Frequently Asked Questions

A Handbook for Practicing Dentists

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A HANDBOOK FOR PRACTICING DENTISTS

Frequently Asked Questions

During the course of a year, the attorneys at Mercado May-Skinner, counsel to MLMIC, handle approximately 5,000 questions, posed by our policyholders, concerning professional liability, risk management, and health care law. Below are some of the questions most frequently asked by these professionals, as well as responses from our attorneys.

Informed Consent

Q. What is informed consent and who is responsible for procuring it?

A. Informed consent is the legal doctrine affirming a patient's right to determine and control his/her own dental treatment. In essence, it is the discussion that takes place between the dentist who is rendering care and the patient. The informed consent discussion may not be delegated to any staff member. It is the responsibility of the treating dentist to provide information and explanations that will assist patients in their decision-making process. In other words, the patient must be afforded the opportunity to evaluate adequate information before making a decision. The treating dentist must advise the patient of the usual risks, benefits, and alternatives of the proposed treatment or procedure, including the option of no treatment, the risks of the alternatives and, specifically, a few of the most severe and most frequent risks. Failure to procure an adequate informed consent from the patient can lead to both malpractice litigation and charges of professional misconduct. This also may be an indication of inadequate dentist-patient communication.

The patient's consent must be voluntary, competent, and informed. The patient must have capacity, i.e. the ability to understand the nature and consequences of the treatment. Although a signed consent form is helpful in defense, a patient's signature is not conclusive evidence of an informed consent discussion. The signed consent document merely confirms that such a discussion took place. A witness to the consent document merely confirms that the patient read and understood the document, appeared to have capacity for the purpose of giving consent, and signed the form.

Q. For what procedures should an informed consent be obtained?

A. Although it is always good practice and important for a dentist to explain to a patient the treatment he/she is rendering, obtaining an informed consent in New York State is only statutorily necessary for a non-emergency treatment, procedure, or surgery, or if a diagnostic procedure involves an invasion or disruption of the integrity of the body. A dentist is not required to obtain an informed consent if the procedure is an emergency and necessary treatment would be delayed by trying to obtain consent. If a dentist is in doubt as to whether a diagnostic procedure requires informed consent, it is a good idea to err on the side of obtaining an informed consent.

Q. What is the legal definition of a minor, and can minors give informed consent?

A. Generally, the New York statute states that persons under the age of 18 are minors. When the patient is a minor, consent for his/her dental treatment must generally be obtained from the parent or legal guardian. There are several exceptions to this:

1. If there is an emergency and the patient in need of dental attention would have an increased risk to life or health due to an attempt to secure consent which would delay treatment, parental consent is not necessary.
2. If a person is married or has borne a child, he/she can give consent for him/her self as well as for the child.
3. Any dental provider who acts in good faith, based upon the representation by a person that he/she is eligible to consent, shall be deemed to have received effective consent.

Q. In addition to having the consent formed signed, should I write a note in the chart after I have an informed consent discussion with a patient?

A. Absolutely yes! The note should be dated and should state the following: "The risks, benefits, and alternatives, including no treatment and risks of the alternatives, were discussed with the patient. The risks discussed included, but were not limited to . . ." We recommend that you list a few of the most severe and a few of the most frequent risks or complications. "The patient understood, had all his/her questions answered, and consented to the treatment or procedure." This type of documentation will confirm and be evidence that a discussion with the patient actually took place.

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The Dentist/Patient Relationship

Q. When does the dentist/patient relationship officially begin?

A. A dentist/patient relationship may be deemed to begin when an appointment has been made or specific advice is delivered before the patient is seen, or there is some other mechanism/interaction which creates a patient's reasonable expectation of care.

