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Ophthalmic Risk Management Digest

OMIC DIGEST

Evaluating Competency, Handling Incompetency

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

All physicians, at some point, will find themselves in situations where they need to evaluate their own or another health care provider's competency. Especially when evaluating others' competency, physicians are often unsure of the best way to do so, how to communicate their evaluation to the subject, and their responsibility to report their findings. Viewing the issue from the patient safety perspective provides guidance. The following two OMIC case studies furnish a basis for considering the process.

A senior ophthalmologist was gravely concerned. This wasn't the first time his partner had run into problems with poor outcomes and dissatisfied patients. Four patients had even sued for medical malpractice about seven years ago. In each case, the other partners, OMIC, and defense experts had supported the ophthalmologist's care, and all four cases had been dismissed without an indemnity payment. Then one year ago, a patient experienced a ruptured posterior capsule. Uncharacteristically, the ophthalmologist didn't manage the complication well in the OR or during the postoperative period. Indeed, his attempts to recover the nucleus caused further damage. He never did a postoperative retinal exam despite worsening vision problems and never referred the patient to a retinal specialist. Discussing his care with the defense attorney assigned to assist him, the ophthalmologist was the first to offer the above criticisms, and agreed to settle the lawsuit against him for $160,000.

Now, nearly a year after that surgery, the group learned of four new cataract cases with poor outcomes, and all felt the surgeon's technique was clearly substandard. They had also noted changes in his behavior. The senior partner raised these quality and health concerns with his colleague at regular, short intervals—to no avail. The partners concluded that something was seriously wrong with their close friend and colleague and issued a mandatory order that he cease patient care. Their worst fears were confirmed when he was examined by a neurologist and deemed mentally incompetent secondary to frontal lobe dementia. Lawsuits based on the ophthalmologist's substandard care ensued, ultimately settling for a total of $850,000.

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MESSAGE FROM THE CHAIRMAN

One of the many benefits of the close relationship between OMIC and the Academy is the ability to coordinate our efforts to address legal, regulatory, and quality of care issues of common concern. Recently, OMIC and the Academy joined forces to stop legislation that would have adversely affected ophthalmic practice in two states.

In March, OMIC responded to a request from Academy EVP/CEO, David Parke, MD, to help the Washington Academy of Eye Physicians and Surgeons (WAEPS) respond to a proposed state Medical Quality Assurance Commission (MQAC) regulation that would characterize retrobulbar and periorbital ocular blocks as anesthesia "where significant cardiovascular or respiratory complications may result." Such a characterization would require every ophthalmology office that administers anesthetic blocks to undergo an accreditation or certification process similar to that of the Accreditation Association for Ambulatory Healthcare. Clearly, the process would not only be burdensome, but also extraordinarily expensive and unnecessary as ophthalmologists have been administering these anesthetic blocks in their office practices for decades with no significant risk to patients.

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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.

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Red Flags Rule, HITECH/HIPAA Obligations, and RAC Audits

The Federal Trade Commission again postponed enforcement of the "Red Flags" rule for health care providers through December 31, 2010, largely in response to a lawsuit by the American Medical Association. The Red Flags rule, passed in 2003 under the Fair and Accurate Credit Transactions Act, requires that "creditors" create a written protocol to protect sensitive financial information and notify clients of security breaches.

The HITECH Act, an amendment to the HIPAA Privacy law, passed in late 2009 as part of the American Recovery and Reinvestment Act. It requires that physicians maintain a protocol to protect patient's sensitive health information. Violations are subject to penalty immediately, with an extended implementation period for physicians who use Electronic Medical Records systems.

As part of the Tax Relief and Health Care Act of 2006, the Centers for Medicare and Medicaid Services authorized the Medicare Recovery Audit Contractor (RAC) program to identify improper Medicare payments. A temporary "stop work" order during litigation regarding the awarding of RAC contracts was resolved in 2009 and the law was expanded to all 50 states this year. Contracted auditors across the country are paid a contingency fee to identify improper billing practices and receive a portion of the over (or under) payments they collect from health care providers.

