Summer - Fall 2022

SCOA PROCEEDINGS

JOURNAL OF THE SOUTHERN CALIFORNIA OROFACIAL ACADEMY

PRESIDENT'S MESSAGE
Bach Le DDS MD

Greetings to fellow colleagues. I hope all of you have had a joyful and productive summer. As practicing oral and maxillofacial surgeons, we play a vital role in maintaining our practices, educating our staff members, and completing the multiple things we do to keep our practices functional. Moreover, we provide exceptional care for our patients. We do all the above and more. I am proud to say that I am associated with a group of professionals who accomplish all this and more daily. When faced with challenging clinical cases, I regularly collaborate and consult with my OMFS and non-OMFS colleagues to diagnose and treat my patients' varied ailments. These include patients with MRONJ, nerve injuries, implant, and bone graft failures. By phone, on the hospital ward, or consult report, we work together to form a treatment plan that best suits patients and their problems. Often, I find face-to-face meeting conversation the best way to exchange ideas and share input. This is one of the primary advantages of attending live meetings. In addition to the shared camaraderie, we can catch up with old friends and develop relationships with new ones. Our next SCOA meeting promises to deliver exciting speakers with updates on clinically relevant topics.

Dr Shuaib Malik trains surgeons and dental specialists nationally and internationally on complex surgical procedures. He will present a Pre-Meeting Zygoma Implants Hands-On Workshop and lecture on Do's and Don'ts of Maxillary Full-Arch Restorations.

Dr Jasjit Dillon is Professor, Chief and Program Director of Oral and Maxillofacial Surgery at the University of Washington, Seattle. She will present MRONJ – 2022 Updates.

Dr Devin Wahlstrom is an active-duty service member with the United States Army. He is a staff surgeon at Brooke Army Medical Center in San Antonio Texas. He will present Pain Management in Oral and Maxillofacial Surgery.

Dr Lenny Naftalin provides sedation services in dental offices through his mobile anesthesiology practice. He will present TXA in Orthognathic Surgery.

Dr James Melville is an Associate Professor in the OMS Department at the University of Texas Health Science Center. He will present Contemporary Maxillofacial Reconstruction: Tissue Engineering, Growth Factors and Surgical Techniques plus Numb Lip-Numb Tongue: What to Do About It showing Advancements in Maxillofacial Nerve Repair.

Dr Christopher Kane was commissioned in the United States Marine Corps following graduation from Tulane University. He attended flight school in Pensacola, Florida and served on the USS Midway for two deployments with 180 aircraft carrier landings. He will present Combat Maxillofacial Surgery.

Natalyn Lewis is a presenter for The fortune Law Firm. She will discuss Taxes, Lawsuits and Estate Planning that put Life and Practices at Risk.

We appreciate your continued participation at SCOA meetings through the years. We are always proud to welcome our United States Navy active-duty officers from Naval Base San Diego. The United States Navy and United States Army will be present October 12. I'll see you in Pasadena!!

SCOA 20th Annual Fall Scientific Meeting
Wednesday October 12
Live at the Hilton Pasadena

Presenters
Jasjit Dillon MBBS DDS
CAPT Christopher Kane DDS
Shuaib Malik DDS
James Melville DDS
Lenny Naftalin DDS
MAJ Devin Wahlstrom DMD

IN THIS ISSUE

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Sponsor Ads in This Issue

NEWS FROM SUSAN

I want to remind you with a request to visit all of our exhibit tables on October 12. As you know, we could not put on our CE meetings without the support of our many dedicated sponsors and reps. These sponsors have been supporting our meetings for many years; some go as far back as our first SCOA CE desert meeting in April 2001.

Howard Davis DDS

In the early days of SCOA and for many years, Howard and Janie Davis never missed a desert meeting. After Janie passed away, Howard continued to attend our meetings in the desert and in Pasadena. I want to share something with our members and I have Howard's permission. I talk to Howard on the phone now and then and he always asks me to tell everyone that he says "Hi." When I opened Howard's dues check in July, I noticed he wrote on the back of the envelope "Congratulations on Continuing Excellence" which I appreciated very much and I want the board to know. After I sent Howard my email confirmation and thanked him for his longtime support of SCOA, he returned an email saying, as he always said, "Hi to All." This is for all SCOA members from Howard.

Our younger members may not know, but may have heard of Dr Howard Davis, who is admired and highly respected by all of his OMS colleagues.

P.S. Howard told me on the phone Sep 5 that he has a birthday this month. I asked him and he told me: He will be 96. Happy Birthday Howard!

