Winter 2005 Volume 15 Number 1 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest

OMIC DIGEST

Lessons from Trials and Settlements of 2004

By Arthur W. Allen, MD, and Anne M. Menke, RN, PhD

Dr. Allen is OMIC's Chairman Emeritus and is currently serving his final year as Chairman of OMIC's Claims Committee. Anne Menke is OMIC's Risk Manager.

OMIC policyholders have indicated on evaluation forms completed after risk management seminars that they would like to know the outcome of trials and settlements. This article will give an overview of last year's claims experience. Claims and lawsuits are evaluated by the OMIC Claims Department and the Board's Claims Committee, as well as by plaintiff and defense attorneys and expert witnesses. The insured ophthalmologist is involved in the process and in the decision to settle a case or take it to trial. Money awarded to plaintiffs as a result of settlements or jury verdicts are called indemnity payments and are reported by OMIC to the National Practitioner Data Bank. As required by state law, some are also reported to the physician's medical board.

In 2004, there were thirteen trials, which resulted in eleven defense verdicts (85%), one plaintiff verdict, and one mistrial due to a hung jury. One case that resulted in a defense verdict required a payment to the plaintiff based on a pre-trial "high/low" agreement. A jury verdict does not always signal the end of a case. Four of the eleven defense verdicts are being appealed, including one that has already been taken to trial three times. OMIC is appealing the one plaintiff verdict of $500,000. The 56 settlements cost OMIC $6,851,155 in indemnity payments.

All three anesthesia cases involved retrobulbar blocks. In one case, the plaintiff alleged inadequate pain relief during cataract surgery; the other two stemmed from globe perforations, a known complication of the procedure that can occur in the absence of negligence. The cause of the poor outcome in one case was excessive anticoagulation from Coumadin combined with inadequate control of intraoperative bleeding. When a patient is on Coumadin, alternative methods of anesthesia should be considered, and the ophthalmologist should consult with the primary care physician to verify that the PT level has been recently checked and is in the appropriate range prior to surgery.

continued on page 4

MESSAGE FROM THE CHAIRMAN

When compared to multispecialty insurers, OMIC and its Board of practicing ophthalmologists have demonstrated a better understanding of how to represent ophthalmologists, both in the courtroom and in the boardroom. On average, OMIC policyholders are paying 8% less in premium than ophthalmologists insured by multispecialty carriers. At the same time, OMIC has a better record when it comes to defending our member-insureds, winning a higher percentage of cases at trial and closing cases without an indemnity payment more frequently than multispecialty carriers. OMIC's Board is committed to hiring the best defense attorneys and outside experts, even though the cost may be high, because we believe that defending our insureds is the most important service we can provide as a malpractice carrier.

Although we have endured rate increases over the past few years, those of us who resist shortsighted decisions regarding our malpractice premiums will be rewarded with better coverage at reasonable cost over the long term. Let me emphasize that we never like to pass on additional expense to you or your practice.

continued on page 2

IN THIS ISSUE

©2005 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

Broad Regulatory Protection Policy for OMIC Members

As reported in the Summer/Fall 2004 issue of the *Digest*, OMIC professional liability policyholders automatically receive a $25,000 regulatory protection policy upon purchase or renewal of their OMIC malpractice policy. Now known as the *Broad Regulatory Protection Policy*, this new program replaces the Fraud and Abuse/HIPAA Privacy Legal Expense Reimbursement Policy and expands coverage to include new exposures. As a benefit of membership, OMIC has purchased a *Broad Regulatory Protection Policy* for each of its physician and entity professional liability policyholders. Because the new policy has been written to extend this coverage to OMIC members automatically, a declarations page is not necessary and will not be produced unless additional coverage (higher liability limits) is purchased. Coverage is currently available up to $1 million.

Policyholders who have provided their email address to OMIC have received a link to the members section of OMIC's web site where they can review and download the policy documents and upgrade forms (see *E-Bulletin*, Feb. 23, 2005). Other OMIC policyholders can view this information by accessing this link: www.omic.com/members/mbrsOnlyBRPP.cfm.

For more information on this policy, please refer to the **Business Coverages** section of OMIC's web site or call MRMI, the plan administrator, directly at (800) 610-6642.

