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OPHTHALMIC RISK MANAGEMENT DIGEST
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A RISK RETENTION GROUP)

OMIC DIGEST

The High Cost of Refused Care

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

A patient calls to report symptoms suggestive of endophthalmitis but refuses to drive to a satellite office where the ophthalmologist is working that day. A patient who recently had cataract surgery calls the surgeon to complain of headaches unrelated to the surgery but won't go see her primary care physician. A glaucoma patient refuses to come in for a follow-up visit to perform visual fields and check the optic nerve but wants the ophthalmologist to keep refilling her prescription. A comprehensive ophthalmologist refers a patient to a glaucoma expert for surgery but the patient won't go. The parents of a minor patient with retinoblastoma won't agree to surgery. These narratives are just a few of the many examples of situations where patients of OMIC-insured physicians, or patients' representatives, have refused care. These patients and parents gambled that they could beat the odds of not only vision-threatening but life-threatening conditions. All patients sustained harm, and all sued their ophthalmologist when they did. In this issue of the *Digest*, we explore the high cost to patients and physicians alike when care is refused, and we propose ways to reduce this risk.

Who may refuse?

Physicians may be uncomfortable when care is refused, but recognize that adult patients have the legal right to consent to, or refuse, recommended care. Indeed, this right is the premise behind informed consent discussions, where the physician explains the patient's condition, proposed treatment, and its risks, benefits, and alternatives, including no treatment. In order to make a meaningful choice, however, adult patients must have decision-making capacity (DMC). Adult patients are presumed to have DMC if they appear to understand their condition and the risks associated with the recommended treatment, and are able to communicate their wishes.

In the Fall 2010 issue of the *Digest*, we addressed the need to screen for dementia, especially in older patients. Patients who seem "difficult" and miss appointments or refuse care may actually be suffering from dementia, so the first step in assessing a patient's refusal of care is to consider cognitive impairment. Such patients should be referred to a primary care physician for evaluation. See "Older Patients Need Additional Informed Consent Consideration" at http://www.omic.com/older-patients-need-additional-informed-consent-consideration/ for a discussion of dementia screening tools and surrogate decision-makers.

Clarify why care is refused

Having ruled out cognitive impairment or lack of decision-making capacity in adult patients, the ophthalmologist will next want to ascertain the reason for the patient's refusal.

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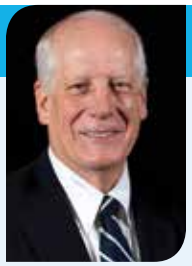

Message from the Chairman

It was Bruce Spivey in his position as Executive Vice President who led the leadership of the American Academy of Ophthalmology to create its own professional liability insurance company in 1987. Dr. Spivey understood that a company dedicated exclusively to insuring ophthalmologists would be in a better position to provide ophthalmic-specific risk management and claims handling services than multispecialty carriers. It is therefore appropriate that OMIC and the Academy would join forces to recognize and honor Dr. Spivey with the establishment of the Bruce E. Spivey, MD, Fund for Risk Management Studies. The fund's mission is threefold:

1. Assist OMIC in developing innovative risk management and patient safety initiatives, studies, and educational programs that will improve the quality of eye care around the world;
2. Explore new ways of bringing risk management and patient safety programs to ophthalmologists who are members of the Academy, including international members;

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Eye on 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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OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

P 800.562.6642
F 415.771.7087
omic@omic.com
www.omic.com

A Fund for Risk Management Studies

The OMIC Board of Directors has unanimously approved an initial donation of $50,000 toward establishment of the Bruce E. Spivey, MD, Fund for Risk Management Studies. This is the latest collaborative effort between OMIC and the American Academy of Ophthalmology to further their shared goals of risk reduction for ophthalmologists and improved ophthalmic care for patients.

The Spivey Fund will operate within the Academy Foundation's H. Dunbar Hoskins Jr., MD, Center for Quality Eye Care. The Hoskins Center will manage funds for projects determined by OMIC and the Academy to be consistent with their risk management and patient safety goals. OMIC will combine its extensive claims database and risk management knowledge with the Hoskins Center's expertise in issue analysis and outcomes measurements. This potent combination of experience and expertise will be useful in developing evidence-based resources and tools for ophthalmologists that improve patient care and minimize the risk of lawsuits.

