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Ophthalmic Risk Management Digest

OMIC DIGEST

Wrong Eye, Wrong IOL, Wrong Patient

By Paul Weber, JD
OMIC Vice President of Risk Management/Legal

To err is human, but in medicine, errors can have life and death consequences. Nearly a decade after it was published, a 1999 headline from an Institute of Medicine report on medical errors is still quoted: "98,000 Americans Dead Every Year from Medical Errors." The IOM report, *To Err is Human, Building a Safer Health System*, shone the media spotlight on the problem of medical errors and raised awareness of the shortcomings of the American health care system. Less publicized was a 2000 follow-up article by PBS health correspondent Susan Dentzer in *Effective Clinical Practice* (vol. 3, no. 6, American College of Physicians). In her article, "Media Mistakes in Coverage of the Institute of Medicine's Error Report," Ms. Dentzer notes that "all too frequently, errors in health care were the result of systems problems rather than of individual acts of malfeasance. In other words, to err really is human; at the same time, health care, like any other system in which we operate, is devised by and composed of humans. As a result, like any system that aims to minimize or eliminate error, health care must be designed to compensate for our inevitable human shortcomings."

All ophthalmologists have heard horror stories of wrong sided, wrong patient, wrong procedure, or wrong IOL cases. Most of us probably haven't read the IOM report, but we are all aware of the need to reduce systemic errors in health care delivery and improve patient safety. The American Academy of Ophthalmology has made a strong commitment to this problem, and in 2001, published "Eliminating Wrong Site Surgery" and "Minimizing Wrong IOL Placement." Both documents were revised in 2005 and are on the AAO web site. In addition, two related patient safety documents may also be found on the AAO web site, "Suggestions for a Checklist to Verify the Operative Eye" and "Suggested Multiple IOL Verification Procedures in the Operating Room for Minimizing Wrong IOL Placement." These documents were first developed by the AAO's Quality of Care Secretariat in collaboration with the American Society of Ophthalmic Registered Nurses and American Association of Eye and Ear Hospitals and were revised in 2005.

continued on page 4

MESSAGE FROM THE CHAIRMAN

Wrong site/wrong IOL surgery errors continue to plague our profession despite a concerted effort by OMIC to educate insureds and others about the circumstances that lead to such errors and provide risk management recommendations to help prevent them. A recent retrospective study of 42 OMIC claims and 64 New York state cases by John W. Simon, MD, et al, published in *Archives of Ophthalmology* (vol. 125, no.11) addressed the effectiveness of the Universal Protocol as a prevention tool. According to the study, even if the protocol were perfectly implemented, 15% of errors would remain. Recent events in Florida, where ophthalmologists have incurred substantial fines and penalties imposed by the state medical board, and the persistence of wrong site/wrong IOL errors has galvanized OMIC and its sponsor, the American Academy of Ophthalmology, to examine what can be done to eliminate these errors.

First, the problem must be put in perspective. Wrong site and wrong IOL errors are very low in frequency, indicating that proper safeguard systems are currently in place and working fairly well. In our 21 years of existence, approximately 4,679 lawsuits, claims, and incidents have been

continued on page 2

IN THIS ISSUE

Eye on OMIC

OMIC

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

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

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Lipo-Dissolve No Longer Covered

In February 2008, the FDA issued the following (excerpted) statement regarding Lipo-Dissolve:

> "The FDA is aware of the practice of using Lipo-Dissolve. Lipo-Dissolve is not FDA approved for any use… there are no FDA-approved drugs with an indication to dissolve fat. FDA cannot assure the safety and efficacy of these types of drugs. These are unapproved drugs for unapproved uses and FDA cannot guarantee consumers' safety… The use of compounded drugs is not considered "off-label" use… FDA approval of a drug includes approved labeling for use, and means that the FDA has evaluated the safety and efficacy of a drug for a specific use and population. Once approved, a drug may be prescribed by a licensed physician for a use that, based on the physician's professional opinion, is appropriate…but it is expected that the physician is well-informed about the product and that the "off-label" use is based on sound scientific rationale and adequate medical advice…"

Numerous medical associations, including the American Society of Ophthalmic Plastic and Reconstructive Surgery, have issued warnings regarding injection lipolysis and cautioned their membership against performing such treatments. In addition, several states seek to ban or regulate Lipo-Dissolve procedures.

