Fall 2005 Volume 15 Number 4 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest
OMIC DIGEST

New Safety Rules for Outpatient Surgery

By John W. Shore, MD, Anne M. Menke, RN, PhD, and Betsy Kelley

Dr. Shore is an OMIC Director and a member of the Risk Management and Underwriting Committees. Anne Menke is OMIC's Risk Manager. Betsy Kelley is OMIC's Product Executive.

When outpatient surgical facilities (OSFs) first opened, physicians frustrated with the heavily regulated world of hospitals opted to perform low-risk procedures there or in their offices. Partly in response to encouragement from health care insurers, the volume, scope, and complexity of procedures performed outside of hospitals grew, and many physicians became owners and directors of ambulatory surgery centers (ASCs). Just as in hospitals, adverse outcomes inevitably occurred in outpatient settings, and states and regulatory agencies predictably responded by introducing laws and regulations to oversee them. Many states now require freestanding ASCs to be licensed. Texas and California permit only certain types of procedures to be performed in office settings, and Florida suspended all office surgery for a period of 90 days in order to evaluate the safety risks.

OMIC's exposure to malpractice claims at outpatient facilities has increased over the years, a result both of the shift toward expanded and riskier outpatient care and of insuring a larger number of such facilities. Whereas there were 27 OSFs insured by OMIC in 2000, today there are more than 130. After paying out on several large claims, OMIC's Board set a goal of improving patient safety in OSFs and asked the authors of this article to initiate a study to determine steps facilities should take to reduce the number and severity of future claims. The following case study highlights the risks of outpatient surgery and illustrates the main concerns the study identified: patient selection, sedation, and perioperative monitoring.

An 81-year-old female presented for upper eyelid functional blepharoplasty for bilateral ptosis at an ASC. She had a history of systemic and pulmonary hypertension, COPD, coronary artery disease, stent placement x 2, carotid artery disease, and peripheral vascular disease, and was on beta-blockers,

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MESSAGE FROM THE CHAIRMAN

The hurricane season of 2005 is behind us but the destruction wrought by Katrina and Rita lingers. Many survivors who lost homes and jobs are still displaced as they continue to try to pick up the pieces of their former lives and livelihoods. Some of our colleagues and fellow OMIC insureds who live and practice along the gulf coast sustained damage not only to their personal property but to their medical practices as well. In addition to wind and water damage to their office structure and contents (including medical records), some lost staff members and patients as a result of the massive relocation of residents from the hardest hit areas. Fortunately for most ophthalmologists, the disruption in practice was temporary but others have themselves been forced to relocate and rebuild their practice.

In the days and weeks following Katrina, OMIC monitored the situation closely to determine the best way to support our member-insureds in need and was one of the first physician-owned

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Eye on OMIC

OMIC

The Ophthalmic Risk Management Digest is published quarterly by the Ophthalmic Mutual Insurance Company, a Risk Retention Group sponsored by the American Academy of Ophthalmology, for OMIC insureds and others affiliated with OMIC.

OMIC, not the Academy, is solely responsible for all insurance and business decisions, including coverage, underwriting, claims, and defense decisions.

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

Phone: 800-562-6642
Fax: 415-771-1810
Email: omic@omic.com
Web: www.omic.com

OMIC Goes Paperless

In a move toward a paperless office, OMIC has implemented the ImageRight document management system by Advanced Solutions, specialists in workflow solutions for the insurance industry. Since "going live" in mid-September, all active files have been scanned into the ImageRight system, allowing the claims and underwriting staffs to view policy and claims information directly from their desktop computers.

As correspondence and new documents come in to OMIC via fax, email or mail, they are scanned and indexed into the appropriate electronic file and are available immediately to service representatives in each department. A workflow task is created to notify the appropriate underwriting or claims representative that something needs to be done with the file based on this new document. Claims with multiple losses can be related within ImageRight, so claims representatives can open all related files simultaneously. Additionally, an unlimited number of users can work on the same electronic file at the same time.

Another advantage is that policy and claims information can be emailed or faxed directly from one computer to another, drastically reducing the amount of time it takes to share information with policyholders. Now, policy verifications and claims histories can be requested and received via fax or email within a few days. Applications are being processed more efficiently as well, and the claims and underwriting review process has been streamlined since documents are now sent electronically to reviewers.

