Charting for the jury

These nine charting tips can prevent patient injury and reduce your risk of malpractice litigation.

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Charting for the jury is a lot like flossing your teeth. You may do it for awhile, then slack off. You may do it sporadically or just when you think you "really need it." You may skip it on days when you feel too busy or too tired to spend the time. But, charting for the jury is as important to the health of your practice as flossing is to the health of your mouth.

The reason this kind of documentation is so important is to protect you from a malpractice action. The decision to file a malpractice claim usually is made in an attorney’s office. The attorney’s decision to file or not is based on two sources of information: (1) the patient’s story (probably not too favorable) and (2) the patient’s dental record. What is included and/or absent from the record can be the deciding factor in whether your patient’s attorney becomes a plaintiff’s attorney.

To protect yourself, take the following nine steps for a healthier practice:

1. Document patient telephone calls. When a patient telephones you with complaints of discomfort or pain, you use your professional judgment to determine if and when he needs to be seen. A malpractice suit can focus on the fact that you failed to see him for an examination, causing further injury. When you are relying on your patient’s description of his symptoms, it is important that you record what he says. Quote him if at all possible, and always tell him to call back if he feels worse or is dissatisfied with his progress.

   Be careful about saying, "Call me in a week." If your patient has an untoward event on Day 4, he may delay calling you because you said "a week." (Hey, if people were logical, men would ride sidesaddle!) Far better to say, "Call me in a week - or sooner - if you feel worse or are not satisfied with your progress."

2. Document patient noncompliance. One of the great frustrations of dentistry is that so much of your patient’s oral health depends on his compliance with home care and the treatment plan. Failure to keep appointments, to see specialists and to maintain good oral hygiene is a common defense in malpractice cases; but, if you don’t note it down, do you think your patient will own up to it? So, then it’s your word against your patient’s.

   Unfortunately for you, you are legally required to keep records about the important aspects of your patient’s care. The patient is not required to keep records.

   By the time a malpractice claim reaches trial, the plaintiff’s attorney is able to question your recollection by asking you how many patients you see in a day, multiplying that by the number of days that have elapsed since you saw the patient and then asking, "Doctor, you have seen patients on 18,000 occasions since the day you injured poor Mr. Jones. Do you expect this jury to believe that you remember Mr. Jones telling you that he was not flossing his teeth? You do? Well, Doctor, do you also remember what you had for lunch that day? Which dental assistant was in the room with you and Mr. Jones? What phone calls did you take during Mr. Jones’
appointment?

"No? You don’t remember? Well, Mr. Jones remembers! He can take the stand and testify that you had lunch at that new gourmet take-out place on your street. Cindy was the dental assistant, and you took a call from your wife during his appointment. And, he remembers distinctly that his home care was never discussed."

The patient’s attorney may not become the plaintiff’s attorney if he sees evidence of patient noncompliance in your records. Document noncompliance and your description of the possible/probable consequences if the patient does not comply. Note that you warned the patient about these consequences.

3. Patient satisfaction and dissatisfaction. Dentists are fortunate, in that they are viewed by the vast majority of patients as trustworthy. According to a recent Gallop Poll, dentists are the third most trustworthy professionals, right behind pharmacists and clergymen. When you have evidence of patient satisfaction, even just a holiday card, keep it on file.

First, you can thank your patient when you next see her. Second, you might need it some day. Be especially conscientious when caring for overly grateful patients, for these patients can turn on you with the same degree of excessiveness.

In the same vein, documentation of complaints serves three purposes:

- To remind you of an earlier problem, so that it doesn’t happen again.
- To show a pattern of complaints that may indicate to you that the relationship is not satisfactory from the patient’s point of view, and probably should be terminated.
- To serve as an indicator to the patient’s attorney that the patient is difficult to please and doesn’t make for an ideal patient or client.

4. Normal is as important as abnormal. It goes without saying that you document and highlight in some way your patient’s allergic reactions to certain medications or a class of medications. The same should be true when your patient’s history includes complications or an unusual experience during or following dental treatment.

But what about the patient who has no allergies to medications or prior difficulties associated with dental care? If you don’t record your patient’s response to the questions you ask, you put yourself on the defensive. Plaintiff’s attorneys often are successful in convincing jury members that "The doctor has an obligation to document the important aspects of care. If he didn’t write it down, you may assume that he didn’t do it."

5. Consent. Yes, consent is boring. Yes, it’s time-consuming. Yes, you can say that you only did what any reasonable person would have wanted you to do. The problem is, unreasonable people have the same legal right to sue you as the rest of us do.