A highlight of the fund will be the "Bruce E. Spivey, MD, Lecture in Risk Management and Patient Safety." This will be an annual lecture at the Academy's annual meeting co-sponsored by OMIC and the Hoskins Center. Susan H. Day, MD, a pediatric ophthalmologist in San Francisco, CA, will be this year's guest lecturer. In addition to serving as Academy president in 2005 and holding numerous other Academy leadership positions, Dr. Day was an OMIC board and committee member from 1996 through 2008. She is also past president of the American Association of Pediatric Ophthalmology and Strabismus. Dr. Day is currently Chair and Program Director for the Department of Ophthalmology at California Pacific Medical Center, a position Dr. Spivey held himself for many years.

Message from the Chairman

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3. Develop tools that measure the effectiveness of risk management and patient safety education initiatives and their impact on physician and institutional behavior.

OMIC has provided $50,000 in seed money to get the fund up and running. There is already a record of several high-value joint Academy/OMIC programs in which OMIC provided not only special expertise but also financial support. Examples include an online informed consent CME course, a "wrong site surgery" patient safety program, and several patient education updates. OMIC funded these projects because they promised to provide ophthalmologists with risk management tools to reduce exposure to lawsuits while, at the same time, improving patient care.

Establishing the Spivey Fund within the Academy Foundation's Hoskins Center will formalize future initiatives between OMIC and the Academy, streamline administration of these initiatives, and allow a way for others to provide vital philanthropic support for these critical projects and activities. As part of the Academy Foundation, the fund is set up so any individual, corporation, foundation, trust, estate, or legal entity may contribute. A description of the fund and how to donate can be found on the Foundation's web site at https://secure.aaofoundation.org/onlinedonate_faao/spivey.aspx.

Potential contributors can feel confident that the Spivery Fund will be well managed. OMIC is an established, financially strong company and is committing its own financial resources to fund joint projects with the Hoskins Center because we believe they will benefit ophthalmology. Furthermore, OMIC will bring its business organizational skills to ensure that clear and measurable goals are set and met.

This new alliance between OMIC and the Academy will make both organizations stronger and better able to cope with the tremendous changes facing healthcare providers in the 21st century.

John W. Shore, MD, Chairman of the Board

Refused Care Coverage and Minor Refusal

Kimberly Wynkoop, OMIC Legal Counsel

As the lead article addresses, there are situations where patients refuse care, their vision is adversely affected, and then they sue their ophthalmologist for failing to treat them. Rest assured that OMIC's policy provides coverage for such allegations. OMIC promises to defend ophthalmologists and pay damages because of claims that result from injury to a patient because of a "professional services incident" arising from "direct patient treatment."

The policy defines direct patient treatment as the provision of health care services to a patient, including making diagnoses, providing medical or surgical treatment, prescribing or dispensing drugs or medical supplies or devices, rendering opinions to a patient, giving advice to a patient, or referring a patient to, or consulting about a patient with, another physician or health care provider.

A professional services incident is any act, error, or omission, that is neither intended nor expected in the provision of, or the failure to provide, direct patient treatment. Coverage for omissions and failure to provide direct patient treatment is an important component of your professional liability coverage, as failure to treat can be the alleged breach of duty that triggers a negligence claim.

Minor refusal of care

Adult patients have the legal right to refuse recommended care as long as they have decision-making capacity. Minor patients, on the other hand, lacking the necessary experience, knowledge, and maturity, are generally considered incompetent to make their own decisions and are not granted the legal authority to consent to or refuse care. Legal decision-making authority is generally achieved only when an individual reaches the age of majority, 18 years of age (or after high school graduation if later) in all but four states. There are two traditional categories of exceptions to the age of majority requirement for consent: individual status and medical service.

Minor patients whose status indicates that they function as adults are granted the right to consent to or refuse treatment. Such status exceptions, which vary by state, include marriage, being a parent of a child, active duty with the Armed Forces, and court ordered emancipation. Another status exception, recognized in California, is self-sufficiency: when a minor is 15 years of age or older, lives away from home, and manages his or her own financial affairs.

