



Specialist's Failure to Follow up Leads to Litigation

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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 everyone can apply to their practice.

A periodontist lost control of her case resulting in the subsequent treating dentists and physicians blaming each other when the patient filed a lawsuit.

In March 2006, Jane Honeycutt met with her general dentist, Dr. Daniel Lombardi, to discuss implants in the area of teeth Nos. 14 and 15. Dr. Lombardi referred her to Dr. Rhonda Chapman, a periodontist, to evaluate Ms. Honeycutt's upper left quadrant for treatment recommendations related to the implants. Due to the proximity of the sinus cavity, Dr. Chapman determined that a sinus lift with osseous grafting was appropriate to prepare the area. She performed the surgery on March 26 and gave postoperative instructions including Peridex to address potential infection and no smoking during the recovery phase. The procedure appeared successful; however, four days later, Ms. Honeycutt noticed that some of the packing had fallen out. She presented to Dr. Chapman's office to have the sinus repacked and to replace two loose sutures. Dr. Chapman kept detailed treatment notes and documented that the patient had no other complaints or apparent complications.

On April 2, Ms. Honeycutt reported she was experiencing pain in the area.

Dr. Chapman prescribed Vicodin and advised her to call if her symptoms did not improve. Two days later, during her regularly scheduled appointment, the sutures and packing material were removed.

Dr. Chapman noted an oral antral fistula approximately 3 mm in diameter. Based upon clinical guidelines, she determined the fistula would spontaneously heal because it had been present for less than a week and was less than 5 mm. Dr. Chapman repacked the site and prescribed 600 mg of ibuprofen for pain.

A week later, Ms. Honeycutt returned to the office complaining of continued discomfort and pain. Although now only 2 mm in diameter, the oral antral fistula communication still existed. Again, Dr. Chapman repacked the sinus with collagen membrane to strengthen the site then sutured the area. She prescribed 500 mg of Biaxin in addition to 600 mg of ibuprofen and 1 mg Vicodin. She reviewed postoperative instructions again with Ms. Honeycutt, including using her remaining Peridex and smoking cessation as previously directed.

The patient reported one week later that she was still in pain and that she was experiencing swelling and fluids draining from her sinus. Dr. Chapman

concluded Ms. Honeycutt had developed an infection due to the inflammation and delayed healing process. She reflected a flap, cleaned out the membrane and packing material and then repacked the area with a bacteriostatic sponge. Approximately one month after the initial sinus lift procedure, a communication was still present although greatly reduced to 1.5 mm in diameter. Unsure as to why the site was not healing properly, Dr. Chapman referred Ms. Honeycutt to an oral and maxillofacial surgeon, Dr. John Hernandez, for evaluation.

Dr. Chapman did not call Ms. Honeycutt nor did she hear from her again until December 2006 when Ms. Honeycutt alleged that Dr. Chapman had deviated from the standard of care in a lawsuit. She claimed Dr. Chapman caused a severe impingement of her middle superior alveolar artery thereby reducing blood flow to her maxilla resulting in necrosis. She further alleged that this necessitated removal and reconstruction of the upper left quadrant of her maxillary bone. However, Ms. Honeycutt did not file suit against Dr. Lombardi or any of the subsequent providers. Dr. Chapman contacted TDIC and was appointed a claims representative and a defense attorney who began an investigation into the allegations.

During Discovery

During her deposition, Dr. Chapman testified that she anticipated Ms. Honeycutt would return to complete the implant treatment as soon as the site had healed. She felt that Ms. Honeycutt's abnormal wound healing may have been due to her continued cigarette smoking despite postoperative instructions to discontinue this activity during recovery. Dr. Chapman acknowledged she had heard nothing further from or about the patient until approximately six months later when a

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prosthodontist contacted her regarding the removal and reconstruction of the necrotic maxillary bone. While a formal referral slip was completed and provided to Dr. Hernandez, Dr. Chapman could not recall whether she had specifically discussed the patient's case with the oral surgeon prior to the patient's initial consultation with him. Additionally, there was no written evaluation from Dr. Hernandez that Dr. Chapman could reference to provide further clarity.