As a result of these developments, the Board of Directors has determined that OMIC will no longer extend coverage for any Lipo-Dissolve, mesotherapy, or similar procedure unless performed as part of an investigational drug trial under an American IRB-approved protocol.

Message from the Chairman

continued from page 1

reported to OMIC. Only about 220, or 5%, have been related to "wrong" events. Since 1997, the percentage of insureds who have reported a wrong site or wrong IOL matter to OMIC has stayed relatively constant at a median annual average of about 0.5%.

However infrequent, these types of errors have drawn the attention of the public and state and federal policymakers, resulting in fines and licensing sanctions against physicians and non-payment of services by Medicare and other payors. The AAO, OMIC, and other ophthalmic societies are taking a two-prong approach to the problem—education and prevention—via the Academy Practice Improvement Task Force and a three-year Academy Campaign to Eliminate Wrong Site/Wrong IOL Surgery.

The first charge of the Practice Improvement Task Force, a group of seven ophthalmologists representing the AAO, ABO, AUPO, and OMIC, is to develop an online CME activity that will allow ophthalmologists to compare their own practice to those that follow evidence-based performance measures and protocols proven to reduce errors. Simple-to-use checklists will help participants adopt the protocols in their own office. Anonymous data collection of pre- and post-education practice activities will enable the task force to evaluate the effectiveness of the practice improvement activity on care outcomes.

The campaign to eradicate "Wrong Site Surgery and Wrong IOL Implantation" in the U.S. within three years is another cooperative group effort of ophthalmologists and is led by Gary S. Schwartz, MD. The group will review suggestions drawn from evidence-based medicine to help surgical teams evaluate and improve their own safety systems to eliminate all sources of wrong site or wrong IOL errors, whether operating in an office, hospital, or ambulatory surgery center.

At the state level, the Florida Society of Ophthalmology is working with OMIC and the Academy to educate FSO members on wrong site/wrong IOL surgery prevention. Florida is "ground zero" when it comes to the regulatory impact of system errors, and ophthalmologists in particular have borne the brunt of fines and licensure sanctions. The reason lies principally with the reporting requirements of ASCs and hospitals to the Florida medical board when a wrong site or wrong IOL error occurs in the operating room. The FSO is partnering with the Florida Board of Medicine to develop a statewide regulatory/disciplinary process to handle and correct the systems that produce such violations.

With the leadership and participation of so many prominent ophthalmic organizations, we hope to make the persistent problem of wrong site/wrong IOL a "never" event.

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

Policy Issues

Coverage for Investigations

By Kimberly Wittchow
OMIC Legal Counsel

Sometime in your career, you may be either the subject of an investigation or the one performing such an investigation of another provider. In limited circumstances, OMIC's policy provides defense and/or liability coverage to help you respond to claims made against you arising from your role in these scenarios.

Coverage for Medical Board Investigations

Anecdotal evidence suggests that there has been an uptick in the frequency of medical board investigations of physicians and their practices. In order to help our insureds respond to such proceedings, OMIC provides assistance in several ways.

OMIC's professional liability policy, Section VII, Additional Benefits, provides limited legal defense coverage for "any investigation, disciplinary proceeding, or action for review (hereinafter "investigation") of the Insured's practice by any federal, state, or local regulatory agency arising from a complaint or report by a patient to such agency of an injury to that patient resulting from a professional services incident involving direct patient treatment provided by the Insured." As the policy explains, coverage applies only when the investigation arises from patient injury due to treatment by the Insured ophthalmologist. Therefore, if the investigation stems from competitor complaints regarding unfair competition or sub-par provision of services, improper billing practices, or anything unrelated to a patient injury, this additional policy benefit does not apply.

OMIC provides this coverage because a complaint to a medical board concerning patient treatment may arise from, or lead to, a companion medical malpractice lawsuit. If OMIC's claims personnel and defense attorneys can be involved in both matters, it can help streamline and coordinate a unified defense. Therefore, we encourage insureds to let us know as soon as possible about any board action involving direct patient care, even if the patient hasn't made a claim or suit directly against the ophthalmologist.