Security measures are in place to ensure confidentiality and document retention in the event of computer failure. Other OMIC departments, including risk management and finance, will implement the system within the next few months. For more information on Advanced Solutions and ImageRight, please visit their web site at **www.imageright.com**.

Message from the Chairman

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insurance companies to respond to this tragedy. The underwriting staff immediately attempted to contact those insureds who were identified as maintaining medical practices in the affected regions of Louisiana, Mississippi, and Alabama. Information was quickly posted on the OMIC web site for insureds concerned about their coverage and liability if they provided emergency medical care or volunteer services during this natural disaster.

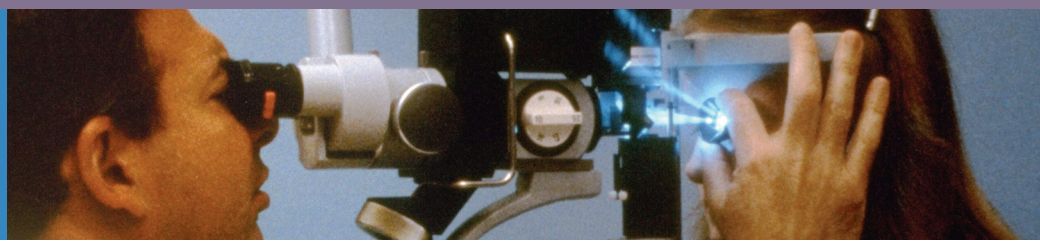
An urgent *E-Bulletin* on September 8 announced OMIC's decision to offer policyholders who maintained a medical practice in the directly affected areas the option of putting their professional liability policy in suspended status while they assessed the damage to their practice and decided what to do next. Suspending their policy would waive their premium while still allowing them to report claims for practice activities that were performed prior to the date of policy suspension. OMIC also stopped processing any cancellations for nonpayment and extended due dates and other normal policy transactions as necessary for members directly affected by the hurricane.

Throughout September and October, OMIC received calls from 23 insureds affected by Katrina and one call following Rita. A few callers requested assistance in providing documents, such as CVs and proof of coverage, since their paperwork had been destroyed. Several requested extensions for payment of premium, and 13 requested temporary suspensions of coverage. Most insureds have since been able to resume practice in some capacity or have relocated to other states. Six insureds remain on suspension.

Recognizing the possibility that some member-insureds may decide to retire rather than start over, the Board voted in November to waive the five-year OMIC-insured length requirement for free tail coverage for policyholders who are in an area affected by a natural disaster and who choose to permanently retire from medicine as a result.

While we cannot reverse the destruction wrought by Katrina and Rita, we can take steps to mitigate the losses suffered by our insureds.

Joe R. McFarlane Jr., MD, JD
OMIC Chairman of the Board



Task Force Studies OMIC-Insured Surgical Facilities

By Kimberly Wittchow, JD
OMIC Staff Attorney

Over the past year, a task force of OMIC Board and staff members, John W. Shore, MD, Anne M. Menke, RN, PhD, and Betsy Kelley, has been examining and revising underwriting requirements and risk management guidelines for coverage of outpatient surgical facilities (OSFs) insured by OMIC. OMIC's Board of Directors assigned the task force to study scope of practice issues, state laws governing OSFs, and national, state, and local practice standards that establish a standard of care for cases performed in facilities insured by OMIC.

Types of Outpatient Surgical Facilities

First, the task force reviewed the type of facilities that OMIC insures. It found that OMIC insures a wide variety of OSFs with varying goals, scopes of business, and types of surgical procedures and anesthesia provided, including in-office surgical suites, refractive laser centers, and ambulatory surgery centers (ASCs). The types of anesthesia used in facilities insured by OMIC range from topical ocular anesthesia to full general anesthesia with invasive monitoring in high-risk surgical patients.

Some facilities are office-based treatment rooms where major eyelid and facial procedures are performed. Some of these offices permit outside surgeons of different specialties to utilize the in-office surgical suites. These surgeons, many of whom are not insured by OMIC, may perform major facial surgery in an unlicensed and loosely structured practice environment. This increases the vicarious liability shared by owners of the facility who are insured by OMIC.

Other surgical facilities are refractive surgical and laser centers. Surgical services in these facilities are usually limited to those requiring only topical anesthesia. The procedures are short in duration and the patients are relatively healthy. Some, however, are free-standing, licensed ambulatory surgery centers (ASCs), where surgeons of almost every specialty provide surgical services to a full range of pediatric, teenage, adult, and geriatric patients.