Message from the Chairman

continued from page 1

I can assure you that, as Chairman of the Board and a fellow policyholder who feels similar financial burdens, those of us charged with OMIC's stewardship will not ask for one penny more than we believe we need to ensure the financial security of this very successful Academy-sponsored program.

When the first signs of a "market crisis" appeared in early 2000, the OMIC Board realized that, as major multispecialty carriers teetered on the brink of financial ruin, OMIC would be called upon to come to the aid of Academy members who had nowhere else to turn for affordable coverage. Over the next four years, OMIC became a welcome refuge for more than 1,300 additional policyholders.

Our most important challenge now is to make sure that we have the resources necessary to meet our obligations to a larger insured base. Insurance regulators want malpractice companies to set aside at least one dollar in a surplus fund for every dollar collected in premium. Policyholder surplus, or a company's "capital," is extremely important because it provides assurance that a company has the ability to pay future claims should unanticipated losses occur. Although we have run OMIC very conservatively and have never dipped into our surplus funds, we must remain prudent and strive for continued success while preparing for a "worst case scenario." OMIC's current premium to surplus ratio is 1.11 to 1, moving us in a favorable direction when compared to the rest of the industry, and we are taking the necessary steps to achieve a 1 to 1 ratio in the near future. In doing so, we are ensuring OMIC's financial health for the next several decades.

When the insurance market eventually recovers, new carriers that were not there for ophthalmologists during difficult times may seek your business. I ask you to remember which company has been writing new policyholders continuously when those other carriers were nowhere to be found. I would like to thank our long-term and loyal policyholders who have helped make OMIC what it is today. Above all, I would like to thank my predecessor and past OMIC Chairman, Arthur W. (Mike) Allen, MD, who has guided the Company through its most successful period to date and is largely responsible for the great benefits we now enjoy as policyholders.

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

Policy Issues

The Cooperation Clause

By Kimberly Wittchow, JD
OMIC Staff Attorney

In order to properly investigate and defend a medical malpractice claim, the professional liability company and the insured must cooperate. The participation of the insured, who is the subject of the lawsuit and holds first-hand information about the incident, is crucial to his or her own defense. Without such cooperation and assistance, the insurer is severely handicapped and may even be precluded from advancing any defense.

While the litigation process nearly always progresses successfully, there are times when some insureds thwart the resolution of their claims by failing to cooperate. Insureds may believe they have done nothing wrong and therefore avoid any work to counter the plaintiffs' allegations. Or, afraid of the consequences, they may keep vital information away from their defense attorney until late into the case development. They might not understand the importance of their presence at litigation proceedings (such as depositions, mediations, or arbitrations) and worry about taking time away from their practice. Some attempt to handle matters "on their own" by discussing the case with plaintiffs' attorneys against the advice of defense counsel or making payments without their insurers' consent. Others may not want to tarnish their record and thus refuse to participate in settlement talks even when there is strong evidence that the standard of care was breached.

Investigation and Defense

That is why many professional liability policies contain Cooperation Clauses that require insureds to assist in the defense of claims made against them. OMIC's policy has such a clause and, broken down, it requires the insured's assistance on three levels. First and foremost, the policy requires that insureds assist in resolving the claim brought by the patient by helping with the insurer's investigation and defense of the claim at trial or through settlement, as appropriate. This includes producing medical records, spending time with defense counsel, coordinating the appearance of staff at depositions or at trial, and attending court proceedings.

Coordination of Payment

The second situation is related to the coordination of payment among various legally responsible parties or insurers. The insured is required to cooperate in enforcing a right of contribution (where the loss will be shared) or indemnity (where another party is responsible for the entire loss) against someone else liable for the claim. For example, an insured may give notice under his or her OMIC professional liability policy for an office premises claim that might also be covered under the insured's business owners or general liability policy. In this case, OMIC would ask the insured to help coordinate the defense and resolution of this claim with the other insurer.

Unauthorized Payments

Finally, the insured is prohibited from making payments, incurring other expenses, or assuming any obligations except at the insured's own cost and with OMIC's permission. OMIC wants to participate in its insured's defense and work with the insured to come to the best resolution possible for the insured and the injured party. If the insured does not allow OMIC to participate, OMIC cannot be responsible for expenses the insured incurs. One example of this situation is where an insured decides, without the advice of defense counsel, to hire a private detective to track a malingering patient. This can be problematic for the defense because the defendant may be compelled to provide the plaintiff with this information. If nothing was revealed through the investigation, this could undermine the insured's defense. Another example is when an insured, believing it is in everyone's best interest, makes an out-of-pocket payment to the patient after a lawsuit has been filed. Again, if the case proceeds, this early payment to the patient may jeopardize its defense.

