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Ophthalmic Risk Management Digest
OMIC DIGEST

ER Call: Another Layer of EMTALA Liability

By Tamara R. Fountain, MD

Dr. Fountain is a member of OMIC's Audit, Finance, and Insurance/Marketing Committees. This article, originally published in the *Digest* in 2001, has been updated to reflect current law.

Fans of the hit television series, *ER*, are familiar with this scenario: a patient is rushed to the ER in need of life-saving treatment but the specialist on call, be it an OB/GYN or CT surgeon, fails to answer the ER's page. Drs. Weaver, Carter, and Company are then charged with cracking chests, doing stat sections, and taking other heroic measures to stabilize the patient—all in one entertaining hour, including commercials.

Even Hollywood knows that transferring an unstable patient is against the law. That federal mandate, the Emergency Medical Treatment and Active Labor Act (EMTALA), is part of the Comprehensive Omnibus Budget Reconciliation Act (COBRA) passed by Congress in 1986. This well-intentioned piece of legislation was enacted to discourage hospitals from turning away patients based on their ability to pay. Widening legal interpretation of EMTALA provisions has created a host of accountability and risk management issues for physicians who provide emergency room coverage.

Under EMTALA, any patient who presents to a hospital ER must be afforded an "appropriate medical screening examination to determine the presence of any emergency medical condition." EMTALA defines emergency medical condition as one in which "the absence of immediate medical attention would…result in placing the person's health in serious jeopardy, cause serious impairment to bodily functions or cause serious dysfunction to any bodily organ or part."[1] An appropriate medical screening examination need satisfy only two elements to be compliant with EMTALA standards: (1) it should be reasonably expected to identify an emergency medical condition; and (2) it need be directed only at the signs and symptoms described by the patient or identified by the physician—NOT signs and symptoms the physician is not made aware of or might otherwise overlook.[2]

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MESSAGE FROM THE CHAIRMAN

One of the measures of a company's success is the strength and continuity of its leadership. OMIC is the only insurance carrier governed by a Board of Directors and Committees composed entirely of ophthalmologists who understand both the practice of ophthalmology and the challenges of modern day medicine. At the end of this year, we say goodbye to two long-time OMIC supporters who will complete their final terms as directors: Bruce E. Spivey, MD, and B. Thomas Hutchinson, MD. These two distinguished leaders in ophthalmology have helped OMIC attain its high level of achievement and recognition in the health care and insurance industries.

No one was more instrumental in bringing to fruition the visionary plan that became OMIC than Bruce Spivey. As executive vice president of the American Academy of Ophthalmology in 1987, Dr. Spivey put the Academy's resources behind the creation of a freestanding independent professional liability insurance carrier

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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.

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New Non-surgical Coverage Class

A new, lower-rated coverage classification is now available for OMIC insureds who limit their practices to purely non-surgical activities. The "Ophthalmology – No Surgery" class, which will be offered on policies effective on or after January 1, 2007, provides coverage for the diagnosis and non-surgical treatment of diseases, prescription of glasses or contacts, mechanical epilation, punctal closure with plugs, and removal of superficial foreign bodies from the cornea and conjunctiva. The premium for this new class will be approximately 10% lower than the former Medical Ophthalmology class.

OMIC will implement two other changes to its coverage classification system effective January 1, 2007. Recognizing that the term "Medical Ophthalmology" does not adequately describe the full scope of coverage afforded within this coverage class (including injections, biopsies, and other incisional or invasive procedures), the class will be renamed "Ophthalmology – Surgery Class 1." Similarly, the "Limited Surgery" and "Surgery" classes will be renamed "Ophthalmology – Surgery Class 2" and "Ophthalmology – Surgery Class 3" respectively.

With the exception of temporal artery biopsies, the permitted procedures within the three surgical coverage classes will remain unchanged. Because of concerns regarding the professional liability exposures of temporal artery biopsies and its risk relativity in comparison to other procedures, the OMIC Board determined this procedure would be more appropriately rated as Ophthalmology – Surgery Class 2.

A list of procedures permitted under each coverage classification is available on the Products page of www.omic.com.

