Summer 2005 Volume 15 Number 3 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest
OMIC DIGEST

ROP Case Defines Legal Duty of Care to Patients

By Anne M. Menke, RN, PhD, and Paul Weber, JD

Anne Menke is OMIC's Risk Manager. Paul Weber is OMIC's Vice President of Risk Management/Legal.

"When does a physician's duty to a patient end?" It is a question frequently asked by the medical profession and debated by the legal profession. In a retinopathy of prematurity case involving blind twins that initially resulted in a $15 million plaintiff verdict against an OMIC-insured pediatric ophthalmologist, two pediatricians, and one of the pediatricians' practice group, OMIC learned just how difficult it can be to answer that question. This article provides an overview of the facts of this case and the many legal hurdles faced by the OMIC defense team before an appellate court reversed the plaintiff verdict and made a final determination that the ophthalmologist had no duty to the patient.

In December 1996, twins were born at 30 weeks gestational age in a hospital with a well-established protocol for screening and treating retinopathy of prematurity (ROP). In early February 1997, the hospital's neonatal intensive care unit (NICU) nurse met with the twins' mother and told her to schedule an outpatient ophthalmic appointment for both babies. A few days later, before the babies' discharge, the neonatologist determined that Twin B met the in-hospital screening criteria and asked the OMIC-insured pediatric ophthalmologist to examine the baby. The insured determined that the baby's retinas were not fully vascularized and noted the presence of Stage I ROP, for which no treatment was indicated. He wrote a follow-up order for a repeat evaluation by a screening ophthalmologist in two weeks to monitor for the development of threshold ROP. The NICU nurse and neonatologist met with the mother at different times to inform her of the results of the ROP examination and to explain the importance of follow-up evaluations; the mother was given a copy of the hospital's letter to parents explaining ROP ("Dear Parent" letter).

As part of the hospital's discharge process, the neonatologist contacted the twins' pediatrician and told him he was referring two premature infants for outpatient care. At the time of the

continued on page 4

MESSAGE FROM THE CHAIRMAN

Seldom does a lawsuit come along that so clearly illustrates the OMIC advantage of Ophthalmologists Insuring Ophthalmologists as the case described in the lead article of this quarter's *Digest*. Several points deserve special mention. The venue was in Texas, at a time when Texas was listed by the American Medical Association as a "state in crisis." The patients were blind twin children, who made very sympathetic plaintiffs. The lawsuit alleged negligence in the treatment of retinopathy of prematurity, which in other cases has resulted in damage awards in the millions. Despite these facts, the OMIC Claims Committee believed strongly that the care delivered by our insured pediatric ophthalmologist met the standard of care. Being able to obtain a quick expert review from an ophthalmologist in the same subspecialty as the insured provided a distinct advantage in this case as it does in all OMIC cases. We gained additional support from our defense experts, who were recognized leaders in the field of ROP. Like

continued on page 2

IN THIS ISSUE

Eye on OMIC

OMIC

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

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

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

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

Stable Rates and Dividend Credit for OMIC Insureds

The OMIC Board has announced two actions that will reduce the 2006 professional liability premium bill of every ophthalmologist currently insured with OMIC. First, there will be no rate increase as the board has extended current base rates through next year. Second, OMIC will return approximately $2 million in premium in the form of a dividend credit for all current professional liability insureds who renew and remain insured with OMIC through 2006. This amounts to a premium savings of approximately 4% for each eligible insured.

"Reinstituting the dividend program honors a Board promise to monitor OMIC's financial health and return premium to our loyal policyholders when it is supported by continued improvements in our claims experience and operational performance," said Chairman Joe R. McFarlane Jr., MD, JD.