Service exceptions occur when minors seek specific treatment for certain medical conditions, such as pregnancy, mental health problems, alcohol or drug dependency, or infectious diseases. The rationale for such exceptions is that minors will be more likely to seek treatment for sensitive health issues if they are not required to notify their parents.

Mature minor doctrine

While courts and legislators have struggled with the issue of when to permit minors to legally consent to medical treatment, they have had even more difficulty when the medical decision-making at issue is refused care. Cases often involving refused care have led to the development of the third exception to the majority requirement for consent, the "mature minor" doctrine. This doctrine recognizes that some minors are mature enough to evaluate treatment options and make their own decisions. Courts look at individual circumstances and factors including the minor's age, behavior, education, competence, and knowledge. They must weigh the state's rights and responsibilities to preserve the life of a minor and maintain the ethical integrity of the medical profession, the minor's rights to autonomy and privacy (and, in some cases, religious freedom), and, if the parents' wishes conflict with the child's, the rights of the parents to make decisions for their children.

The doctrine lacks clear principles for application, however, and varies from state to state (with many states having not addressed the issue yet and at least one state, Georgia, specifically refusing to apply the doctrine). For example, in Illinois, a mature minor can refuse medical treatment unless such refusal would threaten the child's health or welfare, while Virginia (by legislation) permits a minor 14 years or older to refuse, with parental acquiescence, medical treatment even for a life-threatening disease.

Not all state laws are clear on consent and refusal of care and physicians often have to make decisions before getting a court order or legal determination. Therefore, even if minors have the authority to consent to treatment, it is prudent, with the patient's permission, to involve the parents in the discussion. Likewise, in cases where minors do not legally have decision-making authority (e.g., for most ophthalmic treatment), it is recommended that ophthalmologists obtain minor assent in addition to parental consent for or refusal of treatment.

Insureds are encouraged to seek risk management advice on refusal of care through OMIC's confidential risk management hotline at 800. 562.6642, option 4, or by email at riskmanagement@omic.com.

The High Cost of Refused Care

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Ophthalmologists and staff are often quite frustrated when patients refuse recommendations, and just as often make assumptions about the reasons. The healthcare team members may lose important opportunities to intervene if they do not take the time to discern the patient's motives. A simple, straightforward approach can be very effective: "You're not willing to have the surgery? That is certainly your choice, but I would like to understand your decision. Can you tell me more about it?" Sometimes, patients disagree with the diagnosis: "I don't need the surgery because that is not what's wrong with me!" Keeping an open mind, the physician can ask the patient "What do you think is wrong?" Staff can play an important role by anticipating problems with compliance, and letting patients know that it is acceptable to ask questions.

Educate the patient about the disease process and treatment recommendations, targeting the education to the reason for the refusal. When possible, identify social service resources that may help, such as pharmaceutical companies that may provide free or reduced-cost medications. Have information available about the enrollment criteria and process for obtaining state and federal assistance, and be aware of transportation services for patients. If the care is not authorized by the patient's insurance, act as an advocate and appeal the decision. If the main reason behind the refusal is an unwillingness to pay for care, a different approach is needed. See *Risk Management Hotline* on page 7 for suggestions on how to handle this.

Duty to warn

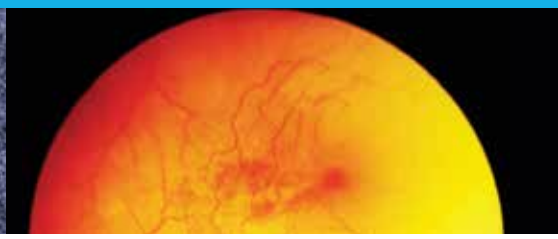
If the patient persists in declining recommended treatment, the physician must then obtain what is referred to as "informed refusal." While courts have recognized the patient's right to refuse treatment, they have consistently ruled that the decision must be an informed one. OMIC's claims experience has shown that experts and juries alike consider the patient to be "ignorant until proven educated." To ensure that patients have adequate information on which to base their choice, physicians are thus required to warn patients of the foreseeable consequences of refusing treatment, such as reduced vision or blindness.

