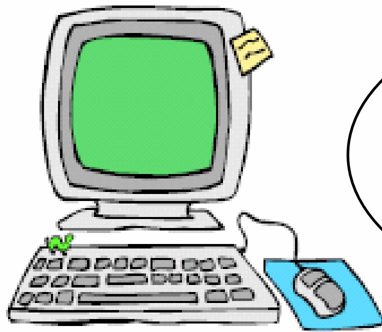

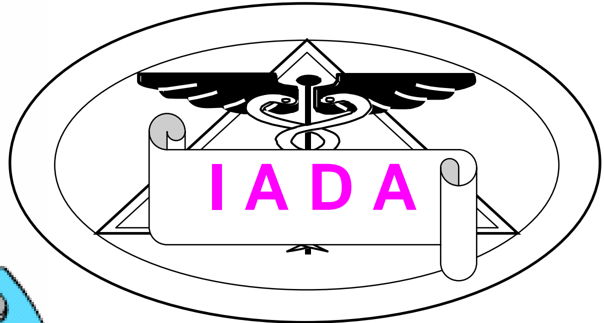

IADA

PRESENTS

Risk Management in Dentistry

(3) Home Study Credits

Risk Managements in Dentistry

DISCLAIMER: The responsibility for possessing a working knowledge of the CDC OSAH dental board, federal and local law and regulation is an important aspect of holding a license in dentistry. Professionals must be current with the latest legislation and regulations affecting their scope of practice and conduct. One way to accomplish this is to belong to your professional organization where you will be informed of changes that impact your profession. Another format of current information is the CDC, OSAH, CAL-OSHA , COMDA and DBC websites as well as the California Legislative Information website. Additionally you will gain information by participating in continuing education courses on the topic. As the DBC and COMDA meet five times a year, you can monitor the changes that take place as a result of these meetings. Regardless of the method employed, it is ultimately the licensee's responsibility to enhance his/her skills, competency, and knowledge and to be aware of changes in the laws and regulations that govern the practice of dentistry. This course doesn't provide legal opinion or counsel. The Dental Practice Act and California Code of Regulations, Title 16 CDC OSAH CAL OSAH Regulations are constantly changed, revised, amended with new regulations and requirements, new divisions and departments. It is your responsibility as dental practitioner to understand your legal obligations and license requirements set forth by the Dental Board of California. While Author/ editor believes the information to be reliable, human or mechanical error remains a possibility as does the delay in the posting or updating of information. Therefore, Author/editor makes no guarantee as to the accuracy, timeliness, currency or correct sequencing of the information. We are responsible for the misuse of the information in the course material. Do not take anything in this course as "Legal Advice"• Author is not an attorney• My interpretation of the Board Rules may not be the same as the those made by the State Board. Author assumes no responsibility for actions taken based on the information herein.

Risk Management: The Top 10 Mistakes Dentists Make

Identifying risks can prevent malpractice lawsuits.

Risk management in a dental setting can be of great benefit for little expense. It's easy to educate a staff to promptly identify and investigate problem situations. Recognizing the need for good documentation and identification of problems can help you avoid claims and lawsuits. While these techniques will not always prevent a claim, they will provide the best defenses to claims.

Mistake No. 1

Failure to recognize problem patients

Early recognition of problem patients is important for risk management. Problem patients may exhibit traits that include lengthy care histories from many providers, courses of care dominated primarily by emergency visits, constant complaints about past or current care, ongoing failure to pay for services, and consistent failures to adhere to advice and instructions. These traits are common in plaintiffs and litigious patients. Prudent practitioners who identify these traits early may discharge or not accept these patients. Often, such decisions save time, money, and aggravation. If you care for such a patient, document the care and issues of the problem.

Solution: Develop systems that will alert you to problematic patients early to determine if patients are worth long-term aggravation.

Mistake No. 2

Pursuing collections for patients where care may be at issue

Many malpractice claims arise when dentists pursue collection claims. Once a malpractice claim is filed in response to a collection claim, a defense to the malpractice claim (however thin) must be made. It is within the control of the practitioner to pursue formal collection of monies owed, but much of the dentist's control of the situation becomes lost. Therefore, any decision to pursue a collection matter - by letter or action - should be evaluated carefully before being pursued. Assess whether you are prepared to defend all of the care if a claim is made, as well as the nature and traits of the patient (i.e., is this a problem patient?). Weigh the amount of money involved against the risk of a claim. If a claim for collection is asserted, be sensitive to

the manner of collection and the personality of the person seeking the unpaid monies in further attempts to avoid a malpractice claim.

Solution: Perform a risk-benefit analysis before each collection attempt.

Mistake No. 3

Failure to advise staff of the need for consistent, accurate, complete documentation

A well-documented chart is the best witness in a lawsuit. It is made contemporaneous with events, it has no faded memory, and it has no bias or prejudice. Ensuring that all aspects of patient care are documented in a timely, chronological, consistent, legible manner is key to proving that you rendered good, quality care. The first thing a potential plaintiff's attorney will do to determine whether to file a lawsuit is to obtain and review a copy of the chart. A well-documented chart outlines all of the dental care and provides a clear chronology of the potential basis for a claim, with no gaps within which a plaintiff's expert can claim, "If it is not documented, it was not done." Every staff member who writes in the chart must be aware of these issues. Timed, dated, contemporaneous entries detailing the action, care, communication, prescriptions, phone calls, missed appointments, instructions, and refusals with consistent approved abbreviations make a good chart.

Solution: Document, document, document. Chart in a clear manner that can be deciphered by others.

Mistake No. 4

Failure to maintain a good chairside manner with patients

Patients who like and respect their providers are less likely to file lawsuits. The manner and method in which a dentist and staff members render patient care have a significant impact on decreasing or increasing risk. Even if quality care is delivered, if a patient has to wait 45 minutes for every appointment, never gets an apology, and the staff is brusque and unfriendly, that patient might become angry at the dentist or group. Staff members who cannot maintain good attitudes with patients should not deal directly with patients. If a serious or unexpected problem occurs, a patient who thinks he or she has a poor relationship with the dentist or staff members will not

hesitate to talk with a lawyer and pursue a claim. A good relationship with the patient can overcome that. If a suit is filed, a good patient relationship always works to the dentist's benefit in favorable testimony by the plaintiff and keeps damages down and plaintiffs reasonable.

Solution: A good chairside manner by you and your staff matters.

Mistake No. 5

Failure to designate a point person to oversee risk-management issues, recognize problem situations early, and investigate them

Early identification of problematic areas or trends that might result in claims can be beneficial, especially if corrections can be made before problems arise. Methods and procedures that identify and sort issues and spot trends must be instituted for prevention. The best way to identify problems is for a designated person to receive reports of problems, similar to the incident-reporting system at hospitals. Staff members must be educated to report events made in an office setting. Reports should be verbal only. For example, when a patient schedules a procedure and says that he or she does not understand the procedure or its risks, that should be reported to the point person. Such identification could show that a dentist's patients are not following the informed-consent process. Before a claim arises, you could educate the staff on the need to follow protocol, or additional double checks could be instituted. Early problems can be resolved prior to claims.

Solution: Designate a point person to oversee risk management and identify problems.

Mistake No. 6

Failure to avoid negative comments and remarks about other treaters or providers.

No dental provider or staff member should criticize other providers in front of patients or in a chart. Document facts, but critical opinions or comments heard or viewed by a patient or attorney will foster potential litigation and may serve as the basis for expert opinions in a lawsuit. Criticism of prior treatment will involve the criticizing treater in a suit against the prior treater. Beware also of patients attempting to

elicit criticisms - they may have already considered or instituted a lawsuit against another. Dentists are well-served in rendering treatment recommendations based on objective evaluation, not plaintiff's subjective claims or descriptions of the history of care.

Solution: Criticisms should not be part of patients' charts or communications.

Mistake No. 7

Failure to follow up

A common area for claims is when dentists fail to document follow-up with patients on important issues or recommendations. Copies of notes on failed appointments, reminder calls or notices, instructions, prescriptions, and attempts to ensure patients return for care should be part of the charts.

Solution: Follow up with patients and document that follow-up was done.

Mistake No. 8

Failure to properly discharge patients from care

Once a patient has been discharged from care, the statute of limitations may begin to run, and obligations under the dentist-patient relationship likely end. Often, this discharge process is informal and not well-documented. Creating a formal procedure and supporting documentation in the chart (including communication to the patient) will help establish a cutoff to liability.

Solution: Formalize the discharge process, and document the steps taken.

Mistake No. 9

Failure to refer when needed

Dentists who know and understand the limitations of their practices and expertise have taken a large step to manage and minimize their risks. Dentists who fail to do so might develop problems from lack of expertise, often resulting in patients seeking care from specialists. In this scenario, specialists, if pressed, often criticize general practitioners

as exceeding their expertise. Specialists can be favorable experts for plaintiffs, as by virtue of their specialties, their expertise is greater than that of general practitioners. When situations necessitate referrals, the referrals should be well-documented with reasons for referrals and, if urgent, prompt action should be taken with patients and specialists. Such actions could cut off liability for general practitioners.