OMIC's financial ratios have steadily improved over the past five years and surpassed those of other physician-owned carriers in 2004. Despite the addition of 1,450 new policyholders and the increased risk exposure of a larger insured base, OMIC has kept rate increases to moderate, actuarially sound levels by reducing expenses and negotiating more favorable terms with reinsurers. Since 2000, OMIC's rates nationally have remained 8% to 15% below those of other carriers that are still actively writing ophthalmic coverage. OMIC's history of fiscal conservatism, prudent underwriting, effective risk management, and aggressive claims handling has resulted, year after year, in better-than-average loss experience.

"As a result, OMIC has been able to remain solvent and generate a profit that it reinvests entirely in the Company to provide a superior and stable insurance program for ophthalmologists at a competitive price," says Dr. McFarlane. "This commitment to long-term financial stability ensures that OMIC will be here in the future to meet the specific ophthalmic insurance needs of members of the American Academy of Ophthalmology, and it is another example of the OMIC advantage of Ophthalmologists Insuring Ophthalmologists."

Ricci A. Rascoe
OMIC Controller

Message from the Chairman

continued from page 1

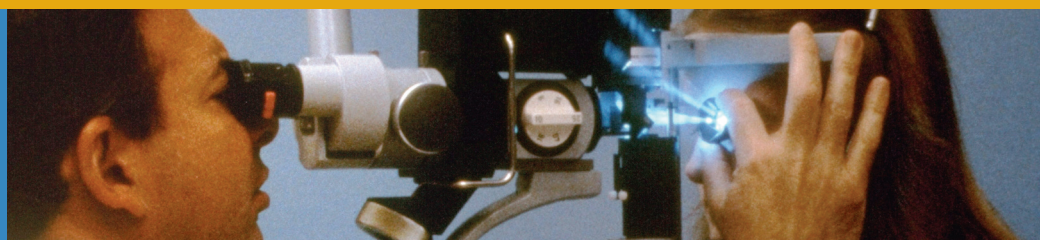
all ophthalmology experts who review litigated cases for OMIC, they were chosen from a select panel of board-certified specialists and then recommended and approved by the Claims Committee.

Unfortunately, the initial trial resulted in a verdict of $15 million against our insured and two pediatricians, one of whom quickly settled. The other pediatrician joined our insured in his appeal. Our defense attorney recommended we appeal, convinced that a doctor-patient relationship had never been established. As with all the trial attorneys who serve on OMIC's defense panel, this attorney was carefully screened for trial experience and familiarity with handling the intricacies of an ophthalmic medical malpractice case. His firm also employed top-notch appellate counsel who assisted our insured. We followed their recommendation, and after five-and-a-half years, multiple appeals, and defense expenditures in excess of $700,000, our insured finally prevailed.

The bottom line message is that the practicing ophthalmologists on the OMIC Claims Committee evaluate each case closely. When they determine that a case should be tried, OMIC hires excellent defense attorneys, utilizes outstanding and respected medical experts, and stands by its insureds all the way to and including the highest court in the state.

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

Policy Issues



Group Policies

By Kimberly Wittchow, JD
OMIC Staff Attorney

Whether you are new to a group practice or leaving a group to work for yourself or with others, you should be aware of how an OMIC group policy works and what to do if your practice situation changes.

A group that has OMIC professional liability insurance is usually issued one policy. The Declarations Page, which accompanies the policy, lists the ophthalmologists, CRNAs, optometrists, and any entities that are covered under the group's policy. Under INSURED AND MAILING ADDRESS on the Declarations Page, the group name, or "policyholder," is listed. This policyholder controls the group policy and is the main party with whom OMIC communicates about the policy.

Notice

Communications are often handled on behalf of the insureds of a group by the policyholder's administrator or representative. OMIC assumes that, as a member of the group, the insured has given this representative the right to speak on the insured's behalf regarding routine underwriting issues. While the administrator may initiate or facilitate a change in coverage, OMIC will seek the insured's consent before changing the insured's coverage limits, provisions, or classifications. Whenever possible, OMIC will communicate directly with an insured regarding any sensitive issues, such as licensure actions, substance abuse problems, or medical or psychiatric treatment.

