Duty to Patients: 
Beginning, Ending, and Obligations

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OPHTHALMIC MUTUAL
INSURANCE COMPANY

Duty Questions

• When does a patient/MD relationship begin?
• What duties are owed to a patient?
• When does the relationship (and the duty) of a referring physician end?
• When does the duty of the physician to whom the patient was referred begin?
• Do I have a physician/patient relationship with all patients who present to the office?
• Do I need to formally end my relationship if I never examined or treated the patient?

DISCLOSURES

• We have no financial disclosures.
• We are both affiliated with OMIC:
  • Dr. Wiggins is a Board Director.
  • Dr. Menke is the Patient Safety Manager.

Case 1: Referral to Another MD

Legal Elements of Medical Malpractice
“The Four D’s”

• Duty of MD to treat patient
• Deviation from standard of care (requires expert testimony)
  – What would a reasonably prudent ophthalmologist do in the same or similar circumstances?
• Direct causal relationship between deviation and the alleged injury/damages (i.e., proximate cause)
• Damages: actual economic and non-economic
  – If paid = “indemnity” payment

Retinal Specialist

• 6/25/15: Optometrist refers plaintiff, a 20 yo female, to retinal specialist to r/o retinal detachment related to a 6-week history of darkness of peripheral vision in the left eye
• Exam: Visual acuity=20/25 OD, 20/50 OS. Dramatic disc edema OU
• Impression: likely pseudotumor cerebri
Retinal Specialist

- Contacted neuro-ophthalmologist (NO) by phone
  - Not in office that day
  - Agreed to see plaintiff within a few days.
- Escort patient NO's office next door.

Looking for some help: 15 days

- That day, plaintiff called PCP for next day appt.
- Next day, tells PCP she needs to see a neurosurgeon and have a spinal tap.
- Nurse tells plaintiff it could take weeks to find a physician to see someone on "public aid".
- Appt. made with neurologist for 7/22/15.

Neuro-ophthalmologist

- NO's wife and office manager/assistant spoke in office with plaintiff and her mother
- Explained that that NO was not contracted to see "public aid" patients
- Offered to see her as a self-pay patient, which plaintiff declined.

Vision getting worse

- 7/3/15: Call center message to primary care MD that vision getting worse
- Primary care MD refers to community hospital ER
- Head CT scan normal-no treatment rendered
- 7/10/15: Plaintiff's mother calls primary care MD's office with complaint of worsening vision
- Primary care MD directs plaintiff to a second local ER
- Neurologist instead recommends plaintiff go to university hospital

Neuro-ophthalmologist

- NO's wife told the plaintiff she would need to go to neuro-ophthalmologist at nearby university and gave her phone numbers.
- Advised retinal specialist that NO would not be seeing the plaintiff.

University Hospital

- 7/10-11/15: Vision HM OD, LP OS; 4+ disc edema OU; MRI/MRV negative; elevated OP
- Dx: Fulminant IIH
- Treatment: IV methylprednisolone, acetazolamide, lumbar drain
- 7/12/15: has bilateral ON sheath fenestration
- 7/21/15: Visual acuity 20/30 OD with 5 degree central island; MD 27.07; "legally blind"
- 6/20/17: Visual acuity 20/30 OD and HM 2 feet OS
Office manager at NO's office denies she performed HVF in deposition

- Yet plaintiff and her mother name her as the one who performed the test and that she was "rude" and "not a nice person."
- All indications are that she performed the test though she doubled down and claimed that must have been at retinal specialist's office.
- Unclear who ordered the test though apparently results not released to either doctor. "results remained on machine."

Lawsuit filed

- Initially against retinal specialist and his corporation and PCP.
- Deposition taken of retinal specialist.
- Plaintiff learns of referral to NO.
- NO summoned for a deposition.
- NO and his practice sued.
- Discovery bombshell.