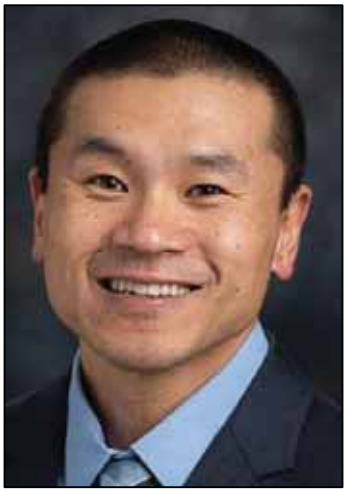
Roberta Ashley CRNA EdD CHSE

We miss Dr Ashley, or as I called her, Dr Wolf. Roberta retired from Keck School of Medicine of USC where she was professor of anesthesiology and education director. She also supervised OMS residents at the Ostrow School of Dentistry of USC and Harbor-UCLA Medical Center. Roberta will move or has moved north to be with her daughter and granddaughter, as I recall, to Washington state. Roberta joined SCOA in 2018 and became a valuable member of the board of directors. She presented at SCOA CE meetings, was an instructor for SCOA hands-on airway management workshops and wrote articles for SCOA Proceedings. We will miss you Dr Wolf.

SCOA 20TH ANNUAL FALL SCIENTIFIC MEETING
WEDNESDAY OCTOBER 12, 2022
LIVE AT THE HILTON PASADENA


Jasjit Dillon MBBS DDS


Shuaib Malik DDS


James Melville DDS


MAJ Devin Wahlstrom DMD


Lenny Naftalin DDS


CAPT Christopher Kane DDS

See Program on Page 4 ►►►►

Southern California Orofacial Academy Scientific Programs & Education
Live Wednesday October 12, 2022 at the Hilton Pasadena

Hands-On Workshop and Scientific Program

7:00 to 9:00	Sign In	Continental Breakfast in International Ballroom
7:00 to 8:50	Pre-Meeting	Zygoma Implants Hands-On Workshop Shuaib Malik DDS
8:50 to 9:00	Welcome	Introductions
9:00 to 9:45	Session I	Dos and Don'ts of Maxillary Full-Arch Restorations Shuaib Malik DDS
9:45 to 10:45	Session II	MRONJ – 2022 Updates Jasjit Dillon MBBS DDS
10:45 to 11:15	Break	
11:15 to 12:00	Session III	Pain Management in Oral and Maxillofacial Surgery MAJ Devin Wahlstrom DMD ▪ United States Army
12:00 to 1:00	Buffet Lunch	Legal MythBusters for Dental Professionals Natalyn Lewis ▪ The Fortune Law Firm ● California Ballroom
1:00 to 1:45	Session IV	Combat Maxillofacial Surgery CAPT Christopher Kane DDS ▪ United States Navy
1:45 to 2:15	Break	
2:15 TO 3:15	Session V	TXA in Orthognathic Surgery Lenny Naftalin DDS
3:15 to 4:00	Session VI	Contemporary Maxillofacial Reconstruction – Tissue Engineering, Growth Factors and Surgical Techniques James Melville DDS
4:00 to 4:15	Break	Wine Bar
4:15 to 5:00	Session VII	Numb Lip-Numb Tongue…What do Do About It Advancements in Maxillofacial Nerve Repair James Melville DDS
5:00 to 6:00	Reception	Hosted Bar and Hors d'oeuvres in International Ballroom
6:00 to 6:30	Board Meeting	San Marino Room

The Peri-Implant Marginal (Jumping) Gap - What should we do?
David Cummings DDS

There are many clinical decisions that we face as oral & maxillofacial surgeons and it can be very difficult to make choices on treatment protocols for certain clinical situations. We are constantly striving to improve our patient outcomes through virtual learning, live continuing education courses, journal articles, textbooks, and case discussions with your fellow colleagues. In the end, the treatment protocols that we choose are guided by many factors. There are concerns we have for immediate implant placement especially in the esthetic zone. These include graft failure, loss of papilla, soft tissue recession, early and late implant failure and many more.

When evaluating patients for immediate implant placement there are many factors that one must consider prior to performing the surgery...Kois described the five diagnostic keys to success for single tooth-peri-implant esthetics: (1) These include the relative tooth position, form of the periodontium, the biotype, tooth shape and the position of the osseous crest. (Fig. 1) The ideal tooth position is slightly coronal and lingual within the alveolar process. (Fig. 2) The gingival form refers to the amount of scalloping of the papillae. The more the papillae are scalloped the higher the risk of gingival loss after tooth extraction. (Fig. 3) The soft tissue thickness can be determined by probing the buccal of the tooth in question. If the probe shows through the attached tissue, then the biotype is considered thin and if you can't see any of the probe through tissue then the biotype is considered thick. (Fig. 4) The shape of the tooth is also one of Kois diagnostic keys to success. Tooth shape can be generally classified as square, oval and triangular. The more triangular shaped the tooth the more likely the papilla will be scalloped. Our concern for a highly scalloped papilla is that after a surgical procedure the papilla may shrink and create a "dark triangle." (Fig. 5) The last criterion is the position of the osseous crest. In a healthy periodontium the alveolar crest is positioned approximately 2 mm apical to the free gingival margin on the facial aspect and 3 mm interproximally. Kois suggests that if the osseous crest position is more than 3 mm from the gingival margin, then these are considered high risk cases and one may consider using orthodontic extrusion to bring the osseous crest down prior to implant placement. Another consideration when planning for immediate implant placement in the esthetic zone is whether the smile line is high or low (Fig. 6). Lastly, to complete the diagnosis requires various radiographic imaging, including a cone beam CT scan and or a periapical radiographic to evaluate the bone in all dimensions. (Fig. 7)

After the complete evaluation of your patient, you should be able to determine if this immediate implant case will be hard or easy (high risk vs low risk). Kois has made it very simple, that after looking at these five diagnostic criteria, you should be able to determine the difficulty of that specific case. Based on the difficulty of each case you can then determine all the treatment modalities that will be needed to obtain the best possible outcome for that specific patient. Once you have ascertained what treatment will be needed, then you can address the patient's needs and expectations appropriately.

