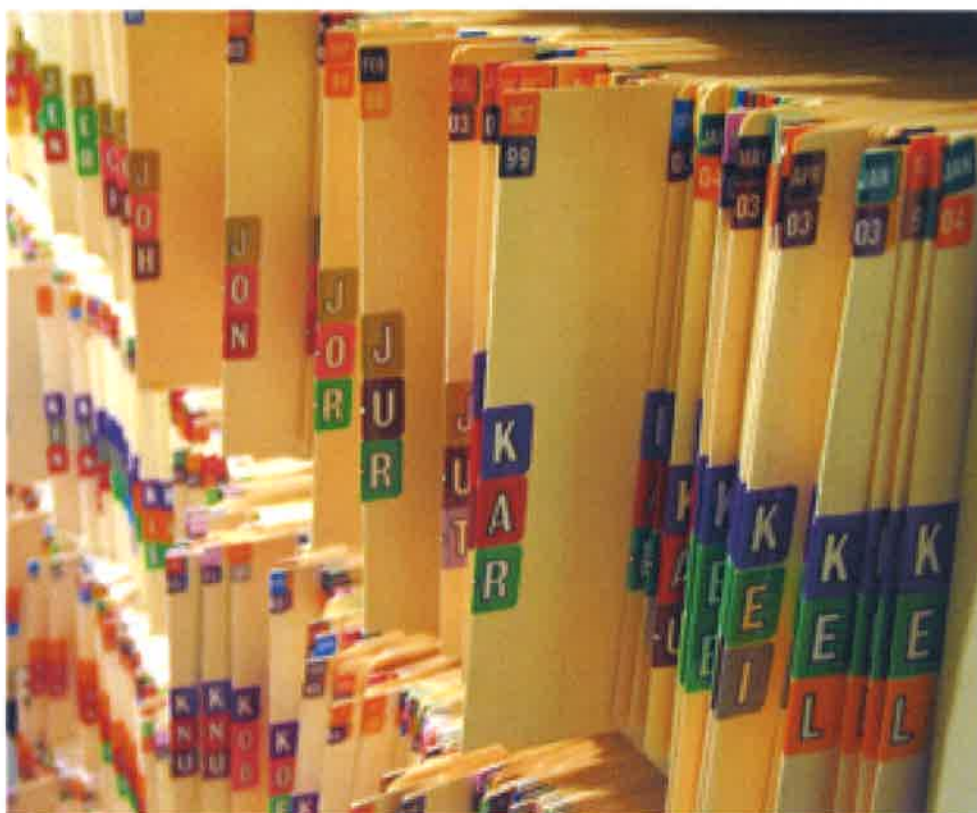

RISK MANAGEMENT FOR DENTAL PROFESSIONALS



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RISK MANAGEMENT FOR DENTAL PROFESSIONALS

Maintaining patients' dental records is an essential component of delivering quality care. Dental records, sometimes referred to as patient charts, document treatment and the communications between a practitioner and patient. Their preservation is governed by state and federal law, as well as local rules and regulations. They allow for continuity of care for patients, and they can be critical in defending a dentist or other oral health care provider against patient complaints and malpractice actions. For these reasons, it is important for practitioners to understand what should be recorded in a patient's chart, and how that information may or may not be disseminated.

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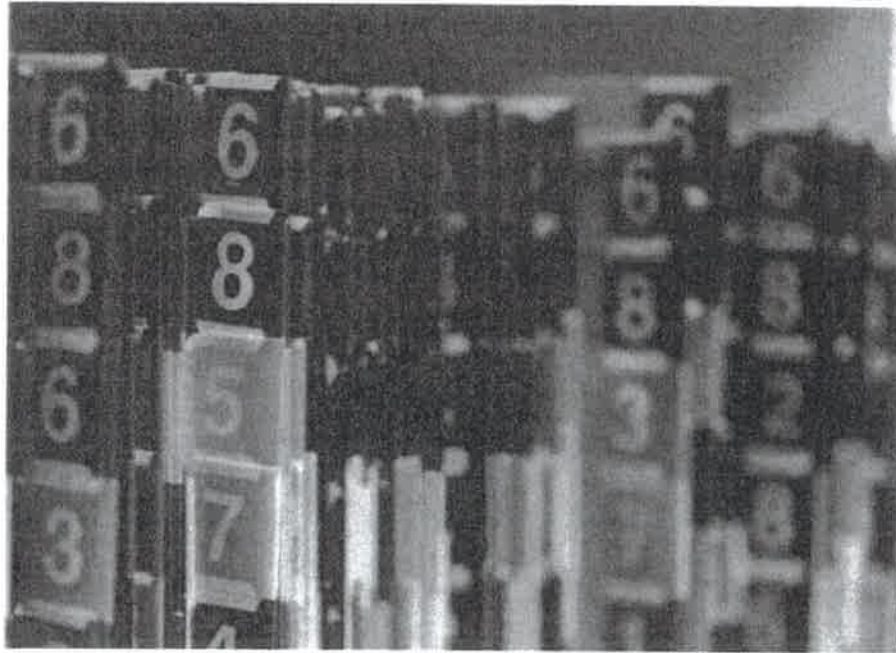
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Dental Records



American Dental Association
www.ada.org

*Council on Dental Practice
Division of Legal Affairs*

Seven out of ten dentists are members of the ADA.

2010

Dental Records

Acknowledgments

This publication was developed by the Council on Dental Practice and the Division of Legal Affairs.

The Mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.

Disclaimer

This ADA publication is designed especially for dentists and the dental team to provide helpful information about the dental record. This publication is not intended or offered as legal or other professional advice. Laws vary from state to state and thus, readers should consult with their personal legal counsel and malpractice insurer to access the applicable laws in their state. *Dental Records* is based in part on questions frequently asked by our members. It is our hope that dentists and their team members will find this publication, helpful but in no way a substitute for actual legal advice given by an attorney in your state.

Dental Records

Introduction

The dental record, also referred to as the patient's chart, is the official office document that records all of the treatment done and all patient-related communications that occur in the dental office. State and federal laws or regulations determine how it is handled, how long it is kept and who may have access to the information. The dental record provides for continuity of care for the patient and is critical in the event of a malpractice insurance claim. This publication will provide some helpful information but the first step should be to review your state dental practice act.

Dental Records

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Records Management

The recording of accurate patient information is essential to dentistry. The **dental record**, also referred to as the patient chart, is the official office document that records all diagnostic information, clinical notes, treatment performed and patient-related communications that occur in the dental office, including instructions for home care and consent to treatment.

Protecting health information—and diligent and complete record keeping—is extremely important for many reasons.

First, it can contribute to providing the best possible **care for the patient**. Patient records document the course of treatment and may provide data that can be used in evaluating the quality of care that is provided to the patient.

Records also provide a **means of communication** between the treating dentist and any other doctor who will care for that patient. Complete and accurate records contain enough information to allow another provider who has no prior knowledge of the patient to know the patient's dental experience in your office.

Beyond providing patient care, the dental record is important because it may be used in a court of law to establish the diagnostic information that was obtained and the treatment that was rendered to the patient. It can be used in **defense of allegations of malpractice**. Information found in the record may then be used in determining whether the diagnosis and treatment conformed to the standards of care in the community.

Another way the dental record may be used is to help provide information to appropriate legal authorities that will **aid in the identification of a dead or missing person**. The most common element of forensic dentistry that a general practitioner is likely to encounter is to supply antemortem (before death) records for a **forensic** odontologist.

Regulations

State: A few dental practice acts or regulations issued by state boards of dentistry specify requirements for dental records. In the vast majority of states, however, patient record keeping requirements are contained in laws or regulations that apply to health care professionals in general and also in more generic state legislative/regulations. Check with your state dental society for information on record keeping requirements in your state. To obtain a copy of your state dental practice act, contact either your state's board of dentistry, also known as the board of dental examiners at <http://www.aadexam.org> or go to <http://www.ada.org/stateorganizations.aspx> to find a link to your state. Many states post the practice act online and it is now easily accessible. (Hint: Google "[name of state] dental practice act.")

Your State Practice Act

Clicking on any state listed below will take you to the licensing institution's Web site for that state.

Alabama: Alaska: Arizona: Arkansas: California: Colorado: Connecticut: Delaware: District of Columbia: Florida: Georgia: Hawaii: Idaho: Illinois: Indiana: Iowa: Kansas: Kentucky: Louisiana: Maine: Maryland: Massachusetts: Michigan: Minnesota: Mississippi: Missouri: Montana: Nebraska: Nevada: New Hampshire: New Jersey: New Mexico: New York: North Carolina: North Dakota: Ohio: Oklahoma: Oregon: Pennsylvania: Rhode Island: South Carolina: South Dakota: Tennessee: Texas: Utah: Vermont: Virginia: Washington: West Virginia: Wisconsin: Wyoming. This can also be accessed at <http://www.ada.org/stateorganizations.aspx>

HIPAA/Protecting Health Information

There is a tendency to regard HIPAA regulations for Privacy and Security with apprehension, and not without some justification, as the civil and criminal penalties for violators can be quite stiff. While HIPAA Privacy and Security Regulations are serious matters deserving serious attention and focused implementation efforts, they are no reason to panic and certainly are not intended to discourage the use of electronic transactions by small health care providers.

Two HIPAA regulations, the Privacy Rule and the Security Rule, impact how a dental office uses and maintains its patients' records. Under the HIPAA regulations, dentists who use electronic transactions are referred to as

"Covered Entities". Most electronic transactions are benefits-related (e.g. claims, eligibility, etc.) communications exchanged between health care providers and health plans via some kind of electronic medium. Voice communications by telephone and most fax communications are not considered to be electronic, at least as far as HIPAA is concerned, but because voice and fax communications may contain individually identifiable health information ("Protected Health Information" or "PHI"), the disclosure of such information must be safeguarded. In the HIPAA context, "electronic" almost always means some kind of computer-to-computer method of communication, either via the internet, private network, a modem-to-modem communication, or physical removal and transportation of a data storage device or medium like a tape, disc, or hard drive. Currently, dentists most commonly perform "electronic transactions" related to electronic claims transactions and electronic eligibility inquiry transactions (whereby dentists can inquire about the status of previously submitted electronic claims).

Use of any one of these transactions, even once, invokes the HIPAA rules regarding electronic transactions with respect to that transaction, which subjects a dentist to HIPAA (although a dentist is always covered by HIPAA with respect to the PHI he or she maintains and transmits). If HIPAA electronic transactions rules do not apply because a dentist does not use electronic transactions, state privacy laws still apply (check with your state dental association!). Even in the absence or relative weakness of state privacy rules, it is still an excellent idea to comply with the HIPAA Privacy and Security Rules. Patients will want to feel that doctors respect their privacy and take care to ensure that sensitive health information remains confidential.

The HIPAA Privacy Rule, which went into effect April 14, 2003, requires covered health care providers, including covered dentists, to protect patients' PHI, inform patients of their rights under the HIPAA Privacy Rule, provide an accounting of uses and disclosures of information and maintain accurate records of Privacy-related incidents. These topics and more are covered in great detail by the ADA HIPAA Privacy Kit, available from the ADA catalog (www.adacatalog.org or call 800-947-4746). With regard to standards for maintaining paper records, the Privacy Rule requires health care providers to make "reasonable efforts to limit protected health information to the minimum necessary to accomplish the purpose of the use, disclosure or request" of the information. These "reasonable and appropriate safeguards/minimum necessary" standards aim to protect information from unnecessary disclosure without inhibiting a health care provider's core business operations, i.e., treating patients, obtaining payment for services, and legal, financial, and administrative tasks that are all part of running a health care provider's business. The most reasonable and appropriate safeguards should be determined by the covered health care provider through a careful analysis of risks and available resources to cope with those risks. A safeguard that inhibits timely and effective care, interferes with obtaining payment for services or creates excessive costs and disruptions may be considered unreasonable and unnecessary for a provider with relatively few risks.

For instance, locking file systems are not specifically required by the HIPAA Privacy Rule, but may be necessary to protect access to paper records using, reasonable and appropriate safeguards. Imagine for a moment that a large health care provider (like a hospital) does a risk analysis of its filing system and decides that since some of the cabinets may be vulnerable to snooping, they should be locked at all times. A much smaller provider (like a dental office) may, after performing a similar risk analysis, decide that since its filing system is under staff supervision at all times and that unauthorized persons have no access to its files, there would be no need for the practice to acquire locking file cabinets. Both approaches are correct because health care providers are permitted to tailor their privacy policies to their specific risks and available resources.

As with filing systems, the HIPAA Privacy Rule does not prohibit the use of so-called "allergy alert" or "medical alert" stickers, as such a prohibition may interfere with a provider's ability to provide timely and effective health care. An office should exercise some caution in its handling of patient records, and the use of generic alert indicators that serve only to prompt caregivers to take a closer look at the patient's health history may be desirable in many instances.

Dentists have had to comply with the **HIPAA Security Rule** since April 21, 2005. There is a key difference between the HIPAA Security and HIPAA Privacy Rules. The HIPAA Privacy Rule applies to individually identifiable health information in any form, written, spoken, or electronic. In contrast, the Security Rule applies only to *electronic* PHI ("ePHI") and requires that covered dentists who store health information in electronic form maintain its confidentiality, integrity, and accessibility.

Confidentiality means that the information is available or disclosed to persons or entities authorized to receive it.

Integrity means the information has not been altered or destroyed without proper authorization; if it changes, there is a record of the change and only authorized user can make a change; and finally, that there are means to verify

that data is only changing according to entries made by authorized users. Data integrity helps prevent GIGO ("Garbage In, Garbage Out") data entry problems and is a safeguard against data corruption, which may be caused by bugs, malware, system crashes, etc.

Accessibility means that data is retrievable under any circumstance. Maintaining data accessibility means sound, thorough business continuity planning.

The American Dental Association published its HIPAA Security Kit to help members comply with HIPAA security regulations and is available from the ADA Catalog (www.adacatalog.org or call 800 947-4746).

There is no such thing as a certified "HIPAA Compliant" product, seminar, technology, or design feature that is effective "out-of-the-box" for all dentists in all circumstances because of the scalable, technology-neutral nature of the Security Rule. Covered dental offices must determine the most reasonable and appropriate safeguards for their particular circumstances and risk profile.

With regard to electronic security standards required by HIPAA, it is essential that any electronic health record be accurate, easy to retrieve under any situation, and that some means of tracking who made changes and when is always available. More information on this can be found in the ADA's *HIPAA Security Kit*, available through the *ADA Catalog*. Your office may need to consult with your software system vendor for assistance in completing tasks related to maintenance of electronic records.

Dental offices subject to HIPAA should have policies, procedures and forms for HIPAA compliance. Your entire office should stay current and informed about HIPAA and state laws regarding the privacy and security of PHI and ePHI. This informational resource is not intended to comprehensively cover all HIPAA related questions.

For additional information on HIPAA privacy, go to <http://www.ada.org/2693.aspx#guidance4den> or order The HIPAA Security for Dental Professionals Seminar DVD, or the ADA's *HIPAA Privacy Kit* and the *HIPAA Security Kit*. You can order these products by contacting ADA Catalog, 1-800-947-4746, or visiting the ADA Catalog's Web site, www.adacatalog.org.

Common Sense Privacy and Confidentiality Steps¹

- Avoid leaving patient information where others can read the content – whether on paper or electronic. Charts should not be left out in public areas. Confidential information should be marked as such and protected from view of others. Try to keep computers reflecting patients' information out of view, or use screen savers or other methods to protect the information as reasonably as possible.
- Avoid asking patients sensitive questions where other patients can hear the conversation.
- Avoid discussing confidential patient information with other dental team members where other people can hear the conversation.

Organization of Dental Records

Most dentists make notes in paper dental records. However, more and more dentists are making use of computerized filing systems to maintain patient dental records. Electronic records have great quality and patient-safety benefits, and will likely increase as more dental offices become computerized. Because many dental offices use the traditional paper charts, traditional filing systems are discussed first.

Generally, patient records are housed in file folders for protection. These files are labeled with the following information (in the following order):

- Patient's surname;
- Patient's first name;
- Patient's middle name; and
- Patient's degree or seniority (i.e., Senior, II).

The files are then arranged in a way for easy retrieval—usually in a lateral, open-shelf filing system.

Color Coding

Many dental offices use a color-coded filing system for patient record files. Color-coded labels—usually the first two letters of the patient's last name and active date of treatment—are placed on the patient's file. This can help make record retrieval fast and easy.

Active and Inactive

Most offices have two categories of patient records files: 1) Active and 2) Inactive.

Active files hold the records of patients currently having their dental care provided by the practice. Inactive patients are considered to be those who have not returned for 24 months. Keep files of active patients on-site. These records should be conveniently located in the office.

Inactive files hold the records of patients who have been treated in the office in the past but are not currently under care in the office. These files are generally located in the office, but in a remote area.

As defined by policy of the American Dental Association, (Trans. 1991:621), an active dental patient of record is any individual in either of the following two categories: Category I - patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II - patients of record who have had dental service(s) provided by the dentist in the past twenty four (24) months, but not within the past twelve (12) months. An inactive patient is any individual who has become a patient of record and has not received any dental services(s) by the dentists in the past twenty four (24) months.

The above definition is typically used in practice appraisals and may not be the same definition of an active patient used in a dental office in records maintenance.

A system should be established in your office to identify a change from active to inactive status on a timely basis. All records, active and inactive, should be maintained carefully to be certain that they are not destroyed or lost.

Content of the Dental Record

The information in the dental record should primarily be clinical in nature. The record includes a patient's registration form with all the basic personal information.

The dental team should be very meticulous and thorough in the dental office recordkeeping tasks. All information in the dental record should be clearly written, and the person responsible for entering new information should sign and date the entry. The information should not be ambiguous or contain many abbreviations. In practices with more than one dental practitioner, the identity of the practitioner rendering the treatment should be clearly noted in the record.

All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Handwritten entries should be legible. If a mistake is made, do not correct it with "white-out." A single line should be drawn through the incorrect info, the new corrected info added, and again, the entry should be signed and dated.

The following are examples of what is typically included in the dental record:

- database information, such as name, birth date, address, and contact information
- place of employment and telephone numbers (home, work, mobile)
- medical and dental histories, notes and updates
- progress and treatment notes
- conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment,
- diagnostic records, including charts and study models
- medication prescriptions, including types, dose, amount, directions for use and number of refills
- radiographs
- treatment plan notes
- patient complaints and resolutions

- laboratory work order forms
- mold and shade of teeth used in bridgework and dentures and shade of synthetics and plastics
- referral letters and consultations with referring or referral dentists and/or physicians
- patient noncompliance and missed appointment notes
- follow-up and periodic visit records
- postoperative or home instructions (or reference to pamphlets given)
- consent forms
- waivers and authorizations
- conversations with patients dated and initialed (both in-office and on telephone, even calls received outside the office)
- correspondence, including dismissal letter; if appropriate

No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payment vouchers are not part of the patient's clinical record. Keep these financial records separate from the dental record.

Other information best left out of the record would be personal opinions or criticisms. Stick to facts, especially those related and relevant to providing dental care. Imagine what you write in a record being read in a court of law (remember that this is a legal document). Do document a patient's refusal to accept the recommended treatment plan and cancelled appointments.

The outside cover of the chart should only display the patient's name and/or the account number, unless more is required by state law or you need to flag a chart on the outside cover. If this is the case, use an abstract, in-office system (color or symbol coding) so that only your office staff will be able to decipher it.

For all offices, but especially those subject to HIPAA, a single sticker on the outside cover can alert the team to look on the inside for important information regarding allergies, medications, antibiotic pre-medications, and clinical conditions that can affect dental treatment. All medical notations belong inside the chart for only authorized personnel to see.

Your professional liability insurance company and or personal legal counsel may have additional recommendations. Many insurance companies make this information readily available on their Web site or may be contacted for the information. A list of professional liability companies is available on ADA.org (www.ada.org).

Retention and Storage

State laws and participating provider contracts generally specify the time following the last patient visit that records must be maintained. There is usually a different requirement for the retention of records of children; these records must be kept for a certain period after the child reaches the age of majority. HIPAA also affects recordkeeping requirements for offices that are covered by generally requiring that such offices maintain patient records for six (6) years and two (2) years after a patient's death. The dental office should have a records retention policy and all staff should understand it. The office's professional liability insurance company will likely have recommendations about retention.

In a multi-practitioner practice of any nature, determining the party responsible for maintaining the original patient record of any patient treated at the practice facility may be dependent on the type of professional corporation (PC) or structure of the practice. Unless the agreement specifies differently, the professional corporation would likely be considered the owner of the dental record, whether paper or electronic. This applies whether or not the owner was involved in the patient's treatment.

If the structure of practice is an office-sharing arrangement and the dentist is an independent contractor rather than practice employee, each dentist would likely be considered as practicing under a separate legal entity, whether a PC, limited liability company, partnership or sole proprietorship. Associate agreements, either for employee associates or independent contractors, should include language that specifies the associate's access to patient charts and ownership issues.

State law may also specify the obligations of buyer and/or seller regarding record ownership, maintenance and/or retention in the event of a practice sale. If the practice has been sold, the sales agreement itself may spell out the terms for record retention and access.

If space for records becomes a problem, dental records may be preserved on microfilm or microfiche, stored with a records storage service (fairly common in many jurisdictions) or scanned for electronic storage. The great benefit of storing records electronically or on microfilm or microfiche is that they take up less space than paper records. Diagnostic and/or treatment casts may be photographed and stored in some cases. However, prior to completely converting records to one of these methods, a dentist should consult with his/her own attorney and professional liability insurance company. In those dental offices that are considered covered entities, a HIPAA business associate agreement may be required if outsourcing records storage. Again, state law must be followed. State law can be quite specific on regulations related to health care recordkeeping.

Health/Dental History

The accurate health/dental history may provide important and valuable information for the dentist prior to beginning treatment. All dentists should take health histories initially and update the same periodically as necessary.² A health history form can address:

- health conditions or illnesses that may affect or be affected by dental treatment;
- medications that a patient is currently taking that will have a potential drug interaction with the local anesthetic or other drugs the dentist may prescribe that may affect dental treatment or a patient's other health condition(s); and
- reason a patient is seeking care.

Dentists have a responsibility to obtain and maintain current health histories of patients. Team members are most often responsible for having patients complete their health/dental history forms but that is only part of the process. It is also important that a patient understands the questions, provides answers where appropriate and sign the completed form. Patients should be encouraged, if they do not understand the form, to discuss it with the dentist or office staff. A health history form provides a starting point for the dental team to fulfill its professional obligations.

Once a patient has completed the questionnaire/health history, it is recommended that the patient's health information be reviewed carefully. The dentist should review and discuss the form with the patient, then sign or initial the form once this review is completed. Interviewing the patient is an important part of the medical history taking process and space should be provided on the medical history form for recording findings gathered during the interview.

The dentist should be prepared to answer any questions that a patient may have regarding the form. No questionnaire addresses every aspect of a patient's health. For example, additional or more focused questioning may be appropriate for patients with specific health concerns. The interaction between the dentist and dental team members, during the health history process, can be equally or more important than the form itself.

Updates to Health History Form

A patient should be questioned at each visit to determine if the health status or medication taken has changed. The record should have a dated notation that the patient was asked about recent health and medication changes and any changes should be updated in the patient's record. A patient's medical status should be monitored at intervals appropriate to the patient's age and medical history.³ The decision about the frequency is professional, not legal. Your professional liability insurance company and/or attorney may be consulted for more information.

The ADA Catalog (<http://www.adacatalog.org> or 1-800-947-4647) also offers both an adult and a child's health history form, both available in English as well as Spanish. These particular questionnaires need not be used by all dentists, and may or may not lead to compliance with all applicable laws.

Health History Forms in Multiple Languages

With the increasing diversity in patient populations, it may be desirable to provide a health history form in multiple languages. The University of the Pacific Dental School in California and Met Dental have both supported the development of a free downloadable standard health history form in over 21 languages, available at: http://www.dental.pacific.edu/Professional_Services_and_Resources/Dental_Practice_Documents.html

University of Pacific Web site includes instructions for use. Be sure to download the English version too. The questions and sequence for all languages correspond to the English version.

Who Makes Entries in the Record?

Attorneys and doctors debate who should make the entries in the dental record, but state law will determine this in most cases. Keep in mind that the dentist is ultimately responsible for the patient's chart.

Some entries may be delegated to office staff if allowed by state law. The administrative assistant can record telephone calls; prescription changes; and canceled, changed, and failed appointments. The dental assistant records the patient's comments, concerns and disposition; vital signs; medical history notations; radiographs and other diagnostic tools taken and used; and instructions given to the patient, etc. Dentists add clinical impressions, treatments performed and any pertinent information. All entries should be initialed and/or signed by the team member writing the entry and the dentist.

If the dentist opts not to make his or her own entries, he/she should dictate what to write to the assistant. The dentist should review the contents of the entry as soon as possible for accuracy and then sign or initial it.

How to Write in the Record

Always think before you make an entry, especially if the remarks are complex in nature. You may want to jot down some of the facts on a piece of paper and then transcribe them in an organized way into the record. It is best to document while the patient is still in the office, or as soon as possible after the patient leaves. The record is the single most important source of evidence in a liability claim. All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Be aware that if different colored ink is used by staff members (i.e., the hygienist's uses red ink); this coding method will not appear on a copy of the record unless a color copier is used. Handwritten entries should be legible.

Make sure all of your entries are objective in nature. Confine your comments to necessary information about the patient's treatment. A patient has a right to request to see their record (including "personal notes" you may keep in a separate chart). Keep in mind that in the case of a malpractice claim, the record could appear in a court case and a judge and jury could read your notes. Imagine the record magnified and displayed in a courtroom. Stick to facts, especially those related and relevant to providing dental care.

Be sure that any attachments are included in the patient's record, especially radiographs. It provides a resource for the dentist to evaluate the short-term and long-term results of treatment performed, the cooperation of the patient and the effects of any complicating factors. Do document a patient's informed consent for treatment. Should a patient refuse to accept the recommended treatment plan, notate the patient's reasons for refusing care in the record. Consult your attorney or liability company for additional steps that should be undertaken when a patient refuses treatment. More information on informed consent and informed refusal can be found in the member section of the ADA Web site (<http://www.ada.org/>) under the topic "Informed Consent".

Use of Abbreviations and Acronyms

If you must use abbreviations or acronyms, make sure they are in common use (or can be easily explained) in your practice and avoid their overuse in record keeping. Those that are used should be clearly understood by those employees in the office with access to the record. Avoid the use of arcane symbols in record keeping. Also be aware that such usage could delay identification in a forensic investigation. It is a good idea to have a universal "key" readily available to all staff, or included in the chart, providing definitions for all abbreviations and acronyms.

Corrections or Alterations

There are times when it is necessary to make a correction. There is nothing wrong with a correction if handled properly. Some state laws may allow you to simply cross out the wrong entry with a thin line, and make the appropriate change. Date and initial the each change or addition. **Never obliterate an entry.** Do not use markers or white-out. The important factor is that you must be able to read the wrong entry.

Do not leave blank lines between entries with the intent to add something at a later date. It could be construed as an alteration. Do not insert words or phrases in an entry; this could be construed as an alteration. If you remember something you wish to record at a later date, just make the entry chronologically and refer to the date of the visit in question.

Professional liability insurance companies have long asserted that errors or inadequacies in the patient record prevent them from successfully defending some dentists against unfounded allegations of malpractice. To identify where there is the greatest need for improvements in record keeping, a 2005 survey conducted by the ADA Council on Members Insurance sought to determine the frequency, severity and causes of dental malpractice claims reported between 1999 and 2003. The survey is available on <http://www.ada.org/>. The following question was posed to the insurers with respect to both general practitioners and specialists:

Please indicate the degree to which your company has noted the following types of problems with its insured's' patient records (whether or not the problem was a primary cause of a paid claim.)

To quantify the responses to this subjective question, a value of ten was assigned to any problem that was indicated as being "very common." If a problem was "fairly common," it was assigned a value of five. If the insurer said that the problem was "not common," it was assigned a value of zero. The average scores for each problem, reflecting the opinions of fourteen insurers weighed equally, are listed below:

Insurers Views as to the Frequency of Various Record Keeping Errors	
Type of Error In Descending Order of Frequency	Average Score
Treatment plan is not documented	6.5
Health history is not clearly documented or updated regularly	6.1
Informed consent is not documented	5.9
Informed refusal is not documented	5.0
Assessment of patient is incompletely documented	4.9
Words, symbols, or abbreviations are ambiguous	4.9
Telephone conversations with patient are not documented	4.6
Treatment rendered is not clearly documented	4.5
Subjective complaints are not documented	4.1
Objective findings are incompletely documented	4.1
Treatment plan is not supported by documented subjective and objective findings	4.0
Reasons for deviation from the original treatment plan are not documented	3.9
Patient non-compliance or failed appointment(s) are not documented	3.7
Records are not legible	3.7
Routine full-mouth periodontal probing not documented	3.4
Insufficient records given the complexity of the issue	3.2
Post-operative instructions are not documented	3.2
Referral to or consultation with another practitioner or physician is not documented	2.8
Comments about the cost of treatment and the patient's payment history	2.6
X-rays were inadequate for the procedure	2.3
Prescription orders are not documented	2.2
Deletions, additions, or corrections are not made properly	2.0
Risk management notations included in the chart	1.4
The name and relationship of the person who gave consent is not documented for minors or patients who are incapacitated	1.4
Alteration of records	1.1
Lost records/X-rays	.7
Records are not written in ink	.7
Record contains notations relating to discussions with an attorney or insurer regarding a possible malpractice lawsuit	.4
Critical or subjective personal comments about the patient in the chart	.4

These results indicate that, in the opinion of professional liability insurance companies, it is fairly common to find that their dentists that have presented claims are not adequately documenting treatment plans, the patient's medical history and the informed consent/refusal process. Whether this result is indicative of the need for improvement in record keeping among all dentists is conjectural. However, the Council believes all dentists should review their own record keeping practices to identify whether any of the issues shown in the survey need to be addressed.

Ownership (see also Retention and Records section for multi-practitioner practice)

The dentist owns the physical record of the patient. He/she is the legal guardian of the chart. Patients do not have the right to possess their original record. They do have the right to see, review, inspect, request, and obtain a copy of their record. The dental team should be aware of HIPAA and the laws of their particular state governing this issue. If the patient requests a copy, the dentist is obligated to provide those records (including radiographs) within a reasonable time frame, which may be specified under state law.

In most cases, reasonable, cost-based fee may be charged for copying records. The fee should be limited to cost of supplies and labor for copying and postage (if mailed). However, state laws vary widely on this issue and may specify a limit on what can be charged. Federal HIPAA regulations generally preempt state law but state law may have a more prescriptive restriction on fees that can be charged.

Do I have to give a patient a copy of his or her records if the patient hasn't paid his or her bill?

Yes, under HIPAA privacy regulations and quite possibly under your state law as well. Your office will most likely have customized policies and procedures for HIPAA compliance in place. Due to the confidential nature of the dental record, before you send out any copies to either the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements. In addition, only send, or copy, the portion of the patient record that is requested. Prompt transfer to another practitioner can avoid any interruption of care for that patient.

"A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental X-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full."⁴

Dentists also own radiographs; since they are an important part of the clinical record made by the doctor and cannot be interpreted by laymen. Patients do have the right to obtain copies of their radiographs.

Transfer or Copies of Records

Due to the confidential nature of the dental record, before you send out any copies either to the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements.

Your office will most likely have customized policies and procedures for HIPAA compliance in place. In addition, only send, or copy, the portion of the patient record that is requested.

What permission, if any, must a patient give to transfer records?

This depends on whether you are covered by HIPAA, your state law and also on the specifics of the case. Because of the confidentiality of the dental record, it is important to make sure you have the necessary permissions before you send out any copies, either to the patient, a patient representative and/or another provider.

Release Form

A simple release form for release of the record to either the patient or another health care provider may be signed by the patient and become a part of the dental record. This release form, signed by the patient, should specify to whom the records are being delivered and identifying the records. Signing such a form is generally not required by HIPAA to send records to another health care provider, but in some states consent is required before releasing

health information. Check with your state dental society about what is required in your state. Your professional liability insurance company may also consider such a release a component of good record keeping.

Who Can Consent to the Release?

State law may determine the permission needed to release medical record information. Generally, the authority to release dental information is granted to: (1) the patient, if a competent adult or emancipated minor; (2) a legal guardian or parent if the patient is incompetent or a minor child; and (3) the administrator or executor of the patient's estate if patient is deceased. The patient's right to authorize release of dental records is codified in many state statutes. These statutes all state that dental records are confidential and cannot be disclosed, except in specifically provided circumstances. However, the extent of the patient's right to access varies from state to state. Some states allow the health care professional or provider to determine patient's right of access. In comparison, some states expressly grant patients access to the dental information contained in their dental records.

General releases may not suffice for records containing HIV or other sensitive material. Most state laws prohibit the disclosure of HIV status test results to a third party without a specific written authorization by the patient or the patient's representative. Any information regarding health issues should be handled with caution and special regard for the patient's privacy. Even if appropriate authorization and consent is received, dentists and other health care professionals may be legally precluded from releasing HIV/AIDS records without specific reference to that information in the release. Some states have heightened confidentiality provisions for sensitive information, such as HIV status.

Typical elements of a valid general release include:

- Patient's name and identifying information;
- Address of the health care professional or institution directed to release the information;
- Description of the information to be released;
- Identity of the party to be furnished the information;
- Language authorizing release of information;
- Signature of patient or authorized individual; and
- Time period for which release remains valid.⁵

When sending records, make a notation in the patient's chart as to the date, where and to whom the copies were sent. There may be office policy restricting sending anything out of the office without the dentist's knowledge and approval. By using certified return receipt requested U.S. Postal Service or another service that provides proof of delivery, you will be able to prove the records were sent. Keep copies of certified receipts or proof of delivery in the chart.

Should original records be sent when a copy is requested?

Never release original records to anyone but rather send copies, including radiographs. There is one exception: you may send the originals if you are required to do so by a government agency with proper authority, such as a court order, or in some states, a subpoena. If this situation were to occur, you should make copies for your office.

Are there exceptions when information in a dental record would be disclosed without a patient's consent?

Below are exceptions that allow disclosure without consent, for these purposes:

- Defense of a claim challenging the dentist's professional competence; peer review process
- Claim for payment of fees
- Third party payer relating to fees or services furnished
- Court order to a police or federal agency as part of a criminal investigation
- Identify a dead body
- Report a legal violation of another health care professional if the dentist reasonably believes it is necessary to disclose the information to comply with Public Health Code⁶

Under HIPAA, covered entity dentists who are otherwise in compliance with the law may transfer records for certain purposes without the patient's explicit permission. For example, covered entity dentists may share records with other health care providers for treatment purposes and transfer patient records to dentists who are purchasing their practice. Also, covered entity dentists may share portions of the patient records as needed to obtain payment for their services. However, disclosures of this type must be limited to "minimum necessary" amount that must be shared for the intended purpose (i.e., obtain payment).

In response to a valid court order, HIPAA regulations (and possibly state law) may not require an authorization to release a patient's record. However, if the subpoena is not accompanied by a court order, the subpoena alone is not a valid basis to disclose the information (unless a subpoena has the force of a court order under state law). Because these situations are complicated and require careful analysis, check with your state dental society or attorney about what is required.⁷

The ADA in 2007 updated its *General Guidelines for the Referral of Dental Patients*, included as an Appendix in this publication.

Informed Consent

What exactly is informed consent? In general, it is required that dentists provide information to patients about the dental health problems that the dentist observes, the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatments, including no treatment. Some procedures call for a separate consent form to be signed, but there are many times when procedures and options are discussed and a consent form may not be utilized. In some offices, notes of the discussion with the patient are entered in the record at the time the discussion is held and the patient is asked to initial the entry.

The dentist must secure informed consent before providing care. The exact requirements vary by state and by the type of procedure being performed. Certain procedures, such as invasive or requiring extensive treatment, should have a signed, written informed consent. In those cases, the appropriate staff person should be sure that a signed written consent form has been obtained before the treatment is provided. Your practice's professional insurance company and/or attorney may also have recommendations and resources, such as sample forms.

Consent for treatment provided to children or an incompetent adult requires special consideration.

The dental record should contain a notation concerning the granting of informed consent to do the treatment proposed, or that consent was not granted (and treatment not done).

Informed Refusal

If the patient refuses the proposed treatment, the dentist must inform the patient about the consequences of not accepting the treatment and get a signed informed refusal. However, obtaining an informed refusal does not release the dentist from the responsibility of providing a standard of care. If, for example, the patient refuses to have radiographs taken, the dentist should refer the patient to another dentist when the original dentist believes that radiographs are a necessary prerequisite to proper care in that case.

Obtaining informed consent/refusal can involve complex issues. You may wish to take continuing education courses on this subject.

Use of Social Security Number

With identity theft occurring at escalating rates, you may find many patients reluctant to provide their social security number (SSN). There are legitimate reasons to ask patients for social security numbers. For example, these numbers may be helpful in determining if the patient is credit worthy. If patients are not financing their dental care, and the number is not needed to file a claim for a dental benefit program, you may not need the patient's social security number. Many third-party payers have created unique IDs for this reason. Your practice may wish to consider using a unique patient ID other than the Social Security number (SSN).

There is a law in California that restricts the use of SSNs in some circumstances. This law restricts businesses and state and local agencies from publicly posting or displaying Social Security numbers. It also bans embedding SSNs on a card or document using a bar code, chip, magnetic strip or other technology. The law takes effect gradually, from 2002 through 2010. The CA Office of Privacy Protection has a good summary of that law, <http://www.privacyprotection.ca.gov/res/docs/pdf/ssnrecommendations.pdf>.

Destruction

If your office decides to destroy records as allowed by state law, caution must be used in the destruction of records. Confidential information is included in the dental record. You have an obligation to protect the patient's privacy and personal health and financial information.

For those inactive patient records (passed the Statute of Limitation) that will not be transferred or returned to patients, a more secure way of eliminating these unwanted records generally involves shredding. There are professional shredding services available to do this for you. You could also rent an industrial-grade shredder and destroy the records yourself. Small paper clips and staples generally do not have to be removed prior to professional shredding.

Many medical facilities outsource the destruction of records. To find such a service, check in the Yellow Pages or use an Internet search under a topic such as "document destruction." A professional shredder service should sign your confidentiality agreement (or HIPAA "Business Associate Agreement," if applicable) and if they will agree, indemnify you in the event of a breach in confidentiality. Most services issue a Certificate of Destruction or the company may allow you or a staff member to witness the destruction. You may wish to check with personal legal counsel before destroying records.

NAID (National Association for Information Destruction, Inc.) claims that it is the international, non-profit trade association for the information destruction industry. Membership includes companies (including suppliers) and individuals involved in providing information destruction services. See <http://www.naidonline.org/> for further details if you need a commercial shredder firm. You might get recommendations for such a service from a larger health care provider in your area, such as a hospital.

CAUTION: Do not burn patient records containing radiographs as the heat could release dangerous metals. Silver recovery by a professional recovery firm might be a better option that pays you for recovering the silver content from x-rays. Check your telephone book or with your state or local dental society for a silver recovery firm or certified waste hauler.