Retinal specialist testimony

- Did not perform HVF.
- Was not notified that NO would not see plaintiff.
- Separate legal counsel assigned to the two defendants.

Found VF On Machine in NO's Office

- Questions
  - Did the retinal specialist owe a duty to the patient once he transferred care?
  - Did the NO owe a duty to the plaintiff?
  - Was the NO required to inform retinal specialist that he would not see patient?
**Plaintiff Experts**

- **Comprehensive Ophthalmologist**
  - Retinal Specialist should have ensured plaintiff received appropriate treatment beyond the phone call and walking plaintiff to NO’s office.
  - NO was liable if his office performed VF and did not act to ensure plaintiff received timely care.

- **Neuro-Ophthalmologist**
  - Testified NO had a duty to see plaintiff or obligated to see that she was evaluated expeditiously given severe VF loss in left eye and moderate in right eye.
  - Testimony was favorable to retinal specialist.

**Strengths and Weaknesses: Neuro-ophthalmologist/Entity**

- **Strengths**
  - NO never examined plaintiff.
  - Offered to see plaintiff as self-pay.
  - Gave plaintiff contact information for neuro-ophthalmology at university.
  - Plaintiff instead contacted primary care MD.

- **Weaknesses**
  - NO agreed to see plaintiff.
  - Plaintiff was seen in NO’s office and had VF test performed by his assistant.
  - NO’s assistant’s denial of performing VF test did not appear credible.
  - Profound vision loss should have prompted greater involvement in assuring timely evaluation by neuro-ophthalmologist.

**Defense Experts**

- **Retinal Specialist/entity**
  - 2 defense experts supportive of retinal specialist.
  - NO’s office manager not credible.

- **Neuro-ophthalmologist/entity**
  - One expert believed retinal specialist only one who understood severity of plaintiff’s condition and should have followed up to make sure plaintiff was seen and treated.
  - Some liability for NO/entity since VF test performed.
  - A second expert was not supportive of NO.

**Claim Outcome**

- Plaintiff: 20/30 OD and HM 2 feet OS.
- NO dismissed; NO entity settled for $1M.
- Retinal specialist/entity went to trial.
  - Retinal specialist dismissed during trial.
  - Jury voted 10-2 in favor of retinal specialist’s entity.

**Strengths and Weaknesses: Retinal Specialist/Retinal Entity**

- **Strengths**
  - Retinal specialist suspected correct diagnosis and made prompt referral to a neuro-ophthalmologist.
  - Co-defendant had opportunity to diagnose and treat plaintiff.
  - Retinal specialist persuasive and effective witness.
  - Plaintiff’s failure to follow instructions and seek necessary consultations.

- **Weaknesses**
  - Plaintiff will be sympathetic to a jury with near total blindness.
  - Discrepancies between retinal specialist’s and NO’s office manager’s version of events.

**Referral problems: MD**

- Plaintiff went to PCP’s office the next day with a single-page note that said “Pseudotumor cerebri, lattice degeneration, papilledema NOS/bilateral.”
- No name on note, not clear who wrote it.
- PCP copied the information into the patient’s record.
Referral Problems: MD

- PCP testified had never heard of pseudotumor cerebri
- Did not understand urgency
- Just knew that it was a neurological condition that should be evaluated by a neurologist
- Local neurologists would not accept "public aid patients" so asked his staff to find an academic center that would see patient

Referral note for patient

- Date: ____________
- Dr. ____________ has referred you to Dr. ____________
- Please call Dr. ____________ at phone: ____________
- Reason for referral: ____________
- This referral is: ____________
  - ___________________ Emergency
  - ___________________ Urgent (24-48 hours)
  - ___________________ Timely (1-2 weeks)
  - ___________________ When convenient

If there are any problems scheduling this appointment, please contact this office. Also, please call our office immediately if there are changes: increased pain, increased redness or decreased vision.

