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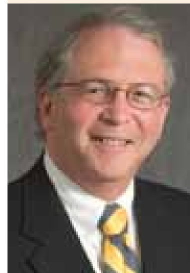
Ophthalmic Risk Management Digest

OMIC DIGEST

MESSAGE FROM THE CHAIRMAN



In this issue of the *Digest,* we review the patient safety and professional liability risks that arise when care is coordinated with optometrists and provide suggestions for minimizing these risks. OMIC's concern comes from the fact that we provide direct professional liability coverage to some 300 optometrists employed by OMIC insured ophthalmologists and cover vicarious liability exposure for approximately 35% of OMIC's 4,200 insureds who employ or contract with an optometrist.

OMIC believes that ophthalmologists and optometrists generally work well together to the benefit of patients. However, to maximize patient safety and minimize professional liability risks arising from MD/OD collaboration, we strongly recommend that the optometrist's role be defined in terms of conditions he or she can manage independently, conditions requiring consultation with an ophthalmologist, and conditions requiring management by an ophthalmologist. To assist our insureds, OMIC has developed comprehensive risk management guidelines and protocols recently published as "Coordinating Care with Optometrists." With these risk management

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Coordination of Care with Optometrists

By Hans Bruhn, MHS
OMIC Senior Risk Management Specialist

As the population of the United States ages, there is an increasing need for ophthalmic services. To meet this growing demand, ophthalmologists are relying on coordinated care with optometrists (ODs) and creating new delivery models for providing care. While physicians have always worked with other health care providers to render needed care, patients are increasingly accessing eye care initially through optometrists. A shared or coordinated care approach is evolving that utilizes the skills of optometrists and ophthalmologists in an efficient and effective manner. There are a variety of shared care models in use, some in which practice entities employ both optometrists and ophthalmologists and others in which the ophthalmologist employs the optometrist.

This issue of the *Digest* discusses the risk issues associated with the integration of patient care between ophthalmologists and optometrists. Specific liability issues associated with coordinated care models, including how your OMIC coverage will respond in the event of an allegation or claim and the use of ODs to provide after-hours call and ER coverage, are addressed. Some of the information provided focuses on the optometrist's independent and different scope of practice and the need for careful credentialing, training, and supervision. OMIC offers a variety of risk management resources to help insureds develop protocols for coordinated care, including recommendations for assessing competency and assigning responsibilities to optometrists. The goal is to provide care that is in the best interest of the patient and reduces the risk of a professional liability claim.

Whether the ophthalmologist employs optometrists in his or her practice, sets up an independent contractor relationship with them, or simply refers/receives referrals from an OD, coordinated *surgical* care (or comanagement) requires special considerations before being initiated. Professional medical organizations, government entities such as the Centers for Medicare & Medicaid Services, state medical boards, and OMIC all agree that the surgeon is responsible for preoperative and postoperative care. The American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgeons (ASCRS) have stated that sharing care for surgical patients should not

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Eye on OMIC

OMIC

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OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

Phone: (800) 562-6642
Fax: (415) 771-7087
Email: omic@omic.com
Web: www.omic.com

Timothy J. Padovese
Editor-in-Chief

Paul Weber, JD
Executive Editor

Anne Menke, RN, PhD
Managing Editor

Kimberly Wynkoop, JD
Associate Editor

Hans Bruhn, MHS
Contributing Editor

Ryan Bucsi
Contributing Editor

Linda Radigan
Production Manager

Panoramic Eyescapes by Ophthalmic Artist & Medical Illustrator Stephen F. Gordon

OMIC Reduces Premium Rates and Issues 2011 Dividend

Following another year of superior operational and financial performance, OMIC will implement a rate decrease and dividend credit for policyholders during 2011. For more than five years, OMIC has experienced a sustained decrease in the number of reported malpractice liability claims. Current levels are approximately 15% below the peak in 2003.

As a result of these favorable trends, OMIC's Board implemented a series of actions to return premium collected from policyholders that was above what was needed to prudently operate the company. OMIC continued its substantial dividend program with credits of 5%, 11%, 20%, 5%, and 10%, respectively, between 2005 and 2011. In addition, OMIC reduced premium rates by a cumulative average of nearly 25% across the country during the same period.