Paper re-cycling is not a good option if you have to get rid of inactive paper dental and business records in order to close a practice. Under most circumstances, recycling companies merely collect then sort paper that comes to the company. In general, the collected paper is bound and sold to the highest bidder weeks or months later (even years later). There is no guarantee of confidentiality and there is no way to ensure just when the paper, potentially containing confidential or sensitive information, was destroyed.

Recycling without destroying patient records for a retiring dentist closing his/her practice and improperly disposing of the records might be viewed as negligent by the court in the event of an allegation of breach of confidentiality or in the case of a federal complaint to the Department of Health and Human Services Office of Civil Rights (for a supposed HIPAA violation by a covered entity) as an illegal practice under the Act. In either case, recycling without documentation of destruction is an example of poor risk management.

Always insist on a certificate of destruction; furthermore, make sure that there are no sub-contractor companies involved which do not also agree in writing to adhere to the privacy policies of the practice.⁸

Access

Only authorized persons should have access to office records. Be sure the dentist has an office policy on this matter, and you understand and abide by that policy. Patient records should not be removed from the dental office without the knowledge and permission of the dentist.

Today, many dentists are still using paper patient records stored in file cabinets and shelves. Increasingly, dentists are incorporating new technologies into their practice to manage the large number of existing records. This information may also be stored on an off-site server that is shared with other users and accessed on a network.

The security of access to digital records and the costs of maintaining a system continue to be a concern. But with today's access technologies featuring fingerprinting, retinal scanning, electronic signatures, and voice recognition, records can be as safe as paper records if managed properly. Data encryption, a process in which data is scrambled before transmission then reconfigured with a special code by the end user, also adds security. The HIPAA Security regulation requires implementation of security measures to patient health information, such as:

- Administrative safeguards such as security policies and procedures
- Technical safeguards such as password protections and back-ups of patient records
- Physical safeguards, such as limiting access to PHI

Electronic Patient Records

The use of electronic records is dramatically affecting the dentistry profession. As a member of the administrative dental team, you must also take the initiative to learn the terms and the tools of the new electronic world—especially with regard to electronic records and HIPAA regulations.

Digital technology, the advancement of networked computing and the digitization of information, will continue to change the profession of dentistry in numerous ways—from the clinical to continuing education and, from practice management transactions such as payment and marketing to e-commerce.

Software programs allow electronic transmission of patient records with sound, text and images to dental specialists for second opinions and preauthorization for insurance purposes. Instead of written descriptions with tooth charts, digital clinical photographs may be attached. For more information on HIPAA Security regulations related to electronic records and communications, consult the *ADA HIPAA Security Kit* available for purchase through the ADA Catalog.

Communicating with Patients by E-mail

Electronic communications use in the dental office can be very beneficial. For example, it can help the dentist save time, and put an end to phone tag with patients. For patients, it may help them compose more detailed questions for the doctor and complete tasks such as scheduling appointments or refilling a prescription.

However, using e-mail for patient care purposes can also raise significant considerations. It is difficult to ensure confidentiality and to confirm the identity of the person when communicating via unsecured e-mail. E-mail could be misdirected in error, or forwarded to an unknown third party without proper controls. Patients should be made well aware of these risks and agree to accept them before use of electronic communications.

But will a patient's acceptance be a binding release? If patients agree, how will these communications be incorporated in the dental record? Can you minimize your exposure/risk or lessen your liability for business you conduct online? And, are you insured? Answers to these and many other open questions will take time to evolve, as users get more familiar with emerging technologies, and the courts grapple with how to resolve bad outcomes arising out of their use.⁹

Making the Transition to a Paperless Office

Digital patient records are an increasingly common practice management tool as technology advances and become more effective.

During the transition from a paper dental office to an electronic one, manual filing and record keeping continue to be extremely important. Dentists should educate themselves as to the legal, ethical, and technological issues that are related to an electronic medium — including whether state law mandates backup paper record keeping. Some states may have "quill" laws that fail to recognize certain types of electronic records as valid in legal proceedings. Carefully check laws related to electronic record keeping as changes in this area occur rapidly.

Even with advancing technologies, practitioners and staff must realize that the transition to "paperless records" is not seamless, totally safe, or problem-free and may not eliminate the need to keep paper records due to legal requirements in some states.

No matter what precautions are taken, there is still a possibility that someone might gain access to stored electronic information. Computer viruses and other computer hardware and software problems can cause information to be lost, as well.

An increasing number of dental offices are using electronic communication and information technologies. The field of dental informatics, "the application of computer and information science to improve dental practice, research, education, and management,"¹ is emerging to work with computer science and telecommunications to bring all of these concepts into workable tools of the future. Dental informatics is helping to develop ways to implement the "sharing" of medical information, yet keep it from unauthorized individuals and comply with HIPAA and other legal requirements.

Interprofessional communications will improve, as dentists will be able to consult more quickly and in greater detail electronically with other healthcare professionals such as physicians, radiologists, pharmacists, psychologists, and nutritionists to deliver the best possible dental care.

National Health Information Infrastructure

How the dental practice manages dental records will change rapidly in the future. There is currently a new initiative to create electronic health records for patients that could be accessed by all health care providers. The goal is for patient records to be available to all health care providers electronically, virtually anywhere in the country, through an interoperable system.

Scheduled for completion in 2015, the National Health Information Infrastructure (NHII) will be a communications system comparable to a network of highways, roads and pathways on which all health information will travel. Its purpose is to enable patients' electronic health records to be accessed and added to by all health care providers electronically (with patient authorization), virtually anywhere in the country, via the network. The electronic health record will include health information entered for a specific patient at a specific point of service. It will travel and be accessible on the NHII.

Falling under the purview of the Department of Health and Human Services, HHS envisions regional collaborations among health care entities, including dentists and other health care practitioners, so that a patient's information can be securely stored in the local community and made electronically accessible to all health care providers involved in treatment of a particular patient.

For updates on this evolving topic, go to the American Dental Association Web site, www.ada.org.

Record Handling When Closing a Practice

Some states have specific record retention and patient & employee notification requirements that apply whenever a dentist decides to retire or close a practice (i.e. Florida's Administrative Rule 59Q-17.001 Required Availability of Dental Records Upon Relocation or Termination of Practice, or Death of Practitioner). Check with your state or local dental society for specific information or with an attorney who knows about the requirements in your state. For contact information in your state, go to the constituent (state) dental organizations list on <http://www.ada.org/stateorganizations.aspx>. All constituent dental societies have Web sites and many provide a link to the state dental practice act.

Patient records must be handled in accordance with applicable laws. However, in most states, a dentist is usually allowed to charge a patient a reasonable fee for duplicating and transferring records to another practice. Under a circumstance of retirement, many dentists provide this service free of charge. They should not refuse to release needed patient treatment information due to the payment delinquency of the patient. Failure (or refusal) to release necessary information to another dentist for a patient's continuing care may be illegal and may be viewed as an unethical practice by your professional association.

If possible, the dentist who is planning to close a practice should notify patients well in advance that the practice is closing. In most states, letters to patients of record or an announcement in a community newspaper are ways in which a dentist might give advance notice of a closing. Notice of 30 - 60 days is sufficient for most patients and circumstances.

Patients should be notified how to obtain a copy of their dental records, notified of the location they are stored or given the option of transferring records. This notification can be by letter and have wording such as:

At your request, copies of the pertinent information from your record can be made available to a dentist of your choosing. If you wish to make a request regarding your patient record, please contact the office before the permanent closing day, as your written authorization is needed to make your records available to another dentist. After that day, you will have to direct your inquiry about the record to (name of dentist or record custodian), located at (complete address, phone number).

Your states' laws actually govern whether a dentist must send originals, however, in most cases, the practice should only send copies of a patient's record to another dentist, and only with the patient's or their representative's (e.g. a legal guardian) permission. Make a note of where copied records are sent. Unless your state laws direct otherwise, original records should remain with the retiring dentist (or with the surviving spouse or his/her legal representative, since a dentist's estate can be sued years after a dentist's death) in accordance with a state's record retention laws.

A proper patient transfer from a retiring dentist who must discontinue treatment in advance of completion may have at least these four requirements: 1) identifying a skilled practitioner who will accept the unfinished case; 2) providing that dentist with necessary clinical information so that he/she knows enough about the patient to continue or alter treatment, if necessary; 3) the patient agreeing to the referral; and 4) the patient actually submitting to the treatment in a cooperative fashion. Short of achieving all four, a dentist could still have trouble defending against an abandonment allegation, depending on applicable law.

Remember of course, that record retention is a matter of state law and risk management. In general, records may be destroyed for inactive adult patients who have not been seen in seven years (longer in some localities) or at the expiration of the statute of limitation on contract and tort actions. The oral health record of inactive minors generally should NOT be destroyed until seven years after a child reaches majority (21 years plus 7 years, or 28 years of age in some localities). Always check your local law. Records should be stored in a moisture and fire resistant container. Check with your attorney or state dental association to learn the record retention requirement in your state and with your insurance company for risk management recommendations. (See section on Destruction).

Record Handling During Sale of a Practice

When selling a practice, three main methods are available to the dentist for a transfer of patient records:

1. The dentist may choose to keep the original patient documents and provide the buyer with a copy of all the patient charts and radiographs. This method would provide the dentist with the best protection in the event of a future malpractice claim, since the old records would be maintained by the seller.
2. The dentist may choose to keep copies of all the patient charts and provide the original records to the buyer. This method may not give the seller the same liability protection as in the previous method.
3. The dentist could obligate the buyer, in the sales contract, to allow the seller access to the records in the event of need. The buyer is typically required to maintain these records for a set period of time after the sale. Further contract language regarding damages for records not maintained could be included. The disadvantage of such a transfer is that even with this provision, the buyer may inadvertently destroy or lose records or make access difficult. In evidence law, there is nothing better than the original document and, therefore, be sure it can be obtained in the event of a question or a professional liability claim.¹⁰

The sales agreement clause related to patient records would typically permit the seller for a specified period of time to have access to the patient charts, records and x-ray file in connection with the practice sale transaction to allow review and making of copies for defense of malpractice litigation or to respond any inquiries from licensing or regulatory authorities.

Releasing the Oral Health Record in Emergencies or Forensic Investigations

Dentists who are covered under the HIPAA Privacy Rule generally may release dental records or make disclosures from the record to law enforcement officials under the regulation without patient authorization provided they present a valid, properly served warrant; court order, subpoena or administrative request. In the case of an administrative request two conditions generally must be met: 1) the information sought must be related to a legitimate law enforcement inquiry; and, 2) be reasonably limited to the scope of that inquiry. The HIPAA privacy regulations also permit dentists covered by the Rule to release patient records and make disclosures to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by state law.

Under HIPAA, a covered entity may use professional judgment to determine when it is appropriate to release clinical records to a family member for identification purposes since the HIPAA regulations indicate that such disclosures may need to be limited to directly relevant information. The most prudent option might be that the dentist, in consultation with his or her attorney, limits a disclosure to just those records or data necessary for victim identification.

Depending on the circumstance of the request, the celebrity of the patient for example, prior to release, a dentist (or the Privacy Officer in a dental practice) might wish to seek permission from the person(s) named in the record as next of kin.

A dentist may need to collect emergency contact and next of kin information from each new patient, and ask existing patients at least annually about any need to alter or update emergency information in their dental record; or any special instruction or restrictions they may elect (allowable by law) concerning the release of their personal health information to others.

While dentists are the owner of the dental patient records in their possession (physical or electronic), a patient generally has a legal right of access to the information contained in their own dental record or in that of a dependent family member. They may have a further legal right to restrict disclosures or release of the record. Consequently, dentists need to become familiar with state and federal requirements and formulate record release policies and procedures specific to their practice. A record release and disclosure policy in an emergency could allow access to the dental records by family members of missing or unidentified persons, or to law enforcement. Written procedures based on your policy should appear in your practice's office manual. Such procedures could help ensure necessary access or disclosure while simultaneously protecting dental record privacy.

In most cases, photocopies of written records are acceptable to a recipient unless originals are specifically required or authenticity is in dispute. If investigators agree to accept photocopies of written dental records, you should provide crisp, clear copies that include both sides of any document containing or providing information on two sides. If a single document contains multiple pages, consistently number and duplicate each page. Prior to releasing copies, make sure that each page identifies the individual in question and the dentist providing the record. If necessary, use a rubber stamp with the dentist's contact information on it, but do not obscure content on the page.

When releasing originals; inventory which documents you intend to release. Some dentists indicate a count on the front of the dental record of how many pages are included if the number is more than just a few. Recording the count could help investigators receiving the records know that they received every document in a large dental file.

Whenever possible, a dentist should release original records and radiographs in person, not by mail. It may also be a good idea for the dentist to obtain a receipt. Always retain a copy of the record.

Subpoenas for Dental Records

A dentist with sufficient reason may choose to restrict (except to the patient) release or disclosure of some of the information contained in the dental records to authorized entities presenting a valid, properly served warrant, court order, subpoena or administrative request. Unless specifically directed, a dentist might choose, for example, to not disclose a summary in the record of a sensitive conversation that is unrelated to identification.

A dentist who gets a request to provide dental records in a forensic investigation should cooperate with authorities who properly identify themselves and who present the dentist with a valid, properly served warrant, court order, subpoena or administrative order. State laws and the HIPAA Privacy Rule, provide for the circumstances under which records may be released in the absence of a valid warrant or court order. Dentists may wish to consult with their private attorney in dealing with these situations.

Types of subpoenas:

- A "subpoena duces tecum" is an order for the dentist to appear in person with the required dental records. Check with your own attorney. In some states, a personal appearance may not be necessary.
- A "subpoena ad testificandum" is a written order demanding that a dentist appear and give testimony. This may be testimony at trial or a court hearing or by deposition. Again, consult with your attorney.

Before releasing any documents, original or copies, it is important to be certain to retain a duplicate set of any released documents. This will help the dentist to confirm the return of all records once the identification is made, and provide a record of what was produced while permitting the dentist at the same time, to maintain a file in the dentist's possession.

If a requested record is "misfiled" or lost within your practice and cannot be located, the dentist should report the result of the unsuccessful search to requesting authorities as soon as possible.

Inactive dental records kept off-site or on microfiche may require more time to locate. However, a dentist responding to a valid subpoena may be required to produce the records by a date specified on the subpoena and within the time frame allowed by law. If the dentist is unable to comply with the subpoena or order within the specified time frame, he or she should immediately contact an attorney who may contact the requesting official to explain the situation.

A dentist who refuses to comply with a final, valid, properly served warrant, court order, subpoena or administrative request for records should appear in court to contest disclosure and explain the basis for refusing before any sanctions for failure to comply are imposed. Refusing to comply is very serious and not an ordinary option. You should not refuse to comply, for example, without first consulting your attorney for local court procedures because you do not want to be found in contempt of court.

Releasing Dental Radiographs

If requested, a dentist should release the original radiographs of a patient to properly authorized investigators. Even a very old radiograph in good condition might assist investigators in identifying a victim in a forensic identification case.

Most duplicate or printed radiographs are not of diagnostic value and could delay victim identification. Radiographs include bitewings, occlusals, periapicals, panoramics and cephalometrics. If other radiographs of the head and neck of a patient are known to be held by a hospital or specialist, a dentist should give contact information so that investigators can reach these colleagues or institutions to collect additional information.

Denote "right" and "left" on mounted radiographs or how you read the indicator bubble. Indicate the date of exposure as well. For copied two-dimensional paper records there is no raised bubble to read, so labeling left and right could become critical whenever the paper copy is diagnostic.

Label any envelope containing radiographs with the patient's name, unique patient identification and a count of the number of individual radiographs contained inside. To prevent loss of content seal each envelope containing loose radiographs before releasing them to authorities. Again, keep track of precisely which records are released.

Frequently, authorized investigators who are working to identify a body, the remains of a recovered missing person, or mass fatality victims may wish to clarify or confirm information with the dentist who released the victim's radiographs. You should place your name, telephone number and address prominently on any radiographic envelopes or mounts that you release.

Another way to denote radiographs as from your office is by securely attaching your business card to each mounted radiograph or envelope. However, do not staple through any radiographs.

A suspected victim's diagnostic casts, if they are available, can be used in identifications. Incidental information, such as rugae patterns on submitted casts, has been used to confirm an identification.

Your patient's name and date of impression should appear on the casts. However, do not use pencil as pencil marks can come off or smudge during handling, possibly delaying a positive identification. Since diagnostic casts are breakable, before release they should be securely wrapped to prevent damage in bubble wrap or loose packing material inside a case box with the dentist's contact information on the outside.

The American Dental Association's policy **Dental Radiographs for Victim Identification** (2003:363) gives guidance with regard to dentists making available original records to authorized investigators attempting to identify a disaster victim:

Resolved, that the ADA actively promote to practicing dentists the importance of providing, as permitted by state law, radiographs and original records of patients of record that are requested by a legally authorized entity for victim identification which will be returned to the dentist when no longer needed, and be it further

Resolved, that copies of these records should be retained by dentists as required by law.

ADA Policy **Dental Identification Efforts** (1985:588) encourages dental societies and others to assist in forensic investigations. The policy states:

Resolved, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

Retention of Other Business Records

In addition to being familiar with the complexities of patient recordkeeping, as a small business a dental office also needs to retain other records.

Records maintenance is important to help with the following:

- Monitor the progress of your business
- Prepare financial statements
- Identify sources of revenue
- Keep track of deductible expenses
- Prepare tax returns
- Support items reported on your tax returns.

Business Record Retention^{11,12,13,14, 15}

Retention period is the number of years from the date of the tax return filed.

All information is general only and not offered as legal advice.*

The proper retention period will vary from state to state and, maybe from practice to practice. Here is a typical schedule of retention periods. Yours may be different. Consult with an attorney to establish your own schedule.

Record Type	Retention Period
Tax & Financial Files**	
Accounts payable ledger & schedule	7 yrs
Accounts receivable ledger & schedule	7 yrs
Audit/accountant annual report	Permanently
Bank statements (monthly)	3 yrs
Capital asset records	Permanently*
Cash receipt journal	Permanently*
Checks (cancelled – see exception below)	7 yrs
Checks (cancelled for important payment – i.e. taxes, purchases of property; file with transaction)	Permanently
Contracts and leases (expired)	7 yrs
Contracts, mortgages & leases (still in effect)	Permanently
Deeds, mortgages & bills of sale	Permanently
Deposit books & slips (duplicate)	3 or 6 yrs*
Depreciation schedules	Permanently
Financial statements (yearly)	Permanently
General ledgers	Permanently
Income tax returns, worksheets and related documentation	Permanently
Insurance policies (expired)	3 yrs
Insurance records, current accident reports, claims, policies, etc.	Permanently
Inventory of products, materials & supplies	7 yrs
List of accounts (assets, liabilities, revenue, expenses, etc)	Permanently
Petty cash vouchers	3 yrs
Retirement plan records (documents, investment records, allocations)	Permanently
Vouchers for payments to vendors, employees, etc. (includes allowances & reimbursement of employees, etc. for travel & entertainment expenses)	7 yrs
Employment Records	
Applications (not hired)	3 yrs
Personnel records (after termination)	7 yrs
Payroll records, taxes & summaries	7 yrs
Time sheets, cards or time clock	7 yrs
Training manuals	Permanently
Workman compensation records	5 yrs
Patient	
Daysheets, schedule	7 yrs
Patient billing/payment or fee statements	7 yrs
Third-party insurance claims, records & correspondence (EOBs)	7 yrs
Other**	
Accident reports/claims (settled cases)	7 yrs
Controlled substance copy	2 yrs
Correspondence, routine with patients or vendors	2 yrs
Correspondence (legal or important)	Permanently
Legal agreements (partnership, associateship)	Permanently
Medicare billing records	7 yrs
OSHA records (log and summary)	5 yrs past the year to which it pertains

*Check with your personal advisor, such as accountant, attorney or professional liability insurance company. State and federal laws may apply, in addition to the state dental practice act.

****When your records are no longer needed for tax purposes, do not discard them until determining if you might need for a longer time period for other purposes. For example, your insurance company or creditors may require you to keep them longer than the IRS does.**

Additional resources

To obtain the following resources, call the *ADA Catalog* at 1-800-947-4746 or order online at <http://www.adacatalog.org>. Following are just a few of the many titles available from the ADA Catalog Sales Department. You may order any of the publications by calling (800) 947-4746, or through the ADA's Web site at <http://www.adacatalog.org>.

Fast-Track Training: The Basics for Dental Staff. Chicago, Ill: Council on Dental Practice, American Dental Association; 2007.

Basic Training II: for New Clinical Personnel. Chicago, Ill; Council on Dental Practice, American Dental Association; 2002.

Basic Training III: for Dental Administrative Personnel. Chicago, Ill; Council on Dental Practice, American Dental Association; 2003.

Employee Office Manual: A Guide for Dentists. Chicago, Ill; Council on Dental Practice, American Dental Association; 2004.

Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.

HIPAA Privacy Kit, American Dental Association; 2002.

HIPAA Security Kit, American Dental Association; 2005.

Starting Your Dental Practice: A Complete Guide. Chicago, Ill: Council on Dental Practice, American Dental Association, 2003.

Valuing a Practice: A Guide for Dentists. Chicago, Ill: Council on Dental Practice, American Dental Association; 2001.

Internet Resources

ADA Resources

<http://www.ada.org>

HIPAA <http://www.hhs.gov/ocr/privacy/>

Risk management article database (members only)

Legal Adviser & law article database <https://www.ada.org/members/1415.aspx> (members only)

Emergency Planning & Disaster Recovery in the Dental Office

http://www.ada.org/sections/professionalResources/pdfs/ada_disaster_manual.pdf

Closing a Dental Practice

http://www.ada.org/sections/professionalResources/pdfs/office_closingpractice.pdf

ADA Policy on **Identification Through Prosthetic Devices** (1978:181)

http://www.ada.org/sections/about/pdfs/doc_policies.pdf (page 135)

Legal & Ethical Frequently Asked Questions (FAQ) <https://www.ada.org/members/1415.aspx>

Directory of Professional Liability Insurers (members only)

Identity Theft Resource located on "Dental Practice Hub" (ADA members-only)

https://www.ada.org/sections/dentalPracticeHub/members/5857_Identity_Theft_Resource.pdf

Non ADA resources

The Dental Record <http://www.dentalrecord.com/>

Dealing with a Data Breach - Information Compromise and the Risk of Identity Theft: Guidance for Your Business, Federal Trade Commission, <http://www.ftc.gov/bcp/edu/microsites/idtheft/business/data-breach.html>.

American Records Management Association, <http://www.arma.org/>

Business Records Resources Related Web Resources

Drug Enforcement Agency (DEA)

<http://www.usdoj.gov/dea/pubs/csa/827.htm> - (21 USC Sec. 827 01/22/02)

IRS

<http://www.irs.gov/>

OSHA Record Keeping

<http://www.osha.gov/recordkeeping/OSHArecordkeepingforms.pdf>

Small Business Administration

http://www.sba.gov/idc/groups/public/documents/sba_homepage/pub_fm10.pdf

BusinessTown – Accounting Basics

<http://www.businesstown.com/accounting/basic.asp>

SBDCNet

<http://sbdnet.org/SBIC/tax.php>

SCORE

http://www.score.org/template_gallery.html

Forensic resources — Training

Armed Forces Institute of Pathology

202-782-2100

Washington, D.C.

<http://www.afip.org>

University of Texas - Southwest Symposium on Forensic Dentistry

Health Science Center

San Antonio, TX

210-567-3177

<http://cde.uthscsa.edu/>

The Council on Dental Practice of the ADA sponsors training programs and conferences on basic dental forensic topics and techniques. Call the Council at 1-312-440-2895.

Organizations

Disaster Mortuary Operational Response Team (DMORT)

<http://www.dmort.org>

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Professional Societies

American Society of Forensic Odontology

<http://www.asfo.org>

American Board of Forensic Odontology

<http://www.abfo.org>

The Diplomate's Manual produced by the ABFO is available at the site for free downloading.

American Academy of Forensic Science

<http://www.aafs.org>

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- ¹ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.
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- ⁶ Weber, Richard, Release of Dental Records, *Journal of the Michigan Dental Association*, (Vol. 83, No. 6), July/August, 2001.
- ⁷ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.
- ⁸ *Closing a Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse*, ADA, Council on Dental Practice, 2005.
- ⁹ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004, p. 61-62.
- ¹⁰ *Valuing a Practice: A Guide for Dentists*, Council on Dental Practice, American Dental Association, 2006.
- ¹¹ Publication 538 "Starting a business and keeping records," Internal Revenue Service, Jan 2007.
- ¹² McGill, John, MBA, JD, CPA, How long should you keep your business records, *Journal of Clinical Orthodontics*, May 2003.
- ¹³ Paoloski, Susana, DDS, "When is it safe to pitch office papers," *Journal of the Greater Houston Dental Society*, Sept 2002.
- ¹⁴ Presavento & Pesavento, LTD, CPAs, "Records retention schedule," Collier, Samer and Assoc Newsletter, Berwyn, IL, May 15, 2005.

APPENDIX

PATIENT INITIALS: _____

DATES OF SERVICES REVIEWED: _____

RECORDKEEPING CHECKLIST

Requirements per Minn. R. 3100.9600

Patient information:	Present	Not Present	Not Applicable	Comments
Subp. 3. PERSONAL DATA.				
A. Name				
B. Address				
C. Date of birth				
D. If minor, name of parent or guardian				
E. Name/Phone of person to contact if an emergency				
F. Name of insurance carrier / insurance ID #.				
Subp. 4. REASON FOR VISIT.				
Subp. 5. DENTAL HISTORY. (Data support tx plan?)				
Subp. 5. MEDICAL HISTORY. (Data support tx plan?)				
Subp. 6. CLINICAL EXAM INFORMATION:				
A. Record of existing oral health status.				
B. Radiographs used.				
C. Facsimiles or results of any other diagnostic aids.				
Subp. 7. DIAGNOSIS.				
Subp. 8. TREATMENT PLAN. • Agreed upon • Dated (when non-routine/preventive visit) • Updated to reflect current status of pt's oral health/tx.				
Subp. 9. INFORMED CONSENT. Shall include notation that: A. Dentist discussed treatment options/ prognosis / risks / benefits. B. Patient consent to treatment chosen.				
Subp. 10. PROGRESS NOTES INFORMATION: • Chronology of treatment / visits. • Identify provider by name or initials. • Identify all medications used. • Identify all materials placed.				
Subp. 10. CORRECTIONS MADE PROPERLY.				

Professional liability insurance companies have long asserted that errors or inadequacies in the patient record prevent them from successfully defending some dentists against unfounded allegations of malpractice. To identify where there is the greatest need for improvements in record keeping, a 2005 survey conducted by the ADA Council on Members Insurance sought to determine the frequency, severity and causes of dental malpractice claims reported between 1999 and 2003. The survey is available on <http://www.ada.org/>. The following question was posed to the insurers with respect to both general practitioners and specialists:

Please indicate the degree to which your company has noted the following types of problems with its insured's' patient records (whether or not the problem was a primary cause of a paid claim.)

To quantify the responses to this subjective question, a value of ten was assigned to any problem that was indicated as being "very common." If a problem was "fairly common," it was assigned a value of five. If the insurer said that the problem was "not common," it was assigned a value of zero. The average scores for each problem, reflecting the opinions of fourteen insurers weighed equally, are listed below:

Insurers Views as to the Frequency of Various Record Keeping Errors	
Type of Error in Descending Order of Frequency	Average Score
Treatment plan is not documented	6.5
Health history is not clearly documented or updated regularly	6.1
Informed consent is not documented	5.9
Informed refusal is not documented	5.0
Assessment of patient is incompletely documented	4.9
Words, symbols, or abbreviations are ambiguous	4.9
Telephone conversations with patient are not documented	4.6
Treatment rendered is not clearly documented	4.5
Subjective complaints are not documented	4.1
Objective findings are incompletely documented	4.1
Treatment plan is not supported by documented subjective and objective findings	4.0
Reasons for deviation from the original treatment plan are not documented	3.9
Patient non-compliance or failed appointment(s) are not documented	3.7
Records are not legible	3.7
Routine full-mouth periodontal probing not documented	3.4
Insufficient records given the complexity of the issue	3.2
Post-operative instructions are not documented	3.2
Referral to or consultation with another practitioner or physician is not documented	2.8
Comments about the cost of treatment and the patient's payment history	2.6
X-rays were inadequate for the procedure	2.3
Prescription orders are not documented	2.2
Deletions, additions, or corrections are not made properly	2.0
Risk management notations included in the chart	1.4
The name and relationship of the person who gave consent is not documented for minors or patients who are incapacitated	1.4
Alteration of records	1.1
Lost records/X-rays	.7
Records are not written in ink	.7
Record contains notations relating to discussions with an attorney or insurer regarding a possible malpractice lawsuit	.4
Critical or subjective personal comments about the patient in the chart	.4

144.291 MINNESOTA HEALTH RECORDS ACT.

Subdivision 1. **Short title.** Sections 144.291 to 144.298 may be cited as the Minnesota Health Records Act.

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(b) "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

(c) "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

(e) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

(f) "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

(g) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting according to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(h) "Provider" means:

(1) any person who furnishes health care services and is regulated to furnish the services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148D, 148F, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section 144A.46;

(3) a health care facility licensed under this chapter or chapter 144A; and

(4) a physician assistant registered under chapter 147A.

(i) "Record locator service" means an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers.

(j) "Related health care entity" means an affiliate, as defined in section 144.6521, subdivision 3, paragraph (b), of the provider releasing the health records.

History: *2007 c 147 art 10 s 2; 2012 c 187 art 1 s 21; 2012 c 197 art 2 s 44*

144.292 PATIENT RIGHTS.

Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the treatment the patient receives and the patient's health record.

Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

Subd. 3. **Additional patient rights.** A patient's right specified in this section and sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 4. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this subdivision are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient:

(1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health conditions; or

(2) the pertinent portion of the record relating to a condition specified by the patient.

With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and \$10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an

amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative may charge the \$10 retrieval fee, but must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act; except that no fee shall be charged to a person who is receiving public assistance, who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 7. Withholding health records from patient. (a) If a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1). The other provider or third party may release the information to the patient.

(b) A provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (3), shall release information upon written request unless, prior to the request, a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), has designated and described a specific basis for withholding the information as authorized by paragraph (a).

Subd. 8. Form. By January 1, 2008, the Department of Health must develop a form that may be used by a patient to request access to health records under this section. A form developed by the commissioner must be accepted by a provider as a legally enforceable request under this section.

History: 2007 c 147 art 10 s 3; 2012 c 247 art 2 s 4

144.293 RELEASE OR DISCLOSURE OF HEALTH RECORDS.

Subdivision 1. **Release or disclosure of health records.** Health records can be released or disclosed as specified in subdivisions 2 to 9 and sections 144.294 and 144.295.

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

- (1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;
- (2) specific authorization in law; or
- (3) a representation from a provider that holds a signed and dated consent from the patient authorizing the release.

Subd. 3. **Release from one provider to another.** A patient's health record, including, but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; or

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

- (i) the use or release of the records complies with sections 72A.49 to 72A.505;
- (ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and
- (iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 8. **Record locator service.** (a) A provider or group purchaser may release patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient, unless the patient has elected to be excluded from the service under paragraph (d). The Department of Health may not access the record locator service or receive data from the record locator service. Only a provider may have access to patient identifying information in a record locator service. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service does not have access to patient identifying information and information about the location of the patient's health records unless the patient specifically consents to the access. A consent does not expire but may be revoked by the patient at any time by providing written notice of the revocation to the provider.

(b) A health information exchange maintaining a record locator service must maintain an audit log of providers accessing information in a record locator service that at least contains information on:

- (1) the identity of the provider accessing the information;
- (2) the identity of the patient whose information was accessed by the provider; and
- (3) the date the information was accessed.

(c) No group purchaser may in any way require a provider to participate in a record locator service as a condition of payment or participation.

(d) A provider or an entity operating a record locator service must provide a mechanism under which patients may exclude their identifying information and information about the location of their health records from a record locator service. At a minimum, a consent form that permits a provider to access a record locator service must include a conspicuous check-box option that allows a patient to exclude all of the patient's information from the record locator service. A provider participating in a health information exchange with a record locator service who receives a patient's request to exclude all of the patient's information from the record locator service or to have a specific provider contact excluded from the record locator service is responsible for removing that information from the record locator service.

Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under section 144.294, subdivision 2, the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

(b) When a health record is released using a representation from a provider that holds a consent from the patient, the releasing provider shall document:

- (1) the provider requesting the health records;
- (2) the identity of the patient;
- (3) the health records requested; and
- (4) the date the health records were requested.

Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When requesting health records using consent, a person warrants that the consent:

- (1) contains no information known to the person to be false; and
- (2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law.

(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request:

- (1) contains no information known to the provider to be false;
 - (2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and
 - (3) does not exceed any limits imposed by the patient in the consent.
- (c) When disclosing health records, a person releasing health records warrants that the person:
- (1) has complied with the requirements of this section regarding disclosure of health records;
 - (2) knows of no information related to the request that is false; and
 - (3) has complied with the limits set by the patient in the consent.

History: 2007 c 147 art 10 s 4; 1Sp2010 c 1 art 20 s 7

3100.9600 RECORD KEEPING.

Subpart 1. **Definitions.** For the purposes of this part, "patient" means a natural person who has received dental care services from a provider for treatment of a dental condition. In the case of a minor who has received dental care services pursuant to Minnesota Statutes, sections 144.341 to 144.347, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

Subp. 2. **Dental records.** Dentists shall maintain dental records on each patient. The records must contain the components specified in subparts 3 to 10.

Subp. 3. **Personal data.** Dental records must include at least the following information:

- A. the patient's name;
 - B. the patient's address;
 - C. the patient's date of birth;
 - D. if the patient is a minor, the name of the patient's parent or guardian;
 - E. the name and telephone number of a person to contact in case of an emergency;
- and
- F. the name of the patient's insurance carrier and insurance identification number, if applicable.

Subp. 4. **Patient's reasons for visit.** When a patient presents with a chief complaint, dental records must include the patient's stated oral health care reasons for visiting the dentist.

Subp. 5. **Dental and medical history.** Dental records must include information from the patient or the patient's parent or guardian on the patient's dental and medical history. The information must include a sufficient amount of data to support the recommended treatment plan.

Subp. 6. **Clinical examinations.** When emergency treatment is performed, items A to C pertain only to the area treated. When a clinical examination is performed, dental records must include:

- A. recording of existing oral health care status;
- B. any radiographs used; and
- C. the facsimiles or results of any other diagnostic aids used.

Subp. 7. **Diagnosis.** Dental records must include a diagnosis.

Subp. 8. **Treatment plan.** Dental records must include an agreed upon written and dated treatment plan except for routine dental care such as preventive services. The

treatment plan must be updated to reflect the current status of the patient's oral health and treatment.

Subp. 9. **Informed consent.** Dental records must include a notation that:

- A. the dentist, advanced dental therapist, or dental therapist discussed with the patient the treatment options and the prognosis, benefits, and risks of each; and
- B. the patient has consented to the treatment chosen.

Subp. 10. **Progress notes.** Dental records must be legible and include a chronology of the patient's progress throughout the course of all treatment and postoperative visits. The chronology must include:

- A. all treatment provided;
- B. all medications used and materials placed;
- C. the treatment provider by license number, name, or initials; and
- D. when applicable, the identity of the collaborating dentist authorizing treatment by license number.

Subp. 11. **Corrections of records.** Notations must be legible, written in ink, and contain no erasures or "white-outs." If incorrect information is placed in the record, it must be crossed out with one single line and initialed by a dental health care worker.

Subp. 12. **Retention of records.** A dentist shall maintain a patient's dental records for at least seven years beyond the time the dentist last treated the patient. In the case of a minor patient, a dentist shall maintain a patient's dental records for at least seven years past the age of majority.

Subp. 13. **Transfer of records.** A patient's dental records must be transferred according to Minnesota Statutes, sections 144.291 to 144.298, irrespective of the status of the patient's account. Digital radiographs shall be transferred by compact or optical disc, electronic communication, or printing on high-quality photographic paper. All transferred film or digital radiographs must reveal images of diagnostic quality using proper exposure settings and processing procedures.

Subp. 14. **Electronic record keeping.**

A. The requirements of subparts 1 to 13 apply to electronic record keeping as well as to record keeping by any other means.

B. When electronic records are kept, a dentist must keep either a duplicate hard copy record or use an unalterable electronic record.

Statutory Authority: *MS s 144.335; 150A.04; 150A.08*

History: *21 SR 1730; L 2007 c 147 art 10 s 15; 35 SR 459; 36 SR 738; 37 SR 1849*

Published Electronically: *July 8, 2013*



2013 MINNESOTA BOARD OF DENTISTRY **SELF ASSESSMENT**

Based on core subject areas of: Ethics, Patient Communication, Management of Medical Emergencies, Diagnosis and Treatment Planning, Record Keeping and Infection Control

Completion of this self-assessment is a required part of your professional development portfolio. You will be granted one (1) fundamental credit per biennial cycle for completion of the self assessment. You are expected to place the completed assessment in your portfolio. In the event you are audited, the Board will review this document to ensure that it has been completed.

The questions contained in this self-assessment reflect real situations/issues as observed by the Board through the complaint process. The objective is to educate dental professionals in order to prevent adverse situations from happening, thereby protecting the public. It is appropriate to complete this self-assessment either on an individual basis or in a group setting such as at a staff meeting or study group.

If you have answered any of the questions incorrectly, it is strongly recommended that you research the sources referenced and/or attend an educational course in relation to the subject area. **The information and resources provided within this assessment are not all inclusive.** Please review the list of resources, web sites and phone numbers at the end of this document. *Be sure to sign and date the Self Assessment on page 8. Neglecting to do so will result in a failed audit.*

ETHICS

1. A daughter schedules an appointment for her elderly mother. She brings her mother to the appointment but wants to leave during treatment. What are the issues the dental professional needs to consider with this type of patient?

2. After an initial consultation, a new patient makes an appointment for December 15th to have extensive dental work done before his insurance expires on December 31th, which he communicates to the dentist. The dentist has an unexpected family emergency that takes him away from the office and the receptionist has to reschedule the appointment to January 5th. When the patient arrives on January 5th he is upset by the change of date and tells the dentist he must backdate the treatment to December 15th because his insurance will not cover the treatment. Otherwise, he will leave without having the work done, because he is now unemployed and will not be able to pay. What should the dentist do?

3. Your patient has presented for care and prior to treatment you have obtained written informed consent for the treatment to be given. The dentist proceeds with three restorations as planned. However, one restoration becomes very deep and now will require a root canal. There is time in the schedule to proceed with the root canal today. Assuming the patient is not under nitrous oxide or sedation what is the best course of action?
 - A. Proceed with treatment and discuss upon completion
 - B. Inform the patient and obtain an amended informed consent
 - C. Provide additional treatment and make a note in the patient record
 - D. Terminate care

4. Your patient has been given local anesthesia and during treatment starts to exhibit signs of a severe allergic reaction. Staff dials 911 and patient is ultimately transported to the hospital. Are you obligated to complete the adverse reaction report?