Endosseous implants do not replicate the exact size and shape of a tooth extraction socket so when immediate implant placement is performed there are "gaps" around the implant between the outer diameter of the implant and the tooth socket. This is what most clinicians refer to as the "Jumping" gap. (Fig. 8) The question we should constantly ask ourselves is what is the best treatment for this "gap?" Different surgical techniques available for immediate implant placement have been studied and advocated. Should we raise a flap or not? Should we bone graft this area or not? Should we perform a connective tissue graft? (Fig. 9)

In 2021, Bakkali performed a meta-analysis on surgical techniques for preserving the peri-implant tissues on immediate implant placement. (2) The inclusion of this meta-analysis was limited to randomized clinical trials. Two articles from this meta-analysis specifically addressed raising a flap vs not raising a flap. Stoupe performed a randomized clinical trial and measured the level of the mucosal margin and the papillae over a 12-month time for immediately placed implants and found no significant differences between sites with a flap vs without a flap. (3)

In 2019, Grassi performed a cone beam CT study comparing three techniques: open flap with grafting, open flap without grafting and flapless with no grafting all with immediate implant placement. (4) This study included dehiscence sites up to 3 mm. Analysis variance indicated no difference between the groups for all outcomes. As a general trend the horizontal resorption occurred in all groups with the least amount in the flapless and no graft group. All three techniques exhibited almost complete bone fill in a vertical dimension but pairwise comparisons suggested that the no flap-no graft might be effective in terms of vertical gap reduction. When comparing pain levels in this study they found the no flap-no graft had the least amount of pain. They summarized by stating that the no flap-no graft surgery for post extraction implants when sufficient buccal bone is present allows for a well-accepted surgical intervention that provides satisfactory results in terms of filling the jumping and dimensional bone preservation.

When addressing bone grafting of the jumping gap the meta-analysis by Bakkali revealed six randomized controlled clinical trials that compared grafting the gap vs not grafting the gap. (2) These were all flapless procedures. In all these trials some form of a xenograft was used for the jumping gap and all included dehiscence sites not bigger than 3 mm. (4,5,6,7,8,9) Grassi's study did not show a statistically significant increase in the horizontal bone loss with a xenograft but when all the trials were pooled there was a significant difference (p value < 0.001). There was less horizontal resorption in the grafted sites. (4) In four of these trials vertical bone loss was addressed. (4,5,7,8) In all four reports there was no significant difference between the grafted and the control groups regarding vertical bone resorption between 4-6 months. Based on this meta-analysis, grafting the jumping gap does not seem to influence the vertical bone changes. (2) In Girlanda's study besides measuring the bone dimensions they also measured the soft tissue heights when grafting the jumping gap vs the control. (6) They measured the mesial buccal and distal buccal at the time of surgery at 3 months and 6 months post-surgery. They found no significant difference on the tissue receding at the mid buccal and there was no statistical significance in the intra group analysis between the distal buccal and the mesial buccal. Even though it was not significant there was a reduction in tissue height on the mesial buccal and the distal buccal site. Bakkali concluded that the placement of bone graft in the gaps reduces the horizontal resorption of the buccal bone but does not influence bone changes in a vertical direction. (2)

When the biotype is thin others have advocated for the use of a connective tissue graft at the same time as an adjunctive procedure in these situations. (10) The use of connective tissue grafts prevents the recession of facial gingival tissue and can be beneficial in high-risk cases. (2). Bakkali' s meta-analysis concluded that use of connective tissue grafts can be useful in high-risk cases but these do not affect the height of the interproximal papillae. When associated with increased gingival thickness it prevents marginal bone loss and improves esthetic outcomes. (2)

