

Professional Liability Insurance and Risk Management

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— *The die is cast.*

Jean-Paul Sartre *Les Jeux Sont Faits*

The potential professional liability issues that can befall a private practitioner can involve the practitioner's person (malpractice, defamation), employees (vicarious liability, worker's compensation, or embezzlement), ophthalmic materials (product liability), office and equipment (premises liability), or casualty loss (fire, burglary, theft, or other perils). With so much at stake, and the cost of professional liability insurance relatively low, it is little wonder that practice-related insurance has become a high priority for most optometrists. Unfortunately, both the cost of professional insurance and the number and likelihood of claims have escalated throughout the past few decades. The trend toward increased exposure is expected to rise in the years to come; as optometrists increase the number of patients for whom primary eye care is provided. For this reason, adequate professional liability coverage has become a necessity for all practitioners.

TYPES OF COVERAGE

Since the potential for loss touches on so many areas of optometric practice, professional liability insurance policies must protect against a wide array of risks. For purposes of this discussion, insurance coverage will be divided into the following four categories: personal liability insurance, workers' compensation, fire insurance, and other property insurance.

Personal Liability Insurance

An optometrist can be personally liable for injuries to patients that arise out of acts of negligence (malpractice, breach of contract); injury to character (defamation); damages from lenses, frames, drugs, and solutions (product liability); injuries that occur on the premises (premises liability); or the negligence of employees (vicarious liability). Indemnification can be obtained for each of these potential sources of liability. Malpractice insurance pays for all costs of a legal defense and for any judgments or settlements arising out of a malpractice claim or a claim of breach of contract (up to the policy limits). Policies usually do not require the approval of the doctor before a settlement becomes legally binding, so an optometrist who wishes to insist on his or her day in court must ensure

that the policy requires the practitioner's approval before any settlement of a claim can be made. Malpractice coverage also includes claims involving employees who are acting in the line and scope of their duties, which means that technicians, assistants, and receptionists are provided with protection. Professional employees, such as other optometrists or opticians, may be added to a policy for little cost. Partners who are legally liable for one another's negligence can indemnify themselves against "joint and several liability" through the purchase of appropriate liability coverage. The employees of professional associations or corporations or limited liability companies can obtain coverage through a policy taken out by the corporation or company.

Defamation insurance provides all legal fees and pays all judgments and settlements (up to the limits of the policy) for any injury to the reputation of another person that arises out of the optometrist's professional activities. The defendant doctor's approval usually is not necessary for the settlement of a claim. The persons covered under a standard policy typically include employees.

Product liability insurance indemnifies the optometrist (to the stated policy limits) against any claim arising out of a defect in a lens or frame or defective drug or solution that results in damage to a patient's person or property; the optometrist's approval usually is not necessary for the settlement of a claim.

Premises liability insurance protects (to the policy limits) against any claims by a patient that result from injury while in the optometrist's office or on the office premises. These claims include injuries from equipment, as well as injuries from falls, shocks, and similar mishaps.

The foregoing are considered part of the basic coverage required for private practice. Additional coverage can be obtained to insure against the following eventualities:

- Automobiles used to conduct business can be insured against accident claims arising out of the negligence of an employee driver.
- Fire loss to leased or rented premises resulting from the negligence of an optometrist or office employees also can be covered.
- Injuries to employees that occur while the employees are acting in the line and scope of their duties can be covered.

This last eventuality is particularly important because insurance coverage for employee injuries will have to be purchased if the optometrist's practice is not covered by state workers' compensation laws.

Workers' Compensation

Workers' compensation laws were enacted to provide benefits for employees injured in on-the-job accidents or by occupational diseases and to limit the liability of employers for legal claims based on these accidents or diseases. Employees are guaranteed a "benefit certain" for their injuries or illnesses, which is paid for by the insurance purchased by the employer. In return, the employer is protected by the "exclusive remedy" provisions of these laws, which prevent employees from suing the employer for damages in court.

State law determines whether an employer must participate in workers' compensation. The key factor in making this determination is the number of employees that work for an employer; this number varies from state to state. For example, in Alabama an employer with more than four employees—full time or part time—must have workers' compensation coverage. In California, all employers must have workers' compensation insurance—even if there is only one employee. (The penalty for not carrying workers' compensation insurance in California is that an employer is deemed automatically liable should there be a claim.)

Generally, an employer can cover workers' compensation liability in the following five ways:

- Purchase insurance from an approved commercial workers' compensation carrier.
- If commercial insurance carriers will not provide insurance, the employer may purchase insurance through the state's "assigned risk pool."
- Obtain coverage through a group self-insurance fund.
- Provide self-insurance, if the employer is qualified to do so.
- Purchase an approved alternative workers' compensation policy from an authorized insurance carrier.

Most optometrists who participate in workers' compensation plans choose to purchase insurance from an approved commercial workers' compensation carrier.

Employers with fewer than the requisite number of employees may elect to participate in a state's workers' compensation plan, usually by applying to that state's workers' compensation agency. This usually requires little more than filling out a form. The employer may later withdraw from the plan if the employer chooses to do so.

Professional liability insurance policies usually do not include compensation for on-the-job injuries suffered by employees (unless it is added as optional coverage), making it essential that coverage from a commercial carrier be purchased if the employer does not elect to apply for coverage under the workers' compensation law. This coverage will increase the cost of the insurance policy but probably will be less costly than payments to a workers' compensation plan. The benefits that may be claimed by injured or ill workers under workers' compensation are limited by state law. Workers' compensation

benefits paid to the employees of an employer will increase the insurance premiums paid by the employer in the future.

