

How physician burnout, fatigue, and exhaustion increase risks of litigation.



# The OMIC Digest

OPHTHALMIC MUTUAL INSURANCE COMPANY

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## Physician burnout a risk to quality eye care in America

LINDA D. HARRISON, PhD, Director, OMIC Risk Management

**P**hysician burnout has become one of the most serious problems in healthcare. Dr. Williams, in his Message from the Chair, references a recent survey<sup>i</sup> that found burnout affects at least 42% of physicians. Ophthalmologists fared better than other specialists, but still report a burnout rate of approximately 33%, the 4th lowest ranking behind plastic surgery (23%), dermatology (32%), and pathology (32%). The most stressed specialists are in critical care, neurology, family medicine, ob-gyn, and internal medicine, reporting a 48% to 46% stress level. On the plus side, ophthalmologists are the happiest of all specialists, at 37%. In addition to the toll on physician health, burnout adversely impacts quality of care, effectiveness of the healthcare team, healthcare costs, and is associated

with increased medical errors and risk of malpractice claims.<sup>ii,iii</sup> In fact, doctors who reported at least one major symptom of burnout were more than twice as likely to report a major medical error within the previous 3 months.<sup>iv</sup>

### Background

Physician burnout was not reported in the literature until approximately 40 years ago. The term was first introduced in 1974 by Freudenberger<sup>v</sup> to describe emotional exhaustion in the workplace. In 1981, Maslach and Jackson published the Maslach Burnout Inventory (MBI), a 22-item psychological inventory that measures occupational burnout, and later created an MBI specifically for medical personnel. They defined burnout as a psychological syndrome

characterized by emotional exhaustion, depersonalization, and a diminished sense of efficacy; "an erosion of the soul caused by a deterioration of one's values, dignity, spirit, and will."<sup>vi</sup>

#### SYMPTOMS OF PHYSICIAN BURNOUT (PHYSICAL)

- Feeling tired and drained most of the time
- Tiredness that does not respond to adequate rest
- Lowered immunity, feeling sick more often
- Frequent headaches, back pain, muscle aches
- Change in appetite or sleep habits
- Decreased libido

#### SYMPTOMS OF PHYSICIAN BURNOUT (EMOTIONAL)

- Sense of failure and self-doubt
- Feeling helpless, trapped, and defeated
- Detachment, feeling alone in the world
- Loss of motivation
- Increasingly cynical and negative outlook
- Decreased satisfaction and sense of accomplishment
- Activities you once enjoyed are no longer pleasurable

### MESSAGE FROM THE CHAIR



GEORGE A. WILLIAMS, MD, OMIC Board of Directors

Physician burnout is a pervasive and often perverse factor in the delivery of health care and it is associated with multiple adverse outcomes including higher rates of medical errors and medical malpractice claims.<sup>1</sup> Although physician burnout is distinct from simple fatigue from overwork or clinical depression, there can be some correlation.

The clinical definition of physician burnout involves three domains: emotional exhaustion, depersonalization, and a sense of decreased personal accomplishment. Emotional exhaustion is the feeling of simply being spent or used up at the end of the day with nothing left to offer patients from an emotional perspective. Depersonalization is the feeling of treating patients as objects or widgets on an assembly line rather than human beings in need. A sense of reduced personal accomplishment includes the feeling of ineffectiveness in solving patient problems and the perception that provided clinical services and professional achievements lack patient-centered value.

Over the past few years, awareness of physician burnout and its implications

In 2007 the IHI (Institute for Healthcare Improvement) launched its Triple Aim initiative that sought to optimize the performance of healthcare systems throughout the world while simultaneously focusing on 1) improving population health; 2) enhancing the patient experience of care; and 3) reducing the per capita

## New cyber liability resources available for policyholders

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**A** new collection of cyber liability risk management resources recently launched online.

OMIC CyberNet® is a comprehensive state-specific library of forms, documents, and suggested protocols and can be found under the Risk Management section at OMIC.com.

