

**The Road to Dental Despair  
Is Paved With**

**Unrealized Expectations**

**A 5-Step Protocol to (Virtually)  
Lawyer-Proof Your Practice**

Duane A. Schmidt, DDS

© 2009 by Duane Arthur Schmidt.

All rights reserved. No part of this book may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publishers, except by a reviewer who may quote brief passages in a review to be printed in a newspaper, magazine or journal.

First printing

ISBN:

PUBLISHED By

Printed in the United States of America

## **Forward**

Duane Schmidt has written a clear, concise, easy-to-follow, five-point protocol to protect dental practitioners from the vicissitudes of the marketplace.

Regardless of your career stage, I think you will find this book useful. For newer practitioners, the issues covered here are both necessary and unavoidable (either to prevent or to surmount) for survival.

For more senior practitioners, you may have taken one or more of these issues for granted for a long time – and may be fortunate none has risen up to bite. For you, this book will be a gentle reminder to renew a guided tour of the modern landscape of dental practice.

In any case, you will not regret this journey for you will learn, as Dr. Schmidt learned in a half century of dental practice, that measures to insulate your practice actually amount to those same measures you may take to grow your practice..

David Johnsen, DDS, MS  
Professor of Pediatric Dentistry and Dean  
College of Dentistry  
University of Iowa

## Introduction

Every action we take in life is accompanied by a risk/reward ratio: The larger the risk, the larger the reward. For example, a trip to the grocery store may result in a car door dinged in the parking lot, a flat tire, or we might slip on a piece of dropped fruit in the produce aisle. These are relatively small risks, with relatively small rewards, i.e. bringing home the bacon.

On another level, as an acrophobic, I fear heights. As I type this, my hands are sweating just thinking about heights. Just saying the word ‘stepladders,’ prompts me to wipe my palms. And so, just as soon as I had earned some money, after I began my pediatric dental practice in Fort Dodge, Iowa, I took flying lessons to break my abnormal fear.

For a few weeks, over a half dozen hours, my instructor taught me the routine stuff—take-offs, landings, flying from point to point, maintaining altitude, vertical stalls and the like. One day he said, “Land the plane and stop on the runway as soon as you can.”

I did as asked, and when we stopped, he opened his door and stepped out on the wing and said, “It isn’t safe to fly with you anymore, Duane. Now, do three take-offs and landings and then come back here and pick me up.” Laughing, he dropped to the ground and waved me off.

My moment of truth had arrived. I gave my Piper Tri-Pacer full throttle and, when I reached take-off speed, I eased the wheel back into one of the most thrilling experiences of my life. I was soloing!

This is an excellent example of a risk/reward situation. The reward was monumental, huge, thrilling. The risk? The same size. Plenty. Experienced pilots have stalled out their planes during take-off or landing. And some never walked away from the crumpled craft. I’m still acrophobic. So much for my remedy.

Much the same is true in dentistry. We live on the threshold of great rewards. We will likely earn more income than most, will enjoy greater community prestige than many, and our advice and counsel may be widely sought after. We often live in finer homes, drive classier cars,

belong to the better clubs, take fancier vacations and educate our children in more expensive institutions than any outside of the top one percent of the population.

But our opportunity for huge rewards carries stratospheric risks. At the worst, a patient may become injured or even die in our dental chair. We clearly exist in a rarefied atmosphere. And there cannot be too much attention paid to mollifying the risks we live amidst daily. There is simply too much at stake.

But the entry-level problem with today's risk management discussion is that it is self-centered. Dentists are taught that risk management is all about them. Too often, risk management is a musty topic, to be brought out of the closet once in a while, dusted off, boringly talked about, then swept under the rug to be forgotten. Later, prompted by pangs of guilt, we drag it out once again and doze through yet another discussion of the dreaded topic, risk management.

In truth, however, risk management is a courtesy we extend to our patients. For they benefit from a practice that cares enough to protect them, by instituting steps to assure their best interests. That the doctor also benefits is merely a handsome rebound and a payback that so few doctors understand. A savvy understanding of risk management is what this booklet is all about. As we have learned at Gentle Dental, you will learn that good risk management is merely practice management dressed in a tuxedo.

