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Ophthalmic Risk Management Digest

OMIC DIGEST

Minor Distractions Lead to Major Problems in the OR

By John W. Shore, MD, FACS

Dr. Shore is a member of OMIC's Board of Directors.

It is well known in aviation circles that minor distractions are often the cause of major airline accidents. A perfect example is the December 29, 1972 accident of an Eastern Airline L-1011 with 176 passengers on board that casually and subtly descended 2,000 feet before crashing into the Everglades while the captain and copilot, sitting in their respective seats, and a third crew member tried to troubleshoot a gear warning light malfunction, all the time ignoring audible and visual instrument warnings that the aircraft was about to crash. The aircraft had been forced to break off its approach to Miami International Airport after the nose gear light failed to illuminate, raising concerns about whether the gear was properly lowered for landing. While in a holding pattern at 2,000 feet above Everglades National Park, the captain bumped his control column, leading to the disconnection of the autopilot. With the attention of all three crew members focused on the landing gear and the extinguished light, the aircraft descended unnoticed into the ground. One hundred passengers and crew members perished.

How could such a thing happen, and how does this incident apply to OMIC's experience with claims involving seemingly simple or minor surgical procedures? Attending to a failed nose gear warning light should not result in the death of 100 people. Likewise, anesthetic injection into a lower eyelid for chalazion removal should not result in penetration of the globe, retinal detachment, and loss of the eye. Yet, this is what happened to a 35-year-old man, who presented with a chalazion in the left lower eyelid. Although the procedure was noted to be "without complication," the patient returned to the office the following day with complaints of severe left eye pain and visual loss. The patient was referred to a retinal surgeon, who discovered a large corneal abrasion, an inferotemporal chorioretinal scar, and an adjacent retinal defect. Despite several surgeries, the patient's vision never improved beyond 20/300; the case was settled during pre-trial mediation for $250,000.

When such an outcome occurs, one can usually point to a breakdown in surgical technique (technical performance),

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MESSAGE FROM THE CHAIRMAN

I am very pleased to announce that the OMIC Board has approved a rate decrease for all professional liability policyholders in 2007. Premiums will decrease an average of 5.2%, with insureds in a number of states receiving as much as a 7% decrease. Of OMIC's 3,675 insureds, 65% will see their 2007 premiums drop between 5% and 7%. How much premiums will decrease in any particular state is based on a number of actuarial indications that take into account past ophthalmic claims experience, the medical malpractice climate, and the verifiable effect of tort reform legislation. More specific information about the rate decrease in each state will be provided in a letter to OMIC insureds this fall.

OMIC began reducing insurance costs earlier this year when all policyholders received a credit toward their 2006 renewal premium, and we are one of the first carriers to announce a premium decrease for 2007 in response to a more stable medical malpractice insurance market. As a mutual insurance company, it has always been OMIC's philosophy to reinvest profits back into the company and, when actuarially supported by our claims experience and operational

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Eye on OMIC

OMIC

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

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

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The PIAA Researches LASIK Risks

The Physician Insurers Association of America recently published its first comprehensive review of LASIK risks compiled from claims reported to the PIAA database by its member insurance companies over the past six years. Since 2000, when PIAA members began reporting closed claim information on LASIK, there have been 114 claims amounting to over $9.1 million in indemnity and $2.9 million in defense expenses. During this same period, OMIC closed 152 LASIK-related claims and paid $2.6 million in indemnity and $1.1 million in defense expenses.

PIAA member companies reported settling 30% of all LASIK cases compared to OMIC's 20%. This is a significant difference and translates into a higher frequency of indemnity payout for PIAA. On a per case basis, PIAA members paid an average indemnity of $236,749 for LASIK, whereas OMIC's average was $83,253. This difference in severity, coupled with higher frequency, accounts for the overall higher loss numbers experienced by the PIAA.

On the other hand, PIAA members reported average defense expenses of $28,771 per settled LASIK claim, compared to OMIC's average cost of $35,735. OMIC believes paying a little more upfront to secure the best defense counsel and experts is in the best interest of the insured and results in overall savings in the long run if a case can be settled with a careful evaluation and lower indemnity.

