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PROFESSIONAL SOLUTIONS INSURANCE COMPANY BRINGS YOU PRACTICAL TIPS FOR AVOIDING A MALPRACTICE ALLEGATION SUMMER 2013

When Multiple Treaters Are Involved, Communication is Key

It is essential that patient care be well-coordinated. This is especially the case when a patient sees several dental providers and there are underlying conditions that may affect treatment.

Mary Robinson, age 25 and a receptionist at an assisted living facility, first treated with general dentist Samuel Gough, DDS, in 2001. During Dr. Gough's evaluation and consultation, Mary mentioned that she wanted to straighten her teeth, so he referred her to Dr. Stevens, an orthodontist, who did an evaluation and consultation.

Dr. Stevens thought that Mary was a candidate for orthodontic care in spite of some bone loss and periodontal-type issues, but she didn't return to Dr. Stevens for the orthodontia. Instead, Mary went to see periodontist Dr. Petrie for unknown reasons.

At Dr. Petrie's office, Mary had scaling and root planing done over three visits. Dr. Petrie agreed that Mary's dental condition might have posed additional risks for orthodontic treatment, but he had no opinion as to whether Mary was a candidate for braces.

Patient Sees More Treaters

In 2003, Mary went to see another orthodontist, Dr. Bream. She still wanted her teeth straightened, and Dr. Bream's office was located near her work. Dr. Bream did an evaluation, took a full-mouth set of films and noted some bone loss that Mary was already aware of. Mary then agreed to proceed with orthodontic care, and she signed a general consent form that spelled out the risks. Dr. Bream initially noted that Mary was under the care of the periodontist Dr. Petrie. Mary's orthodontic treatment with Dr. Bream went as planned, according to his records.

Sometime in 2004, Mary went to see general dentist Dr. Roosevelt because she thought his office, which was located by her home, would be convenient. Mary came in for her first cleaning with a full set of braces on her teeth. She told Dr. Roosevelt that her last X-rays were taken two years prior. The history did not identify any prior dentists, but the handwritten records from the first visit indicated that Mary had scaling and root planning performed and her orthodontist was Dr. Bream. Dr. Roosevelt and Dr. Bream did not know each other.

During that first visit, Dr. Roosevelt did spot probings and recorded in the handwritten chart that there was generalized bone loss and some areas of pockets in the 4-6 mm range. He took bite wing films.

Dr. Roosevelt's records included both electronic and handwritten portions since his office had recently implemented an electronic health record (EHR) system. The EHR system had a template for full-mouth probings, including a detailed periodontal analysis, but Dr. Roosevelt did not use that template.

Dr. Roosevelt took Mary on as a patient and put her on a regular schedule for cleanings. During the next year, Mary came in for cleanings but not always at the recommended intervals. At two of these visits, Mary complained of general discomfort and sensitivity, and Dr. Roosevelt noted she had some recession. Dr. Roosevelt performed two fillings, in addition to the cleanings, during this timeframe. However, neither Dr. Roosevelt nor Dr. Bream communicated with each other about Mary's care—the only updates to the dentists were provided by Mary.

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Dr. Roosevelt recorded in the chart that there was generalized bone loss and some areas of pockets in the 4-6 mm range.

In November 2006, Dr. Bream removed Mary's braces, and she never returned for follow-up care with the orthodontist.

At another appointment with Dr. Roosevelt, Mary had a full-mouth set of films taken, which showed significant and generalized bone loss. Dr. Roosevelt's notes indicated that her periodontal condition should be monitored.

Mary Has Records Sent to More Periodontists

At around the two-year mark in treatment, Mary requested her records be forwarded on to Dr. Paul, a periodontist Dr. Roosevelt didn't know, and Dr. Roosevelt sent the records. The records thereafter show a scaling and root planing was done.

After that visit, Dr. Roosevelt sent records at Mary's request to yet another periodontist, Dr. James, who Dr. Roosevelt also did not know.

After that visit, Dr. Roosevelt called Dr. James who told him that Mary was in danger of losing all of her teeth. All had severe bone loss along with severely increased mobility. Mary later lost six teeth, due to mobility based on bone loss. Mary had implants placed with grafting to replace those lost teeth.