This policyholder resource is available as a benefit of coverage and compliments OMIC's broad portfolio of Additional Benefits for e-MD® Protection. See section V.II.C in your policy booklet for more information on all of the cyber benefits included within your standard OMIC malpractice coverage.

In addition to sample policy and procedure templates, the site offers cyber training for staff including online training courses, guides, awareness posters, and webinars. Insureds will find suggested data security policies, plans, procedures, and sample third party and

### MESSAGE FROM THE CHAIR

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has increased. Indeed, the incidence of physician burnout is growing. A recent survey of over 15,000 physicians found that overall 42% reported burnout with a range of 23% to 48% across 29 specialties; 33% of ophthalmologists reported burnout.<sup>2</sup> Women and younger physicians are more likely to report burnout. The causes of burnout are many, but 56% reported too many bureaucratic tasks (charting, EHR issues, paperwork) and 39% reported too many work hours as the most common causes. Other causes included lack of autonomy, government regulations, decreasing reimbursements, and emphasis on profits over patients.

The consequences of physician burnout cut across all aspects of health care. Health care systems are damaged by reduced physician productivity, increased turnover, diminished patient access and increased costs. Physician health is threatened by substance abuse, poor self-care, depression, increased motor vehicle accidents, and possibly even suicide. And patient care also suffers as measured by lower patient satisfaction, longer recovery times, lower quality of care, and more medical errors.

The role of physician burnout in medical malpractice cases is readily apparent. Physician burnout results in poor communication between patients and physicians, a perceived lack of

healthcare policy agreements. In addition to forms, there are instructions on putting together an incident response team, teaching staff to recognize cyber risk, and testing for scenarios.

Finally, best practices for protecting your data are defined and suggestions for mitigating risks are outlined. To access the OMIC CyberNet® resources visit OMIC.com and follow the link under the Cyber Liability Resources page to the risk management portal or go to <https://www.omic.com/cyber-liability-resources>. The current password is: **omic2018**.

OMIC will periodically change this global password for security reasons and policyholders will be notified of the new password whenever changed by eBulletin and by notice within renewal documents.

Policyholders needing assistance with the new cyber resources may contact their OMIC representative or the risk manager on duty.

empathy or caring about patient problems, and medical errors. It is a perfect storm for malpractice.

The solutions to physician burnout are complex and difficult, but should reflect the underlying causes. These solutions must occur at both the health care system and individual physician level. Of course, physician burnout must be detected before it can be addressed. This will require enhanced vigilance by both health care systems and physicians. Improved instruments for detection and measurement of physician burnout are required. These instruments should be comprehensive enough to detect physician burnout without further contributing to it.

Once detected, physician burnout must be addressed at multiple levels. Potential solutions include decreased regulatory hassles, improved EHR systems and clerical support, diminished clinical workloads, a renewed emphasis on patients over profits, and direct physician engagement through support groups, counseling, or individual treatment. Given the projected shortage of physicians (and ophthalmologists) in the near future, none of these solutions will be easy or inexpensive, but physician burnout is a clear and present danger to quality patient care.

Since its inception over 30 years ago, OMIC has recognized that good patient care requires a supported and protected health care team. And we are here to help. *(All references listed on p. 5)*

## Coverage features we've added to give our insureds a little piece of mind

KIMBERLY K. WYNKOOP, ESQ, OMIC General Counsel

**T**his issue of the Digest is about physician burnout. Did you know there are features of your OMIC coverage that may help alleviate some of the stressors that lead to burnout?

One of the common causes of physician burnout is reported to be lack of work-life balance. How can OMIC help? Some physicians don't want to work the long hours which can be a hallmark of medical practice. They may even choose to work part-time. OMIC understands this and offers part-time discounts for up to a 65% reduction in premium.

