THE SCOPE

MLMIC Insurance Company
a Berkshire Hathaway company

MEDICAL EDITION

ISSUE 10
THIRD QUARTER 2022

INSIDE THIS ISSUE

NY

INSIDE

EXECUTIVE MESSAGE

This issue of *The Scope* focuses on a subject that is always with us, namely, the difficult patient. Somehow, despite the countless ways we help patients on a daily basis, sometimes with astoundingly good results, it is the difficult patient who stays in our minds, whether we are attending a sporting event, spending time with family or friends, or simply enjoying some well-earned time off.

Difficult patients come in many varieties. They can be noncompliant, paranoid, overly dependent, angry, seductive, and — as we have learned, especially lately — even violent. They are always in our thoughts. (I still remember, vividly, the patient who threw a hatchet at me in a psychiatric emergency room, and this happened 47 years ago.) Learning how to better manage such patients is, of course, better for them, but, just as important, it is better for us. I hope that *The Scope* can provide some specific suggestions in this regard.

It is easy, in general, for us to care for the grateful patient who follows our instructions, takes the medicines we prescribe, keeps appointments, and is appreciative of our efforts. In my opinion, it is with the difficult patient that we truly test our mettle, improve our skills, and perhaps succeed where another physician might understandably fail. Dealing with such patients provides an opportunity to care for those who might otherwise be worse off as a result of their difficult nature.

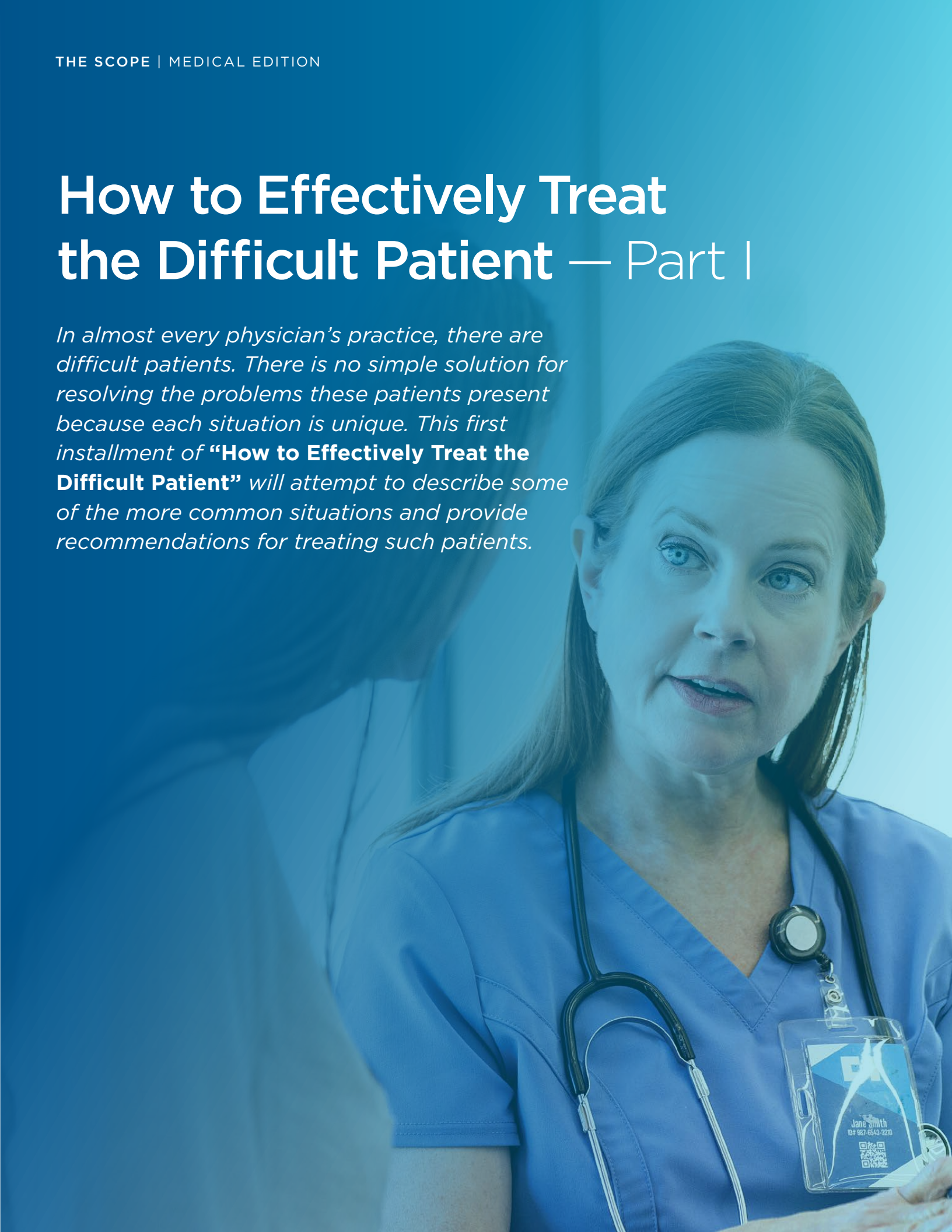
I hope you find *The Scope's* discussion of this subject helpful. If you have any questions, suggestions, or comments, please don't hesitate to contact me at **jlombardo@mlmic.com**. It has become an overused expression, but is most relevant here: "Keep calm and carry on."