Some refused care situations are straightforward, prompting physicians and their staff to warn patients. In the lawsuit featured in this issue's *Closed Claim Study*, a postoperative patient with symptoms highly suggestive of endophthalmitis was asked to come in to a satellite office where a physician could see him immediately since the office he usually went to was closed that day; the patient refused to drive to the other office, claiming it was too far away. Staff and the ophthalmologist were concerned and repeatedly warned the patient that a delay in treatment could lead to serious vision loss or blindness in that eye—all to no avail.

Physicians can only warn of consequences they foresee. About eight days after cataract surgery and the implantation of a premium intraocular lens (IOL), a patient reported that she had experienced migraine-like headaches since the procedure and had been awakened at 3 am by one the night before her appointment. When the eye exam was unremarkable and the only finding was a tender area in the right sub-occipital area, the eye surgeon informed the patient that the IOL was not causing her headaches and instructed her to contact her primary care physician (PCP) to explore other causes. The headaches persisted to the point that the patient called the ophthalmologist five days later and asked to have the IOL removed. The physician again advised her to see her PCP or go to the emergency room. She refused to do either, convinced they would only prescribe more pain medication. The patient was worked in to the ophthalmologist's schedule several hours later and was so ill that she vomited twice while in the waiting room. The eye exam was again normal. Concerned, the ophthalmologist contacted the PCP himself and arranged for the patient to be seen right away. She saw her PCP that day and a CT was performed. The patient collapsed and died the next day right after a return visit to the PCP. The CT showed a large, chronic subdural hematoma, confirming that the cause of the headaches was not related to the cataract surgery. The ophthalmologist was criticized by both plaintiff and defense experts for not examining the optic nerve or ordering a sedimentation rate, since the patient had no history of migraine headaches but did have hypertension. The defense expert acknowledged, however, that the eye surgeon did arrange for the patient to see her PCP and confirmed that her death was unrelated to the eye surgery. The ophthalmologist settled for a nominal amount, and the case continued against the PCP.

Ongoing and repeated noncompliance

OMIC's claims data shows that ophthalmologists who treat glaucoma patients frequently confront noncompliance and refused care, but often do not adequately warn their patients of how such noncompliance puts them at risk. One patient with chronic primary open-angle glaucoma had homes in both the Northeast and the South. Citing a planned trip to her other home as the reason, she declined to come in for her follow-up examination during which visual field testing was scheduled. She nonetheless asked the ophthalmologist to renew the prescription for her glaucoma medication. The physician agreed to the patient's request, not just once, but over many months.



By doing so, he operated on the assumption that the medication was controlling the patient's disease and so did not warn her that the medication might not be effective or that, without an examination, her disease could progress despite treatment. Unfortunately for both the patient and the physician, this is exactly what happened. When she suffered visual loss as the result of progressive glaucomatous changes, she sued her ophthalmologist. Defense and plaintiff experts agreed that the patient's refusal to come for follow-up care was a factor, but felt that it was below the standard of care for the physician to continue to prescribe without examining the patient and warning her of the consequences of refusing to be examined. OMIC settled the case.

Sometimes, the patient provides no reason for refusing to follow treatment recommendations. One such patient changed her appointments at will, coming only when it was convenient for her, as evidenced by several pages in her medical record devoted to the dozens of missed and rescheduled appointments. Despite written instructions and regular documented warnings from her physician about the importance of administering her glaucoma and steroid drops as instructed, she continued to take them as she pleased, leading to sustained increased intraocular pressure over a six-month period during which time she kept missing appointments. It was only when signs of glaucoma progression were noted that the comprehensive ophthalmologist referred her to a glaucoma surgeon. She allegedly refused, but there was no documentation in this instance of the warning. The patient denied that she had refused to see the glaucoma specialist but, since she also denied that she had missed appointments, defense counsel challenged her credibility, and the defense expert pointed to the patient's noncompliance as a significant cause of her diminished vision. Experts on both sides insisted that regardless of the patient's behavior, the eye MD had a duty to take more decisive action in the face of this patient's repeated unwillingness to partner in her care, such as referring the patient much earlier and documenting a warning when she declined the referral. Not surprisingly, the plaintiff did not cooperate any better with her attorney than she had with her ophthalmologist. She "no showed" for her own deposition and eventually decided not to pursue the case. See "Noncompliance: A Frequent Prelude to Malpractice Lawsuits" at http://www.omic.com/noncompliance-guidelines-with-sample-missed-appointment-letter/ for detailed recommendations on prescription refill policies, how to manage missed appointments, track tests, and reduce the risk of noncompliance.

