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Ophthalmic Risk Management Digest

OMIC DIGEST

Twenty Years of Insuring Refractive Surgery

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

For over 20 years, since its founding in 1987, OMIC has insured ophthalmologists who perform refractive surgery procedures while monitoring a key measure of patient safety and satisfaction: professional liability claims (written notices or demands for money or services, including letters, lawsuits, and arbitration proceedings). This spring, we conducted a review of our refractive surgery claims experience to determine if additional measures are needed to ensure that our policyholders continue to reduce patient safety risks and minimize their—and the company's—malpractice exposure. This article reports on the frequency and severity of refractive claims and analyzes the issues driving them. This issue's **Hotline** article presents risk management recommendations.

Frequency of Refractive Surgery Claims

The first refractive claim—for negligent RK—was reported to OMIC in 1989. Claims were infrequent until 1999, four years after OMIC approved coverage for PRK and three after it added LASIK. As of May 2008, OMIC had a cumulative total of 289 refractive claims, of which 58 are still open and under evaluation. Refractive surgery is now the third most frequent area for claims against OMIC insureds, following cataract surgery and general ophthalmology. LASIK claims in particular, and refractive claims overall, represent a significant percent of total open claims (10.41% and 12.31% respectively), although the percentage is lower among total closed claims. LASIK makes up 85% of all open and closed refractive claims, and the number of LASIK claims reported to OMIC has recently increased. When evaluated by the year in which care occurred, however, LASIK incidents peaked in 2000 and have been dropping ever since.

Severity of Refractive Surgery Claims

While a frequency study shows how often a particular type of claim is filed, a severity analysis looks at how often an indemnity payment must be made in order to close the claim and the magnitude of the payment. Compared to OMIC's overall claims data, refractive claims close more often with an indemnity payment and have higher average and median settlement amounts.

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MESSAGE FROM THE CHAIRMAN

During the past 20 years as an OMIC Board and Committee member, I have had the opportunity to observe and learn a great deal about medical professional liability insurance and risk management. One thing that stands out is the dynamic and evolving nature of this business and how strongly it is affected by outside societal forces. This is particularly true of professional liability insurance for ophthalmic practices. I would like to use my final message as your chairman to mention several factors that I believe will impact the liability exposure of ophthalmologists over the next 20 years.

Aging Population. As boomers grow older, their higher expectations of medical care could result in more lawsuits from the elderly population, which in the past has tended not to question doctors' recommendations or the end result of care. Older individuals have more comorbidities and there will be many debates as to how to pay for their care. Medicare reimbursement is not likely to keep pace with inflation and may even decrease on an absolute basis. Decreasing reimbursement will lead ophthalmologists to perform more procedures that can be billed outside the Medicare system, such as multifocal and accommodative lenses for cataract

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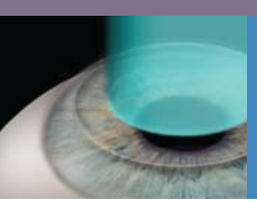

Eye on OMIC

OMIC

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New Chairman to Lead OMIC

Effective January 1, 2009, Richard L. Abbott, MD, will succeed Joe R. McFarlane Jr., MD, JD, as chairman of OMIC's Board of Directors. Dr. McFarlane, who is rotating off the OMIC Board as required under the company's bylaws, sees this as a natural progression for the nation's largest insurer of ophthalmologists.

"I can't think of a better person to lead OMIC," said Dr. McFarlane. "Dr. Abbott's entire career has been dedicated to the support and protection of the ophthalmic profession."

Holding the Thomas W. Boyden Endowed Chair of Ophthalmology as a clinical professor at the prestigious Beckman Vision Center of the University of California, San Francisco, Dr. Abbott has been devoted to ophthalmic research, clinical care, and education for more than two decades and is widely regarded as one of America's foremost authorities on quality of care and risk management issues in ophthalmology.

