

# “Prevention vs. Prosecution: Patient Care Issues in Dentistry”

A Continuing Education Course for Dental Professionals

Presented by

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## Course Objectives

Upon completion of this course, the attendee should:

- Understand the foundations of tort law and how it applies to the profession of dentistry.
- Identify situations in the dental office that trigger liability for dental hygienists and dentists.
- Chart thoroughly and defensively to protect against future liability.
- Avoid costly charting errors.
- Make an informed decision about purchasing professional liability insurance.
- Understand the role that patient communication plays in liability prevention.
- Implement informed consent protocol in treatment planning.

### Standard of Care

What is the standard of care? Here's what most people think:

- *What the normal, average clinician does.*
- *What the clinician was taught in dental/dental hygiene school.*
- *What is taught in dental schools now.*
- *The best he or she can do under the circumstances.*
- *What the majority of clinicians are doing in their practices.*
- *What the specialist would do under the same circumstances.*

"[A dentist is] under a duty to use that degree of care and skill which is expected of a reasonably competent [dentist] acting in the same or similar circumstances" (Blair v. Eblen).

State Boards of Dentistry are mandated to investigate claims made by the public regarding care issues involving the standards of care of dentistry.

The standard of care actually is found in the definition of \_\_\_\_\_, which is said to have four elements, all of which must be met to allow negligence to be found in a malpractice lawsuit. Those four elements are as follows:

