CNA DENTIST'S ADVANTAGE

Dental Professional Liability Claim Report: 2nd Edition

Foreword

Dentist's Advantage has been meeting the insurance needs of dentists for more than 50 years. Never have we seen years like 2020 and 2021. As the fight against the novel coronavirus wages on, so must our strength and support for those who are sacrificing on the frontlines. We've never been more proud of our dental professional clients. Dentists know firsthand that dental care is essential health care. As such, they responded to the pandemic by further enhancing infection control protocols and screening procedures for COVID-19 in an effort to ensure the health and safety of both their patients and staff.

We wish to extend our sincere appreciation to our dentists for their professionalism and ongoing commitment to excellence in patient safety.

Michael J. Loughran
President, Dentist's Advantage

DENTIST'S ADVANTAGE

For more than 35 years, dentists have looked to CNA to provide insurance coverage for the professional liability risks encountered in their dental practices. CNA and Dentist's Advantage have collaborated on this closed claim analysis in order to raise awareness of those circumstances that may result in allegations of patient harm. Notwithstanding the delivery of excellent dental care, patient comorbidities or system failures may result in an inadequate patient outcome. Understanding the conditions that may lead to a claim help dentists develop techniques to mitigate risk and minimize the potential for litigation.

CNA understands that dentistry represents an essential health care service. We are pleased to provide this resource to help dentists working in education, solo, group or corporate practices, hospitals or ancillary healthcare facilities, institutions and other practice locations in order to enhance patient safety.

Michael Scott
Assistant Vice President, CNA Healthcare Underwriting

CNA

Top Ten Key Findings of the Dental Professional Liability Claim Report

The average total incurred for **dental closed claims** with paid indemnity from $10,000 to $1,000,000 **increased 24.1 percent** in the 2020 claim dataset ($134,497) from the 2016 claim dataset ($108,398). (See page 6.)

The percentage of **claims with paid indemnity** from $250,000 to $750,000 has **almost doubled** since the 2016 claim dataset. (See page 6.)

The average total incurred for claims asserted against **general practitioners** has increased by 30.5 percent since the 2016 claim dataset and by 26.6 percent for all other specialists, excluding oral surgeons. (See page 7.)

The percentage of claims associated with an allegation of **inadequate precautions to prevent injury (inadequate precautions)** has increased to 20.5 percent of claims from 11.7 percent in the 2016 claim dataset. (See page 9.)

Claims associated with **nerve injury** have increased as a percentage of all claims and the average total incurred has risen by 43.6 percent to $210,568. (See page 9.)

The average total incurred for claims associated with **infection** have increased significantly by 70.9 percent. (See page 9.)

Each of the top three injuries associated with **surgical extraction** resulted in an average total incurred greater than $200,000. (See page 13.)

Incidents of **swallowed-aspirated object** and **wrong tooth** treatment – considered to be two of dentistry's "never events" – have increased in frequency and continue to be an important patient safety concern. (See page 17.)

The total paid expense for **license protection** matters increased by 18.7 percent. (See page 19.)

License protection matters associated with **documentation error or omission** resulted in board action in 59.7 percent of complaints. Allegations of **medication administration/prescribing** resulted in board action in 50.9 percent of the complaints, and **professional conduct** in 32.8 percent. (See page 25.)

Part 1: Report Overview

Introduction

As a leading underwriter of professional liability insurance solutions for dental professionals for over 35 years, CNA understands the challenges and risks associated with delivering dental care. As part of the partnership between CNA and the Dentist's Advantage program, our mission is to educate our insureds, and the healthcare industry at large, regarding risk-related issues. We are pleased to present our second dental closed claim report, entitled "Dental Professional Liability Claim Report: 2nd Edition." Our goal is to help dentists enhance their practice and minimize professional liability exposure by identifying loss patterns and trends.

Dataset and Methodology

There were 5,113 professional liability closed claims and license protection matters attributed to CNA-insured dentists from January 1, 2015 through December 31, 2019.

Text, figure headers and/or footnotes identify comparative data from the 2016 claim report when included. Note that the 2016 and 2020 claim datasets overlap by one year (2015). Review of claims for the 2020 claim dataset resulted in limited updates to the data for 2015. The latest information is therefore included in the dataset for each report.

As some elements of the inclusion criteria in this report may differ from that of previous CNA claim analysis and claim reports issued by other organizations, we ask readers to exercise caution about comparing these findings with other reviews. Similarly, due to the fundamental uniqueness of individual claims, the average total incurred amounts referenced within this report may not be indicative of the total incurred amounts attributed to any single claim.

There were **5,113** professional liability **closed claims and license protection matters** attributed to **CNA-insured dentists** from January 1, 2015 through December 31, 2019.

Terms

Please refer to the following terms for the purposes of this report:

- **2016 claim dataset** – A reference to the prior CNA dataset used in the report entitled "Dental Professional Liability 2016 Claim Report."
- **2020 claim dataset** – A reference to the current CNA dataset used in the report entitled "Dental Professional Liability Claim Report: 2nd Edition."
- **Average total incurred** – The costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim, divided by the total number of closed claims.
- **Total paid indemnity** – Monies paid on behalf of an insured dentist in the settlement or judgment of a claim.
- **Paid expense** – Monies paid in the investigation, management and/or defense of a claim.
- **Total incurred** – Monies paid on behalf of an insured in the investigation, management or defense and the settlement or judgment of a claim.

Part 2: Dental Professional Liability Closed Claim Analysis

Parts 2 and 3 include 1,089 professional liability (PL) closed claims that meet the following criteria:

- Involved a CNA-insured dentist or dental practice.
- Closed between January 1, 2015 and December 31, 2019 (although claims may have been reported earlier).
- Resulted in an indemnity payment from $10,000 to $1,000,000.

While **Parts 2 and 3** focus on high-cost/high-severity claims and PL claim trends, claims over $1,000,000 paid indemnity are excluded from the analysis. These claims were deemed to be outliers that skewed the results and often involved circumstances such as class action suits and multi-provider liability claims. This is consistent with analysis in the 2016 claim dataset.

Comments on claim categories, specific claim circumstances and outcomes, along with comparisons to the 2016 claim dataset, are used to provide additional context. This analysis should be used to help dental professionals enhance their practice by:

- Identifying loss patterns and trends.
- Evaluating the impact of the safety and quality of dental care provided.
- Mitigating potential liability exposures.

The increasing severity of claim costs can be attributed, in part, to social inflation, which is the growth of liability/litigation risks and costs. This rate of growth is more rapid than what could be explained by general economic inflation, and there are a number of potential drivers of this rate of growth. These possible drivers include more sophisticated plaintiff attorney litigation strategies, tort reform rollbacks, increasing class action suits, and other large jury verdicts across the country. Another possible driver of social inflation is the liability associated with the increasing complexity of patient needs. Meeting the needs of high acuity patients can involve many procedures that are surgical, restorative and diagnostic in nature.

Claim review and case scenarios presented in this claim report and accompanying Risk Management Spotlights indicate that failure to consistently implement risk management principles such as appropriate communication, effective documentation and adverse event management also contribute to increasing professional liability claim costs.

Closed Claims with Paid Indemnity from $10,000 to $1,000,000

The 2020 claim dataset demonstrates a notable increase in claim costs compared to the 2016 claim dataset. This can be attributed, in part, to the liability associated with increasing complexity of procedures, along with social inflation.

KEY FINDING

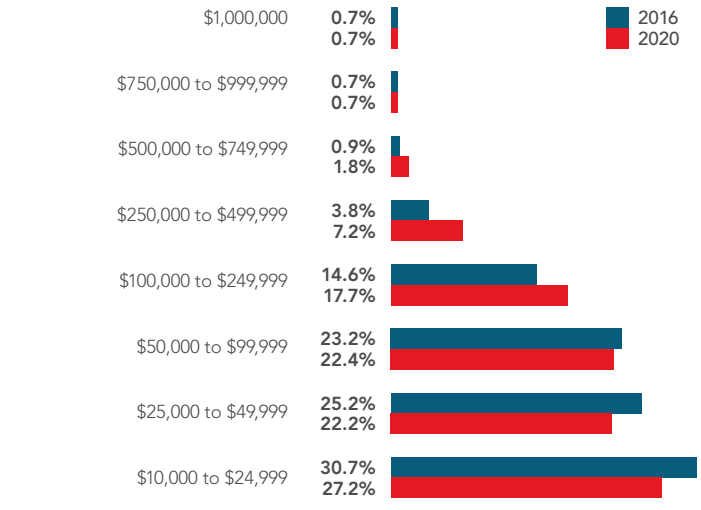
The average total incurred for **dental closed claims** with paid indemnity from $10,000 to $1,000,000 **increased 24.1 percent** in the 2020 claim dataset ($134,497) from the 2016 claim dataset ($108,398).

This increase is driven, in part, by the larger percentage of claims with paid indemnities between $250,000 and $750,000. The percentage change in this range (**Figure 1**) represents a $20 million paid indemnity increase.

KEY FINDING

The percentage of **claims with paid indemnity** from $250,000 to $750,000 has **almost doubled** since the 2016 claim dataset.

