Winter 2010 Volume 20 Number 1 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest

OMIC DIGEST

A "Watchful Eye" on ROP

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

There is no greater liability exposure in ophthalmology than the examination and treatment of premature babies at risk for retinopathy of prematurity (ROP). Unlike most care provided by ophthalmologists, ROP is hospital-centered, multidisciplinary care with a very narrow window in which to provide timely examination, treatment, and follow-up. The challenges include providing ophthalmic care to infants who are often very sick, guaranteeing smooth patient discharge or transfer of care, and ensuring that caregivers understand the importance of compliance with follow-up appointments. This patient safety/liability risk is unlike any other that OMIC has grappled with in its 23-year history. The main obstacle has been developing a multidisciplinary, systematic approach to dealing with this unique liability risk. OMIC believes it has found such a system in the St. Luke's Hospital and Health Network's Watchful Eye Program for Retinopathy of Prematurity (©2008 St. Luke's Hospital of Bethlehem, Pennsylvania).

The Concept

The Watchful Eye program is a fairly simple model of hospital-centered care (see conceptual map on page 4). Its premise is the overall management of ROP care by a Retinopathy of Prematurity Coordinator (ROPC). The ROPC participates in and monitors the ROP care of the infant, both as an inpatient and outpatient, until the infant reaches full retinal vascularization and is no longer at risk. OMIC's own ROP claims analysis and safety net (see "ROP: Creating a Safety Net" at www.omic.com) has pointed out the importance of an ROPC. Identifying the concept of an ROP tracking system and coordinator is clear-cut; however, the Watchful Eye program demonstrates that the commitment and attention to detail required to develop, implement, and monitor results is a complex process that cannot be underestimated.

An Interdisciplinary Approach

The Watchful Eye program was developed by an interdisciplinary team at St. Luke's Hospital and Health Network in Bethlehem, Pennsylvania. The team included nursing administration, nursing staff, legal counsel, ophthalmology, neonatology, and social services. This type of collaboration is the essential first step in the creation and implementation of an ROP patient safety program. The St. Luke's team also underscores the fact that high level leadership within the hospital administration is indispensable to ensuring the success of such a program.

continued on page 4

MESSAGE FROM THE CHAIRMAN

Ten years ago, OMIC emerged from a crowded field of more than 35 malpractice carriers by consistently outperforming the industry in both claims defense and financial results. OMIC had established itself as the nation's leader in ophthalmic risk management. Moreover, recent trends suggest that OMIC's financial success can be directly tied, at least in part, to our revolutionary loss prevention program.

Measuring the effectiveness of risk management is difficult because of the complexities involved in determining the extent to which physicians actually put loss prevention principles into practice (as opposed to physicians who do not) and then matching clearly defined groups to claims activity. Furthermore, we know that claims are sometimes filed no matter what processes a physician puts into place and risk management is simply an attempt to *lessen* the chance, not *eliminate* it.

Intuitively, we know that our claims experience is improved by studying what worked (and what didn't) during the course of litigation and then making adjustments to improve our performance. Not unlike our clinical practice, where adjustments we make to our procedures and techniques eventually take the form of changes to our specialty's preferred practice patterns, OMIC has

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.

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

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

OMIC's Claims Frequency Holding Steady

Since 2005, the medical malpractice environment has been characterized by steadily increasing claims severity and declining or flat claims frequency. However, new statistics released by the Physician Insurers Association of America show that frequency is beginning to increase.

There are varying hypotheses as to why more claims are being filed, including a general change in the insurance cycle after several good years, the overall poor economic environment, changes in reimbursement rules, and societal shifts in attitudes toward healthcare providers.

OMIC is bucking this trend of increasing claims frequency, at least for now. The gap between OMIC's loss experience and the industry's continues to widen. The frequency of OMIC claims, measured by open claims from 2005 to 2009, has remained flat even as the industry as a whole has seen an increase of approximately 4%.

While OMIC's claims severity, meaning the average indemnity paid per claim, continues to be lower than the industry average by a large margin, the average indemnity paid for ophthalmic claims by all malpractice carriers continues to increase. In 2008, the most recent data available, the average indemnity paid by OMIC was approximately $143,000 versus the industry average for ophthalmic claims of approximately $185,000.

