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Avoiding Liability in Dental Sleep Medicine Therapy

Dental sleep medicine (DSM) provides dentists with another avenue for helping their patients. Dentists collaborate with sleep physicians in implementing interventions such as oral appliance therapy (OAT) for patients suffering from sleep-related breathing disorders (SRBDs).

But DSM is not without legal risks. For example, patients who suffer, or believe they have suffered, from a poorly fitting appliance may sue for malpractice. By understanding best practices of DSM and taking several preventive steps, dentists who choose to engage in this practice can mitigate the risk of legal action.

Preparing to practice DSM

DSM focuses on providing treatment for adult patients with SRBDs, including snoring, obstructive sleep apnea (OSA), upper airway resistance syndrome, central sleep apnea/hypopnea syndrome, and sleep-related bruxism. Dentists who engage in this practice are expected to gain expertise in these areas, including use of OAT; failure to do so leaves them open to liability.

Education is key to developing these skills. The American Academy of Dental Sleep Medicine (AADSM) offers courses, as do other dental organizations such as the American Dental Association (ADA) and state dental associations. Many national dental meetings now include courses on sleep medicine. Dentists should retain certificates of completion for education programs to document their knowledge should legal action occur.

Dentists may want to further their sleep medicine expertise by seeking certification. For example, the AADSM offers certification as a "qualified dentist," and the American Board of Dental Sleep Medicine (ABDSM) offers diplomate status. According to the AADSM, dentists who are certified are qualified "to screen for OSA, snoring, and sleep-related bruxism; obtain a detailed medical history; conduct a physical examination; and treat, educate, and provide long-term management of patients who are diagnosed by a physician with either OSA, snoring or sleep-related bruxism." A dentist can also obtain certification for his or her facility through AADSM.

Screening for sleep disorders

In a 2017 policy statement, the ADA encouraged dentists to screen patients for SRBDs. A white paper from the American Association of Orthodontists states "[I]t is strongly recommended that orthodontists screen orthodontic patients for known OSA risk factors."

Risk factors for SRBDs include obesity, upper airway abnormalities (e.g., pharyngeal crowding), and gastroesophageal reflux. Patients should be asked about any snoring or sleeping difficulties; the simple question "Do you snore?" can quickly identify a potential problem. Those with clear problems should undergo additional assessment.

Symptoms of an SRBD include daytime sleepiness, choking, snoring, mouth breathing, and periods of apnea. Dentists should keep in mind that the patient's bed partner or caregiver may have valuable information as to signs and symptoms. Tools that can be used in the screening process are the Epworth Sleepiness Scale (https://epworthsleepinessscale.com), the Berlin questionnaire (www.sleepapnea.org/wp-content/uploads/2017/02/berlin-questionnaire.pdf), and the STOP-BANG questionnaire (www.stopbang.ca/osa/screening.php). The Epworth scale is not specific for SRBD but can still provide useful information. A high score on STOP-BANG indicates OSA.

Patients suspected of having a sleep disorder should be referred to a sleep specialist for additional evaluation, which often includes a sleep study, to confirm a diagnosis. This evaluation is important even in the case of what appears to be simple snoring, which is often a sign of OSA. Failure to diagnose OSA could cause the patient harm and result in complications that leave the dentist open to legal action. The physician sleep specialist, not the dentist, is responsible for diagnosing an SRBD.

Dentists must explain to patients the suspected condition and the importance of following through on the referral. The referral should be documented in the patient's dental record, and the dentist should provide detailed information to the sleep physician. Dentists and sleep physicians should closely collaborate to help the patient obtain a diagnosis and, if an SRBD is confirmed, obtain proper treatment.

Best practices

Dentists need to know the role of DSM in their state dental practice act, as well as any related state board policies, to ensure they adhere to scope of practice. (Links to state dental boards are available at www.aadsm.org/state_dental_boards.php.) In general, dentists cannot diagnose SRBDs and must receive an order for OAT. Dentists should also adhere to the AADSM professional scope of practice and follow the association's standards for screening and managing adults with SRBDs. Failure to adhere to requirements and standards in these documents can lead to legal action and loss of licensure.

Another important document is "The Role of Dentistry in the Treatment of Sleep Related Breathing Disorders," from the ADA. Following this guidance, particularly as it relates to OAT, will provide some protection should a lawsuit occur. (See Oral appliance therapy, below.)

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Benefits vs. risks

DSM offers dentists opportunities to expand their practice. However, it is vital to understand the risks and benefits of offering this treatment in order to make sound decisions and avoid legal jeopardy.

These actions provide the optimal opportunity for successful defense against a claim.

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ORAL APPLIANCE THERAPY

An oral appliance is a custom-fabricated device commonly used in the treatment of SRBD. The device helps to protrude and stabilize the mandible, which, in turn, preserves the patency of the upper airway during sleep. Dentists using oral appliance therapy (OAT) should engage in several best practices:

- After receiving the prescriber's order, evaluate the patient for OAT and fabricate a device, if appropriate.
- Obtain patient consent. The consent should include other treatment options (e.g., positive airway pressure, positional therapy), potential adverse effects, and expected longevity of the appliance. The dentist should cosign, have a witness sign, and keep the form in the patient's dental record.
- Make appropriate referrals if a patient suffers adverse effects from the appliance.
- Check the oral appliance at least annually after the first year and adjust as needed. Assess for effectiveness, stability of the occlusion, and patient comfort, as well for signs of wear and or bacterial growth on the oral appliance and replace as needed.
- Be aware of Medicare requirements to ensure billing is appropriate, thereby avoiding charges of fraud. For more information, refer to an article by Berley and Palmer at www.sleepreviewmag.com/2019/03/dentists-medicare-oral-appliance. Note that dentists must become a durable medical equipment supplier, so they can bill Medicare for custom-made oral appliances.
- Complete continuing education to keep skills current. Education is needed to renew certification.
- Regularly communicate with the referring prescriber and others involved in the patient's care and document those communications in the patient's dental record.
- Ensure that follow-up assessment by a sleep physician is completed to evaluate treatment effectiveness.
- Remember that documentation is a key line of defense in the case of legal action.

