

RISK MANAGEMENT

Risk management has evolved as litigation against dentists has increased since the 1970s. In 2005 the Australian Dental Association (ADA) produced a survey of 15 dental malpractice insurance companies that covered 104,557 dentists regarding the incidence and severity of dental professional liability claims between 1999 and 2003. The incidence of claims and the severity of claims actually diminished. The top three areas involved in paid claims for adverse outcomes for general dentists were:

1. Corrective dental treatment needed (30.7%)
2. Failed root canal (14.3%)
3. Paresthesia/nerve injury (8.3%) [1].

The procedures that were most involved were:

1. Crown and bridge (21.8%)
2. Root canal treatment (20.0%)
3. Simple extractions (13.6%) [2].

Hence, in many cases, the claimed maltreatment was reversible or able to be retreated.

As to the allegations made which involved a paid claim, there were:

1. Failure to diagnose (12.3%)
2. Inappropriate procedure (11.7%)

3. Failure to obtain informed consent (8.5%)

4. Failure to refer (5.4%).

More than half of the paid claims were under \$10,000 [3].

As the number of malpractice lawsuits against dentists increased in the 1970s, risk management courses began to arise under the banner of “better records to provide a better defense.” It was often proclaimed: “Records, records, records.” The next development was dentists being sued for not properly informing the patient. The mantra then became: “Inform before you perform.” With the progression of risk management from properly completing records to obtaining proper informed consent, the current level of risk management includes the inclusion of the patient in a discussion that allows the patient to be able to take part in his or her treatment plan’s decision-making process [4]. I refer to this as a “co-diagnosis”

All these developments in risk management, from records to informed consent to the actual inclusion of the patient in the decision-making process, are important to prevent an alleged malpractice lawsuit. Other current views include “treat your patients as your friends,” “a value-centered practice,” and “make your patients part of your dental team,” though risk management has now evolved to a new proactive perspective: practice enhancement through risk management [5].

Before further discussion of risk management, basic knowledge, and the dos and don’ts of risk management, be sure to understand the difference between an incident and a claim.

If you truly believe the problem is only an incident that is easily corrected without a patient’s legal threat, then try and work out a solution agreeable with the patient. As the saying goes, “The secret of life isn’t what happens to you, but what you do with what happens to you.” When confronted by an upset patient, there are several key guidelines you should follow. First, make sure you understand the patient’s problem: what he or she is actually angry about. Be very attentive and listen. Then look at it from the patient’s point of view: be understanding and empathic, not sympathetic; don’t try to placate the patient. Have confidence in what you are saying and stay calm at all times. Ask the patient, “How can I make you happy?” Then work toward a positive solution for you both. Keep in mind that an alleged malpractice lawsuit, even if it is found in your favor, will be emotionally, physically, and financially draining. However, be alert to the legal ramifications of returning the patient’s money, paying another healthcare provider, or redoing treatment for free. Each of these situations may return to haunt you. If a basic mutual understanding of how the problem will be resolved is agreed upon, be sure to do it properly. If not executed with care, it may appear to be an admission of wrongdoing (malpractice)

in the eyes of the patient and his or her attorney. In such cases, guidance from your malpractice carrier may be worth their involvement.

TRUE CASE 25: Too many "near misses"

The dentist who graduated dental school approximately 5 years earlier had several incidents where patients made complaints about several different treatments, including removable partial denture, complete denture, a root canal, and surgical postoperative infection. Over those past 5 years he had contacted the insurance carrier regarding how to handle these incidents. All situations were eventually treated, corrected, or satisfied without any malpractice claim. When it came time to renew the dentist's malpractice insurance, he was told that it could not be renewed at the same rate. Either he would have to pay an additional premium or he would be refused coverage due to the fact that he reported, in their opinion, too many incidents. This led the insurance company to think that he had a problem. The dentist retained coverage elsewhere.

THE DOS AND DON'TS OF RISK MANAGEMENT

1. *Do retain your records as long as possible*. Do not ever give original records or radiographs to anyone, including your attorney or insurance company, unless under a court subpoena.

Having been involved in many defense and plaintiff attorney offices, I usually see one or two unmarked, unnamed small radiographs floating around or even on the floor. With today's digital radiographs, retrieval is much easier unless they have been deleted. Prior to any radiograph deletion, be sure to print out several copies and mark them as final copies. No deletion should be made prior to the time when the statute of limitation has run its course. It would be best to electronically archive and not delete the old digital images, if possible.

