Winter 2004 Volume 14 Number 1

OMICDIGEST

Ophthalmic Mutual Insurance Company Ophthalmic Risk Management Digest

Telephone Screening as a Risk-Reduction Tool

By Anne M. Menke, RN, PhD

Ms. Menke is OMIC's Risk Manager.

Each day, countless patients call ophthalmologists to report problems and seek advice. During these telephone conversations, the health care team does not have access to the wealth of information obtained from face-to-face communication and physical examination of the patient. After hours, the patient may be unknown to the ophthalmologist and the chart unavailable. OMIC claims experience confirms that making medical decisions on the basis of the limited information obtained over the telephone is a risky–albeit necessary–aspect of ophthalmic practice.

To promote both the continuity and defensibility of telephone care, OMIC has developed sample telephone contact forms and screening guidelines, which are available online at **www.omic.com** or by calling (800) 562-6642, ext. 652. This article provides risk management recommendations on how to develop and implement a screening protocol based on using these contact forms and guidelines.

First and foremost is to exercise the same care when treating a patient over the telephone as you would during an office visit: (1) gather the information necessary to assess the situation and determine the treatment plan; (2) communicate the assessment and treatment plan to the patient; and (3) document the encounter and decision-making process in the medical record. To safely enlist your staff's assistance in gathering information, develop and implement written protocols for telephone screening and treatment that are specific to your patient population, subspecialty, and staff. Supervise staff members who screen calls. In addition to developing and approving written protocols, effective supervision includes: (1) training and verification of competency; (2) willingly accepting questions from staff members unsure of how to handle specific calls; (3) daily review of telephone calls; and (4) periodic review of the screening protocols themselves.

continued on page 4

In This Issue. . .

2
Eye on OMIC
OMIC's newly designed, easy-to-navigate web site offers insureds convenient 24/7/365 access to a full array of risk management documents and insurance services with more online offerings planned later this year.

3
Policy Issues
New federal regulations concerning the release of contact lens prescriptions to patients makes it even more important for ophthalmologists and their staff to be aware of patient safety issues and provider liability risks when prescriptions are filled by third-party dispensers.

6
Closed Claim Study
Lack of documentation and conflicting recollections of what transpired when a post-op cataract patient called to report symptoms of a retinal detachment underscored for one ophthalmologist and her staff the importance of telephone screening protocols.

7
Risk Management Hotline
Although two national studies have concluded that routine medical testing before cataract surgery does not improve patients' health or clinical outcomes, lawsuits involving surgical complications are difficult to defend if preoperative tests which might have identified a risk factor were not ordered.

8
Calendar of Events
Mark your calendar for a host of OMIC risk management seminars and exhibits this spring and summer, including programs in San Diego, Honolulu, and Santa Fe.

©2004 Ophthalmic Mutual Insurance Company, A Risk Retention Group Sponsored by the American Academy of Ophthalmology

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 owns the copyright for all material published in the OMIC Digest (except as otherwise indicated). Contact OMIC for permission to distribute or republish any Digest articles or information. The general information on medical and legal issues that OMIC provides in the Digest is intended for educational purposes only and should not be relied upon as a source for legal advice. OMIC will not be liable for damages arising out of the use of or reliance on information published in the Digest.

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

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

Timothy J. Padovese
Editor-in-Chief

Paul Weber, JD
Executive Editor

Linda Radigan
Managing Editor

Anne Menke, RN, PhD
Associate Editor

Kimberly Wittchow, JD
Associate Editor

Stoller Design Group
Production

Visit the New www.omic.com

Activity at **www.omic.com** has steadily increased as more and more ophthalmologists take advantage of the convenience of 24/7/365 online access to OMIC's full array of risk management documentation and insurance services. Each month, the OMIC web site averages 2,000 visitor sessions lasting one minute or longer and 4,200 viewed and downloaded documents. The most popular of these are the forms for LASIK consent, cataract surgery consent, termination of care, and patient history and physical. In addition, the web site has become a significant source of new business for OMIC. More than 250 online application requests were received in 2003, representing 25% of all applications for coverage requested last year.

In an effort to make the OMIC web site more useful and accommodating to an increasing number of visitors, **www.omic.com** has been extensively redesigned in recent months to give the site a fresh new look, enhanced functionality, and consistent navigability. With just a click of the mouse, ophthalmologists can download the ever popular OMIC FAVORITES and edit these documents on their own computer for immediate implementation in their practice. Developed by ophthalmologists and ophthalmic risk management/legal specialists, these essential forms and documents can help improve patient care and minimize the risk of claims and lawsuits.

