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Liability Lifeline

Fall 2015

Oral cancer case shows necessity of a thorough approach

A dentist insured by The Dentists Insurance Company recently faced a lengthy and expensive lawsuit that claimed he was negligent in diagnosing and referring a patient with oral cancer. The case settled for an amount barely within the dentist's liability limit.

Expert opinion in the case was divided. On one hand, evidence showed the patient resisted proper dental recommendations from multiple providers and assumed

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While experts say one difficulty in diagnosing oral cancer is that its symptoms look similar to symptoms of less serious conditions, recommendations are clear that dentists must err on the side of caution.

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the direction of her own dental care. On the other hand, there were concerns about the dentist's timing and follow-up after identification of the suspicious lesion on the patient's tongue. In addition, the dentist's lack of chart notes and documentation worked against him. Ultimately, the patient's attorney developed a strong case supported by experts that the dentist was at fault for a delay in diagnosing the oral cancer.

Surrounding this case was another prominent oral cancer case in the same state where an otolaryngologist was charged with failure to diagnose oral cancer that resulted in a multimillion verdict. These proceedings illustrate what is described as a general increase in oral cancer cases over the last five years. While experts say one difficulty in diagnosing oral cancer is that its symptoms look similar to symptoms of less serious conditions, recommendations are clear that dentists must err on the side of caution.

This case also highlights the need for dentists to conduct regular oral cancer screenings and clearly document the findings. Additionally, follow-up and referral regarding any suspicious lesion is essential. Here is a closer look at the recent TDIC case:

Background

In November 2007, a patient who had been with the practice for about four years complained of trauma to the right side of her tongue that she thought was caused by contact with the edge of her Invisalign tray. The hygienist noted a direct traumatic relationship between the right lateral border of the tongue and the edge of the tray. The patient was in her late 30s at the time and a nonsmoker in good general health. She had been using the Invisalign trays for eight months.

After the initial complaint of tongue trauma, the practice owner saw the patient numerous times between November 2007 and May 2008 for delivery of progressive orthodontic appliances, whitening and fillings. During this time, the patient did not comment on the trauma or complain of tongue soreness. Because the patient made no complaints, the dentist did not follow up on the previously noted trauma. However, he did note on three separate occasions that the "oral cancer screen" was within normal limits.

There were no further entries related to the tongue trauma until August 2009 when the patient stated to an associate dentist within the practice that there was something on her tongue. The associate advised the patient to follow up with the practice owner regarding her concerns. The dentist saw the patient the following day, noted the tongue abrasion and documented the patient's comment that mouthwash made the condition worse. The dentist recommended a brush biopsy, but the patient refused. There was no documented reason why the patient refused. The dentist agreed to "watch" the area. He believed the tongue irritation was related to the orthodontic tray and advised the patient to stop wearing the retainer and change her mouthwash to another brand. The dentist advised the patient to return in one week for re-evaluation of the condition. The office inadvertently billed for the brush biopsy. (This billing error went undetected until TDIC reviewed the patient charts.)

One week later, the dentist noted the lesion looked slightly better and the swelling was reduced. Documentation

reflected the dentist' explained to the patient that a brush biopsy was not needed at that time because the condition appeared to be inflammatory in nature. The patient asked about the crowding of her lower teeth. The dentist discussed placing a Hawley retainer and took an impression.

In September 2009, the dentist saw the patient for delivery of the Hawley retainer and assessment of the tongue. The dentist noted that if the inflammation and tongue fissure were not gone in one month, then the patient would need a tissue biopsy. An appointment was set for October, but the patient failed to return. There was no follow-up from the office staff.

The patient did not return to the practice until December 2009 when she arrived for a cleaning. The patient stated the right lateral border of her tongue looked callused, but was not painful. The hygienist assessed the area as abraded, noted the tissues were keratinized and advised the patient to return and see the dentist for further evaluation.