Payment of Premium

Often, the business entity for the group will pay for each of the insured's premiums under the policy. Nevertheless, each insured under the policy is considered by OMIC to "own" his or her own coverage. (Note, however, that for slot coverage for residents and fellows, the slot position, and not the individual in the slot, is the insured, and therefore the coverage is controlled entirely by the group practice.) This means that the insured is ultimately responsible for payment of his or her coverage under the policy. However, any refund of premium is credited to the policyholder, and it is the policyholder's responsibility to distribute any refunds to individual insureds as appropriate.

Cancellation and Nonrenewal

Regarding cancellation and nonrenewal, the policyholder may request that OMIC delete an insured from a group policy. OMIC will try to get confirmation from the insured that he or she agrees with this termination of coverage. If OMIC cannot contact the insured, however, OMIC will process the termination, but will continue to attempt to communicate with the insured in order to determine whether he or she would like to remain insured with OMIC under an individual or another group policy.

Prior Acts Coverage

When joining a group, insureds may choose to purchase coverage for claims based on events which occurred before their coverage inception date under the group policy. Some groups do not allow the insured to acquire prior acts coverage under the group's OMIC policy, while others may permit or require it.

Each insured under the group policy will have his or her own retroactive date which will reflect whether that insured has prior acts coverage. Some insureds will not need prior acts coverage because they are either new to practice or their prior acts are covered under another policy. This occurs when insureds were previously covered under an occurrence policy or bought an extended reporting period (tail) endorsement from their previous carrier. Remember that an insured's retroactive date is usually not the same as the group entity's retroactive date, and that the insured's inception date may also be different from the group's if the insured joined after the beginning of the group's policy period.

Tail Coverage

Some groups require physicians to sign contracts when they join the group. Under these contracts, the group might require that, when a physician leaves the practice, he or she maintain coverage for the activities he or she participated in as a member of the group. This might take the form of purchasing a tail upon leaving the group, or proving that he or she maintains prior acts coverage under his or her new insurance policy after being deleted from the group policy. OMIC sends a tail offer directly to the insured upon termination of coverage. While it is ultimately the insured's responsibility to obtain tail coverage if desired, a group may agree to pay for it. If the insured instead purchases prior acts coverage from his or her new carrier, the group might require that certificates of insurance be sent to the group periodically to ensure that the physician who left is maintaining his or her coverage for acts undertaken while with the group.

ROP Case Defines Legal Duty of Care to Patients

continued from page 1

pediatrician's first outpatient visit with the mother and infants, he addressed the babies' numerous medical problems and reviewed the neonatologist's referral letter with the mother. This letter indicated that the mother had made an appointment with an ophthalmologist.

Soon thereafter, on February 16, 1997, the day before the ophthalmic appointment, the mother contacted the pediatrician's office and requested insurance authorizations for a circumcision, hernia repair, and tongue clipping. When she came to pick up the authorizations the next day, she asked, for the first time, for an insurance authorization for the ophthalmologist. The pediatrician's office staff informed her that they could not process her request that day. The authorization form was never sent to the OMIC-insured ophthalmologist. In any event, the mother did not bring the children to the appointment; in her deposition, she claimed that she was told by the insured's staff that the twins could not be seen without an authorization. The insured denied this.

The mother scheduled another appointment with the insured ophthalmologist for February 28, 1997 but again did not show up, this time because the babies were hospitalized for other health problems under the care of another physician. The twins were scheduled to return to the pediatrician for follow-up after discharge, but were never brought in. Instead, the mother sought treatment from a second pediatrician and told this doctor that there were no concerns about the babies' eyes. When this pediatrician reviewed the first pediatrician's records, she noted the concern about ROP and the absence of ophthalmic follow-up; she referred the twins to a different ophthalmologist, not the insured. By that time, June 1997, both babies were blind.