If you are employed, make certain the employer retains the records for at least 10 years after you leave and that you have the right to have access to those records if needed. If you are selling your practice, be sure the buyer retains the records at least 10 years after the sale and that you have access rights to those records if needed.

Both of these situations are necessary with employment or buy/sell contracts so you can have access to needed records in the case of an alleged malpractice lawsuit. Without such agreements the other party may not allow you access without a court subpoena or may even destroy the old records.

2. *Do document all canceled appointments, late arrivals, and no-shows, along with any reasons given*. Do document the patient's failure to cooperate with your care,

including home care instructions. Both of these documentations allow and support the defense's argument of contributory negligence.

3. *Do obtain and document valid informed consents and informed refusals*
4. *Do not use abbreviations in the records that are not universally used.* Do use only those abbreviations which would be understood by any dentist. In the case of an expert's review of the records, if the abbreviations are not understood correctly, the expert may interpret wrongly. Also, ethically, under the concept of non-malfeasance, another dentist may misinterpret your abbreviation and subsequently and inadvertently cause harm by his or her reliance on your abbreviations.
5. *Do medical consultations and document them when necessary.* It is very easy to believe you have a great understanding of the patient's complicated medical history and you are only doing a small, noninvasive procedure, and that a medical consult is not needed until the patient has an unexpected adverse reaction in your office.
6. *Do ask patients for any changes in their medical history at every appointment or as necessary.* There are many changes that may occur to a patient between appointments that the patients think are unimportant to dentistry but in reality have a great impact.
7. *Do inform the patient and document it when things go wrong.* The sooner the patient is told and understands the complication or bad result, the sooner the statute of limitations start tolling. Of course, it is best to correct the situation if possible.
8. *Do not practice beyond your ability.* Knowing your limitations is one of the best ways to prevent a lawsuit. If you are attempting a newer procedure be sure to have been properly trained and have informed the patient that the procedure is new, such that a valid informed consent occurred.
9. *Do not practice beyond the scope of dentistry as defined in your state.* Many states do not allow Botox, collagen injections, rhinoplasties, or other such procedures to be done by dentists. Writing a prescription for an employee who you think only has a cold and who delays treatment, only to end up in the hospital with a more serious condition due to detrimentally relying on your advice and prescription, may cause a court to find you are practicing medicine without a license. Additionally, the removal of all amalgam restorations from a patient to

treat alleged allergies without a medical consultation supporting such treatment may also cause a court to find you are practicing medicine without a license.

10. *Do maintain proper medical emergency protocols and periodic employee training.* This is a necessity on all levels: ethical, legal, risk management, and practice management.
11. *Do refer patients to the proper practitioner when necessary.* Ethically, beneficence, the patient's well-being, should always be at the forefront of your patient care. The standard of care requires you to properly refer the patient.
12. *Do not allow patients to dictate what treatment should be done.* Although patient autonomy is important, the ethical cornerstone of nonmalfeasance also comes into consideration such that the dentist may not participate in the patient's self-injury. In other words, the dentist must not perform treatment that is not in the patient's best interests.
13. *Do not abandon the patient.* Dentists, who have not only an ethical duty but also a duty to fulfill the standard of care, must be available or arrange for after-hours emergency care for their patients. Do not allow the staff to deflect all patient inquiries when they ask to speak to the doctor. Finish all treatment in a timely manner.
14. *Do be available to be contacted or make arrangements for patient care 24 hours a day, 7 days a week.* A dentist's not being available is one of the top reasons lawsuits are initiated.
15. *Do not discriminate or be biased.* Be professional, fair, and just to all.
16. *Do not accept litigious people as patients.* It is difficult to see the unspoken intent of a patient intending to sue regardless of the treatment rendered. Watch out for "patient setups" such as: "You're the doctor, whatever you think is best" or "Do you guarantee your work?"
17. *Do not return a fee without a Release of Liability (also called a Release of All Claims).* The return of a fee without such a signed document may be used to show guilt or the dentist's consent that treatment was wrong.
18. *Do not sue a patient to recover a fee unless you have reviewed the treatment rendered and the chart and know that they will be able to survive the scrutiny of a malpractice claim by the patient.* It is highly advisable to pursue other avenues of collection prior to any lawsuit, including those in small claims court, to collect a fee. Phone calls, internal office letters, and a collection agency familiar with healthcare collections may be a better route to collect fees. Prior to any

collection effort, always talk only to the patient (due to the Health Insurance Portability and Accountability Act [HIPAA]) or guardian (if the patient is under 18) and be understanding of the patient's situation. Endodontic and prosthodontic treatments are easy targets for an unhappy patient's attorney.

