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A Tort Reformed

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Professional liability in sleep medicine can be avoided by staying informed and practicing safely.

Even as tort reform battled its way through statehouses this season, sleep professionals—especially those new to the field—must remain vigilant against errors, slip-ups, sloppiness, and omissions. Remember that a tort reformed is still a tort, injuring both the soul and the purse, even if the monetary damages prove only slightly less, well, damaging

For physicians, the primary danger zones include misdiagnosis of sleep disorders and failure to warn against drowsy driving. Sleep laboratory owners and operators must provide for safe laboratory premises and a competent staff. CPAP suppliers and other durable medical equipment (DME) providers not only have duties to provide for competent staff, they also must consider the fact of patient noncompliance.

Ethical and Legal Duties

Physicians generally owe their patients a duty to exercise good medical judgment. Depending on the exact legal rules in your location, a patient in a medical malpractice case must prove that the physician violated the applicable standard of care for treatment in the community. If the patient can show a connection between the failure and the injury suffered, the patient will likely prevail.[1]

A broad search reveals few reported cases discussing a sleep physician's negligence. Actual cases, if any, were likely settled confidentially out of court and covered by professional liability insurance.

What is unknown is a physician's responsibility to recognize the emerging link between sleep disorders and hypertension, cardiovascular disease, pulmonary dysfunction, and other diseases. Now that the American Board of Medical Specialties formally recognizes sleep medicine as a certified medical subspecialty, routine sleep test referrals may become the community standard of practice for fatigued patients of cardiologists, pulmonologists, and others.[2] Failure to prescribe a polysomnogram or other sleep apnea test may eventually become a factor in standard of care cases to come.

What about a sleep physician's duty to persons other than the patient? Consider the case of the Kansas neurologist who treated a patient with a long-term excessive daytime sleep disorder.[3] The patient's history and tests proved negative for narcolepsy, cataplexy, epilepsy, and sleep apnea. Still, the patient complained of falling asleep at work, but not while driving.[3]

The doctor prescribed medications over several visits. These proved helpful and, in the testimony of experts, appropriate; however, when the patient fell asleep while driving to work and plowed into a pair of bicyclists, the injured bicyclists sued the physician for failure to warn his patient not to drive.

The Kansas Supreme Court disagreed with the bicyclists and ruled in favor of the physician.3 The court noted that the doctor's medical treatment did not increase the risk of harm to the bicyclists or other members of the public. The patient already knew to pull over if she felt drowsy while driving. Accordingly, the court declined to impose a rule subjecting physicians to liability claims from strangers

for the acts of patients over which the physicians have no control.[3]

This rule might not apply in the handful of states that have enacted mandatory impaired driving reporting requirements. For example, Vermont, Oregon, New Jersey, California, Delaware, Pennsylvania, and Nevada require physicians to report specific disorders of their patients to appropriate state agencies, typically the state's Department of Motor Vehicles.[4] Other states permit physicians to report their patients' impaired driving conditions, but do not require reporting. Still other state laws permit the report to be made anonymously, while some laws offer physicians complete immunity from liability if they have reported the patient's condition to the applicable agency prior to a patient's injury.[5]

According to the American Medical Association's (AMA) Physician's Guide to Assessing and Counseling Older Drivers, patients with a diagnosis of narcolepsy should cease driving altogether.[5] The guide suggests that patients with sleep apnea may drive if they do not suffer excessive daytime drowsiness as a consequence of therapy or otherwise.[5] Physicians in reporting states should check with the Department of Motor Vehicles to determine if a sleep disorder is a specified condition for which reporting is required.

Even if reporting is not required, physicians face legal and ethical dilemmas if they judge the patient unfit to drive but the patient refuses to comply. In 2000, the AMA adopted Ethical Opinion E-2.24 to address physicians' ethical obligations in this regard.[6] According to the opinion, if clear evidence of substantial driving impairment implies a "strong threat" to patient and public safety, and if the patient ignores the advice to discontinue driving, then the AMA believes it is desirable and ethical for the physician to notify the applicable Department of Motor Vehicles; however, the opinion clarifies that the physician must follow state law if reporting is required. The opinion also advises that physicians should disclose and explain their responsibility to report to their patients.

Reporting a patient's impaired driving condition impacts an array of legal issues, including patient confidentiality. If a state law requires or permits disclosure, patient authorization may be required prior to the disclosure. HIPAA's Privacy Rule will not stand in the way if state law requires or permits disclosure without authorization. HIPAA permits health care providers to disclose protected health information without individual authorization as "required by law"[7] or to avert a serious threat to health or safety[8]; however, HIPAA's provisions yield to more stringent state laws. So prior patient authorization may still be required under state law even though HIPAA would permit an unauthorized disclosure. You should seek the advice of competent counsel if faced with this situation.

Sleep Laboratory Owners

Sleep laboratory owners owe their patients a duty to provide competent staff and safe premises in the administration of the overnight sleep test. Competence infers proper training and expertise in sleep data acquisition. An operator can presume to meet these standards if the laboratory complies with the accreditation standards of the American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations.

The overnight function of a sleep laboratory presents a premises risk not usually encountered by daytime medical offices. The laboratory must ensure against the slip and fall of a sleepy, pajama-clad patient walking to the bathroom or showering in the morning following the test. General commercial liability coverage can and should be obtained to cover these risks.

Finally, I sometimes get asked how to protect against an employee abusing a patient in the middle of the night. Along with routine employee background checks, I usually recommend continuous audio, video,

and physiological monitoring of the patient throughout the night, which, conveniently, is the very system utilized by most laboratories as part of their security regimen.

CPAP Risks

The liability risks to CPAP providers are similar to those of other health care providers—except for the added wrinkle of patient noncompliance. The best protection is properly trained respiratory therapists or other qualified technicians who know how to operate the equipment and train potentially recalcitrant patients. A threshold step is to ensure that the CPAP supplier's staff is properly licensed to provide CPAP under the applicable state laws.

Even the most efficient supplier risks liability if the patient refuses to use the device as instructed. Consider the case of the obese sleep apnea patient who had surgery at the Mayo Clinic.[9] Afterward, the patient refused CPAP during his postoperative stay; he died overnight. His widow sued the hospital for failure to provide her husband with CPAP and a postoperative supply of oxygen.[9]

The court ruled that testimony on the patient's sleep apnea was important enough to bring before the jury even if the offer of this evidence arose after the cutoff for additional testimony.[9] The inference to be drawn in a hospital postoperative setting is that the decision for CPAP therapy should not be left to the patient alone

Noncompliance in other settings is not as likely to lead to liability. This is because physicians have a solid defense if the patient fails to follow a medical instruction or otherwise refuses or neglects his own treatment.[10]

Health care providers must always stay on their toes to perform safely and provide community-accepted care. Practitioners of sleep medicine must recognize the nuts and bolts of their service and practice and seek counsel from their insurance and legal advisors as protective measures.

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