



DENTAL LIABILITY ALERT®

a bi-monthly nationwide review of dental liability for
DENTISTS - DENTAL HEALTH CARE PROVIDERS
with liability analysis and risk management advisory
by Ira J. Zarin, Esq.

Dental Malpractice Review with Analysis

- **\$200,000 RECOVERY** - Endodontics - Alleged negligent performance of root canal 2
Osteomyelitis of the jaw and trigeminal neuropathy. *(Although dental practitioners are not guarantors of a good result in all circumstances, they can be held liable in damages if it is proven that a poor result occurred because of a deviation from the acceptable standard of care)*
- **DEFENDANTS' VERDICT** - Oral surgical malpractice - Plaintiff contends initial defendant oral surgeon negligently performs root canal 4
Plaintiff contends that second defendant oral surgeon performing apicoectomy on same tooth that flared up when initial defendant is on vacation, negligently perforates sinus and negligently performs repair - Alleged permanent facial pain. *(Where a particular complication to a dental procedure can occur with sufficient frequency to be considered a "known risk" of that procedure, a practitioner can nonetheless incur liability by failing to appropriately advise of that complication in a valid informed consent prior to the procedure or, if the complication occurs, by failing to timely and appropriately treat the complication following its occurrence)*

Additional Dental Malpractice Verdicts

- \$310,000 VERDICT - Failure to advise infant plaintiff and mother that caps and crowns would be necessary after prolonged orthodontic treatment for cosmetic anomaly - Alleged negligent failure to extract bicuspid and subsequent relocation of cuspids 6
- \$176,000 GROSS VERDICT - Medical Malpractice - Dental - Alleged negligent performance of cosmetic dentistry - Work redone - 38% comparative negligence found. 7
- \$125,000 VERDICT - Alleged negligent installation of bridgework - Several unsuccessful attempts to repeat installation - Subsequent need for replacement of bridgework by non-party dentist 7

Medical Practice Liability

BUSINESS PRACTICES/UNFAIR COMPETITION

- A medical practice could have tortiously interfered with another practice through an anticipatory breach of a non-compete clause by inducing a physician to violate the covenant 8

INFORMED CONSENT

- Two consent forms signed by a patient adequately disclosed the risk of dvt during an anterior lumbar interbody fusion 9

PEER REVIEW

- A forensic pathologist's license to practice was revoked based on his documented history of alcoholism and habitual use of hydrocodone. 10

DEFENSIVE ACTIONS/COUNTERMEASURES TO MALPRACTICE SUITS

- A malpractice suit was time-barred because the plaintiff did not properly identify the defendant in the patient's hospital records using instead a "physician unknown" designation 11

NEW/EXPANDED LIABILITY

- A pediatrician was qualified to testify against an internist and emergency room doctor relating to treatment in a hospital emergency room of a child who died from occlusive thromboemboli. 12

INSURANCE

- A hospital's lien relating to the cost of services to a patient did not extend to the medical payments benefits provision of his insurance policy. 13

Dental Malpractice Review

Dental Malpractice Review with Analysis

\$200,000 RECOVERY - ENDODONTICS - ALLEGED NEGLIGENT PERFORMANCE OF ROOT CANAL - OSTEOMYELITIS OF THE JAW AND TRIGEMINAL NEUROPATHY.

CASE SUMMARY

The plaintiff, a 33-year-old woman, contended that the defendant endodontist failed to perform a root canal properly resulting in injury to the plaintiff. The defendant denied any breach of the standard of care and argued that the treatment the plaintiff received was the best and most appropriate form of treatment for her presentation.

CASE DETAILS

The plaintiff underwent a root canal procedure performed by the defendant, an endodontist. The treatment failed and she returned to the defendant for an evaluation. The defendant scheduled the re-treatment of the tooth and prescribed pain medication and an antibiotic to the plaintiff. The plaintiff experienced increased pain in her tooth and she presented to the emergency department of a local hospital. The emergency department physicians who evaluated her and reviewed her CT-scans recommended the urgent extraction of her tooth.

The plaintiff, having been under the care of the defendant who recommended re-treatment, returned to the defendant for his advice. The defendant dismissed the emergency department physician's recommendation that her tooth be extracted and he proceeded with the scheduled re-treatment. The defendant performed the re-treatment and the

plaintiff was advised to wait at least six months for bone healing. A few months later, she was seen by her primary care physician, who referred her to an oral surgeon. The oral surgeon recommended immediate extraction of her tooth, which was performed. During the extraction, a tissue sample was sent to a pathology lab for testing. The testing confirmed the presence of osteomyelitis. The plaintiff went on to suffer trigeminal neuropathy and she will require ongoing medication to manage.

The defendant argued that non-surgical re-treatment was the preferred treatment of choice because the tooth involved was part of a three-unit bridge and extracting the tooth would have compromised the bridge. The defendant also argued that there was no clear evidence that the plaintiff had developed osteomyelitis.

The case was settled in the amount of \$200,000 after extensive discovery, and just weeks prior to the trial, following one full day of mediation.

RISK MANAGEMENT ADVISORY

Practitioners are reminded by this case that even in situations where a root canal seems to have failed, the practitioner involved may not necessarily be implicated in liability simply on the basis of the failure of that procedure. Dental practitioners would do well to remember that when engaging in procedures such as a root canal,

they are not legally the guarantors of a good result in every instance. Rather, what they do guarantee is that they will exercise reasonable care in accordance with the relevant acceptable standard of care to avoid a poor result if possible. However, if a failure of the procedure occurs as a result of a deviation from the acceptable standard of care, then they cannot escape liability unless or until it can be established that the failure occurred by the very nature of the procedure and not by any provable deviation. In this circumstance, the practitioner so involved generally will not be held responsible in damages for the failure of the procedure. Practitioners should also be aware that they can be held responsible for a failure to appropriately and timely react to a failed procedure and institute corrective action to alleviate the pain being experienced by the patient as a result of the failed procedure.

