Approved February 15, 1988
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Representative Robert S. Wunsch at
Chairperson

3:30 xx a.m./p.m. on February 9, 19 88 in room 313-S of the Capitol.

All members were present except:

Representatives Fuller, Peterson and Shriver, who were excused.

Committee staff present:

Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Jill Wolters, Revisor of Statutes Office
Mary Jane Holt, Committee Secretary

Conferees appearing before the committee:

Carol Renzulli, Lawrence
Gerhard Metz, Kansas Chamber of Commerce and Industry
John Reiff, Coleman Company, Wichita
Richard Darnall, D.D.S.
Harold Riehm, Kansas Association of Osteopathic Medicine

Hearings for proponents on H.B. 2690 - Periodic payments of personal injury judgments act
H.B. 2691 - Actions where exemplary or punitive damages recoverable
H.B. 2692 - Damages for noneconomic loss in personal injury action limited to $250,000
H.B. 2693 - Collateral source benefits admissible
H.B. 2730 - Civil procedure; relating to damages for pain and suffering in personal injury actions
H.B. 2731 - Civil procedure; relating to exemplary damages in civil actions
S.B. 258 - Periodic payment of judgments act

Carol Renzulli testified that health care costs are the reason for runaway medical inflation, not tort law. To bring quality health care to all she said health care costs must be lowered. She recommended the state work with the Federal Health Care System, (see Attachment I) in seeking a solution to the high health care costs.

Gerhard Metz testified the Kansas Chanmber of Commerce and Industry supports H.B. 2690, H.B. 2691, H.B. 2692 and H.B. 2693. He introduced John Reiff and Dr. Richard T. Darnall.

John Reiff testified the Coleman Company is a self insured company. They have 40 to 50 product liability cases each year. He stated the money manufacturers have to spend to settle liability claims hurts businesses in Kansas. He urged the Committee to recommend these bills for passage.

Dr. Richard Darnall testified he was an oral and maxillofacial surgeon. He stated he is also a member of the Kansas Coalition for Tort Reform. He expressed his support for the tort reform bills. He distibuted a copy of a consent for surgery form and a form for consent for osseousintegrated implant integral implants, (see Attachment II).

Testimony of Tom Bell, Kansas Hospital Association, (see Attachment III), and Paul E. Fleenor, Kansas Farm Bureau, (see Attachment IV), supporting the passage of these bills were distributed to the Committee.

Harold Riehm testified in support of these bills. He submitted the results of a survey of 124 D.O.'s, who are in general practice. There were 63 respondents. 14 doctors have ceased to do surgery or to assist in surgery, and 15 have ceased delivering babies, (see Attachment V).

The Committee meeting was adjourned at 4:40 p.m.

The next meeting will be Wednesday, February 10, 1988, at 3:30 p.m. in room 313-S.

GUEST REGISTER

DATE *Feb. 9, 1988*

NAME	ORGANIZATION	ADDRESS
Gerhard Metz	KCCI	Topeka
Ron [illegible]	KBA	"
Richard Darnall	KCCI - Ks Soc. Oral & Max. Surgeons	"
Cliff Heckathorn	Ks. Head Injury Assn.	Topeka
Jim Yonally	NFIB/Kansas	Overland Park
Barry Stephenson	NFIB	Denver, Co
Kevin Robertson	Ks. Consulting Engrs	Topeka

Thank you Chairman Wunsch for the opportunity to speak to you today. I am not here to tell you my story. I am here to share with you some of my thoughts on Tort Reform. This is not a subject any of us here take lightly. I would point out that Tort Reform does not only concern Doctors, Lawyers, Insurance Companies and the injured. There is another player here. I do not speak of any one group -- but a thing. This thing is amorphous and is why we meet today. It is a huge balloon the wind has wrested from our grasp that floats silently in the stratosphere. It is invisible -- yet all of us feel and react to it. This "Balloon" is called Health Care Costs. Health Care Costs drive hospitals to raise room rates, doctors to charge more per office visit, insurance companies to raise premiums, not only on malpractice but individual health policies, and lawyers to seek larger and larger settlements for their clients. You will have to agree that no one escapes the sting of the Health Care Cost Wasp.

I see two areas where we might look for solutions to the Health Care Cost problem.