You may also want to take time off for maternity or paternity leave, to care for yourself or a family member who has a prolonged illness, or to take a sabbatical. OMIC offers suspensions of coverage when physicians temporarily cease practice for an extended period of time but intend to return to practice. Under a suspension of coverage you can report claims that arise from treatment that occurred prior to the suspension, but no coverage is provided for services rendered by the insured during the suspension. Coverage will still be in force, though, for other insureds on the policy. For example, the office may remain open so that non-physician staff can refer patients as needed, provide copies of medical records, or order authorized refill prescriptions. Premiums are greatly discounted during suspension since the liability exposure is likewise reduced. Suspensions may range from 90 days (60 for maternity or paternity leave) to a maximum of 1 year.

Worrying about professional liability in and of itself can lead to stress and burnout. After all, statistics indicate that approximately 75% of all ophthalmologists will have faced a claim by age 65. Having OMIC coverage should be of some comfort. As a carrier sponsored by the American Academy of

Ophthalmology, our purpose is to be here for you when you are accused of medical negligence. As practicing ophthalmologists themselves, OMIC Board members know and understand the challenges and risks you face in your profession, and work hard to educate you through risk management programs and services to avoid claims before they arise. But if they do, our ophthalmic-only claims department will walk you through the process.

Sometimes, though, it is the other liabilities in your practice, the more esoteric ones, that keep you up at night. That is why OMIC has added, free of charge to its policyholders, 17 additional benefits. One of these benefits is \$25,000 in disciplinary proceeding coverage to defend you when patients complain about your care to professional organizations.

We have also engaged experts in non-MPL issues to offer \$100,000 in broad regulatory protection (BRP) and cyber liability (e-MD<sup>®</sup>) coverage through NAS Insurance services. They are experienced in handling BRP claims and are committed to providing excellent service to OMIC's insureds. We also recently launched a very robust cyber website for your quick reference and training needs. ([see EYE ON OMIC p. 2](#))

BRP reimburses insureds for legal expenses and some fines and penalties related to regulatory proceedings, which include billing errors proceedings by Medicare/Medicaid and commercial payers, DEA, EMTALA, STARK, HIPAA or covered licensing proceedings, and peer review.

The e-MD<sup>®</sup> benefit was added as insureds began to move more of their records, communications, and marketing online. Worried about claims arising from the loss or unauthorized disclosure of patient or employee information, or your failure to report such loss or disclosure? Or how you are going to pay the breach

response and notification costs; the legal expenses and regulatory fines, penalties, and compensatory awards; and public relations costs related to security and privacy breaches? And what about the income you lose due to such breaches? The 9 e-MD sections respond to these issues and more, so technology does not have to be the bane it has been for so many insureds transitioning to electronic records and communications.

Sometimes financial strains lead to burnout. OMIC works hard to provide coverage to its members at rates that are reasonable, yet conservative enough to withstand unexpected adverse claims experience. In fact, OMIC's Board of Directors has adopted a Value Commitment "to provide its products and services at the lowest cost possible while maintaining its commitment to long-term stability, comprehensive coverage, and superior service." As mentioned above, we achieve this through part-time discounts, as well as loss-free credits, risk management discounts, and other cost savings you may qualify for. Whenever possible, OMIC offers its courses, risk management documents, and other resources free of charge to its insureds. Our mission is not just to serve the needs of members of the American Academy of Ophthalmology by providing high quality medical liability insurance products and services" but to also "be a leader in the medical liability community and to promote quality ophthalmic care and patient safety."

If you have any questions about what coverage and services are available for policyholders, contact your underwriting representative. Visit the Policyholder Services page at [OMIC.com](#) to identify your rep.

We truly hope that these benefits offer you peace of mind in your practice and will lead to a long and satisfying career in ophthalmology.