Through year-end 2005, OMIC and the PIAA each had only one plaintiff verdict in a LASIK case. A $1.3 million judgment was also PIAA's largest reported LASIK loss. OMIC's single plaintiff verdict of $2,200 resulted when the jury simply requested that a bill be paid. OMIC's largest LASIK loss payment was a $450,000 settlement in a case involving a firefighter who claimed he was not a good candidate for surgery due to thin corneas and was not adequately informed of the possible complications. The surgery resulted in a free flap and the patient ultimately suffered double and blurred vision and a severe induced astigmatism from corneal scarring. He was also able to document a large wage loss since he was demoted to a lower paying position due to his disturbed vision.

Message from the Chairman

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performance, to return premium to our policyholders in the form of a premium decrease or dividend credit.

OMIC is the largest insurer of ophthalmologists in the United States with 35% of the eligible national ophthalmology market. This recent rate action is expected to put downward pressure on the cost of insurance for all ophthalmologists and provide an alternative for ophthalmologists whose insurance premiums have doubled or tripled over the past five years with multispecialty carriers.

What distinguishes OMIC from multispecialty carriers is that OMIC is the only insurance carrier governed by a board of directors and committees composed of ophthalmologists who understand both the practice of ophthalmology and the challenges of modern day medicine. A better understanding of the specialty has helped OMIC achieve a superior record of defending ophthalmic claims, beating industry averages every year since the company's inception.

In addition to decreasing premiums, the OMIC Board has agreed to offer cooperative ventures to all state ophthalmic societies and appropriate specialty societies upon request. Under the terms of a cooperative venture agreement, OMIC insureds who are members of a cooperative venture society and attend a qualifying cosponsored risk management event or course can earn an 8% risk management premium discount, instead of the standard 5% discount. By offering this popular program nationwide, OMIC extends the benefits of ophthalmic-specific risk management to insureds in all regions of the country in all subspecialties while supporting the activities of state and specialty societies.

As further encouragement to take advantage of OMIC's high quality educational programs, all OMIC-sponsored risk management activities are now available free of charge to policyholders, including audioconferences and CDs. Conferences where OMIC is an invited speaker usually charge the physician a registration fee.

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

Policy Issues

Entity Coverage

By Kimberly Wittchow, JD
OMIC Staff Attorney

There are numerous ways a practice can be organized and many options for the creation of a legal entity. It is important that OMIC insureds understand both how to secure professional liability coverage for their various business entities and how that coverage works.

OMIC's policy excludes coverage of individuals for liability arising from their status as members, partners, officers, directors, shareholders, or employees (hereafter referred to as "members") of any partnership, professional association, or corporation. Because members and entities may be named as defendants in lawsuits, OMIC offers separate coverage to professional entities. Entity coverage insures the entity itself, its members in their capacity as such, and non-physician employees of the entity for their respective acts and omissions. It also covers the entity and its members for their vicarious liability arising from the acts and omissions of others.

Sole Shareholder Corporations

If an insured ophthalmologist has a sole shareholder corporation, it is included as an additional insured under his or her policy. No additional premium is charged to insure the solo corporation at shared limits with the sole shareholder. Separate liability limits are available for an additional premium. In order to obtain this coverage, the sole shareholder corporation must be listed on the ophthalmologist's application and the applicant must indicate whether shared or separate limits are desired. Coverage is in place only when the sole shareholder corporation is named on the Declarations.

Multi-shareholder Corporations

An insured ophthalmologist may decide to sell or give shares of the sole shareholder corporation to another physician or individual, thus converting the corporation into a multi-shareholder corporation. When this occurs, the corporation must complete an entity application so that OMIC can evaluate the entity's eligibility for continued coverage. If OMIC determines that the change in ownership violates OMIC's eligibility requirements or increases the risk of insuring the entity too dramatically, the entity's coverage may be cancelled mid-term following appropriate advance notice. If new articles of incorporation are filed as a result of the change in ownership, the entity is considered a new entity. Therefore, coverage for the sole shareholder corporation would cease as of the date it is dissolved, and the new entity would not be covered until properly underwritten, paid for, and named on the Declarations.

Multi-shareholder corporations, partnerships and outpatient surgical facilities (OSFs) may obtain entity coverage at separate liability limits. (These limits do not serve to increase an individual insured ophthalmologist's personal limits of liability.) In order to obtain this coverage, the multi-shareholder corporation or partnership must complete an entity application; the OSF, an OSF application. Coverage is in place only when the application has been approved, the required premium has been paid, and the entity or OSF is listed on the Declarations.

