



Prevalent DOH disciplinary actions concerning dentists.

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In the most recent edition of Risk Review, we considered prevalent disciplinary actions concerning allopathic and osteopathic physicians. Presently, we explore disciplinary actions that are common to Florida dentists. Again, as health care attorneys, we feel it is certainly well advised to have dentists consider the incidents and issues that give rise to Florida Department of Health (“DOH”) investigations. It has been our experience that when a practitioner is well informed of potential areas of exposure, as well as the concomitant consequences, the opportunity for more effective risk averse behavior is enhanced. We certainly encourage each dentist to evaluate one’s own practice and take appropriate steps to increase vigilance to decrease risk and thus avoid such an investigation or disciplinary action.

In its 2009-2010 fiscal year report, the Division of Medical Quality Assurance of the DOH (the “MQA”) stated that there are currently 12,760 dentists licensed in the state of Florida, 9,827 of which are in-state active. Additionally, 239 residency permits have been provided. There are 10,278 in-state licensed dental hygienists and 23,418 dental radiographers. These numbers are significant, particularly those of support professionals, given issues faced by dentistry professionals related to improper delegation of duties. In 2009-2010, 635 dentists applied for Florida licenses, with 347 of those practitioners actually being issued licenses. 699 individuals applied to become a licensed dental hygienist and 614 applied to become a licensed dental

radiographer, with 353 and 582 licenses issued respectively.

Investigation Statistics

In fiscal year July 1, 2009- June 30, 2010, 225 statutory reports were filed and 952 complaints were received against Florida dentists. Of those complaints, 354 were found to be legally sufficient and 147 inspections took place. When all was said and done, probable cause was found to exist in 105 cases by the Probable Cause Panel of the Board of Dentistry and the DOH filed 96 administrative complaints against practicing dentists as a result thereof. Interestingly, for 2009-2010, only one emergency suspension order was issued. Additionally, 19 civil court claims and 178 closed claims were received with disciplinary action being taken in nine of the closed claim cases.

Naturally, it is interesting to consider the manner in which investigations resolved during 2009-2010. The MQA reports indicate that there were 2 revocations, 17 voluntary relinquishments, 6 suspensions, 4 probations, 55 limitations/obligations, 54 fines, 21 reprimands, 9 citations and 11 dismissals. 75 were resolved through final orders issued by the Board of Dentistry. Finally, it was very troubling to see the amount of unlicensed activity by dentists for that time period, as 60 investigations were completed with 13 cease and desist orders issued, 27 referrals to law enforcement and 9 arrests.

Prevalent Disciplinary Actions

In no particular order of frequency, the categories below reflect some of the types of disciplinary actions we often see through our representation of dentists in the defense of investigations by the Department of Health.

Recordkeeping

A frequently seen basis for investigation involves failure to maintain appropriate dental records. As discussed in our first installment, we remind our clients that for all practical purposes under the law, “if it is not in the record, it did not happen.” Dentists are often investigated for failing to document a plan of care or treatment plan, examination results and patient histories, including allergies. Even more frequently, dentists face trouble for failing to document in a patient’s record that films were reviewed.

Pursuant to 466.028(1)(m), Fla. Stat., a dental license may be disciplined for failing to keep written dental records and medical history records justifying the course of treatment of the patient including, but not limited to, patient histories, examination results, test results, and x-rays, if taken. Additionally, under 466.028(1)(ff), Fla. Stat., licensed dentists may be disciplined for operating or causing to be operated a dental office in such a manner as to result in dental treatment that is below minimum acceptable standards of performance for the community. This statute specifically indicates that such includes the failure to maintain patient records as required by this chapter. We suggest that dental practitioners review Section 466.028, Fla. Stat., and the respective rules by the Board of Dentistry, particularly the law set forth in 64B5-17.002, Florida Administrative Code (F.A.C.) that specifically delineates the minimum elements required for a dental record.

Importantly, a dental practitioner should be mindful that recordkeeping violations occur not only when information is absent, but also when information present in the record is illegible or does not support the actions taken by that practitioner. Dentists should remain mindful that in situations where a patient claims he or she was not informed

of a test result, was not given appropriate informed consent relative to a procedure or received inappropriate treatment, such allegations are extremely difficult to defend when effective recordkeeping has not been employed. While the First District Court of Appeal determined in *Barr v. Florida Board of Dentistry* in 2007 that the absence of an adequate dental record does not, in and of itself, substantiate substandard care; trying to convince a Board of your dental peers that you met the standard of care without the use of complete records is obviously problematic.