Q. How do I discharge a patient from care?

A. To discharge a patient from care, you must notify the patient in writing. You have the option of giving the patient a defined reason. If the patient has been non-compliant with treatment or appointments, or if the dentist/patient relationship has been disturbed by litigation, non-payment, or threats and abusive behavior by the patient or a family member, you may state a general reason for discharge, i.e. there has been a disruption in the dentist/patient relationship. If the patient is being discharged for non-compliance, you may state "you have been non-compliant with my recommendations for care and treatment." If you have received a request for records from an attorney, have been sued by the patient, or are merely uncomfortable in continuing to treat the patient, a reason does not have to be stated or you may use the disruption in the dentist/patient relationship as the reason. Give the patient a reasonable amount of time to seek a new dentist, considering the patient's course of treatment and the availability of alternative care without interruption. Often 30 days from the date of the letter will be sufficient notice, during which time you agree to be available for emergencies only. The letter should provide resources which will assist the patient to obtain a new dentist, such as the names and phone numbers of the district dental society. We do not recommend that you list the names of specific dentists.

Mercado May-Skinner has sample form letters which can be modified for your use in discharging patients from your care. Remember, patients with urgent or serious dental conditions should not be discharged without immediate access to alternative care so there is no gap in treatment.

Q. Must I continue to see a patient whose insurance I do not accept merely because I have seen the patient once in the Emergency Department as the on-call dentist?

A. The answer to this depends both on the patient's condition and the requirements set forth in the hospital's by-laws. If the patient's immediate problem has been resolved, unless the by-laws require you to provide a follow up visit, you are not obligated to see that patient in your office. However, if the patient is in need of further care, it is recommended that you see the patient until he/she can be safely discharged by letter. If the patient continues to have an urgent or serious dental problem which requires continued care, you must be sure he/she has alternative and uninterrupted treatment prior to discharging him/her. If you are unable to assure that the patient has suitable alternative care, then you must complete the course of treatment for that particular dental problem before discharging the patient from care.

The Dental Record

Q. Why is the appearance of the dental record so important in a malpractice dispute?

A. The dental record is the actual record of treatment provided to the patient, and its appearance is extremely important to your defense. It specifically describes the complete history, evaluation, diagnosis, treatment, and care of a patient. Therefore, it is of maximum value in terms of its accuracy and credibility, especially when used in legal proceedings. Remember, if you didn't document it, you didn't do it. The dental record should be precise, neat, complete, and legible, and it should be written so that any other dentist who has a reason to pick up the record knows exactly what has been done for the patient, when it was done, and why.

Q. How do I appropriately document the paper

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dental record?

A. Entries in the dental record must be contemporaneous with treatment and should be written legibly in ink or transcribed. Be sure to use a consistent style for your entries. If your records are ever challenged in court, consistency will impart credibility to your records and will demonstrate your professionalism in maintaining them. You must accurately record both positive and negative findings, and enter the time and date of all entries, signing each one. All entries should follow sequentially. Do not leave any spaces between them.

If you still have paper records, or have made an incorrect entry, you may strike it out by drawing a single line through the entry, write the word error, and initial and contemporaneously date the correction. Do not, under any circumstances, use white-out or erase an entry. Both techniques suggest you have something to hide. Each correction should be made as it happens with an explanation for the correction to preserve the record's integrity. Be sure to record missed appointments and any failure by the patient to accept or follow instructions. This type of information will be helpful in defending a future court action. If you have an electronic dental record, go to the next entry line and make a note dated that day and refer in this note by date to the erroneous entry and make the correction that you wished to have replacing the original entry. Since attorneys are very sophisticated and can use metadata to show that you have changed or eliminated an electronic note, this is the way to properly amend such an incorrect electronic note and yet not be deemed to have altered the record.

Always be sure to record your observations in an objective and dispassionate manner. The dental record is not the place to settle disputes, assign blame, or write derogatory remarks. Such superfluous entries seem to communicate a lack of professionalism and may raise doubts about the record's overall credibility.

If you are using an electronic dental record, many of the same principles of documentation apply. Use of templates is more frequent, all entries may be time-stamped, and signatures are electronic.

Q: Should the treatment plan be in writing?

A: Yes, it should be in writing and a copy given to the patient after it is discussed and all of the patient's questions have been answered. A copy should also be scanned into the patient's electronic dental record.

