When a Dentist Leaves, What Happens to the Patient?

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It is not uncommon for a dentist to leave a group practice. The departure may be due to retirement, relocation, or a desire for new professional opportunities. Regardless of the circumstances, questions frequently arise regarding who will continue to care for patients seen by the departing dentist, and who should take possession of their dental records. Sometimes, the affected patients have been seen by only the dentist who is leaving. In other cases, the departing dentist was only one of several practitioners who provided care to patients of the practice. This article will attempt to answer some of the questions which arise when a dentist leaves a practice.

Duty to Avoid Abandonment

One of the most critical issues which must be considered when a dentist leaves a practice is how it will impact his or her patients. Thought must be given to the timing of the departure to avoid the possibility of patient abandonment. Education Law § 6509(30) defines professional misconduct as:

Abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patient or clients.¹

The departing dentist must give adequate notice to the group and assist in facilitating the patient’s continuity of care. Therefore, abrupt or precipitous departures are especially risky in terms of exposing the dentist to a charge of patient abandonment.

What constitutes reasonable notice to the group varies with the circumstances. It largely depends on the availability of suitable substitute care in the geographic vicinity. If the departing dentist intends to continue practicing in the area, or if there are other providers accepting new patients, then 30 days is probably sufficient notice to afford the patient to make a smooth transition.

On the other hand, there may be situations where 30 days may not be sufficient notice to ensure continuity of

¹. See also 8 N.Y.C.R.R. § 29.2(a)(1).

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In scarce specialties or subspecialties, it may take longer to arrange a new patient appointment. If the patient has a complex condition or is involved in a course of treatment, it may be difficult to find another provider willing or able to take on the patient. If the departing dentist had a large following, the remaining group members may not be able to absorb a sudden large influx of his or her patients. All these considerations must be carefully weighed when deciding on a plan of departure.

Storage of the Dental Record
When a dentist leaves a practice, questions frequently arise concerning who will take possession of his or her patient dental records. Once again, the definitions of professional misconduct come into play. Regulations governing the practice of dentistry require a dentist to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient for at least six years, and, in the case of minors, until one year after a minor patient reaches age 21.2 Further, Education Law § 6530(40) requires dentists to provide access to the record for those persons defined as “qualified persons” under Public Health Law § 18, including patients and their legally recognized personal representatives. Thus, when a dentist leaves a practice for any reason, there must be a plan for the maintenance of the patient’s dental records and how to ensure the patient’s right of access to those records.

If the practice is dissolving and there is no surviving corporate entity, case law indicates that the treating dentist is entitled to the possession of patient records.3 If, however, the practice is conducted in such a way that no single dentist had his or her own individual patients, then the dental record may be viewed as belonging to the group practice, subject to the dentist’s right to obtain copies.4

If the patient is continuing care with another dentist in the group, the group practice should retain the patient’s original dental record. The group may also retain the original record in situations where the practice itself billed for dental services or where the patient was not seen exclusively by one dentist. If the practice group is not continuing the patient’s care and does not wish to retain the record, however, the departing dentist is responsible for complying with the Education Law to maintain the record and ensure the patient’s right of access. This means that the dentist must either store the record personally or make arrangements for storage and retrieval with a responsible party.

There is no legal requirement that original paper dental records remain in paper form. Dental records may be scanned into an EMR or placed on a CD or other electronic media as long as the following requirements are met:

- The record must accurately reflect the patient’s evaluation and treatment.
- Computer discs must be retained for the same statutory periods as paper records.
- Patients must have access to a copy of their records upon request.
- It must be possible to transfer a copy of the record to another dentist, hospital or other healthcare facility as requested, in compliance with Public Health Law § 17.
- Records must be in readable form and a copy made available for government agencies upon their request.
- A system must be in place to ensure the integrity of the records so that they are not lost, destroyed or altered, and the patient’s confidentiality is protected.
- Employee access to the records must be limited to the minimum necessary to carry out the required task.

The Department of Health has stated that once paper medical records are scanned into an electronic storage system, the original records do not have to be retained. It is critical to spot check that all records have been copied and are legible before the originals are destroyed.