# Physician burnout a risk to quality eye care in America

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cost of providing care.<sup>vii</sup> Subsequently, there was increasing awareness that physician burnout created an obstacle in achieving the three aims. In response, the IHI announced in 2014 that it was committing resources to a fourth dimension to “bring back the joy in work” to the healthcare team, and thus was born the “Quadruple Aim.”<sup>viii</sup>

## SYMPTOMS OF PHYSICIAN BURNOUT (BEHAVIORAL)

- Withdrawing from responsibilities
- Social isolation
- Procrastinating
- Using food, drugs, or alcohol to cope
- Negative attitude towards patients and co-workers
- Taking out frustrations on others
- Skipping work, or tardiness

## Drivers of Burnout

Greater public awareness and validation of physician burnout by respected institutions and thought leaders in healthcare have led to an explosion of research that seeks to understand the stressors that lead to burnout and how to address them. Stressors emanate from both the professional and personal realms of life, and begin to impact physicians even as early as medical school.

Students enter medical school more well-adjusted than their peers entering non-medical graduate programs,<sup>ix,x</sup> but quickly succumb to the stressors of medical school, and later, clinical practice. There is a growing body of literature that links practice dissatisfaction, work life stress, burnout, and fatigue, with behaviors that adversely affect staff relationships and performance efficacy. Stressed and burned-out physicians are more likely to be impatient with staff and patients, and often have trouble remaining focused. These behaviors can compromise quality of care and patient safety, and increase the occurrence of medical errors, adverse events, and the likelihood of litigation.

It is estimated that nearly 80% of the causes of physician dissatisfaction and lack of well-being are systems issues.<sup>xii</sup> Interventions at the organizational level that focus on managing environmental stressors are more successful in decreasing physician burnout than interventions at the individual physician level. Strategies such as Lean Management and Six Sigma that focus on optimizing efficiencies and eliminating errors through redesign of processes have been shown to increase physician engagement, patient satisfaction, and revenue stream. Both levels of intervention are necessary and should be complementary.

## PROFESSIONAL STRESSORS THAT CAN LEAD TO BURNOUT<sup>xii</sup>

- Overwhelming workloads and job demands
- Inefficiencies and limited resources
- Unfulfilled expectations for career
- Conflicting cultures and values
- Loss of control and flexibility
- Lack of social support and community
- Unbalanced work-life integration

## A Top Stressor: The Electronic Health Record (EHR)

As of 2015, 87%<sup>xiii</sup> of office-based physicians had adopted an EHR system. Of the myriad contributors to physician burnout, the EHR is identified as a significant source, and causes some physicians to leave the practice of medicine. Research in 2013 by the AMA and the Rand Corporation found that EHRs were the leading cause of physician dissatisfaction, emotional fatigue, depersonalization, and lost enthusiasm for the job. The AMA also found that for every hour physicians engage in direct clinical time with patients, nearly 2 additional hours are spent on EHR tasks. Outside of office hours, physicians spend another 1 to 2 hours completing other computer and clerical work, dubbed

“pajama time” since many physicians perform these tasks at home after the work day. During clinical visits ophthalmologists spend approximately 27% of the time in the EHR, 42% conversing with the patient, and 31% on examination, which translates to about 3.5 hours per day in the EHR. According to Robert Wachter, MD, professor and chair of the Department of Medicine at the University of California, San Francisco, “EHRs contribute to burnout by turning physicians into unhappy data-entry clerks, and also by enabling 24-hour patient access without any system to provide compensation or coverage.”

Dike Drummond, MD, a former family practice physician who now coaches physicians on burnout prevention and leadership skills development, describes the EHR not as a problem with a discreet solution, but rather as a dilemma requiring a strategy of multiple steps to assist in managing the dilemma.

## DRUMMOND COPING STRATEGIES

### 1. Change your attitude

Accept the fact that the EHR is here to stay.

### 2. Become a power user

Or, identify someone in your practice who is interested, and use that person as a coach. Increasing your knowledge will improve your experience.

### 3. Only document what is necessary for care continuity, billing, compliance, and liability risk management

Don't strive for perfection, but be accurate and thorough in a succinct fashion.

### 4. Create templates

Templates for frequently-used verbiage decrease time, keystroking, and the frustration of repetition. CAUTION: make sure that the template language accurately describes symptoms, diagnosis, and treatment plan.

### 5. Scribes

Consider hiring a scribe.