Even with the notice of required cooperation provided in the policy, some insureds still may not comply. The risk for these insureds is that they may be prevented from recovering under their insurance policies for the particular claim or they may lose their coverage altogether. Before the situation reaches this level, however, the OMIC Claims staff would work diligently to educate the insured regarding the importance of his or her participation and cooperation in the defense of the claim and discuss what specific action is needed from the insured to bring him or her into compliance.

OMIC understands the issues that may impede a physician's cooperation with his or her insurer and has several ways to assist its insureds with the upset of a lawsuit. First, OMIC provides access to one-on-one personal counseling (under the direction of the defense counsel in order to preserve attorney-client privilege) to help insureds deal with the emotional impact of litigation. OMIC also offers litigation and deposition handbooks to help insureds better understand the process. Finally, OMIC's policy pays insureds for reasonable expenses incurred at OMIC's request in the investigation or defense of a claim and for earnings lost as a result of attendance at court hearings or trials (see policy provisions for details).

Lessons From Trials and Settlements of 2004

continued from page 1

The secondary issues in cataract cases were: retinal detachments (5), glaucoma (3), "wrong" IOLs (3), corneal edema (2), endophthalmitis (2), and one each involving informed consent, iritis, retinal toxicity, and payment. Retinal detachments and glaucoma are known complications of cataract surgery, and ophthalmologists who disclosed this information during the informed consent discussion were in a better defense position, especially if the patient had preexisting retinal tears or glaucoma. Failure to diagnose was the main factor in settling these and the iritis case, underscoring the need to determine and treat the cause of visual complaints and to refer patients who do not improve.

"Wrong" cases are considered preventable and are quickly settled. Two were due to using the wrong constant in the A scan, and one from not calculating the effect of pterygium removal on the patient's astigmatism. Physicians must verify these IOL calculations. Corneal edema developed after intraoperative complications; in one case, the nurse did not note that the phaco machine's irrigation fluid had run dry, and the anterior chamber collapsed.

Delay in diagnosis is the most common problem we see in endophthalmitis cases. In one case, the infection only developed after a second surgery, later deemed unnecessary, was performed without intraocular antibiotics (see this issue's **Closed Claim Study**). In the other case of endophthalmitis, while "telephone treatment" may have contributed to a delay in diagnosis, defense experts successfully argued that the outcome was due to Strep pneumonia, known to be virulent in children. Postoperative cataract patients who call with complications should be evaluated in person by the surgeon or immediately referred to another ophthalmologist if the surgeon is unavailable. Another patient felt his eyes had not been properly shielded during use of the microscope, leading to retinal toxicity; at trial, this was appropriately attributed to his preexisting macular degeneration. Failure to perform surgery due to payment issues led to one lawsuit and settlement. Payment issues should be discussed and handled as part of the preoperative evaluation.

Two unexpected complications led to settlements in chalazion cases. In one, the surgeon cut across the lid margin instead of the lid; the suture required to repair this led to a corneal abrasion. Lack of a signed consent form contributed to the decision to settle. In the second case, a 4x4 gauze pad ignited, burning the patient's cheek; the fact that the ophthalmologist did not disclose the nature of the injury no doubt influenced the patient's decision to file a claim.