If patient records are delivered

2. 8 N.Y.C.R.R. § 29.2(a)(3). Because of concerns regarding the statute of limitations in malpractice cases and health care fraud liability, Fager Amsler Keller & Schoppmann, LLP recommends retention of records for at least 10 years after the date of last treatment or service.


into the hands of a third party for storage, it would be prudent to enter into a Dental Records Storage Agreement, which sets forth the legal duties of the custodian. At a minimum, the agreement should contain the following provisions:

- Retention time in compliance with State and Federal laws.
- Protocol for notice and destruction of records after the retention period has expired.
- Standards for the confidential, safe, and secure manner of storage.
- Provisions for providing the dentist access to records when necessary.
- Provisions for providing qualified persons access to records.
- Provisions for providing copies of records pursuant to patient authorizations and as required by law.

Remember to check with your business attorney as to the need for a HIPAA Business Associate Agreement if you decide to send records to a third party for either scanning or storage.

**Notifying Patients**

Patients should be notified in writing that a dentist is departing. The timing and content of the notification will depend upon the specific circumstances. Notification should be given to all those patients whom the dentist considers to be “active.” Who is considered to be an “active patient” will vary depending on the circumstances of the group. Patients should be advised to contact the practice concerning continuity of care. The letter should inform the patient where his or her dental record will be located and how he or she will be able to access a copy. Depending upon the circumstances, the patient may be advised to select another dentist in the group, or provide instructions regarding transfer of care. In either case, the practice should obtain clear direction from the patient.

If the record will remain with the group practice but the patient is not continuing care with that practice, the patient should be asked to sign a release of records to his or her chosen treatment provider. Copies of the record should be delivered to the new dentist in time to ensure continuity of care.5

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5. Although some lower court cases indicate that no written authorization is necessary to share a copy of the record with the provider who created it (e.g., Pullman v. Gormley, supra), the Department of Health has indicated that a best practice is to obtain the patient’s written consent to release the record so that there is no question as to the patient’s wishes.

**Conclusion**

Any time a dentist leaves a group practice, the parties must work together to arrive at a sensible plan to ensure the patient’s continuity of care and access to dental records. The parties should decide how to notify patients, how to handle patient requests for transfer of dental records, and agree upon a plan for the storage of the patient’s dental record and a process for complying with requests for access and disclosure. It almost goes without saying that good communication and cooperation in these matters protects the dentist, the practice group, and the patients.
Case Study

Failure to Diagnose Bruxism: A Patient’s Secret Recordings Absolve the Dentist

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A 37-year-old male had been seen by his general dentist since 1987. He had various fillings placed over the course of several years, with crowns being cemented on #s 7, 8, 9 and 10. For three years, the patient was treated with routine prophylaxis and amalgam fillings. By 1991, the dentist had restored eight lower teeth, #s 21-28. He documented that this treatment was needed because of wear.

From 1991 on, the patient again was treated with routine prophylaxis and fillings. In 1998, the patient relocated out of state. He asked that his records be forwarded to his new dentist. He was seen twice in 1998 by this new dentist, but then transferred to a second dentist in that state. On October 19, 1998, the patient and his second dentist discussed the patient’s wish to replace his upper anterior crowns. This dentist documented that the patient wanted “lighter crowns.” Instead, the dentist suggested a full mouth restoration at an estimated cost of $19,000. Additionally, the dentist advised that if he performed a full mouth restoration, the patient had to wear an occlusal guard at night.

The patient advised that he wanted to wait to decide whether to undergo a full mouth restoration. In December 1998, the patient’s lower anterior teeth #s 22-27 were built up with composite resin, establishing anterior occlusion to allow his posterior teeth to further erupt. In January 1999, the patient underwent crown replacement on teeth #s 7-10. In July 1999, the patient advised the dentist he was dissatisfied with his treatment and refused to pay his bill.

In September 1999, the patient returned to New York State and resumed treatment with his original dentist. Prophylaxis was performed but he refused to have x-rays. An impression was also taken for a night guard.

For the next five years, he received only routine dental care. However, in February 2004, the patient advised the dentist that he was concerned with his occlusal wear. He was promptly referred to an orthodontist. The orthodontist called the dentist and stated that he could not help the patient because he really needed a full mouth restoration. In April 2004, the patient was advised that only a full mouth restoration would resolve all of his dental problems. The patient again refused to comply with this recommendation.