If the policy does apply to a specific investigation, OMIC will pay a maximum of $25,000 per insured for claim expenses related to this medical board investigation. (The defense costs for any related medical malpractice claim are covered as a supplementary payment under Section VI of the policy and end only when the limit of liability for damages is exhausted.) OMIC will not pay any associated fines, sanctions, penalties, or other financial awards resulting from the medical board investigation.

You may also encounter situations where you are contacted by a state licensing authority in relation to another ophthalmologist, to act as a witness, prior or subsequent treater, or other. When you are not the subject of the investigation, the OMIC professional liability policy is not triggered. However, you are welcome to contact OMIC's Risk Management Hotline or Claims Department for advice. In certain situations, because your care of the patient may also come into question, OMIC may assign counsel as a precaution. This courtesy assistance outside of the terms of the policy is determined on a case by case basis. Remember that contacting the Risk Management Hotline is always confidential but does not trigger coverage. If you want to provide official notice to OMIC in order to preserve your rights under the policy, you must contact the Claims Department.

Coverage for Professional Committee Activities

You may also find yourself on the other side of a review board. As part of your professional endeavors, you may be asked to sit on an accreditation, utilization review, credentialing, quality assurance, peer review, or similar professional board or committee for a state licensed health care facility or professional association. With this role comes potential liability. Subjects of such a review may sue you, alleging that you did not accredit them because they are a competitor of yours and you want to restrict their practice in order to benefit your own. They may also allege that your peer review determination is libelous and has ruined their reputation and thus business prospects.

While the facility or association for which you provide this service may cover you for these activities, OMIC's policy also gives you a layer of protection. Section II, Coverage Agreement D, Professional Committee Activities Coverage for Ophthalmologists, covers claims that result from a professional services incident arising from insureds' professional committee activities. Professional services incidents are acts, errors, or omissions that are "neither intended nor expected." Therefore, acts you meant to commit would not be covered.

In addition, even though the policy generally excludes claims based on both wrongful acts and anticompetitive activities, it does provide defense only coverage for such allegations when they result from insureds' good faith professional committee activities. Wrongful acts include allegations of malicious prosecution or abuse of process and libel, slander, or defamation of character. Anticompetitive activities are those alleged to be in restraint of trade, including interference with a contract, interference with a prospective advantage, unfair competition, unfair trade and business practices, and misappropriation of trade secrets.

The limits of liability for this coverage are the full limits of the policy, and coverage for damages (except where specifically excluded), in addition to legal expenses, is provided. To report such a claim, contact OMIC's Claims Department.

Wrong Eye, Wrong IOL, Wrong Patient

continued from page 1

Universal Protocol for Wrong Events

In 2003, the Academy and 50 other professional health care organizations endorsed the Joint Commission's "Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery."™ There are four principal components to the Universal Protocol:

1. Completing a preoperative verification process;
2. Marking the operative site;
3. Taking a time-out immediately before starting the procedure; and
4. Adapting these requirements to non-operating room settings.

Wrong sided cases continue to occur, however, despite the best efforts of the Academy, the Joint Commission, and others. Current data seems to indicate that wrong site surgery is stubbornly defying solutions to eradicate it. (See Joint Commission and OMIC data, Graphs 1 and 2.)

In 2007, the Joint Commission received 5 to 8 new reports a month of wrong site cases nationally, and recently, wrong site surgery became the most frequently reported sentinel event in the commission's database (nearly 550 events reported since 1996). (Go to www.jointcommission.org/PatientSafety/UniversalProtocol/up_facts.htm for details.)

The Joint Commission convened a Wrong Site Surgery Summit in 2007. The organizations represented at the summit, including the Academy, agreed that the Universal Protocol is effective if properly implemented and consistently followed. Ophthalmic data support this conclusion. John W. Simon, MD, et al, concluded in a study for the American Ophthalmological Society that the Universal Protocol would have prevented 85% of the wrong incidents he analyzed had it been implemented ("Surgical Confusions in Ophthalmology," *Arch Ophthalmol.* 2007; 125(11): 1515-22).