Notice, I have not charged any of the three professions represented here. They are not guilty. Health Care Costs are the reason for runaway medical inflation not tort law. What good is it for doctors, lawyers and insurers to fight each other while Health Care Costs soar? The courts have given us some direction about what cannot be done. How can we grasp again the string on the Health Care Cost Balloon and anchor it to terre firma? We don't have to look for foreign solutions because it is in our backyard. Let's consider the Medicaid Program. When you go to your doctor he orders a chest x-ray. His receptionist will take a photocopy

Attachment I

of your card. Your doctor bills medicaid for your x-ray. Medicaid will pay your docotr the national average rate for the x-ray. I will tell you that Medicaid has a firm grip on the Health Care Cost Balloon. Truly, Medicaid does not care if the x-ray machine your doctor uses is ten years old or is new. They will not help you pay for a new machine? but perhaps you as a group of P.A.'s might cost share or lease or utilize your local hospital's machine or even have a leasing agreement with the manufacturer. Another pricing policy that would make much more sense than putting a price on our heads is to "cost out" an illness or disability. That, of course, is where we are headed with DRG's (Diagnostic Related Groups). Let us price the cost of guadraplega, taking stock of proceducres which might have to be done during a quad's lifetime. Illyosotmy, cholostomy, tracheotomy, etc.

Let's lower our voices, stop the bickering and most of all stop trashing our state and federal constitutions. Let's not throw out hundreds of years of common law. We must rediscover the guilty party and call it by name - Health Care Costs Out of Control! It will take many hands to secure this wayward balloon, but if we join together we can, indeed we must, bring Health Care Costs down! For this is the only way to bring quality health care to all; at a price society can reasonably afford to pay.

Clearly there is no quick fix. We must start somewhere. Economists on all sides of this issue should take a really close look at innovative ways in which our state could work with the

the Federal Health Care System. I have been part of the problem for years -- perhaps too long -- I very much would like to be part of the solution.

Carol Renzulli

Carol Renzulli

Hobbyist N/A

RICHARD T. DARNALL, D.D.S.
DIPLOMATE, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
2400 SOUTHWEST 29TH STREET
TOPEKA, KANSAS 66611
AREA CODE 913-266-8770

CONSENT FOR SURGERY

EXPLANATION OF RISKS AND POSSIBLE COMPLICATIONS

Patient: _____

The surgery to be performed has been explained to me along with the risks, aftereffects, possible complications and various alternatives. This is my consent to the surgery indicated below and to any other surgery that might be deemed necessary or advisable in addition to the planned operation. I agree to the use of anesthetic agents for the control of pain and anxiety as deemed appropriate by the doctor for proper care.

I have been informed and understand that there are aftereffects of the treatment, and occasionally there may be complications of anesthesia and surgery. The more common things after surgery are temporary minor bleeding, swelling, discomfort, stiffness of the jaw joints and neck, and bruising of the face and neck. Other less common things that can occur are excessive bleeding, infection, delayed healing and temporary or even permanent numbness and tingling of the lip, tongue, chin, gums, cheek or teeth with surgery of the lower jaw. Medications injected into a muscle or vein may cause swelling or pain afterwards. I may also notice temporary changes in the bite and limited or painful opening of the jaw for a time afterwards. I further understand that nausea, vomiting or allergic reactions can occur after the administration of medications. There may also be damage to adjacent teeth, fillings, or crowns. When upper teeth are removed there is a remote possibility that an opening may occur between the mouth and the sinus that might get infected and require additional treatment.

Bone fractures are very rare, but are possible in cases where the jawbone has been weakened by disease, infection, cysts or tumors. Serious drug reactions are also rare, but possible.

Sedative anesthetic medications given at the time of surgery, or prescribed prior to or afterwards may cause drowsiness and lack of awareness or coordination which could be exaggerated by the use of alcohol or other drugs, and I am hereby advised that the patient is not to operate any vehicle or hazardous device until fully recovered from such effects.

I understand that instructions for after surgery care will be given, and that excessive bleeding, swelling and pain, as well as fever, chills, drainage or other unusual symptoms should be reported to the doctor right away for proper evaluation and treatment.

I understand that there is no warranty or guarantee as to any result and/or cure, but I have been given reasonable expectations of treatment outcome. I have been given full opportunity to ask questions which have been answered to my satisfaction.