### **The needs of the patient:**

The Mayo Clinics, in Rochester, Minnesota, Scottsdale, Arizona and Jacksonville, Florida, reportedly accept around 600,000 new patients annually. Long an admirer, and a patient, of this facility, I have tried to put my finger on the elements that make their clinics so successful. Our dental office of 55 employees who utilize 34 chairs and accept 400+ new patients monthly, certainly, in my opinion, needs to run on a similar philosophy.

One day while browsing in the Mayo library, I found the statement of principle expressed by the Doctors William and Charles Mayo in the early years of the 20<sup>th</sup> Century. These seven words epitomize the essence of patient care at Mayo: "The needs of the patient come first."

As I read those words, I realized that we had already matched that statement with the words that had guided our growth at Gentle Dental: "Every patient leaves this office a better person than when they entered." Not quite the same words but certainly the same essence.

Over the years, our office—Gentle Dental in Cedar Rapids, Iowa—had been plagued by distractions from patients who bore some grievance or another. As we fielded these patients' complaints, we came to realize that, when an untoward circumstance occurred, we needed to analyze it, and then create barriers to prevent its recurrence. And, as those barriers grew, we came to realize that, when we were freed from extraneous issues, we found greater time to focus on our office goals.

The truth of the matter is simply this: Sturdy distraction barriers equal the highest form of practice management. And from this knowledge was born my 5-point risk management protocol. Over many years of treating hundreds of thousands of patients, it has never let us down. It is our contention that our colleagues may follow it safely to a new level of growth.

## **1. Informed Consent**

Today, a dozen dentists received a letter that changed their lives. By the end of the month, hundreds more dentists will have received a similar letter. And by the end of the year, thousands of dentists will have become an ill-fated recipient of this infamous letter. The letters all begin in much the same way: “Dear Doctor, We represent your patient (Mrs. Martha Gotrocks) who reports that she received substandard care in your dental office. We demand that, by return mail, you send copies of all your records, charts and X-rays pertaining to her treatment to our office.”

And now the terrorist attack has commenced and the dentist is aligned in the crosshairs of a litigious rifle. Whatever happens next will cause grief and anguish, lost sleep, time and money, and cause a cloud to hover above the dentist’s head forever. And, if dentists think they are protected because they have professional liability insurance, they live in La-La Land, and are easy game for repeated attacks.

Insurers, out of necessity, may decide to throw a few thousand dollars at the problem, rather than hack it out in court, where the dentist actually might win, but at a far higher cost. It’s simply more economical for them to resolve the problem this way. And the patient’s lawyer, knowing this truth, realizes that he or she may reap a few thousand dollars of reward for merely sending a few form letters. But the cost to the dentist lingers forever.

Consider this scenario: The time is the middle of December. The doctor realizes that not only is payroll due, plus rent and utility payments, but the equipment payment is closing in, as is the 4<sup>th</sup> quarterly tax return. On the home front, Christmas looms and the kids want pricey electronic stuff. The mortgage payment only awaits the turning of the calendar page, as does the car lease, club dues, utilities and, beyond those little concerns, the family would like to eat. To add to this misery, the dentist’s credit cards are fairly well maxed out. And he opens the checkbook with dread and his worst fears are realized.

Just then, the assistant breaks into this reverie of dread to remind: “Mrs. Gotrocks is seated in chair two, doctor.” A smile slowly creases the dentist’s face and a light goes on.

“Good morning, Martha, how are you, my dear? What a charming outfit. I love you in those colors.” He covers her hand with his other hand. Mrs. G. thinks her dentist is next to God, and he gives her hand an extra squeeze. Mrs. G. blushes and giggles and the plot thickens.

At the mention of Mrs. Gotrock’s name, he had recalled that he had been watching six teeth with large fillings for her for the past several years. And he had told her that the day would come when those teeth might need to be crowned. Now, as he examines her teeth, he makes the appropriate comments: “HmMMM. What happened here? Brenda, get some PA X-rays on these teeth. I want to see how far that small crack goes.” Mrs. G. is unaware that cracks can rarely, if ever, be seen on X-rays.

