

Pediatric diagnostic errors can be costly, difficult to defend, and result in a lifetime of blindness for a child.

THE OPHTHALMIC RISK MANAGEMENT DIGEST

OPHTHALMIC MUTUAL INSURANCE COMPANY

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Diagnostic error: Pediatric patients

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

Failure to diagnose a condition in a timely manner may lead to patient harm and professional liability exposure. From 2009 to 2013, failure to diagnose allegations accounted for 14% of all OMIC claims and over a third of all indemnity payments. The previous issue of the *Digest* provided an overview of the types and causes of these failure to diagnose claims. This issue will focus on diagnostic delays in the care of pediatric patients. OMIC Board Member Robert E. Wiggins, MD, and I presented this data at the American Association for Pediatric Ophthalmology and Strabismus meeting in April. Efforts to reduce the likelihood of diagnostic delay is especially critical in pediatric care since such delays can lead to death or a lifetime of bilateral blindness.

Pediatric (PED) diagnostic error (DE) claims are infrequent but costly. There were only 18 such claims involving 13 patients during the period studied, accounting for just 8% of all DE claims reported to OMIC. However, PED DE claims were responsible for 34% of the DE payments in our study and 5 of OMIC's top 10 payments ever. Table 1 provides comparative data on DE payments. DE claims resulted in more paid claims and a higher median and mean payment than OMIC claims overall. Payments for DE claims from pediatric patients are markedly higher than both other DE claims and OMIC claims overall. Indeed, the lowest payment in PED DE claims is \$850,000 compared to \$1,650 for all DE claims, and the highest PED DE payment was the most paid for any DE claim in the study. In addition, both the median

and mean payments were at least \$1,000,000. Information on payments for each clinical condition in PED DE claims is provided in Table 2. The three payments made to settle the ROP claims represent 55% of the total PED DE payments. The highest payment was made to settle one of the two glioma claims. OMIC did not make payments in the trauma, medical, or cornea claims, although a non-OMIC codefendant in the cornea claim settled.

Standard of care evaluation of diagnostic error in PED cases

As part of the investigation of a claim, both plaintiff and defense attorneys hire experts to review the medical records and allegations in order to determine if the standard of care (SOC) was met. To help us identify areas of concern for this article, we reviewed the SOC analysis provided by defense experts (Table 3). All but one of the 13 PED DE cases were reviewed.

OMIC-insured ophthalmologists were deemed to have met the SOC for only 3 patients. Care provided to the other 9 was deemed inadequate, with either below SOC or mixed reviews (classed together as negative reviews).

To further analyze what caused the diagnostic delays or errors, we looked at the role played by physicians, patients, and systems. In some cases, there were multiple factors. Physician errors stem from deficiencies in knowledge, skill, or judgment; patient factors include the patient's condition and behavior; and system causes include the appointment scheduling process, regulations, insurance rules,

MESSAGE FROM THE CHAIR

GEORGE A. WILLIAMS, MD, OMIC Board of Directors



As a lifelong Chicago Cubs fan, I understand the topic of errors better than most folks. Sometimes errors are the individual's fault. Sometimes, they are the team's fault. I can't count the number of times I've seen a routine pop fly drop among three Cubs players in a classic example of "I got it. You

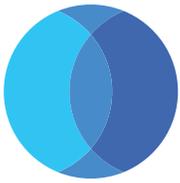
take it." Similarly, errors in medicine can be the fault of the individual or the fault of the team. The difference is that unlike in baseball, medical errors truly matter.

This issue of the *Digest* summarizes OMIC's experience with diagnostic errors in pediatric patients. My thanks to Anne Menke and Bob Wiggins for providing these excellent examples of OMIC's continuing quest to improve care.

It is a sobering report at multiple levels. First and foremost, it is a story of lost opportunity to prevent visual loss or even death in a child—an always tragic occurrence. Second, it demonstrates the personal consequences to the involved ophthalmologists, who are often devastated by the realization that their care has been judged to be negligent. Finally, and frankly least importantly, we see the substantial financial ramifications of such errors.