OMIC's professional liability policy provides coverage for patient notification costs associated with regulations such as the Red Flags rule and HITECH Act, subject to a sublimit of $10,000 per policy period. RAC audits and other "billing errors" proceedings are covered at a sublimit of $35,000 per policy period. Coverage provides reimbursement for legal and audit expenses, including shadow audits, as well as fines and penalties (where allowed by law).

Message from the Chairman

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As is often the case, this rule was "hidden" in a larger regulation pertaining to office-based surgery. When it appeared likely the regulation would pass, WAEPS contacted the Academy for assistance, and Dr. Parke asked OMIC for claims data related to the use of local blocks in office-based surgery. His response to MQAC stated:

"…complications of retrobulbar injection in the outpatient office setting are extraordinarily rare. A survey by the largest medical malpractice carrier in ophthalmology (Ophthalmic Mutual Insurance Company) found only one case in a 21-year review of its claims data bank of a cardiovascular event from a retrobulbar injection performed outside of the operating room. This is in a period of time when literally millions of such injections were performed. This indicates that the risk is very small."

Having compelling evidence-based data is of extraordinary benefit when dealing with regulatory agencies. With the support of the Academy, the Washington Medical Association, and other concerned organizations, WAEPS was successful in having the rule taken off the hearing calendar and reevaluated with more input from ophthalmology.

OMIC also worked closely with Academy Secretary for State Affairs, Dan Briceland, MD, to help the West Virginia Academy of Ophthalmology (WVAO) fight an optometry bill that would have allowed optometrists to perform glaucoma surgery. OMIC has extensive experience in this area. Over 300 optometrists are directly insured by OMIC, and approximately 35% of its 4,100 insured ophthalmologists employ or contract with an optometrist. In a letter drafted for WVAO to present to West Virginia legislators, OMIC pointed out the risk to patients:

"OMIC engages in an ongoing process of assessing the risk of optometrists performing 'surgery.' Based on an objective risk assessment, OMIC is not willing to extend liability coverage to any optometrist who performs laser surgery or any therapeutic ophthalmic laser procedure."

The letter noted that only one state (Oklahoma) allows optometrists to perform surgical or therapeutic laser procedures.

"OMIC's decision to not extend this coverage to optometrists is based on the lack of data available on this liability risk, as well as the company's assessment that there is also an absence of data to properly underwrite, determine a premium rate, and have the expertise to administer claims arising from surgical or therapeutic laser procedures performed by optometrists."

After a hard-fought battle, the WVAO was able to defeat the bill and stop the expansion of optometry into glaucoma surgery.

Richard L. Abbott, MD
OMIC Chairman of the Board

Incompetency: Reporting and Coverage

By Kimberly Wynkoop
OMIC Legal Counsel

Insureds may have to deal with incompetency issues from either the side of the impaired physician or as an evaluator of one of their peers. There are policy issues to consider from either perspective.

When an insured is the physician with potential competency issues, he or she has affirmative reporting duties under the OMIC professional and limited office premises liability insurance policy. Under Section VIII. General Conditions, Rules, and Duties, of the policy, Subsection 2, insureds agree to update OMIC immediately, in writing, about any changes to the statements they made in their application. If the insured fails to notify OMIC within thirty days of the change, OMIC has the right to deny coverage of a claim related to that change, or to cancel the policy. More specifically, Subsection 3 requires insureds to give OMIC written notice within thirty days of certain specific situations, including the insured being advised to or undergoing treatment for substance abuse or psychiatric illness and the insured suffering from an illness or physical injury that could impair his or her ability to practice ophthalmology for thirty days or longer. Regarding group policies, the policyholder has the duty to act on behalf of all insureds under the policy. To the extent the policyholder or its representative is aware of an insured's incompetency, it has the duty to inform OMIC (Section VIII.1).

What occurs after the insured notifies his or her underwriter depends upon the specific facts and circumstances of the insured's situation. The underwriter will require complete details of the impairment or incompetency, including its nature, date of origin, whether treatment has been sought, prognosis, and whether the insured has been cleared by his or her treating physician to continue practice (if applicable). Underwriting will require a letter from the treating physician or treatment program coordinator confirming this information. Underwriting also will want to know if the impairment or condition has affected the insured's licensure or hospital privileges.