- A. Yes
B. No

		MINNESOTA BOARD OF DENTISTRY University Park Plaza, 2829 University Avenue SE, Suite 450 Minneapolis, MN 55414-3249 www.dentalboard.state.mn.us Phone 612.617.2250 Fax 612.617.2260 MN Relay Service for Hearing Impaired 800.627.3529	
ADVERSE REACTION REPORT			
Minnesota Rules 3100.3600 requires that you file this report for any incident that arises from the administration of nitrous oxide inhalation analgesia or of a pharmacological agent for the purpose of general anesthesia, conscious sedation, local anesthesia, analgesia, or anxiolysis that results in a serious or unusual outcome that produces a temporary or permanent physiological injury, harm, or other detrimental effect to one or more of a patient's body system(s). It is NOT necessary to report incidents such as nausea, a single episode of emesis, or mild allergic reaction. This report shall be submitted to the Board of Dentistry within ten days of the incident. You may duplicate this form.			
LICENSEE INFORMATION		License Number:	
Name (please print):			
Address:			
City:		State:	Zip:
I. REACTION INFORMATION			
PATIENT ID/INITIALS (In Confidence)	AGE (YRS)	SEX	REACTION ONSET
			MO DA YR
DESCRIBE REACTION(S)			CHECK ALL APPROPRIATE:
			☐ PATIENT DIED
			☐ REACTION TREATED WITH RX DRUG
			☐ RESULTED IN TREATMENT BY PHYSICIAN AND/OR HOSPITALIZATION
			☐ RESULTED IN PERMANENT DISABILITY
			☐ NONE OF THE ABOVE
RELEVANT TESTS/LABORATORY DATA			
II. SUSPECT DRUG(S) INFORMATION			
SUSPECT DRUG(S) (Indicate manufacturer and lot # for vaccines/biologics)			DID REACTION ABATE AFTER STOPPING DRUG?
			☐ YES ☐ NO ☐ N/A
DOSE	ROUTE OF ADMINISTRATION		
INDICATION(S) FOR USE			DID REACTION REAPPEAR AFTER REINTRODUCTION?
			☐ YES ☐ NO ☐ N/A
DATES OF ADMINISTRATION (From/To)	DURATION OF ADMINISTRATION		
III. CONCOMITANT DRUGS AND HISTORY			
CONCOMITANT DRUGS AND DATES OF ADMINISTRATION (Exclude those used to treat reaction)			
OTHER RELEVANT HISTORY (e.g., diagnoses, allergies, pregnancy with LMP, etc.)			
IV. SIGNATURE			
SIGNED:		DATE:	

K: Anes/Sed, Adv React Req

PATIENT COMMUNICATION

1. Upon request, a provider shall supply to a patient, complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

A. True
B. False

2. A licensed health care provider must wear a name tag which indicates by words, letters abbreviations, or insignia, the profession or occupation of the individual unless wearing the name tag would create a safety or health risk to the patient.

A. True
B. False

3. It is acceptable to state in your advertising for your dental practice that you are a specialist in placing implants and cosmetic dentistry because you have completed a continuing education course with a minimum number of 12 credits in the related practices.

A. True
B. False

4. The license renewal only shall be conspicuously displayed in every office in which that (licensed) person practices, in plain sight of patients.

A. True
B. False

MANAGEMENT OF MEDICAL EMERGENCIES

1. Which of these medical emergencies is most likely to happen in your dental practice?

A. Mild allergy
B. Angina
C. Syncope
D. Seizure

2. What are the minimum contents of a medical emergency kit?

3. How many regulated dental professionals within the clinic need to be healthcare provider CPR certified?

DIAGNOSIS AND TREATMENT PLANNING

1. When completing an initial oral exam for a child, a panoramic radiograph or full mouth radiographic series for a child is not typically warranted until:
 - A. 7 years of age
 - B. 9 years of age
 - C. The first permanent tooth has erupted
 - D. The 2nd permanent bicuspid has erupted
2. Deep sedation is characterized by impairment of the patient's ability to independently maintain ventilator function, spontaneous ventilation potentially being inadequate to meet the patient's needs, and
 - A. The need for a signed informed consent form
 - B. The need for cardiovascular support
 - C. The need for assistance in maintaining a patent airway
 - D. The need for use of intravenous reversal agents
3. Certification in nitrous oxide administration is the primary board requirement for conscious/moderate sedation.
 - A. True
 - B. False

RECORD KEEPING

1. A patient consent to release records is typically valid for three years.
 - A. True
 - B. False
2. How do you correct an error in an electronic record?

3. I noticed in Sunday's obituary that my long time patient of record had passed away therefore I can destroy the patient's record.
 - A. True
 - B. False

4. The Board of Dentistry's recordkeeping rule (MR 3100.9600) details the elements that must be contained in every patient record. For this part of the Self-Assessment, please use the following:
- Recordkeeping Checklist (copy on page 6), you may make copies as needed.
 - 2 current patient records
- For each patient record, utilize the CHECKLIST to determine whether each element identified on the list is documented in that record. *If you are not in clinical practice and do not have access to patient records, we recommend you review this form and become familiar with the Minnesota record keeping rule.*

Examples of minimal recordkeeping (the record *must* include at least the following):

Personal Data

- ☐ Patient Name
- ☐ Patient Address
- ☐ Patient's Birthdate
- ☐ Patient's Parent or Guardian Name (if patient is a minor)
- ☐ Emergency Contact Name and Phone Number
- ☐ Insurance Carrier and Identification Number (if applicable)

Patient's Reason for Visit

- ☐ Chief Complaint

Dental and Medical History

- ☐ Sufficient Information to Support Recommended Treatment Plan

Clinical Examination(s)

[note: when an emergency treatment is performed, the following items may pertain only to the area treated]

- ☐ Recording of Existing Oral Health Care Status
- ☐ Any radiographs/Images Used, and
- ☐ Facsimiles or Results of any Other Diagnostic Aids Used

Diagnosis: must be documented

Treatment Plan

- ☐ Agreed-Upon Written and Dated Treatment Plan (except for routine dental care such as preventive services)
- ☐ Treatment Plan Updated to Reflect Current Status of Patient's Oral Health and Treatment

Informed Consent

Notation in Chart that:

- ☐ Dentist or Dental Therapist Discussed Treatment Options and Prognosis, Benefits, & Risks of Each with the Patient, and
- ☐ Patient has Consented to the Treatment Chosen

Progress Notes

- ☐ Chronology of Patient's Progress Throughout the Course of All Treatment and Postoperative Visits
- ☐ All Treatment Provided
- ☐ Clearly Identify the Provider by Name/Initials
- ☐ Identify ALL Medications Used and Materials Placed

Miscellaneous

- ☐ Each Patient Must have a Separate Chart
- ☐ Chart Entries Must be Recorded in INK (no pencils!)
- ☐ Chart Entries Must be Legible
- ☐ Corrections Made by Drawing a Single Line Through Incorrect Information and Initialing

Electronic Records

- ☐ All Requirements above Apply to Electronic Records, as well
- ☐ A Duplicate Hard Copy Record Must be Kept, or the Electronic Record Must be Unalterable

PATIENT INITIALS: _____

RECORDKEEPING CHECKLIST

Requirements pre Minn. R. 3100.9600

<i>Patient information:</i>	Present	Not Present	Not Applicable	Comments
Subp. 3. PERSONAL DATA.				
A. Name				
B. Address				
C. Date of birth				
D. If minor, name of parent or guardian				
E. Name/Phone of person to contact if an emergency				
F. Name of insurance carrier / insurance ID #.				
Subp. 4. REASON FOR VISIT.				
Subp. 5. DENTAL HISTORY. <i>(Data support tx plan?)</i>				
Subp. 5. MEDICAL HISTORY. <i>(Data support tx plan?)</i>				
Subp. 6. CLINICAL EXAM INFORMATION:				
A. Record of existing oral health status.				
B. Radiographs used.				
C. Facsimiles or results of any other diagnostic aids.				
Subp. 7. DIAGNOSIS.				
Subp. 8. TREATMENT PLAN. - Agreed upon - Dated (when <u>non</u>-routine/preventive visit) - Updated to reflect current status of pt's oral health/treatment.				
Subp. 9. INFORMED CONSENT. Shall include notation that: A. Dentist discussed tx options/ prognosis / risks / benefits B. The patient consent to treatment chosen.				
Subp. 10. PROGRESS NOTES INFORMATION:				
- Chronology of treatment / visits. - Identify provider by name or initials. - Identify all medications used. - Identify all materials placed.				
Subp. 10. CORRECTIONS MADE PROPERLY.				

INFECTION CONTROL

1. Prior to treating a patient, the following procedures should be performed. What is the proper order?
 - A. Acceptable hand hygiene technique along with thorough drying with a disposable towel and gloving with single-use gloves
 - B. Protective eyewear/ face shield and clothing (e.g. long sleeved gowns, lab coat or clinic jackets)
 - C. Surgical mask-covering both nose and mouth

2. If the hands of a Dental Health-Care Personnel (DHCP) are visibly dirty or contaminated or are visibly soiled with blood or other body fluids an alcohol-based hand rub is adequate.
 - A. True
 - B. False

3. Artificial fingernails or extenders have been implicated in multiple outbreaks of fungal and bacterial infections
 - A. True
 - B. False

4. Extracted teeth are considered infectious waste. Therefore, extracted teeth containing amalgam should be placed in a medical waste container and autoclaved or incinerated.
 - A. True
 - B. False

5. How long should hand pieces, ultrasonic scalers, and air/water syringes be flushed at the start of the day and between each patient?
 - A. 5-10 seconds
 - B. 10-20 seconds
 - C. 20-30 seconds
 - D. 30-40 seconds

6. A licensed dental assistant is cleaning the operatory following a dental procedure. During the process of disassembling the used syringe, the cap on the needle comes off and the assistant is poked with the used needle. What steps should be taken?

I, _____ attest to the Minnesota
Board of Dentistry that I have completed this self assessment on _____
(date)

(Signature)

Rev 12/2012

SELF ASSESSMENT ANSWERS

ETHICS

1. The health care professional needs to check with the patient to see if they are responsible for their own care or determine if there is a legal guardian. If there is a legal guardian, write contact information in the chart so as to obtain informed consent prior to providing treatment or in the event treatment changes.

Reference: Minnesota Rule 3100.9600 Subp 9

2. The patient record and billings must reflect actual date(s) of treatment. Improper billing could be construed as fraud and is a violation of board and insurance regulations.

Reference: Minnesota Rule 3100.6200 H and I

3. **B.** Inform the patient and obtain an amended informed consent.

You must receive informed consent before proceeding with the procedure and document it in the chart. Informed consent is specific to a procedure, where options were given including prognosis, risks and benefits, and the patient has consented to the treatment chosen.

Reference: Minnesota Rule 3100.9600 Subp 9

4. **Yes.**

Minnesota Rule 3100.3600 requires that you file the adverse reaction report for any incident that arises from the administration of local anesthesia, nitrous oxide inhalation analgesia or of a pharmacological agent for the purpose of general anesthesia, conscious sedation, analgesia or anxiolysis that results in a serious or unusual outcome that produces a temporary or permanent physiological injury, harm or other detrimental effects to one or more of a patient's body system(s). A dentist, dental therapist, dental hygienist, or a licensed dental assistant **MUST** report within ten business days to the board any incident by any licensed health care professional who, under contract or employment with the dentist, was the actual person administering the analgesia or pharmacological or nonpharmacological method.

Reference: Minnesota Rule 3100.3600 Subp 8 A and B.

PATIENT COMMUNICATION

1. **A.** True.

Reference: Minnesota Statute 144, Patient Rights, 144.292, Subd. 2

2. **A.** True.

Patients have a right to know who is providing their care. Occasionally, despite introductions made, a patient may not understand or remember your name.

Reference: Minnesota Statute 144.6585

3. **B. False.**

The only board recognized specialty practices are: endodontics, oral and maxillofacial surgery, oral pathology, orthodontics, pediatric dentistry, periodontics, prosthodontics and public health.

Reference: Minnesota Rule 3100.7000 Subp 1,2 and 3

4. **B. False.**

The initial license and subsequent renewal certificate of every dentist, dental therapist, dental hygienist, or dental assistant shall be conspicuously displayed in every office in which that person practices, in plain sight of patients. The board shall allow the display of a wallet-sized initial license and wallet-sized subsequent renewal certificate only at nonprimary practice locations.

Reference: Minnesota Statute 150A.06, Subd 6

MANAGEMENT OF MEDICAL EMERGENCIES

1. **C. Syncope.**

The seven most common medical emergencies in the dental office are syncope, mild allergic reaction, angina pectoris, postural hypotension, seizures, asthmatic attack and hyperventilation.

Reference: Academy of General Dentistry

Stanley F. Malamed, Medical Emergencies in the Dental Office, 6th ed. 2007

2. Oxygen, Epinephrine, Benadryl, Inhaler, Nitroglycerin, Ammonia inhalants, Glucose source, Ventilation device and blood pressure cuff and stethoscope.

It is also advised to frequently check expiration dates and know how to use each item in the emergency kit.

Reference: Stanley F. Malamed, Medical Emergencies in the Dental Office, 5th ed 2000

3. All regulated dental professional are required to have and maintain current healthcare provider CPR certification as a condition of licensure. The course for healthcare provider must include: cardiopulmonary resuscitation on an adult, child, and infant; two person rescuer; barrier mask or bag for ventilation; foreign body airway obstruction; and automated external defibrillation. A CPR certificate shall be obtained through the American Heart Association healthcare provider course or the American Red Cross professional rescuer course.

Reference: Minnesota Rules 3100.0100 Subp 9a

3100.5100 Subp 3 A (3)

3100.1700 Subp 2

DIAGNOSIS AND TREATMENT PLANNING

1. **C.** The first permanent tooth has erupted.

There is no evidence-based support for completing comprehensive radiographic surveys on young children until eruption of the first of the child's permanent teeth, unless there is a specific concern regarding the individual patient. The patient record should always include rationale for any radiograph, and additional explanation when it varies from the standard.

Reference: American Academy of Pediatric Dentistry Guidelines 2012

2. **C.** The need for assistance in maintaining a patent airway.

Deep sedation is a depressed level of consciousness during which patients cannot be easily aroused, but do respond purposefully following repeated or painful stimulation. The definition of *deep sedation*, which distinguishes this level of sedation from *mild* and *moderate* sedation, addresses the patient's status as requiring assistance maintaining an airway.

Reference: Minnesota Rule 3100.0100 Definitions, Subp 9b

3. **B.** False.

Moderate sedation, often referred to as conscious sedation, requires that the dentist providing the sedation services complete extensive training and obtain certification from the Board of Dentistry. The use of nitrous oxide, on its own or together with other medications or substances, may on occasion result in the patient reaching a level of moderate sedation, which would require that the dentist be certified in *both* nitrous oxide and conscious/moderate sedation.

Reference: Minnesota Rule 3100.3600, Subp 3

RECORD KEEPING

1. **B.** False.

In general, a release of records consent must be signed by an authorized individual and is valid for 1 year from the date of signature. Minnesota Statute does allow for exceptions.

Reference: Minnesota Statute 144.293, Subd 2, 4, 5 and 6

2. Note new date, state the correction and place initials or if computer allows draw a line through the error and initial it.

Reference: Minnesota Rules 3100.9600 Subp 12

3. **B. False**

You will need to check the last treatment date. A dentist shall maintain a patient's dental records for at least seven years beyond the time the dentist last treated the patient. In the case of a minor patient, a dentist shall maintain the patient's dental record for at least seven years past the age of majority.

Reference: Minnesota Rules 3100.9600 Subp 12

4. The board's Record keeping checklist is available on the board's website at www.dentalboard.state.mn.us under 'other information'.

Reference: Minnesota Rules 3100.9600 Subp 12

INFECTION CONTROL

1. **B, C, A.**

Personal Protective Equipment (PPE) should be placed and removed in a step-by-step process. Don patient-care PPE in the reverse order of what you change the most during the course of the clinic day. Gloves are changed most often, face protection less often, and clothing least often of all. Care should be used when removing PPE to prevent contaminating hands, clothing and skin.

Reference: Minnesota Rule 3100.6300 Subp 11

CDC's MMWR Dec. 2003 "Guidelines for Infection Control in Dental Health Care Setting"
www.cdc.gov

2. **B. False.**

Hand hygiene is considered the single most critical measure for reducing the risk of transmitting organisms to patients and DHCP. If the hands are visibly soiled hand antisepsis should be achieved by using either a plain or anti-microbial soap with water. The simple act goes a long way toward protecting you and your patients and reduces the risk of disease transmission. Gloving is not a substitute for hand washing.

Reference: Minnesota Rule 3100.6300 Subp 11

CDC's MMWR Dec. 2003 "Guidelines for Infection Control in Dental Health Care Setting"
www.cdc.gov

3. **A. True.**

Wearing artificial fingernails can compromise hand washing efforts; they can also make donning gloves more difficult and can cause tears more easily. Keeping nails short enough to thoroughly clean underneath them is recommended.

Reference: Minnesota Rule 3100.6300 Subp 11

CDC, MMWR December 19, 2003, Guidelines of Infection Control in Dental Health-Care Settings.

4. **B. False.**

Extracted teeth containing amalgam restorations should not be heat sterilized because the potential health hazard from mercury vaporization and exposure. Check with your medical waste vendor regarding the requirement for disposal of amalgam. OSHA considers extracted teeth to be potentially infectious material that should be disposed in medical waste containers. However, extracted teeth can be returned to patients upon request, at which time provisions of the standard no longer apply.

Reference: Minnesota Rule 3100.6300 Subp 11
CDC's Dec. 2003 "Guidelines for Infection Control in Dental Health Care Setting"
www.cdc.gov
OSHA Bloodborne Pathogen Exposure Incidents Standard 29 CFR 1910.1030
January 2011

5. **C. 20 – 30 seconds.**

This procedure is intended to help physically flush out infectious debris that might have entered the turbine and air and water lines.

Reference: Minnesota Rule 3100.6300 Subp 11
CDC, MMWR December 19, 2003, Guidelines of Infection Control in Dental Health-Care Settings.
www.cdc.gov

6. Immediately after the exposure wash the wound with soap and water and report the incident to the person(s) listed as the contact. Document the route(s) of exposure and the circumstances of the exposure incident. Identify the source individual, if possible. Obtain consent and send the source individual for a blood test that should include HBV, HCV, and HIV. Obtain consent and send the exposed employee for blood testing at the pre-arranged facility. The blood test should include HBV, HCV, and HIV serological status. Prophylaxis also includes post-exposure evaluation and follow-up testing as needed. Complete OSHA's Form- Injury and Illness Incident Report (within 7 calendar days). Notify Workers comp Insurance -1st Report of Injury.

Post where you and your coworkers go for occupational health needs such as an occupational exposure.

Name of doctor/facility:

Address/phone number:

Reference: Minnesota Rule 6950.1040
Minnesota Statute MS176.231
Work comp 1st report of injury <http://www.dli.mn.gov/WC/Fr01info.asp>
OSHA Bloodborne Pathogen Exposure Incidents Standard 29 CFR 1910.1030
January 2011



MINNESOTA BOARD OF DENTISTRY

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RECORDKEEPING

revised November 20, 2007

REGULATIONS

This issue is regulated by Minnesota Rule 3100.9600. The exact language can be found at the Board of Dentistry web site by clicking on the link "statutes and rules" or the link "other."

BACKGROUND

The Board's recordkeeping rule establishes the *minimum* standard for maintaining dental records. The items addressed in the 14 subparts of the rule comprise what is minimally acceptable... certainly records that are more comprehensive would be preferred.

Why is it necessary to set a standard?

The fundamental concern is that the dentist must maintain a record for each patient that *accurately* and *legibly* documents all the dental care rendered and reasons for providing that care. Comprehensive documentation of the he chronology of care for each patient supports the decisions that were made and provides a record of the care that was both proposed and provided. A good record protects the patient and the provider. A dentist's recollection of events or existence of a standard protocol is not likely to be adequate for a subsequent provider, a Board committee, an insurance claims review, or a jury. The Board has adopted the philosophy that "*if it is not written down, it did not happen.*" It is always better for the provider to **document everything** as if someone else is reading the record, and the information is so understandable that there would be no doubt as to what occurred and why.

COMMON INFRACTIONS

Common recordkeeping errors seen by the Board include, but are not limited to:

- not initially obtaining or updating a patient's personal data (subpart 3)
- not documenting the patient's concerns and complaints, i.e. their reason for the appointment (subp 4)
- not initially documenting or updating the patient's medical and dental histories (subp 5)
- not documenting results of the patient's examination, radiographs, and tests (subp 6)
- not documenting a reason for rendering care, such as: caries, defective restoration, cracks, open contacts, broken cusp, etc. (subp 7)
- not providing a dated and written treatment plan after each examination, preferably including costs and signed by the patient (subp 8)
- not documenting that the patient agreed to a specific treatment after being given the options, benefits and risks of each, and prognosis (subp 9)
- not fully documenting what occurred at every visit, such as: type and amount of local anesthesia, concentration and time of nitrous oxide, all materials used, prescription directions, refusal of recommended treatment, complications, etc. (subp 10)
- not documenting in the progress notes all contacts with or about the patient, such as but not limited to: phone calls, chance meetings or discussions, consultations with other practitioners, letters, e-mails, faxes, etc. (subp 10)
- not signing or initialing all entries in the progress notes (subp 10)
- including improper corrections to the record (subp 11)
- disposing of patient records or components of the records prematurely (subp 12)
- not promptly transferring records (subp 13) ...A dentist may *not* refuse to copy and transfer records, *even if* the patient owes money for previous treatment or does not agree to pay in advance the costs of duplication. See MN Statute §144.291-298 for details.

NOTE: RADIOGRAPHS (AND COPIES MADE FOR TRANSFER) SHOULD BE OF DIAGNOSTIC QUALITY AND ACCURATELY LABELED!

DISCLAIMER: Be advised that because this is an educational document of the Minnesota Board of Dentistry, the information contained in this document is not official policy or law and, therefore, is not legally binding for either the Minnesota Board of Dentistry or the licensee/registrant. Each complaint the Board of Dentistry receives is evaluated under the Board's Practice Act and rules, other applicable laws and the record in the proceeding.



MINNESOTA BOARD OF DENTISTRY

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TRANSFER OF HEALTH RECORDS

revised March 8, 2011

REGULATIONS

The transfer of health records is regulated by Minnesota Statute 144.335 which is referenced in Rule 3100.9600, subp. 13. The exact language can also be found at the Board of Dentistry web site by clicking on the link "statutes and rules."

COPYING CHARGES

The maximum charges allowed for copying records are specified in Statute 144.335, Subd. 5 and the current annually adjusted fee table can be accessed at the Department of Health's web site. The current fee maximums are as follows:

Calendar Year	Per Page Copy Charge	Retrieval Charge
2011	\$1.23	\$16.24

For copying radiographs, specifically, MS § 144.335, subd 5, states that a provider may charge actual costs of duplicating films, plus no more than a \$10 retrieval and copying fee.

NOTE: COPIES OF RADIOGRAPHS SHOULD BE OF DIAGNOSTIC QUALITY AND ACCURATELY LABELED!

COMMON INFRACTIONS

Common infractions that are *not* defensible include:

1. Requiring pre-payment before records will be copied
2. Requiring a zero balance on the patient's account before records are released
3. Refusing to give the records directly to the patient, instead requiring they be sent to a dentist
4. Not transferring records in a prompt manner

Two areas of possible ambiguity may be related to an understanding of the definition of (1) "records," and (2) "prompt" transfer...

(1) **Records:** Does it include...

- the *most recent* bite-wing radiographs?
- *only* the radiographs that are less than 12 months old?
- *all* the radiographs regardless of age?
- progress notes?
- test results?
- letters/reports from specialists?
- periodontal probing measurements?
- study models?

A valid perspective would be that "it depends on what the patient or subsequent dentist wants and considers important to have for review." It would be prudent to ask what is wanted rather than assume to avoid problems and/or complaints. [see MS 144.335, subd 2(a) and (b)]

(2) **Prompt Transfer...**

records should be transferred as soon as possible so as not to interrupt patient care

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INFORMED CONSENT

revised June 9, 2005

REGULATIONS

This issue is actually a part of the recordkeeping rule, but as it is so critical for patient care and a significant cause for complaints it is being addressed as its own educational handout. The exact language of Minnesota Rule 3100.9600, subpart 9 can be found at the Board of Dentistry web site by clicking on the link "statutes and rules" or the link "other."

FUNDAMENTALS

The patient must be given adequate information so that *they* can make a decision that is appropriate and valid for their individual situation at that particular point in time. Therefore, the Board strongly encourages that consent would be reviewed and confirmed and properly documented in the chart at each visit. Comprehensive informed consent includes treatment options, scheduled treatment, costs, risks, benefits, and mechanism of delivery. It is not acceptable to assume a patient's approval for, or that the patient understands each and every treatment intended! It is simple to just ask at each appointment "What do you understand is going to happen today?" Good patient communication goes a long way. *Informed consent is a process.*

ELEMENTS OF INFORMED CONSENT

Dental records shall include a *notation* that...

- the *dentist discussed* with the patient:
 - treatment options, and
 - prognosis
 - benefits, and
 - risks of each; and
- the *patient has consented* to the treatment chosen

Information provided to patients should contain all treatment options, benefits and risks of each, prognosis of each, and all costs involved. The information given should *not* be limited to only those treatments provided in that dentist's practice or what that dentist personally thinks is appropriate.

The burden is on the dental professional to ensure that the patient understands the treatment options. This can be challenging when common terminology among dental professionals is not clear to the public, and *especially* challenging with patients whose primary language is different than the provider's.

COMMON FAULTY ASSUMPTIONS

Page 2 of 2

ISSUE	FALSE ASSUMPTION	ACTUALITY
Implied Consent:	If a patient shows up at the office, sits in the dental chair, and opens up his/her mouth... they've agreed to treatment	There is no provision for the Board to consider implied consent related to dental treatment in Minnesota. Dental procedures/services require informed consent.
Blanket Consent:	When a patient signs a registration form that states that they agree to whatever procedures the dentist deems necessary... everything is covered	There is no provision for the Board to consider blanket consent related to dental treatment in Minnesota. The elements of informed consent within rule require that the consent be treatment-specific.
Informed Refusal	If a patient refuses recommended treatment, no additional action or documentation is necessary	The patient is the ultimate decision-maker regarding their own care. The provider, however, would be wise to document that doing nothing (refusing treatment) is an option that has its own specific risks and benefits, and note that the patient knowingly accepted that particular option

A common mistake is to think that "implied" consent is legal and adequate. "Implied" and "informed" consent are quite different. Another word for "implied" is "assumed." Misunderstanding and disagreement often occurs when the dental provider erroneously assumes that:

- the patient is giving consent for all the treatment planned by the dentist merely because the patient shows up for the scheduled appointment
- the patient fully understands and agrees to what is planned because the patient did not ask any questions or disclose their confusion when treatment was explained to them
- the patient gives informed consent for every and all treatment in the future by signing a general consent agreement when they become a patient of the practice. A general agreement does not reference any specific treatment plan
- they have consent for treatment when a parent drops off their minor child for treatment without asking what treatment is planned and doesn't stay until the child is seated
- a patient automatically accepts the changes in treatment that sometimes happen during treatment. In other words, the patient was never apprised of those changes, options, benefits and risks, prognosis, and costs before continuing.
- the patient is easily confused, and so the dentist only informs the patient about options the provider prefers, thinks is best, or personally performs

COMMON INFRACTIONS

- A frequently seen problematic situation involves a child who arrives for a "preventive" or "recall" appointment, and the dental office performs bitewing radiographs, fluoride, and sealants as well as an exam and prophylaxis. The parent complains because they only expected an exam and prophylaxis. Differing assumptions by both parties is the cause of the problem... so having the treatment plan in writing or reviewing the treatment plan when confirming the appointment could have avoided the problem.

When a patient claims the dentist never told them— and there is not documentation in the chart what the provider told the patient— it creates doubt that the communication ever occurred. Having a standard protocol does not automatically mean the protocol was followed in that instance. *Documentation is key!*

- Costs are often a significant concern for patients; so if a quoted fee does not include every associated procedure, the patient may feel they have been misled. An example relates to quoting the fee for a crown, where it should not be assumed by the dentist that the patient is aware of or agrees to also pay fees such as MNCare taxes, infection control fees, limited exam fees, periapical x-ray fees, and crown build-up fees. Similarly, a patient who has a root canal recommended may not be aware that there is a strong probability that the tooth will require a crown and its associated costs.

People don't remember everything that is told to them, so...
it is preferable and prudent to have every agreement and all care instructions in writing.

ADDITIONAL RESOURCE

Wilkins, Esther. Clinical Practice of the Dental Hygienist, 2005. 9th Edition. pp. 369-370.

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RECORDKEEPING RULE: ADEQUATE INFORMED CONSENT

MR 3100.9600, Subp. ⁹ 13: *Dental records shall include a notation that:*

- A. the dentist discussed with the patient the treatment options and the prognosis, benefits, and the risks of each; and*
- B. the patient has consented to the treatment chosen.*

The complaint department at the Board often hears these words:

- I didn't know what my dentist was doing...
- I was never given a choice...
- No one talked about options to me...
- If I had known the dentist was using white/silver fillings, I would have said "no"....
- I am an advocate for my child's care, why didn't someone tell me what they were going to do...

- Don't I have a right to refuse treatment...
- I don't speak English ...

The Board would like to remind you that your records must comply with MN Recordkeeping Rule 3100.9600. If a complaint is opened on a licensee, we will request a copy of the patient's dental record. Keeping clear and accurate records are beneficial to you. Not only are they legal documentation of patient encounters, but they are good reminders to you of critical information and an essential component of patient care.

Remember to include the patient as part of the decision-making process. *Please make sure the patient understands your treatment plan.* Clear communication and documentation not only enhance your practice, but lead to fewer complaints sent to the Board of Dentistry.

Maximum Charges for Patient Records

This summary is for general information purposes only and should not be regarded as legal advice.

The Minnesota Department of Health (MDH) cannot give legal advice about whether patients or their representatives may be charged fees for copies of the patient's health record. Whether fees may be charged for patient health records, and the amount of any fees, may vary based on the individual situation. The following summary is for general information only.

State and federal laws and regulations can impact whether or not (and how much) a health care provider can charge for copies of patient records. Talk with the provider who has the patient records and explain your situation and what records are sought. Depending on the circumstances, the provider may require you to pay a fee. Ask the provider for an estimate and an explanation of the charges.

State Law and Rule

When providers are allowed to charge for copies of patient records, the following state law or rule limits the amount that can be charged.

- **Annual determination of maximum charges for patient records.** MDH uses the formula in Minnesota Statutes, section 144.292, subdivision 6, to annually determine the maximum allowable fees for copies of patient records.

When section 144.292 applies, the maximum charges for 2014 are \$1.32 per page for copy charges and \$17.54 for retrieval fees. Pursuant to statute, these limits do not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving and copying the x-rays. Read the state law

online at:

<http://www.revisor.mn.gov/statutes/?id=144.292>.

- **Workers' compensation cases.** Payment for copies of medical records that are part of a workers' compensation case may be subject to Minnesota Rules, part 5219.0300. See the Minnesota Department of Labor & Industry's website for more information: http://www.dli.mn.gov/WC/PDF/wc_batg_3.pdf. Read the state rule online at: <http://www.revisor.mn.gov/rules/?id=5219.0300>.

Federal HIPAA Privacy Rule

The federal HIPAA Privacy Rule covers patient access to records and includes prohibitions on retrieval fees and other restrictions. This federal rule is administered by the U.S. Department of Health and Human Services Office of Civil Rights (OCR).

More information about HIPAA is available at: <http://www.hhs.gov/ocr/privacy/index.html>

You may contact the OCR regional office at:

Region V - Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)

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Office for Civil Rights

U.S. Department of Health and Human Services
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OCT 26 1976

Informed Consent: Recall by Patients Tested Postoperatively

George Robinson, M.D., and Avraham Merav, M.D.

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Informed Consent: Recall by Patients Tested Postoperatively

George Robinson, M.D., and Avraham Merav, M.D.

ABSTRACT When tested for recall between 4 and 6 months following operation, 20 patients failed to remember accurately major portions of their informed consent interview. Documentation of the details of consent in the clinical record is considered advisable.

It is the patient's right to determine whether he will or will not undergo surgical treatment, and it is the responsibility of the surgeon to provide information for the patient so that he can make an intelligent decision based upon comprehension of the intended procedure. Variations in the standards of adequacy of such information and recent changes in laws across our nation make judgments on the details and validity of informed consent very difficult [1]. Several recent legal decisions have transferred evaluation of the adequacy of informed consent from physicians to the jury, and it is now the latter who may decide whether adequate information has been supplied to permit the patient to make a sensible decision with respect to treatment. Certainly, when he is considering whether to undergo a major operation the patient requires information as to the possibility of death or injuries from potential complications. He is also entitled to an expert evaluation of the alternatives to surgical treatment.

The extent to which physicians must inform patients has recently been determined to be that information which is material to the decision-making process. Information regarding complex technological methods, surgical procedures, and prosthetic devices is difficult to transmit to the wide spectrum of patients. Total comprehension by patients, even those with a medical background, may be impossible to achieve, yet the physician is duty bound to inform. By

training and experience, the surgeon is accustomed to rendering a prospective analysis of a clinical problem and to evaluating methods alternative to surgery. He should therefore be able to present this material to the patient in a comprehensible form. Documentation of this transmittal of information in the patient's clinical records has been shown to be desirable.

We have made a conscientious effort to obtain fully informed consent from all our patients undergoing cardiac procedures. Since January, 1975, tape recordings have been made of the informed consent conversations; these recordings were made with the knowledge and permission of the patients. In a carefully structured but informal session one or two days prior to operation, the elements of informed consent were systematically covered in considerable detail.

The outline of information included in each interview was as follows:

1. Diagnosis and nature of the illness
2. Proposed operation, surgical techniques to be employed, and prosthetic devices to be used (if applicable)
3. Risk of death resulting from the operative procedure
4. Potential complications of operation and prosthetic devices (if applicable)
5. Benefits of the proposed operative procedure
6. Alternative methods of management and their chances for failure or success
7. Acknowledgment by the patient of his understanding of all explanations and answering of questions

We were first alerted to the major loss of recall that occurs following the informed consent interview when 2 patients, both of whom were convalescing normally at ten days and six weeks after their operations, denied any recollection of the preoperative recorded interview. A formal study of recall by postoperative testing was then initiated.

From the Montefiore Hospital and Medical Center, Bronx, NY.

Presented at the Twelfth Annual Meeting of The Society of Thoracic Surgeons, Washington, DC, Jan 26-28, 1976.

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Materials and Methods

Between 4 and 6 months following operation, 20 patients were selected for reinterview to determine the capacity of each to recall the details of their informed consent interview. Each of these patients had convalesced uneventfully after a satisfactory postoperative course. Patient selection was otherwise totally random. Ages ranged between 35 and 66 years, with a mean age of 52 years. Nine patients had undergone operation for atherosclerotic heart disease, and 11 patients had been operated upon for acquired valvular heart disease. Recordings were also made at the time of the second interview. All patients had been hospitalized one or more times previously for diagnostic or therapeutic purposes, and none had had their operations performed as emergency procedures.

All informed consent interviews were conducted by one author (G. R.), and all reinterviews were conducted by the second author (A. M.). Before reinterview the original tape recording was replayed, and a chart of the points discussed in each category of informed consent was prepared for rapid reference. At the reinterview each category of the consent procedure was reviewed twice to determine the patient's ability to recall. *Primary recall* was the response to general questions in each category of consent (1 to 6). Questions asked during the primary recall portion of the reinterview were identical for all patients. An effort was made to avoid suggesting responses. The questions were:

Do you remember having an interview with Dr. Robinson before your operation?
Tell me what you remember of the interview.

What were you told about what was wrong with you—the diagnosis?

What were you told about the operation to be performed?

Were you told of risks or dangers associated with the operation?

Were any of the possible complications associated with the operation discussed?

What were they?

Were you told in what way the operation would help you?

Were you told about methods of treatment other than operation?

Following this, the itemized list of topics from the prepared chart was then reviewed with the patient. The patient was asked if each item had been discussed originally and, if affirmative, what the substance of the conversation was. The response of the patient to questions regarding specific items known to have been discussed in the original interview was designated *secondary recall*. Suggestions of correct responses were unavoidable in testing for secondary recall.

Accuracy of primary and secondary recall was then graded 0 to 100% in each of the categories 1 through 6 of the informed consent interview. If there was no recall of a category having been discussed, a score of 0 was given. Partial scores were awarded according to the degree of recall in each category. No deductions were made for denial, fabrication, or errors of attribution.

Results

Findings upon reinterview indicated generally poor retention in all categories of informed consent information. The Table indicates the aver-

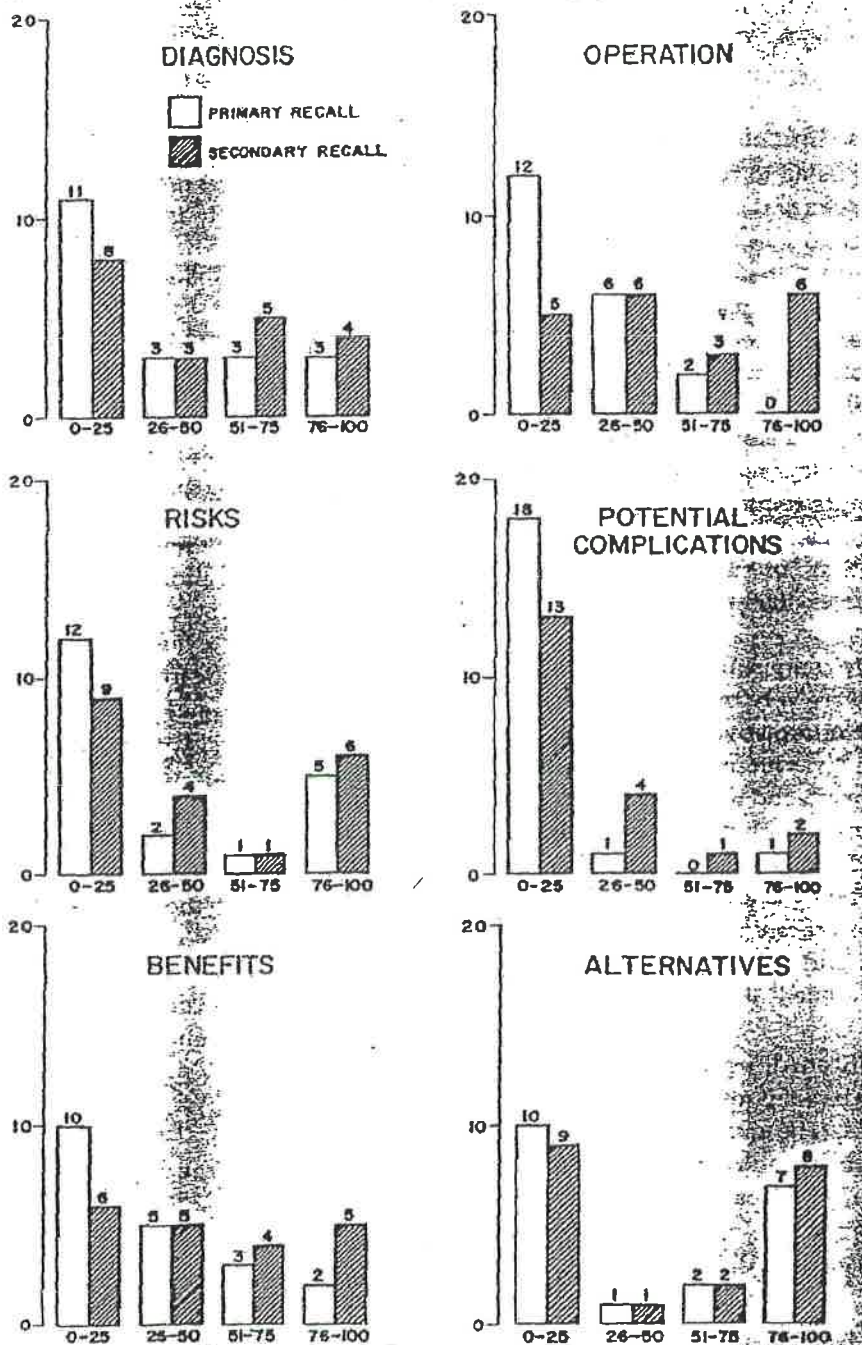
Recall of Informed Consent Interview by 20 Patients 4 to 6 Months Postoperatively

Category of Informed Consent Information	% Primary Recall	% Secondary Recall
1. Diagnosis and nature of illness	33	46
2. Proposed operation	26	51
3. Risks of the operative procedure	35	42
4. Potential complications	10	23
5. Benefits of the proposed operation	29	47
6. Alternative methods of management	43	43
Average	29	42

age scores achieved by 20 patients reinterviewed in each of the 6 categories. The poorest scores were achieved in the single category of potential complications: there was 10% primary recall and, with the suggestion of appropriate

responses, a secondary recall of 23% out of a possible 100% for this category. The average recall in all categories was 29% for primary and 42% for secondary recall. Thus, even with the influence of suggestion and a point-by-point review of every item covered in the original interview, patients could remember only 42% of the items that had been covered in the informed consent interview. The Figure illustrates the

Primary and secondary recall in each category of informed consent. Vertical axis indicates number of patients; horizontal axis indicates scores in percent.



scores achieved by percentage groups in each category and demonstrates the improvement in secondary recall. Of the 20 patients tested, 17 scored 50% or less on primary recall and 12 scored 50% or less on secondary recall. The lowest individual score achieved was 3% primary and 3% secondary recall, and the highest score achieved was 57% primary and 87% secondary recall.