Solution: Do not hesitate to refer when appropriate, and document the process.

Mistake No. 10

Reliance on systems designed to remove narrative progress notes and descriptions of communications

In a lawsuit, the chart and documentation of communication with patients and other treaters are the backbone of a defense. A well-documented chart is a key witness and preserves facts and actions forgotten over time.While technology can help busy practitioners, preprogrammed checklists or forms alone do not create the type of documentation most helpful to defenses. The narrative descriptions or issues pertinent to patients' care help create a more comprehensive picture of the entirety of care, as well as spark memories of those who might be called to testify years later. The clearer the picture, the better the defense.

Solution: Only use charting programs designed to allow and encourage narrative notes.

Table 1
Enforcement Program Staffing

Location and Position Classification	Allocated Positions July 2002	Allocated Positions Dec 2003	Comments
Sacramento Office			
Enforcement Supervisor II	1	1	Statewide Chief of Enforcement
Staff Services Manager I	1	0	Internally redirected – Examinations
Dental Consultant	1	0	Incumbent retired – Position abolished
Senior Investigator	4	3	1 vacant position abolished
Inspector	2	2	
Associate Govt. Program Analyst	2	2	
Consumer Services Analyst	3	3	
Staff Services Analyst	-	-	Not included[1]
Consumer Assistance Technician	1	1	
Office Technician	1	1	
Office Assistant	1	0	Incumbent separated – Position abolished
Total	**17**	**13**	
Tustin Office			
Supervising Investigator I	1	1	Office Supervisor
Dental Consultant	1	1	
Senior Investigator	4	4	
Investigator	4	1	3 vacant positions abolished
Inspector	2	2	
Office Technician	1	1	
Total	**13**	**10**	
Statewide Totals	**30**	**23**	

[1] This position was redirected from the Enforcement Program to a newly created Special Licensing Unit. Most of the position's workload involved Licensing Program activities.

Table 2
Summary of Inspection Outcomes

Type of Action	FY2001/02 (Full Year)	FY2002/03 (Full Year)	FY2003/04 (July – Dec)
Formal Warning Letter Issued	87	136	58
Citation Issued	14	23	21
Referral to Investigation	5	3	2
Informal Notice of Violation Issued	25	8	12
Compliance Verified	174	145	91
No Violation Found	51	31	15
Out of Business	6	1	2

Table 3
Complaints Closed Following Investigation, By Category

	FY2002/03 (Full Year)		FY2003/04 (July - Dec)	
Category	Number	Percent	Number	Percent
Negligence/Incompetence	262	46.4%	111	41.0%
Unlicensed Practice	87	15.4%	37	13.6%
Unprofessional Conduct	47	8.3%	24	8.9%
Fraud	40	7.1%	15	5.5%
Drug-Related Offenses	33	5.8%	17	6.3%
Criminal Charges	28	5.0%	32	11.8%
Substance Abuse	14	2.5%	5	1.8%
No Jurisdiction	9	1.6%	3	1.1%
Sexual Misconduct	6	1.0%	3	1.1%
Other/Unknown	39	6.9%	24	8.9%
Total	565	100.0%	271	100.0%

Table 4
Complaint Unit Closures, By Day Range

Day Range	FY2002/03 (July - Dec)		FY2002/03 (Jan – June)		FY2003/04 (July - Dec)	
	Number	Percent	Number	Percent	Number	Percent
2 Months or Less	391	27%	342	30%	324	30%
2 to 4 Months	383	26%	519	46%	523	48%
4 to 6 Months	301	20%	149	13%	177	16%
More Than 6 Months	398	27%	127	11%	70	6%
Total	**1,473**	**100%**	**1,137**	**100%**	**1,094**	**100%**

Table 6
Summary of Disciplinary Decisions Adopted by the Board

Type of Discipline	FY2001/02 (Full Year)	FY2002/03 (Full Year)	FY2003/04 (July – Dec)
License Revocation	8	13	6
License Surrender	8	5	5
Revocation Stayed/Suspension with Probation	7	17	5
Revocation Stayed/Probation	2	18	2
Public Reprimand	0	1	3
Total	**25**	**54**	**21**

Comparative Summary of Selected Workload and Performance Measures

Section	Workload or Performance Indicator	FY2001/02 (Full Year)	FY2002/03 Full Year	FY2002/03 Jul-Dec	FY2002/03 Jan-Jun	FY2003/04 Jul-Dec
Complaint Intake & Review	Complaints Received	3,178	2,974	1,441	1,553	1,424
	Referred to Consultants	1,490	1,876	1,192	684	752
	Completed By Consultants	1,297	2,093	1,260	833	739
	Closed by Complaint Unit[1]	2,453	2,610	1,473	1,137	1,094
	Average Days to Close[1]	149	116	137	105	92
	Percentage Taking Longer Than 6 Months to Close	35%	20%	27%	11%	6%
	Pending Complaints (End of Period)	971	593	633	593	569
Investigations	Referred to Investigation	556	469	244	225	243
	Closed Following Investigation	462	565	329	236	271
	Complaints Closed Per Investigator Per Month	4.8	5.9	6.9	4.9	5.6
	Average Days to Close (Excluding Intake & Review)	299	315	358	259	249
	Percentage Taking Longer Than 1 Year to Close	37%	33%	37%	27%	31%
	Pending Investigations (End of Period)	432	333	336	333	328
	Investigator Caseloads (Average, End of Period)[2]	54	39	39	39	37
	Referrals for Disciplinary Action (AGO)	118	145	87	58	84
	Referrals for Criminal Prosecution (DAs)	22	32	24	8	15
Legal Actions	Accusations Filed	62	67	NA	NA	42
	Pending Legal Actions	110	141	114	141	153
	Average Days to Complete	NA	NA	NA	NA	NA
	Disciplinary Outcomes (see Table 6)					
Inspections	Referred to Inspection	259	237	127	110	100
	Inspection Unit Closures	NA	167	NA	NA	121
	Inspection Outcomes (see Table 2)					
	Average Days to Close	NA	NA	NA	NA	NA
	Pending Inspections (End of Period)	51	100	NA	100	87
	Inspector Caseloads (Average, End of Period)	13	25	NA	25	22
Total Pending Complaints, Inspections and Investigations (End of Period)		1,454	1,026	1,050 (Est)	1,026	984
Probation	Opened Cases	39	39	NA	NA	18
	Completed Cases	65	26	NA	NA	25
	Pending Cases (End of Period, Excluding Tollers)	179	181	NA	NA	160
Diversion - Number of Participants (End of Period)		94	66	NA	NA	54
Other	Cost Recovery Ordered	$119,501	$176,071	NA	NA	$60,898
	Number of Consumer Refunds and Adjustments	59	79	NA	NA	NA
	Total Consumer Refunds and Adjustments	$60,023	$96,731	NA	NA	NA

[1] Excludes all complaints referred for either inspection or investigation.

[2] Caseloads shown for FY2002/03 and FY2003/04 exclude about two dozen complaints assigned to the Tustin Office Supervisor.

NA - Not available or unknown.

CATEGORIES OF VIOLATIONS

1. Improper Prescribing, Dispensing, or Administering of Drugs
2. Minimal Standards of Care
3. Fraud, Misrepresentation, or Deception
4. Lewd and Immoral Conduct
5. Unauthorized Practice
6. Criminal Convictions
7. Impairment of Ability to Practice
8. Infection Control Violations
9. CE Violations
10. Miscellaneous Violations

DISCIPLINARY PROCEEDINGS

(1) Performing, or holding oneself out as able to perform, professional services beyond the scope of one's license and field or fields of competence as established by education, experience, training, or any combination thereof. This includes, but is not limited to, the use of any instrument or device in a manner that is not in accordance with the customary standards and practices of the dental profession;

(2) Failure to refer a patient, after emergency treatment, to his regular dentist and inform the latter of the conditions found and treated;

(3) Failure to release to a patient copies of that patient's records and x-rays;

(4) Failure to seek consultation whenever the welfare of the patient would be safeguarded or advanced by referral to individuals with special skills, knowledge, and experience;

(5) Failure to advise the patient in simple understandable terms of the proposed treatment, the anticipated fee, the expectations of success, and any reasonable alternatives;

(6) Failure of a dentist to comply with the following advertising guidelines:

(a) shall not advertise in a false, fraudulent, or misleading manner;

(b) shall include in the advertisement the dentist's name, address and telephone number

(c) shall not advertise a practice specialty in a false, fraudulent or misleading manner; and

(d) shall not include a specialty in any advertisement unless the dentist has completed an ADA accredited residency program in the specialty advertised or is licensed by the Board to practice the specialty;