Partnerships

Unlike corporations, which can have changes in ownership or name changes without affecting the legal status of the corporation, partnerships, can exist only in their original form. If a new partner is added or a partner leaves, the partnership ceases to exist. Instead, a new partnership is created. Therefore, the retroactive date for the new partnership, if insured, would be the date the new entity was formed, and the former partnership would need to purchase tail coverage in order to remain insured for future claims arising from past services.

Insureds must remember that entity coverage is not applied automatically. The ophthalmologist application gives several areas to provide information about the applicant's professional entities. It asks for the name under which the applicant does business, inquires about how the practice is organized, and provides space to give the name of the legal entity(ies). Only those entities approved for coverage that have paid the required premium, if any, and are listed on the Declarations or an endorsement to the policy are covered.

Remember that coverage for a claim against an entity, its members, or its non-physician employees is only available if the entity is already listed on the Declarations or an endorsement to the policy at the time the claim is reported. In addition, the incident upon which the claim is based must have occurred on or after the retroactive date applicable to the entity. To prevent an uninsured risk, insureds should notify OMIC immediately if they form or acquire a new entity during the policy period so the entity can be properly underwritten and added to the policy, if approved.

Minor Distractions Lead to Major Problems in the OR

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distraction, or inattention of the surgeon immediately prior to or at the time of the incident, or complacency among the surgical team because the procedure is "simple" or "minor." The adage, "fly the airplane first, and then solve the emergency" applies to surgery as well. To put it in surgical terms: focus on the patient, the surgical field, and the task at hand. Don't be distracted by nearby events. Intuitively, we know from experience that surgeons prepare for, plan, and execute complex or risky cases with great attention to detail. The surgeon is focused on the difficult and challenging technical aspects of the case. The surgical team feels the tension and pressure to perform with a high level of skill. The OR is silent. The surgical team avoids irrelevant discussions that might divert the surgeon's attention from the task at hand. This is not unlike the situation in the cockpit when pilots are circumnavigating thunderstorms and landing in low visibility. As in surgery, everyone involved has a stake in the outcome and everyone's attention is directed at bringing the flight (or surgery) to a successful conclusion.

The Dangers of Complacency

We recognize, however, that it is human nature to let one's guard down in the office treatment room when performing straightforward or routine treatments and even in difficult cases once the critical portions of the case are over. Complacency (and therefore surgical or technical errors) is more likely to develop during "minor" or "routine" cases where the risk is seemingly low and the technical aspects of the case are simple or straightforward. Also, in difficult cases, there is usually good chart documentation of the complex nature of the case, and the risks of the procedure are spelled out in the surgical consent form, often in the surgeon's own handwriting. In the case of "minor surgery," the surgeon may pop into the room momentarily to inject the eyelid and return 15 or 20 minutes later and hastily remove an eyelid papilloma or drain a chalazion. If the surgeon's attention is diverted by a telephone call, or the patient is startled by the surgeon's beeper just as the needle penetrates the skin, inadvertent, sudden movement may lead to ocular penetration with disastrous results. Because the case is "minor in scope," there may or may not be a signed consent. Some physicians require only oral consent for minor cases handled in a treatment room setting. The surgeon or nurse may overlook the importance of sending a specimen to the pathology laboratory because the lesion "appears benign." In other offices, there is no requirement to dictate or even document the performance of "minor" surgical procedures. There may be no written instructions given to the patient at discharge. The patient may be discharged to drive home alone with one eye patched. While everyone recognizes this is not the ideal way to practice, the reality and pressures of a busy clinic or office is the background for distractions that lead to incidents, suits, and even large malpractice awards. It is not until an error occurs that the lack of a signed consent form becomes the key (missing) document in a malpractice case.

These very tendencies towards complacency and inattentiveness were identified years ago as a major contributing cause of aircraft accidents and led air carriers and the FAA to adopt the "sterile cockpit" rule. By regulation, there can be no extraneous or irrelevant conversation in the cockpit by the aircrew when flying lower than 10,000 feet above ground level. The goal is to have the flight crew totally focused on flying the aircraft during the critical phases of flight. This lesson can be applied to the operating room as well.