The studies that have been discussed here have been completed with good to ideal conditions (Deschene < 3 mm) for immediate implant therapy in the esthetic zone. There are times when patients present with unfavorable conditions for immediate implant placement. Recently, Elaskary has published a few articles on Vestibular Socket Therapy (VST). (11,12,13,14) This is a technique used for immediate implant placement in compromised sites, in particular type I or type II sockets. (13) Type I socket is described as labial bone plate deficient in width with the overlying soft tissues intact. Type II is described as a labial plate deficient in both height and width with the overlying tissue intact. The technique described by Elaskary is as follows: Extraction of the tooth with mechanical debridement and followed by chemical debridement with metronidazole 500 mg irrigation. A 1 cm horizontal incision is made approximately 3-4 mm apical to the free gingival margin. At this point a subperiosteal tunnel is created with a periosteal elevator connecting to the socket orifice. The implant is then placed via a surgical guide. Next a cortical heterologous membrane (0.6 mm thick) is hydrated, trimmed and introduced through the vestibular incision and secured with micro screws or membrane tacks. The jumping gap is filled with a combination of 75% autogenous bone chips (taken from the surgical site with a bone scraper) and 25% deproteinized bovine bone. If the gingival phenotype was thin then a subepithelial connective tissue graft was taken from the palate using a single incision technique. This soft tissue graft was secured to the inner surface of the soft tissue tunnel with 6-0 nylon sutures. The vestibular incision is also closed with a 6-0 nylon suture. A custom healing abutment is placed until the implant is integrated and ready to restore. (Fig. 10) In this study he evaluated 27 sites treated with VST over a two-year period and evaluated the bone levels using cone beam CT scans and evaluated the soft tissue via probing and the

pink esthetic score (PES). His results showed a significant difference in bone height and thickness from the surgery date to the one year follow up. From year one to year two there was no significant difference. There was a significant difference in the PES favoring the lateral incisors. There was no significant difference when comparing the soft tissue grafting group with the cases that did not receive a soft tissue graft. He also reported on cases with active infection. (14) If the patient had an active infection with two or more of the following (pain, sinus tract, purulent discharge swelling or mobility) then a six-day protocol was followed. The first step in this protocol is to extract the tooth atraumatically, curette and debride the socket. The socket is then irrigated with a 500 mg metronidazole infusion and the root was trimmed to half its original length and reinserted into the socket. The root was bonded with composite resin to the adjacent teeth and after 6 days the root was removed and the VST was performed. (Fig. 11)

There are many articles on this topic and definitely not all are covered here. If you are a purist and you base your decisions on what is significant then from these studies a flapless no graft treatment plan would be your choice. If you are not a purist then based on the general findings of these studies a flapless-grafted approach would be the best treatment of choice. If the gingival biotype is thin then should consider the use of a connective tissue graft to help with esthetics and preserving the marginal bone. More studies are definitely needed but one could consider the use of this new technique (VST) in cases where conditions are not ideal.