19. *Do not assign employees illegal job duties.* Be fully aware of your state's allowed auxiliary job duties. For each employee who has any type of licensure, update yearly as needed to make sure he or she is still registered or licensed.
20. *Do listen to what is being said by your staff.* There are many situations that occur in the dental office of which the dentist is not aware due to the fact that he or she is normally busy treating patients. The staff may create an unnecessary problem not only by what is said but also by their attitude toward a patient. Additionally, patients notice disgruntled employees or if intra-office bickering is allowed to interfere with patient care and staff interaction.
21. *Do not have staff block patients' phone calls.* Patients often feel they are justified and understood better if only they could speak to the doctor. Most times the patient only needs to express his or her concerns. In this way a small problem can be kept from becoming a major one.
22. *Do check out references of new employees.* Always try to put trust in a newly hired employee to substantiate that your decision to hire the person was a good decision.
23. *Do keep a sample of employees' signatures and initials.* When a lawsuit strikes, there will be questions regarding who made which entries in the chart. Years may pass by and employees come and go. You may have only an undecipherable scribbled initialing to which to refer.
24. *Do have all employees trained per OSHA, HIPAA, infection control, blood-borne pathogens, and Heptevax-vaccinated regulations.* It's the law.
25. *Do document employee training and necessary periodic meetings.* When having an office meeting, always discuss topics as required by law and keep a log or sign-in sheet to verify that employee training is ongoing.
26. *Do maintain adequate malpractice insurance that will cover any new treatment you are providing.* With the advance of newer procedures and the expanded continuing education courses available, always contact your insurance company as to how these new treatment modalities (e.g., implants or Botox) will affect your malpractice insurance.
27. *Do keep all the billing proper.* Use the correct treatment codes and do not "expand" or "upgrade" to a better paying code. This type of misrepresentation

is fraudulent billing. If the insurance-authorized treatment is different from that which you and the patient believe is proper, then write an appeal explaining the situation rather than simply billing wrongly.

28. *Do not overbill or double-bill the patient's dental insurance company.* Do not accept the dental insurance payment as full payment when it is meant to be a percentage of the fee and forgive the patient's portion of payment. When the patient portion or percentage of the bill is forgiven when the insurance only pays a percentage of the total bill, then the true total billing is the amount the insurance paid. Hence the insurance paid 100% of the bill when it should have paid only a percentage of the bill. This type of fraudulent billing is not covered under your malpractice insurance.
29. *Do review patient charts daily.* Daily or at least weekly, the dentist should skim through the charts of the previous day or days to make sure entries are correct, proper follow-through by the staff is occurring, and to have the opportunity to make a "late entry," if necessary, when recollection is clearest.
30. *Do call patients the night after surgery, root canal, or an extensive treatment or problem.* By doing so, the dentist will be able to pick up on any post-treatment problem such as unforeseen pain, bleeding, or swelling. Also, it is a great practice enhancement since patients appreciate the concern shown in a follow-up call.
31. *Do periodically review patient bills and insurance forms the staff has been submitting.* There have been cases against dentists for fraudulent billing by a partner or staff member, while the dentist had no idea that it had occurred. Nevertheless, you will be held responsible via vicarious liability/respondeat superior.
32. *Do check expiration dates on all supplies.* If an employee is given this job duty, be sure to check up on his or her progress once in a while to make sure emergency drugs, anesthetics, and other such items are safe.
33. *Do complete exams before extensive treatment.* Many patients are new to a practice due to an emergency such as pain, swelling, or a fractured tooth or denture. Inevitably, after the emergency is treated successfully, the new patient will seek treatment for other dental concerns. Rather than treating each patient concern or emergency as it arises, a complete exam and treatment plan should take place to prevent improper treatment outcomes (radiographs, PSR-periodontal screening, cancer screening, temporomandibular joint [TMJ] screening).
34. *Do keep treatment plans prioritized: pain, infection, function, aesthetics.* Many treatment plans may become multifaceted and require treatment to take place over numerous months or even years. To keep the patient and yourself on track with a proposed treatment plan that changes due to the lapse in time to complete, break down the treatment so the patient can easily understand that priorities

will be patient-centered and that treatment will be provided first for pain, then infection, function, and aesthetics.