Message from the Chairman

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exclusively for ophthalmologists. When the first Board of OMIC took office on January 1, 1988, Dr. Spivey was appointed secretary, a position he would hold for most of the next 20 years. During this time, he directed OMIC's long-range planning process as chairman of the Strategic Planning Committee and helped negotiate favorable reinsurance terms for OMIC as a member of the Reinsurance Committee.

A long-time believer in the importance of ophthalmic-specific risk management education in reducing claims exposure, Tom Hutchinson brought his passion for quality of care issues to the podium as a frequent lecturer and moderator of OMIC-sponsored risk management seminars and audioconferences. In addition to chairing OMIC's Risk Management Committee for the past four years, Dr. Hutchinson served on the Claims Committee since first becoming involved in OMIC's governance in 1996.

While we will miss the expertise and perspective of Drs. Spivey and Hutchinson, we have been fortunate to be able to recruit additional respected members of the ophthalmic community to continue this tradition of leadership and commitment. This year, we welcomed Steven V.L. Brown, MD, FACS, to OMIC's Claims and Risk Management Committees. Dr. Brown is a solo practitioner specializing in glaucoma and anterior segment in Evanston, Illinois, and an associate professor of ophthalmology at Rush University Medical Center. He is an examiner with the American Board of Ophthalmology.

In 2007, we will welcome two new committee members: Ann Acers Warn, MD, MBA, and Harry A. Zink, MD, FACS. Dr. Warn is a comprehensive ophthalmologist and glaucoma and anterior segment specialist with Dean A. McGee Eye Institute in Lawton, Oklahoma, as well as an assistant professor of ophthalmology and associate professor of family and preventive medicine at the University of Oklahoma. She is the immediate past president of the Oklahoma State Board of Health and currently serves on its Ethics Committee with past service on the Finance and Policy Committees.

Dr. Zink, 2006 president of the American Academy of Ophthalmology and chairman of its Foundation, has held numerous leadership positions with the AAO Board of Trustees, Council, and Committee of Secretaries, including secretary for member services from 1998 to 2004. He is a comprehensive ophthalmologist and glaucoma specialist with a four-physician practice in Wooster, Ohio.

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

OMIC Revises Policy for 2007

By Kimberly Wittchow, JD
OMIC Staff Attorney

OMIC has thoroughly revised its professional and limited office premises liability insurance policy. After almost 20 years in business, the time had come for OMIC to step back and comprehensively review its coverage terms and policy verbiage. Following several years of work on this project, we are pleased to present a more reader-friendly document that better explains what the policy covers. The following article discusses the major modifications to the policy, but does not describe every change. The policy will be effective January 1, 2007, and will apply to insureds' coverage when their policies renew.

In the revised policy, OMIC has replaced the definition of "professional services" with definitions for the different kinds of professional services OMIC insureds provide: "direct patient treatment," "professional committee activities," "premises maintenance," and "eye bank services." The revised policy also changes how we refer to "medical incidents." The new policy uses the term "professional services incident," which is an act, error, or omission in the provision of any of the above services. This allows us to more accurately convey what activities and associated liability exposures the insurance is covering.

The insuring agreement in the new policy has been broken out into five different Coverage Agreements. Again, we made this change so that each Coverage Agreement could explain exactly who is an insured covered under that section, what is covered in that section, and what exclusions apply to that section. Coverage Agreement A provides medical malpractice coverage (direct and vicarious liability) for ophthalmologist insureds, including limited coverage for slots and locum tenens. Coverage Agreement B provides medical malpractice coverage (direct and vicarious liability) for non-physician employees (including ODs and CRNAs).

Coverage Agreement C provides medical malpractice coverage for entities and the members, directors, officers, partners, and shareholders of entities. It covers the direct liability of the entity; professional committee activities by members of the entity performed for the entity; and the vicarious liability of the entity and the members of the entity (MSOs have vicarious liability coverage only). Coverage Agreement D provides coverage to ophthalmologists for their performance of professional committee activities for organizations other than the insured entity. As an additional benefit in the new policy, OMIC will provide defense-only coverage for claims alleging wrongful acts or anticompetitive activities in the performance of professional committee activities.

