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Ophthalmic Risk Management Digest

OMIC DIGEST

My Doctor Never Told Me That Could Happen

By Anne M. Menke, RN, PhD

Anne Menke is OMIC's Risk Manager.

Why do patients sue? This question, pondered by most physicians at some point in their careers, prompted a famous study that was published in JAMA in 1992. GB Hickson and his co-authors queried obstetrical patients who filed lawsuits after their infant had experienced permanent injuries or death. The study showed that patients initiated malpractice claims, in descending order of frequency, when they were advised to sue by a knowledgeable acquaintance (often a physician), needed money, believed there was a cover-up, felt their child would have no future, wanted more information, or wanted revenge or to protect others.[1] This article will explore physician-patient communication with particular focus on how to use the informed consent process to keep the lines of communication open before and after surgical procedures.

The insurance industry has long known that the majority of claims involve a relatively small number of physicians. The Hickson study authors wondered why. Do these high risk physicians attract higher risk patients? Do they practice bad medicine? Or do they relate differently with patients? In order to explore the relationship between physicians' malpractice experience and their patients' satisfaction, the authors devised a new study and asked a different group of mothers about their satisfaction with pregnancy and delivery care (see Table 1).[2]

TABLE 1
PHYSICIAN CLAIMS HISTORY AND PATIENT DISSATISFACTION

AREAS OF CONCERN	PATIENT COMPLAINTS		
PRIOR CLAIMS	0	1-3	>3
Communication	8	18	27*
Care/Treatment	5	15	22*
Access/Availability	7	11	15*
Humaneness of MD	5	6	17*

*statistically significant

continued on page 4

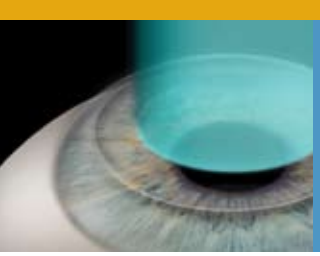
MESSAGE FROM THE CHAIRMAN

Malpractice insurance premiums are a significant overhead expense for most ophthalmic practices, and no one understands this better than the practicing ophthalmologists on OMIC's Board of Directors. As stewards of OMIC, it is the Board's intention to always return any premium that is above the level required to maintain the company's solid long-term financial position. In light of OMIC's favorable claims experience and strong financial results, the Board declared a policyholder dividend in 2006 and a rate decrease in 2007. This year, I am very pleased to announce that we will again be reducing the cost of malpractice insurance for all OMIC policyholders. Effective January 1, 2008, OMIC's annual base premium rate will decrease by an average of 7.2%, depending on each state's specific loss experience. Furthermore, insureds will save an additional 11% in the form of a dividend credit applied to their renewal premium. As a result of these rate decreases and paid dividends by OMIC over the last three years, overall malpractice costs for our policyholders have decreased by 27.5% or $12.5 million.

When setting premium rates each year, the company's officers and directors must ensure that

continued on page 2

IN THIS ISSUE



Eye on OMIC

OMIC

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

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OMIC Makes Consent Forms More Physician-Friendly

While ophthalmologists know they must obtain the patient's informed consent prior to surgery, they often have many questions about how to fulfill this legal duty. How much information must be given to the patient? What role should the physician play in the process? Which aspects of consent can be delegated to the staff?

No other aspect of medical practice raises more questions and causes more misunderstandings than informed consent. How the informed consent process is handled—or mishandled—is frequently the trigger for a malpractice claim and often the determining factor in whether a case is deemed defensible, as illustrated in this issue's lead article, **Hotline**, and **Closed Claim Study**.

OMIC's risk management staff regularly offers guidance on the process of consent in live and online seminars and makes procedure-specific consent forms available on the OMIC web site. Last year, in response to the approval of new intraocular lenses, OMIC revised its sample consent form for cataract surgery to address these IOL options and make the document more comprehensive and patient-friendly. However, many ophthalmologists called OMIC to report that they found the document too long to review with patients during a consent discussion.