Fire Insurance

Although liability insurance can protect against negligence that causes fire loss, to be fully indemnified for loss of instrumentation, equipment, records, furniture, supplies, and other items damaged by fire, an optometrist must acquire fire insurance. There are two fire insurance problems that an optometrist faces when leased office space is occupied: adequate insurance for all property located within the office and adequate insurance for the building in which the office is located. Unless the optometrist owns the building, the only problem that can be solved directly is the first, by adequately insuring all the personal property used in the practice. However, there is still the worry that the structure within which the office is located may not be adequately insured. The best way to obviate this problem is to be certain that the office lease contains a clause requiring the lessor to insure the building adequately.

As for the insurance itself, insurance companies usually require that a building be insured to a prescribed minimum of its value, often 80%, for full benefits to be paid in the event of its loss. As long as the 80% minimum is adhered to, a full 100% of any fire loss normally will be paid by the insurer, no matter whether the loss is partial or total. But if the insurance on the building falls to less than 80% of its value (which it can easily do if fire insurance policies are not adjusted for structure appreciation each year), the insurer is no longer obliged to pay 100% of the claim, reducing its liability in proportion to the percent of underinsurance. This can hinder repairs of partially damaged areas by the lessor and seriously impair an optometrist's ability to keep a damaged office functioning.

The same considerations are involved in the optometrist's leased office space. The lessee optometrist must act as a coinsurer with the lessor (building owner) and acquire fire insurance for all property located within the office, with such insurance amounting to a minimum of 80% of the property's value. Failure to do so may result in only partial insurance coverage, just as with damage to the building. Again, yearly review of fire insurance coverage is a must because new equipment additions can substantially boost a practice's property value.

Documentation of purchased items should be accomplished in the following two ways: all sales receipts and check stubs should be retained and stored for safekeeping, and photo documentation of all new office contents should be performed routinely. Proof of loss is a burden that rests solely on the policyholder and the contractual requirements to document loss under most fire insurance policies are considerable.

The money received for a claim can either be used to restore an item or to purchase a new one. Restoration costs will be paid in full by the insurer, but insurance checks for totally damaged items may not be adequate to purchase a brand new replacement because an item's *cost value* is considered to be the fair market value of the item at the time of loss, which means that an instrument or piece of equipment that is several years old

will be reduced in value according to its age. To obtain a new item, *replacement value insurance* must be obtained. However, replacement value coverage is more expensive than cost value coverage.

Interrupted business losses, or those losses incurred by virtue of the disruption of the practice from a fire, also can be included in a policy, but proof of loss can again be a substantial burden for the policyholder.

Other Property Insurance

Besides premises liability and medical premises insurance (which pays for reasonable medical expenses incurred by persons injured on the premises, regardless of fault), optional property coverage that can be obtained includes loss from burglary and embezzlement.

Professional equipment, furniture, and office equipment can be insured against loss on a replacement cost basis, which means that in the event of loss, new items will be paid for in full, as long as the policy limits reflect the current replacement cost value. Improvements and alterations of an office (such as paneling, fixtures, and other leasehold improvements) also can be insured on a replacement cost basis.

Loss from embezzlement can be a shock for an unsuspecting optometrist, but the traditional method of protecting against employee stealing—by taking out a fidelity bond on employees who handle money—is generally distasteful to an office staff. Fortunately, insurance providing for bonding of necessary employees can be purchased without the stigma that actual bonding confers. Comprehensive insurance protection against theft by employees (i.e., embezzlement) may be obtained by purchasing commercial crime coverage (includes embezzlement, computer fraud, theft, robbery, and burglary). However, proof of economic loss can be difficult to obtain, making reimbursement for embezzled amounts often less than the actual losses sustained.

In addition, employment practices liability insurance is available, but it is expensive and thus primarily used by large employers. Such coverage includes sexual harassment, employee discrimination, and wrongful termination claims.

Other property insurance available to optometrists includes the following:

- Transit coverage can be obtained for equipment while it is away from the office at another location or while it is in transit.
- Personal effects of the optometrist, staff, and patients can be insured against loss by perils such as fire, theft and burglary.
- Office records can be insured for the costs of reproduction.
- Owner, landlord, and tenant liability coverage offers protection against claims that arise from an optometrist's ownership or operation of a building.

Multiperil insurance is a package policy that provides coverage for fire, burglary, theft, office contents, professional equipment, general liability, and other perils; comprehensive coverage under such a package can sometimes be cheaper than purchases of individual policies for various contingencies.

EXTENT OF COVERAGE

A major decision facing any practitioner is how much protection to acquire. This question is often best answered by the individual taking into consideration the quality of care provided, the quality of the records maintained, the individual attention and consideration provided to patients (interpersonal skills), and how easily one is able to sleep at night. In a Houston, Texas case an optometrist agreed to pay a \$7 million settlement to a 10-year-old boy who blamed the optometrist for his impending blindness because of a failure to diagnose a tumor affecting the optic nerve. Fortunately, professional liability insurance for optometrists is relatively cheap. A practitioner can easily afford not only basic coverage but also “umbrella” coverage, which extends the personal liability provisions of the basic policy. Umbrella coverage also extends the amount of protection beyond that found in a standard policy. The cost of this extended coverage is typically less than 1% of the average optometrist's net income. In addition, extra coverage may be obtained at a discounted cost: an extra million dollars of coverage costs significantly less than the first million dollars of coverage.