Over the next five years, the patient was seen only for routine dental care and continued to refuse all x-rays during this period. All refusals were documented. The patient’s final appointment was in January 2009. He then moved to another city where a full mouth restoration was completed.

In 2012, the patient sued his original dentist, alleging his failure to diagnose bruxism, and seeking damages for the resulting pain and suffering and dental costs. MLMIC’s experts who reviewed this case were concerned that there were difficult issues to overcome. The first was the dentist’s lack of documentation. His office notes from the early 1990s were very sparse, particularly for the initial dates of treatment. Unfortunately, the patient’s early x-rays had also been destroyed due to weather related damage to the dentist’s office building. Further, this dentist had never taken a full mouth series. It was not until after the dentist reviewed the full mouth series taken by the out of state dentist that he finally documented the need for a full mouth reconstruction. Although he was certain that he discussed the need for full mouth restoration earlier in the patient’s treatment, his records did not reflect such a discussion. The experts felt this lack of documentation would seriously affect the defensibility of the lawsuit.
At his pretrial deposition, the patient was vague and non-specific. He claimed he was never told that his bruxism would result in the need for a full mouth restoration and denied that such a conversation took place in 2009. In fact, he claimed he was not told that he had bruxism until he moved out of state. Finally, he claimed the dentist advised him to use a soft teeth bleaching tray, instead of a mouthguard, at night.

During his depositions, the patient revealed that he had secretly recorded two of his office visits with this dentist as well as visits to subsequent treating dentists. Fortunately, nothing in these secret recordings supported the patient’s contentions. In fact, they demonstrated the patience and thoughtfulness with which the dentist had answered the patient’s questions. While the dentist admitted that he did not fully document the patient’s bruxism, he stated definitively that he did warn the patient about this and the need to wear a mouthguard at night. While the patient thought the recordings hurt the dentist, in fact they had the opposite effect.

This case was presented to the Dental District’s Professional Liability Component Claim Committee. The Committee reviewed all the records, films and case reports. They determined that the case should be defended despite the poor documentation. They felt the dentist’s kind, compassionate and thoughtful manner would make a very good impression on the jury. An expert witness was retained to support the dentist’s care.

At trial, when the dentist testified, the patient’s attorney not only permitted him to expand on his answers but allowed him to explain his thought process when treating the patient. In anticipation of the testimony of the patient’s expert, the dentist stated that, based on the occasional x-rays permitted by the patient, he diagnosed bruxism and recommended that he use a night guard. Despite the lack of documentation prior to 1999, the dentist testified that the films demonstrated a huge amount of wear. He testified that he could not have failed to see it; nor could he have failed to recommend a night guard and full mouth restoration.

When the patient testified, he could not remember important facts, nor could he recall the care provided by other dentists. He further testified that he declined x-rays several times because he was afraid of radiation. However, on cross examination by defense counsel, he admitted that he had declined x-rays due to cost. This fact was confirmed by the secret recordings, where he never mentioned any concerns about radiation fears.

He also admitted that he declined the dentist’s recommendation to place a crown on #11 for several years. That tooth eventually fractured at the gum line.

He finally admitted that he had declined the recommendation of this dentist as well as that of the two out of state dentists and his subsequent treating dentists to wear a night guard, even following a full mouth restoration.

The patient’s expert was a periodontist. His testimony was based upon his assumption that the dentist had never told the patient he had bruxism nor recommended
a night guard. He opined that this was a deviation from the standard of care. He further testified that the dentist’s documentation was substandard.

The defense expert, in contrast, testified that there was no question that the dentist had diagnosed bruxism from the very beginning of the treatment provided to the patient, as evidenced by the fact that he placed four upper crowns over the very badly worn four upper front teeth. He also had used porcelain fused to gold crowns to intentionally aim at reducing the wear on the lower teeth. Further, he had performed numerous restorations specifically because of wear from bruxism. He testified that recommending a night guard would go hand in hand with making this diagnosis. Finally, he pointed out the patient’s continuous failure to comply with recommendations for treatment, as documented by multiple providers. After a brief deliberation, the jury returned a verdict in favor of the dentist.

