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OMIC DIGEST

Ophthalmic Mutual Insurance Company

Ophthalmic Risk Management Digest

Anesthesia and Sedation Risks and Precautions

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Advances in science, technology, and training, combined with reimbursement pressures by third party payors, have had the effect of moving the vast majority of ophthalmic procedures from hospitals to freestanding ambulatory surgery centers (ASCs) and office-based facilities. While this change has generally benefited ophthalmologists and their patients, there are concerns about compromised patient safety and increased physician liability when sedation and anesthesia are administered outside the hospital setting. The first section of this article outlines several risk avoidance practices that can help ophthalmologists, especially those operating in office-based settings, maximize patient safety and minimize sedation and anesthesia-related liability risks.

In some cases, sedation or anesthesia may be administered by an anesthesiologist or other qualified anesthesia provider, such as a certified registered nurse anesthetist (CRNA). Federal and state guidelines often require that in hospital and ASC settings, the treating surgeon supervise the CRNA. The second section of this article addresses the surgeon's supervisory role and how it affects liability risk.

While hospitals and ASCs are typically closely regulated by accrediting agencies, the office-based surgical setting is currently only regulated in a handful of states. If surgeons do not follow reasonable and published guidelines for office-based surgery and sedation, there is an increased risk that procedures may be performed in settings lacking the appropriately educated and trained clinical staff and/or sufficient equipment and emergency protocols to handle adverse reactions to sedation or anesthesia or other emergencies that may arise. Administering sedation and anesthesia without adequate experience or equipment can have devastating consequences.

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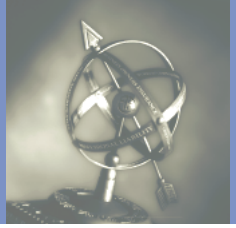

Eye on OMIC

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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Major Enhancements to OMIC's Fraud and Abuse/ HIPAA Privacy Policy

Since early 1999, OMIC has provided its professional liability insureds with free legal reimbursement coverage up to $25,000 for fraud and abuse allegations related to physician billing practices as an added benefit of maintaining malpractice insurance through OMIC. Over the past six years, the policy has been broadened several times to include coverage for HIPAA privacy violations, civil proceedings, qui tam (whistleblower) allegations, and private payor billing investigations. Coverage for fines and penalties at higher limits has been available for an additional premium since 2000.

Due to the increasing vulnerability of physicians to fraud and abuse and HIPAA privacy claims, OMIC is further enhancing its policy for 2005. Effective 1/1/2005, all OMIC professional liability policyholders will be provided with a free $25,000 Fraud and Abuse/HIPAA Privacy policy, *including coverage for fines and penalties.* Standard and higher limits will continue to be available for all members of the American Academy of Ophthalmology to purchase *at the same competitive rates as 2004,* only now coverage for fines and penalties is included under all policy forms at no additional charge. Also effective 1/1/2005, coverage for Emergency Medical Treatment and Active Labor Act (EMTALA) claims will be included under the policy, *also at no additional premium.*

These policy changes come in response to the U.S. Office of Inspector General's announcement that it intends to increase the number of independent and objective audits, evaluations, and investigations conducted as part of the Health Care Fraud and Abuse Control Program to an all-time high in 2005. In addition to improper coding and billing fraud, specific focus will be given to the following areas:

- Arrangements between physicians and other Medicare providers and billing services companies and how they affect physician billing practices.
- Medicare reimbursements for services billed by physicians who receive remuneration from the Department of Veterans Affairs for time reported as being "on duty" at a VA hospital.
- Arrangements and related billing practices initiated by physicians for pathology services both within and outside their medical offices.
- Appropriateness of "long distance" claims involving billing of face-to-face physician encounters when there is a significant distance between the patient's home and the practice setting.
- Medicare reimbursements to entities billing as "provider based" rather than "freestanding" organizations.
- Improper payments to physicians previously excluded from federal health care programs.

OMIC professional liability policyholders will automatically receive their enhanced fraud and abuse policy in late January and can purchase additional coverage to supplement the free $25,000 standard policy. For more information on purchasing standard coverage (non-OMIC Academy members only) or higher limits (both OMIC and non-OMIC Academy members), please contact MRMI, the plan administrator, directly at (800) 610-OMIC (6642).