Coverage is typically written to include the insurance provided per person and per occurrence. For example, a \$1 million/\$3 million policy would indicate that the policy limits are \$1 million per person and \$3 million for the event. Therefore, if an optometrist defamed several persons at once, each person would be covered for up to a maximum of \$1 million dollars in damages providing that the total amount of coverage for all claims stemming from the event would be limited to \$3 million.

Policy coverage pays for an attorney to represent the optometrist, but the attorney in fact represents the insurer. Insurance attorneys typically handle many liability claims and are experienced in liability law, but an optometrist may choose to hire personal counsel to work with the insurance lawyer and represent the optometrist's interests in the case. In such an event, the optometrist is solely responsible for payment of the personal lawyer's fees.

TYPE OF POLICY

Professional liability exposure can continue for a period of years after the optometrist has changed policies or retired from practice. Thus there is a risk that a lawsuit will be filed after the insurance coverage has ended, leaving the optometrist's personal assets at risk. This period of vulnerability after policy premiums are no longer being paid is known as the risk tail, and coverage should be acquired to protect the optometrist during this period.

With an occurrence type policy, all errors and omissions (malpractice) are covered, provided the incident occurred during the policy period, even if the claim is made after the policy has been terminated. This means that an act of negligence, committed during the period that occurrence policy premiums were being paid, is covered even if the claim is brought after the policy has been terminated and another policy purchased (or all coverage ended).

Under a claims-made form of policy, the optometrist is covered as long as premiums are being paid, but coverage ends after the policy is terminated. The insured usually has the right to purchase an extended reporting endorsement or nonpracticing policy within a stated period after terminating the basic policy, and this additional coverage is intended to cover against the tail risk. With such an endorsement policy, an optometrist is insured for a liability claim brought after basic coverage has ended; without it, there is no insurance coverage.

The following are points to consider when choosing the type of policy for private practice:

- Although an occurrence type of policy does not require the purchase of additional tail risk protection, it is more expensive than the claims-made policy, may have less broad coverage, and thus may be a less desirable choice.
- The right to purchase tail risk coverage should be guaranteed in the claims-made policy, irrespective of whether the policy is terminated by the insurer or the policyholder and regardless of the reason for termination.
- The cost of the extended reporting endorsement for the tail risk should be stated in the claims-made policy, either as a specific amount or a definite percentage of the basic policy.

MALPRACTICE CLAIM REPORTING REQUIREMENTS

In 1986 the federal government enacted the Health Quality Improvement Act, which was intended to address rising concerns over medical malpractice litigation and the quality of medical care. This law established the National Practitioner Data Bank (NPDB) and set as its goal the improvement of health care by doing the following:

- Encouraging state licensing boards, hospitals, professional societies, and other health care entities to identify and discipline practitioners who engage in unprofessional behavior.
- Restricting the ability of incompetent practitioners to move from state to state without disclosing past malpractice payments or other adverse actions against them (e.g., loss of license, hospital privileges, professional society membership, or participation in Medicare or Medicaid).

The NPDB began collecting and disseminating information in 1990, as part of the Department of Health and Human Services. It acts as an “alert” system, assisting boards in the review of health care practitioners’ professional credentials. Reports must be submitted to the NPDB in the following two instances: when an insurer makes a malpractice payment in response to a claim against a practitioner and when a hospital or other health care entity, state licensing board, or professional society takes an adverse action against a practitioner. 10 years of NPDB reports are summarized in Table 23-1. During this period, optometrists had the fewest reports of any type of professional degree patient care provider.

This information is available to state licensing boards, hospitals, professional associations, and other entities that license, hire, or grant privileges or membership to health care practitioners. Because of the use of this information by state boards,

TABLE 23-1

National Practitioner Data Bank (NPDB) Reports, 1990-2006

Practitioner Type	Number of Practitioners with Reports to NPDB *	Number of Reports to NPDB *
Physicians	164,877	307,937
Dentists	31,560	52,469
Nurses and nursing-related practitioners	21,853	23,153
Chiropractors	6,587	8,176
Podiatrists and podiatric-related practitioners	4,286	7,223
Psychology-related practitioners	1,251	1,525
Ophthalmic-related practitioners	591	707

* Reports include medical malpractice payment reports, adverse action reports, clinical privilege reports, professional society membership reports, Drug Enforcement Administration (DEA) actions, and Medicare/Medicaid exclusion reports.

it should be realized that settlement of a liability claim can lead to disciplinary action. Individual practitioners may query the NPDB to determine whether personal disciplinary information is in the data bank and whether the information is correct.

TAX ISSUES

Liability insurance coverage is a necessary aspect of the practice of optometry and is a necessary business expense for tax purposes. An optometrist may claim a tax deduction for the liability insurance premium, whether it is for basic or optional coverage.

If an optometrist should be unfortunate enough to have to file an insurance claim under any policy providing property coverage, the reimbursement to the optometrist by the insurer is not taxable. In the event the insurance payment is less than the fair market value of the property at the time of the loss, the optometrist can claim a tax deduction for the amount of the loss in excess of the insurance proceeds (see Chapter 39).

