LITIGATION, LEGISLATION, AND ETHICS

Information pertaining to litigation, legislation, and ethics will be reported under this section of the American Journal of Orthodontics and Dentofacial Orthopedics. Manuscripts for publication, reader's comments, and reprint requests may be submitted to Laurance Jerrold, DDS, JD, 82 Laurel Dr, Massapequa Park, NY 11762

D = IEL

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The simple formula stated above is one that every doctor should commit to memory. Where D stands for expanded duty delegation and IEL for increased exposure to liability; it should be obvious that the more we delegate to our assistants, because of the doctrine of vicarious liability, the more we become liable for the negligent acts of our employees. *Gillis v. Cardio TVP Surgical Associates, P.C.* — S.E.2d — (Ga. App. 1999) and *Delaney v. Rosenthall,* 196 N.E.2d 878 (Sup. Ct. Mass. 1964) are 2 good examples of fact patterns that can be applied to the orthodontic setting.

In *Gillis,* the plaintiff required a quadruple bypass. The surgeon, one of many defendants, performed the thoracic portion of the procedure while his physician's assistant, another defendant and an employee of the surgeon, performed the saphenous vein harvest. The femoral nerve was injured during the procedure causing permanent injury. The trial court granted a number of defense motions for dismissal that became the subject of this appeal. The first issue concerned the plaintiff's claim of battery.

Battery is defined as any unauthorized and unprivileged contact by a doctor, with a patient, occurring during that patient's examination or treatment. To defeat a charge of battery, the doctor only need show that he or she had the patient's valid consent; consent being defined as action of sound mind, given freely, and not obtained by fraud. The plaintiff claimed he never consented to allow a physician's assistant to perform the vein harvesting aspect of his bypass. The defendants countered with a signed consent form that read in part that the plaintiff authorized the surgeon, by name, and "all other medical personnel" to perform the necessary procedure(s).

The Court looked at the Physician's Assistants Act, OCGA Sec. 43-34-100, which establishes the rules governing the practice of assistants in the State. Looking first at the purpose for allowing expanded duties by a physician's assistant, the Court noted that the legislature enacted laws to "encourage the more effective utilization of the skills of physicians by enabling them to delegate health care tasks to such assistants where such delegation is consistent with the patient's health and welfare." Physician's assistants are allowed to do those tasks, specified in their job descriptions, as promulgated by the Composite State Board of Medical Examiners. The job description does not denote specifically each and every allowable procedure, therefore the Court turned to another section of the code which provided in part that:

> "Nothing in this code section shall make unlawful the performance of a medical task by the physician's assistant, whether or not such task is specified in the general job description, when it is performed under the supervision and in the presence of the physician utilizing him." (Cit. Omit.)

However, the Court quickly noted that there are limits to a doctor's ability to delegate "…any medical task… so long as the physician is present and supervises the procedure. To hold otherwise would allow a brain surgeon to delegate brain surgery, a neurosurgeon to delegate a spinal fusion, or a plastic surgeon to delegate a rhinoplasty, all with impunity."

The Court was just as quick to note that the defendant physician's assistant had been adequately trained to perform this procedure and had done a great number of them during his 11 years of employment with the defendant physician. Noting that it was an accepted practice for an assistant to perform this aspect of coronary artery bypass surgery, the Court held that because there is a spectrum of unspecified tasks that could be legally delegated and performed, it was not appropriate for the Trial Court to have decided this issue as a matter of law. It was rather a job for a jury who, after hearing all credible and relevant evidence, would decide whether or not this fell within the realm of delegable tasks, as implied by the Code and not specified by the Board. The jury should also be the ones to determine whether or not the defendant possessed the requisite level skill and training to be able to perform the procedure in question. In other words the trial court was overturned, and this issue was remanded for a new trial.

Although this addressed the delegation of duty issue, there was still the issue of whether the consent was valid. Again the Court turned to section 31-9-6(d) of the OCGA that states: "[c]onsent… which discloses in general terms the treatment or course of treatment… shall be conclusively presumed to be valid… in the absence of fraudulent misrepresentation of material facts in obtaining same." (Cit. Omit.) The Court, turning to a 1-year old case that addressed this issue on point, noted:

> "Where a confidential relationship exists, as here, a person's silence when he should speak, or his failure to disclose what he ought to disclose, is as much a fraud in law as an actual affirmative false representation… . Where a patient suffers injury at the hands of a physician as a result of consent to treatment obtained through the physician's misrepresentation, non-disclo-

> sure, or concealment of a material fact which the patient has a right to know, the patient may recover damages." (Cit. Omit.)

Again, the Appellate Court overruled the Trial Court by finding that this issue could not be decided as a matter of law. Instead, it remanded this issue to be retried in order for a jury to decide whether the plaintiff was sufficiently defrauded to the extent that it would invalidate his consent.

The final issue addressed by the Court was the plaintiff's claim that had he known an assistant would be performing the surgery, he would not have consented to it. OCGA section 43-34-106 holds that "[a]ny physician, clinic, or hospital using a physician's assistant shall post a notice to that effect in a prominent place." The purpose of this law is to allow a patient to be apprised that they will be treated by assistants rather than physicians. The Court reasoned that if this type of notice is required to be conspicuously placed where the services are actually rendered, than it is not unreasonable to assume that it should be just as conspicuously placed in the consent form. Again, the Appellate Court held that the Trial Court erred in holding as a matter of law that such notice was not necessary in the consent form; therefore it also remanded this issue to be decided anew. This time, by a jury.