Besides being able to request an insurance application form or certificate of insurance online, at **www.omic.com** you will find:

- Informed consent documents
- Consent forms in Spanish
- Refractive surgery documentation
- Medical office and patient safety documentation
- Recent and archival issues of the *Digest*
- *E-Bulletin* announcements

Insureds can visit the web site to complete one of OMIC's two online risk management courses *(Ophthalmic Anesthesia Risks* and *EMTALA and ER-Call Liability)* and to learn about upcoming OMIC seminars and audioconferences in conjunction with state and subspecialty ophthalmic society meetings.

Throughout 2004, OMIC will continue to expand its internet capabilities. Future offerings on the web site will include additional online risk management courses and a secure MEMBERS ONLY section where insureds will be able to pay their premium online and update their address and contact information.

Release of Contact Lens Prescriptions

By Kimberly Wittchow, JD
OMIC Staff Attorney

Ophthalmologists have long been concerned about the safety issues and liability risks associated with patients filling their contact lens prescriptions through third-party vendors and not returning to the original provider for appropriate follow-up care. Patients who experience problems with their lenses may blame the ophthalmologist and allege improper prescribing or failure to warn of complications.

Over the past several years, contact lens dispensers have urged federal lawmakers to pass legislation allowing consumers to shop for the best prices. Their perseverance was rewarded when Congress passed the federal Fairness to Contact Lens Consumers Act. The Act, which took effect February 4, 2004, makes it even more important for ophthalmologists and their staff to be aware of patient safety issues and provider liability risks when prescriptions for contact lenses are filled by third-party dispensers.

While the American Academy of Ophthalmology and other provider organizations were able to negotiate many positive changes to the Act before its passage, several troublesome and confusing provisions remain. This article explains certain provisions of the new law and points out areas where questions of interpretation and implementation remain.

Prescription Release

First, the Act requires that a prescriber give the patient a copy of the prescription at the completion of the fitting, whether or not the patient requests it. As defined in the Act, a "contact lens fitting" may include medically necessary follow-up exams. Thus, whether you are prescribing for a first-time or repeat contact lens wearer, you do not need to provide the prescription until you have made the medically necessary determination, through follow-up visits if appropriate, that the prescription is accurate.

However, what happens if a non-disposable or custom soft or rigid lens must be purchased by the patient before the fitting can be completed? It seems you would have to release the prescription to the patient without the proper fitting, or else have the patient order the lenses through your office. Until there is clarification on this issue, you must consider how to marry compliance with this law with prudent patient care decision-making.

Fee and Waiver Limitations

Second, the Act places several limitations on prescribers. You may not require the purchase of contact lenses from yourself or another person or charge an additional fee as a condition of providing a copy or verification of the prescription. However, you can require payment of your regular fees for an eye exam, fitting, and evaluation before the release of the prescription, but only if you normally require immediate payment for other services not related to the provision of ophthalmic goods. Finally, you cannot require the patient to sign a waiver or release as a condition of verifying or releasing the prescription. In addition, you cannot disclaim liability for "the accuracy of the eye examination." However, you might still disclaim liability for mistakes made in filling the prescription or for inferior products dispensed by third parties.

Prescription Verification

Third, you must also provide or verify the contact lens prescription, by electronic or other means, to any person designated to act on behalf of the patient. The Act lists the information a seller seeking such a verification must provide, including a fax and telephone number for a contact person at the seller's company. However, since the Act does not specify what a non-seller designee must present in order for you to provide or verify the prescription, following the HIPAA guidelines (or stricter state law) regarding release of protected health information is advised.

Verification of the prescription by the prescriber can take place in three different ways. The first two verifications occur either when you confirm that the prescription is accurate or you provide the accurate prescription, as the Act requires you do, when the seller tries to verify an inaccurate prescription. The third type, passive verification, was unsuccessfully lobbied against by the Academy. Passive verification means that if you fail to communicate with the seller within eight business hours (or similar timeframe as defined by the FTC's mandated rulemaking under the Act) after receiving a valid verification request, the prescription is presumed verified by you. If the prescription is inaccurate, expired, or otherwise invalid, you are required to specify on what basis it is so and the seller cannot then fill the prescription. The obvious worry is that if you do not verify the prescription in the one day allowed for turnaround, the seller may fill an expired and/or inaccurate prescription to the detriment of the patient.