If an optometrist is a defendant in a professional liability lawsuit and the optometrist decides to hire a personal attorney, the cost of this additional counsel can be deducted. Any judgment an optometrist is ordered to pay that is in excess of the optometrist’s insurance coverage also would qualify as a deduction.

RISK MANAGEMENT

Professional liability insurance is necessary protection against the risk of a liability claim. The need to manage risk is an integral part of health care and is as important to the practitioner in private practice as to the clinician within an institutional setting. Through the use of appropriate communication, testing, and

treatment, the risk of injury to patients may be minimized; by providing adequate documentation of care, the details of management may be preserved. Only by attending to both aspects of care—appropriate testing and adequate documentation—can it be said that risk is truly managed.

Risk management, when properly applied, results in optimal patient care. One beneficial effect of proper care is a reduced likelihood of malpractice litigation. Professional liability has become a serious concern for medicine, reflected in the sizable malpractice insurance premiums that physicians must pay. Premiums are a reflection of liability risk and may be used to determine the exposure of various specialties to malpractice claims. Although the risk of litigation in ophthalmology is about average for all medical specialties, ophthalmologists pay approximately 3% to 5% of gross income for professional liability coverage. In comparison, the risk in optometry is much less, resulting in significantly lower expenditures for premiums, less than 1% of net income for coverage comparable to that obtained by ophthalmologists.

Although laws defining the scope of practice for optometrists vary from state to state, there is no differentiation in premium costs based on whether optometrists are permitted to prescribe therapeutic drugs or are limited to the prescription of diagnostic drugs only. The reason may be found in the types of liability claims brought against optometrists (Table 23-2). Most claims for substantial damages allege failure to diagnose disease rather than errors of treatment; the most important claims involve failure to diagnose open-angle glaucoma, retinal detachment, and tumors affecting the visual system. Because of the preeminence of these diseases, about three-fourths of claims alleging misdiagnosis of disease involve the posterior segment of the eye. For the anterior segment, injuries to the cornea are the most important. Contact lenses are a significant contributor to corneal injury; 40% to 50% of all malpractice claims involve contact lens practice. The great majority of these claims are for minor damages, and a minority of claims involve bacterial or herpetic infection of the cornea. Ocular injury from shattered spectacle lenses is another cause of malpractice claims; the usual allegation is that polycarbonate plastic should have been prescribed rather than a less impact-resistant lens material. Injury from the adverse effects of ophthalmic drugs is a rare cause of litigation involving optometrists.

PROOF OF MALPRACTICE

To apply risk management to the practice of optometry, the legal elements of malpractice must be understood. Malpractice, more properly termed medical negligence, is a civil action brought by an injured party seeking compensation (money). A professional liability claim requires the injured party (the plaintiff) to offer the following to establish proof of negligence:

- The doctor-patient relationship existed, thus a “standard of care” existed.
- The defendant practitioner did not act reasonably; the defendant’s conduct is measured against the “standard of

TABLE 23-2

One Hundred Optometric Malpractice Claims Involving Optometrists

Claim	Percentage
MISDIAGNOSIS OF INTRAOCULAR DISEASE	58% OF CLAIMS
Open-angle glaucoma	20 claims
Retinal detachment	17 claims
Tumors	
Intraocular	6 claims
Brain	8 claims
Diabetic retinopathy	4 claims
Histoplasmosis	1 claim
Toxoplasmosis	1 claim
Temporal arteritis	1 claim
MISDIAGNOSIS OF ANTERIOR SEGMENT DISEASE	11% OF CLAIMS
Corneal disease	6 claims
Ocular foreign bodies	3 claims
Tumors of the anterior adnexa	1 claim
Iritis	1 claim
INJURIES FROM OPHTHALMIC MATERIALS	21% OF CLAIMS
Contact Lenses	
Complications of lens-related corneal abrasions	7 claims
Misdiagnosis of corneal disease	3 claims
Failure to obtain informed consent	1 claim
Spectacles	
Failure to prescribe polycarbonate plastic lenses	7 claims
Defective sports-frame design	3 claims
IMPROPER CO-MANAGEMENT	5% OF CLAIMS
Complications of cataract surgery	2 claims
Complications of refractive surgery	3 claims
INJURIES FROM OPHTHALMIC DRUGS	3% OF CLAIMS
Adverse effects of diagnostic agents (angle closure)	3 claims
MISDIAGNOSIS OF BINOCULAR VISION ANOMALIES	2% OF CLAIMS
Failure to treat amblyopia	2 claims

From Classé JG: *Standards of practice for primary eye care*, Columbus, OH, 1998, Anadem.

care,” which is the conduct that is deemed to be reasonable under the circumstances by members of the profession, in other words, that a standard of care was not adhered to.

- There was actual physical injury to the patient.
- There was a legal link between the act (or failure to act) of the practitioner and the injury suffered by the patient; this link is termed *proximate cause*.
- There are damages (e.g., loss of visual acuity, visual field, or ocular motility).

All five elements must be supported by the preponderance of the evidence, which is provided through expert testimony.

Expert witnesses explain technical information and offer opinions concerning the standard of care. If misdiagnosis or improper treatment of ocular disease is at issue, an ophthalmologist may be deemed competent to offer expert testimony. Thus an optometrist may be held to a medical standard of care with respect to the diagnosis and treatment of eye disease. Expert witnesses can express opinions on the facts presented. Ordinary witnesses are called to provide factual information only. While office staff would be able to testify to the facts as to how records are maintained or the plaintiff as to when entries in those records were made, opinions regarding those facts can only be offered by experts so qualified by the court. It is a well established legal doctrine that an optometrist must, by the nature of the relationship with a patient, assist the patient in a legal matter incident to the care provided.