Errors made by patients in the repeat interview had qualitative differences. They may be described as failure to recall; positive denial of a truth; fabrication, or the assertion of an untruth or falsehood; and errors of attribution.

Each of the 20 patients failed to recall major parts of the interview. Sixteen of the 20 patients positively denied that certain major items had been discussed at all. Of these 16 patients who made positive denials, 13 denied having been informed on multiple (maximum of eight) significant items of information. After failure to recall and denial, the next most common error was fabrication, or the assertion of an untruth or falsehood. This was present to a significant degree in 13 of the 20 patients reinterviewed. A common error (and one that is quite understandable) was attribution of information gathered from other sources to the informed consent interview.

Two patients voluntarily complained that the preoperative interviews were very brief, inferring that they were not informative. One of these stated that "all he did was lift up my shirt, put a stethoscope on my heart, and that was it." The recorded portion alone of this informed consent conference was 24 minutes long. The second complaint about brevity of the interview came from a patient whose recording lasted 23 minutes. The unrecorded portions of each consultation visit easily exceeded 10 additional minutes.

Noteworthy was a significant difference in the self-assurance with which patients responded to questions in reinterviews. The quality of responses to questions often indicated some doubt or lack of certainty. Three patients were

considered to have a quality of response that indicated near total self-assurance in being correct in the details of recall. The poorest score of all 20 patients reinterviewed was achieved by a patient who responded authoritatively and expressed no doubts regarding his recollections. Two other patients, who scored fifteenth and seventeenth, respectively, also had the same quality of response: they were frequently in error but never in doubt.

Comment

Despite meticulous attention to detail by the surgeon in a carefully conducted informed consent procedure, all of 20 patients tested between 4 and 6 months postoperatively failed to recall accurately what had transpired at their interview. The informed consent had been given in a simple, direct, and uncomplicated manner in the form of a dialog between the patient and the surgeon. There were repeated instances in each conversation in which the patient was asked if he understood the explanations, and questions were answered as they arose. We believe, therefore, that all patients completely understood the information imparted and that they gave a truly informed consent to their operations. Noteworthy is the fact that the patients studied had been educated by their previous experience with their disease; all had chronic heart disease and had been hospitalized many times for diagnostic and therapeutic procedures. This study calls attention to the fact that, while these patients were well informed and comprehended their situations prior to operation, they subsequently forgot most of what they had understood and made other qualitative errors in their attempts to recall the consent interview. We believe it is essential to document in some way the details of informed consent so that it becomes a permanent part of the clinical record, since memory of the event is unreliable.

Reference

1. Nick WV: Informed consent—the new decisions. *Bull Am Coll Surg* 59:12, 1974



Your Documentation Can Save the Day

Statistics show that patients remember anywhere from 10 to 50% of what they hear in a doctor's or dentist's office. If a complication occurs as a result of a procedure that has been performed, patients often claim they "were never told about it!" It is therefore very important to document any and all information given to patients.

While the dentists are responsible for giving patients informed consent for all procedures to be performed, staff are often responsible for giving out brochures, showing recorded tapes or DVD versions of procedures, giving out post-procedure instructions, and other related items. All such items should be documented in the clinical chart. The documentation need not be lengthy or cumbersome.

Oftentimes, three or four words will suffice. "Videotape shown to patient," "informational brochure given," or "Post-procedure instructions given" are all that are necessary

for these functions. Be sure that the documentation of these items is made as a separate note in the records. Write the information as a part of your other documentation on the same date, or as a new entry in the records as appropriate. Use the date if it is a new entry, and be sure to sign it!

If a patient claims they were never told or properly instructed about things, their side of the story will fall flat in face of your documentation to the contrary. Your three or four words may make the difference between complaints ending with a review of the records versus a full-blown lawsuit. Knowing that there can be such a big benefit from such a small effort should encourage all staff to take the time to complete this small task.

DOCUMENTATION OF INFORMED CONSENT

Once the oral and maxillofacial surgeon has discussed the necessary issues regarding the proposed treatment with the patient, the next important step is documenting the patient's informed consent. The most commonly used tool for obtaining this documentation is the consent form. The consent form should be viewed as a means to an end, not an end in itself. The consent form does not guarantee a successful malpractice claim defense. **The form CANNOT be used as a substitute for a doctor's discussions with the patient.**

Any consent form should contain, at a minimum, the previously mentioned disclosure items. Consent forms must not be complex and should not contain legal terms and/or technical words. Many courts assume, as a matter of law, that once a subject is put in writing the written document encompasses the total interaction. **IF IT IS NOT ON THE FORM, IT MAY BE PRESUMED THAT IT WAS NOT DISCUSSED.**

Questions often arise about how many different forms a doctor should use. In a practice which performs only a limited number of procedures (i.e., only dentoalveolar surgery with IV anesthesia), it is not difficult to develop written forms which adequately address the treatment and alternatives for all situations. In a practice that performs a full scope of oral and maxillofacial procedures, the task of developing written forms obviously becomes more onerous. Nevertheless, the National recommends that this be done, and especially recommends specific forms for advanced complicated surgery such as orthognathic, TMJ or cosmetic procedures. The more involved and risky the surgery - and especially in treatment where patient expectations are high (implants, orthognathic surgery and cosmetic surgery) - **the more specific a form should be, and the greater the time spent on discussion of all aspects.** It may be possible to develop a "generic" form with information basic to all cases, with space for describing the proposed procedure, various alternatives and the specific risks, but we believe that is more time consuming than developing a good detailed form for each procedure. A generic form also has the disadvantage of allowing the surgeon to forget a critical item of consent. **IN ANY CASE, YOU SHOULD SEEK LEGAL ADVICE DURING DEVELOPMENT OF A CONSENT FORM.**

Another effective claim deterrent is to provide the patient with a meaningful opportunity to ask questions that may arise from reading and discussing the written form. In order to be meaningful, this opportunity must be provided before the patient has been sedated and moved to the site of the procedure, as the quality of the patient's understanding will be questionable after the administration of sedatives or in a high-stress situation. A good alternative is to have the consent consultation on a separate day from the surgery. In general, the more elective the procedure, the greater the need for detailed, documented consent in laymen's language.

ALL DOCTOR-PATIENT DISCUSSIONS SHOULD BE NOTED IN THE PATIENT'S RECORDS TO FURTHER REINFORCE THE SIGNED CONSENT FORM.

CONSENT FOR DENTAL IMPLANT SURGERY

Page 1 of 3

Patient's Name _____

Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

_____ 1. My condition has been explained to me as a **Missing Tooth or Missing Teeth** described as: _____

_____ 2. The procedure proposed to treat this condition is **Surgically Placing a Dental Implant or Implants** into my jaw bones and gums in these positions: _____

_____ 3. I have been informed of possible alternate methods of treatment (if any) including: _____

I understand that these other forms of treatment or no treatment at all are choices. The risks of those choices have been presented to me.

_____ 4. My doctor has explained to me that there are risks and side effects of any surgical procedure. For this procedure, the main risks include:

_____ A. Post-operative discomfort, bruising and swelling needing several days of at-home recovery.

_____ B. Bleeding that is heavy or lasts for a long time that might need more treatment.

_____ C. Injury or damage to teeth or roots of teeth that are near by the place of the implant. This may need root canal treatment of the injured tooth, or even result in tooth loss.

_____ D. An infection after the procedure that might need more treatment or cause loss if the implant.

_____ E. Stretching of the corners of the mouth that might cause cracking and bruising and might heal slowly.

_____ F. It might be hard to open my mouth for several days. This might be from swelling and muscle soreness, or from stress on the jaw joints (TMJ). This could last several weeks or months, or it could be permanent.

_____ G. During the surgery, pieces of bone, synthetic bone, or synthetic membranes may be placed. These pieces of bone or membranes may also become infected or devitalized and require antibiotics and/or more surgical treatment.

_____ H. Allergic reactions (previously unknown) to any medications or materials used in treatment.

CONSENT FOR DENTAL IMPLANT SURGERY

Page 2 of 3

- _____ I. Implants placed in lower jaw might injure the nerve that gives sensitivity to the face. After the surgery, there might be pain or a numb feeling in my chin, lip, cheek, gums, teeth or tongue. It is possible that I might lose my sense of taste. This might last for weeks or months. It can be permanent, but this rarely happens.
- _____ J. Opening into the sinus (a normal bony area above the upper back teeth) that might need additional treatment. If we go into the sinus on purpose to do another procedure (sinus-lift procedure with grafting), I might have several weeks of sinusitis symptoms that will need medicine and more recovery time.
- _____ K. The jaw may break and need more surgical treatment for repair.
- _____ L. Use of other materials bone, (synthetic bone-like materials or membranes) that might have to be removed at a later date.
- _____ M. Bone loss around implants and/or adjacent teeth.
- _____ N. Fracture of the Implant or the restorative parts.
- _____ O. Loss of an implant or implants.
- _____ P. Other: _____
- _____ 5. I understand that cuts (incisions) will be made inside my mouth in the gums to put one or more dental implants into my jaw bone. The implants will be the support for one or more missing tooth replacements to hold a crown, cap, bridge, partial denture, complete denture or plate. The doctor has explained the procedure, and told me how many incisions will be made, where they will be, and what kind of implants will be used. If a crown, bridge or denture is to be attached to this implant(s), this will be done by Dr. _____, and that office will bill me for this procedure.
- _____ 6. Sometimes dental implants remain covered by gum tissue during the initial healing period. If the implant is covered by gum tissue, it will have to be surgically uncovered before it can be restored by the dentist. Sometimes dental implants are left exposed through the gum tissue when placed. Gum tissue grafting or trimming may be necessary before or after restoration by the dentist.
- _____ 7. No one has promised how long the implants will last. I have been told that once the implant is put in, I need to follow through with the whole treatment plan and finish it in the time period that is set by my doctors. If this is not done, the implants may fail.
- _____ 8. If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done
- _____ 9. The anesthetic I have chosen for my surgery is:
- ☐ Local Anesthesia
 - ☐ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
 - ☐ Oral Premedication with Local Anesthesia
 - ☐ Intravenous Sedation with Local Anesthesia
 - ☐ General Anesthesia with Local Anesthesia

CONSENT FOR DENTAL IMPLANT SURGERY

Page 3 of 3

- _____ 10. **ANESTHETIC RISKS** include: pain, swelling, bruising, swelling or infection of the vein area where the anesthesia or sedation was given. This could last a long time or make it hard for you to use your arm. This might need special care. There might be numbness that lasts a long time and allergic reactions. You might have nausea and vomiting from the IV Sedation or General Anesthesia, but this doesn't happen often. IV Sedation and General Anesthesia are serious medical procedures. They are safe, but the rare risks of heart irregularities, heart attack, stroke, brain damage or death are present.
- _____ 11. **YOUR OBLIGATIONS FOR IV SEDATION OR GENERAL ANESTHESIA IS:**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
 - B. During recovery time you should not drive, operate complicated machinery or devices, or make important decisions.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. **However**, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications directed by us, **with only a small sip of water.**

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

150A.10 ALLIED DENTAL PERSONNEL.

Subdivision 1. **Dental hygienists.** Any licensed dentist, licensed dental therapist, public institution, or school authority may obtain services from a licensed dental hygienist. The licensed dental hygienist may provide those services defined in section 150A.05, subdivision 1a. The services provided shall not include the establishment of a final diagnosis or treatment plan for a dental patient. All services shall be provided under supervision of a licensed dentist. Any licensed dentist who shall permit any dental service by a dental hygienist other than those authorized by the Board of Dentistry, shall be deemed to be violating the provisions of sections 150A.01 to 150A.12, and any unauthorized dental service by a dental hygienist shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 1a. **Limited authorization for dental hygienists.** (a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years;

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist;

(3) has documented participation in courses in infection control and medical emergencies within each continuing education cycle; and

(4) maintains current CPR certification from completion of the American Heart Association healthcare provider course, the American Red Cross professional rescuer course, or an equivalent entity.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to:

- (1) oral health promotion and disease prevention education;
- (2) removal of deposits and stains from the surfaces of the teeth;
- (3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
- (4) polishing and smoothing restorations;
- (5) removal of marginal overhangs;
- (6) performance of preliminary charting;
- (7) taking of radiographs; and
- (8) performance of scaling and root planing.

The dental hygienist may administer injections of local anesthetic agents or nitrous oxide inhalation analgesia as specifically delegated in the collaborative agreement with a licensed dentist. The dentist need not first examine the patient or be present. If the patient is considered medically compromised, the collaborative dentist shall review the patient record, including the medical history, prior to the provision of these services. Collaborating dental hygienists may work

with unlicensed and licensed dental assistants who may only perform duties for which licensure is not required. The performance of dental hygiene services in a health care facility, program, or nonprofit organization as authorized under this subdivision is limited to patients, students, and residents of the facility, program, or organization.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise authorized by the board. The board shall develop parameters and a process for obtaining authorization to collaborate with more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(3) copies of consent to treatment form provided to the patient by the dental hygienist;

(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and

(5) a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist. This procedure must specify where these records are to be located.

The collaborative agreement must be signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization; must be reviewed annually by the collaborating dentist and dental hygienist; and must be made available to the board upon request.

(d) Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. If the dental hygienist makes any referrals to the patient for further dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.

(e) For the purposes of this subdivision, a "health care facility, program, or nonprofit organization" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

(f) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Subd. 2. Dental assistants. Every licensed dentist and dental therapist who uses the services of any unlicensed person for the purpose of assistance in the practice of dentistry or dental therapy shall be responsible for the acts of such unlicensed person while engaged in such assistance.

The dentist or dental therapist shall permit the unlicensed assistant to perform only those acts which are authorized to be delegated to unlicensed assistants by the Board of Dentistry. The acts shall be performed under supervision of a licensed dentist or dental therapist. A licensed dental therapist shall not supervise more than four registered dental assistants at any one practice setting. The board may permit differing levels of dental assistance based upon recognized educational standards, approved by the board, for the training of dental assistants. The board may also define by rule the scope of practice of licensed and unlicensed dental assistants. The board by rule may require continuing education for differing levels of dental assistants, as a condition to their license or authority to perform their authorized duties. Any licensed dentist or dental therapist who permits an unlicensed assistant to perform any dental service other than that authorized by the board shall be deemed to be enabling an unlicensed person to practice dentistry, and commission of such an act by an unlicensed assistant shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 3. **Dental technicians.** Every licensed dentist and dental therapist who uses the services of any unlicensed person, other than under the dentist's or dental therapist's supervision and within the same practice setting, for the purpose of constructing, altering, repairing or duplicating any denture, partial denture, crown, bridge, splint, orthodontic, prosthetic or other dental appliance, shall be required to furnish such unlicensed person with a written work order in such form as shall be prescribed by the rules of the board. The work order shall be made in duplicate form, a duplicate copy to be retained in a permanent file of the dentist or dental therapist at the practice setting for a period of two years, and the original to be retained in a permanent file for a period of two years by the unlicensed person in that person's place of business. The permanent file of work orders to be kept by the dentist, dental therapist, or unlicensed person shall be open to inspection at any reasonable time by the board or its duly constituted agent.

Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a licensed dental hygienist or licensed dental assistant may perform the following restorative procedures:

- (1) place, contour, and adjust amalgam restorations;
- (2) place, contour, and adjust glass ionomer;
- (3) adapt and cement stainless steel crowns; and
- (4) place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel.

(b) The restorative procedures described in paragraph (a) may be performed only if:

- (1) the licensed dental hygienist or licensed dental assistant has completed a board-approved course on the specific procedures;
- (2) the board-approved course includes a component that sufficiently prepares the licensed dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed restoration;
- (3) a licensed dentist or licensed advanced dental therapist has authorized the procedure to be performed; and
- (4) a licensed dentist or licensed advanced dental therapist is available in the clinic while the procedure is being performed.

(c) The dental faculty who teaches the educators of the board-approved courses specified in paragraph (b) must have prior experience teaching these procedures in an accredited dental education program.

History: 1969 c 974 s 10; 1976 c 263 s 9; 1986 c 444; 1996 c 273 s 3,4; 1Sp2001 c 9 art 2 s 5; 2002 c 379 art 1 s 113; 1Sp2003 c 5 s 4,5; 2005 c 147 art 4 s 4; 2009 c 95 art 3 s 20-23; 2009 c 159 s 75-77

3100.8200 UNLAWFUL PRACTICE BY ALLIED DENTAL PERSONNEL.

An assistant, hygienist, dental therapist, or dental technician who assists a dentist in practicing dentistry in any capacity other than as an employee or independent contractor, who directly or indirectly procures a licensed dentist to act as nominal owner, proprietor, or director of a dental office as a guise or subterfuge to enable the assistant, hygienist, dental therapist, or dental technician to engage directly in acts defined by the act as the "practice of dentistry," or who performs dental services within the meaning of Minnesota Statutes, section 150A.11, subdivision 1, for members of the public, other than as an employee or independent contractor for an employing dentist, shall be deemed to be practicing dentistry without a license.

Statutory Authority: *MS s 150A.04; 150A.08; 150A.10; 150A.11*

History: *35 SR 459; 36 SR 738*

Published Electronically: *January 5, 2012*

3100.8400 ASSISTANTS WITHOUT A LICENSE OR PERMIT.

Subpart 1. **Permissible duties.** Assistants under this subpart may:

A. perform all those duties not directly related with performing dental treatment or services on patients;

B. retract a patient's cheek, tongue, or other parts of tissue during a dental operation;

C. assist with the placement or removal of a rubber dam and accessories used for its placement and retention, as directed by an operating dentist during the course of a dental operation;

D. remove debris by the use of vacuum devices, compressed air, mouthwash, and water that is normally created or accumulated during the course of treatment rendered by a licensed dentist;

E. provide any assistance, including the placement of articles and topical medication in a patient's oral cavity, in response to a specific direction by a licensed dentist who is physically engaged in performing a dental operation as defined in the act and who is physically in a position to give personal supervision to the assistant;

F. aid dental hygienists and licensed dental assistants in the performance of their duties as defined in parts 3100.8500 and 3100.8700; and

G. apply fluoride varnish in a community setting under the authorization and direction of a licensed practitioner with prescribing authority such as a dentist or physician, as long as the licensed practitioner authorizing the service or the facility at which the fluoride varnish is administered maintains appropriate patient records of the treatment.

Subp. 1a. **Compliance with minimal requirements.** The dentist is responsible for ensuring that any assistant working under the dentist's supervision as defined in subpart 1 complies with items A and B:

A. completing a CPR certification course and maintaining current CPR certification thereafter; and

B. compliance with the most current infection control recommendations, guidelines, precautions, procedures, practices, strategies, and techniques specified in the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control publications of the Morbidity and Mortality Weekly Report (MMWR).

Subp. 2. [Repealed, 10 SR 1612]

Subp. 3. **Other duties prohibited.** An assistant may not perform any dental treatment or procedure on patients not otherwise authorized by this chapter.

Statutory Authority: *MS s 150A.04; 150A.06; 150A.08; 150A.10; 150A.11; 214.15; 319A.18*

History: *10 SR 1612; 20 SR 2316; 35 SR 459; 37 SR 1849*

Published Electronically: *July 8, 2013*

3100.8500 LICENSED DENTAL ASSISTANTS.

Subpart 1. **Duties under general supervision.** A licensed dental assistant may perform the following procedures without the dentist being present in the dental office or on the premises if the procedures being performed are with prior knowledge and consent of the dentist:

- A. cut arch wires on orthodontic appliances;
- B. remove loose bands on orthodontic appliances;
- C. remove loose brackets on orthodontic appliances;
- D. re-cement intact temporary restorations;
- E. place temporary fillings, not including temporization of inlays, onlays, crowns, and bridges;
- F. take radiographs;
- G. take impressions for casts and appropriate bite registration, not to include impressions and bite registrations for final construction of fixed and removable prostheses;
- H. deliver vacuum-formed orthodontic retainers;
- I. place and remove elastic orthodontic separators;
- J. complete preliminary charting of the oral cavity and surrounding structures with the exception of periodontal probing and assessment of the periodontal structure;
- K. take photographs extraorally or intraorally; and
- L. take vital signs such as pulse rate and blood pressure as directed by a dentist.

Subp. 1a. **Duties under indirect supervision.** A licensed dental assistant, in addition to the services performed by an assistant described in part 3100.8400, subpart 1, may perform the following services if a dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed:

- A. apply topical medications such as, but not limited to, topical fluoride, bleaching agents, and cavity varnishes in appropriate dosages or quantities prescribed by a dentist;
- B. place and remove rubber dam;
- C. remove excess cement from inlays, crowns, bridges, and orthodontic appliances with hand instruments only;
- D. perform mechanical polishing to clinical crowns not including instrumentation. Removal of calculus by instrumentation must be done by a dentist or dental hygienist before mechanical polishing;

- E. preselect orthodontic bands;
 - F. place and remove periodontal dressings;
 - G. remove sutures;
 - H. monitor a patient who has been induced by a dentist into nitrous oxide inhalation analgesia;
 - I. remove and place ligature ties and arch wires on orthodontic appliances. A dentist must select and, if necessary, adjust arch wires prior to placement;
 - J. dry root canals with paper points;
 - K. place cotton pellets and temporary restorative materials into endodontic access openings;
 - L. etch appropriate enamel surfaces, apply and adjust pit and fissure sealants. Before the application of pit and fissure sealants, a licensed dental assistant must have successfully completed a course in pit and fissure sealants at a dental, dental hygiene, or dental assisting school accredited by the Commission on Accreditation;
 - M. restorative procedures as permitted in Minnesota Statutes, section 150A.10, subdivision 4;
 - N. maintain and remove intravenous lines while under indirect supervision of a dentist who holds a valid general anesthesia or moderate sedation certificate. Before managing and removing intravenous lines, a licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training; and
 - O. monitor a patient during preoperative, intraoperative, and postoperative phases of general anesthesia or moderate sedation using noninvasive instrumentation such as pulse oximeters, electrocardiograms, blood pressure monitors, and capnography while under indirect supervision of a dentist who holds a valid general anesthesia or moderate sedation certificate. Before monitoring a sedated patient, a licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training.
- Subp. 1b. **Duties under direct supervision.** A licensed dental assistant may perform the following services if a dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and evaluates the performance of the licensed dental assistant before dismissing the patient:
- A. remove excess bond material from orthodontic appliances;
 - B. remove bond material from teeth with rotary instruments after removal of orthodontic appliances. Before utilizing rotary instruments for the removal of bond

material, a licensed dental assistant must have successfully completed a course in the use of rotary instruments for the express purpose of the removal of bond material from teeth. The course must be one that is presented by a dental, dental hygiene, or dental assisting school accredited by the Commission on Accreditation;

C. etch appropriate enamel surfaces before bonding of orthodontic appliances by a dentist;

D. fabricate, cement, and adjust temporary restorations extraorally or intraorally;

E. remove temporary restorations with hand instruments only;

F. place and remove matrix bands;

G. administer nitrous oxide inhalation analgesia according to part 3100.3600, subparts 4 and 5;

H. attach prefrit and preadjusted orthodontic appliances;

I. remove fixed orthodontic bands and brackets; and

J. initiate and place an intravenous infusion line in preparation for intravenous medications and sedation while under direct supervision of a dentist who holds a valid general anesthesia or moderate sedation certificate. Before initiating and placing an intravenous infusion line, a licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training.

Subp. 1c. **Duties under personal supervision.** A licensed dental assistant may concurrently perform supportive services if the dentist holds a valid general anesthesia or moderate sedation certificate, is personally treating a patient, and authorizes the licensed dental assistant to aid in treatment including the administration of medications into an existing intravenous line, an enteral agent, or emergency medications in an emergent situation. Before administering any medications or agents, a licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of general anesthesia and moderate sedation training.

Subp. 2. **Other duties prohibited.** A licensed dental assistant may not perform any dental treatment or procedure on patients not otherwise authorized by this chapter.

Subp. 3. **Limited-license permit.** A dental assistant, who by virtue of academic achievement which is equal to or greater than that of a licensed dental assistant, and is currently qualified in Minnesota in an allied health profession may take dental radiographs under the general supervision of a dentist if the person complies with the requirements of this subpart. The person shall file with the board a completed application furnished by the board and the fee prescribed in Minnesota Statutes, section 150A.091, subdivision 2. In addition, the person shall submit evidence of the successful completion of a course on

dental radiographs and of passing an examination. The course must be board-approved. The course shall be equivalent to the dental radiograph courses offered by dental assisting courses approved by the board under part 3100.1300, item B. The examination must be the radiograph part of the examination which is required of licensed dental assistant applicants.

Statutory Authority: *MS s 150A.04; 150A.06; 150A.08; 150A.10; 214.06*

History: *10 SR 1612; 16 SR 2314; 18 SR 2042; 20 SR 2474; 27 SR 1836; 31 SR 1238; 35 SR 459; 37 SR 1849*

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DELEGATION OF DUTIES TO HYGIENISTS & ASSISTANTS

revised June 9, 2005

REGULATIONS

The duties that dentists may delegate to hygienists and assistants are regulated by Minnesota Rules 3100.8400 (non-registered assistants), 3100.8500 (registered and limited registration dental assistants), and 3100.8700 (dental hygienists), and Statutes 150A.05, subd 1a and 150A.10. The exact language can be found at the Board of Dentistry web site by clicking on the link "statutes and rules." An easy reference chart of allowable duties and levels of supervision can be accessed by clicking on the link "licensing/registration"; then "delegated procedures."

DELEGATION

When the BOD addresses a complaint or question about hygienist and assistant misuse, considerations such as (but not limited to) these may be used:

- The fundamental intent of the rule is to protect the public by allowing only people with proper and recognized training to treat patients.
- The Board currently utilizes *permissive* rules for delegation of duties to dental auxiliaries/allied dental personnel. This means that *any allowable duty must be stated in rule or statute*, otherwise it is not allowable. Therefore, it is imperative to read and know the rules and statutes. The focus is on legally delegable duties, relying upon qualifications and designated levels of supervision related to regulatory status of the position... *not* on outcomes or personal expertise.

LEVELS OF SUPERVISION

In addition to specific duties, there are 4 levels of supervision that apply to these duties. The dental professional must know the differences between these levels of supervision...

- **PERSONAL SUPERVISION:** the dentist is personally operating on a patient and authorizes the auxiliary to aid in treatment by concurrently performing supportive procedures
- **DIRECT SUPERVISION:** the dentist is in the office, and personally diagnoses the condition to be treated, personally authorizes the procedure, and evaluates the performance before the patient is dismissed
- **INDIRECT SUPERVISION:** the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed
- **GENERAL SUPERVISION:** the dentist has authorized the procedures and they are being carried out in accordance with the dentist's diagnosis and treatment plan

COMMON INFRACTIONS

Examples of common infractions include, among others:

- unregistered dental assistants or front desk staff performing duties of a registered dental assistant or licensed hygienist, even if it was allowed in other states or the military
- certified dental assistants performing duties not allowed [certified dental assistants in MN can *only* function as non-registered dental assistants unless they are also registered]
- auxiliaries performing allowable duties under the *wrong level of supervision*
- registered dental assistants performing *duties not allowed*, such as scaling teeth
- registered dental assistants performing *duties without completing required additional training* (e.g., applying sealants, inducing nitrous oxide analgesia, using handpieces in the patient's mouth, etc.)
- licensed dental hygienists performing *duties without completing required additional training* (e.g., administering local anesthetic, applying sealants, inducing nitrous oxide analgesia, using handpieces in the patient's mouth, etc.)
- licensed dental hygienists performing *duties not allowed or under the wrong level of supervision*
- practicing with a *lapsed license or registration*

DISCLAIMER: Be advised that because this is an educational document of the Minnesota Board of Dentistry, the information contained in this document is not official policy or law and, therefore, is not legally binding for either the Minnesota Board of Dentistry or the licensee/registrant. Each complaint the Board of Dentistry receives is evaluated under the Board's Practice Act and rules, other applicable laws and the record in the proceeding.

3100.6300 ADEQUATE SAFETY AND SANITARY CONDITIONS FOR DENTAL OFFICES.

Subpart 1. **Minimum conditions.** Subparts 2 to 15 are minimum safety and sanitary conditions.

Subp. 2. **Premises.** The premises must be kept neat and clean, and free of rubbish, ponded water, or other conditions of similar nature that would have a tendency to create a public health nuisance.

Subp. 3. **Housekeeping facilities and services.** Housekeeping facilities and services necessary to ensure comfortable and sanitary conditions for patients and employees must be utilized.

Subp. 4. **Control of insects and vermin.** The premises must be kept free of ants, flies, roaches, rodents, and other insects or vermin. Proper methods for their eradication or control shall be utilized.

Subp. 5. **Refuse disposal.** Refuse must be kept in approved containers and emptied at frequent intervals.

Subp. 6. **Heating, lighting, and other service equipment.** The heating of offices must be by heating systems conforming to state and local heating codes and regulations. Individual room heaters must be located to avoid direct contact with any combustible material. Installation and maintenance of electric wiring, motors, and other electrical equipment must be in compliance with applicable state and local electric codes and regulations.

Subp. 7. **Water supply.** An ample supply of water of a safe, sanitary quality, from a source that is approved by the agent of a board of health must be piped under pressure, and in an approved manner, to all equipment and fixtures where the use of water is required.

Subp. 8. **Plumbing.** Plumbing must be in compliance with all applicable plumbing codes. Adequate hand washing facilities, of an approved type, must be provided convenient to the work area. Hand washing facilities must be equipped with soap and towels, and the drain from such facility shall be properly trapped and connected directly to the waste disposal system.

Subp. 9. **Disposal of liquid and human waste.** All liquid and human waste, including floor wash water, must be disposed of through trap drains into a public sanitary sewer system in localities where a system is available. In localities where a public sanitary sewer system is not available, liquid and human waste must be disposed of through trapped drains and in a manner approved by the authorized agent.

Subp. 10. **Clean rooms.** Floors, walls, and ceilings of all rooms, including store rooms, must be clean and free of any rubbish.

Subp. 11. **Infection control.** Dental health care personnel shall comply with the most current infection control recommendations, guidelines, precautions, procedures, practices, strategies, and techniques specified in the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control publications of the Morbidity and Mortality Weekly Report (MMWR). The current infection control techniques in the MMWR dated December 19, 2003, volume 52, number RR-17, are hereby incorporated by reference. The MMWR is available at the Minnesota State Law Library, by interlibrary loan, or by subscription from the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The infection control standards in the MMWR are subject to frequent change.

Subp. 12. **Sharps and infectious waste.** Sharp items and infectious wastes must be disposed of according to Minnesota Statutes, sections 116.76 to 116.83, and any adopted rules and requirements established by local government agencies.

Subp. 13. [Repealed, 35 SR 459]

Subp. 14. **Hazardous waste.** Dentists, dental hygienists, and licensed dental assistants shall comply with the requirements for hazardous waste in chapter 7045.

Subp. 15. **Ionizing radiation.** Dentists, dental hygienists, and licensed dental assistants shall comply with the requirements for ionizing radiation in chapter 4732.

Statutory Authority: *MS s 150A.04; 150A.06; 150A.08; 150A.10; 150A.11; 214.06; 214.15; 319A.18*

History: *L 1987 c 309 s 24; 16 SR 2314; 18 SR 2042; 20 SR 2316; 29 SR 306; 35 SR 459*

Posted: *September 30, 2010*

150A.02 BOARD OF DENTISTRY.

Subdivision 1. **Generally.** There is hereby created a Board of Dentistry whose duty it shall be to carry out the purposes and enforce the provisions of sections 150A.01 to 150A.12. The board shall consist of two public members as defined by section 214.02, five qualified resident dentists, one qualified resident licensed dental assistant, and one qualified resident dental hygienist appointed by the governor. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in sections 214.07 to 214.09. The provision of staff, administrative services and office space; the review and processing of board complaints; the setting of board fees; and other provisions relating to board operations shall be as provided in chapter 214. Each board member who is a dentist, licensed dental assistant, or dental hygienist shall have been lawfully in active practice in this state for five years immediately preceding appointment; and no board member shall be eligible for appointment to more than two consecutive four-year terms, and members serving on the board at the time of the enactment hereof shall be eligible to reappointment provided they shall not have served more than nine consecutive years at the expiration of the term to which they are to be appointed. At least 90 days prior to the expiration of the terms of dentists, licensed dental assistants, or dental hygienists, the Minnesota Dental Association, Minnesota Dental Assistants Association, or the Minnesota State Dental Hygiene Association shall recommend to the governor for each term expiring not less than two dentists, two licensed dental assistants, or two dental hygienists, respectively, who are qualified to serve on the board, and from the list so recommended the governor may appoint members to the board for the term of four years, the appointments to be made within 30 days after the expiration of the terms. Within 60 days after the occurrence of a dentist, licensed dental assistant, or dental hygienist vacancy, prior to the expiration of the term, in the board, the Minnesota Dental Association, the Minnesota Dental Assistants Association, or the Minnesota State Dental Hygiene Association shall recommend to the governor not less than two dentists, two licensed dental assistants, or two dental hygienists, who are qualified to serve on the board and from the list so recommended the governor, within 30 days after receiving such list of dentists, may appoint one member to the board for the unexpired term occasioned by such vacancy. Any appointment to fill a vacancy shall be made within 90 days after the occurrence of such vacancy. The first four-year term of the dental hygienist and of the licensed dental assistant shall commence on the first Monday in January, 1977.

Subd. 2. [Repealed, 1975 c 136 s 77]

History: 1969 c 974 s 2; 1973 c 638 s 25; 1975 c 136 s 25; 1976 c 222 s 73; 1976 c 239 s 57; 1976 c 263 s 2; 1986 c 444; 1991 c 199 art 1 s 44; 2009 c 159 s 41

214.10 COMPLAINT, INVESTIGATION, AND HEARING.

Subdivision 1. Receipt of complaint; notice. The executive director or executive secretary of a board, a board member or any other person who performs services for the board who receives a complaint or other communication, whether oral or written, which complaint or communication alleges or implies a violation of a statute or rule which the board is empowered to enforce, shall promptly forward the substance of the communication on a form prepared by the attorney general to the designee of the attorney general responsible for providing legal services to the board. Before proceeding further with the communication, the designee of the attorney general may require the complaining party to state the complaint in writing on a form prepared by the attorney general. Complaints which relate to matters within the jurisdiction of another governmental agency shall be forwarded to that agency by the executive director or executive secretary. An officer of that agency shall advise the executive director or executive secretary of the disposition of that complaint. A complaint received by another agency which relates to a statute or rule which a licensing board is empowered to enforce shall be forwarded to the executive director or executive secretary of the board to be processed in accordance with this section. No complaint alleging a matter within the jurisdiction of the board shall be dismissed by a board unless at least two board members have reviewed the matter. If a board makes a determination to investigate a complaint, it shall notify a licensee who is the subject of an investigation that an investigation has been initiated at a time when such notice will not compromise the investigation.

Subd. 2. Investigation and hearing. The designee of the attorney general providing legal services to a board shall evaluate the communications forwarded by the board or its members or staff. If the communication alleges a violation of statute or rule which the board is to enforce, the designee is empowered to investigate the facts alleged in the communication. In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director, executive secretary, or, if the board determines, a member of the board who has been appointed by the board to assist the designee. The designee may also consult with or seek the assistance of any other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. The executive director, executive secretary, or the consulted board member may attempt to correct improper activities and redress grievances through education, conference, conciliation and persuasion, and in these attempts may be assisted by the designee of the attorney general. If the attempts at correction or redress do not produce satisfactory results in the opinion of the executive director, executive secretary, or the consulted board member, or if after investigation the designee providing legal services to the board, the executive director, executive secretary, or the consulted board member believes that the communication and the investigation suggest illegal or unauthorized activities warranting board action, the person having the belief shall inform the executive director or executive secretary of the board who shall schedule a disciplinary hearing in accordance with chapter 14. Before directing the holding of a disciplinary hearing, the executive director, executive secretary, or the designee of the attorney general shall have considered the recommendations of the consulted board member. Before scheduling a disciplinary hearing, the executive director or executive secretary must have received a verified written complaint from the complaining party. A board member who was consulted during the course of an investigation may participate at the hearing but may not vote on any matter pertaining to the case. The executive director or executive secretary of the board shall promptly inform the complaining party of the final disposition of the complaint. Nothing in this section shall preclude the board from scheduling, on its own motion, a disciplinary hearing based upon the findings or report of the board's executive director or

executive secretary, a board member or the designee of the attorney general assigned to the board. Nothing in this section shall preclude a member of the board, executive director, or executive secretary from initiating a complaint.

Subd. 2a. **Proceedings.** A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction of violating section 609.224, subdivision 2, paragraph (c), 609.23, 609.231, 609.2325, 609.233, 609.2335, 609.234, 609.465, 609.466, 609.52, or 609.72, subdivision 3.

Subd. 3. **Discovery; subpoenas.** In all matters pending before it relating to its lawful regulation activities, a board may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the board or by a subpoena of the board to do so may, upon application to the district court in any district, be ordered to comply therewith; provided that in matters to which the Peace Officers Standards and Training Board is a party, application shall be made to the district court having jurisdiction where the event giving rise to the matter occurred. The chair of the board acting on behalf of the board may issue subpoenas and any board member may administer oaths to witnesses, or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon any person named therein, anywhere within the state by any officer authorized to serve subpoenas or other process or paper in civil actions, with the same fees and mileage and in the same manner as prescribed by law for service of process issued out of the district court of this state. Fees and mileage and other costs shall be paid as the board directs.

