



THE DIGEST

OPHTHALMIC MUTUAL INSURANCE COMPANY

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Dangers posed by systemic medications

LINDA HARRISON, PHD, OMIC Risk Management Director

Ophthalmologists examine many patients who are taking systemic medications that can cause ocular toxicity and a temporary decrease in visual acuity, or at worst, irreversible blindness. Ophthalmologists may be the first clinicians to note adverse effects, or be asked to monitor for them. This issue of the Digest will review closed claims involving hydroxychloroquine, ethambutol, gentamicin, and amiodarone, and suggest risk reduction strategies for ophthalmic practices to implement.

We invited Gaurav Shah, MD, a retina specialist in St. Louis, Missouri, and OMIC committee member, to provide his perspective on the clinical monitoring of patients who are taking these drugs.

Claims Experience

OMIC's loss experience with claims arising from these drugs is small, in terms of number of cases and indemnity paid, yet the harm to patients was significant. Only 14 such cases exist in OMIC's database of closed claims. Three cases led to a claim against the physicians' entity or the surgery center where the incident occurred. Five cases involved hydroxychloroquine (HCQ), 5 involved ethambutol, 3 involved aminoglycosides, and 1 involved amiodarone. The average age of patients was 64; the median age was 65. Eight of the insured physicians in these cases were general ophthalmologists, 5 specialized in retina, and 1 specialized in neuro-ophthalmology. Over half of the 14 cases (57%) involved allegations of

failure to diagnose (6) or misdiagnosis (2), while patients alleged failure to appropriately monitor in 3 cases, and negligent use of an antibiotic in 3 cases. Of 14 total cases, 11 resulted in litigation. Indemnity was paid on 43% of cases (6 of 14), compared to OMIC's average of 21%. Following is a discussion of the closed cases, grouped by the drug which caused the ocular toxicity.

Hydroxychloroquine (Plaquenil)

Hydroxychloroquine is a traditional antimalarial drug commonly used to treat autoimmune diseases such as lupus and rheumatoid arthritis; 4.97M prescriptions for Plaquenil were written in the United States in 2016¹. Although hydroxychloroquine is known to be toxic to the retina, the risk is low (1% to 2% up to 20 years of therapy, and 20% after 20 years). Since progression of retinal toxicity cannot be reversed even when Plaquenil is discontinued, the only way to prevent severe loss of vision is to screen for changes in retinal pigment.

The American Academy of Ophthalmology (AAO) has published guidelines on screening recommendations. These guidelines stress three key components: dosing, screening intervals and type, and communication with the prescribing physician and the patient. According to Michael Marmor, MD, one of the authors of the AAO guidelines, HCQ is "a remarkably safe drug to use if the dose is correct and you're screening properly." For many patients with SLE, RA, and other connective tissue diseases, he stated that "it's much

MESSAGE FROM THE CHAIR



DANIEL BRICELAND, MD, OMIC Board of Directors

It is with great humility that I begin my tenure as the Chair of the Board of a truly extraordinary company - OMIC. Following such legends as Rich Abbott, Tamara Fountain, and immediate past Chair George Williams is a tall task, but one I embrace. Dr. Williams served on Board committees for 14 years and before becoming our Chair he led the Finance Committee. He oversaw the growth of our company to a record high of 5000 insured ophthalmologists and his leadership

left OMIC in the best financial condition in our history.