Sincerely,

John W. Lombardo, MD, FACS
Chief Medical Officer, MLMIC Insurance Company
jlombardo@mlmic.com

How to Effectively Treat the Difficult Patient — Part I

In almost every physician's practice, there are difficult patients. There is no simple solution for resolving the problems these patients present because each situation is unique. This first installment of **"How to Effectively Treat the Difficult Patient"** *will attempt to describe some of the more common situations and provide recommendations for treating such patients.*



Patients Who Demand and/or Abuse Narcotics

Patients who abuse narcotics present a dilemma for physicians. The patient may come to the office with complaints of severe pain, and, as pain is often subjective, the physician must rely on what the patient tells him/her. Some patients may demand a specific narcotic, or even a specific dose. Other patients may claim that non–narcotics have not been effective and ask the physician to prescribe a narcotic. Before the physician prescribes narcotics, he/she must check the I-STOP registry, which will tell the physician if the patient has a history of seeking narcotics from multiple providers and if a narcotic has already been prescribed by another provider.

If it is contemplated that a patient is going to be treated with narcotics over a long period of time, it is recommended that the patient sign a pain management agreement.[1] The agreement sets forth the expectations for the treatment relationship and spells out the consequences if a patient fails to adhere to the agreement. Consequences could include discontinuing the prescription for narcotics, requiring drug testing, and/or discharging the patient from the practice.

> **The patient may claim … something atypical, such as "the dog ate my pills."**

Once a physician decides to prescribe a narcotic, other issues may arise. A patient who is given medication that is intended to last for a specific number of days may call the office requesting a refill before the next refill is due. The patient may claim the prescription was lost, the medications were stolen, or something atypical, such as "the dog ate my pills." Substance abusers will generally have a myriad of excuses. After a few visits, the physician may begin to question the legitimacy of the patient's need for narcotics and become wary of the patient's excuses. This is particularly true when the pain has no obvious cause and/or no objective signs or symptoms of pain are manifested.

Obvious signs of substance abuse include: (1) the physician learning that the patient has been obtaining narcotics from multiple sources; (2) the patient making frequent visits to an emergency department or another covering physician to seek narcotics; and (3) a new patient demanding narcotics for pain control but refusing to authorize the release of

> **Physicians must always be alert to the fact that patients abuse, and may even sell, the narcotics prescribed to them.**

treatment records of a prior physician. Physicians must always be alert to the fact that some patients abuse, and may even sell, the narcotics prescribed to them. The patient may intentionally divert the medication, or a family member or friend may be stealing drugs the patient legitimately needs for pain.

If a physician reasonably believes that a patient is a habitual user or abuser of narcotics, is the victim of the theft of narcotics by a third party, or has stolen narcotics, the physician must contact the New York State Department of Health Bureau of Narcotic Enforcement (BNE) and notify it of that information.[2] The physician may also consider discharging the patient from care. If the patient has an existing appointment or cannot be discharged due to his or her condition, the physician should advise the patient that narcotics will no longer be prescribed and refer the patient to a pain management clinic. If the patient resists, the physician must take steps to wean the patient from the narcotic medication. In addition, all covering physicians must be advised not to refill narcotic prescriptions for that patient.