Dr. Abbott joined OMIC's Board of Directors as chairman of the Underwriting Committee in 1999, after serving on the committee for six years. In 2006, he was elevated to the Executive Committee. In addition to his work at OMIC, Dr. Abbott has held several leadership positions within the American Academy of Ophthalmology, including serving on the Academy's Board of Trustees.

"OMIC is the leader in our industry because ophthalmologists trust and rely on our expertise," said Dr. McFarlane. "Dr. Abbott's commitment to improve the delivery of ophthalmic care and identify the trends that result in lower exposure to malpractice claims will benefit the entire ophthalmic community."

Message from the Chairman

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surgery, off-label use of such lenses for refractive purposes, and cosmetic surgery. Loss prevention strategies will need to be developed to ensure patient safety and minimize the risk of claims.

Advances in Treatment and Technology. New and better drugs will be developed for treatment of neovascular AMD, and new and better IOLs will be developed to meet the needs of the aging population. Stem cell research will continue as will research on treating the genetic basis of certain diseases. It is questionable how many practical applications of this research will be in place in only 20 years, but in any case, new technologies and treatments will likely lead to an initial increase in claims, as we saw with LASIK in the early 2000's.

Tort Reform. It is unlikely that any meaningful federal tort reform measures will be passed in the next 20 years. However, many states passed tort reform laws in the early part of the decade. The closer such laws comport with California's MICRA, which has a hard cap of $250,000 for pain and suffering, the more likely such measures will be of real benefit. As more state laws are passed, fewer "judicial hellholes" should exist. Many of these laws will have provisions for alternative dispute resolution, which can be expected to be utilized more frequently. However, tort reform laws are under constant attack by the plaintiff's bar so physicians and their insurance carriers will have to continue to fight to keep these reforms in place.

Ethics. The public demands ethical physicians and expects state medical boards to discipline those who are not. Ethics will continue to be stressed in medical school and more and more medical professional societies will develop codes of ethics, similar to the AAO's. Sanctions against physicians by state medical boards may trend toward the punitive as has already occurred in some states, notably Florida.

Professional Liability Insurance Industry. The industry is cyclical with specific hard and soft markets that will recur over the next 20 years. In order to obtain market share, some companies will engage in predatory pricing. Such pricing tactics exist in the current soft market and can be expected in future ones. The end result is that these companies may decide to leave the market when their underfunded reserves catch up with them. Physicians may be abandoned and find it difficult or impossible to obtain affordable insurance from another company. Premiums will increase over time due to inflation, increasing claims severity, and rising defense costs.

These leads me to my final words about OMIC. As underfunded insurance companies leave the market, it becomes even more critical that ophthalmologists align themselves with OMIC. OMIC will be there for you in the future with premiums that are fairly priced and service that is second to none.

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

Ensure Coverage for Your Refractive Surgery

By Kimberly Wittchow
OMIC Legal Counsel

Being specialists in the underwriting and management of risk for the practice of ophthalmology, OMIC makes sure that all insureds are individually reviewed and approved for their unique practices. Therefore, OMIC's policy excludes all refractive surgery until the company has had an opportunity to review the credentials and experience of ophthalmologists in the performance of each type of refractive surgery. Once approved, these services are covered at full policy limits by endorsement to the policy. No additional premium is charged for this coverage. However, coverage applies only to the specific procedure(s) added by endorsement. If an insured who has been approved for one type of procedure would like to perform other types of refractive surgery, he or she must apply and undergo underwriting review and approval for each additional type of procedure.