Review Process

Then the task force studied all of OMIC's claims, suits, and settlements involving OSFs. The task force analyzed nursing, anesthesia, pediatric, and surgical standards by national professional groups as well as state and federal laws, regulations, and directives. Information gathered was used to revise existing underwriting requirements and risk management guidelines for OMIC-insured OSFs. In addition to being discussed by both the Underwriting and Risk Management Committees, the proposed changes were extensively reviewed by consultants and practicing ophthalmologists with the goal of providing meaningful, clinically relevant, and workable requirements that cover all types of OSFs insured by OMIC. An anesthesiologist was consulted to review the anesthesia, monitoring, and emergency response requirements.

New Requirements

As a result of its work, the task force produced a rewritten and reformatted "Outpatient Surgical Facility Application" (OSFA), which was adopted by the OMIC Board of Directors. All ambulatory surgery centers, laser surgery centers, and in-office surgical suites used by physicians other than the owners and their employees will be required to complete the new OSFA. The OSFA contains detailed information about OMIC's underwriting requirements pertaining to patient selection, type of anesthesia/sedation, pre- and postoperative assessments and monitoring, and emergency response and equipment. These requirements will be implemented immediately for all new OSF applicants and effective upon renewal in 2006 for facilities currently insured by OMIC.

It is important that insureds abide by all underwriting and notification requirements specified in the OSFA, as failure to do so could result in uninsured risk or termination of coverage. Working with OMIC's experienced underwriters should enable insureds to complete the application, understand its requirements to avoid any coverage problems, and obtain an extension for those facilities that need additional time to comply with the requirements. While OSFs that are licensed or accredited may already meet or exceed these requirements, we anticipate that some OSFs may need additional assistance to implement them. Most accredited OSFs will receive a 5% premium discount for meeting the accreditation standards. There are helpful resources listed at the end of the OSFA itself and OMIC's risk manager is available for confidential consultations.

All OMIC-insured physicians help bear the cost of defending claims and paying indemnity. It is incumbent on the OMIC Board of Directors, therefore, to protect OMIC insureds as a whole by establishing requirements that it believes will best limit the company's liability and by making certain that insureds abide by these requirements, while at the same time offering physicians the ability to practice in various settings.

New Safety Rules for Outpatient Surgery

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ace-inhibitors, statin drugs, calcium, and aspirin. As instructed, she took her antihypertensive medications the morning of surgery. The planned local anesthesia was to be administered by the ophthalmologist, with minimal sedation given by a registered nurse. Preoperatively, the patient's O_2 saturation was 99% but blood pressure was elevated at 168/92, so she was given two doses of oral Valium and sublingual Procardia (nifedipine). The surgery was uneventful and, after a 30-minute stay in the recovery room, the patient was discharged home with a BP of 109/59 and an O_2 saturation of 94%. She later became incontinent of urine, experienced a right-side facial droop, difficulty swallowing, and inability to ambulate without assistance. By the time her family called the surgeon, the patient was sluggish and hard to arouse. She was diagnosed in the emergency room with a cerebrovascular accident, or stroke. Subsequent strokes left her paralyzed on the right side, unable to speak, and in need of a wheelchair, feeding tube, and nursing home care.

The lawsuit alleged negligent prescription and administration of Procardia, negligent choice of anesthesia, negligent monitoring during sedation and in the recovery room, and negligent discharge. Expert witnesses for both the plaintiff and the defendant physician raised concerns about the dosage of Valium in an elderly patient and the administration of Procardia, which carried a "black box" warning that it should not be used sublingually to control blood pressure because of reports of strokes. Given the patient's complex medical comorbidities, it was hard to support the choice of a registered nurse to provide the sedation and monitor the patient. Similar criticisms emerged about the response to the drop in blood pressure, especially the decision to discharge the patient before the pressure returned to pre-procedure levels. Although defense experts felt the stroke was due to the patient's known, severe, cardiovascular disease and not the Procardia, the insureds and OMIC agreed to settle the case because of the numerous concerns about her care. The $750,000 indemnity payment was split equally between the ophthalmologist and the ASC.