(7) Failure to use appropriate infection control techniques and sterilization procedures;

(8) Deliberate and willful failure to reveal, at the request of the Board, the incompetent, dishonest, or corrupt practices of another dentist licensed or applying for licensure by the Board;

(9) Accept rebates, or split fees or commissions from any source associated with the service rendered to a patient; provided, however, the sharing of profits in a dental partnership, association, HMO or DMO, or similar association shall not be construed as fee-splitting, nor shall compensating dental hygienists or dental assistants on a basis of percentage of the fee received for the overall service rendered be deemed accepting a commission;

(10) Prescribe, dispense or administer drugs outside the scope of dental practice;

(11) Charge a patient a fee which is not commensurate with the skill and nature of services rendered, such as to be unconscionable;

(12) Sexual misconduct;

(13) Breach of ethical standards, an inquiry into which the Board will begin by reference to the Code of Ethics of the American Dental Association;

(14) The use of a false, fraudulent or deceptive statement in any document connected with the practice of dentistry;

(15) Employing abusive billing practices;

(16) Fraud, deceit or misrepresentation in any renewal or reinstatement application;

(17) Violation of any order of the Board, including any probation order;

(18) Injudicious prescribing, administration, or dispensing of any drug or medicine;

(19) Failure to report to the Board the surrender of a license to practice in another state or surrender of membership on any medical staff or in any dental or professional association or society, in lieu of, and while under disciplinary investigation by any authority;

(20) Negligent supervision of a dental hygienist or dental assistant;

(21) Cheating on an examination for licensure; or.

(22) Failure to comply with the terms of a signed collaborative practice agreement.

(23) Failure of a dentist of record, or consulting dentist, to communicate with a collaborative practice dental hygienist in an effective professional manner in regard to a shared patient's care under part 17 of these rules.

(24) Assisting a health professional, or being assisted by a health

professional that is not licensed to practice.

(25) Failure to make available to patients a method to contact the treating dentist or other licensed dentist or emergency agency, when the dentist is not available for patient emergencies

Examples of reportable unusual occurrences related to dental procedures

- Allergic reaction
- Aspiration or swallowed substance
- Broken instrument in root canal
- Burns
- Cardiac arrest or arrhythmia
- Damage to patient-owned appliance

• Excessive pain, bleeding, or swelling during or following treatment
• Fractured mandible
• Fractured or damaged non-treated tooth
• Laceration requiring sutures
• Lack of informed consent—patient perceived
• Medical complications resulting from dental treatment
• Oral-antral fistula-iatrogenic
• Paresthesia
• Severed blood vessel
• Severed nerve
• Syncope and vertigo
• Unusual drug reaction
• Wrong part anesthetized
• Wrong post-operative instructions
• Wrong prescription: drug, dose, instructions, etc.
• Wrong tooth treated or extracted
• Physical or verbal altercation

Necessary Conditions for malpractice to have occurred:

- There was a **duty** of the provider to the patient to conform to standard conduct or a standard of care established by the profession or by law.
- There was a **breach of that duty** by the provider, whereby the provider failed to conform to the accepted standard of conduct or care.
- There were **actual damages** to the patient in the form of bodily harm, either permanent or temporary.
- **Causation can be established**; that is the damage must have resulted from the breach of duty, either in fact or by proximate cause. Proximate cause is a legal concept based on foreseeability of harm when a duty is breached. (e.g., one can foresee that failure to use a rubber dam when performing endodontics can result in the aspiration of a dropped file.)

Tips to Reduce Malpractice Risk

- Provide conscientious dental care.

- Encourage and support continuing dental education for employees.
- Make clear and legible entries in the health record.
- Bring the patient into the decision making process through informed consent.
- Have peer review and analysis of adverse events that occur in the clinic.
- Discipline repeat offenders by reducing their privileges or by dismissal.
- Place an emphasis on establishing a good rapport with patients.
- Use a Patient's Bill of Rights and Responsibilities, written in lay language the patient can understand and provided in pamphlet form and as a poster prominently displayed in the health care facility.

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established through the Health Care Quality Improvement Act of 1986 (Title IV of P.L. 99-660). Implementation of the NPDB was the responsibility of the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services (DHHS).

The intent of the law was to improve the quality of health care by encouraging hospitals, state licensing boards, professional societies, and other health care organizations to identify and discipline practitioners who engage in unprofessional behavior and to restrict the ability of incompetent practitioners to move from state to state without disclosure of the person's incompetent or damaging performance. It also enhanced the peer review process by protecting the records of organized peer review from legal discovery in malpractice actions. This provision was intended to allow members of a peer review committee to discuss quality of care issues openly and freely without the fear that their discussions would be used against them in legal actions.

NPDB data are confidential and are disclosed only according to NPDB regulations, although there has been some recent interest among some in Congress to make the information in the NPDB available to the public. Failure to maintain confidentiality can result in a substantial civil money penalty (up to $10,000). Individuals and organizations that knowingly and willfully report

to or query the NPDB under false pretenses or fraudulently access the NPDB computer are subject to criminal penalties, including fines and imprisonment.

Medical malpractice payers, hospitals, professional societies, and state medical and dental boards must promptly submit reports to the NPDB whenever payments are made or reports are received for a practitioner. Sanctions are present for entities that fail to report to the NPDB.

TIPS FOR AVOIDING COMPLAINTS BEING FILED WITH THE BOARD

Train front-office personnel in providing information to your patients and potential patients in a friendly and courteous manner. Be sure they understand the importance of confidentiality. Also, any discussions about fees should include caveats about any additional services that may need to be performed. For instance, if a potential patient calls wanting to know the cost of an extraction, the caller should also be advised that there may be other services and fees required such as for examination and x-rays.

Provide patients with a written copy of your office procedures including fees, payment expectations, insurance filings, management of pediatric patients, cancellation policies and patient responsibilities.

Be specific with patients regarding the treatment plan and procedures that you will be following and the meaning of various terms.

Document in the patient record that you have discussed the treatment plan, various options and risks with the patient and have answered the patient's questions. With some procedures, a signed consent form is appropriate prior to starting treatment. Do not perform any procedure without the patient's permission.

Pre-authorize treatment to be done with the patient's insurance company prior to performing the procedure and share the outcome of the prior authorization with the patient before beginning treatment.

Document all procedures performed, anesthesia administered, x-rays taken, treatment complications, etc. in the patient record. If it isn't documented – it didn't happen! Documentation is your best defense. No one has ever been disciplined by the Board for over documenting.

If in doubt about your diagnosis or treatment plan, consult with a colleague or a specialist.

If a patient is dissatisfied with the treatment received, or the outcome, discuss their concerns with them personally and immediately. Do not be defensive, listen to the patient's concerns and work with them for a mutually acceptable outcome.

Delegate to dental hygienists and dental assistants only those functions that they are legally permitted to perform.

Make sure that everyone in your practice who is required to have a license or permit has the appropriate current license or permit and that it is posted where patients can see it. If a license has expired, not only can the holder of the license be disciplined, the doctor can also be disciplined for allowing an unlicensed person to practice.

Graduation from dental school is only the starting point in your dental education. Continuing education is important to your professional competency. The Board requires that every dentist take 50 hours of continuing education during each two-year licensure period and that a dental hygienist take 25 hours of continuing education every two-year licensure period. There are specific requirements regarding the subject areas that qualify as meeting the Board's continuing education requirement. Be familiar with these, as well as all other, Board requirements.

Discuss and provide patients with a written statement of office procedures including fees, payment expectations, insurance filing, management of pediatric patients, cancellations, and patient responsibilities.
Be specific with patients regarding the procedures you will be following and the meaning of various terms.

Remember that compassion for and cooperation with patients are invaluable in the manner in which patients perceive your concern for their dental needs.

Train office personnel regarding information they are or are not authorized to discuss with the patient.

Delegate to auxiliaries only thosefunctions permitted by law and regulations.

Know your limitations and practice within the area of your professional competence.

Practice infection control at all times.

Read and know the Dental Practice Act and Rules and Regulations.

Make sure your advertising and promotional materials are in compliance with the law and regulations.

1. Billing an insurance company for any type of oral evaluation done by a hygienist and not the dentist could be fraud. The collection and recording of some data and the components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist.

2. A dentist has a responsibility to periodically see patients who receive dental services in their practice. While the frequency of evaluations by the dentist are not defined in the laws, they should be regular in nature. The Board considers regular to be, at least, annually.

3. That it is inappropriate to write a prescription for a relative, friend, or even a patient of record, if that drug is not being used within the scope of the dentist's practice.

4. The performance of an intra-oral task by a dental assistant shall be under the direct supervision of a dentist. The dentist must be on the premises, but not necessarily in the room with the assistant.

5. Coronal polishing and placement of sealants is within the scope of duties that a dentist may assign to Traditional DentalAssistants.