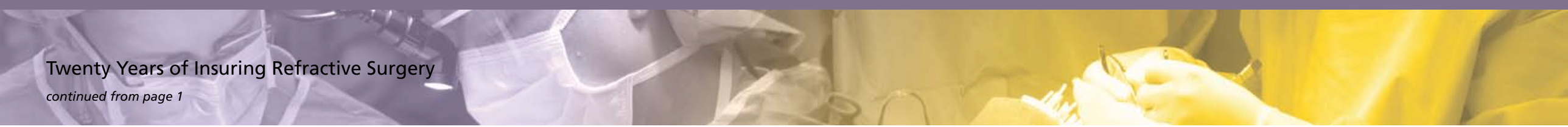
OMIC's refractive surgery endorsements all have a common condition for coverage to apply: the procedure must be "performed within OMIC's underwriting requirements or any exceptions to the requirements granted in writing by OMIC." Specific procedures have their own requirements, and there is also an overall set of refractive surgery requirements applicable to all. These requirements, which address patient selection criteria, informed consent processes, and postoperative care, among other issues, must be met in order for a claim to be covered. All applicants for refractive surgery receive these requirements, and, in their supplemental application, they warrant and represent that they will abide by these rules and deviate from them only after approval on a case-by-case basis from OMIC. To view OMIC's most current underwriting requirements for refractive surgery, go to the Refractive Surgery Information page of OMIC's web site (accessible from the "Favorites" section of OMIC's home page or by selecting "Products," then "Professional Liability") and select the procedure of your choice within the supplemental refractive surgery questionnaires.

The reasons for these requirements are threefold. Performance of refractive surgery procedures within these parameters, based on sensible medical practice and sound risk management principles, should reduce the likelihood of unanticipated outcomes, and consequently, claims. They also protect the insured if a claim does arise, as procedures performed within the requirements are more defensible. The requirements also protect the company and its member-insureds, since more defensible claims protect the financial solvency of the company and therefore enable OMIC to continue to operate for the benefit of all insureds.

The requirements were implemented by OMIC's Board of Directors, under the guidance of the Underwriting Committee, composed entirely of ophthalmologists, including refractive surgery specialists. They are continually reviewed and updated as necessary, with nearly all revisions to date expanding coverage. OMIC's requirements with respect to patient selection are never more restrictive than the FDA on-label requirements and are generally more permissive. Information gleaned from past refractive surgery claims, input from defense attorneys, and studies such as the one discussed in this issue's lead article by Anne Menke, together with personal experience and expertise, all help our Board develop OMIC's refractive surgery requirements. On occasion, the Board also seeks outside input from respected leaders in the refractive surgery community before implementing requirements.

In addition to the underwriting requirements for refractive surgery procedures, OMIC also has specific postop care requirements found in the policy itself in Section III. Common Exclusions, A.16. For coverage to apply, the insured must meet these conditions: (a) the insured operating ophthalmologist or an on-call or locum tenens ophthalmologist must perform the patient's postoperative care throughout the patient's recovery period; (b) the insured operating ophthalmologist must (i) refer the patient to a licensed ophthalmologist or other licensed physician as appropriate and (ii) obtain the patient's informed consent for planned comanagement prior to surgery; or (c) the insured operating ophthalmologist must (i) arrange for a portion of the outpatient postoperative care to be rendered by a non-physician provider who is clinically competent and lawfully able to provide that care and (ii) obtain the patient's written informed consent for planned comanagement prior to surgery. Such delegated postoperative care must be provided under the insured operating ophthalmologist's supervision. In addition to this postop care exclusion, which applies to all ophthalmic surgeries, the refractive surgery requirements oblige the operating surgeon or a designated ophthalmologist to perform the first postop visit. Together, OMIC believes these requirements best protect the insured operating ophthalmologist while providing flexibility in the provision of postoperative care by comanaging providers. Since the operating ophthalmologist is ultimately responsible for the outcome of his or her surgery, we want to facilitate his or her oversight, or proper delegation of the management, of postoperative care.

OMIC's Board is constantly balancing patient safety, claims defensibility, and its fiduciary duty to insureds with the company's desire to cover insureds for their growing expertise in new and modified procedures. So far, we're confident we've gotten it right since OMIC's claims experience is significantly better than the industry average. If you have any questions or comments about OMIC's refractive surgery requirements, please contact your underwriter.