Florida Medical Board Imposes Sanctions Against Violators

State medical boards have also responded to the problem. In Florida, the Board of Medicine requires that:

1. A very detailed mandatory "time-out" needs to occur in all surgeries (surgery is defined as an incision or curettage of tissue) in all settings, including the physician's office; and
2. All licensed facilities and physicians in their own practice must report wrong site/wrong patient incidents.

Penalties for violating these wrong site regulations and/or the time-out rule include fines, community service, and compulsory CME.

Florida recorded 33 ophthalmic wrong sided incidents between 2002 and 2006. Half of these incidents were related to IOLs. Ninety-two percent of the doctors were fined, all had to pay the cost of the investigations, and all but one had to perform community service. Additionally, these disciplinary actions were reported to the National Practitioner Data Bank and to states where the physicians had inactive licenses. One ophthalmologist faced penalties and sanctions in a state in which he had not practiced since residency, 20 years prior to the incident.

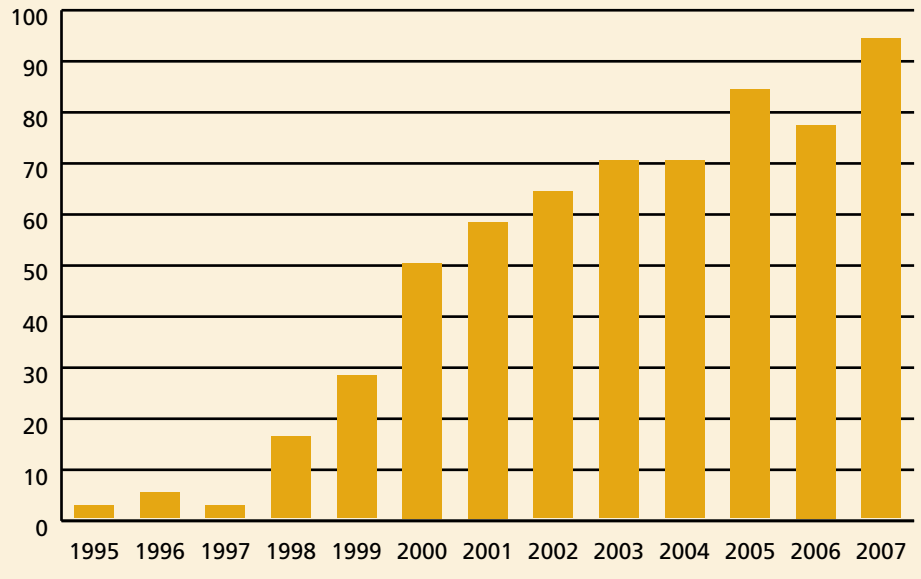
Earlier this year, the Florida Board of Medicine surveyed other states to find out what they're doing about the wrong sided IOL problem. None of the 10 states that responded (AL, ID, MD, NV, NM, NY, OK, TN, WV, and WY) has a separate state statute or medical board rule that addresses wrong site cases. Only New York tracks these incidents, and no New York ophthalmologist has been sanctioned for a wrong site case in the past 5 years.