It is difficult to defend a lawsuit when the dentist has failed to document patient noncompliance. In many instances, as here, the care is provided over a long period of time, and, without contemporaneous documentation, verbal recollections of such care are suspect for lack of veracity. Good documentation of noncompliance, particularly a pattern of refusal or inaction, and documented follow-up with the patient, shifts the burden of proof to the patient. Here, the patient’s noncompliance included his failure to wear a mouthguard after he had been told by several dentists to do so, his refusal to permit x-rays for many years, and his failure to timely undergo a full mouth restoration despite being advised by two dentists to do so. Because there was no documentation of discussions with the patient regarding his failure to adhere to recommendations to prevent damage from bruxism, the patient was able to assert claims in his lawsuit and at trial that he otherwise would not have been able state.

In this case, the patient had surreptitiously recorded conversations not only with this dentist, but with two other dentists. Fortunately, the recordings undermined rather than supported his contentions, including the statement that he had refused x-rays on multiple occasions solely due to a fear of radiation. The recordings contained an admission that the patient refused x-rays solely due to cost. They also showed the dentist to
be kind, thoughtful, and willing to answer the patient’s questions.

Providers often question whether patients can legally record their discussions without their consent. This is a risk, given the widespread use of cell phones. Some record secretly, while others do it openly. In New York State,¹ only one of the two participants to a conversation must consent to be recorded. Thus, you should always recognize the possibility your conversation is being recorded and discuss treatment and/or the patient’s condition in a caring, thoughtful, and open manner.

Frequently, patients use the excuse that they are unable to recall or fully understand treatment conversations as the rationale for recording. Therefore, we recommend that the patient always be asked to repeat his/her understanding of these conversations and that the response be documented. To accommodate patients with low medical literacy levels, all communication must be simple and in plain English. Finally, we recommend that the patient be asked if he/she has any remaining questions before the conversation concludes.

Another issue in this case was the inadvertent destruction of potentially relevant evidence by a weather-related event. New York State regulations require retention of records of adults for 6 years and minors at least 6 years and until one year after the minor is 21 years old.² When records are or appear to be destroyed, an explanation is required. A dentist is obligated to document what was lost and why, and make reasonable attempts to salvage the records. This is particularly true if the records are paper and have been subjected to water damage.

Because of patient privacy concerns, before disposing of or abandoning records damaged due to severe weather, the records must be rendered unusable, unreadable or undecipherable. Evidence and documentation of the destruction must be maintained and counsel

1. N.Y. Penal Law §§ 250 and 250.05.
2. 8 NYCRR 29.2(a)(3).

ABOUT YOUR POLICY: WHEN A PATIENT REQUESTS A REFUND

If a patient requests a refund of your fees, or reimbursement for future dental care, as a condition of your policy you must promptly consult with our MLMIC claims staff for guidance on how to appropriately respond to the patient. Unless you handle the situation properly, you could compromise your coverage under your policy. If the patient’s request is verbal, your initial response is crucial. You should politely state “Before I can consider your request, I will have to review your dental records and files, and get back to you with my decision.” Promising refunds or reimbursement to patients without a careful, principled approach may adversely affect the outcome of the situation.

If you receive such a request, you should contact the appropriate MLMIC claims department. If you practice in the upstate area (all counties above Rockland & Westchester) call our Syracuse Office at 888-744-6729. Our downstate policyholders (including Rockland & Westchester counties) should contact our Long Island Office at 888-263-2729.

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The number of patients and healthcare professionals using social media has exploded in recent years. Social media is used for social networking, professional networking, media sharing, blogging, and research and information gathering. New sites are popping up with increasing frequency, allowing users to easily connect with each other. Dentists and healthcare practices have also recognized the benefits of social media, establishing websites, Facebook pages and Twitter accounts for public relations and marketing.