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EYE ON OMIC

A new logo and brand strategy as OMIC looks forward

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We are excited to introduce a new OMIC brand strategy and corporate logo. In anticipation of our 30th anniversary year in 2017, OMIC has placed a renewed emphasis on defining our core missions in order to best serve the needs of our policyholders. In 2012, we also began an exhaustive process of forming a new strategic plan that will prepare OMIC for a rapidly changing environment in both the insurance and eye healthcare communities. Part of that process was to showcase and celebrate our unique identity.

Our new logo features an abstract graphic that suggests the shapes of overlapping eyes and symbolizes a commitment to a forward-looking vision for OMIC. It signifies the common and shared goals of OMIC, the American Academy of Ophthalmology, and our policyholders to support, defend, and enhance the practice of ophthalmology.

MESSAGE FROM THE CHAIR

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When I say the financial costs are the least important part of the story, it is not because the money does not matter. It does. Your Board carefully considers our fiduciary responsibility to our insureds on every settlement. Fortunately, OMIC has the financial strength to provide appropriate and fair compensation when patients have been harmed due to negligence. The most important issue is to understand what went wrong.

Each of these cases presents an opportunity to ask two important questions: How did this happen and what can be done to prevent it from happening again? Sometimes, it is simple physician error. We all make mistakes and in the current era of increasing patient volumes, increasing clinical knowledge to be mastered, and the often maddening regulatory and documentation requirements, I don't see practice getting any easier. That makes it all the more important that we take the time to ask ourselves how sure we are of a diagnosis and to think what else could this be, particularly when managing an atypical presentation or clinical course. If we are not certain, close follow-up and a second opinion demonstrate to the patient our concern.

As noted by Bob and Anne, sometimes the answer is a systems-based failure. Medicine is

With one eye focused on our past, we reflect on OMIC's origins. Our founding members and sponsoring organization, the Academy, laid a foundation for what would become the largest and most trusted insurer of ophthalmologists in America. We reaffirm our mission, first articulated by OMIC's leaders in 1993, to serve the needs of Academy members by providing high quality medical liability insurance products and services.

With another eye looking forward, we will respond to the changing needs of our policyholders and strive to be a leader in the medical liability community by promoting quality ophthalmic care and patient safety.

In the coming months, members of the ophthalmic community will learn more about OMIC's accomplishments and milestones as we celebrate our 30th year of serving ophthalmology. In addition, our branding strategy will focus on OMIC's future commitments to our specialty.

transitioning to a future of team-based care in which systems of care will become increasingly critical. Nowhere in ophthalmology is this more apparent than in the management of ROP.

Several years ago, OMIC's claim experience in retinopathy of prematurity demonstrated the need to approach ROP from a systems-based perspective. As a result, OMIC developed an evidence-based underwriting process that establishes a rigorous educational program involving not only ophthalmologists, but their offices and neonatal intensive care units as well. We call this process our "Safety Net" and if we can catch even one child, everyone wins. The Safety Net is a dynamic, evolving process and OMIC provides it free to everyone whether an OMIC insured or not. Under the direction of pediatric ophthalmologist Robert S. Gold, the OMIC ROP Task Force is continually evaluating the Safety Net to reflect the best available evidence for the diagnosis and management of ROP. It is another example of the synergy between good medicine and good business.

I am told that this year is different for the Cubs. I hope so. One thing that will not be different is your company's continuing dedication to patient safety. Baseball players often shrug off their errors with the attitude that they will get the next one. For our patients, there is no next one. I got it, you take it is no way to play ball or practice medicine.

Coverage of ROP IVAV Treatment

ANNE M. MENKE, RN, PhD, OMIC Risk Manager, and
BETSY KELLEY, OMIC Vice President, Product Development

OMIC's focus on insuring only ophthalmology allows—and requires—us to thoroughly understand what ophthalmologists do. The ophthalmologists who started OMIC in 1987 wanted to ensure that their colleagues did not subsidize higher-risk specialties by paying unnecessarily high premiums. They also wanted to found a company that was robust enough to stay in business long-term yet flexible enough to change with their specialty.

From the beginning, OMIC's Board and committee members and staff have paid particular attention to claims data to determine how to minimize liability exposure for our policyholders and to enhance safety for the patients these policyholders treat. At times, we have established conditions of coverage for specific types of care in response to an increase in the number of claims or the amount of money needed to settle them. Just as importantly, we have relaxed or eliminated certain requirements in response to feedback from our insureds and when claims data indicated the higher risk had passed. Earlier this year, for example, we removed extraocular refractive surgery from the list of procedures with conditions of coverage. Requirements for refractive surgery continue now only for intraocular surgery, such as refractive lens exchange and phakic implants.