Protecting Your Practice: What You Need to Know About Insurance

Responding to requests for resources to help ophthalmologists and administrators better understand and manage the insurance needs of the ophthalmic practice, OMIC and the American Academy of Ophthalmic Executives, a partner of the American Academy of Ophthalmology, have collaborated on an insurance resource guide for their members. Authored by Robert Widi, OMIC's Manager of Member Services and Sales, this 36-page module leads ophthalmologists and administrators through the process of choosing insurance coverage for professional liability, fraud and abuse, employment practices, business owners, and workers compensation. *Protecting Your Practice: What You Need to Know About Insurance* is a detailed guide to assessing your risk profile, identifying your exposure to litigation, understanding policy types, evaluating carriers, and applying for coverage. It can be purchased through the AAO for $25 for members and $40 for nonmembers. To order, call (888) 393-3671 or go to **www.aao.org/store**.

Advertising for Medical Services

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

Allegations related to physician advertising are surfacing with increasing regularity in medical malpractice claims. In addition to alleging lack of informed consent, patients are using state consumer protection laws to claim that the physician defrauded them. This exposes the physician to punitive damages and other uninsured risks.

Physician advertising is regulated by state law as well as by the Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) under provisions of the Food, Drug, and Cosmetic Act and the Federal Trade Commission Act (FTCA). The American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) have issued guidelines to advise their members on relevant ethical and professional standards.

Advertising "includes any oral or written communication to the public made by or on behalf of an ophthalmologist that is intended to directly or indirectly request or encourage the use of the ophthalmologist's professional medical services … for reimbursement" (ASCRS Guidelines). These guidelines therefore apply to print, radio, and television advertisements as well as to informational brochures, seminars, videos, and the internet.

The FTCA prohibits deceptive or unfair practices related to commerce and "prohibits the dissemination of any false advertisement to induce the purchase of any food, drug, or device." The FTCA and the professional guidelines state unequivocally that advertising for medical and surgical services must be truthful and accurate. It cannot be deceptive or misleading because of (1) a failure to disclose materials facts, or (2) an inability to substantiate claims – for efficacy, safety, permanence, predictability, success, or lack of pain – made explicitly or implicitly by the advertisement. It must balance the promotion of the benefits with a disclosure of the risks *and be consistent with material included in the informed consent discussion and documents*.

Lack of Informed Consent Allegations

When not carefully crafted, advertising runs the risk of overstating the possible benefits of a procedure and potentially misleading patients into agreeing to undergo surgery without fully understanding or appreciating the consequences and alternatives.

In a sense, an advertisement becomes a ghost-like appendage to boiler-plate informed consent forms. If an advertisement overstates the benefits, misrepresents any facts, or conflicts with other consent documentation or patient education material, it can potentially make a jury believe the physician may have overstepped the line of ethical propriety by creating unrealistic patient expectations. Legally, such a scenario might allow a jury to conclude the patient was not given a full and fair disclosure of the information needed to make a truly informed decision.

Punitive Damages and Other Uninsured Risks

Another pitfall for the ophthalmologist who markets medical services are state laws that may allow the plaintiff to ask for punitive damages, which could double or treble the amount of money awarded to the patient by the jury. Physicians should be particularly concerned about such allegations since most professional liability insurance policies, including OMIC's, do not pay for such damages.

OMIC's underwriting guidelines state that advertisements and marketing materials must not be misleading, false, or deceptive and must not make statements that guarantee results or cause unrealistic expectations. In addition, insureds are required to abide by FDA- and FTC-mandated guidelines and state law. OMIC has specific policy language limiting its professional liability coverage to defense costs for claims related to misleading advertisements. No payment of indemnity will be made.

Therefore, if a plaintiff is alleging medical malpractice and has an added allegation of fraud, your OMIC policy will provide defense for both the allegation of malpractice and fraud but would limit any indemnity payment to awards related to the medical malpractice allegation of the lawsuit.

Review of Advertisements

OMIC has developed tools to prevent and/or minimize the risk of these complex cases in the first place and strongly encourages its insureds to evaluate their own advertisements for compliance with policy guidelines. For online assistance, visit OMIC's web site at **www.omic.com/resources/risk_man/recommend.cfm.** Under *Advertisements for Medical/Surgical Services*, you will find a "Review of Advertisement" form to help identify aspects of your advertisement that may be misleading or deceitful. OMIC policyholders who have additional questions or concerns about advertising may contact the Risk Manager at (800) 562-6642, ext. 651.