> **Theft of drugs by a third party is a crime and should be reported to the police.**

If the patient alleges that a family member is stealing the medication, a toxicology screen must be ordered to confirm that the patient is not taking the prescribed narcotic. Theft of drugs by a third party is

1. A sample pain management agreement is available from **Mercado May-Skinner**.
2. Public Health Law §3372. The telephone number for BNE is (518) 402-0709.

a crime and should be reported to the police. Advise the patient that the police will be contacted.

Situations involving abuse of narcotics do not lend themselves to easy solutions. If you have a concern in this area, you should contact legal counsel at **Mercado May-Skinner**.

Patients or Family Members Who Are Rude, Hostile, Abusive, or Threatening

Some patients, or their family members, have a low flash point. If they are given bad news or are inconvenienced, they may become angry or abusive. Others may make threats or become physically intimidating. When a patient makes a threat, the physician must immediately determine how serious the threat is, including whether the individual could potentially carry out any threat of violence. If the threat appears to be legitimate, and if it rises to the level of a criminal act, it should be promptly reported to the police. Criminal acts include trespass,[3] disorderly conduct,[4] harassment,[5] aggravated harassment,[6] stalking,[7] and menacing.[8]

Law enforcement authorities should also be immediately notified of any criminal conduct that takes place on the premises, or of any criminal acts that are committed against the physician and/or staff. If an individual is hostile and threatening to staff and refuses to leave after being asked to do so, the police may be contacted. If criminal charges are filed, the physician and/or staff member may even request that the court issue an Order of Protection, which mandates that the patient refrain

> **Criminal acts include trespass, disorderly conduct, harassment, aggravated harassment, stalking, and menacing.**

from menacing conduct, or that the patient stay away from the protected individual's home or office. In these extreme cases, the patient (and perhaps his or her entire family) should be discharged from the office practice and referred to the emergency department for follow-up care, or to the local medical society for the name of other providers.

If the conduct is less severe, such as rude or disruptive behavior, the physician has several options. Sometimes, a direct conversation with the patient or family member will result in a change of behavior. The physician can plainly state that the

3. Trespass is defined as knowingly entering or remaining unlawfully in or upon premises. Penal Law §140.05
4. Disorderly conduct is defined as engaging in fighting, violent or threatening behavior; making unreasonable noise; using abusive or obscene language or making an obscene gesture in a public place; creating a hazardous or physically offensive condition by an act that serves no legitimate purpose, with the intent to cause public annoyance, inconvenience, or alarm. Penal Law §240.20
5. Harassment is defined as following a person in or around a public place or engaging in a course of conduct or committing acts that place a person in reasonable fear of physical injury. Penal Law §240.25
6. Aggravated harassment is defined as (1) communication, including communication initiated by mechanical or electronic means, with a person, anonymously or otherwise, by telephone, telegraph, mail, or any form of written communication, in a manner likely to cause annoyance or alarm; or (2) making a telephone call with no legitimate purpose for communication; or (3) striking, shoving, kicking, or other physical contact, or attempting or threatening such contact, because of a belief or perception regarding such person's race, color, national origin, ancestry, gender, religion, religious practice, age, disability, or sexual orientation, regardless of whether the belief or perception is correct. Penal Law §240.30
7. Stalking is defined as intentionally, for no legitimate purpose, engaging in a course of conduct directed at a specific person, with the knowledge that such conduct is likely to cause reasonable fear of material harm to a person, his/her immediate family, or an acquaintance. Such conduct consists of following, telephoning, or initiating communication or contact after the actor had been clearly informed that he/she must cease such conduct. Material harm includes harm to physical health, safety, or property, mental or emotional health, and threats to the person's employment, business, or career. Penal Law §120.45
8. Menacing is defined as intentionally placing or attempting to place another person in fear of death, imminent serious physical injury, or physical injury. Penal Law §120.15

behavior is unacceptable and, if it occurs again, will result in discharge from the practice. This conversation can occur either by telephone or at the time of a visit, and it should be documented. Often, this will achieve the desired result. If such a discussion with the patient is not an option, then the patient should be seen for the immediate condition and then discharged. The physician/practice also may wish to discharge other family members, such as siblings or in-laws, if it would be uncomfortable continuing to care for them under the circumstances.