Few carriers in America have matched OMIC's consistent reduction in insurance-related costs for ophthalmologists. There are several reasons for this: a higher than average claims defense "win" rate and indemnity payments that average 25% lower than multispecialty carriers; educational alliances with virtually every ophthalmic society in America resulting in a risk management participation level that is one of the highest in the industry; and a vigorous selection process for OMIC eligibility.

Rates Adjusted to Reflect Claims Trends

After careful actuarial analysis of claims reported during the past decade, OMIC will adjust premium rates to better reflect claims activity. Because OMIC has experienced fewer large losses than anticipated, rates for liability limits above $1,000,000 per claim will be reduced commensurately, while rates for lower limits will increase slightly. Minor adjustments will be made to the claims-made maturity factors, and rates for Surgery Class 2 (Limited Surgery) will be reduced. Rates for employed optometrists will decrease, as detailed in **Policy Issues**.

While claims trends remain favorable overall, claims activity against entities is rising. As a result, rates for medical entities, including sole shareholder corporations insured at separate liability limits, will increase from 5% of underlying premium to 9.5% in 2011. Coverage at shared limits will continue to be offered to qualified entities without charge.

OMIC Insurance Center

OMIC will present several risk management courses at this year's AAO/MEACO annual meeting in Chicago. More information is listed in the **Calendar of Events** and online at www.omic.com. Visit the OMIC Insurance Center in booth 2957 of the exhibit hall in McCormick Place South to consult with OMIC representatives regarding policy and coverage questions, rate and dividend information, and ancillary business coverage.

Message from the Chairman

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guidelines, ophthalmologists will be able to develop written policies and procedures in compliance with their respective state laws and other office policies. This document may be found at www.omic.com/resources/risk_man/recommend.cfm.

OMIC regularly reviews and updates its underwriting requirements and risk management guidelines to keep current with changes in the education and scope of practice of optometrists. Areas of concern recently addressed by OMIC and described in the coordinating care document are risks that arise when optometrists are involved in after-hours care and ER coverage. These risks are increasing as more ophthalmology practices expect their employed or contracted optometrists to see patients after-hours and triage calls from the ER. The practice must have a protocol in place to address situations that optometrists cannot handle independently. If a practice is in a call group, it must also determine whether the other practices in the call group have their own employed/contracted optometrists taking call. If so, it is important that these practices also have a protocol in place to address the role of optometrists on call.

As coordination of care with optometrists increases, we want our policyholders to know that OMIC is supportive of comanagement so long as it is in the best interests of the patient and is carried out in a manner that minimizes unnecessary exposure to claims.

Richard L. Abbott, MD
OMIC Chairman of the Board

Coverage for Optometrists

By Kimberly Wynkoop
OMIC Legal Counsel

OMIC's mission and value commitment are to meet the specific insurance needs of the changing ophthalmic practice of members of the American Academy of Ophthalmology. Academy members often employ optometrists in their practices. Therefore, in order to provide comprehensive medical professional liability insurance for these practices, OMIC offers coverage to employed optometrists.

Optometrists applying for coverage with OMIC must fill out the *Application For Additional Insured Employed Optometrist*. If approved, the optometrist will be named on the policyholder's declarations page. The OMIC policy provides that coverage applies only to services within the scope of the optometrist's training, licensure, and employment by the employer. If the optometrist has other employment or provides activities outside of his or her employment by the OMIC insured, he or she must maintain separate coverage for that.

Optometrists are covered by OMIC for their liability due to their own actions as well as those of persons acting under the optometrist's supervision, direction, or control, so long as that person was acting within the scope of his or licensure, training, and professional liability insurance coverage, if applicable. Likewise, ophthalmologist insureds are covered for their vicarious liability exposure arising out of the actions of any persons, including optometrists (employed or otherwise), under their supervision, direction and control, so long as that person was acting within the scope of his or licensure, training, and professional liability insurance coverage, if applicable. Entity insureds and their owners are also covered for their vicarious liability for the actions of optometrists for whom they are found legally responsible.

