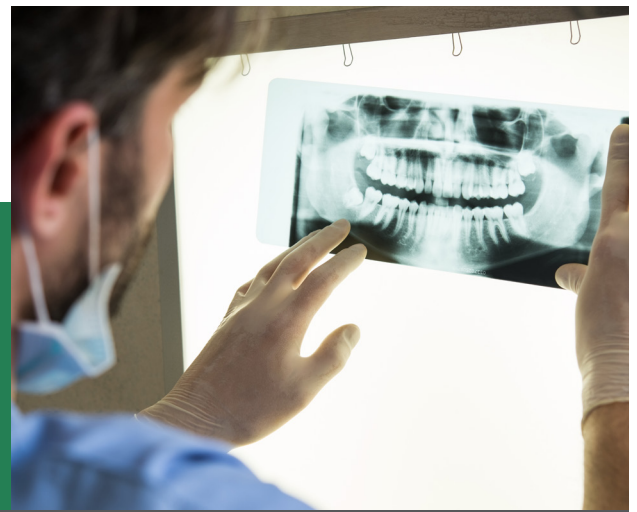


# Root Cause

**IN THIS CASE:** The dentist, who considered himself a “specialist” in extractions, performed an extraction procedure on the patient’s tooth #17; however, following the procedure, the patient alleged that she had ongoing complications due to the dentist’s extraction of the tooth.



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## The Patient & Condition

The 37-year-old female patient presented to her dental office with a partial bony impacted tooth #17, necessitating extraction due to pain. She was introduced to the defendant, a general dentist, who performed the extraction procedure.

## The Treatment

The dentist was assigned the patient for the extraction procedure under local anesthesia. He sectioned tooth #17 and removed it without apparent complications.

## The Allegations

Four causes of action were lodged against the dentist and his office, including (1) Professional Negligence, (2) Lack of Informed Consent, (3) Fraud (concealment), and (4) Fraud (misrepresentation). It was alleged that the dentist did not exercise the requisite skill, knowledge, training, and care in the diagnosis and treatment that other reasonably prudent dentists would possess and use in similar situations. In addition, the patient alleged that she had continuing sensation loss and experienced electric shocks due to the extraction.

## Relevant Facts

The dentist’s testimony revealed that he recalled obtaining written informed consent, but the document was misplaced. His recollection, which was quite detailed, is that he discussed the risks and benefits of the procedure with the patient. Specifically, he informed the patient of the risk of traumatizing the nerve during the procedure. The patient denies that she was provided with this information. The panorex image reveals a complex impaction; the patient claims she was told it was a simple and routine extraction.

The dentist’s notes for the procedure were dated 8 days after the procedure, when the patient had already reported numbness in her lips and gum affecting the extraction side. This untimely and suspect entry describes pre-existing numbness in the area. This treatment note, not contemporaneously written, could negatively impact the dentist’s credibility in the eyes of the jury. A juror may find that the dentist was untruthful in what he wrote in the chart entry after the patient complained of numbness. It raises the probability that the jury will view all his testimony as unreliable.

The dentist considered himself a “specialist” in extractions, as did others in his office. However, the dentist did not have the requisite training and education to obtain a specialty license. To represent yourself as a specialist in extractions, you would need to have the requisite education, training, and licensing. The jury will evaluate the impact of the patient’s decision to have the dentist extract the tooth while misrepresenting himself as a “specialist.”

The dentist’s expert witness characterized the extraction procedure as comporting with the accepted standard of care. The facts support that opinion. Post-operative examination revealed that the bony wall of the neurovascular bundle was intact, and the loss of sensation is most likely the result of nerve compression. Therefore, the dentist’s expert felt confident in defending the actual care in that there was no direct impingement of the nerve or damage to the canal.

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However, the defense team still had a concern that the credibility issues of the dentist – specifically, the untimely chart entry, the false claim that he is a “specialist,” and the lack of written informed consent – will sway the jury to find him not truthful in his testimony. Much of the defense of this matter was “he-said-she-said” testimony.

## The Outcome

As of this writing, the matter is still being mediated. The decision to forgo mounting a defense (i.e., denying the allegations at a jury trial) and instead attempting a settlement, is predicated on the dentist’s credibility issues despite the procedure’s efficacy.

## Risk Management Pointers

This case reminds us of the following:

- **All forms of extraction have inherent risks, which makes informed consent critical.** Having a complete documented record of the informed consent process outlining the risks and allowing the patient to agree to the proposed treatment voluntarily is essential.
- **The importance of keeping detailed contemporaneous records.** Untimely chart entries after complications can result in an adverse opinion of the treating doctor and pose difficulty in defending the treatment performed, despite the treatment comporting with accepted standards of care. Thorough, contemporaneous documentation of treatment provides evidence to the jury that is easy to believe.

It provides a clear, logical, and concise record of the facts regarding the patient’s treatment. Your documentation is your most valuable tool in defending against a board action, an allegation of a breach of the standard of care, or a malpractice suit. Ensure that your records are accurate, timely, and complete.

- **Complications, even those that are untoward and common, can trigger allegations of sub-standard care.** In these situations, your treatment record becomes your best defense, or as in this case, may negatively impact the successful defense of a claim.
- **Office owners may be held responsible for the actions of their employees and independent contractors.** If the owner knew or should have known that the treatment being rendered by an employee or contractor is outside of their abilities, or the employee/contractor is making untruthful assertions regarding their credentials, the owner of the practice can find themselves held responsible.



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