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Anatomy of an Infection Claim

This claim from the CNA HealthPro claim annals demonstrates the need for thorough assessment, communication, and documentation when an infection is presented or suspected.

Facts of the Case

Mary Fuller was a vibrant, active 84-year old who had been seeing Dr. Philip Schmidt for the past thirteen years. Although she resided in an upscale assisted living facility, she lived independently of any substantive assistance from the facility and customarily drove herself to dental appointments. Her dental chart indicated her last recall had been in November 2000, and her last full mouth series of radiographs was taken in 1989.

On Monday, April 16, 2001, she presented to Dr. Schmidt's office with a complaint of swelling and considerable pain in the mandibular right, the extent of which made her unable to open her mouth when Dr. Schmidt asked to obtain an x-ray. Dr. Schmidt performed an exam and later noted that "the swelling was firm, but not rigid" and that "It was roughly the size of a medium chicken egg." Since he was unable to do anything more, he wrote a prescription for Pen VK 500 mg, 2 tablets stat then 1 q6h until completed. He asked her to return in three days for a follow-up visit and made the following entry in her record:

4/16/01	R side mand pain & swelling. Too painful to Dx. Tx: Pen V-K: 500 mg #26; Sig: 2 stat, then 1 q6h until gone

On Thursday, April 19, 2001, Mrs. Fuller returned with continuing complaints of swelling and pain. Dr. Schmidt noted that both symptoms had improved slightly, enough to allow him to take periapical x-rays of the lower right. He diagnosed a periapical abscess of #31. As she had gold crowns on #30, 31, and 32 and was generally attentive to her dental needs, Dr. Schmidt referred her to an endodontist rather than recommend an extraction. He also changed her antibiotic regimen to Keflex, thinking he "might get a broader spectrum antibiotic working to bring down the swelling even more." Dr. Schmidt's assistant wrote the following chart entry:

4/19/01	EOE & 1 PA #31. PA shows abscess on #31 Ref. to Dr. Banks for endo. Sent dup of PA w/pt. Changed antibiotic to Keflex 250 mg #28; Sig: 1 q6hrs until gone.

The following day, the patient dutifully scheduled an appointment to see the endodontist on May 1, 2001. Another day later, on Saturday evening April 21, a telephone conversation took place that Dr. Schmidt did not document in the patient record and, in fact, did not even mention during the reporting to his defense attorney of pertinent facts regarding the claim. Notwithstanding his lack of documentation and recollection, he subsequently believed he had a clear recall of the conversation.

According to Dr. Schmidt, he had received a phone call at home from Janice Wells, a nurse at the assisted living facility. Ms. Wells was calling on behalf of Mrs. Fuller, who appeared weak and debilitated, and who complained her tongue was swollen. He stated Ms. Wells felt Mrs. Fuller might be having an allergic reaction to the antibiotic and inquired if it could be discontinued. Dr. Schmidt advised her to stop the antibiotic if she suspected it was causing an adverse response. He stated that he also advised Ms.

Wells to be sure Mrs. Fuller sought emergency medical care. No substitute antibiotic was prescribed, and no arrangements were made to further evaluate the patient, as Dr. Schmidt believed Ms. Wells would ensure Mrs. Fuller was directed to the appropriate care. In fact, it was the last time Dr. Schmidt had any contact, directly or indirectly, with Mrs. Fuller. He recalled later that he found it odd that Mrs. Fuller had not phoned him herself to discuss the matter, since they had always had a very good relationship.

Ms. Wells' presented a different recollection of the phone call during her deposition. Although she had not made a notation of her conversation with Dr. Schmidt in Mrs. Fuller's chart at the facility, she, too, believed she clearly recalled their conversation. She testified that it was Mrs. Fuller who believed that the swelling was caused by allergy and that she was simply relaying the information because Mrs. Fuller was having difficulty speaking. She also stated that she told Dr. Schmidt she had already advised Mrs. Fuller to go to the hospital, but Mrs. Fuller had steadfastly refused. She further testified that nothing was specifically discussed with Dr. Schmidt with respect to seeking a physician consult going forward.

Two days later, on Monday, April 23, Ms. Wells checked in on Mrs. Fuller and found her condition to be much worse. She convinced Mrs. Fuller to go to the hospital for further care, at which time she was transported by ambulance. She was examined by an otolaryngologist and diagnosed with Ludwig's Angina, a potentially fatal swelling secondary to infection. She was transferred to a second hospital for definitive care where she was given IV Clindamycin and had surgery for the extraction of #31, placement of surgical drains, and a tracheostomy. She had debridement and drainage surgery again on April 25 and April 27, with the placement of additional drains. Following the April 25 surgery, she was intubated and placed on a respirator.

