LEGAL CASE

The Injuries That Weren't

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In order to prove a case in dental malpractice, a plaintiff must demonstrate that there was negligence on the part of the dentist which directly caused, or was at least a substantial factor in causing, an injury or injuries. If any of those components is missing, the claim cannot stand; in other words, if there is no improper treatment, or if there are no demonstrable injuries, or if there is no connection between the treatment and the injuries, the dentist will be successful in defense.

FACTS

A 45-year-old woman had been having pain associated with her lower right third molar (#32) for nearly a week; she had previously experienced the same problem over the years, but the pain resolved after a few days after an uptick in her oral hygiene. But this time was different. So, she went to her dentist, Dr. A, to complain, leading to a panoramic radiograph which showed the tooth to be partially impacted with a distal bony defect present on tooth #31, which was confirmed on clinical examination. Dr. A believed that extraction was the best treatment, given the history and the patient's age; the patient was so uncomfortable that she was happy to hear that proposed solution.

Dr. A had spent several years working in hospitals, so he was well experienced with extractions of this type, and extractions became a regular part of his private practice. What was clear radiographically was the proximity of the root apices to the inferior alveolar canal, so the dentist carefully explained the potential for temporary, or even permanent, loss or alteration of feeling to the areas innervated by the inferior alveolar nerve. The patient was then presented with a detailed informed consent form, which she signed and dated before any aspect of treatment began. Later on, the patient acknowledged having been fully advised of all risks associated with the procedure, as well as viable options, so her initial case claim of lack of informed consent was dismissed by the court early on.

Under local anesthesia, tooth #32 was surgically extracted, seemingly without complication. During the 20-minute procedure, a bite block was placed on the contralateral occlusal surfaces to keep the masticatory muscles comfortable and to reduce the chance of TMJ injury. A silk suture was placed, post-extraction instructions were provided (including that she should refrain from smoking), and a prescription for analgesics was given.

On the second post-operative day, the patient experienced an increase in pain, so she called the dentist's office; she was asked to come in to be checked, and she did so that afternoon. When Dr. A checked the area, he found a dry socket. So he asked the patient whether she had been smoking, and she admitted to having done so. The dentist gently debrided the socket, packed the area with dry socket dressing, reiterated the

warning against smoking, and told the patient that she should return for dressing changes at least every other day. The patient made no other complaints related to her mouth at that visit.

The patient returned quite often for dressing changes, still making no other complaints; her suture was removed one week after the extraction. During the first month, she presented to the office 12 times for dressing changes. At one of those visits, the dentist took an x-ray, which showed a clean site. At 35 days following the extraction, the patient complained, for the first time, that her lower right lip and chin were numb; she stated that the numbness had been that way since the day of extraction. When asked why she had not said anything about that before, she responded that the pain from the dry socket had been so bad that she simply complained of the most significant thing. Dr. A gently used a sharp explorer to try to determine whether there was any painful response, but the patient stated that she felt nothing on her lower right lip and chin areas when poked with the explorer. The dentist wanted to follow that situation, so he had the patient return for continuing dry socket dressing changes, and after that resolved, once a month. He told the patient that, if she did not have a return of feeling by 6 months after the extraction, she would be referred to an oral surgeon.

At nearly 3 months post-op, she made a new complaint: she was experiencing left side TMJ pain (which she attributed to the bite block used at surgery) which was ongoing since the time of the extraction, and which was making it difficult for her to chew. The dentist thought that it was best that she be sent to an oral surgeon at this point, to address the complaints of both numbness and joint pain. The patient became upset that she was being referred elsewhere, asking why Dr. A would do surgery if he was not able to handle post-surgery problems on his own. The dentist explained that he felt comfortable managing post-surgery problems, but when two arose at once, it would be better to have a specialist involved.

The patient never returned to Dr. A, and she ignored voicemails from his office asking whether she had gone to see an oral surgeon.

LEGAL STANCE

The patient became a plaintiff when the attorney she retained filed a dental malpractice action on her behalf: the suit alleged an improperly performed extraction during which the inferior alveolar nerve was not protected, improper use of a bite block, and the failure to obtain informed consent. These issues of malpractice were claimed to have caused permanent injury to the right inferior alveolar nerve (IAN) and damage to the left TMJ complex. (As is noted above, the informed consent claim dropped out of the case.)

ISSUES RAISED

As we commonly see in cases claiming paresthesia due to extractions, the method of extraction is of paramount importance because a properly performed extraction which led to nerve injury is normally not an adequate foundation for a successful dental malpractice case. A less common claim was raised here, that being that it was improper to place a bite block during the extraction, so as to cause a joint injury.

DISCOVERY

In the state where this suit was brought, there is broad discovery permitted by the courts, meaning that attorneys for both the plaintiff and the defendant dentist are allowed to delve into any issue(s) that might at least reasonably lead to relevant evidence. What this practically results in are the (1) depositions of the plaintiff and defendant, as well as of key non-expert witnesses who can likely shed light on important issues of the case; (2) a physical examination of the plaintiff by a doctor of defense counsel's choosing, which is limited to the damages claims; and (3) access to a generally wide array of the plaintiff's dental and medical

records, so long as defense counsel can demonstrate to the court that the records sought are not merely for a fishing expedition, but rather for an exploration of what the plaintiff might have reported – or not reported – to her seemingly unrelated medical providers.