One month later, the patient saw the dentist. The dentist noted that he preferred the patient see an oral and maxillofacial surgeon to perform an excisional biopsy of the suspicious area. The patient was resistant to that suggestion, so the dentist referred the patient to a periodontist for evaluation and possible laser therapy if indeed the condition was an inflammatory response. He also hoped the periodontist might have better luck in getting the patient to see an oral surgeon. Two days later, the periodontist examined the patient and concluded the area reflected a concern that was not indicative of an inflammatory response. He referred the patient to an oral surgeon.

In early February 2010, the oral surgeon's exam revealed a diagnosis of possible squamous cell carcinoma, and he strongly recommended an incisional biopsy for a more definitive finding. Rather than proceed as the oral surgeon advised, the patient returned to the general dentist that day and requested a brush biopsy in lieu of an incisional biopsy. When asked why she was requesting a brush biopsy rather than an incisional biopsy, the patient said she worked in sales and that being able to speak clearly was important to her livelihood.

The dentist discussed the limitations of the test and her future options depending upon the result then proceeded with the brush biopsy. One week later, the dentist called the patient and informed her that the brush biopsy showed signs of dysplasia and indicated the need for an incisional biopsy due to the risk of oral cancer. The dentist referred the patient back to the oral surgeon for the biopsy. Near the end of February, the patient called the dentist to report that the incisional biopsy was positive for oral cancer.

The dentist had no further contact with the patient until June 2011 when she submitted a written request for a copy of her dental records.

Analysis

The claims supervisor who handled the claim said the main learning point from this case is that dentists must err on the side of caution when it comes to suspected oral cancer. "The opposing counsel's central theme was that the patient reported an abrasion on her tongue as early as November 2007. Since the differential diagnosis list included premalignant and malignant conditions, the option of a tissue biopsy should have been considered," he said. Additionally, the dentist did not "document defensively" or otherwise indicate why, for example, the patient refused his recommendation for a referral to an oral surgeon.

Analysts said the errors in this situation included:

- Poor record keeping, chart entries and documentation.
- Poor communication between the hygienist, associate and the practice owner.
- Billing for a 2009 brush biopsy when no brush biopsy was performed.
- Failure to document the appearance and size of the lesion.
- Lack of monitoring of the lesion.
- Lack of office protocol and follow-up with the patient.
- Failure to perform a brush biopsy in a timely manner.
- Delay in referring the patient to an oral surgeon for a definitive diagnosis.

The claims supervisor noted that hindsight analysis, of course, provides a much clearer assessment of all of the concerns. To help navigate situations with the best possible approach, TDIC advises dentists to pay attention to red flags. In this case, red flags included the irregularity on the right lateral border of the patient's tongue, the patient's refusal to consent to a tissue biopsy and comments by the dentist's hygienist and associate dentist who observed and noted the "suspicious" tongue lesion.

Assumptions can also work against a dentist, as in this case. The dentist assumed the tongue abrasion was inflammatory in nature due to the retainer cutting into the patient's tongue. There was also an assumption early in

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the case that because the patient stopped complaining about her sore tongue, there was no need to follow up on the previously noted trauma.

The referral to a periodontist instead of an oral surgeon divided experts involved in the case. Some supported the dentist's reasoning that if the retainer was causing the lesion, then the periodontist could evaluate the abrasion and remove it with a laser. Others did not support this line of thinking. "In hindsight, we know the lesion was cancerous, so it is difficult not to opine the dentist should have referred to an oral surgeon and not a periodontist," said the claims supervisor. However, at the time the dentist was trying to discern the cause of the lesion.

There were dental experts on the case who supported the dentist's care and pointed to intervention such as removing the irritants, which showed some success. It was noted that the T3NO clinical staging of the cancer was "marginally" T3 (just over T2 sizing) and the pathology of T3N1 was "micrometastasis."

Recommendations

Analysts say there are specific actions that could have avoided this situation, including a strong recommendation from the dentist that the patient agree to a tissue biopsy by an oral surgeon. In the event of refusal, document the discussion and follow up in writing that the patient must seek care and treatment from the advised specialist. With proper documentation and follow-up, dentists may refuse care to patients who do not follow recommendations. While science shows that a brush biopsy test cannot provide a conclusive diagnosis of cancer, the test can show signs of dysplastic tissue indicating a tissue biopsy is required in order to rule out cancer.

