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Ophthalmic Risk Management Digest
OMIC DIGEST

The Risks and Benefits of Malpractice Litigation

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

The risks associated with a medical malpractice lawsuit are well known to most ophthalmologists. Not only is there the financial risk of a large monetary award to the plaintiff, but also the threat to the ophthalmologist's professional reputation. Additionally, a malpractice lawsuit can be a very demoralizing event. As observed by OMIC insured Gerhard W. Cibis, MD, "No amount of risk management articles or seminars can prepare a physician for the emotional devastation of being sued."[1] Regardless of whether they win or lose the lawsuit, physicians who are sued are at risk for severe emotional distress. The serious psychological effects of malpractice litigation have been addressed by psychiatrist Sara C. Charles, MD,[2] and best selling author Atul Gawande, MD.[3]

Given what is often a personally and professionally devastating event, it may be hard to believe that anything positive could emerge from malpractice litigation; however, the experiences of ophthalmologists who are sued can teach us valuable risk management lessons and may even help bolster the morale of others who are themselves in the middle of a claim or lawsuit.

In 1995, the OMIC Board of Directors requested that a closed claim questionnaire be sent to any insured involved in a claim at its conclusion. The Board's interest in surveying insureds was twofold. Directors wanted feedback from insureds regarding the performance of staff and defense counsel assigned to their case. This was important to ensure that OMIC was providing an efficient and supportive claims service. They also wanted to follow up with insureds regarding risk management issues that were brought to their attention during the course of the claim as well as loss prevention steps taken by these insureds to reduce the likelihood of future claims. They believed this information could benefit all insureds and help reduce overall frequency and severity of ophthalmic claims.

Over the past 15 years, OMIC's Claims Department has compiled responses from 1,241 questionnaires completed by insureds who have thoughtfully focused on ways to avoid future claims and frequently pointed out how they prevailed in their litigation because of good risk management practices they

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MESSAGE FROM THE CHAIRMAN

It is both an honor and a pleasure to follow Richard L. Abbott, MD, as your Chairman. During his 19 years on the OMIC Board of Directors, the last three as chair, Dr. Abbott guided the organization to unprecedented growth and financial strength. He did so with patience, gentle persuasion, and an unwavering passion for quality patient care and safety. Working with a board he helped shape, and with the support of a stable and professional staff headed by CEO Timothy J. Padovese, Dr. Abbott moved the organization forward in many important areas. As a member and chair of the Underwriting Committee, he drafted revisions to OMIC's underwriting guidelines and introduced policy enhancements to improve coverage of refractive procedures, oculofacial plastic surgery, retinopathy of prematurity, and ambulatory surgical facilities. He authored and presented numerous studies demonstrating the correlation between risk management education and improved quality of care. He was instrumental in driving OMIC to become the recognized leader in ophthalmic risk management. Ophthalmologists and patients worldwide have benefited from

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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.

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OMIC Increases Limits for BRPP

Since 1999 when OMIC first introduced the Broad Regulatory Protection Policy (BRPP), more than 250 incidents, claims, and lawsuits have been reported. While most incidents are related to random billing audits by Medicare, allegations have included fraud and abuse, billing errors, HIPAA privacy violations, and unauthorized release of private information. In some instances, these events have required that our policyholders dedicate significant staff resources to respond to random or targeted inquiries by government agencies and private payers. Investigations also present unforeseen financial burdens, stress, and distraction. Several claims for reimbursement of legal expenses have exceeded tens of thousands of dollars.

OMIC was on the leading edge of this emerging trend more than a decade ago, understanding that the increasing complexities of medical coding, billing, and file storage presented new tangential exposures linked closely to the direct patient treatment provided by our insureds. We were one of the first insurance carriers to add this coverage to the standard malpractice policy as a free supplementary benefit for our policyholders.

Described in Section VII Additional Benefits of your policy, BRPP provides reimbursement for legal expenses, fines, and penalties (where allowed by law) to defend against allegations of fraud, abuse, and billing errors by Medicare and Medicaid, including RAC audits, as well as commercial payers. It also responds to alleged violations of HIPAA Privacy laws and EMTALA, DEA, Stark Act, Red Flag, HITECH, and Gramm-Leach-Bliley regulations. Effective January 1, 2011, OMIC increased the benefit limit for BRPP exposures to $50,000 per policy period (see **Policy Issues**).

