Practical Advice From A Specialist Claimant Solicitor Upon On How To Avoid A Dental Negligence Claim

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My job as a Solicitor specialising in negligence claims against dentists in not an easy one, however, some dentists make it very much easier by not keeping adequate dental records, and not giving and recording proper advice to patients. I explain below in more detail how you can take practical steps in *your* dental practice to help avoid any dental negligence claims.

I have been exclusively practicing in dental negligence since 2001.

Negligence- A Brief Overview

In order to succeed in any claim for negligence, the Claimant (usually an ex-patient bringing the claim) must prove that his ex-treating dentist's duty of care towards his patient has been breached, and that this breach of this duty caused an injury to the Claimant.

A further, but very important duty, which is often overlooked is imposed by the GDC's standards for the dental team which states:

"Standard 4.1 –

You must make and keep contemporaneous, complete and accurate patient records."

The Claimant's First Steps

At this stage, it would be helpful to trace the initial steps involved in a typical dental negligence claim.

Once initial contact has been made by the ex-patient/potential client, one of the first steps that the claimant's solicitors will take is to obtain the patient's dental records, both past and present, in order to build up a

picture of events (rather like building a jigsaw puzzle) in order to properly assess any potential claim for negligence.

What Should You Do If You Receive A Request For Records?

If you ever receive a request for a patients clinical records, firstly, do not panic! This is simply a fact and information gathering exercise by the claimant solicitors.

You are of course at liberty to obtain advice from your defence organisation who will offer you advice and assistance, and will often liase with the claimants solicitors should you not wish to do so directly. It is important to note that no decisions have been made at this stage as to the merits of the patients claim.

Time Limits On Requests For Records

You must try and deal with any request for records quickly, as the Data Protection Act 1990 only gives you a maximum of 40 days to release the records (or at least copies) to the requesting solicitor. You are entitled to charge an "*access fee*" for the records of £10 maximum, plus *reasonable* copying charges up to a statutory prescribed maximum currently £40.00.

If you refuse to disclose the records, then it is likely that an application will be made to the local County Court for an Order that you be forced to disclose them within a very short timescale. If forced to attend the Court due to non production of notes, then this can be a costly exercise for you, as not only will the claimant's solicitors require their costs of attending the hearing, but it is also time for you spent out of the practice, which of course would be better spent within the practice seeing to your patients.

Please try and remember that if the notes have been requested by a solicitors, but they have not been disclosed by you, then this is also seen as a credibility issue, as one of the first conclusions that the claimant's solicitors jump to, is that there is something in the notes that you wish to keep hidden from them, whether or not this is actually the case, if the notes have not been disclosed.

It is therefore vital that you act promptly when notes are requested. If you cannot retrieve the notes after a through search of your practice, then you must say so straight away in order to prevent any Court applications being made. I would suggest that it would also be prudent, (but not compulsory), to provide a short statement clarifying who carried out the

search for the notes, when the search was made, and the time spent on looking for them, so that this can be shown to the Court if an application is subsequently made by the claimant's solicitors.

Types Of Request Commonly Made For Records

There are two types of request that a commonly made, the first is a formal request under the Court rules (a Court "protocol" application) whereby the claimants solicitor fills in a lengthy application form, which gives a brief outline of the allegations against the dentists in question. This formal request is usually made to the dentist who is alleged to have committed the negligence.

The second type of request is an informal request, usually made by way of a letter to the dentist requesting disclosure of the patient's records. Both requests must be supported by way of a form of authority signed by the patient to allow their solicitor access to their confidential records.

At this stage of the claim, the claimant's solicitors are still information gathering, and no decisions of whether negligence has occurred or not have been made, as it is simply too early to tell.

What If The Notes Are Stored In My Practice, But Were Not Made By Me?

A common situation occurs when a request for notes is made, usually when the dentist in question has retired from practice, or the practice has been sold on (maybe to you). Clearly the departing dentist will not take all of his previous patient's notes and records with him in this situation.

If the notes are being stored by you, then The Data Protection Act 1998 is clear and you would then be classed as the "*Data Controller*" as the notes are clearly in your possession or control, i.e.: being stored at your practice. You do not need the departed dentist's permission to disclose his notes, but it would of course be courteous to inform him if you have any contact details for him.

