Duty to Patients: Beginning, Ending, and Obligations

Robert E. Wiggins, Jr, MD, MHA
Anne M. Menke, RN, PhD

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.
- Escorted 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 20/30-2 OD with 5 degree central island; MD-27.07; "legally blind"
- 6/20/17: Visual acuity 20/30 OD and HM 2 feet OS

While things were going downhill, the retinal specialist and NO had no contact with the plaintiff until....

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"

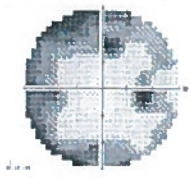
Lawsuit filed

- 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

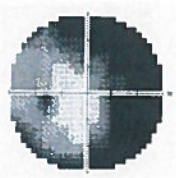
Retinal specialist testimony

- 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



OD
MD-11.69



OS
MD-24.11

Expert Witnesses on Duty

- **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-defendants 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 hours)
- _____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
- "Hand 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

Office Visit Following Day

- Diagnosed with chemical corneal abrasion and corneal edema OS
- Referred to university ophthalmology department

Defense Expert

- No clear indication in hospital records of nature of chemical to which plaintiff had been exposed
- Most of damage would have occurred immediately after injury
- Questions why ED did not refer plaintiff directly to university since insured not on call
- Vision has not been significantly impacted by chemical injury

Treatment at university

- pH measured at 11; more irrigation of eye
- Placental graft placed near limbus
- Ultimate best corrected acuity OS is 20/25-1

Claims Outcome

- Mediation took place with insured agreeing to pay some costs
- Total expenses: $69,303.32

Plaintiff Expert

- **ED exchange**
- Inadequate phone consultation
- Should have advised ED doctor to check pH prior to discontinuing irrigation
- Should have personally examined in ED
- **Care at office**
- Failed to check pH in office prior to sending to university

Duty If Not On Call

- No legal duty to provide advice or care
- 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

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

Telephone care

- This MD/patient relationship creates duties:
  - Ongoing care unless otherwise specified
  - Reasonably "prudent" care
  - 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

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**

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

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

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?

- **ABOUT THIS TALK**
- amenke@omic.com
- Direct 415-202-4651
- **CONFIDENTIAL HOTLINE**
- riskmanagement@omic.com
- 800-562-6642, option 4
- **RESOURCES**
- www.omic.com