Legal experts say that if dentists do not follow up on something they view as suspicious, they risk missing an oral cancer diagnosis and early treatment.

Another key point, according to analysts, is that the dentist did not follow up with the patient after she failed to have the lesion examined in late October 2009. Additionally, when the patient was seen three and a half months later, the hygienist should have immediately informed the dentist that the abrasion was still evident.

Analysts advise dental practices to have a "tickler" system for documenting communication with patients who neglect to show up for appointments, especially if there is a risk of oral cancer. Whether by phone, email or regular mail, document the date and contents of patient communications. If using regular mail, consider sending two letters, one certified and one standard mail.

Legal experts say that if dentists do not follow up on something they view as suspicious, they risk missing an oral cancer diagnosis and early treatment. Also, oral cancer is sometimes thought of as a disease limited to the population with increased risk factors associated with older patients who smoke or drink, but younger people can be at risk too, as this case shows.

A comprehensive oral exam includes an oral cancer screening that begins with the lips and includes the gums, floor of the mouth, tongue and hard and soft palate.

Dentists should photograph any lesion or area that looks unusual. If an intraoral camera is not used, cellphone photos are acceptable. Add the photo to the patient's chart, and be as descriptive as possible about the width, height, shape and color of the lesion including any observations such as swelling or pain. Once the photo is transferred to the patient's chart, delete it from the phone to avoid the potential for accidental disclosure of a patient's protected health information (PHI).

In addition to the above documentation, schedule the patient to return to the office within two weeks. Refer the patient to an oral and maxillofacial surgeon if a lesion looks abnormal or changes in appearance over a two-week period. "This is best for the patient and the doctor," said a consulting attorney. The oral surgeon will perform an exam and a biopsy, if necessary, and an oral pathologist will analyze the tissue under a microscope and determine the nature of the cells.

While TDIC believed the case was defensible, the dentist did not want to risk losing in front of a jury or the potential for negative publicity it could bring to his practice. TDIC settled within the dentist's policy limits.

Following the definitive cancer diagnosis, the patient underwent several surgeries, lost a significant portion of her tongue and part of her right mandible. She is still on a feeding tube and is permanently disabled from her sales occupation due to her inability to speak clearly because of the multiple surgeries.

Because many dentists lease their office space, consideration of things such as the water heater and roof may not come to mind as practice owners assume the landlord is performing this maintenance.

Preempt stress with basic property upkeep

TDIC claims professionals say that when it comes to preventive maintenance, small actions make a big difference.

Scheduling tasks such as installation of a master water shut-off device for the entire office water supply and checking the roof and water heater help dentists take charge of their businesses and not left reacting to a situation such as a flooded office because of a water leak.

"It's likely that every practice owner will have a least one claim, but the important thing is how prepared the dentist is when the claim arises," said John Ratto, a claims adjuster with 26 years of experience in helping dentists navigate claims.

Water damage accounts for the majority of property claims in dental offices. When offices have sinks and water-dependent equipment, the risk of flood increases exponentially. One of the main things dentists can do to prevent water damage to their offices, and neighboring practices or businesses, is to install a master shut-off valve at the main water source coming into the office. The shut-off solenoids can be electrically activated and used with a wall switch or timer. Some systems have automatic leak detection combined with a master shut-off valve.

Because many dentists lease their office space, consideration of things such as the water heater and roof may not come to mind as practice owners assume the landlord is performing this maintenance. A lease will typically specify the responsibilities of the property owner (lessor), but this does not mean the landlord will actually do so. "Know your lease, know your lease, know your lease," Ratto said. "Just take the time to read it and be aware of the responsibilities of each party in the event of property damage."

In one TDIC case, a dental suite sustained damage due to a water leak that originated from a hot water heater

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Beyond the Science:
Patient emotions in dentistry

It's estimated that 75% of U.S. adults experience some degree of dental fear. But fear, as well as anxiety and worry, may not be easily identified by the dental practitioner which can cause big legal issues down the road. Learn to correctly handle patients who exhibit these emotions so you can keep your practice, and your patients, safe.

