CNA HealthPro

Volunteer Dentistry Is Not Risk-free

Many dentists volunteer their time and talents to patients who might otherwise not receive care, delivering free or significantly discounted treatment in their office or a community clinic. The vast majority of such patients are grateful for the services they receive. However, charitable intentions do not negate potential liability. It is necessary to understand the risks posed by volunteer dentistry in order to manage them successfully.

The Dentist-Patient Relationship

When you treat a patient in your office, a dentist-patient relationship is established, which may last decades or just a day. But is a dentist-patient relationship also established when a patient is treated elsewhere, such as a free clinic or a patient's home?

The answer is *yes*. Patients treated on a volunteer basis inside or outside your office are patients of record, as it is the *provision of care* that establishes a dentist-patient relationship, rather than length of time, location or financial arrangement.

Malpractice claims can and sometimes do arise from a single visit. Allegations include failure to diagnose pathology, extraction of the wrong tooth and inadequate follow-up care. Even very short dentist-patient relationships have their occasional problems.

Standard of Care

The standard of care is generally defined as care that a reasonable and prudent practitioner would provide under the same or similar circumstances. The standard is not waived for patients who are indigent, physically or mentally handicapped, or treated outside your premises. Licensed dentists have the same professional duty to all patients for whom they provide care, regardless of remuneration, and failure to fulfill that duty can result in malpractice claims. There is also no difference in the standard of care for donated services in the areas of record keeping, office and staff management, informed consent and informed refusal.

The responsibility to act with skill and due care applies at all times and in all settings, even when the dentist-patient relationship is limited to one visit in the patient's home.

Guardianship

In certain instances, patients treated on a voluntary basis are not able to give consent for their own care, due to their status as a minor, or because of a mental disability such as mental retardation, cerebral palsy or age-related dementia. Patients who are not their own guardian cannot provide informed consent for treatment. Any such consent would have to be obtained from their parent or court-approved legal guardian. Before treating *any* patient, resolve the issue of legal guardianship.

Medical History

The medical histories of patients receiving donated services are likely to be complex, requiring a determined effort to obtain accurate and complete information. Medical histories may uncover:

- complex medication regimens with potentially adverse treatment or drug interactions
- surgical repairs, cardiac anomalies, prostheses or shunts that require investigation
- mental or physical limitations that make certain forms of treatment inadvisable

Orally review the medical history with the patient or guardian and with designated caretakers. Since many of these patients are under constant medical care, their medical history should be carefully reviewed prior to each treatment session, even if very little time has passed since the last visit.

Be diligent in consulting with patients' physicians. If possible, obtain consultants' recommendations in writing and follow up phone consultations with a letter to confirm the accuracy of the information received.

Remember that it is up to you to make the final decision about patient care. If you get information or a recommendation from a physician or other consultant that conflicts with standard dental and medical practice use your professional judgment before proceeding with treatment.

Mental Capacity

Healthcare decisions are valid only when patients have the capacity to comprehend and consent to treatment – and patient capacity can be difficult to gauge.

There are no hard-and-fast rules for assessing mental capacity. However, there are certain basic guidelines to consider when capacity is at issue:

- All adult patients are assumed to be capable of consent unless proven otherwise.
- Only a court can officially designate someone as legally incapacitated.
- Documented evidence of a good-faith effort to determine capacity will be helpful later should the competency issue arise after treatment has begun.

A 1982 report issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research includes a three-part test for decision-making ability. To be considered capable, patients must

- possess a set of values and goals
- be able to communicate and understand information
- have the ability to reason and deliberate about choices

Early communication with patients and their families is the key to minimizing informed consent problems. With elderly and seriously ill patients, important decisions should be made and preferences discussed early in the relationship, before the patient becomes incapacitated. When the relationship begins after incapacitation, it is advisable to contact the patient's previous treating dentist or physician to discuss any advance directive arrangements the patient may have made with them, and to obtain copies of records documenting those arrangements. Make note of these discussions in your own patient records.

Communication

Good doctor-patient communication is a vital component of good risk management, facilitating such duties as

- educating the patient
- managing patient expectations
- obtaining informed consent

- providing appropriate post-operative instructions and information

The patient communication skills and techniques you have developed in your regular practice will be particularly helpful in volunteer settings.

Some patients may have unreasonable or unfounded expectations about their proposed treatment, especially if they have not enjoyed regular dental care over their lifetime. Use patient education and communication techniques to modify expectations as necessary.

Do not commence treatment until you are reasonably certain you can meet patient expectations. When acceptable clinical results do not satisfy unreasonable expectations, patients may seek to express disappointment and validate their viewpoint by bringing a negligence action against the dentist.

Clinical Care

Considering the dental health of many indigent or disabled patients, it is likely that a substantial proportion will require one or more tooth extractions – the procedure that leads to the greatest number of dental malpractice allegations, according to CNA HealthPro claims experience.

Be aware of the risk when performing oral surgery in volunteer settings, and follow the same protocols that you would for any patient in your practice needing an extraction:

- obtain a diagnostic pre-operative radiograph of the entire tooth before beginning surgery
- refer the patient to a specialist when faced with a patient management, medical complication or difficult extraction issue
- secure and document informed consent
- treat the patient with skill and due care
- provide timely and appropriate follow-up care

If your treatment protocols cannot be followed due to the patient's physical condition or lack of cooperation, document in your treatment notes your attempts to follow protocol and the reasons for any deviations.

Some patients may be mentally or physically incapable of maintaining adequate oral hygiene. Complex restorative or surgical treatment requiring a high level of maintenance may not be in these patients' best interest. As you present possible treatment plans to patients or their guardians, be certain to consider such factors as oral hygiene and difficulties with appliance insertion, removal and maintenance.

Terminating the Dentist-Patient Relationship

Until you or your patient formally ends your relationship, it remains in place, even if the last visit occurred years ago. You can reduce the likelihood of an abandonment allegation by clearly informing patients that the dentist-patient relationship has been terminated and properly documenting termination procedures in the patient record.

In many volunteer dentistry settings, patients can be "transferred" to a different dentist within the program or facility, effectively terminating the dentist-patient relationship. Transfer arrangements must be clearly explained to the patient and properly documented.

The patient's health should never be compromised during the termination period. Treatment should only be terminated or transferred at a safe and logical point during care – i.e., after procedures in progress have been completed. If the patient fails to return for unfinished treatment, you may terminate in the midst of active care, but only after making a good faith, well-documented effort to get the patient to return.

Before terminating care, ask the following questions:

- Have I met the required standard of care in my treatment and management of the patient?
- If not, has the patient prevented me from satisfying the required standard of care?
- Have I provided care to the point where the patient has no immediate need for emergent dental treatment?
- If not, has the patient refused to return for care?

If the answer is "yes" to these questions, most courts would probably judge that you have fulfilled your responsibilities and are not liable for abandonment.

Terminating a dentist-patient relationship can be difficult when patients have limited access to subsequent dental care. In such instances, provide the patient with the names and phone numbers of facilities or organizations that can help them find a new dentist to address future dental needs.

Volunteering your time and expertise those who need it most can be a rewarding and enjoyable experience. However, even in this setting, it is necessary to consider the risks and take appropriate preventive measures. Adherence to good risk management principles can make the experience less stressful, allowing you to focus on helping others.