SLEEP MEDICINE
TRANSFERRED (SHARED) LIABILITY

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SLEEP PROFESSIONALS OF ARKANSAS
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WARNING!!

• No agenda! No disclosures!

• I have a STRANGE sense of humor!
  • You can’t take the Arkansas out of the boy!

• I may not tell you what you want to hear, but I will always tell you the truth! “Truth and Nothing But the Truth”

• SARCASM- It’s just another service that I provide!!!!!!
DISCLAIMER!

• NOT GIVING LEGAL ADVICE!!!!
  • Contact attorney in your state
  • Seek an opinion from an attorney with experience practicing before
    your state dental board
  • Nothing that I say has been screened or endorsed by Sleep
    Professionals of Arkansas

• THIS IS JUST MY OPINION!!!!
QUALIFICATIONS

• 1980 Graduate - University of Tennessee School of Dentistry
• 1995 Graduate - University of Arkansas Little Rock School of Law
• Diplomate American Sleep & Breathing Academy
• Diplomate (Candidate) AADSM
• Full Partner - Travis, Borland and Berley Attorneys at Law
• Over 5 years experience in the treatment of Sleep Related Breathing Disorders.
• Over 25 years experience in the treatment of TMD
• Member of the Bar in Arkansas and Texas
Attorney: Doctor, before you performed the autopsy, did you check for a pulse?
Witness: No
Attorney: Did you check for blood pressure?
Witness: No
Attorney: Did you check for breathing?
Witness: No
Attorney: So, then it is possible that the patient was alive when you began the autopsy?
COURT ROOM FUNNY CONT.

• Witness: No

• Attorney: How can you be so sure, Doctor?

• Witness: Because his brain was sitting on my desk in a jar.

• Attorney: I see, but could the patient have still been alive, nevertheless?

• Witness: Yes, it is possible that he could have been alive and practicing LAW!
GOAL OF THIS LECTURE!

• Learn to think like a defense LAWYER!

• Learn how to develop your legal defense, before the problem occurs.
MY 120 ACRES!
WHY AM I HERE?

• The LAW always lags 20 years behind.
  • It takes 20 years for attorneys to discover and develop a new cause of action.
    • Sleep Medicine is a new area of law with no established legal precedence.
  • 20 years to determine how to effectively sue in the new area of law.
WARNING!

• Our 20 years are up!
WHY AM I HERE?

• SLEEP MEDICINE presents unusual levels of risk for the physicians and dentists who practice in this area!
  • My goal is to explain the risk associated with the practice of Sleep Medicine, and
  • Outline a strategy to minimize your level of exposure.
WHY AM I HERE?

• *Lawsuits are coming!*
WHY AM I HERE?

• *The question is!*

• *Will You Be Ready?*

• *How will you get ready?*
AREAS OF EXPOSURE FOR DENTIST/MD (LAWSUITS)

• #1 Negative consequences/complications of CPAP/MAD Therapy! (Easy lawsuit for plaintiff’s attorney)
  • Tooth Movement/ bite change/profile changes
  • TMJ/Perio/sinus infections
  • Decay
  • Fractured teeth/ broken restorations
  • Informed Consent

LOW level of damages!!
AREAS OF EXPOSURE (MD)

• #2 Third party liability
  • Difficult lawsuit for an attorney.
    • The Plaintiff’s (Patient’s) attorney would have to expand the current limits of the law.
      • Car wrecks
      • Industrial accidents
    • Could result in large settlements $$$$
• Ken, I cannot control my patients out of the office:
  • I can’t keep my patient from driving drowsy!
  • I can’t make my patient be compliant with treatment!
  • I cannot force patients to comply with recall!
  • I can’t make patients return to their sleep physician for a PSG!
  • I shouldn’t be responsible for what my patient does outside my office!
RISK MANAGEMENT

• Your Right! It’s Not Your Fault!

• This afternoon we will discuss the techniques that I use to in my office to make sure that a JUDGE or JURY knows its not my FAULT!!!!
WHY AM I HERE?

• Dr. Berley:

• Counsel for co-defendant A___ M__ provided your name to me.

• I am seeking a doctor with expertise in sleep apnea to consult on a case here in _______. My client is A___ H____, board certified Oral and Maxillofacial Surgeon. Dr. H has been involved in treating patients with sleep apnea.

• Dr. H provided Mr. XXXX with a _______ appliance. Mr. XXXX alleges Dr. H____ failed to properly evaluate whether Mr. XXXX was an appropriate patient for a ____ appliance, that he failed to properly instruct Mr. XXXX in use of the ____, that he failed to evaluate whether Mr. XXXX was properly using the ____, that he failed to properly supervise the patient’s use of the ____, and that he failed to obtain informed consent from the patient for use of the _____. Dr. H denies all of these claims.

• Are you available to review records and to provide your expert opinion regarding care provided by Dr. H to Mr. XXXX?

• Thanks for considering this request. I look forward to hearing from you.

• Regards, xxxx
WHY AM I HERE?

• Dear Mr. J_______

• The short answer is, you don’t want me as an expert. While I am willing to help you in any way that I can, as an expert witness, I come with baggage. I have been on the lecture circuit for the last several years warning dentist & MD’s about the lawsuits that are on the horizon in sleep medicine. I have warned that the AADSM/AASM Practice Parameters should be followed in the practice of sleep medicine as I feel that these parameters will be used as a "learned treatise" exception to hearsay and admitted in court to bolster the testimony of the plaintiff’s expert and used to establish a standard of care. I have written numerous articles to this fact and I lecture for Nierman Practice Management and in that 2 day risk management course, one of my tenants is that all dentists practicing sleep medicine should follow AADSM parameters. This information would be discoverable and would likely create issues if Dr. H was not following those parameters.

• So, with that said, I am available to assist if you need/want my help.
  Ken Berley DDS, JD

• Diplomate American Sleep & Breathing Academy
WHY AM I HERE?

• Pxxx

• My true value may be in assisting with cross examination of the plaintiff's expert and assisting if this goes to court.