Anesthesia and Sedation Risks and Precautions

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Precautions for In-Office Procedures

The decision to perform a procedure in an office-based setting should only be made after careful evaluation. The surgeon is responsible for conducting or reviewing an appropriate physical exam and formulating and prescribing a written patient-specific plan for sedation or anesthesia care that addresses fasting requirements and treatment locale. Because it is impossible to accurately predict how each patient will respond to sedation or anesthesia of any type, and given the fact that the physician and office staff may be called upon to rescue the patient if an adverse reaction occurs, all staff should be thoroughly trained in emergency treatment protocols. The surgeon and other clinical support staff should be certified in Basic Life Support (BLS); Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification is ideal.

To address patient safety concerns, the physician must have an adequate number of competent, professional staff members available to monitor the patient during the sedation. The person responsible for monitoring the patient during the procedure cannot be the same one performing it. This person should be familiar with the medications used; know how to recognize airway obstruction and correct it; know how to monitor the required parameters, recognize abnormalities in them, and intervene; and be able to manage ventilation with a self-inflating bag valve mask. Additionally, all staff members who will be involved in patient care duties must meet all licensure and certification requirements; have sufficient experience to perform their duties; and be supervised by the operating surgeon or other licensed physician throughout the peri, intra, and postoperative/anesthesia periods.

Upon completion of the surgical procedure, the ophthalmologist who administered or medically directed the sedation should evaluate the patient prior to transferring the care to a qualified licensed nurse. The nurse assuming care of the patient should be qualified to identify surgical and sedation or anesthetic complications that might occur during the postoperative period. The patient should be sent home only after discharge criteria are met and in the company of a competent adult. (For more information on office-based sedation, see **Hotline** article.)

Supervision of CRNAs at Hospitals and ASCs

In ASC and hospital settings, ophthalmologists are often required to supervise nurse anesthetists and sign various anesthesia-related orders, evaluations, and reports. This has raised questions about the ophthalmologist's exposure to claims based on the actions of the CRNA.

Under federal law, it is a condition of participation in the Medicare and Medicaid programs for ASCs that a non-physician anesthetist be under the supervision of the operating physician. The requirement for hospitals varies slightly in that a CRNA must be under the supervision of the operating practitioner or an anesthesiologist who is immediately available if needed.

States may request that their ASCs and hospitals be exempted from this supervision requirement. According to the American Association of Nurse Anesthetists' web site, however, the only states that had opted out of the federal supervision requirement as of November 2004 were Alaska, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, and Washington. If your state is not on this list, there is likely a state law that either mirrors or expands upon the federal provision. See your state government, state medical society, or nurse anesthetists' association web sites for more information.

Proving Supervision Has Occurred

The Centers for Medicare & Medicaid Services (CMS) do not define or specify how to prove supervision. Nevertheless, having the supervising physician sign certain anesthesia orders, evaluations, or records may be the simplest way for the ASC or hospital to confirm that supervision has occurred.

It is OMIC's understanding that the role of the treating physician, in relation to the provision of anesthesia services, is to (1) determine whether a patient requires the surgery or diagnostic procedure, (2) request that anesthesia be administered, and (3) determine that the patient is an appropriate candidate for the procedure and anesthesia. Therefore, it is not uncommon for the treating physician to be asked to sign perioperative orders for anesthesia, sedation, and anxiolytic drugs and to co-sign the pre-anesthesia evaluation conducted by the nurse anesthetist in addition to signing the record of the operation prepared by the circulating nurse as well as the dictated operative report. It is less common, however, for the surgeon to sign the anesthesia record. If asked to do so, the ophthalmic surgeon may wish to clarify with the ASC or hospital the reason for this requirement, since proof of the surgeon's presence and/or supervision during the procedure should be ample from the aforementioned signed orders, co-signed pre-op evaluation, and/or operative records.

Liability for the Actions of CRNAs

Depending on state law, you may be held vicariously liable under the doctrine of "respondeat superior" for the actions of nurse anesthetists

who are your employees. Also termed the "master-servant rule," this doctrine holds that an employer is liable for the employee's wrongful (or negligent) acts committed within the scope of employment.

If you supervise nurse anesthetists who are not your employees, however, you are not necessarily liable for their actions. Courts generally focus on the amount of control the treating physician exercises over the anesthesia provider to determine whether the physician should be liable for the anesthetist's actions (whether the anesthetist is a CRNA or an anesthesiologist). The fact that you sign certain anesthesia orders, evaluations, or records might be used by a plaintiff's attorney to attempt to prove control, but without further evidence, it would doubtfully be sufficient.