“Is it serious, Doctor?” Mrs. G.’s brow wrinkles.

“Now Martha, would we ever let something serious happen to our favorite patient?”

The X-rays are examined and studied intently, as Mrs. G. threads her hanky through her fingers. Finally, he covers her nervous hands and says: “It’s not all that bad, Martha, but you recall those teeth we’ve been watching? We both knew that the day would come when they would need crowns.” She nods. “Well, I guess it’s time we took control, before we let them take control of you.”

“The crowns? I need them now, Doctor?”

“Yes, I believe it is time. But to make it as easy as possible for you, let’s do three preps today, then next week when we seat those crowns, we’ll prep the other three. You’ll have all the new crowns before Christmas.” He lays down his mouth mirror and studies the X-rays again.

“Can you do them that quickly, Doctor?”

“Well, we’ve got a little more free time around the holidays and it just occurred to me, when you and Tom go to Florida for the winter, you can go comforted by the fact that those little fella’s are not going to spoil your vacation.”

“Doctor, you are so caring.”

“That’s why we’re here, Martha. Brenda set up the tray for Martha’s crown preps.”

So we ask: “Excuse me, Doctor. The needs of the patient ... they were supposed to come first, remember?”

“But I’m only advancing the clock a few months ... or years ... and she really needs the crowns. Well, maybe not now, but she soon will. And this is certainly no financial hardship for Mrs. G. And I have the time. And, too, now she shouldn’t have a problem in Florida, and ... yadda, yadda, yadda.” By now, the Doctor has convinced himself that he is acting in the best interests of his patient.

A few months later, the Doctor opens a registered letter, ‘return receipt requested’ and it begins: “Dear Doctor: Please send us all the records, charts and X-rays for your patient: Martha Gotrocks.”

The Doctor sinks into a chair, uttering a small oath. He knows what happened. Those gorgeous crowns failed to live up to Martha’s expectations. He learns that only a few weeks after he seated them, three of those teeth blew up, i.e. became inflamed, agonizingly sore and needing prompt, emergency care. And this occurred while Martha was still in Florida.

Now she has returned sporting several thousand dollars worth of fresh root canal fillings and, prompted by her husband, has talked to her attorney. Martha has blood in her eye. Her favorite dentist is no longer her god. He has fallen from grace.

But the Doctor has liability insurance, so not to worry ... right? Well, let’s look into that. This year, dentists will purchase over a third of a billion dollars worth of professional liability insurance. Take away a few percentage points for profit and the rest of that money, tens of millions of dollars, is spent defending dentists from patients who expected their dentist to deliver heaven when they could only deliver earth.

The Doctor knew going into Martha’s procedures that teeth that have suffered large intrusions of decay, and that now sport the resultant major fillings, are top candidates for the risk of having had permanent nerve damage. As we all know, while the tooth may remain symptom-free at the time of crowning, permanent nerve damage may be brewing within. And, eventually, this quiescent, chronic infection flares to become acute, with all the classic symptoms. A costly root canal filling is the only treatment if the tooth is to be saved.

How simple it would have been at the outset for the Doctor to have taken two minutes to inform Martha of this risk. She would have understood and been somewhat prepared. But sometimes the eagerness to serve one’s own needs overrides the necessity to serve one’s patient’s needs. And greed often greases the skids that propel us headlong into disaster.

Professional Risk Management expert Tom Beckett reports that 80% of the steady trove of unhappy dental patients stem from expecting far more than the dentist could deliver. The culprit, in this sad scenario, is always the dentist. He let the patient expect a result even he could not deliver.

And more often than not, the deception—innocent though it may be — is done under the banner of ‘patient education.’ In fact, we’re all aware that most patient education is a not-so-subtle sales pitch designed to nudge a patient into buying an elective dental service: a bridge, crown, denture, tooth whitening, tooth straightening, and the like.

And when the appeal is laced with beautiful positives — and the negatives are ignored or downplayed—patient expectations may well be elevated far higher than can realistically be delivered. Later, when the dawn of reality rises, and fancied expectations fail to materialize, seeking redress is the first expedient. And that’s what attorneys do so well.