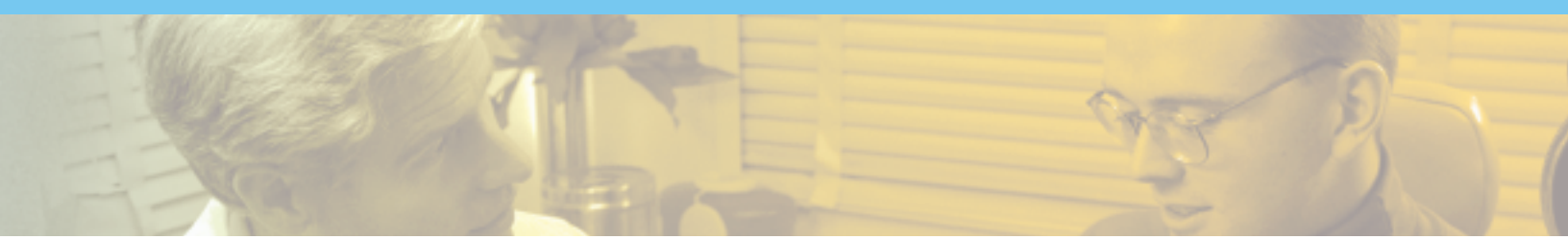
Six different issues in cornea cases led to settlements. In one, when the extended wear contact lenses ordered were not available, a technician substituted daily wear lenses without consulting the physician or warning the patient, who developed corneal edema. One pediatric contact lens wearer was treated with steroids for a corneal abrasion; the drops masked a pseudomonas infection, which was not discovered in a timely fashion due to inadequate follow-up. This poor outcome reinforces the need to carefully follow abrasions in patients with contact lenses until corneal ulcer is ruled out. Another child needed corneal transplants after he was treated for herpes simplex instead of acanthamoeba. The distinguishing features were not recognized, and the patient was not referred to a corneal specialist when he did not heal promptly.

An eye bank was sued for lack of informed consent when it harvested the corneas of a "John Doe" who remained unidentified after his body was found in a park. A patient receiving corneal transplants developed a choroidal hemorrhage postoperatively, which he attributed to inadequate control of his nausea and vomiting. Defense experts refuted his hypothesis for the cause of this known complication, but venue concerns, high wage loss damages, and a persistent plaintiff contributed to the decision to settle for the cost of defense. In the last case, too much cornea was removed during PTK, requiring corneal transplants.

There were six glaucoma cases. A patient with a history of corneal abrasions and corneal erosion suffered another abrasion during pachymetry; failure to warn of the risk of a recurrence was deemed below the standard of care. Two cases involved inadequate diagnostic work-up in patients at risk of developing glaucoma: one had a strong family history and was on nasal steroids; the other was African-American. The AAO's *Preferred Practice Patterns* for glaucoma should be consulted. In another case, although defense experts supported the care of a noncompliant patient, altered records forced a settlement. Additions to the medical record should be rare, clearly labeled as such, and closely related in time to the care provided. No additions should ever be made after receiving notice of a claim or lawsuit.

Medications were the primary issue in two settlements and the secondary one in seven more. A patient with systemic lupus was referred to an ophthalmologist who failed to appreciate and test for the toxic ocular side effects of Plaquenil. A second physician provided psychiatric medications without an examination or informed consent and also failed to monitor the patient. As described above, excessive levels of Coumadin led to a retrobulbar hemorrhage. Another patient suffered a stroke after being given Procardia to control bleeding during a blepharoplasty. The prescribing information contained a warning about the increased risk of stroke in hypertensive patients on beta blockers; there were also criticisms of the perioperative monitoring and decision to discharge.

Lack of informed consent and failure to monitor and treat the side effects of ocular steroids contributed to settlements in five cases. As part



of the informed consent discussion, patients on medications need to understand the risk/benefit ratio, and be carefully educated about the method of administration, follow-up schedule, and symptoms of side effects that should be reported to the physician.

In the sole neuro-ophthalmology case, the ophthalmologist ordered an MRI to rule out a mass or aneurysm in a patient with blurred, double vision and a 3rd motor palsy. Although the report indicated a torturous internal carotid artery and stated that a formal arteriography or CT was needed to rule out an aneurysm, this was not done, and the aneursym ruptured one month later. The fact that the physician suspected an aneurysm but did not act on the radiologist's suggestion to rule out this "worst case scenario" was difficult to defend.

Over 16% of the cases come from oculoplastics. Two resulted in settlements with both the ophthalmologist and the surgery center; the first, involving Procardia, was described above. The second illustrates the importance of team communication: the CRNA did not inform the surgeon when the patient moved his head, and the nurse did not confirm the Bovie settings with the physician and set them too high. The burn caused a corneal perforation. A second equipment-related injury occurred when a patient slid to the floor after a bed malfunctioned. Diagnostic failures led to three settlements, two in patients at risk for their condition. One developed secondary glaucoma from steroids; the other suffered a recurrence of basal cell carcinoma, which might have been diagnosed earlier if tissue had been sent for a biopsy. A third patient reported a significant decrease in visual acuity to the technician involved in the preoperative work-up for ptosis repair. The technician did not report the problem, and the retinal detachment was not diagnosed until after surgery. In addition, the surgeon did not sign the technician's notes, nor did he personally do a complete preoperative examination. In other cases, the surgical technique and intraoperative decision-making in patients with ptosis, repair of an orbital fracture, and orbital decompression for Grave's disease were criticized. It is important in complicated cases, such as those that might require non-ophthalmic expertise (e.g., roof decompression and craniotomy), to confer with and, at times, operate with the consultant.