Duty to report neglect

Patients who have not reached the age of majority, generally 18 years of age, do not usually have the legal authority to consent to or refuse care (see *Policy Issues* for more information on minor consent). Eye surgeons often have questions about how to handle a parent or legal guardian's refusal to give consent for the treatment of a minor. The concern is warranted, for the physician has both a duty to the child to provide needed care, as well as a duty to report suspected child abuse or neglect. State laws generally include in the definition of neglect a situation in which the child's health may be endangered by the failure to provide medical care, demonstrating that a parent's right to refuse certain types of care is restricted. For example, an OMIC-insured ophthalmologist diagnosed retinoblastoma, and explained to the distraught parents that surgery was urgently indicated in order to preserve the child's life. The parents declined. The same advice was given by a series of physicians who were asked by the parents to see the child. Eventually, the parents were reported to the state's child protective services department, and the child had the surgery after being removed from the parents' home. The surgery occurred too late to save the child's life. The parents proceeded to sue each physician who had examined the child; their suit was unsuccessful.

Ophthalmologists who care for minor patients should seek risk management assistance when parents refuse care. Physicians should have a low threshold for reporting refused care as possible child neglect if the minor patient risks significant loss of vision or harm. Consistent with this recommendation, OMIC has amended its sample letters to parents of infants being screened for retinopathy of prematurity, for example, to state that if the parent refuses screening or treatment for ROP, the ophthalmologist will discuss the refusal with the other physicians involved in the infant's care and with the state's child protective services.

These case examples demonstrate that physicians put their professional well-being and the patient's health at risk if they do not manage patients and parents who refuse care. Physicians may improve the likelihood of patients getting the needed care, and reduce their malpractice exposure, by exploring the reasons care is refused, by warning patients of the consequences of refusing care, and by documenting that discussion. When a surrogate decision-maker is refusing care, the physician should consider whether the refusal constitutes neglect and whether there is a duty to report the refusal to adult or child protective services. OMIC policyholders needing assistance with these issues are encouraged to contact our confidential risk management hotline by phone at 800.562.6642, option 4, or by email at riskmanagement@omic.com.

Closed Claim Study

Allegation

Failure to follow up with patient after a negligent injection of Kenalog.

Disposition

Defense verdict.

Abandonment or Noncompliance?

Ryan Bucsi, OMIC Senior Litigation Analyst

Case summary

A 56-year-old male patient with type II diabetes began to complain of decreased vision OD one month following uncomplicated cataract surgery OD. He was referred to an OMIC-insured retinal specialist, who diagnosed diabetic macular edema and proliferative diabetic retinopathy OD. The insured recommended an intravitreal injection of preservative-free triamcinolone acetate (Kenalog), which was performed without complication. The following day, the patient returned to the retinal specialist with hand motion vision, pain, pressure, and photophobia. The insured diagnosed pseudoendophthalmitis and prescribed antibiotics. Three days later, the patient returned to the insured with hand motion vision. The insured diagnosed pseudo versus infectious endophthalmitis and the patient elected to continue with antibiotics and steroid drops versus injection. Ten days later, the patient's visual acuity improved to 20/100 OD; however, two weeks later, the patient called to report pain and redness OD. The insured asked the patient to come into a satellite office, but the patient declined due to the increased driving distance. The patient was advised of the risk of not being seen and an appointment was scheduled for two days later. On the following day, the patient telephoned the retinal specialist to report pain and increased blurring. The patient was advised to come into the satellite office, but once again refused citing the increased distance. When the patient finally did return to the office, visual acuity was hand motion OD and intraocular pressure was 66. The insured tapped the right eye on two occasions, which only temporarily decreased the pressure. When the patient declined a third tap, the insured referred the patient for a trabeculectomy, but this was delayed as the patient was admitted to the hospital for dehydration. Following this hospitalization, a trabeculectomy was performed which eventually resolved the increased pressure. A second retinal consultation by a non-OMIC insured was performed, which revealed hand motion vision, no detachment, vitreous opacity, and controlled pressure OD. A pars plana vitrectomy and lens removal were eventually performed which resolved the endophthalmitis, but the vision remained at hand motion.

