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Ophthalmic Risk Management Digest
OMIC DIGEST

Ocular Anesthesia Claims: Causes and Outcomes

By Anne M. Menke, RN, PhD, and James J. Salz, MD

Anne Menke is OMIC's Risk Manager. Dr. Salz is a member of OMIC's Claims and Risk Management Committees.

Ocular anesthesia presents challenges for both the ophthalmologist and anesthesiologist. Each must address patient anxiety about eye surgery, including concerns about eye pain or movement during surgery, and possible vision loss. When determining the appropriate anesthesia to use, physicians must take into consideration possible multiple medical comorbidities in elderly patients and the particular anesthesia risks for pediatric patients, especially those who may be premature or have congenital syndromes. Following application of the anesthetic agents, they may need to manage intraocular pressure or respond to cardiovascular events precipitated by oculocardiac reflexes.

OMIC recently conducted a review of claims related to anesthesia and sedation in order to identify issues that can be addressed through proactive risk management. The results of this study are summarized in this article and in an online course. The study was a retrospective analysis of 18 years of OMIC claims experience (1987-2005). While OMIC's database includes incidents reported by physicians on a precautionary basis, only actual malpractice claims – defined as written demands for money and lawsuits – were included. Cases were located by searching for anesthesia- and sedation-related words in allegations and through codes assigned to these procedures, such as retrobulbar or peribulbar injections. Therapeutic injections were excluded. At times, information was available only from case summaries, not from medical records. As these results show, very few of the thousands of patients who undergo ophthalmic procedures sue their provider for professional negligence in the administration of anesthesia or sedation.

Out of 2,474 OMIC claims during this 18-year period, only 78, or 3%, were related to anesthesia and sedation. Of the 65 closed anesthesia/sedation claims, 43, or 66%, were closed without any indemnity payment to the plaintiff. Claims resolved without any payment to the plaintiff (former patient) for several reasons: (1) the claim was not pursued by the plaintiff,

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MESSAGE FROM THE CHAIRMAN

OMIC has been fortunate over the years to have achieved balance and diversity among its Board and committee members. A few of the company's original founders remain involved in OMIC's governance, providing institutional memory and an understanding of what is necessary to keep the company on an even keel. Newer Board and committee members, meanwhile, infuse the company with energy, enthusiasm, and a spirit of innovation. Both play crucial roles in OMIC's success.

Recent scandals have heightened awareness of corporate governance and put in sharp relief the importance of properly and ethically managing a company. Although OMIC is a relatively small insurance company, it is no less regulated and scrutinized than larger financial corporations. The company's ultimate goal is straightforward: defend and indemnify insured members who are sued for malpractice and invest members' premiums wisely so there are sufficient reserves to do this. This necessarily involves many highly skilled

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Eye on OMIC

OMIC

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

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Broad Regulatory Protection Now Covers DEA and STARK Violations

Due to the continuing vulnerability of physicians to regulatory investigations, OMIC has further enhanced its Broad Regulatory Protection Policy for 2006 to include coverage for alleged violations of DEA and STARK regulations. Coverage for alleged violations of the Emergency Medical Treatment and Active Labor Act (EMTALA) was added in 2005 when the policy replaced the Fraud and Abuse/HIPAA Privacy Legal Expense Reimbursement Policy. At the same time, the policy extended coverage for fraud and abuse claims related to billing errors and HIPAA privacy proceedings to include fines and penalties (where allowed by law) as a standard policy feature.

As a benefit of membership, OMIC purchases a $25,000 Broad Regulatory Protection Policy for each of its physician and entity professional liability policyholders. For policyholders wishing additional supplementary coverage, OMIC has arranged several purchasing options. Limits of $50,000 and $100,000 may be purchased as a standard BRPP upgrade while limits of $250,000, $500,000, and $1 million are available through a BRPP Plus policy.