35. *Do have the patient understand his or her financial responsibilities before treatment is rendered.* As emphasized under informed consent, cost is often a determining factor in a patient's consent to the proposed treatment.
36. *Do not promise or guarantee treatment outcomes.* To guarantee treatment outcomes is against the standard of care.
37. *Do not make statements that may be used against you.* Statements against your interest that are made at the time of an event or incident may be used against you in a court of law (Res Gestae Exception to Hearsay). The statements made by employees may also be used against you. So be very careful that you or your employees do not blurt out, "Oh no," "Oops," or any other exclamation that may alarm the patient and be used against you in a court of law. Remain professional and calm when situations arise that may be less than ideal.

IF YOU ARE SUED

Approximately one in seven dentists will be sued during his or her professional career. That statistic takes into consideration the fact that some dentists may be sued several times and others never. Also, many people sue for reasons other than having been damaged, for example, the patient needs money, dislikes the staff and/or the dentist, doesn't want to pay the bill, or has a relative who is an attorney. Also, some unethical attorneys may pursue cases for the need to keep busy or to pay rent. Patients may be angry or dislike the dentist for a variety of reasons: the dentist makes too much money, or the patient is in pain and the dentist seems unsympathetic. It is how you handle these types of patients and what you do after things do not work out as planned that makes a big difference in whether or not the patient seeks legal advice.

TRUE CASE 26 (True Case 6 revisited): Dentist leaves state

A state dental board requested a review of several malpractice cases against the same dentist. It was revealed that there were seven cases for review with more pending against this dentist, and the state board wanted to revoke his license. During the process of review and eventual revocation, the dentist relinquished his license to the state board only after he applied for and received a license in another state. Hence, some dentists account for more than that one in seven.

Nevertheless, you need to know what to do in case you find yourself a defendant in a lawsuit. First, if you have employed proper risk management techniques and treatment protocols, you should reassure yourself that being named in the lawsuit does not mean you did anything wrong. As mentioned before, some patients are just litigious people who cannot be foreseen. Being sued affects you emotionally in that you start to question yourself and begin doubting your treatment. Do not panic; these are normal reactions or feelings. Do not call the patient or the patient's attorney. Call your malpractice insurance company immediately. A claims advisor will be most helpful in guiding you through the situation. First remove the chart from general circulation within your office. Review the chart carefully, acting as a "devil's advocate" and questioning your chart for completeness and integrity. On a separate sheet of paper to be kept apart from the file, write down to the best of your recollection what happened. Do not talk to any colleagues regarding the case. Only talk to staff on an as-needed basis. Above all, do not write in the chart or make any changes to the chart.

TRUE CASE 27 (True Case 2 revisited): Changing the chart

After being an expert witness many times, you can usually get a feeling on how the jury is accepting your testimony, in other words, whether the jury is accepting the expert's testimony as the truth. The credibility of the expert witness's testimony is paramount in establishing a solid defense. In this example, after successfully making a solid defense for the dentist, the plaintiff's attorney started to cross-examine. The defense failed to show substandard care. Then the expert was told to read what was written at the top of page three of the patient's chart. After reading what was written, the plaintiff's attorney asked to read what was above that which was just read. The expert said his copy had nothing written above. The plaintiff's attorney proceeded to produce a copy of the patient's chart that had been altered by the dentist. Rather than win the case easily, not only did the dentist lose the case, but the jury came back with damages far exceeding that which was originally sought. Therefore, do not make changes to the chart!

Make complete copies of the chart, including radiographs, the attorney's letter, and any other correspondence. Do not give the originals to anyone, including your attorney. Give the originals only on a court-ordered, subpoenaed request. Attorney's offices are just like any other office in which things fall out of folders and get lost. With today's digital imaging and computerized records, the chance of lost records is lessened, but things can still be accidentally misentered or even deleted. Be sure to check your malpractice insurance if there is a settlement clause whereby the insurance company may settle your case against your approval, or where you may be responsible for any amount above the insurance-approved settlement amount if the successful claim is higher. If the claim is significant and may be beyond or close to your coverage limits, retain a personal attorney to protect you personally.