Underwriting will evaluate all of these factors, either by staff or through the physician review process, and will determine whether and under what conditions OMIC can continue providing coverage to the insured. If the insured is cleared for a reduced scope of practice, reduction in the coverage classification may be warranted. If the insured is temporarily unable to practice, he or she may be eligible for a suspension of coverage. If serious action has been taken against the insured's privileges or licensure, such as suspension or revocation, OMIC may determine that it is no longer in a position to insure the doctor. OMIC generally takes the least restrictive action that is prudent for the company and its members.

For patient safety reasons, and because such claims can be extremely difficult to defend, OMIC does not cover claims arising from insureds' performance of direct patient treatment while under certain impairments. For instance, Section III.B.4. of the policy provides that "OMIC will defend an insured because of a claim otherwise covered by this policy that arises out of, but is not solely limited to, the following; however, under no circumstances will OMIC pay any damages or supplementary payments except Claim expenses resulting from either settlement or judgment attributed to…an act, error, or omission (a) committed while the insured is under the influence of alcohol, drugs, or other substances that adversely affect the Insured's professional ability or judgment or (b) that results from substance abuse." If the insured's condition leads to restrictions on or the loss of his or her licensure (including DEA license), be aware that the policy (Sections III.A.2. and III.A.3.) provides that OMIC will neither defend an insured nor pay damages or supplementary payments because of a Claim that arises out of direct patient treatment or dispensing of controlled substances that occurred in violation of a restricted or revoked license.

In order to financially assist insureds who leave practice due to incompetency and disability, if the insured is judicially determined to be incompetent or is permanently and totally disabled, OMIC provides the insured with free tail coverage upon termination of the policy. In order to receive this benefit, OMIC must receive written notice of the insured's condition and the policy premium must be paid through the date of termination.

Conversely, an insured may be called on to evaluate another physician's competency. OMIC's policy offers protection for this evaluation in certain situations. Coverage D provides defense and payment of damages and supplementary payments for the insured's professional committee activities performed for (a) a state licensed health care facility or clinic that is not the professional entity with which the Insured is affiliated as a member, officer, director, partner, or shareholder or (b) a professional association or society. Professional committee activities are defined as service of an insured while acting within the scope of his or her duties as a member of, participant in, or person charged with the duty of executing the directives of, a formal accreditation, utilization review, credentialing, quality assurance, peer review, or similar professional board or committee. A conditional defense is provided to insureds performing professional committee activities in good faith who are sued for such wrongful acts as slander and defamation of character and alleged anticompetitive activities.

If you have questions about your policy coverage, please call your underwriter for assistance. For help determining what steps to take with a suspected incompetent peer, please call OMIC's risk management hotline.

Evaluating Competency, Handling Incompetency

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Another ophthalmologist did not have the benefit of partners. When this young physician went out of town without arranging for coverage, and his patient presented to the ER with endophthalmitis, the on-call ophthalmologist did not contact him to raise concerns, opting instead to report him directly to the state medical board. Although the board supported the young physician's care, it noted that he had a higher-than-average rate of infection, and ordered him to write an article on endophthalmitis and submit his plan for coverage if he was ever again unavailable to see his patients after-hours. His well-researched article was accepted; but the board wanted more detail on his coverage plan. Rather than comply, he resigned his license, having already relocated to another state.

Pursuant to policies advised by the Federation of State Medical Boards, the first board contacted the second board to alert it to the physician's prior problems and licensure change. In the course of its own independent investigation, the second state's medical board was contacted by several patients and physicians, all of whom raised new quality of care concerns about this ophthalmologist. The board suspended his license, ordered a psychiatric evaluation, and later mandated six months of retraining and mentorship.