Coverage Agreement E provides coverage to ophthalmologists, entities, MSOs (vicarious liability only), and members of the entity for injury to a patient or damage to a patient's property caused by an act, error, or omission in the insured's maintenance of the premises. A new sublimit of $50,000 per claim/$150,000 in the aggregate is applicable to premises liability claims. Insureds should have Commercial General Liability or Business Owners insurance in place for their premises liability and property loss. OMIC's premises liability insurance is offered only to ensure no gaps in coverage.

The Supplementary Payments Section also has been revised. The maximum amount reimbursable for loss of income to insureds attending trial was deleted, so only the daily maximum will apply ($500 per day), as long as the insured requests the payment. This allows insureds who are away from their practice to attend longer than average trials to make up more of their lost income.

The provision for payment of remedial medical expenses was removed. In some but not all circumstances, OMIC may pay a patient's costs of treatment after an accident in the office or a maloccurrence in order to aid the patient's recovery and reduce the insured's liability risk. This change to the policy allows OMIC the flexibility it needs to determine when and how to apply these payments.

The policy language has been elaborated upon in the General Conditions Section. It explains that if the insured fails to comply with his or her obligations under the policy, OMIC's obligations to the insured terminate, including the obligation to continue to defend or pay damages for a claim. This revised section also better explains the insured's responsibilities to report material changes and to cooperate in the claims handling process.

An important addition to the policy is the Arbitration Clause. It requires OMIC and its insureds to resolve disputes via arbitration, not litigation. This forum is more private and confidential and may save the parties time and money. This clause applies only to disputes between OMIC and its insureds and is not a requirement or endorsement of arbitration between patients and their doctors. Because OMIC is domiciled in Vermont and is regulated by that state, we added a provision that Vermont law governs the policy and that arbitration will take place in Vermont or any other place that is convenient for the insured and agreed to by the parties.

This article does not modify the terms of your policy. If there is any inconsistency between this article and the policy, the policy terms prevail. You should carefully read the entire policy mailed to you in November 2006. Please contact your OMIC underwriter if you have questions about your coverage.

ER Call: Another Layer of EMTALA Liability

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If the ER physician determines that an emergency medical condition exists (or cannot be ruled out), he or she may refer the patient to the appropriate physician on call for evaluation and management. The on-call physician is not only obligated to answer a page in a "timely fashion" (the definition of which is usually buried in one's medical staff bylaws) but to evaluate the patient in the ER if requested to do so by the ER physician. The on-call physician must never try to talk the ER doctor out of a request to evaluate the patient. It may sound like the most routine, unequivocal case of conjunctivitis to you over the phone at one o'clock in the morning, but if the ER doctor asks you to come in, you must do so. (By the way, in the real world, those on-call OB/GYN and CT surgeons who failed to respond to their pagers in the *ER* episode would be subject to EMTALA fines of up to $50,000 each.)

Appropriate Patient Transfers

So you leave your daughter's piano recital to see a patient in the ER. You diagnose an open globe with vitreous presenting at the wound—a qualifying emergency medical condition. But the hospital's vitrector is being repaired and there is no surgical eye team available. What should you do? If the hospital's facilities or ancillary staff are inadequate to treat a patient with an emergency medical condition, a transfer must be effected.

Since EMTALA was enacted to prevent indiscriminate transfer of patients to other facilities, one would expect strict guidelines on what constitutes an acceptable transfer. Federal law defines an appropriate transfer as one in which: (1) the patient has been treated within the capacity of the transferring hospital, thereby minimizing the risks of transfer; (2) a hospital with the space and personnel to care for the patient has been identified and has agreed to the transfer; (3) all records are sent, including informed consent, the transferring doctor's certification that transfer is in the best interest of the patient, and, if applicable, the name and address of any on-call physician who refused or failed to evaluate the patient; and (4) qualified personnel, equipment, and transportation are utilized to effect the transfer.