Dentists are urged to ensure that their patient records are complete to improve overall patient care and because solid, detailed records can be quite beneficial in the event that care is questioned. While many practitioners employ Electronic Health Record (“EHR”) systems, which can be terrific if used appropriately, these systems can actually be a tremendous hindrance if used too casually. We frequently observe dentists who rely solely on “check boxes” and “radio buttons,” and include little to no detail about the patient, the patient’s history or the care provided. While the need for detail varies from case to case, more detail is usually better than no detail. This is particularly the case when considering the informed consent process, a treatment plan or discussion of diagnoses, as well as communication with the patient by the practitioner and/or any office staff members.

Standard of Care

One of the violations we most frequently observe regarding dentists is that of Section 466.028(1)(x), Fla. Stat., which concerns being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance. In part, this includes but is not limited to the undertaking of diagnosis and treatment for which the dentist is not qualified by train-

ing or experience or being guilty of dental malpractice. Under this statute, “dental malpractice” includes, but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of \$25,000 in a judgment or settlement, as a result of negligent conduct on the part of the dentist. Additionally, under 466.028(6), Fla. Stat.,

Upon the department’s receipt from an insurer or self-insurer of a report of a closed claim against a dentist pursuant to s. 627.912 or upon the receipt from a claimant of a presuit notice against a dentist pursuant to s. 766.106 the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

Many different kinds of offenses can fall under this statute, which is why it is frequently cited. We have observed numerous cases where a standard of care violation is charged, and such range from patients who complain of poor outcomes, including inappropriate placement of a crown or bridge, inappropriate treatment of caries, lost fillings and infection or even personal disagreements with a practitioner or his or her staff. Very often, we have represented dentists in matters where it is alleged that a general dentist has inappropriately performed a root canal by failing to completely fill the canal. While a general dentist may be fully qualified to complete this endodontic procedure, such dentist is encouraged to ensure that he or she is proficient before undertaking this or any procedure.

The defense of an alleged standard of care violation requires a very fact-specific examination of patient care. For this reason, appropriate and detailed documentation is critical. Whether the matter investigated involves dental care or a mere discussion with a patient concerning payment of a bill, we implore each practitioner to ensure that they and their staff maintain timely and detailed documentation.

Improper Delegation

Perhaps a bit unique to dentistry in an academic setting is the significant issue concerning improper delegation of duties. Such violations are codified under 466.028(1)(g), Fla. Stat. which provides that such occurs when aiding, assisting, procuring, or advising any unlicensed person to practice dentistry or dental hygiene and under 466.028(1)(z), Fla. Stat. which concerns the delegation of professional responsibilities to a person who is not qualified by training, experience, or licensure to perform them. Frequently, we observe improper delegation of duties by a dentist to a dental assistant. As an example, under Florida law, a dentist is required to obtain a primary impression, whereas a dental assistant may obtain an opposing impression. In many cases, a violation is found when a dental assistant has in fact wrongfully obtained the primary impression. Thus, we encourage dentists to not only be well-informed of delegable and non-delegable duties amongst their support professionals, but also to ensure that those professionals are routinely and thoroughly educated as to the limits of their responsibilities within their appurtenant licenses. We would strongly encourage all dentists to review the rules associated with delegable and non-delegable tasks to ensure full compliance. The applicable statutes and rules can be found at the Board of Dentistry’s website.

Risk Rx

Fraud and Deceit

Perhaps one of the more troubling issues facing the practice of dentistry concerns allegations of fraud and deceit, codified under 466.028(1)(l), Fla. Stat. with the making of deceptive, untrue, or fraudulent representations in or related to the practice of dentistry, and 466.028(1)(t), Fla. Stat. regarding fraud, deceit, or misconduct in the practice of dentistry or dental hygiene.

Disciplinary actions relating to matters of fraud and deceit include issues ranging from allegations of straight overcharging to situations where a dentist may recommend a dental implant when a less invasive or expensive treatment, such as a crown or bridge, may be appropriate. This issue is often exacerbated due to the ease of obtaining financing through credit card programs for dental care. However, a positive aspect of such financing was considered by Administrative Law Judge John Van Laningham in Department of Health, Board of Dentistry v. Francisco Fonte, D.D.S. at the Florida Division of Administrative Hearings in May 2011. In this matter, Judge Van Laningham determined that a dentist can only be found to have committed fraud in matters where he had either participation or direct knowledge of the fraud. Thus, a dentist cannot be found to have committed a violation of the Dental Practice Act if such fraud was committed by an employee, without the direct knowledge or participation of the dentist. This higher threshold is critical, particularly in consideration of the fact that dental insurance is far less prevalent than medical insurance. Thus, dental financing is often the only viable option for many patients and the potential for such fraud and abuse is increased. We encourage all dentists who utilize dental financing with their patients to maintain any and all documentation related to the application for or use of such financing. This documentation should be

kept with each related patient record and regardless of whether the dental financing company assures the practitioner that such documentation may be destroyed.

