Lack of Detail in Chart Entry Hinders Dentist's Malpractice Defense

Case Study

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In dentistry, documentation is an essential element of practice, not only for accurate treatment but also for risk management. In this case study, the lack of detail in a dentist's chart entry denoting a patient's treatment impacts the outcome of a malpractice case brought against her.

Key Concepts

- How documentation can protect dentists
- Staff education and management
- What to include in chart entries

his "lower right back teeth." Dr. Z clinically examined her patient and found the first molar, tooth #30, to be exquisitely tender to percussion and tender to palpation in the mucobuccal fold, where slight swelling existed. Radiographically, #30 had an older 3-surface restoration which appeared very close to the pulp chamber; the periapical area adjacent to the mesial root showed some minimal radiolucency, but Dr. Z was not entirely certain as to whether that represented a true early lesion or an artifact. Pulp testing results were equivocal.

After explaining to D what she saw his options to be, Dr. Z, with D's approval, prepared to perform root canal therapy on tooth #30. Dr. Z says that she then went on to discuss the risks and benefits of endodontic treatment. With local anesthesia and rubber dam isolation, Dr. Z completed the root canal therapy, taking a radiograph following obturation. Dr. Z's chart note for the visit read, in its entirety, "RCT complete #30 with local."

Two days later, D called the office, complaining about increased pain and mild swelling. Dr. Z was not in the office, so the receptionist told D that these were expected to occur and asked D to come to the office in 5 days, as previously scheduled. Two more days after that, D noticed a further increase in swelling and some swallowing difficulty, so, on the advice of a family member, he went to a local hospital emergency department. Following a work-up, D was admitted with a submandibular space abscess, placed on IV antibiotics, and taken to the operating room for a submandibular incision and drainage and extraction of tooth #30 under general anesthesia. He remained intubated in the surgical ICU for a day and was then transferred to a hospital room following extubation, where he continued to improve until discharge in 3 days.

Soon thereafter, D began to treat with a different dentist, Dr. L, who advised D that, because of the local loss of alveolar bone from the infection, he was not a candidate for an implant but would instead need a fixed 3-unit bridge to replace the lost tooth. The bridge was fabricated without complication, and D remained comfortable and able to function well. He did, however, have 2 scars near the right inferior border of the mandible, which caused him to be self-conscious.

Legal Action

D wanted to explore legal action against Dr. Z for dental malpractice, so he retained an attorney to look into the possibility. As soon as records were gathered, the attorney forwarded them to a general dentist who was experienced as an expert in dental legal matters. The expert commented that he was "appalled" by the brevity of the chart entry, saying that it gave literally no information about how the procedure was planned for and performed. The attorney knew that this also meant that Dr. Z would have a difficult time providing those details in what would be several years after treatment by the time the case would come to trial. The expert provided various opinions to the attorney regarding the care of D by Dr. Z, citing a number of departures from the standard of care: failing to obtain adequate informed consent, instituting endodontics immediately rather than prescribing antibiotics beforehand so as to allow the area to calm down, failing to prescribe antibiotics following the completion of the procedure, and allowing the receptionist to extend medical advice to D without any input from Dr. Z. All of these departures, according to the expert, were substantial factors in causing D's damages – hospitalization, I&D, tooth loss, lost time from work, and scarring with its after-effects.

After being served with papers, Dr. Z advised her malpractice insurance carrier, which assigned counsel to defend the case. As depositions and other discovery proceeded, Dr. Z and her defense counsel discussed options for resolution of the case. Dr. Z believed that she had acted appropriately at every step, but she saw how the patient's expert could paint a very critical picture to a jury, especially with the lack of detail in her chart entry. Her counsel suggested that all parties go in front of a mediator, to hear how a disinterested third-party might see things. Dr. Z agreed. At mediation, the mediator, after hearing all positions and seeing the relevant documents, spoke with Dr. Z and her counsel alone. The mediator expressed to Dr. Z a big concern about how tenuous a court and jury could see detailed testimony about events years prior, based solely upon such a scant procedure note. The mediator was also taken aback that medical advice – which turned out to be harmful – was transmitted to a patient by Dr. Z's professionally unqualified agent without Dr. Z's input. The defense attorney argued to D's attorney that most of D's potential trial positions could be countered by the defense's planned expert, who was highly credentialed. With the mediator's assistance, and with the carrier's authority and Dr. Z's consent, the case was settled that day for an amount substantially below that which the patient's attorney had previously said was "rock bottom."

Takeaways

Dentists must always walk a fine line as to the detail they enter into their charts. While, on one hand, it is nearly impossible and often impractical to detail every single step of every single procedure performed and conversation had, it is also inadequate to sum up D’s treatment visit with Dr. Z by recording only “RCT complete #30 with local.” That entry failed to include Dr. Z’s radiographic and clinical findings, the informed consent process, the method by which local anesthesia was obtained and the agent(s) used, the techniques employed (file sizes, filling material, cement), and Dr. Z’s diagnostic approaches and reasoning for steps both taken and not taken, just to name a few deficiencies. To walk that fine line, a reasonable rule of thumb is to include in a chart entry enough information so that another dentist would be able to understand exactly what took place, simply by reading the note, without any discussion with the dentist or patient. A judge once said to a jury and to this author as trial attorney, mid-trial, “ladies and gentlemen of the jury, if it wasn’t written, it didn’t really happen.” Some tough words!