The Noncompliant Patient

Noncompliant patients are some of the most difficult patients a physician may encounter. Some of these patients fail to comply with recommendations for treatment, testing, and referrals. Others routinely fail to keep appointments. Although noncompliant patients may be nice individuals, they can be extremely risky to a physician's legal health. Noncompliant patients should be counseled and warned about the consequences of failing to adhere to treatment recommendations, and these discussions should be documented in the medical record. The consequences of failure to comply should also be reiterated in writing to the patient.[9] If the noncompliance persists, he/she should be discharged from care. Although patients legally have the right to refuse treatment, the physician also has the right to discharge the patient for noncompliance. The reason for discharge must be thoroughly documented, both in the patient's record and in the discharge letter, as noncompliance with recommendations for care and treatment.

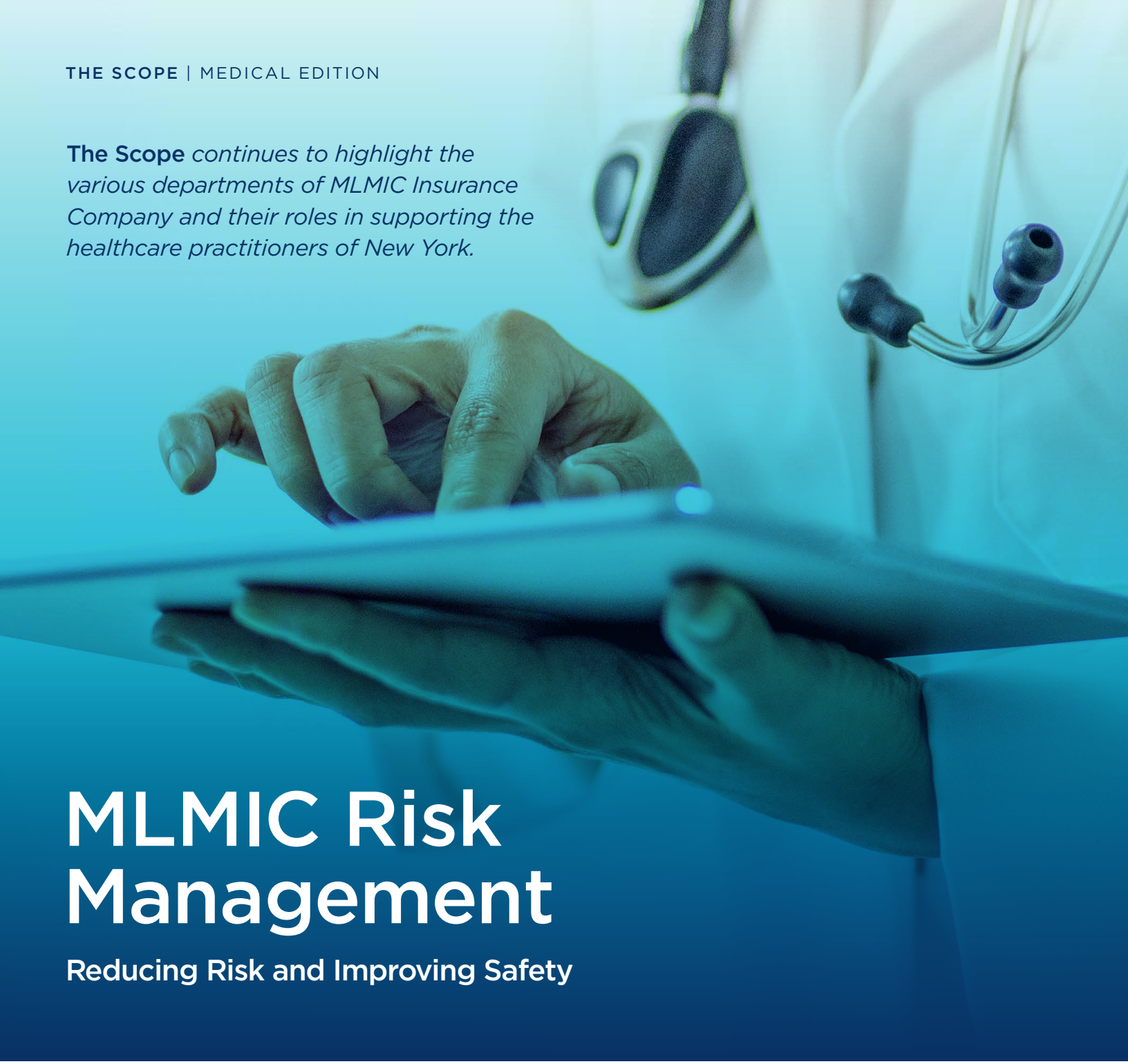
In summary, all patients, even difficult ones, must be evaluated and treated by their physician until and unless they have been formally discharged from care.