Many social networking sites invite participation and engagement by the online community. Practice-owned Facebook pages and websites may allow readers to respond to published content by posting their own comments. Some sites, such as Healthgrades, Zocdocs, RateMDs.com, Vitals.com, Google Reviews, Yelp, and Angie’s List are specifically designed to solicit patient reviews of their experiences with healthcare providers. According to a 2015 study of a large accountable care organization in eastern Massachusetts, 53% of physicians and 39% of patients reported visiting a physician rating website at least once. Interestingly, while physicians had a higher level of trust in comments associated with health system surveys compared to independent websites, patients felt just the opposite.1

Reviews left by patients can be positive or scathing. They are not based upon any empirical data and reflect the patient’s perception of his or her experience. A negative comment about you or your practice will exist in the blogosphere for years to come and could turn up whenever your name is searched online. Thus, when a dentist is faced with a negative review, there is a strong temptation to respond and to defend oneself against the criticism. The fear is that the review is damaging to one’s reputation and that it will be relied upon by others. Yet the impulse to immediately respond should be checked for several reasons.

First and foremost, responding to a negative review online runs the very real risk that the dentist will divulge details about the patient’s care in violation of patient privacy laws. In 2016, The Washington Post reported that Yelp identified 3,500 instances of one-star reviews in which patients mentioned privacy concerns or HIPAA. The report stated that in dozens of instances, responses to complaints about medical care turned into disputes about patient privacy, and it identified at least two instances where dentists were under investigation by the Office of Civil Rights for HIPAA violations.2 In 2013, a California hospital was fined $275,000 for disclosing a patient’s medical information in response to a patient’s complaint to the media.3 Therefore, a dentist cannot generally respond directly to a negative posting without risking a privacy violation. If the patient’s complaint is relatively benign, it may be best to ignore the post.

Dentists may wonder if they can sue a patient for posting an online review. Aside from the notoriety which accompanies suing one’s patients,4 there is little to gain by diving into litigation. Web site operators are insulated

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MLMIC received approval from the New York State Department of Financial Services (DFS) this year to amend and enhance its New Dentist Discount Program.

MLMIC’s enhanced discount program offers New Dentist Graduates more options in choice and savings, and a cost effective way to obtain malpractice insurance with the NYSDA-MLMIC Program, which was designed by and for NYSDA members along with New York State’s leading malpractice carrier.

The choice of either first year claims made coverage or occurrence coverage, at limits of $1 Million/$3 Million, at a flat rate premium of $50 is available to qualifying newly graduated dentists entering private practice for the first time immediately following the completion of training.

Newly graduated dentists who do not qualify for the flat rate premium may be eligible for a 75% first year discount off the standard rates.

We also offer discounts to dentists practicing in years 2 through 4:

- 2nd year: 60%
- 3rd year: 25%
- 4th year: 10%

To learn more about claims made vs. occurrence coverage, go to www.MLMIC.com/dentists/malpractice-coverage/. Interested dentists can work directly with MLMIC underwriters to discuss the options and receive assistance navigating the process of applying for malpractice coverage by contacting our Underwriting Department at one of our regional offices: NYC 1-800-683-7769; Long Island 1-888-263-2729; Syracuse 1-888-744-6729.

2017 Event Calendar

MLMIC representatives will be in attendance at the following events:

**OCTOBER**
10/10/17 Onondaga County Dental Society
10/11/17 Nassau County Dental Society Scrubs & Stilettos
10/19/17 Fourth District Dental Society New Dentist Meeting
10/20/17 New York County Dental Society Full Day Symposium (Manhattan)
10/26/17 Fourth District Dental Society Women’s Dentist Meeting

**NOVEMBER**
11/3/17 Fifth District Dental Society Fall Seminar
11/6/17 New York County Dental Society Membership Meeting
11/6/17 Nassau County Dental Society General Meeting
11/9/17 Second District Dental Society General Meeting (Brooklyn)
11/14/17 Onondaga County Dental Society
11/15/17 Suffolk County Dental Society General Meeting
11/15/17 Ninth District Dental Association General Meeting
11/26-29/17 Greater New York Dental Meeting

For more information on MLMIC’s participation at these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.
Promoting Communication Between the Referring and the Consulting Dentists

**The Risk:** Lack of communication between dentists can result in a delay in diagnosis or treatment, the failure to act upon abnormal test results or findings, the duplication of a prescription, or failure to prescribe appropriate medications or order diagnostic testing. A lack of clearly defined roles and responsibilities for all dentists may impede your ability to provide and promote safe and effective patient care.