As a result of this feedback, the ophthalmologists on OMIC's Risk Management Committee spent several sessions discussing and refining OMIC's position on informed consent. In an *E-Bulletin* announcement emailed to insureds in June, OMIC distributed revised physician-friendly cataract materials, which are now available at www.omic.com. These include risk management recommendations for physicians, a patient information sheet for staff to use to educate patients in detail about their choices, and a short consent document with the information that OMIC feels the surgeon should personally discuss with the patient. Over 1,500 cataract consent forms and cataract patient information sheets have been downloaded since they were posted on the web site in June.

The Risk Management Committee has recently approved a new consent template and is currently in the process of reviewing all of OMIC's current consent forms to determine which need to be revised or created. There are now more than 70 different consent documents addressing a multitude of ophthalmic procedures. Once the review process is completed sometime in late 2008, insureds will find OMIC's consent forms to be more consistent in content and format.

Message from the Chairman

continued from page 1

sufficient premium is collected to cover future claims losses and expenses. We consider the past claims experience of our insureds, our specialty, and the malpractice industry as a whole. We look at our pending claims to determine how we think each claim will be resolved and how much it will cost, depending on whether we think the claim will be dropped, dismissed, settled, or tried.

In 2003, OMIC, like other malpractice insurance carriers, experienced an upward spike in claims. At the same time, there were several open OMIC claims that, were they to go to trial and end in defense verdicts, could have cost the company millions of dollars in damages because of the severity of the complaints. Although in most of these cases our members had delivered excellent care and we were committed to mounting a vigorous defense, the legal system can be unpredictable. So we took the only prudent and responsible action at the time and collected additional premium from our insureds. As it turned out, we were extremely fortunate that OMIC's stellar defense team of claims professionals, defense attorneys, expert witnesses, and the ophthalmologists on the Claims Committee who reviewed these cases were able to resolve them favorably on behalf of our insureds at far less cost than anticipated.

It is encouraging to see what can be accomplished when ophthalmologists band together to protect our specialty. As we complete our twentieth year of insuring the ophthalmology profession, I wish to thank our 3,750 member-insureds for choosing OMIC and encourage you to share the message of our success with your colleagues.

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

Policy Issues

Who Can I Talk To?

By Kimberly Wittchow, JD, OMIC Staff Attorney

Sometimes it can be confusing, even with a small personalized insurance company, to know whom to call when you have questions. Your policy provides various benefits and imposes certain duties all requiring some type of notification. This article is designed to lead you easily to the right contact person or department to meet your needs.

Coverage Questions

Underwriting is the department that issues OMIC's policies. Underwriters are the experts to notify when you have a change in business practices or procedures performed or if you have questions regarding the scope of your coverage. They can guide you in modifying your coverage when you add or remove a partner or employee. And when you leave practice, they can discuss your options for continued coverage for not-yet-reported claims and how and when to terminate your policy. If you have an incident that affects your ability to practice or may impact your licensure, such as a disabling injury or illness or loss of privileges at a licensed health care facility, you will need to let your underwriter know. (Your policy provides that practice changes and personal incidents must be reported within 30 days of their occurrence.) Underwriters and their assistants are assigned to specific territories. Therefore, you will want to discuss your issues with your personal underwriter or assistant.

Insureds sometimes sign agreements that contain provisions requiring them to carry insurance at certain limits with certain provisions. Other contracts may indemnify the insured or require the insured to indemnify the other party. While your personal attorney should advise you on any agreements you enter into, you may also want to ask your underwriter how such a provision could affect your coverage. He or she will review that section of the contract with OMIC's in-house legal staff and give you their input.

Certificates of Insurance and Claims Reports

Insureds often need to supply proof of their coverage to hospitals where they have privileges. They also may need to present evidence of their claims experience. OMIC employs underwriting clerks to handle these requests. Requests can be made via OMIC's web site, fax, or telephone.