"Minor" Oculoplastic Cases

A review of OMIC oculoplastic claims since the company opened for business almost 20 years ago **(Table 1)** reveals some interesting statistics that reinforce the need to maintain diligence during "minor" eyelid surgery. Surprisingly, some of the largest awards in oculoplastic surgery were those involving such "minor" procedures as eyelid biopsy, papilloma or cyst removal, and punctal cautery. The single largest oculoplastic award of $975,000 was for visual loss occurring during excision of a chalazion. In fact, of the $8 million paid by OMIC for oculoplastic claims over 19 years, $1.27 million was paid for incidents that occurred during removal of chalazia **(Table 2)**. Loss of vision due to penetration of

TABLE 1
OMIC PAYMENTS BY PROCEDURE—OCULOPLASTICS

Conjunctiva	$ 10,000
Major eyelid surgery	$ 12,500
Orbital infection	$ 20,000
Socket	$ 26,500
Lacrimal	$ 46,500
Brow forehead lift	$ 65,000
Orbital tumor	$ 183,310
Minor eyelid surgery	$ 270,000
Eyelid cancer	$ 350,000
Graves' related	$ 500,000
Orbital fracture	$ 857,965
Laser resurfacing	$ 971,250
Chalazion	$ 1,271,144
Ptosis	$ 1,373,000
Blepharoplasty	$ 2,066,277

Note: Figures reflect total indemnity payments and do not represent the number of claims or the amount paid per claim. Some procedures (facelift, endoforehead lift) have only recently been covered by OMIC.

the globe with retinal detachment, corneal perforation, and flash fires leading to scarred and poorly functioning eyelids are not expected outcomes of chalazion surgery and such cases are almost impossible to defend. The goal for all should be prevention of such maloccurrences since little can be done after the fact to satisfy a patient or family other than to make financial restitution and settle the claim. Even that is not a satisfactory resolution because the patient has to live forever with severe or total vision loss.

OMIC has paid out $710,000 for claims involving five fires in the surgical setting. Four of the five preventable fires occurred in a treatment room or ASC setting during "simple" or "minor" surgical procedures (Table 3). One such case is presented in this issue's Closed Claim Study, while the Risk Management Hotline focuses on preventing and managing surgical fires.

TABLE 2
OMIC CLAIMS EXPERIENCE—CHALAZION

10 Closed Claims

4	no indemnity paid
2	less than $10,000 paid
2	between $10,000 and $25,000 paid
1	$250,000 paid
1	$975,000 paid

TABLE 3
OMIC CLAIMS EXPERIENCE—FIRE IN OR SETTING

5 Closed Claims

1	$10,000 paid
1	$25,000 paid
3	between $100,000 and $430,000 paid

Risk Management Tips

How can a physician alter behavior to minimize the risk of an inadvertent error during surgery? Here are some suggestions:

1. Remember that any surgical or diagnostic procedure carries risk. Instruct your staff and make a personal commitment to approach every surgical procedure as a major case. Avoid the term "minor procedure" when talking to patients. Use "straightforward" instead.

2. Adopt the sterile cockpit rule—avoid extraneous conversation and don't allow distractions to creep into the operating or treatment room. Turn off your beeper and instruct your staff not to call into the treatment room during surgery.

3. Do not allow yourself to become rushed because of office or waiting room pressures.

4. Let the patient know what to expect so he/she is not surprised into making a sudden or inadvertent move.

5. Check for allergies before giving an injection or using oral/intravenous drugs in the treatment room.

6. Inject anesthetics slowly and ensure the eyelid or eye is totally anesthetized to minimize patient movement due to sudden or unexpected pain.

7. Apply topical anesthesia to the conjunctiva before making a transconjunctival injection to anesthetize the eyelid or conjunctiva for surgery. A comfortable patient is less likely to move inadvertently.

8. Learn to use regional nerve block techniques while working on eyelids, eyebrows, and cheeks. Infraorbital, anterior ethmoidal, supratrochlear, infratrochlear, lacrimal, and supraorbital nerve blocks allow a surgeon to work with the patient's anatomy totally anesthetized and free of pain.

9. Use cornea or globe protection for eyelid procedures (metal corneal protective shields).

10. After discussing the procedure with the patient, always have the patient sign a surgical consent form prior to any surgical procedure.

11. Document each treatment room procedure with a dictated or handwritten operative note that conforms to the current standard for surgical documentation.

12. Give written postoperative or wound care instructions to patients prior to discharge, even in the treatment room setting.

13. Be sure the patient is discharged to the care of a competent adult, particularly if there is temporary visual impairment or mental compromise due to sedation.

14. Obtain and follow OMIC's guidelines, "Office-based Surgery for Adults," which can be found in the **Risk Management Recommendations** section of www.omic.com. These recommendations are applicable to surgery in an ambulatory surgical or hospital OR setting as well as in the treatment room.