In a situation where the tooth can no longer be saved, which was alleged to have been the case in this malpractice action, the practitioner so involved, even though he may not have been responsible for the failed root canal, can indeed incur liability for failing to take all appropriate action in avoidance of further injury or pain suffered by the patient. If the avoidance of further injury to the patient requires that the tooth involved be extracted,



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as was alleged in this case, then the failure to do so in a timely manner can create liability if the patient suffers additional injury or pain as a result of that failure.

The defendant, through his experts, attempted to argue that the non-surgical subsequent treatment that was instituted was the preferred treatment of choice because the tooth involved was part of a three-unit bridge and its extraction would have compromised the success of that particular bridge. However, the evidence presented indicated that an oral surgeon who examined the patient subsequent to the failed extraction recommended immediate extraction of the tooth, which was ultimately performed. During the extraction, a tissue sample was sent to a pathology lab for testing, which confirmed the presence of osteomyelitis.

It was successfully alleged by the plaintiff's experts that the decision to avoid an extraction on the basis of attempting to preserve a treatment plan was not only erroneous, but also detrimental to the patient. The experts argued that this particular decision and treatment plan was unreasonable under the circumstances and was instrumental in causing increased injury to the patient. In this regard, the defendant's treatment plan was determined by the plaintiff's experts to have been detrimental to the patient's health and well-being in that it required the avoidance of an apparently necessary extraction on the basis that the tooth involved was part of a three-unit bridge and that an extraction would have compromised the bridge, despite the fact that the underlying pathology testing confirmed ongoing osteomyelitis.

In this regard, practitioners are reminded that whereas they are free in most instances to render treatment decisions, where they render a treatment decision that is not "reasonable" under the circumstances, because as in this case it unreasonably endangers the plaintiff's health and well-being, then that decision can indeed incur liability to the practitioner involved. However, practitioners can

sometimes avoid liability for rendering an erroneous decision, if such an erroneous decision is found to have been reasonable under the particular prevailing circumstances. Practitioners are also reminded that although they are not insurers at arriving at a correct treatment plan in every case, and can be excused under certain circumstances for having made an error, where they risk the patient's health and well-being and risk the occurrence of a potentially serious injury to the patient from a condition such as osteomyelitis, the practitioner so involved should not expect to avoid liability simply because at the time, they were attempting to preserve bridgework that otherwise would not be preserved by completion of a necessary extraction.

Another interesting aspect of the case is that the case was ultimately settled for \$200,000 following a full day of extensive mediation. It was thought that the use of mediation in this case by consent of the parties probably avoided a much larger verdict that might otherwise have been the case if the matter was left to a jury's determination and not resolved by agreement of the parties through mediation.

Practitioners are reminded that the use of mediation can frequently avoid a far more extensive award and finding being rendered by a lay jury in the absence of the matter being settled. Mediation has many benefits for an accused practitioner. In the first place, it can resolve the issue quickly, sometimes in a matter of months rather than years, and avoid prolonged preparation for litigation and discovery that is involved in reliance on a full litigation procedure which requires depositions, discovery, expert analysis evaluation, and full-throated testimony that can be subject to appellate review even after a verdict is rendered. Furthermore, the utilization of experienced mediators, who are available for mediation in most jurisdictions, can avoid the emotional reaction of a lay jury to accusations against practitioners, particularly where there exists clear and significant deviation, to which a lay jury can

often react negatively as reflected in the rendering of a far more extensive verdict than otherwise might have been the case at the hands of a knowledgeable, dispassionate mediator. Finally, mediation puts the case to rest finally and forever once it is agreed upon, with no basis to appeal for errors committed by a trial judge or by the attorneys in the course of an extensive litigation that otherwise would be the case. In addition, through the utilization of mediation, practitioners should be aware that mediation is not usually held in open court, but most often, in a lawyer's office or a judge's chambers, thereby avoiding the potential for media reporting to any particular verdict or decision by a jury.

Another fundamental benefit to mediation as opposed to relying on a full-fledged jury trial is that the practitioner involved, through his attorney, can observe the process of arriving at a settlement and participate in that process, and can have some fundamental control over the decision-making process, which otherwise would be totally in the hands of inexperienced lay jurors whose reaction may frequently be underestimated or overes-

timated due to the laymen's inexperience in handling and deciding complex dental or medical malpractice litigation. It is only through mediation or arbitration that the practitioner with a limited insurance policy can be assured that the matter being accused against him or her can be settled within the policy limits. This often avoids a situation where a jury gets carried away and renders a very large verdict in excess of the existing liability coverage of the accused practitioner involved.

Another distinct advantage in mediation or arbitration as opposed to a full-fledged jury trial is that medical or dental practitioners, through their attorneys, together with the attorneys for the plaintiff, have a voice in the selection of the mediator or arbitrator, which is agreed upon by both sides to mediate and potentially settle the case. In most arbitration cases, the arbitrators are particularly knowledgeable in the handling of dental malpractice cases and are all respected attorneys who not only follow the law, but are not prone to emotional reactions that otherwise might be the case if the matter were decided at the hands of a lay jury.

For all of these reasons, accused dental practitioners in dental malpractice litigation should seriously consider, whenever possible, the use of mediation or arbitration in final disposition of a pending dental malpractice litigation in which they are involved. A full-fledged trial can potentially create unwanted publicity for the accused dental practitioner, where the matter is tried in open court and where local reporters are known to be present in many instances. Furthermore, through the use of mediators/arbitrators, practitioners can avoid the sometimes oversympathetic reaction of lay jurors who, because they hold their medical personnel in high regard, might react negatively to the extreme when they hear allegations of clear deviation which, to the layman, might well be reflected in a verdict that could be far more than what otherwise would have been the case at the hands of a knowledgeable mediator/arbitrator.

REFERENCE

Plaintiff patient vs. Defendant endodontist. Attorneys for plaintiff: Eric J. Parker and Susan M. Bourque of Parker Scheer in Boston, MA.