Greed is a jealous mistress. And the pages of virtually every newspaper are filled with reports of people who put their own greed ahead of the needs of their patient, their customer, or the needs of their constituency. The perpetrator is almost always disgraced, humiliated, shamed and possibly fined and imprisoned. Often bankrupted.

Am I exaggerating this scenario? Not really. In many respects, cheating is the gold standard of the business world. Cheating in business is endemic and is one of the greatest barriers to success in the business world.

A business guru of the last century, Earl Nightingale, noted: "If honesty were not a known trait in business, it would have to be invented. For, honesty is the only policy that works in the business world."

I once diagnosed a problem for a lad whom I thought I was seeing for the first time. The solution I offered was rather complex and somewhat expensive. His mother promptly gave me the go-ahead. Surprised by her quick decision, I asked how she could make up her mind so quickly.

She told me, "Doctor, you saw Michael last year and told me that he needed the exact same treatment. But then, I stalled. Now that I hear you say it again, I know you are telling me the truth."

Spanish orator, Quintilian, circa 35 AD, wrote: "A liar ought to have a good memory." Few of us have a good enough memory to become skillful liars.

But, if the only reason to not cheat is that one may be exposed, the cheater just doesn't get it. Honesty is its own reward, for businesses leave tracks. That is, they build reputations. And reputations get talked about and become the most sought-after marketing medium. While word of mouth is, by every standard, the finest form of advertising, it is the only acceptable way to build a durable, lasting business.

There's a corollary way to expose business cheating for what it truly is: Consider the relationship between two people, as in a marriage. What happens when a partner cheats on a spouse? He or she will do it again. And again. And soon it becomes commonplace. But, like so many prominent public figures who have been brought down in glaring limelight when exposed for their infidelity, or some other kind of cheating, there is no escape. Cheating comes home to roost, under the family roof, the business roof, or the political roof. And every participant, willing or not, is injured in the process.

What would you suppose would happen to the Mayo Clinic if it were exposed for spurious billing, or for escalation of billings, or for cheating in any of countless possible ways? Correct. It would be the death knell of this incredibly fine institution. And that news would spread through the Mayo system like a California wildfire.

The stopper for this problem is twofold:

1. Do not oversell.
2. Use informed consents to lower patient expectations to the level of reality.

### **Informed Consent Techniques**

Informed consents whether given orally or in writing, have built-in problems. The office may get rushed and an informed consent talk is cut short, or hurried to the point of miscommunication. Or, being human, a chair-side may forget part of the precautions that must be delivered. A written informed consent may be half-read, hastened, or misunderstood. The result is the same. Our patient does not clearly understand this simple rule of life: The larger the reward, the larger the risk.

Further, some informed consents are written so as to gloss over possible negatives that might occur with a procedure. Informed consents that attempt to close the sale serve neither the patient nor the dentist. An honest informed consent reveals the possible negative outcomes of the procedure. Failing to be completely honest with the patient is disingenuous to the extreme.

In the 1980s, upon recognizing that the audio-visual format is a superlative tool for educative purposes, we scripted an informed consent video (ICV) for surgery. In short order, when we realized that the surgery ICV had worked so well, we added informed consent videos for crown and bridge, dentures, and root canal fillings. None of the films ran over four minutes. Each was clearly narrated, in simple English and well-illustrated. The information was given in an unhurried format and, being taped, was repeatedly given again and again, each time exactly like the time before. And, suddenly our patients got it.

To study demos of our informed consents, i.e. Surgery, Crown & Bridge, Root Canal Fillings, Dentures – in English, and also with Spanish subtitles – and to see an informed consent for Orthodontics, please access <http://www.PreOpEd.com>.

## **2. Binding Arbitration**

In the 1990s, we hired a national moving company to move a pricey old pump organ, complete with an ornate hand-carved bench. The bench never reached its destination and we sought redress from the mover. He said that when we engaged them, we had signed on to binding arbitration. Now, our choices were to accept their offer or to go to arbitration. This was an eye-opener and I studied the arbitration program, finally going to the American Arbitration Association for help.