The academic eye center that agreed to retrain him was located in a neighboring state; it not only eventually assured the board that it was satisfied with his care, but offered him a position. The ophthalmologist has practiced there for several years without incident; nonetheless, ten patients in the second state ended up suing him. Defense experts raised the same concerns as the physicians who had contacted the state medical board. Eight of the ten lawsuits settled; indemnity payments ranged from $50,000 to $340,000, and totaled $1,795,000.

Everyday Competency Scenarios

Not all ophthalmologists will have to confront situations as complex as these two, but they will routinely face scenarios where they need to evaluate their own and others' competency. Consider these situations.

You are a comprehensive ophthalmologist and have many patients with AMD who require intravitreal injections. You would like to provide the care yourself instead of referring these patients to a retinal specialist. How do you evaluate your own competency?

You fracture your wrist. How do you know when you are able to perform surgery safely again? Do you need to disclose anything to your patients?

A physician you don't know calls you from the ER to discuss a patient. He feels the patient can be seen by you the next day. How do you assess the ER physician's competency to evaluate an eye condition? What should you do if you have concerns?

The senior partner in your practice is taking longer and longer to complete his surgeries and his complication rate is rising. How should you handle this?

A patient self-refers complaining of a surgical complication resulting from another ophthalmologist's care. Based upon the patient's history and your examination, you have no concerns about the prior care or surgery, even though the patient feels some mistake was made. How should you respond? How should you handle the patient if you do have concerns about the quality of prior care?

Your practice has decided to incorporate optometrists. How do you determine which patients they can see independently, which require a consult with an ophthalmologist, and which should be referred to an ophthalmologist?

Avoiding Harm, Meeting Ethical Duties

Every physician takes the Hippocratic oath, affirming a commitment to "first, do no harm." Doctors are also aware of ethical standards that impose a certain level of responsibility for ensuring that other physicians avoid maleficence as well. According to the American Medical Association, "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."

The American Academy of Ophthalmology encourages members who have a reasonable belief that another ophthalmologist deviated from the standards of patient care or ethics to take action to stop the questionable behavior. As a first step, the AAO recommends communicating directly with the eye surgeon. The Academy member should report the ophthalmologist to authorities only if such communication is ineffective or infeasible.

In both of the situations described earlier, physicians had concerns about the care rendered by another ophthalmologist. Those within the group practice communicated directly with their colleague about his results and his health. The ophthalmologists in the second case made no such attempt. It's unclear why they decided to report the physician to their state medical board as the first step. Perhaps they did not know the physician well enough or felt uncomfortable raising their concerns with him. They may have been direct competitors or had previous unpleasant encounters with this or another physician in similar circumstances. What is clear is that confronting and reporting incompetent physicians is a daunting task.

OMIC policyholders who have attended our risk management course on competency and incompetency at this year's state and subspecialty meetings have been asked to describe the barriers that prevent physicians from taking corrective action when they encounter another physician who is incompetent or impaired. Here are their responses.

Barriers to Taking Corrective Action

- Unprofessional to "break silence"
- Uncertainty about suspicions
- Not sure how to evaluate competency
- No access to physician's medical records
- Lack of personal observation of the physician's surgery or care
- Fear of seeing one's own incompetency
- Fear of retaliation from physician and/or community
- Risk of unintended consequences
- Fear of not being believed
- Fear of being wrong
- Fear of confrontation
- Compassion for incompetent/impaired colleague
- Unwillingness to impact physician's livelihood
- Don't know where to report concerns
- Peer pressure
- Loss of referrals
- Don't want to get involved
- Incompetent physician is in position of authority
- Reticence to judge others
- Rationalization of physician's behavior
- Extra work and time involved to resolve the problem
- No structured venue where issue can be raised without legal ramifications
- Conflict of interest
- Lack of faith that the medical board will handle investigation well

Moving the Conversation Into the Patient Safety Arena

Physicians had these same misgivings years ago when professional associations, insurance companies, hospitals, and regulatory agencies started encouraging them to discuss unanticipated outcomes with patients in a more forthright manner. The same principles evoked in ethical standards about competency run through articles on patient safety: first do no harm, honesty is the best policy, safety must be actively created. Just as patients have the need and the right to know their condition, treatment options, complications, outcomes, and errors, physicians have the right and the need to know of concerns, complaints, and errors attributable to them. Consider these conversations the second wave of disclosure discussions and opportunities to create safety by carefully evaluating all threats to it.