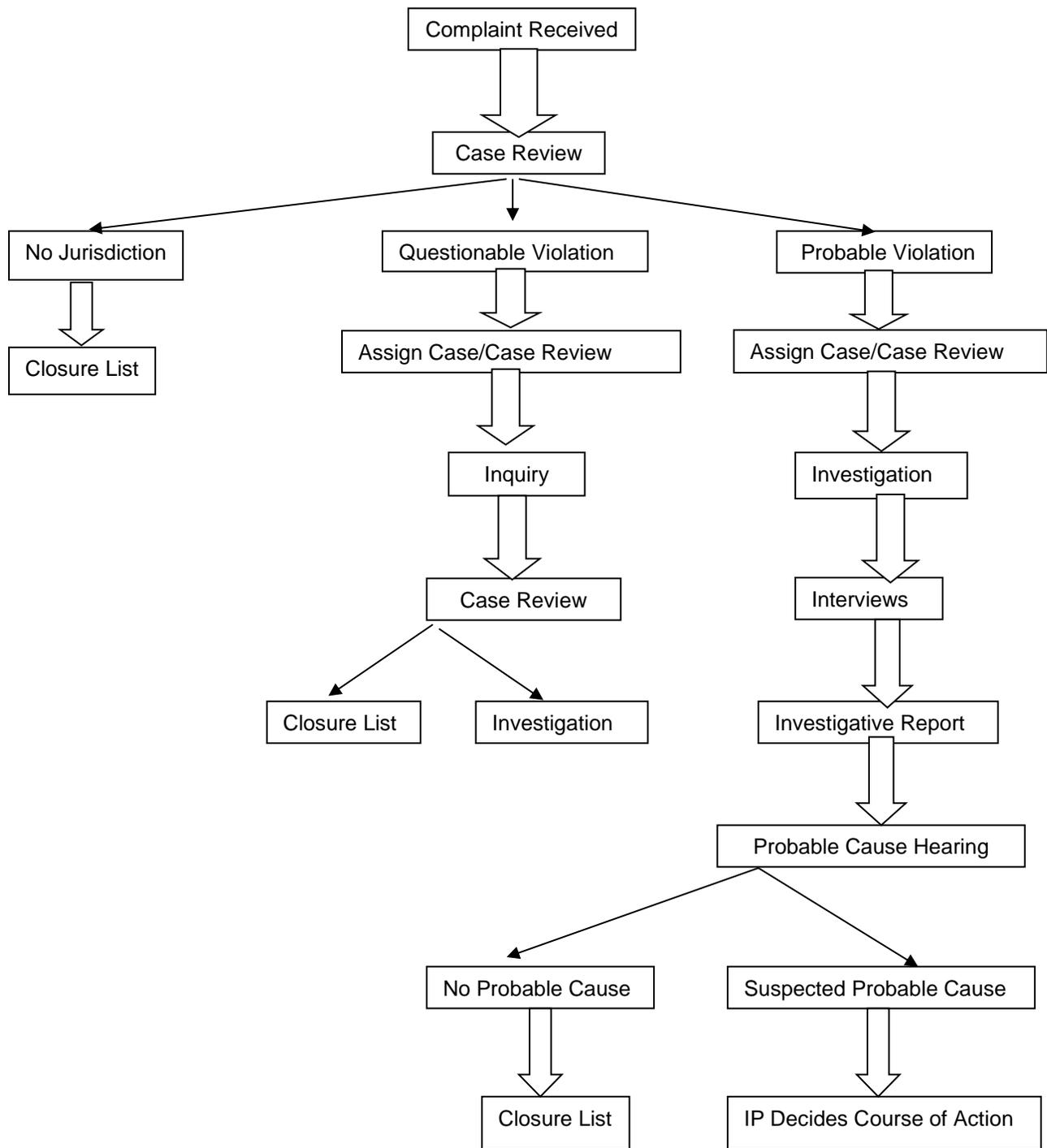
## The four elements of malpractice

- a. \_\_\_\_\_ - the clinician had an obligation to provide competent dental care
- b. \_\_\_\_\_ - the clinician did not provide competent dental care
- c. \_\_\_\_\_ - the patient was injured while undergoing dental procedures
- d. \_\_\_\_\_ - the patient's injury was a result of the clinician's breach of duty

## Legal terminology

- a. \_\_\_\_\_ - a wrongful injury to a person or his or her property
- b. \_\_\_\_\_ - the person inflicting the harm
- c. \_\_\_\_\_ - actions designed to injure another person or that person's property.
- d. \_\_\_\_\_ - a failure to exercise reasonable care to avoid injuring others
- e. \_\_\_\_\_ - (or *Absolute Liability*), is the tortfeasor's responsibility for injuring another regardless of intent, negligence, or fault.

# Processing a Complaint



## The top ten causes of alleged dental negligence for doctors:

1. Complications due to \_\_\_\_\_ – severed lingual nerve, severed inferior alveolar nerve, sinus perforation, fractured mandible, TMJ injuries, and ext. of wrong teeth.
2. Complications due to \_\_\_\_\_ procedures – instruments broken in canals, nerve damage, sinus perforation, other perforations, air embolisms
3. Complications due to \_\_\_\_\_ procedures – postoperative infections, unrestorable implants, implants placed in nerves, implant loss, fractured jaws
4. Substandard \_\_\_\_\_ / \_\_\_\_\_ treatment (open margins, overhanging restorations, poor occlusion – all multiple units or “full mouth reconstructions”)
5. \_\_\_\_\_ – failure to diagnose or treat in a timely fashion, majority had no routine x-rays or probings)
6. \_\_\_\_\_ – root resorption, TMJ injury
7. Dental \_\_\_\_\_ complications
8. Dental \_\_\_\_\_ – brain abscesses, septic arthritis
9. Dental \_\_\_\_\_ – lingual nerve, inferior alveolar nerve
10. Adverse \_\_\_\_\_

## The top ten areas of potential liability for dental hygienists

1. Failure to update \_\_\_\_\_
2. Failure to detect \_\_\_\_\_
  - a. errors in clinical judgment - improper reliance on a diagnostic study, such as relying solely on a negative pathology report despite the presence of a persistent oral lesion; or failure to perform the indicated diagnostic test due to inadequate suspicion of malignancy because the patient is not in a high-risk group.
  - b. failure to follow-up - making sure that the next indicated clinical step is proceeding properly. Follow up failures often result from lack of a reliable tracking system to insure that the patient kept the appointment with the specialist or underwent the diagnostic test that was ordered.
  - c. failure to screen patients appropriately - infrequent examination of patients in a high-risk group and failure to recommend routine screening examinations on a patient in a risk group
  - d. evaluation delays - involves repeated patient visits with continuing or progressive clinical findings, coupled with the practitioner’s failure to perform the indicated diagnostic tests on the patient or refer the patient for proper testing; or failure to request a consult

or referral when a definitive cause for clinical findings cannot be determined. Failure to find a definitive cause for an abnormal clinical finding should always trigger consultation or referral in a timely fashion