Looking forward, I am reminded of Yogi Berra's prediction that "the future ain't what it used to be." Ophthalmology and all of medicine are facing tremendous disruptive changes, which are coming at a fast and furious pace. Every ophthalmologist encounters unsettling challenges on a daily basis, whether from new federal or state mandates, scope of practice issues, private equity agendas, or drug supply and pricing issues. Fortunately our partner, the American Academy of Ophthalmology (AAO), has unequalled federal and state advocacy



EYE ON OMIC

2019 dividend is the 25th declared over the past 30 years

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Due to OMIC's continued healthy balance sheet, we are pleased to report that all active physician policyholders as of December 31, 2019 will qualify for another dividend credit on their policy renewal. **Your Board has approved a dividend equal to 15% of your 2019 annual premium to be paid upon renewal in 2020.** Since 2004, OMIC has returned more than \$83 million in dividends to our ophthalmologist members. That is equivalent to more than two years of the average insured's premium. Historically, OMIC's dividend returns have outpaced the industry averages by a wide margin. Our philosophy remains to return any premium we collected above that needed to prudently operate the company. We do so as soon as we are given assurances by our actuaries that funds may be released.

Industry Outlook

It appears that after many years of relative stability in the medical malpractice insurance market, claim severity and frequency trends are rising. In addition to the normal inflationary pressures surrounding the costs associated with defending claims, there have been more large verdicts and

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staff and physician leadership to advocate for our patients. Dr. Williams transitioned from leading OMIC to current AAO president earlier this year.

OMIC's mission is twofold. First, we want to provide high quality insurance. In other words, we want you to sleep well at night. OMIC's board and committee members are practicing ophthalmologists who face the same disruptive changes all of you do. To make life easier, the Board asked staff to streamline our application process and change our bylaws so we may continue to insure practices that are owned by private equity firms.

The second part of our mission is to promote quality ophthalmic care and patient safety. This *Digest* focuses on ocular toxicity of commonly prescribed drugs often listed in our senior patients' medical records. These include hydroxychloroquine, ethambutol, glucocorticoids, osteoporosis medications (bisphosphonates), erectile dysfunction agents (tamsulosin), topiramate, anticholinergics, and anti-hypertensive agents.

This issue is personal for me. I followed a patient in her mid-seventies who presented with complaints of decreased vision from 20/25 to

settlements across most medical specialties, including ophthalmology. OMIC is well positioned to withstand any future deterioration in results, should they occur. Although we remain one of the strongest carriers in the industry with a premium to surplus ratio that leads virtually all of our peers, we must adjust rates modestly in order to respond to these inflation and claim trends. For 2020 renewals, policyholders will experience marginally higher rates ranging from 6% to 15% which will be offset by a 15% credit for the 2019 dividend.

OMIC last raised rates in 2004, more than 15 years ago. Since then, OMIC decreased rates (in all states) five times – in 2006, 2007, 2008, 2010, and 2016. The cumulative average OMIC rate decrease was more than 41% during this period.

Considering selling your practice to a private equity firm?

We encourage you to contact your OMIC representative if selling your practice to a private equity firm so that we may assist with coverage questions. OMIC is the exclusive carrier for several PE firms and an approved carrier for many others, so in most cases OMIC coverage can be maintained after the sale date.

20/50 while on ethambutol for three months for treatment of atypical mycobacterium infection. Her exam was unremarkable with subtle VF changes and few color vision abnormalities. Stopping ethambutol therapy and observing the patient's vision drop to 20/200 over two agonizing months is an ophthalmologist's worst nightmare. Fortunately, her vision gradually returned to normal within 3 to 4 months. It was alarming to learn that the patient had been prescribed the correct dosage based on her weight yet still developed optic neuropathy.

This patient was lucky: ethambutol toxicity is preventable with careful monitoring of dosage and examination, and immediately discontinuing it prevented irreversible damage. Other drugs present greater challenges. In this issue we provide insights on how to best protect our patients.

Finally, Yogi said it best about our future and as I step up to the plate as your Chair I will be ready for whatever is thrown my way. You can be assured that OMIC's team has its eye on the ball, our head in the game, and we will always have your back.

Limits of liability

KIMBERLY K. WYNKOOP, ESQ, OMIC General Counsel

OMIC's latest claims data indicate that the number of medical professional liability (MPL) claims made against ophthalmologists is slightly increasing; and, since 2016, the dollar amount of awards has also risen. Insureds may wonder if their current limits of liability are appropriate in this environment. This article addresses what limits of liability are, considerations for selecting them, and how changing them affects coverage if claims arise.