As part of ongoing efforts to monitor care and create safety, watch for signs of your own and your colleagues' incompetency or impairment. Early indications are often not clinical. Instead, they include complaints from patients, staff, and other physicians, a disruptive personality, difficulty creating and maintaining rapport with others, and a sense that the physician "does not play well with others." Studies have shown a clear link between poor communication skills and poor outcomes,[1] often starting in medical school. Don't ignore these signs or hope they will go away. Instead, remember that "inappropriate is unsafe" and investigate further.

Take Corrective Action

Research on patient safety has led us to recognize that medicine is a complex process, and that conscious effort is required to create safety. While a non-punitive approach to errors is advocated, it is also clear that disciplinary action, including mandatory remedial training, has its place. Some academic centers have developed models and programs to address competency concerns. For example, Vanderbilt University Center for Patient and Professional Advocacy describes an escalating approach. All physicians are monitored, and each complaint or concern is shared with the affected doctor, who is told that he or she "has a right and a need to know." Please see the **Hotline** article for suggestions on talking to physicians about competency concerns.

If concerns persist, a trained peer counselor meets with the individual in question and explains that other physicians are not generating the same number or type of complaints: "You are an outlier. Please review these materials before our next meeting." If the physician is unable or unwilling to take corrective action, a referral is made to an authority figure who considers whether a disciplinary response is warranted. If, as in the case of the second ophthalmologist, more training is needed, the physician will need to be referred to an academic center. One such center, the University of California, San Diego's Physician Assessment and Clinical Education (PACE) program, offers individualized evaluation and training for physicians whose medical boards or institutions have identified gaps in their knowledge, training, or communication skills.

Physicians are understandably wary of evaluating competency and managing incompetency and impairment. Institutions and professional associations, feeling the public pressure generated by regular stories of medical errors, are less reticent. Many are now requiring outcome tracking and ongoing quality review. OMIC policyholders who face these obligations are encouraged to seek assistance from our confidential Risk Management Hotline at (800) 562-6642, ext. 641.

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. "Patient Complaints and Malpractice Risk." *JAMA* 2002 Jun 12;287(22):2951-7.

Closed Claim Study

Impairment from Alcohol and Cocaine Impacts Defense of Delayed Diagnosis Claim

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Delay in diagnosing and treating retinal detachment.

DISPOSITION

Case was settled on behalf of the insured for $225,000.

Case Summary

The patient was a 60-year-old retired male who had been seeing the insured since 1993 for annual ophthalmic checkups. He had a history of droopy eyelids and in April 2001 presented to the insured complaining that his eye felt "funny" like his "lid was blocking his vision." Visual acuity was 20/30 OD and 20/20 OS. The insured noted 4+ dermatochalasis OU and a restricted upward gaze in the right eye that had been "long standing." A dilated exam with an ophthalmoscope and indirect ophthalmoscope revealed attached retinas. The insured discussed the option of performing a bilateral ptosis repair in an attempt to raise the eyelids.

The patient returned four months later in August for a preoperative workup with taped and untaped visual fields and photographs. Visual fields were the same taped and untaped; however, visual acuity had dropped significantly since April to 20/200 OD. The patient was not examined by the insured ophthalmologist at this visit, and the technician did not inform the insured of the change in visual acuity.

In October, the patient came to the office to sign consent forms for ptosis repair of his upper lids. The insured signed the chart that day but did not examine the patient or review the visual acuity results from August. Three days later, the insured performed bilateral ptosis repair without incident. During the one week postop visit, a visual acuity test was done and the insured noted VA was 20/200 OD. He checked the patient's records and saw that VA was 20/200 OD back in August. The insured immediately referred the patient to a retinal specialist, who diagnosed a retinal detachment OD and performed scleral buckle surgery with cryo treatment and air/fluid exchange to repair it. Over the next seven months, the patient underwent six more retinal surgeries. His final best visual acuity was 20/200 OD with a contact lens. He also had difficulty seeing peripherally and from the right side. The insured was served with a lawsuit in October 2003 for failure to timely diagnose and treat a retinal detachment.

