



## Derma Fillers in Dentistry: Is It Within Scope?

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Once a quarter, the *Journal* features a TDIC risk management case study, which provides analysis and practical advice on a variety of issues related to liability risks.

Authored by TDIC risk management analysts, each article presents a case overview and real-life outcome, and reviews learning points and tips that everyone can apply to their practice. All names have been changed for privacy considerations.

*A general dentist administers derma filler to correct a patient's lip deficit resulting in necrosis of the lip.*

In April 2006, Sharon Lockard presented to Dr. Sean Cole, a general dentist, for consultation about her previous dental treatment. Ms. Lockard complained about her lower lip deficit and that her crowns caused severe headaches. Dr. Cole noted the existing crowns lacked adequate occlusal contact. After taking photographs and impressions and making radiographs of her existing dentition, he diagnosed Ms. Lockard with a temporomandibular joint disorder. Dr. Cole recommended replacing the crowns on her mandibular arch to provide proper occlusion and placing veneers on teeth Nos. 22-27 to improve esthetics. Ms. Lockard agreed to start treatment and asked whether he could fix the deficit of her lower lip. Dr. Cole said he could inject derma filler over a series of appointments to augment the area. With an agreed-upon treatment plan in place, Ms. Lockard authorized initiating treatment.

In June, Dr. Cole began the cosmetic aspect of Ms. Lockard's treatment. He injected derma filler under local anes-

thesia in the vestibule of the mandibular mucosa to correct the asymmetry of her lower lip. Dr. Cole explained that derma fillers generally last a few months and she would require several treatments to restore her deficit fully. She understood and agreed to the treatment timeline.

Ms. Lockard appointed in August and September to start and complete her crown placement. She also received additional derma filler injections, all without incident. Shortly before Christmas, Dr. Cole began the veneer treatment on teeth Nos. 22-27. During the veneer preparation, and while Ms. Lockard was still numb, Dr. Cole placed a small amount of a different derma filler in the lower right area of the lip to fill the deficit.

Three days later, Ms. Lockard presented, without an appointment, complaining of severe pain, swelling, and discoloration on the right side of her lower lip. When she asked why Dr. Cole did not return her three telephone calls, he stated he only received one message, not three, and had planned to call her that afternoon. During the exam, Dr. Cole noted what appeared to be blisters on her lip and prescribed Tylenol No. 3 and Abreva, as he sus-

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pected the blisters were herpes lesions.

Ms. Lockard believed the condition on her lip was more serious than a cold sore and sought a second opinion from a dermatologist. She returned to Dr. Cole's office and explained that the dermatologist prescribed ointment and gauze, and referred her to a plastic surgeon as well. The dermatologist believed only a plastic surgeon should address the issues that Ms. Lockard was experiencing. Dr. Cole recommended she continue to use Abreva as he indicated previously. Two days later, Ms. Lockard called to report she was taking Keflex as prescribed by the plastic surgeon.

Throughout January, Ms. Lockard appointed several times to both the dermatologist and plastic surgeon, who eventually diagnosed necrosis in her lip. After realizing the pain would never subside and that she would need plastic surgery to look normal again, she filed a professional negligence claim against Dr. Cole.

### During Discovery

During his deposition, Dr. Cole stated he injected the first derma filler after injecting two carpules of lidocaine, into the vestibule of the mandibular mucosa in June, August, and September, without incident.

Dr. Cole also stated he prepped teeth Nos. 22-27 for veneers in December. He noted in the chart, that he injected four carpules of lidocaine for buccal infiltration to anesthetize the mandibular anterior teeth. Since Ms. Lockard was already numb, he injected "a little" of the second derma filler into the lower lip. He noted "a little" because he used so little compared to prior injections. Dr. Cole did not inject any derma filler at the commissure of the mouth. His area of delivery of the derma filler was approximately 1 centimeter from the commissure. He switched to a

different derma filler for the fourth injection because Ms. Lockard was not happy coming back every few months for a derma filler injection. Since the company representative stated this filler would last longer, he decided to use it instead.

Dr. Cole said that when he saw Ms. Lockard, she complained of pain, swelling, and discoloration. He diagnosed herpes lesions or blisters and recommended Abreva. He did not feel that he dismissed Ms. Lockard's concerns. He thought it was premature to refer Ms. Lockard to a dermatologist until she used the Abreva for two to three weeks. Since the derma filler material was administered on three previous occasions without reaction, Dr. Cole did not believe her symptoms were a result of the derma filler.

Dr. Cole disclosed that he received training on injecting derma fillers at a hands-on class taught by a registered nurse. He also disclosed that he had used both derma fillers on his wife and other family members several times without incident. Thus, he believed Ms. Lockard's treatment with both drugs would be successful.

During Ms. Lockard's deposition, she stated she first went to Dr. Cole to fix the symmetry of her lower lip. Dr. Cole recommended using a derma filler because the deficit was not that significant. Ms. Lockard appointed to Dr. Cole for several months to have the derma filler injections. At the December appointment, Ms. Lockard remembered Dr. Cole administering approximately a dozen injections, while prepping for her veneers. However, Dr. Cole did not record

any of these injections in her chart.

