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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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Eye on OMIC

OMIC

The Ophthalmic Risk Management Digest is published quarterly by the Ophthalmic Mutual Insurance Company, a Risk Retention Group sponsored by the American Academy of Ophthalmology, for OMIC insureds and others affiliated with OMIC.

OMIC, not the Academy, is solely responsible for all insurance and business decisions, including coverage, underwriting, claims, and defense decisions.

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA 94188-0610

Phone: (800) 562-6642
Fax: (415) 771-7087
Email: omic@omic.com
Web: www.omic.com

OMIC Declares 2010 Dividend

For the fourth time in five years, OMIC announces a policyholder dividend. OMIC member-insureds who renew in 2010 will receive a 5% dividend in the form of a premium credit. Issuance of the entire dividend requires that policyholders remain insured by OMIC throughout the 2010 policy period. Dividend credits will be pro-rated for mid-term cancellations. OMIC has issued dividends 14 of the past 20 years. The nearly $17 million in dividends issued by OMIC to date represents an average total of approximately $6,000 in dividend credits per policyholder.

Change of Servicer for Ancillary Products

For more than a decade, OMIC has written four ancillary business products underwritten by Lloyds of London, including Employment Practices Liability, Directors and Officers, Errors and Omissions/Managed Care Liability, and Broad Regulatory Protection Coverage. Two other products, Business Owners and Workers Compensation, are currently offered through The Hartford.

The current broker for these products, Medical Risk Management Insurance Services (MRMI), will cease operations on December 31. Effective January 1, 2010, these products will be sold and administered directly by NAS Insurance Agency (NAS). Underwriting and claims services will continue to be provided by the carrier of each specific product. Official notice of this change to the broker of record will be sent to current policyholders of these ancillary products. OMIC will continue to write directly the free basic BRPP policy provided to all OMIC professional liability insureds.

For more information on this change, please contact Robert Widi at (800) 562-6642, ext. 654.

OMIC Insurance Center

OMIC will present or participate in several risk management courses at the annual meeting of the American Academy of Ophthalmology in San Francisco in October (see **Calendar of Events**). Visit the OMIC Insurance Center, located in booth 3956 of the exhibit hall at Moscone Center, to consult with OMIC representatives regarding policy and coverage questions, rate and dividend information, and ancillary business coverage.

Message from the Chairman

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As this summer's angry "town hall" meetings and ongoing health care reform debate in Congress demonstrate, people are angry and fearful about the system and the health care being provided. Patients are confronted with a dizzying array of unfamiliar procedures, treatment options, and medication regimens. Issues around insurance and paying for care can further confuse and stress patients.

Physicians have a duty to their staff and other patients to provide a civil and safe practice environment, but disruptive patients expose us, our staff, and other patients to potentially abusive, violent behavior. They can affect our bottom line as well. Non-payment for services, time taken away from providing care to other patients, responding to litigation or regulatory complaints, and even, in some cases, the need for damage-control public relations all take their toll.

This year, OMIC began offering a risk management course, *Difficult Physician-Patient Relationships*. Some of the situations addressed include dealing with hostile and noncompliant patients, communicating with patients who are deaf or limited English speaking, and what to do when patients have vision problems that impair their ability to drive (see this issue's **Hotline** article). In addition, OMIC's web site offers a wealth of protocols on the subject of difficult patients, and risk management staff are available to answer questions and provide guidance to insureds and their staff, who are asked to apply their best clinical judgment even when faced with angry ultimatums from patients.

OMIC risk management staff have learned that one way to prevent frustration and keep patients informed is to provide procedure-specific patient education documents and videos produced by the Academy together with informed consent documents provided by OMIC. Although education is not a fool-proof method of eliminating patient dissatisfaction, it can go a long way toward making the health care you provide more understandable.

Richard L. Abbott, MD
OMIC Chairman of the Board

Reporting Malpractice Claims to the Government

By Kimberly Wittchow
OMIC Legal Counsel

As many of our readers may be aware, the federal government recently passed legislation requiring that liability insurers, such as OMIC, report to the Centers for Medicare & Medicaid Services (CMS) the resolution of claims (by settlement, judgment, award, or other payment) by Medicare beneficiaries for bodily injury and medical payments. OMIC is registered with CMS and is gearing up for submission testing and eventual reporting.