The same principles apply to major ophthalmic cases; however, errors due to inattention or distractions are less likely to occur because of the surgical setting and absence of office pressures in the treatment room. Nevertheless, it is easy to let one's guard down towards the end of the case once the stress of the actual surgery is over. Instruments are dropped, packing is not removed, and patches are inappropriately applied in the rush to get the patient to the recovery room. If the surgical team adopts the approach that the case is not over until the patient is safely in the post-anesthesia care unit, mistakes and the chance for adverse events can be minimized. Again, an airline corollary: the flight is not over until the aircraft pulls up to the gate and the passengers disembark!

Closed Claim Study

Fire In The Operating Room

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Facial burns from a fire in the operating room.

DISPOSITION

Plaintiff verdict and subsequent post-trial settlement of $430,000.

Case Summary

An OMIC insured scheduled a repair for a patient with extreme ptosis on the right side under local anesthesia. The patient's nose and chin were fully draped, and the anesthesiologist was administering oxygen via a mask. The ophthalmologist performed the initial incision and then proceeded to use cautery to achieve hemostasis, sparking a fire. The OMIC insured placed pressure on both eyes, removed the surgical drapes, and splashed water on the patient's face while the nurses and anesthesiologist put out the fire. The surgical wound was sutured by the OMIC insured without performing the ptosis repair. The patient was transferred to the burn unit with first and second degree burns over her lips, the medial aspect of the cheeks, chin, paranasal region, right ear, right lateral neck, and posterior neck. The patient did not lose consciousness during the fire and remained in stable condition. The discharge note stated a diagnosis of 1% total body surface area partial-thickness burns to multiple areas of the face, adjustment disorder with mixed emotional response, and acute post-traumatic stress disorder.

Analysis

Once the fire was recognized, all members of the surgical team did all they could to care for the patient. Unfortunately, the patient not only suffered physical injuries requiring plastic surgery, she was unable to work as a result of post-traumatic stress disorder, severe depression, anxiety, and trauma. The loss of income and necessary psychiatric care greatly increased the economic damages she claimed in her lawsuit and made her allegation that the fire should have been prevented all the more compelling. When plaintiff and defense experts reviewed the care, they both criticized the poor communication between the ophthalmologist and anesthesiologist. The OMIC insured testified that he had a standing order with the facility for no oxygen during ptosis repairs; despite extensive searching, no such document could be found. The ophthalmologist acknowledged that he did not remind the anesthesiologist beforehand not to administer oxygen during the procedure or notify him that he was about to use the cautery. Instead, he assumed that the anesthesiologist would automatically turn off the oxygen and switch the patient to air. The plaintiff's anesthesiology expert testified that the surgeon must either warn of impending cautery use or the anesthesiologist must ask whether any is planned. Other factors contributed to the risk of a surgical fire. Hospital staff testified that the surgeon used a pencil cautery, which does not allow for voltage control. Another expert pointed out that regardless of the type of cautery, by fully draping the patient's head, the surgeon allowed oxygen to accumulate below the drapes and ignite once the cautery was used.

Given the lack of support and substantial economic damages, OMIC and the surgeon's attorney urged the insured to make a settlement offer in response to the plaintiff's global demand of both defendants of $299,999. Despite this advice, the ophthalmologist was unwilling to offer more than $29,000, which would keep him below his state's threshold for reporting an indemnity payment. Accordingly, the case was taken to trial, where the jury found in favor of the plaintiff against both defendants, with the ophthalmologist 80% and the anesthesologist 20% responsible for the outcome. Although the jury awarded a total of $474,994, state law allowed the plaintiff to recover both interest and the cost of the lawsuit, including expert fees. These added costs significantly raised the award, making the OMIC insured alone responsible for $439,325. OMIC was able to settle the case after the trial for $430,000.

Risk Management Principles

As this case demonstrates, surgical fires are difficult to defend. While OMIC has not had many such cases, we have had to settle all five of them, with payments ranging from $10,000 to $430,000. Just because a complication of surgery is extremely rare does not mean that proper precautions should not be taken to decrease the risk. Please see the **Risk Management Hotline** article in this issue for information on how to prevent surgical fires.

