



THE OPHTHALMIC RISK MANAGEMENT DIGEST

OPHTHALMIC MUTUAL INSURANCE COMPANY

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Giant cell arteritis claims are costly and difficult to defend

RONALD W. PELTON, MD, PhD, OMIC Committee Member, and ANNE M. MENKE, RN, PhD, OMIC Risk Manager

A 77-year-old male patient presented for the first time to our insured ophthalmologist to report the sudden onset of intermittent diplopia six days prior and a headache over his eyebrows for one day. Noting right inferior oblique muscle paresis but unable to determine its cause, and with no neuro-ophthalmologist in the region, the eye surgeon referred the patient to a neurologist. The patient told the neurologist that the headache had actually lasted for one month and that he was also experiencing jaw pain. This additional information prompted the neurologist to include giant cell arteritis (GCA, also known as temporal arteritis) in the differential diagnosis and to order an MRI, CT, and lab work.

When the patient saw the ophthalmologist about two weeks later, he reported a new symptom, a low-grade fever, with ongoing headache and diplopia. Five days after that—a full three weeks after the initial visit to the ophthalmologist—the patient lost vision in his left eye. An emergency room physician diagnosed giant cell arteritis and began intravenous steroid treatment, but the patient never regained vision in that eye. The malpractice lawsuit against the ophthalmologist settled for \$85,000; we do not know the outcome of the suit against the neurologist.

Armed with hindsight bias, the classic signs and symptoms of giant cell arteritis jump out: older patient, vision changes, headache, jaw pain, and fever. It is hard to imagine how the definitive diagnosis and treatment

were delayed for so long and easy to erroneously conclude that both physicians must have been incompetent. The claims investigation showed instead that these physicians had treated patients with giant cell arteritis, knew its signs and symptoms well, and understood that emergent treatment is needed to prevent imminent, bilateral vision loss. What, then, led these physicians astray?

Severe vision loss, costly claims

This issue of the *Digest* will report on a study of OMIC claims involving 18 patients diagnosed with GCA between 1993 and 2014. In 12 of the 18 cases (66%), no physician included GCA in the differential diagnosis. Four of these patients were seen only by an ophthalmologist; the rest were examined by an eye surgeon and one to three additional physicians. And although GCA was considered by the ophthalmologists in each of the remaining six cases, symptoms in five patients progressed when either the ophthalmologists or other physicians did not follow through to confirm the diagnosis and coordinate treatment. All 18 patients experienced severe vision loss, often bilaterally. OMIC had to settle twice as many of these claims as OMIC claims overall, and the mean and median payments were both considerably higher (see table 1). The short window for diagnosis and treatment and the risk of severe bilateral vision loss make the high stakes of this relatively rare condition clear. This issue of the *Digest* will explore the reasons for these poor outcomes, the standard to which



MESSAGE FROM THE CHAIR

TAMARA R. FOUNTAIN, MD, OMIC Board of Directors

I'm the daughter of an aviator. I spent hours as a child sitting with my dad on the hood of a '65 Mustang watching planes take off and land at Minneapolis/St. Paul International Airport. A former Air Force instructor pilot and Northwest Airlines captain, he taught me early on how 450 tons of aluminum can become airborne (Newton's Third Law) and other aerodynamic concepts like pitch, yaw, attitude, and angle-of-attack. I still love talking to my father about airplanes and, like cable news outlets, often turn to my own resident aviation expert whenever a commercial airliner goes down. He is nearly always spot on when he predicts a crash was due to pilot error. Though each accident may have different antecedents, the final, often fatal mistake usually boils down to a simple failure of the flight crew to "fly the airplane."

The 2009 crash of Air France 447, an overnight flight from Rio de Janeiro to Paris, is a classic case study in pilot error. Over the Atlantic, three hours into a routine flight, the crew started receiving faulty airspeed readings



Rate decrease and policyholder dividend approved for 2016

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MIC's Board of Directors is pleased to announce a nationwide rate decrease and a 20% policyholder dividend for insureds effective January 1, 2016.

