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INSIDE

EDITORIAL STAFF

Publisher
John W. Lombardo, MD, FACS

Editor
John Scott

Staff
Kevin Francis
Thomas Gray, Esq.
Katherine Lagano
Matthew Lamb, Esq.
Nicole Lombardo
Patricia Mozzillo
Linda Pajonas
Donnaline Richman, Esq.
Marilyn Schatz, Esq.
Keith Vaverchak

EXECUTIVE MESSAGE

Dear Colleagues

There are few events that strike more terror in the heart of the modern dentist than being in a malpractice suit and learning that one's personal assets might be at risk. The idea that, as a result of a jury verdict in a suit, one might lose one's financial security is terrifying indeed and should be taken very seriously.

First, a word of reassurance. Malpractice suits where a dentist's personal assets have been attached are extremely uncommon. The large jury verdicts that one sees touted in subway ads are often reduced by the trial judge or by appeal. Still, the risk remains, and one needs to be prepared.

Most commonly, plaintiffs' attorneys threatening to pursue a dentist's personal assets in the event of a large plaintiff's verdict is often used as a ploy to get dentists to settle what is otherwise a defensible case. In this situation, I strongly recommend that one be guided by the assessment of one's attorney, who usually has a better, more objective view of the case and can better evaluate the true risk of such an occurrence.

When I was on trial, I was struck by how my "calm" assessment of the proceedings went completely out the window. At times, I felt like I was the worst doctor in the world. A verdict in my favor came almost as a shock. Fortunately, my MLMIC-appointed attorney kept things in perspective. He felt the voiced threat to my personal assets was little more than an attempt to intimidate and that the case was "going well." He had a much better perspective than I could ever have. MLMIC uses only the best defense attorneys, and I am grateful to mine to this day.

As the cases presented in this issue demonstrate, the best way to avoid being in this situation is to follow long-established guidelines. Keep good records. Document as much as possible. Treat friends and loved ones in the same way you would other patients, including proper documentation of the treatment. Encourage, and arrange, second opinions when you might need one. Don't consciously or unconsciously push less than optimal results away. If sued, participate in your defense, and take the advice of your seasoned MLMIC attorney seriously.

We have enough pressures and demands on our professional lives already. Hopefully, the contents of this issue will help with some of those sleepless nights.

Sincerely, your colleague,

John W. Lombardo, MD, FACS
Chief Medical Officer, MLMIC Insurance Company
jlombardo@mlmic.com

High-severity Dental Liability Cases: **Infrequent but Dangerous**

Lawsuits brought alleging dental malpractice are often looking for recovery of costs in what MLMIC Insurance Company categorizes as "low-severity injuries" and generally follow dissatisfaction with prosthetic implants, crown applications, and retained foreign bodies, which are often root canal files. In fact, these relatively low-value cases make up more than 75 percent of the lawsuits brought against our insured dentists. Many of these low-severity cases are brought by the patient, without an attorney, in Small Claims Court and are quickly resolved without discovery by negotiation, mediation, or, ultimately, a non-jury trial. These Small Claims Courts cannot award compensation for pain and suffering. Awards are limited to a maximum of $5,000 in city courts, $3,000 in town and village courts, and $10,000 in New York City courts. Most of these are adjudicated in favor of the dentist with no award to the patient.

A much smaller portion of the dental cases brought reach the threshold of "high-severity," which, according to the National Association of Insurance Commissioners' (NAIC) definition, involve serious permanent disability or death. These cases are driven by the value or potential value of the injury alleged. Generally speaking, the patient is represented by counsel, who brings the action to the New York State Supreme Court, which can award damages for pain and suffering and is not limited by any damage cap. Examples include a jaw fracture or nerve injury with allegations of malpractice often related to poor technique or failure to appreciate an existing condition and that can escalate through failure to diagnose and treat infection or cancer, resulting in extensive, expensive, and disfiguring treatment, significant pain and suffering, and, rarely, death. It is the infrequent dental case that is resolved with an indemnity payment of $1 million or more. MLMIC Claims Specialists work to identify these injury allegations early, retain experts to assess compliance with or deviation from the standard of care, mitigate damages, and create a strategy for resolution.