Cataract Surgery, IOLs Involved in Most Wrong Cases

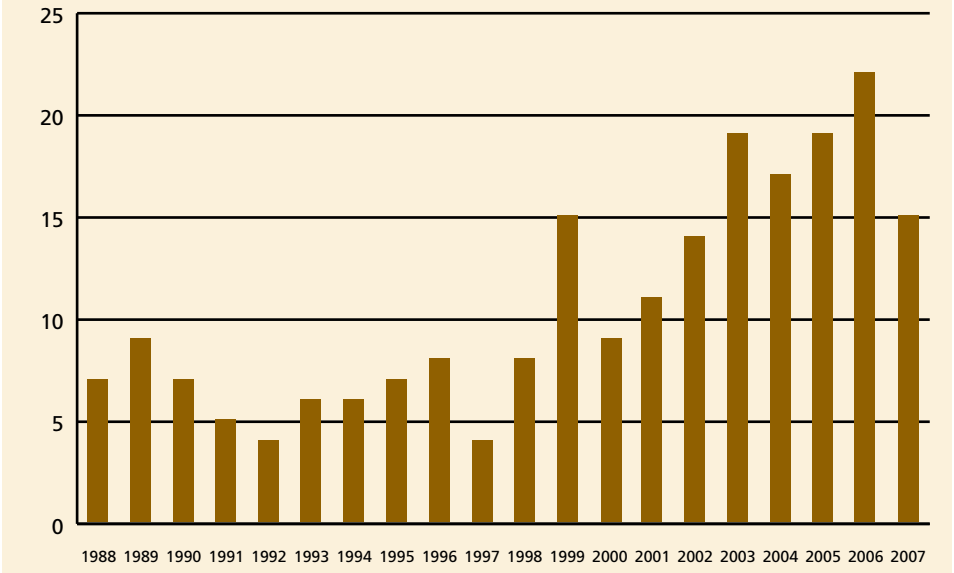
With cataract surgery by far the most commonly performed ophthalmic procedure in this country (1.8 million annually), it's not surprising that most wrong sided cases relate to cataract, and most involve problems with IOLs. Indeed, over 80% of wrong sided eye cases reported to OMIC over the course of 20 years have resulted from wrong IOL implantation, wrong power, or wrong measurement (see

GRAPH 1

INCIDENCE OF "WRONG" CASES REPORTED TO THE JOINT COMMISSION



GRAPH 2
INCIDENCE OF "WRONG" CASES REPORTED TO OMIC



Graph 3). In 1997, Dean Brick, MD, then chairman of OMIC's Risk Management Committee, found that 25% of cataract claims involved an IOL. He recommended the following loss prevention strategies, which remain relevant today:

- Employ one or two technicians who are well trained to perform keratometry and biometry.
- Review the scans and keratometry data when choosing the IOL.
- Use one or two styles of IOLs regularly to prevent confusion about constants or model numbers.
- Use a third generation formula for IOL selection.
- Keep a list of IOL choices for that day's patients on the side of the phaco machine and check it just prior to insertion.
- Use a checklist preoperatively to document data, informed consent, and any preop and postop instructions given to the patient.

Zero Tolerance by Joint Commission

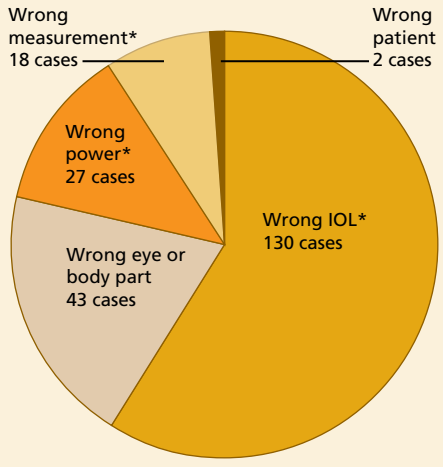
At this time, Florida appears to be the only state to strictly penalize wrong site cases. The state's position is in keeping with the following statement from the Joint Commission's 2007 Wrong Site Surgery Summit:

> "There should be 'zero tolerance' for failure to follow the Universal Protocol as a short term goal and there should be 'zero tolerance' for occurrence of these events."

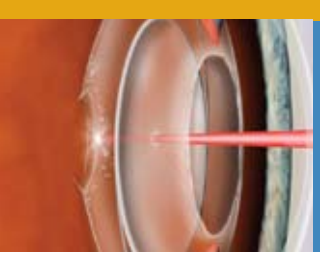
In the move toward "zero tolerance," the Joint Commission is changing the Universal Protocol to provide more flexibility to hospitals, ASC's, and health care providers in its implementation. In addition, there will be more details on implementing the "who, what, when, and how" of the pre-procedure verification process, marking the procedure site, and the time-out. These guidelines are on the Joint Commission's web site at www.jointcommission.org/PatientSafety/UniversalProtocol.