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Friday, Dec. 11 9 a.m. – noon	**Hilton San Diego Resort & Spa – Mission Bay** *San Diego, CA*
Thursday, Jan. 21 9 a.m. – noon	**The Hawaii Dental Convention 2016** Hawaiian Dental Association *Honolulu, HI*

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To receive C.E. credit, registrants must be present for the entirety of the three-hour seminar. This seminar meets the Dental Board of California's requirements for 3.0 Core C.E. credits.

Special Needs

If you or someone in your group requires special assistance to fully participate in the seminar, please call TDIC at 800.733.0634 or email us at risk.management@cda.org.

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The California Dental Association is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual seminars or instructors, nor does it imply acceptance of credit hours by boards of dentistry. CDA designates this activity for 3.0 continuing education credits. This continuing education activity has been planned and implemented in accordance with the standards of the ADA Continuing Education Recognition Program (ADA CERP) through joint efforts between CDA and TDIC.

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A simple reminder about flexible spending accounts

Fall is a good time to remind patients about using their flexible spending accounts (FSA) before the end of the year.

A letter informing patients of their available benefits can serve as a prompt for them to use pretax FSA dollars set aside for dental expenses. Patients can put up to $2,550 into an FSA each year and generally must use that money within the plan year. FSAs cover certain dental expenses, including copayments, deductibles and preventive cleanings.

According to a recent estimate by the U.S. Department of the Treasury, approximately 14 million families participate in FSAs. The IRS in 2013 became slightly more flexible about the "use-it-or-lose it" rule requiring that any FSA account balance remaining at the end of the year be forfeited, and allowed employers to offer a rollover of up to $500 into the next year or a grace period to use funds, but not both. However, the general rule of thumb to use FSA funds by the end of the year remains.

Reminding patients about unused FSA benefits is different from rushing treatment to utilize benefits by the end of the year.

Dental practices can send a letter to remind patients of pending treatment or to encourage a preventive hygiene appointment using remaining dental benefits including FSA. Before sending the letter, note that dental benefit frequency limitations vary by employer, and limitations may not be the same for all groups within a particular plan.

Reminding patients about unused FSA benefits is different from rushing treatment to utilize benefits by the end of the year. Dentists call TDIC every November and December requesting help communicating with patients either who try to push to get treatment completed in time to use their benefits or who are unhappy with the results of an accelerated treatment timeframe. Work with your dental team to prepare to accommodate patients who call for appointments before the end of the year. Do not allow patients to rush treatment that you know should take longer than their remaining benefits for the year. Treatments requiring multiple appointments may require specific scheduling to meet the end-of-year goal. Consider planning holidays and vacation in advance to accommodate schedule demands.

Meeting patients' dental needs to work in conjunction with their dental benefits including FSA is smart business planning. Do not lose sight of what is ultimately best for your patients.

Correction

- Summer 2015 issue, pg 9

Many dental boards allow hygienists to administer anesthesia under direct supervision. This means the dentist is in the operatory.

- The sentence should have read:

Many dental boards allow hygienists to administer anesthesia under direct supervision. This means the dentist is in the treatment facility.

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located on the second floor of the building. Water flooded 95 percent of the dental suite and ruined computers, dental equipment, fixtures and furniture.

Investigation showed the water heater was much older than what a normal warranty covers, and the property owner was found negligent in this situation. The point is to be aware of whether your property owner is maintaining items such as the water heater and replacing it when necessary, and know what is specified in the lease.

In the event of a water-related claim where neighboring practices or businesses are affected, Ratto strongly advised dentists to not immediately assume liability for the damage. "We see this type of situation six or seven times a year," he said. "The recommendation is that dentists inform everyone that the insurance company has been notified and professional investigators are on the way."

Also, with weather patterns intensifying across the nation, the smart advice is to consider the roof on your building and communicate with your landlord about the condition of the roof. Claims professionals point out that most commercial policies do not cover damage from a leaky roof caused by a lack of maintenance.

