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Legal Case:

Differing Interpretations of Radio-opacities on Radiograph at Trial

SPIEGEL LEFFLER PLLC

In both dentistry and medicine, reading radiographs is an aspect of diagnosis that's susceptible to subjective judgment. Different interpretations of radiographs can result in various treatment plans that ultimately affect patient care. When radiographs are used as evidence in a dental malpractice trial, these differing opinions can result in numerous implications for the evidence and a potential misunderstanding of the facts. The following case illustrates how this can happen.

FACTS

A 60-year-old man visited a large dental office in a major metropolitan area after seeing an advertisement for the office. The man had seen many dentists over his lifetime and had multiple dental procedures performed before. When he visited the dental office, he was unhappy with the lower left posterior portion of his mouth. He had an uncomfortable three-unit splint from teeth 18-20, with a virgin, erupted third molar immediately behind. At the dental office, he initially saw Dr. A, a dentist whose job it was to examine all new patients, develop their treatment plans, and hand them off to an employee dentist, Dr. B, who would carry out that plan.

Dr. A, by way of radiographic and clinical examinations, determined that the splint was fully attached only to tooth 20. There was gross decay on both 18 and 19, leaving the restoration essentially floating. He devised a plan to extract the non-restorable teeth 18 and 19 and to prepare 17 and re-prepare 20 for crowns to support a long-term temporary bridge. This would allow for masticatory function while the 18 and 19 sites adequately healed. His plan also included placing implants into the sites of 18 and 19, and placing an implant-supported bridge or four single units on 17, 18, 19 and 20.

Dr. B, a young general dentist who was working at the office for a short time in his first job, was assigned to extract the patient's two teeth and do the pre-implant steps. Dr. B reviewed the treatment plan and agreed that it was a proper approach, and the patient decided to move forward. That day, teeth 18 and 19 were uneventfully extracted after the existing bridge was removed. Then, Dr. B did crown preparations of 17 and 20 and a chairside acrylic temporary for the 17-20 span. Prior to placing the provisional, Dr. B took impressions so that a long-term provisional could be fabricated.

Keeping with the usual methods of this office, whenever a long-term provisional was requested, the impression was given to the on-premises dental lab. The on-premises dental lab would use a thin, thimble-like metal shell on the abutment teeth, to be covered with acrylic and joined with the all-acrylic pontics. After this procedure, patients are told to return in about a week to have the long-term provisional inserted. The patient in this case returned eight days later, when Dr. B was not in the office, but no dental chart entry was made.

This became problematic because the patient claimed that all that was done on his follow-up visit was an occlusal adjustment of the dentist's provisional. However, the long-term provisional had been logged out of the lab the same day, and it was nowhere to be found in the office. The long-term provisional was presumed to have been inserted by somebody who simply did not make a chart entry. This alone wouldn't have been a problem, except that the patient developed significant facial pain, for which he sought dental care elsewhere – from Dr. C. Dr. C attributed the facial pain to hyperocclusion on the provisional. It's important to note that Dr. C took radiographs, which documented the provisional in place. This radiograph turned out to be a focal point at trial.

LEGAL STANCE

The patient retained an attorney, who filed a malpractice lawsuit against Dr. B. The claims in the lawsuit stated that the patient – now plaintiff – began a complex course of treatment for facial pain, and he was never again pain-free in and around the masticatory muscles and the temporomandibular complex. The plaintiff claimed this was all caused by an ill-fitting provisional with hyperocclusion.

ISSUES RAISED

Several allegations were raised in the complaint regarding various aspects of Dr. B's dental care, but all of them except the allegation set forth immediately above were dismissed. These allegations ended up having no role in the facial pain complaint – the only area of claimed damages.

As to the provisional with hyperocclusion, if it was the appliance made on the first visit by Dr. B, then Dr. B was potentially liable if he placed a hyperoccluded temporary which caused the facial pain. But, if the provisional with hyperocclusion was the long-term provisional inserted by some other person at the office, then any potential liability would lie with the practice and/or the person who actually inserted the provisional.

TRIAL

Dr. B was called as a witness by the plaintiff's attorney. Dr. B testified that he placed a temporary bridge that was made purely of acrylic, and that he used articulating paper to assure no high spots. Dr. B was also asked to comment upon the radiographs taken by Dr. C. In Dr. B's opinion, the later x-ray showed the abutment teeth to have "radio-opaque shells" on them, entirely consistent with the type of metal found on the type of long-term provisional made at that dental office's lab.