A well-trained scribe offers many advantages to physicians and patients. Scribes allow physicians to see more patients in a day and spend more time with each patient. Patients report increased satisfaction with the care experience when physicians speak to them face-to-face. Furthermore, increased patient satisfaction is associated with better compliance and fewer claims. While hiring a scribe will add to expenses, most physicians will only need to see 1-3 more patients per day to recoup the additional costs. Consider the additional "lifestyle" benefits of completing patient records by the end of each day instead of spending 1 or more hours of "pajama time" on the EHR at home.

In addition, you may be able to customize your EHR so that appropriate tasks are routed to non-MD members of the healthcare team. Such collaboration distributes the burden of completing clerical work, and utilizes non-MD staff members to the extent of their scope.

## Coping, Prevention, and Wellness

Physicians must learn to recognize the signs and symptoms of stress and burnout, and place a high priority on addressing them in a timely manner. Unfortunately, physicians are sometimes too busy to notice that they are stressed, or accept the condition as the norm; they are also more reluctant to ask for help. Physicians should reflect upon their personal and professional values and goals, and create a burnout prevention strategy. Examples of a strategy might include commitments to take adequate vacation time each year, maintain healthy lifestyle habits, pursue a personal interest, volunteer for a meaningful cause, institute a daily ritual to calm the mind, and confront issues that have been avoided. Some physicians are motivated to address burnout at their institution, or become peer counselors. Once a personal strategy is established, it may be helpful to share it with someone

who will be your champion, help keep you on track, and celebrate your accomplishments. Commit to reviewing your strategy regularly, reassessing goals, and refining methods.

A number of medical schools, health systems, and professional societies have instituted physician wellness programs to address stress and burnout.

A few notable examples of these programs include:

The American Academy of Ophthalmology: <https://www.aao.org/member-services/physician-wellness>

The American Medical Association: <https://www.ama-assn.org/ama-launches-steps-forward-address-physician-burnout>

Stanford University: <https://wellmd.stanford.edu>

Mayo Clinic: <https://www.mayo.edu/research/centers-programs/program-physician-well-being>

## Conclusion

The pervasiveness of physician burnout is concerning, and has led to consensus in the medical community that addressing and preventing burnout is a top priority. Research shows that stress without resolution may lead to burnout, with consequences ranging from lack of focus to abandoning the practice of medicine, and even suicide.

Therefore, it is crucial that physicians, healthcare organizations, and leadership recognize the signs of stress and burnout, institute adaptive coping strategies, and commit to creating a culture wherein work-life balance and physician well-being are shared goals.

Good quality healthcare cannot occur without healthy providers, and only in healthy systems will we have healthy providers.

## References:

- i. Medscape National Physician Burnout and Depression Report 2018. <https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#12>
- ii. Shanafelt, T D. "Burnout and Medical Errors

Among American Surgeons." *Annals of Surgery* 2010; Volume 251, Number 6. <https://www.ncbi.nlm.nih.gov/pubmed/19934755>

iii. Balch CM et al. "Personal Consequences of Malpractice Lawsuits on American Surgeons [https://www.journalacs.org/article/S1072-7515\(11\)00978-1/pdf](https://www.journalacs.org/article/S1072-7515(11)00978-1/pdf) doi:10.1016/j.jamcoll-surg.2011.08.005.

iv. Tawfik DS et al. "Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors." *Mayo Clinic Proceedings* July 9, 2018 <https://doi.org/10.1016/j.mayocp.2018.05.014>.

v. Freudenberger H. Staff burnout. *J. Soc. Issues.* 1974;30:159-165. doi: 10.1111/j.1540-4560.1974.tb00706.x. <http://medicaleconomics.modernmedicine.com/medical-economics/news/top-10-challenges-facing-physicians-2018>.

vi. Maslach C et al. "Burnout in health professions: A social psychological analysis." In G. Sanders & J. Suls (Eds.), *Social psychology of health and illness*. 1982 Hillsdale, NJ: Erlbaum.