Procedure to be performed:

_____ _____
Signature of: Patient - parent - guardian - other Date

_____
Witness (not required)

Attachment II

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION

HOUSE JUDICIARY COMMITTEE

February 8, 1988

The Kansas Hospital Association appreciates the opportunity to comment on House Bills 2690, 2691, 2692 and 2693. We support these bills and urge the House Judiciary Committee to recommend their passage.

During the 1985 and 1986 sessions, the Kansas Legislature enacted measures aimed to deal with the increasing problems caused by the medical malpractice insurance crisis. In 1985, SB 110 changed the collateral source rule and placed certain limits on punitive damages in medical malpractice cases. In 1986, the Legislature passed HB 2661, which we felt was a comprehensive and balanced approach to the problem. HB 2661 contained two important aspects. First, mandatory risk management and reporting provisions in the bill were designed to help identify potential problems before an injury occurred. The risk management provisions are as strict as any in the country. Their implementation has been at considerable expense and effort by both health care providers and state agencies. Nevertheless, the Kansas Hospital Association pledged at that time to do whatever we could to assist in the implementation of the new law. We have followed through on that pledge. It is too early to tell whether these provisions will have any effect on malpractice insurance premiums. We realize, however, that it may take some time before such effects, if any, are seen.

HB 2661 also included several reforms in the legal system, including reasonable limits on awards and provisions for structured payment of future damages through annuities. The courts, however, have not allowed these provisions to have any impact. The Supreme Court's decision in Farley v. Engelken threw out the collateral source provisions of SB 110 and called into question the essential aspects of HB 2661.

The bills before the House Judiciary Committee today are in response to the Supreme Court's decision. They apply reforms in the areas of collateral sources, non-economic damages, structured payments and punitive damages to all personal injury actions. This "across the board" application deals with the Supreme Court's finding that laws applying only to medical malpractice actions violate equal protection.

Attachment III

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436

Because of the complex and diverse nature of hospitals and their relationship with physicians, the hospital's role in the malpractice debate is not easy to define. Yet hospitals, too, find themselves faced with triple digit increases in the cost of malpractice insurance. They also see themselves named more frequently as defendants with physicians in large lawsuits. Hospitals are also faced with growing restrictions on the coverage that insurers offer. In fact, Kansas hospitals are on the verge of a major availability crisis. The withdrawal of Providers Insurance Company from the market this year means that Kansas hospitals may be left with only one company to turn to for coverage. If no new companies begin writing malpractice insurance, many Kansas hospitals will be forced into the Joint Underwriting Administration plan.

Hospitals feel the economic impact of the current crisis in another way. On the one hand, the prospective pricing system and other governmental cost containment measures impose increasing financial restraints. On the other hand, the practice of "defensive medicine" often requires additional tests and procedures to prevent charges that inadequate care was rendered.

Despite these direct economic costs, Kansas hospitals are more concerned that the current malpractice crisis is threatening patient access to affordable and effective health care. This is especially evident in obstetrics, the fastest growing area of malpractice litigation. It is also becoming a problem with some surgeries. Kansas hospitals are beginning to face the possibility of restrictions on some services or, in some cases, the loss of a particular service altogether.

When a community loses a physician or physician services, no matter what the reason, access to care is reduced. In rural Kansas, where many of our small hospitals are struggling to survive, access is already limited. If these hospitals are to remain a viable source of health care for their communities, they must be able to attract and keep physicians without fear of losing them to malpractice pressures.

The Kansas Hospital Association supports HB 2690-2693 because we feel these types of reforms are an essential element of any attempt to deal with the medical malpractice insurance crisis. We urge the committee to recommend them favorably. Thank you for your consideration.

Kansas Farm Bureau

PUBLIC POLICY STATEMENT

HOUSE COMMITTEE ON JUDICIARY

Re: Legislation Pertaining To TORT REFORM and Medical Malpractice

February 8, 1988
Topeka, Kansas

Presented by:
Paul E. Fleener, Director
Public Affairs Division
Kansas Farm Bureau

Mr. Chairman and Members of the Committee:

My name is Paul E. Fleener. I am the Director of Public Affairs for Kansas Farm Bureau.