Finally, although the Act mandates an expiration date of not less than one year for contact lens prescriptions, you can specify a different expiration date based on your medical judgment as long as you document your reasons in the patient's medical record.

For sample letters and more information about releasing contact lens prescriptions, visit OMIC's web site and go to Risk Management under Resources and click on Medical Office Patient Safety/Communication.

Telephone Screening as a Risk-Reduction Tool

continued from page 1

Staff Scope of Practice, Qualifications, Training

Ophthalmologists are fortunate to employ staff members with detailed knowledge about ophthalmology who have undergone extensive training and certification; however, patient safety concerns and the laws governing the practice of medicine place limits on the tasks non-physicians can perform. The role of non-physicians in screening ophthalmic problems consists of gathering information in order to assign an appointment category. They cannot diagnose or treat a condition or provide medical advice; all medical decisions must be made by the ophthalmologist.

Instruct staff members not to minimize patient complaints or provide false reassurance. Handle with care patients who are concerned about their condition and are not satisfied with the type of appointment given. Juries are not sympathetic when a patient with significant vision loss testifies that she begged the receptionist to be seen right away but was told that nothing serious was wrong. Encourage staff to consult with you any time questions arise. Examples include complaints that are not listed in the screening guide, complaints that fall into more than one appointment category, and patients with routine complaints who want to be seen the day they call. In general, err on the side of patient safety when assigning an appointment category.

Take into account the language spoken by the majority of your patients. It might seem obvious, but only authorize staff members with the necessary language and communication skills to screen ophthalmic problems over the phone. Such skills include patience, cheerfulness, compassion, clarity of enunciation, and professionalism, as well as a willingness to abide by the guidelines and seek help whenever needed. Ensure that telephone screening is included as a job responsibility in the employee's job description. Provide training to staff members who handle patient calls, and evaluate their competency in applying screening guidelines before allowing them to implement the screening protocols.

Customize Protocols to Your Practice

OMIC sample telephone contact forms and call screening guidelines do not cover all possible patient complaints and may not apply to every situation. Customize them for your practice and subspecialty; approve the final, written version; and implement them only after extensive staff training. Review the protocols regularly (annually or when there are practice changes) to assure that they still meet the needs of your patients and practice. Include in the protocol how you want staff to address two common situations that have led to delay in diagnosis claims: same day appointment requests and new patients. Ask your staff members to inform you of a patient's desire to be seen the same day, and make every effort to accommodate the patient's wish. If you cannot see the patient when the patient wants to be seen, speak to the patient and carefully screen the call to determine the cause of the patient's symptoms and concern. Suggest alternative sources of care. Remind patients of their right to seek emergency care at a hospital if they feel they have an emergency medical condition. Keep in mind, however, that many emergency departments may not be equipped to carefully evaluate ophthalmic complaints. Direct the patient to a source of care that is likely to prove beneficial.

Indicate in the protocol whether or not your practice accepts new patients and how to handle calls from new patients if it does not. For example, have staff members first ask callers if they are a current patient. If the answer is no, have staff members inform the caller that the practice does not accept new patients, and offer them the names of ophthalmologists in the area who do. Do not discuss callers' conditions or complaints if you are not available to accept them as patients. Once adapted to the individual practice and approved by you, post the guidelines by the phones of all staff members who answer calls. When guidelines are updated, note the new revised date and keep a copy of all former versions in case prior care and screening are ever called into question.

Indicate in the protocol whether you want to be notified of emergent appointments, and what to do if the patient asks to speak with you. Address how you will supervise non-physicians who assist in telephone screening.

Screening, Documenting Calls During Office Hours

The OMIC sample telephone contact form **(Figure 1)** prompts staff members to gather information that will be used to determine the timing of the appointment: emergent, urgent, or routine. On the sample screening guideline **(Figure 2)**, patients with emergent conditions are told to come in or go to the ER immediately. Urgent patients are seen within 24 hours in this guideline, but you may wish to see these patients the same day. Patients assigned a routine category are given the next available routine appointment.

If the patient's complaints fall into more than one appointment category, assign the quickest category. For example, if the patient complains of discharge that causes the eyelids to stick together (urgent appointment) and mild ocular irritation, itching,

Figure 1: Telephone Contact Form (excerpt)

What is your problem?

____

When did your problem begin?

____

How suddenly did it begin?

____

Has the problem worsened, improved, or remained unchanged?