Then, Dr. C testified as the plaintiff's expert. Dr. C was an experienced general/restorative dentist, and he believed that the "radio-opaque shells" on the two abutment teeth were actually just outlines of temporary cement, meaning there was absolutely no metal in the provisional but rather an all-acrylic appliance. Moreover, when Dr. C examined the plaintiff clinically, he found the occlusion on the temporary to be "very high" and having the plaintiff bite down elicited severe pain that radiated to the entire left side of his face. Even when Dr. C placed his own temporary in its stead, the plaintiff experienced pain, which he claimed was a result of irreparable damage from hyperocclusion. This testimony indicated that the offending provisional was the one made by Dr. B. Dr. C went on to explain to the jury that he viewed the degree of radio-opacity to be entirely different (less radio-opaque) than the metal of other crowns in the plaintiff's mouth. Therefore, Dr. C said it could not be metal, but instead it had to be a cement shadow.

On cross-examination, Dr. C was asked if he definitively knew whether the temporary bridge that he x-rayed was, in fact, the temporary bridge placed by Dr. B. Dr. C said that he was unsure because the plaintiff presented to Dr. C with two temporary bridges, one in his mouth and one in his pocket. Needless to say, this put an entirely new light on the facts. This was evidence that the plaintiff had at least received a second temporary bridge when he returned for a second visit, which directly contradicted the plaintiff's own testimony regarding his visit. We never learned with certainty what happened at that second visit, but we knew that the plaintiff's version could not have been correct.

The defense expert, Dr. D, provided testimony that the degree of different radio-opacity between the temporary abutments and the other crowns in the plaintiff's mouth was only nominal. Dr. D attributed it to simple differences in density between various metals. Dr. D explained that his experience as a dentist allows him to discern nuances in x-rays and understand how other dentists may interpret radiographs.

TRIAL MOTIONS

Generally, defense attorneys seek case dismissal at the conclusion of the plaintiff's case, without ever presenting an expert or any other witness. However, scheduling made it impossible to do anything but wait until all witnesses on the plaintiff and defense sides had testified before seeking dismissal.

Dismissal was sought before the case was given to the jury. This process involved arguing to the judge that the plaintiff had not met his burden of proof, because his expert had failed to adequately establish that Dr. B was negligent in his treatment. This failed to create a question of fact for the jury to decide. Juries make credibility assessments when presented with conflicting statements between the plaintiff and defendant. The plaintiff said he never received a replacement temporary, while his expert, Dr. C, said that the plaintiff came to him with two appliances. However, when Dr. C acknowledged that the plaintiff brought two temporary bridges to the appointment, Dr. C was unable to conclude which of those Dr. B made and inserted. Consequently, Dr. C was unable to conclude that the temporary made and inserted by Dr. B was with hyperocclusion and, therefore, negligently performed.

At the end of the trial, the court dismissed the case.

POST-TRIAL PROCEDURES

The plaintiff's counsel did not allow the case to die. He filed an appeal. After a year-long process, including the preparation of papers and oral arguments before an appellate court panel, the higher court ultimately agreed with the trial judge and affirmed the original decision. The case was now truly over.

CONCEPTS OF LITIGATION

In this case, three licensed dentists viewed the very same radiographs and reached different conclusions as to what the same areas of radio-opacities represented. As in clinical dental practice, differing opinions between dentists occur in litigation as well. But in the litigation setting, the basis for those opinions may be constrained by what evidence is properly presented before the court and jury.

Carrying this into practice, dentists will do well for themselves and their patients if they look at their own judgments and decisions as potentially being criticized and second-guessed by other dentists with equal or greater credentials. Thorough assessments in the planning for and performance of dentistry are important if dentists wish to effectively manage risk and reduce the chance of malpractice litigation.

This case also illustrates what so many young dentists face in their first professional jobs: they are told to do certain treatments, often even if they disagree with the approach. While we recognize the dilemma, regardless of their ages and experience levels, dentists are licensed professionals who are obligated to treat patients in ways they believe to be proper. Doing otherwise is counter to ethics and patient needs.

Finally, few healthcare practitioners consider the documentation of the care they provide to be the high point of the patient encounter. However, the importance of complete and accurate documentation cannot be overstated. In this case, if Dr. B documented exactly what was done and why, it is unlikely that he would have been sued in a case which was very possibly without merit.