The EDIC Practice Risk Management Program

"By Dentists, For Dentists"®

EDIC believes that risk management should be practiced every day in a dentist's practice to prevent medical malpractice insurance claims. In fact, since 1992, we know that good risk management practices help prevent medical malpractice lawsuits and claims.

While we cannot prevent every medical malpractice insurance claim, we are diligent in our efforts to minimize the number of professional liability claims. This is why we believe in risk management education and practices, not only for the newly graduated dentist, but also for the seasoned dentist.

As a value-added benefit for our EDIC insured's, we provide various risk management materials such as whitepapers, case studies, our bi-annual newsletter *On the Cusp*, as well as our EDIC Clinical e-Bulletin on emerging and cutting-edge risk management topics.

We encourage our dentist members to call our Risk Management team at any time if they have questions, a doubt or a pending issue. Please feel free to call our toll-free number 1-800-898-3342 for immediate concerns. Or, email us with a question or concern at info@edic.com.

Web Links to EDIC Risk Management

EDIC Website
www.edic.com

Archived Webinars
www.edic.com/webinars.html

EDIC RM Events Calendar
www.EDIC.com/events.html

Claims
www.EDIC.com/risk-management.html

Oral Conscious Sedation
www.EDIC.com/Dental-Resource-Center/EDIC-and-Oral-Conscious-S-3.html

Consent Forms
www.EDIC.com/Consent-Forms.html

Archived *On the Cusps* Newsletters
www.EDIC.com/News-And-Events.html

Look for EDIC's Spring and Fall Webinar Series to earn you FREE CEU's!

ADA C·E·R·P® | Continuing Education Recognition Program

EDIC is an ADA-CERP recognized provider, and dentists with a passing grade, may earn two CEU credits per webinar session and be eligible for risk management insurance discounts.

A Dental Society Risk Retention Group
EDIC® Eastern Dentists Insurance Company
Malpractice Insurance By Dentists, For Dentists®

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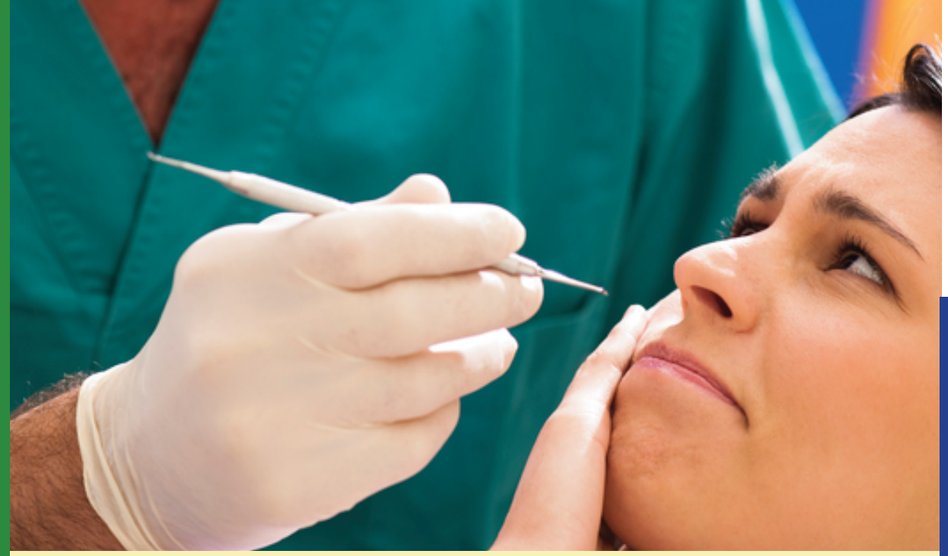

When To Refer A Patient To A Specialist

AN EDIC CASE STUDY

The patient in this matter was a 43-year-old female. She presented to the insured general dentist on an emergency basis on April 6, 2005, complaining of pain and swelling on the right side of her face. The insured informed the patient she would need root canal therapy on tooth #2, which had previously been heavily restored. The patient agreed with the treatment plan, but no written informed consent form was obtained, and no documentation of an informed consent discussion was noted in the patient's chart. The insured began root canal therapy, but was able to identify only two of the three canals. The dentist noted that the canals were "constricted".

The patient returned one week later. The dentist again tried to further negotiate the canals, but still could not locate the disto-buccal root. As he continued to search for the third canal, he noted a perforation on the pulpal floor. The dentist repaired the perforation, completed the obturation of the two canals, and sealed the tooth with a resin sealer. The patient was seen two days later, seemed to be healing fine, and the dentist did a slight occlusal adjustment.

The patient returned about one month later, and the insured began to prepare tooth #2 for a crown, utilizing a post and core build up. A crown was cemented on May 19, 2005, approximately six weeks after the initial emergency visit.

The patient was seen for a hygiene visit on June 9, 2005, with no apparent complaints in relation to tooth # 2.

On November 17, 2005, the patient presented complaining of pain on the upper right for the past four days. The insured adjusted the occlusion and prescribed an antibiotic. The patient returned on December 1, 2005, still in pain. The insured advised the patient they could wait to see if the antibiotic would work, do an apicoectomy, or extract the tooth and place an implant and crown. The patient stated she wanted to obtain a second opinion.

