



CNA HealthPro

Dental Malpractice at the End of the Century

“As long as we have human error, we will have malpractice.” — William Otis Morris

While this statement may be true in some instances, it would be wrong to imply that all human error has been, or presently is, considered malpractice. Malpractice, whether applicable to dentists or other health-care providers, primarily revolves around the issue of reasonableness. This includes both the information provided to the patient making a treatment decision, and the appropriateness and technical proficiency of the procedure ultimately performed.

As we come to the close of the century, let us look back on the concept of malpractice and its impact on the practice of dentistry.

Fundamental Concepts

Our society resolves most questions of professional liability by treating them as *torts* (literally, “wrongs”) within the arena of civil law. Malpractice law has been, and continues to be, governed by certain basic concepts hammered out over a century-and-a-half of jurisprudence:¹

- *dentist-patient relationship*, established when a dentist accepts a patient for treatment, whether or not a fee is involved. Once the relationship is in place, the dentist is obligated to provide due care until the relationship is formally terminated.
- *breach of duty*, that is, the failure of the dentist to treat the patient with the reasonable degree of judgment and skill ordinarily possessed by peers.
- *informed consent*, an important component of the dentist’s duty to patients. In order to make an educated decision about treatment, the patient must first understand the risks and benefits of the proposed plan of care as well as the risks of *not* undergoing the recommended course of treatment. Treatment given without the patient’s permission may be considered battery.
- *proximate cause*, i.e., the direct and major source of patient injury. To recover damages, the plaintiff must prove not only that the dentist violated the professional standard of care, but also that the injury would probably *not* have occurred had the dentist acted appropriately.

The First of Many

The first recorded American medical malpractice case is *Cross v. Guthery*. The 1794 decision involved a Connecticut physician who performed an unsuccessful mastectomy, resulting in the patient’s death by hemorrhage. The doctor then billed the patient’s grieving husband £15. The widower returned the favor by suing the doctor for £1,000 for depriving him of the “service and company” of his wife. After three years of litigation, the jury decided in favor of the plaintiff, but awarded him only £40.

Centrality of Fault

The heart of malpractice law is the concept of *fault-based liability*. Fault-based liability has been the basis of malpractice law since the days of the Industrial Revolution. It reflects the 19th century’s *laissez-faire* philosophy, serving to protect a competitive, individualistic and risk-taking economy from the threat of

excessive litigation. The legal concept is wedded to a particular set of national values; as those values change, other liability ideas — such as no-fault systems or strict liability — may come to the fore.²

Fault-based liability places the burden of proof on the plaintiff, who must demonstrate that the defendant healthcare provider acted unreasonably given the particular circumstances. This is often a formidable task, one that usually requires the testimony of expert witnesses. The need to prove negligence is the major reason malpractice suits last as long and cost as much to pursue as they do. It is also the reason most malpractice suits fail. An analysis of recent CNA HealthPro dental claims showed that 75 percent of the allegations result in no indemnity payment at all.

In light of these tough legal criteria, one might expect that professional liability lawsuits would be a rare thing. But this is hardly the case. Beginning in the 1930s, and accelerating after World War II, malpractice litigation has boomed, and it shows no sign of slowing down. In the late 1940s, some practitioners had \$5,000 coverage limits, and many went altogether bare of insurance; now, rare is the malpractice policy under \$1,000,000 per incident. Some high-risk medical specialists in litigation-prone areas pay six-figure premiums annually, if they can find any coverage at all.³

Contingency Fees

Why this flood of litigation? The answer has much to do with another aspect of our society's emphasis on democratic individualism — our wish to give every citizen access to the court system. Almost alone in the world, the United States permits a contingency fee system, whereby the plaintiff's attorney receives a certain percentage (often one-third to one-half) of the jury award or settlement if the suit is successful, and nothing if the suit fails. In other words, the plaintiff's attorney assumes most of the risk of a lawsuit, and spreads the risk among many different clients.

Under such a system, a losing plaintiff faces little penalty other than lost time and aggravation. This strongly contrasts with other legal systems, such as England's, where the losing plaintiff typically pays the defendant's court costs. Needless to say, England has proportionally far fewer malpractice suits than the United States.

While we tend to think of malpractice, and our concerns over frivolous lawsuits, as a recent phenomenon, consider these words from almost a century and a half ago:

“Occasionally all the arrangements and protections of science and philosophy vanish before the Deity.... It is an ignorance of, or want of reflection upon these principles which forms the foundation for the prevalence of quackery, and of the unjust persecutions which pursue the regular practitioner, and display themselves in groundless suits.”

— Committee on Malpractice, Pennsylvania Medical Society, 1850 (cited in Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America*, New York University Press, 1990.)

While the fault-based liability system took shape during the 19th century, it has been profoundly affected by 20th-century developments in dentistry, law, insurance and society itself. These developments have redefined how fault is perceived and proven, who can claim injury and how damages are calculated.

Dentistry

Over the course of this century, dentistry has become a much more professional, regulated and licensed field. Dental education has become more standardized, to the extent that the older “community standard,” which took into account regional differences and city-rural disparities, has been largely supplanted by a national standard of care. Expert witnesses can be called from far afield to define professional norms and challenge practitioner-defendants' actions.