After a favorable year buttressed by excellent claim results and lower than expected operating expenses, OMIC is experiencing one of our best years ever. In recognition of this development, we are implementing a rate decrease in all states totaling approximately \$6 million nationally. The amount will vary by coverage area and insureds will be notified of the decrease in their territory.

Since 2005, OMIC has lowered rates by an average of nearly 40% nationally. OMIC continues to outperform competitors by making fewer and lower average indemnity payments than the multispecialty industry average.

OMIC will also apply a policyholder dividend for all physician insureds in the form of a 20% credit toward 2016 renewal premiums. Since the company's inception, OMIC has announced

MESSAGE FROM THE CHAIR

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while entering a thunderstorm. Onboard computers, recognizing the erroneous airspeed was inconsistent with all the other normally functioning flight indicators, kicked off the autopilot. Forced to fly manually and distracted by the faulty airspeed, the crew (incorrectly) pulled the nose up, slowing the plane down and precipitating a stall. This error was further compounded when, in a departure from standard cockpit procedure, the pilots failed to monitor and call out loud the plane's altimeter readings (how far up in the air the plane is). Recovering from a stall is as instinctive to an aviator as putting one's hands out to break a fall: point the nose down, build up air speed, restore lift to the wing (Bernoulli's Principle), and pull out into level flight. The crew had at least two minutes during their free fall to safely execute this maneuver but lost situational awareness of where they were in the air. Trying to troubleshoot the various alarms, confused and panicked by conflicting information, the pilots of Air France 447 literally forgot to "fly the airplane." In under four harrowing minutes, the Airbus 330 dropped 38,000 feet from the nighttime sky killing all 228 aboard.

dividend credits totaling more than \$65 million, leading peer companies by a wide margin. Issuance of dividend credits is determined each year after careful analysis of operating performance. OMIC remains committed to returning premium above what is necessary to prudently operate the company and to do so at the earliest opportunity.

Issuance of the dividend requires that an active 2015 professional liability policy be renewed and maintained throughout the 2016 policy period. Mid-term cancellation would result in a pro-rata dividend. Dividends appear on your policy invoice as a credit to either your annual or quarterly billing installment. OMIC issues dividends as a credit toward renewal premiums for two reasons: premium credits offer favorable tax implications for policyholders and allow for easy and efficient distribution of dividends, which keeps operating expenses as low as possible.

This issue of the *Digest* is dedicated to missed diagnoses, the medical equivalent of "forgetting to fly the airplane." By one estimate, failure to diagnose kills over 40,000 people annually in American ICUs alone.¹ That's the equivalent of three Air France crashes every week. Plaintiffs alleged a failure to diagnose in 13% of OMIC's 4,500 closed claims. It's not the "zebras" we overlook; retinal detachment, glaucoma, and intraocular foreign bodies are among the top diagnoses we miss. The same factors contributing to pilot error—conflicting information, distraction, lack of communication, departure from preferred practice patterns—are at work in our clinical environments. Like those Air France pilots who failed to execute a successful recovery from their stall, we ophthalmologists usually have all the clinical information we need to make the correct diagnosis, even when we fail to do so. Maintaining situational awareness in high stakes, high stress situations—Why is this patient deteriorating? What could I be missing?—helps us to better connect the dots. Now sit back, relax, and read on for tips to keep you and your passengers, I mean patients, safe.

1. <http://qualitysafety.bmj.com/content/early/2012/07/23/bmjqs-2012-000803.abstract>

National Practitioner Data Bank reporting

KIMBERLY WYNKOOP, OMIC Senior Legal Counsel



When OMIC settles a claim or pays a judgment against an insured, policyholders often wonder if the payment will be reported to the National Practitioner Data Bank (NPDB). This article will describe under what circumstances federal law requires such reporting.