Generally, OMIC offers coverage to optometrists at either shared limits with the employer or separate limits. Currently, the premium for shared limits is based on 5% of the ophthalmologist Surgery Class 3 premium. The premium for separate limits is 9% of the Surgery Class 3 premium. For policies effective on or after January 1, 2011, the rates will decrease to 3.5% and 6.5% of the Surgery Class 3 premium, respectively. Part-time discounts may be available for optometrists employed for fewer than 10 hours per week.

Optometrists who are not employed by insured ophthalmologists or entities must secure their own coverage from a provider other than OMIC. Optometrists who are employed by an OMIC insured but choose to obtain coverage elsewhere must maintain liability limits at least equal to the limits carried by the employing ophthalmologist or entity. Non-employed optometrists otherwise affiliated with the policyholder (e.g., via contract) are not required to carry the same limits as the policyholder, but it is recommended.

While OMIC does not require implementation of specific optometrist supervision guidelines as a condition of coverage, OMIC recommends that practices have a written protocol that clarifies conditions and situations that optometrists may manage independently, those requiring consultation with an ophthalmologist, and those that must be referred to an ophthalmologist (see the **Hotline** in this issue, as well as "Coordinating Care with Optometrists," available at www.omic.com).

Optometrists who take call must follow written protocols and have appropriate backup. An ophthalmologist must always be available within a reasonable response time to take patient referrals in the event a situation arises that exceeds the optometrist's scope of expertise or legal scope of practice. If the optometrist takes call for a hospital or emergency room, coverage is subject to review by members of OMIC's physician review panel. The optometrist must submit a copy of the hospital's written call protocol for evaluation (see "Coordinating Care with Optometrists").

Regarding postoperative care, OMIC's policy permits optometrists to provide a portion of the outpatient postoperative care if the optometrist is clinically competent and lawfully able to provide the care, the patient has given written informed consent prior to surgery for the planned comanagement, and the delegated care is performed under the operating ophthalmologist's supervision (see the lead article and "Coordinating Care with Optometrists" for more information).

Although at least one state permits optometrists to perform laser surgery, OMIC does not insure optometrists who perform surgery, whether laser or incisional. OMIC based this decision on the lack of data available on this liability risk and on OMIC's assessment that it does not have the expertise to properly underwrite, rate, and administer claims arising from surgical procedures performed by optometrists. Due to the related vicarious liability risks, OMIC is not willing to extend coverage to any policyholder that employs optometrists who perform surgery or to any outpatient surgical facility at which optometrists operate. Coverage of optometrists who perform intraocular injections (if permitted by scope of practice laws) requires physician review.

Special rules for coverage of optometrists apply in Kansas, Nebraska, and Pennsylvania due to state patient compensation fund requirements. (See your policy or inquire with your underwriter for more details.)

Coordination of Care with Optometrists

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be routinely practiced. Instead, it should only be considered when it is in the best interest of the patient for logistical reasons, e.g., when the distance to the surgeon's office makes it difficult for the patient to come in for follow-up appointments, or in cases where overall communication is improved because the patient has an established relationship and good rapport with the optometrist. Failure to meet these considerations could be considered unethical and even patient abandonment. Consider the following case.

An ophthalmologist performs laser surgery on a diabetic patient who lives in another town. Prior to surgery, the ophthalmologist suggests that the patient's postoperative care be provided by an optometrist who practices in the patient's community and who also happens to be a relative of the ophthalmologist.[1]

Such an arrangement is permissible only if the optometrist is legally entitled and professionally trained, experienced, and qualified to perform the postoperative services that the patient will need. The familial relationship between the two providers poses a potential conflict of interest that must be disclosed and consented to by the patient prior to surgery. Alternative postoperative care arrangements should be made if the patient requests them.

Medicare has specifically indicated that coordinated care should not be utilized for purely economic reasons or to accommodate a surgeon's practice schedule.[2] Though Medicare allows for reimbursement of comanaged care, physicians have been excluded from the program for inappropriate use of coordinated care.[3] The following is an example of inappropriate comanagement.

An 81-year-old female patient had a corneal transplant without complication. Due to postoperative astigmatism, the surgeon, an OMIC insured, recommended that the sutures be removed from the transplant. The insured was in the process of moving and referred the patient to an optometrist for suture removal. The optometrist removed the sutures and ordered topical steroids but no antibiotics. Three days later, the patient reported an infection. By the time the optometrist referred the patient back to the insured, all vision in the eye was lost.