1 Paid Indemnity Range Comparison: 2016 Claim Dataset vs 2020 Claim Dataset



Analysis by Dental Specialty

Figure 2 demonstrates that the vast majority of closed claims in both the 2016 claim dataset and the 2020 claim dataset involve general practitioners (GPs). The overall claim distribution has shifted slightly toward GP claims compared to all specialists since the 2016 claim dataset.

In both the 2016 and the 2020 claim datasets, claims involving oral surgeons and all other specialists combined have a higher average total incurred. This is to be anticipated, since specialty practitioners typically provide care for patients with more complex oral conditions and treatment needs.

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Figure 3 provides additional perspective on the average total incurred for all dental specialist claims compared to all GP claims.

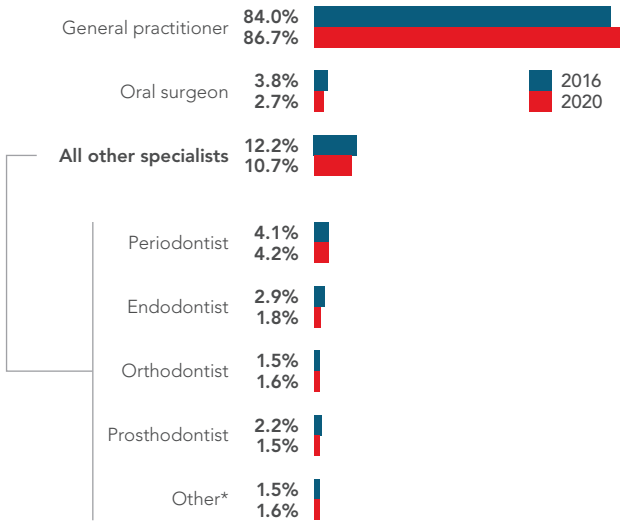
KEY FINDING

The average total incurred for claims asserted against **general practitioners** has increased by 30.5 percent since the 2016 claim dataset and by 26.6 percent for all other specialists, excluding oral surgeons.

- Given the scope and risk profile of oral surgeons, claims for this specialty are shown separately and not included in the analysis for all other specialists. While **Figure 3** reflects a significant decrease in the total average incurred for claims associated with oral surgeons, this disparity can be attributed to four high severity claims at policy limits in the 2016 claim dataset as compared to only one in the 2020 claim dataset.
- The percentages for individual dental specialty claims are relatively low and should, therefore, be interpreted with caution.

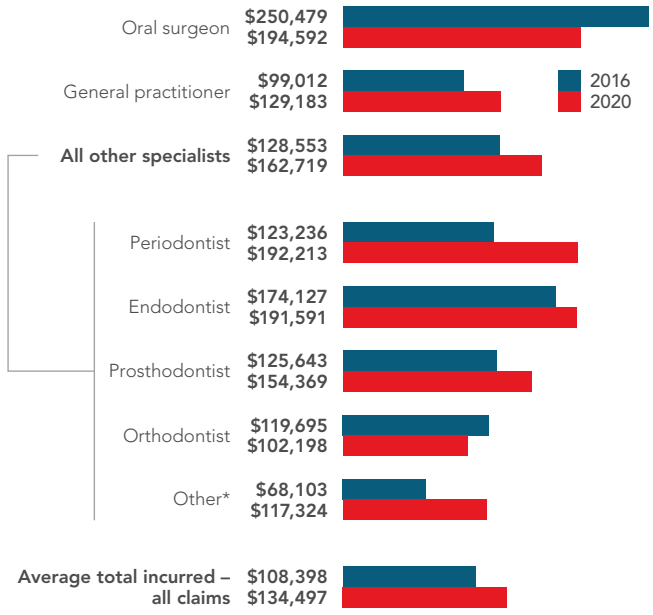
2 Distribution by Dental Specialty

* Other includes Pediatric Dentist and Public Health Dentist



3 Average Total Incurred by Dental Specialty

* Other includes Pediatric Dentist and Public Health Dentist



Analysis by Dental Procedure

Figures 4 and 5 illustrate that the top five dental procedures most often associated with PL claims demonstrate increases in the average total incurred since the 2016 claim report. These findings reveal the types of dental procedures that drive PL costs. Additional analysis beginning on page 10 will improve understanding of the PL risks associated with dental procedures. However, consider that PL claim cost increases are broad-based, involving many procedures that are surgical, restorative and diagnostic in nature. Therefore, social inflation is likely to be a primary factor resulting in increased claim costs.

Claim review and case scenarios presented in this report indicate that failure to consistently implement risk management principles such as appropriate communication, effective documentation and adverse event management, also contribute to increasing PL costs.

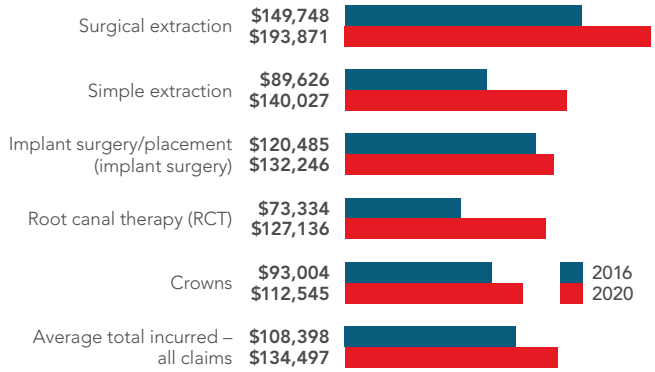
Since claims associated with GPs comprise 86.7 percent of the dataset, **Figure 6** provides additional detail on the change in GP claim distribution by procedure and the increase in average total incurred. This data illustrates an increase in average total incurred for the five procedures from $93,311 to $133,357 since the 2016 claim report.

Claim cost increases are broad-based, **involving** many procedures that are **surgical, restorative and diagnostic** in nature.

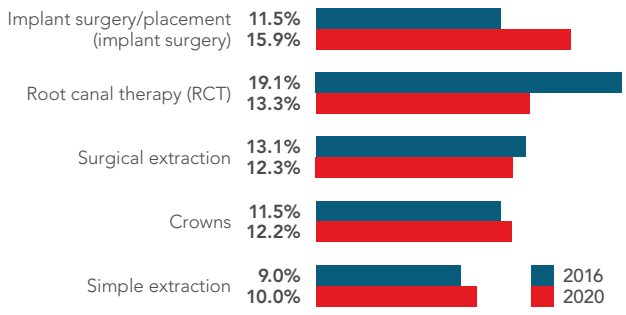
Key Risk Management Principles

- ☐ Appropriate Communication
- ☐ Thorough Documentation
- ☐ Effective Adverse Event Management
- ☐ Detailed Patient Assessment
- ☐ Well-documented Informed Consent
- ☐ Delineated Treatment and Referral Process

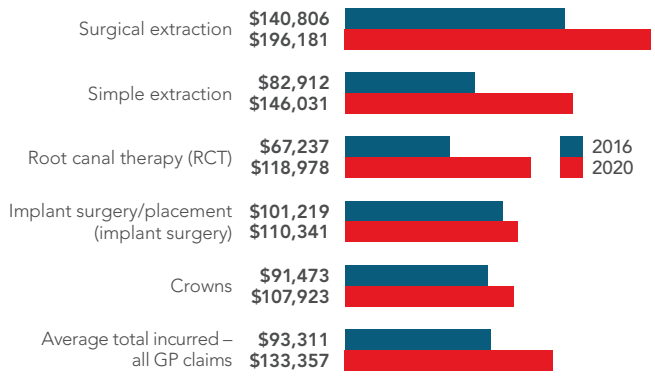
5 Average Total Incurred of Top Dental Procedures Associated with All PL Claims



4 Distribution of Top Dental Procedures Associated with All PL Claims



6 Comparison of Average Total Incurred for Top 5 Dental Procedures – GP Claims Only



Analysis by Allegation

Figure 7 demonstrates the top allegations associated with PL claims.

KEY FINDING

The percentage of claims associated with an allegation of **inadequate precautions to prevent injury** (**inadequate precautions**) has increased to 20.5 percent of claims from 11.7 percent in the 2016 claim dataset.

Figure 8 illustrates an increase in the average total incurred of approximately $50,000 for **inadequate precautions**. **Failed implants**, with a change in severity of 20 percent are now among the top allegations in terms of average total incurred.

Several allegation categories are general in nature, such as **treatment failure** and **inadequate precautions**. Allegations such as **failed implants**, however, focus on a specific procedure that includes associated risk exposures. Treatment failures of any type may be associated with factors other than professional negligence. Examples of claims involving a number of top allegations may be found in **Part 3**, page 10.

Analysis by Injuries and Additional Loss Types (Injuries)

This section categorizes claims by specific injuries and additional loss types (treatment remedies and conditions or findings) related to the associated dental treatment and/or allegations.

In the 2020 claim dataset, **corrective dental treatment required (corrective treatment)** and **injury to nerve/paresthesia (nerve injury)** remain the top two injuries in both the distribution and average total incurred.

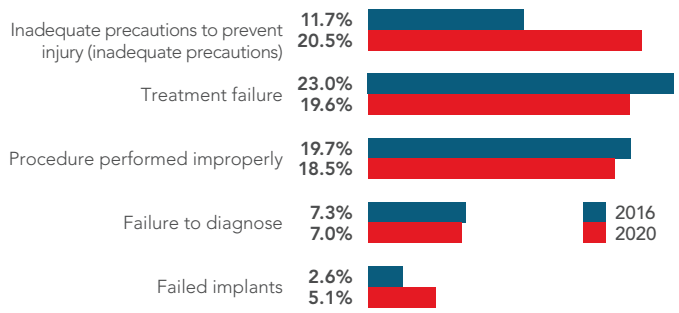
KEY FINDING

Claims associated with **nerve injury** have increased as a percentage of all claims and the average total incurred has risen by 43.6 percent to $210,568.