Figure 1


Figure 2

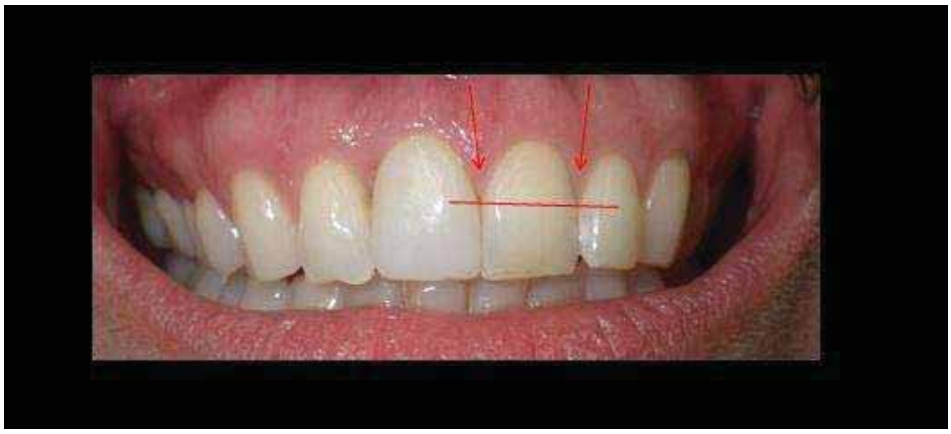


Figure 3

Figure 4

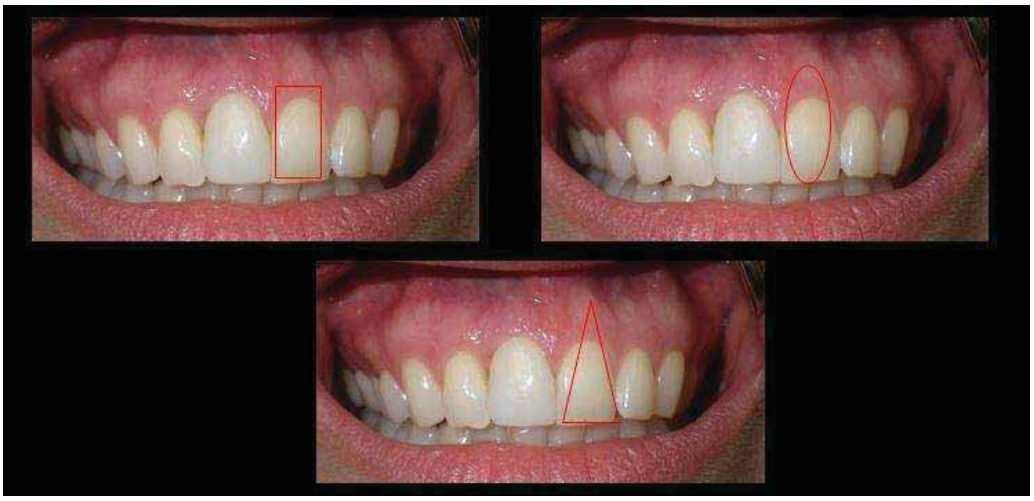


Figure 5

Figure 6

Figure 7

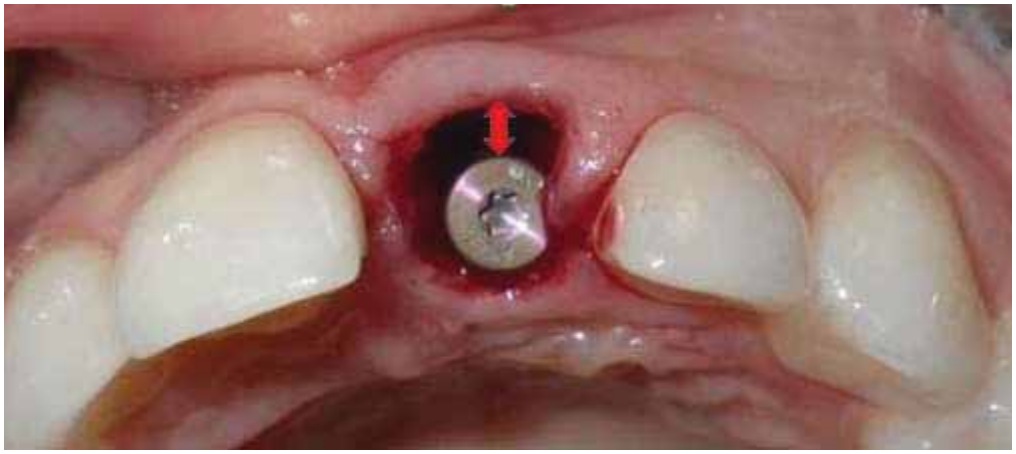


Figure 8

Figure 9

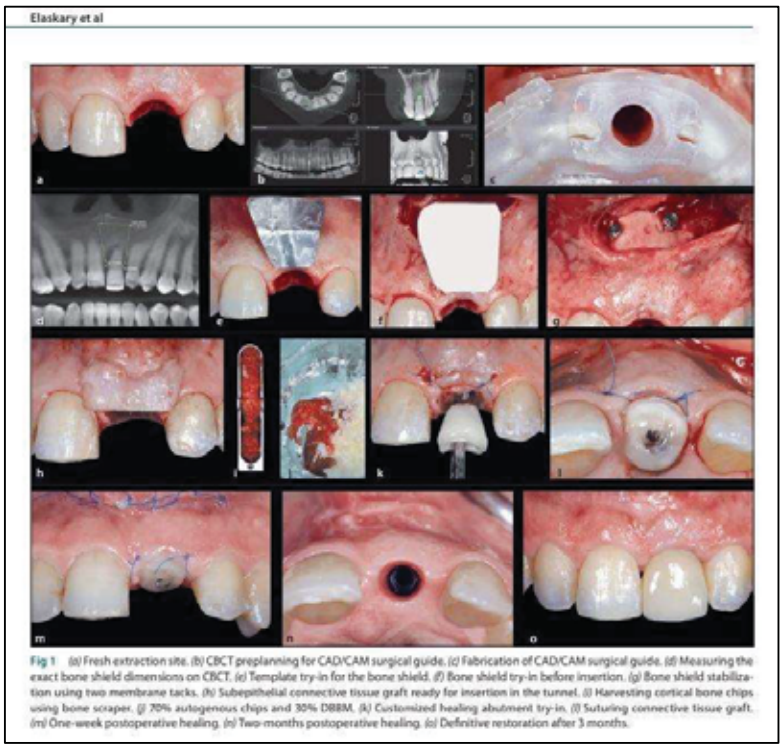


Fig 1 (a) Fresh extraction site. (b) CBCT preplanning for CAD/CAM surgical guide. (c) Fabrication of CAD/CAM surgical guide. (d) Measuring the exact bone shield dimensions on CBCT. (e) Template try-in for the bone shield. (f) Bone shield try-in before insertion. (g) Bone shield stabilization using two membrane tacks. (h) Subepithelial connective tissue graft ready for insertion in the tunnel. (i) Harvesting cortical bone chips using bone scraper. (j) 70% autogenous chips and 30% DBBM. (k) Customized healing abutment try-in. (l) Suturing connective tissue graft. (m) One-week postoperative healing. (n) Two-months postoperative healing. (o) Definitive restoration after 3 months.