DEFENDANTS' VERDICT - ORAL SURGICAL MALPRACTICE - PLAINTIFF CONTENDS INITIAL DEFENDANT ORAL SURGEON NEGLIGENTLY PERFORMS ROOT CANAL - PLAINTIFF CONTENDS THAT SECOND DEFENDANT ORAL SURGEON PERFORMING APICOECTOMY ON SAME TOOTH THAT FLARED UP WHEN INITIAL DEFENDANT IS ON VACATION, NEGLIGENTLY PERFORATES SINUS AND NEGLIGENTLY PERFORMS REPAIR - ALLEGED PERMANENT FACIAL PAIN.

CASE SUMMARY

The female plaintiff in her 30s, who underwent a root canal performed by the initial defendant oral surgeon, contended that this defendant negligently failed to fill the root canals sufficiently close to the apex of the root. The plaintiff maintained that the defendant should have filled to within 1 mm of the apex before applying gutta percha material. The plaintiff alleged that this defendant filled to within 2 mm of the apex.

CASE DETAILS

The plaintiff related that shortly after the procedure by the first defendant, she suffered a flare-up and since the first defendant was on vacation, she visited the second defendant oral surgeon. This defendant performed an apicoectomy, in which the approach is made from the gum line instead of the crown. The plaintiff contended that during the procedure, this

defendant negligently perforated the sinus, alleging that he performed the procedure in a negligent manner.

The plaintiff maintained that she suffered damage to a facial nerve and that as a result, she will permanently suffer facial pain.

The defendants denied that the procedures were negligently performed. The initial defendant contended that he could not fill the canal closer than 2 mm from the apex because of calcification. The second defendant maintained that a perforation of the sinus is a known risk that

can occur in the absence of negligence. The second defendant further denied that the repair was performed in a negligent manner.

Both defendants further questioned the validity of the extent of the plaintiff's claimed continuing facial pain. Both defendants maintained that the plaintiff appeared to be a "drug seeker," who made an excessive amount of requests for pain medications, including OxyContin and Percocet.

The jury found that both defendants were not negligent.

RISK MANAGEMENT ADVISORY

In this case, the defense maintained that a perforation of the sinus is a known risk that can and did occur in the absence of negligence or deviation. Practitioners are reminded that the occurrence of a known risk as a defense to an adverse event occurring during a dental procedure implies that the adverse event occurred as a result of the very nature of the procedure itself and not by provable deviation in the performance of the procedure. However, for this defense to be effective, there must be proofs to the effect by at least testimony of experts involved that the known risk occurs with sufficient frequency to be considered a known risk to the procedure itself that can occur in the absence of any deviation. In a situation where the known risk involved can be proved to have occurred as a result of a particular deviation from acceptable dental practice, then the defense of a known risk to an adverse event will not be applicable.

In this case, the event in question allegedly involving a known risk must occur with sufficient frequency to be considered a known risk, and if the risk involved does not occur with regularity or with sufficient frequency, but only occurs very occasionally, under these circumstances, where there exists a particular deviation in bringing about the occurrence, then it cannot be considered a known risk of the particular procedure involved that occurred in the absence of deviation as a result of the very nature of the procedure itself. Practitioners should also

be aware that where an adverse event occurs that normally and regularly can occur in the absence of deviation, but in a particular instance where there exists provable deviation, then that provable deviation will remain actionable which may not be avoided on the basis of the fact that sometimes the same result occurs by the nature of the procedure itself.

Practitioners are also reminded by this case that where there exists a known risk to a particular dental procedure and the practitioner involved fails to inform the patient of the potential for the occurrence of that risk, particularly where it occurs with sufficient frequency to warrant such an advisement, then the failure to inform the patient prior to the procedure can create liability to the practitioner for lack of informed consent if the patient incurs injury as a result of the occurrence of that risk. The failure to inform the patient of a known risk to a procedure can be considered a failure of adequate informed consent to a known risk given to the patient prior to commencing the procedure.

In addition, where there exists a failure of informed consent, then the practitioner so involved can be responsible for all of the adverse occurrences during the procedure involving the known risks to the procedure. even in the event that there is no deviation in the performance of the procedure which brings about that poor result. In these circumstances, the liability is assessed against the practitioner for failing to inform the patient in a valid informed consent, prior to the institution of the procedure, of the potential for the occurrence of that known complication.

In this regard, practitioners are again reminded of the importance of obtaining a written document from the patient prior to the institution of any procedure, where there exists the potential for the occurrence of a known complication, acknowledging that the patient was appropriately advised of the potential for the occurrence of the known complications. The absence of written documentation attesting to the fact that informed consent was obtained can lead to a

situation in which the accused practitioner must rely on his or her oral representation as to what may have occurred or not occurred years before immediately prior to the procedure being performed, which can frequently be contested by the patient, whose memory may be inconsistent with that being alleged by the practitioner in their attestation of having obtained an oral informed consent from the patient years before.

Under these circumstances, the accused practitioner may not be able to comply with his or her burden of proof in establishing informed consent necessary to defend the practitioner in the litigation. On the other hand, a written, signed informed consent document can resolve the issue once and for all and eliminate the issue as a potential source of liability that could otherwise occur if the practitioner fails to establish years later that the informed consent for the particular occurrence involved was, in fact, obtained prior to the institution of the procedure.

An additional aspect in this regard is the liability that can be assessed for a failure to timely repair or treat the results of a known complication even where the complication occurred without deviation and was addressed in a valid informed consent. Where a known and disclosed complication occurs without deviation, but is not timely and appropriately addressed by the practitioner involved, liability can nonetheless be assessed for the resulting damage by virtue of the untimely or inappropriate repair of the injury sustained as a result of that complication.

