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Legal Case

Dentist's Inexperience in Implant Placement Leads to Inferior Alveolar Nerve Damage

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Over the past decade, the placement of endosseous implants to replace missing teeth has become pervasive in dental practice. In the 1980s, when implants were in their infancy, their placement was limited to oral surgeons and a small number of periodontists. Now, they are widely placed by various types of dental specialists and an increasing number of general dentists, even when their training has not been very extensive.

As a result, we have seen an uptick in the cases we manage associated with implants, including nerve injuries, sinus perforations with sinusitis, loss of the implants and the bone into which they were inserted, infections, and failed implant-supported restorations.

FACTS

A 67-year-old woman who had been a patient of the same general dentist, Dr. S, for nearly 20 years presented to him for a routine exam and evaluation, employing a new full mouth series of radiographs. She had been wearing a unilateral removable partial denture for her lower arch, replacing teeth 29 and 30, which Dr. S had previously and repeatedly suggested be changed to either a traditional fixed bridge or two individual crowns supported by implants. The patient had been resistant to implants in the past, but a close friend of hers had them placed recently and she could not stop "singing their praises".

As additional background, approximately two years prior to the patient's visit, Dr. S had taken a week-long implant course that was being given at a resort; four of the five days were purely classroom lectures, but the final day involved a trip to the instructor's nearby dental office, where the course attendees watched, but did not participate in, the placement of several implants. Dr. S had no further training regarding implants, other than reading a good deal about them, and he had inserted implants in three of his patients, all without complication, as of the time of this patient's current presentation.

Dr. S carefully explained all options available to the patient, as he had done with her in the past, and she now decided that she wanted to go with the implant approach. There was neither panoramic nor cone beam CT capability in the office, but Dr. S was satisfied that his periapical films of the region were adequate for him to plan the angulation and length parameters for the intended implants. In fact, Dr. S was able to visualize the inferior alveolar canal, so he measured the bony height above it, using a Boley gauge, as 15 mm at the sites where teeth 29 and 30 had been; he planned to place two implants, both 13 mm in length, because that would give him a 2 mm safety net.

Dr. S explained to his patient exactly what he planned to do, even showing her the location of the nerve canal, while advising her why he wanted to keep the tip of the implant away from it to avoid an injury that could render

her numb. The office did not make use of written consent forms, but Dr. S wrote a chart entry that day that he had given her the "risks, benefits and alternatives", but nothing more. The patient wanted to go forward.

On the date of surgery, local anesthesia was uneventfully given, using buccal and lingual infiltrations only. Dr. S made a crestal incision and plied the attached gingival tissue away minimally, only enough to fully visualize the bony placement sites. Dr. S found the crest to be slightly sloped, with the lingual aspect of the crest height about 1-2 mm higher than the buccal, so he used a 557 bur to flatten it out, down to the level of the buccal height, allowing for a plateau from which the implant super-structures would emerge.

In the chart, Dr. S recorded this flattening, as well as his use of sequential drills to create the osteotomies into which he screwed the 2 implants. At the depth of the osteotomy at site 30, Dr. S felt a decrease in resistance to his drilling, which was accompanied by "a few drops of blood", but he did not think much of that, and it was not recorded. No radiographs were taken. The area was sutured, the patient was given post-operative instructions, and she was discharged with an appointment in a week and given Dr. S's cell phone number for emergencies.

The following morning, the patient called Dr. S's cell phone before office hours and informed him that the right side of her lower lip and chin remained profoundly numb, well after the local anesthetic effects had dissipated. Dr. S told his patient that she should not be concerned because localized swelling near the nerve was the likely cause, so it should go away in a few days. But, he prescribed a Medrol Dosepak to help reduce any swelling and told her to keep her scheduled appointment.

She returned as scheduled, quite upset and complaining of the same numbness, and with no noticeable swelling. Dr. S assured the patient not to be concerned because this was "very normal" after lower implant placement. He suggested an x-ray to see what was going on, but the patient preferred not to have one taken, and Dr. S said he was willing to defer it until he saw her next in about 4 months.

The day before the 4-month visit, she told the receptionist, who called to confirm, that she was still numb. The receptionist passed this along to Dr. S, who advised the patient to immediately see an oral surgeon for an evaluation. She saw an oral surgeon, Dr. C, that day, who took a Panorex and found the implants to be clinically osseointergrated; the radiograph showed the distal implant to have apparently perforated the roof of the nerve canal and the anterior implant to be in direct contact with, but not through, that roof.

Dr. C stated that the best chance for nerve function return was to remove the implants, which would involve cutting out a block of bone, and possibly then do some type of nerve repair procedure. The patient declined, never had any treatment associated with the implants nor had the implants restored, but instead continued to wear her partial denture, and never communicated with Dr. S again.