Ophthalmologists who provide care to premature infants are at high risk, so we regularly review our conditions of coverage for ROP. Our ROP Task Force recently discussed several articles about intravitreal anti-VEGF (IVAV) injections as primary or salvage therapy for ROP. When OMIC first developed its underwriting procedures for evaluating coverage of IVAV treatment, there was no published, peer-reviewed data to support a particular position.

Therefore, OMIC asked general questions, such as "Under what circumstances do you administer IVAV?" "How long do you monitor patients for recurrence of ROP after IVAV?" and "What is the follow-up interval?"

In 2013, the American Academy of Pediatrics Section on Ophthalmology (AAP SOO) revised the "Screening Examination of Premature Infants for Retinopathy" and included guidelines for use of bevacizumab (Avastin) in the treatment of ROP. In this revised policy statement, the AAP SOO advises that infants treated with bevacizumab should be monitored weekly after injection and that all infants treated for ROP solely with bevacizumab should be followed until full vascularization in close proximity to the ora serrata for 360° occurs. OMIC adopted these recommendations as underwriting requirements in May 2013.

Risk management and underwriting staff have since fielded questions and concerns regarding these follow-up criteria. Weekly exams become increasingly difficult as the infant ages and are not without stress for the infant, parent, and ophthalmologist alike. In addition, some infants' eyes do not fully vascularize. While in some cases the physician may elect to perform laser surgery to prevent recurrence, our policyholders did not feel that all infants warrant such treatment. The physicians who contacted OMIC felt that our requirements were not always consistent with their best professional judgment or in the infant's best interest. Accordingly, they requested that OMIC reconsider them.

OMIC's Task Force noted that guidelines for treatment of ROP are evolving. Many questions are currently being studied and debated about IVAV. These issues include agent, dosage amount, volume, timing of injections, length of follow-up, and

contraindications. There is not yet enough data to develop consensus recommendations. Because of the lack of published, peer-reviewed data regarding follow-up intervals and follow-up endpoints for infants treated for ROP with IVAV, the task force sought input from ROP thought leaders before making a determination. After reviewing the input, the task force concluded that OMIC should retain its current requirement to monitor infants weekly after injection but agreed that changes to the follow-up endpoint were warranted.

The OMIC Board adopted the following revised requirements in May 2016. Infants treated for ROP with IVAV must be followed until 1) full vascularization in close proximity to the ora serrata to 360° occurs or 2) the avascular retina has been successfully treated with laser (e.g., no skip areas). Ophthalmologists may use their professional judgment on continued monitoring in the following circumstances if no treatment endpoint has been reached three months after the injection: 1) low-grade disease that is clearly and slowly improving, 2) stage 1 disease that is unchanged for two months, 3) no disease, no ROP, but incomplete vascularization, and 4) infants with DNR (do not resuscitate) orders.

We are updating the renewal ROP questionnaire to reflect these changes. Although you may receive a questionnaire that reflects the former requirements, the new, broader guidelines are already in effect.

Ophthalmologists who treat ROP with anti-VEGF injections need to remain extremely vigilant. OMIC provides guidance in "Anti-VEGF Intravitreal Injections for ROP: Risk Management Analysis and Recommendations." It is available online at omic.com/rop-intravitreal-anti-vegf-injections-risk-management-recommendations/.



Diagnostic error: Pediatric patients

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1. DIAGNOSTIC ERROR INDEMNITY PAYMENTS (2009–2013)			
	Claims Overall	All Diagnostic Errors	Pediatric Diagnostic Errors
% Paid	19	28	26
Range	\$1,650– \$2,000,000	\$1,650– \$2,000,000	\$850,000– \$2,000,000
Median (middle)	\$125,000	\$200,000	\$1,000,000
Mean (average)	\$199,347	\$333,479	\$1,270,000

and drug manufacture, ordering, and administration, etc.^{1,2} Physician factors predominated (73%), while system issues played a significant role. These findings are similar to those for all DE claims in our study, as we reported in the previous issue of the *Digest*. In those claims, physician factors impacted 71 out of 82 claims (87%), patients had no discernible impact, and system issues figured in 11 claims (13%).