Figure 10

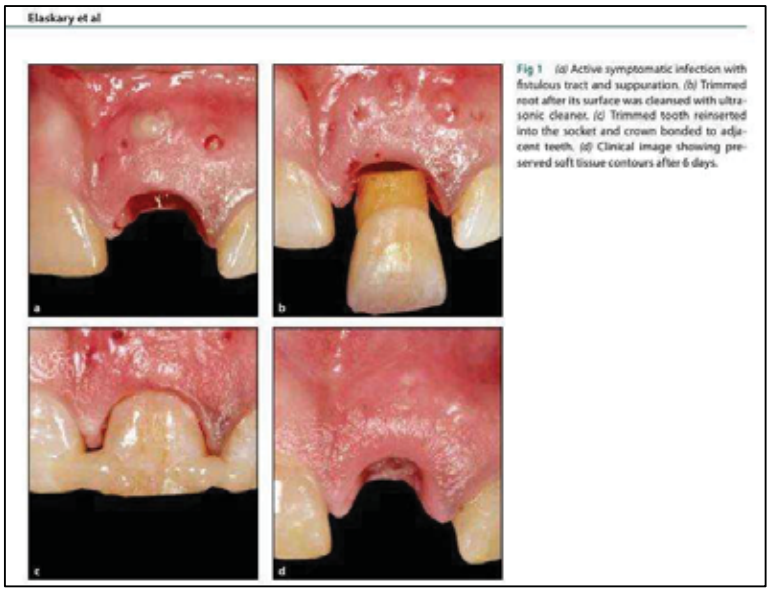


Figure 11

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Unexpected complications following facial cosmetic surgery – A case study
Marc Leffler DDS Esq

Claims of malpractice are always a source of stress and concern for practitioners who are sued, but looking at them retrospectively provides valuable information which can help mitigate malpractice risk. In this malpractice case study, orthognathic surgery performed on a young and seemingly healthy patient led to serious complications due, in large part, to an undiagnosed underlying medical condition. The case presented, which ended up in litigation against several medical providers, takes you through the pre-, intra- and post-operative phases of treatment, explores the legal concepts of negligence and informed consent, and explains the court's actions in response to the legal defense team's strong advocacy approaches. The risk management principles demonstrated go well beyond the facts and circumstances presented here and may be incorporated into everyday practice.

Underlying Facts

A 17-year-old high school elite basketball star presented to a cosmetic facial surgeon with complaints of a "gummy smile" and a "very pronounced" lower jaw. His initial presentation was in early spring, prior to the end of his junior year. Based upon clinical and radiographic assessments, he was determined to have the skeletal disorders of a vertical maxillary excess with a prognathic mandible. The surgeon suggested an orthognathic surgery plan of a maxillary Le Fort I osteotomy to impact the maxilla vertically and decrease his facial height, in conjunction with bilateral mandibular vertical oblique osteotomies to set the lower jaw back. The procedures would require a short hospital stay with surgery under general anesthesia.

In consultation with his parents, the patient agreed to go forward with the planned procedures, but they wanted the surgery to be performed at a time such that he would be fully healed and ready to be back on the basketball court in the fall, so that he could play in front of college scouts whom he realistically anticipated recruiting him on a scholarship. Surgery was scheduled for the end of June, as soon as the summer school break began.

In the pre-operative phase, the seemingly healthy patient was referred for medical clearance and standard laboratory testing. Because of personal preferences, he opted against the advice of the surgeon to donate his own blood in advance, to allow for an autologous transfusion if required, with the understanding that, if he required transfusion, he would be given banked blood. A detailed standard informed consent process took place between the surgeon, patient and parents, with the parents signing the surgeon's usual consent form that contained what the surgeon believed were the foreseeable risks; nothing in the form documented the surgeon's verbal explanation that trauma to the face prior to full bony healing at approximately six months post-surgery (as might occur in a basketball game) could be detrimental to the surgical result.

The surgery went smoothly, with no problematic intra-operative events, and there was apparent hemostasis before the patient was sent to the recovery room, with the patient in maxillo-mandibular fixation, as would be in place for some six weeks. At some point within the first few hours, he began to ooze dark red blood from all through his oral cavity, and he developed significant and increasing swelling in the mid- and lower-face regions. Laboratory testing revealed significant blood loss, so he was returned to the operating room, where he was immediately transfused with packed red blood cells per the direction of the medical consultant and, once anesthetized, all surgical sites were re-opened, and the maxilla was re-downfractured. Surgically, no large vessel intrusions were noted, so all sites were irrigated and cleaned, with fixation devices reapplied. Slowly, the bleeding lessened, and it remained fully controlled as the hours passed.

Suspecting that the issue was hematological and not surgical, based upon the series of events, the surgeon obtained further internal medicine consultation, which led to a diagnosis of Von Willebrand

Disease, an inherited non-sex-linked (unlike hemophilia) bleeding disorder associated with an (intermittent) decrease of a protein needed to properly form stable blood clots. Usual pre-op blood work does not necessarily test for this, especially when in mild form, and there had been no reported prior bleeding episodes to alert the surgeon or internist of a potential problem. The patient recovered well in the short term, with the internist commenting that the patient's unwillingness to provide an autologous blood donation, thereby necessitating the use of another's blood, seemingly played a helpful role in resolution.

