POTENTIAL LEGAL RISKS ASSOCIATED WITH THE PRACTICE OF OROFACIAL MYOLOGY

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Members of the IAOM are well-meaning professionals who are interested in the health and overall welfare of patients served. Orofacial myologists participate with health professionals from a variety of medical and dental specialties in the care of mutual patients. By doing so, orofacial myologists become privy to many medical and dental aspects related to their patients that may transcend the training or expertise that they can defend.

There are potential legal risks associated with the practice of orofacial myology that the membership should be aware of. Some risks can be self-generated by the inclusion of various questionable claims on member websites. A discussion of selected examples of practices used by some orofacial myologists may help to protect the membership from over-reaching by providing advice or treatment in areas outside of the field and scope of orofacial myology.

HYPOTHETICAL SITUATION: If a patient with an OMD had an unknown heart condition during the time that orofacial myology is provided for the OMD, and later suffered injury as a result of that unknown condition, the patient would not be able to recover damages against the orofacial myologist since there was no duty on the part of the OMT to assess or treat that condition. The focus of both the patient and the OMT was on treatment of the patient's OMD.

If however, the orofacial myologist noted something that caused him/her to believe that the patient possessed a heart ailment and proceeded to give advice and direction related to that ailment, the case may be different. The difference is that the orofacial myologist will have taken on a different role from a legal standpoint, thereby assuming a greater duty than was otherwise the case.

The hypothetical example portrayed above can relate to the practice of orofacial myology in a number of ways. The use of *lip taping* raises questions about the implications of this therapy to breathing and cardiac functions. If lip taping treatment is undertaken and if the orofacial myologist does not recognize these possible links and a cardiac or breathing problem ensues, *negligence* can be claimed since there was no attempt to relate the treatment provided to possible consequences of a heart or breathing problem. By contrast in the first hypothetical, no OMD procedure was being utilized that would affect the heart, so no liability was involved. The point is, since some therapies can impact other areas, such as the heart, lungs, or stomach, therapists have an obligation to investigate whether such therapies can result in a problem associated with a particular therapy. If a clinician actually claims some expertise in peripheral areas and then makes recommendations related to medical problems, such recommendations also lead to a liability.

Some examples: 1) the recommendation of a *specific pillow type* or *sleep position* by an OMT directly links therapy to any medical consequences that may occur with sleep apnea; 2) If sinus infections or aspiration of fluid into the lungs occurs during the time that *nasal irrigation* therapy is provided, a liability may be assumed; 3) If elastics are used as reminders to help with tactile feedback for spot placement for night use and are aspirated, a legal issue may follow; and 4) Counseling a patient about a gastro-esophageal reflux disorder (GERD) that a patient may have, or claiming a link between orofacial myology procedures and the possible resolution of GERD can directly implicate an OMT if a problematic medical consequence develops from the GERD.

There are many instances where orofacial myologists may be tempted to advertise success in working with specific medical and dental conditions. While such advertising does call attention to patient groups that OMTs may wish to serve, the problem with such lists is that they may also imply that OMT can correct the conditions involved. Such linking of swallowing disorders or tongue thrusting with specific conditions may include: 1) crooked teeth or orthodontic relapse; 2) headaches; 3) TMJD (jaw joint) pain; 4) forward head posture; 5) digestive disorders such as acid reflux or stomach aches from air swallowing; 6) sleep and breathing disorders; 7) oral lesions from tongue irritation; 8) gum disease; 9) psychological problems; 10) failure to thrive and other child development problems; and 11) middle ear drainage issues. In each of these claimed links, there are a myriad of contributing factors that may have no specific causal relationship to an OMD. To imply such causation should be avoided and to claim that OMT can alleviate or eliminate such conditions is also ill-advised. If however, a referral is made for you to provide a specific therapy for an OMD with such patients, it may be appropriate for you to provide the therapy.