The NPDB Guidebook states that a payment made by an entity for the benefit of a healthcare practitioner to satisfy a written claim or judgment for medical malpractice must be reported. This sounds simple enough, but breaking this requirement down shows that there are situations where the requirement to report is not always clear.

First, what is “making a payment”? The NPDB considers making a payment to be the exchange of money. A fee refund is considered “making a payment.” A waiver of a patient’s debt, on the other hand, is not considered “making a payment” and therefore should not be reported.

What if the payment is made for the benefit of an entity, not for the benefit of a healthcare practitioner? A medical malpractice payment made solely for the benefit of a corporation, such as a clinic, group practice, or hospital, should not be reported. However, a payment made for the benefit of a business entity that consists of only a sole practitioner must be reported. In other words, a payment made for the benefit of a sole shareholder corporation is considered a payment made for the benefit of the individual sole practitioner.

What constitutes a reportable claim? Only medical malpractice payments resulting from a written complaint or a written claim demanding monetary payment are to be reported. This includes tort actions brought in state or federal court or before another adjudicative body, such as a claims arbitration board, and any form of pre-litigation written communication demanding

payment for damages. This could be a letter from a patient alleging a botched surgery and demanding compensation (a specific dollar amount need not be requested). Conversely, payments based solely on oral demands are not to be reported. For example, if a patient calls or comes in person to the office and demands a refund for what he or she considers poor treatment, payment of the refund would not be reportable.

For reporting purposes, the claim must be based on a practitioner’s provision of or failure to provide healthcare services; the NPDB interprets this broadly. For instance, if a suit is brought against a practitioner alleging medical malpractice and other torts, and the medical malpractice counts are dropped, if the insured is still named in the suit and OMIC makes a payment on behalf of the insured practitioner, OMIC must report the payment. The narrative portion of the report can be used to explain why the payment was made, that the medical malpractice allegations were dropped, or any other relevant data.

A report is only required if the practitioner is named, identified, or otherwise described in both (1) the written complaint or claim demanding payment and (2) the settlement release or final adjudication, if any. So if a practitioner is named in the release but not in the demand or lawsuit, that practitioner need not be reported. If a practitioner was named in a lawsuit but is later dismissed and is not identified in the settlement release, a payment need not be reported for that practitioner unless his or her dismissal resulted from a condition in the settlement or release.

Even if several ophthalmologists are insured under one policy, a report is made to the NPDB only for the individual practitioner for whose benefit a payment was made. If OMIC makes a payment for the benefit of multiple insureds due to one claim,

reports must be submitted for each insured. If it is impossible to determine the amount paid on behalf of each insured individually, the total amount and the total number of practitioners must be reported on each submission. If payment can be apportioned, OMIC must report the actual amount paid for the benefit of each practitioner on their respective reports. If multiple payers contribute to the settlement or satisfaction of a judgment for the benefit of one practitioner, they each must submit a report. For example, if OMIC and a patient compensation fund each pay a share of an award, they report their respective payments to the NPDB.

OMIC is also required to submit a copy of the NPDB report to the appropriate licensing board in the state where the act or omission that was the basis of the claim occurred. Generally, OMIC does not supply any further information on the claim to any state administrative body unless it is necessary to coordinate payment with a patient compensation fund.

As a reminder, the NPDB was created by Congress as an electronic repository of information on medical malpractice payments and certain adverse actions that authorized organizations can access to make licensing, credentialing, privileging, or employment decisions. The reports are confidential and not available to the public, though the subjects of these reports have access to their own information. Federal law makes clear that reporting a medical malpractice payment is not an admission that the practitioner did anything wrong. The law states that a “payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.” The NPDB recognizes that some claims are settled for convenience and are not a reflection of the professional competence or conduct of a practitioner.

Giant cell arteritis claims are costly and difficult to defend

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medical experts hold physicians who treat these patients, and the measures ophthalmologists can take to improve the likelihood of a correct and timely diagnosis.