From a risk management perspective, MLMIC believes that there are lessons to learn from the most common small claim to the rarest and most severe losses. The difference between a good outcome and a poor one, between a healthy, satisfied patient and an expensive, time-consuming, anxiety-inducing lawsuit, is often the result of thorough documentation and effective patient communication, as well as timely and appropriate referral. This edition of *The Scope* focuses on three high-severity dental case studies that involve some of these actionable points, with helpful legal analyses of the vulnerabilities that led to patient dissatisfaction, litigation, and settlements.

Case Study #1: Sepsis

A disabled 55-year-old female with a history of fibromuscular dysplasia and a subarachnoid hemorrhage from a congenital parietal aneurysm two years earlier was referred to the insured oral surgeon for tooth restoration. She was missing several teeth and then had teeth #3 and #4 extracted with bone grafting facilitated by IV sedation. Notably, there was no signed informed consent form for these extractions.

> **Notably, there was no signed informed consent form for these extractions.**

The patient returned 6 months later to discuss dental implants. It was noted that the patient had a persistently elevated white blood count (WBC) for a month prior to the scheduled implant procedure. Although the oral surgeon and a witness signed the consent form for implants with IV sedation,

the patient did not. In addition, the oral surgeon did not obtain medical clearance prior to placing implants at teeth #3, #4, #5, #6, #19, #20, and #21. He gave the patient IV antibiotics and believed her when she assured him she had amoxicillin at home and would take it for the next seven days.

On the first postoperative day, the oral surgeon called the patient, who reported that she was taking vitamin B-12 to "treat an elevated WBC count."

On the second postoperative day, the patient called the insured's office with complaints of constipation. She was advised to stop taking oxycodone. Her spouse reported that the patient exhibited signs of confusion but refused medical intervention. It was at this time that the insured wrote addenda to the patient's chart to document her post-implant course.

Later that night, the patient fell at home and became unresponsive. Emergency medical services were delayed due to winter weather conditions and unable to intubate the unresponsive patient when they arrived. Aggressive resuscitative efforts continued at the hospital but failed, and the patient was pronounced dead.

> **The spouse reported to the oral surgeon that his wife died of a myocardial infarction secondary to sepsis.**

Laboratory results indicated a Group A streptococcal infection and a WBC of 2,000. The patient's spouse declined an autopsy, and there was no definitive cause of death. The spouse reported to the oral surgeon that his wife died of a myocardial infarction secondary to sepsis. An infectious disease expert who reviewed the case concluded that the patient did die from sepsis. An internal medicine expert contended that the patient died from Call-Fleming syndrome, a reversible segmental vasoconstriction of cerebral arteries. The oral surgeon was criticized for failing to obtain a complete patient history, not taking into account her cognitive deficits, and treating the patient more like a professional colleague than someone with a history of a ruptured cerebral aneurysm.

Due to multiple weaknesses in the case and defense costs that escalated to $164,000, the suit was settled on behalf of the insured oral surgeon for $600,000.

A Legal & Risk Management Analysis

This case represents significant problems with the dentist's management of the patient's treatment. The first issue was the lack of informed consent. Not only was the patient's mental capacity to consent to treatment an issue, she never actually signed the consent form. Incredibly, both the dentist and an assistant signed the form, which stated that they had witnessed her signature and consent when, in fact, she had never given informed consent nor signed the form. Pre-signing the consent form implies that informed consent, which is a discussion of the procedures' risks, benefits, and alternatives, and the risks of these alternatives, never actually took place. The obvious conclusion to be drawn is that there was no informed consent at all.

> **Not only was the patient's mental capacity to consent to treatment an issue, she never actually signed the consent form.**

As previously noted, due to the patient's underlying medical conditions affecting her mental capacity, it is questionable whether she had the requisite legal capacity to provide consent or the ability to comprehend the attendant risks of the procedures she was to undergo. The dentist should have had doubts about the patient's capacity, especially since he was familiar with how the patient had previously reacted in various situations, and when the dentist called the patient and learned she was acting confused, he should have urged the patient's spouse to take rapid and definitive action before she collapsed.

