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Ophthalmic Risk Management Digest
OMIC DIGEST

Endophthalmitis and TASS: Claims Results and Lessons

By Anne M. Menke, RN, PhD

Anne Menke is OMIC's Risk Manager.

Uncomplicated cataract surgery was performed on an elderly woman. At the end of the procedure, the ophthalmologist was informed by the nurse that the sterilization indicator on the instruments had not changed. It was feared that the instruments had been washed but not sterilized. The physician and ASC medical director decided not to inform the patient of the potential problem, opting instead to increase the frequency of topical antibiotics. No signs of infection were noted at the first postoperative visit, but two days later, endophthalmitis developed. Ten days after surgery, the two physicians informed the patient and her family that the same strain of pseudomonas aeruginosa had grown in the eye and the ultrasonic bath water at the ASC, leading them to conclude that problems with sterilization were the likely cause of her endophthalmitis and phthisical eye. The patient's lawsuit was settled on behalf of the ASC for $650,000.

Poor outcomes such as this make infectious endophthalmitis one of the most feared complications of ophthalmic surgery. Recently, a type of inflammatory response known as TASS, or Toxic Anterior Segment Syndrome, has garnered attention and prompted calls to OMIC's Risk Management Hotline. While not all adverse events can be prevented, there is much ophthalmologists can do to reduce the incidence of endophthalmitis and TASS. In its review of OMIC's claims experience and the lessons learned from it, this article offers risk management guidance on more effective prevention, recognition, and response to these sight-threatening conditions.

Since OMIC's inception in 1987, endophthalmitis has accounted for 6% of claims frequency (150 claims out of 2,559 total) and 5% of claims severity ($3,345,964 in paid indemnity out of $63,191,199 total). Of these 150 cases, 25 remain open; of the 125 closed cases, only 8 were taken to trial, and in all but one, the jury returned a defense verdict. A poll of the jury after the sole plaintiff verdict of $735,000 revealed that the award was in response to the defendant group's practice of

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MESSAGE FROM THE CHAIRMAN

Since 1997, OMIC has put considerable effort into forming strategic alliances ("cooperative ventures") with state and subspecialty societies and ophthalmic special interest groups. Under the terms of these alliances, OMIC agreed to provide an annual jointly sponsored risk management seminar or audioconference to the society's membership. OMIC insureds who were members of a cooperative venture society received a 10% risk management discount on their OMIC premium if they participated in one of these jointly sponsored programs. This discount was 5% more than the standard risk management premium discount available to all OMIC insureds who participate in an OMIC-sponsored program.

These cooperative venture alliances benefited both parties. They allowed OMIC to solidify its relationship with key states and subspecialty groups and provided opportunities for face-to-face contact with OMIC insureds. The cooperative venture societies benefited because their annual meetings were often better attended when an OMIC-sponsored seminar was scheduled.

In 2003, OMIC began to examine the cost-effectiveness of continuing the cooperative venture

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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: 415-771-7087
Email: omic@omic.com
Web: www.omic.com

OMIC Reduces Surcharge for Liposuction and Full Facelifts

In 1997, OMIC began offering coverage for full cosmetic facelifts (procedures performed on the lower one-third of the face) and liposuction at the request of several oculoplastic surgeons. Because limited data was available at that time regarding the loss experience for these procedures when performed by ophthalmologists, OMIC relied upon industry information in establishing appropriate rates for this coverage. As indicated by the company's research, surcharges of 200% for full cosmetic facelifts and 160% for liposuction were adopted. OMIC believed these rates to be comparable to those charged by other carriers.

Recently, several members of the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) and OMIC insureds approached OMIC about this rating structure. In response, the company conducted further analysis based on OMIC claims experience, updated industry experience, and current market research. After carefully reviewing the new information and discussing it in detail, the Underwriting Committee concluded that the new data supported a reduction in the rates charged for coverage of both procedures.

OMIC is pleased to announce that the surcharges for coverage of liposuction and full cosmetic facelifts will be reduced from 160% and 200%, respectively, to 50% for policies effective on or after June 1, 2006. Physicians who perform both liposuction and full facelifts will be subject to a single surcharge of 50%. Because coverage for these procedures is specifically excluded under the standard policy, physicians must apply, be approved for, and have coverage endorsed to their policies to be insured for liposuction or full cosmetic facelifts.

