Medical Liability Reform and the Case of the Dislodged Tooth

By Kenneth Y. Pauker, M.D., Vice Chair of LPAD; Director, District 13; Associate Editor, CSA Bulletin

Within the debate concerning medical liability reform, we have heard the MICRA system in California held up as the standard against which reform in other states should be measured. However, many experts feel that what MICRA provides, as good as it is compared to many other jurisdictions, is still seriously flawed and must be fundamentally overhauled. Recently I have had the enlightening experience of being sued over a rather simple matter. Recounting my journey in this forum may serve to illustrate why we are still so far removed from a system which works.

The case is that of a patient who presented for repair of a recurrent para-esophageal hernia. He underwent an uneventful general anesthetic with one notable exception: after removal of a bougie, a tooth was discovered to be dislodged.

Following the induction of general anesthesia, the patient had an uneventful and atraumatic direct laryngoscopy and intubation. At a certain point in the middle of the case, in order to size the esophageal-gastric junction, the surgeon requested that I pass a blunt-tipped bougie. This I did carefully and gently into the mouth, the pharynx, and then into the esophagus and slowly into the stomach.

I was particularly careful because the surgeon informed me that, in his opinion, the reason that his first repair failed was that when the anesthesiologist inserted a naso-gastric tube at the conclusion of the initial laparoscopic repair, the tube perforated the anastomotic site, requiring immediate exploratory laparotomy and revision of the just completed repair. This occurred several years previously.

When the bougie was gently removed, I noted that a dislodged tooth was now evident resting on the left lower lip. Careful inspection of the tooth and mouth disclosed that the left upper incisor had broken off horizontally at the gum-line. Examination of the tooth and the residual root revealed that there appeared to be a very small amount of natural core and a large amount of synthetic material used to make a crown on its outside. Polaroid pictures were taken of the tooth and the mouth, and these were placed in the chart. There were no other fragments visible and hence none which might result in aspiration on emergence.

The Dislodged Tooth–Cont'd

At the conclusion of the surgery, the patient awakened uneventfully. The events were relayed to the patient's significant other, with whom I spoke in the surgical waiting room and to whom I gave the tooth. I explained the events and said that I did not feel like I had done anything to cause this injury to the tooth. The person said, "Oh, that's OK. He has terrible teeth and has had a lot of dental work done. Don't worry about it." I told the same thing to the patient in the PACU and then again when I saw him in his room on POD # 2. I told him that I did not believe that I had done anything to injure his tooth, that he had, according to his companion, "terrible teeth," and that I did not believe that I had any responsibility for his tooth breaking. He listened and made no comments.

The next communication to me from this patient was a letter sent by certified mail to my billing office. It contained a demand for $4,476 to pay for extraction of the tooth by an oral surgeon, a temporary bridge, and a dental implant and crown, and threatened legal action if I did not comply promptly.

I discussed this with a friend who is an experienced general dentist and who does considerable work as an expert in dental malpractice cases. He said that there were several curious aspects to this scenario. First, he did not know why the patient needed to have the tooth extracted by the oral surgeon rather than having a root canal and a crown, unless there was an underlying structural problem with his bone. In fact, he said that it might be dental malpractice for the oral surgeon not to have offered the option of trying to save the tooth. Furthermore, he suggested that obtaining previous dental X-rays, as well as a current X-ray, and some discussion with the oral surgeon as to why he extracted the tooth would help a dental expert determine a great deal about the underlying dental condition, and therefore whether the removal of the bougie would have had some or no part in precipitating this tooth fracture, which after all could have been partially fractured before the para-esophageal hernia surgery. Finally, this expert informed me that the patient would be hard pressed to find an attorney willing to bring a suit for this level of claimed damages.

My insurance carrier opened a file and assigned a claims adjuster. Because this is a "loss of tooth under anesthesia" case, he suggested that we just settle for the amount requested without investigation because "these things happen," it may even be more expensive to defend it, and it likely will not be worth my time. However, I was troubled by this approach because I had seen that the tooth had no internal structure and that I did nothing out of the ordinary. Therefore, at my request, his dental records and X-rays were requested and an investigator was assigned so that it could be determined if that tooth had a

pre-existing problem. I sent a narrative summary to the claims adjuster, and the hospital records were also requested. The claims adjuster spoke with the patient to explain that if after investigation it was determined that his tooth was not impaired, that he would be paid.