Another significant aspect of this case was the defendants questioning of the validity of the extent of the continuing pain that the patient was claiming during trial. The defendants alleged that the plaintiff had appeared to be a drug seeker who made an excessive amount of requests for pain medications including Oxycontin and Percocet. In this regard, practitioners, when preparing for a dental malpractice litigation, should become aware of a patient's drug habits or

any evidence indicating that the accusing plaintiff was involved in unauthorized drug use that could be affecting their motives for the institution of the action in court seeking money damages against the physicians involved that could affect the outcome of the litigation. Evidence of an accusing patient's unauthorized, extensive drug use can have the effect of impairing the patient's credibility in the eyes of the court and the jury. Such evidence can also establish a motive for the malpractice claim having been made against the practitioners involved to sustain what might be an ongoing drug habit requiring sufficient funds to be continued.

Evidence of a patient's habits such as unauthorized and habitual drug use can often be very effective in establishing a motive outside of malprac-

tice for making a claim against the practitioners involved because such a claim could involve a significant monetary consideration. Furthermore, the very provable allegation of unauthorized drug use, in addition to establishing a motive for the action for money damages, can also severely impair the credibility of the accusing patient. In addition, the very fact that the jury will hear during the course of the litigation about an accusing patient's drug habit may understandably, under these circumstances, discourage them from otherwise awarding money damages where the jurors themselves become reluctant to feed that habit by rendering an award in money damages that could further encourage the accusing patient's use of unauthorized drugs. For these reasons, a patient's drug habit,

if significant enough, could be relevant during cross-examination of the accusing patient in a dental malpractice litigation.

EXPERTS

Initial defendant's expert oral surgeon: Ira Cheifetz from Mercerville, NJ. Second defendant's expert oral surgeon: Patrick Pirozzi oral surgeon from Montville, NJ.

REFERENCE

Monmouth County, NJ. Patient Doe vs. Drs. Roe, et al. Docket no. MON-L-002433-01; Judge Jamie Perrie. Attorney for initial defendant: Joseph K. Cooney of Widman Cooney & Wilson, Oakhurst. Attorney for second defendant oral surgeon: Stephen H. Schechner of Milburn.

Additional Dental Malpractice Verdicts

\$310,000 VERDICT - Failure to advise infant plaintiff and mother that caps and crowns would be necessary after prolonged orthodontic treatment for cosmetic anomaly - Alleged negligent failure to extract bicuspid and subsequent relocation of cuspids.

The plaintiff contended that when the nine-year-old infant plaintiff presented to the defendant orthodontist with an anomaly involving a transposition of the cuspids and bicuspid that caused a cosmetic deficit, but no functional difficulties, the defendant negligently embarked on a prolonged course of orthodontic treatment. The plaintiff maintained that over the course of the next several years, she became increasingly dissatisfied with the crowded appearance of her teeth. The plaintiff contended that the defendant should have allowed for more room by extracting the bicuspid and subsequently relocating the cuspids.

The plaintiff also maintained on an informed consent theory that the infant plaintiff and her mother were not advised

that the defendant's course of treatment would mandate the subsequent placement of caps and crowns. The plaintiff contended that she now requires caps and crowns and will need a number of replacements of these caps and crowns.

The defendant contended that the plaintiff's suggested course of treatment was not viable and that he embarked on the proper course. The defendant also maintained that he had advised the plaintiffs of the need for crowns and caps. The plaintiff countered that the defendant could not document having provided such information.

The jury found that the defendant's treatment was not negligent, but that he failed to obtain the patient's informed consent. They then awarded \$310,000,

including \$15,000 for past pain and suffering, \$95,000 for future pain and suffering and \$200,000 for future dental costs.

EXPERTS

Plaintiff's dentist/odontologist experts: Jeffrey Ginsberg, DMD from Yorktown Heights, NY, and Howard Jay Kirschner, DDS from Rockaway Beach, NY. Defendant's orthodontist experts: Angela Andretta, DDS from Flushing, NY, and Mark Bronsky, DDS from New York, NY.

REFERENCE

New York County, NY. Bianco vs. Dr. T. Index no. 107982/08; Judge Jeffrey Oing, 01-20-11. Attorney for plaintiff: Albert W. Chianese of Albert W Chianese & Associates in Rockville Centre, NY.

\$176,000 GROSS VERDICT - Medical Malpractice - Dental - Alleged negligent performance of cosmetic dentistry - Work redone - 38% comparative negligence found.

The plaintiff was a female physician, an osteopath, who underwent cosmetic dentistry performed by the defendant dentist. The plaintiff alleged that the defendant negligently performed the work necessitating that it be redone by another dentist. The defendant argued that his work met the standard of care, but that the plaintiff failed to return for follow-up treatment as instructed.

The plaintiff was 40 years old at the time she sought treatment from the defendant for improvement of the appearance of her teeth, including caps and laminates. She treated with the defendant for approximately 15 months and claimed that the defendant never indicated that it was important for her to receive prompt follow-up dental care.

The plaintiff's dental expert testified that the defendant over-ground the plaintiff's teeth and that the caps were not appropriately seated, causing them to continually come off. The plaintiff alleged that this and other complaints required that the dental work performed by the defendant be redone by another dentist at a cost of approximately \$127,000.

The defendant's dental expert testified that the plaintiff had been fitted by the defendant for temporary caps, her teeth were not over-ground as alleged and that the cause of the plaintiff's problems was her own failure to return for follow-up treatment. The defense argued that the plaintiff cancelled dental appointments because she was undergoing a Lap-Band procedure for weight control.

The jury found the defendant 62% negligent and the plaintiff 38% comparatively negligent. The plaintiff was awarded \$176,000 which was reduced accordingly. The award included \$88,000 in past and future dental expenses and \$88,000 in past and future pain and suffering. The plaintiff's motion for additur is pending.

REFERENCE

Jessee vs. Dr. S. Case no. 08004927 CI SEC 013; Judge Anthony Rondolino. Attorney for plaintiff: Sandra Lynn Bucha of McCue, Reams & Associates, P.A. in Bradenton, FL. Attorney for defendant: James B. Thompson of Thompson Goodis & Thompson in St. Petersburg, FL.

