DENTAL Insights
Professional SOLUTIONS
PROFESSIONAL SOLUTIONS INSURANCE COMPANY BRINGS YOU PRACTICAL TIPS FOR AVOIDING A MALPRACTICE ALLEGATION FALL 2009

Cancer in the Dental Practice

In 2007, Mike Basset was 55 years old and had been a patient at a periodontal practice since 1995. He was on a four-month recall program where he would alternate visits between a periodontist and a general dentist.

Periodontist Jason Penwell, DDS, had been treating Mike since 1999; however, Mike often failed to come in for the regular four-month appointments. In addition, Mike had been to a few general dentists between 1995 and 2004 before seeing general dentist Howard Finn, DDS, in 2004.

Mucocele Identified by Periodontist

In February 2004, Mike was in the process of having an implant placed in the area of tooth 19 when Dr. Penwell identified a mucocele. However, he did not include a description in the notes about the mucocele's location, visual appearance, size, extent or possible cause. At the time, the implant had been placed but the crown had not.

In May 2004, the general dentist, Dr. Finn, placed the crown. There were no notes for that visit regarding any abnormalities.

About six months later, Mike returned for a follow-up appointment, but Dr. Penwell noted nothing about the mucocele or other abnormalities in the area of tooth 19, the tongue, the surrounding area or anywhere else.

The biopsy revealed squamous cell carcinoma

In November 2004, Mike returned to Dr. Finn who noted a keratosis of approximately 9 x 3 mm on the lateral side of Mike's tongue around the location of teeth 18 and 19. Dr. Finn attributed the keratosis to the crown on tooth 19, and he adjusted it.

Dr. Penwell again saw Mike in February 2005, and he took an X-ray of tooth 19, which revealed no notable abnormalities.

In May 2005, Mike came in to Dr. Finn's office complaining of a sore tongue. Dr. Finn had no further notes as to any abnormalities or continued keratosis. What's more Dr. Finn did not record any details about the specific findings related to the sore tongue, such as the location of the soreness, the type of soreness or its possible cause.

In September 2005, Mike had a periodontal cleaning by the hygienist in Dr. Penwell's office. No abnormalities or keratosis were noted for that visit either.

Mike's Tongue Soreness Returns

Mike returned to Dr. Finn in November 2005. At that visit, Dr. Finn again observed Mike's tongue was still sore. He referred back to his note of November 2004 that identified the keratosis.

On March 2, 2006, Dr. Penwell saw Mike and identified a "12 x 12 mm ulcer lateral left tongue and adjust to implant #19." Dr. Finn saw Mike that very same day and also noted the presence of the ulcer. Dr. Finn tentatively attributed the ulcer to the crown on tooth 19.

Dr. Penwell noted on March 9, 2006, that Mike had developed another ulcer in the same area. Consequently, Dr. Penwell referred Mike to oral surgeon Robbie Rush for a biopsy. A photo of the lesion taken at that time revealed a fairly large, clearly visible lesion on the front lower left portion of Mike's tongue.

The biopsy revealed squamous cell carcinoma, which was initially diagnosed as a Stage III cancer. Mike immediately began treating with physicians at two well-respected medical centers, and surgery to remove the lesion was

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The case centered on whether the dentists deviated from the standard of care.

performed on April 4, 2006. Further testing revealed the cancer had metastasized to one of 17 lymph nodes. Mike was started on radiation therapy, but due to the severe side effects, he discontinued it after two weeks.

Mike's cancer recurred in August 2006 as Stage IV with a number of lesions present. He underwent a complete course of radiation and chemotherapy.

By January of 2007, the disease had progressed significantly, and Mike passed away in March of that year. At the time of his death, Mike worked at a computer software company where he had been employed for 25 years, earning just under $100,000 a year. He was divorced with three children.

Legal Process Begins

After Mike's death, his family contacted Dr. Finn and Dr. Penwell and asked to resolve the matter before they retained an attorney. Both Dr. Finn and Dr. Penwell each promptly reported the matter to their respective malpractice carriers. Both carried professional liability insurance with $1 million in policy limits.