Twenty Years of Insuring Refractive Surgery

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As expected, the majority of the 64 indemnities paid by OMIC for refractive claims were for LASIK and most were under $100,000 (see **Table 1**). PRK claims occur less frequently, but have a higher average and median payment and more often require an indemnity payment to close. In 2006 and 2007, there was a sharp increase in the average amount and number of refractive settlements, 50% of which involved ectasia; 2008 showed a marked decline (see **Table 2**).

Clinical issues predominate in refractive surgery claims, accounting for half of the identified problems in both LASIK and PRK; systems, provider, and patient issues follow (see graphs on page 5). The primary systems issues, in decreasing order of frequency, are equipment, informed consent, and comanagement for LASIK claims; these same three figure in PRK cases as well. Provider problems in LASIK claims center on documentation, failure to perform the preoperative assessment, and knowledge/skill deficits. Ophthalmologists were criticized for treatment decisions and lack of knowledge/skill in PRK. Patient issues were not a significant factor in LASIK, but they slightly outnumbered provider allegations in PRK.

TABLE 1: INDEMNITY PAYMENTS FOR REFRACTIVE CLAIMS 1989-2008*

	NO. PAID	% PAID	AVERAGE	MEDIAN	LOW	HIGH
LASIK	53/196	27%	$147,909	$90,000	$4,600	$983,772
RK	7/21	33%	$35,000	$21,000	$5,000	$125,000
PRK	4/13	31%	$321,875	$200,000	$37,500	$850,000
LASEK	0/2	0%	n/a	n/a	n/a	n/a
RLE	1/2	50%	$25,000	$25,000	$25,000	$25,000
CK	0/2	0%	n/a	n/a	n/a	n/a
TOTAL	**65/231**	**28%**	**$144,564**	**$75,000**	**$4,600**	**$983,772**
ROP	5/12	42%	$939,270	$400,000	$80,000	$3,375,000
OMIC	530/2496	21%	$144,145	$98,000	$500	$3,375,000

**As of 8/08*

Causes of Refractive Claims

In our analysis, we divide the cause of claims into four groups: clinical, provider, patient, and systems. Two of these—provider and patient—are self-evident. Clinical issues are areas of controversy or of limits in knowledge or diagnostic/treatment modalities. Systems issues cannot be attributed to a single individual; instead these are processes in which many individuals and entities are involved. A much-studied example is medication: the process spans from research and product development, labeling, packaging, distribution, ordering, dispensing, and administering.

Clinical Issues

Preoperative care was the focus in 83 of 196, or 42%, of LASIK claims. The primary preoperative clinical issue was the preop assessment (a factor in 71 of 83, or 86%, of claims). In particular, plaintiffs alleged contraindications to refractive surgery, especially clinical and topographical signs of forme fruste keratoconus, pellucid marginal degeneration, and other corneal problems (see **Table 3**). Other preop issues include candidacy for retreatment, monovision trials and candidacy, and the interval between retreatments. Only 8 of 39, or 20%, of the allegations focused on preop care in PRK claims; preoperative assessment and choice of procedure were the main issues. The **Hotline** article discusses preoperative assessment in more detail.

Two aspects of care accounted for the majority of the 101 intraoperative LASIK allegations, namely, flap creation (49) and identification of the patient, procedure, and laser settings (18). Corneal injury, decentration, equipment malfunction, anesthesia complications, double carding, ablation zone size, sterilization breakdowns, and power failure accounted for the rest, in decreasing order of frequency. The allegations in PRK intraoperative claims were decentered ablation, wrong nomogram, and wrong procedure.

Not surprisingly, corneal complications led to 72 of 91, or 79%, of postoperative LASIK claims, with negligent diagnosis and treatment of post-LASIK ectasia and inflammation/infection the top allegations (see **Table 3**). Non-corneal issues included retinal complications, dissatisfaction with monovision, diplopia, glaucoma, depression, and pain. In PRK, postoperative problems accounted for 70% of the clinical issues; of these, cornea-related issues predominated (63%), including (in decreasing order) haze, ectasia, central island, abrasion, infiltrate, scarring, and SPK. Other allegations focused on glare, ghosting, night driving, diplopia, headache, and ptosis.