Q. What other important items must be documented?

A. At every visit, document that you checked the patient's mouth for oral cancer and that there were no signs or symptoms of oral cancer. This is particularly true with the passage of Lavern's Law which has extended the statute of limitation to sue for malpractice for failure to diagnose cancer to 7 years. Further, it is critical for you to also document that you checked for periodontal disease and your findings.

Q. How long must I retain dental records?

A. All patient records must be retained for at least six years, with the exception of records for minor patients, which must be maintained for at least six years and for one year after the minor patient reaches the age of 21, whichever is longer. It is, however, recommended that dental records be retained for 10 years from the date of submission of the last claim for payment. The longer time period is recommended in view of state and federal statutes and regulations pertaining to malpractice and offenses, such as insurance fraud.

Q. What documents do I need to release dental records to someone other than a patient?

A. If you are a HIPAA covered entity, you may release patient information to third parties for purposes of treatment, payment or health care operations without a written patient authorization. Under New York law,

however, patient consent is required to release information even for those purposes. You may obtain the patient's general consent to release information for treatment, payment and health care operations as part of your normal registration process.

In order to disclose patient information to third parties for other purposes, you must have a written HIPAA compliant authorization form signed by the patient or by an individual legally authorized to release health care information. The authorization must be dated and must designate the name of the party who is releasing the record and to whom the records are to be released. A release that states "to bearer" is not acceptable. The authorization or release form must state the reason for the authorization ("at my request" is sufficient) and must specify the dental information to be released (e.g., "all my records"). Each authorization form must contain an expiration date or event. In addition, HIPAA requires that certain statements be included in each authorization form. Thus, you must confirm that the authorization form is HIPAA compliant and that it contains all of the required elements.

You should compare the patient's signature on the release form to his/her signature in your records. If there appears to be a discrepancy, you have the right to request that the signature on the authorization be notarized. If the patient is not the person who signed the authorization, then a copy of a legal document permitting the designee to sign the authorization must be also obtained. These may include, for example, guardianship papers, a copy of a power of attorney, healthcare proxy documents, a certified copy of a death certificate and the signature of the next of kin or court papers appointing the person as the administrator or executor of a deceased patient's estate. In unusual circumstances, such as those concerning custody or divorce, patient incompetence, or death, you should contact your attorney to discuss how to proceed.

Q. What type of information requires specific or special authorizations to release the dental record?

A. Any dental records containing HIV-related information require a specific and special authorization, or you can redact (cover up) that information from the record when making a paper copy.

Q. Should I write an addendum to office dental records many days, weeks, or months after patient has been injured? Sometimes I have forgotten to document certain important information prior to a patient's injury.

A. The general rule is that an addendum should be timely-generally within 42-72 hours after the patient has been seen- and should contain information relevant and necessary to the patient's present and/or future care and treatment. Never write an addendum weeks or months after a patient has died or after an attorney or government agency has requested the records. Any addendum that does not meet these criteria may be considered self-serving or even deemed an alteration of the record. If it is necessary to write an addendum to a patient's record, indicate the date of and reason for the supplementary information. Remember that accurate recordkeeping is vital, not only in the course of providing good patient care, but also because carefully maintained records offer a credible and accurate defense in court. Any record that appears to have been altered for the purpose of covering up an error, or to improve the record for litigation, completely lacks credibility.

HIV Confidentiality

Q. If a patient advises me that he/she has risk factors and/or has been tested for HIV, may I include that in my progress notes or the patient history?

A. Yes, if the patient relays this information as part of his/her history, or it is medically relevant to his/her present care and treatment, it may and, in fact, should be documented. However, that record then becomes a protected record under Article 27F of the Public Health Law, which governs the confidentiality of HIV-related information.

Q. May I release records containing HIV information when I receive a subpoena, particularly if it is a judicial subpoena?

A. The HIV law clearly requires the release of HIV information only with a special HIV consent form or upon receipt of a court order, issued only after a hearing, at which time the patient has had an opportunity to contest the release. A bare subpoena is NOT sufficient.

Q. Does even a negative HIV test result require specific protection of the chart?

A. Yes, the fact that an HIV test has been done, regardless of the result, raises the possibility that the patient has risk factors for HIV. The patient may sustain harm if this information is released inappropriately.