Both insurance companies retained attorneys to evaluate and assess the matter and to determine possible defenses in the event a lawsuit ensued. Specifically, the defense counsel would need to consider whether Drs. Finn and Penwell complied with the applicable standards of dental care. If they didn't, the defense would need to assess if any deviations in the standard of care affected Mike's outcome.

Defense counsel evaluated verdicts and settlements in comparable cases to assess the potential value of the claims. While there were some defense verdicts,

there were also large settlements and verdicts against dentists in similar cases. These ranged from $700,000 to $12 million dollars, with an average of approximately $1.5 million.

Evaluating the Evidence

Defense counsel also obtained copies of records, photographs and films from Drs. Finn, Penwell, and Rush, along with other subsequent treating dentists and physicians.

In addition, if called to testify, Drs. Finn and Penwell would have responded as follows:

- Dr. Finn—the keratosis first noted in November 2004 continued to be present until November 2005.
- Dr. Penwell—the hygienists in his office performed a thorough examination and cleaning that he followed with a cursory examination. Dr. Penwell would state that he would have expected the hygienist to note a small white lesion, had it been present.

Defense counsel also retained consultants to review materials and render opinions on whether Drs. Finn and Penwell deviated from the standard of care. The consultants were also asked to determine whether any deviations caused injury, and if so, the nature and extent of the injury. Importantly, they were also asked to evaluate whether any deviation caused a delay in diagnosis that reduced Mike's chance of recovery or caused his death.

The expert consultants reviewed all of the records, photographs and films and made the following conclusions:

- **The dental consultants** believed that the general dentist and the periodontist deviated from the standard of care. Their thought process was that a keratosis is a protective layer typically formed in response to trauma, which is not necessarily cancerous. However, if the keratosis is still present after the trauma is removed, it should be biopsied. Thus, the initial evaluation by the general dentist, Dr. Finn, might have been appropriate, but by November 2005, the standard of care would have required a biopsy of the lesion.
- **The periodontal consultant** thought it was a significant problem that Dr. Finn's records noted a keratosis before and after the September 2005 periodontal visit to Dr. Penwell. Unfortunately, Dr. Penwell had no documentation of any kind of abnormality, let alone a lesion. Without question, according to the oral cancer specialist, this lesion was cancerous well before any referral or diagnosis was made. Earlier diagnosis likely would have meant a better result due to intervention before any metastasis. The clear consensus was that Dr. Penwell's office missed the lesion entirely, and this was reflected

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in the lack of documentation.

- **The oral cancer specialist** did not offer an opinion on when the lesion turned cancerous. However, he was confident that the cancerous lesion was the same lesion identified by Dr. Finn in November 2004.

Mike's failure to go to regularly scheduled appointments may also have delayed his care.

Supporting the Dentists' Cases

At the same time, there were several factors in favor of the defense. These included: later treaters' records that revealed Mike himself didn't notice the lesion until only a month or two before its diagnosis; the lesion may have been properly diagnosed initially as a response to the trauma in the area and it would be hard to establish when it became cancerous; the cancer was aggressive; and Mike's failure to go to regularly scheduled appointments may have contributed to his delay in care. In addition, it was not clear how soon the cancer would have had to be diagnosed to have made a difference in the outcome.

Moreover, the fact that Mike did not complete the radiation therapy the first time could have been important to his recovery. (The records confirmed, however, that the side effects were indeed very severe.) Most all of these factors, however, would have mitigated the case, and would not have provided a complete defense against all the allegations.

Resolving the Cases

Weighing all these factors, the defense decided to attempt to resolve the matter pre-suit, if possible. As a result, settlements were negotiated and the matter was settled for $200,000 on behalf of Dr. Penwell and $650,000 on behalf of Dr. Finn.