Five cases involved children. Four, discussed elsewhere, stemmed from a corneal ulcer, endophthalmitis following cataract surgery, surgical repair of an orbital fracture, and a traumatic foreign body. In another case, failure to evaluate for an accommodative component and a decision to strengthen the lateral rectus muscle in response to a tight medial rectus caused a poor outcome in strabismus surgery.

Three of the five LASIK settlements resulted from "wrong" data. The two wrong laser setting cases could have been prevented by complying with the new JCAHO protocol that includes a "time out" before beginning a laser procedure, while obtaining two axis measurements would have brought the problem in the third case to the surgeon's attention. Informed consent for the partial, off-label treatment would have helped prepare the patient for the fact that the laser could not treat the amblyopia resulting from her esotropia. A defense verdict was rendered in a free-flap complication case where the patient experienced halos, and in an RK case with macroperforation in which the patient required penetrating keratoplasty and cataract surgery five months later. The only PRK case involved inadequate monitoring of postoperative steroids in a patient with a history of glaucoma and thin corneas.

Failure to diagnose retinal detachment occurred in two cases. Nonclinical, largely preventable problems led to settlements in the remaining retina cases. An ophthalmologist and a medical group were both involved in settling a case of macular pucker. Although the care was defensible, records were altered and there was no consent form for the surgery. Lack of an operative report and failure to obtain and document informed refusal of fluorescein angiography in a patient with AMD treated with photocoagulation led to a settlement, as did performing an incision on the wrong eye.

In addition to the case involving surgical treatment of an orbital fracture, there were two other trauma cases. In both of these, undiagnosed foreign bodies led to endophthalmitis and enucleation. In trauma cases, to rule out foreign bodies, the ophthalmologist must obtain a careful history, perform a dilated examination, and order a CT scan. These patients must be carefully followed until the eye heals.

As this article demonstrates, some poor outcomes can be prevented by keeping current with clinical guidelines, conducting a "time out" before surgery, and obtaining and documenting all care, including informed consent. Sometimes, however, patients sue physicians when they experience known complications. When the outcome is less than the patient or ophthalmologist anticipated, the physician needs to use his or her very best communication skills. OMIC policyholders are encouraged to call our Risk Manager for help in these instances. OMIC treats these calls as confidential; only the policyholder has the right to share the information with Claims or Underwriting. Also, see "Responding to Unanticipated Outcomes" in the **Risk Management Recommendations** section of our web site as well as an expanded version of this article, with tables summarizing the cases and illustrating the associated nonclinical issues, in the ***Digest*** section of the web site (**www.omic.com**).

Closed Claim Study

Codefendant Ophthalmologist Testifies Against OMIC Insured at Trial

By Ryan Bucsi, OMIC Senior Claims Associate

ALLEGATION

Negligent cataract surgery and displaced intraocular lens, resulting in endophthalmitis and enucleation.

DISPOSITION

Defense verdict for OMIC insured. Codefendant settled with an indemnity payment.

Case Summary

An OMIC insured ophthalmologist performed a cataract procedure on a 73-year-old male patient. During the procedure, there was a posterior capsule rupture with some corneal edema. The insured performed a Weck cell vitrectomy, an "open sky" procedure that uses a cellulose sponge to hold the vitreous as it is cut with scissors. The following day, he noted that the patient still had blood in the eye and visual acuity of hand motion. Seven days postoperatively, the insured concluded that there was still blood in the eye but no sign of infection. Visual acuity had improved to count fingers.

Approximately two weeks later, another ophthalmologist saw the patient in the emergency room. This ophthalmologist diagnosed a dislocated intraocular lens. He admitted the patient to the hospital and removed the intraocular lens; no antibiotics were administered during this procedure. He discharged the patient on the second postoperative day despite examination evidence of increased inflammation, which was left untreated.