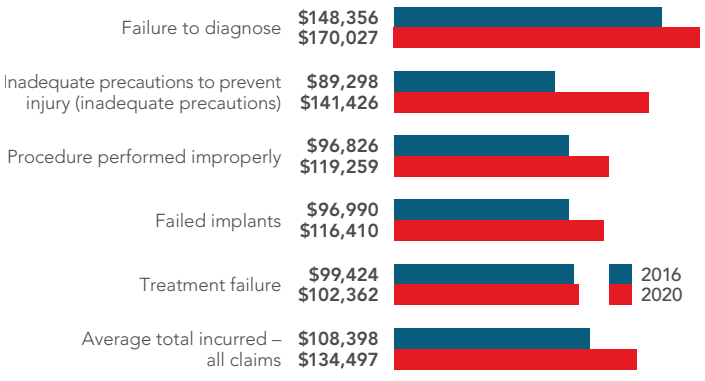
KEY FINDING

The average total incurred for claims associated with **infection** have increased significantly by 70.9 percent.

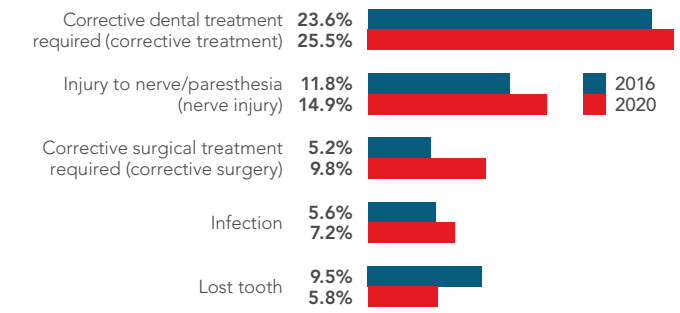
7 Distribution of Top Allegations Associated with PL Claims



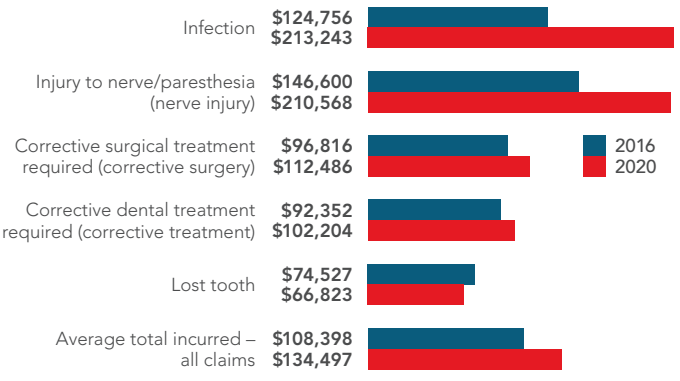
8 Average Total Incurred of Top Allegations Associated with PL Claims



9 Distribution of Top Injuries and Additional Loss Types Associated with PL Claims



10 Average Total Incurred of Top Injuries and Additional Loss Types Associated with PL Claims



Part 3: Further Analysis

Dental Procedures and Professional Liability Injuries

This section provides further analysis of PL claims for the top dental procedures, including their most commonly associated injuries and allegations. An analysis of claims associated with each procedure is conducted in order to identify trends and possible risk mitigation actions. In **Part 4** of the report on page 18, risk management recommendations are provided.

Implant Surgery/Placement

Figures 11 and 12 illustrate the top injuries and costs associated with **implant surgery/placement (implant surgery)** procedures. **Corrective surgery, nerve injury** and **corrective treatment** represent a similar number of claims and comprise 71 percent of **implant surgery** claim injuries. The majority of associated allegations (**Figure 13**) relate to **treatment failure**, **failed implants** or **procedure performed improperly**.

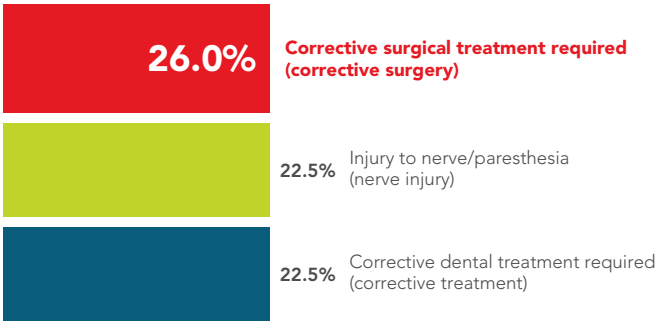
The following provide examples of failed implants:

In this first case example, a dentist undertook training to begin offering dental implant therapy to patients in the practice. The doctor sought education and experience from multiple vendors, but not from academic or independent professional education sources. Ultimately the dentist chose one system for implant therapy. Allegations of failed treatment and the requirement for additional corrective surgery resulted in multiple claims being asserted against the dentist. Several cases were reviewed by experts indicating potential standard of care breaches related to: incomplete patient assessment, failure to provide treatment options, poor implant placement/bone support, and inadequate implants for planned fixed restorations. Experts opined that substandard care resulted from a combination of the limited amount and type of dental implant education and experience obtained, as well as the limitations of the selected implant system. In addition, the dentist was alleged to have failed to seek consultation, or refer a complex case that exceeded the doctor's level of skill and experience. Documentation deficiencies also contributed to defense challenges and the claim closed with total incurred costs in the mid six figures.

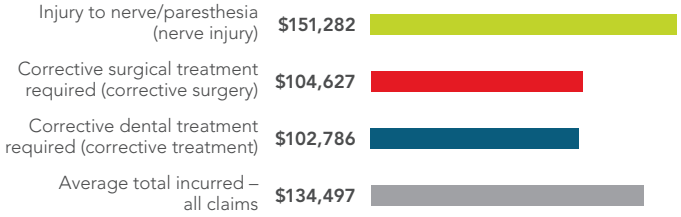
An example of a claim related to improper and inadequate assessment involved a patient who had previously received dental implants placed by a prior dentist. The patient presented to a second provider for additional implants after extraction of hopeless teeth. The implants began to fail sequentially after restoration. Expert testimony asserted that previous implants were improperly positioned, leading to the failure of the implants the second provider placed and requiring the patient to seek extensive corrective treatment. The claim against the second dentist was settled prior to trial with total incurred costs in the mid six figures.

The comprehensive Dental Risk Management Manual provides CNA/Dentist's Advantage insureds with detailed information and recommendations to help mitigate professional liability and licensing board action risks. To access additional detail from the manual, see the "Risk Management Spotlight" graphics on pages 11 through 14 and page 17. Dentist's Advantage members may access the full Dental Risk Management Manual from the Prevention and Education Web page.

11 Implant Surgery – Distribution of Top Injuries



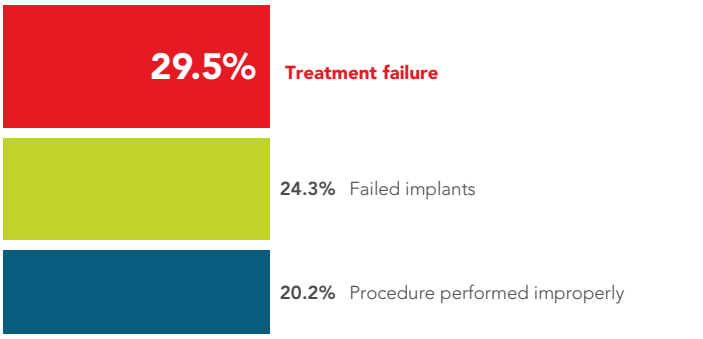
12 Implant Surgery – Average Total Incurred of Top Injuries



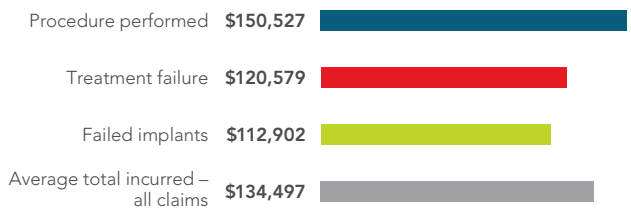
Nerve injury is among the top injuries in four of the five top dental procedures that are associated with PL claims. Claims associated with **nerve injury** related to **implant surgery** (**Figure 12**) experienced the highest average total incurred. These claims primarily involve mandibular nerve damage that may occur during the osteotomy procedure, or due to encroachment/pressure on the nerve with implant placement. Extraction and immediate implant placement also may result in damage to the nerve during one or both procedures. As illustrated below, patient assessment and advance surgical planning represent critical steps in preventing nerve injury.

A 52 year-old male patient sought care for a faulty bridge from tooth 29 to 31. The abutment teeth were non-restorable due to severe recurrent decay. After extractions and implant placement, the patient complained of pain and paresthesia. The doctor monitored the situation for approximately two weeks, taking no other action. The patient sought a second opinion one month after implant placement and later filed a lawsuit asserting negligent care. Expert review indicated standard of care concerns including: inadequate pre-surgical planning with a poor-quality panorex and no documented implant length planning, no intra-operative images, absence of diagnostic images at the follow-up visit, failure to remove implants to prevent permanent nerve injury, and missing records regarding treatment and follow-up care. A cone-beam CT image indicated clear evidence of mandibular nerve impingement. The patient suffered permanent nerve damage and total incurred claim costs over $400,000.