3. Failure to detect \_\_\_\_\_
4. \_\_\_\_\_ to a patient
5. Failure to record thorough \_\_\_\_\_ in patient chart
6. Not protecting patient \_\_\_\_\_ /divulging confidential patient information
7. Failure to ask if patient has \_\_\_\_\_
8. Failure to inform about treatment \_\_\_\_\_ and consequences of non-treatment
9. Practicing outside the legal \_\_\_\_\_ of practice
10. Failure to practice to the established \_\_\_\_\_

**“Respondeat superior”** - (Latin for “Let the master answer”) states that the doctor is legally responsible for the errors and omissions of staff members committed during the scope and course of the employment, subject to the employer control, and for the benefit of employer's business.

### **The four reasons dental hygienists should carry liability insurance:**

- a. to protect the dental hygienist's personal and professional assets
- b. the employer's policy represents the dental hygienist only if the dentist is named in the lawsuit
- c. to cover attorney and court costs in case employer's limits are exceeded
- d. to provide for independent legal representation if needed

### **Types of insurance**

- a. \_\_\_\_\_ - protects the professional against claims occurring during the policy period, regardless of when the claim is presented to the insurance company.
- b. \_\_\_\_\_ - covers the dental hygienist against malpractice allegations that arise from dental treatments rendered and reported while the policy is in force. If a claim is brought after the policy has terminated, there is no protection. Extended reporting endorsement or “tail coverage” may be purchased to provide coverage after a claims made policy has been terminated. (<http://www.proliability.com> for malpractice quote)

## Elements of good documentation

1. Make all entries factual.
2. It is recommended that the date and time be recorded.
3. Make sure all handwritten entries are legible.
4. Use standardized abbreviations.
5. When using electronic records, do not skimp on chart notes.
6. Make all entries thorough and complete.

## What NOT to Include in Patient Records

- Do not use correction fluid to correct errors.
- Do not skip lines between entries or write in margins.
- Do not write disparaging or subjective comments or abbreviations about the patient, such as “patient is a jerk,” “patient is nuts,” or “PITA.”
- Do not write disparaging comments about previous providers.
- Do not record the patient’s daily fees in the progress notes. Fee amounts are not considered part of a clinical treatment record.
- Do not use words that are ambiguous or vague. “Periodontal diagnosis: poor” does not adequately describe the clinical findings or the true diagnoses
- Do not record information that requires follow-up action on your part if you are not going to take that action. For example, writing “Patient to be seen in 3 days for re-evaluation” places the onus for evaluating the patient’s subsequent status on the clinician.
- Do not use language that suggests carelessness or negligence. Example – “I hadn’t noticed the ulceration at any of the previous appointments.”
- Do not write inflammatory chart notes disparaging other coworkers. “Former hygienists should have dispensed Peridex” or “Calculus remaining at 19D from previous appointment.”
- Do not erase previously charted restorations to show them completed. This is considered record adulteration.
- Do not record telephone conversations with attorneys, risk managers, claims specialists, or insurance agents.
- It is recommended that patient financial information be included in the progress notes only when the financial issue directly relates to the delivery of patient care or a patient’s treatment decision. An example of a recommended financial reference would be when a patient declines your recommended treatment or opts for a less expensive alternative due to financial reasons.

## Determining How Much to Write – the \_\_\_\_\_

*If you were to forget everything you ever knew about each and every one of your patients, but you remembered everything you know about how to practice dentistry/dental hygiene, you would be able to read any one of your patient charts and quickly be able to:*

- *know what treatment the patient has had and why, and*
- *perform whatever treatment is next for that individual and know why it is necessary.*

Two criteria should dictate how much to write:

(1) Write sufficient information that would allow you or any other clinician to determine exactly what treatment was performed at each appointment, why that treatment was necessary, and what treatment is next – based solely on your documentation.

(2) Meet all the record keeping requirements of your state board.