Other factors within dentistry have also widened the web of risk. Specialization has increased, as has the number of multi-chair practices, resulting in less opportunity to cultivate dentist-patient relationships and

creating the potential for vicarious (indirect) liability stemming from the actions of another dentist, assistant or hygienist. Additionally, the rate of change within the dental field has accelerated, and the number and complexity of procedures have grown, which in itself leads to greater uncertainty of outcome.

Every forward movement in dentistry — professionalism, specialization, more efficient organization — tends to produce an opposing risk factor. As the number of “routine” procedures grows, so do patient expectations and the potential cost of disappointment. At times, the perception of what is “routine” can differ greatly between patient and practitioner. Consider this episode from the last century:

Addressing a plaintiff who had sued his physician for allowing his badly broken leg to shorten as it healed, Abraham Lincoln thundered: “Well! What I would advise you to do is get down on your knees and thank your heavenly Father, and also these two Doctors, that you have any legs to stand on at all.” The jury in this 1856 case ruled in favor of the defense and charged all court costs to the plaintiff. (cited in De Ville.)

Law

The United States has always produced more lawyers than other nations. And where there are more lawyers, there is a greater accessibility to the legal system by patients who believe they have been wronged.

The 20th century has seen the plaintiff’s bar, represented by organizations such as the American Trial Lawyers Association, become a powerful political force at the federal and state levels. These organizations lobby legislators to preserve the contingency-fee system and prevent imposition of mandatory arbitration or a loser-pays system. Their opponents — organizations such as the American Tort Reform Association, supported largely by insurers and professional associations — fight an ongoing battle to cap malpractice and product liability awards and otherwise slow down or reverse the liability spiral.

Insurance

The liability insurance industry’s major effort in recent decades has been to limit the volatility of a highly unpredictable and crisis-prone business. The industry has attacked the malpractice problem on three major fronts:

New types of policies. Over the last 25 years, malpractice carriers have largely switched from occurrence policies to claims-made policies, which reduce their exposure to allegations from incidents that happened years earlier. This lag period between incident and allegation is what makes professional liability insurance so uncertain from an actuarial standpoint.

Greater emphasis on risk management. Especially since the malpractice crisis of the 1970s, insurers tend to see their role as consisting of not just legal defense and indemnification of insureds, but also of educating policy holders about strategies for reducing potential liability.

Tort reform. Liability carriers and healthcare professional groups (such as the ADA and AMA) have spearheaded state and federal initiatives to increase the efficiency and effectiveness of the claims-resolution process, moderate unreasonable awards, limit punitive damages and eliminate court-clogging frivolous lawsuits.

Government and Society

The forces and movements affecting society as a whole have left their mark on malpractice. The rise of the medical and dental consumer has had a profound impact on the liability climate, as many patients have come to see their physicians and dentists more as service vendors than as practitioners of a delicate healing art without guarantees. For a variety of reasons, including increased patient loads and changes in

patients' insurance benefit programs, the practitioner-patient relationship has changed, and the professional mystique has dimmed somewhat. As medicine and dentistry are perceived more as bottom-line businesses, patients are quicker to express their disappointment or anger in the form of a malpractice claim.

One offshoot of the consumerist impulse is the public demand for greater openness about practitioners' liability histories. In 1986, Congress created the National Practitioner Data Bank, a massive nationwide clearinghouse of information on malpractice awards, settlements and disciplinary actions. While open to hospitals and licensing boards, the database is closed to the public. However, some states, led by Massachusetts, have recently begun to provide state residents with instant on-line access to information such as civil jury verdicts against physicians, disciplinary actions and criminal convictions.

The civil rights movement, with its drive for equality, has also helped redefine professional liability. The dental office has been deemed a "place of public accommodation," and dentists have been successfully sued for racial discrimination. With the passage of the Americans with Disabilities Act, these protections were extended to people with HIV.

The HIV virus has led to one of the most significant changes in dental practice over the last two decades: the use of universal precautions to protect dentists, patients and staff. Faced with this bloodborne pathogen, dentists proved they could quickly adopt the necessary safety measures without compromising quality of care. Today's universal gloving and other infectious disease-control measures also show the impact of OSHA employee safety regulations — another relatively recent and significant source of potential liability for dentists.

What Is to Be Done?

What can be done about malpractice — a concept that adapts to changing circumstances?

First, it is necessary to be realistic: dental malpractice is not going away. Tort reform may reduce the potential for damages, screening panels may weed out weak cases more quickly, but risk itself will always remain a factor in clinical practice. Dentists must acknowledge risks and limitations, and communicate these realities to their patients. An attitude of honest humility can do much to defuse the emotional conflicts and sense of betrayal that underlie many lawsuits.

By viewing every patient encounter as a possible brush with the unexpected, rather than as part of a daily routine, dentists are more likely to address potential conflicts and injuries before they occur. By carefully listening to patients and treating them as individuals, practitioners can best develop the dentist-patient bond. The goal is to create a trust-based relationship in which expectations are realistic and problems can be resolved through dialogue instead of litigation.

1. William Otis Morris, *The Dentist's Legal Advisor*, Mosby, 1995.
2. Sylvia Law and Steven Polan, "An Introduction to Malpractice Law," 1977.
3. Samuel Ursu, "The Medical Malpractice Dilemma," *Dental Clinics of North America*, April 1982.

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