Similarly, the fact that you are required to supervise nurse anesthetists' provision of services during a procedure does not, by itself, create an employer-employee relationship, nor does it prevent you from maintaining independent contractor relationships with them (or no formal relationships at all, such as in a hospital setting). The substance of the relationship, not the label, governs the nurse anesthetist's status as an employee or independent contractor. In order to determine whether a CRNA would be considered an employee, there are several factors to consider:

- Do you have a right to direct and control how the nurse anesthetist does the task for which he or she was hired? An employee is generally subject to the employer's instructions about when, where, and how to work.
- Does he or she bill separately for his or her own services? Independent contractors are more likely than employees to have non-reimbursed expenses and to bill separately for their own services.
- Is there a written contract describing the relationship of the parties? Do you provide the nurse anesthetist with benefits, such as insurance, a pension plan, vacation pay, or sick pay? Is his or her compensation subject to withholdings for income taxes, unemployment, or workers' compensation? Whether under contract or not, an employee often will receive benefits and his or her compensation is subject to withholdings.

An ophthalmologist's supervision of one portion of the nurse anesthetist's provision of services is not determinative of the nurse anesthetist's employment status. Rather, it is only one of many factors used to determine the nature of the relationship.

OMIC's policy covers its insureds for liability arising from the supervision of nurse anesthetists (subject to all policy conditions and exclusions). It is your decision whether to seek less responsibility for CRNA supervision at ASCs or hospitals.

Monitoring and Recovery Equipment for Office-Based Anesthesia

If an anesthesia-related emergency arises during ophthalmic surgery, immediate access to the appropriate monitoring and recovery equipment could mean the difference between life and death. All clinical staff should be trained in the proper use of this equipment. The American Society of Anesthesiologists' (ASA) Guidelines for Office-Based Anesthesia (available at **www.asahq.org**) include the following provisions about appropriate office-based monitoring and recovery equipment:

1. At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment, and emergency drugs.

2. There should be sufficient space to accommodate and allow easy access to all necessary equipment and personnel.

3. All equipment should be maintained, tested, and inspected according to the manufacturer's specifications.

4. Back-up power sufficient to ensure patient protection in the event of an emergency should be available.

5. There should be appropriate anesthesia monitoring equipment consistent with ASA Standards for Basic Anesthetic Monitoring and documentation of regular preventive maintenance as recommended by the manufacturer.

6. Where anesthesia services are to be provided to infants and children, the required equipment, medication, and resuscitative capabilities should be appropriately sized for a pediatric population.

Emergencies and Transfers

In the event of an emergency requiring transfer to a hospital, the office-based facility must have:

1. Written emergency and evacuation protocols, including provisions for cardiopulmonary emergencies and disasters such as fire, weather-related events, and terrorist actions. All staff should be appropriately trained in these protocols.

2. Medications, equipment, and written protocols in place to treat adverse reactions such as malignant hyperthermia.

3. A written transfer agreement with a hospital.

Globe Perforation and Vision Loss in High Myopic, Deaf Patient

By Paul Weber, JD
OMIC Vice President

Allegation

Negligent choice of anesthesia and failure to communicate patient history to anesthesiologist, resulting in globe perforation and loss of vision.

Disposition

Settled with indemnity payments on behalf of the insured ophthalmologist and codefendant anesthesiologist.

Case Summary

A 36-year-old deaf male was referred to the insured for cataract surgery. He presented with cataracts OU and myopic degeneration. VA was 20/400 OD and 20/60 OS in a dark room and 20/100 OS with the lights turned up to normal. The patient elected to have cataract surgery on the left eye only because there would have been little to gain from surgery on the right eye. The risks and benefits of surgery were discussed using a sign language interpreter with the patient and his wife. They were informed of the risk of complete loss of vision and/or loss of the eye with surgery, including the significantly greater risk of retinal detachment (RD) due to high myopia. The insured maintains that prior to surgery he informed the anesthesiologist that the patient had the longest eye he had ever encountered and that special care needed to be taken with the peribulbar injection.

Delivery of the anesthesia and surgical procedure proceeded uneventfully. On the first day post-op, when a vitreous hemorrhage was noted by the insured, the patient was immediately referred to a retinal specialist. The diagnosis was a posterior perforation in a mid-equatorial staphyloma from the anesthetic injection, resulting in a posterior RD. The RD was repaired the following day, but the patient developed a hyphema, a vitreous and subretinal hemorrhage, and a recurrent detachment postoperatively. Although the second reattachment was successful, post-op VA was light perception only.