In this case, the dentist did not appropriately investigate the patient's capacity to comprehend that an undesirable outcome could result unless certain essential steps were taken. This patient clearly lacked the understanding she needed to transfer to a more skilled provider with the necessary training and expertise. The dentist may have also failed to appreciate the severity of the

patient's elevated WBC as indicative of the need for immediate intervention by a medical professional. This case's devastating outcome exemplifies the potentially dire consequences of erroneously assuming that no complications will result from the care and treatment rendered by a dental provider.

Case Study #2: An Overconfident Dentist

A 52-year-old male presented to the insured general dentist's office with multiple dental issues. This dentist, who had no advanced training, completed a complex full mouth restoration on the patient that included sinus lifts, bone grafting, root canal treatments (RCTs), apicoectomies, extractions, implants, and restorations.

Due to failure, many of these procedures had to be re-done, some over prolonged periods of time. Some procedures became progressively more invasive. For example, an RCT took eight visits to complete. A sinus communication with infection was treated over 15 visits. A tooth with a good prognosis received a filling and, shortly thereafter, needed an RCT, which then became infected and required extraction, grafting, and an implant. This implant then failed, requiring that treatment begin yet again. After five years of care with this dentist, the patient finally left the practice and sought treatment elsewhere.

> ...the dentist testified that he did not need to consider referring the patient to any other specialists...

The patient filed a lawsuit against the dentist alleging negligent full mouth restoration, failure to refer him to a specialist, and a lack of informed consent. He claimed that the dental care provided by this dentist resulted in not only the need to retreat his teeth, but the loss of all his remaining natural teeth.

At his deposition, the dentist testified that he did not need to consider referring the patient to any other specialists and asserted that he was capable of performing all the treatments provided despite his lack of specialty training.

MLMIC experts and the District Claim Committee reviewed the case and determined that there were serious issues involving the dentist's ability to provide the treatment itself. They opined that the documentation was sparse and lacked comprehensive treatment notes.

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The reviewers also found that he failed to develop a comprehensive treatment plan, did no periodontal charting, had no written informed consent forms, and, finally, had made no referrals to specialists.

Over a five-year period, the dentist had treated every tooth in the patient's mouth. Some teeth were either retreated or later underwent more aggressive procedures with extensive restorative, endodontic, periodontal, and surgical treatment. It was quite evident to the reviewers that the patient should have been promptly referred to other specialists, especially when his initial treatment began to fail. Instead, the dentist performed multiple retreatments of those teeth. Finally, the reviewers found that this patient should have been referred to an oral surgeon for the sinus lift.

The plaintiff's demand was $450,000 for expenses paid to this dentist and the current and future costs of care from other dental specialists. The lawsuit was ultimately settled for $260,000.

A Legal & Risk Management Analysis

The primary challenge to successfully defending this lawsuit was the lack of informed consent or offer of the option to transfer care to a specialist. Informed consent documentation should have included the need to have a specialist involved in much of the patient's care. It is unclear whether this omission was due to the dentist believing he could successfully complete all treatment the patient required, or his concern about referring the patient for dental work that had to be redone.

This case exemplifies the extremely poor communication between the dentist and the patient. Prompt referral to a specialist would have saved the patient many appointments and dental bills over five years and, more importantly, some, if not all, of his natural teeth. Unfortunately, as is very evident in this case, the patient was also quite dilatory over a period of five years in seeking other dental care or opinions, to his detriment. Another weakness in this case was the very poor documentation in the dental record.

Finally, the lawsuit resulted in an expensive settlement, which was primarily due to the dentist acting as an expert in all areas of dentistry and providing specialized treatments despite his lack of proper specialty training in the multiple procedures he performed. His lack of communication did not allow proper informed consent from the patient because he was unaware that the dentist was exceeding his training and expertise in the many procedures he provided. This significant omission became apparent since the dentist had to redo much of the work.