During any examinations before trial (depositions, arbitrations, settlement hearings) always dress professionally. Answer questions only if you are absolutely positive of the answer. Do not guess the answer or try to impress the attorney, judge, or jury. If you do not know the answer or do not understand the question, simply say so. If necessary, ask to hear the question again or to have it rephrased. Do not lie or try to outwit the attorney. He or she has been trained to ask leading questions that may lead you down the wrong path, which you will not realize until it is too late. Be aware of leading questions and also those questions in which the attorney rephrases your previous answer in a following question, such as, “Isn’t it true that,” “You are aware that,” or “You said that.” Always be sincere in your answers and polite. Do not show anger or contempt.

There is no way anyone can predict the outcome of a lawsuit due to the many players and facets involved: dentist, patient, dentist’s attorney, patient’s attorney, expert witnesses, judge, and jury. Most dental cases are settled before trial, as the costs of a trial and the damages, relatively speaking, are small.

PRACTICE ENHANCEMENT THROUGH RISK MANAGEMENT

Both practice enhancement and risk management discussions have a basis in good patient communications. Through risk management, dentists attempt to prevent lawsuits by informing patients (and receiving their consent) through proper communication. In practice enhancement, dentists attempt to have patients accept a treatment plan of optimum dental care through communication [6]. Risk management began as a tool to strengthen a dentist defendant’s defense in a malpractice lawsuit. Emphasis was first placed on proper chart entries to provide complete dental charts of the treatment performed; hence the mantra “Records, records, records.” Then with a rise in lawsuits seeking damages on the basis that the patient was not properly informed of all the risks, it was widely proclaimed, “Inform before you perform.” These both are important teachings to reduce successful lawsuits. Newer phrases include “value-centered practice” and “evidence-based practice” [7]. However, all these risk management views do not truly approach risk management in a proactive manner.

The 2005 ADA survey of fifteen dental malpractice insurance companies uncovered the top three dentist–patient communication problems:

1. Critical comments of the insured’s work made to a patient by another dentist
2. Professional liability claims filed in retaliation for billing or collection problems
3. Lack of or poor communication between a primary dentist and a specialist [8].

The total inclusion of the patient in the decision-making discussion truly enhances the practice and manages malpractice risks. Risk management actually begins prior to the patient entering the dental office. Communication with the patient begins in the external marketing/advertising of the practice and the image or perception of the dental office. Prospective patients have an impression of the office through the direct discussion/referral from another patient, external advertising, Internet websites, and dental insurance information/provider lists. Prospective patients' impressions are also affected by the internal marketing of the practice through the manner in which the first phone call is handled, office décor, office cleanliness, and proper scheduling. All these things make an impression on the prospective patient before the first entry into any chart is ever made. That impression adds to or takes away from the trust that should develop in a positive doctor-patient relationship. The more the trust the patient has in the dentist and the office, the less chance of a falsely accused malpractice lawsuit and the patient questioning whether the dentist's treatment is or was right.

Once the patient has filled out all the proper initial visit forms, the dentist and the entire dental staff must take part in developing a trusting doctor-patient relationship. Before the dentist ever meets the patient, there have been at least three patient contacts made that have already influenced the patient's attitude toward the dentist and his or her office:

1. How the phone is answered
2. How the patient is welcomed to the office and requested to fill required forms
3. How the assistant or hygienist greet and treat the patient.

The dental staff is very much a part of the risk management effort. Communication is necessary not only between the patient and the office but also between the staff and the dentist. Without proper intra-office communication, patient care may not be optimum.

TRUE CASE 28: Who knows what is going on?

The patient showed up on time for her appointment for the crown preparation of a molar. The patient was in need of several crowns, including #18 and #19. The schedule only noted that the appointment was for a crown on the lower left. The dentist anaesthetized the lower left. Knowing the patient wanted to have only one crown due to the expenses and that only one of the two teeth was approved by the insurance company because of yearly maximum limits, he proceeded to prepare the worst of the two needed crowns on the lower left, #18. During the appointment, the assistant noticed in the chart that tooth #19 was actually the tooth approved by the insurance company. The dentist immediately informed the patient of the

(Continued)

miscommunication and stated that if it was okay with the patient, he would also do the tooth that was approved by the insurance company since it was already numb. The patient agreed but questioned if she would have to pay for the other tooth already started but not covered by insurance. The dentist, ethically and legally accepting the fact that he had prepared the wrong tooth, explained to the patient that #18 was the worse of the two teeth and that he was sorry for the mixup. He then informed her that there would be no charge, but if at all possible she should cover the lab fee. The patient, knowing that the tooth did need the crown, agreed to cover the lab fee, and was thankful to the dentist for being honest about it.