Analysis

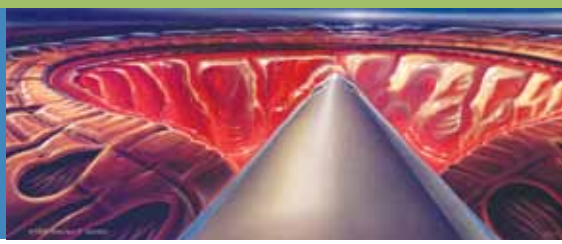
Unknown to either defense counsel or OMIC, the insured had been struggling with alcohol and drug problems for several years, and was voluntarily participating in an anonymous state-sponsored recovery and monitoring program prior to and during the time he was treating this patient. Unfortunately, he was unable to stay drug free and, one month after litigation was initiated, his license to practice medicine was suspended for failure to comply with the voluntary recovery program. The insured never informed OMIC or his defense counsel of his license suspension. He then signed and filed a sworn statement that the injury alleged in the plaintiff's complaint was not caused by the care rendered, even though it was required to be signed by a licensed physician. When the licensure problem was discovered, the plaintiff's attorney filed to dismiss the defendant's answer to the complaint because the insured's statement had not been signed by a licensed physician. If the court granted the dismissal, as seemed likely, the only issue left would be how much money to award the plaintiff. With the insured's consent, the case was settled for $225,000.

Risk Management Principles

Initial review of this case raised concerns around staff supervision and preoperative evaluation. Prior to scheduling surgery, had the ophthalmologist reviewed all chart entries made by staff and asked the patient about changes to his medical or ocular history since the last exam, he might have been prompted to explore other causes for the patient's decreased vision.

However, the focus of the defense quickly shifted to the insured's substance abuse problems when they came to light. The insured is to be commended for seeking help for his addictions. It is widely understood that drug addiction and alcoholism are medical/psychological illnesses that can be ameliorated by treatment. Provided the guidelines of a recovery and monitoring program are followed, a physician's license to practice medicine is not affected. However, by not informing OMIC of his participation in the program or his subsequent license suspension, the insured weakened his defense and potentially put his professional liability coverage at risk. See **Policy Issues** for guidelines on why and when to contact OMIC with competency related issues and how to preserve your coverage.

Risk Management Hotline



Competency Reviews and Discussions

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

Physicians in group practices and those who are owners of ambulatory surgery centers are often interested in monitoring outcomes as part of credentialing processes. Here are some questions our policyholders have posed.

Q My group would like to begin tracking outcomes. How do we begin?

A There are guiding principles that may help to allay concerns and ensure a sense of fairness. First, it is best to discuss the planned review process with all stakeholders. Sufficient time needs to be allotted to achieve consensus on what objective criteria will be used. Clinical material from the American Academy of Ophthalmology, such as *Preferred Practice Patterns,* will be helpful. Ask the medical staff office at the hospital where you have privileges what criteria it uses and how it conducts and documents evaluations. Medical staff bylaws contain a fair hearing process that is usually based upon state law, vetted by the hospital's general counsel, and indicates if any reports must be made to the state medical board. Obtaining these policies and procedures saves time and money, but you will still want to determine if the laws pertaining to groups or surgery centers are the same as those governing hospitals. Ensure that the same evaluation process is applied to all physicians. Develop clearly stated, written objectives geared toward patient safety and continuous quality improvement. Use multiple tools, such as a chart audit based upon a checklist form, patient complaints, feedback from staff and colleagues (see the lead article for signs of issues), and outcome data. If the group is small or there are obvious conflicts, enlist an outside ophthalmologist's assistance.

Q We have been tracking performance in our surgery center and have concerns about a colleague. How do we prepare to talk to him?