### Ten commandants of charting

1. Never, ever \_\_\_\_\_ charts. “The single most common cause of punitive damages in a dental malpractice suit is altering the chart.” Never use correction fluid to correct an entry, but rather mark out the incorrect entry with a single line (so that it can still be read) and initial it. Also, do not go back and add to entries already made to make them appear contemporaneous with the events in question. Juries may perceive such added entries to be fraudulent and deceptive. Additionally, do not mark in margins or write below the last line. Doing so can cause juries to wonder why the text was not formatted within the lines.
2. Use \_\_\_\_\_ to chart patient compliments. This is especially important when making follow-up telephone calls after a difficult or invasive procedure. Example:

Date	Treatment Rendered	Fee
6/10/2010	Gum ck. Pat. Reports "my gums feel so much better now." Tissue tone and texture much improved. (DGlasscoe)	

3. Chart patient \_\_\_\_\_. **This is extremely important for hygienists.** Sometimes we refer patients to specialists, but the patient refuses to go. Example:

6/10/2010	Px, Ex, 4 BWs, PP. Suggested that patient needs to see a periodontist, as his perio condition appears to be worsening. Pat. refused referral and signed refusal of tx form. (DGlasscoe)	
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In addition, we need to chart our patients' refusal to follow recommendations. “Periodontal problems are a recurring area of patient neglect. Often good dental procedures are compromised by (1) poor oral hygiene, (2) continued smoking, (3) failure to regulate diabetes, or (4) failure to follow specific instructions. Most practitioners will chart the first few instances of neglect, but then tire of the endless repetition.” A quick referral to previous charting is an efficient alternative – ‘pt. again warned as per (date of previous chart entry)’.

4. Spend an extra five minutes charting bad or \_\_\_\_\_ results. Don't rush through your charting. If time is a problem, review the chart at the end of the day when you have no distractions. This gives you time to gather your thoughts and record certain appointments thoroughly and accurately, especially on those 'unusual' patients.
5. Make chart entries \_\_\_\_\_ with the appointment book. With most dental software and computer scheduling, the patient's name must be on the schedule in order to make a chart entry. However, with manual appointment books, entries can be erased and changed. If the treatment dates in the chart do not match the appointment book entries, doubt may be cast on the reliability of the doctor's records. If the patient is being seen as an emergency patient, that should be recorded in the chart. In addition, ALL cancellations should be written in the patient chart.

Date	Treatment Rendered	Fee
6/10/2010	Pt. Telephoned to cancel 6/11/06 appointment (DGlasscoe)	

Date	Treatment Rendered	Fee
6/10/2010	Tele. Pt. to confirm 6/11/06 appt. Pt. cancelled. Said she would call to reschedule later. (DGlasscoe)	

Date	Treatment Rendered	Fee
6/10/2010	Pt. called to cancel 6/15/06 appt. Told her that it was extremely important to finish perio tx to prevent reinfection of previously tx areas. (DGlasscoe)	

6. Use dental \_\_\_\_\_ personnel for difficult crown and bridge.
7. Place follow-up \_\_\_\_\_ for difficult or invasive procedures. My rule of thumb has always been to call any patient that required anesthesia for their visit that day. If the patient was seen after 3 p.m., take the patient's telephone number home with you and call after dinner.

Date	Treatment Rendered	Fee
6/10/2010	5:00 pm Telephoned pt. at home to ck. on her. Pt. "is doing well." Reminded to use salt water rinse before bedtime. (DGlasscoe)	

8. Chart alternative/recommended \_\_\_\_\_. The 'ADRA' abbreviation stands for *advantages, disadvantages, risks, and alternatives*. This abbreviation minimizes charting, yet fulfills legal requirements. This is especially important for hygienists that spend copious amounts of time discussing treatment options with patients. In addition, when patients reject certain treatment options that should be charted.

6/10/2010	Pat. Rejects perio therapy. Discussed chronic nature of disease and ADRA of tx. (DGlasscoe)	
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9. Dentists should \_\_\_\_\_ charting from hygienists and assistants. Any hygienist or assistant entries should be made **before** the dentist's entries. In addition, everyone should use the same abbreviations and charting methods.
10. Update medical status for each visit. Patients do not usually volunteer information when they are taking a new medicine or if there has been a change in their medical history. Make it a habit to ask: "Have there been any changes in your medical history since we last saw you?" Use the abbreviation "NCMH" – no changes in medical history – to designate no changes.

