Getting clear on clearance

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Most of us do it in one way or another and at one time or another. We try to pass the buck. We think we do it for a good and valid reason; sometimes it is, but we do it most often in an attempt to cover our derrieres. What is this thing we all do that doesn't mean as much as we think it does? We send clearance letters. You know, the ones you send to the general dentist, pediatric dentist, periodontist, oral surgeon, and so on. The ones that say in countless ways, "please clear Mary Smith for orthodontic treatment." You want to know that Mary has seen someone who will assert that she is cavity free and her soft-tissue support is compatible with the initiation or continuation of orthodontic treatment, as the case may be. Yes, my friends, we seek clearance.

What is clearance? Essentially, you are seeking a consultation. You want the consulting doctor to tell you that yes, Mary has no cavities, and she should be seen at XYZ intervals for routine checkups that can include, but are not limited to, a periodic examination, acquisition of appropriate radiographs, routine prophylaxis, or some other type of periodontal therapy. You want this oral health care practitioner to say that Mary's supporting soft tissues are free and clear of any infection or inflammation, and that the soft supporting tissues can withstand the rigors of orthodontics. For example, this might include stressing the attached gingival tissues if you are embarking on expansion therapy. You believe that having this clearance letter will protect you if the patient's treatment takes a turn in a southerly direction. You believe in that event you can wave this piece of paper like a banner on high, puff out your chest, and say: "See, I did what I was supposed to do. I got clearance. I was told everything was okay. It's not my fault that Mary suffered from undetected or, worse, untreated caries. It's not my fault that her perio condition was exacerbated; I was told that everything was okay." If those aren't the exact words, I'll bet they're close.

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In *Elias v Bash*, 54 AD3d 354, lv denied 11 NY3d 711, 2008, about an hour after giving birth, the patient suffered a drop in blood pressure. Her ob-gyn called in a number of specialists including a cardiologist, who performed an electrocardiogram and an echocardiogram. He ruled out cardiovascular disease and a heart attack and advised the defendant that he should look for possible internal bleeding somewhere. The specialist returned later in the day to check on the patient and discovered that she was slightly worse off. He recommended a CAT scan and opined that there might be pelvic bleeding of some type, and it could be life-threatening if it continued to be unresolved. On checking the patient the next day, the cardiologist noted tachycardia and prescribed appropriate medication to address the problem, indicating again that internal bleeding might be causing all of these symptoms. The next day, the patient went into cardiac arrest, and the cardiologist's partner was in the process of inserting an intra-arterial line when the patient died. A pathologist determined the cause of death to be an amniotic fluid embolism causing intravascular coagulation leading to massive bleeding in the arteries supplying the rectus muscle.

A lawsuit was filed, and the jury decided that the cardiologist was 2.5% liable and his partner was 10% liable. Upon appeal, these 2 awards were nullified because the appellate court ruled that they were against the weight of the evidence, since the defendant's actions had nothing to do with the patient's passing. The court stated:

> The evidence presented at trial demonstrated that [the cardiologist] reporting his findings to the attending physician, and [made] appropriate suggestions for follow-up. Although the plaintiff's expert opined that [the cardiologist] should have taken additional steps to ensure that the bleeding was resolved either by exploratory surgery or embolization, it is undisputed that [the cardiologist] clearly and repeatedly advised the attending physician, who was an obstetrician, of the necessity of checking for intra-abdominal bleeding. Moreover, it is also undisputed that [the cardiologist] . . . did not practice obstetrics, gynecology, or surgery. Under these circumstances, there is no rational basis to support a jury finding that [he] departed from good and accepted practice by failing

> to take steps, beyond the normal scope of his role as a consulting cardiologist and outside of his area of specialization, to resolve a suspected post-surgical bleed.

The court also cited another case in fashioning its holding by noting the following.

> [t]he duty the doctor owed to the patient once the doctor became a mere consultant was "to advise and make appropriate recommendations to the plaintiff's treating physician. The primary duty of a consulting specialist is to advise and make recommendations to the treating physician himself who may, then, with full knowledge of the patient's history and other conditions, make the ultimate decision as to the scope of the information that should be given to the patient." (cit. omit.)

COMMENTARY

Although in this case the players were both specialists, the legal precepts are the same as when we are dealing with a specialist and a generalist. One doctor sends the patient to another doctor to (1) get an opinion about XYZ, (2) treat whatever findings the referee discovers that are within the scope of his or her practice, (3) make any recommendations that need to be followed, and (4) be available for further follow-up consultation if necessary.

I don't know any orthodontist who was not a dentist before deciding to become a specialist. We were all taught how to examine the oral cavity for signs of hard-tissue and soft-tissue diseases or abnormalities. We were all taught how to read radiographs to diagnose caries and periodontal breakdown. We were all taught basic oral pathology regarding both hard-tissue and soft-tissue anomalies. The bottom line for me is that we are dentists first and specialists second. Why is that? You can be a dentist without being an orthodontist, but you can't be an orthodontist without being a dentist. The only other way to practice orthodontics without being a dentist is to be a high school graduate working for an orthodontist as an expanded-duty auxiliary, but that's another story.

As a dentist who is an orthodontist, you are quite capable of performing a caries examination as well as probing and periodontal examinations. I cannot tell you how many times (and I hear this from countless orthodontists every year) I have sent a patient to have some cavities filled before initiating treatment, and the patient returns with caries still present. Another peeve I have is when I refer a patient because of a periodontal inflammatory condition; when the patient returns, the problem is still there, but the patient thinks that because she had a cleaning (read that as *prophy*) all now is right with the world, and it is okay to strap the case up.

Sending a patient for clearance is nothing more than an example of how orthodontics, in its own small way, is contributing to the spiraling rise in health care costs as a result of practicing defensive medicine. If the patient had a clean mouth, virgin teeth, good oral hygiene, a good history of routine general dental visits, and so on, do you really need to send a clearance letter? Conversely, if you send a clearance letter and the patient comes back "cleared" but you can see that all is not right with the world, are you now cleared to start, and have you absolved yourself of any potential liability merely because you have another doctor's say-so? Of course not.

Remember the bottom line: it is the treating doctor who, after making a referral, obtains whatever feedback there is to receive from the other doctor. Then, using one's SKEEE (skill, knowledge, expertise, education, experience), the treating doctor makes diagnostic and treatment decisions including the preferred mechanotherapeutic approach in conjunction with the patient's desires and input. You are the treating doc. You collect the information you need to collect. You make the treatment recommendations. You ultimately make the decisions. You are in charge. You get the big bucks. But you shoulder the responsibilities. As was noted earlier, it is the responsibility of the treating physician "who may, then, with full knowledge of the patient's history and other conditions, make the ultimate decision."

Clearance is merely a way to obtain clear information to clarify what is now muddy and to provide this information to the patient so that there is a clear understanding of what needs to be done. Obviously, you can see that merely sending a clearance letter espousing certain recommendations does not mean that you are in the clear because you didn't see what was right in front of you. Clearance letters do not necessarily clear the patient or clear your conscience.