Her condition improved during the course of her hospital stay and the swelling and infection of Ludwig's Angina eventually resolved. During this time, she told her family she never wanted to be intubated again. As her dental condition improved, Mrs. Fuller suffered a setback, initially thought to be a simple bronchial infection. She was diagnosed with pseudomonas pneumonia on May 19, and her physical status deteriorated abruptly eleven days later. In order to best stabilize her during treatment of the pneumonia, her physicians recommended that she be re-intubated, which she refused. Mrs. Fuller died on June 4, 2001 of complications of pseudomonas pneumonia.

Allegations Made in the Patient's Complaint

The patient's estate (Mrs. Fuller's son and daughter) alleged wrongful death subsequent to Dr. Schmidt's failure to diagnose and treat infection and failure to properly supervise patient care.

Claimed Injury/Damages

The patient's estate submitted a demand of $900,000 for her wrongful death, heath care expenses ($161,000), funeral expenses ($1,600), and pain and suffering.

Outcome

The claim settled during mediation proceedings for $325,000.

Discussion of Risk Management Issues

Dr. Schmidt believed he had properly treated Mrs. Fuller and that he had met, if not exceeded, the standard of care. He questioned whether an undisclosed underlying medical problem was a factor in Mrs. Fuller's demise. The plaintiffs had a different perspective and produced numerous experts critical of Dr. Schmidt's care.

All five plaintiff experts opined that Dr. Schmidt made several errors on the first day Mrs. Fuller presented with her problem, Monday, April 16. He failed to update her medical history and inquire about any changes since she had last been seen, which would have revealed that a general malaise had recently begun. They believed the malaise was caused by the developing infection. Considering the size of the

swelling and the presentation of trismus, they expressed that he also should have taken Mrs. Fuller's temperature to check for fever, an important consideration in the assessment and treatment of infection.

When Mrs. Fuller's trismus precluded obtaining an intraoral radiograph, they felt he should have taken an extraoral film or referred her to someone who could, considering the size of the swelling. Instead, he chose to forego radiography entirely. There was also criticism of the fact that Dr. Schmidt had never taken a new full mouth radiographic series over the preceding twelve years. Some speculated that a FMX taken at the most recent recall may have shown early periapical pathology of #31.

A reasonable and prudent dentist, they said, should have known that a swelling of that size required definitive treatment – such as endodontics, extraction, or incision and drainage – and not antibiotics alone. The combination of marked swelling, trismus, and the inability to obtain the diagnostic image needed for a definitive diagnosis should have given Dr. Schmidt great cause for concern. The plaintiff experts agreed that Dr. Schmidt should have made an immediate referral to an oral surgeon and also should have made certain the patient was able to be seen promptly. No such referral was made. Additionally, they stated that he should have maintained daily contact with Mrs. Fuller to closely monitor her condition, rather than direct her to return in three days with no follow-up contact over that interval.

Plaintiff experts opined that Dr. Schmidt's treatment at the second appointment, on April 19, also failed to meet the standard of care. When he concluded that the Pen V-K had not resolved the infection and swelling to his satisfaction, he should have intervened to immediately establish drainage in some way or arranged for a referral specialist to do so. They were unanimous in their criticism of his new choice of antibiotic, indicating that clindamycin should have been selected. In their view, Keflex was an inappropriate alternative to Pen V-K in the face of such an extensive dental infection. (Clindamycin was later given to Mrs. Fuller upon admission to the hospital.)

Dr. Schmidt believed that his referral to an endodontist, for Mrs. Fuller to schedule at her convenience, was entirely adequate. However, plaintiff experts agreed that Dr. Schmidt failed to appreciate the seriousness of the situation and seemed to take a rather cavalier attitude toward Mrs. Fuller's care. He failed to convey any sense of urgency to Mrs. Fuller. He also was criticized for again failing to personally speak with a referral specialist to emphasize the urgency of treatment and facilitate its delivery. Even our own defense expert was forced to admit that, although he supported a referral to an endodontist, an "urgent" referral was necessary, either that same day or within a day or two at most. He further admitted that Mrs. Fuller would not necessarily have understood the importance of an immediate referral unless Dr. Schmidt had told her or directed the referral on an urgent basis.