\$125,000 VERDICT - Alleged negligent installation of bridgework - Several unsuccessful attempts to repeat installation - Subsequent need for replacement of bridgework by non-party dentist.

The plaintiff, in her 50s at trial, contended that the defendant dentist, who installed temporary and permanent bridges between January, 1996 and February, 2000, did so in a negligent manner, contributing to his subsequent inability to remove and replace the bridgework after noting decay on February 9, 2002. The plaintiff also contended that between February 9, 2002 and July 23, 2008, the defendant, noting decay that required removal and replacement of the bridgework, negligently failed to perform this work in

a successful manner and that she required the services of a non-party subsequent treating dentist who completed the work.

The defendant pointed to a 33 month hiatus in care after February, 2000, denied that the plaintiff underwent continuous treatment, and that any claim for negligence occurring before November 9, 2002 was barred by the Statute of Limitations. The court concurred. The defendant further denied that the treatment was negligent and contended that any difficulties stemmed from periodontal disease.

The plaintiff, an RN, worked as a paralegal and the plaintiff made no income claims.

The jury found for the plaintiff and awarded \$125,000, including \$79,053 for past pain and suffering and \$45,947 for past dental costs.

EXPERTS

Plaintiff's dentist/odontologist expert: Peter Blauzvern, DDS from Jericho, NY. Defendant's dentist/odontologist expert: Leslie Seldin, DDS from New York, NY.

REFERENCE

Nassau County, NY. Weinberg vs. Dr. L. Index no. 20701/08; Judge Thomas Feinman, 03-22-11. Attorney for plaintiff: Albert W. Chianese of Albert W. Chianese & Associates in Rockville Centre, NY.

Medical Practice Liability

Business Practices/Unfair Competition

A MEDICAL PRACTICE COULD HAVE TORTIOUSLY INTERFERED WITH ANOTHER PRACTICE THROUGH AN ANTICIPATORY BREACH OF A NON-COMPETE CLAUSE BY INDUCING A PHYSICIAN TO VIOLATE THE COVENANT.

One medical practice could have tortiously interfered with another practice by an anticipatory breach of a non-compete clause in an employment agreement by luring a physician to practice in a way that violated the covenant, a Florida appellate court has held.

A physician entered into a Staff Physician Employment Agreement with Southeastern Integrated Medical (SIMED) to provide services to SIMED's patients on a full-time basis. The parties agreed that the physician would perform services for a three and one-half year term, unless she provided notice of her intent to terminate her employment within 90 days. In addition, a covenant not to compete in the agreement provided that upon termination of the business relationship, the physician was restricted for two years from providing medical services within a twenty-five mile radius of any SIMED medical office; and that SIMED had the right to seek liquidated damages in lieu of injunctive relief for breach of the non-compete provision.

Eleven months into the contract, SIMED became aware that North Florida Women's Physicians solicited the physician to leave her employment with SIMED and work at North Florida. SIMED alleged that the physician provided North Florida with a copy of the employment agreement and North Florida informed her that it had devised a plan to allow her to quit her employment with SIMED and to come work for North Florida within the restrictive zone without compensating SIMED. The complaint alleged that with actual knowledge of both the business relationship between SIMED and the physician and the terms of the employment

agreement, North Florida offered the physician employment which she accepted and then informed SIMED that she was quitting.

SIMED filed an action against North Florida for tortious interference with a business relationship alleging that it suffered damages in the loss of legitimate business interests, including substantial relationships with specific prospective or existing patients.

The trial court found that SIMED failed to allege facts indicating that the physician breached the agreement and that North Florida's actions were done for a competitive business purpose and, thus, not actionable. Accordingly, the court dismissed the complaint. However, this ruling was reversed on appeal. The appellate court decided that SIMED sufficiently alleged that North Florida tortiously interfered with its business relationship with the physician even though she still worked at SIMED when the complaint was filed because there was an anticipatory breach of the contract.

COMMENTARY

Ordinarily, an action for tortious interference with a business relationship requires the plaintiff to allege the existence of a business relationship; knowledge of the relationship on the part of the defendant; an intentional and unjustified interference with the relationship by the defendant; and damage to the plaintiff as a result of the breach of the relationship.

In this case, the appellate court found that the plaintiff pled the existence of a business relationship between itself and the physician, as evidenced by the employment agreement; that the defendant had actual

knowledge of the noncompete provision in the agreement; and that the defendant intentionally interfered with the relationship by encouraging the physician to join its medical practice and to practice in the restricted area within a two-year period after leaving the plaintiff in breach of the noncompete provision.

The trial court had found that the complaint was not yet "ripe" based on its determination that no actual breach had occurred because the physician was still employed by the plaintiff at the time the complaint was filed. However, in the view of the appellate court, the plaintiff sufficiently alleged an anticipatory breach of the employment agreement. The physician stated her intention to terminate her employment with the plaintiff and the plaintiff alleged that she accepted an offer of employment from a competitor located within the twenty-five mile prohibited zone.

A breach of contract by anticipatory repudiation may allow the non-breaching party to terminate their own performance and bring litigation for damages. This could occur when a physician employee informs the employer that she would not abide by an employment agreement. And, where an anticipatory repudiation occurs, the non-breaching party may be able to bring an action immediately since requiring an actual breach as a prerequisite would nullify the doctrine of anticipatory breach.

REFERENCE

Southeastern Integrated Medical, P.L. v. North Florida Women's Physicians, P.A., 50 So.3d 21 (Fla. App. 2010).

Informed Consent

TWO CONSENT FORMS SIGNED BY A PATIENT ADEQUATELY DISCLOSED THE RISK OF DVT DURING AN ANTERIOR LUMBAR INTERBODY FUSION.

Two consent forms signed by a patient adequately disclosed the risk of deep vein thrombosis (DVT) during an anterior lumbar interbody fusion, an appellate court in Louisiana has held.