This case study was derived from the files of Linda Hay, J.D. All names used in Dental Insights case study are fictitious to protect patient privacy.

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Practice Tips

An oral cancer evaluation should be a regular part of any dentist's practice, and should be updated on a regular basis. Documentation of the evaluation and examination is critical to later prove the findings with specificity, to assist with proper and consistent follow up recommendations. (The CDT evaluation codes and their components apply to both general dentists and specialists; see 0120, 0150, and 0180 of the CDT.) In this case, at the very latest in November 2004, the notes should have documented, in addition to the size, the location, a detailed description of the keratosis, the type, the probable etiology, the services rendered, and the recommended follow up and timing. The documentation also should have indicated that the patient understood any follow up and timing recommendations.

As for Dr. Penwell, **better documentation of the mucocele—including its location, size, extent and probable cause in February 2004—would have been very helpful**. It also would have been beneficial to have it noted six months later that the mucocele was gone. Concerning the hygienist's appointment, it would have been a meritless defense in a lawsuit to claim that the hygienist missed the lesion, since the dentist is the one ultimately responsible.

As for Dr. Finn, once the crown adjustment took place, the patient should have been re-evaluated to determine whether the keratosis improved. If it didn't, **a referral for a biopsy should have been promptly made at that time**. The lack of any notes over a one-year period about the keratosis and whether it improved, resolved, stayed the same or worsened made it difficult to prove it resolved during that time frame. That, combined with the vague references to tongue soreness in that time frame, would provide strong ammunition for plaintiff's expert that the situation was worsening throughout that time.

Any persistent or inexplicable soft tissue lesions must be closely monitored and referred for biopsy. The sooner the referral, the better. That process must be well documented with sufficient detail. It also must include proof that the patient understood the need for a prompt referral and follow-up care.

Should You Forgive Patient Fees?

In today's current economic environment, more dentists are experiencing patients who either refuse to pay or who request their money back after care is provided.

This is especially true with cosmetic and elective procedures not covered by insurance. In addition, layoffs have caused unanticipated financial hardships for many patients.

Whether the patient doesn't want to pay for financial reasons or due to other considerations, make sure to weigh the alternatives before deciding whether to waive/refund the fee.

Reasons Not to Refund

Many dental and risk management experts believe it's best to stand firm on fees because:

- A refund could be construed as an admission of guilt if the patient alleges malpractice against you, claiming the procedure or treatment didn't work or wasn't effective.
- Not collecting fees may be in violation of third-party insurer agreements, your state's dental practice act and the provisions of your professional liability policy.
- Agreeing not to charge a patient even just once could set a precedent. For example, the patient may expect you to pay for further testing or treatment. Also, if other patients hear about it, they may have similar expectations.
- Once you waive a fee, it can be difficult to start charging again. Many times, the patient will expect free dental care for life.

Reasons to Refund

Returning money to patients may be a new trend, one that's simply a twist on the common business practice of providing a money-back guarantee.

From a practical perspective, agreeing to refund a patient's fee may soothe an unhappy patient, avoiding bad word-of-mouth in the community. In addition, unhappy patients are more inclined to file malpractice claims, complain to a state board or share their negative stories with the media.

You may conclude that agreeing to waive/refund a patient's fee is potentially less "costly" than the consequences of refusing to do so.

If You Decide to Refund

If you decide to waive/refund the fee, make sure the patient agrees to execute a release before you agree to provide any reimbursement. In essence, the release should state the patient agrees not to pursue a claim against you. A copy of the release should then be placed in the patient's record along with other documentation on the patient's care.

Though there is no certainty that a patient will not litigate after signing a release, taking this step usually resolves the matter. Keep in mind that any release should be drafted with the assistance of your practice's legal counsel.