Dentists who own their building can start now to prepare for winter weather by cleaning off debris on the roof and in the gutters and downspouts. Consider if it is time for a new roof. "Summer to early fall is typically a good time," Ratto said. "Roofers are backed up, but if you schedule now you can get them working before storms hit."

FCC: Dentists must get consent to make billing calls

Dental practices now must obtain authorization from a patient to call him or her on his or her cellphone to discuss account and insurance information, according to a recent ruling. A July 10 order by the Federal Communications Commission, interpreting a rule it promulgated in 2013, is cause to advise dental practices to ensure their policies and procedures for communications using patients' cellphone numbers is in compliance with the law.

The FCC issued its recent order under the Telephone Consumer Protection Act of 1991 (TCPA). The FCC's order addressed several issues and includes an exemption for health care treatment communications. TCPA rules require a business to obtain an individual's consent prior to calling or sending a text to an individual's cellphone number. The health care exemption applies if the communication:

- Is sent only to the cellphone number provided by the patient to the health care provider.
- States the name and contact information of the health care provider (information must be at the beginning of a voice call).
- Does not include telemarketing, solicitation, advertising, billing or financial content (including insurance information requests).
- Complies with the HIPAA Privacy Rule.
- Is short (one minute or less for voice calls and 160 characters or less for text messages).

A health care provider must:

- Limit communication to one per day and three per week for each individual.
- Provide individuals with a simple method to opt out of receiving communications.
- Immediately honor the opt-out requests.

Teresa Pichay, regulatory analyst with the California Dental Association, recommends dental practices take the following steps:

- Review procedures to determine if the practice uses patients' cellphone numbers for communications related to dental benefits, financial arrangements or marketing/solicitation. Review patient forms to determine if required consents, obtained after Oct. 16, 2013 (effective date of original rule), are included. Update forms as needed.
- Ensure that the practice's HIPAA business associates who communicate on behalf of the practice are in compliance with TCPA rules.

Pichay advises dental practices to obtain consent using language that allows the practice to communicate with patients on most subjects. The following can be on a separate form or added to

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an existing patient form that is used to collect patient information:

I consent to the dental practice using my cell phone number to *(choose one or both)* ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time.

My cell phone number is *(include area code):* _____

_____ *(initial or signature)*

I consent to receiving from the dental practice email communications regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time.

My email address is:

_____

_____ *(initial or signature)*

If a dental practice does not do in-house marketing or promotions, remove the term "special promotions" from each of the above paragraphs.