The initial exam in any situation other than emergencies should include, but should not be limited to, a complete examination, a full medical–dental history, measurement of blood pressure and pulse, periodontal charting or a periodontal screening report (PSR), cancer screening, TMJ screening, a full set of radiographs, and a caries/restorative examination. The examination may entail more diagnostics (such as intraoral photographs, hot/cold testing, CAT scans, cone beam images), depending on the treatment needs of the patient. On examination, any diagnostic procedures performed and the results therefrom must be recorded, a treatment plan must be developed, the patient must be informed, and the treatment or refusal of treatment must be recorded, or the patient should be referred to the proper professional.

It is strongly advised to perform a complete periodontal charting on any patient more than 25 years old or on those younger if indicated via radiographic or visual examination. If the radiographic and visual examination does not reveal a need for complete periodontal charting, then a PSR as promoted by the ADA and the American Academy of Periodontists may be sufficient. It is an easy and quick way to screen for periodontitis. Simply “walk” the periodontal probe around each tooth and spot check areas of concern as indicated on the radiographs or as visually observed. Then divide the mouth into six parts (sextants) and record the deepest pocket in each section. A code of 0–4 is then given to each section. A section with a code of 0 (all probings \leq 3 millimeters, no bleeding, no calculus, and no defects) is healthy and only requires routine preventive care. A section with a code of 1 (all probings \leq 3 millimeters, bleeding present, no calculus, and no defects) requires subgingival plaque removal. A section with a code of 2 (all probings \leq 3 millimeters and supra- and subgingival calculus present) requires subgingival calculus removal. A section with a code of 3 (probing $>$ 3 millimeters and $<$ 5 millimeters and supra- and subgingival calculus present) requires full mouth charting and scaling. A section with a code of 4 (probings $>$ 5 millimeters, supra- and subgingival calculus present, and osseous defects) requires full mouth charting, scaling, and root planning, as well as referral

to a periodontal specialist or further periodontal treatment after re-evaluation [9]. Oral hygiene instruction should always be given to a patient, including the proper cleaning under bridges and proper cleansing of removable appliances.

Patients older than 25 years should also receive a cancer screening (younger if the patient is a smoker or in another high-risk group), and a TMJ screening if temporomandibular dysfunction (TMD) was present prior to any treatment rendered (this prevents a claim of causing iatrogenic TMD).

Having good diagnostic skills is an important step in risk management but also in practice enhancement, because if you do not diagnose it, you will not treat it. As a result of skilled diagnostic time with the patient, the practice will have improved production and, subsequently, profit. Even with superior diagnostics, the most important factor in preventing a lawsuit may be left out: trust. The dentist must gain the patient's trust to truly allow practice enhancement through risk management to take place. To gain the patient's trust, the dentist must strive to include the patient in all treatment discussion to the level of actually having the patient "co-diagnose" his or her dental needs.

If the digital images (both radiographs and intraoral photos) are the size of the monitor screen, it is relatively easy to show and involve the patient. By listening to the patient about what is perceived as his or her dental needs and wants, the dentist is able to bring the patient into the treatment plan discussion. Once you understand the patient's concerns, desires, and expectations, you can turn his or her needs into wants through an educational discussion, thereby raising the patient's "dental IQ" one notch. It is advised to empathize and to understand the patient's life from the patient's perspective. He or she has numerous other responsibilities and obligations that may impact the decision-making process. Through this discussion, the dentist is developing a trusting doctor-patient relationship that decreases the chances of a lawsuit, since the patient is trusting and the avenues of communication are open in case of an unexpected problem.