Gaps in the Process of Care

The insured ophthalmologist had only seen Twin B once in the hospital. He had never been asked to see Twin B again in the hospital or in his office and was initially bewildered when he was served with a lawsuit in March 1999 alleging negligent care of twins with ROP whose name he did not recognize. Only after reviewing the complaint did he realize that the plaintiff was the mother of Twin B and that she had scheduled an outpatient appointment with him for both twins in mid-February *under a different last name*. He checked his appointment records and found that his office had placed a reminder call before the appointment but that the mother did not bring the twins to that appointment or to one that she rescheduled for the end of February. Per office policy, his staff did not follow-up with new, self-referred patients who did not keep appointments, assuming they had decided to seek care elsewhere. The first pediatrician noted that appointments had been made for follow-up of the ROP during the initial visit, but he did not have a system in place to ensure that he received consultant reports. The second pediatrician was given falsely reassuring information by the parents and only later learned of the ROP after asking for and reading the medical records of the first pediatrician.

The Trial and Verdict

Efforts to dismiss the OMIC insured from the case were successful for Twin A since the insured had never examined that infant. OMIC's Claims Committee and expert witnesses believed the insured had met the standard of care in his treatment of Twin B, and they challenged the existence of an ongoing physician-patient relationship. OMIC and the insured ophthalmologist accordingly decided to take the case to trial. After a five-week trial, the jury awarded the plaintiffs $15 million (plus prejudgment interest) according to the breakdown of fault in the chart on page 5.

TIMELINE

Twin babies born	Dec. 26, '96
Twin B seen by OMIC-insured ophthalmologist in hospital	Feb. 8, '97
Insured ophthalmologist served with summons and complaint	Mar. 3, '99
Jury verdict of $15 million against three defendants (pediatrician 1 settles before verdict entered)	Feb. 26, '01
Three-justice court of appeals overturns verdict against ophthalmologist and pediatrician 2	Feb. 26, '04
Eight-justice court of appeals denies rehearing	Sept. 2, '04
State supreme court denies review	July 1, '05

The jury assumed that the insured's relationship with Twin B did not end after his consult in the hospital but followed him after Twin B was discharged. The percentage of fault the jury assigned to the parents ignored the undisputed evidence and the following facts:

- The mother played a significant role in the delay in diagnosis and treatment of ROP by not informing the ophthalmologist of the twins' name change, not keeping the outpatient appointments with him, and not providing accurate information to the second pediatrician when asked about the condition of the babies' eyes.
- Her noncompliance occurred despite conscientious efforts to educate her: she was counseled about ROP by the neonatologist

JURY VERDICT AGAINST	FAULT IN TWIN A'S INJURIES	FAULT IN TWIN B'S INJURIES	JUDGMENT*
Ophthalmologist	0%	15%	$1.2 million
Pediatrician 1	60%	50%	Settled with plaintiffs before verdict for $7.5 million
Pediatrician 2 *(also sued pediatrician's group under respondeat superior)*	35%	30%	$6.3 million
Parents	5%	5%	$0

*Approximate dollar amounts not including prejudgment interest.

and NICU nurse; she received a letter from the hospital about ROP; and she spoke to the first pediatrician about the babies' health problems. During her testimony, however, she denied understanding the significance of the problem, and her lawsuit blamed the care providers for inadequate follow-up.

Both OMIC and the trial counsel for the insured strongly believed that there was no *legally sufficient evidence* to support the jury's finding that an ongoing physician-patient relationship existed between the insured and Twin B. Additionally, when polled after the verdict, the jury cited concern for the infants as the primary factor in its decision-making process. This presented a very compelling case to appeal.

Standard of Review for Appealing a Case

Typically, under a "no evidence" review, the court of appeals (or supreme court) must adhere to what the jury found unless there is *no more than a scintilla of proof* to establish a particular issue, "scintilla" being shorthand for that virtually indefinable quantum of proof that makes the reviewing court comfortable enough to say, "there is sufficient evidence to support the jury's verdict."

In the OMIC insured's case, the defense argued primarily that there was no legally sufficient evidence – no more than a scintilla – to establish that the insured had an ongoing physician-patient relationship with Twin B. If no physician-patient relationship existed, there could be no duty, and therefore no malpractice, regardless of how badly the patient may have suffered.