OMIC's decision to reduce the surcharge was a direct result of the persuasive letters we received on this issue. OMIC's mission is to serve ophthalmology, and we could not be as successful as we are in this endeavor without valuable feedback from our current and potential insureds.

Message from the Chairman

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program. The OMIC Board and management had a number of concerns, among them: the increased cost of presenting on-site seminars coupled with very low attendance at some events; the loss in premium dollars as a result of the supplemental risk management discount; the inequity of allowing insureds in cooperative venture groups to earn a 10% risk management discount while others were limited to a 5% discount; and the inability to show a cost-benefit relationship between attendance at an on-site risk management program and implementation of loss prevention techniques into an insured's practice.

Over the next two years, OMIC piloted a project with 18 cooperative venture groups to provide risk management education to their members and OMIC insureds via the internet. The use of computer technology allowed OMIC to reach out to greater numbers of insureds who previously had been left out of the education process because they could not travel to on-site programs. In 2005, over 700 OMIC insureds participated in online risk management education and received a 10% premium discount. Furthermore, follow-up online testing encouraged retention and implementation of the course material.

At the same time this pilot project was under way, the OMIC Board was considering a proposal to extend the cooperative venture program to all interested state and subspecialty ophthalmic groups. After thoughtful discussion and analysis, the Board ultimately decided it would not only be fair but also in the best interests of the company and its members to do so. However, given OMIC's fast growing and geographically diverse membership, the Board recognized the need to change the cooperative venture premium discount from 10% to 8% to minimize the fiscal impact on the company. This new discount rate will be implemented in 2007.

The OMIC Board appreciates that cooperative venture alliances have played an integral role in establishing and maintaining OMIC's reputation as a strong national carrier while providing an effective forum for ophthalmic risk management education. We now look forward to offering this opportunity to all state and appropriate subspecialty societies.

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

Defending Claims, Selecting Counsel

By Kimberly Wittchow, JD
OMIC Staff Attorney

Ophthalmologists inquiring about professional liability insurance often ask how OMIC selects defense counsel when a claim or lawsuit arises. They want to know which attorneys OMIC uses in their city, how OMIC chooses the attorneys it appoints, and if insureds can select their own counsel.

Selection of counsel is not specifically addressed in OMIC's insurance policy. The policy does explain, however, that OMIC has the right and duty to defend each covered claim brought against the insured. In order to protect insureds against even frivolous claims, the policy requires that OMIC defend claims "even if wholly without merit." The reciprocal duty of the insured is to immediately report the claim or any circumstances that might give rise to a claim. Without timely notice, OMIC may not be able to adequately exercise its right and fulfill its duty to defend the insured. OMIC must be involved from the beginning of the claim in order to actively participate in the insured's defense. In the experience of OMIC's Board and staff, if OMIC does not have control of the defense process from the earliest stages of litigation, its mission of effectively defending ophthalmologists is frustrated, which ultimately works to the detriment of the insured and the company as a whole.

Expert Defense of Ophthalmologists

Implicit within OMIC's right and duty to defend each covered claim is the right to select and appoint defense counsel. Currently, OMIC has approximately 190 attorneys and law firms on its nationwide list of active counsel. These are the most qualified and consistently successful medical malpractice defense attorneys in the country. Most have worked on several OMIC cases and many are considered "subspecialists" in the defense of ophthalmologists. Given this large base of competent attorneys, assigning defense counsel has been a relatively smooth process in all of the claims OMIC has handled since its inception.

For their part, most OMIC insureds handle the stress of emotionally charged medical malpractice litigation very well and do not allow their anxiety to spill over and adversely impact the selection of counsel and defense of their claim. Mutual trust and a professional relationship between the insured ophthalmologist and his or her attorney are fundamental to a successful defense. OMIC carefully monitors this relationship throughout the course of litigation and surveys every insured after a claim is closed to get feedback about the insured's experience with counsel.