If you really do not wish to be involved at this stage, then I would suggest that you inform your defence organisation who will be happy to become involved upon your behalf, (even if you have retired from practice, or are no longer practising for some other reason) assuming that at the time you were treating your patients, you had proper indemnity insurance in place.

What Happens Once The Records Have Been Disclosed?

Once all of the patients records have been gathered, then a complete assessment is made of the clients case, looking at the whole picture, taking into account certain factors. The factors that the claimant's solicitors would consider are as follows:

1. Limitation, (as the client needs to bring any claim for personal injury within 3 years of the date of the injury),

2. Quantum, (the amount of the claim) as most solicitors would not take on any claims worth less than £1000 because this would be a "*small claim*" where costs would not be recoverable from the losing party.

3. Legal elements such as breach of duty and causation are also carefully considered at this stage.

A full statement of events has usually been taken from the client by now, and this is read in conjunction with the records which have been obtained in order to check for any inaccuracies or any discrepancies in the evidence which may support or harm the client's case.

What Is Looked At In The Records In Making The Assessment?

Firstly the records themselves are checked for both completeness and accuracy, the dates themselves are checked against the client's instructions, and finally the details of each entry are gone through in detail to find out exactly what treatment was carried out by the dentist. It is fairly common to find a patient, who attended for treatment, but no explanation of treatment was given to the patient or recorded in the notes, and therefore the patient really has no idea of what treatment was carried out at the time.

What Is The Key To Avoiding A Dental Negligence Claim?

The key to avoiding any dental negligence claim is a simple one – **Keep good records.**

Be honest and up-front when explaining treatment options and procedures, and record appropriate warnings given to the patient regarding treatment. Ensure that you record any conversations had with the patient regarding the treatment.

There is nothing that I fear more as a claimant's solicitor, than when looking through a patient's clinical notes and records, than to find an entry relating to a conversation between a dentist and a patient regarding proper warnings being given to the patient of a certain procedure. Even worse from a legal point of view is when the patient has signed the entry on the record card as being correct and accurate. Quite often, patients who later become clients, do not understand the significance of a signature upon the notes, which confirms that they have had all treatment options explained to them, and have agreed to take certain risks, as explained to them and recorded in the notes.

Another good idea which for some reason dentists seem reluctant to adopt, is the idea of giving the patient an information leaflet before treatment commences, outlining the nature and the dangers or risks of the treatment proposed even for example a simple procedure such as a Root Canal Treatment. If you were to give the patient an explanatory leaflet, then ensure that you record the giving of this leaflet in the clinical notes, this will help you if later faced with a claim in negligence.

<u>When Is The Final Decision Made?</u>

You must remember that a decision to take on any professional is not made lightly by any solicitor. The Courts do not take kindly to claims being made where a professional person's reputation can be tarnished by claims of negligence. For each case that is taken on, there are a multitude of others that are rejected for various reasons.

The main reason that a claimant's solicitor would re-consider bringing any claim for dental negligence is the prompt disclosure of clear, accurate and detailed clinical notes, with the patients consent to treatment signature endorsed where appropriate across the notes along with a brief explanation of the risks also recorded.

It is essential that you give your patients proper advice and treatment options, as gone are the days of "*the dentist knows best*" without question by the patient. The patient now demands choices and options, along with accurate information so that proper consent can be given. Not only is proper advice essential, *the recording* of that advice is even more essential to disprove a claim in negligence.

A solicitor is always under a strict duty to act in the best interests of their clients at all times. One of the hardest jobs faced by a claimant's solicitor

is to explain to their client (who is adamant about bringing a claim against their dentist) that it is not in their best interests to proceed with a claim in negligence when faced with good, accurate clinical notes and records.

Summary

Keep the following points in mind if you wish to avoid a dental negligence claim:

- Keep clear, neat and accurate treatment notes.
- Clearly record any treatment options and warnings given to the patient.
- Clearly record any relevant conversations with the patient in the notes.
- Consider drafting "*information leaflets*" to be given to patients before any treatment is carried out.
- Obtain the patients consent to treatment on the notes before carrying out any treatment.
- When carrying out any lengthy or complex treatment, give your patient a full written treatment plan, breakdown the costs of the treatment, and consider giving the patient a "cooling off" period, to think about the proposed treatment. Once a decision has been made by the patient to commence treatment, obtain the patients signature upon the treatment plan and estimate, along with the date.

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