In his own deposition, Dr. Schmidt admitted that he did not specify any time period for the referral, and that he certainly did not convey any urgency about it. This fact supported a theory the plaintiffs planned to present at trial that Dr. Schmidt "lost interest" once he made the endodontic referral. Unfortunately, this theory was further reinforced by the fact that, later informed of her swollen tongue, a well-recognized symptom of both Ludwig's Angina and anaphylactic reactions, he did nothing to ensure that Mrs. Fuller be seen by a physician. Nor did he follow up at any time with her facility to check on her status. To further complicate matters, Dr. Schmidt stated during his deposition that he had not been cognizant of the term "Ludwig's Angina" prior to Mrs. Fuller's death and that he learned of it only after consulting his textbooks in preparation for defense of the malpractice allegation. The plaintiff experts were highly critical of his lack of knowledge about this very significant and potentially life-threatening complication of dental infections.

The undocumented telephone call Dr. Schmidt received on Saturday, April 21 from Nurse Wells on behalf of Mrs. Fuller also created multiple issues. Prior to learning of the phone call, two defense experts, an infectious disease specialist and an endodontist, had initially reviewed the claim and each found it defensible. Afterward, both experts expressed severe reservations about the defensibility of the claim, with one rescinding his support entirely. Notwithstanding the fact that Dr. Schmidt had failed to disclose the conversation to defense counsel, claiming he had forgotten about it, he initially believed his recollection of the call was clear. As time passed, it became apparent that Dr. Schmidt's memory of the conversation was minimal, at best. Whatever recollections he had could not be corroborated by a chart entry, as he had not made one. There were no casual notes of the call, either, such as on a nearby envelope or note pad. Additionally, Dr. Schmidt claimed he was not aware that he should document

pertinent telephone calls in the patient record. The lack of any documentation in the facility records of the call by Nurse Wells reduced the issue to a finger pointing exercise over who said what and who was responsible for further follow-up of Mrs. Fuller.

The extent to which Dr. Schmidt had actually documented Mrs. Fuller's complaints and physical status, as well as his own decision making and treatment, left much to be desired. All emergency dental visits should be documented using the SOAP format. The SOAP format facilitates a thorough review of the patient's subjective complaints, the clinician's objective findings, the diagnosis, and the treatment planned and performed.

In his progress note for Mrs. Fuller's emergency visit of April 16, Dr. Schmidt noted only "pain & swelling." Yet, he would later characterize the swelling in greater detail for his claim defense, indicating that "the swelling was firm, but not rigid" and that "it was roughly the size of a medium chicken egg." Why weren't these descriptions included in his original progress note from April 16? His comments would have been viewed with far more credibility had they been written in the chart. Additionally, Dr. Schmidt testified that he was uncertain exactly what he meant when he wrote that the swelling was "too painful to Dx."

Much of Dr. Schmidt's certainty that he provided good care was based on his assessment that Mrs. Fuller was healthy and able bodied, and showed no signs of being seriously ill, despite the localized infection. For example, he indicated that she had no fever. In his deposition testimony, he noted that Mrs. Fuller had driven herself to the second appointment. Dr. Schmidt went on to state that he had watched her drive away from his office on her own, and that he remembered this because he had admired her car, a gold Acura. According to his testimony, this observation played a role in assessing her condition on that occasion.

However, plaintiff's counsel was prepared to depose a close friend of Mrs. Fuller who would testify that she personally drove the decedent to both dental appointments. Further, the potential deponent would testify that the decedent never owned an Acura automobile. She planned to describe just how ill Mrs. Fuller was when being transported to and from these appointments. Additionally, Mrs. Fuller's son and his wife planned to testify that when at their home a week before for Easter, she complained of pain in her mouth and had a swollen neck. Her mouth pain had prevented her from participating in her family's Easter dinner, which she had never missed in her life. Plaintiff experts countered Dr. Schmidt's statement about Mrs. Fuller's lack of fever by stating that he failed to adequately check or ask about systemic symptoms and therefore, failed to note their presence or absence. If he had taken her temperature and found no fever, it should have been documented along with other findings from his clinical examination, they contended.

Because of their common occurrence and relative safety, local anesthetic injections are often overlooked as a professional liability risk. While not a significant source of professional liability claims, adverse events can occur during and in response to local anesthetic injections, sometimes with serious consequences.