On rare occasions, the fit between an insured and an attorney is not right. When this occurs, insureds are encouraged to make OMIC aware of any issues they are having with their counsel. Oftentimes, these issues are a natural consequence of the stress of litigation and frequently resolve themselves without OMIC intervening. However, in a few circumstances, OMIC has felt that an insured's defense would be better served by a change of counsel and has appointed a different attorney.

The Need for Separate Counsel

There are some occasions during litigation when OMIC may have the duty to advise an insured to retain his or her own separate counsel. This happens when some of the allegations in the lawsuit are not covered by the OMIC policy or when the policy pays defense costs but not indemnity for certain allegations. Sometimes OMIC must advise the insured to retain separate counsel if the claim is likely to result in a judgment in excess of the insured's policy limit or if the judgment may include non-covered sums, such as punitive or other exemplary damages. In many of these situations, the uninsured allegations are dismissed before there is a need to retain separate counsel. Unfortunately in other cases, the allegations remain and the insured must bear the cost of any separate legal defense.

In a handful of cases, OMIC has learned that the insured has engaged his or her own private counsel prior to reporting the claim to OMIC or without OMIC's approval. Insureds have even tried to settle cases themselves without informing the company of the claim. In these situations, if the insured engages counsel directly without OMIC's approval, the defense costs accrued will not be covered by OMIC. In addition, any indemnity payments made by the insured without OMIC's approval also will not be covered by the company.

For more information on this subject, please see OMIC's *Litigation Handbook for the Ophthalmologist* or the following articles, which can be found on the OMIC web site at www.omic.com:

- "Choosing Defense Counsel," by Mary Kasher, MSN, JD, *OMIC Digest*, Winter 2001.
- "How to Survive a Malpractice Suit," by Paul Weber, JD, *Review of Ophthalmology*, July 1997.
- "Anatomy of a Claim," by Marilys Fernandez, RN, JD, *OMIC Digest*, Winter 1991.

Endophthalmitis and TASS: Claims Results and Lessons

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locking up medical records on weekends, thus preventing access to key patient information needed to assess the plaintiff's condition. Since the practice's name did not appear on the jury's form, a settlement on its behalf was effected for the amount of the verdict, and the plaintiff award against the ophthalmologist was vacated.

More than three-quarters (78%) of OMIC's endophthalmitis cases have closed without an indemnity payment. The percentage of cases that have settled (22%) and the median settlement amount ($75,000) are comparable to OMIC's overall data. Despite the severity of the outcome for the patient, endophthalmitis settlements have ranged from $9,000 to $735,000 compared to a low of $500 and a high of $1.8 million for all settlements. Reflecting the relative novelty of TASS, allegations in all but 3 of the 150 claims involve an infectious rather than an inflammatory process.

Given the estimated 2 million cataract procedures performed annually in the United States, one might anticipate that cataract surgery would account for 61% of all endophthalmitis cases. Surprisingly, however, only 23% of cataract-related endophthalmitis cases resulted in an indemnity payment. During the informed consent process for cataract surgery, ophthalmologists routinely disclose this rare complication, and most actively try to prevent its occurrence by treating preexisting conditions such as blepharitis, preparing the eye with povidone iodine, and administering antibiotics. Assuming cataract surgery was indicated in the first place and the endophthalmitis was promptly recognized and treated, experts view this complication as a tragic maloccurrence rather than malpractice. On the other hand, cases of endophthalmitis resulting from trauma are rare (5%), but they result in settlement 57% of the time. Clearly, ophthalmologists who do not administer antibiotics and/or carefully monitor the eye for signs of endophthalmitis after trauma are not supported by defense or plaintiff experts.

Analysis of Risk Issues

It is helpful to analyze the risk issues associated with substandard care by dividing them into four categories. "Clinical" issues include debates in the ophthalmic community on the standard of care and the natural history of the disease or condition. "Systems" issues involve complicated processes of care, such as medications (research, manufacture, distribution, ordering, etc.), equipment, and follow-up and telephone screening methods. Finally, the acts, omissions, and decisions of individual physicians and patients also impact care outcomes. Table 2 indicates the type and frequency of risk issues in OMIC's endophthalmitis and TASS cases.