OMIC participates in the AAO's drive to eliminate wrong site, wrong IOL, and wrong patient surgery. This year's OMIC Forum at the Annual Meeting in Atlanta will focus on these "never events." We will review OMIC's claims and lawsuits, discuss the faulty systems and processes that led to them, discuss state board actions, and review the Joint Commission's latest Universal Protocol. The panel will include James B. Sprague, MD, a member of OMIC's Risk Management Committee, and William J. Knauer III, MD, chairman of OMIC's Marketing Committee. Dr. Simon will discuss his findings and Peter Angood, MD, vice president and chief patient safety officer of the Joint Commission, will review the Universal Protocol. The OMIC Forum will be held Sunday, Nov. 9, at 1:00 pm in the Georgia World Congress Center. Preregistration is not required, but participants must complete an attendance form on-site to receive CME credit and an OMIC premium discount.

GRAPH 3
TYPE OF "WRONG" CASES REPORTED TO OMIC 1987–2008



* IOL-related cases = 80% of total



Closed Claim Study

State Medical Board Equates Wrong Powered IOL Implant With Wrong Site Surgery

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Misreading of intraocular lens power calculation, resulting in incorrect lens implantation and a need for a second surgery.

DISPOSITION

Case was settled between the insured and the state board of medicine. The patient did not pursue a claim.

Case Summary

An OMIC insured performed an uncomplicated cataract surgery; however, on postoperative day one, the patient's vision was 20/200 OD with a significant hyperopic refractive error that corrected to 20/20. The insured realized that the power of the posterior chamber lens implant had been inadvertently switched with the corresponding power for an anterior chamber lens, resulting in an implant difference of 3.5 diopters. He informed the patient of the error and presented options for treatment, such as wearing glasses, a contact lens, or undergoing an IOL exchange. The patient chose the IOL exchange procedure, which was uncomplicated, and eventually the patient's uncorrected vision was 20/25 OD.

Analysis

Soon after, the insured received and responded to a letter of investigation from the state medical board. Without contacting OMIC, the insured acknowledged the error that led to the implantation of the wrong IOL. The medical board examiner retained an ophthalmology expert, who opined that the implantation of the incorrect powered IOL was beneath the standard of care. Following this expert's review, the examiner presented the insured with a settlement proposal, which included a fine, reimbursement of costs of the investigation, a letter of concern from the board, continuing education units, and community service. Upon receiving this proposal, the insured reported the matter to OMIC. The case was referred to an attorney, who advised that the insured had put himself at a disadvantage by directly responding to the medical board and not making his response through an attorney. Since the board had already conducted an investigation and proposed sanctions, it was significantly more difficult to handle the matter.

OMIC counsel retained two experts who disagreed with the original opinion that the implantation of a wrong powered IOL was beneath the standard of care. While the medical board's expert did not change his opinion that the insured had violated the standard of care, he disagreed with the board's finding that wrong powered intraocular lens insertion was tantamount to wrong site surgery and warranted the same fines and penalties. This expert believed that a letter of concern would be sufficient in this case, especially since the insured had taken steps in his practice to ensure that such an error would not recur. The medical board disagreed with its own retained expert and continued to view wrong powered IOL insertion as the equivalent of wrong site surgery.

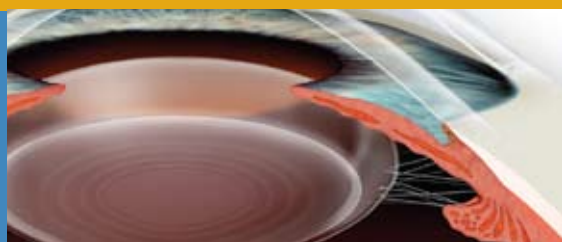
Risk Management Principles

The insured ophthalmologist should be commended for working with the patient to avoid a claim. Once the error was recognized on postoperative day one, he candidly discussed the error with the patient and the treatment options to address the error. With the insured's assistance, the patient was able to make a well educated decision on how to proceed. In the event of a medical error, it is wise to withhold billing for the errant surgery and to perform any follow-up procedures at no out-of-pocket cost to the patient. These steps may decrease the likelihood of a patient pursuing a claim or litigation.

As this case illustrates, however, state medical boards have become proactive in response to concerns of patient safety and may take action even if the patient involved is satisfied with the care. Medical board investigations are now often triggered by mandatory reports from surgery centers and hospitals. Once an insured becomes aware that a wrong site surgery or incorrect power IOL insertion has occurred, the incident should be reported to OMIC's Claims Department or confidential Risk Management Hotline at (800) 562-6642, option 2 for Claims or option 4 for Risk Management.