One day after discharge, the patient presented to this ophthalmologist's office with additional signs and symptoms consistent with an infection. The ophthalmologist administered topical antibiotics but took a "wait and see" approach and had the patient return in 24 hours. When the patient returned the following day, he was diagnosed with endophthalmitis.

The patient underwent a vitreous tap and injection of antibiotics by a third ophthalmologist but ended up with no light perception in the operated eye. Eventually, the patient required an enucleation and later developed orbital cellulitis, which required removal of the implant.

Analysis

Taking a case to trial, much like performing a surgical procedure, has its risks and potential for complications. In this case, OMIC had what it believed to be a unified defense for its insured going into trial but recognized the difficulties facing the codefendant ophthalmologist's case.

During the first day of trial, the codefendant ophthalmologist settled with the plaintiff. He then testified that the insured's Weck cell vitrectomy had created areas and grooves, which had allowed bacteria to land and grow, thus providing a tissue environment for the subsequent infection. This was new information that the codefendant had not offered in his deposition. Had OMIC and defense counsel known that the codefendant was going to be critical of the insured's care, this may very well have changed the pre-trial evaluation of the defensibility of this case.

However, upon cross examination, OMIC counsel was able to get the codefendant to admit that it was not below the standard of care for the insured to have had the complication of the broken capsule or to have used the Weck cell for the vitrectomy in the initial cataract surgery. In fact, there were absolutely no signs of infection during the insured's treatment of the patient and no signs of infection detected until after the codefendant's removal of the intraocular lens.

The plaintiff and codefendant could not dispute these medical facts or OMIC's strong expert witness support for the insured. The jury agreed and rendered a defense verdict on behalf of the OMIC insured.

Risk Management Principles

Statements criticizing the care of another treating physician are often the root cause of malpractice claims and lawsuits. It is imperative to exercise great caution when commenting on another physician's care in front of a patient. Concerns about the care of a treating physician are more appropriately discussed with the physician, not with the patient.

Going into trial with a unified defense is extremely helpful to the overall defense of a case. Finger pointing among defendants is usually not well received by a jury. When codefendants criticize one another, they are essentially testifying for the plaintiff. Shifting blame or criticizing someone else does not guarantee that you will not also be named in the lawsuit nor will it necessarily help you at trial.

Risk Management Hotline

Confidentiality and Malpractice Claims

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

Physicians often have questions about sharing protected health information (PHI) with their professional liability carrier or an attorney during the investigation and litigation of a medical malpractice incident, claim, or lawsuit. The patient's right to confidentiality, and the treating ophthalmologist's obligation to protect it, are due to physician-patient privilege, the patient's constitutional right to privacy, the patient's right to privacy of medical information under state law and HIPAA, and the physician's professional obligation to maintain the secrecy of patient confidences. While the physical records belong to the ophthalmologist, the patient *at times* both controls the use and disclosure of the information contained in the record and is entitled to know to whom PHI is disclosed. Some disclosures are mandatory (e.g., reporting obligations for communicable diseases), while others are permitted without patient notification or authorization (e.g., for treatment, payment, healthcare operations under HIPAA).

Q My patient experienced a poor outcome, and I'm concerned I might be sued. Can I disclose PHI to OMIC or my attorney?

A As the treating physician, you have a duty to protect the confidentiality of the patient's PHI. You can, however, disclose PHI to your professional liability carrier or personal attorney without asking the patient for authorization or accounting for it under HIPAA, since this disclosure is considered to be part of healthcare operations. You need to enter into a business associate agreement with your carrier and attorney to ensure that they will protect the confidentiality of PHI (OMIC has such an agreement with every policyholder). The minimum necessary rule applies, but the entire medical record, including billing documents, is usually needed to review the patient's care. Under state law, such disclosure is generally allowed without authorization in anticipation of litigation in order to prepare the physician's defense.

OMIC encourages policyholders to call our Risk Manager for help in these situations and considers these calls confidential: the Risk Manager will not share any information about an insured with the Claims or Underwriting staff without the insured's approval. OMIC has developed detailed guidelines for "Responding to Unanticipated Outcomes," which can be downloaded from the **Risk Management Recommendations** section of the OMIC web site (**www.omic.com**).

Q An attorney contacted me to discuss a patient of mine who is suing (or considering suing) another physician. Can I talk to my patient's attorney?