• Ken
WHY AM I HERE?

• Dr. Berley:

• I have been authorized to retain you to review records and consult for the defense. We will assemble records and forward same to you this week. Please advise as to the address for mailing of the records. Also, please send your current CV via email along with your hour fee schedule. Thank you.

• Pxxxx
WHY AM I HERE?

***** Lawsuits Are Coming!!! *****

*****Will You Be Ready??**********
Lawsuit (Russell v. A. H. et al.)

• Attorney Client Privilege! Don’t Ask Me!

• I am now co-counsel and dental sleep medicine consultant for the defendant in this lawsuit.
RUSSELL V. A.H. ET.AL.

• The dentist (A.H.) is being sued, as well as the manufacturer of the OSA appliance. A.H. is being sued for:
  • Lack of informed consent
  • Lack of adequate exam
  • Lack of recall (monitoring)
  • Lack of monitoring/testing for effectiveness
  • Lack of patient instructions
LAW SUIT (RUSSELL V. A.H ET. AL.)

• Informed Consent?
  • Easiest type of lawsuit to bring for a plaintiff’s attorney.
  • The area of greatest exposure and likeliest future litigation.
    • Why?
  • Inadequate informed consent is the easiest type of lawsuit to prevent.
    • Inform the patient and document the permission (consent)!
William Shakespeare on Lawyers:

“The first thing we do, let’s kill all the lawyers.”

2 King Henry VI
RISK MANAGEMENT

• To successfully protect your practice you must learn to look at each patient as a possible lawsuit waiting to happen.

• *Think like a lawyer!*
RISK MANAGEMENT

• Build your case against each and every patient (plaintiff) before the lawsuit happens!

• Develop your defense before you need it!
Minimizing RISK by identifying potential plaintiffs

• Who do we have a duty to protect. (Malpractice)
  • Patients?
  • Patients families?
  • Business Invitees?
  • Third parties?
RISK MANAGEMENT

• **Figure out what or who can hurt (sue) you!**
  
  • Patient
    • We have a direct duty to our patients
  
  • Patient’s family
    • Loss of Consortium?
      • What is Loss of Consortium?
      • Not available in all jurisdictions!
  
  • Third party plaintiff
    • Auto accident
      • Industrial accident
    • Business invitee?
RISK MANAGEMENT

• Figure out how potential Plaintiffs can hurt (sue) you!
  • Sleep Patients
    • TMJ Lawsuits
    • Perio Lawsuits
    • Decay/damage to the teeth
    • Fracture of teeth or restorations
    • Tooth movement/Jaw movement
    • Lack of Informed consent
    • Failure to properly evaluate as a candidate for MAD
      • Supervise (monitor), Instruct, Recall, Refer
RISK MANAGEMENT

• Develop a plan to reduce the risk of being sued and implement it!
  • Shared (transferred) Liability
    • Develop forms/consent and use them properly
  • Comparative fault/ negligence
• Document/ Document/ Document
  • If it is not written down, it didn’t happen!
RISK MANAGEMENT STRATEGY

• 1. We will follow AASM/AADSM Practice Parameters
   • 2005 Practice Parameters will be introduced to the jury as our Standard of Care!

• 2. Shared (Transfer) Liability
   • Originally was derived from the concept of contributory negligence and comparative fault
   • We will share (transfer) liability at every opportunity!
• Never go to court alone!

• Share (Transfer) Liability
PARTNERSHIP (MD’S & DENTISTS)

• Dentists and Sleep Physician’s should be partners in the treatment of OSA patients.
  • They should routinely refer and share in the treatment of OSA patients.
  • If treatment is shared, then liability is shared.
    • Monitoring compliance
    • Recording efficacy
    • Snoring
    • Partner satisfaction
KEN’S THOUGHTS (THE PROBLEM)

• Some MD’s don’t seem to trust dentists! Therefore, they don’t refer!
  • In my opinion, there seems to be little respect shown between the professions.
  • Reasons:
    • Some MD’s don’t appear want dentists to be included in the treatment of OSA patients.
    • Some MD’s seem to think that if they refer OSA patients for MAD therapy, the patient will not be referred back for monitoring.
    • Some MD’s do not think MAD therapy is effective.
    • MD’s are afraid they will lose control of the patient.
    • MD’s are worried that patients will be treated without their involvement.
THE PROBLEM!

• Some Dentists don’t trust Sleep Physicians! Therefore, dentists don’t refer! Why?
  
• Numerous dental labs are attempting to teach Physicians to fabricate MAD’s
  • SomnoMed

• Some dentists do not think CPAP is a very effective treatment.

• CPAP is not tolerated by many patients, and the patients who are trying to comply frequently wear CPAP only a portion of the night. (4 hours/night)

• Dentists have watched their patients with an AHI of 5-10 placed on CPAP without being offered any alternative therapy.

• Many dentists are now screening for OSA and are then faced with the decision of what to do with these patients. (Refer to a Sleep Physician who doesn’t respect you and will not give you a chance to participate in treatment?)

• This has resulted in numerous HST companies recruiting dentists to use their services and not refer to Sleep Physician.
  • HST read by a Sleep Physician working for the HST company.
THE PROBLEM

• MD’s and Dentists must come together for the good of our patients and our profession.

• As a team, we can share in the treatment of our mutual patients and Share Liability.