OMIC is collaborating with the American Academy of Ophthalmology and other ophthalmic organizations on a campaign to prevent wrong patient, wrong surgery, and wrong IOL insertion. The **Lead** and **Hotline** articles in this *Digest* provide further insight in to this area of concern.

Risk Management Hotline



Identify and Manage Preoperative Causes of Wrong IOL Placement

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

Every ophthalmologist has heard stories of the wrong eye being enucleated or the wrong procedure being performed. The Joint Commission's Universal Protocol (UP)—preoperative verification, site marking, and time-out—was developed to prevent such cases. While the UP is capable of catching 85% of "wrong" errors in ophthalmic procedures performed in hospitals and surgery centers, it does not address the cause of wrong IOLs, the most frequent type of surgical confusion in ophthalmology.[1] As John Simon's study shows, 25% of IOL mistakes originate in the physician's office.

Q When I examined my cataract surgery patient at his first postoperative visit, his refractive outcome (+3 D) was not what I had expected. I reviewed the medical record and discovered that I had implanted the wrong IOL. I informed the patient of the error, apologized, offered to refund the cost of the procedure, and disclosed the treatment options. What else should I do?

A Your honest and compassionate discussion with the patient will go a long way to helping him through the postoperative period. Studies show that in addition to a truthful accounting and an apology, patients also want to know that you will take steps to protect others from the same outcome.[2] One method proposed by patient safety experts is to inform your patient that you will conduct an event analysis that exposes not only the error that occurred in this instance, but potential mistakes in the sequence of care that could culminate in choosing or implanting the wrong IOL in another patient.

Q I already know what happened! My new technician made a mistake during the A scan. Should I fire her?

A While firing an employee involved in an error that harmed a patient is an understandable initial reaction, it does not address your role in training her, may send your staff the wrong message, and could lead to the loss of your best ally in preventing future errors. Your technician no doubt feels as badly as you do about this outcome. Rather than allowing her to shoulder the entire blame and punishing her, you can show staff that you take ultimate responsibility for the care provided in your office, as well as for hiring, training, and supervising them. Indeed, you can show them how to use mistakes as a learning opportunity. Call a meeting and explain that wrong IOLs are the most frequent type of error and cause of malpractice claims in cataract surgery. Ask for their assistance in reviewing office practices. Ask the technician to be part of the effort to analyze the event. Invite her to tell her story, and then explain how you dealt with the patient. You and your technician will thus demonstrate your commitment to the patient, the staff, and to improving the quality of your care.

Q What are the next steps in the event analysis?

A Ask your staff to map out the entire office-based sequence of events involved in choosing and ordering an IOL. You might want to have two teams, one that focuses on the clinical process (A scan and choice of IOL) and one that studies the administrative sequence of events (transferring the physician's order to the ASC or hospital, informed consent, etc.). Experts suggest establishing two timelines: one for how the process is actually done and one for how it should be done.[3] Once the team is sure that all of the steps are noted, it brainstorms on how this part of the sequence can go wrong, thus beginning the "hazard analysis" part of the review, which also includes determining the effect, severity (impact on the patient), probability, and detectability of the "failure." The hazard analysis helps the team determine which errors in care constitute critical failures and these become the focus of your efforts to design a safer process.

Q Has anyone analyzed "wrong IOLs" this way?

A I have not seen a formal failure mode and effects analysis, but there are several studies of wrong IOLs. Dr. Simon's article on surgical confusion cited earlier explains some common causes, and the AAO/ASORN and American Associate of Eye and Ear Hospitals have identified ways to prevent wrong IOL. In addition to ensuring adequate training of personnel and calibration of equipment, the AAO/ASORN/ASEEH report suggests that you instruct your staff to test both eyes and then compare the results of each eye to itself and to the other eye (in the same eye, the difference between the two scans should be ≤ 0.2mm, while between eyes it should not exceed 0.3mm unless the patient is known to have anisometropia).[4] Verify the results of the IOL Calculation Report and the formula used to pick the IOL yourself, and take a copy to the OR. Assign two staff members to compare the results to the preop orders sent to the ASC.

