EDIC RISK MANAGEMENT STUDY

Foreign Body Aspiration in the Dental Office

In Massachusetts, the legal history of dental foreign body (FB) aspiration cases dates back over one hundred years. One of the earliest dental aspiration cases in Massachusetts, Toy v. Mackintosh, 222 Mass. 430 (1916), involved allegations that a dentist performing an extraction allowed a tooth to fall into the throat, which later became lodged in the patient's lung. Similar allegations were reported in Malone v. Bianchi, 318 Mass. 179 (1945). The most recent Massachusetts reported decision involving dental FB aspiration was Lipman v. Lustig, 346 Mass. 182 (1963), which involved allegations that the dentist allowed a 1 ½-inch reamer to fall into the patient's throat during treatment. Under the facts of these cases, expert testimony was not required to prove the dentist's negligence. However, the need for expert testimony to prove causation and damages depended on the facts of the case.

Despite advances in the profession over the last 100 years, dental aspiration events continue to occur. There are several reasons for this, including the positioning of the patient (semi- reclined) and the use of tools and small objects in the oral cavity. Objects that can be aspirated include, but are not limited to, whole or portions of teeth, restorations, dental implants, burs, or files. There are safeguards that can be used to reduce the risk of aspiration, including rubber dams and strong suctioning during treatment. Other issues that may impact the risk of aspiration include the age of the patient (elderly or pediatric), atypical oral anatomy or gag function (stroke patients), as well as medical or psychological conditions that may cause

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a patient to move unexpectedly during treatment (i.e., dementia, alcohol, or opioid withdrawals). Some of these conditions may not be readily knowable by the dentist. Even with careful history and patient selection, appropriate training, safeguards, and technique, there are no guarantees in the practice of dentistry. Errors, mistakes, and complications occur.

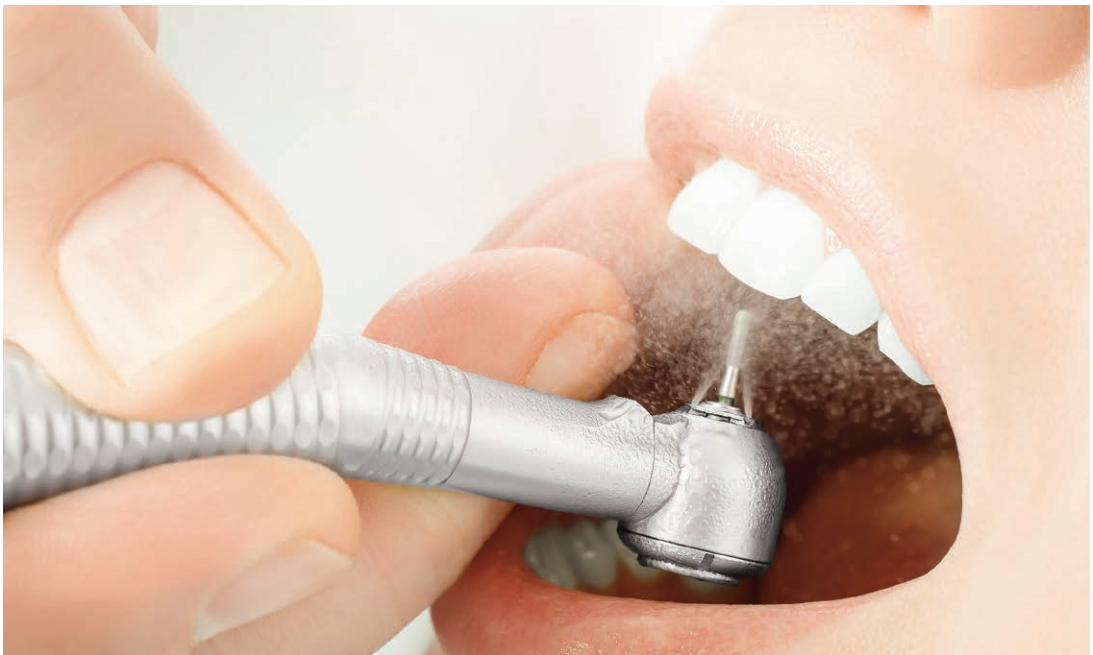
> *Underestimating the potential risk of a FB aspiration or ingestion can create additional harm to the patient that may be avoided with immediate evaluation and treatment by a specialist.*

The following are risk management recommendations for how to react to a FB dental aspiration event. Patient safety remains the most significant issue when there is FB aspiration in the dental office setting. Initially, the dentist should determine whether to initiate the emergency protocol. This will depend on what was aspirated — a natural tooth versus a sharp instrument or restoration — and the size of the item. The dentist should make an immediate decision whether to call 911 to transport the patient to a hospital emergency room. The dentist will need to evaluate whether the FB was ingested or aspirated to the lung and whether the event poses an immediate risk to the patient's airway. This determination should be made cautiously and with the knowledge that a patient who initially appears stable may deteriorate depending on the FB and whether it is ingested or aspirated.

If the emergency protocol is initiated, the dentist should explain to the patient, first responders, and the emergency department what occurred, including the patient's status and what was aspirated or ingested. If there are uncertainties regarding whether the FB was aspirated or ingested that information should be included. It is also important for the dentist to provide information regarding what the FB was made of and its size so that the emergency department can select the appropriate diagnostic imaging or testing to further evaluate the patient. If possible, the dentist should provide documentation to the responders when the patient is being transferred to the emergency department.

