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Ophthalmic Risk Management Digest

OMIC DIGEST

When Patients Become Difficult, Hostile, or Violent

By Paul Weber, JD
OMIC Vice President of Risk Management/Legal

Ophthalmologists have the ability to provide care that improves their patients' quality of life. This leads to many rewarding physician-patient relationships. Occasionally, however, ophthalmologists call OMIC's Risk Management Hotline to ask how to best deal with very angry and sometimes violent patients. These situations range from patients who are merely complaining about their treatment and perhaps demanding a refund to physical assaults on the ophthalmologist or staff.

Data from the Bureau of Labor Statistics shows that in 2000, 48% of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. OSHA, which publishes guidelines to prevent workplace violence, believes that the actual numbers are much higher. According to OSHA, "Incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the health care industry that assaults are part of the job."[1]

The vast majority of assaults on health care workers occur in hospitals, nursing and personal care facilities, or while providing residential care services. Ophthalmology offices are not immune to such violence, however. In April 2001, an ophthalmologist and a refractive surgery coordinator were shot by a patient at the Anheuser-Busch Eye Institute at St. Louis University. The man, who had recently undergone cataract surgery, was caught an hour later with four guns and 400 rounds of ammunition. Noteworthy is the reported comment of the department chair, Oscar Cruz, MD, "We have had the perception that things like this cannot happen to us, but this shows that is erroneous."

Recently, OMIC received a report from a practice where the patient, a pilot, underwent successful LASIK surgery. He later returned to the practice and asked the ophthalmologist to write a letter on his behalf to the FAA. The ophthalmologist explained that the FAA would only accept a particular form and assured the patient he would complete it for him. The patient became angry, locked the office door, and proceeded to hit the ophthalmologist, who only avoided injury by curling up in a fetal position. A female technician who was also in the room screamed. Others in the office at first thought it was a nursing home patient

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MESSAGE FROM THE CHAIRMAN

Over the past five years, OMIC has witnessed a steep drop in the number of claims and lawsuits reported by its members, from a high of 284 in 2003 to 203 in 2008. At the same time, the number of OMIC insureds increased from 3,200 in 2003 to 3,939 by year-end 2008. While we are delighted to see this downward trend, there has been a dramatic increase in the number of reported "incidents" (potential claims) to OMIC's claims and risk management departments. Nearly 6% of OMIC insureds reported an incident in 2008, up from a low of 2.7% in 2004. Many of these incident reports relate to behavior problems, i.e., difficult, noncompliant, and hostile patients. What accounts for this increase?

Recent membership data from the American Academy of Ophthalmology indicates that the average ophthalmologist sees 114 patients per week. Collectively, OMIC insured ophthalmologists, now numbering nearly 4,100, see over 450,000 patients per week. Thus, it is not surprising that some of these patients and their family members will confront us with challenging behavioral problems such as those cited in the lead article.

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with dementia who was having a problem, but soon staff and patients gathered in the hall outside the door where the patient was assaulting the ophthalmologist. Four technicians managed to open the door and pull the patient off the ophthalmologist. Instead of leaving with his letter, the patient left in handcuffs.

Another OMIC report came from an insured who was being stalked by a patient. The patient, who had a history of itchy eyes, had not been seen in the practice for over a year but called in for a prescription refill for NSAID drops. He was told, per the insured's policy, that he needed to be examined before a medication prescription could be renewed. He became verbally abusive to the office staff during several calls and threatened to go to the ophthalmologist's home, indicating that he knew the address. One of the technicians who had dealt with the patient wanted to call the police, but the practice manager felt it wasn't necessary since the patient had no history of inappropriate behavior. Staff did contact the ophthalmologist, who was out of town at the time, to warn him of the patient's threats. The patient did in fact show up at the ophthalmologist's house, and the house sitter immediately called the police, who came and told the patient to leave. The ophthalmologist took out a restraining order and terminated his care of the patient. As might be expected, this practice now has a lower threshold for calling police when patients are verbally threatening.

Be Prepared for Violence

Although actual physical violence is rare, every practice has angry and dissatisfied patients who might become violent. Practices would be well advised to assess this risk. The first step is to define workplace violence. The Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."[2] This includes psychological trauma, such as threats, stalkings, obscene phone calls, intimidating presence, and harassment of any nature, including following, swearing, or shouting at another person. It is widely agreed that violence at work is underreported, particularly since most violent or threatening behavior may not be reported until it reaches the point of actual physical assault or other disruptive workplace behavior. Staff should understand that even non-physical acts, such as the psychological traumas listed above, are "violent acts" that need to be reported and handled.[3]

Once workplace violence is defined, a practice should develop policies and procedures identifying staff responsibilities in the event of violence (see sidebar). The OMIC web site has a detailed sample policy for handling disruptive or dangerous patients, http://www.omic.com/resources/risk_man/recommend.cfm.

Non-violent Aggression—When to Terminate the Physician-Patient Relationship

More typically, ophthalmologists and their staff are confronted with non-violent expressions of anger and aggression in the form of malicious oral and written criticisms of care, ultimatums for fee refunds, and threats of litigation. Some disgruntled patients are now taking to the internet and blogosphere to launch smear campaigns against physicians.