1. Simon JW, Ngo Y, Khan S, Strogatz D. "Surgical Confusions in Ophthalmology," *Arch Ophthalmol.* 2007; 125(11): 1515-22.

2. Vincent C, Young M, Phillips A. "Why Do Patients Sue Doctors? A study of patients and relatives taking legal action," *The Lancet.* 1994; 343: 1609-13.

3. Stow J. "Using Medical-Error Reporting to Drive Patient Safety Efforts," *AORN Journal.* 2006; 84(3): 406-424.

4. AAO/ASORN/ASEEH. "Minimizing Wrong IOL Placement," *Patient Safety Bulletin #2*. Iss 2001, rev 2005. Available at www.aao.org and www.asorn.org.

Calendar of Events

OMIC continues its popular risk management programs this 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 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 at www.omic.com. CME credit is available for some courses. Please go to www.aao.org to obtain a CME certificate.

Online Courses *(Reserved and free 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, *Now What Do I Do?,** will be available later this year for physicians in California, Colorado, Hawaii, Iowa, Louisiana, Missouri, Nevada, Oklahoma, Washington, the American Society of Plastic and Reconstructive Surgeons, and Women in Ophthalmology. Contact Linda Nakamura at OMIC to register.

CD Recordings *(Free to OMIC insureds; $60 for non-insureds)*

- **Coming this fall!** *Lessons Learned from Settlements and Trials of 2007* (2008). Available as a CD or accessible from OMIC's web site as an MP3 file. Includes indications for surgery, risk of hemorrhage, disclosure of postop conditions, reducing risk of complications.
- *Medication Safety and Liability* (2007)
- *After-Hours and Emergency Room Calls* (2006)
- *Lessons Learned from Settlements and Trials of 2006* (2007)
- *Lessons Learned from Settlements and Trials of 2005* (2006)
- *Lessons Learned from Settlements and Trials of 2004* (2005)
- *Noncompliance and Follow-Up Issues* (2005)
- *Research and Clinical Trials* (2004)
- *Responding to Unanticipated Outcomes* (2004)

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 lnakamura@omic.com.

Upcoming Seminars

November

8 *Risk Management Liability Review for OMP*
JCAHPO Annual Continuing Education Program for Ophthalmic Medical Personnel at the AAO Annual Meeting
Hilton Atlanta, GA
Time: 9:10–10:05 am
Register with JCAHPO at www.jcahpo.org/meetings/annual.cfm

8 *Quality Issues in Retina*
ASORN Annual Meeting at the AAO Annual Meeting
Georgia World Congress Center, Atlanta
Time: 11:10 am–12:10 pm
Register with ASORN at webeye.ophth.uiowa.edu/ASORN/Annual Meeting.htm

9 OMIC Forum: *Preventing Surgical Confusion: Wrong Patient—Wrong Site—Wrong IOL*
AAO Annual Meeting
Georgia World Congress Center, Atlanta
Time: 1:00–3:00 pm
Complete attendance form on-site. Contact Linda Nakamura at (800) 562-6642, ext. 652

10 *ROP: What to Discuss with Your Hospital*
Breakfast with the Experts, Roundtable B131
AAO Annual Meeting
Georgia World Congress Center, Atlanta
Time: 7:30–8:30 am
Register with the AAO: $30 in advance

10 *Ultimate Chart Audit*
AAOE at the AAO Annual Meeting
Georgia World Congress Center, Atlanta
Time: 9:00–11:15 am
Register with AAOE at www.aao.org/aaoesite/annualmeeting/

10 *Fluorescein Angiography: Preventing and Responding to Complications*
JCAHPO Annual Continuing Education Program for Ophthalmic Medical Personnel at the AAO Annual Meeting
Hilton Atlanta, GA
Time: 1:50–2:45 pm
Register with JCAHPO at www.jcahpo.org/meetings/annual.cfm

10 *Legal Issues in Ophthalmology*
ASORN at the AAO Annual Meeting
Georgia World Congress Center, Atlanta
Time: 1:15–2:15 pm
Register with ASORN at webeye.ophth.uiowa.edu/ASORN/AnnualMeeting.htm

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