Under most state laws, hospitals that are legally obligated to provide emergency care are also obligated to accept a patient transferred from another facility. Not as widely recognized, however, is an EMTALA provision affectionately known as the "snitch rule." This whistleblower statute obligates the receiving hospital to report any inappropriate transfers to federal authorities. Failure to report such an infraction may invoke the same penalties for the receiving hospital (fines of up to $50,000 and exclusion from Medicare) as are levied on the hospital that initiated the transfer.

While this covers the primary areas of EMTALA's impact on ER call physicians, there are many gray areas not addressed by its statutes (see **Frequently Asked Questions About ER Call** and this issue's **Risk Management Hotline**, which elaborates on follow-up duties). As legal interpretations and provisions vary from state to state and hospital to hospital, OMIC recommends that ophthalmologists seek the counsel of their hospital medical staff office or our risk management department for further guidance.

1. 42 C.F.R. §489.24(b)
2. Reynolds v. Maine General Health 1st Cir, 2000 218F.3d78.

Frequently Asked Questions About ER Call

Q: Do I have to take call at my local hospital if most of my cases are handled in an ASC?

A: It depends. Federal laws do not mandate taking calls, but whether you volunteer, take call as a requirement of medical staff bylaws, or independently contract your services to an ER, once you enter into a formal agreement to provide emergency coverage, you must comply with EMTALA regulations. Some ophthalmologists need hospital privileges as a condition of being a provider in a managed care contract and end up with call coverage as a result of those privileges.

Q: My hospital's ER is poorly equipped to evaluate and manage eye emergencies. Do I have to come in if I know the patient will be transferred anyway?

A: Yes. You are still obligated to stabilize the patient within the available capabilities of the hospital's staff and facilities. Once the risks of transfer have been minimized and if you determine that the benefits of transfer outweigh the risks on an unstable patient, you must effect a transfer. Later, you may want to discuss with your department chair or the ER department the need for adequate equipment to properly evaluate and manage common eye emergencies.

Q: I'm on call during a busy clinic day and get called to see a patient in the ER. Wouldn't it be easier to have the patient come to my office for an evaluation?

A: Yes, but only easier for you. The ER doctor is asking you to come

in to see the patient and, instead, you are proposing that the patient come to your office solely for your convenience. If the patient deteriorates enroute, you will effectively have authorized, by phone, an inappropriate transfer under EMTALA laws. If, however, the ER doctor determines that no emergency medical condition exists, then the patient can be safely discharged from the ER to follow up in your office.

Q: I am an oculoplastics specialist. Do I have to come in for a retinal detachment?

A: Yes. Staff bylaws may spell out the scope of your clinical privileges and expertise, but if you take call, it is assumed that you are capable of evaluating ocular problems even if you're not qualified to treat them. Again, your job as an on-call doctor is to stabilize the patient and arrange appropriate consultation as needed. Some hospitals arrange call schedules so that various subspecialists provide back-up coverage. If a patient must be transferred to another facility, document that the benefits of a transfer outweigh the risks.

Q: The ER doctor calls and tells me a patient has conjunctivitis and, while I don't need to come in, the ER doctor wants the patient to follow up in my office. The patient presents the next day with a corneal ulcer, not conjunctivitis. Am I in violation of EMTALA laws?

A: No. If you were not asked to come in, the ER doctor is effectively saying that he or she has ruled out (albeit incorrectly) an emergency medical condition based on a screening examination. Case law generally holds that a hospital and its ER physicians are not in violation of EMTALA for failing to treat an emergency medical condition if the facts demonstrate the hospital had no knowledge of the condition despite an appropriate screening examination. The ER doctor still may be liable for failure to diagnose and delay in treatment under regular malpractice laws, however, and such situations may expose the ophthalmologist to malpractice claims. Thus, it is critical to properly document and retain a record of your discussion with the ER doctor.

Q: If I am called in to treat a patient emergently, do I have to provide follow-up care?