## Adequate Chart Notes

(used with permission Marsha Freeman & Asso. www.marshafreeman.com)

Date \_\_\_\_\_

1. Reason for the visit
2. Thorough review of health and dental history
3. Patient's chief complaint in his/her own words
4. Symptoms (symptomatic or asymptomatic)
5. Clinician's visual findings
6. Diagnostic records
7. Doctor's examination
8. Doctor's diagnosis
9. Doctor's recommended treatment
10. Discussion with patient and his/her choice of treatment
11. Treatment rendered
12. Items given to patient

Next visit: \_\_\_\_\_ Initials \_\_\_\_\_

## Informed Consent and Informed Refusal

### A. Principles of Informed Consent

1. **Informed consent** is about a patient's understanding and willingness to voluntarily agree to proposed treatment after the recommended treatment, alternate treatment options, and the benefits and risks of treatment have been thoroughly described to the patient in language understood by the patient. Informed consent must be voluntary. Informed consent originates from the legal right the patient has to direct what happens to his or her body and from the ethical duty of the healthcare provider to involve that patient in his or her own health care.
2. **Informed refusal** is about a patient's refusal of all or a portion of the proposed treatment after the recommended treatment, alternate treatment options, and the likely consequences of declining treatment have been explained to the patient in language understood by the patient. A patient has a legal right to refuse proposed medical or dental care.

### B. Scope of Information. The most important goal of informed consent is that the patient has an opportunity to be an informed participant in his or her health care decisions. It is generally accepted that complete informed consent includes a discussion of the following elements:

1. A diagnosis and an explanation of the medical or dental condition that warrants the proposed treatment.
2. An explanation of the purpose of the proposed treatment.
3. A description of the proposed treatment and the individual patient's role and responsibilities during and after treatment.
4. A discussion of the known risks and benefits of the proposed treatment.
5. An assessment of the likelihood that the proposed treatment will accomplish the desired objectives. When discussing treatment outcomes it is important not to appear to guarantee treatment outcomes to the patient. Remember that individual patients will respond differently to treatment.
6. A presentation of alternative treatment options, if any, and the known risks and benefits of these options.
7. A discussion of the prognosis if no treatment is provided.
8. A discussion of the actual costs associated with the proposed treatment.
9. Reinforcement of the individual's right to refuse consent to the proposed treatment. Patients often feel powerless. To encourage the patient's voluntary consent, the healthcare provider can

make it clear to the patient that he or she is participating in a decision, not merely signing a consent form.

- C. Ethics and Informed Consent. The doctrine of informed consent reminds us to respect patients by fully and accurately providing information relevant to their healthcare decisions. In deciding how much information is adequate, it will be helpful for the healthcare provider to ask herself, “*What would this patient need to know and understand in order to make an informed decision?*” It is generally accepted that informed consent include:
1. Information that is provided in understandable language. It is the healthcare provider’s responsibility to present all information necessary for informed consent to the individual in a way that is understood by him or her.
    - a. Use simple, straightforward sentences.
    - b. Use commonly recognizable terms. Avoid the use of jargon or technical terms, and explain terms that may not be easily understood.
    - c. Use a family member or a staff member as a translator if the patient does not speak English or speaks with little understanding.
  2. An opportunity for the patient to answer and ask questions. Foster an open exchange of information and encourage the patient to ask questions.
  3. Assessment of the patient’s understanding of information provided. Use open-ended and nondirective questions.
    - a. “*What more would you like to know?*”
    - b. “*What are your concerns?*”
    - c. “*What is your next question?*”
- D. Format for Consent Process. Informed consent may be either verbal or written.
1. Many dental healthcare providers prefer to have the patient sign and date a written consent form for documentation of the consent process. In addition, the written consent document should be signed and dated by the dentist and a witness (generally, the dental assistant).
  2. Once signed, a written consent document becomes part of the individual’s permanent dental record.
  3. If a written consent document is not used, the patient’s verbal consent should be documented in the patient chart. An example of documentation of verbal consent is: “*Discussed the diagnosis; purpose, description, benefits and risks of the proposed treatment; alternative treatment options; the prognosis of no treatment; and costs. The patient asked questions and demonstrates that he understands all information presented during the discussion. Informed consent was obtained for the attached treatment plan.*”
  4. If a patient refuses recommended treatment and further refuses to sign an informed refusal form or the chart notes, this notation should be made: *Patient refused recommendations for treatment of periodontal disease and also refused to sign documentation of refusal. (Your name) (Witness name)* The witness should be another staff member and/or the doctor.
  5. Signatures never expire.