For more information or to purchase additional excess coverage above the $50,000 limit automatically provided by your OMIC professional liability policy, please contact your OMIC underwriter or Dana Pollard at NAS/Lloyds Insurance Agency at (877) 808-6277 or dpollard@nasinsurance.com.

Message from the Chairman

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Dr. Abbott's support of physician education, evidence-based insurance coverage decisions, and patient safety. Of course, the strength of OMIC does not flow from one person. I attribute OMIC's success to these four factors.

Commitment of staff and senior management. The staff works diligently to implement the board's initiatives and support the nearly 4,300 ophthalmologists and ophthalmic practices insured by OMIC. Low staff turnover is a testament to a company's success. Turnover is less than 2% at OMIC, and many of the senior staff have been with the company 15 years or longer.

Involvement of clinicians at the board level. The company's founders had the foresight to set up a governance structure that requires a long-term commitment from the ophthalmologists who serve on OMIC committees and a rotation policy that allows time for committee members to gain insight and experience before assuming leadership positions on the board. The close working relationship between board members and staff is unmatched among professional liability insurance companies and has fostered a *commitment of service* to insured physicians and an *environment of safety* for their patients.

Financial strength. The board and staff take very seriously their fiduciary responsibility to provide a viable and fiscally sound professional liability insurance program for members of the American Academy of Ophthalmology. OMIC has one of the strongest balance sheets in the industry. Its outstanding financial performance year after year ensures that the company is well positioned to meet the challenges of an evolving health care environment and withstand adverse claims trends or market conditions.

Relationship with the AAO. OMIC and the Academy have a close working relationship and frequently share resources and expertise to achieve common goals for the benefit of our profession. The co-authored "Practice Guidelines for Informed Consent" guides ophthalmologists through the informed consent process, while the co-sponsored "Annual Patient Education Check-Up Week" encourages use of the most current patient education and informed consent documents.

My commitment to you during my term as your chairman is to build upon OMIC's strong foundation and lead the company through the challenges and uncertainties that lie ahead as health care reform is implemented in America.

John W. Shore, MD
Chairman of the Board

Cyber Liability Coverage

By Robert Widi,
OMIC VP, Marketing & Sales

Not long ago, eye health information was stored almost exclusively in tattered folders on dusty shelves in a back room of the ophthalmologist's medical office. Not anymore. Use of full or partial electronic medical record (EMR) systems increased 270% among ophthalmologists between 2005 and 2010. Nearly half of all ophthalmic practices now use some form of electronic record keeping and many use email and other web-based services to transfer medical information.

For all their efficiency and convenience, electronic filing systems present new liabilities for ophthalmologists, including violations of privacy regulations such as HIPAA and the new HITECH Act. Potentially damaging events include malicious virus attacks, accidental data breaches, or even an intentional act of sabotage by a disgruntled employee. Recent studies reveal that many private medical offices have failed to implement security features required under HITECH, highlighting a need for greater security of personal medical information. The lack of continuity between various electronic medical information and record systems and new technology that allows sensitive information to be wirelessly transferred to portable devices such as iPads and smart phones will probably complicate security challenges going forward. Should a breach occur, even if not intentional, costs related to data recovery, patient notification of privacy breaches, and financial credit monitoring, could add up very quickly, and the time required to manage these issues is likely to distract staff from their normal responsibilities.

In recent months, policyholders have reported potential claims related to various breaches of sensitive patient health information, including lost and/or stolen laptops and unauthorized release of data over the internet. Recognizing these emerging exposures and the potential threat posed to our insureds, cyber liability coverage was added under the BRPP supplementary benefit of your OMIC policy effective January 1, 2011. The BRPP coverage limit is $50,000 per policy period and is automatic for active OMIC professional liability policyholders. You will receive a policy insert with your 2011 OMIC renewal documents describing this expanded benefit.

What it Covers

Privacy Violations. Reimburses you for fines and penalties associated with breach of federal, state, or local statutes related to personal medical or financial information, including HIPAA, Gramm-Leach-Bliley Act, HITECH, FTC and Fair Credit Reporting Act. Also responds to general allegations by patients of violations or release of their private information.