A: The emergency transfer laws do not address the issue of follow-up care to patients who have been treated and stabilized in the ER and then discharged. However, a common law duty to the patient may arise since, arguably, a doctor-patient relationship is established by your treatment of the patient in the ER, giving rise to the expectation by that patient that you will provide follow-up care. You should consult your medical staff bylaws, as some specifically address this issue. Some bylaws establish a duty and require the on-call physician to see the patient in follow up and throughout the course of the illness that brought the patient to the ER.

Q: A patient is evaluated and treated in the ER while I'm on call but no one notifies me. The ER doctor discharges the patient to follow up with me the next day. Am I required to see this patient?

A: Not from an EMTALA standpoint. While there would be no EMTALA violation since the patient was presumably stabilized and discharged by the ER, your medical staff bylaws may require you to see the patient. When in doubt, you should accept a patient who presents to your office if the patient was treated in the ER while you were on call. Work with your hospital to establish a protocol for follow-up care.

Q: The ER doctor calls me one night and based on his or her description, I decide to wait to see the patient in my office the next morning. Is this an EMTALA violation?

A: It depends. If the ER doctor asks you to see the patient, you must do so when called, not the next morning. If the ER doctor feels the patient is stabilized and can wait until the next morning and the patient's condition deteriorates because of the delay, the primary malpractice liability rests with the ER doctor. (EMTALA does not apply in this case because the patient was discharged in stable condition.) If the ER doctor cannot rule out an emergency medical condition, you as the on-call specialist cannot do so over the phone, as an appropriate medical screening exam has not technically been performed. As always, it is critical to document your discussion with the ER doctor.

Q: It's bad enough that I can be fined by the federal government for EMTALA violations. Can I be sued by the patient too?

A: The federal government may fine both hospitals and individual physicians for EMTALA violations. Additionally, a patient may sue a hospital for EMTALA infractions. A patient may NOT sue a physician for breaking EMTALA laws. However, any doctor or hospital providing emergency room care is subject to civil claims of negligence and medical malpractice.

Closed Claim Study

Traumatic Eye Injury and Patient Abandonment

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to go to ER to see patient and failure to wait for or reschedule a missed office appointment.

DISPOSITION

Case settled for $10,000 prior to litigation.

Case Summary

A 25-year-old female presented to an emergency room after accidentally stabbing herself in the left eye with a knife while she was picking up her child. The emergency room physician performed a slit lamp examination and noted an intact pupil, a partial-thickness laceration in the lower tangential cornea touching the sclera, specks of blood in the laceration, an intact anterior chamber, and normal fundus. He contacted the on-call ophthalmologist to set up a follow-up appointment for the next day. The patient was discharged with instructions to apply Erythromycin ointment and a double patch for a period of 24 hours. The next day, the patient failed to show up at the ophthalmologist's office for her 9 am appointment. At 9:40 am, she contacted the insured as he was driving back home to say she had just woken up, would need to find a sitter for her child and a ride to his office, and could arrive there in an hour and a half. The insured became angry and instructed the patient to proceed to the ER or seek treatment from another physician. At 10:35 am, the patient presented to a different ER and was diagnosed with a full thickness corneal laceration with hypopyon. She underwent multiple procedures, was twice readmitted to the hospital, and ended up with a VA of 20/40 OS, correctable to 20/25.

Analysis

When he telephoned the ophthalmologist, the ER physician informed him that the patient had suffered a laceration that had not entered the anterior chamber, and assured him that he was comfortable performing the eye exam and didn't need the ophthalmologist to see the patient in the ER. Experts who reviewed the records felt the ER physician failed to diagnose a full-thickness laceration and the ophthalmologist did not ask enough questions to verify the diagnosis (e.g., is the anterior chamber clear or are there white or red blood cells?). Moreover, if the insured had seen the patient in the ER, he probably would have sutured the laceration and prescribed antibiotics, thereby substantially reducing the patient's subsequent problems. An attorney retained by OMIC to review the defensibility of this case prior to formal litigation feared the plaintiff might successfully argue that by agreeing to examine the patient the day after the ER visit, the insured had established a physician-patient relationship. Therefore, his refusal to return to the office to examine the patient might constitute abandonment and arguably could have contributed to the subsequent complications that required multiple procedures. The attorney's main concern, however, was that the potential venue in which the case would be tried was an urban center known to be plaintiff-oriented. The insured agreed that the best course would be to settle the case, which OMIC was able to do for an amount far below the plaintiff's demand.

