Minimizing Risk:
The importance of taking and documenting Medical and Dental history
By Marshal S. Endick

Dental practitioners routinely face malpractice claims stemming from the failure to take and document a proper medical and dental history. The potential risks of such failure can be catastrophic, both from a patient care perspective, and with respect to the potential for significant jury or settlement awards. The likelihood of adverse outcomes in both the dental and legal arenas can be minimized by taking a thorough history, documenting it in the chart, following up with the patient on any potential contraindications to treatment and, where appropriate, obtaining medical clearance.

By way of cautionary tale, we note that in recent years we have seen an increasing number of dental malpractice claims where the failure to take and document a patient’s history was a central factor. For example, in one recent case, a patient bled to death shortly following a routine extraction. The patient had not disclosed, and the dentist had not elicited, that she had a liver disease which negatively impacted her clotting ability. The central issue in the case was whether the dentist had departed from the standard of care in taking and documenting the patient’s medical history and what he would have done differently had he known of the underlying medical condition.

In other recent cases, dentists have been faced with claims of failure to appreciate underlying cardiac conditions and prescribe prophylactic antibiotics leading to bacterial endocarditis. As lengthy hospitalizations, loss of earnings, exacerbation of pre-existing cardiac conditions and/or death of the patient are regularly claimed as the resulting injury, the potential damages in such cases can be significant. As these cases often stem from minor procedures, they serve as a reminder that even the most routine treatment should be preceded by the taking and documenting of a comprehensive health history.

Courts also routinely see cases involving the failure to appreciate the significance of drug allergies or adverse interactions with a patient’s medication regimen. The damages in these cases can be substantial. In one recent case, while performing routine extractions on a forty year old woman the dentist administered sodium pentothal as a sedative. The patient suffered respiratory distress during the procedure and had to be transported to a hospital via ambulance and underwent an emergency tracheotomy. She was in a coma for one month and sustained ischemic brain damage. During the ensuing lawsuit, the patient claimed that the dentist failed to take a proper history and, if he had done so, he would have appreciated that she had recently undergone radiation therapy for thyroid cancer, which created intolerance to sodium pentothal. The case was settled for $900,000.

As you can see, the stakes are high. The use of a pre-printed dental/medical history questionnaire can serve a valuable role in taking and documenting history. The use of such forms (often completed under the watchful eyes of office staff), however, is not a substitute for the practitioner exploring a patient’s dental or medical history directly with the patient.

For the sake of patient health and from a risk management perspective, we urge practitioners to take the time to obtain, document and respond appropriately to a patient’s medical and dental history. While taking an initial history is crucial, routine review and updating of the history is equally important. These steps should not be viewed as rote or administrative functions, but rather are essential to delivering quality patient care and minimizing the risk of adverse outcomes.

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