• *Together we are BETTER!*
THE SOLUTION (MY OPINION)

• Sleep Physicians need to have one or more dentists that are consulted after any patient fails to wear a CPAP all night! CPAP Non-compliance/refusal and Co-therapy

• In my opinion, co-therapy is the best possible treatment for most patients.
  • CPAP for maximum effectiveness
  • MAD use to assist anytime CPAP is inadequate
    • Mask leaks
    • When patient removes the mask in the middle of the night
    • Camping trips
    • Electricity out
    • Avoid chin straps

• Sleep Physicians- Please show respect to the dentists you work with.
  • Referral results in liability sharing with the dentist.
  • The patient was given every opportunity to control their OSA.
THE SOLUTION

- Dentists should have one or more Sleep Physicians that they refer to.
  - Sleep Physicians should act as the quarterback of your Sleep Practice team.
  - Dentists- Please show respect to the Sleep Physicians you work with.
  - This allows the dentist to share liability with the Sleep Physician and deflect/defer most medical decisions to the Sleep Physician.
- In-lab sleep studies!
- Dentist should screen all patients for possible referral (share liability)
  - Sleep Physician
  - PCP
  - ENT
  - Etc.
KEN’S CREED #4

• Shared (transferred) Liability
  • Share liability with other professionals
  • Look for reasons to refer

• Transfer liability to our patient
  • Place the blame on the PATIENT! (Document)
    • Failure to return for recall
    • Failure to comply with treatment
    • Failure to comply with referral
  • “Its Not My Fault”
RISK MANAGEMENT STRATEGY

• Shared (transferred) Liability- Not a true risk management strategy
  • Concept that I apply in our office where we look for opportunities to transfer liability (place the blame on others)
    • Place the blame on the patient for a problem (lawsuit) that has not happened!
  • Look for reasons to refer or include other practitioners in the treatment of your patient
RISK MANAGEMENT STRATEGY

- Transferred (Shared) Liability
  - Think of a 6 year old child
    - Not my fault— it did it all by itself!
    - Never their fault!
  - Look for opportunities to document lack of compliance!
    - Any area where the patient did not follow instructions
TRANSFER LIABILITY

• Placing the blame on the patient is a very common Defense used in court!
  • The basis for the defense must be developed before the problem arises. Before the lawsuit is filed.
  • You must document any and every incident of patient noncompliance.
  • Document all instructions.
  • Document that the patient was given written copies of instructions.
  • Document all positive comments about the treatment by patient.
SHARED (TRANSFERRED) LIABILITY

• Frequently, during litigation, recorded documentation of instructions or conversations with the patient is lacking. (I see lots of records)
  • No documentation exists that the patient was told ___!
  • Paper Records can be problematic!
    • Record can appear to be changed or tampered with!
    • Record appears to be added to!
  • The defendant will have an incredible ability to remember details of the patient visit with no records to verify the statements!
    • But the defendant cannot remember what the patient was wearing on the day of the visit.
KEN’S CREED #5

• Develop a record so complete and intimidating that no attorney in his right mind would take you to court.
SHARED (TRANSFERRED) LIABILITY

• Plaintiff’s attorneys love cases where the defendants have no records.
  • If an event or issue is documented in a patient’s record, juries generally trust the defendant’s record!
  • If an event is not written in the record, juries tend to believe the patient!
    • Juries don’t believe that a MD/dentist can remember what happened on each patient.
    • But they do believe that a patient can remember what happened in the office.
SHARED (TRANSFERRED) LIABILITY

• Patient Record:
  • We want to document any event where the patient did not follow instructions;
    • Refused Referral to Sleep Physician/Dentist.
    • Refused Referral to weight loss clinic.
    • Refused Referral to PCP.
    • Did not wear the CPAP or MAD appliance as directed.
    • Patient is not using his morning repositioner.
    • Did not maintain his periodontal recall appointment.
    • Did not maintain his recall appointment with his dentist.
    • Patient does not adequately clean his teeth.
  • We want to fill the record with occurrences where the patient is to BLAME!
SHARED (TRANSFERRED) LIABILITY

• CPAP/MAD Compliance!
  • Document Compliance-or lack thereof
  • Inform the patient that wearing the CPAP/MAD is mandatory!
    • Explain to the patient they need to inform your office or the DME provider any time they cannot wear or use their CPAP/MAD.
  • Document- #day/week & #hours/night of appliance wear
  • Change appliances/masks.
    • Mask change
    • Get the patient off his/her back
    • Refer if no solution is readily available, DO SOMETHING!
WARNING!

• Your patient records speak loudly to anyone who looks at them.

• What do your records say?
PATIENT RECORD

• **THE most important items in your office are your patients’ records!**
  
  • Without a good record, a malpractice suit is almost impossible to win.
  
  • The Record MUST contain ammunition for your attorney to work with.

  • Medical or Dental issues before treatment.

  • Positive comments

  • Non-compliance

  • Referral Refusals

  • Hygiene failure

  • Plaque, gingivitis,
PATIENT RECORD

• Patient Record Use in Court!

• You can call the plaintiff (Patient) to testify and examine the patient on each occurrence where you documented the patient noncompliance.
  • “Mr. Jones, you did not use the Morning Repositioning Appliance every morning.” Isn’t that CORRECT?
  • “Dr. Berley told you that the Morning Repositioning Appliance was to prevent your teeth/jaw from moving. Isn’t that correct?
  • The Record (Chart) goes with the jury during deliberation
SHARED (TRANSFERRED) LIABILITY

• Who can your office Share (transfer) Liability with?
  • PATIENT!
    • Easiest party to transfer liability to!
    • Patients frequently develop excuses why they are not complaint with MAD/CPAP therapy!
      (Document them)
    • Use that time to warn against the dangers of non-compliance!
      • Document the non-compliance and warning!
        • Examples:
          • Had a COLD!!
          • Got a FEVER Blister!
          • Girl friend has been at the house a lot!!!!!!
• Who you CAN share liability with:
  • Patient
  • Patient’s Sleep Physician/Dental Sleep Medicine Practitioner
  • Patient’s general dentist
  • Patient’s Periodontist
  • Patient’s Primary Care Physician
  • Patient’s family
  • ENT
  • Endocrinologist
  • Cardiologist
  • Weight Loss Clinic???
  • Dental Appliance Lab???????
SHARED LIABILITY

• Thoughts to Ponder!

• TEAMWORK.....means never having to take all the blame yourself!
SHARED LIABILITY

• Who you CANNOT share liability with!

• YOUR EMPLOYEES!

  • Employers are vicariously liable, under the respondeat superior doctrine, for negligent acts or omissions by their employees in the course of employment (sometimes referred to as 'scope of employment'). For an act to be considered within the course of employment, it must either be authorized or be so connected with an authorized act that it can be considered a mode, though an improper mode, of performing it.