That study led to the realization that binding arbitration is a growing way of life in America – used by banks, insurance companies, moving companies, the construction industry, international commerce, securities dealers, trade associations, professional societies, and in labor-management disputes. Virtually every one of us has signed a document requiring resolution of a conflict by binding arbitration, a home mortgage being a prime example.

The process is fairly simple: When a dispute arises, both sides pay a small stipend to fund the arbitrator's fee, who is someone with adjudication experience. Both parties may or may not be represented by a lawyer. The process is done quickly and fairly, in private, without publicity. Awards are considered more equitable than jury awards. HMOs and many health care providers are jumping onto the arbitration bandwagon, so why not dentistry?

Who opposes binding arbitration? Since legal counsel is not required, obviously some trial lawyers are against the process. As are many unions, wanting instead to negotiate and either strike or litigate for perceived benefits. Businesses that employ this concept, on the other hand, are solidly behind its use.

In consultation with the American Arbitration Association and legal counsel, we fashioned a binding arbitration statement for our office and promptly began asking new patients to sign off on this process. They did so on the introductory health questionnaire and on each informed consent release form, all carrying this notation:

“I further agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services, either in this instance or in any other treatment rendered by staff in this office, shall be submitted to binding arbitration under Chapter 679A of the Code of Iowa (1993) to the American Arbitration Association. It is understood by both doctors and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, patient and doctors have given up their right to a jury or a court trial.”

The morning we launched this program, my staff was certain that I had lost it. They were sure—and I was half sure—it might be a program we would back down from soon afterward. The confronting fear, upon launching such an *avant* program, was the dread of negative patient response. Further, our contact at the American Arbitration Association told us we would be the first dental office to use this technique. There's a small scare factor in being first, at anything.

Sure enough, on the first day, a new patient said that he would not sign the statement and he walked. After analysis, it seemed that he might have had some nefarious purpose in becoming our patient, and his walk may have been in our best interests.

However, since that single patient walked, literally hundreds of thousands of signed informed consent forms have been scanned and shredded, to now reside in our computer files. We invite our patients to sign twice: once when they submit their health history and again after watching an informed consent video.

In the first chapter of this booklet, I counseled the use of Informed Consent Videos as one barrier to prevent unwarranted litigation. The second nail in the coffin of senseless litigation is the employment of 'Binding Arbitration.' Legal in all fifty states, binding arbitration frees the courts from messy lawsuits. In the case of us dentists, those lawsuits are costly in terms of time, effort, money and angst. And the publicity they generate may besmirch our reputations beyond all measure.

When a patient expresses a desire to lodge a complaint, we first follow the admonition that I counsel, which is to use any means possible to defuse the situation: (see Chapter 5) that is, to offer an apology, a remake, or perform a repair. In short, do whatever it takes to assuage our patient's grievance. If the patient refuses to accept any of those tenders, then we offer our Patient Satisfaction brochure that outlines how our patient may pursue binding arbitration. A copy may be downloaded from our PreOpEd.com website.

Three national organizations are available to help our understanding of this simple process: the American Arbitration Association--<http://www.adr.org/>--the National Futures Association--<http://www.nfa.futures.org/dispute/faq.asp>--and net-ARB (interNET-ARBitration)--<http://www.net-arb.com/>. The AAA no longer adjudicates dental binding arbitration but the NFA and net-ARB do so. Net-ARB conducts its arbitrations conveniently by email and at a fraction of the cost. Ask your legal counsel to fashion a document that follows your state laws.

### **3. Payment**

It is a sad truth that some patients who want out of paying their bill will invent an excuse to charge that their treatment was rendered below the standard of care. The other half of that coin is that management experts tell us we dentists tend to extend too much credit, ending up with what is often staggering accounts receivable (a/r). And accounts receivable are nothing more than our money in someone else's pocket.

In the 1980s, realizing that our a/r was starving our cash flow, and stemming our ability to grow, we addressed the problem. First, we made sure we had the major payment plans available: Mastercard, Visa, American Express and Discover. Using a credit card scanner, the money is deposited into the office account daily.