Experts criticized the surgeon for failing to assess the experience level of the optometrist, who had never removed sutures before. The claim was settled for $185,000 on behalf of the insured ophthalmologist.

Comanagement Plan

If comanagement is deemed appropriate, a written plan is needed. A critical element of the plan is an independent preoperative assessment by the ophthalmologist. Are there clear indications for surgery based upon the history and physical findings? Are there any contraindications to surgery? Does the patient understand the risks, benefits, complications, and alternatives to the proposed surgery?

Even though an optometrist may recommend surgery, it is incumbent upon the ophthalmologist to conduct his or her own independent examination and confirm the need and appropriateness of surgery. OMIC requires, as a condition of coverage, that the surgeon "perform and document an independent evaluation to determine the patient's eligibility for surgery." A *personal* examination must be done by the ophthalmologist.[4]

With the need for surgery confirmed, the next step is to document precisely how and when care will be coordinated between the ophthalmologist and optometrist. OMIC's newly completed Risk Management Recommendation, "Coordinating Care with Optometrists," provides guidelines for developing protocols for comanagement. Properly developed protocols will stipulate which conditions the optometrist may manage independently, which require consultation with an ophthalmologist, and which must be referred to an ophthalmologist. The protocols assist in preventing miscommunication, delays in treatment, and patient dissatisfaction. A sample protocol is part of OMIC's recommendation on coordination of care.

Competency Assessment

To provide the best possible care to a comanaged patient, an objective assessment of the optometrist's skills and experience is critical. This will ensure that care delegated to the optometrist will be performed to the standard of care expected. Verification of skills in a comanaged ophthalmic case is the responsibility of the ophthalmologist. As the corneal transplant case illustrated, if the ophthalmologist had simply *asked* the optometrist about his experience in removing sutures, rather than *assuming* he had these skills, the infection and resulting vision loss could have been prevented. Reviewing the following criteria will help you assess the skills of another provider:

- Licensure;
- Education, training, continuing education, and experience;
- Scope of practice;
- Current competency;
- Professional liability insurance coverage;
- Details of any prior claims experience;
- Willingness to develop and abide by a protocol;
- A site visit to each other's office to observe office climate, review staff qualifications, and discuss differences in equipment used;
- Means for ongoing communication and dialogue regarding patients, concerns, availability, and educational needs.

Informed Consent

Physicians often underestimate the importance of managing patient expectations with respect to care and, more specifically, the preoperative, intraoperative, and postoperative aspects of surgery. To avoid claims of negligence, patients must be informed about their eye condition and who will be involved at each step of their care. Obtain patient consent to comanaged care prior to proceeding with surgery so complications and provider handoffs during care are not a surprise to the patient. Eliminating surprises reduces the likelihood of patient dissatisfaction and claims of negligence or abandonment. Patients can become alarmed when they arrive for postoperative visits and learn that the ophthalmologist has delegated their follow-up exam to the optometrist—regardless of the OD's skill and experience—or when their after-hours calls are directed to another provider because the ophthalmologist is not available. Eliminate these risks by taking patients through a detailed informed consent discussion of how their care will be comanaged.

OMIC requires use of a comanagement consent document in addition to a procedure-specific consent document as evidence that the patient has agreed to receive care from multiple providers (see OMIC's consent document on comanagement at www.omic.com). The surgeon must *personally* obtain the patient's consent for *both* the comanaged care and the operative care. Both consent documents should be signed by the patient and included in the patient's medical record.

Planning and Communication

Comanagement arrangements date back to the late 19th century when ophthalmologists, who had long been recognized as the sole "medical professionals" for eye care, found themselves competing for patients with non-physician providers, especially optometrists. By the 1920s, laws defining optometry as an autonomous profession separate from ophthalmology had been enacted in all states. The two professions have worked to share care appropriately ever since.

Patients can benefit from having both ophthalmologists and optometrists involved in their care, as long as there is ongoing communication and agreement on what is in the best interest of the patient. To provide the best possible outcome for the patient, a written protocol should delineate the specific duties and responsibilities of each provider. No care plan should proceed without the full knowledge, understanding, and documented informed consent of the patient.