As soon as the patient is stabilized and the care of the patient has been transferred, the dentist should fully document what occurred. The documentation should include enough information that would assist those providing subsequent care to the patient. If possible, the dentist should document the size and shape of the FB. If the FB has a manufacturer label, a copy should be provided in the patient's chart. If the FB is a dental device, the dentist should document the specific item, size, and manufacturer. If the event was caused by a malfunction in dental equipment, the equipment should be tagged and removed from service. The dentist should also document any instructions provided to the patient and identify any subsequent provider or emergency department personnel with whom the dentist spoke. If there were other office staff involved in the care or who responded to the event, those individuals should independently document what transpired.

Ultimately, the patient has the right to decide whether to follow the dentist's recommendations. There may be situations where a patient refuses the dentist's advice or refuses transportation to the emergency department. If the dentist determines that the emergency protocol should be initiated, it should be initiated and EMS called, even over the patient's objection. If the patient refuses transportation to the emergency department by EMS, there should be independent documentation from EMS



regarding the patient's decision. The dentist should also document any refusal of the patient to follow recommendations and have the patient acknowledge in writing that the information was provided.

Likewise, the dentist should be careful when deciding not to initiate the emergency protocol. The communications with the patient over what transpired, as well as the reasoning behind the dentist's decision, should all be documented. When making this evaluation, the dentist should be certain as to the identity of the FB and whether it poses an immediate risk to the patient.

Generally, the risk of more serious complications exists when a FB is aspirated to the lungs, rather than ingested to the digestive tract. However, depending on the FB and the patient, ingestion can also cause significant complications such as blockages or perforations. Whether or not a patient requires further care should be a decision made by the appropriate medical specialist and not the dentist. Underestimating the potential risk of a FB aspiration or ingestion can create additional harm to the patient that may be avoided with immediate evaluation and treatment by a specialist. Further, a determination by the treating medical specialist that the patient is not at risk of harm and no further treatment is required may limit damages in a subsequent lawsuit or claim.

Without the appropriate communication with the patient and documentation that this was done, there may be questions whether the dentist made the appropriate recommendations to the patient or even whether the dentist advised the patient of what occurred. Appropriate documentation remains key evidence in proving what the dentist told the patient and recommended. The dentist should do whatever can be done to facilitate the patient going to the emergency department, including direct communication to the emergency department staff. The dentist should follow up with the patient and, if there is authorization, follow up with the subsequent providers to confirm that the dentist's recommendation was followed. If the patient suffers harm by not following the dentist's recommendation,documentation that the appropriate recommendations were provided and not followed may be evidence to mitigate or limit damages alleged by the patient. Conversely, the lack of such documentation may make it difficult for the dentist to prove what was communicated or recommended at the time.

In Massachusetts, dentists and other healthcare providers have a statutory duty to fully disclose to the patient or family when there has been an "unanticipated outcome with significant medical complication resulting from a provider's mistake." M.G.L. c. 233, Section 79L. While the statute does not define "significant medical complication," the aspiration or ingestion of a FB during a dental procedure is likely to trigger this statutory obligation. Appropriate communication to the patient and documentation, as discussed above, provides evidence of compliance with the statute in addition to reducing the risk of further harm to the patient.

From a risk management perspective, dental FB aspiration events require the dentist to make several decisions. Once the FB aspiration occurs, it is imperative that the dentist exercises the appropriate clinical judgment to reduce the risk of further harm to the patient. These decisions should be fully communicated to the patient and documented in the chart. A dentist may feel hesitancy to initiate the emergency protocol in the dental office setting due to potential embarrassment or disruption to other patients. This should not be a factor in the decision-making process.

Depending on the specific facts, it may be difficult to defend the occurrence of a FB aspiration during dental treatment. Remember that, under certain circumstances, a jury may be permitted to determine whether the occurrence of the FB aspiration is negligence without the need for expert testimony. However, the plaintiff may still be required to prove causation and damages with expert testimony. If the patient is appropriately advised of the event and is provided the appropriate recommendations, damages from the event may be limited. If damages are

DID YOU KNOW?

Documentation of Foreign Body (FB) Aspiration Incidents

As soon as the patient is stabilized and the care of the patient has been transferred, the dentist should fully document what occurred. The documentation should include enough information that would assist those providing subsequent care to the patient.

- Document the size and shape of the FB, including a copy of the FB's manufacturer label.
- Tag and remove malfunctioning equipment from service.
- Document instructions provided to the patient.
- Identify any subsequent provider or emergency department personnel with whom the dentist spoke.
- If there were other office staff involved in the care or who responded to the event, those individuals should independently document what transpired.

limited, there is less incentive for patients or their attorneys to initiate litigation. In addition, the way the dentist reacts to the event may very well influence whether a patient decides to pursue litigation. While the risk of complications cannot be eliminated, the dentist, to some extent, is able to control what is done to minimize harm once it occurs. If harm to the patient is minimized, the risk of the patient pursuing a claim should be reduced.

Finally, the dentist should report the event to his or her malpractice insurer, including the dentist's actions following the event, and the patient's decision about follow up. This report should include a description of the incident, the dentist's recommendation of a medical evaluation including imaging, how the patient was transported for medical evaluation and by whom, and any telephone discussions with the medical facility and treating physician. The dentist should also inform the insurer of all preventive measures (rubber dam, etc.) that he or she took to prevent the ingestion or aspiration of the FB. Note that EDIC's malpractice policy includes coverage for Medical Payments, which may reimburse the patient or the dentist for the costs of imaging or other medical evaluations resulting from the event.

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