Physicians were unfamiliar with clinical guidelines, showed poor judgment in when to order imaging and reexamine or refer patients, and missed key findings on exams and in photos. The lack of a differential diagnosis and absence of imaging studies together suggest that physicians are overconfident in their diagnostic ability. Time constraints or distractions during the diagnostic process may also have adversely

affected the physician’s ability to correctly identify the patient’s condition. Ways used to track hospital appointments and document follow-up intervals contributed to the problems in the ROP cases, as well as deviation from well-established clinical guidelines on the timing of follow-up exams. The handoff from pediatricians and ER physicians to ophthalmologists in the trauma cases took place over the phone and did not address key aspects of the child’s care. This risky telephone care is addressed in the *Hotline* article. The care in the ROP and oncology claims was deemed to be below the SOC and resulted in the highest payments. The rest of the article will analyze these claims in more detail.

ROP claims

Providing care to infants who may develop ROP remains the highest liability risk for ophthalmologists. Here is an update on our claims experience, including the claims from this diagnostic error study. Since OMIC’s inception in 1987, OMIC-insured physicians and their practices have been sued for medical malpractice on behalf of 21 infants with ROP, resulting in 30 claims. ROP

2. PAYMENT AND CLINICAL CONDITION IN PED ED CLAIMS (2009–2013)			
Clinical	Patients/Claims	Clinical Condition	Payments
ROP	4/6	ROP	3 payments \$3,500,000 total 55% of total PED DE payments
Oncology	2/3	Glioma	2 payments \$2,850,000 total Highest DE payment
Trauma	4/6	Foreign body Orbital fracture Retinal detachment (2)	
Medical	2/2	Osteogenesis imperfecta Meningitis after ductal probe	

blindness or severe visual loss. ROP claims account for 6% of paid OMIC claims. They close with an indemnity payment more than twice as often as overall claims (45% vs. 19%) and have a higher mean (\$932,928 vs. \$199,347) and median (\$487,500 vs. \$125,000) payment than overall claims. Four of our top 10 indemnity payments were for ROP, including our highest ever payment of \$3,375,000.

OMIC remains committed to providing assistance to those who take care of these vulnerable patients. To lessen the liability exposure for policyholders and the company overall and to reduce the occurrence of preventable blindness, OMIC developed our ROP Safety Net in 2006. It includes clinical guidelines and detailed toolkits for hospital- and office-based care. Each year, we ask policyholders if they provide ROP care and then carefully review hospital and office protocols for all who do. We also require specific ongoing education in ROP. In addition, our ROP Task Force keeps abreast of significant publications and presentations in this field and updates our policyholders accordingly. Recently, for example, our ROP Task Force reviewed new studies of the effect of anti-VEGF agents on the infant’s neurodevelopment. We revised our consent form, recommendations, and conditions of coverage to address these concerns. See the *Policy Issues* article in this *Digest* for more details. For a detailed analysis of the many causes of this diagnostic delay, see “Retinopathy of Prematurity: Create a Safety Net” available at omic.com/rop-safety-net/.

Oncology claims

Pediatric patients whose cancer diagnosis was allegedly delayed make very sympathetic plaintiffs in a medical malpractice lawsuit. Both cases of diagnostic error in our study involved glioma. A review of the expert opinions in these two claims provides guidance on how to prevent this diagnostic error.

3. STANDARD OF CARE (SOC) ANALYSIS OF CARE PROVIDED TO 12 PATIENTS

Type (Patients)	Met SOC	Below SOC	Mixed Review	% Negative (Below/Mixed)	Payments
ROP (4)	0	3	1	100	3
Trauma (3)	1	0	2	66	None
Medical (2)	2	0	0	0	None
Oncology (2)	0	2	0	100	2
Cornea (1)	0	1	0	100	1 (non-OMIC)
TOTAL (12)	3	6	3	75	3