Here, the plaintiff's deposition was not overly helpful in areas beyond the usual inquiry into the plaintiff's background and her version of the treatment timeline, including interactions with the defendant and others.

However, we had an oral surgeon who was familiar with issues relating to the TMJ and to nerve injuries examine the plaintiff. When challenged with various stimuli to the areas innervated by the IAN, she claimed that she could not feel the right side, but she could feel the left side; of course, this is subjective, so patient truthfulness is an important component of this type of examination (which is why we sometimes forego such examinations in claimed nerve injury cases, based upon how we view the plaintiff's veracity). Regarding the claim of left-sided TMJ pain, she told our examining oral surgeon, and acted as such when asked to perform opening and lateral movements, that she could only open vertically to 25 mm when asked how wide she could open, but when the oral surgeon asked her (off-the-cuff, so to speak) to open so that he could view the back of the extraction site with a mouth mirror, she opened 45 mm without even a hint of discomfort. More importantly, regarding the left-sided TMJ pain, she claimed to be unable to move laterally, at all, to the left, but freely moved toward the right without any restriction. The written report of this examination was shared with counsel for the plaintiff, as is required.

What the plaintiff did not know is that, due to the functions and pulls of the lateral pterygoid muscles, patients are able to freely move toward the injured side, and prevented from moving to the opposite direction of injured TMJs. Without anyone intentionally setting it, the plaintiff fell into an anatomic trap, proving her to be untruthful regarding her TMJ claim, which immediately raised our awareness that, perhaps, she was also being untruthful about the nerve injury claim.

The plaintiff was a patient who saw doctors quite frequently, so the volume of medical records to be reviewed was enormous. However, we recognized that they could contain very valuable information. Roughly 18 months after the extraction at issue, the plaintiff saw her primary physician for a routine physical and blood studies: therein, her liver function tests were grossly abnormal, so her physician referred her to a hematologist for a work-up, and she went.

Luckily for us, and in conformity with good medical care, the hematologist obtained a complete medical history and conducted a thorough physical exam. In the history, within the section entitled "neurological", the hematologist noted the history from the plaintiff, which included her statement of "no areas of numbness or altered sensation." As helpful as that, alone, would have been for our case, during the physical exam, the hematologist conducted a neurological exam, in which it was noted "CNs (cranial nerves) II-XII intact." Given that the IAN is within the third division of CN V, we knew, from a totally unrelated but authoritative source, that no nerve was injured, at least as of then.

Subsequently, and pursuant to a HIPAA authorization, we spoke with the hematologist. We explained the plaintiff's claim in the suit and asked whether the notes of the history and physical were accurate. The hematologist responded to the effect of, "I never enter a patient chart note that is not complete and accurate. I see almost every patient with either a medical student or resident also present, so complete history taking, thorough examinations, and accurate chart entries are absolutes." We made plans to have the hematologist testify at trial, if needed.

TRIAL

In the lead-up to trial, we explained to the plaintiff's attorney that we strongly believed that the claimed injuries did not exist. The attorney did not accept our assessment, maintained a settlement demand value which we viewed as exorbitant, and wished to proceed to trial.

At trial, our client testified regarding his professional credentials, including his practice background, and the facts specific to this plaintiff. A key area of questioning against him, which was effective, focused on the concepts that oral surgeons are specifically trained to remove impacted teeth. As compared with general dentists such as he was, they are more familiar with handling complications (which the dentist clearly agreed with, as he had ultimately referred the plaintiff to an oral surgeon after two problems emerged), and despite his experience doing oral surgery, an oral surgeon with more experience might have taken different approaches and precautions to decrease the likelihood of complications. In all candor, plaintiff's counsel seemed to have impressed the jury on the negligence aspect of the claim.

However, things turned around starkly during the cross-examination of the plaintiff's expert witness. That expert acknowledged the anatomic and physiologic incongruities associated with the plaintiff's claimed limitations and abilities relating to her TMJ and its muscular attachments, and essentially admitted that the plaintiff could not have been truthful when reporting her TMJ symptoms. It became even worse for the plaintiff when the expert was confronted with the hematologist's records, which he had never previously reviewed, and was forced to admit that this unbiased, unrelated practitioner had essentially debunked the plaintiff's claimed permanent nerve injury, based upon a history from the plaintiff and an examination which took place well after the subject extraction.

The jury quickly returned a verdict in favor of the dentist. One of the jurors, who was interviewed after, said that they completely disbelieved everything about the plaintiff's claim once her own expert was painted into a corner.

TAKEAWAYS

For a plaintiff to win a dental malpractice case, every element of the claim must be met. So, an injury caused by proper treatment will lead to results in favor of the dentist. Of course, the true facts may not always appear from the start, so a deep dive into every aspect of litigation investigation must be undertaken in all cases, not only by the attorneys, but by the expert witnesses as well, because they are the witnesses who are usually the most critical to juries.

Very important from a risk management standpoint is the concept to always practice within your own abilities. Especially in office settings when young employee dentists are pushed to produce, but also in situations where such pressures are not externally placed, we often see litigation arising after dentists perform procedures for which they are not adequately trained, for which they have limited experience, or which they are trying to do as "a favor."