Network Security. Reimburses you for damages related to inadvertent transmission of harmful viruses, unauthorized access to sensitive information stored on computer systems, prevention of authorized access to computer systems, and failure to prevent identity theft or credit/debit card fraud.

Data Interference. Reimburses you for damage to sensitive data you maintain through intrusion of computer systems and electronic communication devices without your knowledge, whether intentional, malicious, reckless, or negligent.

Patient Notification. Reimburses you for costs related to patient notification of privacy breaches, including all reasonable legal, public relations, advertising, IT forensic, call center, credit monitoring, and postage expenses incurred.

Data Recovery. Reimburses you for all reasonable and necessary expenses required to recover and/or replace data that is compromised, damaged, lost, erased, or corrupted.

Additional coverage is available through Lloyds of London underwriters administered through NAS Insurance Agency. If you would like to purchase excess limits above the $50,000 limit provided in your OMIC policy, please contact Dana Pollard at (877) 808-6277 or dpollard@nasinsurance.com.

Risk Management Tips

Breaches of information are usually unintentional; however, you can take steps to protect yourself from both negligent and malicious events involving employees or third parties. Although no data security policy will be 100% effective, following are some areas to focus on when planning, developing, and implementing your office protocol for the privacy and security of patient information.

- Make sure electronic health records, and any other electronic data systems you use in the practice, are protected with vigorous virus and data protection software and that the software is updated automatically whenever a new version is released.
- Perform a regular back-up of all sensitive data and store in a secure area with a third party and/or off site.
- Use encryption services whenever possible and make sure passwords are changed on a regular basis.
- Limit access of private health information to medical office staff when the information is not necessary for their particular job function by storing on separate computers in a separate area away from any systems on which they are able to engage in personal electronic communications.
- Install tracking software to log and monitor each time a staff member accesses or retrieves sensitive information.
- Distribute and rotate duties in such a way that prevents any one person from having complete access to a patient's health record.

The Risks and Benefits of Malpractice Litigation

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had already implemented. The two areas of concern that are consistently cited by insureds are problems with documentation and informed consent.

Documentation Issues

Documentation issues manifest in claims in different ways, sometimes serving as a shield to protect and defend the physician and other times used as a sword by the plaintiff if critical documentation is found lacking. About the importance of documentation, one insured wrote on his questionnaire, "I am much more aware of the need for careful documentation of my communications with other physicians, optometrists, and others involved in the patient's care." Another said simply, "Documentation cannot be overstated."

One particular area of concern frequently cited by insureds is the importance of documenting telephone calls. In several cases, the only connection the insured had with a patient was one phone call from the hospital ER. A bad outcome for the patient and different accounts of what the ER physician and the ophthalmologist said, and documentation of the phone conversation became a critical factor in the insured's defense.

One approach to documenting after hours or out of office phone calls is to use OMIC's "Patient Care Phone Call Record Pad." This is a 3 x 6 inch pad of 25 perforated, lined forms that prompt the ophthalmologist to document relevant information, such as patient history, prescribed medications, and follow-up. These pads have been very popular with insureds for many years as they can be placed in various places where calls are taken after hours or while on call (e.g., at home or in the car). The form can later be placed in the patient's chart. Phone pads are available free to OMIC insureds upon request. Contact the Risk Management Department at (800) 562-6642, ext. 652.

OMIC has also developed a detailed guide to help ophthalmologists and their staff effectively screen, manage, and document patient calls. "Telephone Screening of Ophthalmic Problems: Sample Contact Forms and Screening Guidelines" may be found on the OMIC web site at www.omic.com.

Informed Consent

Approximately half of the claims brought against OMIC insureds are related to surgical procedures. Allegations include improper performance of surgery, improper management of a surgical patient, unnecessary surgery, and wrong eye/wrong powered lens. Every surgical procedure an ophthalmologist performs involves the informed consent process. Lack of informed consent is a frequent allegation that plaintiff lawyers include in any medical malpractice lawsuit.