Amid ongoing debate of evidence-based guidelines for prevention of

TABLE 1
ENDOPHTHALMITIS CLAIMS BY SPECIALTY

SPECIALTY	TOTAL CLOSED CLAIMS	CLOSED WITHOUT INDEMNITY	CLOSED WITH INDEMNITY	SETTLEMENT RANGE	MEDIAN SETTLEMENT
Cataract	77	59	18	$9,000 – 735,000	$75,000
Retina	23	19	4	$58,000 – 101,476	$75,000
Cornea	14	13	1	$300,000	
Trauma	7	3	4	$24,999 – 248,000	$31,000
Glaucoma	2	2	0		
Endogenous	1	0	1	$15,000	
Uveitis	1	1	0		

TABLE 2
INCIDENCE OF RISK ISSUES IN ENDOPHTHALMITIS AND TASS CASES

CLINICAL	**4**
Antibiotics	
• Route	
• Timing	
SYSTEMS	**32**
Telephone care (16)	
• After-hours (12)	
• Staff (4)	
Sterilization (6)	
• Not done (2)	
• Ultrasound bath contaminated	
• Cracked irrigation bottle	
• Saline flush contaminated	
• Donor tissue not cultured	
Equipment malfunction (3)	
Product liability (2)	
Medical records (1)	
PHYSICIAN	**57**
Diagnostic process (18)	
• Diagnosis did not account for symptoms	
• Exam elements	
Documentation (7)	
• Missing	
• Late	
• Altered	
Surgery not indicated or contraindicated (6)	
Treatment (6)	
Follow-up interval (5)	
Referral delay (5)	
Informed consent and disclosure (4)	
Coordination of care with PCP (3)	
Supervision of OD (2)	
Discharge instructions (1)	
PATIENT	**5**
• Noncompliance	

endophthalmitis, it is noteworthy that antibiotic administration was not a key issue in any case; nor was patient noncompliance a significant factor. Ophthalmologists have a leadership role to play in addressing the many systems issues that adversely impact care outcomes. In their capacity as users, surgical directors, board members, and owners, they can review equipment maintenance and infection control measures in hospitals and ASCs, focusing particular attention on issues such as flash sterilization, re-use of single-use items, and the ordering, preparation, and use of ophthalmic products, devices, and medications.

Screening Patient Complaints

The two primary issues in OMIC's endophthalmitis cases—telephone care and the diagnostic process—indicate the need to carefully screen patients who present with ophthalmic complaints, especially postoperatively, and to educate them about which symptoms to report. Each of these identified risks is squarely within physician control and thus can be modified. This issue's **Closed Claim Study** illustrates the perils of inadequate screening and failed coordination of care; the **Risk Management Hotline** advises physicians on how to disclose and investigate sterilization problems or clusters of cases, and prevent TASS. "Telephone Screening of Ophthalmic Problems" provides screening protocols and contact forms for both staff and physicians taking after-hours calls and can be found at www.omic.com.

"A Witty (WIT-D) Approach to Avoiding Mistakes" proposes an easy-to-remember and effective strategy for improving the diagnostic process. Establish a prioritized differential diagnosis in order to rule out the worst case scenario; determine the information you need to obtain during the history and examination, or through studies, to rule that in or out; tell the patient and other health care providers to ensure that you are notified of all signs and symptoms that could help establish the diagnosis and determine the treatment plan; and document your decision-making process and follow-up plan.

Endophthalmitis or TASS?

Failure to rule out endophthalmitis has resulted in harm to patients and significant liability exposure for OMIC policyholders. Emerging research indicates that the ophthalmologist should also include inflammatory reactions such as TASS in the differential diagnosis. Indeed, mistaking one for the other could lead not only to a delay in treatment but may worsen the outcome. Table 3 summarizes some of the distinguishing features. Although this table may be helpful, it can still be difficult or impossible at times to distinguish between endophthalmitis and TASS. For more information see, "Endophthalmitis and TASS: Prevention, Diagnosis, Investigation, Response" at www.omic.com.