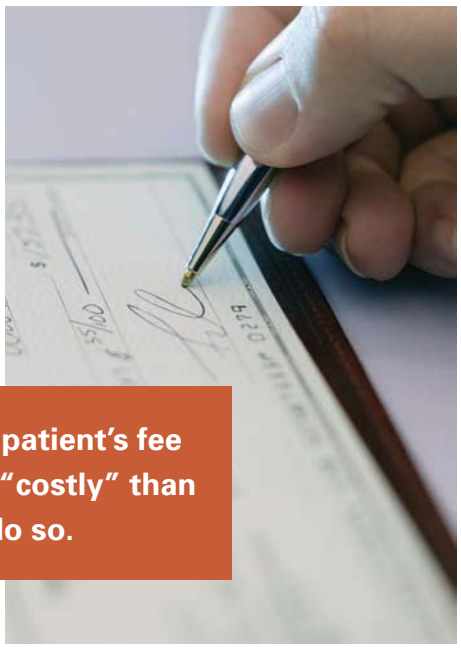
Refunding a patient's fee may be less "costly" than refusing to do so.

Understanding Patients and Involving Staff

Patients may discuss billing issues with your staff before you're even aware of a problem. That's why it's essential to have standardized procedures for patient refund requests and to thoroughly train your staff on these protocols.

Regardless of what you decide, if the element of trust has been broken, it may be advisable to end the dentist/patient relationship. In these instances, make sure to avoid an allegation of abandonment by providing the patient with the names of other dentists to continue their care and emergency care if necessary in the interim.

There is no right or wrong way to approach a patient request that you waive their fee or refund their money. However, understanding the problem from the patient's point of view will go a long way toward reaching an amicable resolution. Your previously established dentist/patient relationship will play a crucial role in how the patient perceives the decision.



If you'd like assistance in responding to a patient's request to waive/refund a fee, contact NCMIC at 1-800-640-6504. Our professional claim representatives can help you evaluate the situation, the risks involved and determine the best solution for your specific situation.

A dentist's new balancing act ...

Prescribing Without Being Taken By Drug-Scammers

The issue of over-prescribing has come to the public forefront in the healthcare arena with celebrities like Michael Jackson, Heath Ledger and Anna Nicole Smith taking lethal combinations of prescription drugs.

Today's dentists are not exempt from the pressure to prescribe, but they should be aware that the Drug Enforcement Administration is cracking down on the over-prescribing of pain medicines. While the enforcement is justifiable, dentists face unique challenges with this issue.

Drug-seekers are targeting dentists because they are more likely than their medical colleagues to prescribe painkillers over the phone. They are becoming increasingly sophisticated and convincing in their efforts to obtain prescription drugs for illegal use or distribution. Drug-seekers increasingly do their "homework" and know just what to say to a dentist to obtain a signed prescription in hand for a controlled substance that can feed a personal addiction, have a high street-sale value or both.

It can be helpful to raise your index of suspicion when patients present with the following behaviors commonly associated with drug abuse:

- Escalating-use patterns
- Drug-seeking behavior
- Doctor shopping
- Using scams to maintain and increase their supply of drugs

Other red flags include patients who imply the only solution to their problem is the prescription of a controlled substance, particularly on the first visit, and patients who say they can't take generics or are allergic to any non-controlled drug you recommend.

Can you identify which of the following patients have a legitimate need for prescription drugs?

Prescription Request #1: It's Friday afternoon. You have one more patient to see before you're off for the weekend. Your office manager stops you before you examine the last patient. She informs you there's a very persistent woman—not a regular patient—at the front desk who says she has "a dental emergency and needs to see a dentist."

As you approach her, you see a very well-dressed middle-aged woman in no apparent distress. After an exchange of introductions, the woman tells you she just flew into town on business, is staying at a hotel down the street, and her luggage was lost by the airlines. She tells you she needs her pain meds—a strong analgesic—for dry socket pain and they were in her luggage. Her dentist "back home" is already gone for the weekend and she doesn't know how long she can go without her meds.

She wants you to write a prescription for her to have filled. She tells you the specific drug and dosage she needs and "this is the only drug" that has provided pain relief for her. Is she a drug-seeking patient?