The claims investigator reviewed the records and spoke with the patient and his dentist, but notably was not sent my narrative summary by the claims adjuster. The investigator suggested that we settle because the "tooth was knocked out during intubation," meaning that even if there was a pre-existing condition, I likely had at least some responsibility. I was dismayed because of this apparently sham "investigation." The investigator had not even been supplied my written summary and had taken what the patient and dentist said at face value. I asked the investigator to send me the dental records and I would have my own expert review them.

Only one X-ray, one taken a full year before the incident, was sent. The full file from the dentist's office was copied with the patient's permission. Review of this extensive file by my dental expert produced the "smoking gun." A full nine months before the tooth was lost, the patient had complained of pain in that very tooth and sought treatment. A notation in the dental chart stated that there "appears to be open margin" in that tooth and a new crown was recommended. No further mention of this being done or any follow-up of this tooth was found in the record. An "open margin" on a tooth means that a dental probe can be inserted at the margin of the crown into the tooth, and it indicates an opening for decay and weakening of the tooth. My expert was able to state in unequivocal terms that this tooth was damaged, needed to be repaired, was neglected, and could have fractured at any time without any undue force being applied.

I discussed the entire situation with my carrier approved attorney who concurred with all that we had done, and agreed that I could settle just to minimize the "hassle factor," or that I could await the possible filing of a small claims case.

The claims adjuster notified the patient of the decision not to compensate him for this tooth fracture because that tooth had a significant pre-existent problem. Within weeks I received notification that the patient was suing me in Small Claims Court. I reported this to the claims adjuster and thence spoke to my attorney who asked to review all of the records.

The Dislodged Tooth–Cont'd

My attorney's assessment of the case was that I almost certainly would prevail in court. He marked the appropriate pages in the records and also reviewed the relevant CACI (California Approved Civil Instructions) sections with me, including also the potential claim of Res Ipsa Loquitor, which I was counseled how to address, if raised. He also informed me that he knew this plaintiff from when he had brought a previous claim against a partner anesthesiologist of mine concerning the initial repair of the para-esophageal hernia.

I arrived at court with all of my certified records and other materials. My dental hygienist spouse accompanied me so that she could act as an expert in interpreting the dental records if needed. Attorneys are not permitted to represent parties in California Small Claims Court, although they may be consulted in preparation. The afternoon court docket had five cases and mine was the fourth, so I anticipated possibly being there most of the afternoon. The roll was called for each case, and then announcements were made about the advantages of trying to use pretrial mediation. Finally, the judge appeared and miraculously, mine was the first matter called.

We all stood at a long table in front of the judge, the plaintiff on one side, my witness and me on the other side. The judged asked the plaintiff what this was about and he gave his version: I had knocked his tooth out during a surgery; the tooth was not loose beforehand and he had a letter from a periodontist stating this; and he was "very low income" and could not afford to pay for this. Interestingly, the tooth apparently had been repaired already because when he spoke, no evidence of a missing tooth was evident.

When asked by the judge for my response, I explained the surgery, what I had done, and how I had been particularly careful of his teeth because they were obviously extensively capped. I explained what a bougie was and when the tooth fractured at the gum line and what its structure appeared to be. He asked me how common loss of teeth was during anesthesia, and I explained how unusual it was and how laryngoscopy, not bougie removal, was the most likely related maneuver. He asked if the tooth would have been dislodged if I did not do what I did; I said that although I was there when it happened, this tooth could have fractured when he bit into an apple or at any other time. He asked whether I would have done anything differently if I had known that this tooth was unstable. I replied, "No, but I would have worried more." I supplied the letter from my dental expert, and after that he asked me for no further materials.

The Dislodged Tooth–Cont'd

He then asked the plaintiff if he had anything further to say and he said, "Look, I have lost a tooth here and I did not do anything wrong. The tooth was not loose. I am very low income and I cannot afford to pay for this and he has insurance." The judge explained that it was not a question of whether he was at fault but whether I was responsible, and that he was the only person talking about a loose tooth.

The judge excused us, and told us that he would notify us of his decision. The patient walked out and we followed. My wife heard him say as he exited the courtroom, "Well, I guess if he is not responsible, he is not responsible."

The judgment of the court for the defense arrived by mail two days later.

It should be noted that this case cost the plaintiff $50 to file, and he likely had it served by the sheriff for free because he claimed he could not afford it. It cost my carrier the expenses of investigation ($1,500 for copying the hospital and dental records and the one X-ray, $1,800 for the investigator), the expert fee ($750), the lawyer's fees ($1,500), my loss of income for the day I had to appear, and the carrier to pay me for my appearance in court ($250). This amounts to $5,800, plus my lost income for the day.