STANDARDS OF CARE IN CLINICAL PRACTICE

Four types of “standards of care” exist. They are as follows:

1. Statutory standard of care: some states have statutory requirements as to what comprises appropriate care and these standards then become mandatory.
2. Voluntary standard of care: if an institution or hospital voluntarily adopts policies as to patient care, these policies may dictate a voluntary standard that should be followed.
3. Judicial standard of care: a court may rule in a case in such a way as to dictate a standard of care. Such was the case in *Helling v. Carey* (1974) in which the Washington state supreme court ruled that it was so imperative that everyone obtaining an eye examination be confident that elevated pressures would be detected that the court would impose its own judicial standard of care, despite expert testimony in the case that there was no standard of care dictating that intraocular pressures be measured on someone under the age of 40.
4. Community standard of care: this is the most common standard and is determined by what is prudent, what one’s colleagues in the profession would do in a similar situation.

Risk management is based on an understanding of standards of care and stringent observance of them. Because of the importance of proper diagnosis, the procedural aspects of care receive the greatest emphasis: what to ask during the history, which tests to perform, when to periodically reevaluate the patient, and when to refer to another practitioner. Because adherence to standards of care must be established to avoid liability, proper documentation of communications, test results, and recall and referral appointments are essential. Examples of standards of care and of documentation are provided below for the areas of practice, which are most likely to produce a negligence claim: misdiagnosis of ocular disease, use of ophthalmic drugs, and the prescribing of contact lenses and spectacles.

It is important to remember that doctors are human—they are not perfect nor can they be held responsible for what others with similar skill and training would also fail to detect

or diagnose. It is understood that diseases may be misdiagnosed or not detected. However, if standards of care were followed a plaintiff should not be successful in his or her claim against a defendant doctor. It is not reasonable for a plaintiff to assume that a doctor is perfect or that fees should be refunded or compensation awarded when no standards of care were breached. Doctors, lawyers, and other professionals give their time and expertise and charge fees accordingly. For that fee, they do the best job they can for their patients or clients. They do not and cannot promise success nor is their fee contingent on that success.

Diagnosis of Ocular Disease

The three diseases most likely to result in allegations of misdiagnosis are open-angle glaucoma, retinal detachment, and tumors affecting the visual system. The most common reason for errors of diagnosis is failure to dilate the pupil. Clearly, the most important step to limit the risk of misdiagnosis is to develop a protocol for the use of pupillary dilation. Examination of the fundus should include both the retinal periphery and the posterior pole and should entail the use of the appropriate instrumentation (e.g., 60, 78, or 90 D fundus lenses, direct and binocular indirect ophthalmoscopes). Communication of findings and planned follow-up also are significant aspects of care and should not be neglected.

Open-Angle Glaucoma

Failure to diagnose open-angle glaucoma often has been linked with failure to perform tonometry; however, a significant number of glaucoma suspects will have applanation intraocular pressures (IOPs) that are normotensive, and patients with low-tension glaucoma will possess IOPs in the mid- to low teens. Although tonometry is a test that should be performed liberally, without regard to the age of the patient, it will not detect glaucoma suspects who are normotensive. Although the effect of open-angle glaucoma is to diminish the field of vision, few practitioners perform a sensitive test of the visual field unless there is clinical justification for it. A screening test, such as confrontation fields, is often used as part of the general examination, but this test will not reveal diminution of the visual field until the disease has reached an advanced stage. For these reasons, examination of the optic nerve head is often the most crucial aspect of diagnosis. Assessment through a dilated pupil, with the advantage of stereopsis offered by fundus biomicroscopy, may offer the best opportunity to detect disease, for often one eye will precede the other in degree of involvement. Distinct or subtle differences in the cupping of the neuroretinal rim may provide the clue that leads to further testing and to differential diagnosis.

If a patient is a glaucoma suspect, a sensitive test of the visual field must be performed, which requires the use of perimetry at threshold. This obligation extends to ocular hypertensive patients, who have about a 10% risk of developing the disease. Periodic reassessment of intraocular pressures and visual fields must be performed, which creates a long-term obligation for management. The risk of disease and the rationale for

testing must be explained to the patient and documented in the record of care.

Retinal Detachment

There is a timeliness to the diagnosis of retinal detachment that, if not observed, can lead to significant loss of vision. Therefore patients who are symptomatic for retinal detachment (blurred vision, seeing sparks or lights, and reduced visual field) must receive a timely dilated fundus examination and a thorough assessment of the retina. Both the periphery and the posterior pole must be examined; failure to perform a dilated fundus examination will inevitably be construed as negligence. Prompt referral is necessary if a detachment is found.