Consent is a discussion, not a form. Discuss with your patient the nature of the procedure you are recommending, the potential risks and benefits, and the alternatives, including doing nothing. Then, see if your patient has any questions. Then say, "Now that we’ve discussed your alternatives, what would you like me to do?" If your patient can’t answer or says, "Whatever you think best, Doc," he is not adequately prepared to give an informed consent.
A consent form given to a patient after treatment is a farce. Don’t allow this to become an administrative duty of the front-desk staff. Having a patient sign a form he can’t read or understand is pointless, too. Plaintiff’s attorneys love to stand up in front of a jury and read a technically-complex form and say: "Ladies and gentlemen, I don’t know what this form means. Do you know what this form means? How could my poor slob of a client understand what he was signing?"

Consent is not a form, but forms can be helpful. When my husband and I were considering orthodontic treatment for our daughter, her orthodontist gave us a beautiful folder from the American Academy of Orthodontics. He checked the sections that were most pertinent to her treatment plan. The NCR consent form allowed us to keep a copy of our signed consent and the discussion points. After asking ourselves, "How bad are crooked teeth?" we decided to proceed. Should our daughter ever need a root canal or have complications secondary to her braces, we certainly will know that we entered into treatment aware of the risks.

6. Corrections and alterations. If you receive an attorney’s letter, asking for a copy of the patient’s record, each page of that chart is magnified 1,000 times in your mind. You read your notes as you have never read them before. Why didn’t I write down her blood pressure? What was I thinking of when I wrote, "This patient is a moron.." If a correction needs to be made, use the SLIDE (Single Line, Initials, Date Explanation) rule to make it properly. In other words, draw a single line through the incorrect information, leaving the original entry legible. Note the date of the change, the initials of the person making the change and an explanation of the change.

But, think twice before making any corrections after you have noticed that a malpractice suit may be pending. Make corrections only with the advice of your attorney, who may instruct you to write an addendum or a letter of clarification for his use in your defense.

To change or add something to a record, after the fact, without explanation, is a smoking gun that never cools. Malpractice trials are won by the person who convinces the jury that he is telling the truth. To do so, that person must be confident and authentic ... and the dental record must be, as well.

7. Discharge instructions. Discharge instructions are your best opportunity to share and shift risk with your patient. Written information is valued by patients, but also serves as a record for you. If you use printed information, keep a master copy on file, showing the date you began giving the information to patients and the date on which you stopped distributing it. If you take the time to teach your patient, document this as well.

8. Termination of the dentist-patient relationship. If you decide to terminate a patient from your practice for failure to pay for services, noncompliance, or whatever reason, you must have documentation that this was done in a proper manner. Failure to do this can leave you open to charges of abandonment.

Many dentists believe that a relationship is terminated when a patient’s account is referred to a collection agency. Not so! It isn’t even terminated when a patient sues you for malpractice, unless you or the patient have formally terminated it.

The American Dental Association publication, "Terminating the Dentist-Patient Relationship: Questions & Answers" is a valuable source of information for
frequently-asked questions on this topic.

9. PSR scores. In the February 1996 issue, Consumer Reports advised its readers to "...be sure your dentist is checking your gums during your routine checkup. The dentist should scan your X-rays for bone loss and probe the gum line for areas that bleed easily."

Patients are beginning to expect that a "good" dentist performs periodontal probing. If you aren’t, you run the risk that your patient will have less trust in you and be more likely to blame you if he has a less than perfect outcome.

In addition, patients switch dentists due to changes in their employer’s dental coverage, relocation, etc. If a new dentist diagnoses periodontal disease, and your record shows no evidence of periodontal screening, you are leaving yourself wide open for a "failure to diagnose" malpractice claim.

These nine charting tips can prevent patient injury and reduce your risk of malpractice litigation. They take time, but so do interrogatories, depositions and courtroom appearances. Good documentation habits can prevent a patient from suing you. Make them part of your daily risk-management program!

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Terminating a patient from your practice

1. Send a certified letter, return receipt requested. Some attorneys suggest using restricted delivery.

2. Keep a copy of the letter and attach it to the patient’s medical record.

3. Use general and professional reasons for discharge. Failure to pay for care and noncompliance are the two best reasons.

4. Offer dental care for 30 days from the date of the letter.

5. Offer to send records to another dentist, whether or not the patient owes you a balance.

6. If further dental care will be needed, refer the patient to the local dental society for a referral.

7. The patient is terminated 30 days after notification.

Important: Check with your insurance company before instituting this procedure. The company may have a specific format to be followed or sample letter to be sent.

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