During his deposition, Dr. Hernandez testified that Dr. Chapman did not refer many cases to him and that he rarely, if ever, referred patients to Dr. Chapman. He stated he remembered Ms. Honeycutt very well and that when he re-evaluated the site, the sinus perforation had decreased in size to 1 mm. Dr. Hernandez noted there was no sign of infection present. Upon irrigation with peroxide and warm water, Ms. Honeycutt reported the area was still tender. When the patient experienced persistent pain and delayed healing, she consulted with Dr. Hernandez regarding a possible antrostomy. Dr. Hernandez performed the antrostomy a week later. Postoperative re-examination of the site indicated the surgery was ineffective and Dr. Hernandez referred Ms. Honeycutt to an ear, nose and throat, ENT, specialist for further evaluation and treatment.

The ENT performed an endoscopic maxillary sinustomy on Ms. Honeycutt on July 5, attempting to close the oral antral fistula and assist the healing process. Unfortunately, the site remained prob-

lematic, and over the next month Ms. Honeycutt suffered from drainage and pain. She contacted her general dentist, Dr. Lombardi, who noted in the patient's chart that she called him in July claiming she wanted to "kill herself" to escape the torment and that she had "never experienced such an intense pain."

Dr. Lombardi reported that he directed Ms. Honeycutt to contact her ENT immediately and wished her a speedy recovery. Three weeks later, the ENT referred the patient to a prosthodontist to assess the viability of the patient's maxillary bone. The prosthodontist determined that Ms. Honeycutt's upper left jawbone was necrotic and referred her to a reconstructive head and neck surgeon at the University of California, Los Angeles.

During her deposition, the head and neck surgeon revealed she found, upon examination of the patient, that the entire posterior lateral quadrant of her maxilla on the left was nonviable and needed to be debrided.

On July 10, the surgeon performed a left partial maxillectomy on the patient and discovered osteomyelitis present on the left maxilla. A month later the patient returned to UCLA for palate reconstruction using a local turn-in mucosal flap and a right radial forearm free flap, skin graft, and neck exploration. Ms. Honeycutt tolerated the procedures well and was discharged one week later.

During the discovery phase, Ms. Honeycutt's attorney interviewed and implicated each doctor as being liable for the adverse outcome and ultimately challenged each treatment provider to delineate their specific role in her care. Her counsel successfully applied a divide-and-conquer strategy to the proceedings. The prosthodontist insinuated that the patient's outcome was directly related to Dr. Chapman

cutting through the middle superior alveolar artery, but admitted she had not reviewed films and radiographs and was not sure of this conclusion. When counsel asked the reconstructive surgeon if the necrotic bone resulted from the treatment Dr. Hernandez provided or if it was due to his late recognition of necrotic bone, she said “possibly.”

However Dr. Lombardi testified that when he spoke with the reconstructive surgeon, she had criticized the ENT’s surgical abilities and had remarked that the flap procedure he performed was “old school” and ineffective.

Ms. Honeycutt’s attorney used the lack of communication and teamwork by the treatment stakeholders effectively against them. Dr. Chapman’s legal counsel felt it was in her best interest to settle rather than risk a trial and potentially sympathetic jury verdict given the complexity of this case.

Learning Points

Referrals and Follow-up

Referrals are usually sought when dentists with primary clinical responsibility recognize patient treatment is beyond their level of expertise or available resources. The referring dentist should explain the referral process to the patient, supply the consulting colleague with pertinent information, and continue to monitor the patient and coordinate his or her overall care.

It is the referring dentist’s responsibility to follow up (preferably in writing) with referral practitioners and the patients on the status and progress of each referral. Consider providing the patient with a copy of the referral letter. Keep a copy of the referral in the patient’s chart.

Additionally, the specialist who is receiving the referral should always provide a written evaluation, including treatment recommendations, to the referring den-

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tist. Similarly, if a patient who is referred to a specialist fails the appointment, the specialist should notify the referring dentist. Assign a reasonable time frame, based on when you think the referral evaluation should be completed, for staff to follow-up on a specialist referral.