vii. <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

viii. Perlo J et al. *IHI Framework for Improving Joy in Work*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

ix. Frank E et al. "Physical activity levels and counseling practices of U.S. medical students." *Med Sci Sports Exerc.* 2008 Mar; 40(3):413-21.

x. Frank E et al. "Basic demographics, health practices, and health status of U.S. medical students." *Am J Prev Med.* 2006;31:499-505. [PubMed]

xi. Shanafelt TD, et al. "Longitudinal study evaluating the association between physician burnout and changes in professional work effort." *Mayo Clin Proc.* 2016;91(4):422-431.

xii. <https://www.acponline.org/acp-newsroom/american-college-of-physicians-launches-physician-well-being-professional-satisfaction-initiative>

xiii. <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php>

## References (Message from the Chair page 2)

1. Medscape National Physician Burnout and Depression Report 2018. <https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#12>
2. West CP, Dyrbye LN, Shanafelt DB, Physician burnout: contributors, consequences and solutions. *J Intern Med* 2018. <https://doi.org/10.1111/joim.12752>



## CLOSED CLAIM STUDY

# Litigation stress contributes to two large settlements

RYAN M. BUCSI, OMIC Claims Manager

### Allegation

Negligent treatment of a retinal detachment in two patients six months apart.

### Disposition

Each case settled for \$900,000.

### Takeaway

Stress of litigation can be overwhelming. Your OMIC claims representative and defense counsel are your allies and will do all they can to defend your interests during litigation. If you experience stress or anxiety during the course of a lawsuit, it is best to be candid with OMIC and your defense attorney so we can help you through the litigation process and achieve the best result possible for both you and the claim.

**A** 23-year-old patient was referred by his optometrist for retinal detachment (RD) OD with lattice. Visual acuity (VA) was CF OD; 20/25 OS. The insured diagnosed chronic inferior RD with detached macula and subretinal fibrosis OD; chronic RD OS; and lattice degeneration OU. The next day the insured performed scleral buckle, cryopexy, gas fluid exchange, and endophotocoagulation OD; a vitrectomy was performed to address hemorrhaging during the scleral buckle. Two months later, the insured diagnosed PVR OD, and peripheral RD OS. The insured performed PPV with retinotomy, gas fluid exchange, and endophotocoagulation OD, and retinal photocoagulation OS. Ten days post-op, the insured found a renewed RD OD and treated with perfluorocarbon, but 6 days later the retina had detached again. Laser was attempted in the office but was unsuccessful due to a cataract, and thus the insured performed PPV, lens extraction perfluorocarbon liquid infusion, and endolaser OD. VA continued to be HM OD and 20/25 OS. The PFO was removed 1 week later in the OR. YAG laser treatment OD was performed. Three weeks post-op, there was a redetachment OD. Silicone oil injections were discussed, but the patient transferred care to a new provider. VA remained unchanged at HM; VA OS was 20/30.

### Analysis

The plaintiff expert criticized the insured for negligent treatment of the retinal detachment and the use of perfluoron. The defense expert criticized the insured for lack of informed consent for the PFO infusion, and questioned the decision to perform just a scleral buckle OD as the initial procedure, and the method of dealing with the submacular hemorrhage. Furthermore, our expert also had serious concerns about the decision to use PFO and SF6 during the second surgery, lasering to the arcade, and further injection of PFO in the office.

### Discussion

Initially, the insured was adamant that this case proceed to trial despite the unsupportive expert opinions. Two months prior to trial, the insured presented to defense counsel's office with his spouse and asked defense counsel to settle this case. The insured was uncomfortable with the

deposition process and felt that plaintiff counsel was effective in building a case that the standard of care was not met. The insured insisted that he could not bear the stress of a potential trial. The case was settled for \$900,000.