Your per claim limit of liability is the maximum amount of damages OMIC will pay on your behalf as a result of a covered claim. Damages, sometimes referred to as "indemnity," means the money paid as compensation to someone bringing a claim against you. This amount may be awarded in a lawsuit or arbitration, or agreed to in a settlement between the parties. OMIC pays your defense costs in addition to your liability limits.

You also have an aggregate limit. This is the maximum amount OMIC will pay per insured for all claims made and reported during the policy period (generally one year). This is often two or three times the per claim limit.

There are several factors to consider when selecting limits of liability. Your state's laws may influence what limits you carry. Some states have medical liability damage caps (the maximum amount a plaintiff can recover in a malpractice lawsuit). Physicians may want to insure their total exposure under the cap. For example, in Virginia this cap is currently \$2.35 million per claim and OMIC offers corresponding limits. Your state may have a patient compensation fund (PCF) with voluntary or mandatory participation. Laws in these states establish minimum liability limits doctors must carry. Often, the minimum limits are low since the PCF will pay all or some of any additional indemnity owed. Hospitals where you have privileges

may also specify the minimum limits you must carry.

Claims statistics and risk relativity provide additional helpful information. For example, as of 4/15/2019, OMIC's average indemnity payment was \$180,500 and OMIC's largest indemnity payment was \$3.375 million. Because of the relatively small number of indemnity payments made by OMIC on behalf of its insureds, it is difficult to make a statistically significant determination of the states with the highest severity. However, the following states with at least 50 current insureds have at least two of the following three characteristics – indemnity paid on one policy of \$1 million or more; average indemnity over \$260,000; and at least one plaintiff verdict: Alabama, Arizona, Connecticut, Florida, Illinois, Massachusetts, South Carolina, and Virginia.

You may want to consider the liability limits your peers are carrying. Most OMIC insureds (60%) carry \$1 million per claim/\$3 million aggregate limits. 31% of insureds carry higher limits: 24% carry \$2-2.2 million per claim, 3% carry \$3 million per claim; and 4% carry \$5 million per claim. 9% of insureds carry less than \$1 million/\$3 million limits: 7% carry OMIC's lowest generally offered limits of \$500,000/\$1.5 million, and 2% have other lower limits due to PCF participation.

You should assess the risks specifically related to your practice. Does your subspecialty experience high claims frequency (e.g., comprehensive/cataract) or large damage awards (e.g., pediatric)? Do you share your coverage and limits with any employees or your medical entity? Have you ceased performing most surgical procedures and/or practice only part-time?

Finally, assess your level of risk aversion. Often, plaintiff attorneys will not seek more than the insured's limit

of liability in damages for their clients. The higher the limits you carry, the more they may demand. Would you be worried about having such "deep pockets," or would a larger indemnity cushion make you feel more secure?

Changing your limits will affect the limits available to pay future claims. The limits of liability that apply to a claim are those that are in effect as of the date the claim (or potential claim) is reported in writing to OMIC. In other words, if you increase or decrease your coverage after an incident occurs but before you report the claim, the new limits, not the limits that you carried when the incident occurred, will apply. However, note that any increase or decrease to your limits is subject to underwriting approval. Your claims history will be taken into account and you will need to confirm that you are not aware of any claims or potential claims that you have not already reported to OMIC.

Note that OMIC has certain limits requirements when practicing in a group. Your OMIC underwriter is available to discuss your limits options with you. However, they are not in the position to offer you advice; if needed, you should consult your personal attorney.

This explanation is intended to give you an overview of what damages are covered within your policy limits, what supplementary payments are available, and which sums are not covered by your policy. It does not address the additional benefits for disciplinary and regulatory proceedings and cyber liability that are also provided by your policy. For all terms, conditions, and exclusions of your policy, please reference your policy booklet.