In the next installment of *How to Effectively Treat the Difficult Patient*, we will examine Patients Who Fail to Pay Bills, The Intoxicated/Impaired Patient, and Patients Who Lack Capacity, as well as discuss the proper way to discharge a patient from care.

Please be sure to read the case study on page 10 for a practical example of treating a difficult patient.

9. When a physician sends a letter containing critical information to a patient's address, it is recommended that the letter be sent by first-class mail with a certificate of mailing purchased from the Post Office. As long as this letter is not returned as undeliverable, it may be presumed that it was received.

The Scope *continues to highlight the various departments of MLMIC Insurance Company and their roles in supporting the healthcare practitioners of New York.*



MLMIC Risk Management

Reducing Risk and Improving Safety

Having seen many changes and emerging trends in healthcare and risk management these last few years, MLMIC's Risk Management professionals have become more proactive than ever in the production of educational opportunities offered to our policyholders and their staff.

These educational offerings are always produced in alignment with the vision of our insured healthcare providers and facilities, as well as that of our many partner medical societies and healthcare advocacy organizations. The quest to improve patient safety and minimize exposure to risk is always our main objective. We know innovative risk management in healthcare may not only reduce medical malpractice claims, but can also save lives.

Our Risk Management Consultants are constantly developing programs for our policyholders that will raise awareness of current trends and address the ever-important safety and risk issues. We monitor these state and national claims trends to identify the top liability risks for healthcare providers, and partner with our colleagues from the law firm of Mercado May-Skinner to provide the current legal, regulatory, compliance, and quality topics that are vital to healthcare providers and their organizations.

MLMIC proudly awards over 40,000 continuing medical education (CME) credits to physicians each year. Our CME program is accredited through the Medical Society of the State of New York. Numerous opportunities and incentives are offered to our policyholders to receive education through MLMIC. Satisfactory completion of our Proactive Premium Credit and Excess Eligibility **CME courses** allows physicians to earn *AMA PRA Category 1 Credits*™ and the applicable premium credit (**5%, VAP, ECPIP, etc.**), as well as qualify for participation in the **New York State Insurance Department Regulation 124** medical malpractice excess insurance program. In addition to our Proactive courses, we have numerous patient safety educational offerings that physicians may take for CME credit. Last year, over 7,000 physicians participated in 48 of our programs and earned *AMA PRA Category 1 Credits*™.

> **We encourage our insureds' nursing and support staff to participate in all our education offerings, as these providers play an integral role in ensuring a culture of safety.**

Our Risk Management Department also offers a lengthy catalog of live CME and non-CME courses that are available both online and in person for the convenience of our policyholders. We encourage our insureds' nursing and support staff to participate in all our education offerings, as these providers play an integral role in ensuring a culture of safety. At the end of many of our programs, staff members will receive a certificate of completion, which can be incorporated into the staff member's yearly competencies and continuing education file. Some of the available courses include Anatomy of a Lawsuit, Claims & Lessons Learned, Managing Your Social Media Presence, and Addressing the Disruptive Patient: Strategies for a Changing Dynamic.

In addition to our educational offerings, MLMIC Risk Management offers valuable consultative services. Our Consultants are available to discuss and plan on-site medical office and group practice surveys, as well as department-focused surveys for our insured facilities. These assessments provide a review of policies and procedures and medical record documentation practices, as well as an appraisal of follow-up processes, from a patient safety and loss reduction perspective. Risk Management Consultants are also available to walk our insureds and their staff through their risk management concerns, whether over the phone, through email, or in person.

MLMIC's Risk Management Consultants are based in New York, are highly skilled in loss prevention, and possess diverse backgrounds within the healthcare continuum. They, along with MLMIC attorneys, work closely with insureds and their staff to develop and enhance patient safety and risk reduction programs that fit their organizations' needs.

All of these educational and consultative services are offered to our MLMIC policyholders, at no additional cost, as a value-added service to their MLMIC professional liability policies. Taking advantage of the education and consultation services of MLMIC's Risk Management Department can also potentially help insureds maintain their Claims-Free Discount of up to 12% off their professional liability premium. Please contact us at **(800) ASK-MLMIC** or via **email** to speak with one of our Risk Management Consultants today.