**CASE 2:** A 38-year-old patient presented to the insured with complaints of floaters and a 6-week history of decreased vision. The insured diagnosed a retinal detachment with 3 large breaks superior nasally OS and immediately performed a pars plana vitrectomy, retinal cryopexy, and gas fluid exchange. The retina reattached, but one month later the patient developed cystoid macular edema, which the insured treated with a Kenalog injection. Ten days later, the insured diagnosed a new large retinal tear and immediately performed a pars plana vitrectomy, membrane peel, fluid gas exchange, and endophotocoagulation. Seven weeks later the insured returned the patient to surgery due to an epimacular membrane and cataract and performed pars plana vitrectomy, membrane peel, PCIOL, fluid gas exchange, and photocoagulation. Eventually, hypotony led to a ciliary body shutdown and severely swollen retina. Final visual acuity was hand motion.

### Analysis

The plaintiff expert criticized the insured for misdiagnosing cystoid macular edema OS, which led to a failure to perform the correct procedures. In this case, our defense experts were extremely supportive of the insured's care even though there was one missing piece of documentation related to the size and location of the retinal breaks. Defense counsel, defense experts, and our insured all felt the case was defensible and agreed with proceeding to trial.

### Discussion

Unexpectedly, plaintiff counsel notified defense counsel that the insured had left his medical practice. Defense counsel confirmed this news with the insured's office, and verified that the insured had made appropriate arrangements for the continuing care of his patients. Our defense attorney eventually gleaned that the insured had taken a medical leave due partially to the stress of the litigation. The insured was unable to withstand the rigors of trial, and the case was settled for \$900,000.



## Dealing with a disruptive patient

HANS K. BRUHN, MHS, and MICHELLE PINEDA, MBA, OMIC Risk Managers



**A**s noted in the lead article, there are myriad factors that lead to physician stress and burnout. One of those factors is disruptive patients. On the Hotline, we receive many calls from insureds who need assistance in managing patients who are rude, demanding, and non-compliant. Taking early action to resolve these issues will mitigate the risk of a medical malpractice claim, ensure your patients receive the excellent care you wish to provide, and help you avoid burnout.

**Q** More and more of my patients are rude, demanding, and sometimes hostile to me and my staff. What is the liability to my practice from these patients and how can I manage them more effectively?

**A** Difficult or demanding patients are distractions to providing quality care in a timely fashion (see OMIC Digest Vol. 19, No 3, 2009 (Summer): When Patients Become Difficult, Hostile or Violent <https://www.omic.com/when-patients-become-difficult-hostile-or-violent-2/>). Difficult patients can also create a stressful situation for you and your staff, and may result in hostile work environment claims. Patients who witness such behavior in your office may lose confidence in your practice and be reluctant to return. They may also post their dissatisfaction on social media, which is a very difficult issue to manage.

Develop a clear code of conduct that explains how patients are expected to behave, and how they can expect to be treated. Post this information in your practice and provide patients with a copy. Include the consequences for not following the code. Unacceptable behavior should be reported to you and your practice administrator's attention so it can be addressed.

Mutual trust is the basis for an effective physician-patient relationship. Disruptive behavior may indicate an erosion of that trust, and immediate action is needed to determine the cause for the behavior. If trust cannot be reestablished, consider a second opinion (to confirm your medical advice) or discharging the patient.

The informed consent discussion is an opportune time to confirm that mutual trust is in place. Avoid meeting surgical patients for the first time on the day of surgery. It is difficult for a patient to trust his or her physician if they have not had time to establish a relationship.

Be aware of challenges to providing care, such as a patient's special needs or disabilities, as well as the behavior of family or friends who accompany a patient. If the individual authorized to make decisions is disruptive, determine if care can be provided effectively.

Surgical patients who experience a complication can become disruptive due to frustration with care. The entire practice can be proactive to build faith and trust.

High deductibles, copays, and large out-of-pocket expenses can cause patients to become angry. Train billing staff to report patient concerns to the physician and practice management.

Develop a protocol to handle disruptive patients. It should include steps to: alert patients regarding unacceptable behaviors, explain how such behavior negatively impacts quality of care, and communicate consequences of non-compliance, including discharge from the practice. Contact our Risk Management Hotline (800) 562-6642, Press 4, for guidance on developing a protocol and help with specific patients.