Although it is unclear why the patient remained at this practice to have multiple repeated procedures, it is likely and understandable that patients trust and have confidence in a dental professional to provide appropriate treatment within the standard of care. The patient in this case lacked the awareness he needed to transfer to a more skilled provider with the necessary training and expertise to properly handle his dental needs. Unfortunately, both the patient and the dentist made the erroneous assumption that no complications would result from the care and treatment rendered.

continued on page 11 ›

From the Oral Cancer Foundation:

The Role of Dental and Medical Professionals

After an informed public that is knowledgeable about the risk of oral cancer, the dental community is the first line of defense in the early detection of the disease. Including both generalists and specialists, there are over 100,000 dentists in the US, each one seeing between 8 and 15 patients per day. If one includes those patients who come to a practice and see someone other than the dentist, such as the hygienist, the number of patient visits is significantly higher. The American Dental Association states that 60% of the US population sees a dentist every year. Just doing "opportunistic" cancer screenings of the existing patient population that visits a dental office every day would yield tens of thousands of opportunities to catch oral cancer in its early stages.

One of our goals is to initiate an effort within the dental community to aggressively screen all patients who visit their practices. At the same time, we are launching a campaign intended to drive public awareness of oral cancer and instill in the public's mind the need for an annual screening for this disease. One only has to look at the impact of the annual Pap smear, mammogram, and prostate exam to see how effectively an aware and involved public can contribute to early detection when coupled with a motivated medical community.

The dental community must assume the same leadership role if oral cancer is to be brought down from its undeserved high rank.

5 Things to Consider When Choosing a Dental Professional Liability Insurance Carrier

As a dentist, you work hard to maintain a successful practice and deliver excellent dental services to your patients. Choosing the right dental professional liability insurance carrier is an important part of your practice's foundation and the best initial way to protect yourself against a dental malpractice claim. While many of you reading this have already made a great choice with MLMIC Insurance Company, the following is a reminder of the five basic things to look for in a carrier.

Please feel free to share these tips with your colleagues, new dentists you may be hiring or mentoring, or dentists joining your practice.

1. Claims Experience

A dental professional liability insurance carrier's presence and experience in New York State, and especially in your local area, is extremely important to the handling of malpractice claims. Knowledge of the New York malpractice environment, including the laws, courts, judges, attorneys, and damage values, is a fundamental part of successfully defending a dental malpractice claim. Presence alone is not enough; find out how long an insurance carrier has been in the New York State insurance market and look at their claims results.

2. Financial Strength, Stability, and AM Best Rating

Financial strength and stability are other key considerations when choosing the right insurance carrier and can demonstrate an effective history in handling past claims, as well as the ability to successfully defend future claims.

A key indicator of an insurance carrier's financial strength in the market is its AM Best rating. AM Best is a global credit rating agency specializing in the insurance industry. While this is not the

only factor when evaluating an insurance carrier's financial strength and stability, it should be a top consideration. You certainly do not want to learn of your carrier's financial instability while facing a claim of malpractice. MLMIC has an AM Best rating of A+, with a stable outlook.

3. Insurance Policy Choices, Costs, and Discounts

The two Cs — "Choice and Cost" — are two considerations when choosing an insurance carrier. Some specific items that are part of the two Cs include the following:

- The availability of both Claims Made and Occurrence policies
- The availability of both consent and non-consent to settle policies
- The availability of coverage for professional entities and employees
- The availability of various discount programs, such as MLMIC's new dentist $50 first-year policy with continuing discounts for several years thereafter, a risk management course completion discount, and more

You should keep two sayings in mind when considering cost: *"penny-wise, pound foolish"* and *"an educated consumer is the best customer."* Cost is an important consideration but should not be the only one. When comparing costs, make sure that you are getting the same product, protection, and services.