Consent forms specifically addressing the comanagement portion of care provide a defense against allegations of miscommunication and negligence and should be part of the patient's record along with the operative care consent form. Failure to appropriately use and follow a shared care plan can lead to disciplinary action by government agencies as well as coverage issues with malpractice insurance carriers. Most importantly, comanaged care arrangements should never be motivated by financial gain, which can be deemed unethical.

CONSIDERATIONS BEFORE PROCEEDING WITH COMANAGEMENT

Reasons for Comanagement:

- Clinically appropriate and in patient's best interest?
- Necessary due to patient's proximity to optometrist?
- Good rapport between patient and optometrist?

Legal Concerns:

- Beware of kickbacks, fee-splitting, and referral prohibitions.
- Patient safety issues.

Indications for Surgery:

- Preoperative assessment by *ophthalmologist* of patient's condition and expectations of surgery as part of informed consent process.
- Prior agreement to comanagement plan by patient and providers.
- Assurance of training and qualifications of individuals involved in patient's care.

Postoperative Care:

- Optometrist avoids delays in diagnosis and treatment of complications and promptly refers patient back to ophthalmologist, if indicated. Ophthalmologist is advised of frequency and scope of patient's postoperative visits.

1. AAO's Advisory Opinion of the Code of Ethics, "Postoperative Care," June 2006.

2. AAO/ASCRS Joint Position Paper, "Ophthalmic Postoperative Care," February 2000.

3. Greene v. Bowen, 639 F. Supp. 544, D.C. Cal. 1985.

4. "Standard Refractive Surgery Requirements," June 2010, www.omic.com/products/bus_products/ref_guid.cfm.

Closed Claim Study

Misdiagnosis of a Nevus by an Optometrist Insured with Another Carrier

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to diagnose choroidal melanoma resulting in patient's death.

DISPOSITION

The case settled for $1.5 million with an arbitrator apportioning $500,000 of the settlement to an OMIC insured group.

Case Summary

A patient presented to an OMIC insured ophthalmology group for a routine eye examination. The patient was examined by an optometrist who was employed by the group but who maintained separate professional liability insurance with another carrier. During the examination, the optometrist identified a nevus on the patient's right eye. A diagram of the nevus was drawn in the patient's chart, and the optometrist instructed the patient to return in one year. The patient returned on an emergency basis about 11 months after the initial exam, complaining of an inability to see out of a portion of the right eye. During this visit, an ophthalmologist examined the patient, diagnosed a choroidal melanoma, and immediately referred the patient to a retinal specialist for a same-day consult. The retinal specialist confirmed the diagnosis and sent the patient to a local specialist for treatment. The melanoma measured 16 x 17 mm with a height of 7 mm. Despite treatment for the melanoma, the patient died approximately three and a half years following the initial examination by the optometrist.

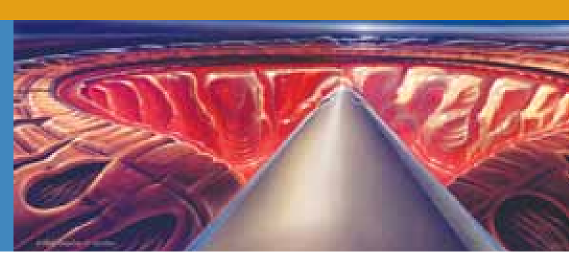
Analysis

The optometrist testified during deposition that although the nevus was not suspicious, she had ordered a fundus photograph. The medical record contained neither a fundus photograph nor a record of a bill for a fundus photograph. Plaintiff experts opined that the optometrist failed to diagnose a suspicious nevus, failed to take a fundus photograph, and failed to advise the patient to return in three months. Plaintiff experts also opined that the group was negligent for failing to properly train and supervise the optometrist. Furthermore, plaintiff experts felt the group fell below the standard of care by not notifying the patient that she was being treated by an optometrist and not an ophthalmologist. There was no formal training program or written protocols at the OMIC insured group office. Physicians there stated that they were comfortable with the competence of the optometrist based on her five years of experience. The defense had trouble finding experts to support the care rendered by the optometrist and the group. In addition, the defendants could not establish a causation argument. Melanoma experts opined that the size of the tumor at the time of diagnosis indicated that it was likely present but missed on the initial exam by the optometrist. Without a fundus photograph, the defense could not argue to the contrary. A settlement of $1.5 million was reached, but OMIC and the other carrier could not agree on how the liability should be apportioned. A binding arbitration was scheduled; the only agreement going into arbitration was that neither carrier would be required to pay over its $1 million policy limit. The arbitrator ruled that the optometrist was 70% liable and OMIC's insured group was 30% liable. Since 70% of $1.5 million exceeded the co-defendant's policy limits, the other carrier paid $1 million and OMIC paid the remaining $500,000.