So what does this case illustrate?

This is just a little small claims case, but it illustrates the larger issues quite well. One need merely multiply the costs manyfold for cases that are for significantly more damages and are tried in a larger stage with more preparation, investigation, debate, discovery, time and fees, and lost income and court costs. The plaintiff gets a free ride and the defendant and his insurance carrier eat the costs. Costs for the defense are almost never awarded, and even less likely to be recoverable even if awarded, and so my lawyer advised me not to bother to file a cross-complaint in this regard. Focusing on the issue of capping non-economic damages prevents examination of an entire liability system which is inefficient, unreliable, costly, and largely a waste of time for everyone except the lawyers who get to play the lottery and the defense attorneys who get paid to defend these cases.

It should be no surprise that this whole affair is all about money, at every level, at every stage of this odd journey through this system. The defendant with little money sees a deep pocket, the physician and his insurance carrier. The insurer sees the costs of defense versus the costs of settlement. The physician sees loss of income, even if he did nothing wrong. The adjusters and the investigators

and the attorneys all translate this into money for themselves. The plaintiff's bar claims that money is just an efficient accounting measure for what is right and wrong. Bull-ding-whiz! This process is about money, pure and simple, certainly not about discovering the "Truth of the Matter," and any Justice, whatever that is, which pokes its head up into the sunshine, seems to appear almost as a by-product or a fortuitous accident of the circumstances of the case.

It cannot be overemphasized how important it is for physicians to take even these Small Claims Court cases seriously and to be as prepared as possible. They follow rules and procedures and state law concerning how a case is to be proved. Any adverse judgment, no matter the size of the award, is reported to the California Medical Board and could precipitate an investigation by them. My attorney told me of a case of a physician who was ill-prepared for such a case, had a $3,500 judgment against him, appealed, and lost on appeal largely because the court did not want to bother rehearing details of a small claims case. Then the physician had not just lost, but had lost again on appeal. Now he was really guilty of malpractice, and then the California Medical Board came to investigate something which should never have been filed in the first place.

Several enormous wrinkles in this big picture have now surfaced in Florida, where three new state constitutional amendments have just passed.[1] Amendment 3, passed with 64 percent of the vote, caps contingency fees for plaintiff attorneys in medical liability lawsuits at 30 percent of the first $250,000 in damages, and 10 percent of all damages in excess of $250,000. Amendment 7, passed with 81 percent, opens a wide range of now-confidential reports on physicians' errors to the public. Amendment 8, passed with 71 percent, permanently revokes the medical license of any physician with three malpractice judgments against him–whether by jury verdict, administrative ruling or arbitrated finding. Any number of settlements is allowed, and in fact the apparent thrust of this amendment was to encourage settlement and to unclog the courts. However, this may produce such a strong incentive to settle that many fewer cases will be tried and hence won by the defense. This may further burden insurers and drive medical liability rates even further upward. All of these amendments have come under fire and intense legal attacks which are only just beginning by the various sides according to differing legal theories.

Cognizant of the approach in Florida, one might wonder if the referendum process in California might be employed to reform fundamentally the California medical liability system. Ideas which have been espoused by the Common Good[2] include: professional jurors, screening panels, and costs to be born

The Dislodged Tooth–Cont'd

by losing plaintiff attorneys. Furthermore, in baseball, the rule is "three strikes and you're out." It appears that Florida has passed a similar rule for physicians who commit malpractice. How many strikes do you suppose a plaintiff attorney should get if he keeps suing in looking for his one big hit? There is much to be discussed and much to be done concerning medical liability reform in California and elsewhere. Please stay tuned, participate in the debate, and help to craft the solution.

[1] http://biz.yahoo.com/law/041105/837ae30615c84e993afed4e2ee6e130c_1.html
[2] http://cgood.org/

Guidelines for Decreasing Dental Injury Claims

By Ann S. Lofsky, M.D., and Mark Gorney, M.D.

Ann S. Lofsky, M.D., is a practicing anesthesiologist in Santa Monica, California. Dr. Lofsky is a member of the The Doctors Company Board of Governors and is a diplomate of the American Board of Anesthesiology and the American Board of Internal Medicine. Mark Gorney, M.D., is a clinical professor emeritus of plastic surgery at Stanford University and is a founding member and current medi8cal director of The Doctors Company. Dr. Gorney practiced for 40 years in San Francisco, where he also served as director of plastic surgery at St. Francis Memorial Hospital. He is a past president of the American Society of Plastic and Reconstructive Surgeons and senior examiner for the American Board of Plastic Surgery.