Patients presenting with only visual problems

Giant cell arteritis, a systemic inflammation of the blood vessels that restricts blood flow causing organ and tissue damage, most commonly affects patients over the age of 50. In addition to the symptoms noted above and scalp tenderness, varied and non-specific constitutional symptoms, such as fatigue, malaise, and weight loss, may develop over time. It can be difficult to diagnose GCA when the only symptom is a change in vision. Four of the 18 patients presented this way. In two of these cases, defense experts supported the ophthalmologists' care and the claims closed without payment, even though the insureds did not diagnose GCA or such diagnosis was delayed. In one case, a patient with dense cataracts that explained her vision loss was appropriately referred for work-up of a choroidal mass; the jury returned a defense verdict. In the second case that closed without a payment, a patient who presented with intermittent blurry vision was diagnosed with amaurosis fugax, a temporary loss of vision in one eye caused by a lack of blood flow to the retina. Because the patient was 79, the ophthalmologist ordered an erythrocyte sedimentation rate (ESR). When the result was normal at six, he repeated the test and got the same result. He diagnosed GCA six days later when the patient complained of a shade over the eye and developed a Marcus Gunn pupil and visual field deficit. OMIC declined the patient's settlement demand and the case was ultimately dismissed. The two other cases where vision change was the only symptom were settled when OMIC could not find supportive defense experts.

1. INDEMNITY PAYMENTS MADE TO SETTLE GCA CASES		
	GCA Claims	All OMIC Claims
Closed with a payment	44%	21%
Mean (average) payment	\$203,250	\$165,282
Median (middle) payment	\$335,000	\$81,875
Highest payment	\$450,000	\$3,375,000

In one, the ophthalmologist noted papilledema in an 81-year-old who presented with sudden vision loss, but he did not work up its cause. The case settled for \$275,000. In the other, the ophthalmologist was criticized for not clarifying the nature of the visual complaint. The 82-year-old patient had written on the history form that her vision "blacked out." The surgeon did not read the form and documented only "blurry vision" and diagnosed her with visual migraine. The case settled for \$350,000.

Problems eliciting a thorough and accurate history

Exploring the precise nature of the vision change would have helped another ophthalmologist entertain a GCA diagnosis. His patient complained of a headache for two days and a "curtain," which he understood to be transparent. It was only during the investigation of the lawsuit that he learned the patient had experienced a "dark" curtain that caused frank vision loss. He felt, in retrospect, that the combination of vision loss and headache in an elderly patient should have alerted him to GCA and agreed to settle the claim for \$100,000.

While it is important to get accurate information about the eye complaint, it is crucial to query older patients about constitutional symptoms. A careful review of signs, symptoms, and systems can help distinguish the few patients who could have GCA from the large number of older patients with eye problems seen daily in ophthalmic practices. Which symptoms did the patients in

our study exhibit? Consistent with GCA's usual appearance in patients over 50 years old, those in this study ranged from 62 to 86. As part of a claims investigation, defense attorneys obtain and review all of the patient's medical records. These reviews revealed that 15 of the 18 patients (83%) were experiencing GCA symptoms other than vision changes at the time of their initial visit to the ophthalmologist. Of these 15 patients, 12 reported headaches and 7 of the 12 had additional symptoms (see table 2).

The ophthalmologists, however, failed to elicit the non-vision-related symptoms in 10 of the 15 patients (66%) who were having them. Defense experts opined that this inadequate history contributed to the delay in diagnosis and was below the standard of care. The ophthalmologist in the claim described in the beginning of this article learned only of the vision complaints and headache, while the neurologist, who saw the patient near the same time, elicited the duration of the headache and the existence of jaw pain. Ironically, the ophthalmologist testified in his deposition that he did not consider GCA in his differential diagnosis since the patient did not complain of jaw pain. He did not explain why he relied upon the patient to offer this information instead of asking for it.