ISSUES RAISED

When we were assigned the defense of this case, we met with Dr. S to review his chart and discuss all of the pertinent events; we then obtained Dr. C's records and Panorex. After review, there were several issues to consider:

1. Informed consent: Dr. S's training regarding implants was minimal, and his experience was limited. Neither of these were documented as being passed on to the patient during the informed consent process, and there was no memorialization from the patient's perspective as to her having been informed and gaining an understanding.

2. Testing: The pre-assessment/pre-treatment radiographs could be seen as questionably adequate because periapical films may be subject to measurement errors due to angulation and lack of 3-dimensionality. Additionally, when Dr. S opened the site surgically and reduced the lingual height of bone, he did not realize that what he had seen on the films as the crestal height was the highest point (lingual), and he had reduced that height by the amount of his safety net, without taking any further radiographs for re-measurement after the height reduction.

3. Complications: In this case, Dr. S didn't seem to recognize the significance of the decrease in resistance and the "few drops of blood" he encountered surgically, especially retrospectively when the patient later complained of numbness, at a time when backing out the implants was doable.

4. Follow-up Treatment: Dr. S did not require the patient to have radiographs taken at the post-op visit; and, he did not schedule another follow up appointment for a patient complaining of numbness, which nearly closed the window of opportunity for nerve repair and when osseointegration had precluded atraumatic implant removal.

RESOLUTION

While many lawsuits have little merit or are otherwise readily defensible, there are times when the most appropriate course of action is to try to resolve a case through settlement early in the litigation process. There are times that dentists' treatments do fall short of the standard of care, and that leads to patient injury. It is a significant part of our roles to recognize and explain that to our client.

In this case, a dental malpractice lawsuit was brought against Dr. S alleging negligence and failure to obtain informed consent. Based upon the issues presented above, and the review performed by experts, Dr. S agreed to consent to the settlement of this claim.

PRACTICE TIPS

It is often, and correctly, stated that we learn from our failures more than our successes, however, no one wants our failure to result in injury to a patient. Ultimately, determination of and conformity with the standard of care lies with the treating dentist, taking into account the specific facts and circumstances at hand.

First, as a good rule of thumb, it is unwise to perform treatments for which the dentist lacks sufficient experience, training and expertise. This is a Catch-22 because, in order to gain experience, you need practice. So, it is most ideal to gain sufficient practice in the context of continuing education under the stewardship of course teachers. It is clearly arguable that part of the informed consent process dictates that the patient be aware of the practitioner's personal experience, so that they may choose whether or not to move forward with treatment provided by that practitioner.

Further, when tests are ordered, a dentist should consider the adequacy of certain tests, limitations of the testing method and the degree of error provided by such test. For example, in this case, periapical films may have been subject to measurement errors due to angulation and lack of 3-dimensionality. While it is a clinical question as to whether periapical or panoramic or 3-dimensional radiographs are adequate and/or required for diagnosis and treatment planning, dentists should have in their possession all necessary diagnostic tools with which to make treatment decisions in a given case. If patients refuse, advising the patient of the significance of their refusal is necessary, along with a chart entry documenting the refusal.

Additionally, obtaining informed consent from a patient prior to an invasive procedure is generally required. States may differ as to what is legally required in terms of documenting what took place during the process, but the process itself typically requires a give-and-take to assure that the patient is a fully educated consumer before deciding upon treatment.

Ideally, a detailed and signed consent form will memorialize the oral discussion about risks, benefits and alternatives. Of course, patients who become plaintiffs may deny the authenticity of their signatures, claim that they were rushed through the signing process without adequate time to read it, or later assert that their reading glasses were in the waiting room, thereby precluding their ability to read. But these issues can be resolved during the litigation process.

A less ideal situation is simply the dentist's note in the chart setting forth the specifics of the discussion in detail. Further, a broad note of such a discussion, without details, is not ideal. In these scenarios, plaintiffs often testify that no such discussion took place, and many jurors tend to agree. The most difficult scenario is having nothing documented, leaving the dentist to testify as to usual custom and practice or specific recall of events (sometimes years later); plaintiff denials of any informed consent is very typical in these situations.

As another consideration, if circumstances change during a procedure, follow-up diagnostics – such as further radiographs during surgery – may become necessary. In this case, because Dr. S reduced the lingual height of bone, further radiographs may have needed to be taken for re-measurement after the height reduction. Similarly, in situations where treatment is not progressing optimally, the dentist should consider suspending treatment or, in this case, possibly backing out the implants. Any problems or unusual events that occur during a procedure should be carefully documented, including the plan to deal with the change in circumstances.

Finally, all patients need to be followed up with after procedures, especially when the patient reports or exhibits any post-procedure problem or complication. If, at any point during treatment, the practitioner is not fully comfortable with all that is going on, a referral to a specialist is recommended. In addition to maximizing the benefits to the patient, patients who feel they are well cared for by their doctors are less likely to involve lawyers when results are not what they had hoped.