Then, we connected a hotline to the Credit Bureau so that in twenty seconds we could check the credit worthiness of any person simply by typing their social security number into the line. The credit report, then, rated the patient by a number from one to five, with one being highly credit-worthy and number five extremely cautionary.

Finally we printed a sign for the front desk: Payment is Expected on the Day of Service.

For the patient who wanted to write a check, we installed a device that, upon running a check through the slot, gives us an electronic deposit authorization. At the end of the day, these checks are batched and deposited via a desktop deposit device, of which there are several on the market.

With our plan in place, we created treatment forms that listed the patient portion and the insurance portion. Now the patient may see exactly what was expected of them. The chair-side, then, asks the patient how he intends to pay. When the patient chooses a method, we verify that that option is available to them, depending upon the outcome of the credit report. For example, we accept no monthly payments. That's what banks and credit card companies do, and we are neither.

Patients with a number one credit rating were allowed to pay at the time of delivery. The higher number patients were asked to pay for crowns, bridges and dentures – half before delivery of the prep and the other half before the seat. For surgery or root canal fillings, these rated patients were required to pay in full before the service was delivered. If the patient balked, we simply blamed our accountant: "I'm sorry, but our accountant requires us to follow this payment policy."

In a short while, a/r that had exceeded 130%, began slipping lower until they now hover at 70%. [For this illustration, a/r are figured by dividing the monthly production into the a/r.]

#### **4. Staff Disclaimer**

The morning paper was uneventful except for one small, front page item above the fold, the position where newspaper editors place a 'hot' story. The headline read, "Local dentist charged with sexual harassment." It held serious implications for only one person: The involved dentist. And I read in stunned silence that it was me.

This story could have happened in any dental office in America. It revolved around a chair-side assistant who had been in my employ for eight months. Despite her demonstrated superb chair-side skills, Melinda could not work well with her teammates. I had long ago learned that one bad apple can indeed spoil the barrel, and Melinda had to go.

Wanting to save her the ignominy of being fired in front of her peers, I called her into my private office and closed the door. In my naiveté, closing the door was a serious breach of management ethics, inviting everything that was to follow.

I told Melinda her tardiness and unwillingness to arrive early to help the staff set up for the day, and her ease with slipping out early at the end of the day, had caused staff antagonism. I then wished her well in her next job. I handed her a severance check. She gathered her things and the situation was closed . . . or so I thought.

That proved not to be the case, and the morning newspaper told me how terribly wrong I had been.

A few days after Melinda left, I received a letter from a local attorney asking for \$15,000 to quell Melinda's story. Melinda claimed that she had been told to either have sex with me or be fired. Refusing my purported advances, she quit my employ.

The attorney's letter went on to say that if I refused to pay, I would be reported to the Civil Rights Commission.

Few moments in a dental practice carry greater terror. My attorney told me that sexual harassment is not covered by professional liability insurance and, therefore, my options were to negotiate a lesser amount, pay up, or face the consequences.

In my anger, I chose to ignore what I considered to be blatant blackmail and take my chances. The morning paper now revealed how foolish my decision had been.

There is a fallout effect that needs to be addressed. The jury of public opinion, fanned by a spurious charge, works the opposite of the rule of law where a charged person is innocent until proven guilty. In the jury of the public press, a charged person is guilty until they prove themselves innocent. This is not a happy situation to be in and exposing the fact that the employee had signed off to no cheating, while they were working for you, goes a long way toward dispelling a fabricated claim. Visit with your counsel about this thought, for this may be the finest idea you can cull from these pages.

### **No dentist is immune**

That this scenario plays out in dental offices everywhere testifies to the fact that we dentists have a serious breach in our ability to manage risk. An assistant, even though fired for good reason, may vent her spleen by seeking revenge in any of several forms. She may make a false report — as Melinda did — to the Civil Rights Commission. She might also report imagined violations of the Dental Practice Acts to the State Board of Dental Examiners or report noncompliance to OSHA rules and regulations. Dentists are also frequently accused by vengeful ex-employees of falsely elevating insurance codes or of illegal drug or prescription practices.