RESOURCES

American Academy of Dental Sleep Medicine. Scope of practice. 2018. www.aadsm.org/scope_of_practice.php.

American Association of Orthodontists. White paper: Obstructive sleep apnea and orthodontics. Amended 2019. www1.aaoinfo.org/wp-content/uploads/2019/03/sleep-apnea-white-paper-amended-March-2019.pdf.

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Dental Sleep Medicine: Case Scenario and Risk Considerations

Introduction:
Providing oral appliance therapy (OAT) for a patient with obstructive sleep apnea (OSA) based upon the prescription of a qualified physician would generally be considered an acceptable activity for dentists. As with traditional dental care and treatments, remaining current on clinical guidelines and adherence to sound risk management principles, such as effective doctor-patient communications, informed consent and appropriate medical consultation are essential to risk mitigation and positive outcomes. This case scenario highlights related management considerations, which also apply more broadly.

Practitioner:
General dentist

Claimant:
52-year old male patient

Risk management topics:
Clinical guidelines; informed consent/patient communication; guaranteed outcomes; refund of fees

Facts:
The patient sought evaluation and treatment due to dissatisfaction with his continuous positive airway pressure (CPAP) machine. He informed the dentist that his CPAP "was not working successfully" for him.

The dentist had treated many OSA patients that were not able to tolerate CPAP therapy. However, this patient also complained that the CPAP therapy was ineffective.

Upon examination, the dentist found that the patient had 6 remaining maxillary teeth and no mandibular teeth, with an unstable mandibular complete denture. The dentist recommended treatment to stabilize the lower denture, followed by OAT.

The dentist obtained informed consent for the implant therapy and OAT. However, the patient refused a recommended removable partial denture (RPD) for the maxilla.

Four mini-implants were placed in the mandible soon after the patient agreed to OAT. The following day, the patient reported by telephone that he was "doing well". Three days after implant placement an impression was obtained. Approximately two months after implant placement, the relined/modified mandibular denture was delivered. An impression for the oral appliance followed, with appliance delivery occurring approximately 3 months after the implants were placed.

After 3 months of oral appliance use, one of the mini-implants dislodged and was nearly swallowed. Two weeks later (a little over 6 months after implant placement), the dentist replaced the missing implant and two other failing implants. The patient did not return to the dentist's office after this visit.

Three months after the patient's last visit (approximately 9 months after placement of first 4 implants), the dentist received a letter from an attorney on behalf of the patient, seeking a full refund of professional fees. Refusal to do so would result in the patient pursuing legal action.

Key Allegations:
Failure to deliver promised results

Claimed injury/damages:
Professional fees paid

Analysis:
Clinical guidelines. Dentists must remain current on clinical guidelines that apply to their scope of practice and the patients they treat. Guidelines exist for the treatment OSA and snoring with OAT. [https://aadsm.org/clinical_guidelines.php] In this scenario, the patient sought evaluation and possible OAT without his physician's recommendation. The dentist did not receive a prescription for OAT. While an attempt to communicate with the patient's physician was initiated, the dental healthcare record included very limited information and no physician recommendation.

Dentists know that each patient and dental situation is unique, and that not all guidelines and recommendations are equally valid. However, effective medical/dental communication and collaboration are critical for OAT in order to optimize care and mitigate associated risks.

Informed consent/patient communication. While patient communications do not always involve the informed consent process, consent cannot be truly "informed" without effective doctor-patient communication.

The dentist obtained a signed consent form. However, the form did not include information about treatment alternatives, solely referencing the recommended mini-implant procedure. Although treatment benefits were covered, the form was silent on risks and possible adverse outcomes. Finally, the dental healthcare record did not include a progress note to confirm that an informed consent discussion occurred.

The patient also refused part of the recommended care as he did not agree to proceed with a new maxillary RPD. Every patient has a right to refuse care. However, each treating dentist also has a responsibility to assess how a patient's refusal may affect the health/safety and the overall treatment outcome. It may be appropriate in certain situations to dismiss a patient, rather than to continue with a compromised partial care plan.

Guaranteed outcomes. The dentist did not guarantee that OAT would be as effective as CPAP, or that it would adequately treat the patient's condition. He did however guarantee his patients that if the recommended OAT did not reduce their sleep apnea score by fifty percent (per results of recommended home sleep apnea testing), the OAT fee would be refunded.

Note that treatment guarantees and warranties may expose dentists to breach of contract claims, which may have a longer statute of limitations than malpractice claims.

Refund of fees. Through his attorney, the patient demanded a full refund of professional fees. The dentist initially refused a refund, since the patient did not comply with the baseline and follow-up home sleep apnea testing. See the Outcome below for the final decision. For a detailed review of patient refunds, access the NSDP Risk Management Newsletter, Volume 33, Number 4 (2018): www.dentists-advantage.com/Prevention-Education/Newsletters.

Outcome:
In consultation with his insurer's Claim and Risk Management professionals, the dentist later decided that the best course of action would be to refund fees to the patient. From personal funds, the dentist sent a refund for $8,850 after receipt of a signed refund/waiver of liability statement.

Summary:
The patient was dissatisfied with the OAT results and demanded a refund. The dentist complied, using personal funds for the refund of professional fees.

While the case resolved amicably, the facts of the case and brief analysis highlight several risk management concerns. These concerns and others may just as easily have led to several professional liability allegations and related claimed damages.

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