4. Risk Management Education and Services

Malpractice claims begin during the treatment of a patient. Education and training on risk mitigation strategies have been shown to be effective tools for dentists to avoid claims and/or lower damages. In addition, the availability of an insurance carrier's legal team — well-versed in New York law — can prove to be valuable in situations leading to potential malpractice claims such as unexpected or bad outcomes, dissatisfied or difficult patients, refunds, and regulatory questions. MLMIC policyholders can call **(844) MMS-LAW1** or email **hotline@mmslawny.com** for 24/7 emergency support services and expert, one-on-one assistance with risk management and patient safety issues, research, or educational matters.

5. Fighting for the New York Dental Community

A final consideration in choosing the right dental professional liability insurance carrier is whether the carrier is vested in fighting for the interests of New York dentists. Is the carrier active in fighting legislation that would expand dental professional liability, such as the recently vetoed Grieving Families Act? Does the carrier have a record of fighting for tort reform and supporting legislative efforts to lessen malpractice in the dental community? Has the carrier partnered and collaborated with organized dentistry to lessen malpractice liability? Has the carrier regularly engaged in risk management education to help mitigate claims and/or liability? Partnering with a carrier that supports the dental community makes you part of the team fighting for tort reform.

Choosing the right dental professional liability insurance carrier is an important decision in your professional career. MLMIC thanks its loyal policyholders and looks forward to supporting both existing and new customers for many years to come!

Al Anthony Mercado is the Managing Attorney for Mercado May-Skinner NY and a MLMIC Insurance Company employee.

amercado@mlmic.com

CHECKLIST #5

MANAGEMENT OF NEGATIVE ONLINE REVIEWS

Dentists recognize that, along with their practice's website, public websites, such as Yelp, Healthgrades, and Rate MDs, and social media sites like Facebook and Twitter, can be used as marketing tools to inform the public of their services. The online community, however, can respond, rate, and, at times, complain about those services. These statements and reviews are readily accessible to anyone with an internet-ready device.

While there is a basic instinct to immediately respond to negative online reviews, dentists must remember that privacy rules make a complete response via social media inappropriate, and responding directly to an online post puts the provider at risk of disclosing protected health information (PHI). Your response may not contain any identifying statements, but the mere recognition of a patient-provider relationship is a potential HIPAA violation.

	YES	NO
1. All social media posts are critically reviewed for accuracy and authenticity. While some negative statements regarding the performance of the dentist(s) or staff may be difficult to read, these reviews are evaluated to determine if there is any opportunity for learning or process change.	☐	☐
2. We do not engage in online arguments or retaliation — especially if the comments made are particularly negative and potentially detrimental to the reputation of the practice or dentist(s).	☐	☐
3. In order to protect patient privacy, all patient concerns and complaints are resolved by our practice through direct patient contact and not through social media.	☐	☐
4. A standard response that also serves as a marketing opportunity for our practice is used for social media responses. Some examples include: • "[Insert name] practice is proud to have been providing dental care in the community since [insert year] and takes the treatment of our patients and their privacy seriously. Because federal privacy laws govern patients' protected health information, it is not the policy of [insert name] practice to substantively respond to negative reviews on "ratings" websites, even if they provide misleading, unfair, or inaccurate information. We welcome all our patients and their families to address any concerns/requests or information about their care with us directly, as we continue to provide individualized care in our community." • "At our practice, we strive for patient satisfaction. However, we cannot discuss specific situations due to patient privacy regulations. We encourage those with questions or concerns to contact us directly at [insert phone number]."	☐	☐
5. Local authorities are notified if the safety of the staff is threatened or at risk at any time.	☐	☐

If the patient's complaint has disrupted the provider-patient relationship, discharging the patient from your practice should be considered. This action may be viewed as retaliatory by the patient and may set off a new series of negative posts. Attorneys at Mercado May-Skinner are available to assist with this process and can be reached at **(844) MMS-LAW1** (844-667-5291).

‹ *High-severity Dental Liability Cases: Infrequent but Dangerous, continued from page 6*

Case Study #3: Oral Cancer

A 47-year-old male, the insured dentist's patient for five years, was seen for routine dental care in October 2011. The patient had been a smoker for many years but had quit about 10 years earlier. His medical history was unremarkable.