The defense attorney for the ophthalmologist and the ASC readily acknowledged that this surgeon was highly respected and that the ASC was by far the best he had ever seen. As this case shows, even the most competent and caring providers are at times involved in medical errors. The physician and nurse in this case deeply regretted the patient's poor outcome and were determined to evaluate the entire care process to ensure that similar problems did not recur. OMIC worked with them to help revise protocols and later incorporated the lessons learned from this case into the new requirements for patient selection, sedation, monitoring, and emergency response that apply to outpatient surgical facilities. These "Outpatient Surgery Facility Risk Management Requirements" are included in OMIC's new application for coverage and also can be found in the **Risk Management Recommendations** section of **www.omic.com.**

Facilities Affected by New Rules

There is no change in the facilities that must comply with the requirements, as insured ophthalmologists who operate ambulatory surgery centers or refractive surgery centers and those whose in-office surgical suites allow "outside utilizers" already must apply for coverage by submitting a surgery center application. These OSFs have liability exposure for activities such as credentialing, quality assurance, and peer review, and for the care provided by their staff. Policyholders will complete the simpler "Outpatient Surgical Facility Application" (OSFA) and be expected to comply with the listed underwriting and risk management requirements by their 2006 renewal date.

OMIC-insured physicians who do surgery in their own offices and do not allow "outside utilizers" need not complete the OSF application, since they do not have the peer review exposure and their policy provides coverage for them, their staff, and their practice or entity. (If the ophthalmologist does not want to share the limits of his or her coverage with the entity, an additional premium is charged.) While they are not bound by these risk management requirements, policyholders who perform office-based surgery nonetheless face the same clinical risks. To assist them in promoting patient safety, OMIC has developed *voluntary* guidelines, "Office-Based Surgery for Adults," which can be found in the **Risk Management Recommendations** section of **www.omic.com**. OMIC is developing guidelines for pediatric office-based care.

Patient Selection

Unlike hospitals, OSFs do not usually have critical care specialists available to respond to emergencies. The case discussed earlier and our analysis of all outpatient surgery claims convinced us that proactive steps must be taken to ensure that patients selected for outpatient procedures can be safely cared for if adverse events develop. The surgeon must carefully evaluate the patient's overall condition and risk and be satisfied that the procedure is within the facility's capabilities and scope of practice and competency of the health care providers who work there. The American Society of Anesthesiologists established a physical status (PS) classification system to help assess the patient's

risk during operative procedures. We combined the patient's PS classification and age in order to determine which patients can be selected for surgery at OMIC-insured outpatient surgical facilities:

- Adults (age 15 and older) who are healthy (PS 1), have mild systemic disease (PS 2), or severe systemic disease that is not a constant threat to life (PS 3) are, as a rule, appropriate candidates for outpatient procedures. Patients with systemic disease that is a constant threat to life, or who are moribund, not expected to survive the procedure, or declared brain-dead (ASA PS 4, 5, and 6) may not have surgical procedures performed at OMIC-insured outpatient facilities.
- Neonates (0 to 30 days), infants under 6 months of age, and ASA PS 3 pediatric patients of any age should receive care only in centers that are specifically designed for patients of this age or complexity and that have equipment and qualified providers immediately available to handle all possible complications.
- Infants aged 6 months to 1 year and children age 1 to 14 years with PS 1 or 2 status can, as a general rule, be provided safe care at OSFs. Those in these age groups with PS 3, 4, 5, or 6 must be referred to centers that specialize in complex pediatric care.

Sedation Administered by Non-anesthesia Personnel

Sedation can pose significant risks for the ophthalmic patient because, in general, eye patients tend to be older than other surgical patients and may have comorbid diseases that complicate their anesthesia care. That risk is amplified when non-anesthesia personnel (i.e., ophthalmologists, registered nurses, and physician's assistants) administer and monitor moderate ("conscious") sedation to adults, or when any sedation is provided to pediatric patients (children under 15).

Patients receiving moderate sedation and all children can slip into deeper levels of sedation that approach general anesthesia and compromise their protective reflexes. To ensure that patients can be rescued from deeper levels of sedation, non-anesthesia providers who prescribe, administer, or monitor the effects of moderate sedation (including any pediatric sedation) must demonstrate an understanding of the pharmacological agents/reversal agents and recognize the associated complications of each, be able to rescue patients who enter a state of deep sedation, be capable of establishing an airway and/or providing positive pressure ventilation, and have advanced age-specific cardiopulmonary resuscitation skills (ACLS or PALS).