1. Carolyn Buppert, "A Witty (WIT-D) Approach to Avoiding Mistakes," *Gold Sheet* 4(6), 2002. See "Risk Management Issues in Failure to Diagnose Cases: A Focus on Traumatic Eye Injuries."
2. Table compiled from information in Mamalis, Nick et al. "Review/Update: Toxic Anterior Segment Syndrome." *J Cataract Refract Surg* Vol 32, February 2006:324-333; Ronge, Laura J. "Toxic Anterior Segment Syndrome: Why Sterile Isn't Clean Enough." *EyeNet*, November/December 2002:17-18; and Davis, Brandon L, and Mamalis, Nick. "Averting TASS: Analyzing the Cause of Sterile Postoperative Endophthalmitis Provides Valuable Clues for its Prevention." *Cataract & Refractive Surgery Today*, February 2003:25-27.

TABLE 3
DIFFERENTIAL DIAGNOSIS: TASS OR ENDOPHTHALMITIS?

	TASS	ENDOPHTHALMITIS
Cause	Noninfectious reaction to toxic agent present in: BSS solution Antibiotic injection Endotoxin Residue	Bacterial, fungal, or viral infection
Onset	12-24 hours	4-7 days
Signs/ Symptoms * distinguishing feature	Blurry vision Pain: none, or mild to moderate Corneal edema: diffuse, limbus to limbus* Pupil: dilated, irregular, nonreactive* Increased IOP* Anterior chamber: mild to severe reaction with cells, flare, hypopyon, fibrin Signs and symptoms are limited to anterior chamber* Gram stain and culture negative	Decreased VA Pain (25% have no pain) Lid swelling with edema Conjunctival injection Hyperemia Anterior chamber: marked inflammatory response with hypopyon Vitreous involvement Inflammation in entire ocular cavity*
Treatment	Rule out infection Culture anterior chamber Intensive corticosteroids Monitor IOP closely for signs of damage to trabecular meshwork and side effects of steroids Watch closely over next few hours for signs of bacterial infection	Culture anterior chamber and vitreous Intravitreal and topical antibiotics Vitrectomy

Closed Claim Study

Inadequate Hand-offs Between Physicians Delays Treatment of Endophthalmitis

By Ryan Bucsi, OMIC Senior Claims Associate

ALLEGATION

Failure to timely diagnose and treat endogenous endophthalmitis.

DISPOSITION

Settled at mediation for $45,000. Primary care physician (PCP) and hospital contributed $25,000, OMIC insured contributed $15,000, and on-call physician for the PCP contributed $5,000. On-call ophthalmologist was not named in the lawsuit.

Case Summary

An elderly female patient telephoned the OMIC insured's office complaining of blurred vision and floaters. The insured was out of town, so the patient was referred to the on-call ophthalmologist, who scheduled a same day appointment. The appointment was cancelled, however, because later that day, the patient was hospitalized by the physician on-call for the patient's primary care physician (PCP) for treatment of a systemic infection. Four days later, at the request of the PCP, the hospital contacted the OMIC insured's office to request a consultation and was informed that he would not be returning to the office for two days. When the insured returned, he contacted the hospital and was told by a nurse that the patient had been diagnosed with conjunctivitis. The following morning, he went to the hospital for his sole examination of this patient. The patient's left eye was red and painful with an intraocular pressure of 53 and visual acuity of light perception. A slit lamp exam revealed a 30% hypopyon with 4+ cells and flare in the remainder of the anterior chamber. There was no red reflex in the left eye with the ophthalmoscope on the highest setting. The B-scan displayed moderate debris in the vitreous with an attached retina. The insured diagnosed probable endogenous endophthalmitis secondary to E-coli and referred the patient to a retina specialist. The retinal specialist treated the patient in the hospital for two weeks, but after a total retinal detachment, the patient suffered complete loss of vision in the left eye.

Analysis

Multiple opportunities to intervene in a more timely manner in the infectious process were lost because of inadequate "hand-offs" between the attending physicians and their call partners. Instead of cancelling the scheduled office visit with the on-call ophthalmologist, the on-call PCP should have arranged an in-hospital consultation. The on-call ophthalmologist never informed the insured about the patient's call, cancelled appointment, or hospital admission. Thus, when the insured did finally speak to the hospital nurse, he relied upon the diagnosis of conjunctivitis and did not clarify the patient's symptoms or recognize the urgency of the situation.