Patients who are at risk for retinal detachment also should receive a dilated fundus examination. These patients include individuals with the following:

- Significant myopia
- Aphakia or pseudophakia
- Open-angle glaucoma and significant myopia that is treated with miotic drugs
- Lattice degeneration
- Proliferative retinopathy (e.g., proliferative diabetic retinopathy, sickle cell hemoglobinopathy, and branch retinal vein occlusion)
- Nonpenetrating trauma to the eye
- Retinal detachment in the fellow eye
- Patients who have had a YAG laser capsulotomy

Patients with acute onset symptomatic posterior vitreous detachment (PVD) also must receive a timely, thorough evaluation of the ocular fundus. Between 8% and 15% of patients with symptomatic PVD will have suffered a retinal tear, and approximately one-third of these patients will experience a retinal detachment. The retinal break may not be apparent at the time of examination; a partial PVD may produce a retinal tear afterward, when there is complete separation of the vitreous. Even if the results of the initial assessment are negative, the patient must be reexamined 4 to 8 weeks later because the risk of retinal detachment remains significant, especially for aphakic patients. The patient must be warned of the symptoms of detachment and instructed to return for assessment immediately if they occur. These communications should be carefully documented in the patient's record.

Tumors

Intraocular tumor is an exceedingly rare disease, but if a tumor produces symptoms, misdiagnosis caused by failure to perform a dilated fundus examination may result in litigation. Even tumors as rare as malignant melanoma, retinoblastoma, and tumors found in patients with von Hippel-Lindau disease have been the source of malpractice claims. Failure to examine the peripheral retina in symptomatic patients is considered to be a breach of the standard of care.

Silent intraocular tumors pose a genuine diagnostic challenge to practitioners. The most troublesome situation is in the asymptomatic first-presenting patient: does the standard of care require a dilated fundus examination and evaluation of the peripheral retina of these patients? The growing

medical orientation of the standard of care is moving inexorably in that direction, as indicated by recent litigation. Therefore it is wise to include a dilated fundus examination as part of the general assessment of "routine" first-presenting patients.

Misdiagnosis of external tumors, such as basal cell and squamous cell carcinoma, also can be construed as negligence. Questionable lesions of the adnexa should be referred for biopsy and when appropriate, for surgical removal. Patients with visual field loss indicative of intracranial neoplasms must likewise receive referral for definitive diagnosis. For patients with a suspicious history (e.g., headaches, neurologic symptoms) or findings (e.g., decreased acuity, papilledema), perimetry is indicated. Tumors can not only threaten vision but also life, and optometrists must remain vigilant for these rare but potentially devastating diseases.

Use of Ophthalmic Drugs

Although the adverse effects of drug use are a liability issue for ophthalmologists, they are a rare source of litigation for optometrists. In fact, considering the importance of the diagnosis of intraocular disease, failure to use a mydriatic drug (to obtain pupillary dilation) is a much more likely source of litigation than an adverse effect of drug use (e.g., acute angle closure or anaphylaxis). All drugs have side effects, however, and ophthalmic drugs are no exception. For convenience of discussion, drugs are categorized as diagnostic or therapeutic.

Diagnostic Drugs

The most commonly used drugs are anesthetic and mydriatic agents. Anesthetic agents should not be applied copiously to a cornea with a compromised epithelium because a permanent corneal opacity may result. Mydriatic agents should not be administered without first assessing the anterior chamber angle. If the angle is anatomically narrow and has the potential to precipitate an angle closure during pupillary dilation, the patient must be warned of this risk and an informed consent to proceed must be obtained (Figure 23-1). Provisions also must be made for management of the angle closure should it occur. Patients who have undergone pupillary dilation during general examination should be advised that blurred vision and photophobia will persist for several hours and that caution is needed while operating a motor vehicle or performing other potentially hazardous tasks. The same warning must be given to patients who have received cycloplegia. In some instances (e.g., uncorrected hyperopes with significant refractive error), it is prudent to have a third party transport the patient during the period that acuity is reduced.

Therapeutic Drugs

Litigation from therapeutic drug use most often involves topical steroids. Adverse side effects of long-term use include cataracts and open-angle glaucoma. Patients who must undergo a long-term regimen of steroid use must be warned of side effects and monitored with sufficient frequency to detect these

EXAMPLE INFORMED CONSENT DOCUMENT FOR DILATION OF THE PUPIL WHEN A PATIENT HAS A NARROW ANTERIOR CHAMBER ANGLE

Dilation of the pupil is a common diagnostic procedure used by optometrists to better examine the interior of the eye. It allows a more thorough examination by making the field of view wider and by permitting the doctor to see more of the inside of the eye. Being able to examine the inside of the eye is essential to determining that your eye is healthy.

To dilate the pupil, eye drops must be administered. They require roughly half an hour to take effect. Once your pupils are dilated, it is common to be sensitive to light, a symptom that is usually alleviated by sunglasses. If you do not have any sunglasses, a disposable pair will be provided for you. Another common symptom is blurred vision, especially at near. It will require about 4-6 hours for your vision to return to normal. During this time you must exercise caution when walking down steps, during a vehicle, operating dangerous machinery, or performing other tasks that may present a risk of injury. If you have any special transportation needs, please let us know so that they can be arranged prior to dilation.

In about 2% of people there is a possible complication of dilation of the pupil; if it has been determined that you fall into this category. You must understand this complication before you give your consent to have this procedure performed.

The doctor's examination has revealed that there is possibility of elevating the pressure inside your eye when dilation is performed. The medical term for this eventuality is "angle closure glaucoma". Because of this possibility, once your eye is dilated and the interior of the eye has been examined, the pressure will be checked again. Should it become elevated, it will be necessary to lower the pressure by administering eye drops and oral medication. Afterwards, it may be necessary to refer you to an eye surgeon for treatment with a laser to prevent further occurrences of this kind.