Charges such as these almost always make the news, but if they are proven to be false, that news is rarely deemed worthy of similar coverage.

### **Forestalling disaster**

While there is no foolproof way to bar the potential for these incidents, I discovered a strategy that has saved our office several times. We designed what we call a “staff disclaimer,” that all staff members must sign monthly. The text states that the staff member has seen no illegal billing, drug use, staff functions, or sexual harassment. And, if the staff member knows of any illegal office activity, he or she is invited to report it directly to the proper authorities. Contact information for the proper authorities is included on the staff disclaimer.

Here’s how our staff disclaimer document reads:

#### **STAFF DISCLOSURE Statement of Knowledge**

I understand that (INSERT NAME OF PRACTICE) requires a commitment to honesty and that one of my roles in this office is to help achieve that. In order for management to be aware of departures from office policy, I willingly report the following for the past twelve months:

#### **Sexual Harassment**

I have not seen an instance of sexual harassment either by the doctors or staff members. I agree to immediately report all such instances. I understand that patients who exhibit improper behavior are to be promptly dealt with by doctors and/or management.

## **OSHA**

I have been trained in OSHA procedures and know of no instance where (**INSERT NAME OF PRACTICE**) has failed to provide materials and staff for OSHA compliance. I agree to report such instances of staff failures, knowing management will deal with these.

## **Illegal Acts**

I know of no instance of illegal acts being performed by staff members. I agree to report such instances should I observe their occurrence.

## **Drug Abusive Practices**

I know of no instance where drugs have been abused by staff members. I know of no instances where prescriptions have been written for non-dental needs. I agree to report all such instances to management.

Management has informed me that I may report rules violations not only to management but also to any state authority having jurisdiction in those matters.

The staff signature, date and a witness signature follows. We have our signed forms notarized simply because a staff member is a notary public; but that is actually not integral to the program.

## **The Importance of Risk Management**

Superb risk management allows the doctor to focus on serving people, not fighting off former staff, or dissident patients. And with these efforts comes the realization that profound risk management barriers are the epitome of superb practice management.

An after-note: Melinda left town before any action by the Civil Rights Commission. I was thus denied even the opportunity to prove her claim was false.

## 5. Settle Quickly

Malcolm Gladwell, in his bestseller *Blink* (BackBay Books, ©edica2005), reports on a study by medical researcher Wendy Levinson, who taped hundreds of physician-patient conversations. About half the doctors had never been sued; the other half had been sued at least twice. Her findings were startling. The doctors who had never been sued spent at least three minutes longer with their patients than the doctors who had been sued.

The doctors who spent those three extra minutes more often oriented their patients with comments like, “Tell me more about that,” and “Let’s first talk about my examination findings then we’ll talk the problem over,” and/or “I’ll leave time for your questions when we’re finished.” Further, they were more likely to laugh and be funny during the visit.

In other words, they humanized their patient contact. This simple factor, Levinson believes, is a key point in human interactions. There is no reason to believe the same factors do not guide the thoughts and actions of our dental patients. Levinson reports that when some patients who wanted to sue their specialist were told by counsel it was more likely the referring doctor’s fault – a person the aggrieved patient actually liked – the patient refused to sue someone they held in higher esteem.

Solo dental practitioners can be a feisty sort. We have to be because we slug it out daily, each on our own turf, trying for the winning edge, the sale, the satisfied customer, the growth we feel entitled to. But there are some patients whom we either will not please or cannot be pleased. As my friend jokes, “Some people would complain if you hung them with a new rope.”

A displeased patient, if he does not vote with his feet and simply walk, seeks one of three responses: 1. Awareness of his complaint, 2. a rebate, or 3. retribution. Often he will settle for the simple admission that we were wrong. But we dentists tend to begrudge any action that smacks of kowtowing to a customer who claims to be dissatisfied. Our combative instincts have programmed us to take no prisoners. When the ‘fight or flight’ hormone adrenaline flows into our veins, we are prone to forget the flight and roll up our sleeves. And that attitude breeds danger.