13 Implant Surgery – Distribution of Top Allegations



14 Implant Surgery – Average Total Incurred of Top Allegations



Root Canal Therapy (RCT)

Analysis of injuries associated with RCT (**Figures 15 and 16**) shows that **nerve injury** is the highest proportion of claims at 17.9 percent and also has the highest average total incurred cost of $239,045. Review of **nerve injury** claims associated with **RCT**, frequently involve extruded endodontic materials or canal disinfectant solutions. Alleged damages include long-term or permanent physical and/or chemical nerve injury, pain, ongoing medical expenses and lost wages, all of which can contribute to a higher-than-average settlement or indemnity payment. The top allegation of **inadequate precautions**, at 25.5 percent, is often associated with both types of **RCT/nerve injury** claims (**Figure 17**). The following case example describes a serious nerve injury outcome.

A 35 year-old male patient with widespread dental caries required RCT on several anterior teeth. The general dentist conducted an informed consent discussion and obtained a signed consent form. During the procedure, the patient had no complaints of pain or swelling, though a purulent discharge was present during canal instrumentation. Upon irrigation with sodium hypochlorite solution, the patient experienced "tingling" and discomfort. Due to this reaction and the observed discharge, the dentist did not proceed with completion of RCT. The patient later reported excruciating pain and moderate swelling and saw an endodontist for a second opinion – whose findings included paresthesia, allegedly from a chemical nerve injury. Expert opinion did not support the dentist's care due to issues such as excessive root instrumentation, no documented root length measurements or imaging, and inadequate follow-up. The plaintiff asserted that the dentist's failure to observe these clinical and safety-related requirements led to permanent nerve injury. This case resulted in total incurred costs exceeding $500,000.

Risk Management Spotlight: Implants

Click here for further risk management information on dental implants.

Although dental/oral **infection** may be associated with any procedure, this injury is among the top three most frequent for **RCT** and extraction procedures. It is not unusual for a patient to develop an infection associated with **RCT**, either before or after treatment. Infection may occur with no breach in the standard of care, as it is a recognized risk of **RCT** that may require extraction and treatment plan reassessment. Dentists may mitigate the risk of infection with **RCT** by performing a thorough assessment and following recommended infection control practices, including isolation of the tooth with a dental dam. Dentists also may wish to consult the ADA Clinical Practice Guideline entitled "Antibiotic Use for the Urgent Management of Dental Pain and Intra-oral Swelling." In the following case example involving **infection**, the dentist proceeded with **RCT** against his better judgment.

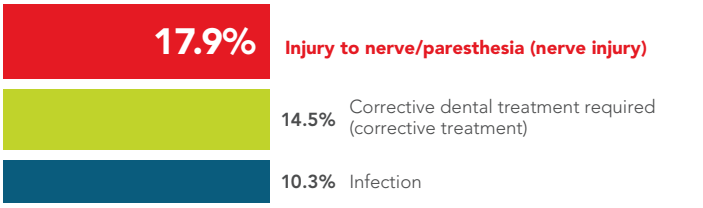
A 35 year-old female patient sought care for pain in the posterior mandible. Obvious severe decay was noted on examination and treatment options were discussed. The dentist recommended extraction due to the extent of decay and the possibility of root fracture. The patient preferred to save the tooth and RCT was completed without complications. Two days after the procedure, the patient presented with complaints of continued pain, slight swelling and trismus. Upon examination, the dentist advised that these symptoms were not unusual and should improve progressively over a few days.

The patient did not return for a follow-up visit and did not respond to telephone calls. However, the patient sought care at a local hospital for increased swelling several days after the last dental office visit. The lawsuit described a hospital stay with antibiotic therapy, incision and drainage, as well as ongoing medical care after discharge and lost time from employment. Expert review found the records to be incomplete and radiographs lacked sufficient quality. A root crack was suspected, but no imaging such as cone-beam computed tomography (CBCT) was employed to confirm or rule this out prior to treatment. The dentist preferred to settle the case rather than proceed to a jury trial, resulting in payment and expenses of more than $100,000.

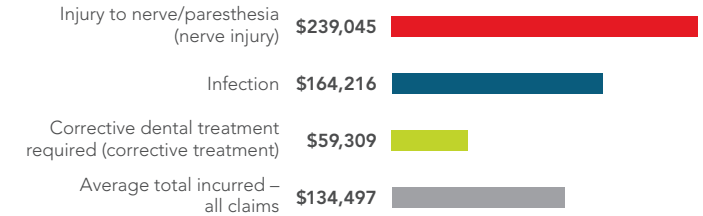
Risk Management Spotlight: Oral Infection

Click here for further risk management information on dental/oral infection.

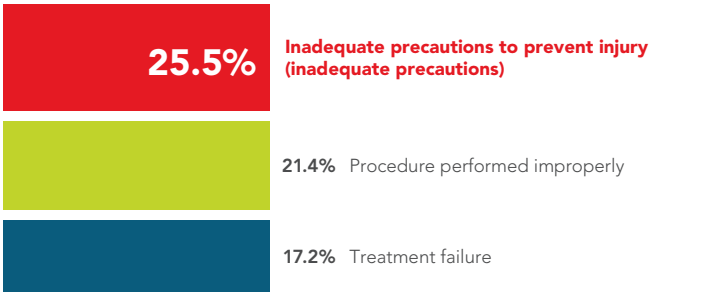
15 Root Canal Therapy – Distribution of Top Injuries



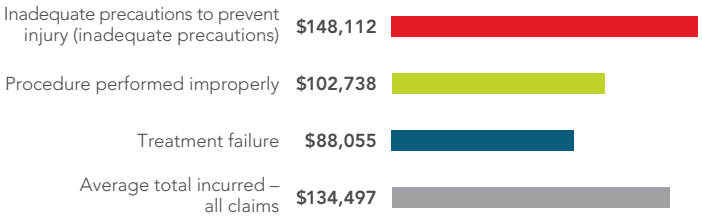
16 Root Canal Therapy – Average Total Incurred of Top Injuries



17 Root Canal Therapy – Distribution of Top Allegations



18 Root Canal Therapy – Average Total Incurred of Top Allegations



Surgical Extraction

Figure 19 illustrates the top injuries associated with **surgical extraction**.

KEY FINDING

Each of the top three injuries associated with **surgical extraction** resulted in an average total incurred greater than $200,000.

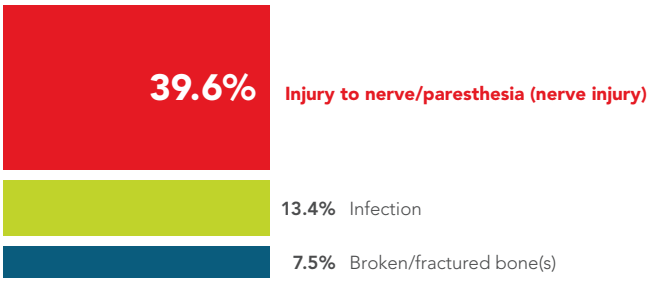
As a top injury class, the average total incurred for all claims associated with surgical extractions is $193,871 (**Figure 5**, page 8 and **Figure 22**). While all surgical extractions involve inherent risks, an analysis of claims involving surgical extraction indicates that third molar extraction claims have a much higher average total incurred than all other surgical extractions ($222,512 vs $159,597). (**Figure 22**).

…**analysis of claims** involving surgical extraction indicates that **third molar claims** have a **much higher average total incurred** than all other surgical extractions.

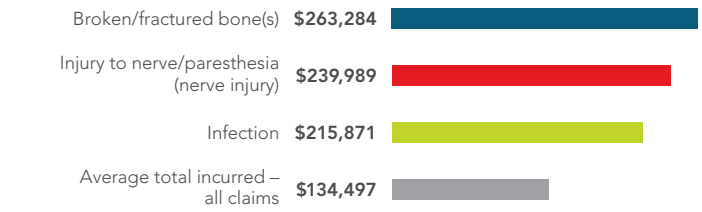
Risk Management Spotlight: Extractions

Click here for further risk management information on dental extractions.

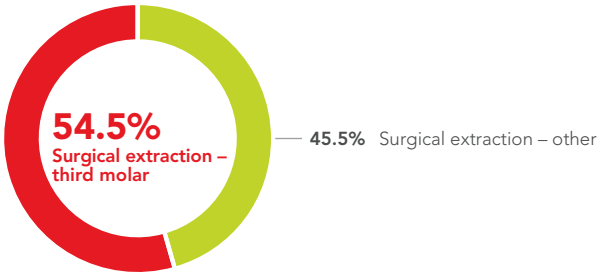
19 Surgical Extraction – Distribution of Top Injuries



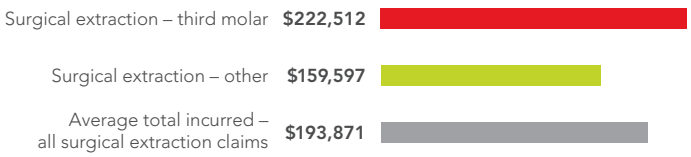
20 Surgical Extraction – Average Total Incurred of Top Injuries



21 Surgical Extraction – Distribution by Procedure Sub-code



22 Surgical Extraction – Average Total Incurred by Procedure Sub-code



Depending on the claim circumstances, the top allegation of **inadequate precautions** (**Figure 23**) may be associated with any of the top three injury categories (**Figure 19**). This allegation applies to the majority of **nerve injury** claims. As **nerve injury** is a known risk for many procedures, including **surgical extraction**, an injury may occur even absent a breach of the standard of care. **Inadequate precautions** may be alleged for a number of reasons, though a common situation involving the risk of nerve injury relates to the failure to disclose this risk during the informed consent process. The following case example is an example of inadequate documentation of the consent process.