Because of structure of your eyes, it is possible of an angle closure to occur at some other time, when the symptoms may not be recognized and treatment may not be immediately provided. Such an eventuality could seriously affect your vision. Therefore, there is a benefit to you in having dilation performed today and in allowing this complication. If it occurs, to be diagnosed and treated immediately.

The decision to undergo dilation is yours. You may choose not to have dilation performed, but because of your history, symptoms, or examination findings, the doctor recommends that dilation of the pupil be used today to examine your eye for disease. If you have any questions concerning the procedure, please ask them so that we may answer them. Then please sign your name in the appropriate place below to signify your decision.

- I understand the risks and benefits of the pupillary dilation and I consent to have the procedure performed.
- The risks and benefits of pupillary dilation have been adequately explained to me and I understand them, but I do not wish to undergo the procedure.

Date

Signature of Patient

FIGURE 23-1 Sample informed consent agreement for dilation of the pupil when there is a risk of angle closure.

effects if they occur. Prescriptions should specify the number of permissible refills. If no refills are permitted, the prescription should contain language to this effect.

A second source of litigation is the use of systemic steroids, which often have significant side effects. These drugs should not be used unless it can be ascertained that a topical route of administration would not be adequate. Warnings of expected side effects should be given and documented.

Drugs used for the treatment of open-angle glaucoma also can produce the following undesirable side effects: β -blockers can significantly affect individuals with uncompensated congestive heart failure or chronic obstructive pulmonary disease; miotic agents may precipitate a retinal detachment in patients

who are significantly myopic; and systemic carbonic anhydrase inhibitors may cause adverse effects ranging from kidney stones to aplastic anemia. Patients must receive adequate warnings of drug side effects and must be examined periodically to ensure that injurious effects have not occurred. In all cases, ophthalmic drug use must be adequately documented in the patient's record of care.

Contact Lenses

Risk management in contact lens practice is most easily described by type of lens modality: daily wear or extended wear. Although the risk of significant complication is greater

for patients fitted with extended wear lenses, the much larger number of individuals wearing daily wear lenses causes more legal claims to be brought by these patients. Because of the greater likelihood of complications found in extended wear (estimated to be 4 to 15 times that for daily wear) patients must be informed of the risks and a structured program of care should be devised. Written agreements are used to satisfy informed consent requirements and to describe management, which should obligate patients to return at stated periods for follow-up.

Agreements may be tailored to meet the needs of the mode of wear: daily wear, extended wear, disposable wear, or monovision for presbyopia. An important component of any fitting agreement is the contact lens prescription. The practitioner's policy for release of the prescription, which must be in accordance with the provisions of federal and state law, should be made clear to the patient before the fitting. When a prescription is released to the patient, it should contain all the information necessary to allow the patient to obtain the lenses fitted.

Liability issues vary somewhat, based on the type of lens prescribed.

Daily Wear Lenses

The six major areas of litigation involving daily wear lenses, requiring the application of risk management, are as follows:

- Fitting patients with nonapproved lenses, use of nonapproved solutions, or using approved lenses or solutions in a nonapproved manner (e.g., allowing disposable wear lenses to be cleaned overnight and reused)
- Inadequate disclosure of the limitations of monovision wear
- Failing to verify lens parameters before dispensing lenses to patients
- Negligence by a contact lens technician
- Misdiagnosis or inadequate management of contact lens–related corneal abrasions or infections
- Failing to periodically evaluate the ocular health (external and internal) of contact lens patients

The most important considerations are the management of contact lens–related abrasions and the periodic evaluation of the ocular health of contact lens wearers. If neglected, they create the best opportunity for significant injury and significant damages.

Extended Wear Lenses

In addition to the problems enumerated for daily wear lenses, the following special considerations apply to patients fitted with extended wear lenses:

- Improper selection of patients for extended wear (e.g., patients with dry eye)
- Inadequate instruction given to patients (e.g., failing to inform patients of proper methods of lens disinfection and maintenance)
- Improper wearing schedule (e.g., recommending continuous wear beyond what is appropriate and clinically justified)

- Improper management of contact lens–related complications (e.g., corneal abrasions that evolve into ulcerative keratitis)
- Inadequate monitoring of ocular health

A special concern is found in disposable lens wear. Because several months' supply of lenses are dispensed to patients at 1 time, the customary obligation of inspecting and verifying lenses before dispensing cannot be fulfilled. The patient must be informed of this deviation from usual practice and instructed to return immediately for reevaluation if acute problems arise after insertion of lenses (e.g., pain, redness, decreased acuity, or discharge). This information should be included in the informed consent agreement.

Spectacle Lenses and Frames

Legal claims involving spectacles are brought because a lens or frame breaks, causing ocular injury. Spectacles are prescribed based on the primary purpose for which they will be used: dress wear, occupational or industrial use, or for athletic competition or sporting activities. Protection from injury is always a consideration regardless of the type of use, but whenever protection becomes a key clinical concern, the lens material of choice must be polycarbonate plastic. Patients for whom ocular protection is important constitute a sizable group of individuals, including the following:

- Monocular persons
- Athletes
- Individuals whose occupation may place them at special risk for ocular injury (e.g., law enforcement officers, operators of machinery)
- Children
- Persons with corneas that have been compromised by surgery (e.g., aphakia, penetrating keratoplasty, or radial keratotomy)

Dress eyewear may be inadequate to protect patients from injury; industrial strength frames or athletic frames may be necessary, with polycarbonate lenses. If secondary use (such as occasional participation in athletic events) poses a significant risk of injury, patients must be advised of the need for protective eyewear, and the proper lenses and frames must be prescribed.