____

Does it affect one eye or both?_______________ If one eye, which one? *Right/Left*
Have you recently had surgery or a procedure? *Yes/No*
Type and date of surgery/procedure:

____

Figure 2: Telephone Screening of Ophthalmic Problems (excerpt)

Assign category after completing telephone contact form

COMPLAINT	EMERGENT	URGENT	ROUTINE
VISION CHANGES	Vision changes after surgery or procedure	Sudden onset of diplopia (double vision) or other distorted vision Double vision that has persisted for less than a week	Difficulty with near or distance work, or fine print

and burning (routine), give the patient an urgent appointment. If the patient has any complaint that falls into the emergent category, give an emergent appointment.

Document all patient care-related calls in the patient's medical record. Some practices may want to use a telephone contact form that prompts staff members to ask questions and documents the answers on the same form (the sample provided is designed for ease and speed of documentation by allowing staff members to circle answers instead of writing them out). Other practices may choose to provide staff with a list of questions to ask (such as the ones on the sample contact form) but chart only the pertinent information, either in the progress notes or on a phone message slip that is taped into the medical record (e.g., "10/1/03 11:15 am. Mary Smith called to report sudden onset of 'flashing lights' and 'floating things' OD. Had cataract surgery OD on 8/15/03. Given emergent appointment for today at 1 pm. AMP, receptionist").

Staff members will understandably be concerned about the time required to screen calls using these suggestions. Not every phone call will require asking every question. Rather, the patient's complaint will determine the extent of the screening process. For example, as soon as enough information is obtained to categorize the appointment as emergent, no more information needs to be obtained since the patient will be asked to come in immediately. Differentiating urgent from routine problems will take more staff time and effort and may require asking all or nearly all of the questions. The time spent carefully screening calls is time well spent, however, if it preserves a patient's vision.

Review, date, and initial all calls on a daily basis. This provides a safety net for patients and documents the supervision of your staff. Regardless of the type of appointment, file all telephone contact forms in the patient's medical record.

Screening, Documenting Calls After Hours

While these guidelines are designed for use during office hours, your after-hours and on-call telephone contacts with patients or other caregivers also need to be carefully screened, handled, and documented. OMIC claims experience includes multiple cases where the ophthalmologist's only involvement in a patient's care was an undocumented after-hours contact or prescription refill.

A sample after-hours form is included on the web site that prompts you to ask about recent procedures or surgeries and whether the patient has contacted other health care providers about the same or related problems. Compact *Patient Care Phone Call Record* pads also can be purchased from OMIC and kept in your car, purse, brief-case, or locker. Once you return to your office, place the contact form in the patient's medical record. If you provide on-call coverage for a physician in another practice, fax a copy of your contact form and records to the other physician and retain the original in a file designated *On-call Coverage Contacts*.

Negligent Telephone Care of Postoperative Patient

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

Allegation

Delay in diagnosis and treatment of retinal detachment following cataract surgery.

Disposition

Defense verdict at trial.

Case Summary

A 58-year-old female with lattice degeneration had uncomplicated cataract surgery. Three months postoperatively, the patient called the surgeon to report seeing branches and black spots of one day duration and was told to come in. She denied seeing flashing lights. BCVA was 20/25, and a dilated fundus with scleral depression examination of the right eye revealed vitreous hemorrhage and floaters. The macula and peripheral retina were flat without holes, tears, or evidence of retinal detachment. The ophthalmologist prescribed bed rest (with the head of the bed elevated at 30 degrees) and advised the patient to follow up in 1 to 2 weeks or sooner if she developed increasing floaters, photopsia, or a veil/curtain formation.

The patient said she called the office four days later to report that she could barely see through a dark bubble. She claimed to have spoken to the receptionist, who consulted with the ophthalmologist, and was told not to worry. There was no documentation of the call. In deposition, the insured recalled being told only that the patient wanted to know when the floaters would resolve. She believed that she either asked the receptionist to call the patient back and verify the lack of new symptoms or that she called the patient herself. Five days later, the patient called again and said she was coming in. At the visit, she reported fluctuating vision and was noted to have a VA of CF, with both a horseshoe tear and a macula-on retinal detachment in the superotemporal quadrant. The insured spoke with a retinal specialist, who agreed to see the patient the next day; the call was not documented and the specialist had no recall of the conversation. When the patient was seen the next day, the detachment had progressed to macula-off. The patient had a scleral buckle, vitrectomy, air/fluid gas exchange, and endolaser surgery. At the time of trial eight months later, the retina was still attached, with vision pinholed to 20/60; the patient reported multiple visual problems.