Defense experts noted that a consulting physician should generally see the patient within a couple of days for a non-emergent consultation. They pointed out that the one day delay in treatment would not have improved the outcome of an E-coli infection. The defense was complicated, however, by the hospital consultation request, which identified the reason for the patient's admission as bacteremia. Arguably, this diagnosis and a report of red eye should have alerted the insured to the possibility of endophthalmitis. The nurse was expected to testify on behalf of the hospital that the complaint of pain and poor vision was communicated to the insured. Given these troubling issues, mediation was arranged and the case was settled.

Risk Management Principles

Careful telephone screening of ophthalmic problems is perhaps the most effective patient safety and risk reduction measure ophthalmologists can take. Neither patients nor other health care providers can be relied upon to provide the information necessary to diagnose an eye condition over the phone. The ophthalmologist must, therefore, be proactive and "drive" the conversation, being sure to ask not only about ocular symptoms but also about the patient's overall condition. OMIC has prepared sample contact forms that prompt ophthalmologists and their staff to ask about symptoms, prior surgery, medication use, and problems reported to other physicians, and to report contacts with other members of the health care team (see " Telephone Screening of Ophthalmic Problems" at www.omic.com/resources/risk_man/recommend.cfm). Ophthalmologists going on or off call should conduct and document "hand-off" discussions and may want to devise an ophthalmic consultation form for referring physicians, including those in the emergency department, so they have the information necessary to determine the urgency of a consultation request.

Risk Management Hotline

Sterilization Breakdowns in Endophthalmitis/TASS

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

The malpractice case featured in this issue's lead article stemmed from a series of breakdowns in the facility's sterilization process. When notified of the problem, the physician consulted with the ASC's medical director and together they decided not to alarm the patient until they knew the facts. By not warning the patient of the symptoms to watch for, they arguably missed an opportunity to diagnose the problem earlier.

Q Should I tell my patient of potential problems with sterilization?

A Yes for several reasons. Patients have a need and a right to know about their own condition and can help monitor the development of symptoms. Such disclosure of adverse events is best understood as a continuation of the informed consent process begun before the surgery. Moreover, communicating with the patient sympathetically and non-defensively within the shortest appropriate time period may help dispel much of the anger, confusion, and distrust that complications may engender, while preventing allegations of fraudulent concealment that could extend the statute of limitations or allow for punitive damages. Stick to the currently known facts, avoiding speculation or blame. As more information becomes available, share it with the patient and document it in the medical record.

Q How should I proceed if I suspect a cluster of endophthalmitis or TASS cases?

A You will need to coordinate with the facility, your staff, and your patients in order to respond effectively. All patients operated on that day need to be notified of the events, screened for symptoms, and educated about when and why to contact you. The facility needs to sequester all involved materials, interview staff, and evaluate equipment, devices, solutions, medications, and the sterilization process. The investigation will help locate the responsible organism or toxic agent, ascertain liability, and determine what steps to take to remedy any identified problems.

Q What specific information do I need to collect for the investigation?

A Nick Mamalis, MD, of the Intermountain Ocular Research Center at the University of Utah has developed an Excel-based protocol that can be used for individual or clustered cases of infectious or sterile endophthalmitis. Detailed information about each patient's pre- and postoperative course, the facility, equipment, supplies, medication preparation, and sterilization technique are compiled, entered into the spreadsheet, and sent to the center for review. Research fellows are available for on-site evaluations, and charge only airfare and nominal expenses. In response to more than 80 TASS cases nationwide, the AAO and ASCRS announced in May 2006 that an ad hoc committee chaired by Dr. Mamalis had been established to help determine the causes. Ophthalmologists with TASS cases are urged to complete two short questionnaires about the products involved during cataract surgery and the actual process of cleaning and preparing instruments and patients for surgery and forward them to Dr. Mamalis. The protocols and questionnaires are available on the OMIC web site, via email at nick.mamalis@hsc.utah.edu, or by calling (801) 581-6586.

Q What measures can I and the ASC take to prevent TASS?