Based on past claims experience, TDIC developed both a referral letter and a referral response letter. They are available at thedentists.com in the “Risk Management” section. The chart should also reflect the referral process, including:

- Why and to whom was the patient referred?
- Did the patient agree to the referral?
- What is the time frame for the referral?
- Did the patient follow through with the referral?
- When was the treatment completed?
- What was the treatment outcome?
- Were there complications or modifications to the requested treatment? Why?
- Has the patient been scheduled for follow-up treatment?

The American Dental Association outlines the purpose of consultation and referral in Section 2.B of the organization’s Code of Ethics. The section also asserts the underlying ethical fundamentals that govern consultation and referral, and clarifies the responsibilities of those who request and those who provide consultation. The ADA advisory opinion is directed to dentists but it should be recognized that nondental practitioners may also be involved in the referral process.

Dr. Chapman should have contacted Dr. Hernandez to discuss the evaluation’s outcome and treatment of Ms. Honeycutt. She may have discovered that he referred the patient to an ENT and together they could have worked toward a resolution. Additionally, neither contacted Dr. Lombardi, the general dentist, to discuss their diagnoses and treatment recommendations.

While Dr. Chapman was responsive to Ms. Honeycutt’s complaints, she did not initiate any follow-up with her. She waited until the patient called to report pain to act. Had she initiated the follow-up, she may have retained both her relationship with Ms. Honeycutt and control of the case.

Team Approach

Problems or unexpected outcomes may occur over differences of opinion about treating a particular clinical situation. A difference of opinion on a clinical issue does not mean a colleague is wrong or in violation of the standard of care. When a colleague chooses a different approach to treatment, discuss it with him or her to determine why he or she chose that approach. A collaborative approach ensures the patient receives the best care. When there are treatment deviations, address the issue with all practitioners involved. Discussing the situation with the other practitioners and reaching a mutual agreement, verifies the patient’s best interest is met.

In this case, Ms. Honeycutt’s attorney effectively demonstrated how all of the treating practitioners failed to communicate about her care and blamed the results and complications she experienced on the lack of communication. This created a situation where each practitioner felt vulnerable to criticism because they were not aware of the patient’s collec-

tive treatment process. The defendants were more susceptible to being criticized and this prompted them to criticize each other to avoid being the focus of attack.

Dr. Chapman should have kept Dr. Lombardi informed, as well as been actively involved in seeking a resolution, especially since she initiated the referral to Dr. Hernandez. She should have initiated a discussion between herself, Drs. Hernandez and Lombardi, and other subsequent treaters. Had all of the practitioners discussed the events, they may have agreed on the best course of treatment to remedy the situation in a timely manner. This collaborative approach would have assured the patient that her health and well-being were a mutual priority. A united presentation of options validates the team approach to treating a patient and a new treatment direction.

Documentation

If one or more dentists are involved in your patient's treatment (e.g., orthodontist, periodontist, prosthodontist, oral surgeon), then the record should document your communication with the other practitioner. Include notes on their progress with the patient and how that progress will affect your work. Similarly, if the patient is undergoing treatment with other health care providers, such as a physician or psychiatrist, the progress of that care as it relates to the patient's health should be monitored and documented in your progress notes.

If, during a procedure, you discover the need for further treatment, document that fact as well as the subsequent treatment plan, treatment options, and discussions with the patient and the den-

tal team. If applicable, also note any new referral or recommendation for referral. TDIC provides a referral letter and referral evaluation sample forms that you may access online at www.thedentists.com.

Records are your best defense. The first thing a plaintiff's attorney will do is request the records. TDIC claims experience shows time and again that a case is less likely to be pursued if the dentist keeps excellent records. The dentist should inform the patient of the need for the referral and discuss options with the individual. A collaborative relationship between the dentist, the dental team, and the patient can greatly improve the quality of care the patient receives. ■■■■

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