Message from the Chairman

continued from page 1

improved our defense of ophthalmic claims by studying past performance and developing underwriting guidelines and risk management recommendations to reduce exposures.

OMIC's loss experience over the past decade points to significant cause and effect between risk management participation and positive claims trends. Although losses have decreased for all malpractice carriers in recent years, OMIC's experience has been significantly better than the comparable ophthalmic claims experience of multispecialty carriers. I'm convinced that OMIC's above average risk management activity is a major factor in our superior results and the reason we continue to expand our competitive advantage over other carriers.

In 2000, OMIC's market share was about 20% (2,000 policyholders out of a market of just over 10,000 U.S. ophthalmologists in private practice), and one-third of insureds participated in our first-of-its-kind ophthalmic-specific risk management program. In addition to a growing collection of ophthalmic consent forms, loss prevention articles, and case studies, OMIC formed educational alliances with nine state and subspecialty ophthalmic societies through which we could reach a wider audience.

By 2009, OMIC had doubled in size to more than 4,100 policyholders—40% of the nation's private practice ophthalmologists—making us the largest carrier in our market. At the same time, our risk management participation rate rose to 60%, an incredibly high level rarely seen in the insurance industry. The number of educational alliances between OMIC and ophthalmic societies has quadrupled to nearly 40, in virtually every state and region. Thousands of ophthalmologists now attend our jointly-sponsored risk management events in venues across the country. OMIC's collection of ophthalmic-specific risk management resources, disseminated through OMIC.com and the OMIC hotline, are used by a majority of ophthalmologists, including non-OMIC-insureds, in countries around the world.

While our growth in all these areas should make us extremely proud as an organization, the most satisfying trend is the effect our risk management program is having on our successful defense of claims. OMIC has consistently done a better job of defending ophthalmic claims than multispecialty carriers, but over the past decade, we widened the gap between how much OMIC and multispecialty carriers pay out per claim by 5 percentage points. In 2000, OMIC paid an average of 20% less per ophthalmic claim than our competitors. By the end of 2009, our average was 25% lower. Similarly, OMIC settles more claims without payment, up from 77% in 2000 to 81% today (vs. a static 70% for multispecialty carriers).

The fact that we are becoming better at defending ourselves from litigation does not surprise me. During my tenure at OMIC, I have seen a level of engagement and involvement by our members that is unique among physicians. However, to see such tangible results from our efforts is the proverbial "icing on the cake."

Richard L. Abbott, MD
OMIC Chairman of the Board

Providing Care When Disaster Strikes

By Kimberly Wynkoop
OMIC Legal Counsel

When disaster strikes, as it has done so devastatingly in Haiti, many physicians want to offer their skill to aid the victims in their recovery. The last thing a physician pursuing such an altruistic mission may consider is claims arising from this care. Nevertheless, prudent physicians will want assurance that what they are undertaking will not expose them to uninsured losses. OMIC would like to explain how its policy covers its insureds for claims that might result from such volunteer services.

Practicing Outside Coverage Area

When insureds look to provide health care outside of the United States, they should be aware of the Coverage Territory provision in their policy (Section VIII.22). It states that, in order for coverage to apply, the insured's principal place of practice must be the same as that specified in his or her application for insurance. This does not prevent insureds from occasionally practicing outside of this area, it just ensures that they are underwritten and rated appropriately for the majority of their practice. As long as this is the case, coverage will apply to professional services incidents that take place anywhere in the world. However, in order for OMIC to cover the claim, it must be brought within the 50 United States or Washington DC.

Most, if not all, medical professional liability policies contain this language limiting where claims may be brought. This is because insurers are generally unfamiliar with the laws and court systems outside of the U.S. This, coupled with the distance and language barriers posed, makes it extremely difficult to control and manage claims and to find appropriate personnel to oversee and adequately defend them. In addition, the insurer may not legally be permitted to operate in these foreign countries.[1] (Note that OMIC's policy does not cover claims brought in any U.S. territories or possessions. Although the law is not settled on the issue, it appears that risk retention groups are not permitted to operate outside of the 50 states and DC. Additionally, most of the other concerns noted above also apply to these territories and possessions.)