Why is obtaining an accurate history so difficult? First, patients often report their history differently to each healthcare provider based upon the questions asked and the time spent gathering the information. Often it was other physicians who

obtained a more thorough history, but in two of our claims, the ophthalmologists' staff members obtained and documented the presence of GCA symptoms. Not only did the ophthalmologists not get the same information when questioning the patients a few minutes later, they also did not review the notes made by their staff members. This lapse was criticized by defense experts and contributed to the decision to settle these claims. Second, patients presenting with eye complaints often do not think that it is important or pertinent to tell their ophthalmologist about non-ophthalmic problems they are experiencing. More than in most diseases, however, prompt diagnosis of GCA depends upon the thoroughness and accuracy of the health history. In each of the 15 claims where patients had more than just visual symptoms, the plaintiff expert alleged that the diagnosis could have been made earlier if the ophthalmologist had obtained a more thorough history. Ophthalmologists examining older patients, especially those with vision changes and headache, need to take a more active role in obtaining the history. Dr. Ron Pelton, a practicing oculo-facial surgeon who serves on OMIC's claims and underwriting committees, has developed a GCA checklist to prompt ophthalmologists to ask key questions and document both positive and negative findings. It can

be found at www.omic.com/giant-cell-arteritis-checklist/.

Missed opportunities

So what happened in the first case? While the ophthalmologist did not elicit a thorough history or include GCA in his differential diagnosis, the neurologist to whom he referred the patient did ask the appropriate questions. The combination of diplopia and pain in the temporal mandibular joint led the neurologist to a robust differential diagnosis, which included right fourth nerve palsy versus right inferior oblique palsy, brain stem ischemia, myasthenia gravis, and vasculitis. He appropriately ordered an MRI, CT scan, and laboratory work, including an ESR. About a week after he examined the patient, the neurologist realized that the lab had mistakenly not performed the ESR. He mailed the patient a prescription to have it done the next day but the patient never went. Six days later, the patient brought the results of the MRI, CT, and lab work (minus any ESR results) to his second visit with the ophthalmologist, who skimmed the report, which discussed the non-specific MRI and CT results and the normal lab results. He failed to notice that the lab had not performed the ESR. While he did see that the patient had been given a prescription to have the ESR repeated six days prior, he assumed the test had been done and

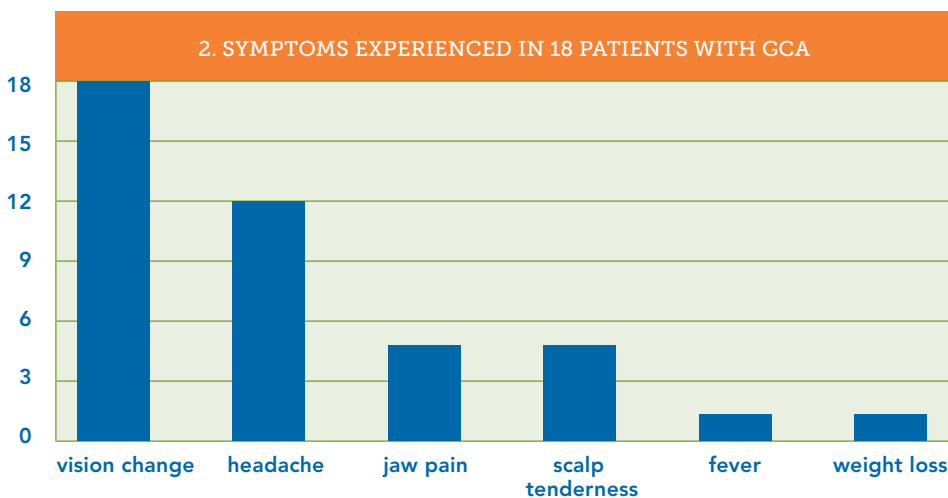
was again normal. The ophthalmologist advised the patient to keep his follow-up appointment with the neurologist in four days time. Experts who reviewed the claim felt that four opportunities for an earlier diagnosis that would have preserved the vision had been lost: when the lab did not perform the first ESR ordered, when the patient did not go back to get the ESR lab test done, when the neurologist did not follow up to ensure it was done, and when the ophthalmologist failed to note the lack of ESR results. Had the ophthalmologist asked the patient, he would have learned that no ESR had been done. This information, combined with the new symptom of fever, could have prompted him to consider GCA and order a stat ESR.