You can find a copy on OMIC's website at <https://www.omic.com/policyholder-services/policy-information/> when logged into MyOMIC.

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safer than steroids and immunosuppressives.”²

Dr. Shah: A common question that often arises in both the practices of general ophthalmologists and retina specialists is how to rule out HCQ toxicity. This is a complicated question since there are many different imaging modalities, such as OCT, color photographs, visual fields and mfERG, and it is debatable which is the best test for screening.³ Currently we have EMR systems that allow us to flag these patients so that they can be identified and monitored. The best action we can take as ophthalmologists is to suspect the toxicity and communicate with the patient's prescribing physician.

Two of these cases were settled. One of the settled cases illustrates the difficulty of making the diagnosis when the presentation is atypical, there are co-morbidities, and the communication between the prescribing physician and the ophthalmologist is inadequate. In that case, the 68 year-old female being treated with HCQ for lupus was referred to our insured for monitoring for HCQ toxicity. The patient was also being evaluated for Alzheimer's disease and thus was an unreliable historian. The prescribing physician failed to notify our insured that lupus-associated cerebritis had been ruled out. Our insured attributed some of the visual changes to that condition, especially in light of a normal-appearing macula. Decline in the patient's visual acuity and continued subjective complaints did not prompt the ophthalmologist to order color vision and VF tests. It was not until approximately 7 years into monitoring for the condition that a consulting retinal specialist ordered a fluorescein angiogram that revealed macular pigment loss in a pattern typical of HCQ toxicity. Unfortunately, the patient's bilateral visual acuity had declined from 20/30 to legally blind. The practice did not have a protocol in place for missed appointments, which resulted in gaps in monitoring of up to 2 years. Experts criticized the lack

of documentation of visual symptoms and changes observed in the retina, which should have been recorded at each visit. Review of angiograms interpreted by the insured revealed a classic pattern of HCQ toxicity, yet the diagnosis was not made. This lawsuit settled for \$325,000. The Claims article in this issue describes the case in more detail.

In the second case, the patient had self-referred for a comprehensive eye exam. The insured noted that the patient had a 10-year history of lupus for which she was taking HCQ. The insured described the drug as “high risk” in the record. Defense experts opined that while the insured had followed the Academy's screening recommendations, he failed to investigate why the patient missed color plates on 3 sequential exams. Detailed examination of the macula might have revealed pigment changes and led to discontinuation of the medication. Although the patient's visual acuity remained good, the 3-year delay in diagnosis resulted in significant visual field abnormalities and increased the likelihood for future central vision field loss. The case settled for \$100,000.

Ethambutol Cases

Dr. Shah: Ethambutol is a common drug used by pulmonary specialists for the treatment of not only tuberculosis but also mycobacterium avium complex (MAC), a condition that is increasing in the current population. Unlike HCQ, ethambutol is often not on the radar for many ophthalmologists, but is important to recognize as a cause of optic neuropathy. As a clinician, a pupil exam for afferent pupillary defect and color vision test become critical tools to monitor for toxicity and must be done at every visit. Objective testing including visual fields and visual evoked potential testing (VEP) should be considered for these patients. Unlike HCQ, the changes can be reversed, which makes it critical to suspect, test, and follow these patients.

Of the 5 ethambutol cases, defense experts concluded that 2 cases met the standard of care and 2 did not; 1 suit was dismissed prior to review. In the cases determined to be below standard of care, medical records available at the first visit contained information that the patient was either taking ethambutol or was referred for monitoring for ethambutol toxicity. In the one suit that resulted in an indemnity payment (\$80,000), the patient was referred to our insured due to difficulty reading fine print and “severe” difficulty driving in any type of bright light. The tech had noted that the patient was on antibiotics for a lung infection, and listed Biaxin, rifampin, INH, “and 1 more.” Unfortunately, the insured did not contact the prescribing physician to determine the name of the other drug, which was ethambutol. Regardless, both rifampin and INH are known to cause toxic optic neuropathy, which should have alerted the insured to monitor the patient closely. In other words, the physicians were on notice that these patients were at risk for ocular toxicity.