Now that we have the legal background, the *Delaney* decision showed its application. The plaintiff injured his thumb in a machine shop accident. The plaintiff was taken to the defendant's office where he received 37 stitches in his finger. He returned to the office 2 days later and was treated by the doctor's assistant, Phyllis, a high school graduate who had previously been employed for 2 years as a hospital aide. She soaked the hand, rebandaged the thumb, and told the defendant to return in 2 days. The thumb was now swollen to twice its normal size, and the sutures were disappearing into his flesh. The defendant removed some of the stitches, expressed some purulent exudate, and then left, instructing Phyllis to reapply the bandage and provide the plaintiff with instructions for keeping the wound clean and wet.

Three days later, the plaintiff returned to the office and was again seen by the assistant, who bathed and redressed the hand and also gave the plaintiff a shot of penicillin. Four days later, the plaintiff, returning to the defendant's office, was again seen by the defendant's assistant who removed the remaining sutures, expressed more pus from the wound as she had seen the doctor do, cleaned the thumb, and redressed the wound.

After another 4 days had passed, the thumb was now 3 times its normal size, immobile, reddish brown in color, and when touched was extremely painful. Again, Phyllis saw the patient and continued to cleanse and redress the injured digit. Some $4\frac{1}{2}$ weeks after the first visit and about 3 weeks since the defendant had last seen the patient, and at the plaintiff's urging, the defendant finally took an x-ray. The resulting diagnosis of osteomyelitis required extensive hospitalization and surgery. The plaintiff was out of work for over a year and never regained full use of his thumb. Looking back over the course of treatment, the medical record revealed that in 17 visits to the defendant's office, he had only been seen by the doctor 4 or 5 times.

The Trial Court gave a directed verdict in favor of the defendant, and this appeal ensued. The issue was whether the standard of care was met as a matter of law. In the first of 2 appeals, the Appellate Court noted that:

> "The duty owed by a physician to his patient… is that he possesses and will use the reasonable degree of learning, skill, and experience which is ordinarily possessed by others of his profession in the community where he practices, having due regard to the current state of advance of the profession… and that he will in case of doubt use his best judgment as to the treatment to be given in order to produce a good result." (emphasis added)

The Supreme Court, in upholding the decision to overturn the Trial Court, noted that it was for a jury to decide matters of fact such as whether the standard of care had been breached; or whether the doctor in question exercised his best judgment to obtain a good result. The Court stated that a jury could easily reach a contrary finding in that:

> "[The defendant] left the treatment largely to Phyllis, whose medical training and experience were almost nonexistent. …A girl who had merely graduated from high school and had worked in a hospital as a nurses aide for about two years was permitted, by the defendant, to treat the plaintiff on at least twelve out of seventeen visits. She removed stitches, squeezed pus out of his thumb, prescribed pills, injected penicillin, removed bandages and reapplied bandages to his hand, and even advised the plaintiff as to the treatment to be followed."

COMMENTARY

The reader should appreciate the power invested in a jury. Judges are triers of law, not fact. In other words, how we do what we do will be judged by the fictional "everyman." We are at a very interesting juncture in the history of our profession. We are generally busier now than we have been in many years and have a larger patient pool than ever before with an increased ability to pay for services. The trickle-down effect of this phenomenon caters to the use of practice management techniques to help us be "more efficient" in delivering orthodontic services. We are relying more and more on auxiliary delegation and the question that arises is: should this issue be a voice for concern?

There are very few practitioners out there who follow a given States' Dental Practice Act to the letter; many allowing their staff to do "slightly" more than they are technically allowed to do by law. Okay, no big deal, no harm — no foul. That is, of course, unless there is harm. There are some prac-

titioners who are literally, even though they don't think about it in these terms, aiding and abetting the unlawful practice of dentistry. This is neither good for the public nor for our profession. Obviously in these situations there is tremendous exposure to liability. The problem is not with the minority but with the majority. The consistent overutilization and overdelegation of duties, albeit minor, when the numbers play out, will mean that some patients will have been overtreated by our assistants, undertreated by us; and some will be harmed to some degree in the process; it is inevitable.

The risk management lesson is to realize that this is a subtle danger. As the responsible party, we must make sure to train our staff to the best of our and of their abilities, to monitor closely the results of their machinations, and to be responsive to our patient's needs and concerns. Understanding and recognizing risk is the first step to accepting it and dealing with it effectively.

The next issue is the ethics of expanded duty utilization vis-à-vis the patient's acquiescence to this practice. If we truly believe that we are acting in our patient's best interest by delegating specific tasks to our assistants why not justify this practice by using the ethical principle of publicity. Let's tell patients, up front, by signage and on our consent forms that a "significant" portion of their treatment will be rendered by dental assistants. If we are not willing to do that, then at some level, the ethics of our actions regarding expanded duty delegation become suspect.

Another concern is, if we are saying you don't need to be a trained professional to straighten teeth, merely a well-supervised technician, what floodgates are we opening? By allowing and fostering expanded duty utilization, are we creating a situation where future generations of orthodontists will be of thinner ranks? In addition, it's hard enough as it is to find, pay, and keep competent staff. What are we prepared to do to increase the labor pool necessary to facilitate expanded duty practices?

Long-range planning for the orthodontic profession must address the legal, ethical, behavioral, labor, and practice management issues if we are to survive and prosper in this millennium.