However, the patient continued to claim over the following weeks that he felt weak and easily winded, attributing that in his mind to the surgical blood loss. The hematologist advised the patient that he had a mild deficiency in red blood cells, but not enough to warrant a diagnosis of anemia or treatment for it. At the end of August, after all fixation devices had been removed, he began basketball practice with his school teammates. During routine drills, he fell to the ground because he "felt weak and short of breath," striking his head and face; he immediately felt that his jaws were not aligned as they had been up until that point post-surgically. He returned to the surgeon, who, after clinical and radiographic examination, determined that the trauma had caused minor movements of the osteotomized bony segments, necessitating the reapplication of the intermaxillary fixation for an additional six weeks. The patient was, therefore, sidelined from basketball for the fall season and was not offered the college scholarship he had hoped for.

Legal Action

An attorney was retained who filed suit on behalf of the patient—now plaintiff. Both the surgeon and internist were named as defendants for having been negligent in their care and treatment of the plaintiff. The surgeon was also accused of failing to provide informed consent regarding the risks and potential outcomes of playing basketball after surgery. Regarding the negligence claims, the assertions against the surgeon focused on his having caused excessive surgical bleeding, which led to the significant blood loss that caused the damages; the claims against the internist centered upon his having failed to address the "post-surgical anemia."

The plaintiff sought monetary damages which were primarily based upon his having "passed out" on the basketball court, which caused the need for additional fixation to stabilize the bony changes, the resulting inability to play basketball during recruiting season, and the consequent loss of the college scholarship he had hoped for and been told he was a "shoe in" for.

The Litigation Process

Based upon the claims of negligence and damages, attorneys for the doctors filed papers, known as motions for summary judgment, seeking to dismiss the claims. With the support and affidavits of surgical and medical experts, the attorneys argued, as to the surgeon, that his surgical technique was in full compliance with the standard of care, that the post-surgical bleeding was entirely due to the undiagnosed underlying bleeding disorder rather than any improper surgical steps, and that Von Willebrand Disease would be quite unlikely to be diagnosed by the laboratory studies which are standard before surgery of this type on healthy patients. Regarding the internist, the attorneys contended that the objective post-surgical laboratory tests demonstrated that the plaintiff's red blood cell count fell within the normal range, albeit on the lower end, thereby requiring no intervention as might be required if he were truly anemic.

As is permitted, and essentially always done, the plaintiff's attorneys argued to the court in opposition. However, the judge determined that the surgeon followed usual surgical protocol which was, in fact, not challenged by the plaintiff's expert, and that, with no prior reported bleeding history by the patient, there had been no necessity for the specialized pre-surgical blood testing that would have more likely led to the Von Willebrand's diagnosis, as had been promulgated by plaintiff's expert. Additionally, the court found that the internist had no obligation under the standard of care to treat a condition – anemia – which was not confirmed by standard objective testing. Therefore, all negligence claims were dismissed.

Regarding the claim of lack of informed consent against the surgeon, the court reasoned that, because the surgeon did not document his verbal warning about the effects of potential trauma after surgery, and the plaintiff and his parents contended that such advice was never provided to them, that claim could not be dismissed due to the question of fact between the parties, thereby requiring a jury's determination. However, because the plaintiff's ultimate damages claim was that he lost out on a

scholarship that would have eliminated the nearly $250,000 in tuition costs that he was now forced to pay, the judge held that the basis of the claim was speculative: even though the plaintiff was the top prospect from his high school, and even from the entire region, there was no assurance that basketball scouts and coaches would have necessarily viewed his abilities to be at the level of top-tier college players, and offered the scholarship he had sought. Therefore, the lack-of-informed-consent claim was also dismissed on this basis, ending all of the plaintiff's claims.

Takeaways

In order for a malpractice claim to succeed, a plaintiff must demonstrate, through non-speculative and science-based testimony, that the doctor departed from the standard of care, thereby directly causing the injuries/damages claimed. Unless all of those elements are established, the case will not proceed to trial. Here, regarding the negligence claims against both defendants, there was no credible basis, in the eyes of the court, for those assertions to stand, warranting their dismissal. As to the consent issue, while the surgeon failed to document what would later become an important part of the process, the fact that, again in the eyes of the court, the damages claim was based upon speculation, that prong could not be "legally" proven, so it, too, was dismissed.

Many doctors believe that, once they are sued, they must either agree to a settlement or go before a trial jury, which will determine the fate of the case. That is not true. There are times that plaintiffs and their attorneys will discontinue a case because defense counsel demonstrate to them that the weaknesses of the case will be too difficult to overcome, or they cannot afford to retain high quality experts for trial or pre-trial proceedings, or because they never intended from the start to take their cases to trial but instead hoped to obtain a settlement which never came. Furthermore, as this case demonstrates, there are situations which warrant case dismissals before trial because the underlying facts and assertions do not meet the legal requirements.

As a cosmetic surgeon, it is imperative to obtain malpractice insurance from a company that retains attorneys who are intimately familiar and experienced with the legal maneuvers and medical considerations necessary to properly defend a case and willing to spend often significant sums of money to hire experts who have real expertise in the medical matters involved.