Good Samaritan and Bona Fide Emergency Treatment

In order for coverage to apply, the rest of the policy provisions must also be adhered to. This includes practicing within the scope of one's licensure and within the ordinary and customary scope of practice of ophthalmologists. OMIC considers ophthalmic or non-ophthalmic treatment provided as a Good Samaritan or in a bona fide emergency to be within the ordinary and customary scope of practice of ophthalmologists. This means providing emergency medical services to an injured person at the scene of an accident without expecting to receive compensation from the injured person for the service. Regarding licensure, insureds will want to check the licensure provisions and requirements in both their state of practice and the location where they will be providing volunteer services.

Responding to emergency medical needs in a disaster zone immediately after the disaster has struck would be considered a bona fide emergency or "Good Samaritan" situation. This could occur, for example, in treating victims and evacuees for non-ophthalmic injuries in the direct aftermath of an earthquake, hurricane, or terrorist incident. Attending to victims' and evacuees' non-immediate medical needs after the disaster would not be considered occurring during a bona fide emergency. Therefore, OMIC would cover an ophthalmologist for ophthalmology-related treatment only in this scenario.

If an insured plans to assist in a disaster-stricken or underserved area on a volunteer basis through an organization, the insured should check with that organization, as it might also provide or give access to professional liability coverage for these services. Since the aim of these organizations may be to provide medical care in non-U.S. territories, and they may anticipate that specialists could provide care outside of their specialty, they might offer or provide access to coverage for claims beyond the scope of your OMIC policy.

Documentation of Care

From a risk management perspective, OMIC advises that insureds maintain, to the degree possible, at least basic documentation of any treatments performed, including identifying information of the patient and a short narrative summary of the diagnosed injury/condition and specific medical care delivered by the insured. For easy retrieval, such notes should be arranged alphabetically in a file labeled "Care Provided to [Incident] Disaster Victims." If resources are available, since it is likely that patients will not be seen again by the insured, the insured should give patients a copy of the visit note, with treatment and follow-up recommendations. For more risk management advice, call (800) 562-6642, ext. 641.

If you plan on spending any significant amount of time providing services outside of your typical practice territory, please inform your OMIC underwriter before doing so.

1. Bregman RA and Gibson JP. "Professional Liability Insurance." International Risk Management Institute, Inc. (Dallas). 2009; Sections VII.B.14 and XXII.E.11.