6. Failing to make available promptly a copy of a patient's dental records or radiographs to a patient, the patients representative, succeeding health care professionals or institutions, upon proper request may be grounds for discipline. Fees as outlined may be charged for copying and duplicating, but copies cannot be withheld for failure to pay fees (including duplicating charges) or as an incentive to secure payment for a balance on a patient bill.

7. Termination of dental services. When a decision has been made to terminate a patient from your practice the Board strongly encourages the practitioner to do so, in writing. Termination should not occur during the course of treatment for a procedure that requires multiple visits, such as crown work. However, if it does the patient should also be provided with names of other practitioners that they can contact.

8. Fitting dentures in terms of your patients satisfaction (partials or complete) is difficult at best. Quite often a patient does not understand fully the common problems that occur in making dentures. They assume that the dentures were improperly made, when in fact it may be how they fit that causes the problem. Be absolutely sure to take the time to explain to new denture patients, as well as patients who have had dentures but are replacing them, what you expect in terms of fit. Find out what their expectations are of how the dentures might fit, for that is the time to correct any mis-perception they may have. With some patients you may need to have more visits for adjustments then with others, be flexible, and communicate.

9. Informed Consent - many times practitioners assume that their patients fully understand what they are doing, and what will happen. More often than not, this is not the case. Practitioners can save themselves a lot of hassle by being sure that patients know at each visit what is planned, and what it entails. This helps to avoid the possibility that the patient expects one

procedure, and you perform another. Be especially communicative when dealing with minor children, keep the parent(s) informed before proceeding.

10. Be absolutely sure that all your dental assistants, and hygienists are properly registered with this Office. You will be held responsible if it is determine that you allowed an unregistered, or unqualified person to perform work in your practice. It is your license that is at risk.

11. Review the ADA Code of Ethics

Complete Denture Prosthodontics - Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
Extension	1. Denture exhibits proper peripheral seal at mucobuccal fold and covers those areas of the arches that provide maximum support. 2. Denture base adapts closely to soft tissues without evidence of inflammation or ulceration.	1. Borders are overextended or under extended, peripheral seal is not acceptable. 2. Tissue irritation is present, tissue is inflamed or ulcerated.
Occlusion	1. Occlusion is functional and noninterfering. 2. The occlusal vertical dimension is within the physiological tolerance of the patient.	1. Occlusal surfaces lack anatomic detail; occlusal disharmony is present; occlusal or lateral interferences are present; occlusal surfaces are not polished; patient bites cheek or tongue; denture is displaced in closure or by excursive movements. 2. Occlusal vertical dimension is not within the physiological tolerance of the patient.
Stability	1. Denture remains seated when biting pressure is applied in anterior and posterior segments of the arch. 2. Denture remains seated	1. Noticeable movement of loosening occurs when biting pressure is applied. 2. Denture is loosened or dislodged during talking and

	during talking and smiling.	smiling.
Retention	1. Denture remains seated during normal functional activity.	1. Denture exhibits no resistance to dislodgement in an occlusal direction during normal muscular activity.
Esthetics	1. The denture harmonizes with the patient's facial appearance. Position, size, shape and shade of the teeth appear natural. The contour and shade of the base appear natural. 2. When possible, esthetics were thoroughly checked at the try-in stage and the patient's acceptance was verified. 3. The labial position of the maxillary anterior teeth provides adequate lip support.	1. The denture appears unnatural and the position, size, shape and shade of the teeth or base do not harmonize with the patient's facial appearance. 2. Esthetic limitations were not explained to the patient. 3. Adequate lip support is not provided by the maxillary anterior teeth. 4. The denture contributes to speech deficiencies.

Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
MEDICAL AND DENTAL HISTORY	Recorded on chart with notation of periodic updating. Any significant history noted in a conspicuous way on patient's records (e.g., drug allergy, rheumatic heart, heart disease, etc.). Consultation with patient's physician when indicated by information elicited in history.	No medical and past dental history taken or recorded. No evidence of updating. No evidence of consultation with patient's physician where such consultation is indicated.
INSPECTION OF EXTRAORAL HEAD AND NECK TISSUES	Recorded with notations of periodic updating at recall examinations (e.g., swellings, lymphadenopathy, skin texture, etc.).	Not recorded. No evidence of updating.
INSPECTION OF INTRAORAL HARD AND SOFT TISSUES	Recorded in systematic manner (e.g., lips, cheeks, tongue, floor of mouth, throat, hard and soft palates, gingiva; teeth: mobility, pocket formation, restorations satisfactory and unsatisfactory, caries, etc.)	Not recorded. No evidence of updating
RADIOGRAPHIC EXAMINATION	I. All areas of proposed treatment visible on radiographs. 2. Radiographs within a satisfactory range of	1. Proposed treatment areas not visible. 2. Poor film contrast and/or density.

	density and contrast. 3. Root apices visible on periapical films. 4. Crown image not overlapped on bite-wings.	3. Apices of teeth not visible on periapicals. 4. Crown image overlapped on bite-wings. 5. Excessive elongation or foreshortening.
DIAGNOSIS	A specific diagnosis recorded.	No diagnosis recorded.
TREATMENT PLANNING	In general, the following is a suggested sequence: 1. Relief of pain and non-elective surgery. 2. Elimination of infection, 3. Discussion with patient of the possible causes of any disease so that when treatment is instituted elimination of these causes will effect a more lasting result. 4. Thorough prophylaxis. 5. Treatment of caries. 6. Periodontal treatment and elective surgery. 7. Prosthodontic replacements. 8. Placement of patient on recall.	Inappropriate sequence of diagnosis and treatment planning (e.g., construction of a final prosthesis without first removing all caries).
PATIENT CONSULTATION	1. Adequate documentation of the review of the treatment plan; alternative treatment (if any), limitations of treatment, fees for services and payment methods discussed fully with patient. 2. Referral to other health care providers should be made and documented when warranted.	Patient has not been informed of treatment alternatives

Endodontics Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION

	ACCEPTABLE	NOT ACCEPTABLE
VITAL PULP THERAPY Direct Pulp Capping Indirect Pulp Capping Pulpotomy	Performed when there is a Pulpal exposure but no prior evidence of irreversible pathosis. Performed when there is no prior evidence of irreversible pulpal pathosis **Deciduous teeth** (with a useful life and function). Performed only when coronal pulp pathosis is evident or when a pulp exposure is too large to be pulp capped. **Permanent teeth** Performed only when there is no evidence of pulpal or periapical pathosis and apical development of the root(s) is incomplete.	Performed when there is evidence of pulp necrosis. Performed when there is evidence of massive pulp pathosis, periapical involvement in either deciduous or permanent teeth or deciduous teeth that are soon to be exfoliated and where there is complete apical development of permanent teeth.
ROOT CANAL THERAPY	Periapical radiographs show good endodontic treatment and periapical healing The patient indicates the tooth has been asymptomatic (apart from transient discomfort immediately after filling).	No follow-up examinations established Edema is present in the area and/or a fistula has developed in relation to periapical infection. An area of rarefaction increases in size.
Access Obturation	The response to endodontic treatment has been evaluated by follow-up examinations The access is suitable to accomplish intraradicular cleansing, enlarging, shaping and filling of the root canal(s). The radiographic image appears to occupy the root canal space totally, both laterally and vertically. Inadvertent overfills or underfills are satisfactory if no postoperative sequelae of long duration have occurred. There are no voids in the apical one-third of the tooth, which may precipitate periapical pathosis.	Perforation of the crown or root has occurred and has not been repaired. Access is other than directly into the canal orifice, except when malpositioning or crowded conditions indicate otherwise. The radiographic image of the filling material appears not to totally occupy the root canal space; particularly as observed in the apical one-third, chronic periapical inflammation continues or has occurred.
Apexification	Closure of the apex is evident radiographically or clinically.	A fistula or prolonged periapical inflammation persists.
SURGICAL TREATMENT	Clinical and radiographic evidence shows healing	Inadequate followup with clinical and radiographic examination
OTHER ENDODONTIC PROCEDURES Hemisection Root amputation Beaching Replantation	All of the procedures are satisfactory when adequate clinical and radiographic evidence justify their use	Clinical and radiographic evidence is insufficient to justify use of the procedure.