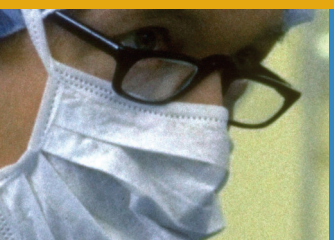
Specifically, the insured argued, and the state court of appeals accepted, that the various pieces of evidence – the "Dear Parent" letter, the missed appointments, the participation in the twin's health plan, the alleged referral from the first pediatrician – did not constitute legally sufficient evidence that the insured had an ongoing physician-patient relationship with Twin B. The plaintiffs argued the opposite interpretation of that same evidence.

Rendered in February 2004, the opinion of the majority of the state court of appeals explained: "We believe, however, that none of these facts, either individually or combined, are evidence of the actual continuation of the physician-patient relationship." The appellate court was concerned about expanding the duty of continued care and stated: "If we were to expand the duty of continued care to all patients who are seen at hospitals by consulting physicians beyond the hospital setting based solely upon the fact that they were seen by the physician in the hospital, there would be no end to the physician-patient relationship."

Supreme Court's Final Review

The case was by no means over after the appellate court's opinion. Over the following eighteen months, the plaintiffs petitioned for an *en banc* rehearing, in which the full eight members of the court of appeals would review the case, but their petition was denied. They appealed the rehearing denial to the state supreme court, arguing that the court of appeals did not apply the appropriate standard of review in a "no evidence or legal sufficiency" case. The state supreme court denied a rehearing. OMIC was delighted with this decision in the ophthalmologist's favor and felt that the $730,000 it cost to defend this insured's care was money well spent.

This case illustrates both the complexity of providing medical care to premature infants and the intricacies of the legal process. The appellate court's decision was based on the particular facts of this case and may not apply generally to ophthalmology consultants. Additionally, this case was state specific and may or may not be used as precedent for other states. The detailed risk management recommendations for hospital- and outpatient-based ROP care that OMIC developed in response to this case, however, have proved generally useful to pediatric ophthalmologists and retina specialists. This sample protocol better protects physicians and premature infants by standardizing the nonclinical aspects of care and assigning responsibility for all steps in the treatment process. This document, "ROP: Creating a Safety Net," can be found in the **Risk Management Recommendations** section of **www.omic.com**.



Closed Claim Study

Outgoing Answering Machine Message Wins Case for Ophthalmologist

By Ryan Bucsi, OMIC Senior Claims Associate

ALLEGATION

Failure to give appropriate medical advice and proper emergency contact information post blepharoplasty.

DISPOSITION

Defense verdict.

Case Summary

An OMIC insured performed a bilateral lower lid blepharoplasty on a 57-year-old male patient on a Friday afternoon. Immediately following the procedure, the patient and his wife drove two hours from the insured's office to their vacation home. Per his normal routine, the insured telephoned the patient that evening. The insured documented in the chart that the patient had no complaints of pain or vision loss, however he did report some mild bleeding from the stitches around his right eye. The insured advised the patient to apply pressure and ice to stop the bleeding and to telephone him if the bleeding did not stop or if he experienced visual changes. The patient did not contact the insured on Saturday or Sunday. On the following Monday, the patient returned for his first postoperative appointment. He reported a recurrence of the bleed on Saturday night for which he had applied direct pressure and ice. There was no pain or swelling on Saturday, but by Sunday, the patient reported that his vision had become darker. At the time of his visit on Monday, the patient reported seeing several dark spots in the right visual field with light perception vision in the right eye. The insured suspected a branch artery retinal occlusion. He ordered a carotid Doppler, an echocardiogram, CBC, sedimentation rate, ANA, C-reactive protein, and a fasting lipid profile as well as referring the patient to a second ophthalmologist. Upon consultation, the diagnosis was a transient retinal artery occlusion with a somewhat enlarged branch retinal vein inferiorly. The patient received a complete vascular work-up and was followed by his primary care physician. The patient's visual acuity did not recover past 20/200 with a 50% visual field loss in the right eye.