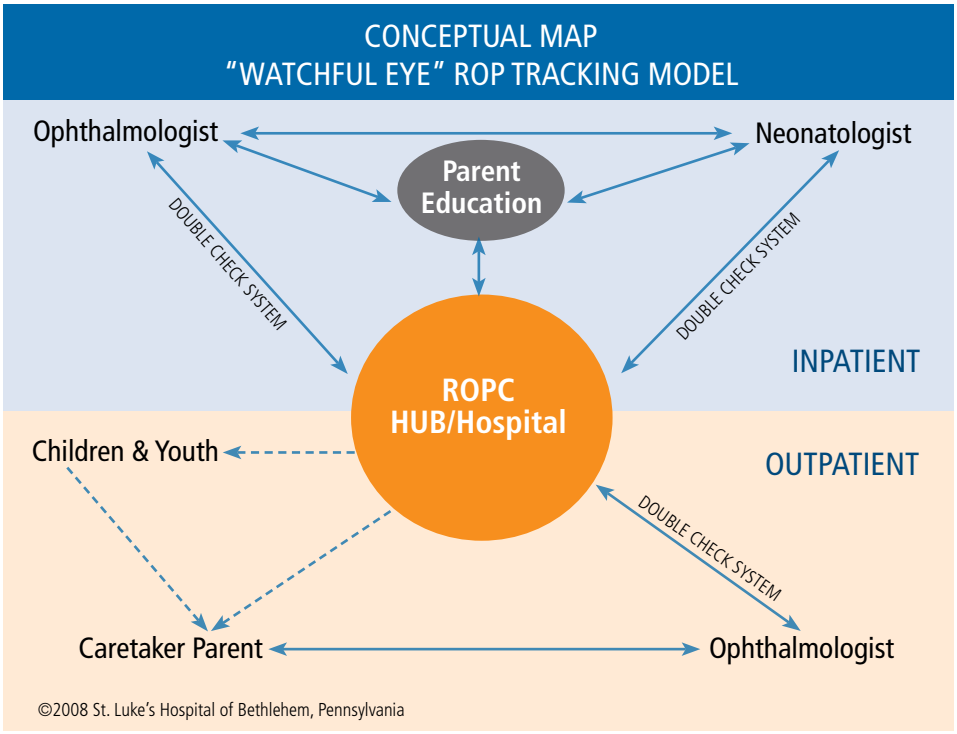
A "Watchful Eye" on ROP

continued from page 1

Besides preventing blindness in premature infants, an important goal of the Watchful Eye program is to reduce St. Luke's exposure to large losses arising from ROP claims. The leadership of St. Luke's learned in 2006 of the $20 million dollar judgment against a Pennsylvania hospital and neonatologist who were found to be jointly responsible for discharging an at-risk infant and failing to provide adequate follow-up care—just one of several multimillion dollar ROP verdicts passed down in recent years. For St. Luke's, the decision was straightforward: allocate the requisite time and money to proactively prevent this type of claim or pay untold millions in damages sometime in the future.

The Role of the ROPC Nurse

There are many more facets to the Watchful Eye program than this article can address. (See "Keeping a Watchful Eye on Retinopathy of Prematurity" in *Neonatal Network,* Sept/Oct 2008; v. 27, n. 5.) However, the heart of the program is the ROPC, a registered nurse with neonatal nursing experience who is responsible for identifying and tracking infants, assisting the ophthalmologist during the screening exam, and caregiver education. At St. Luke's, the ROPC is a 16-hour-per-week position. The thorough development of this key position is a feature that underscores the innovative aspect of the Watchful Eye program. The patient safety challenge has always been how to ensure that there is someone who will take responsibility for monitoring the infant until the risk has passed. The ROPC nurse takes full responsibility and is dedicated to the inpatient and outpatient tracking of ROP care of premature babies in the program. Until now, inpatient and outpatient tracking and monitoring has been fragmented, leading to tragic injury to the infants and finger-pointing among the healthcare providers and caregivers. In fact, several surveys of ophthalmologists indicate that the liability risk arising from improperly tracking and monitoring ROP care convinces many to simply stop providing ROP services. This exodus of well-qualified, well-trained ophthalmologists creates a public health risk.