The purpose of this "Section 111" reporting (referring to Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007)[1] is to ensure that Medicare makes payments in the proper order or recovers payments when another entity (such as an insurer) is required to pay for covered services before Medicare does. Section 111 requires that OMIC determine whether a claimant or a potential claimant for damages due to bodily injury or medical payments is entitled to receive Medicare benefits. If so, OMIC must report the identity of the Medicare beneficiary whose illness, injury, incident, or accident is the subject of the claim, and provide other information that will enable CMS to appropriately coordinate benefits. The law sets forth procedures that Medicare can use to bring legal action against various parties, including a liability insurer, for failure to make proper reimbursement, and subjects responsible reporting entities (RREs) to fines for noncompliance.

This Section 111 reporting is separate from and in addition to the reports OMIC already sends to the National Practitioner's Data Bank (NPDB), under another federally mandated reporting scheme. OMIC is required to submit NPDB reports when OMIC makes a payment for the benefit of an ophthalmologist or other health care provider in the settlement or satisfaction of a claim or judgment. (Insureds may have their own reporting responsibilities to the NPDB, as well. See the OMIC **Risk Management Recommendations** letter titled "Responding to Unanticipated Outcomes" found on OMIC's web site at http://www.omic.com/resource/risk_man/recommend.cfm#responding.)

In order to trigger OMIC's reporting responsibility, there must be an exchange of money resulting from a written complaint or claim demanding monetary payment based on the provision or failure to provide health care services. Per the NPDB requirements, OMIC sends a copy of the NPDB report to the appropriate state licensing board. The Health and Human Services Office of Inspector General (OIG) has the authority to impose civil money penalties if these reporting requirements are not met. Whenever the Data Bank receives an NPDB report, it sends a Subject Notification Document to the subject of the report (the OMIC insured ophthalmologist or other health care provider, not the patient).

In addition to this federally mandated Section 111 and NPDB reporting, many states also are seeking reporting of the same or additional claims information through their departments of insurance, departments of health, boards of medicine, or other state agency or department.

OMIC was formed as a risk retention group under the federal Liability Risk Retention Act of 1986 (LRRA) to insure the liability risks of American Academy of Ophthalmology members.[2] As a risk retention group, OMIC is governed by only one state, its state of domicile, which is Vermont. This eliminates the need for redundant regulation.[3]

When these state-specific claims data calls were infrequent and the data sought was minimally burdensome to acquire, OMIC voluntarily complied with the requests. Over the past several years, however, the requests have multiplied and the data sought has increased dramatically. For this reason, OMIC has begun to respectfully decline these requests from the various states. To provide the federally required CMS and NPDB reports, plus detailed closed claims reports in every state, each requiring reporting in a different manner and on different time frames, would be extremely burdensome. This runs contrary to the intent of the LRRA, which is to increase the availability of commercial liability insurance by allowing RRGs to offer insurance nationwide while avoiding regulatory redundancy.

It is OMIC's position that voluntarily completing such reports would pose a substantial administrative burden, the cost for which would ultimately be borne by our insureds. We are also concerned that our members' confidential claims data could be subject to potential disclosure under state freedom of information acts, which could be detrimental to our insureds' interests.

In some states, this may mean that OMIC's insureds must report claims data that is not on the NPDB report to the licensing agency, department of insurance, or other state governmental entity, as provided by state law. We apologize for any inconvenience this may cause to our insureds, but believe it is in our policyholders' best interest to resist this encroachment by state agencies outside of Vermont. OMIC, via your appointed defense counsel or claims representative, will be happy to assist you with obtaining the necessary information for the report (for example, the plaintiff's address or date of birth).

1. 42 USC § 1395y(b).

2. 15 USC § 3901 et. seq.

3. National Association of Insurance Commissioners. *Risk Retention and Purchasing Group Handbook.* Rev. June 1999, p. II-2.