This case incorporates a litigation step which has not often been discussed in this series, that of mediation. While some jurisdictions require it, many others do not; in those that do not, mediation usually comes about only by an agreement between the parties to so engage. But the value of having an experienced intermediary – often a retired judge or attorney – to hear and see what a jury would eventually hear and see and offer insights in an informal environment, cannot be overstated. It is far from uncommon that parties emerge from mediation with a wholly different understanding of the positives and negatives of each party’s positions. This is not to say that all mediations result in settlements, or that all lead to changes in litigation strategy, but these sessions frequently offer perspectives – often more to the litigants than to their attorneys – not considered prior.

Dentists spend their work days treating patients, not answering telephones. The latter is usually left in the hands of office staff. While office staff provide critical and invaluable roles in office public relations, billing, scheduling, and general management, they are not trained as healthcare professionals, and they are not the people appropriately qualified to offer advice about medical or dental conditions. That task is within the sole purview of dentists and other healthcare providers. Here, the receptionist’s advice led to a delay and likely worsening of D’s infection. The problem with that from a legal standpoint is that most jurisdictions will view the actions of an employee as though they came directly from the employer; the concept is known as vicarious liability, making the dentist liable for any improper advice from the receptionist.

We conclude with a brief discussion about antibiotics. It lies within the dentist’s clinical judgment as to whether and when to prescribe antibiotics. Also noteworthy is a fairly recent and growing push by dental groups, authors, and academics, clearly recognizing what some might view as a past tendency for dentists to incorporate antibiotic use in their treatment approaches too frequently, that antibiotics should be prescribed in a more judicious way. But in the end, the treating dentist has the best seat in the house to be able to make that determination. That does not mean, however, that experts in litigation settings will not freely criticize defendant dentists, both for prescribing antibiotics when the expert believes they should not have been given and for not prescribing them when the expert sees a need for having done so. Such is the world of litigation. Here, the expert was critical of Dr. Z’s failure to prescribe, so that would have been an issue for a trial jury to resolve, but the details which led to her decision was lacking from her chart entry, creating a likely uphill battle for herself.

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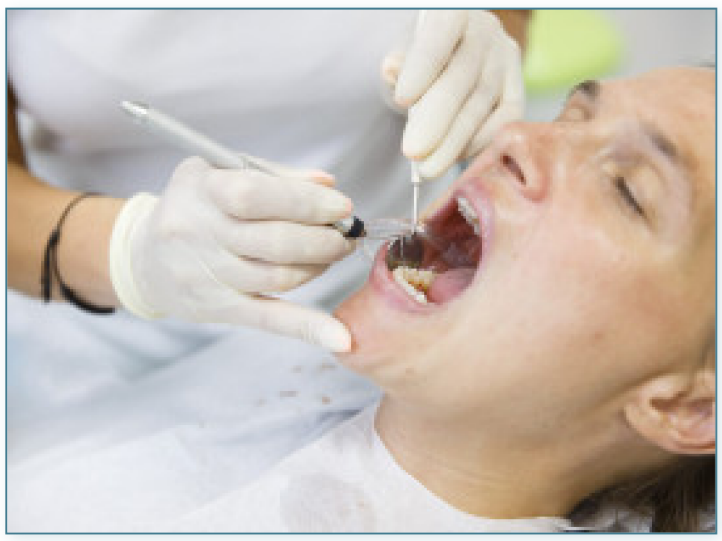

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Risk Tips

Dentists must simultaneously balance patient desires and needs. In this case study, a patient with gum disease sues their dentist after refusing treatment.

[Unforseeable Seizure Sparks Lawsuit Against Dentist]

Risk Tips

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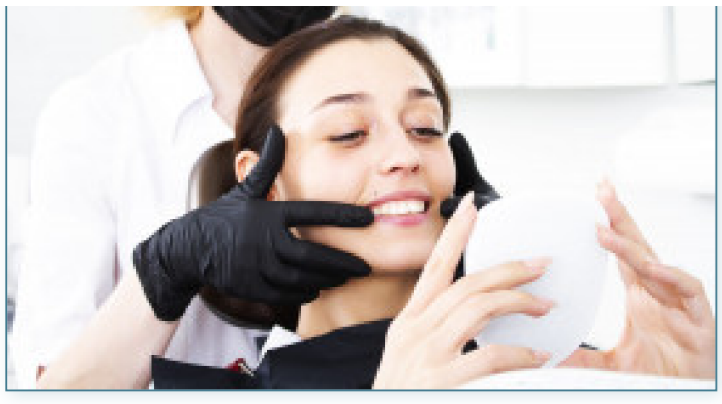

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Risk Tips

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