Analysis

No claim was made challenging the medical necessity of the procedure or the insured's surgical technique. The claim centered solely on the post-surgical care. Contrary to the insured's documentation of the Friday evening phone call, the patient and his wife testified that they informed the insured of significant pain, blurry vision, and excessive bleeding from the stitches around the right eye. The patient and his wife also testified that the symptoms were so severe that they were about to proceed to an emergency room on Friday evening before the insured called them and told them to apply direct pressure and ice to control the bleeding. Furthermore, the patient testified that they called the insured's office on Saturday and Sunday to report increased bleeding, pain, and visual loss, but that the insured's outgoing answering machine message did not give an emergency contact number.

There was no mention in the insured's documentation of the Friday night phone call of any significant pain, vision loss, or bleeding. Furthermore, the defense was able to produce the recorded outgoing phone message from that weekend, which did indeed give an emergency contact number. Although the patient and his wife remained adamant that, at the time of the incident nearly two years prior, this was not the case, the defense was able to successfully refute this allegation as the insured had saved his notes from a staff meeting prior to this incident, which included documentation that an emergency contact number was recorded on the outgoing phone message.

Risk Management Principles

When it's the patient's word versus the physician's word, prevailing at trial comes down to who the jury believes is the more credible witness. The likelihood of a defense verdict is greatly improved when there is solid documentation to back up the insured's story, no matter how insignificant such documentation might seem at the time. In this case, the Friday night phone conversation was well documented, which greatly helped the defense refute the patient's claims of severe and emergent symptoms. However, it was the notes taken during a staff meeting establishing the presence of an emergency contact number on an outgoing answering machine message that won the case. This documentation was essential to the defense as it discredited the patient's recollection of postoperative events.

Risk Management Hotline

Who Can Perform Preop History & Physical Exams?

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

Many patients contemplating eye surgery also have medical conditions that could increase the risk of operative or diagnostic procedures and anesthesia/sedation. While ophthalmologists are medical doctors, as specialists they generally limit their care and treatment to ophthalmic conditions. Accordingly, most ophthalmologists do not perform the preoperative history and physical examination (H&P) themselves. Instead, they regularly refer the patient to the primary care physician (PCP) for medical clearance. In the past, H&P exams performed by the PCP within 30 days of surgery met the requirements of regulatory and credentialing organizations. In 2002, CMS began mandating a reassessment within 7 days of surgery, and JCAHO recently instructed facilities that the patient's condition must be updated within 24 hours of the procedure. As a result, ophthalmologists are being asked to either conduct the reassessment themselves or cosign one done by a Certified Registered Nurse Anesthetist (CRNA), Physician's Assistant (PA), or Nurse Practitioner (NP).

Q My hospital has asked me to update the patient's preoperative history and physical examination by conducting a physical assessment prior to surgery. I haven't done a preoperative H&P since my residency years ago, and I don't feel competent to do one now. What should I do?

A There is no way to *truthfully* sign a reassessment form without conducting a history and physical examination, however brief. Ophthalmologists whose current competency does not include these skills should decline such requests and work with the hospital administration to find alternative solutions, such as those described below.

Q I have been conducting these reassessments for several years. What are the malpractice risks?

A The primary purpose of the preoperative evaluation is to determine if the chosen procedure and anesthesia are safe and appropriate for the patient and to help anticipate potential complications related to ophthalmic or medical comorbidities. If a patient experiences an unanticipated outcome, he or she might allege that the reassessment was negligent or failed to detect preexisting medical conditions. If you conduct these evaluations, make sure your H&P skills are up-to-date.

Q The ASC where I operate has hired NPs and PAs to reassess patients. Is it risky for me to cosign their evaluations?