Analysis

Plaintiff experts focused on the increased risk of retinal detachment in patients with lattice degeneration and cataract surgery. They doubted the ability to visualize the retina in the presence of vitreous hemorrhage and criticized the delay in referral to the retinal specialist then and when the detachment was diagnosed. Defense experts supported the insured's examinations and treatment; moreover, they felt strongly that an experienced cataract surgeon, who had explicitly warned the patient about retinal detachment, would never ignore reports of a dark bubble. The lack of documentation, especially of the phone calls with the patient and the retinal specialist, became the focal point of the trial. Jurors who returned a defense verdict later explained that the plaintiff lost credibility when she refused to pursue the recommendations of a blind vocational rehabilitation expert. Nonetheless, they had sharp criticism for the insured's call screening process and failure to document telephone care.

Risk Management Principles

Telephone screening of eye complaints, especially in postoperative patients, is an extremely risky aspect of ophthalmic practice and a regular feature of malpractice lawsuits. Physicians need written protocols, including contact forms that prompt them and their staff to ask crucial questions and document the responses, as well as guidelines to determine when the patient needs to be seen. Such sample forms and protocols are available online and from OMIC's Risk Management Department (see cover article). The physician's screening process is intended to gather the information necessary to develop a differential diagnosis that includes the worst case scenario for the patient's presentation. In this case, the ophthalmologist clearly identified the risk of retinal detachment, but she could have been more proactive in managing it by making an early referral to a retina specialist to verify her examination in the presence of hemorrhage and by scheduling frequent follow-up visits before the patient left her office.

Risk Management Hotline

Preoperative Testing and Examination

By Paul Weber, JD
OMIC Vice President

The need for preoperative medical testing and examination has been studied primarily in the context of cataract surgery, although it applies to many other ophthalmic surgeries. A national survey published in 1995[1] showed that the majority of ophthalmologists, anesthesiologists, and internists routinely order certain tests prior to cataract surgery, generally lab work and ECGs but sometimes chest x-rays and blood clotting studies as well. Even though many physicians in the study did not think the tests were necessary, they ordered them anyway because of hospital or surgery center requirements or their own medicolegal concerns. A subsequent study published in January 2000[2] concluded that routine medical testing before cataract surgery does not improve patients' health or clinical outcomes. Nevertheless, lawsuits involving surgical complications (especially those related to anesthetic reaction) are difficult to defend if routine tests which might have identified a risk factor were not ordered.

Equally difficult to defend are cases in which tests were performed but the ophthalmologist did not review the results or communicate them to the patient. OMIC's first large indemnity payment was made in 1990 on behalf of a cataract surgeon who failed to review and notify the patient of an abnormal preoperative chest x-ray; the mass soon metastasized into inoperable adenocarcinoma. More recently, in a non-OMIC case, a jury handed down a $5.1 million verdict against an ophthalmologist who failed to diagnose diabetes or to refer the patient to a specialist after receiving three separate lab studies over the course of four months all showing that the patient had elevated blood glucose levels. The patient eventually had to have a right below-the-knee amputation and a left great-toe amputation.

Q Are there any exceptions to ordering pre-op tests?

A Probably not if your hospital or ASC requires them. Because cataract patients tend to be elderly and often have coexisting illnesses, many physicians believe that a medical examination with laboratory testing must be performed before a patient can be considered eligible for surgery. On the other hand, some physicians feel that lab work is unnecessary in a healthy patient with a negative history undergoing straight topical anesthesia without an injection. Anytime an injection is involved, however, a preoperative history and physical examination may be warranted.

Q How extensive should the preoperative history and physical examination be?

A There appears to be a wide variance in how ophthalmologists approach the history and physical. Some ophthalmologists obtain preoperative approval via a telephone conversation with the patient's internist, general practitioner, or primary care physician (PCP) and will request that the referring physician dictate a note stating that the patient is cleared for surgery. During the call, the ophthalmologist will inquire about recent labs, tests, medications, and health history; for example, a prothrombin time for a patient who has stopped taking Coumadin in preparation for surgery or ECG results on a patient with significant cardiac history. A well-documented discussion with a PCP who has examined the patient recently may suffice to approve the patient for surgery.

Q May I perform my own pre-op examinations?