Our members have followed with interest the legislative activity on Medical Malpractice and Tort Reform. We were present during the 1976 Interim when exhaustive studies were held and many remedies were advanced. A package of 13 bills was the product of that Interim Committee study. Twelve of those bills passed into law. Yet, **the problem continues nearly unabated.**

Awards are astronomical. Medical practitioners are regrouping, retrenching, or retiring. In the rural communities of this state, the medical malpractice problem poses not just serious, but dire prospects and consequences.

Our farmers and ranchers have continued to study this issue. They examined it before our 1985 Annual Meeting. At the 1986 Annual Meeting, the issue of Tort Reform was discussed at length in the business meetings of the voting delegates from 105 county Farm Bureaus. Then, because of court actions, the whole issue of Tort Reform and Medical Malpractice again came before our

Attachment IV

membership and voting delegates in the '87 Annual Meeting. Delegates adopted the resolution which is attached. That policy position puts us in the position of **a strong proponent for Tort Reform** as contained in many of the bills before you today.

The notion of "liability" has been expanded broadly in recent years. Legislators, judges and juries have been pushing out the frontiers of responsibility. The result has been that individuals, businesses and public agencies are being required to compensate more readily, **and more generously,** than ever before. Clearly, individuals do bear the cost of the liability crisis. Consumers pay higher fees for health care, for education, for entertainment. They pay higher state and local taxes and higher prices for almost everything they purchase. Society is going to bear the cost, as well, for the countless products and activities that will no longer be available unless this "tort liability crisis" is met head-on.

Perhaps the biggest cost in all of the liability litigation is this: It is undermining the competitiveness of U.S. industry. Our society today has **an almost irrational focus on litigation** as the way to solve all problems. We are not here to point fingers at any one profession or service. We are here simply to tell you that farmers and ranchers across this state have a felt need, more than a perception ... a genuine belief ... that something needs to be done now to reform the situation.

Finally, Mr. Chairman, our overall policy statement supports a prohibition of **"filing of liability claims in circuits other than those whose jurisdiction includes the location of the event ..."** We believe this certainly relates to more than public

utilities and common carriers, addressed in 1987 legialation. There is a good rationale for lawsuits to be tried in the county where the action arises. We ask for Committee consideration of our position on venue as you work Tort Reform in 1988.

Attachment
Tort Reform
House Judiciary
February 8, 1988

Below is the resolution adopted by voting delegates from 105 county Farm Bureau organizations at the Annual Meeting of Kansas Farm Bureau held in Wichita, Kansas on November 29-30, December 1, 1987.

Tort Liability Reform

We commend the Kansas Legislature for its support of legislation in 1987 to provide a start on "Tort Reform." We believe more needs to be done. We support additional tort reform measures which would:

* Limit use of contingency fee arrangements;
* Reform the collateral source rule to mandate revealing other sources of compensation for damages available to the plaintiff;
* Establish a maximum seven-year statute of limitations on liability claims and reduce the time of discovery for an alleged act of negligence or omission;
* Prohibit the filing of liability claims in circuits other than those whose jurisdiction includes the location of the event from which the liability claim arises, or the plaintiff's home address;
* Prohibit any person from filing a liability claim if the person is trespassing or breaking a law at the time of an injury.
* Prohibit publication of the dollar amount sought in any malpractice suit;
* Require professional review and fact-finding in cases where any professional is charged with malpractice, negligence or omission;
* Establish a legal procedure for arbitration of cases where negligence or omission is charged; and
* Limit the amount of money which can be recovered in any malpractice suit.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

FEBRUARY 8, 1988

H.B. 2690, 2691, 2692 and 2693

Mr. Chairman and Members of the House Judiciary Committee:

My name is Harold Riehm and I represent The Kansas Association of Osteopathic Medicine. I appear today in support of House Bills 2690, 2691, 2692 and 2693.

I will not address the specifics of those Bills. Members of KAOM think the contents of the collateral source bill of 1985 and of H.B. 2661, passed in 1986, were reasonable and reasoned approaches to very complex problems. We regret the Courts have seen otherwise. We also continue to think that these changes need to be adopted in the "across the board manner" proposed by these four bills even though it appears such an approach is in considerable jeopardy.

This Committee does not need a reiteration of our testimony of two years ago. Permit me, though, to just list in outline form, an update. The common theme to these points is that time and unchanged trends have exacerbated a situation that was already serious in 1986. The points we wish to emphasize are these, at times including results from a recent KAOM SURVEY. The survey was made of 124 D.O.s who are in general practice. It was administered in early January and the return rate was 51% (63 total respondents).