Implants		

Implant Dentistry Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
Operational Explanation	1. The implant is of satisfactory quality and is expected to support the prosthesis and not damage the surrounding tissues.	1. The implant is not of acceptable quality. Damage to the bone and/or surrounding tissues is now occurring or is likely to occur.
Location and Placement	1. Ideal placement, inclination, number and spacing of implants. 2. Unavoidable off ridge placement or inclination. 3. Asymptomatic penetration of floor of nose or sinus or inferior border of mandible.	1. Unnecessary tipping or inclination compromising prosthetic stability, esthetics or design. 2. Severe tipping or malposition requiring implant burial or removal (prosthetically useless) 3. Too few implants for occlusal load requirements. 4. Implants too close together to maintain health of surrounding bone and soft tissue. 5. Violation of mandibular canal, symptomatic violation of sinus, nose or inferior border of mandible.
Mobility	No mobility of root form implant body. Slight mobility acceptable for blades and others that heal with connected tissue integration.	Slight to progressive mobility indicating irreversible loss of integration; removal indicated.
Peri-implant Tissues	1. Healthy sulcus 2. Ample kerantinized gingiva where necessary, or stable mucosa otherwise.	1. Pathologic pockets. 2. Dehiscence, fistula, or abscess present, indicating removal of implant.
Radiographic Appearance	1. Implant body full approximated by healthy bone, and minimal crestal bone loss. 2. No widening implant space present.	1. Progressive crestal cratering to untreatable vertical bone loss noted. 2. Slight widening to progressive widening of peri-implant space. 3. Symptomatic apical radiolucency present.
Subjective Symptoms	Lack of significant symptoms	1. Pain with normal function to steady pain; marked with function. 2. Dysesthesia etiologic to implant impingement on nerve. 3. Infection
Esthetics	1. Teeth are of acceptable form, size,	1. Tooth form and size

	position and alignment. 2. Teeth are of suitable shade, compatible with adjacent teeth. 3. Normal soft tissue profiles when they are visible as part of esthetic frame.	disproportional; teeth are malpositioned or misaligned. 2. Shade noticeably different from adjacent or opposing teeth or inappropriate shade. 3. In the esthetic zone, tissue heights noticeably different from those of natural teeth.

Operative Dentistry - Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	**NOT ACCEPTABLE**
Treatment Plan and Diagnosis	1. Diagnostic exam is performed with properly exposed and developed radiographs. 2. All areas of proposed treatment visible on radiographs. 3. Symbolic tooth charting is used to indicate pathological conditions. Patient is made aware of proposed treatment and possible alternatives.	1. No evidence of pretreatment charting or planning. 2. Lack of adequate radiographs. 3. Patient not informed of possible complications or alternatives in treatment.
Pain Control	1. Attempt made with local anesthesia to prevent a painful response during operative procedures. 2. Adequate post-operative instructions, as well as appropriate provisions for post-treatment professional care.	1. Inadequate pain control and resulting patient discomfort. 2. Lack of adequate post-treatment care for the patient.
Outline Form and Cavity Preparation	1. Includes all pits and fissures. 2. Extends into cleansible areas. 3. Exhibits retentive design and sufficient bulk to resist masticatory forces. 4. Complete caries removal except documented indirect pulp capping.	1. Does not include possible sites of recurrent caries. 2. Cannot be adequately cleansed by patient in course or routine acceptable hygiene procedures. 3. Insufficient extension and depth suggestive of potential displacement and/or fracture. 4. Cusps, where involved, not adequately protected. 5. Incomplete caries removal.
Surfaces and Esthetics	1. Surface smooth. 2. Color esthetics acceptable.	1. Surface rough, pitted, no discernible attempt to finish. 2. Color esthetically unacceptable.
Endodontic	1. Adequate measures taken to prevent over-heating pulp, i.e. water and/or	1. No indication of bases pulpal protection used under deep

Consideration	air spray. 2. Use of cavity liner and/or medicated base and/or bonding in deep preparations to aid in prevention of post-op discomfort. 3. Direct pulp capping performed when there is a pulpal exposure but no prior evidence of irreversible pulpal pathosis. 4. Indirect pulp capping when decay is deep, but there is no evidence of pulpal exposure and no prior evidence of irreversible pulpal pathosis.	preparations. 2. Evident that gross decay was not completely removed under completed restoration.
Anatomic Form and Occlusion	1. Contour continuous with existing tooth form. 2. Cusps, planes, grooves, marginal edges, contact areas, embrasures restored. 3. Occlusion harmonious: neither prematurities nor infraocclusion.	1. Little or no attempt at restoring contour. 2. Marginal ridges higher or lower than adjacent ridges, except where occlusion warrants. 3. Contact open. 4. Embrasures not contoured to allow for integrity of interproximal issues. 5. Axial contours flattened or exaggerated. 6. Restoration not in harmony with occluding teeth.
Periodontal Consideration	1. Periodontal health of tooth is such that its loss is not indicated in the immediate future. 2. Thorough prophylaxis is performed before operation procedures are begun.	1. Restorations done on teeth considered periodontally hopeless. 2. No considerations given to plaque or calculus prior to cavity preparations.
Marginal Integrity	1. No visible marginal defect or defect which can be detected by an explorer. 2. No gingival overhang. 3. No discoloration of margin.	1. Marginal tooth structure or restorative material fractured. 2. Gingival overhang. 3. Caries at margin. 4. Cement lines visible at margins of inlay/only restorations. 5. Discoloration at margin.

Bonding and Veneer - Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
Operational	The restoration is of acceptable quality and is	The restoration is not of acceptable quality.

explanation	expected to enhance patient esthetics.	Damage to the tooth and/or surrounding tissue has occurred or is likely to occur.
Indications	Bonding or veneers are the restoration of choice for requested cosmetic enhancement. Treatment creates no or minimal harm to teeth or adjacent tissues.	Restoration was made without consideration of other treatment possibilities. Special considerations requiring evaluation are not discovered or taken into consideration. Restoration may cause damage or adversely affect the prognosis of the treated tooth or teeth.
Surface and color	The surface of the restoration is smooth. No irritation of adjacent tissue is occurring. There is harmony in color, shade, and translucency between restorations and adjacent teeth.	Surface is irregular or fractured. Color discrepancy is outside the range of color, shade, or translucency of adjacent teeth.
Anatomic form	Restoration contours are confluent with adjacent teeth and soft tissues, and its exhibits acceptable anatomic form.	Restoration is grossly over contoured or under contoured. Contours are contributing to traumatic occlusion, caries, or periodontal disease.
Marginal integrity	There is minimal evidence of marginal discrepancy into which an explorer will penetrate. Margins are not thick or bulky.	Marginal discrepancy is evident. Marginal overhangs are present or contacts are faulty. Discoloration is found between restoration and tooth structure, excess cement is present, and restoration is mobile or fractured. Caries is detected.

Oral and Maxillofacial Surgery – Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
Dental and medical history and physical examination	The criteria should be generally the same as approved for "Examination, Diagnosis and Treatment Planning," considering the specific problem being evaluated.	The criteria should be the same as approved for "Examination, Diagnosis and Treatment Planning."
Radiographs	The criteria should be basically the same as approved for "Radiographic Examination." Necessary preoperative and postoperative radiographs taken.	The criteria should be basically the same as approved for "Radiographic Examination."
Surgical considerations	1. The surgical procedure judged an acceptable resolution for the problem presented. 2. The physical findings and the patient's general condition considered. 3. The type of anesthetic agent and the administration also carefully considered.	1. If another type of procedure far preferable to the surgical procedure, taking all facets of the individual case into consideration is routinely available. 2. Inappropriate use of one anesthetic agent where another would be safer. 3. Catastrophic accident resulting from poor preoperative evaluation. 4. Procedure done without necessary

	4. Appropriate study aids.	preparation and materials. 5. Anesthetic agents administered by unqualified and unsupervised personnel.
TECHNIQUE	1. Adheres to modern standards of cleanliness, sterility and instrumentation. 2. Treatment complete with involved tissues, hard and soft, treated or removed without undue trauma to adjoining tissues. 3. In a case where root tip remains following extraction, proper disposition made. 4. A working knowledge of emergency procedures, along with the presence of necessary emergency drugs and equipment according to accepted peer standards.	1. Improper sterilization of instruments and general lack of cleanliness in offices. 2. Incompleteness of treatment, improper management of soft tissue incisions and undue trauma to adjoining tissue.
MAINTENANCE OF RECORDS	Notations of an appropriate history and physical examination, treatment performed and follow-up care, drugs used, appropriate reports and correspondence, radiographs ordered by the oral surgeon or dentist included in the records and kept for the period of time prescribed by law. Proper consent of patient obtained.	Little or no information concerning the history and physical examination, no indication of final treatment, no mention of drugs if they were used; laboratory reports, operative reports, and correspondence not present and radiographs when ordered by the treating dentist, not kept for the period of time prescribed by law. Lack of patient consent.
POST-OPERATIVE AVAILABILITY	The individual performing the surgery or a qualified alternate available to treat or to get suitable treatment for postoperative complications.	Lack of reasonable availability of the surgeon or a qualified alternative.

Periodontics - Quality Evaluation Criteria

CATEGORY	DEFINITION	CLINICAL FEATURES	THERAPY OPTIONS	ACCEPTABLE	NOT ACCEPTABLE
Gingivitis	Inflammation of the gingiva around natural teeth or implants	Redness, edema, bleeding on probing, no radiographic bone loss.	Patient education; debridement of tooth surfaces; mechanical and/or chemical plaque control; evaluation of restorative factors.	Improved gingival tone, reduction of inflammation; acceptable plaque level.	Continuation of bleeding on probing, redness, and edema.