Generally, these situations don't occur suddenly without warning, but rather rise to a boiling point over a period of time. Staff may not always notify the ophthalmologist when there is a problem, and, even when they do, the ophthalmologist may be reluctant to confront the patient and set limits. Recognition of worrisome behaviors and prompt discussion between the ophthalmologist and staff about how to proceed are undoubtedly the best first steps in managing the problem. Policyholders are encouraged to call OMIC's Hotline for assistance as soon as a problem is recognized. As each situation is unique, there is no "one size fits all" approach.

Often, by the time the insured and staff call OMIC, they have already tried more than one approach to reason with and accommodate the patient and have concluded that the patient's behavior has become so inappropriate that the ophthalmologist can no longer effectively provide the needed eye care. Even when the decision has been made to terminate the physician-patient relationship, there are several issues that commonly arise and can be addressed by OMIC risk management staff.

What is the reason for the patient's anger? Oftentimes, a patient's anger is understandable, e.g., a complicated surgery results in a poor outcome. However, it is the patient's behavior (outbursts in the reception area, ultimatums to staff, threats of a lawsuit) that compels the physician to terminate the relationship. While the anger can be understood and acknowledged, the behavior should not be tolerated. Even though situations involving an "unanticipated outcome" often raise fears that the patient may file a lawsuit, in the vast majority of cases, OMIC risk management and claims staff are able to assist insureds in averting such a claim or minimizing the adverse impact if one is eventually filed.

Are family members involved? When a spouse or other family member who accompanies the patient is acting inappropriately (threatening litigation, calling or writing the ophthalmologist, or otherwise making it difficult for the ophthalmologist to provide care), it may seem unfair to terminate the relationship with

the patient. However, the patient is usually implicitly or explicitly allowing the other person to interfere and there may be no alternative but termination.

Is the patient a minor? Situations in which a parent or guardian is behaving in a manner that prevents the ophthalmologist from providing care can be the most difficult to deal with because the ophthalmologist is relying on the parent for compliance with treatment, appointments, and other aspects of the child's care. For some ophthalmologists, terminating the care of a minor patient becomes a moral dilemma. Will the child be harmed if the parent decides not to seek care from another physician? Is this a case of neglect on the part of the parent? Is it appropriate to contact child protective services?

What is the patient's current clinical status? It may not be possible to terminate a patient who is in an acute stage of an illness; however, if another provider is willing to take over care, even an acutely ill patient may be transferred out of the practice. Most patients can be safely discharged from care with 30 days notice.

Does the patient have limited English proficiency? Patients should understand why they are being terminated from a practice. If there is a language barrier and a family member or other person is translating for the patient, this should be documented in the chart.

Is the patient seeking a refund/fee waiver? Refund/fee waiver issues frequently arise with very angry patients. While a patient's demand for a refund/waiver may be presented in a reasonable manner initially, if the practice refuses this "reasonable" request, the patient's posture may quickly become more aggressive.

Should local defense counsel be assigned? OMIC may engage an attorney on behalf of an insured or advise the insured to seek personal counsel if, for instance, the patient's behavior is in violation of the law, such as posting libelous statements about the insured on the internet. In such cases, a letter from an attorney warning the patient to "cease and desist" generally results in the patient discontinuing the behavior.

Is the patient mentally impaired? One very sad case involved a patient who believed his eyes were infected with crab lice. Neither the OMIC insured nor the prior treating ophthalmologists could convince the patient that he did not have crab lice. In an effort to self-treat, the patient poured highly concentrated enzymatic cleanser in his eyes and suffered very severe burns of the cornea and conjunctiva, causing pain which he believed was due to the crab lice. The insured attempted to treat the burns over the course of ten visits, during which he urged the patient to be seen at the university hospital for a second opinion and possible hospitalization. The patient filed a complaint with the state medical board alleging negligent treatment by the insured. Although the patient was clearly delusional, the medical board complaint still needed to be addressed in a timely and matter-of-fact manner.

Fortunately, most patients do not become angry at their physician and most behave in a manner that is conducive to the provision of care. However, in those cases where a patient's behavior is unmanageable, ophthalmologists and their staff will benefit from having a plan in place to deal with unacceptable behavior. This includes calling OMIC for support and assistance in managing the situation to minimize the risk of harm to the patient and a professional liability claim against the insured.

The OMIC web site has a full discussion on terminating the physician-patient relationship along with sample letters in the **Risk Management Recommendations** section at www.omic.com.

ASSIGNMENT OF RESPONSIBILITIES IN EVENT OF WORKPLACE VIOLENCE

Your office policy for handling disruptive or dangerous patients should outline specific procedures for notifying employees, outside authorities, and others in an emergency situation, including:

- How to assess the severity of the situation and its impact on the office.
- When to call police or other appropriate authorities.
- The chain of command. Each employee and supervisor should know their specific responsibilities in an emergency and at what point those responsibilities shift to others.
- Who determines what information is communicated to other employees.
- How to handle public relations issues for the office, if applicable.
- How to determine whether counseling will be provided to affected employees and other individuals.

(FROM ECRI SPECIAL REPORT: PHYSICIAN OFFICE SAFETY GUIDE, 1998)

1. US Department of Labor Occupational Safety and Health Administration. "Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers." OSHA 3148-01R 2004, p. 6.

2. Ibid, p. 4.

3. National Institute for Occupational Safety and Health. "Workplace Violence Prevention Strategies and Research Needs." NIOSH 2006-144. http://www.cdc.gov/niosh/docs/2006-144/#a1.