Although OMIC emphasizes that informed consent is a process and not simply a matter of the patient signing a document, we have addressed the documentation component of the process by developing more than 60 procedure-specific informed consent documents. They can be found on our web site at http://www.omic.com/resources/risk_man/forms.cfm.

These documents are specific to the procedure being performed (e.g., cataract, retina, oculoplastic) and are meant to memorialize that the patient had a discussion with the ophthalmologist and understood the risks, benefits, and alternatives to this procedure. One insured commented, "I now use my own specific informed consent document for my chart regardless of what is required at the facility where I operate."

Insureds who have had claims know from experience that informed consent is further complicated because patients may have difficulty understanding the medical information and complex procedure they are consenting to. Plaintiff attorneys highlight this complexity and try to show that the physician did not take the time necessary to help the patient adequately understand the risks. Every ophthalmologist and practice faces this challenge and needs to address the consent process differently depending on the procedures performed, the communication skills of support staff assisting in the process, the patient population, and the availability of patient education materials.

Despite these differences, all insureds who have been sued agree that the experience makes them more focused on having meaningful discussions with patients and efficiently documenting the consent process.

"I now ask patients what they expect from planned surgery to see if they have realistic expectations."

"I am more open with patients about possible complications and have longer pre-op discussions."

Some ophthalmologists find that using a checklist helps them address specific issues with a particular patient (e.g., language barriers, use of herbal medicines) and document the process. This approach won't work in all practices or situations, but a checklist can take some of the complexity out of the informed consent process. A sample checklist, "Consent to Treatment Certification Document,"[4] is available on the OMIC web site at http://www.omic.com/resources/risk_man/recommend.cfm#obtaining.

The Defense Team

OMIC insureds who have been through litigation comment on the importance of becoming a team member with defense counsel and OMIC staff. Staff is integral to the defense team and is the first point of contact when insureds find out they are going to be sued. Each insured is assigned a litigation analyst, who manages the claim until it is resolved. The analyst explains the litigation process and makes sure the ophthalmologist is informed about each step in the process and able to participate fully in his or her own case.

"OMIC staff worked closely with me and my defense attorney. She kept me in the loop and kept my confidence up that we had a good team and defense."

The "quarterback" of the team is the defense attorney who is retained to represent the insured. OMIC appoints attorneys who have significant expertise in medical malpractice litigation, knowledge of ophthalmology, and proven effectiveness in jury trial cases. OMIC insureds prevail in almost 90% of the cases taken to trial and having an attorney who is skilled in trial tactics and strategy is fundamental to success in the courtroom.

"He was a very experienced attorney with excellent knowledge of the clinical issues involved in the case. He was always available and went out of his way to become informed and do the necessary 'leg-work' to offer our side every advantage at trial."

But no matter how exemplary the skills and experience of the attorney and OMIC staff, a successful defense requires the full participation of the ophthalmologist whose knowledge, insight, and experience are essential elements in preparing the defense's case. Litigation is often a long and tortuous process that can play out over many years. Understandably, attending depositions, reviewing documents, and meeting with defense counsel can be frustrating for busy physicians. However, OMIC insureds have learned that making the commitment to become an active member of the defense team is an important element in bringing about the best possible resolution to their case. Dr. Cibis advises insureds:

"Go over the facts of the case, especially the medical records, again and again. Each time you do, new angles and facets will appear. Do not begrudge the time you spend with your defense attorney. Do not cancel or cut short meetings with your attorney. Thoroughness in preparation comes to the fore during the deposition and especially during the trial."

Other Lessons Learned from Litigation

In addition to risk management issues, insureds who have been sued provide insights and perspectives on the overall litigation process. Over three-quarters of claims against OMIC insureds are dismissed without any payment to the patient. A large percentage of these claims have no legal merit and arguably should never have been filed. Consequently, many comments from insureds center on the arbitrary or unfair nature of the tort (justice) system in this country and its negative impact on practicing medicine.

"It is a travesty that this case proceeded as far as it did. What a splendid reason for tort reform."

"The patient would have sued regardless of any steps I, or anyone, could have taken."

Insureds who are sued because of unrealistic patient expectations report that the experience makes them better at identifying a patient's motives for surgery.

"I now listen more to my 'gut' and take this into consideration as far as patient selection."

"I try to be more aware of patients' personality and character."