A No. These are highly trained mid-level practitioners whose scope of practice regularly includes H&P exams. OMIC has analyzed the liability risk for ophthalmologists when CRNAs provide anesthesia care during ophthalmic procedures ("Anesthesia and Sedation Risks and Precautions," *OMIC Digest*, Summer/Fall 2004). When physicians supervise CRNAs who are not their employees, they are not necessarily liable for the actions of the CRNA. Courts generally focus on the amount of control the physician exercises over the provider to determine whether the physician should be held liable for the anesthetist's actions—whether the anesthesia provider is a CRNA or an anesthesiologist. While plaintiff attorneys might argue that the ophthalmologist's signature on anesthesia orders, evaluations, or records is proof of control, they will need further evidence that the physician directed the actions of the CRNA to win their case. Similarly, simply cosigning the update to the patient's condition does not make the ophthalmologist liable for the actions or omissions of the NP or PA.

Q Does my signature imply that I am certifying the reassessment?

A No. Your signature on a reassessment form acknowledges that the patient's medical condition has been evaluated but does not imply that you are attesting to the accuracy or thoroughness of the examination in question. Once the NP or PA has completed the history and physical examination, read it and write "Patient reassessed and medically cleared for surgery by _____ NP/PA" (include the provider's name and title).

Q Can the preanesthesia evaluation performed by the anesthesia provider be used to update the patient's condition?

A Yes, and many hospitals and surgery centers meet the CMS and JCAHO requirements in this way. Anesthesiologists and CRNAs have considerable expertise in conducting H&Ps, and must evaluate the patient prior to administering sedation or anesthesia. In the "Updates to the Patient's Condition" question on its web site **(www.jcaho.org)**, the JCAHO states, "In the situation where the patient is going to have surgery within the first 24 hours of admission, the update to the patient's condition and the preanesthesia assessment (PC.13.20) could be accomplished in a combined activity."

Calendar of Events

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

Online Courses

- *EMTALA and ER-Call Liability* addresses liability issues surrounding on-call emergency room coverage and EMTALA statutes. Frequently asked questions on both federal and state liability are answered, and a test reinforces the risk management principles covered in the course.
- *Ophthalmic Anesthesia Risks* offers an overview of anesthesia risks and provides actual case studies supporting the issues addressed in the overview.
- *Informed Consent for Ophthalmologists* provides an overview of the doctrine of informed consent as it applies to various ophthalmic practice settings. Examples illustrate practical ways that ophthalmologists can support the consent "process" to foster more effective patient/provider communications as well as improve the defense of malpractice claims.

State and Subspecialty Society Online Courses

- California Academy of Ophthalmology/OMIC*: *CAO Informed Consent for Ophthalmologists.*
- Hawaii Ophthalmological Society/OMIC*: *HOS Informed Consent for Ophthalmologists.*
- Louisiana Ophthalmology Association/OMIC*: *LOA Informed Consent for Ophthalmologists.*
- Nevada Ophthalmological Society/OMIC*: *NOS Informed Consent for Ophthalmologists.*
- Oklahoma Academy of Ophthalmology/OMIC*: *OAO Informed Consent for Ophthalmologists.*
- Washington Academy of Eye Physicians and Surgeons/OMIC*: *WAEPS Informed Consent for Ophthalmologists.*
- Women in Ophthalmology/OMIC*: *WIO Informed Consent for Ophthalmologists.*

Contact Linda Nakamura in OMIC's Risk Management Department to register for these online courses.

CD Recordings Available

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

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

Upcoming Seminars

December

11 *Responding to Unanticipated Outcomes**
Florida Society of Ophthalmology (FSO)
Boca Raton Resort and Club, Boca Raton, FL
7–8 am
Register online with the FSO at www.mdeye.org

February

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

March

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

This schedule is subject to change. To confirm dates and times, or if you have questions about OMIC's risk management offerings, please contact Linda Nakamura at (800) 562-6642, ext. 652 or via email at lnakamura@omic.com.

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610