Periodontics	Inflammation of supporting tissues of the teeth which results in loss of periodontal ligament and supporting bone.	Edema, redness, bleeding on probing, and bone loss, resulting in loss of attachment. Clinical features may be generalized or localized, and could include health, slight, moderate and advanced conditions within the same patient.	Patient education; initial therapy including scaling and root planing, occlusal evaluation and elimination of local contributing factors; reevaluation; periodontal surgery, if periodontal health	Elimination of clinical signs of inflammation and reduced probing depths.	Continued inflammation and excessive probing depths.
Mucogingival Abnormalities	Aberrations in the relationship between the margin and the mucogingival junction (MGJ).	Recession, reduction of keratinized tissue, probing depths extending beyond the mucogingival junction.	Scaling and root planing; gingival augmentation.	No inflammation, satisfactory attached gingiva, acceptable patient esthetics.	Continued recession, exacerbation of the mucogingival defect.
Supportive Periodontal Treatment (SPT)	Maintenance initiated after completion of active periodontal therapy and continued at varying intervals for the life of the dentition or implant(s).	Continued monitoring through clinical examination, including periodontal charting and radiographic evaluation.	Periodontic debridement; adjunctive antimicrobial agents as necessary; retreatment when indicated.	Maintenance of periodontal health status attained as a result of active therapy.	Failure to offer supportive periodontal treatment.

Crowns and Fixed Partial Prosthodontics Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE
Treatment Planning	1. Adequate pretreatment records (radiographs, patient history, diagnostic casts, etc.). 2. Root structure and supporting soft and hard tissues adequate to support the prosthesis, and no compromising pathology.	1. Lack of proper pretreatment records. 2. Inadequate support for the prosthesis in supporting structures, and/or compromising pathology.

Surface and Color	1. The surface of the restoration is smooth with no irritation of soft tissue. 2. There is no *significant* mismatch in color shade or translucency between the restoration and adjacent teeth (anterior teeth only).	1. Surface is rough, pitted, grossly irregular, very porous or fractured. 2. There is a noticeable mismatch between restoration and adjacent teeth (anterior teeth only).
Anatomic Form and Occlusion	1. Restoration contour is in functional harmony with adjacent teeth and soft tissue with good individual anatomic form. 2. Size, shape and contour esthetically pleasing, consistent with age, sex and complexion. 3. Harmonious occlusion with no premature contacts and no interferences in excursive movements.	1. Restoration is over contoured, under contoured, open contacts, marginal overhang, and damage to tooth, soft tissue, or supporting periodontal tissues, marginal ridges of uneven height. 2. Improper size, shape or contour, not consistent with age, sex, and complexion. 3. Lack of occlusion, premature contacts—or interference in lateral or protrusive excursions.
Main Integrity	1. Margins nicely finished and well-adapted to the tooth with no clinical or radiographic evidence of opening, overhang or deficiency. 2. Margins finished in a cleansable area.	1. Open, thick, short or overhanging margins, visible clinically or radiographically. 2. Margins cannot be adequately cleaned.

Removable Partial Prosthodontics

Removable partial prosthodontics deals with the replacement of teeth by means of removable appliances that may be either entirely tooth supported or tooth and soft tissue supported. The appliance usually derives its support principally from tissues underlying its base with a lesser amount of support from the remaining teeth. If a removable appliance is used as an interim prosthesis, it may be entirely tissue borne. If it is supported both mesially and distally by abutment teeth, it may be entirely tooth borne. The prostheses should function passively, fit the natural teeth accurately, be well adapted to the soft tissues and provide adequate masticatory function for the patient.

- A removable partial prosthesis is indicated when:
- One or more teeth are to be replaced and a distal abutment is absent.
- Replacement of an anterior tooth or teeth is required immediately following extraction and an acrylic provisional appliance will provide adequate esthetics during healing.
- A provisional appliance is used where a final diagnosis cannot be made.
- It may serve as a more esthetic alternative for replacement of missing anterior teeth.
- Edentulous spans are too extensive and/or resorbed to be successfully restored by fixed partial prostheses.

Removable Partial Prosthodontics - Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION	
	ACCEPTABLE	NOT ACCEPTABLE

Material	1. Non-toxic, color stable, non-porous, esthetically pleasing, satisfactory strength, non-abrasive to opposing dentition.	1. Esthetics not acceptable, abrasive to opposing dentition, allergenic, unrepairable, warps, easily breaks, discolors easily, porous.
Function	1. Functions passively, fits natural teeth accurately, no damage to abutment teeth or periodontal tissues. 2. Stable during function. 3. Non-interfering functional occlusion. 4. Facilitates oral hygiene.	1. Inadequate retention, torquing forces on teeth upon insertion and removal, periodontitis, oral pathology, pain in abutment teeth induced by wearing appliance. 2. Displacement during function, unsatisfactory distribution of forces during function or does not aid function. 3. Decreased occlusal function, occlusal interferences, tooth movement or appliance contributing to craniomandibular disorder. 4. Excessive space between major connector and tissue, doesn't facilitate or prevents adequate oral hygiene.
Stability	1. The prothesis is firm, steady, resists displacement by functional stresses and is not functional stresses and is not subject to a change of position when forces are applied. 2. Basal areas covered adequately and tissue areas exhibit normal tone.	1. The denture moves or rocks on its basal seat and away from its abutments. 2. Basal seat areas inadequately extended, lack of stability, irritated or inflamed basal seat areas.
Retention	1. The prosthesis resists gravity, adhesiveness of foods, forces associated with jaw opening and normal musculature function. 2. The appliance provides sufficient clasps, attachments, rests, indirect retainers, connectors and base extensions. 3. The prosthesis is passive when fully seated.	1. Excess seating pressure is required to place the partial prostheses. It snaps to place. 2. There is insufficient retention causing the prosthesis to be displaced without resistance. 3. The retainers are not passive. The base or connectors do not maintain intimate seating with the teeth and soft tissues

Removable Partial Prosthodontics - Quality Evaluation Criteria

ITEM	RATING AND EXPLANATION

	ACCEPTABLE	NOT ACCEPTABLE
Material	1. Non-toxic, color stable, non-porous, esthetically pleasing, satisfactory strength, non-abrasive to opposing dentition.	1. Esthetics not acceptable, abrasive to opposing dentition, allergenic, unrepairable, warps, easily breaks, discolors easily, porous.
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Risk Managements in Dentistry

PROFESSIONAL LIABILITY

• **Negligence** – unreasonable act or omission resulting in harm to patient
• **Malpractice** – negligence arising out of the doctor/patient relationship
• **Lack of Informed Consent**
• **Breach of contract** – not covered by all policies
• **Wrongful death**

Maintain adequate malpractice insurance to protect your practice and personal assets.

What to do if you make an error:
• Inform patient, attempt to correct error
• Notify your insurance carrier immediately

Claims NOT Covered by Malpractice Insurance:
• Not all policies cover breach of contract claims
• Claims of deliberate, intentional harm
• Claims arising from contractual assumption of the negligence of a third party

MOST Common Professional Liability Claims:
• Dissatisfaction with prosthetics
• Failure to treat or improper treatment of endodontic pathology
• Periodontal neglect

Reporting a Potential Claim:
• Follow specific requirements of your insurance policy
• Report as soon as you become aware an incident may lead to a claim
• When in doubt, make a report

Professional Liability Claims Committee Overview (*process used to provide a review of merits of the patient's claim, fair and impartial manner before case goes to court*):
• Plaintiff first files a claim against the dentist
• Dentist notifies insurer of the claim
• Insurer prepares and submits report to District Claims Committee

Administration of Professional Liability Claims Committee:
• Established by NYSDA Council on Insurance as a subcommittee in every local dental society also referred to as District Claims Committee
• Insurance carrier notifies the ccommittee of a claim
• Component claims committee consists of a chair and at least 5 members

Professional Liability Claims Process:
• Patient files a claim
• Dentist notifies insurance carrier who investigates and prepares claim
• Carrier submits report to component claims committee
• Committee renders opinion – settle or defend case in court

Alternative Path:
• Patient expresses intent to bring a claim
• District Claims Committee hears info. regarding event before it becomes a lawsuit
• Decision of committee may help resolve matter prior to litigation

Four Elements of Malpractice:
• **Duty** – in patient/doctor relationship the doctor must treat the patient within standard of care in the community
• **Breach of Duty** – failure to treat within standard of care in community
• **Proximate Cause** – patient must show a departure from standard of care
• **Damages**

National Practitioner Data Bank – Maintains records of medical malpractice settlement payments or payments of court ordered malpractice judgments. Insurer must report payments within 30 days of payment.