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(1) Many D.O.s have, in recent years, made substantial changes in their practices. Most of these changes have been in reaction to rapidly increasing malpractice insurance rates.

SURVEY RESULTS: Of 63 respondents 14 doctors have made a major change other than obstetrics. In most cases, this was ceasing to do surgery or assist in surgery.

Of 63 respondents, 40 D.O.s either have provided or are providing obstetrical care. Of these 40, 15 (38%) have ceased delivering babies from the period 1984 through 1987. Of these 15 ceasing obstetrics, 9 indicated the reason was solely due to malpractice insurance rate increases; 4 indicated the large number of O.B. malpractice cases filed; and, 2 indicated both of these reasons.

(2) Decisions to change the nature of one's practice are not made lightly. Many respondents said they regretted backing off from a responsibility to the communities they serve but economics offered no choice. Many also lamented that premiums are the same whether they deliver 6 babies or 60 babies.

(3) Unless there are major changes, the trend of physicians changing their practices will continue:

SURVEY RESULTS: In response to a question of whether or not they would discontinue obstetrics if total premiums were to increase 30 to 60 percent this year, 11 of the 25 respondents still providing O.B. services responded "YES"; 5 responded "NO"; and 9 were "UNDECIDED". If those plans became a reality, it would mean 26 of the 41 doctors who at one time did or are doing O.B., would have ceased providing O.B. services during the 5 year period 1984-1988.

Attachment V

(4) Even when physicians continue to provide obstetrical services, there have been substantial increases in patient charges.

SURVEY RESULTS: Of the 25 physicians still delivering babies, 19 (76%) have raised patient charges for obstetrics in the past three years. Five have doubled fees; 4 have raised fees 50%; 3 have raised fees about 33%; 2 have raised charges 25%; and 5 have increased fees 20%. Almost all respondents indicated that they were breaking even or losing money delivering babies.

(5) KAOM applauds this Committee for its responses to similar appeals to these in recent years. Regarding the courts' decisions, constitutional rights are never to be taken lightly, but neither are the "rights" of patients to have adequate medical care available, close enough to respond to emergencies. In obstetrics, we think this is not now the case in some areas of the State.

(6) KAOM emphasizes the "quo" of the quid pro quo in recently enacted malpractice proposals. Physicians have agreed to some of, if not the most strict reporting requirements in the U.S., along with substantially increasing attention to quality assurance. These are important, and KAOM continues to endorse them, even though the "quid" part (tort reforms) are gone or in jeopardy.

(7) The osteopathic profession, in some respects, has been the hardest hit within the physician community. Medical Protective Insurance Company continues to not insure most osteopathic physicians, despite an earlier pledge to this Legislature to do so. At the present time, there are only two alternatives for most new D.O.s in the State--the JUA or a newly approved company, Professional Mutual Insurance Co.

(8) KAOM commends the Kansas Insurance Department for two recent moves. The first was to urge the Plan (JUA) to remove the 20% surcharge over St. Paul rates, in light of the St. Paul moratorium. This had been done. Second, in August, 1987, the Department gave its approval to a new Company that writes mostly osteopathic physicians. The usual licensing approval process was expedited by the Department to permit the new Company access as soon as was practical.

With these observations and for these stated reasons, we conclude, Mr. Chairman, by stating that the situation is serious. We commend your call for creative thinking in this period of uncertainty in how to proceed. KAOM pledges to contribute to that process in any way we can.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION AND CONSENT FOR OSSEOUSINTEGRATED IMPLANT INTEGRAL IMPLANTS

State law requires that you be given certain information and that we obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment, and the feasible treatment alternatives; that you have been given an opportunity to ask questions; that all your questions have been answered in a satisfactory manner; and that all the blanks in this form were filled in prior to your signing it. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain.

CONSENT FOR OSSEOUSINTEGRATED IMPLANT, INTEGRAL

I hereby authorize and direct the oral surgeon whose name appears below with associates or assistants of his choice to perform surgery upon me (or upon the person identified below as the patient, for whom I am empowered to consent) to insert an osseousintegrated implant in my upper and/or lower jaw.