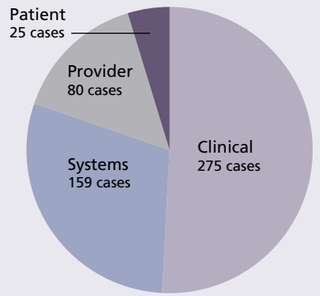
TABLE 2: REFRACTIVE SETTLEMENTS AND AVERAGE INDEMNITY PAYMENT

2001	2002	2003	2004	2005	2006	2007	2008*
3	6	12	5	5	9	10	3
$31,667	$58,333	$156,217	$35,400	$56,250	$242,954	$335,550	$81,667

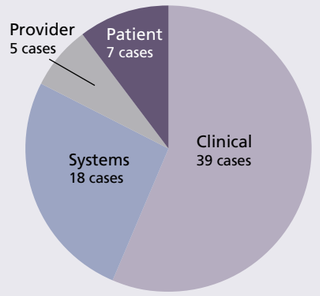
**As of 8/08*

ISSUES IN LASIK AND PRK CASES REPORTED TO OMIC

196 LASIK CASES



16 PRK/LASEK CASES



Multiple issues may apply in each claim.

Systems Issues

Ophthalmology is heavily dependent upon medical devices, and equipment issues account for 30% (48 of 159) of LASIK claims involving systems issues. This was particularly true when there were problems with flap creation. Informed consent was a close second at 28%. Issues included failure to address ocular and medical comorbidities, the timing of the consent discussion, the surgeon's role in the consent process, the FDA status of the device, flap complications, and monovision.

Comanagement allegations were found in 23% of claims, most often criticism of the surgeon's role in the preoperative assessment, informed consent process, and postoperative care. Misidentification of the patient, procedure, or laser settings occurred in 18 cases, accounting for 11% of systems issues.

Claims of false advertising and fraud are becoming more commonplace and occurred in 3% of claims. Financial issues, such as refunds, procedure-related costs, and collection efforts, as well as sterilization issues occurred in a few claims. Half of the 18 systems issues claims for PRK were due to consent, followed by equipment, comanagement, and advertising.

Provider Issues

The most common provider issue in LASIK claims involved documentation; lack of documentation was the problem 85% of the time. Failure to perform needed tests and evaluations was alleged in 21% of claims. Missing elements in descending order included the preoperative assessment, refraction, topography, pachymetry, and monovision trials. Physicians were deemed to lack knowledge and skill in 16% of claims, specifically in topography interpretation, inadequate microkeratome suction, ablation profile, and poor centration. They showed poor judgment when deciding to retreat, performing bilateral procedures the same day, and choosing appropriate flap thickness (11%). Remaining issues, each accounting for 3% of allegations, included poor communication, practice issues (employee, on-call partner, nearing retirement), personality issues, treatment choices (for abrasion, dry eye, and the use of rigid gas permeable contact lenses with free flaps), and failure to diagnose the cause of decreased and fluctuating visual acuity. Provider issues were the least frequent allegation in PRK; 3 cases involved treatment choices and 2 the physician's knowledge/skill.

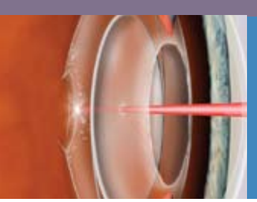
Patient Issues

Defense expert witnesses did not feel patients played a significant role in the outcome of LASIK procedures, pointing to issues in only 25 claims. Noncompliance occurred in 9 and personality issues in 8. Unsubstantiated complaints and self-inflicted injury (head movement, rubbing, scratching) were found in 4 cases each. As with LASIK, noncompliance was the most frequent patient issue in PRK claims (4 out of 7), followed by individual healing patterns, and self-inflicted injury.

Go to the **Hotline** article for recommendations on how to reduce the risks associated with refractive surgery.