Referral note to MD

- I am referring my patient named __________________ to you. The patient's phone number is ____________
- The appointment: __________________ will be made by the patient
- __________________ will be scheduled by my office
- Reason for referral: __________________
- Input needed: __________________
- This referral is: __________________
  - __________________ Emergency
  - __________________ Urgent (24-48 hour)
  - __________________ Timely (1-2 weeks)
  - __________________ When convenient

If there are any problems scheduling this appointment, please contact this office.

Referral duty

- DUTY ENDS WHEN:
  1. Confirm that appointment scheduled

Referral problems: Patient

- Does the patient understand the reason for the referral and when the care is needed?
  - If not, might later allege lack of informed refusal

Who should schedule?

- Take into account consequences of non-adherence if patient does not schedule
- Schedule for patient:
  - if significant risk
  - if patient is a minor
  - if need urgent or emergent appointment (usually get earlier appointment with specialist if your office schedules)
Referral duty

• DUTY ENDS WHEN:
  1. Confirm that appointment scheduled
  2. Get letter (or test results) back and have communicated ongoing care plan to patient

History and Exam

• Insured saw two-year old with history of parathyroid disease
  • VA: OD = OS; anisocoria OD > OS; no strabismus.
  • ONs “gray”; ? Drusen OS.

Follow up on input from consultant

• Appointment to discuss input & care plan
  – Schedule before patient leaves office so is in your system
• Tickler file to watch for results and then inform patient of input and care plan
  – Note date of expected letter
  – Call MD if no letter by then
  – Call patient if did not keep appointment

First F/U Visit

• 1 year later
  • VA difficult monocularly; 20/70 (near) with OU
  • Drusen OU
  • Pallor questioned OU.
  • Wrote referral letter to specialist at a university requesting further evaluation

Case 2: Referral to Academic Center

Second F/U Visit

• Another year later
  • Learned never went to academic center
  • VA decreased OD (<20/100) ? Neuropathy vs. amblyopia
  • No definite APD
  • Optic nerve pallor noted OU
  • Referred again for university consultation
Neuro-ophthalmology Consult

- Neuro-ophthalmology consultation
- VA 20/160 OD, normal OS.
- Disc pallor noted
- Further work-up: increased ICP.
- Rx: shunt placement.
- No further loss of vision.

Duty when patient referred

- **DUTY BEGINS WHEN:**
  - Staff schedule appointment
  - You speak to the referring MD about a specific patient
  - Patient presents to your office

Defense Experts

- Ultimate responsibility for assuring consultation occurs lies with referring ophthalmologist
- Unclear if consulting physician had some duty to contact the patient when no appointment scheduled

Do you have a duty if...

- You get a referral letter from another physician but no appointment is ever scheduled?
  - "Reasonable expectation of care"?
    - Was the patient given your name?
    - AMA Code of Ethics: "...generally entered into by mutual consent."
    - "Reasonable expectation that you will accept referral"
    - Do you regularly accept referrals from this physician?

Claims Outcome

- Settled at mediation for $425,000

Do you have a duty if...

- You get test results for a patient you have never met (but no referral or letter)?
Duty when patient referred

- **DUTY ENDS WHEN:**
  - You will not be providing ongoing care:
    - Inform patient who will provide that care
    - Send letter to referring MD with any advice about management
    - State in letter that referring MD will take over care
  - You will not provide any care
    - Inform patient and explain how to get care OR
    - Arrange for timely care elsewhere

Office F/U Next Day

- Mother brought child to office next day
- Did not identify themselves as referral from ER
- Mistakenly reported condition as “pink eye”
- Was told office had a policy of not seeing “public aid” patients

Case 3: On-call MD Duty

Evaluation at Children’s Hospital

- Pt was ultimately seen at the local Children’s Hospital 2 days later by pediatric ophthalmologist and cornea specialist
- Dx: Significant corneal ulcer
- Led to permanent decrease in vision