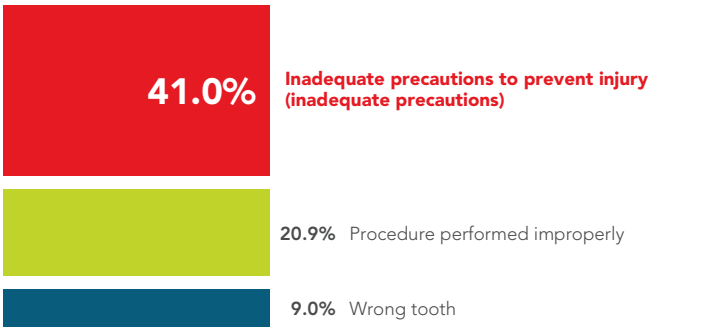
> *A 26 year-old female patient presented for examination and treatment, which revealed third molars were present with mandibular impactions. Though no problems were reported by the patient, tooth 32 was at risk for pericoronitis. Although the dentist believed that he discussed surgical risks with the patient, this discussion was not documented in the patient record.*
>
> *During extraction of tooth 32, the surgical burr penetrated the cortical bone in the distal-lingual area, causing soft tissue damage. The patient did not report residual numbness (although present) until a follow-up visit a week later. Evaluation confirmed loss of sensation to the tongue, which remained unchanged nearly one month later, after which the patient was referred to a specialist for an assessment. The lingual nerve suffered severe damage and the recommended micro-surgical repair occurred less than three months after extraction. Though the procedure provided partial relief, the patient alleged permanent nerve injury. This injury, as well as ongoing medical expenses, allegations of lost wages and defense costs, resulted in total incurred costs in the high six figures.*

Inadequate precautions may be alleged for a number of reasons, though a **common situation** involving the risk of nerve injury relates to the **failure to disclose this risk** during the **informed consent** process.

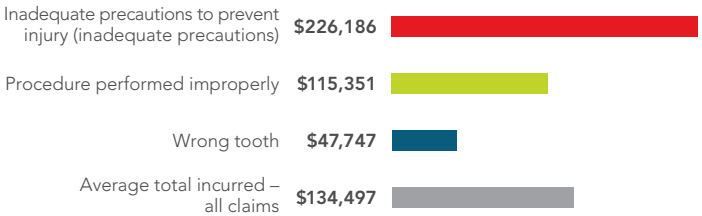
Risk Management Spotlight: Nerve Injuries

Click here for further risk management information on nerve injuries.

23 Surgical Extraction – Distribution of Top Allegations



24 Surgical Extraction – Average Total Incurred of Top Allegations



Crowns

Analysis determined that PL claims associated with **crowns** require **corrective treatment** (**Figure 25**) 48.9 percent of the time. These injury allegations are not unexpected due to the technical, clinical and cosmetic challenges involved with crowns, including patient expectations for perfect results.

Figure 26 provides the top allegations related to crowns. **Treatment failure** and **procedure performed improperly** may each result from a myriad of issues such as inadequate assessment and treatment planning (including poor tooth/bone support), poor esthetics, poor occlusion, failure to remove (or recurrent) dental caries, open restoration margins, or lack of retention. **Inadequate precautions** may be asserted with respect to **swallowed-aspirated object** injuries (**see dental never events**, page 17), or when **RCT** is required after crown delivery (especially when this material risk is not disclosed prior to treatment). Inadequate informed consent, treatment planning issues and/or poor clinical recordkeeping are challenges to an effective claim defense as illustrated in the following scenarios:

A 48 year-old female patient sought dental care for missing teeth. In the course of treatment, tooth supported crowns were placed at significant cost. Multiple restorations failed over 12 to 18 months and sinus perforation resulted from a subsequent extraction.

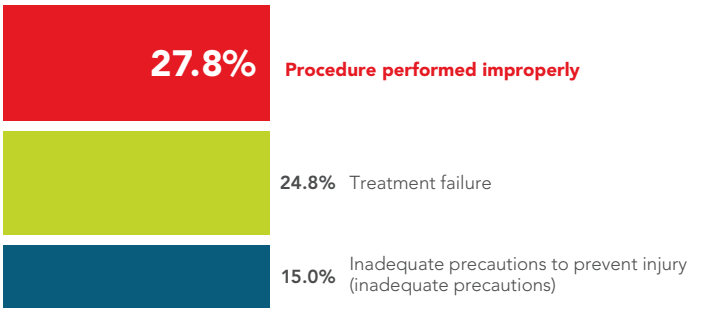
The patient filed suit for negligent care. During the claim investigation, a periodontal defense expert opined that the standard of care had been breached due to inadequate/poor quality imaging and inadequate treatment planning (failure to fully assess/treat the patient's periodontal condition and occlusal problems) prior to proceeding with costly restorative care. Bone loss progressed, which resulted in restoration failure. Total incurred claim costs approached $200,000, including damages, pain and suffering and future treatment (bone grafts, implants, full-mouth restoration).

A GP performed a coronally-positioned gingival flap procedure that failed to meet the patient's expectations. The patient filed a lawsuit alleging a permanent injury, disfigurement, pain, and loss of business income due to a poor surgical/cosmetic outcome. Defense experts were unable to support that the standard of care was met. The patient denied being offered an option for specialty care or alternate surgical procedures. Moreover, the patient record contained no supporting documentation to help bolster the GP's defense. Total incurred costs were in the high six figures.

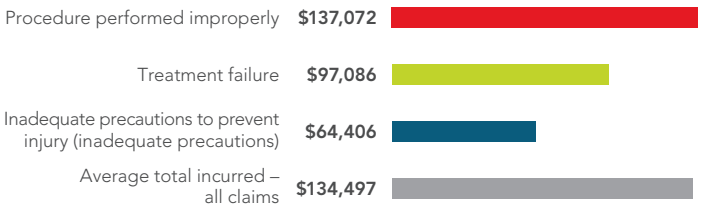
25 Crowns – Distribution and Average Total Incurred of Top Injuries

Dental procedure	Injury	Percentage of procedure	Procedure Average total incurred
Crowns	Corrective Dental Treatment Required (Corrective Treatment)	48.9%	119,313
Average Total Incurred – All Claims			$134,497

26 Crowns – Distribution of Top Allegations



27 Crowns – Average Total Incurred of Top Allegations



Simple Extraction

Figures 28, 29, 30 and 31 list the top injuries and allegations for claims associated with **simple extraction**. A comparison of the 2016 claim dataset to the 2020 claim dataset demonstrates that the severity of simple extraction claims has increased by 56.2 percent. This can be attributed to an increase in claims associated with post-treatment infection and related outcomes, including brain abscess and death. Among the top five dental procedures associated with PL claims, the average total incurred for simple extractions is second only to surgical extractions. (**Figure 5**, page 8).

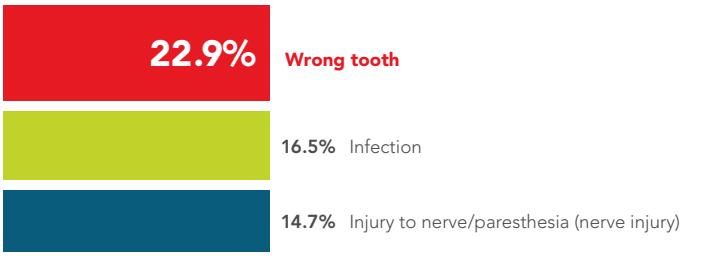
Similar to **surgical extraction**, the average total incurred for claims associated with **infection** and **nerve injury** exceeds $200,000. The most common injury – **wrong tooth** – is discussed in the next section on dental never events.

While **many dentists** may **consider simple extraction** to be "routine" and **low-risk**, since no tissue flap, bone removal or tooth sectioning is required, **claim experience** often **reflects the opposite**.