Mary went on to file a lawsuit against Dr. Bream and Dr. Roosevelt. At Mary's deposition, she contended that neither treater had referred her to a periodontist or told her she had periodontal problems. In her testimony, Mary said:

- She did not know what scaling and root planing were.
- Dr. Petrie had known she was intent on having braces to straighten her teeth and never discouraged her.
- She decided to go to a periodontist in 2006 only because friends encouraged her to try a periodontist first because her teeth were sensitive, not because Dr. Roosevelt referred her.
- Mary said that she went to all her visits as recommended other than having to reschedule at times because of her work.

Mary said she took care of her teeth as best she could, but she relied on the dentist to help clean her teeth because this was difficult with braces. She expected Dr. Roosevelt to do the cleanings since that's why she went to him in the first place.

Mary denied vehemently that Dr. Roosevelt ever referred her to a periodontist. She also said Dr. Bream never explained the importance of follow-up care with her periodontist or that she was at risk of losing her teeth because of periodontal issues. As for the consent form, Mary said she didn't really understand it, and Dr. Bream never discussed it with her. She admitted she had signed the form, but she was nervous about getting braces and was worried the form would scare her, so she didn't thoroughly read the form or ask questions about it.

Mary contended that if the treaters would have referred her to a periodontist, she would have gone immediately. What's more, her current periodontist, Dr. James, was very critical of Dr. Bream's and Dr. Roosevelt's care. Dr. James had told Mary that if either treater had identified the problem and removed Mary's braces sooner, he could have treated her periodontal problems and saved her teeth.

Dental Treaters Respond

Dr. Roosevelt testified that he believed Mary understood her periodontal issues because she used the terms "scaling" and "root planing" in discussing her care. As for the recession and bone loss, Dr. Roosevelt said he was aware of these issues when Mary first came in, and that is why he recommended regular cleanings.

Dr. Roosevelt further contended that Mary's cancelation of appointments and lack of good home care contributed to her problems. He insisted that both he and his office staff had clearly told Mary that she should see a periodontist, which is why Mary sought out two different specialists.

Dr. Bream assumed Mary treated with a general dentist and periodontist regularly.

In his testimony, Dr. Roosevelt admitted his records were not detailed on the issue of referral. However, he said the entirety of his notes clearly showed that he began to refer Mary to a periodontist once her braces came off and the full mouth films were taken.

Dr. Roosevelt had to admit that the office's computer systems included detailed templates for patients with periodontal issues that he didn't use. If he had used these templates, there would have been a far more detailed picture of the extent of Mary's dental and periodontal condition. This would have helped to establish the progression of Mary's condition. Dr. Roosevelt could not explain why those forms were never used.

Once Dr. Roosevelt learned that Mary had not yet been to a periodontist as recommended, he testified that he absolutely stressed her need for follow up care. Since Mary returned for visits after the referral and because he thought Dr. Bream would have contacted him if there were issues, Dr. Roosevelt felt he acted appropriately.

Dr. Bream testified that he had a lengthy discussion with Mary about the risks of placing orthodontia on a patient with periodontal issues. He recognized that this was a concern at the time of placement of the braces, but with regular cleanings that situation was not so dire that it would cause tooth loss. Dr. Bream said Mary had told him that she had been to a periodontist before seeing him and that periodontist was aware of Mary's planned orthodontia and expressed no problems with it.

Dr. Bream contended that Mary had told him she would continue to follow up with that periodontist, but he never noted the periodontist's name in the chart or checked on whether the patient actually received that follow-up care. Dr. Bream further testified that he assumed Mary treated with a general dentist and periodontist regularly and that those dentists would have contacted him if there were problems. Therefore, Dr. Bream felt he acted appropriately.

Mary's later treating periodontist, Dr. James, was indeed critical of both Dr. Roosevelt and Dr. Bream. The defendants each retained experts to defend their care. After this testimony, the dentists settled for a confidential amount estimated to be in the low six figures. Costs to defend the dentists were projected to be close to $100,000.