The first case involved a pediatric ophthalmologist who had diagnosed this condition before. The patient, however, had none of the signs and symptoms he associated with glioma and at 9 months of age was younger than usual for its presentation. The pediatric ophthalmologist's familiarity with the condition and clear sense of how the condition usually presented gave him confidence when appraising the child. He attributed the child's asymmetric nystagmus to spasmus nutans (SN) and reassured the parents, asking them to bring the child back at age 2 or earlier if strabismus developed. In his letter to the child's pediatrician, the ophthalmologist was also reassuring: he stated that a different kind of nystagmus in older children was associated with tumors, but he wasn't worried about a tumor in this younger child. Unfortunately, his diagnostic certainty was not warranted. When examined again at age 4 (two years later than advised), the child's condition had significantly deteriorated and an MRI was ordered, which detected the glioma. The child ultimately lost all vision.

The plaintiff expert insisted that imaging studies were required as of the first visit with a finding of asymmetric nystagmus, and that follow-up should have occurred in three to six months. The defense expert clarified that imaging was not standard at the time of care. The defense expert was concerned, however, that the ophthalmologist made SN his definitive diagnosis

in the letter to the pediatrician without doing anything to confirm it. He also agreed with the plaintiff experts that follow-up was needed much earlier, citing literature from the time that urged close follow-up. The case settled with the defendant's permission for \$2,000,000.

While the ophthalmologist in the first case believed he knew the cause of the child's condition, the defendant in the second glioma case never arrived at an explanation for the child's vision loss. The 9-year-old child had been referred by an optometrist after vision in the right eye had deteriorated from 20/50 to 20/200 over the course of three years despite vision therapy. On initial exam, the ophthalmologist noted a pale optic nerve and hypoplasia. He continued the vision therapy and requested a return visit in nine months. The parents did not feel the vision therapy was helping and returned one month later. Despite the parents' concern and a decrease in visual acuity to 20/400, the ophthalmologist described the condition as "stable." It was only when vision had deteriorated to HM on the right and 20/400 on the left that the ophthalmologist referred the patient to a neuro-ophthalmologist, who ordered the MRI that detected an optic nerve glioma.

Plaintiff and defense experts criticized the defendant for failing to appreciate and discern the cause of the deteriorating vision. They also noted the differences in his exams and those of the

neuro-ophthalmologist, who found an afferent pupillary defect not mentioned by the defendant and described only optic disc pallor rather than optic nerve hypoplasia. All experts felt that poor vision and a pale optic nerve in a child required an immediate referral to a neuro-ophthalmologist. This case settled with the defendant's permission for \$850,000.

Slow down the diagnostic process

Ophthalmologists know that infants being screened for ROP are high risk. These two glioma claims show that extreme caution is also required when pediatric patients present with neurological symptoms such as acquired nystagmus and unexplained vision loss accompanied by optic disc pallor. Ophthalmologists should be wary of atypical presentations and consider early referral to a neuro-ophthalmologist. If they choose to monitor the patient themselves, diagnostic studies and close follow-up are needed to confirm the diagnosis and rule out vision- and life-threatening tumors.

Join OMIC's Chairman Dr. George Williams in asking yourself "How sure am I of the diagnosis?" Here are some more ways to help make the diagnostic process more deliberative. "Can I explain what is wrong to the patient?" Tell patients when you are not sure of the cause of the loss. Explore alternative diagnoses by asking "Could this be something else?" and rule out the worst case scenario by asking "If I am wrong, what don't I want this to be?" Watch for unexplained findings and test results that challenge your diagnosis. Review prior records to check for long-term changes that signal worsening of the condition, such as vision that deteriorates slowly.

1. Gandhi TK et al. "Missed and delayed diagnoses in the ambulatory setting: A study of closed malpractice claims." *Ann Intern Med.* 2006; 145: 488-496.
2. Hoffman J, ed. "2014 Benchmarking Report: Malpractice risk in the diagnostic process." *Crico Strategies.*



CLOSED CLAIM STUDY

Telephone consultation on minor patient with foreign body injury

RYAN BUCSI, OMIC Claims Manager

Allegation

Failure to evaluate and treat a minor patient with a foreign body injury.

Disposition

Defense verdict at high-low arbitration. \$175,000 paid on behalf of insured.