TABLE 3: PRE- AND POSTOPERATIVE ISSUES IN LASIK CLAIMS

PREOPERATIVE ISSUES		POSTOPERATIVE ISSUES	
Alleged contraindications	**71**	**Corneal complications**	**72**
Keratoconus/ectasia	27	Ectasia	21
Pupil size	9	Infection/inflammation	16
Prior ocular surgery	7	Flap problems	9
Refractive stability	6	Epithelial defects	8
Dry eyes	5	Epithelial ingrowth	7
Amblyopia	3	Central island	3
Glaucoma	3	Abrasion	2
Retinal conditions	2	Recurrent corneal erosion	2
Rheumatoid arthritis	2	Ulcer	2
Strabismus	2	Opacity	1
Blepharitis	1	Sands of the Sahara	1



Closed Claim Study

Lack of Informed Consent and Failure to Review Topographies

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

PRK contraindicated by keratoconus.

DISPOSITION

Case was settled for $850,000.

Case Summary

During the plaintiff's first exam, the OMIC insured informed him that he was a good candidate for LASIK. Pachymetry revealed a corneal thickness of 545 OD and 499 OS, and topography was performed. Months later, the patient returned and repeat pachymetry revealed corneal thickness of 475 OD and 443 OS. Topography was also repeated. Uncorrected visual acuity was 20/400 OD and 20/200 OS. The patient signed a LASIK consent form and was warned of the risks of operating on both eyes on the same date; however, after considering the options, he decided to proceed with bilateral same day sequential surgery. After initially confirming that the patient was a candidate for bilateral LASIK, the insured telephoned the patient to inform him that he had a thin cornea in the left eye and that he intended to perform PRK OS and LASIK OD. However, when the patient presented for surgery, the insured informed him that PRK would be performed OU since he was not a good candidate for LASIK surgery in either eye. Bilateral PRK was performed.

The patient did well during the initial postoperative period with uncorrected vision ranging from 20/50 to 20/100 OU. However, within a week, his uncorrected vision declined to 20/200 OU with corneal haze greater OD than OS. His condition did not improve and, less than one month following the bilateral PRK, the insured provided the patient's disability carrier with a letter stating that the patient was completely disabled due to corneal ectasia. The patient was subsequently fitted with custom contact lenses to help decrease the distortion resulting from the weakened corneas, but he could not tolerate the lenses, which only corrected to 20/200 OU.

Analysis

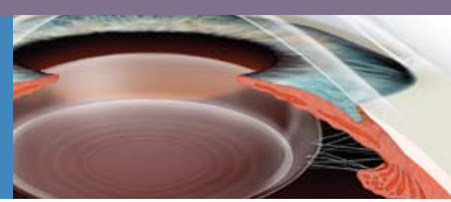
According to the plaintiff expert, the patient suffered from keratoconus OS based on a preoperative topography that revealed central corneal steepness greater than 50 diopters and corneal thickness of 440 microns. There were also preoperative clinical signs of keratoconus, including an unstable prescription, a best correctible visual acuity of less than 20/20, and increasing irregular astigmatism. Plaintiff expert stated that the patient suffered from forme fruste keratoconus in the right eye as the topographic data revealed inferior steepening and a thin cornea and should have been better counseled on his condition and not allowed to have bilateral PRK performed on the same day. Plaintiff testified that he initially presented to the OMIC insured, not for refractive surgery, but to have his glasses prescription changed. He also alleged that he was never told that the condition of his corneas increased the risk that he might suffer complications.

Unfortunately, there was no evidence in the insured's records that he had reviewed the topographies that were taken on two separate occasions. The insured clearly did not suspect that the patient was suffering from either keratoconus or forme fruste keratoconus and did not warn the patient of the increased risk of ectasia. Further complicating the defense was the fact that the patient had not signed a consent form specific to PRK.

Defense experts were unable to support the insured's care and focused instead on evaluating the plaintiff's claimed damages. Faced with the probability of a plaintiff verdict exceeding his $1 million policy limits, the insured consented to a settlement and the case was resolved.