Fatalistic and sometimes angry comments about a particular patient or patient population are not an uncommon reaction to feeling attacked both professionally and personally. The Physician Litigation Stress Resource Center says anger is a repercussion of litigation.

"Sued physicians, for example, often feel that the suit is not only unfair but totally unjustified. These feelings can translate into intense anger that can result either in outbursts toward others or simmering inward rage that can contribute to the development of guilty feelings and/or significant stress-related symptoms, such as headache, hypertension, coronary artery or gastrointestinal disturbances."[5]

Resources to deal with the anger and other difficult emotions that might arise during and after litigation may be found on the Physicians Legal Resource Center web site at http://www.physicianlitigationstress.org/index.html.

Fortunately, most OMIC insureds are able to work through their anger and their comments are particularly instructive for others who are facing or might face litigation in the future.

"I was able to get through this horrific ordeal relatively unscathed, but a bit stronger from my scars. The phone call I received informing me that my case had been dismissed ranks, in terms of emotional impact, just below that of my children being born."

"I had often thought I would not survive a lawsuit. I did. I am even more committed to my job as an ophthalmologist than before."

"I am humbled at the experience I have gone through during this four-year process. I am grateful (to OMIC) to have the representation that I had to help resolve the case prior to trial. I hope to be able to share my experience with others in the future so they understand that while frustrating, the process works."

"It was a very stressful experience but I am a wiser doctor for having gone through it."

There is an eloquence, poignancy, and hopefulness to these comments. The willingness of these insureds to share their sentiments about litigation and their insight into risk management is of benefit to all OMIC insureds. We owe them a debt of gratitude.

1. Cibis GW, MD. "How to Survive a Malpractice Lawsuit and Emerge Stronger." *OMIC Digest*, Fall 1993.

2. Charles SC, Frisch PR. "Adverse Events, Stress, and Litigation: A Physician's Guide." Oxford University Press, 2005.

3. Gawande A. "Complications: A Surgeon's Notes on an Imperfect Science." Picador, Henry Holt and Company, 2002.

4. Rozovsky FA. "Consent to Treatment: A Practical Guide," 4th Edition. Aspen Publishers, 2011 (with annual supplements).

5. Physicians Litigation Stress Resource Center, http://www.physicianlitigationstress.org/physician_support.html.

Closed Claim Study

Failure to Treat and Refer Patient with Diabetic Retinopathy

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to refer patient to a retinal specialist and failure to perform a YAG in a timely manner.

DISPOSITION

Case settled for $1,275,000.

Case Summary

A young insulin-dependent diabetic on dialysis presented to an OMIC insured complaining of blurry vision. Upon initial examination, the patient was best corrected to 20/80 OU and diagnosed with bilateral cataracts. The insured performed cataract surgery on both eyes and vision improved to 20/30 OU. The patient was subsequently examined by the group's employed optometrist, who documented disc neovascularization and noted that the insured ophthalmologist also examined the patient. This turned out to be the only record of the ophthalmologist's exam that day. He later told defense counsel he did not agree with the optometrist that the patient had disc neovascularization; however, neither his exam nor decision-making process was documented. The same optometrist examined the patient one month later and documented a stable fundus.

During this time, a non-OMIC insured ophthalmologist wrote a letter on the patient's behalf to the County Health Department's Division of Disability Determinations recommending a YAG laser capsulotomy to evaluate the fundus for diabetic retinopathy. A copy of this ophthalmologist's letter was sent to the insured's group, but no action was taken. In fact, the patient was again examined by the group's optometrist and advised to return in four months. The patient did not return until eight months later, by which time vision had deteriorated to NLP OD and CF OS. A different OMIC insured in the same practice diagnosed a questionable retinal detachment OS and performed a paracentesis. He prescribed drops and scheduled a YAG for the following week, but the procedure was later postponed pending approval of the patient's eligibility by the Division of Blind Services. The second insured finally performed the YAG two months after determining it was needed. He referred the patient to a retinal specialist, who performed two vitrectomies and retinal detachment repairs; however, massive bleeding led to complete visual loss OU.