Subd. 4. [Repealed, 1993 c 326 art 7 s 22]

Subd. 5. [Repealed, 1993 c 326 art 7 s 22]

Subd. 6. [Repealed, 1993 c 326 art 7 s 22]

Subd. 7. [Repealed, 1993 c 326 art 7 s 22]

Subd. 8. **Special requirements for health-related licensing boards.** In addition to the provisions of this section that apply to all examining and licensing boards, the requirements in this subdivision apply to all health-related licensing boards, except the Board of Veterinary Medicine.

(a) If the executive director or consulted board member determines that a communication received alleges a violation of statute or rule that involves sexual contact with a patient or client, the communication shall be forwarded to the designee of the attorney general for an investigation of the facts alleged in the communication. If, after an investigation it is the opinion of the executive director or consulted board member that there is sufficient evidence to justify disciplinary action, the board shall conduct a disciplinary conference or hearing. If, after a hearing or disciplinary conference the board determines that misconduct involving sexual contact with a patient or client occurred, the board shall take disciplinary action. Notwithstanding subdivision 2, a board may not attempt to correct improper activities or redress grievances through education, conciliation, and persuasion, unless in the opinion of the executive director or consulted board member there is insufficient evidence to justify disciplinary action. The board may settle a case by stipulation prior to, or during, a hearing if the stipulation provides for disciplinary action.

(b) A board member who has a direct current or former financial connection or professional relationship to a person who is the subject of board disciplinary activities must not participate in board activities relating to that case.

(c) Each health-related licensing board shall establish procedures for exchanging information with other Minnesota state boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for the forwarding to other regulatory bodies of all information and evidence, including the results of investigations, that are relevant to matters within that licensing body's regulatory jurisdiction. Each health-related licensing board shall have access to any data of the Department of Human Services relating to a person subject to the jurisdiction of the licensing board. The data shall have the same classification under chapter 13, the Minnesota Government Data Practices Act, in the hands of the agency receiving the data as it had in the hands of the Department of Human Services.

(d) Each health-related licensing board shall establish procedures for exchanging information with other states regarding disciplinary actions against licensees. The procedures must provide for the collection of information from other states about disciplinary actions taken against persons who are licensed to practice in Minnesota or who have applied to be licensed in this state and the dissemination of information to other states regarding disciplinary actions taken in Minnesota. In addition to any authority in chapter 13 permitting the dissemination of data, the board may, in its discretion, disseminate data to other states regardless of its classification under chapter 13. Before transferring any data that is not public, the board shall obtain reasonable assurances from the receiving state that the data will not be made public.

Subd. 9. Acts against minors. (a) As used in this subdivision, the following terms have the meanings given them.

(1) "Licensed person" means a person who is licensed under this chapter by the Board of Nursing, the Board of Psychology, the Social Work Licensing Board, the Board of Marriage and Family Therapy, the Board of Unlicensed Mental Health Service Providers, the Board of Behavioral Health and Therapy, or the Board of Teaching.

(2) "Crime against a minor" means conduct that constitutes a violation of section 609.185, 609.19, 609.195, 609.20, 609.205, 609.21, 609.215, 609.221, 609.222, 609.223, 609.342, 609.343, 609.345, or a felony violation of section 609.377.

(b) In any license revocation proceeding, there is a rebuttable presumption that a licensed person who is convicted in a court of competent jurisdiction of committing a crime against a minor is unfit to practice the profession or occupation for which that person is licensed.

Subd. 10. Board of Peace Officers Standards and Training; receipt of complaint. Notwithstanding the provisions of subdivision 1 to the contrary, when the executive director or any member of the Board of Peace Officer Standards and Training produces or receives a written statement or complaint that alleges a violation of a statute or rule that the board is empowered to enforce, the executive director shall designate the appropriate law enforcement agency to investigate the complaint and shall order it to conduct an inquiry into the complaint's allegations. The investigating agency must complete the inquiry and submit a written summary of it to the executive director within 30 days of the order for inquiry.

Subd. 11. Board of Peace Officers Standards and Training; reasonable grounds determination. (a) After the investigation is complete, the executive director shall convene

a three-member committee of the board to determine if the complaint constitutes reasonable grounds to believe that a violation within the board's enforcement jurisdiction has occurred. At least two members of the committee must be board members who are peace officers. No later than 30 days before the committee meets, the executive director shall give the licensee who is the subject of the complaint and the complainant written notice of the meeting. The executive director shall also give the licensee a copy of the complaint. Before making its determination, the committee shall give the complaining party and the licensee who is the subject of the complaint a reasonable opportunity to be heard.

(b) The committee shall, by majority vote, after considering the information supplied by the investigating agency and any additional information supplied by the complainant or the licensee who is the subject of the complaint, take one of the following actions:

- (1) find that reasonable grounds exist to believe that a violation within the board's enforcement jurisdiction has occurred and order that an administrative hearing be held;
- (2) decide that no further action is warranted; or
- (3) continue the matter.

The executive director shall promptly give notice of the committee's action to the complainant and the licensee.

(c) If the committee determines that a complaint does not relate to matters within its enforcement jurisdiction but does relate to matters within another state or local agency's enforcement jurisdiction, it shall refer the complaint to the appropriate agency for disposition.

Subd. 12. Board of Peace Officers Standards and Training; administrative hearing; board action. (a) Notwithstanding the provisions of subdivision 2 to the contrary, an administrative hearing shall be held if ordered by the committee under subdivision 11, paragraph (b). After the administrative hearing is held, the administrative law judge shall refer the matter to the full board for final action.

(b) Before the board meets to take action on the matter and the executive director must notify the complainant and the licensee who is the subject of the complaint. After the board meets, the executive director must promptly notify these individuals and the chief law enforcement officer of the agency employing the licensee of the board's disposition.

Subd. 13. Board of Peace Officers Standards and Training; definition. As used in subdivisions 10 to 12, "appropriate law enforcement agency" means the law enforcement agency assigned by the executive director and the chair of the committee of the board convened under subdivision 11.

History: 1976 c 222 s 5; 1977 c 326 s 10; 1979 c 117 s 1-5; 1981 c 310 s 15; 1982 c 424 s 130; 1985 c 247 s 22,23,25; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 557 s 5; 1991 c 265 art 9 s 62; 1993 c 326 art 7 s 4-7; 1995 c 164 s 33; 1995 c 229 art 4 s 10; 1Sp1997 c 3 s 25; 1999 c 227 s 22; 2000 c 284 s 7; 2003 c 118 s 21

214.109 RECORD KEEPING.

(a) A board may take administrative action against a regulated person whose records do not meet the standards of professional practice. Action taken under this paragraph shall not be considered disciplinary action.

(b) Records that are fraudulent or could result in patient harm may be handled through disciplinary or other corrective action.

History: 2012 c 278 art 4 s 4

150A.08 LICENSURE AND REGISTRATION ACTIONS.

Subdivision 1. **Grounds.** The board may refuse or by order suspend or revoke, limit or modify by imposing conditions it deems necessary, the license of a dentist, dental therapist, dental hygienist, or dental assisting upon any of the following grounds:

(1) fraud or deception in connection with the practice of dentistry or the securing of a license certificate;

(2) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of a felony or gross misdemeanor reasonably related to the practice of dentistry as evidenced by a certified copy of the conviction;

(3) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of an offense involving moral turpitude as evidenced by a certified copy of the conviction;

(4) habitual overindulgence in the use of intoxicating liquors;

(5) improper or unauthorized prescription, dispensing, administering, or personal or other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter 151, or of any controlled substance as defined in chapter 152;

(6) conduct unbecoming a person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting, or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;

(7) gross immorality;

(8) any physical, mental, emotional, or other disability which adversely affects a dentist's, dental therapist's, dental hygienist's, or dental assistant's ability to perform the service for which the person is licensed;

(9) revocation or suspension of a license or equivalent authority to practice, or other disciplinary action or denial of a license application taken by a licensing or credentialing authority of another state, territory, or country as evidenced by a certified copy of the licensing authority's order, if the disciplinary action or application denial was based on facts that would provide a basis for disciplinary action under this chapter and if the action was taken only after affording the credentialed person or applicant notice and opportunity to refute the allegations or pursuant to stipulation or other agreement;

(10) failure to maintain adequate safety and sanitary conditions for a dental office in accordance with the standards established by the rules of the board;

(11) employing, assisting, or enabling in any manner an unlicensed person to practice dentistry;

(12) failure or refusal to attend, testify, and produce records as directed by the board under subdivision 7;

(13) violation of, or failure to comply with, any other provisions of sections 150A.01 to 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board, sections 144.291 to 144.298 or 595.02, subdivision 1, paragraph (d), or for any other just cause related to the practice of dentistry. Suspension, revocation, modification or limitation of any

license shall not be based upon any judgment as to therapeutic or monetary value of any individual drug prescribed or any individual treatment rendered, but only upon a repeated pattern of conduct;

(14) knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo; or

(15) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

Subd. 2. [Repealed, 1976 c 222 s 209]

Subd. 3. **Reinstatement.** Any licensee whose license has been suspended or revoked may have the license reinstated or a new license issued, as the case may be, when the board deems the action is warranted.

Subd. 3a. **Costs; additional penalties.** (a) The board may impose a civil penalty not exceeding \$10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive a licensee of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or any other licensee, or to reimburse the board for the cost of the investigation and proceeding, including, but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(b) In addition to costs and penalties imposed under paragraph (a), the board may also:

(1) order the dentist, dental therapist, dental hygienist, or dental assistant to provide unremunerated service;

(2) censure or reprimand the dentist, dental therapist, dental hygienist, or dental assistant; or

(3) any other action as allowed by law and justified by the facts of the case.

Subd. 4. **Records.** The executive secretary of the board shall keep a record of all licenses and registration certificates issued, suspended, or revoked.

Subd. 5. **Medical examinations.** If the board has probable cause to believe that a dentist, dental therapist, dental hygienist, dental assistant, or applicant engages in acts described in subdivision 1, clause (4) or (5), or has a condition described in subdivision 1, clause (8), it shall direct the dentist, dental therapist, dental hygienist, assistant, or applicant to submit to a mental or physical examination or a chemical dependency assessment. For the purpose of this subdivision, every dentist, dental therapist, dental hygienist, or dental assistant licensed under this chapter

or person submitting an application for a license is deemed to have given consent to submit to a mental or physical examination when directed in writing by the board and to have waived all objections in any proceeding under this section to the admissibility of the examining physician's testimony or examination reports on the ground that they constitute a privileged communication. Failure to submit to an examination without just cause may result in an application being denied or a default and final order being entered without the taking of testimony or presentation of evidence, other than evidence which may be submitted by affidavit, that the licensee or applicant did not submit to the examination. A dentist, dental therapist, dental hygienist, dental assistant, or applicant affected under this section shall at reasonable intervals be afforded an opportunity to demonstrate ability to start or resume the competent practice of dentistry or perform the duties of a dental therapist, dental hygienist, or dental assistant with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor the orders entered by the board is admissible, is subject to subpoena, or may be used against the dentist, dental therapist, dental hygienist, dental assistant, or applicant in any proceeding not commenced by the board. Information obtained under this subdivision shall be classified as private pursuant to the Minnesota Government Data Practices Act.

Subd. 6. **Medical records.** Notwithstanding contrary provisions of sections 13.384 and 144.651 or any other statute limiting access to medical or other health data, the board may obtain medical data and health records of a licensee or applicant without the licensee's or applicant's consent if the information is requested by the board as part of the process specified in subdivision 5. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and shall not be liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision shall be classified as private under the Minnesota Government Data Practices Act.

Subd. 7. **Self-incrimination.** No person is excused from attending and testifying at any proceeding initiated by the board or from producing any document before the board on the ground that the testimony or evidence required may tend to incriminate the person; but no person may be prosecuted for any crime related to the matter about which the person testifies or produces evidence required or requested by the board if the person first claims a privilege against self-incrimination. This immunity from criminal prosecution does not apply to prosecution for perjury or contempt committed in testifying or producing the evidence.

Subd. 8. **Suspension of license.** In addition to any other remedy provided by law, the board may, through its designated board members pursuant to section 214.10, subdivision 2, temporarily suspend a license without a hearing if the board finds that the licensee has violated a statute or rule which the board is empowered to enforce and continued practice by the licensee would create an imminent risk of harm to others. The suspension shall take effect upon written notice to the licensee served by first class mail specifying the statute or rule violated, and the time, date, and place of the hearing before the board. If the notice is returned by the post office, the notice shall be effective upon reasonable attempts to locate and serve the licensee. Within ten days of service of the notice, the board shall hold a hearing before its own members on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the board or licensee shall be in affidavit form only. The licensee or counsel of the licensee

may appear for oral argument. Within five working days after the hearing, the board shall issue its order and, if the suspension is continued, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act within 45 days of issuance of the order. The administrative law judge shall issue a report within 30 days of the closing of the contested case hearing record. The board shall issue a final order within 30 days of receiving that report. The board may allow a person who was licensed by any state to practice dentistry and whose license has been suspended to practice dentistry under the supervision of a licensed dentist for the purpose of demonstrating competence and eligibility for reinstatement.

Subd. 9. Tax clearance certificate. (a) In addition to the grounds provided in subdivision 1 and notwithstanding subdivision 3, the board may not issue or renew a license to practice dentistry if the commissioner of revenue notifies the board and the licensee or applicant for a license that the licensee or applicant owes the state delinquent taxes in the amount of \$500 or more. The board may issue or renew the license only if (1) the commissioner of revenue issues a tax clearance certificate and (2) the commissioner of revenue or the licensee or applicant forwards a copy of the clearance to the board. The commissioner of revenue may issue a clearance certificate only if the licensee or applicant does not owe the state any uncontested delinquent taxes.

(b) For purposes of this subdivision, the following terms have the meanings given.

(1) "Taxes" are all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes.

(2) "Delinquent taxes" do not include a tax liability if (i) an administrative or court action that contests the amount or validity of the liability has been filed or served, (ii) the appeal period to contest the tax liability has not expired, or (iii) the licensee or applicant has entered into a payment agreement to pay the liability and is current with the payments.

(c) In lieu of the notice and hearing requirements of subdivision 8, when a licensee or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the licensee or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice provided in paragraph (a). The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the Office of Administrative Hearings. Notwithstanding any law to the contrary, the licensee or applicant must be served with 20 days' notice in writing specifying the time and place of the hearing and the allegations against the licensee or applicant. The notice may be served personally or by mail.

(d) The board shall require all licensees or applicants for a license to practice dentistry to provide their Social Security number and Minnesota business identification number on all license applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all licensees and applicants for a license to practice dentistry including the name and address, Social Security number, and business identification number. The commissioner of revenue may request a list of the licensees and applicants no more than once each calendar year.

History: 1969 c 974 s 8; 1976 c 222 s 77; 1976 c 263 s 6; 1978 c 770 s 6; 1983 c 70 s 5-10; 1984 c 608 s 1; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1986 c 444; 1Sp1986 c 1 art 7 s 9; 1989 c 184 art 2 s 6; 1992 c 559 art 1 s 5; 1992 c 577 s 4; 1993 c 84 s 8; 1999 c 227 s 22; 2003 c 66 s 6,7; 2004 c 279 art 7 s 2; 2007 c 147 art 10 s 15; 2009 c 95 art 3 s 10-12; 2009 c 159 s 51-56

3100.6200 CONDUCT UNBECOMING A LICENSEE.

"Conduct unbecoming a person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting, or conduct contrary to the best interests of the public," as used in Minnesota Statutes, section 150A.08, subdivision 1, clause (6), shall include the act of a dentist, dental hygienist, licensed dental assistant, or applicant in:

- A. engaging in personal conduct that brings discredit to the profession of dentistry;
- B. gross ignorance or incompetence in the practice of dentistry or repeated performance of dental treatment that falls below accepted standards;
- C. making suggestive, lewd, lascivious, or improper advances to a patient;
- D. dentists charging a patient an unconscionable fee or charging for services not rendered;
- E. performing unnecessary services;
- F. dental therapists, hygienists, or licensed dental assistants performing services not authorized by the dentist under this chapter or Minnesota Statutes, chapter 150A;
- G. accepting rebates, split fees, or, applicable to dentists only, commissions from any source associated with the service rendered to a patient; provided, however, that the sharing of profits in a dental partnership or association, or dental professional firm approved by and registered with the board, shall not be construed as splitting fees nor shall compensating allied dental personnel on the basis of a percentage of the fee received for the overall service be deemed accepting a commission;
- H. falsifying records relating to payment for services rendered, participation in a CDE course; or other records with respect to licensure, CDE, and the practice of dentistry;
- I. perpetrating fraud upon patients, third-party payers, or others relating to the practice of dentistry;
- J. failing to cooperate with the board, its agents, or those working on behalf of the board required by part 3100.6350;
- K. failing to maintain adequate safety and sanitary conditions for a dental office specified in part 3100.6300; and
- L. failing to provide access to and transfer of medical and dental records prescribed by Minnesota Statutes, sections 144.291 to 144.298.

Statutory Authority: *MS s 150A.04; 150A.06; 150A.08; 150A.10; 150A.11; 214.06; 319A.18*

History: *10 SR 1613; 14 SR 1214; 16 SR 2314; L 2007 c 147 art 10 s 15; 35 SR 459; 36 SR 738*

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150A.11 UNLAWFUL ACTS.

Subdivision 1. Unlawful practice. It is unlawful for any person to: enable an unlicensed person to practice dentistry; to practice or attempt to practice dentistry without a license; to practice dentistry under the name of a corporation or company; or to practice under any name that may tend to deceive the public or imply professional superiority to or greater skill than that possessed by another dentist. If a dentist practices under the dentist's own name, any public display or cards shall include the initials of the dentist's dental degree, such as D.D.S. or D.M.D., following the name. If a dentist practices under another name, the name shall include some designation which makes clear that the person is practicing dentistry or a specialty of dentistry; and that the names of all of the participating dentists practicing under the name be clearly identified on letterheads and building or office signs that display a name other than the dentist's own name. Any communication between dentist and patient shall clearly indicate the name of the dentist treating the patient. The board may promulgate rules regarding the name under which a dentist may practice. No corporation shall practice dentistry or engage in it, or hold itself out as being entitled to practice dentistry, or furnish dental services or dentists, or advertise under or assume the title of dentists or dental surgeons or equivalent title. No corporation shall furnish dental advice, or advertise or hold itself out with any other person or alone, that it has or owns a dental office or can furnish dental service, dentists, or dental surgeons, or solicit, through itself, or its agents, officers, employees, directors or trustees, dental patronage for any dentist or dental surgeon. This section:

(1) Does not apply to any licensee while acting as an instructor in or under the University of Minnesota, the Mayo Foundation, or any other school in the state recognized by the state Board of Dentistry;

(2) Does not prohibit dentists from incorporating their practice of dentistry for business purposes under the special provisions of a corporate practice act for dentistry;

(3) Shall not be construed to change or amend the right of licensed dentists to provide dental care under any form of organization that is lawful under the laws of this state, or to contract to sell their services in any manner that is lawful under the laws of this state.

Subd. 2. Professional advertising. Public advertising by dentists may be controlled by reasonable rules of the board. Such rules shall include permission for such things as publication of a professional card, reasonable signs on or about the place of business, announcements of changes or opening of offices and telephone listings.

Subd. 3. Advertising or use of dental services and appliances. No person shall advertise in any manner the sale, supply, furnishing, construction, reproduction, relining, or repair without a written work order by a licensed dentist of prosthetic dentures, bridges, plates or other appliances to be used or worn as substitutes for natural teeth, or for the regulation thereof. All such advertisements shall contain the words "A written work order from a licensed dentist is required" in at least 10-point type size. Except for advertising permitted under this subdivision, a person not licensed to practice dentistry in this state shall not sell or offer any such service or products to other than the dental profession or its ancillary trades, provided, however that the mere delivery of such products to an ultimate consumer or person acting in the consumer's behalf for the purpose of transporting such products to the licensed dentist who provided the work order shall not violate this subdivision. This subdivision shall not apply to mailings, displays, and advertisements the primary distribution of which is to the dental profession or its ancillary trades.

Subd. 4. **Dividing fees.** It shall be unlawful for any dentist to divide fees with or promise to pay a part of the dentist's fee to, or to pay a commission to, any dentist or other person who calls the dentist in consultation or who sends patients to the dentist for treatment, or operation, but nothing herein shall prevent licensed dentists from forming a bona fide partnership for the practice of dentistry, nor to the actual employment by a licensed dentist of, a licensed dental therapist, a licensed dental hygienist, or another licensed dentist.

History: 1969 c 974 s 11; 1980 c 596 s 5; 1983 c 29 s 2; 1985 c 248 s 70; 1986 c 444; 2009 c 95 art 3 s 26

150A.13 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person who has knowledge of a licensee unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition may report the licensee to the board.

Subd. 2. **Institutions.** A hospital, clinic, or other health care institution or organization located in this state shall report to the board any action taken by the agency, institution, or organization or any of its administrators or dental or other committees to revoke, suspend, restrict, or condition a licensee's privilege to practice or treat patients or clients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action against a licensee described under subdivision 1. The institution or organization shall also report the resignation of any licensees prior to the conclusion of any disciplinary action proceeding against a licensee described under subdivision 1.

Subd. 3. **Dental societies.** A state or local dental society or professional dental association shall report to the board any termination, revocation, or suspension of membership or any other disciplinary action taken against a licensee. If the society or association has received a complaint against a licensee described under subdivision 1, on which it has not taken any disciplinary action, the society or association shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the board. This subdivision does not apply to a society or association when it performs peer review functions as an agent of an outside entity, organization, or system.

Subd. 4. **Licensed professionals.** (a) A licensed health professional shall report to the board personal knowledge of any conduct by any person who the licensed health professional reasonably believes is a licensee described under subdivision 1.

(b) Notwithstanding paragraph (a), a licensed health professional shall report to the board knowledge of any actions which institutions must report under subdivision 2.

Subd. 5. **Insurers and other entities making liability payments.** (a) Four times each year as prescribed by the board, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to licensees, shall submit to the board a report concerning the licensees against whom malpractice settlements or awards have been made to the plaintiff. The report must contain at least the following information:

- (1) the total number of malpractice settlements or awards made;
- (2) the date the malpractice settlements or awards were made;
- (3) the allegations contained in the claim or complaint leading to the settlements or awards made;
- (4) the dollar amount of each malpractice settlement or award;
- (5) the regular address of the practice of the licensee against whom an award was made or with whom a settlement was made; and
- (6) the name of the licensee against whom an award was made or with whom a settlement was made.

(b) A dental clinic, hospital, political subdivision, or other entity which makes professional liability insurance payments on behalf of licensees shall submit to the board a report concerning

malpractice settlements or awards paid on behalf of licensees, and any settlements or awards paid by a clinic, hospital, political subdivision, or other entity on its own behalf because of care rendered by licensees. This requirement excludes forgiveness of bills. The report shall be made to the board within 30 days of payment of all or part of any settlement or award.

Subd. 6. **Courts.** The court administrator of district court or any other court of competent jurisdiction shall report to the board any judgment or other determination of the court that adjudges or includes a finding that a licensee has a mental illness, is unable to practice with reasonable skill and safety due to a mental condition, is guilty of a felony, is guilty of a violation of federal or state narcotics laws or controlled substances act, or is guilty of an abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the licensee pursuant to sections 524.5-101 to 524.5-502, or commits a licensee pursuant to chapter 253B.

Subd. 7. **Self-reporting.** A licensee shall report to the board any personal action that would require that a report be filed by any person, health care facility, business, or organization pursuant to subdivisions 2 to 6.

Subd. 8. **Deadlines; forms.** Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Subd. 9. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 7 or any related documents.

Subd. 10. **Failure to report.** On or after August 1, 2012, any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

History: 2002 c 341 s 2; 2004 c 146 art 3 s 47; 2009 c 159 s 79; 2012 c 278 art 2 s 18; 2013 c 62 s 9

3100.8300 RESPONSIBILITIES OF LICENSED DENTIST.

Nothing in this chapter relating to the scope of services rendered by assistants, technicians, hygienists, or dental therapists shall diminish or abrogate the professional and legal responsibilities of employing dentists to their patients, to their profession, and to the state of Minnesota. Dentists employing assistants, technicians, hygienists, or dental therapists shall be fully responsible for all acts or omissions of these personnel performed or omitted if the acts or omissions are within the normal scope of their employment. Acts or omissions of personnel means whether or not omitted or committed by personnel at the instance and request of the employing dentist if the omission or commission is within the normal scope of their employment.

Statutory Authority: *MS s 150A.04*

History: *35 SR 459; 36 SR 738*

Published Electronically: *January 5, 2012*

3100.6350 REQUIRED COOPERATION.

A licensee or applicant who is the subject of an investigation or proceeding under this chapter or Minnesota Statutes, sections 150A.08 and 214.10, shall cooperate with the board, its agents, or those working on behalf of the board by complying with any reasonable request including requests to:

- A. furnish designated papers, documents, or tangible objects;
- B. furnish in writing a full and complete explanation covering the matter under consideration;
- C. appear for conferences and hearings at the time and places designated.

Violation of this part is conduct unbecoming a licensee or conduct contrary to the best interests of the public. Good faith challenges to requests of the board will not be deemed a failure to cooperate. These challenges shall be brought before the appropriate agency or court.

Statutory Authority: *MS s 150A.04; 150A.08; 319A.18*

History: *10 SR 1613; 35 SR 459*

Published Electronically: *September 30, 2010*

CORRECTIVE ACTIONS

08/31/07 - 11/30/2008

The Minnesota Board of Dentistry has determined that there may be an educational benefit to publishing summaries of allegations that have led to an Agreement for Corrective Action (ACA). ACAs are classified as public documents, but are not disciplinary, and are not reported to the National Practitioner Data Bank. The following summaries include the allegations and the resolution of the complaints, but do not identify the licensee/registrant. The profession and effective date of the Agreement are included for reference.

Profession	Violation(s)	Remedies
Dentist 8/31/07	Licensure *Practice Without Current License	Written Report: Submit protocol for monitoring and maintaining current licensure and current address. Community Service: Complete 20 hours of community service at a voluntary dental access clinic. Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater.
Dentist 9/10/2007	Substandard Care *Diagnostic *Recordkeeping	Course Work: Diagnosis/Treatment Planning/Recordkeeping Courses Written Report: Submit a report within 30 days of completion of course work regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.
Dentist 9/19/2007	Substandard Care *Diagnostic *Periodontal *Recordkeeping Inadequate Safety/Sanitary Conditions *Infection control	Course Work: Periodontics, Infection Control, Treatment Planning/Recordkeeping Written Reports: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Office Inspections: Infection Control, Recordkeeping
Dentist 10/11/2007	Licensure *Practice Beyond Scope	Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater. Prohibited Procedures: Prohibited from administering and monitoring nitrous oxide inhalation analgesia to patients. Course Work: Nitrous Oxide Inhalation Analgesia Written Reports: Submit appropriate forms showing successfully completed educational course.
Dentist 10/15/2007	Licensure *Practice Beyond Scope Auxiliary Misuse	Course Work: Nitrous Oxide Inhalation Analgesia. Direct certain staff members to successfully complete require education. Written Report: Provide proof of each individual's completed course work.
Dentist 10/17/2007	Substandard Care *Diagnostic *Endodontic *Recordkeeping	Course Work: Recordkeeping (10/07) Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater. Course Work: Treatment Planning/Recordkeeping, Endodontics Written Reports: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will Incorporate new knowledge into their practice. Office Inspections: Patient Records Review – Treatment and Recordkeeping
Dentist 10/18/2007	Substandard Care *Diagnostic/Dental Care/Recordkeeping *Periodontal Care/Recordkeeping *Radiographic Diagnosis/Recordkeeping *Recordkeeping	Course Work: Periodontics, Treatment Planning/Recordkeeping Written Reports: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Office Inspections: Recordkeeping inspection

Profession	Violation(s)	Remedies
Registered Dental Assistant 10/26/2007	Licensure *Practice Without Current License	Written Report: Submit protocol for monitoring and maintaining current licensure and current address. Community Service: Complete 15 hours of community service at a voluntary dental access clinic. Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater.
Dentist 11/15/2007	Drugs *Improper prescribing/dispensing/storage *Inadequate Safety/Sanitary Conditions Advertising *Misleading statements Unprofessional conduct	Advertisements: Make necessary corrections to current advertisements Anxiolysis: Prohibition: Prohibited from using his current protocol of administering multiple dosages and/or multiple medications to patients for anxiolysis. Written Report: Anxiolysis protocol, medication regimen the continuum of administering certain dosages of medications. Course Work: Medical Emergencies, Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. - Medical Emergency Kit and protocol for handling emergencies - Sample of recordkeeping forms
Dental Hygienist 12/3/2007	Licensure *Practice Without License	Written Report: Submit protocol for monitoring and maintaining current licensure and current address. Community Service: Complete 20 hours of community service at a voluntary dental access clinic.
Registered Dental Assistant 12/6/2007	Licensure *Failed audit of Professional Development Portfolio	Professional Development: Submit acceptable documentation as proof of completed 25 required hrs of fundamental/elective professional activities, CPR, at least two core subjects, and self-assessment. Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater.
Dentist 12/14/2007	Substandard Care *Diagnostic *Periodontal *Recordkeeping	Dental Radiolucency Report: Submit written report regarding the differential diagnosis and appropriate treatment of a radiolucency in the maxillary anterior region Course Work: Treatment Planning/Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.
Dentist 1/17/2008	Drugs *Improper prescribing/dispensing/storage	Course Work: Professional Boundaries, Pharmacology Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.
Dentist 2/19/2008	Unprofessional Conduct *Physical abuse *Informed consent of Patient (Minor)	Course Work: Pediatric Behavior Management Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.
Dentist 4/2/2008	Substandard Care *Orthodontic *Recordkeeping	Course Work: Risk Management, Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.
Dentist 4/2/2008	Auxiliary Misuse	Photograph: Photograph of current certificates of licensure and/or registration of all staff. Community Service: Complete 10 hours of community service at a voluntary dental access clinic.
Registered Dental Assistant	Licensure *Practice Beyond Scope *Practice Without License	Written Report: Submit written report which discusses the meaning and implications of 3100.8400, which lists procedures an assistant is authorized to perform.

Profession	Violation(s)	Remedies
6/16/2008		Community Service: Complete 20 hours of community service at a voluntary dental access clinic. Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater.
Dentist 6/26/2008	Substandard Care *Diagnostic *Recordkeeping Drugs *Improper prescribing/dispensing/storage	Written Report – Sedation: Submit written report regarding maximum cumulative dosing, titration protocols, intervals between doses, and choices of sedation agents. Course Work: Treatment Planning/Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Patient Records Review – Conscious (Moderate) Sedation: Submit to the Board requested original records of randomly selected patient's records, including radiographs, where Licensee administered either oral or intravenous conscious (moderate) sedation.
Dentist 7/14/2008	Substandard Care *Recordkeeping Inadequate Safety/Sanitary Conditions *Inadequate infection control Unprofessional conduct *Lack of informed consent	Course Work: Infection Control, Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Infection Control Inspection Recordkeeping Inspection
Dentist 7/14/2008	Drugs *Improper prescribing/dispensing/storage Licensure *Practice Beyond Scope Substandard Care *Recordkeeping Unprofessional conduct *Inappropriate communications Fraud *Altered records	Course Work: Pharmacology/Prescribing, Temporomandibular Disorder, Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Recordkeeping Inspection
Dentist 8/6/2008	Inadequate Safety/Sanitary Conditions *Inadequate infection control Substandard Care *Recordkeeping	Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater. Infection Control Consultant: Hire Board-approved infection control consultant for an evaluation and inspection services. Must comply with consultant's recommendation and submit written report indicating changes, copy of entire infection control manual for review and verification that all staff has fully read and reviewed and received training. Course Work: Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice. Infection Control Inspection Recordkeeping Inspection
Dentist 9/8/2008	Substandard Care *Recordkeeping Inadequate Safety/Sanitary Conditions *Inadequate infection control Auxiliary Misuse	Jurisprudence Exam: Take the Jurisprudence Exam and achieve a score of 75% or greater. Infection Control Consultant: Hire Board-approved infection control consultant for an evaluation and inspection services. Must comply with consultant's recommendation and submit written report indicating changes, copy of entire infection control manual for review. Course Work: Recordkeeping Written Report: Submit reports within 30 days of completion of the above listed courses regarding the following: - Report of how Licensee will incorporate new knowledge into their practice.

CORRECTIVE ACTIONS

12/1/2008 - 6/30/2009

Complaint matters are reviewed on a case-by-case basis. The Board is not always able to prove each allegation from complaints received. Agreements for Corrective Action (ACAs) are sometimes used to resolve complaints which allege violation(s) of the Dental Practice Act when the specific, individual circumstances of the case are determined not to warrant disciplinary action.

The Agreement for Corrective Action is:

- expected to lead to closure within a reasonable period of time.
- not intended for long-term monitoring or conditions;
- a public agreement, but it is not considered disciplinary action, and therefore, is not reported to the National Practitioner Data Bank.

Profession	Violation(s)	Remedies
Dentist 12/18/2008	<u>Substandard Diagnostic/Restorative/Oral Surgery/Radiographic Diagnosis/Recordkeeping</u> Failure to: - document, diagnose, or provide timely and appropriate dental treatment concerning perio, apical abscess and decay - assess and document periodontal conditions - take a sufficient number of radiographs and/or take radiographs of diagnostic quality <u>Infection Control & Safety/Sanitary Condition</u> - Failed to comply with the most current infection control recommendations and guidelines of CDC, (gloves, eyewear, laundering guidelines, bag and sterilize dental instruments, properly perform weekly spore testing)	<u>Consultative Monitoring Service</u> - Licensee must contract with a one on one consultative and monitoring service for an accumulated period of one year in which every 90 days licensee must present at least ten different active pt records including radiographs to the evaluator for review and evaluation <u>Coursework</u> - Infection Control - Treatment Planning/Recordkeeping - Submit written reports for coursework and report on Professional Boundaries & Dental Treatment Planning <u>Infection Control Consultant</u> - Licensee shall hire an infection control consultant for an evaluation involving consultative and inspection services. Licensee shall comply with consultant's recommendations and submit a written report that indicates the changes relative to infection control made in the dental office - Subsequent evaluation with infection control consultant one year after initial evaluation
Dentist 2/2/2009	<u>Practice Without Certification</u> Failed to obtain proper certification from the Board to administer conscious sedation to patients	<u>Conscious Sedation Certificate Terminated</u> - Effective immediately prohibited from administering conscious sedation to patients - Licensee must successfully complete all applicable requirements for conscious sedation <u>Coursework</u> - Jurisprudence Examination

Profession	Violation(s)	Remedies
Registered Dental Assistant 2/9/2009	<u>Failure of Professional Development Audit</u> - Failure to demonstrate current Healthcare Provider CPR certification - Failure to renew registration	<u>Corrective Action</u> - Registration Renewal Application - Renewal fee and late fee - Proof of completion of an appropriate CPR course - Jurisprudence Examination
Dentist 3/26/2009	<u>Medications</u> - Improper prescribing of narcotics <u>Substandard Care</u> - Failed to adequately document pertinent information and/or provide appropriate endodontic treatment (lack of rubber dam use, inadequate file instrumentation of root canals, and lack of referral to endodontist)	<u>Coursework</u> - Professional Boundaries - Endodontics <u>Written Reports for Coursework to the Board</u> - Proof of attendance - Copies of all materials used and/or distributed in the course - Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice
Dentist X 3 4/8/2009 4/8/2009 4/13/2009	<u>Auxiliary Misuse</u> Permitted Allied Personnel to administer IV medications	<u>Prohibited Procedures – Allied Personnel</u> - Licensee will immediately stop allowing Allied Personnel to perform the procedure of augmenting/administering IV medications to patients <u>Coursework</u> - Jurisprudence Examination <u>Community Service</u> - Complete 20 hours each of unpaid community service within six months
Dentist 6/9/2009	<u>Unprofessional Conduct</u> - Charges of discrimination related to gender/sex and sexual harassment - Convicted of federal charge of making material false statements <u>Substandard Recordkeeping</u> Failure to: - make or maintain an adequate patient record for the patient in regard to medical history - oral health - dental caries - periodontal conditions - diagnoses for all dental treatment - informed consent - medications used	<u>Corrective Action</u> - Jurisprudence Examination <u>Coursework</u> - Treatment Planning / Recordkeeping - Ethics <u>Written Reports for Coursework to the Board</u> - Proof of attendance at courses - Copies of all material used and/or distributed in the courses - Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice
Dentist 6/16/2009	<u>Substandard Recordkeeping:</u> Failed to: - make and/or maintain adequate dental records for a patient regarding patient's oral examination. Not documented: - written treatment plan - medical history, and - periodontal conditions including a tissue assessment	<u>Corrective Action</u> - Jurisprudence Examination <u>Coursework</u> - Treatment Planning / Recordkeeping <u>Written Reports for Coursework to the Board</u> - Recordkeeping sample, submit all information regarding coursework

CORRECTIVE ACTIONS

7/1/2009 — 6/30/2010

Complaint matters are reviewed on a case-by-case basis. The Board is not always able to prove each allegation from complaints received. Agreements for Corrective Action (ACAs) are sometimes used to resolve complaints which allege violation(s) of the Dental Practice Act when the specific, individual circumstances of the case are determined not to warrant disciplinary action.

The Agreement for Corrective Action is:

- expected to lead to closure within a reasonable period of time.
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- a public agreement, but it is not considered disciplinary action, and therefore, is not reported to the National Practitioner Data Bank.