Preventing vision loss

This constellation of incomplete history, poor coordination of care among physicians, and problems with patient adherence occurred in many of the claims, including the one in the *Closed Claim Study*. This article provides information on actions ophthalmologists can take, such as proactively obtaining a more thorough history, to improve the likelihood of including GCA in the differential diagnosis when older patients present with vision changes. The checklist created by Dr. Pelton can prompt such questions and help track the completion of key tests and consults. A robust appointment and test tracking system plays a pivotal role in preventing diagnostic error (see "Test Management System is Key to Prompt Diagnosis" and "Noncompliance" at www.omic.com for advice on how to implement one). The *Hotline* article in this issue provides recommendations on ways to improve communication with other physicians and your staff.

GCA Chart Supplement History:

Ocular history/symptoms? (see new patient form)					
Onset of symptoms: ___weeks					
Hx of acute visual loss?: N	Y	months	OD	OS	OU
Symptoms: Any visual disturbance or vision loss?	N				
Temporal pain?					
Scalp tenderness?					
Hearing loss?					Y
Drooping lid?					Y
Jaw pain (w or w/o chewing)?					Y
Fatigue?					Y
Fever?					Y
Loss of appetite?					Y





CLOSED CLAIM STUDY

Poor communication between providers delays GCA diagnosis

RYAN BUCSI, OMIC Senior Litigation Analyst

Allegation

Failure to diagnose and treat giant cell arteritis.

Disposition

Settled for \$50,000 on behalf of OMIC insured. Codendants later settled for \$500,000.

An 85-year-old patient with polymyalgia rheumatica (PMR) was being treated with steroids by her internist. He tapered her off the steroids when her symptoms were controlled but restarted the drug at a low dose two weeks later when she experienced a headache. Two weeks after that, the internist suspected giant cell arteritis (GCA) due to diplopia. He provided two referrals: one to our insured ophthalmologist to evaluate the diplopia, and the second to a neurologist to initiate and manage high-dose steroids. The referral slip noting the history of PMR and steroid treatment never reached the ophthalmologist. However, the ophthalmologist's technician documented that the patient was on steroids. The insured obtained a history of chronic headaches and new onset of intermittent vertical diplopia. He found a large left hypotropia as well as moderate macular degeneration and recorded uncorrected visual acuities of 20/60 OD and 20/40 OS. The insured discussed the possible causes of diplopia with the patient and recommended that she follow up with her internist and see a neurologist. The patient saw a neurologist, who diagnosed GCA, increased her dose of steroids, recommended hospitalization—which she refused—and referred her back to the ophthalmologist. The patient was seen by our insured five days later (two weeks after the initial visit) and reported that earlier in the day she experienced dramatic vision loss and headache. VA was hand motion OD and 20/400 OS. A dilated examination revealed inferior retinal ischemia indicating central retina artery occlusion with acute optic neuritis. The insured concurred with the diagnosis of GCA. He explained to the patient that her vision was unlikely to improve and advised her to follow up with her internist and neurologist for steroid management. He asked her to return in two weeks but she did not. Eventually, the patient ended up with bilateral blindness and required 24-hour care.

