



Medical Release Forms: Not a Replacement for a Conversation

Once a quarter, the *Journal* features a TDIC risk management case study, which provides analysis and practical advice on a variety of issues related to liability risks.

Authored by TDIC risk management analysts, each article presents a case overview and real-life outcome, and reviews learning points and tips which everyone can apply to their practice.

A 47-year-old male patient alleged his dentist practiced below the standard of care by prescribing ibuprofen even though he disclosed he had cirrhosis and hepatitis C, and was awaiting a liver transplant. The patient spent two days in the hospital due to gastrointestinal bleeding.

The patient presented to the dentist as a new patient. He explained to the appointment coordinator that he had not seen a dentist in at least seven years and his teeth were bothering him. He also explained he wanted to restore all of his teeth. The coordinator scheduled a new patient exam and allowed extra time to discuss potential treatment.

On the day of the appointment, the patient filled out the health history form and indicated he had viral hepatitis C and cirrhosis, and took Pegasys and Copegus to treat his liver damage. The dentist reviewed the form with him and noted in the chart the patient was on a waiting list for a liver transplant.

After taking a full-mouth set of radiographs and completing the exam, the dentist recommended extracting three teeth due to advanced periodontal disease, endodontic treatment and crowns on several teeth, as well as several simple restorations. She suggested starting with the extractions,

since those teeth were bothering the patient most, then proceeding with deep-cleaning appointments before addressing the remaining restorative work.

The dentist told the patient she wanted to discuss the treatment plan with his physician to ensure it was safe to proceed with treatment. She was unable to reach the physician but sent a fax listing the treatment recommendations for the patient and requesting authorization to proceed with the extractions. Since the patient was complaining of pain, she prescribed 800 mg of ibuprofen, every four to six hours for discomfort from the teeth that were to be extracted. The dentist told the patient she would call him after hearing from the physician to schedule the extraction appointments.

The next morning, the fax transmission arrived from the physician authorizing the recommended dental treatment. The appointment coordinator left a message for the patient to contact the office to appoint for the extractions. The office never heard back from the patient.

Two months later the dentist received a letter from an attorney indicating the patient was suing her for negligence in prescribing ibuprofen, which resulted in the patient's hospitalization for gastrointestinal bleeding. He demanded \$25,000 for loss of earnings as well as pain and suffering.

During Discovery

The patient's treatment record only contained four entries and the signed medical clearance from the physician. The first entry was the new patient exam, which included notes about the impending liver transplant, and a fax to his treating physician. The entry made the following day by the appointment coordinator, indicated she left a message at the patient's home to call and schedule an appointment for extractions. The next entry was three weeks later. It indicated another dental office was requesting copies of the patient's chart and radiographs. The final entry, which was four weeks later, read "letter from attorney."

The dentist's own attorney questioned her about the request for records. She stated she was not aware of the request until she received the letter from the patient's attorney, prompting her to review the chart. The dentist could not confirm whether the patient signed an authorization to release the records or whether the records had, in fact, been mailed or hand delivered. The dentist explained she had a complete staff turnover since seeing this patient, and the person who would have handled this request was no longer with the practice. She admitted to only learning the patient had been hospitalized after receiving the letter from his attorney.

The expert witness for the plaintiff was a physician. When the plaintiff's attorney questioned him about prescribing ibuprofen to patients with liver damage, he explained any nonsteroidal anti-inflammatory medication is contraindicated for patients with advanced liver damage regardless of its origin, including the possibility of hepatitis C. The expert was also critical of the fax transmission form. He felt that by not including the prescription for nonsteroidal, anti-inflammatory medication, the physician was responding directly to the list of medications

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listed. For those medications listed, no contraindications existed for a patient with advanced liver disease. The expert did comment that in cases of severe liver damage, a physician should have a conversation with the dentist to discuss the recommended treatment, rather than merely signing a medical release form.

The dentist was aware the patient's health necessitated a conversation with the treating physician prior to treatment. However, since she could not speak directly to the physician, she faxed a medical release form that indicated the need for extractions. The fax listed several types of anesthetics she typically used, as well as antibiotics and pain medications she may prescribe. She did not feel it was necessary to include the ibuprofen and expected the physician to indicate any other contraindicated medications that were not on her list.

The defense attorney questioned the plaintiff's expert witness about the role a pharmacist plays when dispensing medication. He asked whether the pharmacist should have filled the prescription for ibuprofen knowing the patient was taking Pegasys and Copegus to treat his liver disease. The expert stated that without the patient's health history, the pharmacist would have little reason to contact the prescribing doctor to verify the prescriptions.

The defense attorney was unable to find an expert to support prescribing ibuprofen to a patient with liver

disease and recommended offering a settlement. After negotiations, both parties agreed to settle for an amount lower than originally demanded.

WHAT CAN BE LEARNED FROM THIS CASE?

Medical Release

When requesting a medical clearance for a patient from another practitioner, it is vital for the dentist to include all information necessary. The dentist knew the patient's advanced liver disease necessitated a conversation with his treating physician. However, her impatience led her to fax a medical release form rather than waiting to speak to the physician. Furthermore, the medical clearance form contained medications (anesthetics, pain medications, and antibiotics) she typically administered or prescribed when performing extractions. Not only did she not customize the clearance form for the patient, she did not list the ibuprofen, which was a critical oversight. Be sure to include all prescription and over-the-counter medications you anticipate using during treatment, whether you believe they are contraindicated or not.

Additionally, providing treatment to patients anticipating an organ transplant requires antibiotic prophylaxis because they are usually provided less than 24 hours' notice prior to surgery. In fact, one of the protocols for pending organ transplant patients is to have all dental treatment performed prior to the transplant surgery. It is best to discuss the patient's needed dental treatment with the treating physician and agree on a course of treatment and timeline. Do not substitute a form for this conversation.

There were two checkboxes at the bottom of the form, "proceed with treatment" and "do not proceed with treatment." Medical release forms should have an area that allows physicians to

comment on the patient's overall health and alert dentists to potential issues. In cases where the patient's health is severely compromised, a conversation with the treating physician must occur before initiating treatment of any kind, including prescribing medication.

Staff Training

Dentists are responsible for everything that occurs in the office. For this reason, it is imperative staff is properly trained to bring patient issues to the dentist's attention right away. These issues include patient complaints, letters from patients or their representatives, and any requests for records. Staff turnover is not a defense for failing to provide proper training for each staff member.

Staff should also understand copies of patient records can be mailed or given to the patient, a new treating dentist, or anyone the patient designates as long as the patient is making the request. The chart should reflect the date the records were requested, when they were mailed or delivered, and to whom they were sent or delivered. It is preferable to have the patient's written authorization but not mandatory when requested directly by the patient. When patients do request their records, it is typically the first sign of discontent. Had the staff informed the dentist of the patient's request, a call to the patient would have enlightened the dentist to the situation and possibly headed off a lawsuit.

When dentists accept patients into their practices, it subjects dentists to liability, even before rendering physical treatment. Any miscommunication on the dentist's or staff's part can create a chain of events that may lead to serious consequences. ■■■■

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