Conclusion

It is imperative that all dental practitioners ensure that they are familiar with the laws and statutes governing the practice of dentistry. Furthermore, much information can be gleaned from considering the actions and inactions which give rise to DOH investigations. Appropriate documentation is essential and it is critical that dentists ensure that they practice within the confines of the law.



REDUCING LIABILITY IN COMPLEX CASES

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Defining Your Role

Most medical errors are attributed to system errors – not faulty medical judgment. System failures increase with medical complexity and the number of physicians involved even when involvement is tangential. Malpractice claims attributed to a failure to timely diagnose and treat patients that are being followed by multiple physicians is an alarming trend. A common root cause of these claims is faulty coordination and management of care – easily prevented with fundamental risk management practices.

The most prevalent type of error in medical malpractice claims is not medical at all.(1) Surprising-

ly, claims that are absent a medical error are the most frequent type of claim. One example of claims that are absent a medical error is those involving the failure to supervise or monitor the patient's case. When the root cause of claims is attributed to a lack of coordination and management, even the strongest defense may not prevail. Although every case is unique, juries tend to adopt higher expectations in direct relation to the size of the medical team.

System failures, such as faulty communication of clinical concerns and stat test results contribute to the number of adverse events, resulting in severe patient injury and costly medical malpractice claims. Inadequate documentation of the entire process often undermines the defensibility of otherwise acceptable medical judgment.

Delay in diagnosis continues to remain one of the most prevalent allegations in malpractice claims. (2) Among the most frequent causes are lost or misdirected diagnostic test results. A common root cause in these cases is the failure to address abnormal test results in a timely manner. The unfortunate end result is often an absence or delay in treatment to the point of irreversible damage to the patient – and to a defense. In a survey of 42 academic medical centers across the United States, factors that contribute to medical error were identified and include order entry, decision making, and complex systems.(3)

Delineation in physician responsibility and care is a fundamental risk management measure that is essential in complex medical cases and those with a sizeable medical team. Consultations, orders and reports should clarify your specific role in the care and treatment of the patient and document its parameters. Recall this caveat as the medical team morphs. Failure to act on abnormal (diagnostic) results is a common source of medical error.(4)

Case Synopsis Delay in Diagnosis and Treatment:

Wrongful death action of a 52 year-old female due to an alleged failure to diagnose and treat an aortic dissection. Although the case was defensible in terms of medical causation-the patient's chances of surviving the dissection were virtually nonexistent upon her initial presentation-the lack of delineation in the medical management and coordination of care among the healthcare team necessitated settlement. Medical records could not support which physician was responsible for pursuing emergent diagnostic work-up or acting on the results of same. Consequently, aortic dissection was not included as a differential diagnosis, the patient was misdiagnosed with pancreatitis and surgical intervention was delayed.

Risk Management Guidelines:

- Determine who the primary attending physician is: direct communication accordingly.
- Clarify the reason for your participation and the extent of same.
- Define your role and document the date and time of initial and final contact and contributions in the care and treatment delivered.
- Do not assume responsibility for management beyond parameters.
- Document follow-up efforts and communication of test results.
- Verify when outstanding diagnostic studies, labs, and consults are complete.
- Clarify that on-call physicians, covering physicians, and physician extenders under your supervision are fully apprised and have delineated their respective care and treatment.

- Advise the patient and/or family member(s) of your participation in the medical team and the extent of same – document such disclosure.
- Document discussions with other clinical team members, including your understanding of your role and the parameters of your care.
- Provide directions for the daytime office and after-hours communication pathway of stat diagnostic test results and emergent orders.
- Document the chart in a way that clearly supports your medical rationale.
- Seek legal or risk management guidelines when uncertain how to proceed from a liability standpoint.

- (1) *Physician Insurers Association of America. Research Department. PIAA Risk Management Review Combined Specialties. 2006 Edition. Rockville, MD 20850*
- (2) *Closed PIAA Cumulative Data Sharing Report. Closed Claim Data 1985 to 2006.*
- (3) *University HealthSystem Consortium, Performance Improvement Benchmarking Survey Results. Oak Brook, IL: Author, 2000*
- (4) *The Patient Safety Handbook. Youngberg, B.J., Hatlie, M.J., 2004. Jones and Bartlett. Sudbury, MA 01776*

The information above does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. It is recommended that legal advice be obtained from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

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