Treatment plans may be confusing to a patient with limited dental knowledge. To help clarify the proposed treatment and its sequence, it is best to prioritize the treatment in a way the patient can understand it. The treatment plan should be prioritized, as previously discussed, into four categories: pain, infection, function, and aesthetics. Of course, there are times when these categories intermingle and must be considered equally at the time of treatment [10]. More time should be spent discussing the results of the proposed treatment rather than how the treatment will be done or how well the dentist can do it. Patients perceive dental care, except when in pain, as a discretionary expense; they view it with respect to what value the proposed treatment will have in their lives. Raising the value of treatment to the patient by raising his or her understanding (dental IQ), the patient's needs turn into wants. What has developed is an enhancement to the practice when patients understand the need and value of

the proposed treatment, and a fulfillment of risk management for the practice when the patient has developed a full trust in an understanding, knowledgeable, and caring dentist. Normally, people do not sue people they trust.

Patients with dental emergencies often need immediate attention. Often these types of appointments are rushed. When fitting an emergency patient into a tight schedule, some of the usual patient evaluations may inadvertently be sidestepped. When the emergency patient comes in, be sure to follow proper patient medical history evaluation, including taking blood pressure. Full documentation of emergency treatment is a must. The “SOAP” rule is the best example of how to organize the emergency:

S: Subjective comment of the patient. It is the patient’s chief complaint.

O: Objective evaluation. These are your diagnostic tools and their findings used to evaluate the patient’s chief complaint.

A: Assessment, analysis, diagnosis. This is the differential diagnosis of the patient’s complaint.

P: Plan the treatment. This is the treatment plan with alternatives rendering a successful treatment of the patient’s complaint and needs.

There are also the medical emergencies that may erupt unexpectedly. Legally and ethically you need to be prepared and up-to-date with emergency training and protocols, equipment, and medications. You also are expected to have your staff properly trained in emergency situations that might occur. An office meeting once or twice a year to reinforce emergency situation responsibilities and training/drills helps to keep everyone up-to-date and attentive to potential emergencies.

The scheduling of the patient is another key to practice enhancement through risk management. Enough time must be given to properly develop a trusting doctor-patient relationship. Some patients require more time than others. When insufficient time is allotted, the patient perceives the dentist as rushed and uncaring. Therefore, it is important to properly schedule sufficient time to allow the patient to ask any questions and feel he or she has the dentist’s full focus during the dental visit. Even long-term patients may find their trust in the dentist slipping if the dentist begins to take the patient’s trust for granted or does not focus entirely on the patient. Therefore, it is always good to remember that there is a mutual investment in the doctor-patient relationship that must always be protected.

Once the patient leaves the office, the practice enhancement through risk management continues. After any traumatic treatment such as endodontic therapy, periodontal surgery, or extractions, making a follow-up call that evening or the next day promotes the quality of care, keeps you aware of any patient concerns, and allows

you to prevent those unexpected problems that unnecessarily complicate the doctor-patient relationship. It is always better for the dentist to head off a situation rather than to wait for the patient to question a situation that would weaken the previously built trust.

Another important step in risk prevention is to review the charts from the previous day or days before they are filed away, to be aware of any small problems. There are three things to look for:

1. Did the patient make a next appointment or was the patient placed on the proper maintenance recall?
2. If the patient did not make an appointment, was the patient placed on a “to be called” list, or in some kind of notebook that lists those patients who need to be called for a follow-up appointment?
3. Are the chart notes accurate and complete?

If any problem is found with the above, easy and fast correction may be made prior to a small situation developing into a massive miscommunication. It is also an excellent way to make any notes that were inadvertently missed. If you do, do not change the chart. Date a new entry, mark it as a “late entry,” make your notation, and sign it. Your best chance to make the addition properly is when your recollection is clearest. If the change is substantial, then the patient must be informed of the change at the next visit (if reasonably soon), must be called to discuss the change, or should come in to have his or her understanding clarified and the chart entry rectified. Making a late entry is a rare occurrence, but the accuracy and truthfulness of the chart is paramount.

Therefore, five major practice enhancements exist from using good risk management techniques:

1. Improve the quality of practice
2. Improve practice production
3. Improve practice profits
4. Decrease the practitioner’s stress
5. Decrease the costs to defend malpractice lawsuits.

By using simple, time-effective risk management techniques, the dentist will also find an increase in treatment plan acceptance by trusting patients through proper

communication and co-diagnosis. Through the proper patient communication by the doctor and the staff, a great doctor-patient relationship will develop, such that risk management is easily accomplished and the threat of a lawsuit is greatly lessened.

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