A minor patient sustained an eye injury when a metal fragment struck him while he was hammering a penny. The parents flushed his eye with water. The following day his pediatrician diagnosed decreased vision and a conjunctival hemorrhage. The pediatrician called the OMIC insured after hours and informed the insured that she did not see any signs consistent with a penetrating injury. The pediatrician stated that the cornea was intact with no abrasion and that the anterior chamber appeared intact as well. The insured specifically asked if this was a high-speed impact injury and the pediatrician responded that it was not. Our insured advised that he could not make a diagnosis over the phone but he suspected a possible conjunctival hemorrhage or an abrasion. The insured recommended antibiotics and follow-up with the pediatrician or the emergency room if the condition did not improve. The insured informed the pediatrician that he was on call at the local children's hospital emergency room and could see the patient that evening. The pediatrician did not ask the insured to see the patient nor did she tell him that she would instruct the patient to go to the emergency room. Six days later, the pediatrician informed the insured via telephone that a general ophthalmologist had examined the patient and had diagnosed a foreign body in the eye, confirmed by orbital CT. The patient was referred to a retinal specialist, who immediately performed surgery to remove the foreign body. The patient later developed endophthalmitis and underwent a corneal transplant but ended up with only count fingers vision.

Analysis

Plaintiff's experts alleged that the insured should have advised the pediatrician to send the patient to an emergency room for a CT scan or MRI to determine whether there was a foreign body in the eye. Plaintiff also alleged that the pediatrician violated the standard of care by not immediately sending the patient to the emergency room. During her deposition testimony, the pediatrician testified, consistent with her records, that the patient's vision had been drastically affected. The ophthalmologist, however, contended that he was not informed of any drastic vision loss during the initial phone conversation. The defense expert felt that the

insured's care met the standard assuming that his version of the phone call with the pediatrician was accurate. However, if the expert assumed that the pediatrician's version of the phone call was accurate, then the insured failed to meet the standard. Our defense expert believed that any penetration of the globe by a foreign object should be treated as an emergency situation and that the delay in diagnosis caused the patient to experience significant vision loss. This was a case involving significant loss of vision in a minor and the defense was not comfortable taking the case to trial. Therefore, binding high-low arbitration was agreed upon. The case was heard by an arbitrator with a plaintiff high of \$750,000 and a defense low of \$175,000. The arbitrator ruled in favor of the defense and OMIC paid \$175,000 to the plaintiff. The pediatrician settled her portion of the case for an undisclosed amount.

Risk management principles

The insured admitted that to meet the standard of care an ophthalmologist must examine a child who has experienced a drastic visual decrease following trauma. The defense expert indicated that he routinely examines children with such injuries. The crux of this case then was whether the ophthalmologist was informed that a drastic visual decrease had occurred. The pediatrician documented that she told the insured that vision in the patient's eye had been drastically affected. Our insured did not recall being informed of this but had no documentation to support his position. Fortunately for our insured, his lack of documentation did not keep the arbitrator from ruling in his favor. The defense attorney filed a motion challenging the establishment of a physician/patient relationship when the only involvement was a phone call. As in other OMIC claims, the court ruled that this relationship is clearly established when a physician gives advice about a specific patient. The court did note that a relationship is probably not established if a colleague calls and asks general questions, such as how to manage trauma cases. In any event, when consultations on specific patients occur, the best course of action is to document the information presented and the advice given.

Telephone care

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

Telephone care was the central focus of the case featured in the *Closed Claim Study*. Our policyholder's care consisted of just one conversation with a pediatrician who called for advice. This single call determined not only the child's clinical outcome but also the liability risk for the two physicians who spoke to each other. Telephonic exchanges can occur between the ophthalmologist and other physicians involved in the care, but most physician-to-physician calls come from the Emergency Department (ED). These calls raise a number of concerns.

Q Do I establish a physician-patient relationship by speaking to another physician about a patient?

A To many physicians, the only fair and obvious answer is no: one would have to examine or treat a patient to establish a relationship with so many risks and duties. After all, how can you be legally responsible—and potentially liable—if you never even meet or speak to the patient? (Of course, never seeing or speaking to the patient is the norm for specialties such as pathology and still quite common in radiology.) Contrary to this assumption, courts have consistently ruled that telephone advice provided about a specific patient does indeed establish a physician-patient relationship.

Q Do I have to provide advice on the phone to any physician who calls me?