• Ex: (Hygienist Perio Case)
SHARED (TRANSFERRED) LIABILITY

- **Comparative negligence** is a partial legal defense that reduces the amount of damages that a plaintiff (patient) can recover in a negligence-based (malpractice) claim based upon the degree to which the plaintiff's own negligence contributed to cause the injury.
SHARED (TRANSFERRED) LIABILITY

• Comparative negligence (fault)
  • When the defense is used, a jury, must decide the degree to which the plaintiff's (Patient’s) negligence versus the combined negligence of all other relevant actors contributed to cause the plaintiff's damages.
SHARED LIABILITY

• Comparative Negligence (fault)- In most jurisdictions, if the patient’s (plaintiff’s) fault (negligence) is greater than the defendant’s (i.e. 51%), the plaintiff is barred from recovery.

• *If you can show that the patient was more at fault than you were, the patient cannot win the lawsuit.*
CONTINUING COVERAGE
ACTOR TRACY MORGAN CRITICALLY INJURED IN DROWNING ATNJ TURNPIKE
SHOWS THAT
IT WAS A SEVERE CRASH
HERE’S WHAT SERGEANT GREGORY
TRACY MORGAN V. WALMART

• Morgan sued Walmart in July after a collision with a Walmart truck left him seriously injured, and killed his friend and fellow comedian Jimmy Mack, also known as James McNair.

• Morgan spent days in intensive care and weeks in rehab. He has not fully recovered, and it could be months until he can fully walk again.

• USA Today
TRACY MORGAN V. WALMART

• Plaintiff Morgan alleges the defendant Walmart knew or should have known that its employ was driving sleepy.

  • Walmart truck driver allegedly fell asleep while driving causing a 6 vehicle accident.

  • The truck driver may have been awake for 24 hours before the accident?

  • Morgan alleges the Walmart was negligent in letting its’ employee drive.
Actor and comedian Tracy Morgan and others in his limousine were not wearing seat belts when their vehicle was struck by a Wal-Mart truck in a June highway accident, the retailer said on Monday.

In its filing, Wal-Mart said the injuries suffered by surviving passengers were caused in whole or in part by their "failure to properly wear an appropriate available seatbelt restraint device."
MORGAN V. WALMART

• Morgan failed to “exercise ordinary care in making use of available seat belts . . . and acted unreasonably and in disregard of plaintiffs’ own best interests,” Wal-Mart alleged.”
What do we call this type of defense?

Comparative fault? Transferring liability to the plaintiff!

Will the defense work?
Yes!

The Limo driver was wearing his seatbelt and sustained minor injuries.

Comparative fault argument will be used to mitigate damages.

Mr. Morgan’s damages will be decreased by the percentage that his negligence contributed to his injuries.

That percent will be determined by the jury.
WAL-MART DEFENSE STRATEGY

• Comparative Fault - If the plaintiffs had been wearing seat belts they may not have been seriously hurt.

• Wal-Mart is sharing (transferring) liability to the plaintiffs
  • Plaintiffs’ damages should be reduced by the percentage of his fault. (Determined by the Jury)
  • If more that 51%, the plaintiff should not be allowed to recover damages.
SHARE (TRANSFERRED) LIABILITY

• Two realistic ways for DDS/MD to share liability!
  • Document Patient conditions, complications, compliance and instructions
  • Include other practitioners in treatment.
SHARED (TRANSFERRED) LIABILITY

• **Goal! (It’s Not My Fault)**
  
  • Show that it was the patient fault!
  
  • *It was the patient’s decision to drive drowsy! (I warned her/him)*
  
  • Show the patient was referred to weight loss clinic and refused the referral!
  
  • Show the patient was referred for excessive daytime sleepiness and refused the referral. *(MD’s-please control EDS)*
  
  • Show non-compliance!
    
    • CPAP/MAD
SHARED (TRANSFERRED) LIABILITY

• Patient Record (Documentation)
  • Consent,
    • Conversations,
    • Instructions,
    • Lack of compliance,
    • Conditions present at the time of treatment
SHARED LIABILITY

• Be Smart! (Beauty is nothing without Brains)
  • Look for opportunities to share liability.
    • BP > 160/90
    • BMI > 30
    • No physical in the last year.
    • No dental check-up in the last year
    • EDS
MALPRACTICE

- **Medical Negligence** - Divided into 4 separate areas that must be proven at trial.
  - Duty
  - Breach of the Duty
  - Proximate Cause
  - Damages
MALPRACTICE

- **Breach of duty**: Breach of the Standard of Care
  - Plaintiff must establish the standard of care
    - What a reasonable and prudent practitioner would have done in the same or similar circumstances
  - **Expert Testimony**!
    - The **standard of care** must be established by a competent member of the profession.
STANDARD OF CARE

Definition of STANDARD OF CARE-

What ever the 12 individuals in the jury box say it is!!!!!
STANDARD OF CARE-DSM

1. No standard of care has been established in SM/DSM
   - Standard of care is a legal term not a Dental/Medical term
   - In every Malpractice case more than one Standard of Care is presented.
     - Both the plaintiff and defendant have an expert witness that presents opposing standards.
     - The JURY then establishes what should have been done.
       - “Standard of Care”
AADSM/AASM PRACTICE PARAMETERS

- From a risk management standpoint these documents create a real problem!
  - **DO NOT** establish your Scope of Practice!
    - Scope is determined by your State Dental Practice Act and Board regulations and your education.
  - **DOES** outline an alleged **STANDARD OF CARE**!
    - For AADSM/AASM Members
WARNING!!