<u>Profession</u>	<u>Violation(s)</u>	<u>Remedies</u>
Dentist 07/06/2009	<u>Substandard Recordkeeping</u> Failure to complete or document: - Name/telephone number of emergency contact - Initial and update dental and medical history - Existing oral health status - Diagnoses for dental treatment / treatment planning - Informed consent - All medications and material used during treatment procedures	<u>Corrective Action</u> - Jurisprudence Examination <u>Coursework</u> - Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Dentist 08/28/2009	<u>Substandard Orthodontic & Endodontic Care / Recordkeeping</u> Failure to: - Adequately perform and document comprehensive assessment and diagnosis - Provide and document adequate treatment plan - Obtain and document informed consent - Provide appropriate treatment - Indicate rationale for ordering CT scan - Document chronology of dental treatment provided and rationale for certain treatment <u>Failure of Professional Development Audit</u> - Did not provide documentation and/or complete a second core subject category	<u>Coursework</u> - Decision-making / Ethics - TMD and Orofacial Pain - Endodontics - Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Dentist 08/31/2009	<u>Improper Prescribing</u> - Improperly, or in an unauthorized manner, prescribed, dispensed or administered a legend drug, other chemical, or controlled substance, including personal use of medications to treat a medical condition. Licensee admitted that they had not keep on file at each office location from which dispensing is taking place a record of drugs received, administered, dispensed, sold, or distributed. <u>Substandard Infection Control</u> - Failed to comply with the most current infection control recommendations and guidelines of the CDC. <u>Substandard Diagnosis / Periodontal / Prosthodontic Care / Recordkeeping</u> - Failure to document pertinent information and/or provide an appropriate diagnosis, periodontal,	<u>Corrective Actions</u> - Only prescribe, administer, or dispense legend drugs or nitrous oxide inhalation analgesia for dental purposes - Maintain a record of drugs received, administered, dispensed, sold, or distributed at dental office - Submit written verification of review of duties with each staff member employed by licensee - Evaluation by a multifaceted assessment program, and provide a written report of the evaluation and treatment recommendations - Jurisprudence Examination <u>Coursework</u> - Professional Boundaries - Treatment Planning / Recordkeeping - Prosthodontics - Prescribing Course <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Office Inspections</u>

<i>Profession</i>	<i>Violation(s)</i>	<i>Remedies</i>
	and/or prosthodontic treatment. Placement of permanent crowns revealed open margins. Failure to perform a comprehensive periodontal diagnosis or treatment prior to placement of crowns which were extracted at a later date due to advanced periodontal disease. • Failure to make or maintain adequate patient records	• Infection Control Inspection • Recordkeeping Inspection
Dentist 09/04/2009	<u>Substandard Diagnostic / Periodontal / Recordkeeping</u> • Failed to thoroughly assess and document status of periodontal conditions • Failed to make and maintain adequate dental records	<u>Corrective Action</u> • Jurisprudence Examination <u>Coursework</u> • Periodontics Course • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Recordkeeping – Patient Record</u> • Submit patient records for treatment planning and recordkeeping for review
Dentist 10/26/2009	<u>Improper Prescribing</u> • Improperly prescribed a drug to patient (beyond the scope of practicing dentistry), and failed to document prescriptions. <u>Substandard Periodontal / Diagnostic / Restorative Care / Recordkeeping</u> Failed to: • Thoroughly assess and document status of periodontal conditions • Adequately document pertinent information and appropriate diagnostic and restorative care • Make and maintain adequate dental records	<u>Corrective Action</u> • Jurisprudence Examination <u>Coursework</u> • Periodontics Course • Professional Boundaries • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Recordkeeping Inspection</u> • Unannounced office visit and review of patient records for treatment planning/recordkeeping compliance
Dental Hygienist 10/26/2009	<u>Substandard Periodontal / Diagnostic / Recordkeeping</u> • Failed to thoroughly assess and document status of periodontal conditions • Failed to adequately document pertinent information and appropriate diagnostic and treatment planning	<u>Corrective Action</u> • Jurisprudence Examination <u>Coursework</u> • Periodontics Course <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Recordkeeping Inspection</u> • Unannounced office visit and review of patient records for treatment planning/recordkeeping
Dentist 10/29/2009	<u>Improper Prescribing</u> • Improperly prescribed and failure to document prescribing large amounts of controlled substances and not properly document prescription • Improperly prescribed a drug to patients beyond the scope of practicing dentistry • Failure to maintain a record of drugs received, administered, dispensed, sold, or distributed at dental office <u>Substandard Recordkeeping</u> • Failed to adequately document pertinent information and appropriate diagnostic and treatment planning	<u>Corrective Action</u> • Jurisprudence Examination <u>Prescription Report</u> • Submit written report regarding protocol for writing prescriptions, documentation, and appropriate use of Vicoprofen <u>Coursework</u> • Professional Boundaries • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Licensed Dental Assistant 11/05/2009	<u>Practice Beyond Scope</u> • Performed dental services beyond those allowed including task of packing retraction cord	<u>Corrective Action</u> • Jurisprudence Examination <u>Community Service</u> • Complete 20 hours of unpaid Community Service

Profession	Violation(s)	Remedies
Licensed Dental Assistant 11/24/2009	<u>Practice Beyond Scope</u> Performed dental services beyond those allowed including taking radiographs	<u>Corrective Action</u> - Jurisprudence Examination <u>Community Service</u> - Complete 20 hours of unpaid community service at a voluntary dental access clinic
Dentist 12/07/2009	<u>Improper Prescribing</u> Improperly or in an unauthorized manner prescribed, dispensed, administered, or personally used legend drug, other chemical, or controlled substance. Licensee improperly prescribed drugs to patient beyond the scope of practice nor documented the prescriptions.	<u>Coursework</u> - Professional Boundaries <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Dentist 02/09/2010	<u>Substandard Periodontal / Diagnostic / Recordkeeping</u> - Failed to thoroughly assess and document status of periodontal conditions - Failed to adequately document pertinent information and appropriate diagnostic and treatment planning	<u>Corrective Action</u> - Jurisprudence Examination <u>Coursework</u> - Periodontics Course - Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Recordkeeping Inspection</u> - Unannounced office visit and review of patient records for treatment planning/recordkeeping
Dentists x 4 12/09/2009	<u>Auxiliary Misuse</u> Permitted an unlicensed dental assistant to perform services, including taking radiographs, beyond those allowed under Minn.R.3100.8400.	<u>Corrective Action</u> - Jurisprudence Examination <u>Community Service</u> - Complete 20 hours each of unpaid community service at a voluntary dental access clinic within one year.
Dentist 03/26/2010	<u>Drugs</u> Chemical abuse/dependency.	<u>Corrective Action</u> Participation in Professional Recovery Assistance (PRA) and monitoring
Dental Hygienist 03/26/2010	<u>Substandard Periodontal and Diagnostic Care and Recordkeeping</u> - Performed both a debridement and four quadrants of scaling/root planning on two patient during one brief appointment - Performed four quadrants of scaling/root planning without administering any local anesthesia to patient - Failed to perform a second periodontal assessment - Failed to document scheduling information <u>Practice Beyond Scope</u> - Placed dental sealants on various premolar and molar teeth for patients 21-36 years old. - Failed to indicate patient's progress notes: dentist diagnosed and treatment planned for sealants, rationale for placing sealants based on caries risk assessment, and informed consent for providing sealants	<u>Corrective Action</u> - Written Reports - Periodontal Proper protocol for providing periodontal scaling/root planing treatment including appropriate use of local anesthesia - Sealants – Proper protocol for placement of sealants - Fluoride Treatment – Proper protocol for providing fluoride treatments
Dentist 03/29/2010	<u>Substandard Prosthodontic / Diagnostic and Recordkeeping</u> - Failed to adequately document pertinent information and provide appropriate prosthodontic treatment - Diagnosis did not include relevant factors and symptom etiology - Failed to provide appropriate treatment options to patient - Failed to document informed consent and maintain adequate patient records	<u>Coursework</u> - Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice

<u>Profession</u>	<u>Violation(s)</u>	<u>Remedies</u>
Dentist 03/31/2010	<u>Substandard Diagnostic and Recordkeeping</u> - Misuse of the Diagnodent dental laser when making caries diagnoses - Failed to follow proper protocol for sealants - Failed to make and maintain adequate dental records <u>Advertising</u> - Advertising contained misleading information regarding dental services and costs - Advertising also included discount coupons not offered to all payers	<u>Coursework</u> - Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Written Reports to Board:</u> - Diagnodent laser - Dental Sealants - Advertisements - Billing/Discount Coupons
License Dental Assistant 04/09/2010	<u>Practice Beyond Scope and Without Current License</u> Provided falsified records to practice as a licensed dental assistant and performed dental services prior to receiving license	<u>Corrective Action</u> - Written response to Notice of Conference - Written report, which discusses the meaning and implications of MN Rule 3100.6200F, 3100.8400, 3100.8500 <u>Coursework</u> - Ethics <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice <u>Community Service</u> 20 hours of unpaid community service at a voluntary dental access clinic
Dentist 04/15/2010	<u>Practice Beyond Scope and Without Current License</u> Licensee permitted an unlicensed dental assistant to perform expanded function duties beyond their scope of practice	<u>Corrective Action</u> - Jurisprudence Examination <u>Community Service</u> 10 hours of unpaid community service at a voluntary dental access clinic
Dentist 04/19/2010	<u>Practice Beyond Scope</u> Licensee employed, assisted, enabled, authorized and permitted allied dental personnel to practice dentistry beyond legal scope of practice	<u>Corrective Action</u> - Jurisprudence Examination <u>Verification of Duties</u> - Written verification of duties with each dental professional employed by licensee <u>Community Service</u> 20 hours of unpaid community service at a voluntary dental access clinic
Dentist 04/20/2010	<u>Unprofessional Conduct</u> - Verbal abuse / Inappropriate communications with patient - Physical abuse of patient <u>Substandard Periodontics Care</u> - Failed to follow the proper sequencing of periodontal procedures	<u>Coursework</u> <u>Stress/Anger Management</u> <u>Periodontics</u> <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice
Licensed Dental Assistant 04/20/2010	<u>Practice Beyond Scope and Without Current License</u> Failure to renew licensure and perform duties beyond scope of practice	<u>Corrective Action</u> - Jurisprudence Examination <u>Community Service</u> 20 hours of unpaid community service at a voluntary dental access clinic
Dentist 04/26/2010	<u>Substandard Diagnostic and Recordkeeping</u> - Failure to document complete periodontal charting of probing, informed consent, sufficient radiographs for diagnosis; and properly maintained original radiographs - Failed to make and maintain adequate dental records	<u>Coursework</u> - Treatment Planning - Recordkeeping <u>Written Reports of Coursework to the Board</u> - Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice
Dentist 04/30/2010	<u>Substandard Endodontics, Diagnostic, Operative, Periodontal Care and Recordkeeping</u> Failed to: Adequately document pertinent information and	<u>Corrective Action</u> Endodontics -- Submit 5 cases for review and approval by Committee <u>Coursework</u>

<i>Profession</i>	<i>Violation(s)</i>	<i>Remedies</i>
	- provide appropriate endodontic and periodontal care • Perform adequate pulp testing and document a diagnosis for endodontic treatment • Document an adequate treatment plan • Document information and provide appropriate diagnostic and/or restorative care • Take sufficient number or diagnostic quality of radiographs • Obtain informed consent	• Endodontics • Periodontics • Radiology • Treatment Planning / Recordkeeping • Professional Boundaries <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into the practice <u>Patient Records Review – Treatment and Recordkeeping</u> • Unannounced office visit to review records for treatment planning and recordkeeping
Dentist 05/07/2010	<u>Substandard Prosthodontic Care</u> • Failure to provide evidence of appropriate prosthodontic treatment • Failure to provide evidence of proper assessment and diagnosis • Failure to provide evidence of all appropriate treatment options <u>Auxiliary Misuse</u> • Authorized and permitted an unregistered dental assistant to take dental radiographs	<u>Corrective Action</u> • Jurisprudence Examination <u>Coursework</u> • Esthetic Dentistry • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Dentist 05/11/2010	<u>Substandard Endodontic Care and Recordkeeping</u> • Failure to provide adequate endodontic care • Failure to provide endodontic treatments, current endodontic techniques and meet standard of care • Failed to maintain adequate dental records	<u>Coursework</u> • Endodontics • Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice <u>Patient Records Review – Treatment and Recordkeeping</u> • Submit 5 records for review by the Committee
Dentist 06/23/2010	<u>Substandard Prosthodontic Care and Recordkeeping</u> • Failure to provide adequate prosthodontic treatment • Multiple crowns were unacceptable having to be recemented, or having open margin, open contact or ledge • Failure to make or maintain adequate dental records • Failed to properly document and administer the appropriate dosage of local anesthesia	<u>Corrective Action</u> • Written report focusing on proper administration of local anesthesia <u>Coursework</u> • Fixed Prosthodontics • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Dentist 06/28/2010	<u>Substandard Recordkeeping</u> • Failed to maintain adequate dental records	<u>Coursework</u> • Treatment Planning / Recordkeeping <u>Written Reports of Coursework to the Board</u> • Specific information addressing the knowledge gained from courses and how it will be incorporated into practice
Licensed Dental Assistant 06/29/2010	<u>Practice Beyond Scope</u> • Performed initial adjustment of a permanent crown on patients	<u>Corrective Action</u> • Jurisprudence Examination <u>Community Service</u> • 20 hours of unpaid community service at a voluntary dental access clinic
Dentist 06/29/2010	<u>Practice Beyond Scope</u> • Exceeded scope of limited faculty license by providing dental care to friends and family members	<u>Corrective Action</u> • Jurisprudence Examination <u>Community Service</u> • 20 hours of unpaid community service at any voluntary community service project located in Licensee's community
Dentist 06/30/2010	<u>Practice Beyond Scope and Without Current License</u> • Licensee permitted an unlicensed dental assistant to perform expanded function duties beyond scope of practice	<u>Corrective Action</u> • Jurisprudence Examination <u>Community Service</u> • 20 hours of unpaid community service at a voluntary dental access clinic

Complaint Resolution Process

The Board of Dentistry's mission is to ensure that Minnesota citizens receive quality dental care from competent dental health professionals. One of the ways the Board achieves this goal is by taking corrective or disciplinary action when the Minnesota Dental Practice Act (Minn. Statute 150A) has been violated by a dentist, dental hygienist or dental assistant.

Information regarding possible violations comes to the attention of the Board through written complaints. Complaints may be filed by anyone. Complaints are not public information and may not be discussed with anyone except the respondent (subject of the investigation) and the complainant. The Board is mandated to investigate all jurisdictional complaints against regulated individuals.

The Board receives and processes approximately 200-300 complaints each year. Because of the number of complaints, it is usually necessary that two Complaint Committees exist at any given time to process complaints in a timely manner.

The Board of Dentistry's Complaint Committees

The two Complaint Committees are each comprised of three current Board members who have agreed to serve on a Complaint Committee. Currently, one Committee is composed of two dentist members and a dental hygienist and the second Committee is composed of two dentists and a licensed dental assistant.

Protocol for Complaint Processing

1. **Complaint Registration.** When a potential complainant calls the office for information about filing a complaint, the Complaint Analyst mails a packet of information that includes a cover letter, a Complaint Registration form, an Authorization to Release Complaint form and a Records Waiver Authorization form.

2. **Complaint File Set Up.** When the complaint registration packet is returned to the Board office, the Complaint Analyst assigns a file number to it and the file is then assigned to one of the Complaint Committees.

3. **Investigation of Complaints.** For most complaints, the analyst will obtain a written response from the dentist through a "letter of inquiry." The purpose of a letter of inquiry is to obtain the licensee's typewritten response to a given complaint and, along with all pertinent dental records.

Complaints alleging certain misconduct must, by law, be investigated by the Minnesota Attorney General's Office (AGO). The Complaint Committee may forward other complaints to the Attorney General's Office. The purpose of an AGO investigation is to gather sufficient evidence from sources in addition to the licensee to either refute or confirm that a statute or rule has been violated, so that the Complaint Committee can sufficiently establish the facts in a case.

Pursuant to Minn. Statute Chapter 214, complaints alleging the following types of misconduct must be forwarded to the Attorney General's Office:

1. Any violation of chapter 609 (relates to criminal conviction);
2. Any conduct which would have to be reported under Minn. Statute 626.556 (relates to abuse of a minor or a vulnerable adult);
3. Any sexual contact or sexual conduct with a client;
4. Any violation of federal law;
5. Any actual or potential inability to practice the regulated profession or occupation by reason of illness, use of alcohol, drugs, chemicals or any other material, or as a result of any mental or physical condition;
6. Any violation of state medical assistance laws;
7. Any disciplinary action related to credentialing in another jurisdiction or county which was based on the same or related conduct specified in Minn. Statute 214.103, subdivision 8 (see a-f), above).

4. **Outside Consultant Reviews.** The Complaint Committee or the Attorney General's Office may request that a consultant review the complaint material to determine if the dentist's treatment met the minimum standard of care.

Types of Actions

1. **Closure.**

A complaint is closed when two or more Complaint Committee members vote to close the matter after a review of the alleged violations and the licensee's response to the allegations.

A response is obtained through a letter of inquiry and/or through an appearance before the Complaint Committee. Based on a review of the information, the Committee may close the matter if it determines that disciplinary action or corrective action were not warranted in the matter.

In regard to alleged substandard dental treatment, the Committee may choose to close a complaint if they determine that the treatment did not constitute gross incompetence and/or repeated performance of substandard care (pursuant to the Minnesota Dental Practice Act).

The complaint and the licensee's letter of response are retained in the Board's nonpublic files. If the Board receives additional complaints of a similar nature in the future, the Complaint Committee may choose to reopen a closed complaint.

2. Agreement for Corrective Action.

Purpose: An Agreement for Corrective Action is used (1) to resolve complaints which allege minor violation(s) of the dental practice act, and (2) when the nature of the violation(s) does not warrant disciplinary action.

The Agreement for Corrective Action:

1. An Agreement for Corrective Action is expected to lead to dismissal.
2. It is not intended for long-term monitoring or conditions (whereas a Board order may place limits or conditions for long time periods);
3. It is a public agreement, but it is not considered disciplinary action, and therefore, is not reported to the National Practitioner Data Bank.
4. Agreement for Corrective Action's are public information, but are not published on the Board's website. These documents, however, are available upon request by contacting the Board office.

3. Disciplinary Order.

Purpose: A licensee is placed under the Board order to protect the public from mistreatment or misconduct by the individual and to hold the individual accountable for past actions.

The Stipulation and Order:

1. When the Complaint Committee finds the licensee in violation of the Dental Practice Act, it will ask the licensee to voluntarily enter into a Stipulation and Order to place conditions and/or limitations on their license.
 2. The Stipulation is an agreement between the licensee and the Complaint Committee in which the licensee agrees that certain restrictions should be imposed on their license as a result of the committee having identified areas in which the individual violated the Dental Practice Act.
 3. The Order is issued by the full board when it has reviewed and ratified the Stipulation between the Complaint Committee and the licensee. The Order implements the terms of the stipulation. The Stipulation and Order are incorporated into one written document.
 4. Should the licensee refuse to agree to stipulate to the conditions or limitations offered by the Complaint Committee, or if the full Board rejects the proposed Stipulation and order, the matter may proceed to a contested case hearing initiated under the Administrative Procedures Act. The hearing is held before an Administrative Law Judge (ALJ) and involves the presentation of testimony and submission of exhibits in a manner similar to a civil trial.
- If the Complaint Committee is successful at the contested case hearing the ALJ will indicate that the Board's position is correct and make a recommendation which will be limited to "discipline" or "no discipline." After reviewing the ALJ report, the Board may issue a Findings of Fact, Conclusion of Law and Order, which describes the disciplinary action taken against the licensee.

Types of disciplinary actions:

- Conditional license. This permits the individual to continue to practice, but must meet certain conditions within a specified time period.
- Limited / restricted license. This permits the individual to continue to practice, but only within well-defined parameters. Some orders allow for the limitation to be lifted once certain conditions are met.
- Suspension. This requires the individual to cease all practice until the suspension is lifted.

[Note: If the Complaint Committee determines that there is an imminent risk of harm to the public, they may act quickly to temporarily suspend a license. Within 10 days of the suspension, the Board will hold a hearing before its own members to determine whether the suspension should be continued, modified or lifted. Evidence may be presented by the Board or the licensee in affidavit form only. The licensee, or their counsel, may appear for oral argument. Within five working days of the hearing, the Board shall issue its order. If the suspension is continued, based on a finding that the licensee has violated the Dental Practice Act, the licensee is entitled to a hearing before an Administrative Law Judge within 45 days of the issuance of the suspension order.]

- Voluntary Surrender. This action is taken when an individual agrees to surrender their license as a resolution to violations found in their practice.
- Revocation. This action results in the individual's license being annulled altogether. This is the most extreme disciplinary action that can be taken by the Board.

4. **Dismissal**. A complaint is dismissed when:

- Two or more Complaint Committee members decide a matter is non-jurisdictional.
- Two or more Complaint Committee members have accepted the licensee's completion of the requirements of his/her Agreement for Corrective Action.
- The Board approves an Order for Unconditional License for the licensee who has completed the requirements of his/her disciplinary order.

Complaint Process

Minnesota dentists, dental hygienists, and licensed dental assistants are regulated by the Minnesota Board of Dentistry. Below are the forms you may use to file your complaint against these dental providers. Fill out the applicable forms and return them to:

Minnesota Board of Dentistry
2829 University Avenue SE, Suite 450
Minneapolis, Minnesota 55414

The information you provide will be evaluated to determine whether the matter is a violation of the Dental Practice Act, which requires the Board to obtain additional information and, if indicated, take appropriate action against the provider.

Provide Your Identity Information

The Minnesota Board of Dentistry does not accept anonymous complaints. When completing the forms, the Board asks that you provide your identity information. You have a choice about whether to allow us to release a copy of your actual complaint (see description below relating to the form titled, "Authorization to Release Complaint").

Your identity will be kept confidential under Minnesota Statute §13.41, subd. 2. Once a complaint matter is resolved (through closure, taking corrective action or taking disciplinary action), the classification of the complaint and investigation information changes from "confidential" to "private." You may call to speak with a Board Complaint Unit staff member if you would like to learn more about the classification of data maintained by the Board

There are rare instances when the Board's proposed resolution for a complaint matter is contested by the dental provider and your identity could be disclosed.

Please be aware that failing to provide the Board with identity information may result in the Board not being able to adequately investigate alleged violations. It also prohibits Board staff from providing you with updates regarding the Board's review and resolution of your complaint.

FORMS

Before completing these forms, please understand that the Board of Dentistry does not assist individuals in obtaining monetary refunds related to dental treatment. The Board of Dentistry's authority is limited to taking disciplinary or corrective action against a dental care provider when warranted in order to protect the public at large. If you are seeking monetary reimbursement, please call the Board office (612-548-2124) for information about where you may seek such assistance.

1. COMPLAINT REGISTRATION FORM:

While we do not wish to unduly complicate the filing of complaints, we ask that you submit your complaint in writing so that it can be properly evaluated. Please provide as much detail as you can regarding all facts which relate to the complaint, including records which you may have or know about, and any attempts you may have already made to resolve your complaint with the provider. If you are unable to submit your complaint in writing, please call our office.

2. AUTHORIZATION TO OBTAIN RECORDS:

If your complaint alleges that the dental care provider improperly treated you in some way, it will probably be necessary for the Board to obtain your dental records so that your complaint can be properly evaluated. For this reason, we have included an Authorization to Obtain Records form for your signature. It is not legally necessary for you to sign this form; your complaint will be evaluated regardless of whether you sign. However, it may be easier for the Board to evaluate and resolve your complaint if you sign this authorization.

If your complaint is for a minor or dependent, please complete and send us the Records Waiver Authorization for Dependent Form.

3. AUTHORIZATION TO RELEASE COMPLAINT:

When we analyze your complaint, we will likely seek a response from the provider. When requesting the provider's response, it could be helpful to share your complaint with the provider. For this reason, we have included an Authorization to Release Complaint form for your signature. This form would authorize us to mail a copy of your complaint to the provider when we request a response. It is not legally necessary for you to sign this form; your complaint will be evaluated regardless of

whether you sign it. However, it may be easier for the Board to evaluate and resolve your complaint if you do sign it. If you choose not to sign the Authorization to Release Complaint form, and the complaint becomes part of an active investigation, the complaint is classified as confidential data in accordance with the Minnesota Data Practice Act.

RIGHTS UNDER DATA PRACTICES ACT

In accordance with the Minnesota Data Practice Act, information supplied to the Board as part of an active investigation is classified as confidential data. However, the complaint may be disclosed to the Board members assigned to this case, Board staff, consultants retained by the Board, the Attorney General's Office, other licensing officials and, when necessary, the courts. In addition, even if you do not sign the Authorization to Release Complaint form, the substance of the complaint may be disclosed to the provider. Disciplinary actions taken by the Board are public, but they do NOT include specific patient names.

Finally, may we again remind you to sign and date the Complaint Registration form. Please return it and the authorizations, if appropriate, to the address noted above.

The entire complaint resolution process can be very lengthy, but you will be notified in writing about the Board's decision regarding the resolution of your complaint.

Thank you in advance for taking the time to file your complaint.

For more information regarding the complaint process:

- [Overview of the Complaint Resolution Process](#)
- [Frequently Asked Questions of the Complaint Process](#)
- Contact: Judith Bonnell, Complaint Analyst at 612-548-2124 or email: Judith.Bonnell@state.mn.us



LAWYER AT LARGE

REPRESENTING HEALTH PROFESSIONALS BEFORE LICENSING BOARDS

BY LUCINDA JESSON AND DEBORAH MANDE

Periodically, local newspapers carry accounts of health professionals who have been disciplined by their licensing boards. We read of "boundary violations," mismanagement of patient records, substance abuse, and "unprofessional conduct." We look through the names to make sure our doctors, nurses, psychologists and dentists are not on the list. With a sigh of relief, we turn the page. We do not pause to wonder how the underlying investigation was conducted. We do not ask ourselves how the ultimate decisions were reached. That is, we do not ask these questions until a client calls and seeks advice because a complaint has been filed against her with a health licensing board.

If you find yourself with such a client, know that such complaints are not unusual. About five percent of physicians and psychologists, for example, have complaints filed against them each year.¹ For these professionals and their lawyers, learning about licensing board procedures becomes a priority. Yet the investigative and complaint resolution process is largely a closed, private affair. Certainly, that confidentiality has benefits. A drawback is that the complaint process can appear mysterious if you do not frequently appear before the boards. In this article, we hope to provide information that will demystify the process.

INITIAL PROCESSING

The process begins with the receipt of a complaint by the licensing board. A complaint can be made either orally or in writing and can be submitted by anyone. Upon receipt of a complaint, the board first looks to see if the complaint is juris-

"About five percent of physicians and psychologists ... have complaints filed against them each year."

dictional; that is, whether the complaint alleges a violation of a statute or rule that the board is empowered to enforce. A complaint about a licensee's personality, for example, typically would be dismissed as nonjurisdictional.

Most licensing boards have at least one complaint committee. Typically, this committee is made up of at least two board members and board staff. The committee evaluates the complaint and decides on the best way to pursue it. Some complaints do not require much investigation at all. With most complaints, however, board staff will subpoena relevant medical records. The subpoena power of the boards to collect this information is broad. Several Minnesota court decisions note that because the boards' investigations are "preliminary fact-finding investigations," full due process is not required.²

Sometimes boards hire a consultant to help the complaint committee assess a particular complaint. Other complaints may be referred to the Office of the Attorney General for a more formal investigation.

About 10 to 15 percent of complaints are referred by the health boards to the Office of the Attorney General (AGO) for a formal "field investigation."³ These investigations generally fall into one (or both) of the following categories: 1) complaints that are viewed as more serious, calling for interviews; and 2) complaints that involve allegations of sexual misconduct or an active chemical dependency problem. In investigations by the

AGO, the licensee typically is interviewed after all the documents are acquired and other witnesses are interviewed. If the AGO calls for an interview and you are the licensee's attorney, you should arrange to be present during the interview. While, generally, the best approach is for the licensee (not the lawyer) to answer questions during the interview, you can play a critical role before the interview, gathering information about the scope of the investigation and preparing the licensee to answer the interviewer's questions.

On some occasions, you may become concerned that information provided to the investigator may incriminate your client, the licensee. This issue may arise during an interview and often surfaces in fraud and abuse cases. Keep in mind that most licensing boards mandate, by statute, that the licensee cooperate with an investigation. Generally, licensees cannot escape this requirement based on the constitutional prohibition against compelling self-incrimination. Some practice acts address this by prohibiting the use of such evidence or testimony in a criminal case, but how these provisions would be interpreted by a criminal court is not crystal clear. On the other hand, if a licensee broadly refuses to answer questions based on the 5th Amendment, he likely will face a summary judgment motion and discipline based on what the board will view as unrefuted evidence. In this situation, your ability to line up evidence that supports the client's position, without relying on his testimony, will be critical to protect the client's interests.

Careful attention to document production also is called for. Check the

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law in the public and private sectors. She also serves as an adjunct professor at two Twin Cities-area law schools.



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including representation of individuals before licensing boards. She is a graduate of the University of New Mexico Law School.



"One may agree to act as assisting lawyer for the good of the profession, but jeopardize his continuing representation of his own clients if he looks innocently at the wrong file."

BUSINESS AND TRUST ACCOUNTS

The rule must also address the assisting lawyer's responsibility with respect to the dead or disabled lawyer's business assets and trust accounts. The business assets including business bank accounts are the property of the lawyer and should be handled as part of his estate by his personal representative or his conservator.¹⁹ The trust accounts are not the property of the lawyer, and therefore do not pass to the personal representative of his estate.²⁰ Surprisingly, the current rules governing lawyer trust accounts do not clearly address the responsibility of the lawyer to make arrangements for someone to have charge of the disposition of the accounts at death or disability. The opinion should consider the lawyer's trust accounts and require that the lawyer provide for their disposition either by the assisting lawyer or some other responsible person who would have a fiduciary duty to the clients to disburse their funds as directed.

CONCLUSION.

More lawyers than ever before are reaching the age when death or disability is more likely to occur. The system of informal winding up of practices that terminate or are interrupted unexpectedly has worked reasonably well and is likely to continue to be used. The Lawyers Professional Responsibility Board can help assure that the informal system will continue to work as it is used more often by adopting an opinion that guides lawyer as they plan for death or disability. □

NOTES

1 Peter Geraghty, "Handling Files of a Dead Lawyer," in *The Lawyer's Guide to Retirement*, 505 (3d ed., David A. Bridewell and Charles Naut eds., 1997); William D. Haught, "A Solo Practitioner's Letters of Instructions," in *The Lawyer's Guide to Retirement*, 498 (3d ed., David A. Bridewell and Charles Naut eds., 1997).

2 *Disposition of Deceased Sole Practitioner's Client Files and Property*, A.B.A. Stand. Comm. on Ethics and Professional Responsibility, Formal Op. 92-369 (1992).

3 A.B.A. Senior Lawyers Division, Recommendation, May 21, 1997.

4 Stephen Maskaleris and Vivienne Cooperman, "What Happens When A Lawyer Dies: A Survey of the Problem and the Response of the Organized Bar" (1997) (unpublished, on file with A.B.A. Senior Lawyers Division).

5 MN Rules on Lawyers Professional Responsibility Rule 26.

6 MN Rules on Lawyers Professional Responsibility Rule 28.

7 MN Rules on Lawyers Professional Responsibility Rule 27.



8 MN Rules on Lawyers Professional Responsibility Rule 28; Under this rule the Supreme Court may immediately transfer a lawyer to disability inactive status upon proof that the lawyer has been found in a judicial proceeding to be a mentally ill, mentally deficient, incapacitated, or inebriate person. Otherwise, the Court may transfer a lawyer to that status in a proceeding initiated by the Director of the Office of Professional Responsibility.

9 Oregon State Bar Ethics Opinion 1991-129 (1991).

10 MN Rules on Lawyers Professional Responsibility Rule 27.

11 Or. Rev. Stat. § 9.725 (2001)

12 A.B.A. Stand. Comm. on Ethics and Professional Responsibility, *supra* note 2.

13 Wis. Sup. Ct. R. 22.27(14) and 22.271(6)

14 See MN Op. of Lawyers Professional Responsibility Bd., Op. No. 1.

15 See Rules Governing the Courts of the State of New Jersey, Rule 1:20-19(d); Idaho Bar Commission Rules, Rule 519(g).

16 Wis. Sup. Ct. R. 22.27(15) and 22.271(7).

17 See *id.* 22.27(11) and 22.271(1)(d).

18 Minnesota has established a Client Security Fund but claims must allege that the client's loss arose out of the wrongdoing of a lawyer in the "lawyer-client relationship." See Rules of The Minnesota Client Security Board, Rule 3.02.

19 But see Alaska Rules of Court, Rule 31(b) that grants the trustee counsel in a formal winding-up proceeding the powers of the personal representative as to the deceased lawyer's practice.

20 Under Minn. Stat. Chapter 524 the personal representative of the decedent's estate has authority only over property of the decedent. Kenneth L. Jorgensen, First Assistant Director of the Lawyer's Professional Responsibility Board, notes that in practice the personal representative or some other person interested in the decedent lawyer's estate makes disbursement of the trust funds informally.



Curtis L. Stlne is professor of law at William Mitchell College of Law. He currently serves on an MSBA subcommittee examining issues surrounding attorneys' unexpected death or disability.

individual practice act in your client's profession as you consider how to handle the identification of patients whose medical records are subpoenaed in an investigation. For example, some practice acts require provision of records to the board even without the patient's written consent, but require the deletion of the patient's name. Another area where careful thought is required is where the board's subpoena calls for the production of documents that may constitute peer review material.

- ✓ Despite these caveats, as a general matter the best approach during an investigation is to promptly respond to investigative requests by a licensing board. Provide the requested documents. Learn about the parameters of the complaint being investigated. If your client needs to review records before answering a question, tell that to the investigator.

COMMITTEE DELIBERATIONS

After the investigation is complete, the complaint committee typically chooses one of four alternatives: 1) dismiss the complaint; 2) seek temporary suspension of the licensee; 3) conduct an "informational" or "educational" conference; 4) hold a formal conference.

Because temporary suspensions are rare (and dismissals do not require additional participation by the licensee), most licensees involved in the process face either the informal or the formal conference. The "informal" or "educational" conference typically is between a committee member or a medical coordinator and the licensee. Some boards use these informal conferences to obtain the licensee's response. Others use informational conferences to educate a licensee on a problem that does not rise to the level of requiring disciplinary action. Even in these informational conferences, a licensee is entitled to be represented by an attorney.

If the committee decides that a formal conference is necessary, your client will be notified by a "notice of conference" that explains (usually in detail) the conduct that arguably violates the board's practice act. Typically, your client will be asked to respond in writing to the allegations set out in the notice of conference.

The conference is similar to a hearing. The complaint committee members and the board's attorney and board staff usually attend, as would you and your client. A conference may serve several purposes. These include further investigation, education of the licensee, negotiation, and con-

ciliation. Typically, the conference opens with a statement by the committee chair about conference procedures. Committee members then usually question the licensee about the allegations found in the notice of conference. Sometimes, board staff or the attorney for the board ask questions as well. Committee members assess not only the licensee's factual responses, but also her credibility. At the end of the conference, the committee has several choices. Typically, the licensee will be excused while the committee discusses these alternatives. The committee may decide to dismiss the complaint, continue to gather information (which may mean another conference at a later date), or negotiate a resolution. The licensee will often be called back into the conference and told the committee's decision. If the committee decides to seek a negotiated "stipulation and order" for disciplinary action, the committee chair usually will share with the licensee the type of discipline that is sought (e.g., reprimand, suspension) and ask the complaint committee's attorney to draft the proposed stipulation and forward it to the licensee.⁴

If the committee either seeks a temporary suspension of a licensee or cannot agree on a stipulation, the committee may decide to recommend discipline to the board. If this occurs, a contested case hearing is held to determine whether disciplinary action is proper.

NEGOTIATING RESOLUTION

After the initial formal conference, the committee generally will present a recommended resolution. The proposed stipulation and order not only will spell out the disciplinary action sought, it will also describe the underlying conduct. The rationale behind the factual specificity is that, given the confidentiality of the complaint process, this ensures accountability. With the facts on the record, there is less likelihood that the board (which is predominately composed of other health professionals) is sweeping misconduct "under the rug." The factual detail, however, is unusual in settlement documents and likely to take attorneys new to the area by surprise.

It is unlikely that the proposed stipulation and order will indicate any flexibility on the part of the complaint committee. Typically, however, the committee's position is not written in stone. It is possible to successfully negotiate with the committee, but it is important to be prepared. In your negotiations, keep the following matters in mind:

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LAWYER PREPARATION

LAWYER AT LARGE

■ Identify the board's underlying concern. It is important to understand what issues or behaviors concern the board. (Although you are negotiating with the committee, the board, who may not always accept the compliant committee's recommendation, must approve any resolution.) Many professionals, when faced with an investigation by the licensing board, assume that their competency to perform their profession is being questioned. However, boards are also concerned about financial wrongdoing, insurance fraud, substance abuse, and boundary issues. The board's primary concern may be that your client (a technically proficient professional) not abuse her position.

■ Understand what constitutes "discipline." Corrective action agreements, for example, are not "discipline" and not reported to the various professional data banks. Discipline includes revocation or suspension of a license or placing limitations or conditions on a license. Limitations may include having your client's practice supervised or the areas of practice restricted. Conditions typically include additional course work and testing. The board may also require that a civil penalty or fine be paid. Finally, note that a reprimand also constitutes "discipline." If disciplinary action is taken, the respondent is almost always required to reimburse the board for costs associated with the proceedings, including attorneys fees. (The amount of these costs, however, may be subject to negotiation.)

■ Determine if your client is eligible for referral to the Health Professionals Services Program (HPSP). HPSP was created as an alternative to the disciplinary process. It is an early intervention and monitoring program for health professionals who have an illness that may result in their inability to practice with reasonable skill and safety. It permits these health care practitioners to fulfill their professional reporting requirements by enrolling with HPSP to document the effective management of their chemical health, medical condition, or psychiatric illness. While this program is voluntary, a board may require an impaired practitioner to enroll to avoid disciplinary action.

■ Review other cases. Determine what types of discipline were imposed in cases with facts similar to those of your client. Boards try to be consistent in their disciplinary procedures. Knowledge of decisions in other cases will give you an idea about whether or not your position is reasonable. It also may provide leverage during negotiations.

■ Research implications of discipline beyond licensure. For example, if your client agrees to a formal reprimand for over-charging a patient, how will this affect his ability to qualify as a Medicare or HMO provider? Are there possible criminal implications? If your client is disciplined for negligence, what exposure might he have for a malpractice claim?

■ Negotiate the facts where possible. Determine whether there is a basis for negotiating the "facts" that the committee wants your client to admit. If your client may face potential malpractice actions, this will be particularly important.

■ Examine the costs of contesting the matter. If your settlement negotiations fail, the case will go to a contested case hearing. The contested case hearing is conducted before an administrative law judge (ALJ) employed by the Minnesota Office of Administrative Hearings. These hearings often involve extensive expert testimony and can spread across several months. After the hearing the ALJ makes a recommendation to the full board as to whether a violation of statutes or rules occurred. The board may accept the ALJ's recommendations either in whole or in part. It is the board that ultimately decides whether or not to impose discipline. The board's decision can then be appealed to the Court of Appeals. While the costs of these proceedings are significant, remember that the committee should also factor in these costs.

■ Consider mediation. Often it is also helpful to conduct the negotiations with the help of a trained mediator. Private mediators can serve this role, as can several of the ALJs with experience in this area. □

NOTES

1. See Office of the Legislative Auditor, Occupational Regulation, A Program Evaluation Report, (January 1999), Table 3.3 at p. 64.
2. See Humenasky v. Minnesota Bd. of Medical Examiners, 525 N.W.2d 559, 565 (Minn. App. 1994).
3. Occupational Regulation at p. 66.
4. The committee may also propose a "corrective action agreement". This agreement typically calls for additional training and education. It is intended for two sets of cases. In the first set, the committee identifies practice problems that do not warrant disciplinary action. In the second set of cases, the committee identifies concerns but the evidence is insufficient to sustain disciplinary action. The corrective action agreement is a written, public document between the committee and the licensee.

The Board of Medical Practice Improves Its Complaint Handling System

By Kent G. Harbison, Health Care

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E-Mail: kharbison@fredlaw.com

January 1995 (As seen in Minnesota Medicine)

When the Minnesota Board of Medical Practice* was created in 1887, it was intended to serve basic licensing and regulatory functions. It established testing and licensure requirements for physicians, set basic medical practice standards, and performed a variety of regulatory roles, including the job of policing and disciplining licensed physicians for violations of the standards. During the past 10 to 15 years, handling disciplinary complaints has almost overshadowed the board's other functions.