Ms. Lockard alleged she called Dr. Lockard's office several times the night of the procedure and the next day. After no response from Dr. Cole for three days, she went to his office with complaints of severe pain, swelling, and discoloration. Neither the visit nor her multiple phone calls were documented in her chart. Ms. Lockard did not feel that Dr. Cole properly addressed her complaints.

Ms. Lockard was a national trainer for the sales representatives of a large health care group. After her treatment with Dr. Cole, she had to change careers. She can no longer speak for long periods because she tires easily and her lip swells. Accountants projected she would make \$20,000 less a year in her new career. Ms. Lockard cannot pucker her lips to kiss, which has affected her relationship with her husband. She has difficulty speaking clearly because of the lip defect and has to pinch or hold her bottom lip together with her fingers to be understood.

Plaintiff's counsel suggested that Dr. Cole injected excessive amounts of anesthetic solution containing epinephrine in the lower lip causing constriction of the blood vessels resulting in necrosis of the tissue. However, neither plaintiff nor the defense experts could conclude whether the necrosis was caused by the injections of derma filler or anesthetic. The expert witness for the defense indicated that necrosis of the lip would not occur from the vasoconstrictor contained within the anesthetic solution alone. Further, the package insert for the second derma filler, which is FDA-approved, stated that the safety and efficacy of the product "for use in the lips has not been established."

Given this information, the defense attorney urged the dentist to settle the case before it went to trial. He believed given the inconclusive findings of the ex-

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perts and Dr. Cole's poor documentation, a jury would decide Dr. Cole was practicing outside the scope of his license and award Ms. Lockard a substantial amount. Ms. Lockard is now undergoing reconstructive surgery of her lip with a plastic surgeon. Her original demand was more than \$400,000 for past and future medical costs and loss of earnings. The case settled for an undisclosed amount prior to trial.

### Lessons Learned

*What lessons can we learn from reviewing this case?*

#### Scope of Practice

With such a high demand for cosmetic procedures, many dentists are trying to determine what services they can or should provide. Even though dentists are educated to treat symptoms of the head and neck, as well as the oral cavity, they must remember to follow the statutes and regulations that govern the practice of dentistry in their states.

It was determined that Dr. Cole, a general dentist, was performing elective cosmetic procedures by injecting derma fillers and therefore violating the state's Dental Practice Act. Practicing outside the scope of a dental license is a violation of dental practice statutes. A statutory violation that results in an injury to a patient is a presumption of negligent care. Ordinarily, a plaintiff must prove the defendant acted negligently. However, the burden of proof shifts from the plaintiff to the defendant when the defendant is found to be practicing outside scope of his or her license. When dentists practice outside the scope of their licenses, TDIC will not be able to defend or indemnify policyholders if a patient makes an allegation of negligence related to these procedures or treatments. In this case, TDIC provided coverage for Dr. Cole because the cause

of the injury was never determined.

Prior to providing cosmetic treatment, ensure it is within the scope of practice for dentists in California. In January 2000, the Dental Board of California mailed a letter to all licensees clarifying the scope of practice of a dental license. With regard to cosmetic surgery procedures, the board stated:

*California law currently prohibits a dentist from performing cosmetic procedures that are not part of the treatment, by surgery or other methods, of diseased, lesions, or the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures. This includes unrelated cosmetic procedures.*

In 2006, the passing of Senate Bill 438 further clarified the Dental Board's statement, that no one other than appropriately permitted oral and maxillofacial surgeons may perform elective facial cosmetic procedures.

#### Patient Complaints

Every office should have an established protocol and recordkeeping system in place for patient calls concerning pain or other issues. When Ms. Lockard called to report severe pain, swelling, and discoloration the night of the procedure, she was only able to leave a message for Dr. Cole. When she did not receive a call back, she went to the office where Dr. Cole dismissed her complaints.

When Dr. Cole finally saw Ms. Lockard, he noted she had an ulcerated lesion and recommended Abreva. Dr. Cole did not document the visit in the chart or discuss the possibility of the injury being something other than viral. Patient

complaints should be taken seriously. Ms. Lockard called several times. Dr. Cole did not give her complaints much attention. The lack of attention appears as if Dr. Cole did not care. His office should have a system in place for follow-up with patients who report problems after receiving treatment. Staff should notify the treating dentist about the call. If the treating dentist is not in the office, they should notify the dentist in charge. The dentist can then decide the best course of action. Document the incident and its outcome in the patient's chart.

#### Documentation

Complete and thorough documentation is essential for defending allegations of professional negligence. Dr. Cole did not document how many injections he did or Ms. Lockard's phone calls to the office complaining of pain. Dentists should be especially cognizant of documenting all patient complaints and steps they took to resolve them.

A dentist's memory cannot be relied upon solely as evidence. At the heart of most lawsuits is the "he said/she said" argument. While a dentist will have many patients to remember, a typical patient only has one dentist to remember. Clear patient records should give an accurate picture of the conditions present at the initial exam as well as the diagnosis, treatment options, the proposed treatment plan, and a thorough record of treatment rendered and patient complaints, if any. In the event of an untoward result, the only proof of what happened is either what is said in the present or what was written in the past. Written records carry more evidentiary weight than memory and are more likely to convince a jury. The defense could not refute Ms. Lockard's allegations due to the insufficient recordkeeping and lack of detail in the patient's chart. ■■■■