In another ethambutol case, a 69 year-old female was referred by her pulmonologist for decreased vision bilaterally (20/25 and 20/30). On exam, the retina appeared normal. The insured diagnosed cataracts and planned to monitor the patient. Just 3 months later, the patient returned complaining of worsening vision, measured as 20/60 OU. The patient was scheduled for cataract surgery, which occurred 6 weeks later. On post-op day 1, although vision was 20/400, no tests were ordered until 1 week post-op when vision had declined to CF. Visual fields showed central deficits, and an MRI was normal. Referral to a neuro-ophthalmologist resulted in the diagnosis of ethambutol toxicity. Review of the medical record showed that the EHR had embedded the medication list, which included ethambutol, in every visit note. So why was the connection not made between rapidly declining visual acuity

and ethambutol toxicity? The error highlights the importance of reviewing key medical records, attention to detail, and the art of distilling medical facts to arrive at a diagnosis and treatment plan.

Aminoglycoside Cases

The 3 aminoglycoside cases illustrate the importance of communication with and oversight of nursing staff who prepare medications, verification at the start of surgery of the dose of all medications to be used, and choosing the least harmful medication. None of the experts were supportive of the care and treatment in these cases. Two of the 3 cases were performed on the same day, at the same surgery center, by the same physician. The physician's standing orders included diluted gentamicin in BSS (balanced salt solution). The BSS for each patient was prepared by an experienced ophthalmic nurse who was very knowledgeable about the dose and dilution procedure. She did not recall doing anything differently that day. Defense experts agreed, based on post-op imaging and the surgeon's standing orders, that the patients had most likely sustained aminoglycoside toxicity from a dilution error. They criticized the ophthalmologist, however, for continuing to use aminoglycosides with known toxicity issues when other, safer antibiotics were available. Both patients went from a visual acuity of between 20/30 and 20/50, to legally blind. Both cases were settled on behalf of the ophthalmologist (\$122,500 and \$49,000) with the surgery center contributing \$91,000 in each case. The surgery center's records include a surgical checklist in which there is an intraoperative item named "appropriate use of intraop meds/fluids/devices." There was no checkmark by this item. There is no information about whether part or all of the checklist was utilized. A 2016 article estimates that preventable medication errors impact more than 7 million patients and cost almost \$21 billion annually

in the United States.⁴ Ensuring that intraoperative medications are properly prepared is a shared responsibility between the surgeon and nursing staff. OMIC's surgical checklist, available on our website, specifically states that "surgeon and nurse confirm antibiotic" amongst other items.⁵

The third aminoglycoside case involved a 34-year-old female who underwent penetrating keratoplasty OD to treat keratoconus. An injection of Garamycin was administered by the physician at the end of the procedure. The patient's visual acuity on post op day 1 was LP, which did not improve. Defense experts hypothesized that the mechanism of injury was inadvertent orbital needle penetration, which allowed the antibiotic to come into contact with the optic nerve. Fluorescein angiograms several weeks post op revealed severe ischemia of the retina, macula, and optic nerve, which are consistent with Garamycin toxicity. The surgeon's technique of removing the speculum prior to injecting in the sub-Tenon space was criticized by experts, since the speculum allows visualization and thus decreases the risk of the injury that occurred. The patient in this case was young (34 years old) and suffered loss of vision in her right eye. The case settled for \$500,000.