In April 2007, the insured was served a summons and complaint. The patient alleged that the dentist was negligent for not obtaining proper informed consent; that the dentist was negligent for not referring the patient to a specialist when the radiograph showed calcified canals; that the dentist was negligent in completing the root canal therapy without finding and filling the third root; that the dentist was negligent in perforating the

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canal; that the dentist was negligent for not referring the patient out to an endodontist for follow up when the patient was complaining of pain; and that the dentist was negligent for placing the crown on the tooth too soon after the root canal therapy.

The patient was subsequently seen by an endodontist, who confirmed that the disto-buccal root was untreated and that the pulpal floor had been perforated. The endodontist performed a non-surgical retreatment and perforation repair in an attempt to save the tooth. However several months later the patient experienced more pain and discomfort, and the tooth needed to be extracted.

EDIC had the case reviewed by an expert endodontist. His opinion was in line with the plaintiff's expert, in that he agreed that when the general dentist could not locate or access the disto-buccal root, he should have referred the patient to a specialist. This patient's argument would be strengthened at trial by the subsequent endodontist's testimony that he was able to locate and treat the third canal using a micro-scope and fiber optic light. While the expert would opine that causing a perforation was not necessarily below the standard of care, the fact that the dentist placed a crown on the tooth without first advising the patient of the perfora-tion, or referring the patient to a specialist to treat the perforation, was below the standard of care. Also, the lack of documentation of an informed consent discussion would also be below the standard of care.

The patient alleged $16,000 in dental expenses due to the retreatment costs, extraction of the tooth, and the need for a four-unit bridge. The patient's demand to settle the case previous to trial was $90,000. Since a likely result at trial would be a verdict against our dentist, and with the dentist's permission, EDIC agreed to go to non-binding mediation before a superior court judge. We argued that a four-unit bridge was not necessary solely because of the negligence of the dentist, and that a single implant and crown was the treatment needed to replace the tooth lost due to the negligent endodontic therapy. EDIC offered $15,000 to settle the case. After several rounds of negotiations, EDIC was able to settle the case in the amount of $27,500.

CASE STUDY
Risk Management Comments

While general dentists are trained to perform all types of dental procedures, care should still be taken in deciding which cases to do yourself and which cases should be referred to specialists. Pre-operative radiographs in this case indicated a degree of calcification that should have been a concern to a general dentist. Once the tooth was open, and the general dentist could not locate the third canal, it became incumbent of him to advise the patient of the complication and refer the patient to an endodontist. While even specialists can have perforations while searching for canals, their specialized training and greater experience in dealing with these types of situations was called for in this case. Unfortunately, whenever a general dentist performs work that is also done by a specialist, the general dentist is opening himself up to second guessing if a complication occurs. A dentist in a malpractice case is being judged by a jury of non-dentists who have the benefit of hindsight. In this case, a jury would hear that a specialist was able to locate, access, and obturate the third canal using a microscope and fiber optics. To a layperson, this case could have looked like the general dentist did not have the correct experience to treat this case successfully.

FAQs

How long should I retain my records?

As long as possible! In many states, you are required to keep records for a certain number of years after you last saw a patient. Apart from this, you may wish to consider that most states have a "discovery rule" which, under certain circumstances, allows a patient to bring a malpractice action beyond the ordinary statute of limitations. Essentially, the discovery rule provides that the clock does not begin to run on the statute of limitations until the patient knows or should have know that he or she may have been injured by the dentist's treatment. (The operation of this rule varies from state to state.) In addition, most states treat children differently than adults. For example, in some states, an action for malpractice brought by a patient who was a minor at the time of treatment can be filed some amount of time after the child reaches age 18, regardless of how many years have gone by since the time of the treatment in question.

As a practical matter, EDIC recommends you maintain your records for 10 years on an adult patient after his or her last visit, and 10 years after a minor patient reaches the age of 21. From a risk management perspective, however, it is important to keep in mind that your office records will usually be your most impor-tant ally in the event that you are sued by a patient. Why throw it away?

Under what circumstances is it all right to change a note in a patient's record?

In short, under no circumstance should you ever change a note that appears in a patient's chart. Even if you are only trying to correct an honest error, making an alteration to a record is an enormous mistake. Among other problems that this may bring about, if the patient ultimately brings a claim or lawsuit, the damage to your credibility by making an alteration in the record may be insurmountable even if the alteration was not material to the allegations in the case. In essence, you are casting doubt upon the accuracy of all of your entries in the record.

If you realize shortly after the fact that you forgot to note some-thing in the record, you should make a separate dated entry in the chart as an addendum to the previous note, explaining the reason for the correction. If you made an error in the process of writing a note in the first instance, you should cross off the error with a single line, initial it, and proceed with writing the correct information. Do not white out or obliterate the mistaken entry.

Are there any requirements or laws that pertain to computer records?

A number of states have laws that concern the confidentiality of patient's medical records, including those records kept on a computer, but these laws vary considerably by jurisdiction. Some states have laws that provide for criminal or civil penalties for unauthorized access to such data.

As a practical matter, patient confidentiality should be a paramount concern with regard to all patient records. You should limit access to computerized records as you would with paper records, keeping access to a "need to know" basis. With regard to computerized records, you may wish to consider using a password system for access to data, and requiring staff to log off a computer containing patient data when it is not in use. In addition, in order to prevent loss of patient records kept on computer, you should routinely back up this data to diskette, re-movable hard drive, or tape, and secure the storage media as you would a chart. Lastly, the same documentation rules as to what should be contained in a patient's treatment record apply to computer records as well as for paper records! Every note needs to be dated, signed, and/or initialed by its author, and your system should be able to provide an audit trail for anyone who accessed a record.