## Importance of Good Communication

A breakdown in communication often leads to lawsuits. Mark Swarts, PhD, instructor at Mt. Sinai Hospital in NYC, made this comment for a *USA Today* article on malpractice: “Poor communication, rather than malpractice, is responsible for 85% of the malpractice litigation in the United States.”

Communication tips to avoid malpractice:

1. When a patient is \_\_\_\_\_, always give the patient an opportunity to voice the concern. Never casually dismiss their complaint.
2. \_\_\_\_\_ difficult cases.
3. In prosthetic cases where the patient is unhappy with the result, \_\_\_\_\_ the patient's money when all else fails.
4. Keep the patient \_\_\_\_\_ when a procedure does not go as planned.
5. Every complaint does not require restitution, but every complaint does deserve a direct and prompt \_\_\_\_\_.
6. \_\_\_\_\_ when a procedure fails.
7. Before beginning treatment, make sure the patient is aware of possible \_\_\_\_\_, both good and bad.
8. Treatment options are available in many instances. Discuss \_\_\_\_\_ treatments when applicable.

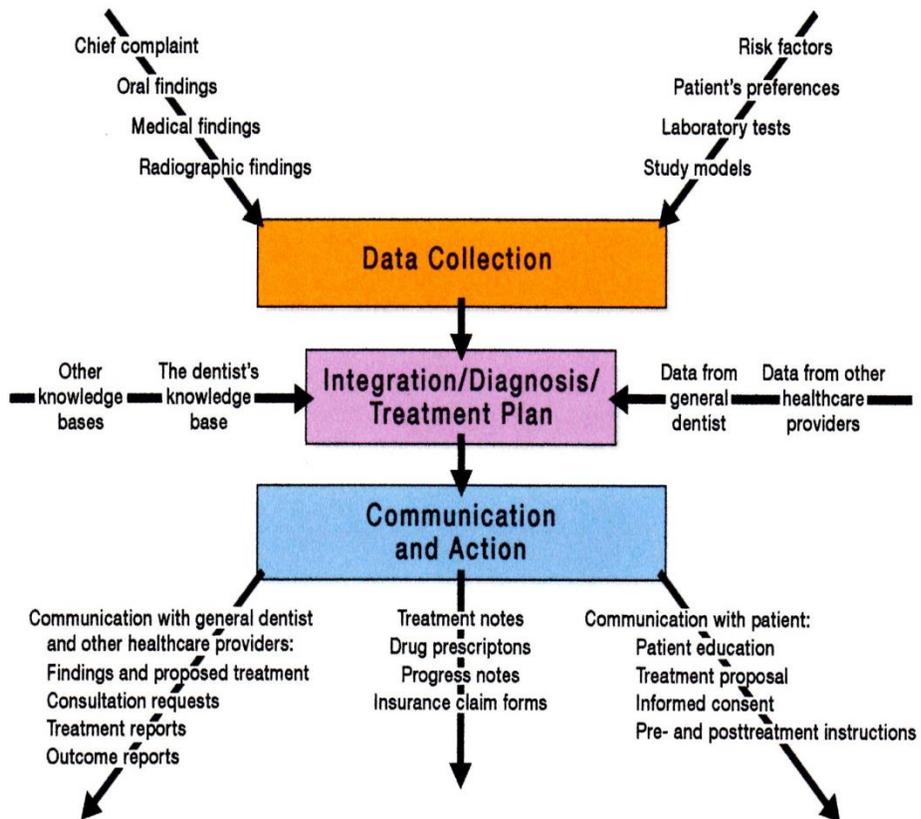
Defusing the angry patient:

1. Don't lose your cool.
2. Encourage the patient to vent.
3. Find out the facts.
4. Understand your patient's feelings.
5. Suggest a resolution.
6. End on a positive note

A hygienist goes to prison:

Read the story of Cherie R. Dillon, RDH, who is currently serving a 5-year sentence in a federal prison for healthcare fraud and identity theft. <http://markrdh.com/?p=1836>

## Summary Sequence of Care



# Refusal of Treatment Recommendation

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Last First M.I.