Amiodarone Case

Amiodarone is one of the most commonly prescribed antiarrhythmic drugs in the United States: 2.9M prescriptions were written in the U.S. in 2016.⁶ Ocular toxicity generally occurs within 1 year of initiation of therapy, with a median time of 6 months for onset of symptoms. Toxic effects include corneal deposits and colored halos around lights. Optic neuropathy is seen less frequently.⁷ Resolution of the toxicity is variable: permanent blindness in at least one eye has been reported for one-fifth of affected individuals, and the risk of nonarteritic anterior ischemic optic neuropathy is higher for amiodarone compared with several other drugs, including

ethambutol.⁸

In OMIC's one case involving amiodarone, the 78-year-old male patient was referred to our insured due to sudden vision loss in the left eye. Visual acuity was 20/30 OD and 20/40 OS. Color plate testing was normal OD (8/8) but abnormal OS (0/8). Exam of the left eye revealed pupillary defect; mild superior disc swelling with pink neural tissue; isolated epipapillary nerve fiber hemorrhage with absent central cup; and slightly elevated, largely amelanotic circumscribed lesion with adjacent dot retinal hemorrhages in the supranasal periphery OD. The diagnosis was non-arteritic anterior ischemic optic neuropathy (NAION) and retina lesion OS. No treatment was ordered. At the time of the lawsuit 2 years later, the plaintiff's visual acuity was 20/50 OD with cataract and bare LP OS. The plaintiff alleged misdiagnosis of amiodarone side effects and that the insured should have discussed discontinuing the medication with the patient's cardiologist. The plaintiff's expert acknowledged that visual acuity OS might not have been much improved had this been done, but that the right eye might have been saved from any further damage. Defense experts disagreed: they were completely supportive of the diagnosis of NAION, and felt that stopping the amiodarone would not have changed the outcome. The case was eventually dismissed without payment.

Risk reduction strategies on page 7

FOOTNOTES:

1. <https://clinical.com/DrugStats/Drugs/HydroxychloroquineSulfate>
2. <https://www.aao.org/eyenet/article/plaque-guidelines-point-out-new-risks>
3. <https://www.aao.org/clinical-statement/revise-recommendations-on-screening-chloroquine-h>
4. da Silva, B. A., & Krishnamurthy, M. (2016). The alarming reality of medication error: a patient case and review of Pennsylvania and National data. *Journal of community hospital internal medicine perspectives*, 6(4), 31758. doi:10.3402/jchimp.v6.31758
5. <https://www.omic.com/wpcontent/uploads/2016/02/Ophthalmic-Surgery-Checklist.2019-1.pdf>
6. <https://clinical.com/DrugStats/Drugs/HydroxychloroquineSulfate>
7. <https://www.uspharmacist.com/article/ophthalmic-toxicities-of-systemic-drug-therapy>
8. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3322295/>



CLOSED CLAIM STUDY

Other factors delay the diagnosis of Plaquenil toxicity

RYAN M. BUCSI, OMIC Claims Manager

Allegation

Failure to diagnose Plaquenil toxicity.

Disposition

The case was settled on behalf of the OMIC insured for \$325K.

The insured examined this 68 year old patient twice in a 2 month span and diagnosed ptosis OU. The patient returned to the insured 1 month later and reported that she had been prescribed Plaquenil 200mg for Lupus. No signs of Plaquenil toxicity were observed.

After 5 months, the insured noted that the Plaquenil dosage increased to 200mg twice daily. Color testing by Ishihara plates was normal. Despite a normal appearing macula, a visual field test was ordered for 6 months, which displayed unreliability, and the patient's mental status was somewhat altered. The patient only saw the light 7 out of 11 times in the right eye, which was unusual for someone with 20/40 vision. The patient's treating physician scheduled an MRI to determine if Lupus cerebritis might be the cause of the unreliable field.

Two years passed and the patient returned and complained of photophobia and occasional pain in each eye. The insured noted that cerebritis had been diagnosed after his last examination. The macular appearance was normal with 20/30 OU.

Approximately a year and a half after this the patient again returned to the insured and reported seeing spots in both eyes. The Plaquenil dosage was unchanged as was the vision of 20/30 OU, with normal appearing maculae. The patient's emotional deportment was difficult to interpret and the insured questioned whether this was due to past cerebritis.