In August 2011, the patient had a sore on the inside of his cheek. His wife, a registered nurse, observed the sore and thought he may have thrush. At the end of that month, the patient's primary care physician diagnosed the sore, which was present in the left buccal mucosa as an aphthous ulcer, also known as a canker sore. He referred the patient to his regular dentist for further evaluation. The insured dentist attributed the lesion to the malposition of wisdom tooth #16 and recommended extraction. Unfortunately, he wrote a very brief note and failed to mention the lesion at all.

> **The insured dentist attributed the lesion to the malposition of wisdom tooth #16 and recommended extraction.**

Several weeks later, the patient returned for his last visit to this dentist with a fractured #13 tooth. He was referred to a periodontist for extraction, but he did not go. Once again, the dentist made no notation about the ulcer's status.

Three weeks later, the patient emergently went to see another general dentist about tooth #13. This dentist also advised the patient to consult promptly with a periodontist for possible restoration or extraction. The patient declined to do so, and instead returned to this same general dentist for the extraction of tooth #13. Although this dentist noted that there was tissue ulceration distal to tooth #16, he described it in his record as a "traumatic lesion." He did not consider the diagnosis of oral cancer because the lesion was clinically consistent with trauma. The dentist recommended the extraction of tooth #16, but the patient refused.

During the next visit, this dentist noted that the lesion appeared more diffuse and irritated. He again recommended tooth #16's extraction. The patient initially consented to the extraction but then changed his mind and revoked his consent.

The following month, the dentist noted that the lesion had increased in size, was becoming a mixture of red and white tissue, and was visually concerning. Two days later, the patient consented to the extraction of tooth #16. However, after the extraction, he continued to experience discomfort on the left side of his mouth and he returned to this dentist. By now, the lesion involved the oropharynx, which the dentist documented. Because the extraction failed to resolve the lesion, the dentist considered it suspicious, performed a brush biopsy, and took multiple photographs of the lesion. The biopsy results showed "atypical cells, a portion of which were found to be at least dysplastic."

Shortly thereafter, the patient presented to an oral surgeon for a "pathology consultation." Unfortunately, the oral surgeon did not consider an oral cancer diagnosis because he did not believe the lesion's clinical appearance was suspicious for cancer. He later testified that he saw "no signs of cancer at this point." This was five months after the patient's last office visit to the original dentist. Instead, the oral surgeon diagnosed a slow-healing extraction socket and intended to do a biopsy of that area if it did not heal in two weeks. The biopsy was never performed and, at his deposition, he had difficulty explaining this lapse.

Seven months after the patient's last office visit, the oral surgeon referred the patient to a head and neck surgeon for a fine needle biopsy. The results of this biopsy confirmed the diagnosis of stage IV squamous cell carcinoma. Subsequently, the patient underwent a radical left composite resection involving the removal of the bone, muscle, and soft tissue in the area. He was left with a significant cosmetic deformity and subsequent postoperative complications. Unfortunately, the cancer recurred and metastasized, and the patient expired five months later.

> **The dentist had recently retired and was very concerned about the possibility of such personal exposure.**

A lawsuit was brought by the patient's wife against the original insured dentist, the subsequent treating dentist, and the oral surgeon. Damages in this case were compounded by the fact that the patient earned over $146,000 annually as a university professor and IT manager. The potential value of a verdict was estimated to be in the $5,000,000 range. The plaintiff's demand was $6,000,000.

Inside and outside reviews by dental experts noted the atypical presentation of the disease. However, the original insured dentist failed to document any warnings to the patient that the irritation could be cancerous.

All the experts were critical of the subsequent treating providers. For instance, the dentist observed that the lesion was expanding but did nothing at a time when the patient might have had a better prognosis. Unfortunately, by the time the oral surgeon became involved, it was too late.

The reviewers were also extremely critical of the lack of documentation by the original dentist with respect to the patient's complaints and his findings. The Dental Claims Committee felt that, although the subsequent providers' treatment had serious problems, the original dentist did nothing wrong and unanimously voted to defend him. However, the plaintiff's counsel told the defense counsel that he planned to pursue the insured dentist's personal assets if the case proceeded to trial and ended in a plaintiff's verdict beyond the dentist's policy limits. The dentist had recently retired and was very concerned about the possibility of such personal exposure.