Initial Phone Consult from ED

- 2 yo fell into “oily matter” in driveway
- ED doctor called insured on a Sunday to report dx of “corneal abrasion with acute inflammatory response”
- Insured was leaving on vacation-did not alert office about ER consult and that mother was told to bring pt to office the next day

Plaintiff Expert Opinion

- Failure of office to see ED patient when covering call for hospital constituted malpractice
- Failure to timely diagnose corneal ulcer led to irreversible vision loss
Defense Expert Opinion

- Insured met SOC with phone consultation with ED
- "Hard off" to office is "troublesome"
- Office not seeing patient is "concerning"
- Pts amblyopia is a result of delay of care (fluctuating between 20/40 and 20/70 with patching therapy) and is a major issue

Duty of On-Call MD

- **FOLLOW-UP DUTY?**
  - Yes if this is an established patient
  - Not under EMTALA
  - Check medical staff by-laws to see if you are required to provide outpatient care
    - After consultation with ED or exam in ED
    - Any patient seen in ED who needs outpatient ophthalmic care

Claims Outcome

- Case went to trial
- Settlement negotiations are entered into during all pre-trial matters
- Corporation lost all key motions to keep out fact that pt was turned away because was on public aid-evidence too inflammatory
- Corporation (entity) settled for $1 million
  - Doctors were dismissed from case

Duty of On-Call MD

- **RISK MANAGEMENT**
  - "Drive the conversation" and document all phone calls with the ED physician.
  - Clarify/document follow-up responsibility
    - With the ED physician
    - With the patient
    - With your office
    - With the hospital

Duty of On-Call MD

- **BEGINNING**
  - Your are on call that day for that ED
    - "I am not on call today, please check the schedule."
  - You are contacted by the ED physician
  - You examine the patient in the ED

Duty of On-Call MD

- **RISK MANAGEMENT**
  - Add patient to tickler file until appointment scheduled.
  - Follow up if the patient does not present for outpatient visit
  - "The ED physician felt you have a condition that could cause vision loss..."
Duty of On-Call MD

- **ENDING:**
  - You have provided the needed care.
  - You are not asked to provide ongoing care.
  - You have already terminated this patient from your practice:
    - Inform ED MD and remind patient.

Case 4: Duty When Not On Call

Declining to See Patients

- Policy of not seeing "public aid" patients
- Physicians/groups may choose not to see patients if:
  - Patients are not protected by Americans with Disabilities Act (ADA)
  - No contractual obligations
  - No pre-existing physician/patient relationship

ED Evaluation

- 15 yo male presented to ED
- Reported chemical splashed in the left eye while disposing of garbage while at work at a dry cleaners
- Eye irrigated in ED
- No pH testing

Declining to See Patients

- **RISK MANAGEMENT**
- If patient presents to your office:
  - Examine patient
  - Provide emergent and/or stabilizing care
  - Provide urgent care or arrange for another physician to see patient in timely manner
- Send termination letter if will not continue to provide care