Analysis

Plaintiff alleged that the Kenalog injection caused glaucoma and endophthalmitis resulting in hand motion vision OD. He also alleged that he was not aware of the off-label use of Kenalog and that the insured "abandoned" him. Plaintiff's expert testified that the insured had a duty to travel to see the patient. The defense argued that the insured met the standard of care for informed consent by advising the patient of the risks and alternatives and that the patient signed a consent form for the Kenalog injection. The defense refuted the abandonment allegation and argued contributory negligence by the patient when he declined to drive to a satellite office, even though it was no more than 27 additional miles from where he was regularly seen. The defense expert testified at trial that the patient's noncompliance played a definite role in his outcome. The defense also noted that post-injection, steroid-induced glaucoma and endophthalmitis are known side effects of intravitreal Kenalog injections. Although the discussion about the off-label use of Kenalog was not documented in the patient's chart, during deposition the office technician explained that the insured "always" explained to patients when drugs were used off-label. The plaintiff demanded $750,000 to settle, but the insured and OMIC agreed that the case was defensible. After a three-day trial and 90 minutes of deliberation, the jury returned with a defense verdict.

Risk management principles

To prove abandonment, the plaintiff must show that there was an established physician-patient relationship and that care was withdrawn without adequate warning. OMIC is not aware of any legal duty during this relationship for a physician to go to a patient's home, nursing home, or, as in this case, another office. Patients have a legal right to refuse care. On the other hand, physicians have a legal duty to explain the consequences of refused care, which the insured did. OMIC recommends that physicians inform patients of off-label use, especially if the treatment consists primarily of an off-label medication, as in this case (see sample consent form at http://www.omic.com/informed-consent-for-off-label-use-of-a-drug-or-device/).

When Patients Won't Pay for Care

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

Some patients who opt for high-deductible health insurance plans or go without insurance altogether decide to postpone or refuse recommended care. Some of these patients are perfectly willing to receive the care, but not to pay for it. When patients base their healthcare decisions primarily on financial considerations, they put their physicians in a difficult position. OMIC's risk management team has received a number of calls from policyholders trying to balance their professional liability risk with their practice's financial well-being. The following discussion assumes that the patient has some financial resources and provides general principles for dealing with this situation. In the case of indigent patients who have no financial resources, ophthalmologists may decide to provide care at little or no cost and/or help the patient find alternative sources of care. OMIC believes this is not only compassionate but also helps minimize the risk of a claim. Please call our confidential risk management hotline at 800.562.6642, option 4, for specific advice.

Q My patient presented with a macula-on retinal detachment. I recommended that surgical repair take place within several days. When my surgery scheduler informed the patient of the price, the patient said he was not willing to pay and refused to sign a financial agreement form. Do I have to provide the surgery free-of-charge now that I have established a physician-patient relationship?

A No. OMIC is not aware of any law or regulation related to outpatient, non-emergent care that requires a physician to provide free care. To our knowledge, the only situation in which patients have the legal right to obtain care without payment being an issue is in an emergency room. The law governing this care is the Emergency Medical Treatment and Active Labor Act, or EMTALA, and applies only to care provided in the ER, and only until a physician determines that the patient does not have an emergency medical condition (EMC), or that the emergency medical condition has been stabilized. If no EMC exists, or it has been stabilized, the hospital may then ask about the patient's insurance status, and may then either provide further care with payment provided by insurance or on a fee-for-service basis. Hospitals provide patients who choose not to pay for non-emergent care information on where such care may be obtained outside the hospital. Ophthalmologists may also choose to refer patients who are not willing to pay for care to other possible sources of care.