Q. If a patient tells me prior to dental surgery that he/she is HIV positive, may I inform the staff who will be involved in the patient's care?

A. You may NOT tell the staff if the sole purpose of informing them is infection control, such as having them take extra precautions when caring for the patient. You may tell the licensed staff who are assisting in the dental procedure, only if the disclosure is necessary for the patient's care and treatment.

The National Practitioner Data Bank

Q. I am a co-defendant in a malpractice lawsuit. If my insurer pays money to satisfy a settlement or judgment on behalf of my co-defendants, but does not make a payment on my behalf, will I still be reported to the Data Bank?

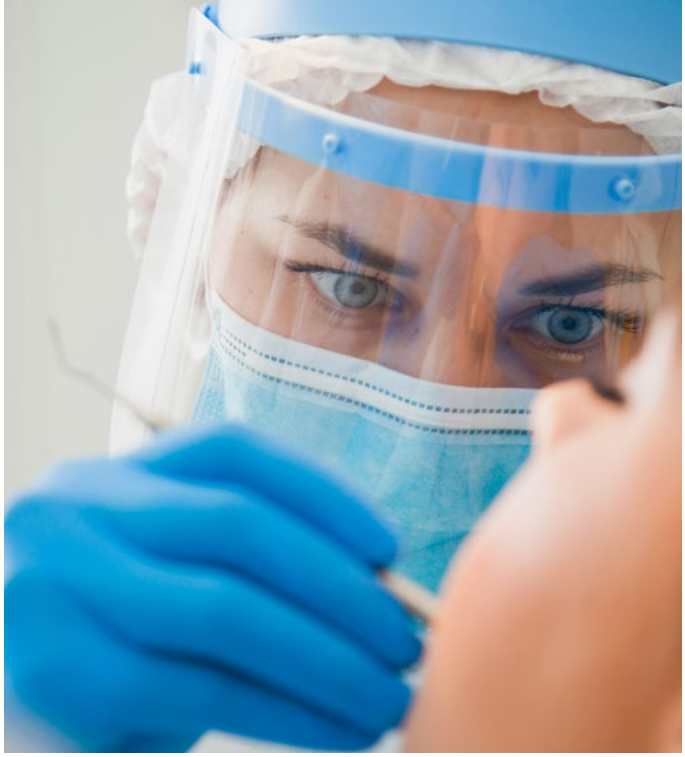
A. No, the National Practitioner Data Bank only requires your insurer to report indemnity payments made on your behalf as a result of a written claim.

Q. Must I permit insurers and hospitals to query the National Practitioner Data Bank?

A. Group dental practices qualifying as entities under the Data Bank plan because of their professional and formal peer review activity may query the Data Bank. Hospitals must query the Data Bank when a dentist applies for a position on the dental staff or applies for a change in clinical privileges. Hospitals must also query the Data Bank when re-credentialing members of the dental staff. The initial inquiry must be done at the time the dentist is first credentialed and every two years thereafter. An insurance carrier cannot request information from the Data Bank.

Q. Will I be notified by the Data Bank if an inquiry about me is made?

A. Practitioners can receive copies of their complete file at any time, free of charge, by submitting a Request for Information Form to the Data Bank. Health care practitioners are not automatically notified when a report is released on them in response to an inquiry, but may periodically obtain this information by requesting a copy of their Data Bank file. Practitioners are only notified when they are the subject of a report received by the Data Bank.



Q. Is there a minimum threshold of loss payment that does not require a report by my carrier for a settlement made in my behalf?

A. No. All payments made on behalf of a practitioner are reportable to the Data Bank.

Diagnostic Test Follow-Up

One of the most frequent causes of dental malpractice litigation is the failure to diagnose several types of dental diseases, including periodontal disease, and oral cancer. To avoid malpractice litigation, it is essential that you implement a procedure in your office to monitor the performance of requisite laboratory tests, confirm that patient appointments with specialists are kept, and record that patient test results have been received and reviewed by you and if necessary communicated to the patient.. Unless such a procedure is implemented, you risk liability because the patient did not receive appropriate and necessary notification and follow-up care and treatment.