Before 1985, the board received an average of 220 complaints against physicians per year. Although the number of licensed Minnesota physicians has grown somewhat since that time (now slightly less than 15,000), the number of complaints filed with the board in recent years has grown at an almost phenomenal rate – nearly 1,200 reports each year. For several years, the board attempted to manage this growth in complaints mainly by seeking legislative approval to increase the size of its staff, particularly the number of investigators from the board and those provided to the board by the Minnesota attorney general's office. Even adding more investigators, however, has not been totally satisfactory. Because it may take an average of 12 to 18 months to complete the complaint review process, neither the persons who file the complaints nor the physicians who are the subjects of them are usually satisfied, and certainly the board and its own staff would like to expedite the process, as well.

In the past two and one-half years, the board has taken some laudable actions to deal more efficiently with the growing number of complaints. During this period, the board has made three significant changes to its complaint processing system: 1) the use of a triage process for screening all complaints against physicians, 2) the use of "corrective action" agreements as an alternative to discipline, and 3) the development of the Health Professionals Services Program, a nondisciplinary diversion program for certain impaired physicians, established by the Minnesota Legislature in 1994. (This program is discussed in detail in the September 1994 Minnesota Medicine, page 41.) Given the significant changes in the board's disciplinary process during the past two years, this article is offered as an update of "The Board of Medical Practice and Its Disciplinary Process" from the December 1991 Minnesota Medicine.

The Board's Makeup

First, a review of the board's makeup may be helpful. The board comprises 16 members, 10 of who must be Minnesota licensed physicians with doctor of medicine degrees. One member must be a doctor of osteopathy, and the remaining five members are lay persons. Each member must be appointed by the governor, who typically receives nominations from various professional organizations, including the Minnesota Medical Association. Two other requirements for membership on the board are significant: 1) the overall makeup of the board must reflect a state geographic balance, and 2) the 10 M.D. members must "reflect the broad mix of expertise of physicians practicing in Minnesota." All members serve terms of four years; no member may serve more than eight consecutive years.

The process for handling complaints against physicians has several components. The full-time board staff, which is managed by an executive director, handles the bulk of the initial complaint review process. The staff is often assisted by the attorney general's office, which provides legal advice through assigned attorneys and legal assistants, who handle a wide range of investigative and interviewing functions for the board. The board also designates six of its members to serve on two three-person complaint review committees. Each committee usually consists of one lay member and two professional medical members. In late 1992 the board also began for the first time referring relatively routine or minor complaints to physicians appointed by the board as "medical coordinators, who are not board members, as a part of the new triage system.

Complaints— Many Sources, Many Reasons

The board's disciplinary function usually is triggered when an outside entity or person files a complaint or similar report with the board. Most physicians probably believe that patients are the primary source of complaints. Although patients do make such reports, there are many other sources, including relatives of patients, pharmacists, the state Medicare/Medicaid program (especially regarding prescription practices), and even physicians themselves. Because the board in recent years has shown a strong interest in enforcing the statutory obligation of most physicians to report misconduct by other physicians and even themselves, more reports are being made by physicians.

Complaints reported directly by patients can probably be reduced substantially simply by better communication between physicians and their patients. A fair number of patient complaints are generated because patients are upset by or misunderstand comments from physicians. This is particularly true with respect to complaints of perceived sexual or physical overtones. Overall, the types of complaints are almost unlimited. They can range from very minor criticisms, such as long waits in a clinic, to very serious allegations, such as sexual abuse, criminal fraud, or alcoholism. Since the mid-1980s, the most common allegations filed against physicians have included inappropriate prescribing practices, boundaries issues (physical/sexual contact), improper management of medical records, and alcoholism or other forms of chemical dependency.

The Minnesota Medical Practices Act set out more than 20 different statutory classifications of misconduct justifying some type of disciplinary sanction. Some of these categories are quite narrow, such as the revocation of a physician's license by another state or physician's conviction for certain types of criminal offenses. Other categories of misconduct are quite broad, such as "engaging in unprofessional conduct."

As noted above, physicians may also be disciplined for failure to report their own violation of any part of the Medical Practices Act. The board also has the power to discipline physicians for not reporting personal knowledge of misconduct by another physician. No report is required, however, if the knowledge was obtained during a physician-patient relationship if the patient is the reportable physician, as long as the treating physician "successfully counsels" the other physician to terminate the conduct in question. Finally, the board can discipline physicians who are already the subject of investigation if they refuse to "cooperate" with the investigation. There is little guidance in the law regarding the definition of "cooperation," but refusal to cooperate surely would include a physician's refusal to submit to an interview or produce records in response to the board's investigation requests.

Triage Screens Complaints for Severity

All complaints, regardless of their type, are now processed through the board's triage system, which was implemented in the fall of 1992. Misconduct allegations are initially analyzed by board staff members and one of the medical coordinators (currently three) retained by the board to assist with this program. Most complaints are then sent to other board staff members or investigators at the attorney general's office to obtain information pertinent to the subject of the complaint. Collection of such information may include asking the physician to provide a written response to the complaint or submit to a personal interview and often will also entail the production of medical records, consultants' reports, and other relevant documents. Depending on the severity and urgency of the complaints, this information gathering may take many weeks or months to complete.

All of this information, which at this stage is confidential and not available to the physician, is given to one of the two board complaint review committees to evaluate. The complaint review committee acts initially as a screening mechanism without any personal contact with the physician. It may choose at this early point to dismiss the complaint without any further proceedings, or it could conclude that discipline is justified and make a recommendation accordingly to the board. Another option is to have the complaint investigated further for more complete consideration during a conference with the physician before the complaint review committee (discussed below) or one of the medical coordinators. The triage panel may believe that a physician has technically violated the Medical Practices Act but in a relatively minor manner

that does not justify discipline. In such a situation, the panel may refer the report to a medical coordinator, who would schedule an informal one-on-one meeting with the physician to discuss the complaint at the board offices. Physicians are generally notified of these meetings by telephone rather than letter but are usually expected to travel to the board offices in St. Paul for the meeting.

Physicians asked to meet with a medical coordinator probably can conclude that the board has tentatively determined that the complaint is relatively minor and not likely to result in discipline. The primary purposes of the medical coordinator meetings are to confirm whether the tentative conclusions are accurate and to provide a subtle message to the physician to be careful to avoid further complaints.

Although the medical coordinator sessions usually result in complaint dismissals, the medical coordinator has the authority to refer complaints back to the complaint review committee for more formal review and consideration. Thus, physicians should be well prepared and are wise to be accompanied by an attorney, to which they are entitled. The meetings usually last no more than 30 to 45 minutes.

The use of the triage approach and the medical coordinator sessions was intended to help the board eliminate many of the hundreds of complaints on file at any given time. This approach has been somewhat successful, but there are so many complaints on file with the board that it still often takes at least nine to 12 months to resolve them, and in some cases, much longer. Nonetheless, the recent changes in the process have begun to bear fruit. At the end of fiscal year 1991, the board had 1,874 unresolved complaints on file. By the close of fiscal year 1992, the number of pending complaints had dropped to 1,295, and as of April 1994 the total was 990. These numbers are still quite large, but the trend is promising.

The board usually processes the more serious complaints through the complaint review committee conference system. This does not mean that physicians directed to appear for a conference with a complaint review committee should assume they are likely to be disciplined. In fact, the majority of all complaints ultimately are dismissed without any public record.

Complaint Review Committee Conferences

The complaint review committee conference is somewhat more formal than the medical coordinator meetings and usually covers issues or subjects of greater concern. The basic purpose of the conference is to give the committee members and the physician a fuller opportunity to speak directly to one another regarding the accusations of misconduct and to ensure that the board's decision is based on more complete information than that presented during the investigative stage of the process.

Physicians are entitled to be represented by attorneys at these conferences, and again, such representation is wise.

Physicians who are directed to appear for a conference with a complaint review committee are usually given written notice approximately one month before the conference. Conferences are held at the board offices in St. Paul, and the board seldom agrees to reschedule them.

A conference notice typically identifies the factual allegations against the physician and describes the physician's legal rights and responsibilities. The notice also refers to the specific sections of the Medical Practices Act that will have been violated if the allegations of misconduct are true. The notices state that the reports constitute only "allegations," and that the board has not made any prejudgments regarding their validity. The purpose of the conference is to help the complaint review committee make that decision after questioning the physician.

Because the Medical Practices Act provides that all parts of the investigative and predisciplinary determination are confidential, the physician is not entitled to know the source of the complaint. If the subject matter of the complaint necessitates the review of patient records, the board usually will issue a subpoena for records, which it is entitled to do under the Medical Practices Act. Sometimes the board will

also provide the physician with a statement by the patient authorizing the physician to release the records to the board.

In some cases, it is not possible for the physician to respond adequately to a complaint without knowing the identity of the patient involved. For example, if a physician is questioned regarding prescribing practices over a period of years, the board usually focuses on prescriptions to specific patients on specific dates. In fact, conference notices in prescribing cases may contain many pages of information for each patient's prescriptions, such as date of issue, type of prescription, and dosage amounts. However, unless the identity of the patient is critical to the physician's defense of the allegations, the board usually will not disclose it.

The confidentiality requirement has a twofold purpose. First, if the source of a complaint knows that his or her identity will not be disclosed to the physician, the complainant will be more willing to submit a complaint. Second, it is unfair and a breach of privacy to disclose publicly allegations that may not constitute a reason for discipline, especially since most of the complaints are dismissed.

The conference before a complaint review committee usually lasts about one hour, depending on the number of allegations and their seriousness. The conference is tape recorded and closed to the public. The only persons present besides the physician, the physician's attorney, and the three committee members are the committee's attorney and usually four to five other board staff members, including the executive director. In most cases, the committee meets for an entire day, scheduling several separate physician complaint conferences that day.

The conference is usually a question-and-answer session between the physician and the three members of the committee. The committee chair usually begins the conference by asking specific questions related to the allegations contained in the Notice of conference. Other committee members also usually ask questions and, of course, the physician is the person expected to answer. Occasionally, a consultant may assist the committee in asking the questions, especially if the allegations center on a specialized practice area that may be beyond the expertise of the individual committee members. (Sometimes the committee will rely on a report from a consultant who previously reviewed the allegations and the medical records to help determine the validity or seriousness of the allegations.)

The committee's attorney seldom asks any questions at all; those who do ask questions usually limit them to one or two. The committee usually gives physicians and their attorneys an opportunity to make closing statements or other comments to ensure that the physician's side of the story is presented. Although it is not generally appropriate for the physician's attorney to answer many committee questions, the attorney can help clarify issues and questions for the physician.

At the end of the questioning, the committee usually excuses the physician (and attorney) from the conference room while it discusses the allegations and evidence. The committee then promptly informs the physician of its recommendation, which is almost always adopted by the full board.

Board Options for Resolving Complaints

The decision by the complaint review committee usually comes in one of five forms.

Dismissal: It may dismiss the complaint, meaning that the case is closed and confidentiality maintained. (Again, the full board must approve complaint review committee decisions, but it is rare that such decisions are not accepted.)

Further investigation: The committee may send the case back for further investigation or consideration by consultants, especially when the committee is concerned that the evidence is incomplete or believes an expert opinion from a specialist is needed.

Disciplinary sanction: The committee may recommend some type of disciplinary sanction against the physician. These sanctions may range from a simple reprimand to the revocation of a physician's license.

Revocation is quite rare, but the board has almost unlimited discretion in fashioning other types of remedies or sanctions, including requiring the physician to attend refresher courses on particular subjects (such as prescribing practices or patient boundaries), assessing monetary fines of up to \$10,000 per violation, and placing other conditions on a physician's license.

Minnesota courts have made it clear that the primary purpose of board disciplinary orders is to protect patients and the public at large rather than to punish individual physicians. In other words, the board should not discipline a physician unless it is convinced that the discipline will help protect and serve patients and the public generally.

Corrective action agreement: A fourth option available for a complaint review committee is "corrective action agreements." The corrective action remedies are settlement agreements between the board and a physician whereby the physician agrees to make certain changes in his or her practice or to take some type of refresher course in exchange for the board's ultimate dismissal of the complaint. Although corrective action agreements are technically part of the board's public files, they are not considered forms of discipline and are not reported separately by the committee to the board. They are also not reported to the news media, whereas disciplinary remedies are. The use of corrective action agreements represents another effort by the board to expedite the investigative process and to help eliminate some of the complaint backlog. The board began using corrective action agreements when it adopted the triage system.

As Minnesota Medicine goes to press, the board's complaint review committees have entered into corrective action agreements in 19 cases: seven for chemical dependency or mental illness, nine for competency (including prescribing practices and record-keeping), and three for patient boundaries.

Referral program: The fifth and most recent remedy is the "Health Professional services Program" created by a 1994 statute. The board may refer certain impaired physicians to a treatment and monitoring program as an alternative to discipline (see September article, page 41).

The Physician's Options

Because the committee's decision at the complaint review conference is often a recommendation for the full board, the physician has the option of accepting or rejecting the recommendation. If the physician chooses to reject a recommendation of discipline, he or she has the right to a full evidentiary contested case hearing before a state administrative law judge. This hearing is quite similar to a court trial and enables the physician to present his or her own evidence and witnesses and to cross-examine the opposing witnesses. At this stage of the proceeding, the physician also has the opportunity to learn the identity of the complaining person or persons and has access to some of the board's previously confidential files affecting the case.

Although the right to an administrative contested case trial seems attractive, it is not necessarily what it may appear. The decision of the administrative law judge is simply a report of the findings of fact and legal conclusions based on the evidence presented during the trial or hearing. The judge does not make the final decision regarding whether or not discipline is to be imposed; rather, that decision remains with the full board after it receives the report and transcript of evidence from the administrative law judge. Consequently, so long as the board concludes that a physician has engaged in some type of misconduct or violation of the Medical Practices Act, regardless of how significant or insignificant, it still has the authority after an administrative trial to impose public disciplinary sanctions against the physician.

A physician also has the right to challenge the board's final decision through an appeal to the Minnesota court of Appeals, but the courts have often shown great deference to the board's decisions. The courts' attitude seems to be that, so long as the board's decision is reasonably supported by the evidence in the administrative law judge's report, that courts will not set aside a disciplinary decision based on that evidence. This is true even if the court itself might subjectively believe that discipline is not justified.

Given these factors and the time and expense necessitated by an administrative contested case hearing, physicians rarely challenge board decisions through a contested case hearing or judicial appeal.

Reporting Requirements

The board is required by law to periodically publish a summary of all disciplinary decisions against physicians to the Legislature and the news media. Furthermore, all disciplinary decisions must be reported to the National Practitioner Data bank in California, which was established several years ago as a national record center and monitoring system for physicians throughout the country. State licensing boards, hospitals, and certain other entities may have access to the Data Bank records to determine whether physicians have been disciplined or otherwise had their licenses restricted.

There are two exceptions to the public reporting requirement concerning medical board decisions. Discipline imposed because a physician is impaired and unable to practice medicine with reasonable skill and safety is specifically exempted by state law from being reported to the news media, although the decision is in the board's public files and available for inspection. This is more fully explained in the September article on the Health Professionals Services Program. Also, corrective action agreements between the board and physicians are not reported to the news media because they do not constitute disciplinary decisions. These agreements are, however, part of the board's public files. (A pending or dismissed complaint is not reported or otherwise open to the public.)

No Statute of Limitations

Unlike most other legal claims, medical board disciplinary investigations and remedies are not restricted by a statute of limitations. The board has the power to investigate and discipline physicians for alleged misconduct occurring even 10 or 20 years in the past. In fact, it is not unusual for the investigation and the conference with a complaint review committee to be held one or two years after the complaint has been filed with the board. These facts definitely raise the possibility of complaints reported at a time when witnesses and other evidence are no longer available or the witness's memories of the case have greatly faded.

Perhaps the most extreme illustration of the dilemma potentially created by the absence of any time limitation arises in the context of patients who have received therapy for emotional, psychological, or other mental illnesses. For example, a patient may allege that a physician violated professional boundaries in the physician-patient relationship 15 years before the patient's memory was refreshed so that he or she could recall the violation. Furthermore, the patient hypothetically could wait another two to three years before reporting the allegation to the Board of Medical Practice.

Conclusion

In light of all these factors, a physician is well-advised to take seriously all medical board investigations. Even though most board complaints are dismissed without any public record, there is too much at stake for a physician to participate in the process without careful preparation and advice.

The board has recognized the problems created by the growing number of complaints lodged with it – problems for physicians, patients, and the board itself. During the past three years the board has attempted to eliminate from the disciplinary system frivolous complaints and to expedite the processing of all reports. In the meantime, it attempts to strike a balance between the perception in some quarters, including the news media, that it is too lenient with "bad" physicians and the perception among many physicians that it is unnecessarily accusatory and punitive. Considering the competing interests and conflicting opinions, the board is not likely ever to satisfy everyone.

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PRESS: The “Dos and Don’ts” for Physicians and Nurses Appearing Before the Texas Medical Board or Texas Board of Nursing



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The number of complaints filed with the Texas Medical Board and Texas Board of Nursing has greatly increased over the past several years. This influx of cases is due largely to Texas legislation that capped the amount of non-economic damages that patients could recover in a medical malpractice lawsuit.

Date Released: 07/04/2009



The number of complaints filed with the Texas Medical Board and Texas Board of Nursing has greatly increased over the past several years. This influx of cases is due largely to Texas legislation that capped the amount of non-economic damages that patients could recover in a medical malpractice lawsuit against physicians, nurses and other health care providers. And while Texas became a more welcoming state for physicians who appreciated the lower malpractice insurance and the lessened threat of a lawsuit, more patients now feel that their grievances are better addressed through the medical or nursing boards instead of the courtroom. Will you be prepared if you receive a written notice of investigation into a complaint?

While your attorney should prepare you for what you can expect when you appear before the medical or nursing board to answer the complaint filed against you, I would like to share my recommendations on what your chosen approach should be from the moment you find out that your day in front of the panel is coming.

The “Dos”

1. Do dress professionally

You may believe you are demonstrating a dedication to your profession by arriving at your hearing in scrubs or wearing a stethoscope, but there will be other opportunities to prove that you are a serious member of the medical community. Instead, the business attire that you would wear in any courtroom setting should be your clothing of choice for this important day.

2. Do be willing to admit to error

The board will be more lenient if you acknowledge that perhaps your best efforts were not demonstrated during the instance in question. As with Americans and their elected leaders, an honest apology goes a long way in mending a wrongdoing. Of course, your legal counsel should be very careful in advising that you not testify to matters that may be self-incriminating or self-indicting.

3. Do reinforce your position with documentation

The best way to avoid your day in front of a board panel is to be meticulous in your words, actions, and decisions. Nurses need to know everything possible about their responsibilities regarding record keeping, how to provide optimal patient safety, and the procedures to follow when leaving an assignment. Doctors must always be polite and honest with patients, and be thorough in documentation and reporting. A solid paper trail that supports your side of the story is one of the strongest weapons that you have at your disposal.

4. Do accept the decision of the board panel

Once both sides have presented the facts, witnesses have spoken, and you have had a chance to share your recollection of the incident, the board is going to issue its decision. If the panel finds that the complaint has merit, the panel will share its

recommendation for your penalty. There will be some room to negotiate, however. And if that fails, you will have the opportunity to appeal the decision to the State Office of Administrative Hearings (SOAH), at which time an administrative law judge will be assigned to the case and a more formal trial system takes over.

The "Don'ts"

1. Don't ignore notices from the boards

Like the electricity bill and those weekly phone calls from your mother, notices that you receive from the medical or nursing board must receive a response. Pretending an allegation against you does not exist is not a wise way to assert your innocence.

2. Do not circumvent the chain of command

Perhaps your favorite cousin is a staffer for your state representative and you think that a good word from the legislator would make this problem disappear. Or, you are considering a phone call to the local newspaper to share the unfair accusations that are being made against you. Do not circumvent the process. Be a strong advocate for yourself, but do so within the legal system.

3. Do not expect your attorney to do most of the talking

The members of the board panel want most of the discussion to be directly with you. You must be thoroughly prepared on the facts of the complaint; the details can be presented on your behalf, and your version of the events that prompted the hearing in the first place. If you constantly defer to your legal counsel, your competence and confidence in your own actions will be questioned and remain under serious scrutiny.

Conclusion

To be certain, no medical professional wants to be brought before a review board to defend his or her practices against the complaints of an unhappy patient, medical professional colleague or employer. However, if you find yourself in that situation, you want to know that you are taking every step possible to insure the best outcome. Your license, livelihood and reputation as a physician or nurse may be at stake. By knowing what to expect before that board notice ever arrives in the mail, you are creating the circumstances for a pleasant resolution to the complaint process.

Tony R. Bertolino is the managing partner at Bertolino LLP with law offices located in Austin, Houston and San Antonio, Texas. A member of the Trial and Appellate Litigation Team, Mr. Bertolino's practice is devoted largely to complex transactions, commercial litigation, business law, entertainment law and family law matters. You can read more about Mr. Bertolino at <http://www.belolaw.com>

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NOTICE: THIS OPINION IS DESIGNATED AS
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CEPT AS PROVIDED BY MINN. ST. SEC.
480A.08(3).

Court of Appeals of Minnesota.
Deeanne M. CARLSON, Appellant,
v.

Richard F. RIEMENSCHNEIDER, DDS, Respon-
dent.
No. A06-106.

Feb. 13, 2007.

Ramsey County District Court, File No. C1-04-1134.
Lawrence J. Skoglund, Erstad & Riemer, P.A., Min-
neapolis, MN, and Jon R. Hawks, Minnetonka, MN,
for appellant.

Gregory W. Deckert, Vest & Deckert, P.A., Minnea-
polis, MN, for respondent.

Considered and decided by KALITOWSKI, Presid-
ing Judge, WRIGHT, Judge, and CRIPPEN, Judge.

UNPUBLISHED OPINION

CRIPPEN, Judge.^{FN*}

^{FN*} Retired judge of the Minnesota Court
of Appeals, serving by appointment pursuant
to Minn. Const. art. VI, § 10.

*1 Deeanne Carlson appeals from the district court's denial of a new trial in an action for dental malpractice. Appellant disputes the sufficiency of the evidence to support the jury's finding that respondent Richard F. Riemenschneider, DDS, was not negligent in the treatment he provided to her, and she contends that the district court improperly excluded evidence from earlier Minnesota Board of Dentistry proceedings and from prior malpractice lawsuits. Appellant also disputes the jury's zero-damages determination and the district court's refusal to allow a punitive-

damages claim. Because the record permits the jury's verdict and because the district court did not abuse its broad discretion in excluding evidence, we affirm. Other contentions of appellant are also without merit.

FACTS

Appellant brought this action against her former dentist for treatment he provided to her over the course of the 18 years that she was his patient. After respondent sold his practice in 2000, appellant began seeing other dentists. Appellant claims that she incurred more than \$30,000 in dental care expenses after leaving respondent's care. She attributes her damages to respondent's failure to diagnose and treat her dental problems.

Prior to the 2005 jury trial, the district court ruled that evidence from proceedings involving respondent before the Minnesota Board of Dentistry (the board) and evidence of prior lawsuits against respondent were inadmissible. Also, reversing its earlier decision, the court denied appellant's motion to add a claim for punitive damages. In its subsequent verdict, the jury found that respondent was not negligent and that appellant had been contributorily negligent and was 100% at fault for the problems she experienced.

The district court later denied appellant's new trial motion, in which appellant argued that the jury's verdict was contrary to the evidence, that the district court erred in excluding evidence, that the jury's award of zero damages was insufficient and made under the influence of passion or prejudice, and that the court erred in refusing to allow a punitive-damages claim to go to the jury.

DECISION

1.

This court reviews a district court's denial of a motion for a new trial for abuse of discretion. Halla Nursery, Inc. v. Baumann-Furrie & Co., 454 N.W.2d 905, 910 (Minn.1990). "[W]e will not set aside a jury verdict on an appeal from a district court's denial of a motion for a new trial unless it is manifestly and palpably

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contrary to the evidence viewed as a whole and in the light most favorable to the verdict." *Navarre v. S. Washington County Schs.*, 652 N.W.2d 9, 21 (Minn.2002) (quotation omitted). In other words, the jury's verdict "will not be set aside unless the evidence against it is practically conclusive." *Ouellette by Ouellette v. Subak*, 391 N.W.2d 810, 817 (Minn.1986). When "reviewing the sufficiency of the evidence to support a jury verdict ... we may not substitute our judgment on disputed questions of fact." *Sherlock v. Stillwater Clinic*, 260 N.W.2d 169, 172 (Minn.1977).

*2 A malpractice claim against a health-care provider is established by showing: "(1) the standard of care recognized by the medical community as applicable to the particular [provider's] conduct; (2) that the [provider] departed from that standard; (3) that the [provider's] departure from that standard was a direct cause of the patient's injuries; and (4) damages." *Tousignant v. St. Louis County*, 615 N.W.2d 53, 59 (Minn.2000). The standard of care in medical-malpractice cases is a fact question for the jury. *Kaiser-Bauer v. Mullan*, 609 N.W.2d 905, 910 (Minn.App.2000), review denied (Minn. July 25, 2000).

Appellant first argues that respondent was negligent in failing to diagnose and treat appellant's abscesses or to refer her to a specialist and that these failures were a direct cause of her injuries. Appellant's oral argument focused on abscesses found under three teeth. Abscesses are infections that can lead to more serious problems if left untreated.

The evidence permits a finding that respondent was not negligent regarding the abscesses. The jury heard testimony regarding respondent's diagnosis and treatment of appellant's abscesses. Respondent, a general practitioner, had endodontics training for treatment of abscesses and performing root canals to address them, and there was testimony that the standard of care did not require a specialist to perform endodontics work. Endodontics is the dental practice involving root canal-surgery and dealing with abscesses. There was also testimony that respondent complied with the standard of care and that the root canals he performed on appellant, including those involving the three teeth that appellant refers to, were done appropriately. The jury also heard evidence about appellant's poor oral hygiene and how that

could cause dental decay that leads to abscesses; for example, an endodontist's records from January 2001 described appellant's oral hygiene as "very poor." The record supports the jury's finding that respondent was not negligent in his treatment of appellant's abscesses.

Appellant poses similar arguments regarding her periodontal disease. Periodontics deals with bone loss due to acute infection around gums. The jury heard testimony that respondent was trained in periodontics and that he treated appellant appropriately for periodontal disease by performing root planing and scaling, by giving appellant home-care instruction for gum treatment, providing her dental rinses, and advising her to use a Waterpik to massage her gums. There was expert testimony that respondent complied with the standard of care for a general dentist performing periodontal work and that it is common for general dentists to treat periodontal disease. There was also evidence that appellant did not develop acute periodontal disease and its resulting bone loss until late 1998, that in June 1999 appellant reported to respondent's staff that she was about to see a periodontal specialist, and that respondent did not learn otherwise until he saw her in 2000, the year he sold his business. Again, the jury considered evidence of appellant's poor hygiene as a cause of her problems; a periodontist's records in December 2000 and April 2001 indicate that appellant's oral hygiene was poor on those occasions. Appellant, a cigarette smoker since 1975, testified that she learned in the 1980's that smoking was bad for her dental health, but that she did not stop smoking until 2000, after she was no longer being treated by respondent. Overall, there is sufficient evidence to permit a finding that respondent was not negligent in his periodontal treatment of appellant and that appellant herself was the cause of any further problems she had.

*3 Finally, appellant argues that respondent was negligent in failing to take a proper dental history and full-mouth x-rays, which would have enabled respondent to diagnose appellant's worsening periodontal conditions and her abscesses. But respondent testified that his office recorded appellant's history when she first came to see him and that they would update her records as needed on each visit. His practice was to purge his files every few years after a treatment was completed and that was why he did not have a complete copy of appellant's dental records. There

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was also evidence that the standard of care did not require a dentist to take full-mouth x-rays in 1982 when appellant starting seeing respondent. Respondent testified that once full-mouth x-rays for new patients became the norm in the 1990's, he took them for his new patients but did not need to do so for appellant, an established patient for many years. He also testified that the bite-wing x-rays that he took were sufficient for him to detect any abscesses or gum problems that were developing. The jury could have accepted the testimony that the 60 bite-wing x-rays respondent took of appellant were adequate for diagnostic purposes.

On the record before us, the district court did not abuse its discretion by denying a new trial based on insufficient evidence to support the jury's verdict. The jury's verdict is not manifestly and palpably contrary to the evidence viewed as a whole and in the light most favorable to the verdict.

2.

A "decision to admit or exclude evidence rests within the broad discretion of the [district] court and its ruling will not be disturbed unless it is based on an erroneous view of the law or constitutes an abuse of discretion." Uselman v. Uselman, 464 N.W.2d 130, 138 (Minn.1990). The complaining party must demonstrate prejudicial error from an improper evidentiary ruling before being entitled to a new trial on those grounds. *Id.*

Evidence of other wrongs or acts is not "admissible to prove the character of a person in order to show action in conformity therewith." Minn. R. Evid. 404(b). Even relevant "evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury." Minn. R. Evid. 403.

The board found that respondent failed to maintain adequate safety and sanitary conditions and appropriate infectious disease control measures in his dental practice from 1991 through 2003, a period of time that overlaps with the time respondent treated appellant. The board also found that respondent failed to provide or document appropriate periodontal treatment, to provide appropriate endodontics treatment, to provide appropriate restorative treatment, or to make or maintain adequate patient records. The board's find-

ings over this period of time could be considered relevant to the issues in the present case because they show that respondent was sanctioned for some of the same failings that are being alleged here. But as the district court concluded, the risk is that the evidence could substantially and unfairly prejudice respondent by confusing the issues presented to the board with the issues that the jury must consider. The court also found that admitting evidence of the board's actions would invade the province of the jury because the jury might infer that respondent was negligent in this case based on facts determined by the board in other matters, rather than on facts determined by the jury in this matter. The court did not commit legal error or abuse its discretion in excluding this evidence.

*4 Similarly, the district court was within its broad discretion by excluding evidence of four prior malpractice lawsuits brought by appellant's attorney against respondent. The court found that the jury could wrongfully conclude that if respondent is accused of malpractice in other matters, then he must be liable for malpractice in the present case. The court was within its discretion to make that determination and to exclude the evidence.

3.

Appellant contends that the verdict awarding no damages appears to have been given under the influence of passion and prejudice and that she is entitled to a new trial. A damage award that is less than the proved or undisputed damages may be overturned as the product of passion or prejudice unless the jury has also determined that there is no liability on the part of the defendant, and that finding is supported by credible evidence. Wefel by Wefel v. Norman, 296 Minn. 506, 507-08, 207 N.W.2d 340, 341 (1973) (stating that, "It is clear that the jury realized that their findings on liability rendered the damage question moot."); see also Radloff v. Jans, 428 N.W.2d 112, 115-16 (Minn.App.1988), review denied (Minn. Oct. 26, 1988) (upholding award of less than proven damages when credible evidence supports jury's verdict of no liability on defendant's part). The jury found respondent not negligent on credible evidence. The jury decided that appellant's contributory negligence was 100% and that it was the cause of her own injuries. And the jury was asked to determine the amount of damages "directly caused by [respondent's] dental care and treatment." Having found respondent to be

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not negligent at all, the jury could only determine, as it did, that the amount of damages was zero. The district court did not abuse its discretion in denying a motion for a new trial based on the jury's determination of zero damages.

Finally, appellant contends that the district court erred by refusing to allow the jury to consider a claim for punitive damages. This court may not reverse a denial of the motion to add a claim for punitive damages absent an abuse of discretion. L.M. by S.M. v. Karlson, 646 N.W.2d 537, 545 (Minn.App.2002), review denied (Minn. Aug. 20, 2002). There is no such abuse here. The district court found that appellant had failed to produce clear and convincing evidence that respondent deliberately disregarded appellant's safety. See Minn.Stat. § 549.20, subd. 1(a) (2006) (requiring clear and convincing evidence before allowing a punitive-damages claim). Even if the jury had found respondent negligent, it would not be sufficient for a punitive-damages award. See Utecht v. Shopko Dep't. Store, 324 N.W.2d 652, 654 (Minn.1982) (holding that conduct more egregious than mere negligence is necessary to constitute the deliberate disregard required for a punitive-damages claim).

Affirmed.

Minn.App.,2007.
Carlson v. Riemenschneider
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C

Court of Appeals of Minnesota.
In the Matter of the PROPOSED DISCIPLINARY
ACTION AGAINST the DENTIST LICENSE OF
Roger W. SCHULTZ, DDS, License No. 7280.
No. C9-85-761.

Oct. 15, 1985.

Dentist sought certiorari to review order of Board of Dentistry suspending him indefinitely from the practice of dentistry. The Court of Appeals, Sedgwick, J., held that evidence sustained Board's findings with respect to overcharges, billing for work not performed, and engaging in improper conduct with patients.

Affirmed.

West Headnotes

[1] Health 198H 221

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk214 Disciplinary Proceedings

198Hk221 k Findings. Most Cited

Cases

(Formerly 299k11.3(4) Physicians and Surgeons)
Although Board of Dentistry referred in its conclusions to the dentist's suffering from mental or emotional difficulties, suspension was not improperly predicated on that finding but, rather, was predicated on other findings of statutory grounds for suspension. M.S.A. § 150A.08, subd. 1.

[2] Health 198H 204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.2 Physicians and Surgeons)
Suspension of dentist's license may be made on any one of the 13 statutory grounds. M.S.A. § 150A.08, subd. 1.

[3] Health 198H 204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.2 Physicians and Surgeons)

Health 198H 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases
(Formerly 299k11.2 Physicians and Surgeons)

Health 198H 210

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk210 k. Relationship with Patient; Sexual Conduct. Most Cited Cases

(Formerly 299k11.2 Physicians and Surgeons)
Finding of Board of Dentistry that dentist demonstrated a course of dishonest behavior, charging for services not rendered, performing unnecessary services, engaging in sexually inappropriate touching of patients, perpetuating fraud upon patients and third-party payers, and displaying threatening behavior towards his colleagues and others supported honest and strong suspicion that physician had a mental, emotional, or other disability adversely affecting his ability to perform as a dentist. M.S.A. § 150A.08,

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subd. 1(8).

[4] Administrative Law and Procedure 15A
⚡462

15A Administrative Law and Procedure

15AIV Powers and Proceedings of Administrative Agencies, Officers and Agents

15AIV(D) Hearings and Adjudications

15Ak458 Evidence

15Ak462 k. Weight and Sufficiency.

Most Cited Cases

General burden of proof for administrative hearings is the preponderance of the evidence standard unless the substantive law provides for a different standard or burden.

[5] Health 198H ⚡218

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk214 Disciplinary Proceedings

198Hk218 k. Evidence. Most Cited

Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Proof required for suspension of dentist's license by the Board of Dentistry is proof by preponderance of the evidence. M.S.A. § 150A.08, subd. 1.

[6] Health 198H ⚡212

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk212 k. Dealing with Unqualified or Unlicensed Persons. Most Cited Cases

(Formerly 299k11.2 Physicians and Surgeons)
Suspension of dentist's license for enabling an unlicensed person to practice dentistry does not require repeated pattern of conduct. M.S.A. § 150A.08, subd. 1(11).

[7] Health 198H ⚡212

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk212 k. Dealing with Unqualified or Unlicensed Persons. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist's hygienist took x-rays, informed patient that she had a number of cavities which required treatment, and informed patient that her wisdom teeth should be taken out sustained finding of Board of Dentistry that dentist assisted the hygienist in the "practice of dentistry." M.S.A. § 150A.08, subd. 1(11).

[8] Health 198H ⚡206

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk206 k. Patient Records; Confidentiality. Most Cited Cases

(Formerly 299k11.3(4), 299k11.3(3) Physicians and Surgeons)
Evidence sustained finding of Board of Dentistry that dentist grossly deviated from minimal standards required of a professional in maintaining adequate records, thereby authorizing suspension of license. M.S.A. § 150A.08, subd. 1(6).

[9] Health 198H ⚡204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist billed family for dental services after having agreed with the family and a sponsoring church to accept medicaid payments in full did not show that dentist engaged in personal conduct bringing discredit to the profession in view of fact that it was unclear as to whether the family was, in fact, eligible for medical assistance. M.S.A. § 150A.08, subd. 1(1).

[10] Health 198H ⚡209

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198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases
(Formerly 299k11.3(4), 299k11.3(3) Physicians and Surgeons)

Evidence that dentist's hygienist donated her services to refugee family but that dentist submitted bills to medical assistance for the services performed by the hygienist sustained finding of Board of Dentistry that he engaged in deception in connection with the practice of dentistry, justifying suspension of license. M.S.A. § 150A.08, subd. 1(1, 6).

[11] Health 198H ↪ 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist admitted billing patient both for work which was done and for work which had not been done sustained finding of Board of Dentistry that dentist provided inadequate documentation and treatment and charged for services not rendered.

[12] Health 198H ↪ 204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist agreed to take payments of \$25 to \$50 per month from patient and not to charge interest but that he later began charging a service fee and shortly thereafter turned the patient's account over to a collection agency sustained finding of Board of Dentistry that dentist engaged in personal conduct which brought discredit to the profession of

dentistry. M.S.A. § 150A.08, subd. 1(1).

[13] Health 198H ↪ 204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.2 Physicians and Surgeons)
Rule of Board of Dentistry prohibiting dentists from engaging in personal conduct which brings discredit to the profession of dentistry does not require a repeated pattern of conduct to warrant suspension. M.S.A. § 150A.08, subd. 1(1).

[14] Health 198H ↪ 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist told patient that she had seven cavities, that patient went to another dentist who determined that patient had no cavities, and that dentist admitted that his x-rays of the patient were unusable sustained finding of Board of Dentistry that physician engaged in deception in connection with the practice of dentistry. M.S.A. § 150A.08, subd. 1(1).

[15] Health 198H ↪ 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Testimony by another dentist that there was a MOD alloy filling and no pulp cap on patient's tooth but that dentist had charged patient for an MOD buccal-lingual filling and for a pulp cap sustained finding of

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Board of Dentistry that physician had violated rules of Board of Dentistry.

[16] Health 198H 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist charged \$210 to remove two teeth and that another dentist would have charged only \$35 to \$40 for the same service because there was no bone holding the teeth sustained finding of Board of Dentistry that dentist charged an unconscionable fee.

[17] Health 198H 205

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk205 k. Negligence, Malpractice, or Incompetence. Most Cited Cases
(Formerly 299k11.3(3) Physicians and Surgeons)

Health 198H 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist charged \$25 for tooth extraction and \$15 for abscess removal for each of two teeth but that another dentist testified that the teeth were so loose that was a "matter of just picking them out of there" and that the normal fee would have been \$25 with no separate charge for abscess removal sustained finding of Board of Dentistry that dentist was either grossly incompetent or charged an unconscionable fee, or both.

[18] Health 198H 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist billed Department of Welfare for root tip removal and abscess removal on two of patient's teeth but that x-ray taken before surgery showed that there were no root tips present for either of the teeth sustained finding of Board of Dentistry that dentist charged for services not rendered.

[19] Health 198H 218

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk214 Disciplinary Proceedings

198Hk218 k. Evidence. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Findings of Board of Dentistry that dentist had billed Department of Public Welfare for services not performed was not supported by substantial evidence where the Board's findings only related to a different area of the mouth than that involved in the billing and dispute.