Liability and Managed Care:

Capitation Plans –dentist agrees to fixed ceiling of reimbursement paid in advance in return for providing required dental care within defined time.

Preferred Provider Organization (PPO) – accepting discounted fees in return for access to pool of enrolled patients.

Health Maintenance Organization (HMO)- independently contract to provide services to the HMO in return for access to pool of patients

Independent Practice Association (IPA) – network of providers join together to contract as a group with HMO's

Malpractice Risks in Managed Care:
• Risk of DIRECT errors being committed by the plan that lead to dentist being negligent
• Risk of INDIRECT pressures from the plan that induce the dentist to be negligent
• It is NEGLIGENT to follow a managed care plan determination that violates a standard of dental care

II. RECORD KEEPING:

Good Record Keeping System:
• Always record required information consistently
• Are always complete
• Use same forms for every visit
• Record the same information, same place on form for every visit

Required Patient Information:
• Medical and Dental History
• Radiographs, study models
• Drug, lab prescriptions
• Correspondence
• Consultation and referral reports
• Signed consent form
• Name, address, phone number, age, date of birth
• Physician's name and phone number
• Emergency contact information

Dental Office Visit Information:
• Services provided
• Date, time (initial each entry)

• Instructions to patient
• Drugs, reactions
• Administered/prescriptions
• Cancellations/missed appointments
• Patient comments, complaints
• Referrals made, referrals not followed or refused
• Telephone conversations with patient or physician (include date, time)

Diagnosis and Treatment Plan:

• Diagnosis and treatment plan must be fully explained and understood
• Any changes to treatment must be discussed with patient and recorded
• Documentation demonstrates a *complete record*

Informed Consent: ***required*** for non-emergency treatment or diagnostic procedure

Patient Record Entry Rules:

ALWAYS Rule:

• Use a consistent style of entry
• Use ink
• Write legibly
• Express concern
• Date and initial all entries

NEVER Rule:

• Write derogatory comments
• Record fee information
• Alter a record

Making Correction: Never alter records. If you must correct an error use a single line cross out, describe the reason for the correction. Date and initial the entry

Recording Patient Complaints: Use your judgment about complaints without merit, BUT it is better to record and explain the resolution of complaint than to make no record that the complaint was addressed. If it is without merit explain why it is of no merit.

Treatment Refusals by Patients should always be recorded. .

Electronic Record Keeping:

• Use a record keeping program that "locks" records to prevent alterations
• In legal proceeding, you must demonstrate that your records are "authentic," unaltered and reliable.

III. MEDICAL & DENTAL HISTORY:

Medical History:

• Use a history form that combines checklist and narrative
• Check box stating: "reviewed the medical and dental history directly with the patient" initialed by dentist and patient

Content:

• Name, phone number of patient's physician(s)
• Date of last physical
• Your evaluation of general health and appearance of patient
• List of any systemic diseases
• Current medications (birth control, aspirin, recreational drugs)
• Current treatments

• Bleeding disorders
• Allergies
• History of smoking, drinking, radiation, chemotherapy
• Adverse reaction to dental anesthetics
• Any prosthetic joint replacements
• Mitral valve prolapse
• Record blood pressure, pulse
• Your evaluation of patient’s physical and emotional ability to tolerate procedures

Dental History: (Failure to do so constitutes a departure from standard of care: failure to do so is negligence)
Content:
• Chief complaint
• Past dental records
• Past dental treatment
• Radiographs
• Patient’s view of oral hygiene status
• Oral hygiene status
• Oral hygiene habits
• Treatment plan/referral info.
• Progress notes
• Discharge/termination notes
• Have patient describe their dental history in their words. What they say can be a safeguard.
• Record patient awareness of grinding or clenching
• Record patient’s view on local and general anesthesia
• Record dental hygiene info.
Interview:
• Proceed with caution if new patient tells of dissatisfaction with previous practitioners
• Refrain from making gratuitous comments regarding prior treatment

IV. INFORMED CONSENT:

(The conversation a dentist has with a patient
prior to treatment in which options and possible risks of the proposed treatment are explained and discussed – required by law)
Avoiding an informed consent action:
• Maintain excellent records
• Document informed consent conversation
• Document the patient’s reactions and concerns
• Document patient’s agreement to treatment plan

Who can give informed consent?
• Parents and guardians of children under 18 years.
• Anyone over 18 years of age
• Patients under 18 if they are married or have children
Informed Consent Procedures:

Dentist's Responsibility: Obtaining informed consent cannot be delegated. It is the duty of the dentist performing the procedure to inform the patient.

Informed Consent is required when:

- You are performing a procedure for which a reasonable person would expect to receive a formal explanation of risk
- For invasive procedures and those with foreseeable risks
- For all non-emergency procedures

Elements of Informed Consent:

Dentist MUST explain:

- Procedure in understandable terms
- Reasons for the procedure
- Benefits of procedure
- Alternatives and consequences for alternatives including no treatment
- Risks associated with procedure

The Dentist MUST:

- Determine whether the patient has understood the information provided
- Give the patient opportunity to ask questions
- Obtain a clear expression of patient's desire to proceed with treatment

Approach to Informed Consent:

- Should be formalized to ensure that you consistently cover required elements
- Allocate plenty of time for discussion
- *Do Not Rush the Patient*
- Patient should not feel pressured
- Explain in detain the risks and benefits of procedure
- Explain alternatives with risks and benefits
- Explain technical terms when you can't substitute terms
- Draw pictures to describe problems and treatments

Documenting Informed Consent:

- Informed Consent should be documented in chart
- Notation in chart should be initialed by dentist
- Signing should be witnessed by someone other than dentist
- REMEMBER informed consent is the discussion not the form
- Purpose of the form is to show that informed consent took place

Informed Consent Form:

- Should be tailored to particular circumstances of each case
- Patient should sign form to acknowledge that he/she had a conversation with the dentist about risks and benefits of treatment and alternatives
- He /she has read the consent explanation and agrees to proceed

Special Circumstances:

- ***Emergency Treatment*** (when patient is in need of immediate attention and delay of obtaining an informed consent would increase risk of person's life or health)
- Only deal with the emergency, do not go beyond
- ***Non-English speaking patient*** may require an interpreter
- Consent form should be in the patients speaking language

• ***Hearing Impaired Patient*** – law requires you to make appropriate and reasonable accommodations for disabled patients. This may require you to provide language interpreter.
• ***Mentally Incapacitated Patient*** - legal guardian must give consent

V. OWNERSHIP OF RECORDS:

(a property rights issue which relates to
custodianship of the physical documents, not the medical information in the documents)
Private Practice – dentist owns all patient records
Retired Dentist – still holds a license and is bound for rules of Professional Conduct to maintain records for 6 years minimum and longer for minors
Selling Practice – selling dentist should maintain access to all patient records of practice being sold, and must secure patient consent prior to disclosure of any patient health information. **IMPORTANT –** send a letter to patients explaining custodianship of records will be transferred to the purchaser. Offer to send records to another dentist if patient prefers.
Purchasing Dentist – must maintain the transferred patient records for full 6 yrs. minimum or longer for minors
Insurance Company Access to Patient Records:
• When a patient signs a form authorizing insurance company to access their records, authorization is limited to records necessary to process the claim.
• Keep a copy of release form signed by patient
Patient Access to Records: Law requires upon WRITTEN request, make copies of records for patients within a reasonable time. Always retain originals.
Failure to comply with request constitutes professional misconduct.
Patients Oral Request for Records do not automatically trigger patient's rights mandated by Public Health Law.
Ownership in a partnership – records belong to the partnership. In a breakup the ownership is a matter of contract and agreement between parties.
Owner/Employee Relationship: Owner dentist owns the records, employee dentist has no rights to the records unless there is a written agreement. If employee dentist leaves a practice he/she will need to obtain copies of records for the patients he/she treated.
Independent Contractor Dentist: Iif the dentist sees his own patients and is fully in charge of his work, then that dentist owns the records for his own patients.
Transferring Records: records may not be transferred without authorization of the patient. A written authorization is always preferable.
• If an employee dentist leaves the practice to begin his/her own practice, employer dentist has the *ABSOLUTE OBLIGATION* to provide a copy of the patient record upon written request by patient
Disposing of Records: (Ideal strategy is to keep records forever)
• Instead of destroying records it is acceptable to create a record archive for inactive files in an other location as long as you retain access to them
• Wait until records are at least older than 10 years and possibly longer for minor patients.
• *ALWAYS* dispose of records in a manner that they will not be inappropriately viewed or taken by an unauthorized person.
• Best way to dispose of records is to contract with a firm that provides

confidential record disposal and provides documentation of disposal.