A While it can be very difficult to pinpoint the cause of TASS, pH, preservatives, and cleaning solutions are often implicated. Dr. Mamalis suggests a whole team approach to the ordering, cleaning, sterilizing, and preparation of all instruments, viscoelastic, medications, and irrigation solutions to ensure proper pH, osmolality, and non-toxicity. Avoid re-use, especially of cannulas and damaged instruments. Rinse I/A tips and phaco hand pieces at the conclusion of each cleaning step with sterile, deionized water through both ports. Replace ultrasound water baths daily. Change the steam autoclave sterilizer at least weekly. Take care with wound construction and avoid ophthalmic ointment and patches with clear corneal incisions.[1]

Q Does the OMIC endophthalmitis claims study identify specific ways that physicians can minimize their liability?

A Yes. Treat preexisting blepharitis. Screen for and stabilize medical conditions, such as immunosuppression or uncontrolled diabetes, that could adversely impact the patient's healing process. Use povidone iodine to prepare the eyelid, carefully construct the wound, and check for leakage. Base your choice of antibiotic prophylaxis on current peer-reviewed recommendations. Provide written discharge instructions on wound care, signs and symptoms to report, and contact information. Carefully screen complaints from postoperative patients and evaluate the need to personally examine the patient. Following possible breaks in sterilization or clusters, consider examining or talking to the patient daily until infection/TASS has been ruled out or effectively treated.

1. Mamalis, Nick et al. "Review/Update: Toxic Anterior Segment Syndrome." *J Cataract Refract Surg* Vol 32, February 2006:324-333.

Calendar of Events

OMIC continues its popular risk management courses through 2006. 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 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* addresses liability issues surrounding on-call emergency room coverage and EMTALA statutes.
- *Ophthalmic Anesthesia Risks* offers an overview of anesthesia risks supported by case studies.
- *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, Colorado, Hawaii, Louisiana, Nevada, Oklahoma, and Washington.

CD Recordings *(No charge for OMIC insureds)*

- *Lessons Learned from Trials and Settlements of 2004.* (Subjects include Informed Consent for Cataract Surgery, Traumatic Eye Injuries, and ASC: Anesthesia Provider, Monitoring, Discharge)
- *Noncompliance and Follow-Up Issues*
- *Research and Clinical Trials*
- *Responding to Unanticipated Outcomes*
- *Risks of Telephone Screening and Treatment*

Go to www.omic.com/resources/risk_man/seminars.cfm to download CD order forms.

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.

Upcoming Seminars and Exhibits

July

22 *Ophthalmic Anesthesia Liability*
Four State Joint Meeting (Tennessee, Louisiana,* Alabama, Mississippi)
Grand Sandestin Hotel, Sandestin, FL
12 noon-1:30 pm
Register with the TAO at (615) 794-1851 or the ALAO at (334) 279-9755

August

9 *Lessons Learned from Settlements & Trials of 2005*
OMIC Annual Nationwide Live Audioconference
Originates from the OMIC office in San Francisco
2:00-3:30 pm Pacific Daylight Savings Time
No charge for OMIC insureds
Register with Linda Nakamura at OMIC at (800) 562-6642, ext. 652

11 *Ophthalmic Anesthesia Liability*
Women in Ophthalmology Annual Meeting* (WIO)
Hyatt Regency Montreal, Montreal, Quebec, Canada
7:30-8:30 am
Register with the WIO at (415) 561-8523 or contact wio@aao.org

20 *Ophthalmic Anesthesia Liability*
Florida Society of Ophthalmology Annual Meeting* (FSO)
Ritz-Carlton, Naples, FL
7:00-8:00 am
Register with the FSO at (904) 998-0819 or go to www.mdeye.org

November

11-14 *Academy/OMIC Insurance Center Exhibit*
Annual Meeting of the American Academy of Ophthalmology
Booth 2231, Hall B, Upper Level, Sands Expo Convention Center, Las Vegas, NV

12 *OMIC Forum: After-hours and Emergency Room Calls*
Annual Meeting of the American Academy of Ophthalmology
Vendome B, Paris Hotel, Las Vegas, NV
10:00 am-12 noon
Register with Linda Nakamura at (800) 562-6642, ext. 652

12 *OMIC Annual Members Meeting*
Titian 2201, Venetian Hotel, Las Vegas, NV
1:15-1:45 pm

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