Deanna Mirro Altmann is a Risk Management Consultant with MLMIC Insurance Company.

daltmann@mlmic.com

UNDERWRITING UPDATE

Limited Coverage for a *"Qualified Professional Entity"* Under MLMIC's Physicians and Surgeons Professional Liability Insurance Policy

Protecting insureds is of the utmost importance in the MLMIC mission. To assist in this endeavor, the question-and-answer session presented below addresses an oftentimes unfamiliar beneficial coverage aspect in our Physician and Surgeons Professional Liability Insurance Policy.

Is my professional corporation covered under my individual policy with MLMIC?

A professional service corporation, professional limited liability company, partnership, or limited liability partnership are all included in the definition of a "Qualified Professional Entity" under the MLMIC Physicians and Surgeons Professional Liability Insurance Policy (your "Policy"). If your Qualified Professional Entity is named as a defendant in a professional liability claim, your Policy would provide limited coverage under its terms and conditions. In the event that a claim is made against your Qualified Professional Entity for damages that result from Professional Services that were provided by you or another MLMIC insured for whose actions you are legally responsible (such as a physician assistant you are supervising), MLMIC may provide your Qualified Professional Entity with a defense and indemnification up to the limits of your Policy. However, it is important to be aware that this is not a separate limit of coverage for the Qualified Professional Entity; it shares in your Policy's limits of liability.

UNDERWRITING UPDATE

Is my solo professional corporation considered a Qualified Professional Entity and afforded the same coverage under my individual Policy with MLMIC?

While a solo professional corporation is not a Qualified Professional Entity under your Policy, your Policy still affords coverage to your solo professional corporation when you are its sole shareholder and it has no more than five employed healthcare practitioners. Your Policy would respond and cover your solo professional corporation's vicarious liability emanating from the acts of its employees under your individual Policy's limits, subject to its terms and conditions. Just as described above, this is not a separate limit of coverage for your solo professional corporation; it shares in your individual Policy's limits of liability.

What should I know about this limited coverage?

The limited coverage for your Qualified Professional Entity or solo professional corporation, as described above, does not increase your Policy's limits of liability, which are stated on your Policy's declaration page. It allows your Qualified Professional Entity or solo professional corporation to share in the indemnity limits of your Policy. It is also important to know that your Policy does not cover the liability you may have as a shareholder, Member, or partner of your Qualified Professional Entity.

What is the optimal coverage for insuring my professional entity?

Optimal coverage for your professional entity lies with the purchase of MLMIC's optional "Professional Entity" coverage, which is separate from your Policy and is available for an additional premium. This coverage affords your Professional Entity with a separate limit of liability and also provides direct coverage for Employees of the Professional Entity while acting within the scope of their employment by such entity. This direct coverage for Employees shares in the Professional Entity's limits of liability and does not cover physicians or mid-level providers.

What if I have more questions?

MLMIC Underwriters or your Agent (if so assigned) are available to address any questions that you may have on this or any other matter concerning your policy. Please refer to the Policy Producer section of your Declarations page for your Agent's contact information, or, if not applicable, call (800) ASK-MLMIC and ask to speak to your assigned Underwriter.

*This article is intended to point out certain policy provisions that provide coverage for professional entities owned by a MLMIC policyholder. It is **not** a substitute for any of the terms and conditions of any MLMIC medical professional liability policy. The insurance coverage afforded by your Policy is subject to all of the terms, conditions, limits, and exclusions contained within the Policy. It is essential that you read your entire Policy. If there are any conflicts between this article and your Policy, the terms and conditions of your Policy control and prevail.*

Robert Pedrazzi is an Assistant Vice President of Underwriting with MLMIC Insurance Company.

rpedrazzi@mlmic.com

CASE STUDY:

Treating a Noncompliant Patient

Initial Treatment

When the MLMIC-insured ophthalmologist first treated the patient, a 51-year-old married male who was a physical education teacher and coach, he diagnosed bilateral cataracts and open-angle glaucoma with visual acuity of 20/70 in the left eye. During the next two years, the patient underwent cataract surgery on both eyes, which restored his vision to 20/20.

> **The patient missed numerous appointments and did not return to see the ophthalmologist for months at a time.**

The ophthalmologist continued to treat this patient for another two years. During this time, he documented poor compliance by the patient regarding the treatment of his glaucoma, which was shown to be worsening on visual field testing. The patient missed numerous appointments and did not return to see the ophthalmologist for months at a time. Even more significantly, he frequently failed to take his glaucoma medication. Due to the patient's poor compliance, the ophthalmologist had to perform a left selective laser trabeculoplasty (SLT). One year later, a right SLT was performed by an associate.