VI. PATIENT RELATIONS:

(Minimizing risk of malpractice lawsuits
depends on your interactions with patients)

- Put yourself in the patient's shoes especially when there is a problem
- Be empathetic
- Discuss alternative solutions to problems
- Stay calm

Dealing with Conflict

- Maintain confidence
- Speak slowly
- Be positive

Guidelines for Dealing with Patients

- Communicate effectively - listen, don't interrupt
- Don't argue
- Don't use provocative language
- Smile
- Convey understanding
- Use patient's name
- Discuss topics of mutual interest
- Provide quality care
- Provide outstanding customer service

Train Your Staff to:

- Respond in a positive way to patients
- Convey understanding
- Treat patients with dignity even when confrontational
- Use phrases like:
  - I can certainly understand how you feel
  - I can see why you feel that way

Conduct Morning Management Meetings with Staff to review the day's patients, plan special considerations and adjust schedule to give more time to a patient who usually needs extra time to talk.

Evaluation by Staff: Have your assistants evaluate your communication skills to identify if you interrupt a patient, use a patient's name. Have staff give you feedback to help you improve your communication skills.

Abusive/Disruptive Patients: Calmly talk to the patient in a nonconfrontational way. If that does not work, ask patient to leave. As a last resort, call the police.

- Record these kinds of events in patient's record in an objective way
- Do not make disparaging comments in the records
- You may need to consider terminating the dentist/patient relationship

Sexual Relationships with Patients: NEVER appropriate.

Selling to Patients: It is NEVER appropriate for a dentist to exploit the dentist/patient relationship for the purpose of promoting products for financial gain. Only dental or oral health care products may be sold from an office.

Patients Suffering from Alcohol or Substance Abuse: You may clinically deal with such situations in order to provide oral health treatment.

Federal Disability Law Applies: It is illegal to refuse dental care to patients suffering from alcohol or substance abuse. They are classified as disabled.

VII. TRAINING STAFF AND EMPLOYEES:

(Training your staff to
understand their responsibilities and to perform procedures correctly will reduce your risk of malpractice)

Vicarious Liability: Acts of negligence performed by employees can create liability for the employer dentist. An employer is responsible for acts or omissions of the individuals he/she employs. The malpractice claim will be that the proximate cause of the negligent act or omission was due to the employer dentist's failure to appropriately supervise and/or train the employee.

Respondeat Superior is the legal doctrine that causes an employer to be subject to vicarious liability. An employer is not liable for a deliberate act of an employee who sets out to violate rules governing appropriate care.

Staff Supervision:

- **Direct Personal Supervision of certified dental assistants -** requires a dentist be on site and personally: diagnose patients, give instructions on procedures, authorize treatment and examine patient after treatment.
- **Personal Supervision of dental hygienist** - requires the dentist to be on site to diagnose, authorize treatment, examine patient after treatment.
- **General Supervision for dental hygienists –** requires the dentist be "available" for diagnosis, authorize the treatment procedure, and exercise the degree of supervision appropriate to circumstances.

VIII. CONFIDENTIALITY AND ABANDONMENT:

Confidentiality: A duty that flows from the dentist/patient relationship. Dentist may not divulge any information about the patient or treatment without patient permission.

Abandonment: Once the dentist/patient relationship is established, the patient has a right to expect continued care from the dentist

Termination – is the process a dentist must follow to end a dentist/patient relationship to avoid a charge of abandonment.

- Termination must only take place when you reach a normal stopping point in the treatment plan. Reasons to terminate include: unworkable relationship with a patient, threats of harm to you or staff, repeated failure to keep appointments, failure to pay in good faith.
- Always fully document the termination of a patient in the chart.

IX. REFERRALS:

Failure to refer is a basis for negligence if a general dentist who failed to refer is found to have known or should have known that the patient's treatment was beyond his/her knowledge, technical skill or ability to treat with a reasonable likelihood of success.

Guidelines for Referral:

- Is the treatment technically beyond my capability?
- Is there a high risk of complications for the indicated procedure?
- Is the patient comfortable about my ability to perform the procedure?
- Is this procedure in my repertoire?

What to Communicate:
• The entire treatment plan
• That you will remain available to answer questions
• Follow-up work that will be required when patient returns from referral
Patient Refuses Referral:
• Record the patient's refusal or failure to attend referral appoint in chart
• Explain the risks with not following through with treatment plan
• Record in patient record that you explained risks
Refer Only to Capable Specialists

X. SEXUAL HARASSMENT: (

unwelcome conduct of a sexual nature
directed which is directed at an individual whose submission to or rejection of this conduct is used as a factor in decisions affection his/her employment in any way. It also encompasses conduct that substantially interferes with a person's employment or creates a hostile, intimidating or offensive work environment.
Quid Pro Quo Harassment: Employer or supervising employee "acting on behalf" of the employer in holding out the employer's benefits as an inducement to the employee for sexual favors.
Hostile Environment Harassment: Pervasive atmosphere of discriminatorily severe or unwelcome working conditions that interfere with an individual's work performance.
Liability and Discriminatory Acts: An employer ban be held responsible for the discriminatory actions of an employee ONLY if the employer acts in a way that condones such behavior

PAYMENT METHODS: IADA Members: Free Non-Members: $25.00

◯ Check ◯ Cash ◯ Credit Card #______________________Exp. _________

Billing Zip Code: ________________

I hereby authorize IADA to debit my credit card in the amount of:
$_____________________

Signature _________________________________ Date: ____________________

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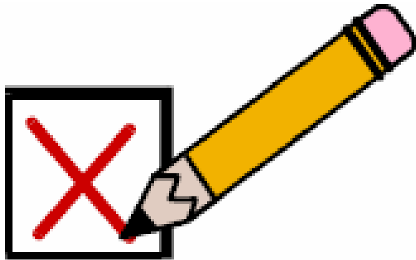
When you finish reading the course text, use the form to submit your answers to the self test. Circle the correct letter for each question indicating your answer. Pen or pencil may be used. There should be only one correct answer for each question. Upon completion of the course, mail or fax the answer sheet to IADA.



True or false Questions

1: Malpractice Improper care or treatment of a patient

2; Malpractice Prevention The conscious effort by a professional to reduce the chance of being sued for malpractice.

3; Negligence The omission to do something which a reasonable dentist, guided by those considerations which ordinarily regulate the conduct of dentists, would do, or something which a prudent and reasonable dentist would not do. It is a failure to do what a reasonably careful and reasonably prudent dentist would do in the given circumstances. It is a breach of duty – the duty to take care.

4; Standard of Care Acts performed that any reasonable professional would have performed under the same or similar circumstances; the criterion by which professional performance is measured.

5: Risk Management The practice of surveying one's practice for risks and potential sources of lawsuits, and taking action to reduce injuries and claims.

6: Claim Any formal or informal demand for monetary compensation, refund or re-treatment.

7: Legal Action A formal demand for money or other relief made through the courts.

8: Legal actions typically take three to four years to be heard in court. Because of the frailty of human memories, the record provides reliable details of the patient's care.

9: Many legal actions are nuisance claims. Accurate, legible and timely documentation can result in dismissal of these claims.

10: No changes, additions or deletions should be made after notification of a claim or a problem. Subsequent notes should be made separately and accurately dated.

11. A licensee must complete **_______** hours of continuing education in order to renew a dental hygiene license for a two-year period.
a. 12 hours
b. 15 hours
c. 25 hours
d. 50 hours

12. A licensee must complete **_______** hours of continuing education in order to renew a dental license for a two-year period.
a. 12 hours
b. 15 hours
c. 25 hours
d. 50 hours

13. Failure to renew your license on time will result in the license being automatically:
a. revoked
b. suspended
c. lapsed
d. Forfeited

14. Renewal for dental hygiene licensure occurs every:
a. 1 years
b. 2 year
c. 3 years

15. Renewal for dental licensure occurs every:

a. 1 years
b. 2 year
c. 3 years

	True	False
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐
6.	☐	☐
7.	☐	☐
8.	☐	☐
9.	☐	☐
10.	☐	☐
11.	☐	☐
12.	☐	☐
13.	☐	☐
14.	☐	☐

References:

California Dental Association Foundation. (2004). Dental professionals against violence. Sacramento, Ca: Author.

Dental Board of California. (2002). Dental practice act with regulations and related statutes. Sacramento, Ca: Author.

Official California Legislative Information. (2004). Bill information. Sacramento, Ca: Legislative Counsel of California. Available: www.leginfo.ca.gov.

State Committee on Dental Auxiliaries. (2004). Dental practice act and California code of regulations, title 16. Sacramento, Ca: Author. Available: www.comda.ca.gov.

Resources:

To access the most current information regarding California laws and the Dental Practice Act, use the following resources:

- Committee on Dental Auxiliaries

  (916) 263-2595
  www.comda.ca.gov
- Dental Board of California

  (916) 263-2300
  www.dbc.ca.gov
- California Legislative Information

  www.leginfo.ca.gov
- California Dental Association

  (916) 443-3382
  www.cda.org
- California Dental Hygienists' Association

  (818) 500-8217
  www.cdha.org