Because the standard $25,000 coverage is automatically extended to OMIC professional liability insureds, a declarations page is not necessary and is not produced unless additional coverage (higher liability limits) is purchased.

Policyholders who have provided their email address to OMIC have received a link to the **Members Area** of OMIC's web site where they can review and download the policy documents and upgrade forms (see *E-Bulletin*, March 1, 2006). Other OMIC policyholders can view this information by going to www.omic.com/members/mbrsOnlyBRPP.cfm. If you would like OMIC to have your email address, please contact us at omic@omic.com.

Message from the Chairman

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people and entities to carry out specific tasks over a long period of time. It is the responsibility of the ophthalmologists who make up the OMIC Board of Directors to oversee this long, complex process and the people involved with it. They must formulate strategy, establish norms and procedures, select competent senior management and advisors, and monitor their performance as well as that of the company itself.

In screening potential new Board and committee members, we look for insured ophthalmologists with an interest and experience in insurance operations who have held leadership positions in state and/or national ophthalmologic organizations. Candidates must understand OMIC's mission of exclusive service to Academy members and appreciate the cooperative relationship between the two organizations. We seek individuals who are representative of the diversity of OMIC's insured base as well as its subspecialty and geographic distribution. The individual must maintain the highest ethical standards.

Potential Board members first serve on one or more of five committees to gain experience in insurance operations. These committees oversee insurance finance, underwriting, risk management, claims, and marketing. When committee members attain a certain level of expertise, they are nominated to the Board where they help develop Board strategy as well as continue their committee work. Currently, we have a particular need for ophthalmologists with an aptitude for finance and accounting principles, in part because of recent reforms that necessitate the formation of an audit committee to oversee the company's financial reporting.

A significant time commitment is required of Board and committee members, including attendance at three Board meetings a year. The Finance Committee holds a fourth meeting each August in Vermont, where OMIC is domiciled. Additional responsibilities between Board meetings include speaking at various state and subspecialty meetings, reviewing underwriting applications and claims, developing risk management materials, and spending time at the OMIC exhibit booth during the AAO annual meeting.

I encourage any member who possesses the skills, the time, and the interest to become a part of OMIC's governance to write us. We are always looking for a few good men and women with the "right stuff." I cannot promise that any particular individual will be selected, but I can promise that each letter will be carefully considered.

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

Policy Issues

The Impact of a Claim on Your OMIC Policy

By Kimberly Wittchow, JD
OMIC Staff Attorney

Stress and worries abound when a patient sues or claims malpractice. One concern of insureds is the effect such action will have on their insurance coverage. Although claims can and sometimes do have an impact on insurability, understanding how a claim is handled at OMIC may provide insureds with some peace of mind.

Each department at OMIC has a different responsibility when a claim arises. Risk Management encourages insureds to be proactive and contact the department when medical incidents or issues occur so the risk manager can help them appropriately respond to the incident and incorporate any necessary changes in their practices or procedures. The Claims Department, in cooperation with the insured, wants to resolve the claim or lawsuit as efficiently and cost effectively as possible. Underwriting, meanwhile, must make certain that OMIC insures good risks. Insureds may therefore get several seemingly conflicting messages from the company depending on the status of their claim. Rest assured, however, that there are checks and balances in OMIC's operational protocols to balance these priorities. Most importantly, OMIC's Board of Directors is made up of ophthalmologists who not only approve company processes but also conduct claims and underwriting reviews.

Physician Review Panel

OMIC employs a continuous underwriting process, monitoring the claims activity of all insureds not only in anticipation of policy renewal, but also during the course of the insured's coverage. Whether an insured's claim(s) will warrant further review by OMIC's physician review panel depends upon the insured's history of claims frequency (the number of claims or suits) and severity (indemnity amounts) and on the specific circumstances surrounding the claim(s). This could include indications that an insured is performing experimental procedures outside of the ordinary and customary practice of ophthalmology or has provided substandard care, followed poor informed consent techniques, or failed to cooperate during the claims-handling process. OMIC's reviewers consider the insured's entire claims experience, including his or her experience with insurance carriers other than OMIC.