• **PRACTICE PARAMETERS** article 2006,

• **AADSM/AASM POLICY STATEMENT 2013**

• “**Clinical Guideline for the Evaluation, Management and Long-term Care of Obstructive Sleep Apnea in Adults**” (2009)
  • Will be ADMITTED into evidence and presented to the JURY as YOUR STANDARD OF CARE!!!!!!!
THE PROBLEM (DENTISTS HAVE 2 STANDARDS OF CARE FROM THE AADSM)

• It is my professional legal opinion that the “AADSM/AASM Practice Parameters 2006” will be introduced into evidence as a learned treatise exception to the hearsay rule in a malpractice action.
  • It could easily be used by the jury to determine a standard of care for DSM.
  • This document does not require a face-to-face visit with a Sleep Physician; it does not state who must write the prescription for OAT;
  • It does not require that a dentist provide treatment (qualified dental personnel);
  • It does require the patient return to the referring physician for monitoring.
TWO STANDARDS OF CARE?

- It is my professional legal opinion that the “AADSM/AASM Policy Statement of 2013” will NOT be introduced into court as your standard of care.
  - This document contains a number of legally inaccurate statements, therefore, it is my opinion that no trial judge would allow this document into court. However, I could be wrong!
  - The 2013 Policy Statement: requires a face-to-face consultation with a Sleep Physician before a dentist can provide OAT; requires that a Sleep Physician write the prescription for OAT;
  - Requires that a qualified dentist provide treatment;
  - Requires that the patient be monitored by a Board Certified Sleep Physician.
“AND IF A HOUSE BE DIVIDED AGAINST ITSELF, THAT HOUSE CANNOT STAND.” MARK 3:25

• Dental Sleep Medicine is truly a house divided.

• In my 34 years of practicing dentistry and 20 years of practicing law I have never been associated with a more splintered, and apparently confused, group.

• Unfortunately, each faction seems staunchly determined to stand their ground and battle to the death.
WHAT A MESS!

• We have two published “standards of care” by the same organization.

• I believe that this disparity is responsible for the divergent approaches outlined by different practitioners. We need strong leadership in Dental Sleep Medicine to bring these two groups together. Our house is divided and will not last in this state of disarray.
DENTAL SLEEP MEDICINE

• DSM is divided down the middle between the “haves and the have-nots.” Or, if you prefer, between, those dentists who receive adequate numbers of referrals from Sleep Physicians/PCP’s to survive and those who don’t.
DENTAL SLEEP MEDICINE

• DSM is separated into two factions. The first group of dentists want desperately to practice Dental Sleep Medicine but they have no diagnosed patients. They are fearful that a referral to a Sleep Physician will result in the patient being forced into CPAP without OAT being offered. These dentists are being encouraged by corporate entities to employ HST and avoid Sleep Physician referral.
DENTAL SLEEP MEDICINE

• The second faction in Dental Sleep Medicine are those dentists who became involved very early in the practice of DSM. These lucky few have been able to develop a referral pool of Sleep Physicians. Many of these practitioners have been able to limit their practices to Sleep Disordered Breathing and are able to fill their schedules with patients referred by Sleep Physicians. Therefore, DSM has two separate and distinct practice models and both groups adamantly defend their practice philosophy. However, legally we cannot have two standards of care.
I appreciate and respect the physicians who have referred patients to me.

However, it took several months of referring patients from my practice before I received a referral.

I understand the mentality of those who have been successful in garnering the trust of Sleep Physicians in their market.

However, I empathize with those who are trying to play by the Position Papers of the AADSM/AASM and have NO patients to treat.
WHAT DO WE DO?

• Together we are better!
  • Sleep Physicians- cut us (dentists) some slack!
    • Respect your dental colleagues
    • Find time to visit with any dentist who is referring to you.
    • Please be willing to help any dentist new to DSM!
  • Dentists- cut the Sleep Physician’s some slack
    • Respect the Sleep Physician’s you are working with.
    • Remember they are the quarterback of the team
    • Remember you must prove yourself.
      • Develop your skills
      • Make sure that you know the protocol for the treatment of OSA with OAT.
COURT REPORTER FUNNY

• **Attorney:** So the date of conception of the baby was August 8th?

• **Witness:** Yes.

• **Attorney:** And what were you doing at that time?

• **Witness:** Getting laid.
STANDARD OF CARE!!!

- AASM & AADSM—
  - From a Risk Management prospective, AASM & AADSM “SHOULD NOT” be involved in establishing treatment protocols/standards of care!!
  - Written protocols are frequently admitted into evidence in court to establish a standard of care.
STANDARD OF CARE!

• Juries have to be informed by the plaintiff and the defendant of the standard of care they want applied to the case. (Expert Testimony-Learned treatise)

• Dental Sleep Medicine has no established standard of care!

• Juries will consider all expert testimony and any “learned treatise” documents that are admitted into evidence.
  
  • Documents are given undue weight in court!
STANDARD OF CARE

• AADSM & AASM publications (Practice Parameters 2006) will fall into the hearsay “learned treatise” exception and therefore become ADMISSIBLE!!
  • Is Defendant a AASM/AADSM member?
  • Reads AASM/AADSM materials?
HEARSAY “LEARNED TREATISE”

• Learned Treatise-
  • Considered an exception to the Hearsay Rule
  • Can be introduced only when there is an Expert on the stand
  • Generally is introduced by being read to the jury!!!
    • Federal Rules of Civil Procedure
MALPRACTICE

• Learned Treatise!!!!

• “Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnea With Oral Appliances: An Update for 2005.” *SLEEP* 2006; 29(2): 240-243

• Introduced into evidence by Plaintiff’s Expert
MALPRACTICE

• Hearsay-Learned Treatise documents
  • Not subject to cross-examination
    • Authors are not in the court room for questioning!
  • Impossible to minimize the effect (impeach)!
  • Adds credibility to the expert introducing it!
  • Makes it too easy for the jury to find a breach of the standard of care.
RISK MANAGEMENT STRATEGY

• Memorize the AASM/AADSM Practice Parameters 2006!
  • If this document is your standard of care you have to know what is in that document!
    • What are the Recall Requirements in the Parameters?
      • How frequently are you to recall your completed patients?
    • What are the titration requirements in the Practice Parameters?
    • What results should you expect?
Unfortunately, most MD’s and Dentists practicing Sleep Medicine don’t know what is contained in the Practice Parameters.

Therefore, we will quickly look at the recommendations contained in the Practice Parameters.