An Accident Occurs

The following year, the patient slipped and fell at work, injuring both his knee and his head. Four days after this fall, he experienced headaches, dizziness, and visual changes. At that time, he texted the ophthalmologist and advised of these visual issues, and also that he had stopped taking his medications several months prior to this.

The patient scheduled an appointment online and was seen by the ophthalmologist within two days. This was 20 months after the patient's last appointment. He complained of shadows over his left eye over the previous five days. His uncorrected vision was 20/20, with pressures of 12 in the right eye and 16 in the left eye. A visual field test found a dense superior defect in the right eye and a dense nasal defect in the left eye.

The patient underwent a complete examination and was immediately referred to a glaucoma specialist. Glaucoma medications were also prescribed for him. Unfortunately, this glaucoma specialist was not available to see him right away, so an appointment was made for the following week.

The following day, the patient experienced a flickering in the left eye, but did not report this to the ophthalmologist.

The patient came unannounced to the ophthalmologist's office the day after experiencing flickering. The ophthalmologist performed an SLT on the patient's left eye, which reduced the pressure to 11.

> **The message had not been changed to reflect that the doctor was going to be unavailable for several days.**

Later that day, when attempting to report new complaints of flashes and floaters, rather than calling the office number as he had been instructed to do, the patient called the ophthalmologist's cellular telephone number. The recorded greeting at this number indicated that patients should "come to or contact the office the following day." This message had not been changed to reflect that the doctor was going to be unavailable for several days. However, the recorded greeting at the physician's office number directed all

patients to proceed to the hospital in an emergent situation when the physician was unavailable.

When the patient appeared in the office for his scheduled appointment with the ophthalmologist, it was noted that the vision in the patient's left eye had decreased to 20/200. Additionally, a positive afferent pupillary defect was noted in this eye. The pressure was 13, but a dilated examination was not performed.

The following day, at his next appointment, the patient's vision had decreased to only detect hand motion. The ophthalmologist performed a B-scan ocular ultrasound. A retinal detachment was noted, and the patient was promptly referred to an ophthalmological specialist, who performed a scleral buckle procedure with a pars plana vitrectomy. The patient's visual acuity was subsequently documented to be 20/50 in his left eye. After his appointment with the ophthalmological specialist, the patient never returned to the initial treating ophthalmologist's office.

Lawsuit Filed

A lawsuit was filed against the treating ophthal mologist alleging a failure to diagnose retinal detachment and the misdiagnosis of glaucoma. It also alleged that the ophthalmologist improperly performed a laser trabeculoplasty. As a result, the patient allegedly suffered decreased vision in the left eye, visual distortion, dry eyes, and difficulty focusing on objects.

In addition, the suit further claimed that, as a result of the treating opthalmologist's actions, the patient had required more extensive surgery, had had a longer recovery period, and now had an increased chance of further retinal detachment The patient, in fact, had required three weeks in a special chair with his head down as a result of the retinal detachment he suffered.

Finally, the patient claimed he had experienced pain and suffering for a period of 10 weeks, was unable to coach his students, and had $5,000 in lost earnings. His wife also made a claim for loss of consortium. Fortunately, the patient was eventually able to return to work in his original capacity.

The patient underwent an independent medical examination that confirmed post bilateral cataract extractions with posterior chamber lens implants; status post scleral buckle in the left eye; and mild epiretinal membranes in the left eye. The patient's best corrected vision was 20/60 -2 in the left eye and 20/30 +2 in the right eye.

Expert Reviews

The patient apparently had a history of floaters and flashes that he never reported to the ophthalmologist. Had he done so, a detached retina might have been suspected. Due to the patient's failure to comply with properly taking his glaucoma medications, the ophthalmologist felt his symptoms were the result of worsening glaucoma. Additionally, the patient's use of the physician's cellular telephone number may well have led to his delay in being directed to the hospital for this emergent situation.

The treating ophthalmologist had made multiple attempts to maintain the patient's vision, despite the patient's constant lack of cooperation and noncompliance with the glaucoma treatment. This was documented in the medical record. However, a review by an ophthalmology expert for MLMIC suggested there were other serious departures from the standard of care by the treating ophthalmologist, including a clear delay in diagnosing the retinal detachment. Fortunately, the patient's visual acuity did not appear to have been affected.