I am being provided with this information and refusal form so I may better understand the treatment recommended for me and the consequences of my refusal. I understand that I may ask any questions I wish regarding the recommended treatment.

It has been recommended that I have the following treatment: \_\_\_\_\_  
\_\_\_\_\_

This recommendation is based on visual examination, on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. The treatment is necessary because of:

Decay      Broken tooth/teeth      Infection      Periodontal disease      Pain      Other

Note: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I have had an opportunity to ask questions about the recommended treatment.  
Patient's Initials

I understand that complications to my teeth, mouth, and /or general health may occur if I do not proceed with the recommended treatment. These complications include: \_\_\_\_\_  
\_\_\_\_\_

## **Acknowledgement**

I, \_\_\_\_\_, have received information about the proposed treatment. I have discussed my treatment with Dr. \_\_\_\_\_ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my refusal. I have read this document in its entirety.

**I do NOT wish to proceed with the recommended treatment.**

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Treating Dentist

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Witness

# Informed Consent

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## ***Periodontal Scaling and Root Planing***

I understand that I have periodontal (gum and/or bone) disease. The disease process has been explained to me and I understand that it is caused by bacterial toxins (poisons) and my host response to these toxins. I realize that this disease may be painless and without symptoms, but that usually symptoms such as bleeding, swelling or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity and soreness may be noticed. Treatment of periodontal disease may include periodontal scaling and root planing, either as a therapeutic procedure, or preliminary to more extensive treatment.

Periodontal scaling and root planing involves the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root surface) and diseased tissue from the inner lining of the crevice surrounding the teeth. The purpose of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my own efforts with home care are just as important as my professional treatment.

Consequences of doing nothing about my periodontal condition may be, but are not limited to:

- Increased recession of gum tissue and exposure of root surfaces (as tissue heals, swelling decreases).
- Increased sensitivity to hot, cold, or sweets; this may require further treatment, may fade with time, or may persist no matter what is done.
- Exposed roots that may acquire stain more readily.
- Food may collect between teeth. Proper cleaning techniques will be explained in detail.
- If teeth were loose prior to the procedure, they may seem looser immediately after. Usually after healing, teeth “tighten.”
- Some pain, swelling or bruising may be experienced after treatment.
- Infection of the gums and other supporting structures.

I understand the recommended treatment, the risks of such treatment, and any alternative treatment and risks have been explained to me. I understand the fee(s) involved in the treatment as well as consequences of doing nothing.

I give permission for the use of local anesthetic and any anxiolytic and/or sedative medications that may become necessary. The possible side effects of local anesthetics are prolonged or permanent numbness of the lips, cheeks or gums, rapid heart rate, allergic reactions, and reactions with other drugs that you are taking.

If there are any problems, contact the dental office immediately.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# **Informed Consent**

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## ***To Perform Dental Work on My Child***

I have been informed that the following procedures are necessary for my child:

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Although every effort will be made to adhere to the proposed treatment plan, unforeseen circumstances or conditions may require a departure from the plan.

After treatment, your child may experience pain and swelling. There is a possibility that the child may bite the inside of the mouth or tongue before the anesthesia wears off, and that the child must be instructed not to do so.

In addition to local anesthetic, nitrous oxide (laughing gas) is frequently used to make the dental visit less stressful. Although the child is usually alert and awake upon leaving the office, there are rare instances of lingering sedation. Some of the possible side effects of local anesthetic are prolonged or permanent numbness of the cheeks, lips, tongue or gums, allergic reaction, rapid heart rate, or a reaction with other drugs that you are taking.