A Assess your motives, check for any possible conflict of interest, and develop a plan to disclose and manage any conflicts that are present. Determine who is the best person to lead the discussion. Factors to consider include personality issues and who has the best access to information, rapport with the physician, and communication skills. Plan on a face-to-face meeting, in a neutral location, as close in time as possible to when the problem or complaint surfaces. Schedule the meeting for a time free of patient care and other obligations.

Q I dread having this conversation. What can I do to make it as painless as possible for both of us?

A Remind yourself that physicians have a right and a need to know if there are concerns about their care, and that your goal is patient safety. Think of how you would like to be approached if a colleague had questions about your competency. Begin by expressing your respect and explain that the conversation may be difficult: "Joe, I need to talk to you and am a little nervous about having this conversation. I've enjoyed having you as my colleague and have learned a lot from you. Because I respect you, I want to share some concerns I have." Or, "As you know, I am in charge of reporting back to physicians when there is a complaint. This might be awkward but you deserve to know the feedback we have gotten about your care." Arrange comfortable seating, and maintain a relaxed posture. Emphasize the physician's value to the ASC and the patients, and that you want to help. Provide the objective data. Allow the physician time to respond and explain.

Q I am a subspecialist. Often, I have concerns about physicians who refer patients to me. What feedback can I give?

A If your concerns center on the diagnosis, explain your own diagnostic process in detail in your consultation report, or consider sending an article on the topic along with the report. It may be worthwhile to explain when and why you like to be contacted if you feel the ophthalmologist has waited too long to refer. Focus on how an earlier referral will benefit the patient. If you feel the referring physician is attempting to treat conditions beyond his expertise, ask about his or her skill set: "Most comprehensive ophthalmologists who refer to me don't provide this treatment. Tell me about your experience in this technique." Determine if the patient was reticent to see another physician or if there are logistical or payment barriers.

Q My patient needs subspecialty care. The last few patients I have referred to this ophthalmologist have suffered serious complications that seem to be due to negligence. Could I be liable if I continue to refer patients to this physician?

A Yes. Under a legal theory known as "negligent referral," you may be held liable for substandard care provided by a physician who you knew, or should have known, was incompetent. Addressing quality of care concerns at the earliest opportunity reduces your own possible liability exposure in addition to promoting patient safety.

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Calendar of Events

OMIC continues its popular risk management courses throughout 2010. Upon completion of an OMIC online course, CD, 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.

Upcoming Seminars

July

15 *Difficult Physician-Patient Relationships*
Rocky Mountain Regional Roundup includes AZ*, CO*, ID, MT, NV*, NM, ND, SD, UT, WY
Teton Room, Snow King Resort, Jackson Hole, WY; 12:30 pm
Register with Laurel Walsh at laurelwalsh@netzero.net.

23 *Evaluating Competency; Handling Incompetency*
Southeast Regional Annual Meeting includes ALAO*, LOA*, MEENTA*, and TAO*
Magnolia C, Sandestin Resort, Destin, FL; 7:00–7:50 am
Register with ALAO at www.alabamaeyedoctors.com.

August

14 *Evaluating Competency; Handling Incompetency*
Women In Ophthalmology*
Pinehurst Resort, Pinehurst, NC; 11:45 am–12:30 pm
Contact WIO at http://www.wioonline.org/index.php/meetings.

September

25 *Evaluating Competency; Handling Incompetency*
Indiana Academy of Ophthalmology*
Crowne Plaza Hotel, Indianapolis, IN; time TBA
Register with IAO at (317) 577-3062 or www.indianaeyemds.com.

30 *Evaluating Competency; Handling Incompetency*
Table Rock Regional Meeting includes AOS*, KSEPS*, MoSEPS*, and OAO*
Big Cedar Lodge, Branson, MO; afternoon session
Register with AOS at (501) 224-8967 or www.ArkEyeMDs.org.

October

17 *OMIC Forum: Retina Closed Claims Study*
Annual Meeting of the American Academy of Ophthalmology
McCormick Place, Chicago, IL; 2:00–4:00 pm
Register onsite in the presentation room. For more information, contact Linda Nakamura at (800) 562-6642, ext. 652.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management seminars, CD/DVD recordings, or online courses.