The case was then mediated. MLMIC was successful in settling this lawsuit on the insured's behalf in the amount of $575,000. The oral surgeon settled for $490,000. However, the subsequent treating dentist did not contribute at all to the settlement and received a stipulation of discontinuance prior to the trial.

A Legal & Risk Management Analysis

This patient did not appear to question the involved dentists about the need to perform procedures. His communication with the dentists is unclear. The patient was also noncompliant because he kept changing his mind about undergoing recommended procedures and one extraction that may have led to an earlier oral cancer diagnosis. It is uncertain whether he fully understood why the recommendations were made by the two dentists he visited, resulting in an overdue definitive treatment for oral cancer. These delays were clearly to his detriment and, unfortunately, led to his death.

The patient's dental record lacked the disclosure of important findings. It is difficult to determine whether this was just a noncompliant patient or whether he did not communicate with the first dentist. Unfortunately, even when the patient was referred to and ultimately was seen by an oral surgeon, there was a lack of any communication by this surgeon about oral cancer.

The patient's obvious confidence in the skills of his regular dentists led to the delay in obtaining a timely diagnosis. Progress notes in the dental records did not include any findings and did not reflect the dentists' recommendations. The failure to document communication with patients significantly contributes to the indefensibility of malpractice lawsuits. Therefore, it is crucial for a dentist to incorporate into the dental record all conversations with a patient in which the dentist discloses suspicion of a serious condition. Any finding of a

potentially significant ailment, such as oral cancer, requires immediate referral to a specialist.

> **The failure to document communication with patients significantly contributes to the indefensibility of malpractice lawsuits.**

If a patient refuses to follow a dentist's advice, as in this case, the implications may be dire. Dentists should consider promptly discharging a recalcitrant patient from the practice due to noncompliance and provide important recommendations for proper dental care and treatment. A discharge letter, especially one based on noncompliance, should also advise the patient of the need to immediately seek care from an oral surgeon.

Not only was this lawsuit costly to resolve but, unfortunately, the patient succumbed to oral cancer because of a missed opportunity to control the primary malignancy.

Thomas Gray is Senior Vice President of Risk Management for MLMIC Insurance Company.

tgray@MLMIC.com

Linda Pajonas is a Claims Specialist with MLMIC Insurance Company.

lpajonas@mlmic.com

Donnaline Richman is an attorney for Mercado May-Skinner and an employee of MLMIC Insurance Company.

drichman@mmslawny.com

Marilyn Schatz is an attorney for Mercado May-Skinner and an employee of MLMIC Insurance Company.

mschatz@mmslawny.com

Keith Vaverchak is a Claims Unit Manager with MLMIC Insurance Company.

kvaverchak@mlmic.com

FROM THE BLOG

MLMIC's dental blog provides ongoing and up-to-date news and guidance on important events and announcements that affect the practices of our dentist and oral surgeon policyholders. You can also sign up to receive MLMIC's *Dental Impressions* — featuring the latest MLMIC Insurance Company news and links to relevant and valuable industry articles.

JANUARY 16, 2023

A Sticky Situation: What Dentists Should Know About Vaping and Dental Health

According to the CDC, 9.1 million American adults and 2 million teenagers use tobacco-based vaping products. The e-cigarette was invented in 2003 as an alternative to smoking tobacco. Here's what dentists should know about vaping and dental health.

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JANUARY 9, 2023

NYS Dentists: Complete This NYSDA Risk Management Course for a 10% Policy Discount!

Want to brush up on your risk management knowledge and get a discount on your MLMIC policy? We encourage you to complete this free, on-demand NYSDA risk management course, sponsored by MLMIC! This course, developed according to New York State laws and regulations, is less than three hours long and will get you a 10% discount from MLMIC on your liability premiums for a three-year period!

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P.O. Box 1287
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