Risk Management Principles

Optometrists and ophthalmologists have different scopes of practice and competencies. While some eye conditions can be managed independently by optometrists, others require consultation with, or management by, an ophthalmologist. Eye conditions that can lead to severe vision loss, systemic disease, or death are best managed in consultation with an ophthalmologist. In this case, the role of the employed optometrist was not well defined by the OMIC insured group and there was no formal training, ongoing evaluation of her competency, or written protocols. The optometrist felt the nevus was non-suspicious so she did not consult with the ophthalmologist during her one and only examination of the patient. As this case demonstrates, communication between a group's optometrists and ophthalmologists is, at times, critical in order to achieve optimal patient care. Risk management experts at OMIC recommend that the optometrist's role be defined in writing in terms of what conditions he or she can manage independently, what conditions require consultation with an ophthalmologist, and what conditions require management by an ophthalmologist (see this issue's **Hotline** column and "Coordinating Care with Optometrists," available at www.omic.com, for a more detailed discussion and sample protocol).

Risk Management Hotline



Issues Associated with Therapeutic Optometry

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

According to the American Academy of Ophthalmology, about half of all ophthalmology practices now include an optometrist and nearly all see patients referred by optometrists (ODs). Traditionally, the practice of optometry was "medicine-free." Nationwide, between 1971 and 1989, optometrists (ODs) lobbied for, and were granted, the legal authority to use topical medications for diagnostic purposes. A second wave of legislative efforts from 1976 to the present resulted in limited prescriptive authority for optometrists in some states, and the development of "therapeutic optometry."

Q My group wants to hire an optometrist. How do I determine what care he or she can provide?

A Patient situations handled by ODs fall into three categories. The first category includes those types of care that the legal scope of practice allows optometrists to provide independently (e.g., refraction and prescribing glasses and contact lenses). In the second category, optometrists with additional types of training and certification may diagnose and treat patients with more complex eye conditions. Depending upon state law, they may be required to consult with an ophthalmologist in certain situations. Finally, there are patients who need to be referred to an ophthalmologist for diagnosis or management (e.g., patients with cataracts or retinal detachments). Your state's optometric practice act defines the legal scope of practice. It also details the education, training, and certification required for optometrists to diagnose and treat ocular conditions, and usually includes a list of the therapeutic agents they may prescribe and procedures they may perform. Ask the optometrist to provide you with a copy of his or her license, certification, and optometric practice act and verify the licensure/certification directly with the optometric board. You may also wish to contact your state ophthalmology society to obtain a copy of the current regulations and any guidance papers. Contact your underwriter if the optometrist is endorsed on your policy and you have questions about coverage for certain procedures.

Q Am I required to supervise the therapeutic optometrist in my practice?

A Not as a general rule. Unlike allied health professionals such as physician assistants and nurse practitioners, optometrists have an independent scope of practice that does not require supervision by a physician. OMIC's Postoperative Care Exclusion and Refractive Surgery Requirements, however, state that postoperative care that is comanaged with an optometrist must be provided under the surgeon's supervision (see the lead article, "Comanagement of Surgical Care," as well as "Coordinating Care with Optometrists," which is available at www.omic.com). Again, these rules do vary between states and there may be state-specific comanagement requirements regarding training, equipment, and communication.

Q Are therapeutic optometrists required to consult with ophthalmologists and other physicians?