After consideration, the physician review panel may determine one of several outcomes, including any of the following:

- The panel may continue the insured's coverage without any conditions placed on his or her policy.
- The panel might continue the policy coverage with conditions, such as endorsing the policy to exclude coverage for certain activities or reducing the policy limits.
- The panel could also conclude that the insured's risk profile falls outside of OMIC's conservative underwriting standards, and that OMIC, therefore, is no longer in a position to cover the insured beyond the expiration of the insured's policy.
- Finally, the panel, in rare circumstances, might determine that the insured's actions warrant mid-term cancellation if the reasons for the cancellation fall within the policy provisions. These include fraud relating to a claim made under the policy and a substantial increase in "hazard insured against," such as claims frequency or severity or unacceptable practice patterns.

Insureds are provided the opportunity to appeal coverage and termination decisions to the full Underwriting Committee. OMIC would not generally apply a policy surcharge (higher premium) because of claims experience.

Reporting a Claim or Medical Incident

The policy requires that an insured report to the Claims Department any claim or medical incident that occurs during the policy period which may reasonably be expected to result in a claim. The reporting of such an incident triggers coverage with OMIC. Even if the insured doesn't obtain an extended reporting period endorsement (tail coverage) when he or she leaves OMIC, OMIC will continue to insure him or her for all covered claims and incidents reported while the policy was in force. An incident that does not develop into a claim will have no effect on the insured's premium and will not be included in claims history reports provided to hospitals or other third parties. Claims or incidents reported to OMIC's Risk Management Department are kept confidential: they are not shared with the Underwriting or Claims Departments without an insured's permission and are not considered reported to OMIC for coverage purposes.

Finally, any indemnity payment made by OMIC on behalf of an insured will result in the removal of the insured's loss-free credit upon renewal and for two policy terms. Then, if no further claims payments are made on behalf of the insured, the insured will begin earning loss free credits again, beginning at 1% and increasing 1% annually to a maximum discount of 5%.

Ocular Anesthesia Claims: Causes and Outcomes

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often after OMIC denied it for lack of merit; (2) the physician was dismissed from the lawsuit through legal action; this was most common when he or she did not administer the anesthesia; or (3) a jury, medical review panel, or arbitrator supported the physician's care.

In 22 of the 65 closed cases, the plaintiff was awarded money as a result of settlements or plaintiff verdicts at trial or arbitration. While the frequency of anesthesia claims is low, both the percentage of claims resulting in payments and the severity of the indemnity awards were higher than OMIC's overall claims averages (see **Table 1**). Defense costs for these 65 closed claims, however, were somewhat lower than OMIC's overall average ($34,574 vs. $39,324) and median ($21,688 vs. $26,223) cost per case.

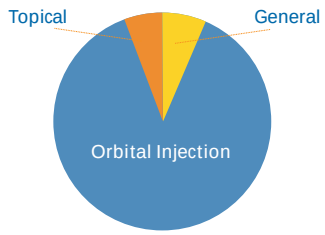
TABLE 1
ANESTHESIA OVERALL

	INDEMNITY	INDEMNITY
High	$ 999,999	$ 1,800,000
Low	$ 5,500	$ 500
Average	$ 202,993	$ 131,960
Median	$ 150,000	$ 75,000
Total	$ 4,446,853	$55,360,884
% Payment	34%	21%

Types of Anesthesia Resulting in Claims

Complications of orbital injection anesthesia accounted for the overwhelming majority of anesthesia/sedation-related claims against OMIC insureds (69 claims), while general and topical anesthesia accounted for only 5 and 4 claims, respectively. Sedation was an issue in 5 of the 69 orbital claims. Retrobulbar anesthesia was administered in 49 cases: 32 times by ophthalmologists, including one ophthalmology resident, 14 times by anesthesiologists, and 3 times by Certified Registered Nurse Anesthetists. Of the 16 peribulbar blocks, 9 were given by eye surgeons and 6 by anesthesiologists. The only O'Brien block was injected by an ophthalmologist; the type of orbital anesthesia was not specified in 3 claims. Of note, there were no claims resulting from sub-Tenon's blocks.