Confidential Risk Management

The Risk Management Hotline is available for any insured to call and discuss issues of concern in a confidential forum. A specialist is on call each day during OMIC's business hours to attend to physicians in need of advice. The queries can be general in nature, about, for example, best practices in documentation, telephone screening, or ROP screening. They can also be specific to an incident that has just occurred. For instance, an insured may have experienced a maloccurrence and want advice on the best way to discuss the outcome with the patient. The risk manager will discuss ideas and options with the insured but will not communicate this occurrence to OMIC's underwriting or claims departments.

Reporting Incidents and Claims

However, when an incident has occurred that the insured believes is likely to result in a claim, he or she must report the occurrence to the claims department in order to trigger coverage. Indications of a potential claim include threats or statements from the patient about suing the doctor. Records requests that follow maloccurrences may also indicate a potential claim. Actual claims, in the form of requests for indemnity made by the patient or his or her attorney or lawsuits filed, must be reported immediately. In addition to claims coverage, insureds also have an additional benefit providing $25,000 for the legal defense of any investigation or proceeding by a medical board arising from a patient complaint about the insured's direct patient treatment. This should also be reported to the insured's claims representative for prompt action. Because every jurisdiction has different laws and administrative requirements, claims representatives, like underwriters, are each responsible for different territories. Therefore, you will want to speak to your assigned claims representative about your potential or actual claim.

Payment Questions

Occasionally insureds have questions about their bills. They might need a breakdown of how the premium has been calculated or to inquire if a bill they paid has been received. If you have specific questions regarding your premium calculation, for instance, whether certain discounts have been applied, they should be directed to your underwriter. For more general information regarding your account, such as when your payment is due or the amount owed, OMIC's accounting department can assist you.

Risk Management Courses

One of OMIC's most valuable member benefit is its ophthalmic-specific risk management program. More than 2,400 insureds per year participate in an online, live, or CD course. OMIC's risk management coordinator is happy to assist you in learning more or signing up for a current course offering. For inquiries about risk management discounts as applied to your account, contact your underwriter.

To reach any of these departments, please call OMIC toll free at (800) 562-6642 and follow the prompts or press 0 for the operator.

My Doctor Never Told Me That Could Happen

continued from page 1

The results confirmed the authors' hypothesis that lawsuit frequency correlates with the volume of patient complaints about interpersonal aspects of care. Physicians with no claims history were perceived as "concerned, accessible, and willing to communicate," whereas those with multiple claims were viewed as "hurried, uninterested, and unwilling to listen and answer questions." In a companion article that examined quality of clinical care, SS Entmann et al found no correlation between prior malpractice history and either objective or subjective measures of quality of care.[3] This supports the Hickson findings that factors other than bad medicine are to blame for lawsuit frequency.

The central role that provider-patient rapport plays in malpractice claims was also supported by a 1994 finding by HB Beckman et al that a breakdown in patient-physician communications could be associated with over 70% of professional liability litigation.[4] Patients would rather not sue their physicians. Vincent et al note that they want their doctor to do three things after a poor outcome: explain what happened, say he or she is sorry that the patient experienced the poor outcome, and assure the patient that steps will be taken to prevent the same thing from happening to other patients.[5]

Risk management experts have suggested that much of this communication dysfunction could be avoided by engaging the patient and family in a constructive, ongoing informed consent dialogue designed to invite them to participate in their care, clarify misconceptions, and minimize unrealistic patient expectations. Rather than being a purely legal function that must be fulfilled prior to invasive procedures, consent becomes an opportunity to establish a "therapeutic alliance" between the ophthalmologist and the patient wherein each acknowledges the clinical uncertainties that exist to some degree with each medical or surgical intervention.[6] As the next section shows, forging such an alliance takes careful consideration and thoughtful communication.

What Do Patients Want?

Weighing the risks and benefits of a proposed surgery is central to the informed consent process and begins with understanding what the patient wants from surgery. CK Pager's Expectations and Outcomes in Cataract Surgery (EOCS) study analyzed preoperative expectations about outcomes and studied what led to patient satisfaction.[7] After an informed consent discussion, patients completed the Visual Function Index, known as the VF-14, and indicated what they felt their score would be after surgery. Expectations ran "unreasonably high" in the patients in this 2004 study. They anticipated achieving a mean VF-14 score of 96.1 (an 11 point gain), and fully 60% assumed they would achieve a perfect score of 100 postoperatively.