Dental damage continues to be the most common cause of malpractice actions against anesthesiologists, constituting 15 percent of claims for the specialty.

To explore possible solutions, The Doctors Company hosted an Anesthesia Advisory Board in 1997 to address the problem. As a result, the following recommendations were made.

Preoperative Evaluation

All panel participants advocated that anesthesiologists conduct a thorough preoperative evaluation of patients' mouths. To help identify dentition that is

particularly at risk, evaluations should include:

- A review of the patient's dental history as well as examination of his/her mouth;
- A specific discussion with patients about any existing dentures, bridges, or caps;
- Particular scrutiny of patients' upper front incisors–the most likely teeth to be injured during the perioperative period–including an inspection of these teeth for pre-existing damage and recording any existing chips or missing teeth in preop note.

Some panelists recommended using preprinted dental diagrams to help eliminate frivolous claims. The diagrams are useful for anesthesiologists or patients to note specifically where abnormalities or pre-existing injuries exist.

Informed Consent

Because dental damage commonly occurs, informed consent should specifically mention this possibility. Give a brief description of how and why the intubation process may cause pressure on the teeth. By forewarning patients about the possibility of a problem, you decrease the likelihood of their being surprised or angry if damage does occur.

If any dental problems are identified preoperatively, the need to discuss the possibility of tooth damage becomes all the more critical. During preanesthesia evaluation, share information with patients about any problems that you identify. Be as precise as possible about the options available for dealing with particularly vulnerable teeth.

One possibility is for surgery to take place as scheduled, with the patient agreeing in writing beforehand that his or her anesthesiologist cannot be held responsible for injuring teeth that are already damaged. Another option is to encourage patients to cancel surgery until a professional dental examination and repair can be accomplished. In any case, uncomfortable as it may be, *tell patients in a straight forward way that no payment will be made for pre-existing dental work damage or dental conditions.*

Circumventing Anger

Most claims for dental damage occur to teeth that have not been identified with problems preoperatively. For this reason, it is imperative to inform patients in

advance that accidental dental injury is a risk of general anesthesia–both from intubation and post-operative biting on plastic oral airways.

Prior to discharge, make every effort to discuss any injury as soon as possible. Patients are more likely to become angry if they feel you are either ignoring them or refusing to acknowledge responsibility for injured teeth or dental work.

Preventive Procedures

One panel participant discussed a system that virtually eliminated dental injury claims for a large practice group. The system includes the following:

- Designate an anesthesiologist to contact all patients complaining of dental injuries. This mediator role limits emotional interaction between patients and the anesthesiologists involved.
- Express empathy about the dental injury, but at the same time, explain that damage can occur with the most expert practitioner.
- Offer injured patients dental evaluations tha are paid for by the anesthesia group.
- Obtain written estimates for necessary dental work, then negotiate agreements with patients to either reimburse them for the work required or to issue checks that will cover the expense of dental work to be done at a later date.
- Ask patients to sign liability releases that indicate checks are accepted as payment in full for injuries.

You can also:

- Arrange in advance for a community dentist or oral surgeon to provide impartial consultations for a reasonable fee.
- Avoid financial conflicts of interest by having the evaluating dentists or oral surgeons agree not to perform the dental repair.
- Obtain a detailed, written report regarding the exact repair work necessary, and have the anesthesiologist or a designee phone other dentists to request verbal estimates. By obtaining an average range, you can make a reasonable offer to the patient for covering all or a portion of repair expenses.

Important NPBD Info

Malpractice carriers are required to report all claims settlements to the National Practitioner Data Bank (NPDB). Therefore, if an anesthesiologist insured by The Doctors Company requests that we pay a dental injury claim, the settlement will be reported to the NPDB. Settlements paid by an individual physician (not a corporation) do not require NPDB notification. Claims representatives from The Doctors Company can help guide you through the process and make sure your liability is minimized.[1]

Conclusion

Although dental injuries can be decreased through the use of plastic dental guards, nasal airways, and early removal of oral airways, dental damage remains a fact of life for anesthesiologists. Risk management techniques described in this article can minimize inconvenience and help alleviate legal actions that arise when dental damage occurs.

Claims representatives from The Doctors Company can assist you by acting as impartial negotiators with patients, helping to obtain dental repair estimates, and furnishing you with liability release forms.

[1] For more information, see "National Practitioner Data Bank Reporting Rules," *The Doctor's Advocate*, second quarter 1997.