Thirteen months later the patient returned to the insured and reported seeing clouds, dark spots, and circles while watching television. The Plaquenil dosage was unchanged and the patient was seeing a neurologist for possible Alzheimer's. Vision varied during this exam from 20/200 OD to 20/80 OD, 20/50 OS to 20/60+2 OS. A dilated examination showed no change in the macular appearance.

Another year passed and the patient returned and reported that the Plaquenil was reduced to 200mg daily. The patient could not see television or read. Vision was tested at CF at 4 to 5 feet in each eye but retested to 20/70-2 OD and 20/80-1 OS. A dilated examination did not show classic bull's eye maculopathy but a possible subtle loss of pigment. The insured referred the patient to a retinal specialist for a fluorescein

angiogram, which displayed macular pigment loss consistent with Plaquenil toxicity. Plaquenil was discontinued, but unfortunately, the patient's vision decreased to BCVA 20/400 OD and 20/100 OS, and was thought to be permanent.

Analysis

Retained experts could not support the insured's care. Specifically, our experts opined that the standard practice for a patient on Plaquenil is to perform an eye exam every 6 months. Our insured noted that he did not schedule exams every six months and that some follow up visits were scheduled for 1 year.

When the patient did not return for exams as advised, the insured's office did not follow up with the patient. The insured also commented that during some examinations, no appointment for a recheck was scheduled. Furthermore, our experts stated that the examinations every six months should have included color vision testing and a visual field using a central field 10-2 Humphrey performed with a red test object.

During each exam, a history should have been taken related to difficulty reading, photophobia, blurred or cloudy vision, spots in the vision, and a color vision test, visual field test and careful exam of the retina should have been done. Furthermore, our experts stated that when the vision first started to decrease and became variable, the insured should have ordered a fluorescein angiogram, which likely would have revealed Plaquenil toxicity earlier and perhaps saved some vision in each eye. Since we could not obtain expert support, we negotiated a settlement of \$325,000.

Takeaway

The insured was aware that this patient was taking Plaquenil. However, the presence of other factors such as cerebral vasculitis, variable vision during repeated visits, unreliable visual field testing, and possible cerebral dementia, complicated and delayed the diagnosis of Plaquenil toxicity. These complicating factors aside, the insured should have followed up with this patient on a more frequent basis and also should have performed multiple tests during each visit to rule out Plaquenil toxicity. Had this been done, it is more likely than not that Plaquenil toxicity would have been diagnosed much earlier and the patient would likely have retained greater visual acuity.

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The cases outlined in the lead article illustrate that diagnosing drug toxicity is not always a straightforward proposition. However, they also remind us that ophthalmologists and their staff can mitigate the risk of vision loss in patients taking these drugs by establishing protocols that address each of the key factors illustrated in the case examples.

1. When seeing a patient for a follow up visit, make a habit of refreshing your memory regarding how and why the patient came to your practice. Was it a referral from another physician? What was the reason?
2. Review the last few visits for symptoms, progress, and treatment plan, so that you can build on this history during the present visit.
3. Review the patient's medication list (if one exists), and consider the medications contextually with the patient's history and symptoms. To quote Dr. Shah, "suspect toxicity," especially if patients are taking HCQ, ethambutol, or amiodarone.
4. If no medication list exists, query the patient. This task can be delegated to staff, but you should review the list and confirm with the patient or the prescribing physician.
5. If the patient is on HCQ, consult the AAO guidelines for appropriate screening measures: <https://www.aao.org/eyenet/article/plaquenil-guidelines-point-out-new-risks>.
6. Inform patients of the risk of ocular toxicity if they are taking the drugs discussed in this article or any others known to cause ocular toxicity. Do not assume that the prescribing physician has done so.
7. If you have an EHR, be familiar with the location of key categories of information (e.g., medication lists), and remember to consult these items when examining patients.