Again, I’ve been there and done that, too, so I speak from experience – quite a lot of it. In my early years of business, when my patient held a brief with my services, I fought to prove my complaining patient wrong, and I often went to unreal lengths to do so. In some cases, I won and felt a smug vindication. More often than not, I reached a stalemate, or I lost. In time, I realized trying to tame my upset patient was futile, both financially and emotionally, not to

mention being a plainly stupid waste of time. After all, if I won, I had to ask myself, just what had I won: The right to gloat? And to whom would I brag?

Earlier we spoke of the waste of life that cheating brings on. But there is another moral admonition that seems to apply here. It is found in Matthew 5:25 and Luke 12:58, both (paraphrased) exhorting us to: ‘Settle with our adversaries, as we wind our way to court.’

As my eyes gradually opened to a more intelligent way to deal with these patient adversaries, I would invite them to sit with me, face to face, where I asked: “What is the problem and what would you like me to do about it?”

Amazingly, some patients just said they simply wanted me to know of the problem they had with my office. And I could assure them in all honesty that I would indeed look into the situation and correct whatever was needed in a delivery system that had let them down. I never failed to follow through on that promise.

That does not mean I corrected whatever had stuck in their craw. I addressed it, meaning I studied to see if there truly was a fixable flaw or whether the patient’s complaint stemmed from a skewed viewpoint that was unable to weigh the professional implications.

Some patients wanted a refund, a remake, a different treatment option, or even another doctor to work for them. We promptly gave them whatever they wanted and we bore the cost. Many felt that we handled the remake situation well and often remained as patients, but sometimes not. Still, that approach cost far less than a couple of hours of legal time. And we wasted no time arguing, stewing or negotiating. The methodology at work here is to defuse the patient by resolving his complaint.

The business adage holds fairly true: a satisfied patient may tell some family and friends. But a patient who is dissatisfied is guaranteed to broadcast his vitriol far and wide.

## **Conclusion**

This 5-Step module, to create a virtually lawyer-proof dental practice, has born the test of decades of use, in the drama of a dental practice that has served hundreds of thousands of patients. Now it's your turn to choose, either to ignore these lessons and practice on the edge of peril, or create this safety net that will turn possible nightmares into sweet dreams.

And you will learn the lesson we learned: These solid measures of risk management are merely practice management in disguise.

Bon voyage!

## **About the Author**

A life member of the IDA and the ADA, Duane Schmidt is a Fellow in the American Academy of Pediatric Dentistry, a Distinguished Fellow at the University of Iowa, College of Dentistry, an Adjunct Professor at that college and author of a dozen books. He has spoken at professional meetings from coast to coast and was, for five years, a member of the Dental Economics advisory editorial board.

For fourteen years, Schmidt practiced pediatric dentistry in Fort Dodge, Iowa, then, entered the business world for five years. In 1976, he established what was to become one of the largest, privately-owned dental practices in the world, Gentle Dental, Inc.(GD)\* in Cedar Rapids Iowa. GD has been hailed by JADA (Jan. '92) as the first dental office in America to have passed a six-hour OSHA examination without a single violation of a blood borne pathogen standard.

Considered by many in the industry to be first, GD was certainly among the first dental offices to become completely paperless, today hosting three-quarters of a million dollars worth of computer hardware and software. Paper in the office is scanned and saved on computer files, after which it is shredded and recycled. However, no acetate films are generated.

Today GD, on average, hosts between 250-300 patient visits daily that are served by a staff of 55, including twelve hygienists, four laboratory technicians, four doctors and support personnel. During a normal month, GD accepts approximately 600 new patients.

Dr. Schmidt can be reached online at [DuaneASchmidt@aol.com](mailto:DuaneASchmidt@aol.com) and on cell at 319-431-7486. He accepts a limited schedule of speaking engagements to share his fresh vision of a lawyer-proof dental practice.

In 2005, Schmidt sold ownership of GD to his long-time friend, and associate, Masih Safabakhsh, DDS, who today practices in and manages GD, continuing its phenomenal growth.

\* Gentle Dental, Inc. is not to be confused, and is not associated with, the El Segunda, California-based chain of more than 160 dental offices, established in the early 1980s.