• Warning!!!

• THIS WILL BE BORING!!!!
3.0 Recommendations:

3.1 Diagnosis:

3.1.1 “The Presence or absence of OSA must be determined before initiating treatment with oral appliances to identify those patients at risk due to complications of sleep apnea and to provide a baseline to establish the effectiveness of subsequent treatment. Detailed diagnostic criteria for OSA are available and include clinical signs, symptoms and the findings identified by polysomnography. The severity of sleep related respiratory problems must be established in order to make an appropriate treatment decision.”
3.2 Appliance Fitting

3.2.1 Oral appliances should be fitted by qualified dental personnel who are trained and experienced in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures. Dental management of patients with OAs should be overseen by practitioners who have undertaken serious training in sleep medicine and/or sleep related breathing disorders with focused emphasis on the proper protocol for diagnosis, treatment, and follow up.
AADSM PRACTICE PARAMETERS

• 3.2.2 Appliance Fitting

• 3.2.2- Although cephalometric evaluation is not always required for patients who use an oral appliance, appropriately trained professionals should perform these examinations when they are deemed necessary.
• 3.3 Treatment

• 3.3.1 Treatment Objectives

• 3.3.1.1 For patients with primary snoring without features of OSA or upper-airway resistance syndrome, the treatment objective is to reduce the snoring to a subjectively acceptable level.
• 3.3.1 Treatment Objectives

• 3.3.2 Oral appliances are appropriate for use in patients with primary snoring who do not respond to or are not appropriate candidates for treatment with behavioral measures such as weight loss or sleep-position change.
3.3.1 Treatment Objectives

3.3.3 Although not as efficacious as CPAP, oral appliances are indicated for use in patients with mild or moderate OSA who prefer OAs to CPAP, or who do not respond to CPAP, are not appropriate candidates for CPAP, or who fail treatment attempts with CPAP or treatment with behavioral measures such as weight loss or sleep-position changes.
Clinical Practice Parameters

• 3.3.1 Treatment Objectives

• 3.3.4 Patients with severe OSA should have an initial trial of nasal CPAP because greater effectiveness has been shown with this intervention than with the use of oral appliances. Upper airway surgery (including tonsillectomy and adenoidectomy, craniofacial operations and tracheostomy) may also supersede use oral appliances in patients for whom these operations are predicted to be highly effective in treating sleep apnea.
3.4.3 Patients with OSA who are treated with oral appliances should return for follow-up office visits with the dental specialist. Once optimal fit is obtained and efficacy shown, dental specialist follow-up at every 6 months is recommended for the first year, and at least annually thereafter. The purpose of follow up is to monitor patient adherence, evaluate device deterioration or maladjustment, evaluate the health of the oral structures and integrity of the occlusion, and assess the patient for signs and symptoms of worsening OSA.
• Intolerance and improper use of the device are potential problems for patients using oral appliances, which require patient effort to use properly. Oral appliances may aggravate temporomandibular joint disease and may cause dental misalignment and discomfort that are unique to each device.

• In addition, oral appliances can be rendered ineffective by patient alteration of the device. (Option)
3.4.4 Patients with OSA who are treated with oral appliances should return for periodic follow-up office visits with the referring clinician.

The purpose of follow up is to assess the patient for signs and symptoms of worsening OSA. Close communication with the dental specialist is most conducive to good patient care.

An objective reevaluation of respiration during sleep is indicated if signs or symptoms of OSA worsen or reoccur. (Option)
SLEEP MEDICINE CLINICAL GUIDELINES


• Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults.

BACKGROUND: Obstructive sleep apnea (OSA) is a common chronic disorder that often requires lifelong care. Available practice parameters provide evidence-based recommendations for addressing aspects of care.

OBJECTIVE: This guideline is designed to assist primary care providers as well as sleep medicine specialists, surgeons, and dentists who care for patients with OSA by providing a comprehensive strategy for the evaluation, management and long-term care of adult patients with OSA.
Close follow-up for PAP usage and problems by appropriately trained health care providers is indicated to establish effective utilization patterns and remediate problems, if needed. This is especially important during the first few weeks of PAP use (Standard). General OSA outcomes should be assessed in all patients (Consensus) (Table 6).
Positive Airway Pressure- Page 268 cont.:

If CPAP use is considered inadequate based on objective monitoring and symptom evaluation, prompt and intensive efforts should be implemented to improve PAP use or consider alternative therapies (Consensus). After initial PAP setup, long-term follow-up by appropriately trained health care providers is indicated yearly and as needed to troubleshoot PAP mask, machine, or usage problems (Option). The General Outcomes assessment described above and in Table 6 should be performed at follow-up visits.
**TABLE 6**

**SLEEP MEDICINE CLINICAL GUIDELINES**

General OSA Outcomes Assessment

- Resolution of sleepiness
- OSA specific quality of life measures
- Patient and spousal satisfaction
- Adherence to therapy
- Avoidance of factors worsening disease
- Obtaining an adequate amount of sleep
- Practicing proper sleep hygiene
- Weight loss for overweight/obese patients
SLEEP MEDICINE “STANDARD OF CARE”


- Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults.
  - This document will be admitted into evidence in a malpractice case as a “learned treatise” exception to the hearsay rule.
  - Document will be used by a jury to determine Sleep Physician’s SOC.
SLEEP MEDICINE MALPRACTICE

• Medical/DENTAL Negligence (MALPRACTICE)- is an “instance of negligence or incompetence on the part of a professional where he failed to exercise the degree of care and skill that a physician, surgeon or dentist would use under similar circumstances.
CPAP COMPLIANCE

• Positive airway pressure device compliance of the patients with obstructive sleep apnea syndrome.
• Boyacı H¹, Gacar K, Barış SA, Başyığıt I, Yıldız

Abstract

OBJECTIVES:

• The aim of this study was to evaluate factors affecting the usage of continuous positive airway pressure (CPAP) device in patients with obstructive sleep apnea syndrome (OSAS).
• MATERIAL AND METHODS:

This study included 47 patients with OSAS who were suggested to use CPAP device at home and expected to use the device for at least 6 months. The compliance of CPAP device was determined by 2 different methods. In subjective evaluation, total time for usage of the device was recorded according to patients’ declaration. In objective evaluation, total time of usage was recorded from the counter on device and it was divided into the number of days passed from the beginning of the treatment and at least 4 h of usage in a day was accepted as an effective usage. Data of compliant and non-compliant patients were compared in order to determine the factors affecting CPAP treatment.
CPAP COMPLIANCE

• RESULTS:

Ten patients were female, 37 of them were male and mean age was 52.98 ± 20.4 years. Mean Apnea Hypopnea Index (AHI) was 54.4 ± 20, mean oxygen saturation (SO2) was 87.3 ± 4.6 and mean CPAP pressure was 7.4 ± 1.9 in the whole study population. The compliance of CPAP treatment was found to be 48.9% according to objective evaluation whereas it was 80.9% according to subjective evaluation. Five of 8 patients (62.5%) who did not use the device stated the problems about the device mentioning the mask as a reason for their non-compliance. Treatment compliance was better in the patients with high Epworth sleepiness scale (16.5 ± 5.5 vs. 11.8 ± 4.1, p < 0.05). Epworth sleepiness scale of the patients who were compliant to the treatment was significantly decreased after the treatment both in subjective and objective evaluation. Treatment compliance wasn't different between male and female patients, however it was significantly lower in active smokers compared to non-smokers and ex-smokers.
CPAP COMPLIANCE

• CONCLUSIONS:

• It was concluded that the most important factor associated with compliance to CPAP treatment in the patients with OSAS was Epworth sleepiness scale while mask related side effects might be a reason of treatment withdrawal and all these issues should be addressed carefully in order to increase compliance.
CPAP/MAD COMPLIANCE

• AADSM/AASM parameters require recall for all completed patients.
  • Patient compliance should be monitored yearly.
  • The compliance of CPAP treatment was found to be 48.9% according to objective evaluation whereas it was 80.9% according to subjective evaluation.
  • Compliance with MAD has been reported to be between 75-80% one year after completion of treatment.
KEN’S CREED #1

• ALL SLEEP PATIENTS MUST:

  1. Make a **RECALL APPOINTMENT** before they leave our office. Explain the serious nature and Dr. B requires a recall appointment to remain a patient!!!

     a. If the patient has a recall appointment made each and every time they enter your office, it would be difficult for a jury to find you negligent for failing to recall.

     b. If patient cancels or fails to keep a recall appoint, document 3 attempts to contact him by phone at different times of the day/evening or e-mail.

     c. Send certified letter.
PATIENT RECALL (DENTIST)

• Dentists are accustomed to recalling patients on a 6mo/1year basis.
  • Most dentist have software which will accomplish yearly recall.
    • Have a reminder service to text, e-mail, call your patients to remind them of their appointment.
      • If your patient’s fail to keep this appointment document 3 attempts to get the patient in the office.
PATIENT RECALL VISIT

• 1. Update medical/dental history
• 2. Determine efficacy/usage of MAD
  • Number of hours/ nights used
  • Epworth
  • Snoring
• 3. Check the fit, function, and wear of the appliance
• 4. Clean the appliance
• 5. If there is a return of symptoms/EDS/ Snoring:
  • Advance the appliance to resolve snoring.
  • HST
  • Refer to Sleep Physician
RECALL PROTOCOL

• RECALL:

  • If a patient is not 100% compliant with treatment, CPAP/MAD
    DO SOMETHING!
  • Document Concern/warning/encouragement
    • Refer for Co-therapy
    • Refer to weight-loss clinic
      • Exercise program
    • Appoint in 6 mo?
MALPRACTICE CASE I

• Pertinent facts:
  • 62 year old white male
  • AHI of 28
  • Diagnosis of Moderate OSAS
  • BMI of 35
  • EPWORTH of 18
  • Patient admits to falling asleep while DRIVING!!!
  • Patient titrated in lab with nasal CPAP, 12CM/water
  • Patient volunteers as a BUS DRIVER FOR HIS CHURCH!!!
RISK????
MALPRACTICE CASE I

• Your Patient was killed in a church bus accident with an 18 wheeler.
• Patient fell asleep at the wheel and lost control of the bus hitting the 18 wheeler.
• Patient was a volunteer bus driver for Pleasantville Baptist Church.
• 8 people died in the accident.
MALPRACTICE CASE I

• Patient was fitted with a Nasal CPAP @12 cm/water for the treatment of his moderate OSA.
• Patient was instructed verbally to return if he had any problems.
• No further contact was had with the patient before the fatal accident.
  • The accident occurred 3 years after the CPAP therapy was initiated!!!!
  • Patient quit using CPAP one month after therapy began.
  • Patient was not seen for recall.
MALPRACTICE CASE 1

- How would I defend this case?
- I would argue that the victims of the bus accident have no legal standing to sue Dr. Thomas. He did not owe them a duty. (Zone of Danger)
- I would argue that it would place an undue burden to require Dr. Thomas to protect all motorist from Mr. Smith.
- That it is not Dr. Thomas’s fault, it is Mr. Smith and the Church’s fault.
- Therefore, the case should be dismissed?
MALPRACTICE CASE I

• If the motion to dismiss was denied at the Circuit Court level, I would appeal the motion.
  • This would be a terrible precedent to let stand

• If my motion to dismiss was denied at the State Court of Appeals and the State Supreme Court:
  • I would settle this case
  • I would not go into court with 8 mothers crying and drawing sympathy from the jury.
  • This may settle for the policy limit.
MALPRACTICE CASE #1

• Recall all patients in active treatment!

• If the patient is non-compliant with treatment, do something!
  • Create a record that blames the patient. (Document non-compliance)
  • Create a record that shows that you did everything you could to help the patient. (Changes treatment/Referral)
  • Create a record that shows that you complied with published parameters or protocols.
• Attorney: She had three children, right?
• Witness: Yes
• Attorney: How many were boys?
• Witness: None.
• Attorney: Were there any girls?
• Witness: Your Honor, I think I need a different attorney. Can I get a new attorney?
EXAMINATION OF THE OSA PATIENT

**Examination!**

"From a risk prevention/management prospective!"