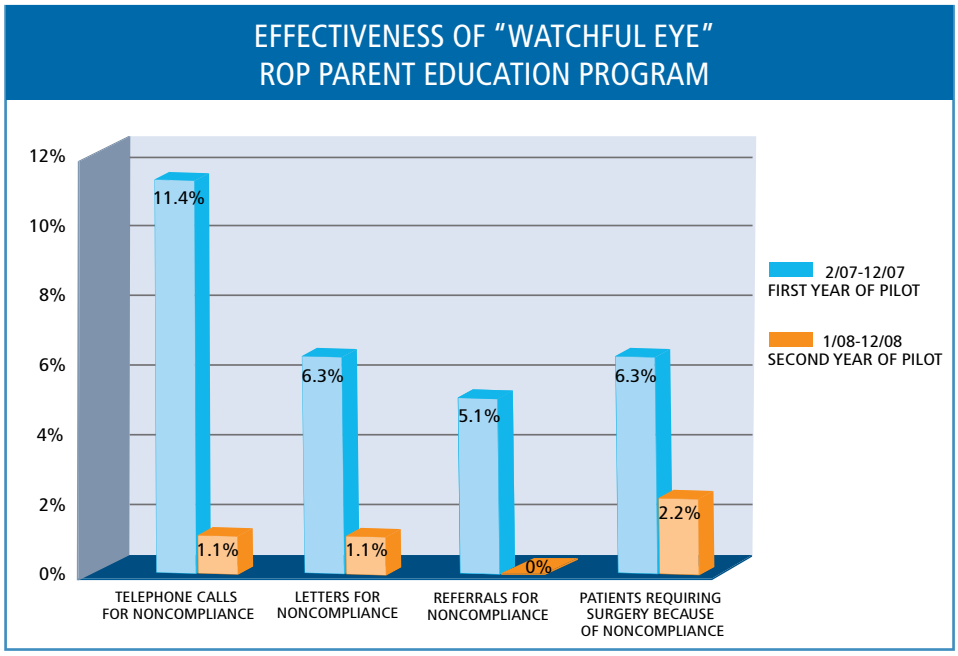
Double Check System and Filing

The Watchful Eye program employs a unique and very detailed "double check" strategy and filing system. The double check system ensures that at each step of the process there are two people checking the status of ROP care to be provided. The ROPC is always one of the people involved in the double check system, together with either the neonatologist or ophthalmologist (examining or treating), who follow the infant's inpatient and outpatient care.

The actual documentation and recording of the double check is carried out through a detailed color coded filing system maintained by the ROPC as an adjunct to St. Luke's electronic medical record (EMR) system. The ROP filing system is maintained even after the infant is discharged. Only when the infant reaches full retinal vascularization is the ROPC filing closed and scanned into St. Luke's EMR system. The underpinnings of the double check strategy and filing system again hinges on the ROPC. Without an ROPC, the double check and filing system simply is not viable.

Caregiver Education

In most hospitals, the only healthcare provider who participates at each step of ROP care is the NICU nurse. The ROPC nurse interfaces not only with the neonatologist and ophthalmologist but, most critically, with the parents. The St. Luke's Watchful Eye program now has an ROPC nurse responsible for the most precarious step in the care continuum: ensuring compliance with the follow-up appointment. The ROPC understands that caregivers are dealing with a needy infant requiring multiple post-discharge appointments and follow-up care. The ROP follow-up appointment is only one of many issues the caregiver must handle. Simply providing a document about the importance of the follow-up appointment is a precarious way to



ensure compliance. The Watchful Eye program addresses the importance of follow-up care even before the infant's first ROP examination in the NICU. As soon as it is determined that the infant needs to be followed for ROP, the ROPC approaches the parents and provides both oral and written information about ROP. The ROPC informs the family that the infant's first eye exam will be at four weeks of age. The parents are invited to be present for the examination and are fully informed about the procedure. After the exam, the ROPC nurse assists in educating the family about the results.

Outpatient Coordination

When the infant is ready for discharge, the ROPC makes the follow-up appointment at the ophthalmologist's office. In scheduling the appointment, the ROPC communicates the family's needs to the ophthalmologist's appointment scheduler. The ROPC nurse then records the appointment date on a discharge instruction form. Developed by the ROP team, the discharge form provides educational information about ROP and contains this disclosure: "If you fail to keep this (follow-up) appointment, the ophthalmologist and/or St. Luke's Hospital and Health Network may contact the appropriate legal authorities, as required by law, in an effort to locate your baby and provide treatment." After the parent signs the form, copies are made for the family, the ophthalmologist, and the hospital records. Again, it must be emphasized that this is only one step in the education and orientation process of the parent/caregiver. This step by itself would be too little too late.

Part of the Watchful Eye program is careful outpatient coordination with the ophthalmologist's office. As noted above and in the conceptual map on page 4, the double-check strategy and filing system continues after the infant's discharge from the hospital.

Unit-wide Orientation and Monitoring

The Watchful Eye program is not an isolated component of care for the premature infant nor is it static. It is a dynamic process that has to be integrated into the infant's overall care and updated when necessary. This multidisciplinary approach extends beyond the providers active in treating ROP to the NICU unit responsible for the overall care of the premature infant. The entire NICU unit needs to be oriented to the program, including social services, administrative staff, discharge planners, etc.