Q. What is my responsibility or liability if a patient fails to have a laboratory or other test performed or to keep an appointment with a specialist?

A. There is a duty imposed upon the attending dentist to follow up all tests and consultations he/she has ordered. The failure to do so could lead to a delay in diagnosis or misdiagnosis of a serious disease. The dentist should follow-up first by telephoning the patient or the specialist's office, and then by writing a letter to the patient to remind the patient of the importance of the referral or test and the consequences of non-compliance. These efforts should be documented in the record. If the patient continues to fail to comply with your recommendations for treatment or

fails to undergo requested evaluation by a specialist or by you, you should consider discharging the patient from your practice for noncompliance with your recommendations for care and treatment.

Handling Requests from Attorneys

Q. If a patient signs an authorization solely for release of his/her records, am I at liberty to speak to his/her attorney or to the defense counsel?

A. One area of concern for dentists and their attorneys involves requests from patients' attorneys for records, especially when the reason for the request is not made clear. On occasion you may receive a call from an attorney requesting an appointment to discuss your care of a patient, or to have you interpret your notes in the patient's dental record, which the attorney already has in his/her possession. Even if the attorney assures you that you will not be sued, or that your conversation is off the record, exercise caution and immediately contact your malpractice carrier or their counsel before agreeing to speak with him/her. Frequently, these statements are simply not true. Further, it should be noted that an authorization to release records requires only that you release the patient's records. It does not permit discussion with any attorney. If an attorney wishes to question you about a patient's care, the appropriate place to do so is at an Examination Before Trial (EBT) or deposition, where you may have defense counsel present for your protection. If you have been retained to be an expert witness for a plaintiff's attorney, you should request a specific and HIPAA compliant release from the patient, which will permit you to discuss all aspects of his/her care, treatment, diagnosis, and prognosis with that attorney. If, however, a case against a colleague is going to trial, you may receive a subpoena to be a witness. However, if you have cared for the patient as well as the defendant dentist, you may receive an "Arons " authorization which is from defense counsel. This form requests that you speak with defense counsel before trial. This only occurs when the case has already had a trial note of issue filed, which means the case is ready for trial. Simultaneously, you may also receive a note or call from Plaintiff's counsel requesting either that you do not comply with the request of the defense counsel or permit Plaintiff to attend any meeting or call. It is up to you to make that decision. There is no risk to you to speak to defense counsel in that situation.

Q. If a patient's attorney asks me to provide a narrative summary of my care or sends me written questions for my response, must I agree to do so?

A. No. You are not obligated to respond and we recommend you not do so. The best way to handle such a request is to ask the attorney to obtain a properly signed and dated patient authorization allowing the attorney to obtain access to the patient's dental records. You should then advise the attorney that your records speak for themselves. In addition, you are not obligated to be an expert witness for a patient you have not treated.

Other FAQS

Q: Can I delegate duties to any member of my staff whom I have trained to perform them?

A: No. It is professional misconduct and actionable by the Office of Professional Discipline (OPD) to delegate to a licensed person those duties not within the scope of practice of his/her license. Unlicensed personnel cannot perform tasks which are limited to, and within the scope of practice of, licensed individuals.

Q: How do I respond to a request for records or an interview by representatives of the OPD?

A: We recommend that you speak with Mercado May-Skinner regarding the request and then contact MLMIC to open a defense only file. You can obtain from either source the names of counsel to prepare you and accompany you to any interview that OPD requests. When receiving a telephone call or letter from OPD requesting an interview with you, we recommend that you have a member of your staff return the call and advise OPD that your attorney will call to schedule the interview. We do not recommend you speak to OPD without the preparation by and attendance of counsel.

Q. If a dental hygienist or dental assistant employed by me injures a patient, can I be held liable for his/her acts?

A. There is a duty imposed upon you by law to provide supervision to your employees. You may also be found vicariously liable for the acts of an individual because of your employee/employer and/or supervisory relationship.

**The information contained herein is provided to educate the reader. It is intended for general information and risk management purposes only. It is not, nor is it intended to be, legal advice.*

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