NATURE AND PURPOSE OF THE PROCEDURE

I understand incision(s) will be made inside my mouth for the purpose of placing one or more metal or coated metal composite structures in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown (cap), denture, or bridge. I acknowledge that the oral and maxillofacial surgeon whose name appears below has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap), denture, or bridge will later be attached to this implant by a general dentist or prosthodontist and that the cost for that work is not included in the charge for this procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant must remain covered under the gum tissue for at least three months before it can be used and that a second surgical procedure is required to uncover the top of the implant. Finally, I understand that this is a relatively new procedure and that only the Branemark implant has been approved by the American Dental Association at this time. I understand that the other implants have, however, been approved by the Food and Drug Administration, tend to be less costly than the Branemark implant, and that most oral and maxillofacial surgeons have found them to be satisfactory.

ALTERNATIVES TO AN OSSEOUSINTEGRATED IMPLANT

The alternatives to use of an osseousintegrated implant, including no treatment at all, construction of a new standard dental prosthesis; augmentation of the upper or lower jaw by means of vestibuloplasty, skin and bone grafting, or with synthetic materials; and implantation of another type of device have been explained to me as have the advantages and disadvantages of each procedure and I choose to proceed with insertion of the osseousintegrated implant.

AUTHORIZATION FOR ANCILLARY TREATMENT

I also authorize and direct the oral surgeon whose name appears below with associates or assistants of his choice to provide such additional services as he or they may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary labratory, radiological (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion, or by other medically accepted route of administration; and the removal of bone, cartilage, tissue, and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices.

AUTHORIZATION FOR SUPPLEMENTAL TREATMENT

If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia, I further authorize and direct the oral surgeon whose name appears below with associates or assistants of his choice to do whatever he deems necessary and advisable under the circumstances with the exception of _____. Prior to performing such additional or different procedures, however, I desire that they be discussed with _____ whom I, hereby, authorize and designate to give consent to treatment on my behalf.

NO GUARANTEE OF TREATMENT RESULTS

I understand that oral and maxillofacial surgery is not an exact science and that complications do occur; and I confirm that I have been given no guarantee or assurance by the oral surgeon whose name appears below, or by anyone else, as to the results that may be obtained from treatment.

RISKS ASSOCIATED WITH OSSEOUSINTEGRATED IMPLANTS

The following risks known to be associated with this procedure and with the anesthesia have been explained to me: death; brain damage; paralysis; loss of or loss of function of an organ or limb; swelling; damage to and possible loss of other teeth, fillings, or other dental work; infection or abscess; pain; irritation of or damage to the vein into which anesthetic medications may be placed; allergic reactions to the medications used; bleeding which may be heavy and prolonged; sinus or nasal problems and infections; poor healing; loss of bone; fracture of the jaw; injury to nerves near the treatment site which may cause pain, numbness, or tingling of the lips, chin, face, mouth, teeth, and tongue which is usually temporary but which may be permanent; loss of or damage to the ability to taste, speak, and/or hear; stretching of the corners of the mouth with resultant cracking and bruising; breakage of a tooth root which may have to be left in the jaw or which may require additional surgery for its removal; accidental opening of the normal sinus cavity located above the upper teeth; and burns from the electro-surgical unit (if such a unit is used). I have also been informed that any procedure which is performed outside the mouth will leave a scar on the skin, and that although a good cosmetic result is hoped for, it cannot be guaranteed. I also

understand that any of these treatment complications may necessitate additional medical, dental, or surgical treatment; may necessitate wiring of my teeth or jaws; and may require an additional period of recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of this implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period.

I hereby state that I have read and that I understand this three page consent form, that I have been given an opportunity to ask any questions I might have had, that those questions have been answered in a satisfactory manner, and that all the blanks in this form were filled in prior to my signature. I also understand that I am free to withdraw my consent to treatment at any time.

Date_____ Time_____

Signature of Patient_____

Signature of Relative or
Representative (where required)_____

Witness_____

I certify that the matters set forth above were explained to the patient, that the patient was given an opportunity to ask questions, that all questions asked were answered in a satisfactory manner, and that all the blanks in this form were filled in prior to signature by the patient. Where this form has been signed by the patient rather than his representative, I certify that, in my judgment, the patient was competent to understand the matters discussed and to give his consent to treatment.

Oral and Maxillofacial Surgeon_____