The process is dynamic in that the principles of continuous quality improvement are applied. An excellent example is a 2008 revision to the Watchful Eye program placing stronger emphasis on ROP education for parents *prior to discharge* to help them understand the potential risks and consequences of their infant's condition. This increased emphasis on caregiver education has resulted in better outcomes while maintaining 100% follow-up compliance. The need for ROPC interventions dropped from 23% to 2% and the number of patients requiring surgery decreased from 6% to 2% in the year following this revision (see graph).

The "Watchful Eye" and OMIC

On behalf of the 325 OMIC insureds and other ophthalmologists who screen and treat for ROP, OMIC has been at the forefront of addressing the unique liability risks of ROP for more than two decades. During this time, it has become evident to us that many hospitals are reluctant to create and implement a comprehensive ROP tracking and monitoring program. This frustrates ophthalmologists who would provide ROP care if hospitals were more involved.

OMIC believes the Watchful Eye program presents an opportunity for hospitals, nurses, neonatologists, and ophthalmologists to work together in a collaborative and innovative way to solve this problem. St. Luke's Hospital and OMIC are in the process of bringing the Watchful Eye program to OMIC insureds and others interested in a comprehensive ROP tracking system. We anticipate a great deal of interest from the AAO, AAPOS, SOOp, and ASRS as we tackle one of ophthalmology's greatest challenges: preventing blindness in premature infants.

Closed Claim Study

Patient's Finances Alters Evaluation and Treatment of Penetrating Globe Injury

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to diagnose intraocular foreign body.

DISPOSITION

Case settled for $210,000.

Case Summary

An uninsured illegal immigrant was examined by the insured ophthalmologist after a nail struck his right eye while hammering. Visual acuity on presentation was 20/50 OD. The insured diagnosed hyphema and a full thickness corneal laceration with a self-sealing wound. An undocumented slit lamp examination "ruled out" the presence of a foreign body. The insured patched the patient's right eye, prescribed Ciloxan, and asked the patient to return the following day. The next day, the patient's visual acuity was 20/40 OD with a negative Siedel Test demonstrating no wound leakage. A hyphema and a small self-sealing corneal wound were present. A dilated fundus exam was not performed, so the retina was not visualized. The impression was a corneal scleral laceration with slightly improved vision with no mention of a foreign body. The patient was told to return in four days.

The following day, the patient self-referred to another ophthalmologist with hand motion vision OD and complaints of sharp throbbing pain in the injured eye. The patient was diagnosed with a traumatic vitreous hemorrhage OD, resolving hyphema OD, and a partial thickness corneal laceration OD. An exam during an emergency retinal consult revealed a reflective foreign object in the vitreous space. A CT scan done at the local charity hospital confirmed an intraocular foreign body. Residents there performed lensectomy, vitrectomy, anterior chamber membrane removal, attempted foreign body removal, and administered an intraocular antibiotic for endophthalmitis. During surgery, the foreign body slipped into the membrane temporally and could not be located. Two days later, a pars plana vitrectomy with membrane peeling, retinectomy, and foreign body removal was done. One week later, the patient had an enucleation for uncontrolled endophthalmitis.

Analysis

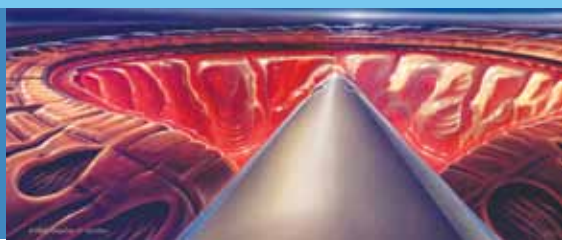
Experts for both the defense and plaintiff agreed that the insured did not meet the standard of care. Specifically, the experts opined that the insured should have ordered an x-ray or CT scan of the right orbit to rule out the presence of a foreign body. The slit lamp exam that the insured said he performed but did not document was inadequate to rule out the presence of an intraocular foreign body. The experts believed that an immediate referral to a retinal surgeon was warranted. Regarding a potential causation defense, there was a question as to whether the injury may have been serious enough from the outset to require an enucleation. Defense counsel and our experts believed it would be extremely difficult to rebut the fact that the failure to locate the foreign body led to the infection and the eventual enucleation OD. There was also an issue regarding the surgeries performed by the residents at the local charity hospital. Some of the experts were critical of the technique used during these two surgeries. However, defense counsel and experts agreed that any potential criticism of the residents probably would not hold up in light of the severity of the endophthalmitis at the time of the first surgery.