Risk Management Hotline

Preventing and Managing Surgical Fires

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

As the **Closed Claim Study** in this issue illustrates, there is much ophthalmologists, anesthesiologists, nurses, and surgical facilities can do to avert these rare but devastating occurrences. Accordingly, many professional organizations have issued guidance, most of it based upon the research of ECRI's Accident and Forensic Investigation Services. Moreover, accrediting organizations have made minimizing OR fires a compliance issue for many ophthalmologists who own or operate accredited office-based surgery suites or ambulatory surgery centers. The Joint Commission on Accreditation of Healthcare Organizations included surgical fire prevention in its 2005 and 2006 National Patient Safety Goals, and the Centers for Medicare and Medicaid regards this risk management effort as a condition of participation. This **Hotline** article will present actions ophthalmologists can take to protect themselves, their patients, and the entire surgical staff.

Q What causes surgical fires?

A Three elements are needed: oxygen, fuel, and a spark, and all are present wherever surgery is performed. Oxygen is abundant in the operative setting; heavier than air, it pools under drapes. The list of fuels is extensive, and includes prep solutions, ointments, cotton balls, drapes, sponges, endotracheal tubes, masks and tubing, and the patient's hair, especially the fine hair on the face. The spark is provided by electrosurgical units, electrocautery units, and lasers.

Q What precautions need to be taken before the surgery begins? As the surgeon, am I responsible for these?

A The entire surgical team must cooperate to prevent fires, and as the surgeon, you can take a leadership role. If flammable preps such as alcohol are used, allow them to fully evaporate and dry before draping the patient, and check for pooling or wicking.[1] Arrange the drapes to fully expose the face; this helps minimize oxygen and nitrous oxide buildup underneath. Place suction under the drapes to scavenge oxygen and further reduce the concentration of pooled oxygen. Use a properly applied incise drape, if possible, to help isolate head and neck incisions from oxygen-enriched atmospheres and from flammable vapors under drapes. As a general policy, use air or ≤ 30% oxygen for open delivery during procedures. Coat facial hair near the surgical site with water-soluble surgical lubricating jelly to make it nonflammable. Moisten sponges, gauze, and pledgets (and their strings) to make them resistant to ignition; keep a water sponge on the Mayo stand for this purpose.

Q Are there steps I should take when using electrosurgery, electrocautery, or laser surgery?

A Yes. Communicate with anesthesia personnel about the need for oxygen and inform them of planned use of equipment that could cause sparks, such as cautery units and laser. Ask the anesthesia provider to stop using supplemental oxygen (if > 30%) at least one minute prior to and during the use of the unit if possible. Use clear methods to communicate the use of oxygen, i.e., "Oxygen on!" and "Oxygen off!" Activate the unit only when the active tip is in view, and deactivate the unit *before* the tip leaves the surgical site. Place electrosurgical electrodes in a holster or another location off the patient when not in active use. Place lasers in standby when not in active use. Do not place rubber catheter sleeves over electrosurgical electrodes; instead, use manufactured insulated electrodes. Keep the endoscope light away from drapes to prevent heat from igniting the drapes.

Q What should I do if I notice a surgical fire?

A First, the fire needs to be extinguished. If it is small, pat out or smother it, or remove the burning material from the patient.[2] For large fires on the patient, stop the flow of breathing gases to the patient, and remove the burning material from the patient. At times, a fire extinguisher may be needed. Next, care for the patient by resuming ventilation, controlling bleeding, evacuating from the room if there is ongoing danger from smoke or fire, examining the patient for injuries, and treating as needed. If the fire cannot quickly be controlled, notify other operating room staff and the fire department. Save all involved materials and devices for later investigation. Contact the risk manager of the facility, as well as OMIC's Risk Management Department, for assistance in discussing the fire with the patient and in determining reporting obligations.

1. Recommendations are from "Only *You* Can Prevent Surgical Fires: Surgical Team Communication is Essential." ECRI. This free poster is available at http://mdsr.ecri.org/static/surgical_fire_poster.pdf. To order in color or to obtain more information about surgical fires, contact ECRI at (610) 825-6000.

2. Recommendations are from "Surgical Fires," *Operating Room Risk Management*, ECRI, 2004.

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 in 2006 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.

Effective summer 2006, all OMIC-sponsored risk management activities are available free of charge to policyholders, including audioconferences and CDs. Conferences where OMIC is an invited speaker usually charge the physician a registration fee.

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, Washington, and the American Society of Plastic and Reconstructive Surgeons (ASOPRS).

Contact Linda Nakamura at lnakamura@omic.com in the Risk Management Department to register for these online courses.

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

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

Seminars and Exhibits

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

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

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

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