Risk Management Principles

There were several things the ophthalmologist could have done to promote patient safety and reduce his liability risk. First, knowing the risk of a full-thickness corneal laceration, he should have taken a more active role in the phone conversation with the ER physician and then carefully documented the call. If the answers to his questions raised concerns, or he couldn't rule out a full-thickness laceration, he should have evaluated the patient himself. Although his anger at the patient's delay in presenting to his office was understandable, especially on a Sunday, it did not relieve him of his duty to provide ongoing care to a patient with an acute condition whom he had agreed to treat. Once a physician-patient relationship has been established, a physician has an ongoing responsibility to the patient until the relationship is terminated by one of the parties. In order to terminate the relationship, the physician must give the patient written notice sufficiently in advance to allow the patient to secure the services of another physician. Before sending such notice, however, acute problems must be resolved. All ER patients referred for follow-up arguably have unresolved acute problems, so the on-call physician must either continue to treat the patient or arrange for another physician to do so. In this case, the insured should have carefully queried the patient about her condition; this likely would have revealed the need for urgent care, and he could have offered to meet her at the ER to provide it. See "Terminating the Physician-Patient Relationship" at www.omic.com.

Risk Management Hotline

Follow-up Duty to ER Patients

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

The most frequent **Hotline** question we receive related to EMTALA concerns follow-up care. EMTALA stipulates that the hospital must provide the patient with a plan for appropriate follow-up care that is geographically and financially accessible to the patient as part of the discharge instructions. It does not, however, state who must provide the post-discharge services, or make the hospital ensure that follow-up care is obtained. Furthermore, once the patient is discharged, EMTALA no longer applies. Regardless of EMTALA's silence on the who and how of follow-up, hospital emergency rooms routinely send patients to the appropriate specialist for post-discharge care.

Q Does serving as an on-call physician create a physician-patient relationship that would require me to provide post-discharge care?

A The legal theory of professional negligence is based upon the duties that arise from the physician-patient relationship. It is not always clear if a physician-patient relationship has been established that would impose an ongoing duty to the patient, as the on-call physician's involvement may include personally examining and treating the patient, speaking only to the ER physician, having his or her name appear on the discharge instructions, being the on-call physician for that day, or simply being part of an on-call panel. Moreover, even if a physician-patient relationship was established, the relationship may be limited to providing stabilizing treatment in the ER rather than obliging the physician to provide ongoing care. Patients may reasonably assume that if you provide emergency care and tell the patient of the need for ophthalmic follow-up care, you will provide it. The same is true if the ER tells a patient for whom you provided a telephone consult to follow up with you, or if your name appears on the discharge instructions. If you do not intend to provide post-discharge care, you need to take certain steps. OMIC policyholders who need help determining their relationship and duties to ER patients are encouraged to call our Risk Management Department.

Q One of my patients was seen in the ER. Do I have a duty to provide post-discharge care?

A Yes. If you have a preexisting physician-patient relationship with the individual, you should assume that you are responsible for outpatient follow-up care whether or not you were on call. Obtain the ER record so you know what care was provided.

Q If I accept patients for post-discharge care, and they don't make or show up for their appointment, do I have any follow-up duties?

A You and the patient both face risks in this situation if the patient does not receive the appropriate care. Your name may very well be in the ER record and on the discharge instructions. A plaintiff attorney will likely argue that you have a duty to follow up on this patient; the defense attorney may respond that there was no relationship and that the patient was noncompliant. Ask in writing that the ER fax you the ER record of all patients you saw, were contacted about, or who were referred to you for post-ER follow-up, and get the patient's name, address, and phone number. Notify your staff of the type of appointment that should be scheduled, and follow-up on missed appointments and test results. For more guidance on this issue, see "Noncompliance" at www.omic.com.