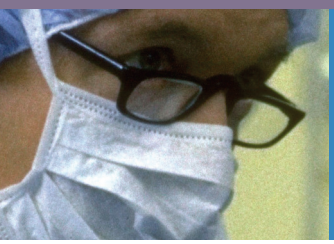
Monitoring Post-procedure Care

Ophthalmic personnel are highly skilled in the technical aspects of patient care. Many, however, do not have the licensure, training, or expertise needed to administer sedation, monitor and manage patients, and effectively respond to complications during the perioperative period. To protect patients, at least two staff members, one of whom must be a licensed health care provider with ACLS/PALS certification (e.g., the surgeon or a registered nurse), must be present until all patients have been discharged from the surgical facility. If moderate or deep sedation or general anesthesia are administered, at least two staff members with ACLS/PALS certification must be present at all times until the patient is ready for discharge. If anesthesia other than straight local or peripheral nerve block is used, the patient must be monitored after the procedure/ anesthesia and up until discharge by a registered nurse or other licensed health care provider whose scope of practice includes post-anesthesia care for that age group.

The patient must meet all written, age-appropriate discharge criteria prior to discontinuation of monitoring and discharge. The decision to discharge a patient may be made only by the surgeon, the anesthesiologist/ CRNA, or the post-anesthesia care registered nurse and should be based upon established and pre-written discharge criteria. Prior to discharge, the patient and the responsible caregiver (if applicable) must be educated about postoperative care and given a copy of the discharge instructions. The instructions must address pain relief, activity restrictions, special diet requirements (if any), and wound and follow-up care, including the name of the physician providing follow-up care and the date of the appointment. The instructions also must clearly explain the symptoms of complications and instruct the patient when and how to contact the physician if any noted symptoms arise.

Support Available for OMIC-insured Facilities

OSFs presently licensed and/or accredited may already meet or exceed these requirements. We anticipate, however, that some OSFs may not yet meet all of the requirements and may need additional time or assistance to implement them. If your OSF will need more time to comply, please contact your underwriter to request an extension. As always, OMIC's risk manager is available for confidential advice and assistance, and resources to help with implementation are included at the end of the OSFA. While we recognize that change can be difficult, we are convinced that the practices we are requiring will reduce the liability risk of our policyholders and ultimately result in better, and safer, care of patients.



Closed Claim Study

Orbit Compartment Syndrome Leads to Poor Outcome Following Blepharoplasty

By Ryan Bucsi, OMIC Senior Claims Associate

ALLEGATION

Failure to monitor and treat bleeding following an upper lid blepharoplasty, resulting in complete vision loss OS.

DISPOSITION

Claim was settled prior to litigation.

Case Summary

A male patient in his late forties presented to an OMIC insured with a complaint of eyelid swelling after a minor injury. The patient was refracted to 20/20 OU, and a visual field test was performed, taped and un-taped, revealing severe superior defects, which were completely relieved by taping up the eyelid skin. This confirmed the ophthalmologist's impression of severe dermatochalasis and the need for a non-cosmetic upper lid blepharoplasty. Prior to surgery, a platelet function test revealed abnormal EPI and ADP platelet function. The surgical procedure was unremarkable, but the patient needed treatment with several medications for elevated blood pressure in the post-anesthesia recovery room. An hour-and-a-half after surgery, the nurse notified the physician of ongoing bleeding and swelling. Detained in surgery, the ophthalmologist instructed the nurse to apply iced saline gauze and pressure dressings, which stopped the bleeding. Ninety minutes later, the insured examined the patient, found moderate lid edema and chemosis OS, and ordered an orbital CT scan. Three hours later, he reviewed the CT report of a hematoma on STS lateral to the globe with medial and some inferior displacement of the globe but no compression or displacement of the optic nerve. The patient's left orbit was extremely tense with proptosis. Seven hours after he was first notified of the bleeding, the insured performed a left lateral canthotomy and lysis of the inferior crux of the lateral canthal tendon in the operating room, and transferred the patient to a hospital. While the edema had decreased by the following day, the patient's vision was LP to NLP and never improved.