Analysis

OMIC's defense experts had mixed opinions about the insured's care. One felt management at the initial visit was appropriate since no circulatory issues were identified during the dilated exam. Others felt our insured could be criticized for not reading the note about the patient's steroid use and eliciting her history of

PMR, which is strongly associated with GCA. He was also criticized for not considering GCA given the patient's age, headache, and diplopia. Furthermore, our experts pointed out that the insured did not take a sedimentation rate, CBC, CRP, or platelet or fibrinogen levels, nor was there a recommendation that these be obtained by the internist or neurologist. Additionally, the insured did not recommend a temporal artery biopsy. Our experts' major issue with the insured's care was his failure to communicate to the patient, her family, and other doctors involved in her care the high risk for vision loss and need for emergent intervention. However, the experts felt the internist and neurologist had greater exposure than the ophthalmologist. Fortunately, plaintiff counsel agreed that our insured's liability was limited and a settlement of \$50,000 was negotiated. The internist and neurologist later settled for a total of \$500,000.

Risk management principles

This case highlights the importance of communication with other healthcare providers. The ophthalmologist, internist, and neurologist did not effectively communicate with each other and did a substandard job of coordinating this patient's care. Two of the three physicians suspected GCA before serious vision loss occurred but did not share this crucial information in a timely manner with the ophthalmologist. The internist did not provide our insured with an adequate history about the PMR and suspected GCA, which could have assisted the insured in reaching the correct diagnosis and increasing her steroid dosage to treat the GCA. The ophthalmologist, moreover, missed an opportunity to intervene earlier by not reading his technician's note about Prednisone use, exploring the reason the patient was on it, and making the association between PMR and GCA. The ophthalmologist was in the best position to know the risk with regard to potential loss of vision and the urgency of increasing the steroid dosage and obtaining a temporal artery biopsy. Furthermore, our insured's documentation was inadequate. When the records were reviewed, our expert could not understand what the insured's thought process was and if he passed his thoughts and opinions on to the internist and neurologist.

Clear communication is key to timely diagnosis and treatment

ANNE M. MENKE, RN, PhD, OMIC Risk Manager

The claims discussed in the lead and *Closed Claim* articles resulted partly from poor communication among treating physicians and staff members. Here are some recommendations about ways to ensure that the necessary information is received from and communicated to the appropriate members of the healthcare team. The scenarios come from actual giant cell arteritis (GCA) claims, and some of the “advice” is from the defense experts who reviewed the claims.

Q An emergency room physician from one of the local hospitals called me about a patient of mine. I don’t take call at that hospital and told him to have the patient schedule an appointment with me. Now I’m being sued along with the ER physician, who says he informed me that the 72-year-old patient had a headache and vision loss. The lawsuit says I should have at least warned the ER physician about GCA. What was I required to do?

A You have no legal duty to provide assistance to a hospital when you are not on call for it. As an ophthalmologist, however, you know more about the risk of severe vision loss from GCA than an ER physician. To protect the patient, urge the ER physician to contact the on-call ophthalmologist to evaluate the patient. (The claim closed without a payment.)

Q I work in a practice that employs optometrists. One of them asked for my opinion about a 67-year-old patient who presented with vision loss, a headache, jaw pain, and scalp tenderness. The OD thought the patient had GCA. I agreed and told him to start steroids and provided the starting and maintenance dosages. The technician who was scribing

made a mistake and wrote the prescription for 20 mg daily instead of four 20 mg tablets daily. Now I’m being sued for not taking over care of the patient from the OD and not adequately supervising the technician. What should I have done?

A Optometrists often perform the initial evaluation for patients in a group practice. However, when a patient has a serious, vision-threatening condition such as GCA that requires urgent treatment and careful coordination of care, an ophthalmologist should assume responsibility. Your practice’s written protocols should address this (see “Coordination of Care with Optometrists” at www.omic.com). This optometrist did not have the legal authority to prescribe systemic steroids. In addition, while your technician may know the names and dosages of the eye drops you normally prescribe, she is obviously not familiar with oral steroids. You should have written the prescription yourself and provided written instructions to the patient on how much to take each day and when to see her primary care physician (PCP). Finally, you should have conducted a formal hand-off with the PCP to clarify that the PCP would be responsible for ongoing management of the steroids. It is helpful to give the patient a referral note that explains the reason for the referral and when it should take place (available at www.omic.com/referral-note-for-patient/). (The claim settled for \$350,000.)

