate them and act accordingly. If the injured requires immediate medical attention, call 911. Do not withhold treatment while you call your liability carrier for advice. Once the injured person is stabilized, complete an incident report.

Incident reports will help you mitigate liability claims. Complete an incident report when patients or visitors are involved in an incident that has caused injury, loss or damage to their personal property. This includes incidents where the likelihood of injury existed but no injury actually occurred. The person completing the incident report should be the individual who witnessed or is most familiar with the incident. The report should include:

- The date, time and location of the incident
- A brief description of the incident including injuries. Factually explain what happened, but do not include a judgment as to the cause of the incident or the extent of any injuries
- Names of witnesses along with their contact information
- All action taken by you and your staff. If emergency medical treatment was necessary, document what treatment was delivered, where and by whom. Also, note if medical treatment was offered and denied by the patient
- The weather conditions at the time of the incident, if applicable
- Any devices such as walker, cane or crutches that the patient was using at the time of the incident
- The signature of the injured person, if possible

File the report in a separate and readily accessible folder, and give a copy to the injured person. Remember that incident reports can be used in court as evidence. How well you and your staff respond and document an incident will determine the likelihood or the extent of future claims from the injured party. Similar to the documentation in your patient charts, proper documentation of an incident can be an excellent defense to a potential lawsuit.