Telephone call to eye MD

- Insured MD not on call at hospital
- Was told patient referred for exam in office next day
- Does not recall any details of what he was told
- No notes taken
<table>
<thead>
<tr>
<th>Office Visit Following Day</th>
<th>Defense Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosed with chemical corneal abrasion and corneal edema OS</td>
<td>• No clear indication in hospital records of nature of chemical to which plaintiff had been exposed</td>
</tr>
<tr>
<td>• Referred to university ophthalmology department</td>
<td>• Most of damage would have occurred immediately after injury</td>
</tr>
<tr>
<td></td>
<td>• Questions why ED did not refer plaintiff directly to university since insured not on call</td>
</tr>
<tr>
<td></td>
<td>• Vision has not been significantly impacted by chemical injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment at university</th>
<th>Claims Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• pH measured at 11; more irrigation of eye</td>
<td>• Mediation took place with insured agreeing to pay some costs</td>
</tr>
<tr>
<td>• Placental graft placed near limbus</td>
<td>• Total expenses: $69,303.32</td>
</tr>
<tr>
<td>• Ultimate best corrected acuity OS is 20/25-1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plaintiff Expert</th>
<th>Duty If Not On Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ED exchange</td>
<td>• No legal duty to provide advice or care</td>
</tr>
<tr>
<td>• Inadequate phone consultation</td>
<td>• HHS Office of Civil Rights has paid close attention to selective acceptance and may consider you to be on call if you appear to only accept patients who can pay</td>
</tr>
<tr>
<td>• Should have advised ED doctor to check pH prior to discontinuing irrigation</td>
<td></td>
</tr>
<tr>
<td>• Should have personally examined in ED</td>
<td></td>
</tr>
<tr>
<td>• Care at office</td>
<td></td>
</tr>
<tr>
<td>• Failed to check pH in office prior to sending to university</td>
<td></td>
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</tbody>
</table>
Telephone care

- "In for a penny, in for a pound"
- Telephone care establishes a physician/patient relationship
  - Discussion of an issue ≠ care
    - "Do you get an MRI on all patients with trauma to rule out a foreign body?"
    - "How do you decide when to treat over the phone versus examine a patient?"

Case 5: Duty To Follow Up

History and Exam

- 1st visit: 3 yo with visual acuity of 20/300 OD and 20/30 OS; Diagnosis: Amblyopia OD; Recommendation: Patch OS. A handout on amblyopia was given.
- 2nd visit (1 month later): No patching performed. Recommend patching OS half-day/after school; Recheck in 6 weeks
- Family cancelled f/u appt. Advised did not wish to reschedule at that time

Patient Returns 4 Years Later

- Visual acuity CF OD; best corrected to 20/20 OS; glasses prescribed for anisometropia
- Claim subsequently filed alleging practice should have 1) followed up to schedule another appt. and 2) should have explained the window of opportunity to treat amblyopia

Telephone Care Risk management

- Treat each telephone call as an office visit
- Obtain careful history and develop a differential diagnosis
- Rule out "worst case scenario"
- Examine if can’t rule out WCS
- DOCUMENT
Expert Opinions

**Plaintiff Experts**
- Practice should have contacted plaintiff to schedule a follow up appointment

**Defense Experts**
- Diagnosis and treatment were appropriate
- It was the parents' responsibility to reschedule the follow up appointment

Duty to Follow Up

- How much follow up?
  - One call, one letter for 99% of patients
  - Letter states condition, needed treatment, when treatment needed, and consequences of not getting treatment
  - Sent via regular mail
  - Samples in "Noncompliance" at [www.omic.com](http://www.omic.com)

Claim Outcome

- Case dismissed
- Claims expenses: $25,531

Appointment Follow-Up

- Risk of acute, severe vision loss
  - Contact Child Protective Services if children involved and parents won't bring child in
  - Contact Adult Protective Services if patient is dependent adult and caretakers won't bring patient in
  - Call again and send 2nd letter stressing urgency, with cc to other doctors

Duty to Follow-Up

- Established physician-patient relationship
  - Appointment scheduled
  - Phone consultation
  - Examination
- Expectation of ongoing care
  - ROP: infant known to be at risk for specific period
  - Postoperative period
  - Amblyopia

Amblyopia: Risk management

- Whose responsibility is it to ensure children are examined as needed?
- Parents may be held liable for their noncompliance.
- "Comparative negligence"
  - May lead plaintiff attorney or court to dismiss lawsuit
  - May reduce the amount of damages if physician is also found to be negligent
- MD may be held liable for failing to address noncompliance and obtain informed refusal.
Ways to Reduce Follow-Up Burden

- Schedule appointment before patient leaves office
- Provide prescription only for appropriate interval and make patient return for exam and refill
- Ask staff to review and report missed, rescheduled, etc., to MD who determines follow up

Questions?

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