Q If I refuse to provide the care I am recommending unless the patient pays, am I "abandoning" the patient?

A If you offer to treat the patient, you have not abandoned him. Clarify to the patient that you are available to provide the treatment, but that you expect to be paid for your care. Explain when the care is needed, what the consequences of not getting the care are, and where else the patient may go for care. Document the conversation, and provide the patient with a list of resources as well as a written discussion of the consequences of not getting treatment. Consider discharging the patient (see http://www.omic.com/terminating-the-physician-patient-relationship/ for a sample form).

Q Should I provide emergent care even if my patient won't sign a financial agreement?

A While we are not aware of a law or regulation that requires physicians to provide any care for free except as discussed above in the context of EMTALA, we feel that the risk to the patient and physician alike is too great to refuse to provide emergent care when you have established a physician-patient relationship. Our risk management recommendation, therefore, is to provide the emergent care, and then address the patient's financial obligations. If the patient continues to refuse to pay for care after the emergent condition has been treated, consider terminating the relationship.

Q My patient showed up for an appointment for a non-emergent condition, but won't pay her copay or deductible. May I reschedule the appointment?

A Yes. As long as you are confident in the screening process your staff use to determine the appointment category, you may ask patients to come back when they are prepared to meet their financial obligations. See "Telephone Screening of Ophthalmic Problems" at http://www.omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/.

Ophthalmologists should consider developing a "Patient Financial Responsibility" policy and statement that clarifies what options are available for payment, and what consequences the patient might face if he does not meet his financial responsibility. Many sample statements are available on the internet.

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

Calendar of Events

OMIC continues its popular risk management courses in 2013. Upon completion of an OMIC online course, CD/DVD, 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 seminars, CD/DVD recordings, or computer-based courses.

NEW!

My Doctor Never Told Me That Could Happen! Webinar available to OMIC insureds at no charge. Contact OMIC's risk management department for more details.

APRIL

3–7 *Lessons Learned from 25 Years of Pediatric & Strabismus Claims.** American Association for Pediatric Ophthalmology & Strabismus. Westin Copley Place, Boston, MA; time TBA. Register at 415.561.8505 or http://www.aapos.org/meeting/2013_annual_meeting_/.

22 *Successfully Maneuvering the Legal Rapids.* American Society of Cataract & Refractive Surgery. Marriott Marquis, Room Yerba Buena 5-6, San Francisco, CA; 8–9 am. Register at http://13am.ascrs.org/.

MAY

17–18 *OMIC Closed Claims.** Kentucky Academy of Eye Physicians & Surgeons. 21 C Hotel, Louisville, KY; time TBA. Register at http://www.kyeyemds.org/.

17–18 *OMIC Closed Claims.** Texas Ophthalmological Association. Henry G. Gonzalez Convention Center, San Antonio, TX; time TBA. Register at 512.370.1504 or http://texaseyes.org/.

JUNE

9 *OMIC Closed Claims.** American Society of Ophthalmic Plastic & Reconstructive Surgery. Hyatt Regency, Newport, RI; 10:15 am. Register at http://www.asoprs.org/.

14–16 *OMIC Closed Claims.** Georgia Society of Ophthalmology. The Cloister at Sea Island, GA; time TBA. Register at http://www.ga-eyemds.org/.

15 *OMIC Closed Claims.** Virginia Society of Eye Physicians & Surgeons. Virginia Beach Hilton Oceanfront Hotel, VA; time TBA. Register at http://www.vaeyemd.org/.

20–23 *OMIC Closed Claims.** West Virginia Society of Eye Physicians & Surgeons. The Greenbrier, White Sulphur Springs, WV; time TBA. Register at http://www.vaeyemd.org/.

28–30 *OMIC Closed Claims.** Arizona Ophthalmological Society Grand Canyon Meeting. High Country Conference Center, Flagstaff, AZ; time TBA. Register at 602.347.6901.

28–30 *OMIC Closed Claims.** Florida Society of Ophthalmology. The Breakers, Palm Beach, FL; time TBA. Register at http://www.mdeye.org/display.php?n=299.