The plaintiff saw the defendant for an evaluation of his back pain. An earlier MRI revealed a degenerative disc at L4-5 with protrusion. The defendant recommended an anterior lumbar interbody fusion. The plaintiff signed a consent form for this procedure at the defendant's office. The plaintiff had a preoperative visit with a general surgeon who was to assist with the surgery. At this visit, he also signed a consent form. The surgery was performed at Lafayette Surgical Specialty Hospital. Due to damage to a blood vessel that occurred during the surgery, the plaintiff incurred significant blood loss, suffered cardiac arrest and had to be resuscitated. He was transferred to The Heart Hospital of Lafayette for cardiac monitoring. An ultrasound later revealed that the plaintiff experienced a post-operative, left lower extremity DVT.

The plaintiff filed a complaint with the Louisiana Patient's Compensation Fund against both surgeons alleging failure to obtain his informed consent, among other things. A medical review panel unanimously decided that the evidence did not support the conclusion that either defendant failed to meet the standard of care for obtaining the plaintiff's informed consent including the risk of bleeding and damage to blood vessels. The consents stated that bleeding and injury to the vena cava was a recognized complication of the procedure.

The plaintiff then filed a medical malpractice action including an allegation that the surgeons failed to adequately disclose the potential complications associated with the procedure, namely, DVT. The defendants moved for summary judgment which was granted and affirmed on appeal. The appellate court decided that the consent forms signed by the plaintiff provided an appropriate level of disclosure of the risk of DVT.

COMMENTARY

As a rule, in a claim alleging failure to obtain a patient's informed consent, the plaintiff has to show the existence of a material risk which the physician had to disclose; the failure of the physician to inform the patient of the risk; the realization of the risk; and a causal connection between the failure to inform the patient of the risk and realization of the risk. Louisiana has a statute that requires consent be obtained from a patient before a medical procedure is performed. The consent has to set forth "in general terms the nature and purpose of the procedure . . . the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss . . . of function of any organ or limb [and] of disfiguring scars associated with such procedure . . ." It also had to acknowledge that such disclosures and that all questions had been answered in a satisfactory manner as evidenced by the patient's signature. The statute concluded that such consent "shall" be presumed to be valid and effective, in the absence of proof that execution of the consent was induced by misrepresentation of material facts.

In this case, the plaintiff executed two consent forms. The principal dispute was whether they adequately disclosed the risk of DVT. The first consent form referred to injury to major blood vessels and blood clots in legs which might break off and go to lungs resulting in breathing problems, possibly death. The second consent form was virtually identical, but added, in hand, the additional risks of "infection, bleeding, hematoma formation, hernia in incision, injury to nerves, bowel, ureter." On this evidence, the appellate court concluded that the plaintiff did not establish a failure of the defendants to inform him of the risk of DVT associated with the surgical procedure.

The defendants usually bear the burden of proof of their entitlement to summary judgment. However, they do not generally bear the burden of proof at trial on the issue of informed consent, in other words, they are not required to negate all essential elements of such a claim, only show an absence of factual support for one or more elements essential to the claim. If the defendants are successful in doing so, the burden may then shift to the plaintiff to produce factual support sufficient to establish that he will be able to satisfy his evidentiary burden of proof at trial.

REFERENCE

Labit v. Cobb, 50 So.3d 267 (La. App. 2010).

Peer Review

A FORENSIC PATHOLOGIST'S LICENSE TO PRACTICE WAS REVOKED BASED ON HIS DOCUMENTED HISTORY OF ALCOHOLISM AND HABITUAL USE OF HYDROCODONE.

The revocation of the license of a forensic pathologist to practice medicine was affirmed by a New York appellate court based on his long documented history of alcohol abuse and his habitual use of hydrocodone.

The plaintiff, a forensic pathologist, was licensed to practice medicine in New York in 1990 and, since the mid-1990s, had limited his practice to providing consultation services as a medical expert. He had several medical conduct issues through the years, including a voluntary temporary suspension of his license in 1991 followed by two years of probation, a consent agreement limiting the scope of his practice in 1998 and a six-month suspension in 2007.

In 2008, the Bureau of Professional Medical Conduct (BPMC) filed a statement of charges against him alleging cocaine dependency, habitual abuse of alcohol, habitual abuse of the prescription drug hydrocodone, a psychiatric condition impairing his ability to practice medicine, neglect to pay a civil fine of \$2,500 and failure to report self-prescribed medication in violation of a prior voluntary agreement.

A hearing committee dismissed the charge alleging cocaine dependency, but sustained the remaining charges and, as a penalty, suspended the plaintiff's license for two years. The suspension was stayed upon the condition that he comply with various terms of probation. The parties sought review by Administrative Review Board for Professional Medical Conduct (ARB), which affirmed the committee's findings regarding professional misconduct. However, the ARB unanimously

overturned the Committee's penalty and, instead, revoked the plaintiff's license to practice medicine.

The plaintiff then commenced a court proceeding to challenge this determination. The appellate court affirmed based on the documented history of the plaintiff's acute alcohol problems and of his habitual use of hydrocodone.

COMMENTARY

The plaintiff argued on appeal that there was insufficient evidence to support the ARB's determination upholding the charges that petitioner habitually abused alcohol and hydrocodone. The appellate court responded by pointing out the plaintiff's documented history of acute alcohol problems beginning in the early 1990s when, as an assistant medical examiner, he arrived intoxicated at a death scene. He voluntarily surrendered his license because of his alcohol problem and, during treatment, was diagnosed with a severe alcohol-dependent condition. After a period of probation, he admittedly returned to drinking, which resulted in additional alcohol-related incidents. Recently, he had been involuntarily hospitalized after his sister found him highly intoxicated and threatening self-harm. He failed to follow through on recommended treatment.

A physician who evaluated the plaintiff and testified at the hearing stated that he "chronically and repeatedly engaged in a pattern of excessive and problematic use of alcohol" and that his actions were consistent with alcohol dependence. The ARB found this opinion had a factual basis and was credible. This proof was deemed adequate to uphold the finding regarding habitual alcohol abuse.