TYPES OF ANESTHESIA RESULTING IN CLAIMS



Complications of Ocular Anesthesia

The complications resulting from retro- and peribulbar blocks in the OMIC cases correlate closely with those reported in the medical literature[1,2] (see **Table 2**). Perforation was the most likely complication, followed by cardiovascular events and hemorrhage. Sedation-related problems were the primary issue in two settled claims. In one case, the plaintiff alleged that her pain and anxiety were inadequately controlled, resulting in a $450,000 indemnity payment on behalf of the ophthalmologist. In the second, the ophthalmologist ordered a nurse to administer sublingual Procardia and oral Valium to an elderly patient, who suffered a series of strokes after she was discharged with a blood pressure significantly lower than upon admission. Neither the ophthalmologist nor the nurse was aware of the "black box" warning associating sublingual Procardia with severe hypotension and stroke. The ophthalmologist and ambulatory surgery center each contributed $375,000 toward the settlement.

TABLE 2
ORBITAL ANESTHESIA COMPLICATIONS

Perforation	28
Cardiovascular event	10
Hemorrhage	8
CRAO	4
Corneal abrasion	3
Diplopia	3
Pain	3
Optic nerve damage	2
Seizure	2
Vision loss	2
Brain stem anesthesia	1
Numbness	1
Vitreous prolapse	1

In all 4 closed general anesthesia claims, the ophthalmologists were dismissed from the lawsuits despite complications that included adult respiratory distress syndrome, intraoperative choking with a postoperative CVA, and death due to aspiration. The authors do not have information on the outcome for the anesthesia providers in these claims. Failure to control pain and/or movement was the allegation in 2 open topical anesthesia claims, while inadequate pain relief allegedly led to hypertension and hemorrhage in 2 closed topical anesthesia claims. In the closed cases, a cataract surgery claim closed without payment, while a combined cataract/trabeculectomy case settled for $150,000. Both plaintiff and defense experts criticized the use of topical anesthesia for trabeculectomy and felt surgery was not indicated in the first place, as the patient did not have glaucoma.

Standard of Care Was Met But Other Issues Arose

Eye surgeons who meet the standard of care expect to successfully defend

their treatment. Nonetheless, in 6 of the 22 paid indemnity cases, the plaintiff prevailed even though OMIC's Claims Committee, claims associates, and defense experts were fully supportive of the care provided. Three of these cases were settled at the request of the insured physician due to the ophthalmologist's health issues, nervousness, or desire to compensate the patient for lost wages. In another, an unwitting dictation mistake concerning the timing of a perforation following a retrobulbar unduly complicated the defense. In 2 instances, the plaintiff attorneys made side deals with the anesthesia providers just before trial in order to pressure the ophthalmologists to settle, even though the anesthesiologists were felt to be responsible for the plaintiffs' injuries. The anesthesiologist was dismissed in one of these cases and the anesthesiology group made a nominal payment, leaving the ophthalmologist as the sole defendant. After similar maneuvers in the other case, a new theory of negligence was introduced against the ophthalmologist. When the medicine is complicated, the venue is plaintiff-oriented, the outcome is poor, and the ophthalmologist is the only defendant left, a settlement within policy limits can be a prudent move to protect the insured's personal assets.