**Recommendations:**

1. Referring dentists should develop a method for determining whether a consultation has been completed and if a written report has been received.
2. As a matter of standard office policy, all consultation reports must be reviewed by a dentist, initialed, and dated prior to being filed in the patient’s dental record.
3. Office follow-up procedures should provide for easy identification of a patient’s noncompliance with the recommendation for a referral, such as when a written report has not been received from the consultant.
4. If a patient has been noncompliant in obtaining the recommended referral/consultation, follow-up with the patient is necessary. Your discussion with the patient should include reinforcement of the necessity and reason for the referral/consultation, as well as documentation in the patient’s dental record of all attempts to contact the patient and obtain compliance.
5. If a written report from the consultant is not received in a timely manner, you should contact the consultant to determine whether a written report has been generated.
6. Consulting dentists should routinely send written reports to referring dentists in a timely manner. These reports should include:
   a. findings;
   b. recommendations, including interventions and the delineation of the dentist responsible for treatment; and
   c. follow-up of abnormal test results, including incidental findings.
7. To promote effective communication, the consultant should contact the referring dentist about any patients who fail to keep appointments. Dental record documentation should reflect the missed appointment, as well as notification of the referring dentist.
8. Telephone conversations between referring and consulting dentists are important when clarification of the contents of a report is necessary. Timely contact must be made when an urgent or emergent clinical finding is identified. These conversations must also be documented in the patient’s dental record.
from liability for the content of patient reviews under federal law.\(^5\) Under First Amendment principles, patients have a right to voice their opinions online, no matter how hurtful those opinions may be. An action for defamation will not be successful unless the posting, read as a whole and looking at the overall context, states false facts rather than protected opinions.\(^6\) Finally, if a dentist wishes to bring legal action against a patient for a negative review, the dentist will have to pay his or her own attorney’s fees. Professional liability polices do not cover the initiation of a lawsuit against a patient.

So, what can you do by way of a response to a negative online review? Caution is advised before you make any response. Don’t do anything immediate or rash. Take a step back, a deep breath, and think carefully about your response strategy. Remember that one bad review will not destroy an otherwise good reputation and that many readers will just ignore comments which seem malicious or motivated by spite.

Try to determine if the review is from a patient, an unhappy employee or former employee, or a friend or relative of a patient. If you choose to respond online, keep the comment general. You may speak to your overall policies or procedures without mentioning any patient identifying information. You may reiterate that your office is always available to discuss concerns with patients and that they should feel free to contact you directly.

If you are able to identify the patient, you may wish to reach out to that patient with an invitation to personally discuss his or her concerns. Think carefully before discharging the patient in response to the review because it may be viewed as retaliation and may set off another round of negative comments. However, if the post threatens the safety of you, your staff or your family, you should notify the police. Finally, if you believe the review raises the possibility of a malpractice action against you or your practice, notify your professional liability carrier to report the event.

Generally speaking, the best course of action in response to a negative online posting is to not spend a great deal of energy refuting it. Instead, encourage all your patients to provide honest feedback regarding their experiences. You will most likely find that most patients are happy with your services and the good reviews will far outnumber the bad ones.\(^*\)

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5. The Communications Decency Act, 47 USC § 230.
consulted as necessary. If the records are totally damaged, both records and films must be shredded or properly destroyed so patients cannot be identified. If the record is electronic, an independent expert should be retained to verify that the records are not salvageable. There are websites which deal with the preservation and salvage/recovery of damaged records.3

Although not an issue in this case, the loss of a patient’s records could result in an allegation of spoliation of records by the patient’s counsel. This could potentially lead to the imposition of a variety of sanctions being sought, particularly if the evidence lost was crucial to the patient’s case. The sanctions range from a charge to the jury that they can presume the missing record or films would have been favorable to the patient, to financial penalties, or to a verdict being directed in favor of the patient for liability with only a trial for damages remaining.

This case could have turned out very differently. From the perspective of both the Dental District Claims Committee and the patient’s counsel, the lack of documentation was the dentist’s Achilles heel. Only his manner as a witness and a well-prepared, competent expert helped to overcome this and enabled him to win the lawsuit.

Finally, when a patient continues to be noncompliant despite multiple discussions of necessary treatment, fails to keep appointments, or refuses x-rays or other reasonable preventative measures, we recommend discharging the patient for noncompliance. A memorandum explaining how to discharge dental patients is available from Fager Amsler Keller & Schoppmann, LLP.