Risk Management Principles

Diagnostic tools such as topographies are only useful if they are accurately reviewed and considered in tandem with the clinical picture. No matter how similar the risks and complications, specific informed consent must be obtained for each procedure. This includes a discussion with the patient of the procedure-specific risks, potential complications, and benefits and requires that the patient sign each consent form. If a different procedure is substituted for the original planned procedure, the consent process should begin anew, including obtaining the patient's signature on a procedure-specific consent form. To avoid an allegation of performing a contraindicated procedure, ophthalmologists should ensure that their preoperative assessment is thorough and well documented in the medical record. See the **Hotline** article.



Reduce Your Risk of a Refractive Surgery Claim

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

The refractive surgery claims study featured in this *Digest* points to actions ophthalmologists can take to improve the safety of these procedures and reduce the likelihood of a malpractice claim. Document any actions you take in the patient's medical record.

Q OMIC's refractive surgery underwriting requirements state that the "*surgeon* must perform and document an independent evaluation of the patient's eligibility for surgery, including performing a slit lamp exam and reviewing topography, pachymetry, pupil size, and discuss monovision option for presbyopic patients" and "*personally* obtain informed consent." Is OMIC opposed to comanagement?

A No, but we have learned from our claims experience that comanaged care has risks that must be reduced. Experts for the plaintiff regularly scrutinize how much care is delegated to non-ophthalmologists, whether such delegated care is properly supervised, and if the patient freely consented to the arrangement. We recommend that you develop and implement written protocols for comanagement (see "Comanagement of Ophthalmic Patients" at www.omic.com). Clarify in the protocol the role of the surgeon in preoperative and postoperative care and consent. Release the patient to the care of the non-surgeon only when deemed stable, and especially continue to see the patient if there have been complications. Request that comanagers send you reports on all visits, and review, date, and sign the reports before they are filed in the medical record.

OMIC's position on the role of the surgeon reflects that of the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS). In joint clinical statements, these organizations have clarified that the "ultimate responsibility for obtaining accurate preoperative assessment and the patient's informed consent to refractive surgery rests with the ophthalmologist who performs the surgery."[1] Referencing case law, Medicare regulations, actions by the Office of the Inspector General, and ethical standards, their analysis notes that the law imposes duties on surgeons who do not provide the postoperative care. Ophthalmologists who do not meet this obligation could be accused of patient abandonment and risk "liability for patient injury, including injury resulting from the acts or omissions of others to whom the provision of postoperative care is inappropriately delegated, or for inadequate patient informed consent, or both."[2]

Q What has OMIC learned that can help me improve the quality of my preoperative care?

A Patients who present to ophthalmologists have often already decided that they want refractive surgery, and know that they have myopia, hyperopia, and astigmatism, the conditions refractive surgery is designed to treat. Rather than focusing on indications for surgery, therefore, the preoperative assessment aims to ensure that the patient is a good candidate and to fully advise him or her of the expected risks, benefits, and alternatives. First, avoid if possible meeting the patient for the first time on the day of surgery. If you cannot avoid this, obtain and review the patient's medical record, especially the topography, before the day of surgery. Send the patient a copy of the consent form to review, and ensure that the consent is not signed until after you conduct the informed consent discussion.

During the preoperative evaluation, rule out ocular and medical contraindications to refractive surgery, initially and before each retreatment. In particular, ensure that there are no topographical or clinical signs of forme fruste keratoconus or ectasia. Assess and disclose the impact of ocular and/or medical comorbidities that are not absolute contraindications but that may influence the visual outcome (e.g., glaucoma, diabetes, stable autoimmune disease, dry eyes). Verify refractive stability and the cause of decreased visual acuity (i.e., regression vs. ectasia), especially before performing repeat surgery. Ask the patient to help identify work and leisure activities that could be impacted by the refractive outcome, such as night driving, piloting a plane, working as an accountant, and knitting. Consider providing the patient with the new AAO guide "Is LASIK for Me?" available at www.aao.org. Ascertain the patient's goal for surgery and ability to handle disappointment ("How will you feel if you still need to wear glasses at work after surgery?").