**Q** Patients who don't pay their bills can be difficult to deal with and contribute to physician stress. Does OMIC have recommendations for dealing with these patients?

**A** Patients who carry insurance with high deductibles are often slower or noncompliant with paying their bills, especially in the first quarter of the year.

Ask new patients about their insurance when the appointment is scheduled. It is better to resolve this before the patient is seen.

Provide new patients with a written explanation of the financial protocol, and ask them to sign it at the first visit. The financial responsibility form might include statements like:

"I understand that I am financially responsible for my deductible, coinsurance, or non-covered service. Co-payments are due at time of service."

"If my plan requires a referral, I must obtain it prior to my visit."

"I agree to pay for charges that are not covered by my health plan."

"If I am uninsured, I agree to pay for the medical services at time of service."

Discuss financial issues. Patients with serious conditions might need extensive treatment that involves costs exceeding the patient's ability to pay. In this situation, consider care options that might reduce financial burden, such as referring the patient to a teaching or county hospital, or offering to create a payment plan for your services.

Dissatisfied patients often don't pay their bills. Ask the patient if he has any questions or concerns, and address those carefully. Talking to the patient can prevent escalation to a claim or lawsuit.



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## CALENDAR OF EVENTS

Upon completion of an OMIC online, CD/DVD, or live seminar, OMIC insureds receive a risk management premium discount. Contact Linda Nakamura at 800.562.6642, ext. 652, or [lnakamura@omic.com](mailto:lnakamura@omic.com), for questions about OMIC risk management options.

### Webinars and Videos

For a complete listing of current CD/DVD recordings and computer-based courses available for OMIC insureds, visit the risk management page at [omic.com](http://omic.com).

### Live Seminars

OMIC conducts live presentations at venues across the U.S. For a complete listing of upcoming courses visit [omic.com/calendar](http://omic.com/calendar).

### September

**6** Delaware Academy of Ophthalmology (DAO) *The Good, the Bad, and the Ugly: OMIC's Top Cataract Claims.*

**8** Midwest Ophthalmologic Symposium. *Lawsuits Alleging Failure to Diagnose Retinal Detachments.*

**14** Indiana Academy of Ophthalmology (IAO). *Co-management Liability & Risk Management.*

**21** North Carolina Society of Eye Physicians and Surgeons (NCSEPS). *Co-management Liability & Risk Management.*

**22** Wisconsin Academy of Ophthalmology (WAO). *Lessons Learned from OMIC Malpractice Claims.*

**28** New Jersey Academy of Ophthalmology (NJAJO). *Use Checklists to Prevent Patient Harm.*



**28** New England Ophthalmological Society (NEOS). *Managing Disruptive Physician Behavior.*

**29** Table Rock Regional Meeting Arkansas (AOS). *Vulnerabilities in Real-World Patient Care.*

### October

**27** AAO Annual Meeting. *Medical Malpractice Insurance: Incident Management.* (AAOE SPE#35)

**28** AAO Annual Meeting. OMIC Bruce Spivey MD Forum *Informed Consent: What Plaintiff Attorneys Don't Want You to Know.* (SPE#25)

**28** AAO Annual Meeting. *Medicolegal Issues of the Electronic Health Record.* This is a nurse/technician course requiring an IJCAHPO ticket.

**29** AAO Annual Meeting. *The Intersection of Liability and Ethical Professionalism.* (SYM #46)

**29** AAO Annual Meeting. *Prevent Falls in the Ophthalmic Office and OR.* (AAOE Course #473) Academy Plus Course Pass required.

**29** AAO Annual Meeting. *Why Take the Risk? How to Create an Effective Risk Management Strategy with Patient Education and Informed Consent.* (SPE #30)

### November

**5** Northern Virginia Academy of Ophthalmology (NVAO) *Lessons Learned from OMIC Malpractice Claims.*

### December

**8** ROP Update. *Liability Risks of "Off-Protocol" Treatment Decisions.*



[OMIC.com/risk-management](http://OMIC.com/risk-management)