Q A 76-year-old patient called our practice and spoke to my technician, who reported the conversation to me. I recall her telling me that the patient had pain in the back of his neck, so I instructed her to tell him to



see his PCP. The lawsuit alleges that we were told that the pain was also in the temple area and accompanied by visual disturbances, and that given his age, I should have seen him right away. Am I expected to speak to each patient myself or review each note about phone calls?

A You obviously cannot talk to every patient who calls, so you need an efficient and effective way to share information. OMIC claims experience makes it clear that making medical decisions on the basis of the limited information obtained over the telephone is a risky, albeit necessary, aspect of ophthalmic practice. During the phone call, you and your staff need to gather the information necessary to assess the situation and determine the treatment plan, communicate the assessment and plan to the patient, and document the encounter and your decision-making process in the medical record. To ensure that you have the most accurate information, provide staff with a checklist of questions to ask and instruct them to document the answers. Review the contact form when you can give it adequate attention, and document the information you would like your staff to communicate to the patient. To assist you, OMIC developed a sample phone contact checklist and appointment scheduling guide called “Telephone Screening of Ophthalmic Problems” available at www.omic.com. Use this guide to develop written protocols for telephone screening and treatment that are specific to your patient population, subspecialty, and staff; train staff in the use of the protocols and verify competency; and willingly accept questions from staff members unsure of how to handle specific calls. (This claim settled for \$200,000.)



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Using Checklists to Prevent Patient Harm

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September

25 Diagnostic Errors. Table Rock Regional Meeting—Arkansas (AOS),* Kansas (KSEPS),* Missouri (MoSEPS),* Oklahoma (OAO).* Big Cedar Lodge, Ridgedale, MO; 8:10–9:10 am. Register with your state society at <http://www.tablerockroundup.org/registration>.

25 Diagnostic Errors: Lessons Learned from Closed Malpractice Claims. Indiana Academy of Ophthalmology.* Ritz Charles Conference Center, Indianapolis, IN; 4–5 pm. Contact the IAO at 317.557.3062 or <http://www.indianaeyemds.com/event-1861366>.

November

9 EHR to the Rescue? Not So Fast: Liability Risks in the Electronic Platform. Northern Virginia Academy of Ophthalmology. McCormick & Schmick on



Westpark Drive, McLean, VA; 6–9:30 pm. Register with Linda Nakamura at OMIC risk management, 415.202.4652.

15 Diagnostic Errors—The OMIC Forum (Special Meeting #15).

American Academy of Ophthalmology. Venetian Ballroom AB, Sands Exposition & Convention Center, Las Vegas, NV; 2–3:30 pm.

16 Medicolegal Aspects to EHRs That You Need to Know (AAO Course SYM #29).

American Academy of Ophthalmology. Venetian Ballroom AB, Sands Exposition & Convention Center, Las Vegas, NV; 2–3 pm.

17 Prelitigation Services (AAOE Instruction Course #606).

American Academy of Ophthalmology. Room Casanova 606, Sands

Exposition & Convention Center, Las Vegas, NV; 9–10 am. You must purchase an "ACADEMY PLUS COURSE PASS" to attend this course! (Prior to meeting, pass is \$225. Onsite fee is \$275.)

17 The Code of Ethics: A Shield of Litigation (AAO Instruction Course #710).

American Academy of Ophthalmology. Room Galileo 907, Sands Exposition & Convention Center, Las Vegas, NV; 2–3 pm. You must purchase an "ACADEMY PLUS COURSE PASS" to attend this course! (Prior to meeting, pass is \$225. Onsite fee is \$275.)

January

14 OMIC: Cataract Malpractice Settlements of 2015.

Cataract Surgery: Telling It Like It Is! Naples Grande Beach Resort, Naples, FL; 8:30–9:30 pm. Register at <http://www.cstellingitlikeitis.com/>. Sign in onsite.