1. We will look for things that can be used to Transfer Liability it our OSA patient.

2. What do we look for in order to share liability with our patient?
EXAMINATION

• Answer:

• “Any Thing That Isn’t Perfect”
PATIENT EXAMINATION

• Begins with a complete Patient History
  • Medical History
  • Dental History
EXAMINATION OF THE OSA PATIENT

• Medical History
  • Have ALL Patients complete a Medical History before they present for the first intake appointment.
  • Prescription list- including over the counter medications.
    • List the Name and Address of all their doctors.
      • Sleep Physicians
      • PCP
      • Cardiologist
      • Endocrinologist
      • Etc.
MEDICAL HISTORY

• Looking for Co-morbid diseases (diagnosis)?
  • Dates these conditions were last checked?
  • Are the co-morbid diseases under control

• Medications used to control co-morbid diseases
  • List of medications
    • How the meds are taken
      • Strength and frequency
      • Is the patient compliant with their meds?
EXAMINATION OF THE OSA PATIENT

• Have all patients complete a Dental History before their first appointment.
  • Name, address and phone # of the patient’s general dentist.
  • Date of last dental appointment
  • Date of last decay detecting x-rays
  • Date of last cleaning
  • Treatment pending
OSA EXAMINATION

• Can be broadly divided into 3 categories.
  • 1. Physical examination
  • 2. Dental examination
  • 3. Social/neurocognitive
TRANSFER/SHELP LIABILITY

- Medical history
  - cardiac/stroke/BP/diabetes/a-fib
- Medications that increase the incidence of OSA
- BMI
- Lack of exercise
- Alcohol consumption/document the daily intake
- Tobacco use/smoking/chewing
- Brushing habits/Flossing habits
- Dental visits/cleaning frequency
TRANSFER/SHARE LIABILITY

- Patient Transferred Liability
  - Torus Mandibularis
  - Shape of the jaw/palate/soft palate/uvula
  - Condition of the teeth/Poor dentistry/Poor Root Canals
  - Shape of the nose
  - Deflection/deviation of nasal septum
  - Enlarged turbinate
  - TMJ/Perio
  - Hygiene/gingivitis
  - Bruxism
  - Shape/size of the tongue
  - Shape/size of tonsils
  - Class 3
  - Lack of protrusion/range of motion
PHYSICAL EXAMINATION

• BMI
  • We routinely determine BMI on all OSA patients.
  • Your software will figure this for you.
  • Sleep Physician’s will include this number in their intake examination if you have a referral.
KEN’S CREED #18

• Refer all OSA Patients with a BMI over 30 to a Weight Loss Clinic
  • Document the referral and the reason for the referral in patient record!
BMI REFERRAL

**Obesity is a disease:**

- All diseases with negative medical consequences need to be treated if a reasonable treatment exists.
- Obesity is a co-morbid disease of OSA and has severe health consequences.
- By treating obesity, our OSA treatment outcomes improve.
- **If we fail to treat obesity, or refer the patient for treatment, an argument could be made that we have breached the standard of care.**
- Is it MALPRACTICE to fail to refer an obese patient?
Even if it isn’t malpractice, it is good policy!
• **SHARE (Transfer) Liability to the Patient!**

• By referring all patients with a BMI over 30:
  • Place part of the burden of success on the patient
    • Inform the patient that OAT works best on patients who are within normal weight ranges.
    • Research shows us that a 10% weight loss can decrease the patients AHI by 1/3.
    • Inform the patient that weight loss will be beneficial from a health prospective.
      • B/P
      • Stroke
      • Heart Disease
      • Diabetes
BMI REFERRAL
Why Choose The New Direction® System?

- Proven treatment for the disease of obesity.
- Part of the comprehensive treatment plan for diseases including diabetes, hypertension, cardiovascular disease and sleep apnea.
- Wellness approach in the prevention of coronary heart disease and many types of cancer.

- Comprehensive Intensive Behavioral Therapy Program complemented by patient education materials for facilitating healthy choices.
- Offers a variety of programs to meet the needs of all patients while enabling patients to stay in control of their eating.
INFORMED REFUSAL

• By refusing the referral the Patient assumes responsibility for the success of the treatment.

• By informing the patient that treatment may not be successful if he/she doesn’t lose weight, the patient is placed on notice that he is in control of the success.

• If treatment is unsuccessful, the patient has to shoulder a portion of the blame.

  • “Its Not My Fault!”
KEN’S CREED #17

• Do not let a sleepy patient leave your office and drive.
  • Coffee to go.
  • Energy drinks.
  • NoDoze caffeine tablets
  • Have a family member drive the patient home.
  • Have a staff member drive the patient home.
  • Call a cab.
    • Document conversation
    • Document steps taken to revive the patient!
EXCESSIVE DAYTIME SLEEPINESS

• Medications for sleepiness!
  • Provigil
  • Nuvigil
  • Modafinil
  • Armodafinil

• Who would prescribe a temporary prescription?
• Who would keep Provigil in the office for this emergency?
EXCESSIVE DAYTIME SLEEPINESS

• **Provigil 200mg**- is used in the treatment of shift work sleep disorder, obstructive sleep apnea/hypopnea syndrome; narcolepsy and belongs to the drug class CNS stimulants.

• **Provigil 200mg**- has a low potential for abuse relative to other schedule 3 drugs.
ASSUMPTION OF RISK (CONCLUSION)

• Have your patient sign the Assumption of Risk Document.
• Warn your patients against driving sleepy.
  • Document the warning in the record. DW
• Screen for Excessive Sleepiness at each appointment.
  • Document results of screening
• If screening shows excessive sleepiness:
  • Coffee, Energy Drinks, No Doze tabs, Have someone drive the patient, Provigil, etc....
  • DOCUMENT
THANK YOU

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