A Consultations may be required by law or by the standard of care. As noted above, some state optometric practice acts mandate consultations with ophthalmologists or appropriate physicians/surgeons in certain situations. For example, California requires therapeutic optometrists to consult with an ophthalmologist if a patient younger than 16 has glaucoma, and when patients on topical steroids or those with diseases such as episcleritis, herpes simplex infection, or glaucoma are worsening or not responding to treatment. Texas requires therapeutic ODs to consult with an ophthalmologist after an initial diagnosis of glaucoma, and on any patient whose glaucoma is not responding appropriately to treatment. Texas law also requires ODs to refer patients to a physician before prescribing beta blockers if the patient has not had a physical examination within 180 days.

Q If our state law is does not provide guidance, how can we decide on the need for consultation?

A Consider situations that could lead to patient harm or liability. Just as with ophthalmologists, the standard of care requires optometrists to seek a consultation or referral when the patient's condition requires diagnostic or therapeutic skills beyond one's scope of practice, competency, certification, or training. Consideration might be given to conditions that could lead to severe, imminent vision loss or death, eye conditions associated with a systemic condition (e.g., giant cell arteritis, rheumatoid arthritis, multiple sclerosis, and patients with neurological abnormalities), patients who are not improving or worsening, and cases where there is unexplained vision loss or no clear-cut diagnosis.

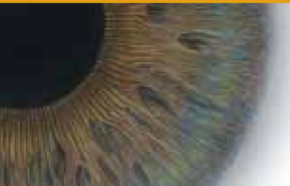
Q The new optometrist in my practice seems uncomfortable asking questions and I worry that he won't come to us for advice.

A The best protocol in the world will be ineffective if the practice does not nurture an environment where all members of the health care team feel safe enough to ask questions and seek advice. It may be helpful to hold regular meetings where all have the opportunity to address difficult or interesting patient situations and seek input from others. Modeling an open discussion might encourage your new colleague to be more forthcoming.

OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610



Calendar of Events

OMIC continues its popular risk management programs throughout the fall. Upon completion of an OMIC online course, CD recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are listed below and 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.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management programs or to register for online courses.

Upcoming Seminars

October

2 *Evaluating Competency; Handling Incompetency*
Table Rock Regional Meeting for AOS*, KSEPS*, MoSEPS*, OAO*; Big Cedar Lodge, Branson, MO; 10:30–11:30 am. Register with AOS at (501) 224-8967 or www.tablerockroundup.org.

15 *Documentation and Consent Process in the ASC/OR*
ASORN Annual Meeting at AAO/MEACO Annual Meeting; Grand A/B at McCormick Place, Chicago, IL; 1:00–2:00 pm. Register with ASORN at www.asornannualmeeting.org.

16 *ACE Program: Liability Review for OMP (Course 11SA2)*
JCAHPO Annual Continuing Education Program for Ophthalmic Medical Personnel; Hilton Hotel, 720 South Michigan Ave, Chicago, IL; 9:10–10:05 am. Register with JCAHPO at www.jcahpo.org/ACE2010/default.aspx.

17 *ROP Screening & Treatment: What You Wanted to Know, But Were Afraid to Ask (Course 211)*
AAO/MEACO Annual Meeting; Room S50-BC, McCormick Place, Chicago, IL; 2:00–3:00 pm. Register with AAO at www.aao.org.

17 *OMIC Forum: Retina Closed Claims Study*
AAO/MEACO Annual Meeting; North Hall B, McCormick Place, Chicago, IL; 2:00–4:00 pm. General AAO meeting registration at www.aao.org. Register onsite in presentation room. Contact Linda Nakamura at (800) 562-6642, ext. 652.

18 *Focused Chart Audit (Course 349)*
AAOE Annual Meeting; Room S105-A, McCormick Place, Chicago, IL; 9:00–11:15 am. Register with AAOE at www.aao.org/aaoesite/index.cfm.

18 *Informed Consent for Our Older Patients: An Ethical Field Guide (Symposium)*
AAO/MEACO Annual Meeting; Room S406-A, McCormick Place, Chicago, IL; 11:30 am–12:30 pm. Register with AAO at www.aao.org.

18 *Why Take the Risk? How to Create An Effective Risk Management Strategy with Patient Education and Informed Consent Documents (Course SPE43)*
AAOE Annual Meeting; Room S403-B, McCormick Place; 12:45–1:45 pm. Register with AAOE at www.aao.org/aaoesite/index.cfm.