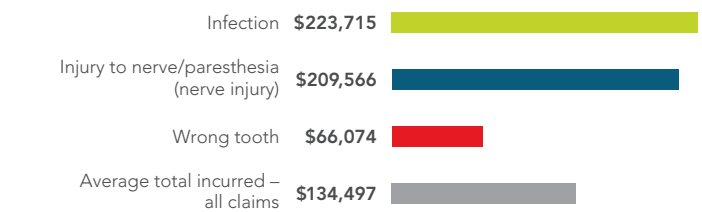
The top allegations of **inadequate precautions**, **wrong tooth** and **procedure performed improperly** are the same as **surgical extraction**, though the frequency varies. While many dentists may consider **simple extraction** to be "routine" and low-risk, since no tissue flap, bone removal or tooth sectioning is required, claim experience often reflects the opposite, as the following examples illustrate:

> *A 50 year-old male patient required simple extraction of erupted teeth numbers 15 and 16. The patient routinely presented at recall visits with heavy plaque and calculus in the area. On examination, both teeth had severe periodontal breakdown, with tooth number 15 also diagnosed with severe decay. The dentist recommended extraction of the teeth. During the surgery, a root tip and the buccal plate fractured and the root tip entered the sinus. Post-surgery, the patient developed chronic sinusitis and severe pain. A complex cascade of complaints and symptoms led to long-term opioid pain management, antibiotic therapy and nerve ablation surgery related to a diagnosis of trigeminal neuralgia. The patient allegedly required long-term medical management related to permanent nerve injury. The plaintiff attorney asserted inadequate discussion of treatment options, failure to offer a referral for endodontic evaluation, and inadequate management/referral post-surgery. Documentation in the patient record and subsequent expert review did not support the defense of these allegations. Total incurred costs exceeded $300,000.*

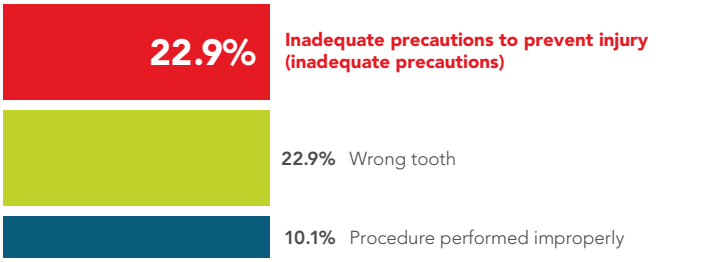
28 Simple Extraction – Distribution of Top Injuries



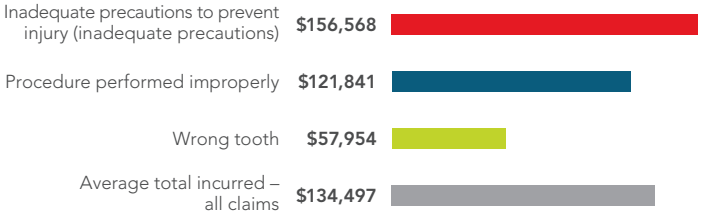
29 Simple Extraction – Average Total Incurred of Top Injuries



30 Simple Extraction – Distribution of Top Allegations



31 Simple Extraction – Average Total Incurred of Top Allegations



A 58 year-old patient with a history of suboptimal home care resulting in prior extraction presented with pain in the posterior mandible. The patient refused RCT and, following consultation, decided on extraction of the second molar tooth. The dentist prescribed pain medication and antibiotic therapy. A few days later, the extraction site appeared to be healing with no signs of infection, although the patient complained of discomfort. One week after extraction, the patient presented for medical evaluation with a fever and facial swelling. The provider changed the antibiotic, which proved to be ineffective. A few days later, the patient was hospitalized with a recurring fever. Incision and drainage with IV antibiotics were effective and the patient's condition improved. However, the patient developed severe temporomandibular joint dysfunction requiring ongoing medical and dental care. Failure to diagnose infection, ineffective prescribed medications and inadequate informed consent were alleged, with injury resulting in long-term dental disability. A lack of documentation of the informed consent process delineating risks associated with the procedure, as well as a lack of documented post-surgical patient instructions, led to difficulty defending the case and resulted in total incurred costs in the mid six figures.

Risk Management Spotlight: Swallowed/Aspirated Objects

Click here for further risk management information on never events: swallowed/aspirated objects and wrong tooth treatment.

Dental Never Events

According to the National Quality Forum (NQF), "never events" are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a serious problem with the safety and credibility of a health care facility. While this definition was initially proposed for hospitals, its implications are also relevant to dental practices.

KEY FINDING

Incidents of **swallowed-aspirated object** and **wrong tooth** treatment – considered to be two of dentistry's "never events" – have increased in frequency and continue to be an important patient safety concern.

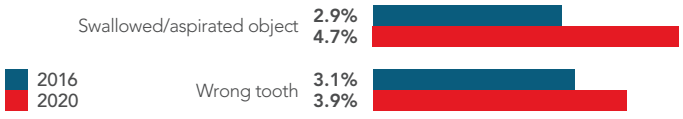
Figure 32 illustrates that these two injuries combined now account for 8.6 percent of claims in the 2020 claim dataset.

Though typically not the most costly dental claims, individual cases periodically can and do lead to severe losses and liability. Incidents of **swallowed-aspirated objects** have increased in terms of severity as they may immediately result in a life-threatening medical emergency. Patients also may be initially asymptomatic for either a swallowed or aspirated object and develop severe complications weeks or months after the incident. **Swallowed-aspirated objects** present a universal risk in the dental office, irrespective of the procedure.

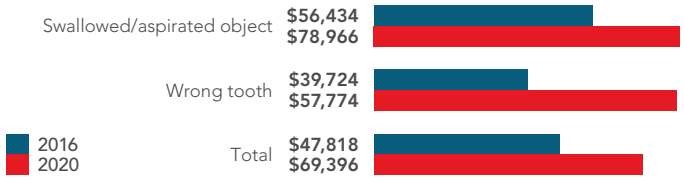
Never events such as **swallowed-aspirated object** and **wrong tooth** are "preventable harm" in the majority of cases. With increasing claims in this area, dentists should review their patient safety protocols to ensure that risk reduction strategies have been established, updated and implemented. See **Part 4**, on page 18, for further risk management recommendations.

Wrong tooth treatment reflects the top injury for **simple extraction** in the 2020 claim dataset (**Figure 28**). The risk of **wrong tooth** treatment exists for all dental procedures, though claims related to extraction of the wrong tooth far outpace other procedures.

32 Distribution for Dental Never Events



33 Average Total Incurred for Dental Never Events



Part 4: Risk Management Recommendations

This section provides risk management strategies to assist in the mitigation of risk exposures relevant to practicing dentists. Dentists may access additional risk management content on the Dentist's Advantage website.

Patient Assessment and Treatment Planning

- Review and closely follow appropriate evidence-based clinical guidelines, including those for the use of antibiotics and potentially malignant disorders. Access additional resources on oral cancer at the American Dental Association and Academy of General Dentistry websites.
- Complete a thorough patient assessment in order to determine the recommended treatment approach and acceptable alternatives. Utilize additional diagnostic information, such as CBCT imaging, when necessary to prevent or minimize the risk of nerve damage or other injuries.
- Consider appropriate consultations/referrals and ensure thorough documentation of diagnosis and treatment rationale to support a strong defense in the event of a claim.
- Verify that a patient's demands for a specific treatment option do not supersede a professional's judgement in weighing the risks and benefits of proceeding with care. The patient's demand does not absolve the dentist from meeting the standard of care.

Informed Consent

- Ensure that the informed consent process is completed and documented, including communication about the risks, benefits, alternatives and outcomes, as well as details pertinent to the individual patient's concerns and questions.
- Conduct a well-documented consent discussion that includes patient expectations, whether outcomes are of a cosmetic or functional nature.
- Disclose the costs associated with treatment options in order to avoid the risk of miscommunication and frustration, which may lead to PL claims or complaints to licensing boards.
- Implement consent forms for procedures with high claim frequency, significant risk of injury and for other complex/costly treatments.
- Provide the patient a copy of the written consent forms.

Services Within the Scope of Dental Specialty Care

- Maintain the skills and experience required to meet the standard of care for the treatment options provided.
- Offer and document referral options that are provided to the patient, regardless of level of skill and experience of the dentist.

Treatment Follow-up

- Emphasize the importance of recognizing the signs of infection with patients and provide written post-operative instructions that include information about obtaining care outside of the regular office hours.
- Assess patients with symptoms consistent with nerve injury as soon as possible or provide immediate referral to a nerve injury specialist. Document all discharge instructions in the patient record.

Never Events

- Implement protocols to prevent wrong tooth treatments, such as a "time out" policy, based upon the Joint Commission's Universal Protocol for preventing wrong site surgery.
- Utilize and document prevention methods for swallowed-aspirated objects such as: dental dam or other barriers, high velocity evacuator systems, dental floss tied to implant tools, fixed bridges and other objects, and consider dental chair/patient positioning.
- Implement written medical emergency protocols, along with staff training, and conduct mock emergency drills.
- Ensure medical referral for patient assessment, imaging and monitoring as necessary.

Dental professionals should continuously seek and implement safety improvements that will benefit both patients and dental healthcare workers. An American Dental Association initiative on safety culture in the dental practice may be of interest for further information.

Part 5: Analysis of License Protection Matters with Defense Expense Payment

Introduction

License protection (LP) matters involve actions associated with state regulatory agency civil investigations (i.e., dental licensing boards) submitted to CNA and pursued in the defense of insured dentists. A regulatory or licensing board action against a dentist's license to practice differs from a PL claim in that it may or may not involve allegations related to patient care and treatment. While LP matters may be independent of any PL action, licensing boards may require that reports be submitted to the board as the result of a PL judgment or settlement against the dentist.

Dataset and Methodology

The 2020 claim dataset discussed in this section consists of LP matters which closed between January 1, 2015 and December 31, 2019, and resulted in a defense/expense payment of at least one dollar. These criteria, applied to the total number of reported dental LP matters, create a 2020 claim dataset consisting of 1,786 closed matters. Similar criteria produced a 2016 claim dataset comprised of 1,623 closed matters.