A No, there are situations when you may refuse to provide such advice. You may decline the request if the call concerns someone who is not your patient. Before saying no, be sure that you do not have a contractual obligation to accept the call, such as a condition imposed by a health

insurance company in order to be on its panel. If you or your group are not accepting any new patients, it might be prudent to tell the caller to contact someone who is available for ongoing care. There are, however, certain times when you do have an obligation to discuss a patient. Other physicians who are part of a current patient's healthcare team often need to speak to you in order to safely diagnose and treat the patient. You not only receive such calls, but make some yourself and no doubt appreciate the time the other physician takes to answer your questions. You or a physician in your practice must take these calls.

Q What about calls from the ED?

A You are required to speak to physicians who call from an ED in two instances. First, whether you are on call for that hospital or not, you are expected to answer questions about your own patients. Be sure to document these conversations and clarify who will provide any needed care. If the patient needs to be examined or treated in the ED, you may—but are not required to—provide that care even if you are not on call that day for that hospital. Or you could, for example, speak with the ED physician, advise on needed exams, tests, or treatment, and then ask the ED physician to contact the ophthalmologist who is on call to the hospital that day. Document this conversation as well. Second, you must provide telephone advice to an ED physician if you are the on-call ophthalmologist that day for that hospital. And you must examine the patient in person if the ED physician requests it. Review your medical staff bylaws to determine if you are serving on call for just that hospital or any hospital in an affiliated group of hospitals. Remember also that the hospital must accept transfers of patients who need a higher

level of care if it has the capacity and capability. By extension, you must respond to calls about these patients. The call may come from the transferring hospital trying to reduce the risks of the transfer as much as possible. If an ED physician from a hospital that wants to transfer a patient contacts you first, ask the physician to discuss the transfer with an ED physician at your hospital.

Q How do I know if I can trust that the physician who calls me has made a competent assessment of the patient?

A Your ability to safely provide telephone care depends upon your assessment of the other physician's knowledge, skill, and judgment. Do not assume that the history and physical examination reported to you are adequate. Make that determination only after asking enough questions to ensure that you, as the specialist in eye conditions, have the information you would gather yourself if you were seeing the patient. Document the conversation. Consider using our telephone contact form as a template. It is available at omic.com/after-hours-contact-form-and-recommendations/.

Q Can my technician handle calls from patients that come during office hours?

A Technicians can help by gathering the information you need and relaying your advice to the patient. Consider using our template in omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/. Review the information to determine if you need to speak to or examine the patient. Document your decision and instructions.





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(available to OMIC insureds at no charge)

My Doctor Never Told Me That Could Happen!

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Using Checklists to Prevent Patient Harm

Storm Hit! Now What Do I Do?

Claims are More Than Just Lawsuits

Call Early, Call Often

November

14 OMIC Risk Management Course. Northern Virginia Academy of Ophthalmology (NVAO). Maggiano's Little Italy, Tyson's Corner, McLean, VA; 6:30 pm. Contact Linda Nakamura at OMIC, 415.202.4652.



December

2 Ethics/Risk Management. New England Ophthalmological Society (NEOS).* Back Bay Event Center, Boston, MA; morning session. Register with NEOS at neos-eyes.org/app/attendee/index.cfm?ID=LZUN022.

8 Identify and Manage Unhappy Patients. Delaware Academy of Ophthalmology (DAO).* Medical Society of Delaware Conference Center, Newark, DE; 6:30-7:30 pm. Register with DAO at 302.366.1020 or email angela.jarrett@medscodel.org.

January

26 OMIC Risk Management Symposium. Cataract Surgery—Telling It Like It Is! (CSTILII 2017). Naples Grande Beach Resort, Naples, FL; 8-9 pm. Register at cstellingitlikeitis.com/.

February

25 Prevent Falls in the Ophthalmic Office and OR. Ohio Ophthalmological Society (OOS). Hilton Columbus at Easton, Columbus, OH; 2:40-3:40 pm. Register at ohioeye.org or contact OOS at 614.527.6799 or oos@ohioeye.org.

OMIC has announced a 20% dividend credit to be applied to 2017 renewal premiums plus OMIC's competitive 2016 rates will be extended through 2017. Call 415.202.4654 or email getaquote@omic.com to take advantage of these savings.