If I do not remain in the dental office while my child is receiving dental treatment, I am leaving the treatment up to the doctor's judgment and experience, understanding that other treatment may have to be rendered. If contact with me is not successful the doctor and his staff have permission to do whatever they feel is necessary. In case I need to be contacted during my child's dental visit, my cell phone number is \_\_\_\_\_

Card # for patient portion \_\_\_\_\_ exp/-----

Signature authorizing use of credit card \_\_\_\_\_

Child's Name \_\_\_\_\_

Parent of Guardian's Name \_\_\_\_\_

Date \_\_\_\_\_



## DENTAL LAW

# Informed consent

**Author details range—and limits—of legal requirement.**

**I**nformed consent is a legal requirement premised on the patient's right to control his or her own body. In a seminal 1972 case, the U.S. Court of Appeals in Washington, D.C., recognized the right

BY PETER SFIKAS, J.D. of a patient's self determination,

and observed that a healthcare professional must disclose all relevant risks to the patient in order for the patient to approve the treatment plan.<sup>1</sup>

The clear message of this decision is that if you do not provide appropriate disclosure and yet perform surgery, you have committed a medical battery. Medical battery can be defined as an illegal touching of another.

State laws vary as to what the standard is for providing informed consent. In some states, the test is whether the healthcare professional has disclosed the risks that a reasonable practitioner would disclose under comparable circumstances.<sup>2</sup> Other states establish the standard as providing disclosures that a reasonable patient would consider important to know about the proposed treatment.<sup>3</sup>

Because state laws differ on what is required for informed consent, dentists should be certain that they fully comprehend their obligations under their respective state laws.

Whether your state requires it or not, you should, of course, obtain

your informed consent in writing. The reason for this is obvious. If there is any controversy or litigation on the issue of what you provided, in your informed consent you will have written evidence to substantiate your position.

Once you have acquired an appropriate form of informed consent, you have significantly reduced the opportunity that your patient will file a lawsuit against you, claiming that you are guilty of a dental battery.

### **Informed consent vs. malpractice**

However, it's important to know that informed consent does not lessen the potential for a claim of dental malpractice. To establish a dental malpractice case, the patient must demonstrate: (1) the standard of care by which the dentist's treatment is measured, (2) a breach of that standard of care, and (3) that the breach proximately caused the patient's injury.<sup>4</sup>

Thus, even if you obtained a proper informed consent, it is irrelevant on the question of malpractice.

Courts assess a claim for medical battery as being completely distinct from a medical malpractice claim. In one relevant case, a patient argued that the informed consent was not broad enough to cover the surgery that was performed on his hand. But he did not allege in his lawsuit that this

constituted a medical battery; he made a claim for malpractice.

The court stated that the patient could have filed an action on the theory of battery, except that would be only an alternative theory and would not affect the patient's malpractice action. (Under the law, a patient could sue for both battery and malpractice, as they're considered what's called "alternative" claims; however, the patient could only recover damages for one of the actions.)

### **Standard of care**

After reviewing the evidence, the appellate court held that the standard of care had been proven; that a deviation from the standard of care was also proven; and that the patient was injured by reason of the deviation. Accordingly, the court found that the physician was liable for malpractice.<sup>5</sup>

Even though this case involved a physician, the same rationale would be applied in a dental malpractice case. It is important to note that dentists are vulnerable to both battery and malpractice claims. Obtaining informed consent from patients helps to protect dentists against a battery claim, but does not preclude a malpractice action.

Thus, it is also important for dentists to comply with the appropriate standard of care. ■

*This article does not constitute legal advice; it is only informational.*

1 *Canterbury v. Spence*, 404 F.2d 772 (D.C. Cir. 1972)

2 *Ramos v. Pyati*, 534 N.E. 2d 472 (Ill. App. 1989)

3 *Kethup v. Howard*, 543 S.E. 2d 271 (Georgia App. 2000)

4 *Ramos* at 475.

5 *Ramos* at 479.

## SOUND

Send comments about this story to [practice@advanstar.com](mailto:practice@advanstar.com)

Mr. Sfikas served as the General Counsel to the American Dental Association from June, 1995 until October, 2006. He is a fellow of the American College Of Trial Lawyers, and he has written, taught and lectured on dental legal issues. If you have any questions or comments about this article you may call Mr. Sfikas at 312-802-0476.

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