A As the patient's current or prior treating physician, you have a duty to protect PHI and would need the patient's authorization to discuss your care. In this situation, the patient's attorney usually obtains it for you. With the patient's written authorization, you can both release your records and discuss your care *if you want to*. There is, however, no legal requirement to discuss your care unless there is a court order or valid subpoena. Some physicians who have discussed their care informally with a patient's attorney have ended up being named as a defendant in the malpractice claim. Others have unwittingly jeopardized the defense of their partners or colleagues. For these reasons, contact OMIC before agreeing to talk to the patient's attorney. In some cases, you will be assigned an attorney to protect your interests.

Q A professional liability carrier (or attorney) called me to discuss a patient. The carrier (or attorney) represents another physician. Can I talk to the other physician's carrier (or attorney)?

A As the patient's current or prior treating physician, you have a duty to protect PHI. You would need to both obtain the patient's authorization to discuss your care and account for it, since discussing your care with the attorney or carrier of another physician is *not* considered a healthcare operation *for you*. If either you, the attorney, or carrier obtain the patient's written authorization, you can release your records. There is, however, no legal requirement to discuss your care unless there is a court order or valid subpoena. Without the patient's written authorization, disclosure of PHI may not be lawful. Contact OMIC or your own attorney if you need advice.

For information on testifying about care rendered to a patient who is suing another doctor, or about protecting PHI when hired as a medical expert, please review "Confidentiality During Litigation," available on the OMIC web site (**www.omic.com**) in the **Risk Management Recommendations** section. OMIC policyholders who have questions or concerns about disclosure of PHI may contact the Risk Manager at (800) 562-6642, extension 651.

Calendar of Events

OMIC continues its popular risk management courses this winter. Upon completion of an OMIC online course, audioconference, or seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society may earn a 10% discount by attending a qualifying cosponsored event (indicated by an asterisk). The courses are listed below and on the OMIC web site (**www.omic.com**). CME credit is available for some courses. Please go to the AAO web site (**www.aao.org**) to obtain a CME certificate.

Online Courses

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

Audioconference CDs

- *Research and Clinical Trials: Patient Safety and Liability Risks.* Nationwide audioconference held August 11, 2004.
- *Responding to Unanticipated Outcomes.* Statewide audioconference cosponsored by California Academy of Ophthalmology and OMIC.*
- *Responding to Unanticipated Outcomes.* Statewide audioconference cosponsored by Louisiana Ophthalmology Association and OMIC.*
- *Responding to Unanticipated Outcomes.* Statewide audioconference cosponsored by Washington Academy of Eye Physicians and Surgeons and OMIC.*

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

Upcoming Seminars

April

16 *Responding to Unanticipated Outcomes* (Course #1312)
American Society of Cataract and Refractive Surgery (ASCRS)
Grand Hyatt Hotel, Washington, DC
1-2:30 pm
Register with ASCRS at (866) 878-5588 or www.one-stop-registration.com/ascrs/osr.index

29 *Responding to Unanticipated Outcomes*
West Virginia Academy of Ophthalmology & the Kentucky Academy of Eye Physicians and Surgeons
The Greenbrier, White Sulphur Springs, WV
2-4 pm
Register with Nancy Tonkin at (304) 343-5842

May

14 *Responding to Unanticipated Outcomes**
Texas Ophthalmological Association
Grapevine, TX
Time TBA
Register with Michael Duncan at (512) 370-1504

13 or 14 *Responding to Unanticipated Outcomes**
Illinois Association of Ophthalmology
Navy Pier, Chicago, IL
Early afternoon session
Register with Rich Paul at (847) 680-1666

June

17 *Responding to Unanticipated Outcomes**
American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS)
Jackson Lake Lodge, Grand Teton, WY
Register with ASOPRS at (407) 774-7880

Summer

TBA *Lessons Learned from 2004 Trials and Settlements**
OMIC nationwide audioconference
Originates from the OMIC office in San Francisco
Fee-based
Register with Linda Nakamura at (800) 562-6642, ext. 652

October

15 *OMIC Forum: Noncompliance and Follow-up Care Issues**
Annual Meeting of the American Academy of Ophthalmology (AAO)
Chicago, IL
10-Noon
Register with Linda Nakamura at (800) 562-6642, ext. 652

This schedule is subject to change. To confirm dates and times, or if you have questions about OMIC's risk management offerings, please contact Linda Nakamura at (800) 562-6642, ext. 652 or lnakamura@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