One might expect satisfaction to correlate with improvement in VF or the actual outcome. Instead, patients weren't satisfied unless they got what they expected, and those with an ocular comorbidity were most likely to be dissatisfied. When patients had expectations of reading small print, doing fine handiwork, reading a newspaper, or driving at night, they were decidedly unhappy if they had difficulty performing these tasks postoperatively. Indeed, few patients realistically achieved their goal, leading Pager to conclude that 70-year-old patients expect cataract surgery to enable them to see like 20-year-olds. Given the current advertising about the benefits of "multifocal" and "premium" IOLs, it is worth noting that these unrealistic patients all had monofocal implants, and had not been subjected to advertising promising them full recovery of their youthful vision. The only suggestion the study offered was to use the informed consent process to contribute to more accurate patient expectations.

What Do Patients Hear?

What do patients hear and understand about risk during an informed consent discussion? More pointedly, if patients expect perfect vision, how can ophthalmologists prepare them to accept not only realistic outcomes but possible complications? Unfortunately, just as prospective patients overestimate the benefits of cataract surgery, they underestimate the risks.[8] In a study by CG Kiss et al, patients were provided with a standardized informed consent document that fully explained the risks, benefits, and alternatives. When questioned after the consent discussion, patients nonetheless believed that cataract surgery was relatively easy. Fully 76% felt there was no risk of a complication; when pressed, 60% maintained that even in their own surgery, there was no risk of a severe complication. Even when they finally admitted that the risk of a severe vision-threatening complication was real, 77% did not take risk into account when making the decision to proceed with surgery. Indeed, 78% said that the discussion had no impact on their decision, while the rest reported that it only confirmed the choice they had already made.

What frustrates ophthalmologists and healthcare risk managers is that these same patients may well claim in court that the discussion never took place or that they never would have consented to the surgery if informed of the risks. The authors of the study acknowledge that some patients do lie, but feel this explanation does not account for flawed recall of the informed consent discussion. They concluded instead that when patients come to ophthalmologists with a visual

problem, they have already made a decision to have surgery in order to solve the problem and improve their vision. When confronted with what they perceive as negative objections (i.e., an accounting of associated risks), patients experience stress. Since they need to feel comfortable with their decision and minimize the stress, patients hear (and remember) what enhances a positive attitude and devalue (and forget) objections. In other words, patients "believe in and hope for the best." To counteract this cognitive dissonance and help patients take in more accurate information about the risks of treatment, patients should be given information about the procedure earlier than the day before surgery.[7]

Why Don't Patients Hear?

JE Pauling, an expert from a non-medical field who has studied how to communicate risks to the public, feels the problems lie not so much in how patients process information as in the way it is communicated to them.[9] In other professions such as aviation and nuclear energy, there is great concern about the consequences of misunderstanding. To decrease its likelihood, only a few well-trained individuals are authorized to speak to the public. They always begin their message by addressing the potential emotional impact of the message before going on to provide information in the form of visual aids.

In the medical field, almost all clinicians are called upon to communicate risk. They receive little to no training, minimize their own and the patient's emotions, and offer data with few visual aids. Poor process and training are only part of the problem, Pauling argues. Physicians want to build trust with their patients and know that it depends in part upon showing the patient that one is a good doctor. They assume that their patients know they care ("I went into medicine to help people") and focus their efforts on demonstrating their competence, calling upon science and probability to calculate comparative risks. They are quite comfortable both with accepting a certain level of risk as inherent in treatment and with the uncertain, ever-changing nature of knowledge. Patients, on the other hand, assume that physicians are competent ("she went to medical school") and watch anxiously for signs that their physician cares about them. Disregarding the data, they are only interested in hearing if the proposed procedure is or isn't safe for them and knowing the personal consequences of treatment. Moreover, patients consider any discussion of uncertainty as evidence not of competence but rather of the physician's lack of knowledge ("he doesn't know the answer").