A You may do so if you are able to document continuing proficiency in general medicine; otherwise, it is advisable to refer patients to their PCP. That being said, some ophthalmologists prefer to be involved in the pre-op workup rather than to delegate it entirely to the PCP because it allows them, as the surgeon, to become better acquainted with the patient's overall health status. In such cases, after discussing the patient's history with the PCP, the ophthalmologist performs a brief physical exam and orders any tests not recently obtained by the PCP.

Q What steps should I take to ensure that patients are informed of test results?

A Develop office systems to assure the efficient processing of all diagnostic clinical information, including:

- A method for ensuring that lab results, consultation reports, and other pertinent documents are seen by the treating/attending physician before they are filed.
- A reminder or diary system to ensure that follow-up tasks, such as notifying patients of test results, are undertaken when warranted.
- A formal arrangement whereby adverse test results or those requiring immediate attention are reported personally by the consulting physician to the requesting physician.

1. Bass EB, et al. "Do Ophthalmologists, Anesthesiologists, and Internists Agree About Preoperative Testing in Healthy Patients Undergoing Cataract Surgery?" *Arch Ophthalmol* 1995; 113:1248-1256.
2. Schein OD, et al. "The Value of Routine Preoperative Medical Testing Before Cataract Surgery." *NEJM* 2000; 342:168-175.

Calendar of Events

OMIC continues its popular risk management seminar program this spring and summer in conjunction with state, regional, and subspecialty ophthalmic society meetings. CME credit and OMIC's risk management premium discount are available for attending most OMIC-sponsored seminars or for participating in one of OMIC's two online courses *(Ophthalmic Anesthesia Risks* and *EMTALA and ER-Call Liability)* at **www.omic.com**. Registration for certain seminars is free for OMIC insureds. Seminars that qualify for OMIC's 10% double risk management discount are indicated with an asterisk. OMIC insureds must be a member of the cosponsoring society to earn the special 10% discount.

Visit the Academy/OMIC Insurance Center during the ASCRS/ASOA Symposium and Congress May 1–4. Located in the San Diego Convention Center, Exhibit Hall A/B, Booth 929, the Academy/OMIC Insurance Center will provide a central location for ophthalmologists to learn more about the sponsored professional liability, business liability, and life and health insurance programs available to members of the American Academy of Ophthalmology. Representatives from OMIC, Medical Risk Management Insurance Services, and Marsh Affinity Group Services will be at the booth to provide coverage and rate information on their respective programs.

April

3 *The Risks of Telephone Screening and Treatment*
Virginia Society of Ophthalmology
Marriott Westfields Hotel, Chantilly, VA
2:30–3:30 pm
Register with VSO, (804) 261-9891

May

1 *Malpractice Litigation and Refractive Surgery Complications*
ASCRS Course 1201
ASCRS/ASOA
San Diego Convention Center, San Diego, CA
10–11:30 am
Register with ASCRS, (703) 591-2220

15 *Telephone Screening for Ophthalmic Problems: Clinical, Ethical and Risk Management Aspects**
Texas Ophthalmological Association
Austin Convention Center, Austin, TX
12:30–2 pm
Register with TOA, (512) 370-1504

15 *The Risks of Telephone Screening and Treatment**
Hawaii Ophthalmological Society CodeQuest
Kamehameha Auditorium, Queen's Medical Center, Honolulu, HI
Time TBA
Register with AAO, (415) 561-8500

21 *The Risks of Telephone Screening and Treatment**
Missouri Society of Eye Physicians and Surgeons
Country Club Hotel, Lake of the Ozarks, MO
Time TBA
Register with MoSEPS, (847) 680-1666

23 *OMIC Course TBA**
Tri-State Meeting (AZ, NV, NM)
Loretto Inn, Santa Fe, NM
Time TBA
Register with individual state society:
AZ (602) 246-8901
NV (800) 394-4968
NM (505) 272-3211
OMIC's 10% premium discount available to AOS and NOS members only

July

10 *The Risks of Telephone Screening and Treatment*
Southeastern Regional Scientific Symposium for AL, GA, KY, NC, SC, TN, WV
Amelia Island Plantation Resort, Amelia Island, FL
Time TBA
Register by calling (919) 833-3836

31 *The Risks of Telephone Screening and Treatment**
Women in Ophthalmology
Stein Eriksen Lodge, Park City, UT
Time TBA
Register with Denise Wilson, (415) 561-8523 or dwilson@aao.org

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

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

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