Q What actions should I consider at the surgery center?

A Verify that equipment is regularly maintained, and check for proper functioning of equipment before procedures. Implement the recommendations of the AAO Prevention of Medical Error Task Force so that the correct patient, procedure, eye, and laser settings are assured. If there is a flap complication, refund the patient's fees and stay in regular phone contact while the cornea heals.

1. AAO/ASCRS Clinical Statement. "Appropriate Management of the Refractive Surgery Patient" (Issued August 2004, Revised January 2008). Available at www.aao.org.

2. AAO/ASCRS Clinical Statement. "Ophthalmic Postoperative Care (OPC)" February 2000. Available at www.aao.org.

Calendar of Events

OMIC continues its popular risk management programs in 2009. Upon completion of an OMIC online course, CD recording, or live 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 (indicated by an asterisk) may earn an additional discount by participating in an approved OMIC risk management activity. Courses are listed below and at www.omic.com. CME credit is available for some courses. Please go to www.aao.org to obtain a CME certificate.

Online Courses *(Reserved for OMIC insureds and members of cooperative venture societies/No charge)*

- *Documentation of Ophthalmic Care*
- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*
- *Responding to Unanticipated Outcomes*

CD Recordings *(No charge for OMIC insureds)*

- *Medication Safety and Liability* (2007)
- *After-Hours and Emergency Room Calls* (2006)
- *Lessons Learned from Settlements and Trials of 2006* (2007)
- *Lessons Learned from Settlements and Trials of 2005* (2006)
- *Lessons Learned from Settlements and Trials of 2004* (2005)
- *Noncompliance and Follow-Up Issues (2005)*
- *Research and Clinical Trials* (2004)
- *Responding to Unanticipated Outcomes* (2004)

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

Upcoming Seminars

January

14 *Difficult Patient-Physician Relationships*
Washington DC Metropolitan Ophthalmological Society*
Location: TBA
Time: 6:00 pm
Register by calling (301) 787-6607 or e-mail info@wdcmos.org

21 *Now What Do I Do?*
Hawaiian Eye 2009
Grand Wailea Resort, Maui
Time: 2:00 pm
Register by calling (888) 960-0256 or http://www.osnhawaiianeye.com

February

21 *Difficult Patient-Physician Relationships*
Illinois Association of Ophthalmology*
Stevens Conference Center, Rosemont, IL
Time: 11 am–Noon
Register with the IAO at (847) 680-1666 or e-mail EyeOrg@aol.com

21 *Dissatisfied Patients*
Ohio Ophthalmological Society*
Hilton at Easton Town Center, Columbus, OH
Time: 2:40–3:40 pm
Register with OOS at (614) 527-6799 or e-mail oos@ohioeye.org

March

6 *Handling Impaired & Incompetent Colleagues and Unanticipated Outcomes:*
New England Ophthalmological Society*
John Hancock Hall, Boston
Time: Afternoon session
Register with NEOS at (617) 227-6484

13–15 *Now What Do I Do?*
Florida Retinal Symposium
Ritz Carlton, Sarasota, FL
Time: TBA
Register at www.retinasymposium.com or call 863-683-3905

April

5 *Preoperative Assessments Issues Identified in LASIK Claims Study*
American Society of Cataract & Refractive Surgery
Moscone Center, San Francisco
Time: TBA
Register with ASCRS at (703) 591-0614 or www.ascrs.org

18 *Dissatisfied Patients*
American Association for Pediatric Ophthalmology & Strabismus*
Hyatt Regency, San Francisco,
Time: TBA
Register with AAPOS at aapos@aao.org or call

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 lnakamura@omic.com.

The OMIC office will operate on a dramatically reduced schedule and will respond only to urgent matters between December 25 and January 2. If you have an urgent matter and must speak to a 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 calls will be returned on Monday, January 5. The OMIC staff wishes you and your family a safe and happy holiday season.

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