When Patients Become Difficult, Hostile, or Violent

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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.

Closed Claim Study

Personal Relationship with a Physician-Patient Clouds Judgment on Documentation

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to educate patient on the symptoms and urgency of treatment for a retinal detachment.

DISPOSITION

The case was settled for $300,000 at mediation.

Case Summary

An OMIC insured examined a physician colleague he had known professionally for several years. The examination took place in the insured's office. Indirect ophthalmoscopy revealed a "definite small vitreous hemorrhage," but no holes or tears were noticed OS. A follow-up examination was scheduled for three weeks. Exactly two weeks after the initial exam, the patient was out of town when he experienced a progressive decrease in vision and total vision loss OS. He did not report the vision loss until six days later when he returned to the insured's office one day prior to his scheduled appointment. The patient was seen by a partner of the OMIC insured, who diagnosed a retinal detachment involving the macula with a large circumferential tear along a vessel. Surgery was performed the same day and the retina was successfully reattached; however, the patient was left with 20/70 corrected visual acuity OS, which was deemed the maximum medical improvement. As a result of his decreased vision, the patient retired from medical practice and sought recovery under two disability insurance policies.

Analysis

The patient sued the OMIC insured over standard of care issues. At question was whether the insured discussed the symptoms of a retinal detachment and if he relayed the importance of immediate treatment if the patient experienced a loss of vision. There were no concerns about the insured's examination of the patient; however, a record keeping issue directly impacted the standard of care. The patient informed the insured, after the fact, that one day before his initial visit he had hit his head on a heavy flower pot while gardening. The patient thought this was most likely responsible for his vision loss, and, under one of his disability policies, a "sudden or accidental" injury would allow him to collect more money.

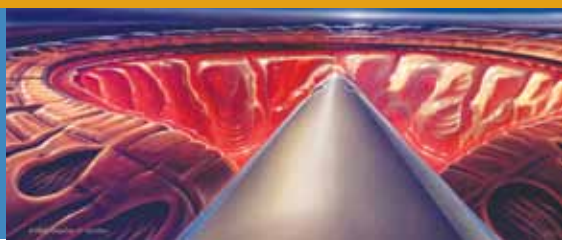
The insured stated that the patient had drafted a written narrative about striking his head as this would likely benefit him with regard to obtaining the disability monies and had requested that the narrative be placed in his medical record. Unfortunately, the insured then removed his initial documentation and created a second chart note of the visit. This note included the patient's narrative and added that the patient was told to immediately contact the insured if there were any signs of a retinal detachment, such as a sudden loss of vision.

This presented a problem for the defense in that the original chart note did not make any mention of the insured explaining the symptoms of a retinal detachment to the patient, while the second note, which the patient allegedly requested, did. The insured maintained that he did not intentionally fabricate or in any manner embellish the findings of his examination, but had changed the record as an accommodation to his colleague. The plaintiff contended that he did not ask the insured to make any changes to the record and that the insured was covering his tracks and had altered the record in order to boost the defense's position. Defense counsel advised OMIC and the insured that his story about trying to help out a colleague would not be well received by a jury and that alterations or additions to a chart, especially ones perceived as self-serving, usually reflect unfavorably on the defense. The insured agreed to settle.

Risk Management Principles

This case illustrates how physicians can get into trouble when they let personal relationships cloud their professional judgment. It is vital that ophthalmologists treat and keep records on patients they know (friends, family, or office staff) just as they would any other patient. Often, documentation is sparse or nonexistent when a physician has an outside relationship with a patient. In this case, the collegial relationship between the insured and the patient led to a breakdown in record keeping such that vital information about what was said during the initial visit was not recorded in the original documentation. When the insured then attempted to change the record after the follow-up visit, he dealt a death blow to his later defense of this claim.

Risk Management Hotline



Duty to Warn Patients Not to Drive

By Anne M. Menke, RN, PhD
OMIC Risk Manager

The establishment of the physician-patient relationship imposes certain duties upon ophthalmologists. Some—privacy, confidentiality, continuity of care, and reasonable prudence—are well known and much discussed. Other duties, such as reporting and warning obligations, may give physicians pause, especially if they require a breach of confidentiality or disregard for the patient's express wishes. This **Hotline** addresses the duty to warn a patient and report to the state if driving ability is impaired.