While **LP matters** may be **independent of any PL action**, licensing boards may require that **reports be submitted to the board** as a result of a **PL judgment or settlement** against the dentist.

34 License Protection Matters – Percentage Increases Between 2016 and 2020 Datasets

	Percent Change 2016 to 2020
Average Number of LP Matters with Expense Per Year	10.0%
Total Expenses Paid	18.7%
Average Payment Per LP Matter	8.1%

Data Analysis

Comparison of 2016 and 2020 License Protection Matters

As shown in **Figure 34**, the average number of annual LP matters has increased by 10 percent since the 2016 claim report while the average payment per LP matter increased by 8.1 percent (from $4,096 to $4,428). A comparison of total expenses paid demonstrates an increase of 18.7 percent since the 2016 claim report.

KEY FINDING

The total paid expense for **license protection** matters increased by 18.7 percent.

License Protection vs. Professional Liability. What is the difference?

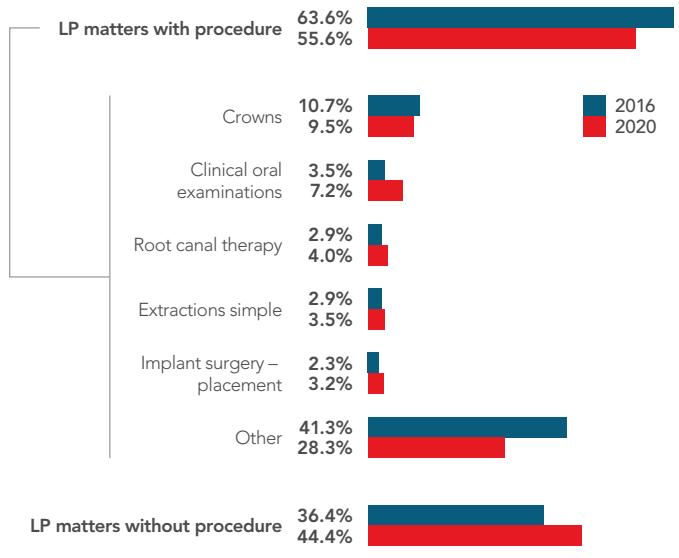
License Protection	Professional Liability
Inquiry by the State Board of Dentistry, arising from a complaint.	**Civil lawsuit** arising from a patient's malpractice claim.
Allegations can be directly related to a dentist's clinical responsibilities, and they can be of a nonclinical nature, such as physical abuse, unprofessional behavior, or fraud.	**Allegations are related to clinical practice** and professional responsibilities.
The State Board of Dentistry can suspend or revoke a license. Its primary mission is to protect the public from unsafe practice.	**The civil justice system cannot suspend or revoke your license to practice.** Professional liability lawsuits serve to fairly compensate patients who assert that they have suffered injury or damage as the result of professional negligence.
	A professional liability claim with or without a civil lawsuit may result in a license protection inquiry.

Analysis by Dental Procedure

While the overall dataset includes 70 to 80 unique dental procedures associated with LP matters, this section highlights the top five procedures (**Figure 35**). Many LP matters are not associated with a specific dental procedure. Instead, 36.4 percent of matters in the 2016 claim dataset and 44.4 percent of matters in the 2020 claim dataset were not associated with a specific dental procedure. The listed procedures represent approximately 63.6 percent (2016 claim dataset) and 55.6 percent (2020 claim dataset) of LP matters. The case scenarios in this section illustrate allegations related to procedural issues or injuries.

In the **2020** claim dataset, **LP matters** related to **clinical oral examinations more than doubled**.

35 Analysis of Top LP Matters with Procedure



Clinical Oral Examinations

In the 2020 claim dataset, LP matters related to **clinical oral examinations** more than doubled. While this procedure was not a part of the top five of the 2016 claim dataset, it is in the 2020 claim dataset, representing 7.2 percent of total LP matters. The following scenario, as well as some of the complaints listed in the subgroup analysis, will demonstrate risk exposures that may be associated with **clinical oral examinations**.

> *An adult female patient filed a licensing board complaint regarding her new patient examination. After the examination and dental prophylaxis, the dentist met with the patient to discuss findings and recommendations. The dentist allegedly explained that she needed an emergent gingival graft on an upper molar and, if not completed within one month, it may be too late and the tooth may require extraction.*
>
> *The patient was skeptical about the necessity of the treatment and sought a second opinion. The subsequent dentist disagreed with the diagnosis and advised that, while the patient did have recession, it was his opinion that a graft was not required. The licensing board sent a non-disciplinary advisement letter. The letter noted that the dentist had no history of prior disciplinary action, but warned of the potential for future sanctions and recommended improved communication.*

Implant Surgery

Allegations related to **implant surgery** comprise 3.2 percent of total LP matters. The defense of these allegations can be complex and costly, with cases often also associated with PL claims as seen in the following scenario:

> *The complaint resulted from a professional liability action related to the damage of a healthy tooth following a dental implant placement. Following settlement, a subsequent licensing board investigation was initiated. After a comprehensive review of the case records, the board's clinical expert opined that the standard of care had been breached. Following a two year licensing board investigation, the dentist decided to voluntarily relinquish his dental license in lieu of facing the significant costs associated with proposed disciplinary sanctions.*

Analysis by Allegation – Complaint Group/Subgroup

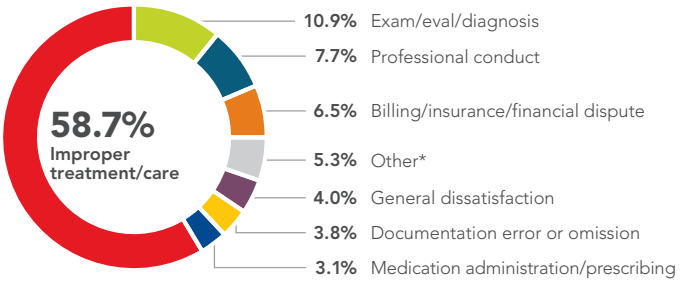
This section of the report highlights the most common licensing board allegations against dentists. **Figure 36** summarizes the distribution of LP matters by complaint in the 2020 claim dataset. Allegations of **improper treatment/care** comprised 58.7 percent of all closed LP matters. **Exam/evaluation/diagnosis** was the second highest allegation by distribution at 10.9 percent, while **professional conduct** followed at 7.7 percent. Each of these top allegation categories will be discussed in greater depth in this section of the report. **Figures 36a-c** report the top allegation subcategories.

Improper Treatment/Care

Improper treatment/care significantly exceeds other closed LP matter allegation categories at 58.7 percent. This category includes allegations of a restorative or surgical standard of care breach, as well as allegations of treatment not being completed, unnecessary treatment and infection control breaches, as detailed in **Figure 36a**.

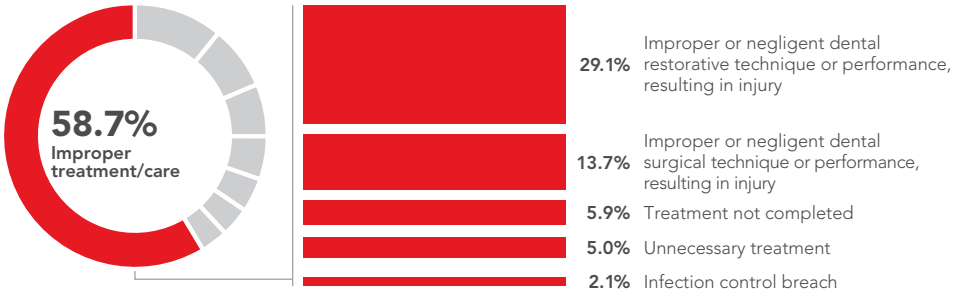
36 Analysis by Allegation

* Other Miscellaneous Allegations



36a Improper Treatment/Care Analysis

This figure is limited to top improper treatment/care allegations.



While many board investigations do reveal cases of substandard care, complaints in the **improper treatment/care** category also are initiated due to patient frustration, anger, or miscommunication/lack of communication between the patient and dentist, as demonstrated in the following scenario. Careful documentation of information discussed and shared with the patient can help to mitigate communication-related risks.

> *An adult male patient filed a complaint with the dental board alleging negligent care. The investigation revealed that the patient received a treatment plan for restorative care and RCT on two teeth. The dentist completed RCT on the two teeth with no complications and temporary fillings were placed. The patient was advised that it was necessary to return for crowns, as well as other restorative care, but did not receive a written treatment plan or documented instructions. The patient did not return until eight months post RCT, at which point the temporary fillings had been lost, and a tooth had fractured – which the dentist subsequently extracted gratis. The patient complained that the fracture and extraction resulted from negligent care. After approximately a year, the board closed the investigation, finding no probable cause.*

LP matters related to **treatment not completed** comprise 5.9 percent of all LP matters. These cases often reflect frustration, including issues such as:

- Initiation of treatment, followed by referral due to complexity or treatment failure.
- Appointment scheduling delays for various reasons.
- Patients who disagree with and challenge treatment recommendations.