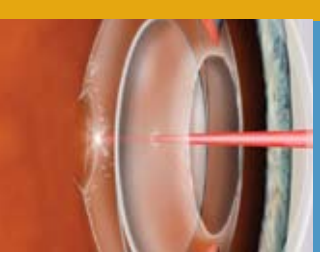
Pauling illustrates his points and begins to give some practical advice with the following example. Imagine you are an obstetrician and are trying to help a 39-year-old woman understand her risk of having a fetus with Down's syndrome. You know that it is 1.2% or 1 in 83. You provide these figures and reassure the woman that her risk is "quite low." As Table 2 shows, however, a patient's perception of quite low is different, as anything higher than 1% is actually considered a high risk. Only when the likelihood falls in the 1 in 1000 to 1 in 10,000 range is it considered by patients to be a low risk.

TABLE 2
PATIENT PERCEPTION OF PROBABILITY ODDS

DESCRIPTION	FREQUENCY	ODDS
Very high	10-100%	1 in 1 to 1 in 10
High	1-10%	1 in 10 to 1 in 100
Moderate	0.1-1%	1 in 100 to 1 in 1000
Low	0.1-0.01%	1 in 1000 to 1 in 10,000
Very low	0.01-0.001%	1 in 10,000 to 1 in 100,000
Minimal	0.001-0.0001%	1 in 100,000 to 1 in 1 million
~ Zero	< 0.0001%	1 in 1 million to 1 in 1 billion

In addition to using the same risk calculus, there are other steps physicians can take. First, use a common denominator to place the particular patient's risk in a continuum (e.g., for a 35-year-old woman, the risk of having a child with Down's syndrome is <3/1,000, and for a 40-year-old woman, it is <9/1,000). Second, to improve the likelihood of being understood, the physician can translate this information into a visual aid by using a graph available online at www.riskcomm.com. A 35-year-old woman would see a chart with stick figures for 1000 people. Three of those would be darkened to represent the number of women who will have a Down's infant. The woman would also note that the vast majority—997/1000 women in her age group—are likely to have a child without Down's syndrome. Providing both a positive and negative perspective and context enhances the message. Finally, relate the risk to one the patient knows and understands (e.g., people have a 1 in 10,000 risk of being struck by lightning or of dying from an accident in their own home).

Please go to the **Risk Management Recommendations** section of www.omic.com for an extended version of this article, including detailed suggestions for the consent process and footnote references.



Closed Claim Study

Off-Label Use of ICG Dye During Vitrectomy for Floaters

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Lack of informed consent for off-label use of ICG dye during vitrectomy.

DISPOSITION

The case settled for $30,000.

Case Summary

A patient with a past history of LASIK OU and floaters OU presented to an OMIC insured complaining that the floaters were worse OD than OS. The insured noted the patient's vision at 20/20 OU and recommended a vitrectomy. During a preoperative work up the next day, LASIK scars were discovered on both corneas. A fundus exam displayed an unusual vitreous opacity with waves of vitreous material that obscured the view of the posterior pole. The left eye displayed the same abnormal vitreous but was somewhat less significant than the right eye. A vitrectomy was performed that same day. The operative note indicated that the insured used ICG dye on two separate occasions to visualize residual vitreous and then lavaged the eye each time to remove all remaining dye. Immediately following surgery, the patient complained of a large blind spot in the center of vision on the operated eye. He was evaluated by a retinal specialist, who measured the patient's vision at 20/300 OD with no improvement. There was no other therapy available to improve the patient's visual acuity.