Q Am I liable for any harm done by my patient while driving?

A Ophthalmologists have been sued by patients and third parties who were involved in motor vehicle accidents. Expert witnesses who evaluate these cases for breaches in the standard of care address two issues. First, did the patient have a condition that should have led a reasonably prudent ophthalmologist to warn the patient not to drive? Second, if the patient had such a condition, did the ophthalmologist warn the patient and document the discussion? In our experience, suits have been dropped if the medical record indicates there was no such condition or, if there was, that the ophthalmologist did warn the patient. Conversely, physicians have been held liable for harm to the patient and injured third parties if no such warning was given.

Q Based upon my examination, I don't feel it is safe for my patient to drive. Am I obligated to inform and warn the patient not to drive?

A Yes. If the patient has a condition that may prevent safe driving, warn the patient and document the discussion. Reasons to conclude a patient shouldn't drive include conditions characterized by lapses of consciousness (seizures and epilepsy), dementia, and those that result in certain amounts of uncorrectable decreased visual acuity and reduced visual fields, as well as side effects of medications (tranquilizers and pain medications) and substance abuse.[1] Some patients may be able to drive only under certain conditions, such as daylight. Others may need to abstain for only a short period; this is usually the case after dilating drops have been inserted for diagnostic and therapeutic procedures. In addition to reminding patients to wear sunglasses, warn them that dilating drops may adversely affect their ability to drive.

Q My patient says dilating drops do not impact his driving and refuses to have someone else drive him to my office. May I still administer the drops?

A Yes. Many ophthalmic conditions can only be diagnosed and monitored if the pupil is dilated. As long as you have warned the patient, you may administer the drops.

Q I have warned my patient about driving, but she refuses to heed my advice. What else can I do?

A Patients who can no longer drive may fear a loss of independence and worry about imposing upon friends and relatives. It is thus understandable when patients are reluctant to heed a physician's advice. Repeat the discussion at each visit in the hope of breaking through the patient's denial. Consider contacting the patient's primary care physician for help in convincing the patient. You may also discuss your concerns with the patient's family and friends. The HIPAA web site clarifies that you may speak to family and friends if you have been given permission, if they accompany the patient to visits or are involved in the patient's care or payment, or if your professional judgment indicates that such a discussion would be in the best interest of the patient.[2]

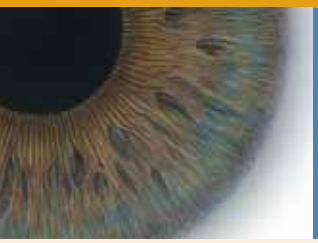
Q Am I required to report a patient's inability to drive to my state department of motor vehicles (DMV)?

A The American Medical Association advises physicians that "in situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles."[3] Some states require physicians to report, others allow but do not mandate reports, while a few consider a report a breach of confidentiality. There could be liability and penalties if a physician does not act in accordance with state laws on reporting and confidentiality. The safest course is to verify the law. Many states clarify driver's license laws on the DMV web site or provide a link to email the DMV. If you cannot get an answer from the DMV, contact your state medical board, state medical association, or state ophthalmology organization. If you are required to notify the state, do so only after discussing your evaluation and informing the patient that you will be notifying the state. If you are allowed but not mandated to report, consider that in the event of an accident, a jury may find you did not do all you could have to prevent harm to the patient and others if you do not contact the DMV.

1. For more information on determining a patient's driving capacity, see the AAO's Clinical Statement, "Vision Requirements for Driving," at www.aao.org. The American Medical Association's web site contains "Physician's Guide to Assessing and Counseling Older Drivers" and "Impaired Drivers and Their Physicians" at www.ama-assn.org.

2. See the FAQ section of the US Department of Health and Human Services web site. Discussing a patient with family and friends is addressed at http://www.hhs.gov/ocr/privacy/hipaa/faq/notice/488.html.