Analysis

When the insured ophthalmologist reported the claim, OMIC asked two oculoplastic experts to review it in light of the severity of the injury. The first expert felt that even though the patient had undergone previous surgical procedures without excessive bleeding, the abnormal platelet functions warranted a consultation with a hematologist before proceeding with the blepharoplasty. Both experts raised concerns about the postoperative management of the patient. While the insured's decision not to perform bedside canthotomy and cantholysis when he first saw the patient in the recovery room was acceptable, his failure to closely monitor the patient over the next four to six hours fell below the standard of care. He was faulted for not adequately instructing the nurses on which symptoms to monitor and report to him. Noting that the insured was concerned enough to order a CT, the experts criticized the two-hour delay in reviewing it. Finally, when the insured examined the patient for a second time after surgery, he did not take immediate action to reduce the orbital pressure, such as a bedside canthotomy and cantholysis. Both experts felt that the insured's failure to recognize and treat an evolving orbit compartment syndrome led to the patient's poor outcome. Notified of the review, the insured ophthalmologist agreed to settle the claim within his policy limits and avoid the expense and risk of a trial.

Risk Management Principles

Hemorrhage during or following blepharoplasty is a significant vision-threatening risk that warrants prudent preoperative planning and postoperative management. Ophthalmologists should carefully evaluate any aspect of the patient's condition that increases a particular risk (e.g, hypertension and bleeding disorders), obtain preoperative clearance from the appropriate specialist, and disclose the added risk to the patient during the informed consent discussion. When patients develop a complication, all members of the health care team (and family members if appropriate) should be advised of what to watch for and when and how to notify the surgeon. To avoid allegations of failure to diagnose, ophthalmologists should use the WIT-D approach.[1] "W," the worst case scenario, is helpful in establishing a prioritized differential diagnosis (here, compartment syndrome); "I" represents the information needed to rule the diagnosis in or out; "T" stands for telling interested parties so they can help monitor the patient; and "D" is, of course, for documentation.

1. Carolyn Buppert, "A Witty (WIT-D) Approach to Avoiding Mistakes," *Gold Sheet* 4(6), 2002, www.medscape.com/viewarticle/438381.

Risk Management Hotline

Clarification of Roles During the Informed Consent Process

By Anne M. Menke, RN, PhD
OMIC Risk Manager

Recently, OMIC revised its sample consent form for cataract surgery, partly in response to the new "multifocal IOLs" and partly to better prepare patients for the procedure and defend ophthalmologists against allegations of lack of informed consent. Soon after the form revision was announced in our *E-Bulletin* and the *AAO Express*, policyholders began calling with questions about the roles they, their office staff, and the ASC play in the informed consent process.

Q I just reviewed OMIC's new cataract consent form. Do you really expect me to review all six pages with each of my patients?

A The short answer is no. A more complete response should help clarify the phases of the informed consent process and the roles played by various members of the health care team. As the surgeon, you have a legal duty to obtain the patient's informed consent, which is best understood as an oral agreement you reach with the patient after the informed consent discussion. This face-to-face talk addresses the ophthalmic condition and the risks, benefits, and alternatives—including no treatment—of the proposed procedure. The discussion must always take place before the patient signs any consent form, while the patient is awake and aware, and free from the effects of any medication that could interfere with his or her ability to participate in the decision-making process. The form itself serves to document and verify that the informed consent *discussion* with you took place. Neither the form nor any video or teaching aids can substitute for the face-to-face talk with the surgeon.

Q Do I have to mention all known risks during my discussion?

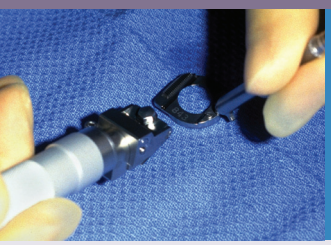
A No. The standard discussion most ophthalmologists conduct is rarely as detailed as a procedure-specific consent document and usually consists of a summary of this information. You do, however, need to address any particular concerns of the patient as well as any condition that puts the patient at increased risk, and then write a brief note in the medical record. To help educate the patient and provide more details about the surgery, OMIC recommends that you give patients a copy of the procedure-specific consent form. Some practices ask the patient to read it before the preoperative meeting with the surgeon; others have a staff member go over it with the patient afterwards.

Q Can my staff members witness the patient's signature even if they were not present during the discussion?

A Yes, since what is being witnessed is the patient's signature. While they cannot obtain the patient's informed consent, staff members play an invaluable role in patient education. As a risk management measure, staff members should ask patients what procedure will be done and why before asking them to sign the form. If the patient does not appear to understand, staff members should inform you so that you can discuss the procedure again and clear up any confusion or misunderstanding. Staff members can then document that you discussed the procedure again with the patient and that the patient appeared to understand and signed the consent.