The patient claimed that loss of vision resulted in loss of independence. He asserted that prior to surgery he was self-sufficient and independent, but afterwards he could no longer leave the house by himself, ride his bike, or walk to work. As a result of his vision loss, the plaintiff claimed his marriage ended and he was forced to move in with and become completely dependent upon his mother.

Analysis

The medical records reflected appropriate informed consent and no deviation in the insured's surgical decision-making or technique. The ophthalmologist maintained that the risks of general anesthesia outweighed the risks of local anesthesia because, regardless of the shape of the eye, there is always space to safely place a peribulbar injection without perforating the globe if the physician stays outside the muscle cone. Unfortunately, the anesthesiologist entered the papilomacular bundle during administration of the peribulbar block and pierced the globe.

Several issues made defense of this case difficult. The anesthesiologist alleged that the insured did not fully inform him about the extent of the patient's eye abnormalities. If he had, the anesthesiologist claimed he would not have performed a peribulbar block. Defense experts argued that the patient should have been offered the option of general anesthesia given the extreme myopia of his eye and the fact that deafness is a relative contraindication to a peribulbar block. Additionally, the patient's staphyloma was not documented in the medical record and there was a discrepancy between the axial length determined by the MRI (27mm) and the axial length determined by the ultrasound (35mm). Furthermore, a PAM (Potential Acuity Meter) test was never performed, and there was no evidence that cataract surgery would have benefited this patient.

Risk Management Principles

Documentation of eye abnormalities must be meticulous; discrepancies between test results must be resolved before surgery; and diagnostic procedures must be thorough. The final determination as to what type of anesthetic to use should be made jointly by the anesthesiologist and the ophthalmologist, taking into consideration the patient's medical status and any significant ocular abnormalities. Documentation should include the medical reasons for the choice of anesthesia. Discussions with a hearing and visually impaired patient regarding the risks and benefits of eye surgery and anesthesia options and the signing of consent forms should take place at least one day prior to surgery. On the day of surgery, the patient should again verify that he/she has made an informed decision.

Pediatric Sedation for Office-Based Procedures

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

Ophthalmologists are performing an increasing number of diagnostic and therapeutic procedures in office settings. While most of these are done under local anesthesia, some require sedation and analgesia both in order to accomplish the procedure and to ensure the comfort of the patient. There are important safety concerns when care traditionally rendered by anesthesiologists or CRNAs in hospitals with back-up emergency staff and equipment is provided by non-anesthesia personnel in offices. Using administration of chloral hydrate (CH) to pediatric patients as an example, this article will address some of the risks of office-based sedation and offer recommendations for reducing them.

Q The practice I joined administers chloral hydrate to pediatric patients in order to conduct examinations. Is CH considered safe?

A While CH is widely used "off label" for the sedation of infants and toddlers and has a reputation as a safe medication with minimal effects on respiration, an analysis of adverse pediatric sedation incidents found that 13 out of 60 cases resulting in death or permanent neurologic injury involved the use of chloral hydrate alone or in combination with other medications.[1] Factors contributing to the outcomes included overdosage, administration at home, administration by non-medically trained personnel (technicians), and premature discharge from medical observation. Unlike some opioid medications used for sedation, CH has no known reversal agent, and a very long half-life in children (27.8 +/- 21.3 hours in newborns, 9.7 +/- 1.7 hours in toddlers). Without the stimulation of the examination, the sedating effect returned; children suffered respiratory compromise that went unnoticed by the parent, often during the car ride home.

Q Could the deeper level of sedation be prevented by giving the correct dose?

A Not necessarily, since some of the children who were injured had received the appropriate amount. As the American Society of Anesthesiologists' "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" warns, sedation is a continuum. Four levels have been identified, based upon responsiveness, the airway, spontaneous ventilation, and cardiovascular function: minimal sedation (anxiolysis), moderate (formerly known as "conscious sedation"), deep sedation, and general anesthesia.[2] The Guidelines clarify that since it is not always possible to predict how an individual patient will respond, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper and causes hypoventilation, apnea, airway obstruction, or cardiopulmonary impairment.[3] Proper monitoring can detect these problems, but the training and expertise needed to recognize these complications and rescue the patient from them are usually not part of the skill set of most ophthalmic personnel. Accordingly, CH is usually administered only in the hospital setting. Increasingly, it is being replaced by reversible IV agents that also provide better pain relief.