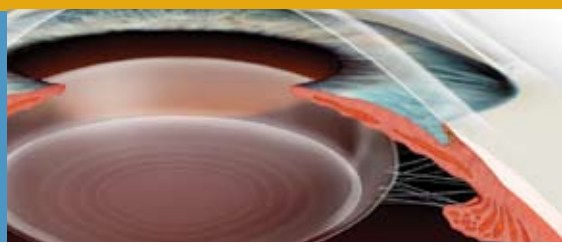
Analysis

According to the expert witnesses in this case, at the time this care was delivered, the insured's decision to perform a vitrectomy to treat floaters and use ICG dye to better visualize residual vitreous was a controversial one. Furthermore, the insured did not have a detailed informed consent signed by the patient. Rather, he had a dictated risk/benefit note in the hospital record of a conversation with the patient in which the ophthalmologist explained and the patient understood the risks of surgery, including hemorrhage, infection, retinal detachment, loss of vision, risk of cataract progression, and the visual limitations of pseudophakia. The surgeon was careful to report the patient's acknowledgment that some individuals are not bothered in the same way he was by vitreous opacities and that the surgery was being performed to address the patient's unhappiness with the quality of his vision. However, the dictated note did not address the off-label use of ICG dye and the risk of retinal toxicity. Accordingly, the patient not only alleged a lack of informed consent but also contended that the ophthalmologist minimized the risks, stating that the procedure to remove the floaters was "more simple than LASIK" and would not threaten his vision. The patient recalled only the risk of infection and the doctor's assurance that an infection could easily be treated with antibiotics. It was certainly helpful that the insured had documented the discussion in the hospital record, but the case would have been more defensible if he had also used a procedure-specific consent form signed by the patient. The absence of any documentation on the use of ICG and the patient's poor outcome supported the decision to settle the case on behalf of the insured.

Risk Management Principles

As this case and the lead article demonstrate, patients often forget or misinterpret what they are told and have a hard time recalling risks that the ophthalmologist disclosed to them during the informed consent discussion. Staff can improve patient understanding by using educational aids such as brochures, handouts, and videos. Having the patient sign a procedure-specific form can also help the defense in several ways. First, it serves as further evidence that the consent discussion took place. Second, patients can be given a copy of the form, and encouraged to read it again at home with their family and to call back if they have any questions. Finally, if patients experience a complication, physicians can use the document to help them come to terms with the outcome. In this case, the insured should have modified a procedure-specific form for vitrectomy to include information about the off-label use of ICG and asked the patient to sign it following a thorough discussion of the risks and benefits of the procedure. OMIC policyholders who need assistance developing forms that are not already available on our web site may call the **Risk Management Hotline**.

Risk Management Hotline



Obtaining Consent on the Day of Surgery

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

As the lead article suggests, helping a patient to understand the risks, benefits, and alternatives of a planned procedure is no easy task. When the consent discussion takes place on the day of surgery, new opportunities for misunderstanding and liability are introduced.

Q I perform refractive surgery at several laser surgery centers. Sometimes, I meet the patient for the first time on the day of surgery. Can the optometrist who performed the preoperative evaluation obtain the informed consent or do I have to?

A First, for elective surgeries, the discussion should take place before the day of the surgery whenever possible. Some patients who have had surgery the same day as the informed consent discussion have later sued for lack of informed consent, arguing that they were coerced into having the procedure and did not have time to weigh the risks and benefits. Second, organizations such as the AAO and ASCRS consider it the responsibility of the surgeon to determine the patient's candidacy and obtain informed consent. Third, OMIC policyholders who perform refractive surgery must comply with certain underwriting requirements, such as personally obtaining consent, as a condition of coverage. If the patient cannot be seen until the day of surgery (e.g., either the surgeon or the patient lives far away), but the type of surgery is already determined, taking a few extra steps before the day of surgery will facilitate patient understanding and ensure that consent is both informed and voluntary. Obtain information—from the referring physician or directly from the patient per telephone or questionnaire—about the patient's medical and ocular health in order to rule out contraindications to the procedure and screen for conditions that could affect the safety of the surgery or anesthesia (e.g., significant coronary artery disease, need for anticoagulants, etc.). Next, send the patient a copy of the procedure-specific consent form along with other educational information, and ask the patient to review the materials. At the time of the preoperative visit and consent discussion, address any questions or concerns, and ask the patient to sign the form. Be prepared to postpone the procedure if you are not convinced that the patient fully understands its risks and is committed to proceeding.

Q I perform oculoplastic procedures. Sometimes, on the day of surgery, the patient asks me to perform an additional procedure. Can I safely accommodate the patient's request?