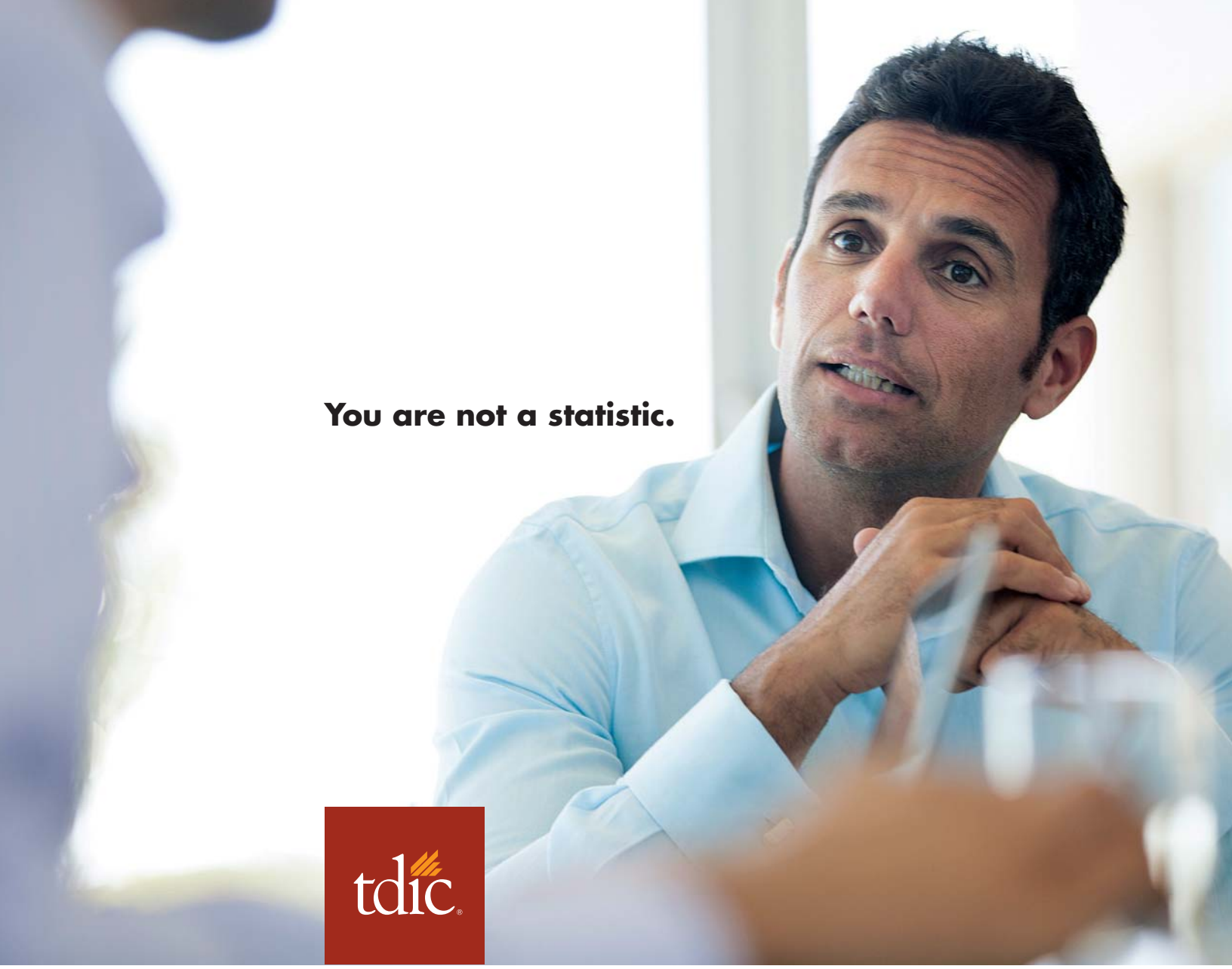
Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws.

Question and Answer

Q: I am a general dentist and I find myself in an interesting position. I have treated a family friend for years. He moved about five years ago then returned in 2014. I re-established him as a patient in my practice. During that first appointment, I noticed a lesion. I referred him to an oral surgeon for a biopsy. It was benign and we were all relieved. I had recommended the patient see a periodontist for some issues he was having. He went, but said he didn't like the periodontist and couldn't afford the treatment anyway. We agreed to more frequent cleanings to see if that would improve the periodontal condition. The next time he came to my practice, I noticed the lesion has progressed, and I sent him back to the oral surgeon. The biopsy report came back as cancerous. When I saw the patient about a month later, he said the oral surgeon didn't really say much during the consult therefore the patient "…decided to treat the infection holistically." I told the patient the results were in fact not indicative of an infection. Rather, it was cancerous. The patient and his wife were very surprised. I recommended they consult right away with the oral surgeon. As soon as they left, I called the oral surgeon. I told him the patient referred to his lesion as an infection and didn't seem to understand the actual results or how to address it. I asked him to talk to the patient. I'm not sure if he did. The patient called me the next day and asked me what to do. I referred him to a local dental school for treatment. That was the last time I spoke to the patient.

Unfortunately, the patient has since passed away. Yesterday, the oral surgeon called me asking for a phone conference. I think the family is going to try to sue the oral surgeon. I am not sure what happened between the patient and the oral surgeon. I have not returned the call. I don't really want to and frankly am unsure what to say.

A: This is certainly a difficult position to be in, but you cannot avoid the return call. Call the surgeon and find out what he wants to discuss. Ask if there is a lawsuit pending. Certainly, if there is a pending lawsuit, you should refrain from making any definitive statements as much as you can. Explain that you are uncomfortable making any comment considering the recent circumstances. Considering you were the treating general dentist, either the patient's attorney or the oral surgeon's attorney will likely depose you. Contact TDIC when that time comes.



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