Q The ER referred a patient to me for post-discharge care. When she presented to my office, my staff learned that she had an insurance plan we don't accept. They offered to help her set up a payment plan, but she left without being seen. Can I ask patients to pay for post-discharge care? If they won't pay, do I have to see them?

A Staff may follow normal protocol with new patients referred for outpatient care, including those referred by the ER. In most practices, this protocol includes determining insurance coverage and informing the patient of charges and financial responsibilities. Patients who have no coverage should be told that you are available to care for them. Many practices allow patients to set up payment plans. Such an offer helps refute allegations of abandonment. Patients have the right to refute treatment, whether for financial or other reasons. Patients who leave without being seen or who decline fee-based services when making the appointment should be reminded of the need for proper follow-up. See the sample Refusal of Care letter in "The Ophthalmologist's Role in Emergency Care: On-Call and Follow-up Duties" at www.omic.com.

Calendar of Events

OMIC continues its popular risk management courses into 2007. 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 an additional discount by attending a qualifying cosponsored event or completing a state society 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 *(Reserved for OMIC insureds/No charge)*

- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Risks*

State and Subspecialty Society Online Courses

A society-specific online course on *Ophthalmic Anesthesia Liability* is available for physicians in California, Colorado, Hawaii, Louisiana, Nevada, Oklahoma, Washington, the Contact Lens Association of Ophthalmologists (CLAO), and the American Society of Plastic and Reconstructive Surgeons (ASOPRS).

Contact Linda Nakamura at lnakamura@omic.com to register for these online courses.

CD Recordings *(No charge for OMIC insureds)*

- *After-Hours and Emergency-Room Calls*
- *Lessons Learned from Trials and Settlements of 2004* (Subjects include Informed Consent for Cataract Surgery; Traumatic Eye Injuries; ASC: Anesthesia Provider, Monitoring, Discharge)
- *Lessons Learned from Trials and Settlements of 2005* (Subjects include Follow-up on High-risk Postoperative Patients; Minimizing Failure to Diagnose Allegations with Focus on Giant Cell Arteritis; Monitoring Patients on Steroids for Ongoing Need, Effectiveness, Safety, and Compliance)
- *Noncompliance and Follow-Up Issues*
- *Research and Clinical Trials*
- *Responding to Unanticipated Outcomes*
- *Risks of Telephone Screening and Treatment*

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

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

Upcoming Seminars

January

22 *Documentation of Ophthalmic Care**
Washington DC Metropolitan Ophthalmological Society (WDCMOS)
Falls Church, VA
6:00 pm
Register with the WDCMOS at (301) 365-2092

February

3 *Documentation of Ophthalmic Care**
Illinois Association of Ophthalmology (IAO)
Stephens Conference Center, Rosemont, IL
11 am-12 noon
Register with the IAO at (847) 680-1666 or refer to www.midwesteyemd.org

17 *Documentation of Ophthalmic Care**
Ohio Ophthalmological Society (OOS)
Easton Hilton, Columbus
Time TBA
Register with the OOS at (614) 527-6799

April

11 *Documentation of Ophthalmic Care**
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
Seattle, WA, 2-3:15 pm
Register for AAPOS at (415) 561-8505
Register for OMIC seminar with Linda Nakamura at (800) 562-6642, ext 652

28 *Documentation of Ophthalmic Care*
Texas Ophthalmological Association (TOA)
Dallas, TX
Afternoon session
Register with the TOA at (512) 370-1504 or go to www.txeyenet.org/2007

May

20 *Documentation of Ophthalmic Care*
Tri-State Ophthalmological Association
(AZ*, NV*, NM)
Las Vegas, NV
Afternoon Session
Register with the Arizona Ophthalmological Society at (602) 246-8901

Holiday Closure

In recognition of the holiday season, the OMIC office will be working on a significantly reduced schedule responding only to urgent matters the week of December 25 through January 1, 2007. If you have an urgent matter and must speak to an OMIC staff member during the holidays, please call (800) 562-6642, ext. 609, and leave a message. Staff will check this message line throughout the week and 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 on Tuesday, January 2. The OMIC staff wishes you and your family a wonderful holiday season.

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