MedPro Group
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# Legal Case

## How Ignoring a Patient's Medical History can Lead to a Malpractice Lawsuit: Antibiotic Prophylaxis for Dental Prophylaxis

### BACKGROUND FACTS

A 67-year-old woman presented to a new general dentist, Dr. A, for a check-up and a cleaning, having recently retired to the community where the dentist practiced. She was presented with traditional "welcome" documents, which she completed. Among the papers was a medical history form with yes or no checkboxes for several conditions. She checked yes for Type II diabetes, and next to heart disease, she checked yes and wrote in "IE".

After she was seated in the dental chair, a dental hygienist introduced herself, silently reviewed the completed paperwork, took a full series of radiographs, did periodontal probing, and performed supra- and sub-gingival prophylaxis using a Cavitron and hand scalers. Then, Dr. A joined them in the treatment room, engaged in small talk, and did a tooth-by-tooth caries check, finding nothing warranting treatment. Dr. A explained to his new patient that because of her gingival inflammation and propensity to develop calculus she should be placed on a 3-month recall regimen, to which the patient agreed.

Four or five days later, the patient began to feel ill, exhibiting fever, chills and fatigue. She presented to a free-standing medical clinic, where a physician reviewed her medical history and her recent activities. She discussed her diabetes and her history of IE, infective endocarditis, many years ago, as well as her recent dental appointment. When she responded to the doctor's question as to whether she had been given antibiotics in association with the dental treatment, she said that she had not; she was referred to the local hospital to be seen by a cardiologist.

After a work-up, it was determined that she had endocarditis, so she was admitted to the hospital for intravenous antibiotics; blood cultures confirmed the bacterial source to be an organism often found in the mouth. She remained in the hospital until her symptoms resolved nearly a week later and several echocardiograms were determined to be within normal limits. As she would need to continue IV antibiotics for a month or more, a PICC line (peripherally inserted central catheter) was placed so she could receive them at home. She continued to do well, with the PICC line removed after six weeks. While she steadily improved, she experienced shortness of breath on a regular basis with even minimal exercise, which became her baseline going forward, although she functioned well in day-to-day activities.

### LEGAL STATUS

The patient retained an attorney to pursue an action against Dr. A and his dental hygienist. The attorney obtained the dental records and immediately noticed that the patient had disclosed her history of infective endocarditis ("IE"), but it was not recognized and not acted upon as part of treatment.

The dentist notified his malpractice insurance carrier upon receiving a request for records, which initiated pre-suit discussions between the carrier and the attorney, reaching a settlement agreement. Because the patient did reasonably well and did not require surgical intervention, the settlement value was not much greater than what the defense litigation costs and expenses were anticipated to be if the situation moved into the courts. Additionally, confidentiality and protection from social media postings could be included in the agreement, whereas that would not be so if the case ended up with a trial verdict against the dentist and/or hygienist.

**TAKEAWAYS**

The prescribing of antibiotic prophylaxis to prevent infective endocarditis is a topic that is not often discussed. Infective endocarditis, also called bacterial endocarditis, is an infection caused by bacteria that enter the bloodstream and settle in the heart lining, a heart valve or a blood vessel. It can be caused by any number of sources, among them certain invasive dental procedures including subgingival scaling, although routine home oral hygiene can also be the cause in susceptible patients.

For more than a half-century, the American Heart Association (AHA) has been issuing guidelines on the use of prophylactic antibiotics in association with invasive dental procedures. Over the years, the guidelines have changed often and significantly, with regard to which underlying medical conditions warrant such prophylaxis, the antibiotics recommended, the regimen for prescribing the antibiotics, i.e. pre-treatment, pre- and post-treatment, the number of doses, dose strength, etc. and approaches to handling situations when susceptible patients are already on a course of antibiotics prior to the invasive dental treatment. It is not the purpose here to dictate the judgment of a dentist in a given situation, but, as a practice risk management consideration, a current knowledge of these factors is valuable, and consultation with a patient's cardiologist or internist is an advisable action.

The scenario here of a dental hygienist being the first practitioner to become involved is not uncommon. All practitioners involved in patient care should regularly, before treatment starts, review patients' medical histories, verbally clarify and discuss with patients their positive responses and assure that there are no other conditions which were not reported, confirm the meaning of abbreviations which may be used by patients (even if the practitioner might find it embarrassing to ask), and be willing to research the significance of existing medical conditions and/or ask the assistance of others with greater knowledge on the subject. Here, for whatever reasons, the hygienist proceeded with care without investigating the patient's reported history, and the dentist followed suit.

In a number of jurisdictions, and under certain circumstances, both a dentist and the hygienist working with that dentist can be held liable for the negligence of the hygienist ("vicarious liability"). It is an important task for a dentist to periodically assure that their malpractice policy will provide coverage to the dentist for the negligence of hygienists, assistants and other office staff members, even if those people have their own policies.

A pre-suit settlement was the best outcome for this case. Here, the defense would likely have included the causation issue, meaning that the IE could have arisen from the patient's home care, or lack, rather than from the dental procedures. But the liability concerns were significant, and a jury would have been presented an argument by the plaintiff that her oral hygiene was a constant for years, and it would have to have been mere coincidence for IE to have developed just days after her dental treatment. This settlement, like all others, involved input from experts and the insured dentist, working in conjunction with the carrier and attorneys.

Finally, regarding a related matter, it is an ongoing question in the dental community whether an antibiotic prophylaxis regimen exists for orthopedic patients who have had joint replacements or other implanted devices. While this article does not speak to what may or may not be appropriate in specific circumstances, the AHA recommendations are cardiac- and cardiovascular-related only. Whether an orthopedic surgeon may suggest antibiotic prophylaxis in association with invasive dental procedures, and what such a regimen may look like, is likely specific to the situation and best determined in consultation with the orthopedist or other applicable practitioner.