> **... a review by an ophthalmologist expert ... suggested there were other serious departures from the standard of care ...**

In addition, this expert believed that the treating ophthalmologist should have referred the patient to a glaucoma specialist who was available at the time the patient came to see the physician with visual changes. Further, the treating ophthalmologist did not examine the patient's retina at that visit. This, according to the expert, was a clear departure from the standard of care.

Although the patient was historically noncompliant with his treatment, the MLMIC-insured ophthalmol-ogist's departures from the standard of care clearly caused delay in treatment, and, with the ophthalmologist's consent, a decision was made to settle this matter for $287,500.

Case Study: A Legal and Risk Management Analysis

There were several serious flaws in the actions of the ophthalmologist that resulted in liability.

Maintaining Proper Communication

The biggest issue in this case was the fact that the physician gave his cell phone number to the patient without clarifying that it was for a one-time use. As a result, the patient typically called the cell phone, and only used the office number to make appointments.

This breakdown in communication was compounded by the fact that the physician failed to change the recorded greeting on his cell phone when he was unavailable to answer. Therefore, the patient was still able to leave messages and rightfully expected that the physician would return his call promptly. Unfortunately, despite experiencing serious visual problems, the patient left additional messages on the physician's cell phone instead of calling the office or seeking care in the nearest emergency department.

The physician was left without a defense to the fact that the patient was abandoned during the time the physician's cell phone was turned off. Although the patient had repeatedly called the ophthalmologist's cell phone in the past, there appeared to be no credible effort shown or documented that the physician had asked him to use the office number instead. It is unlikely that a jury would have seriously considered that the patient had inappropriately called the physician on his cell phone since the physician had always responded to the patient's cell phone communication in the past.

Unfortunately, it is common practice to save a cell phone number from a prior call for future use. When a physician provides a patient with cell phone access, it is strongly advisable to give the patient clear, and perhaps written, instructions not to use it regularly. In addition, patients should be informed that if they do not receive a return call within a short period of time, they should call the office or emergency line in the event of a serious medical situation. In this case, the recorded messages at both the physician's cell and office phone numbers should have told patients to go immediately to the hospital in the event of an emergency and not wait for a return call from the physician.

Patient Noncompliance

As this case clearly exemplifies, it is possible for a noncompliant patient to impose liability on a treating physician. Efforts should be made to contact the patient to improve compliance with the physician's treatment plan. However, when it is apparent over an extended time frame, such as in this case, that the patient's behavior will not change or improve, discharge is indicated.

Patients Dictating Care

Finally, this patient seemed to be trying to dictate his treatment to the physician. When patients think they know more than the physician does, and they try to control the care they receive, this disruption may trigger the need to terminate the physician-patient relationship. Unfortunately, in this instance, the physician seemed overwhelmed by, and tended to adhere to, the patient's demands, and accepted his noncompliant behavior. As a result, the ophthalmologist was responsible for what eventually occurred to the patient's vision.

Please do not hesitate to contact MLMIC Insurance Company with any questions you may have regarding the treatment of a difficult patient.

Kathleen Harth is an Assistant Vice President, Claims, with MLMIC Insurance Company.

kharth@mlmic.com

Donnaline Richman, Esq. is an attorney with Mercado May-Skinner.

drichman@mmslawny.com

Marilyn Schatz, Esq. is an attorney with Mercado May-Skinner.

mschatz@mmslawny.com

Medical Society of the State of New York

Connect, Engage, Influence, and Learn

Join MSSNY today!

Whether you work in independent practice or for a large group or institution, as a New York State physician, you're invited to join the Medical Society of the State of New York.

Start leveraging business solutions that help you with your patients and

MAKE YOUR LIFE EASIER!

- **Insurance payer assistance for disputed claims**
- **Access to business practice webinars**
- **Access to 20,000+ industry experts**
- **Advocacy for legislation favorable to physicians**
- **Over 60 free CME courses**
- **Significant discounts on select insurance policies**
- **Discounted legal services**
- **Discounted financial services**
- **Weekly newsletter**

For more information or to become a member, visit mssny.org/join or contact MemberResources@mssny.org.

P.O. Box 1287
Latham, NY 12110

New York City | Long Island | Colonie | Syracuse | Buffalo

(800) ASK-MLMIC