[20] Health 198H 209

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk209 k. Advertising or Fraud; Dishonesty. Most Cited Cases

(Formerly 299k11.3(1) Physicians and Surgeons)
Fact that dentist had performed some of the services for which he billed was no defense to charges before the Board of Dentistry that he billed for services not performed.

[21] Health 198H 216

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198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk214 Disciplinary Proceedings

198Hk216 k. Complaint, Petition, or Pleading. Most Cited Cases

(Formerly 299k11.3(2) Physicians and Surgeons)
Notice from Board of Dentistry that dentist was charged with "attempting to inflate the bill with unnecessary work and extra charges" was sufficient notice that dentist was alleged to have billed for services not performed.

[22] Health 198H ⚡205

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk205 k. Negligence, Malpractice, or Incompetence. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist placed temporary crown on patient's tooth, that the crown fell off several times because of swollen gum tissue, and that, each time dentist replaced it, he charged for palliative care as well as recementing sustained finding of Board of Dentistry that dentist's treatment fell below acceptable dental standards in that the dentist had a choice of either restoring the tooth or extracting it.

[23] Health 198H ⚡204

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk204 k. Grounds in General. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist threatened another dentist with his doubled up fist in a dispute over remodeling work which was annoying dentist sustained finding of Board of Dentistry that dentist engaged in conduct unbecoming to a person licensed to practice dentistry.

[24] Health 198H ⚡210

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk210 k. Relationship with Patient; Sexual Conduct. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist, in explaining origin of pain being felt by patient, told patient that drainage was going from her head down her neck and the side of her chest and evacuating through her groin and that, while making the explanation, dentist ran his hand down the side of patient's breast and onto her leg and groin area sustained finding that dentist engaged in personal conduct discrediting the profession of dentistry and made suggestive, lewd, lascivious or improper advances to a patient.

[25] Health 198H ⚡210

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk201 Discipline, Revocation, and Suspension

198Hk210 k. Relationship with Patient; Sexual Conduct. Most Cited Cases

(Formerly 299k11.3(3) Physicians and Surgeons)
Evidence that dentist visited patient who was hospitalized to have her wisdom teeth taken out and examined her breasts, explaining that he was checking for swollen glands, sustained finding of Board of Dentistry that dentist engaged in personal conduct discrediting the profession of dentistry and made suggestive, lewd, lascivious, or improper advances to a patient.

[26] Health 198H ⚡215

198H Health

198HI Regulation in General

198HI(B) Professionals

198Hk214 Disciplinary Proceedings

198Hk215 k. In General. Most Cited Cases

(Formerly 299k11.3(1) Physicians and Surgeons)
There is no statute of limitations in the statutes governing the dental profession. M.S.A. §§ 150A.01-150A.21.

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**511 Syllabus by the Court*

1. The Minnesota Board of Dentistry complied with statutory requirements when it suspended Roger Schultz.

2. The evidence supports the Board's findings and, with two exceptions, its findings support its conclusions.

Owen L. Sorenson, St. Paul, for appellant.

Hubert H. Humphrey, III, State Atty. Gen., St. Paul,
Paul G. Zerby, Sp. Asst. Atty. Gen., Minneapolis, for
respondent.

Heard, considered, and decided by POPOVICH, C.J.,
and SEDGWICK and LANSING, JJ.

***512 OPINION**

SEDGWICK, Judge.

Roger Schultz, DDS, appeals by writ of certiorari from an order of the Minnesota Board of Dentistry suspending him indefinitely from the practice of dentistry and imposing conditions for reinstatement. Schultz contends that the Board's suspension of his license is illegal, its findings are unsupported by substantial evidence, and the findings do not warrant discipline.

We affirm.

FACTS

Roger Schultz has been licensed to practice dentistry in Minnesota since 1967. The Board of Dentistry initiated proceedings to determine whether his license should be revoked, suspended, limited, modified or conditioned because he violated Minn.Stat. § 150A.08 (Supp.1983) and Minn.R. 3100.6200. A 12 day hearing was held before an administrative law judge. The administrative law judge concluded that although a number of the charges were not proved, Schultz violated the statute and rule in 16 separate instances. He recommended that the Board take disciplinary action. He specifically noted that he did not believe Schultz in most instances where the testimony was in conflict.

The Board adopted most of the findings made by the administrative law judge and made additional findings. It adopted most of the administrative law judge's conclusions that there were violations of the statute and rule but rejected several. Based on its additional findings, the Board concluded there were violations in addition to those found by the administrative law judge. These additional violations mainly relate to incompetence in recording diagnosis and treatment, unwarranted charges, and deviations from the accepted standards of practice. In total the Board found 20 separate violations.

The Board indefinitely suspended Schultz's license to practice dentistry. It further ordered that Schultz could petition for reinstatement but no sooner than April 8, 1986. Under the Board's order, Schultz has the burden of proving that his petition should be granted. At a minimum, he must receive a psychiatric evaluation within 30 days of his suspension, comply with a treatment plan if one is recommended, be evaluated by a psychiatrist 60 days immediately preceding his petition, successfully complete courses in dental ethics and oral diagnosis, make a report about his intervening activities, and write a paper about the application of dental ethics to his new dental practice.

Schultz seeks review of the suspension.

ISSUES

1. Did the Board comply with statutory requirements when suspending Schultz?
2. Does the conduct, as stated in the findings, warrant discipline?

ANALYSIS

I.

Schultz contends that the discipline imposed by the Board and the Board's Conclusion of Law 5 clearly suggest that it was relying primarily upon Minn.Stat. § 150A.08, subd. 1(8), as the ground for suspending him. This statute provides that the Board may suspend a dentist if any physical, mental, emotional, or other disability adversely affects his or her ability. See Minn.Stat. § 150A.08, subd. 1(8). He further con-

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tends that if this ground is used without first having probable cause to believe that his mental or emotional condition adversely affects his performance and without obtaining an expert opinion, the suspension is unlawful. Schultz rests his argument upon two bases. First, one of the Board's conclusion of law states that:

Respondent has demonstrated over the years a course of dishonest behavior, charging for services not rendered, performing unnecessary services, engaging in sexually inappropriate touching of patients, perpetuating fraud upon patients and third party payers, displaying threatening behavior towards his colleagues and others, and either unwillingness or *513 inability to engage in minimal acceptable documentation required for safe practice. The Board concludes that such behavior *evidences* a mental, emotional, or other disability adversely affecting his ability to perform dental services.

Conclusion of Law 5 (emphasis added). Second, as a condition of reinstatement, Schultz must consult with a psychiatrist within 30 days of his suspension, comply with a treatment plan if one is recommended, and be evaluated by a psychiatrist 60 days immediately preceding his petition.

[1] We are unpersuaded by Schultz's argument. The suspension of a license to practice dentistry is governed by Minn.Stat. § 150A.08, subd. 1. The Board may suspend a license:

upon *any* of the following grounds:

- (1) Fraud or deception in connection with the practice of dentistry * * *;
- (6) Conduct unbecoming a person licensed to practice dentistry * * * or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;
- (8) Any physical, mental, emotional, or other disability which adversely affects a dentist's * * * ability to perform * * *;
- (11) Employing, assisting, or enabling in any manner an unlicensed person to practice dentistry * * *.

Minn.Stat. § 150A.08, subd. 1 (emphasis added). Minn.R. 3100.6200 defines "[c]onduct unbecoming a person licensed to practice dentistry * * * or conduct contrary to the best interests of the public * * *."

The Board concluded that Schultz violated the statute in 20 instances. Its conclusions were specific and based upon specific findings. It found three violations of subdivision 1(1) and one violation of subdivision 1(11). The remainder were violations of subdivision 1(6) and the rule. It made no conclusion that Schultz violated subdivision 1(8) and no finding which would support such a conclusion. Its Conclusion of Law 5 is one of 45 and, unlike the conclusions relating to violations, it draws no conclusion that Schultz violated a specific statutory section.

[2] A suspension may be made on *any* one of 13 grounds. The Board relied on three different grounds but not upon mental or emotional disability. Its reliance was proper.

Schultz also contends that there is no evidence that there is probable cause to believe that he has any mental, emotional or other disability which adversely affects his ability to perform as a dentist. Under Minn.Stat. § 150A.08, subd. 5, the Board is *mandated* to "direct the dentist * * * to submit to a mental or physical examination or a chemical dependency assessment" if it has probable cause to believe that the dentist has a condition described in Minn.Stat. § 150A.08, subd. 1(8). In its Conclusion of Law 5, the Board listed conduct which it concluded evidences a mental, emotional, or other disability which affects Schultz's ability to perform as a dentist. Based on this conclusion it ordered psychiatric evaluations as a condition for reinstatement.

[3] Although we are dealing with a civil matter, we find the following test of probable cause in a criminal context to be useful:

[W]hether the objective facts are such that under the circumstances "a person of ordinary care and prudence [would] entertain an honest and strong suspicion" that a crime has been committed.

State v. Johnson, 314 N.W.2d 229, 230 (Minn.1982) (quoting State v. Carlson, 267 N.W.2d 170, 173 (Minn.1978)). "This standard is a flexible common sense one." State v. Skoog, 351 N.W.2d 380, 381

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(Minn.Ct.App.1984) (citations omitted). The Board's findings outlined in Conclusion 5 cover a wide range of inappropriate conduct that support an honest and strong suspicion that Schultz has a mental, emotional, or other disability which adversely affects his ability to perform as a dentist. The findings outlined in Conclusion 5 justify a conclusion that there is probable cause.

*514 II.

During the administrative process, Schultz took the position that the Board must prove its claims by a preponderance of the evidence. On appeal he argues the burden of proof is by clear and convincing evidence.

[4][5] The general burden of proof for administrative hearings is preponderance of the evidence, unless the substantive law provides a different burden or standard. Minn.R. 1400.7300, subp. 5 (1983). Because the substantive law provides no different standard, the proof is by a preponderance of the evidence. See also In re Polk, 90 N.J. 550, 449 A.2d 7 (1982).

Schultz challenges the violations found by the Board. In some cases he contends that the findings are not supported by substantial evidence and in others he contends that his conduct does not warrant discipline.

A. Schultz's hygienist took x-rays of B.K. and informed her that she had a number of cavities, that one required urgent treatment, and that her wisdom teeth should be taken out. The Board concluded that one who reviews x-rays, determines the presence of cavities, informs the patient, and recommends urgent treatment is diagnosing and recommending treatment. Schultz was found to have violated Minn.Stat. § 150A.08, subd. 1(11), ("[e]mploying, assisting, or enabling in any manner an unlicensed person to practice dentistry").

[6][7] Contrary to Schultz's arguments, subdivision 1(11), unlike subdivision 1(13), is self-contained and does not require a repeated pattern of conduct. It requires only "enabling in any manner" an unlicensed person to practice dentistry. The Board's conclusion that the hygienist's actions constituted diagnosis and thus "the practice of dentistry" was within its expertise.

[8] B. The Board described eleven instances of erroneous and inadequate recordkeeping with respect to both diagnosis and treatment. It concluded Schultz grossly deviated from the minimal standards required of a professional in maintaining adequate records, thereby violating subdivision 1(6) and Minn.R. 3100.6200B. Schultz admits the instances but argues that they have been taken out of context and blown out of proportion. We can find no basis for this claim. The Board is uniquely suited to make the determination whether the instances rise to the level of gross incompetence in the practice of dentistry. Cf. Reyburn v. Minnesota State Board of Optometry, 247 Minn. 520, 78 N.W.2d 351 (1956) ("Unprofessional conduct" is conduct which violates those standards of professional behavior which through professional experience have become established * * *. In establishing * * * such standards, every member of the profession should be regarded as an expert."); Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238 (Minn.1984) (deference is to be shown to agency expertise, restricting judicial functions to a narrow area of responsibility, lest the court substitute its judgment for that of the agency). Its assessment of sanctions is not a factual finding but the exercise of a discretionary grant of power. See In re Haugen, 278 N.W.2d 75, 80 n. 10 (Minn.1979). We find no abuse of discretion.

[9] C. Schultz provided services to a Vietnamese family sponsored by a church. The Board found that as a medical provider Schultz agreed to accept Medicaid reimbursement as full payment for covered services but he repeatedly billed the recipient family and their church as well as Medicaid. Both the patient and the church paid for part of the services. The Board concluded Schultz violated Minn.R. 3100.6200 by engaging in personal conduct which brings discredit to the profession of dentistry. Schultz argues that his conduct was nothing more than an honest effort to collect the fee for which he contracted.

The Board did not adopt the administrative law judge's findings that the family was initially ineligible for medical assistance and it was unclear when they became eligible and whether they maintained eligibility. The Board substituted another finding*515 detailing billings made by Schultz and payments received but did not address the uncertainty noted by the administrative law judge. Because the church and pa-

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tient could have paid for services provided during a period of ineligibility, the Board's findings do not support the conclusion that Schultz was engaging in personal conduct which brings discredit to the profession.

[10] D. Schultz's hygienist donated her services to the Vietnamese family. Schultz submitted bills to medical assistance for the services performed by the hygienist. Medical assistance paid for the services. The Board concluded that Schultz violated Minn.Stat. § 150A.08, subd. 1(1) and (6) and Minn.R. 3100.6200H and I. Schultz argues that the conduct does not amount to a violation of any rule or law. Under subdivision I(1) the Board may suspend a license for "deception in connection with the practice of dentistry". The findings support the conclusion of deception in connection with the practice of dentistry.

[11] E. D.D., in the process of getting a divorce, asked Schultz to complete needed dental work because it was covered by her husband's insurance. Because Schultz recommended such extensive work, D.D. consulted another dentist and did not return to Schultz. Schultz had performed some work for D.D. Schultz admits billing D.D. both for work which was done and for work which had never been done. The Board concluded Schultz violated Minn.R. 3100.6200B because of inadequate documentation and treatment and Minn.R. 3100.6200D for charging for services not rendered. The Board's conclusion is supported by Schultz's admission.

[12][13] F. Schultz performed extensive dental work for R.J. and J.J. The Board found that prior to treatment Schultz agreed to take payments of \$25 to \$50 per month and not to charge interest. In 1979 Schultz began charging a service fee and shortly thereafter turned the J.'s account over to a collection agency. The Board found that Schultz engaged in personal conduct which brings discredit to the profession of dentistry. The Board's findings are supported by substantial evidence. The rule does not require a repeated pattern of conduct.

G. Schultz told R.W. that she had seven cavities. Because she had had few dental problems in the past, she saw another dentist who determined that she had no cavities. Schultz testified that his x-rays of R.W. were unuseable and based upon the x-rays he was unable to identify any cavities or needed dental work.

[14] The Board found Schultz's conduct constituted a violation of Minn.Stat. § 150A.08, subd. 1(1) and (6) and Minn.R. 3100.6200B and/or I. The testimony of Schultz and the patient conflicted on this matter, as was the case in many of the charges. The Board believed the patient. The Board's findings are supported by substantial evidence supporting a conclusion that there was "deception in connection with the practice of dentistry." See Minn.Stat. § 150A.08, subd. 1(1).

[15] H. Schultz charged N.O. for a MOD buccal-lingual filling and for a pulp cap for tooth 21, whereas x-rays revealed only a MOD alloy filling and no evidence of a pulp cap. The Board concluded Schultz violated Minn.R. 3100.6200A, D and I.

The Board's findings are based upon record evidence including testimony of another dentist that there was a MOD alloy filling and no pulp cap.

I. Schultz billed N.O. for a mesial-lingual filling on tooth 22. The Board found that there is no mesial-lingual filling on tooth 22. It concluded that Schultz billed for a service not performed in violation of Minn.R. 3100.6200D and I.

[16] The Board's findings are supported by testimony of another dentist that a mesial-lingual filling does not appear on later x-rays and does not show in N.O.'s mouth.

J. Schultz removed teeth 29 and 30 from N.O.'s mouth. He charged \$55 for root tip extraction and \$15 for abscess removal for each tooth. He also removed *516 tooth 31 and charged \$70. The total bill was \$210. Another dentist testified that he would charge \$35 to \$40 for the same service because there was no bone holding the teeth. He testified that his fees were within the median range of those in the dental community. The Board concluded that Schultz violated Minn.R. 3100.6200D by charging an unconscionable fee. This finding is supported by record evidence.

[17] K. Schultz removed teeth 25 and 26 from N.O. Schultz charged \$25 for extraction and \$15 for an abscess removal for each tooth for a total of \$80. Another dentist testified that the teeth were so loose it was a "matter of just picking them out of there." He

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said the normal fee would be \$25 total and there is no separate charge for abscess removal because a dentist always cleans up the extraction site.

The Board found that the abscess removal is part of an extraction, it should not be billed separately unless there is strong documentation to justify it, and Schultz was vague and uncertain about the meaning of his own records. It concluded Schultz violated Minn.R. 3100.6200B and/or D.

Schultz argued that the Board's findings do not support the conclusion that his fees were unconscionable or excessive. The Board concluded that Schultz was either grossly incompetent or that he charged an unconscionable fee or both. Again the Board is uniquely suited to make the determination of whether Schultz's conduct rises to the level of gross incompetence. It did not abuse its discretion in concluding the fees were unconscionable.

L. Schultz performed oral surgery on H.T., a Vietnamese refugee. At the request of H.T.'s sponsoring church, Schultz billed the Department of Public Welfare for root tip removal and abscess removal for teeth 19 and 30. The Board found that an x-ray taken before surgery showed that there were no root tips present for either tooth 19 or tooth 30. Schultz conceded that there was no root tip present on tooth 30 and that he billed for its removal and for abscess removal. The Board concluded that he violated Minn.R. 3100.6200D by charging for services not rendered.

[18] We are unpersuaded by Schultz's arguments that the entries related to tooth 30 were due to a charting error by an assistant.

The record and his own admission support the conclusion that he charged for services not rendered.

M. The administrative law judge found that after surgery on H.T., Schultz billed the Department of Public Welfare for an antrum repair with a bone graft in the area of the upper left bicuspid, an antrum repair with bone graft in the area of the upper right cuspid, and an alveolectomy and gingioplasty on all four quadrants.

The Board found that the antrum repair with bone

graft could not have been performed on the upper right side because the bicuspid was not removed. It found no need for an alveolectomy in the lower right area of H.T.'s mouth and that one hour and five minutes of surgery was insufficient time to perform all the services billed.

The Board concluded that with the antrum repair Schultz violated Minn.R. 3100.6200B and D and/or I; with the unnecessary alveolectomy, he violated Minn.R. 3100.6200B and/or E; and his non-performance of services violated Minn.R. 3100.6200D and/or I.

[19] We agree with Schultz that the finding regarding the antrum repair on the upper right side is unsupported by the evidence. The Department of Public Welfare was billed for repair in the right cuspid area and Schultz testified that he performed the work in that area. The Board's findings only relate to the bicuspid area. The remainder of the Board's findings are supported by substantial evidence. The findings support the conclusion.

N. Schultz removed tooth 30 from P.T. and billed the Department of Public Welfare \$25 for surgical root recovery and \$370 for additional procedures in the area.

Schultz had no recollection or record related to the procedures. Schultz wrote to *517 the Department of Public Welfare and indicated that he placed three stainless steel sutures in P.T.'s mouth, but at the hearing he could not recall why or when they were put in. The Board found that placement of stainless steel sutures is uncommon and absent documentation could find no reason they should be used. It also found that Schultz removed tooth 2 without reason; he billed for a distal lingual amalgam on tooth 6, but there was no filling in the tooth; he billed for work on tooth 31 which was not performed; and he billed for work on tooth 18 which was not performed. The Board concluded that there were violations of Minn.Stat. § 150A.08, subd. 1(1) and (6) and Minn.R. 3100.6200D, E, H and I.

[20][21] Schultz argues that the Board ignored the procedures actually performed and its findings are unrelated to the charge. The performance of some procedures is no defense to billing for those not performed. With regard to patient P.T., the Board

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charged Schultz with "attempting to inflate the bill with unnecessary work and extra charges". This notice is sufficient.

[22] O. At the request of a church, Schultz provided services for N.T., a Vietnamese refugee. The church instructed Schultz to perform only work that was absolutely necessary because the family had no money and medical assistance would not pay for a permanent crown. Schultz placed a temporary crown on the tooth. It fell off several times because of swollen gum tissue. Each time Schultz replaced it, he charged for palliative care as well as recementing. The charges totalled \$240. The Board found that Schultz had a choice of either restoring the tooth or extracting it and that his treatment fell below acceptable dental standards in violation of Minn.R. 3100.6200B. The determination made by the Board is one that it is uniquely suited to make. We find no abuse of discretion.

P. Schultz was charged with billing additional fees for abscess removal when the fee for this procedure is customarily included in an extraction. The Board found two patients, in addition to N.O., were so charged and concluded that Schultz either made an unconscionable separate charge or deviated from minimally accepted standards for documentation or both. Although the Board neglected to make a finding to support this conclusion, the record contains ample evidence to support it.

Q. Workmen used a jackhammer while remodeling the dental office below Schultz's. Schultz expressed his displeasure to the dentist and his staff with four letter words and threatening body language. They were intimidated and frightened. Schultz also threatened the dentist by phone at 10:30 P.M.

Another dentist stated by affidavit that Schultz swore at one of his employees, causing him concern for his family's safety. A pharmacist testified that Schultz had threatened him with doubled up fists.

[23] The Board concluded that this conduct was conduct unbecoming a person licensed to practice dentistry as the term is defined in Minn.R. 3100.6200A. Schultz contends the conduct would not discredit the profession and was an isolated incident not warranting discipline. Again we find that the Board is uniquely able to determine whether Schultz's per-

sonal conduct brings discredit to the profession. We find no abuse of discretion.

R. After having dental work performed by Schultz, R.J. returned because of head and neck pains. Schultz explained that drainage was going down her neck and the side of her chest and was evacuating through her groin. While making this explanation, Schultz ran his hand down the side of her breast and onto her leg and groin area. The Board found the touching was irrelevant to any professional service and R.J.'s failure to make a complaint was not a defense. It concluded Schultz violated Minn.R. 3100.6200A and C.

[24] Schultz argues that his conduct was not contemplated by rule and statute and there was "nothing more here than a dentist explaining to a patient the way and *518 manner that her lymph node system worked." We disagree. The Board's finding that the touching was irrelevant to any professional service supports the conclusion that his personal conduct discredited the profession of dentistry and that he was making suggestive, lewd, lascivious, or improper advances to a patient.

S. K.M. was hospitalized to have her wisdom teeth taken out. The Board found that on one post-extraction visit at the hospital, Schultz examined K.M.'s breast and explained he was checking for swollen glands. The Board found Schultz's touching of K.M.'s breast was unrelated to any professional service and concluded he violated Minn.R. 3100.6200A and C.

[25] Schultz complains that the finding ignores the hospital records which explain the examination, ignores the fact that the incident happened in 1975, ignores his denial, and fails to recognize that K.M. is a known user of street drugs.

There is substantial evidence of record to support the Board's finding and its conclusion.

[26] Schultz states that it is "unfair" to consider an incident which took place in 1975. There is no statute of limitations in the statutes governing the dental profession, Minn.Stat. §§ 150A.01-21.

DECISION

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The Board complied with statutory requirements when it suspended Schultz. The evidence supports the Board's findings and, with two exceptions, its findings support its conclusions.

Affirmed.

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Westlaw

Page 1

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C

Only the Westlaw citation is currently available.

NOTICE: THIS OPINION IS DESIGNATED AS
UNPUBLISHED AND MAY NOT BE CITED EX-
CEPT AS PROVIDED BY MINN. ST. SEC.
480A.08(3).

**This decision was reviewed by West editorial
staff and not assigned editorial enhancements.**

Court of Appeals of Minnesota.

Carla PAUL, Appellant,

v.

Charles E. CRUTCHFIELD, III M.D., et al., Re-
spondents.

No. A09-1458.

April 13, 2010.

Dakota County District Court, File No.
19HA-CV-09-1333.

Dean M. Salita, Brabbit & Salita, P.A., Minneap-
olis, MN, for appellant.

Angela M. Nelson, Lynn M. Schmidt Walters,
Brock P. Alton, Gislason & Hunter LLP, Min-
neapolis, MN, for respondents.

Considered and decided by WORKE, Presiding
Judge; LARKIN, Judge; and COLLINS, Judge.^{FN*}

FN* Retired judge of the district court,
serving as judge of the Minnesota Court of
Appeals by appointment pursuant to Minn.
Const. art. VI, § 10.

UNPUBLISHED OPINION

WORKE, Judge.

*1 Appellant challenges the district court's
grant of summary judgment in favor of respondents,

arguing that her battery claim was improperly dis-
missed as a medical-malpractice claim. We affirm.

DECISION

When reviewing a grant of summary judgment, we determine whether there are genuine issues of material fact and whether the district court erred in its application of the law. *State by Cooper v. French*, 460 N.W.2d 2, 4 (Minn.1990). Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that either party is entitled to judgment as a matter of law." *Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn.1993) (citing Minn. R. Civ. P. 56.03). "We view the evidence in the light most favorable to the party against whom summary judgment was granted." *STAR Ctrs., Inc. v. Faegre & Benson, L.L.P.*, 644 N.W.2d 72, 76-77 (Minn.2002). But "there is no genuine issue of material fact for trial when the nonmoving party presents evidence which merely creates a metaphysical doubt as to a factual issue"; "the party resisting summary judgment must do more than rest on mere averments." *DLH, Inc. v. Russ*, 566 N.W.2d 60, 71 (Minn.1997).

Appellant Carla Paul sued respondents Charles E. Crutchfield, III M.D. and Crutchfield Dermatology for battery, medical negligence, and intentional infliction of emotional distress (IIED), stemming from an elective cosmetic procedure. Specifically, appellant asserted that respondent-physician injected Restylane in an incorrect area above her lip, causing scarring and discoloration. Appellant failed to serve the requisite expert affidavits for a medical-malpractice claim under Minn.Stat. § 145.682 (2008), and respondents moved for summary judgment. Appellant voluntarily dismissed the medical-malpractice claim, but opposed respondents' summary-judgment motion on the other claims. The district court concluded that appellant's battery claim was indistinguishable from her medical-malpractice claim, noting that the location of an in-

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jection within an inch of where appellant consented "is clearly a question of professional judgment and one of a technical nature. The procedure falls within [appellant's] informed consent and is not battery, but more appropriately a medical negligence claim, for which [appellant] failed to provide an expert affidavit." The court dismissed appellant's battery and IIED claims, but she only challenges the dismissal of the battery claim.

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"[O]rdinarily, a malpractice action without supporting expert testimony is frivolous per se." *Sorenson v. St. Paul Ramsey Med. Ctr.*, 457 N.W.2d 188, 191 (Minn.1990). But a claim for battery can exist within a medical context which would not require expert affidavits. *Kohoutek v. Hafner*, 383 N.W.2d 295, 299 (Minn.1986). A claim for medical battery exists when a physician engages in "touching of a substantially different nature and character from that to which the patient consented." *K.A.C. v. Benson*, 527 N.W.2d 553, 561 (Minn.1995).

*2 Appellant principally contends that the district court erred because the actual location of the injection was a substantial departure from the location to which she consented, and thus did not require supporting expert affidavits. Appellant asserts that our interpretation of a "substantial departure" should be narrowed in cases involving an elective procedure, arguing that even the most acute mistake overrides a patient's consent in this particular field of medicine. However, appellant presents no legal authority to support this argument, and failed to produce *any* evidence at summary judgment to sustain her claim. Appellant relied solely on mere averments and thus failed to adequately resist summary judgment. Accordingly, the district court did not err in determining that appellant's claim involved a question of professional judgment and was truly a medical-malpractice claim requiring expert affidavits, which appellant failed to provide.

Affirmed.

Minn.App.,2010.
Paul v. Crutchfield

541.076 HEALTH CARE PROVIDER ACTIONS.

(a) For purposes of this section, "health care provider" means a physician, surgeon, dentist, occupational therapist, other health care professionals as defined in section 145.61, hospital, or treatment facility.

(b) An action by a patient or former patient against a health care provider alleging malpractice, error, mistake, or failure to cure, whether based on a contract or tort, must be commenced within four years from the date the cause of action accrued.

(c) A counterclaim may be pleaded as a defense to any action for services brought by a health care provider after the limitations described in this section, notwithstanding it is barred by the provisions of this chapter, if the counterclaim belonged to the party pleading it at the time it became barred and was not barred at the time the claim sued on originated, but no judgment on the counterclaim except for costs can be rendered in favor of the party so pleading it.

History: 1999 c 23 s 2

573.02 ACTION FOR DEATH BY WRONGFUL ACT; SURVIVAL OF ACTIONS.

Subdivision 1. **Death action.** When death is caused by the wrongful act or omission of any person or corporation, the trustee appointed as provided in subdivision 3 may maintain an action therefor if the decedent might have maintained an action, had the decedent lived, for an injury caused by the wrongful act or omission. An action to recover damages for a death caused by the alleged professional negligence of a physician, surgeon, dentist, hospital or sanitarium, or an employee of a physician, surgeon, dentist, hospital or sanitarium shall be commenced within three years of the date of death, but in no event shall be commenced beyond the time set forth in section 541.076. An action to recover damages for a death caused by an intentional act constituting murder may be commenced at any time after the death of the decedent. Any other action under this section may be commenced within three years after the date of death provided that the action must be commenced within six years after the act or omission. The recovery in the action is the amount the jury deems fair and just in reference to the pecuniary loss resulting from the death, and shall be for the exclusive benefit of the surviving spouse and next of kin, proportionate to the pecuniary loss severally suffered by the death. The court then determines the proportionate pecuniary loss of the persons entitled to the recovery and orders distribution accordingly. Funeral expenses and any demand for the support of the decedent allowed by the court having jurisdiction of the action, are first deducted and paid. Punitive damages may be awarded as provided in section 549.20.

If an action for the injury was commenced by the decedent and not finally determined while living, it may be continued by the trustee for recovery of damages for the exclusive benefit of the surviving spouse and next of kin, proportionate to the pecuniary loss severally suffered by the death. The court on motion shall make an order allowing the continuance and directing pleadings to be made and issues framed as in actions begun under this section.

Subd. 2. **Injury action.** When injury is caused to a person by the wrongful act or omission of any person or corporation and the person thereafter dies from a cause unrelated to those injuries, the trustee appointed in subdivision 3 may maintain an action for special damages arising out of such injury if the decedent might have maintained an action therefor had the decedent lived.

Subd. 3. **Trustee for action.** Upon written petition by the surviving spouse or one of the next of kin, the court having jurisdiction of an action falling within the provisions of subdivisions 1 or 2, shall appoint a suitable and competent person as trustee to commence or continue such action and obtain recovery of damages therein. The trustee, before commencing duties shall file a consent and oath. Before receiving any money, the trustee shall file a bond as security therefor in such form and with such sureties as the court may require.

Subd. 4. **Applicability.** This section shall not apply to any death or cause of action arising prior to its enactment, nor to any action or proceeding now pending in any court of the state of Minnesota, except, notwithstanding section 645.21, this section shall apply to any death or cause of action arising prior to its enactment which resulted from an intentional act constituting murder, and to any such action or proceeding now pending in any court of the state of Minnesota with respect to issues on which a final judgment has not been entered.

History: (9657) *RL s 4503; 1911 c 281 s 1; 1935 c 325 s 1; 1943 c 538 s 1; 1951 c 697 s 1; 1955 c 407 s 1; 1957 c 712 s 1; 1965 c 837 s 1; 1967 c 158 s 2; 1971 c 43 s 1; 1973 c 717 s 30; 1978 c 593 s 1; 1983 c 347 s 2,3; 1986 c 444; 2002 c 403 s 6*

145.682 CERTIFICATION OF EXPERT REVIEW; AFFIDAVIT.

Subdivision 1. **Definition.** For purposes of this section, "health care provider" means a physician, surgeon, dentist, or other health care professional or hospital, including all persons or entities providing health care as defined in section 145.61, subdivisions 2 and 4, or a certified health care professional employed by or providing services as an independent contractor in a hospital.

Subd. 2. **Requirement.** In an action alleging malpractice, error, mistake, or failure to cure, whether based on contract or tort, against a health care provider which includes a cause of action as to which expert testimony is necessary to establish a prima facie case, the plaintiff must: (1) unless otherwise provided in subdivision 3, paragraph (b), serve upon defendant with the summons and complaint an affidavit as provided in subdivision 3; and (2) serve upon defendant within 180 days after commencement of the suit an affidavit as provided by subdivision 4.

Subd. 3. **Affidavit of expert review.** The affidavit required by subdivision 2, clause (1), must be by the plaintiff's attorney and state that:

(a) the facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff; or

(b) the expert review required by paragraph (a) could not reasonably be obtained before the action was commenced because of the applicable statute of limitations. If an affidavit is executed pursuant to this paragraph, the affidavit in paragraph (a) must be served on defendant or the defendant's counsel within 90 days after service of the summons and complaint.

Subd. 4. **Identification of experts to be called.** (a) The affidavit required by subdivision 2, clause (2), must be signed by each expert listed in the affidavit and by the plaintiff's attorney and state the identity of each person whom plaintiff expects to call as an expert witness at trial to testify with respect to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. Answers to interrogatories that state the information required by this subdivision satisfy the requirements of this subdivision if they are signed by the plaintiff's attorney and by each expert listed in the answers to interrogatories and served upon the defendant within 180 days after commencement of the suit against the defendant.

(b) The parties or the court for good cause shown, may by agreement, provide for extensions of the time limits specified in subdivision 2, 3, or this subdivision. Nothing in this subdivision may be construed to prevent either party from calling additional expert witnesses or substituting other expert witnesses.

(c) In any action alleging medical malpractice, all expert interrogatory answers must be signed by the attorney for the party responding to the interrogatory and by each expert listed in the answers. The court shall include in a scheduling order a deadline prior to the close of discovery for all parties to answer expert interrogatories for all experts to be called at trial. No additional experts may be called by any party without agreement of the parties or by leave of the court for good cause shown.

Subd. 5. **Responsibilities of plaintiff as attorney.** If the plaintiff is acting pro se, the plaintiff shall sign the affidavit or answers to interrogatories referred to in this section and is bound by those provisions as if represented by an attorney.

Subd. 6. Penalty for noncompliance. (a) Failure to comply with subdivision 2, clause (1), within 60 days after demand for the affidavit results, upon motion, in mandatory dismissal with prejudice of each cause of action as to which expert testimony is necessary to establish a prima facie case.

(b) Failure to comply with subdivision 2, clause (2), results, upon motion, in mandatory dismissal with prejudice of each cause of action as to which expert testimony is necessary to establish a prima facie case.

(c) Failure to comply with subdivision 4 because of deficiencies in the affidavit or answers to interrogatories results, upon motion, in mandatory dismissal with prejudice of each action as to which expert testimony is necessary to establish a prima facie case, provided that:

(1) the motion to dismiss the action identifies the claimed deficiencies in the affidavit or answers to interrogatories;

(2) the time for hearing the motion is at least 45 days from the date of service of the motion; and

(3) before the hearing on the motion, the plaintiff does not serve upon the defendant an amended affidavit or answers to interrogatories that correct the claimed deficiencies.

Subd. 7. Consequences of signing affidavit. The signature of the plaintiff or the plaintiff's attorney constitutes a certification that the person has read the affidavit or answers to interrogatories, and that to the best of the person's knowledge, information, and belief formed after a reasonable inquiry, it is true, accurate, and made in good faith. A certification made in violation of this subdivision subjects the attorney or plaintiff responsible for such conduct to reasonable attorney's fees, costs, and disbursements.

History: 1986 c 455 s 60; 1992 c 549 art 8 s 1; 2002 c 403 s 1



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Matt Sloneker is a shareholder with Lind, Jensen, Sullivan & Peterson. Matt strives to provide his clients with aggressive and enthusiastic representation in order to resolve disputes quickly and in a cost-effective manner. He defends clients in a wide variety of civil matters, including personal injury, professional liability, construction defect, liquor liability, and products liability.

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Matt is a graduate of the University of Minnesota Law School and has been named a Rising Star (2012) and Super Lawyer® (2013-2014) by Minnesota Law & Politics. He lives in St. Paul with his wife and their two young children.

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Minnesota Defense Lawyers Association (Co-Chair of Construction Law
Committee, 2011-2013)

Published Works / Presentations

Guide to Investigating and Defending Minnesota Civil Damages Act Claims, 2011
Remodeling Duties: An Insurer's Duty to Advise the Insured to Request an
Allocation of Damages, Minnesota Defense Fall 2012, Volume 33, Issue 3,
Minnesota Defense Lawyers Association

PRESENTATIONS

Recent Decisions in Construction and Insurance Coverage Law, presented to the
Minnesota Defense Lawyers Association Mid-Winter Conference, 2013.
Experts in Cases Involving Built Facilities, presented to the Minnesota Defense
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Hamline University School of Law,
J.D., 1976

Rick is a founding shareholder and President of Lind, Jensen, Sullivan & Peterson, P.A. Rick is a trial lawyer with 35 years of civil trial experience and 100 plus jury trials to his credit. He has extensive experience in all types of trials, with an emphasis in the defense of professionals, brokers, business entities, contractors and insurers. His practice includes coverage disputes, commercial litigation, professional errors and omissions claims, construction defect litigation and product liability defense. In addition, Rick regularly represents professionals before licensing boards and the Department of Commerce. In his representation of professionals he has become well recognized in the defense of dentists, insurance agents, real estate sales persons and real estate brokers. Rick is also regularly asked to serve as a mediator and arbitrator in alternative dispute resolution efforts and will occasionally be appointed to act as special master and receiver. He is a founding member and member of the Board of Directors of Business Counsel, Inc. Rick is proud to be a Top 100 Super Lawyer® with the recognition of his peers in the support of this honor.

Certifications/Specialities

Trial Advocate, National Board of Trial Advocacy (1990-Present)
Civil Trial Specialist, Minnesota State Bar Association (1988-Present)

Honors & Awards

University of Minnesota, Cum Laude (1971)
President, Delta Tau Delta Fraternity (1970-71)
Hamline University School of Law, Magna Cum Laude/Silver Gavel Award (1976)
Hamline University School of Law 2011 Distinguished Alumni
AV Preeminent Rated Lawyer by Martindale-Hubbell (1985-2014)
Super Lawyer®, Minnesota Law & Politics (1998-2014)
Top 100 Super Lawyer®, Minnesota Law & Politics (2006-2013)

Professional Associations & Memberships

Minnesota Defense Lawyers Association
Minnesota Bar Association
Hennepin County Bar Association
Academy of Certified Trial Lawyers of Minnesota
American Board of Trial Advocates, Minnesota Chapter

Business Counsel, Inc.
American Bar Association
Counsel of Litigation Management
Public Investors Arbitration Bar Association
DRI
National Board of Trial Advocacy
University of Minnesota Alumni Association
Hamline University School of Law Alumni Association
Member, American Board of Trial Advocates (2010-Present)
Business Counsel, Inc., Board of Directors (1999-Present)
Minnesota Defense Lawyers Association, Board of Directors (1999-2000)
Member, International Ski History Association (2010-Present)
Minnesota District Judges Association Committee on Jury Instruction Guides
Minnesota Supreme Court Committee on Rules of Civil Procedure

Published Works / Presentations

Risk Management for Doctors, 2011-Present
Guide to Investigating and Defending Minnesota Civil Damages Act Claims, 2011
Confidentiality of Settlements, MDLA Release Handbook, 1998-2009