8. Communicate as necessary with the referring/prescribing physician to understand more about the patient's disease process and medications to the extent that it impacts your care and treatment. Phone conversations should be documented. Or, request a written report to include in the patient's record.

9. Maintain an efficient, effective missed-appointment protocol, and periodically reinforce with staff. OMIC has a protocol with recommendations and sample letters to patients: <https://www.omic.com/noncompliance-guidelines-with-sample-missed-appointment-letter/>

10. During procedures, whether in your office, a surgery center, or hospital, use an ophthalmic-specific surgical checklist (<https://www.omic.com/ophthalmic-surgical-checklist/>). Remember that you share responsibility (and usually, liability) with non-MD staff who assist you.

11. Document the medical record thoroughly. To accomplish this, notes needn't be long, but they must convey a history, your observations and objective findings, diagnosis, and plan. Procedure notes should record what you did, complications encountered, and how they were addressed.

Applying these protocols consistently in your practice will reduce the risk of patient harm and enhance quality of care.

Does your staff know?

OMIC has many risk management resources available for insureds. We are also committed to making many of our forms and publications available to the wider public in the interest of patient safety.

See the list to the right for a summary of OMIC's current resources, publications, and services.



RECOMMENDATION GUIDES

OMIC has created several recommendation documents to give insureds tips and suggestions on how to handle difficult situations and when to put in place protocols and procedures for a variety of practice activities.

CONSENT FORMS

OMIC has the most comprehensive collection of patient education documents and informed consent forms in the industry. Forms may be downloaded in word processing software and modified as needed.

DIGEST ARCHIVES

The complete collection of Digest archives, including all of our articles, claim studies, and Hotline Q&A discussions are available online.

ALERTS AND NOTICES

OMIC publishes a monthly risk management bulletin and disseminates advice on how to handle major product recalls and alerts.

CYBER SECURITY RESOURCES

OMIC has contracted with a service to provide a complete library of state specific cyber security resources, checklists, and templates.

ONLINE COURSES

OMIC has created a wide variety of online risk management courses for insured physicians and their staff to use for training and loss prevention purposes. Physician insureds earn a premium discount of up to 10% for completing a course each year.

POLICYHOLDER HOTLINE

OMIC receives thousands of calls each year on our exclusive policyholder hotline for OMIC insured physicians and staff to use whenever they need advice or assistance when handling practice situations. Insureds should post the number in a common area for practice physicians and staff: **(800) 562-OMIC (6642). Press 4.**



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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, 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.

Live Seminars

OMIC conducts live presentations at venues across the U.S. For a complete listing of upcoming courses visit omic.com/calendar.

October

- 13** OMIC Bruce Spivey MD Forum. *Ophthalmic Anesthesia: Plan, Prepare and Be Ready When Things Go Wrong (SPE#52)*
- 14** *Why Take the Risk? How to Create an Effective Risk Management Strategy with Patient Education and Informed Consent (SPE #54)*

(See AAO 2019 Schedule for OMIC AAOE and IJCHAPO courses)

November

- 7** *Great Expectations: Liability Risks of Unrealistic Surgical Goals. 2019 (DAO) Delaware Academy of Ophthalmology's DAO CME Lecture Series*
- 16** *Lessons Learned From OMIC Malpractice Claims. Wisconsin Academy of Ophthalmology (WAO) Eye MD Symposium*



For a complete guide to OMIC courses offered at the 2019 American Academy of Ophthalmology Annual Meeting, please visit the OMIC Calendar at OMIC.com.

Visit the OMIC Exhibit at the 2019 AAO Annual Meeting next to the Academy Resource Center. Booth #7236

New Digests, Alerts, and Bulletins page at OMIC.com

See OMIC's advice and sample forms and letters for product recalls and alerts.

OMIC has archived past Digests and Monthly Bulletins.

Find in the Risk Management section at www.omic.com.



OMIC.com/risk-management