Analysis

Defense experts voiced some support for each insured's care but also criticism. They noted that the first insured did not follow up after the cataract surgery even though this patient was highly likely to develop diabetic retinopathy. The second insured ophthalmologist, after diagnosing retinal detachment, did not properly treat it or perform the YAG or refer the patient in a timely manner. Plaintiff counsel alleged that the group delayed this patient's care due to a dispute over a $15 balance which the patient claimed she could not afford. Since the patient had lost her Medicaid coverage, the County Health Department referred her to the Division of Blind Services to arrange payment for the YAG but not in a timely enough manner. Defense counsel for both insureds felt that the payment issues could alienate jurors and potentially sway them to return a verdict well in excess of the $1 million policy carried by each insured. The insureds demanded that OMIC settle the case within policy limits. The first insured's case settled for $700,000 and the second for $575,000 for a total of $1,275,000.

Risk Management Principles

The primary risk in this case was not lack of physician knowledge or skill. Familiar with the natural history of diabetes and aware that the disease had already led to renal failure requiring dialysis, both ophthalmologists and the optometrist knew the disease would manifest in the eyes eventually. No one kept this knowledge in mind, however, when treating this patient. Instead, "systems" issues appear to have interfered with proper care. The optometrist noted the early signs of retinopathy, but backed off when the ophthalmologist, who was above him in the group hierarchy, did not agree with the assessment. Both ophthalmologists were employees of the practice and may not have been in a position of authority to determine who should be assigned to high risk patients or to effectively challenge financial policies that delayed acute care. The group's policies and structure hindered any one provider's ability to take ownership of the patient and follow the care through to completion. In hindsight, it is easy to acknowledge that emergency treatment should never be delayed due to issues with an account balance or the patient's inability to pay and that ophthalmologists have a duty to advocate on behalf of the patient.

Risk Management Hotline

Payment Issues: Avoid Delays in Treatment

By Hans Bruhn, MHS, OMIC Senior Risk Management Specialist

By the time a patient is referred and examined by an ophthalmic specialist, he probably has already been seen by a primary care physician and a general ophthalmologist. Most health insurers require patients to go through a referral process before they can be seen by a specialist. This can be problematic if the patient's eye condition requires rapid diagnosis and treatment by the specialist. Critical care can also be delayed when patients do not have health insurance and cannot pay out of pocket for these services. When delays in critical care result in less than desired or poor outcomes, some patients will file a claim against the specialist and all referring health care providers, alleging failure to provide timely treatment.

Q Can I withhold care because of a patient's inability to pay (including co-pays)?

A This is always a tricky situation. Ophthalmologists may be required to collect co-pays or deductibles by third party insurers. If emergent care is needed, we recommend separating payment issues from decisions about care. Proceed with providing as much care as possible and sort out the financial issues after the patient is stable. This will avoid delays in treatment and reduce the risk of a claim. Notify the insurance company of the urgent care situation and the patient's inability to pay the co-payment. The insurance company may allow you to waive the co-payment; however, waiving fees without first checking with the insurer can jeopardize your provider contract. You should make a reasonable effort to work out a payment plan with the patient; document your efforts and the results.

You may have less control over the situation in a surgical facility or hospital setting that requires payment up front as a condition of admission. But before you send the patient elsewhere, act as the patient's advocate. Explain to the facility the urgent nature of the required treatment and ask if it will work out a payment plan with the patient. If not, promptly refer the patient to another facility that may be willing to do so. If all attempts fail, it may be necessary to refer the patient to the local emergency room, where federal law mandates that treatment be provided. Throughout this process, keep the patient informed about your efforts on his behalf. This will help reduce the likelihood that you will be perceived by the patient as withholding care. Document carefully.

Q During follow-up, I noted that a patient I first saw in the ER needed surgery. Since I am not part of her HMO, I promptly called her primary care physician to secure a referral to a participating ophthalmologist, but the PCP was out of town. What action should I take?

A Advise the patient about the situation (PCP is not available; surgery is needed and you are not in her insurance provider network). If the patient elects to pay out of pocket, get that in writing and proceed with care. If not, help the patient find another provider to assume care. Contact her HMO directly and request a referral to another ophthalmologist. Once another provider is identified, contact that new physician and facilitate transfer of care along with patient authorization and your recommendation for surgery. Advise the patient of your actions and document accordingly.