Result: The patient was legitimate. The physician was able to reach the woman's dentist, who verified her related history and confirmed the drug and dosage.

Prescription Request #2: A patient you've treated regularly for TMJ for more than a year stops by the office within a few days of his last visit. He tells you he left the prescription you just gave him in his shirt pocket and his wife inadvertently ran it through the laundry, so he'll need a replacement prescription. He presents a scrap of obviously washed paper as evidence.

After he leaves, one of your staff laughingly comments about the patient's repeated inability to hold on to his prescriptions, "We're always replacing Bob's prescriptions for one reason or another." Could there be something else beside his losing prescriptions going on?

Result: The patient was trying to obtain additional medications without a prescription to alleviate his increasing levels of pain. The casual comment about the patient's repeated loss of prescriptions and good staff documentation were key to discovery. The patient actually was filling and taking all of the prescribed pain medications himself.

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What Can We Learn?

In each situation, the patient exhibited behavior that should have been a red flag about possible drug-seeking behavior. At the same time, they could have been legitimate patient encounters where the requested prescription was appropriate.

For situations like the first prescription request, you should watch out for patients who show up at the office from "out-of-town" or just before the office closes needing prescriptions, purporting to be referred by a Dr. X. Look for inconsistencies between related symptoms, patient behavior and/or physical findings, and specific drug requests—if the facts don't match up, ask questions.

If a patient is new to your practice, take a thorough history, including:

- Information on other practitioners the patient has seen
- Other medications being used
- Past controlled substances prescribed
- Dosage and frequency of usage

Have the patient sign a record release to allow you to request records from the previous treating dentist(s) to confirm the related condition, medication regimen, drug allergies, etc. If the patient is trying to scam you, this alone may be sufficient to dissuade further contact.

Do a complete work-up that supports your diagnosis and treatment recommendations and track and document the patient's response to the drug so indications for subsequent dose increases or drug changes are apparent to anyone reviewing the patient's record.

The second request clearly illustrates one of the characteristic warning signs—an escalating-use pattern. Yet, in this case, the patient did have chronic pain and needed continued analgesia.

Since chronic pain patients are not common in a dental office (other than TMJ), it may be advisable to refer similar cases to the patient's physician or a TMJ specialist. These practitioners deal with chronic pain more frequently and may be better able to monitor and help a patient who is abusing narcotics.

It's important to document any prescription reissues so patterns of lost or damaged prescriptions or early requesting of prescription refills are readily apparent.

Risk Management Tips:

1. **Know and comply** with the federal and state laws and regulations for prescribing drugs, especially controlled substances.
2. **Keep your prescription pads safe**, secure and out of view of patients and visitors and lock up any controlled substances. Only designated professionals should be allowed to handle controlled substances and have access to the drug storage area. All drugs should be logged into inventory and an annual inventory of all drugs performed.
3. **Maintain a high level of suspicion** when individuals show up unannounced with prescription "emergencies." Set up specific time periods or days when calls for refills will be accepted, discouraging after-hours prescription solicitation.
4. **Inform the patient** of your reason for recommending this course of treatment, the benefits and risks of the chosen medication, including its potential for physical dependency, as well as alternatives to this treatment and the consequences of no treatment. This discussion should be thoroughly documented.
5. **Advise the patient** that many controlled substances can adversely affect the ability to drive safely. This should be mentioned and documented when you write the initial prescription and any time the dose increases. With some drugs, this risk is exacerbated by consumption of alcohol.
6. **Develop practice policies for prescription** refills and dose adjustments. Document carefully, including the rationale behind the initial selection of the drug, treatment goals and expectations, the patient's response or lack thereof to prescribed medications, and indications for changing a dosage or prescription. Monitor the patient regularly.
7. **Do not place your safety at risk.** If a drug-seeking patient becomes aggressive, violent or physically threatens you or your staff, write the prescription. Then, notify the appropriate law enforcement authorities as soon as the person is off the premises.

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