Risk Management Principles

The insured explained that because of the patient's limited financial resources, he hoped to minimize the cost to the patient by monitoring the situation instead of ordering expensive diagnostic tests. The insured felt justified in doing this because the patient had "good visual acuity and an intact ocular structure." Due to the nature of the injury, however, the insured's focus should have been on ruling out the presence of a foreign body. A simple x-ray could have accomplished this at much lower cost than CT imaging.

Unfortunately, the patient's illegal residency status and inability to pay allowed the insured to lose sight of what was best for the patient and altered his diagnostic workup. As a result, tests that would have led to an earlier and more definitive diagnosis were not ordered. Alternately, the insured could have made an immediate referral to the local charity hospital, where evaluation and treatment would have been provided at reduced or no cost to the patient.

Risk Management Hotline



Differential Diagnosis: Develop and Disclose It

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

Failure to diagnose is a frequent allegation in medical malpractice lawsuits. OMIC claims analysis and peer-reviewed studies point to some ways to reduce this obstacle to safe, quality patient care.

Q Are there common problems that surface in "failure to diagnose" cases?

A Yes, but they are not what the court system would lead us to believe. Alleging that a patient suffered harm due to a physician's negligence implies that the diagnosis was missed because of that particular doctor's shortcomings. In fact, inadequate knowledge or skill was the cause in only 4 of 100 malpractice cases in one study, and all four involved rare conditions.[1] Other cognitive errors, such as faulty data gathering and information synthesis, occurred frequently in the cases studied and were often compounded by faulty systems such as equipment and organizational issues. Cognitive scientists who have analyzed diagnostic errors point out that the way physicians reason, formulate judgments, and make decisions works well most of the time. In some instances, however, cognitive rules of thumb and shortcuts lead to error. Examples include memories of former cases, the way information is presented and framed, obedience to authority figures, and premature closure of the diagnostic process.[2] These cognitive "pitfalls" are inherent in the process itself; another physician may well make the same errors.

Q Do studies of OMIC claims data reveal these cognitive errors?

A Yes. In a recent OMIC study, three conditions were frequently misdiagnosed: retinal detachment, glaucoma, and foreign bodies. Retinal detachment and glaucoma were often missed if the patient had ocular comorbidities that could explain some of the symptoms, leading the ophthalmologist to assume it wasn't necessary to complete a comprehensive evaluation, including a dilated eye exam. Retained foreign bodies were missed when the physician did not obtain an adequate history or failed to order x-rays to rule out their presence (see **Closed Claim Study**). Systems issues, particularly office appointment scheduling and follow-up protocols, also contributed to patient harm and led to settlements. When an on-call physician did not notify his staff of a patient due to come in the following morning after an ER consultation, his staff would not schedule the appointment, citing the office policy of declining public aid patients. After the child developed a corneal ulcer and needed a transplant, the practice settled for $1,000,000. Some conditions manifest themselves more clearly with time, and are often correctly diagnosed at the follow-up visit. If the patient does not show up for the visit, and staff do not notify the ophthalmologist of the missed appointment, an opportunity to intervene is lost. (See OMIC's "Telephone Screening of Ophthalmic Problems" and "Noncompliance" at www.omic.com.)

Q What strategies do cognitive scientists suggest to improve the decision-making process?

A Strategies that encourage physicians to stop and examine their thinking process may help. Two key safety steps are: 1) pause to consider what else could produce the same signs and symptoms, and 2) entertain, however briefly, the worst possible scenario. By developing a differential diagnosis, the ophthalmologist can determine not only when a complete, dilated exam is required, but also when additional tests are needed to rule out vision-threatening conditions. A diagnosis that does not account for all of the signs and symptoms needs to be reconsidered, as does one that leads to a treatment plan that is not effective. When the patient's course is unexpected, start over by reviewing the record with an open mind and asking questions such as "What else might be going on?" These strategies might prompt additional testing and examination, an expanded differential diagnosis, and a clearer picture.[3]

Q Why do you recommend disclosing the differential diagnosis to the patient? Doesn't that just confuse the patient?