Another allegation of improper treatment/care includes complaints of **unnecessary treatment** at 5.0 percent. The following scenario provides an example of when **unnecessary treatment** was allegedly recommended and completed:

> *The spouse of a patient filed a complaint with the board against the treating GP regarding unnecessary and sub-standard treatment related to a detailed treatment plan for extractions, implants and restorations. The licensing board engaged a prosthodontist expert who, after a review of all the clinical records, opined that much of the recommended care was questionable. The prosthodontist also concluded that the quality of the work performed failed to adhere to the standard of care, with multiple acts of gross negligence. A board citation levied several fines and also required continuing education with a period of restricted practice.*

Although a complaint may be initiated related to care or treatment, the licensing board investigation often leads to other deficiencies which are frequently the result of **documentation** matters, such as failure to comply with state regulatory requirements, as noted in the following example:

> *The dental licensing board received a complaint against a dentist alleging care and documentation lapses with multiple patients. The board requested the complete dental record for 10 patients, as well as information/records related to infection control/sterilization logs, nitrous oxide analgesia administration, continuing education and amalgam separator maintenance logs. After a year of investigation, the board found substandard recordkeeping including incomplete medical histories, undocumented medical consultations, missing progress notes and failure to maintain adequate sterilization logs. The dentist received a fine and admonition with conditional license restrictions which would be lifted upon completion of required continuing education.*

Exam/Evaluation/Diagnosis

Top allegations for the **exam/evaluation/diagnosis** category are noted in **Figure 36b**. The allegation of **failure to diagnose** is the top subgroup in this category comprising 4.9 percent of all LP matters. This category includes LP matters related to failure to diagnose a periodontal condition, failure to assess patient's expressed complaints/symptoms and failure to diagnose oral cancer, among others. An example includes:

> *An elderly patient sought care for problems with his existing removable full and partial dentures. After examination and prophylaxis, the dentist recommended soft liners in the patient's dentures to improve tissue health before completing relines and repairs. After a few months, the patient failed to return for the completion of the treatment plan. The patient had apparently sought care with another provider, believing that his issues were not resolved by the insured dentist and was eventually diagnosed with oral cancer. Several months later, the dentist was notified of a board complaint filed by the patient's spouse following his death. Upon investigation, the board determined that the dentist had breached the standard of care by failing to perform a comprehensive oral exam, including an oral cancer screening. The dentist also failed to document a complete medical history, to include history of significant cardiac complications. A consent order was issued, which encompassed several disciplinary actions including a fine, license probation/restriction and continuing education.*

[A] licensing board **investigation often leads to other deficiencies** which are frequently the **result of documentation matters**…

36b Exam/Evaluation/Diagnosis Analysis

This figure is limited to top exam/evaluation/diagnosis allegations.

Professional Conduct

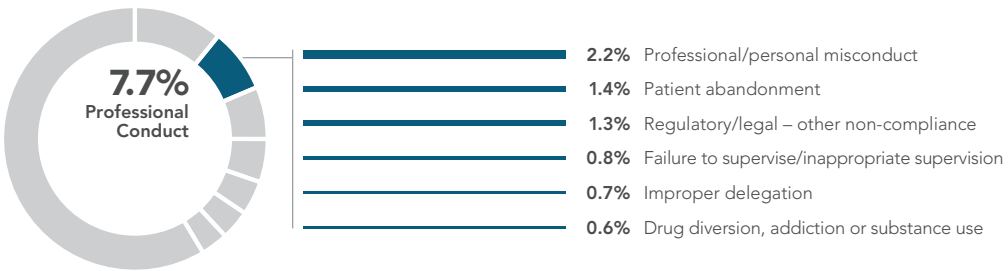
Professional conduct allegations represent 7.7 percent of all closed LP matters in the 2020 claim dataset as seen in **Figure 36c**. Although the proportion of data may appear minimal, a review of the top LP matters that resulted in action taken by the board (**Figure 39**) in the next section demonstrates that 32.8 percent of these allegations resulted in board action.

Professional conduct LP matters typically involve allegations of failure to exercise sound professional judgement. Included in these actions are instances of **drug diversion**, **patient abandonment**, and **failure to supervise** or **inappropriate supervision**. Cases under the **drug diversion-substance use** subgroup are almost equally divided between drug diversion and substance use. Increased requirements, regulations and oversight related to controlled substances have expanded nationally and in virtually every state and jurisdiction, as the nation continues to battle the opioid epidemic. Therefore, dentists must understand and comply with all controlled substance requirements, including prescribing and pain management guidelines.

Also included in the professional conduct subgroup are **regulatory/legal non-compliance/other**. Examples of allegations in this subgroup include: ignoring a board's request for records, failure to understand or seek a permit to administer oral sedation, performing cosmetic procedures beyond the scope of dental practice, and failure to observe requirements pertaining to the state prescription drug monitoring program. An additional exposure in this subgroup encompasses allegations of false/misleading advertising, including the false promotion of dental specialty status.

36c Professional Conduct Analysis

This figure is limited to top professional conduct allegations.



Analysis of Licensing Board Actions/Outcome

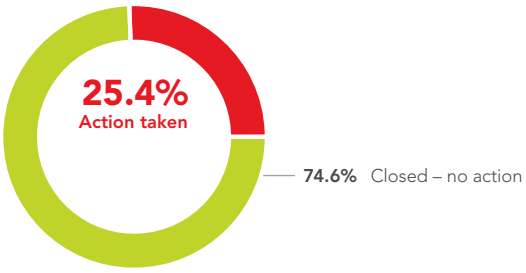
Disciplinary actions imposed by the licensing board may include fines, public reprimands, continuing education, monitoring, remediation, practice restrictions or suspension, and license revocation. These actions may affect a dentist's licensure and ability to practice.

Figure 37 presents the distribution of licensing board actions, illustrating that 74.6 percent of LP matters closed with the licensing board deciding to take no action. It is important to consider that a licensing board may reopen cases at a later time and, unlike professional liability matters, there may be no statute of limitations applying to a complaint against a professional license, dependent upon relevant state regulations.

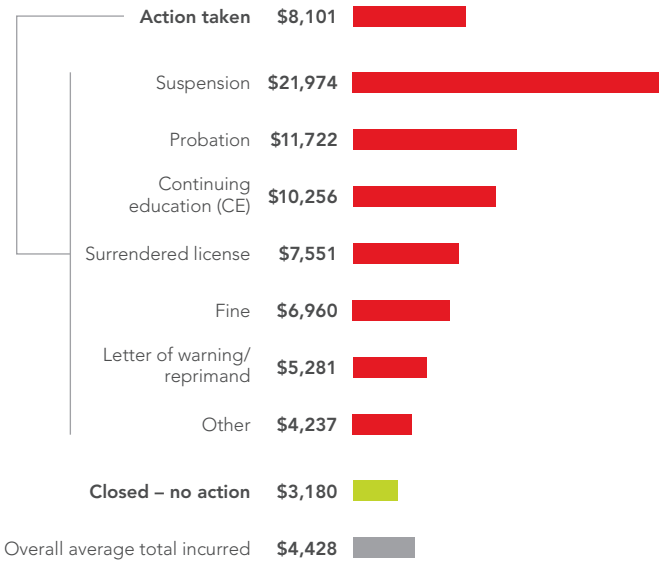
Licensing board complaints represent an inexpensive means for a patient to seek a remedy from, or retribution against, a dentist. The dental licensing board (or in some states, the board of health or another agency) is authorized and/or mandated to investigate all complaints in the interest of protecting public health and safety. Irrespective of their merit or final outcome, all complaints and board investigations instituted against a licensee may pose significant emotional and professional impact upon a dentist and other dental practice personnel.

It is **important to consider** that a **licensing board may reopen cases** at a later time and, unlike professional liability matters, there may be **no statute of limitations** applying **to a complaint** against a professional license…

37 Board Action Analysis by Distribution



38 Board Action Analysis by Average Total Incurred



37a Board Action Analysis by Action Taken Subgroup

Figure 39 further examines the disciplinary actions taken against licensees and analyzes the 25.4 percent of allegations that were closed with action. This analysis demonstrates that some allegations were more likely to result in board action.

KEY FINDING

License protection matters associated with **documentation error or omission** resulted in board action in 59.7 percent of complaints. Allegations of **medication administration/ prescribing** resulted in board action in 50.9 percent of complaints, and **professional conduct** in 32.8 percent.

Although it may be difficult to prevent complaints from being filed, following risk mitigation strategies, including strict adherence to state practice acts and standards of care, proactively obtaining professional education and training to maintain clinical competencies, and effective documentation help to increase the likelihood of a "no action" decision by the board.

The Importance of Documentation

The healthcare record is a legal document. A well documented record can:

1. **Provide an accurate reflection** of patient assessments, changes in clinical state, and care provided.
2. **Guard against miscommunication and misunderstanding** among dental/ medical providers and all patient care team members.
3. **Demonstrate your competence as a provider** and help to bolster your credibility.
4. **May help guard** against a lengthy litigation process.

…strict **adherence to** state practice acts and **standards of care**, proactively obtaining **professional education** and **competencies**, and **effective documentation** help to **increase** the likelihood of a **"no action" decision** by the board.

39 Top License Protection Allegations with Disciplinary Action

Allegation	Percentage of LP Matters	Closed with action
Documentation error or omission	3.8%	59.7%
Medication Administration/Prescribing	3.1%	50.9%
Professional Conduct	7.7%	32.8%

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