3. "Impaired Drivers and Their Physicians" at www.ama-assn.org.



Calendar of Events

OMIC continues its popular risk management programs throughout 2009. Upon completion of an OMIC online course, CD/MP3 recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are listed below and on the OMIC web site, www.omic.com. CME credit is available for some courses. Please go to the AAO web site, www.aao.org, to obtain a CME certificate.

Online Courses *(Reserved for OMIC insureds and members of cooperative venture societies/ No charge)*

- *Documentation of Ophthalmic Care*
- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*
- *Responding to Unanticipated Outcomes*

CD Recordings *(No charge for OMIC insureds)*

- **NEW & UPCOMING! 2009 Nationwide Audiocourse,** *Lessons Learned from Trials and Settlements of 2008.* Available on OMIC web site as downloadable file in late 2009.
- *Lessons Learned from Trials and Settlements of 2007 (2008).* Available as downloadable file.
- *Medication Safety and Liability (2007)*
- *After-Hours and Emergency Room Calls (2006)*
- *Lessons Learned from Trials and Settlements of 2006 (2007)*
- *Lessons Learned from Trials and Settlements of 2005 (2006)*
- *Lessons Learned from Trials and Settlements of 2004 (2005)*

To download CD order forms, go to www.omic.com/resources/risk_man/seminars.cfm.

Upcoming Seminars

TBA Fall 2009

Lessons Learned from Trials and Settlements of 2008
Annual Nationwide Audiocourse
Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com
Free to OMIC insureds; $60 for non-insureds.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management programs or to register for online courses.

October

2 *Difficult Physician-Patient Relationships*
Indiana Academy of Ophthalmology
University Place Convention Center, Indianapolis, IN
Time: 8:00–9:00 am
Register with IAO at (317) 577-3062 or kwilliams@indianaeyemds.com

24 *Documentation of Ophthalmic Care*
ASORN Annual Meeting at AAO/PAAO Joint Meeting
Colonial Room, Westin St. Francis, San Francisco, CA
Time: 1:20–2:20 pm
Register with ASORN at http://webeye.ophth.uiowa.edu/ASORN/AM2009/Fillinregform2009.pd

25 *OMIC Forum: Shared Care*
AAO/PAAO Joint Meeting
Esplanade Ballroom, Moscone Center, San Francisco, CA
Time: 1:00–3:00 pm
General registration http://www.aao.org/meetings/annual_meeting/sanfrancisco.cfm. No preregistration. Attendance form on-site.

25 *Risk Management Liability Review for OMP*
JCAHPO Annual Continuing Education Program for OMP at AAO/PAAO Joint Meeting
Imperial Ballroom B, Hilton, San Francisco, CA
Time: 3:00–3:55 pm
Register with JCAHPO at www.jcahpo.org/meetings/

26 *Ultimate Chart Audit*
AAOE at AAO/PAAO
Yerba Buena Room 7, Marriott, San Francisco, CA
Time: 9:00–11:15 am
Register with AAOE at www.aao.org/aaoesite/annualmeeting/

26 *Why Take the Risk? How to Create an Effective Risk Management Strategy with Patient Education and Informed Consent Documents*
AAO/PAAO Joint Meeting
Moscone Center West, Room 2009, San Francisco, CA
Time: 12:45–1:45 pm
General registration http://www.aao.org/meetings/annual_meeting/sanfrancisco.cfm. No preregistration. Attendance form on-site.

27 *Documentation of Ophthalmic Care*
JCAHPO Annual Continuing Education Program for OMP at AAO/PAAO Joint Meeting
Continental Parlor 2 & 3, Hilton, San Francisco, CA
Time: 9:10–10:05 am
Register with JCAHPO at www.jcahpo.org/meetings/

27 *ROP Screening & Treatment: What You Wanted to Know, But Were Afraid to Ask*
AAO/PAAO Joint Meeting
Moscone Center West, Room 3009, San Francisco, CA
Time: 10:15–11:15 am
Register with AAO at http://www.aao.org/meetings/annual_meeting/sanfrancisco.cfm

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610