A This is a risky situation, especially if the procedure is being performed for cosmetic rather than therapeutic reasons. The informed consent discussion should take place when the patient is awake and aware, free from the effects of any medication that could interfere with the patient's ability to participate in the decision-making process. Therefore, if the patient has already received any sedation, you should either perform only the planned procedure or delay the surgery until the patient can fully participate in the discussion. A change in the requested procedure may well indicate that the patient is having second thoughts about having the surgery or is confused about what he or she really wants. It is usually prudent to postpone the surgery and give the patient time to reconsider. However, if you know the patient well, and you are completely comfortable with proceeding, you should have and document an informed consent discussion, preferably in front of witnesses. Please note that most hospitals and ambulatory surgery centers now have detailed protocols in place to prevent surgical confusion such as wrong patient, site, or procedure. The facility's policies may prohibit a change in the surgical plan.

Q Isn't there a clause in hospital consent forms that authorizes me to do additional procedures? When can I rely upon that instead of obtaining informed consent on the day of surgery?

A This type of consent clause is designed to address situations that arise unexpectedly during surgery, such as when you need to perform a vitrectomy after rupture of the posterior capsule. These events call for immediate treatment to minimize harm to the patient. Indeed, failure to provide such treatment could be considered negligent management of a complication. On the other hand, if the patient has a condition that can reasonably be foreseen to require additional surgical procedures, that eventuality should be discussed during the preoperative visit. For example, patients on medications such as Flomax are now known to develop intraoperative floppy iris syndrome or IFIS. Ophthalmologists who operate on these patients must be prepared to adjust their cataract techniques and utilize mechanical expansion devices.[1]

1. For an update on IFIS, see Chang DA, Managing Intraoperative Floppy Iris Syndrome, available on the AAO web site at http://aaophp.aao.org/current_insight/managing_IFIS?from=0,0.

Calendar of Events

OMIC continues its popular risk management courses throughout 2007. Upon completion of an OMIC online course, CD recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society may earn an additional discount by attending a qualifying live 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 *(No charge for OMIC insureds)*

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

State and Subspecialty Society Online Courses

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

- *After-Hours and Emergency Room Calls (2006).*
- **NEW!** *Lessons Learned from Trials and Settlements of 2006.* (Subjects include claims resulting from a "wrong" IOL, hemorrhage during blepharoplasty, and dry eye following co-managed LASIK surgery.) Free to OMIC insureds; $60 for non-OMIC insureds.
- *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.)
- *Lessons Learned from Trials and Settlements of 2004.* (Subjects include Informed Consent for Cataract Surgery; Traumatic Eye Injuries; ASC: Anesthesia Provider, Monitoring, Discharge.)
- *Noncompliance and Follow-Up Issues (2005).*
- *Research and Clinical Trials (2004).*
- *Responding to Unanticipated Outcomes (2004).*
- *Risks of Telephone Screening and Treatment (2003).*

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

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

Seminars and Exhibits

October

19 *Liability Risks of Off-Label Medications**
New England Ophthalmological Society
John Hancock Hall,
Boston, MA
Time: 1–1:30 pm
Register with NEOS at (617) 227-6484

November

10-13 *OMIC Insurance Center*
Annual Meeting of the American Academy of Ophthalmology.
Time: 11-11:30 am
Booth #3339, Hall G
Morial Convention Center, New Orleans, LA

11 *OMIC Members Meeting*
AAO Annual Meeting
Time: 11-11:30 am
Z Morial Room #237
Morial Convention Center, New Orleans, LA

11 *OMIC Forum: Medication Safety & Liability*
AAO Annual Meeting
La Nouvelle C, Morial Convention Center, New Orleans, LA
Time: 1–3 pm
No registration required; complete attendance form at meeting. For more information, contact Linda Nakamura at (800) 562-6642, ext. 652

12 *AAOE Morning Session: Documentation of Ophthalmic Care*
AAO Annual Meeting
Room 391, Morial Convention Center, New Orleans, LA
Time: 10:15–11:15 am
Register with the AAO at http://www.aao.org/meetings/annual_meeting/index.cfm

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