All lenses and frames prescribed for occupational or industrial use ("safety glasses") must meet specific federal standards for impact resistance. Eyewear must be inspected before it is dispensed to ensure that it meets these standards, which include a minimum lens thickness requirement (3 mm, regardless of lens material) and a "Z-87" logo for the frame.

Frames prescribed for athletic use, particularly for racquet sports, should meet the requirements of the American Society for Testing and Materials Standard F803. Polycarbonate lenses are mandatory. The same type of frames should be prescribed for persons involved in contact sports such as baseball, basketball, and football.

In the dispensary, patients should be informed of the difference between lens materials and frame types and the choice of eyewear should be documented.

GOOD SAMARITAN STATUTES

Any doctor who renders first aid at a scene of an accident is not liable for malpractice where such statutes exist. However, such statutes do not apply to treatment rendered by physicians (optometrists) as part of their normal course of practice. Under common law, physicians were under no duty to render aid to a person in peril. However, a person who stopped to render emergency treatment assumed a legal duty to act with reasonable care and was held to the degree of care that other physicians would have given under similar circumstances. However, because of the circumstances of such situations, the quality and quantity of treatment was reduced and the chances of medical failure were increased. Although the common law standard of care reduced the chances for a patient's success at trial, it did not discourage the commencement of malpractice actions. In response, many states enacted Good Samaritan statutes, which declare that no physician who in good faith rendered emergency care at the scene of an emergency would be liable for damages for acts or omissions in rendering emergency care. A person who shows up at the optometrist's office with an emergency would not fall within the protections afforded by a Good Samaritan statute in that the court would likely find that the care provided was part of the normal course of practice.

RECORDKEEPING AND DOCUMENTATION

Even though care is provided in accordance with recognized standards, the defense of a legal claim may be impaired because the practitioner's record does not adequately describe the care rendered. There are two aspects to proper risk management: the use of an appropriate method of recordkeeping and the diligent documentation of test results, important communications, and treatment plans.

Problem-Oriented Records

To obtain efficient, clear, and thorough recordkeeping, a problem-oriented system should be used. Problem-oriented recordkeeping, whether applied to written or electronic records, achieves effective risk management and is the preferred method for optometrists (see Chapter 16). Risk management through documentation is most importantly directed at descriptions of findings, informed consent, and follow-up appointments.

Description of Findings

When recording examination findings, the optometrist should use descriptive terminology. Rather than empty terms such as "normal," "unremarkable," and "WNL" (within normal limits), language describing the practitioner's observations should be used (e.g., the optic nerve may be recorded as "C/D .3/.4, margins distinct, no pallor, NRR1" [neuroretinal rim intact]). The findings of ophthalmoscopy and biomicroscopy should be documented; in addition, the details of testing should be recorded (e.g., instruments used, drugs administered). All aspects of the

eye health assessment should be accorded this descriptive documentation, which constitutes a most important part of the defense of a malpractice claim.

Informed Consent

The obligation to provide informed consent arises in many aspects of practice; examples include contact lens fittings, dilation of a narrow anterior chamber angle, and prescribing of drugs for treatment. To ensure that the appropriate information is conveyed and to preserve a written record of the patient's consent, printed forms are often used (see Figure 23-1). These forms expedite the process of adhering to informed consent requirements, provide excellent evidence should a legal dispute arise, and are a necessary part of clinical practice.

Follow-up Appointments and Referrals

If patients require follow-up visits, a definite recall appointment should be scheduled, even if the date is remote (e.g., 3 to 6 months in the future). The patient should be contacted by mail or telephone (or both) just before the appointment date and reminded of the examination. If referral is necessary, a practitioner should be chosen and contacted, and a definite appointment should be scheduled. The date of the appointment should be noted in the patient's record. If practical, a letter should be sent to the practitioner to whom the patient is being referred, describing the reason for the referral and requesting notification if the patient does not keep the appointment.

Maintaining well-organized records is one of the most important steps that clinicians can take to manage risk. The importance of proper recordkeeping and documentation as necessary components of risk management cannot be overemphasized.

Statute of Limitations

A statute of limitations determines the time limit within which a patient may bring suit for alleged malpractice. These limits differ from state to state. In California the statute of limitations for medical malpractice is either 3 years after the date of injury or 1 year after discovery, whichever is less. There are exceptions, however, in the case of fraud, intentional concealment, or for minors.

Retention of Records

Records should be kept for as long as practical. It is impossible to know now what information may be helpful in a patient's future treatment. It may be difficult, if not impossible, to adequately defend a malpractice suit in which records have been destroyed, although the applicable statute of limitations should be the absolute shortest retention period. The costs of maintaining and storing records are minimal compared to potential liability in which records are shredded. Other statutes also have a bearing on records retention such as tax codes with regard to financial information, health and safety codes with regard to controlled substances prescribed by optometrists, specific contractual obligations incurred by third parties, etc. The California Hospital Association has

noted that 99% of claims filed against hospitals, independent of eventual rulings with regard to the statute of limitations, are done within 10 years of the incident. This may suggest a minimum record retention period of 10 years.

ACKNOWLEDGMENTS

The authors of this chapter in the first and second editions of *Business Aspects of Optometry* were John G. Classe' and Lawrence Thal.

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