This case study was written by Linda Hay, J.D. All names used in Dental Insights case studies are fictitious to protect patient privacy.

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What Can We Learn?

Without question, better communication among the dentists would have provided Dr. Bream and Dr. Roosevelt with a stronger defense. The lack of coordination between the dentists allowed the patient to essentially dictate her care and to misrepresent what she told Dr. Bream. Had Dr. Bream communicated with Drs. Petrie and Roosevelt, he might have learned about and been able to take action about those misrepresentations before the case was litigated.

As for Dr. Roosevelt, if he had spoken to Dr. Bream and documented his referral, the reasons for the referral and his ongoing discussions with Mary about the increased urgency of seeing a specialist, his defense would have been stronger.

In addition, while not a direct issue in this case, the use of templates may have helped its defense. It would have been far easier to determine the extent of any progression of the periodontal disease over the course of time if the details about the periodontal condition had been thoroughly noted.

Films taken during the orthodontic care also would have helped lay this groundwork. While the defense experts relied on the testimony of the defendants, it came down to their word against Mary's. More thorough documentation, better use of a detailed electronic format and improved communication and coordination among the providers would have furthered the defense of both Dr. Bream and Dr. Roosevelt—in a defense victory or through a reduced settlement amount.

Difficult Employees Can Create Malpractice Risk

Just one difficult staff member may be enough to disrupt your practice dynamics, annoy patients and raise your malpractice risk.

The success of your practice depends in part upon effectively dealing with difficult employees. Problem employee behavior is not a one-time occurrence or someone having a bad day, but a pattern of inappropriate behavior that may include: expressions of anger; profanity; bullying or harassment; threatened or actual physical assault; or an uncooperative, non-compliant attitude. It can affect several areas of a practice, including:

- **Quality of patient care.** Troubles can arise when a staff member shows a poor work ethic and other employees have to pick up the slack. Overextended workers are more likely to make mistakes.
- **Practice environment.** Anxiety and stress levels can rise and productivity decrease. Good employees may perceive there is favoritism or no accountability for bad behavior and decide to look for a more positive work environment elsewhere.
- **Patient trust.** When patients witness disruptive behavior, it has a detrimental effect on their confidence in the dentist and the practice.
- **Practice reputation.** Unhappy patients and employees are likely to tell others, negatively impacting the reputation of the practice in the community.
- **Liability issues.** When a negative work environment and/or poor quality of work is tolerated, the practice may become less safe, raising the potential for malpractice allegations. It may also increase the practice's employment practices liability.

Resolving the Conflict

The most effective way to deal with a troubling staff member is to gather all the facts and have a private conversation with that person. During the meeting, don't rush to reprimand or accuse. Instead, ask the person to explain how he or she perceives what happened. It is likely you will have conflicting reports, but by listening to both sides, you will be less likely to jump to conclusions.

Take the opportunity to remind staff of the ultimate and shared goal of providing excellent dental and customer service to patients. To accomplish that everyone must be pulling together in a true teamwork effort.

Sometimes, difficult employees will refuse to take responsibility for creating the problem or may claim that others have a grudge against them. In these situations, ask the employee to identify the behaviors that led to the conflict. It is important that the employee takes ownership of the situation, especially if the problem could impact patient care.

If the employee does not take ownership, you must consider terminating employment.

Terminating Employment

If you decide to terminate employment, follow a standardized discipline process. Terminating an employee without providing an opportunity to correct the behavior is usually done only in the case of abuse, fraud or grievous misconduct.

It is important to document the offense and the steps taken to remedy it. This gives the staff member an opportunity to correct the problem and to avoid a wrongful termination lawsuit.

1 **Tell the employee specifically how to correct the behavior** and provide a timeframe for improvement. Provide measurable benchmarks so the process is not subjective.

2 **Re-evaluate the employee at the end of the progress improvement time** and provide feedback about whether the employee met the goal. Document in the employee record the observation of improvement or lack thereof to meet defined goals.

3 **Initiate disciplinary action** and identify what conduct would lead to further disciplinary action, up to and including termination.

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