Q A patient that I have been treating since June 2008 has developed a serious corneal ulcer (OS), possibly fungal. I prescribed Natamycin drops, but the patient has not gotten the drops and has canceled follow-up appointments because of the cost. The patient is blind in his right eye, and now his left eye is compromised with this serious condition. Am I obligated to continuing seeing him?

A Contact the patient and tell him of your concern. Explain that many patients are having trouble affording care and ask if his financial situation is keeping him from getting the care he needs. Advise him of the seriousness of his eye condition, including the consequences of not using the drops you prescribed and not coming in for exams. Given the urgency of the situation in this functionally monocular patient, encourage him to come in to see you so you can conduct an exam and provide care, including drops, if possible. If the patient is still reluctant to see you, ask if there are any relatives to assist him. Offer to set up a payment plan for incurred medical expenses. As a last resort, advise the patient to go to the nearest emergency room for care. If the patient refuses, document your discussion and send a letter reiterating your recommendations and explaining again the consequences of not getting care. If the patient does not respond to your discussions and letter, consider sending OMIC's "noncompliance" letter, which gives the patient one last chance to come in for care before the physician-patient relationship is terminated.

Contact OMIC's Risk Management department for assistance or visit our web site, www.omic.com, for our recommendation "Discontinuing Treatment for Financial Reasons and Noncompliance Guidelines."

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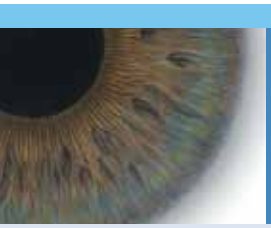

Calendar of Events

OMIC continues its popular risk management courses in 2011. Upon completion of an OMIC online course, CD or 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 here and on the OMIC web site, www.omic.com.

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.

Upcoming Seminars

May

13 *The Risks and Benefits of Malpractice Litigation*
Kentucky Academy of Eye Physicians & Surgeons*; Bellterra Resort & Spa, Florence, IN; 8:30–9:30 am. Register with KAEPS at (866) 328-0554 or http://www.kyeyemds.org.

13 *Malpractice Case Studies*
Texas Ophthalmological Assn*; George R. Brown Convention Center, Houston, TX; 9:45–11 am. Register with TOA at (512) 370-1504 or http://www.TexasEyes.org.

15 *Malpractice Case Studies*
American Society of Ophthalmic Plastic & Reconstructive Surgery*; Ritz-Carlton, Amelia Island, FL; 11:30 am–12:30 pm. Register with ASOPRS at (952) 646-2037 or http://www.asoprs.org.

20 *Malpractice Case Studies*
Maryland Society of Eye Physicians & Surgeons*; Hilton BWI Hotel, Linthicum Heights, MD; Time TBA. Register with MSEPS at (609) 392-1201 or http://www.marylandeyemds.org.

20–21 *Malpractice Case Studies*
Tri-State Annual Meeting includes Arizona Ophthalmological Society,* Nevada Academy of Ophthalmology,* New Mexico Academy of Ophthalmology, and ASORN 2011 Meeting; High Country Conference Center, Flagstaff, AZ; Time Midday. Register with AOS at (602) 347-6901 or www.azeyemds.org.

June

3–4 *Malpractice Case Studies*
Virginia Society of Eye Physicians & Surgeons*; Williamsburg Lodge, Williamsburg, VA; Time TBA. Register with VSEPS at (804) 261-9890 or http://www.vaeyemd.org.

10 *Malpractice Case Studies*
Connecticut Society of Eye Physicians*; Aqua Turf Club, Plantsville, CT; Time TBA. Register with Debbie Osborn at CSEP at eyemaster2020@yahoo.com.

17–19 *Malpractice Case Studies*
West Virginia Academy of Eye Physicians & Surgeons*; The Greenbrier Resort, White Sulphur Springs, WV; Time TBA. Register with WVEPS at (304) 345-6808 or http://www.wveyemd.org.

24–26 *Malpractice Case Studies*
Florida Society of Ophthalmology*; The Breakers, Palm Beach, FL; Time TBA. Register with FSO at (904) 998-0819 or http://www.mdeye.org.