A In a busy ophthalmic practice, it is easy to overlook the need to obtain a thorough patient history and to rely solely upon the information provided by the patient to you or your staff. The patient's presenting "complaint" may be misleading or irrelevant unless specific questions are asked, or the patient may have been interrupted before he or she had time to give a full account of all symptoms. Make the patient part of the healthcare team from the beginning of the diagnostic process by allowing sufficient time for the patient to present his or her concerns. Disclose your differential diagnosis and treatment plan. Ask the patient to watch for new symptoms and to contact you if the condition worsens or does not improve before the next appointment.

1. Graber ML, Franklin N, and Gordon R. "Diagnostic Error in Internal Medicine." *Arch Intern Med*. July 11, 2005; v. 165: 1493-1499.

2. Redelmeier DA. "The Cognitive Psychology of Missed Diagnoses." *Ann Intern Med*. 2005; 142: 115-120. For a detailed discussion, see Croskerry P. "Achieving Quality in Clinical Decision Making: Cognitive Strategies and Detection of Bias." *Acad Emerg Med*. 2002; v. 9, n. 11: 1184-1204.

3. "Failure to Diagnose Traumatic Eye Injuries" and "Failure to Diagnose Giant Cell (Temporal) Arteritis" at www.omic.com.

OMIC
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 courses throughout 2010. Upon completion of an OMIC online course, DVD, CD or MP3 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 here and at www.omic.com. CME credit is available for some courses. Please go to 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 seminars, CD/DVD/MP3 recordings, or online courses.

Upcoming Seminars

May

6 *Evaluating Competency; Handling Incompetency*
Kentucky Academy of Eye Physicians & Surgeons*; Griffin Gate Marriott, Lexington, KY; 6:00–7:00 pm. Contact KAEPS at (866) 328-0554 or http://www.kyeyemds.org.

7 *Evaluating Competency; Handling Incompetency*
Maryland Society of Eye Physicians and Surgeons*; Hilton BWI Hotel, Linthicum Heights, MD; 1:00–3:00 pm. Contact Lauren Myers at MSEPS at (410) 244-7320 or mseps@verizon.net.

21-23 *Evaluating Competency; Handling Incompetency*
Arizona Ophthalmological Society*, Nevada Academy of Ophthalmology*, New Mexico Academy of Ophthalmology; High Country Conference Center, Flagstaff, AZ; morning session. Contact AOS at (602) 246-8901 or http://www.azeyemds.

June

10-13 *Evaluating Competency; Handling Incompetency*
American Society of Ophthalmic Plastic & Reconstructive Surgery* St. Regis Hotel, Aspen, CO; time TBA. Contact ASOPRS at http://www.asoprs.org.

11-12 *Evaluating Competency; Handling Incompetency*
Virginia Society of Eye Physicians & Surgeons*; Boar's Head Inn, Charlottesville, VA; time TBA. Contact VSEPS at (804) 261-9890 or http://www.vaeyemd.org.

11-13 *Evaluating Competency; Handling Incompetency*
Georgia Society of Ophthalmology* Ritz-Carlton Reynolds Plantation, Lake Oconee, GA;11:30 am–12:30 pm. Contact GSO at (404) 299-7700 or http://www.ga-eyemds.org.

25-27 *Evaluating Competency; Handling Incompetency*
West Virginia Academy of Ophthalmology*; Stonewall Resort, Roanoke, WV; 6:00 pm. Contact WVAO at (304) 343-5842 or http://www.wveyemd.org.

27 *Evaluating Competency; Handling Incompetency*
Florida Society of Ophthalmology* Ritz-Carlton Orlando Grande Lakes, Orlando, FL; 7:00–8:00 am. Contact FSO at (904) 998 0819 or http://www.mdeye.org.