Q Can I just use the consent form at the hospital or ambulatory surgery center (ASC)?

A No, since that form's primary purpose is to document that the ASC or hospital has fulfilled its own, separate legal duties. The ASC or hospital cannot obtain the patient's informed consent for the procedure you are performing; only the ophthalmologist can do that. Hospitals and ASCs must *verify*, however, that the surgeon obtained informed consent before allowing the procedure or surgery to take place. ASCs and hospitals also have a separate duty to obtain what is known as general consent for the care and treatment provided at their facility by their employees and other providers, e.g., the anesthetist. There is no discussion of specific risks or benefits of the ophthalmic procedure when obtaining this general consent. ASCs and hospitals often use a single form both to verify that the surgeon obtained informed consent and to obtain general consent for care rendered at their facility. The patient is usually given this form to sign by a facility employee during the registration or admission process. To protect themselves against allegations of lack of informed consent, therefore, ophthalmologists should have the patient sign the procedure-specific consent form in their office and place it in the patient's medical record.



Calendar of Events

OMIC continues its popular risk management courses this winter. Upon completion of an OMIC online course, audioconference, or seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society may earn a 10% discount by attending a qualifying cosponsored event or completing a state or subspecialty society course online (indicated by an asterisk). Courses are listed below and on the OMIC web site, (**www.omic.com**). CME credit is available for some courses. Please go to the AAO web site (**www.aao.org**) to obtain a CME certificate.

Online Courses

- *EMTALA and ER-Call Liability* addresses liability issues surrounding on-call emergency room coverage and EMTALA statutes. Frequently asked questions on federal and state liability are answered.
- *Ophthalmic Anesthesia Risks* offers an overview of anesthesia risks and provides case studies supporting the issues addressed in the overview.
- *Informed Consent for Ophthalmologists* provides an overview of the informed consent doctrine as it applies to various practice settings.

State and Subspecialty Society Online Courses

Special society-specific edition of *Informed Consent for Ophthalmologists* online course for physicians in California, Hawaii, Louisiana, Nevada, Oklahoma, Washington, and Women in Ophthalmology members.*

CD Recordings

- *Lessons Learned from Trials and Settlements of 2004* (2005 Nationwide Audioconference) $40
- *Noncompliance and Follow-Up Issues* (2005 OMIC Forum) $50
- *Research and Clinical Trials* (2004 Nationwide Audioconference) $40
- *Responding to Unanticipated Outcomes* $25
- *Risks of Telephone Screening and Treatment* $25

Go to the OMIC web site to download order forms at www.omic.com/resources/risk_man/seminars.cfm.

Seminars and Exhibits

February

18 *Ophthalmic Anesthesia Liability**
Illinois Association of Ophthalmology (IAO)
Conference Center in Rosemont, IL
Time TBA
Register with the IAO at (847) 680-1666

March

16 *Lessons Learned from Claims Against Pediatric Ophthalmologists**
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
Keystone Resort, Keystone, CO
1–4 pm
Register for AAPOS at (415) 561-8505.
Register for OMIC seminar with Linda Nakamura at (800) 562-6642, ext 652

18-21 *Academy/OMIC Insurance Center*
Annual Symposium of the American Society of Cataract and Refractive Surgery (ASCRS)
Booth 1312, South Hall, Moscone Center, San Francisco, CA

20 *Medicolegal Aspects of Multifocal IOLs*
Course 20-306
American Society of Cataract and Refractive Surgery (ASCRS)
1-2:30 pm
Room 305, Moscone Center, San Francisco, CA

Holiday Closure

In recognition of the holiday season, the OMIC office will be closed the week of December 26 and will reopen on Tuesday, January 3, the day after the federal New Year's Day observance. If you have an urgent matter and must speak to an OMIC staff member during the holiday closure, please call (800) 562-6642, ext. 609, and leave a message. Staff will check this message line throughout the week and will return urgent calls in a timely manner. Non-urgent messages may be left for specific staff members by calling their usual phone extension. These calls will be returned when the office reopens. The OMIC staff wishes you and your family a wonderful holiday season.

For further information about OMIC's risk management offerings, please contact Linda Nakamura at (800) 562-6642, ext. 652 or via email at lnakamura@omic.com.

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610