The appellate court also found sufficient evidence as to the plaintiff's habitual use of the prescription drug hydrocodone. While the total pills purchased by him over a 730-day period were within the therapeutically prescribed regimen when considered over the entire time, there were periods during this time of excessive purchases. "Significantly," he received prescriptions from multiple physicians and used multiple pharmacies to fill those prescriptions. As observed by a physician who testified for BPMC at the hearing, the plaintiff's behavior of rotating pharmacies and obtaining prescriptions from more than one doctor (without informing of his other prescribing doctors) was inappropriate, manipulative, "[v]ery suggestive of chemical dependency," and reflected an effort to "stay off the radar." The ARB's determination on this issue was found not to be arbitrary.

Courts usually give great credit to a determination by a professional licensing board if it has a rational basis and is supported by the facts. Accordingly, review by a court of discipline taken on a physician license is usually limited with deference to the administrative body's judgments on issues such as the credibility of witnesses and the weight given to expert testimony. Such deference can also apply to the penalty imposed so that a revocation may only be disturbed if disproportionate to the offense or shocking to the court's sense of fairness.

REFERENCE

Citation: 910 N.Y.S.2d 299 (3rd Dept. 2010).

Defensive Actions/Countermeasures to Malpractice Suits

A MALPRACTICE SUIT WAS TIME-BARRED BECAUSE THE PLAINTIFF DID NOT PROPERLY IDENTIFY THE DEFENDANT IN THE PATIENT'S HOSPITAL RECORDS USING INSTEAD A "PHYSICIAN UNKNOWN" DESIGNATION.

A malpractice suit was time-barred because the plaintiff did not properly identify a defendant by using a "physician unknown" designation and because she could have identified the physician's name in the patient's hospital records, an Ohio appellate court has held.

The patient fell in her home in April 2004. She was discovered the following day and rushed by ambulance to Marymount Hospital. A CT scan of her chest showed multiple rib fractures and other injuries, resulting in her being admitted to the Intensive Care Unit (ICU). Hospital records showed that shortly after the patient arrived in the ICU, a physician inserted a chest tube. The patient died in May. An autopsy listed the cause of death as hypertensive congestive cardiovascular disease.

In October 2005, the plaintiff filed a malpractice action alleging that negligence in the diagnosis and treatment of the decedent's heart condition and in the improper insertion of a chest tube caused her death. The plaintiff referred to the doctor who inserted the chest tube as the defendant characterizing him as an "a physician unknown."

In October 2006, she sought leave to file an amended complaint specifically naming this physician for the first time. She claimed she did not know the name of this doctor until that information was disclosed during the course of the proceeding. The trial court granted the plaintiff leave to file an amended complaint which she did, but in November 2007, she voluntarily dismissed the claim. The plaintiff refiled her claim in October 2008.

The defendant moved for summary judgment on the basis that the action was barred by the statute of limitations. He argued that because the plaintiff failed to comply with the requirement for naming the defendant in the amended complaint it did not relate back to the original filing date of October 2005. The trial court granted the motion and this ruling was affirmed on appeal. The appellate court explained that the plaintiff could have discovered the name of the physician from the hospital records and that she did not comply with the statutory requirements by using a "physician unknown" designation.

COMMENTARY

A statute of limitations sets the time period a plaintiff has to file a complaint. In jurisdictions such as Ohio, when the plaintiff does not know the name of a defendant, that defendant may be designated "by any name and description," although when the name is discovered, the pleading has to be amended.

In this case, the plaintiff failed to identify the defendant physician in her original complaint. She employed only a generic description, identifying him as a "physician unknown." Additionally, the plaintiff did not state in the complaint that she could not discover this physician's name and a summons with the words "name unknown" was never served as required. Thus, she failed to comply with the requirements of the statute governing a lawsuit against a physician not known at the time of the complaint. Thus, the amended complaint adding the physician's name did not "relate back" to the original complaint

and, therefore, the original date the complaint was filed could not be used as the date for determining whether the amended complaint complied with the statute of limitations.

The appellate court also found no merit to the argument that the plaintiff was unable to discover the doctor's identity prior to filing the complaint. The medical records identified him as the "surgical house officer" who saw the decedent in the ICU in April 2004 and who inserted the chest tube. And, the hospital records were in the plaintiff's possession prior to filing the action. The plaintiff stated that she was unable to ascertain the information because the medical records contained more than 800 pages but this did not excuse her for properly identifying this physician.

Using a generic designation of a defendant physician in a malpractice case may be permitted in some instances. However, the plaintiff may bear the burden of proving that she could not identify the defendant. She may have a duty to investigate to ascertain the defendant's identity and if contained in the hospital records the fact that they are voluminous may be insufficient to relieve the plaintiff of an obligation to ascertain the defendant's name.

REFERENCE

Shura v. Marymount Hospital, 2010 WL 4307691 (Oh. App. 2010).

New/Expanded Liability

A PEDIATRICIAN WAS QUALIFIED TO TESTIFY AGAINST AN INTERNIST AND EMERGENCY ROOM DOCTOR RELATING TO TREATMENT IN A HOSPITAL EMERGENCY ROOM OF A CHILD WHO DIED FROM OCCLUSIVE THROMBOEMBOLI.

A board-certified pediatrician was qualified to testify against a board-certified internist and emergency room physician as to the care provided in a hospital emergency room to a child who later died of occlusive thromboemboli, according to a recent federal court decision in Maryland.

The plaintiffs took their child to Holy Cross Hospital of Silver Spring, Inc. with complaints of vomiting, diarrhea, and choking. Her vital signs revealed tachycardia and tachypnea, and she began vomiting upon feeding in the emergency room. A board certified internist and emergency care doctor instructed the plaintiffs to give the child Pedialyte and to see a pediatrician. The medical records for the pediatrician listed this visit as a “check up” and the history given to the doctor was the same given during the visit to Holy Cross.