It cannot be emphasized enough that chart documentation at the time of treatment, patient meetings, telephone calls, and all patient interactions are critical to the defense of a malpractice lawsuit. That documentation should be contemporaneous with the event it records, should be accurate, and should be complete. Plaintiffs' attorneys are known to argue to juries, "If it wasn't written, it didn't really happen." While that may or may not be true, it is an argument often accepted by juries. Finally in this respect, medical records should never be altered; if a doctor realizes after a note is entered that it requires modification, that change should be made as an addendum, with a brief explanation as to why it was made. Alteration of medical records is a crime in some jurisdictions, and it makes the defense of a malpractice claim much more difficult, if not impossible.

MedPro Group's risk consultants are available to discuss all of the issues raised in this case study, as well as any other questions or concerns you may have regarding malpractice insurance or the malpractice litigation process.

Note that this case presentation includes circumstances from several different closed cases, in order to demonstrate certain legal and risk management principles, and that identifying facts and personal characteristics were modified to protect identities.

The content within is not the original work of MedPro Group but has been published with consent from the authors. Nothing contained in this article is intended as legal advice. There are variations in rules of practice, evidence, and procedure among the states. Some of the facts and other case information have been changed to protect the privacy of actual parties.

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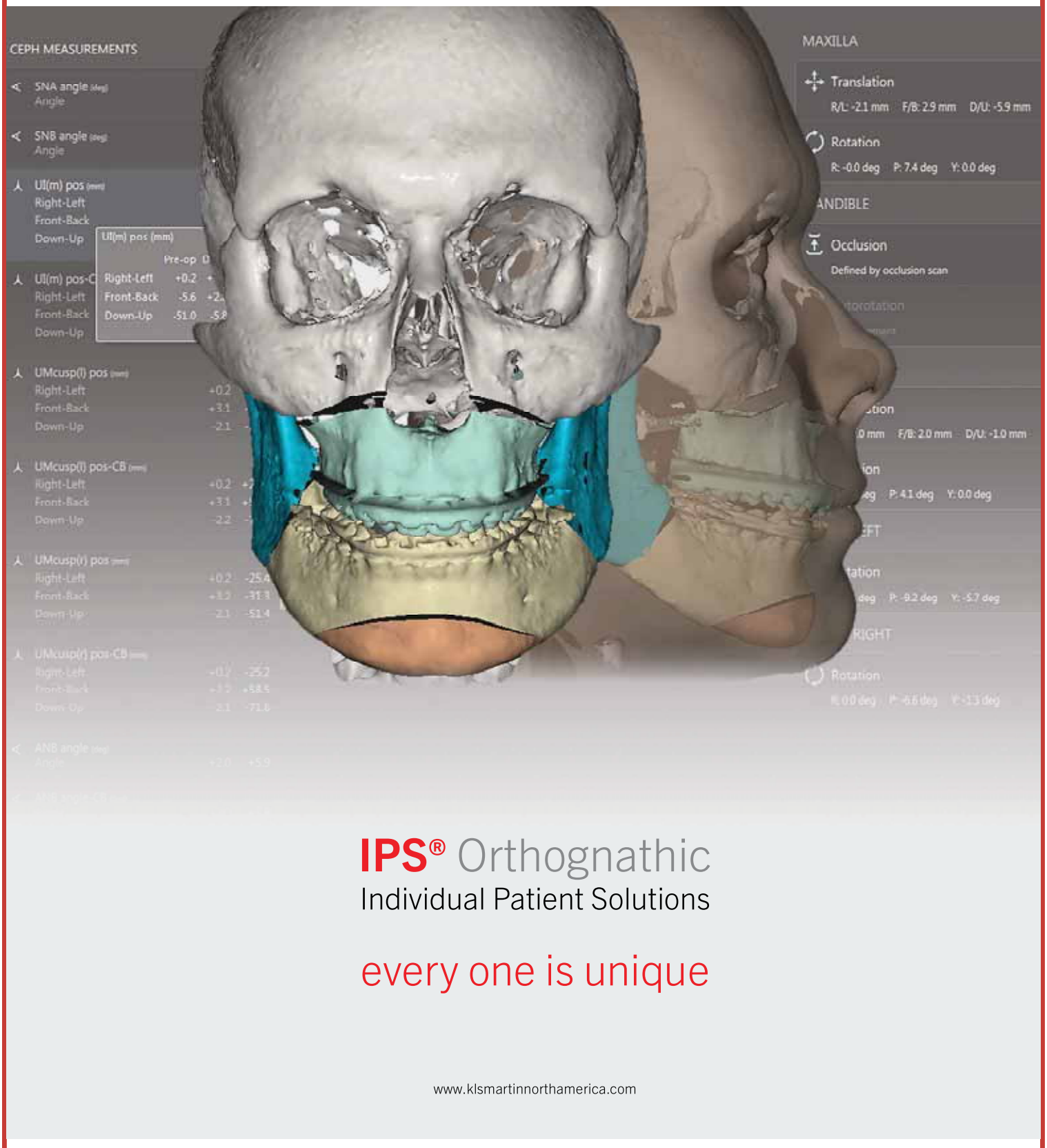

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