Q What measures should I take to protect children receiving sedation?

A Ask the anesthesiology department of your local hospital to help you devise an office-based sedation protocol that addresses drug and patient selection criteria, dosing regimen based upon the child's weight, NPO (nothing by mouth) guidelines, monitoring and discharge criteria, and rescue practices and equipment (see also the ASA and AAP guidelines referenced in the footnotes below). The order for the medication should include the child's weight, the mg/kg dose, and the total dose to be administered. Never allow pre-procedure administration at home. After the procedure, observe the child in a quiet monitored area, even if he or she seems to be completely awake immediately after completion. This is especially important when using medications with long half-lives (chloral hydrate, promazine, promethazine, chlorpromazine, phenobarbital).[1] Use only qualified personnel whose training and competency include cardiopulmonary assessment, airway management, and resuscitation to monitor the child during and after the procedure and to determine if the child meets discharge criteria. Provide oral and written discharge instructions for the adult accompanying the child home that address expected behavior, eating, warning signs of complications, special instructions in case of an emergency, and how and when to contact you.[2, 3]

1. Cote, Charles J et al. "Adverse Sedation Events in Pediatrics: Analysis of Medications Used for Sedation." *Pediatrics* 2000: 106; 633-644.
2. American Society of Anesthesiologists. "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists," approved 17 October 2001, available online at **www.asahq.org/publicationsAndServices/sedation1017.pdf**. See also the ASA "Sedation Model Policy" at **www.asahq.org/clinical/toolkit/sedmodelfinal.htm**.
3. American Academy of Pediatrics, Committee on Drugs. "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures." *Pediatrics*, v. 89, n. 6, June 1992. See also American Academy of Pediatrics, Committee on Drugs, "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: Addendum." *Pediatrics*, v. 110, n. 4, October 2002.

Calendar of Events

OMIC continues its popular risk management courses this winter. Upon completion of an OMIC online course, audioconference, or seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society may earn a 10% discount by attending a qualifying cosponsored event (indicated by an asterisk). The 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

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

Audioconference CDs

OMIC has made CD recordings of the following audioconferences. Insureds who complete an OMIC evaluation form after listening to one of these CD recordings will be eligible for a 5% premium discount and CME credit.

- *Research and Clinical Trials: Patient Safety and Liability Risks.* Nationwide Audioconference. August 11, 2004.

These state-specific CD recordings are only available to insureds in these states.

- *Responding to Unanticipated Outcomes.* California Academy of Ophthalmology/OMIC.*
- *Responding to Unanticipated Outcomes.* Louisiana Ophthalmology Association/OMIC.*
- *Responding to Unanticipated Outcomes.* Washington Academy of Eye Physicians and Surgeons/OMIC.*

Order forms can be downloaded from the OMIC web site at **www.omic.com/resources/risk_man/seminars.cfm**

Upcoming Seminars

January

29 *Responding to Unanticipated Outcomes*
Colorado Society of Eye Physicians and Surgeons (CSEPS)
Great Divide Lodge, Breckenridge, CO
9:45-10:45 am
Register with Laurel Walsh at (303) 832-4900 or laurel@coloradoeyemds.com

March

4 *What to Disclose and When–Patient-Physician Communication After an Adverse Outcome and Ethical & Risk Management Issues Arising from Clinical Trials*
New England Ophthalmological Society (NEOS)
John Hancock Hall, Boston, MA
Morning Session
Register with NEOS at (617) 227-6484

10 *Risk Management Issues for Pediatric Ophthalmologists: ROP Update*
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
Walt Disney World Swan Hotel, Orlando, FL
1:30-3 pm
Register with Maria Schweers at (515) 964-7835 or maschweers@mchsi.com

April

15-20 *Responding to Unanticipated Outcomes*
American Society of Cataract & Refractive Surgery (ASCRS)
Grant Hyatt Hotel, Washington, DC
Time TBA
Register with ASCRS at **www.one-stop-registration.com/ascrs/osr.index**

If you have any questions about OMIC's risk management offerings, please contact Linda Nakamura at (800) 562-6642, ext. 652 or lnakamura@omic.com.

This schedule is subject to change. Please call OMIC's Risk Management Department to confirm dates and times.

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The OMIC office will be closed for the holidays December 24 through 31. We will reopen January 3, 2005. Have a safe and joyous holiday season!