A week later, the child was again brought to the pediatrician who found her to be having convulsions. He instructed the plaintiffs to bring the child to the Children’s hospital National Medical Center where she was found to be dehydrated and acidotic. After being transferred to the Pediatric Intensive Care Unit fluid resuscitation was attempted but the child fell into cardiac arrest and subsequently died. An autopsy revealed the cause of death to be occlusive thromboemboli of the pulmonary trunk and both major pulmonary arteries as complications of dehydration.

The plaintiffs filed an action in a federal court against the doctor who treated the child in the emergency room, Holy Cross, and others, alleging malpractice in the treatment received in the emergency room.

They filed two Certificates of Qualified Expert and Report which the defendants challenged seeking dismissal of the action, which the trial court declined to grant. The court explained that the plaintiff’s expert (a pediatrician) practiced in a field “related to” that of the defendant, an internist and emergency room physician, with respect to the medical issues that arose in this case, namely, the diagnosis and treatment of the child in the emergency room

COMMENTARY

In Maryland and other jurisdictions, a plaintiff has to comply with a mandatory prerequisite for the institution of a medical malpractice claim by filing a Certificate of Qualified Expert and Report. The defendants contended that due to filing by the plaintiffs of improper certificates and reports, they could not proceed with a court suit and had to submit their case to arbitration. The state’s malpractice statute described the requirements of an expert executing the certificate of a qualified expert, providing that such an expert had to have had clinical experience; provided consultation relating to clinical practice; or taught medicine in the defendant’s specialty or a related field of health care or in the field of health care in which the defendant provided care or treatment to the plaintiff within five years of the date of the alleged act or omission giving rise to the action; and if the defendant was board certified in a specialty, the expert also had to be board certified in the same or a related specialty as the defendant.

The defendants challenged the plaintiffs’ expert because he was a board certified pediatrician rather than either a board

certified internist or emergency care physician, as the defendant was. The court focused on what constituted a “related field of health care.” The procedure at issue was the examination of the child. The court found that both the defendant, an internist and emergency medicine doctor, and the plaintiff’s expert, were qualified by their specialties and training to perform the procedure involved in treating the child in this case which created an inference that the specialties were “related.” The court added that no arguments were presented that the standard of care was strongly different between the procedure as performed by the two health care providers. Nor did the fact that the examination was performed in an emergency room appear to change the standard of care.

A physician may be permitted to testify as an expert witness if he practices in a field of medicine related to that in which the defendant practices. Among the questions examined are whether the procedure at issue is common to both fields of medicine and whether the standard of care is the same for both types of practitioners. If the procedures are performed by both specialties with similar standards of care, then the specialties have a good chance of being considered related allowing the practitioner in the related field to present evidence against the defendant.

REFERENCE

Jones v. Bagalkotaker, 2010 WL 4610411 (D. Md. 2010).

Insurance

A HOSPITAL'S LIEN RELATING TO THE COST OF SERVICES TO A PATIENT DID NOT EXTEND TO THE MEDICAL PAYMENTS BENEFITS PROVISION OF HIS INSURANCE POLICY.

A hospital's statutory lien relating to the cost of services provided to an automobile accident patient did not extend to the medical benefits provision of the patient's insurance policy, according to a recent decision by the Supreme Court of Tennessee.

The patient sustained head trauma in an automobile accident and was taken by ambulance to a local medical center then transferred to another medical center operated by the plaintiff, Shelby County Health Care Corporation. On the following day, he was discharged. The cost of medical services amounted to \$33,823. The patient was covered by an insurance policy issued by the defendant, Nationwide Mutual Insurance Company, which included medical payment benefits up to \$5,000. Shelby filed an Affidavit for Hospital Lien, as authorized by statute.

Those named as liable for the charges, costs, and expenses of hospital care and treatment included Nationwide. After the filing of the lien, Nationwide made two medical benefit payments for care related to the accident, \$1,290 for ambulance services and \$3,710 to the first medical center to which the plaintiff was taken. These payments exhausted the medical benefits available under the policy.

Shelby filed suit claiming that Nationwide had impaired its hospital lien by making the

payments and sought to recover \$33,823, the full amount of its costs relating to the patient. Both Shelby and Nationwide filed motions for summary judgment. The trial court concluded that Shelby had a valid lien and that Nationwide had impaired the lien, but that Shelby was entitled to recover only \$5,000, the limits of the medical coverage.

An intermediate appellate court reversed ruling that Shelby's lien had been impaired by Nationwide and that it was entitled to recover the full reasonable cost of its care and treatment of the patient. However, the state's highest court, in turn, reversed this ruling concluding that the statutory hospital lien did not extend to payments made pursuant to the medical payment benefits provision of an insurance policy.

COMMENTARY

Hospital lien statutes have been adopted in most jurisdictions. Tennessee's hospital lien statute created a lien upon all actions for "damages" accruing to persons having received care and treatment for illness or injuries.

The plaintiff argued that the defendant impaired its lien by making payments to others who had provided medical services to the patient, and that because the defendant impaired its lien it was entitled to recover the full cost of the patient's medical treatment rather than only the \$5,000 covered by the policy. However,

Tennessee's highest judicial tribunal was not in agreement. In its view, after reviewing the statutory language and scheme, and its legislative history, the statute limited hospital liens and did not extend to medical payment insurance proceeds that the defendant paid to a patient's other service providers.

The purpose of hospital lien statutes is to ensure that hospital bills are paid. They were enacted upon the recognition that hospitals were losing funds from providing care to individuals who later collected a settlement or judgment for their injuries, but failed to pay their hospital bills. Such statutes are generally intended to keep hospital costs down by setting up an orderly method for the establishment of liens on such settlements or judgments. However, individual state statutes might use language that only allows a lien on certain sources (e.g., damages recovered in a lawsuit) and not from other sources (e.g., money paid by a patient's medical insurer to other medical service providers).

REFERENCE

Shelby Co. Health Care Corp. v. Nationwide Mut. Ins Co., 2010 WL 4027887 (Tenn. 2010).





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