Concerns About Care

During the informed consent discussion, ophthalmologists warn patients about the complications associated with anesthesia and the patient's particular surgery. If a complication occurs but is promptly recognized and appropriately managed, the outcome is considered to be a maloccurrence rather than malpractice or negligence. A single concern about an aspect of care can usually be explained to a jury. Multiple concerns about care still do not constitute negligence, but they can greatly strengthen a plaintiff's case and persuade a jury to give the plaintiff, rather than the physician, the benefit of the doubt. Three of OMIC's 22 cases that closed with indemnity payments fall into this category. In the first case, lack of indications for surgery, failure to communicate to the anesthesiologist the difficulties of a wide and long eye, and criticisms about the lack of documentation of a staphyloma led to a settlement. In the second case, a settlement was reached because there was no documented consent, the cause of the injury to the optic nerve could not be ascertained, and the postoperative management was subpar. Questionable indications for a second surgery coupled with scanty documentation and a difficult venue led to a settlement in the third claim.

Negligence

Physician negligence was felt to be the cause of the plaintiff's injury in 13 of the 22 cases that resulted in an indemnity payment. **Table 3** indicates the point in the care process at which the skill, judgment, or expertise of the insured was not that of a reasonably prudent ophthalmologist, which is generally the standard experts use when evaluating a case.

Lawsuits may be mitigated by applying risk management principles at every step of care, from determining the proper procedure to making appropriate care decisions after maloccurrences, and documenting that care clearly and completely. Careful informed consent discussions about anesthesia choices, clear communication with other providers, and an empathetic response to patient concerns and questions can also significantly reduce the likelihood of claims. Please see the document "Ophthalmic Anesthesia Liability" at www.omic.com.

Finally, while the actual choice of anesthesia or its administration was less frequently a concern, physicians should consider substituting sub-Tenon's for orbital injection anesthesia when appropriate, given its significantly lower risk profile. OMIC's online "Ophthalmic Anesthesia Liability" course, nearing completion, will feature a video demonstrating this technique.

TABLE 3
INCIDENCE OF RISK ISSUES INVOLVING NEGLIGENCE
(more than one may apply)

Negligent management of complication: • After-hours telephone screening • Failure to refer to subspecialist • Poor control of IOP	7
Documentation issues concerning: • Informed consent • Findings • Errors • Decision-making process • Altered records	6
Surgery not indicated	4
Negligent choice of anesthesia and inadequate control of: • Pain • Movement • Anxiety	3
Negligent administration of orbital injection: • Oxygen mask hindered view while injecting • Injected into wrong muscle • Injected into wrong eye	3
Negligent preoperative assessment of: • Patient on Coumadin • History of hemophilia	2
Negligent choice of anesthesia provider to administer and monitor sedation	2
Negligent communication with anesthesia provider	1

1. Stead SW and Bell SB, Focal Points: Ocular Anesthesia, The Foundation of the American Academy of Ophthalmology, March 2001: Vol. XIX, No. 3.

2. Anesthesia Alternatives for Ocular Surgery, American Academy of Ophthalmology, 2001.

Closed Claim Study

Codefendant Nurse Anesthestist's Insurance Carrier Builds a Case Against OMIC Insureds

By Ryan Bucsi, OMIC Senior Claims Associate

ALLEGATION

Against Insured A

Negligent supervision of nurse anesthetist during administration of a retrobulbar block.

Against Insured B

Negligent use of gas bubble injection to repair a retinal detachment.

Against Non-Insured Nurse Anesthetist

Improper administration of a retrobulbar block.

DISPOSITION

Insured A was dismissed prior to trial while insured B received a defense verdict at trial. Jury verdict of $250,000 against non-OMIC insured codefendant nurse anesthetist.

Case Summary

An elderly male patient underwent a retrobulbar block by the codefendant nurse anesthetist, apparently without complication. Insured A then performed cataract surgery on the left eye. When the patient returned the following day, insured A diagnosed a submacular hemorrhage and referred the patient to insured B, a retinal specialist. Insured B performed a TPA/gas injection and two weeks later performed a pars plana vitrectomy. Subsequent procedures were performed by insured B because of a retinal detachment resulting from proliferative vitreous retraction. The patient ultimately lost all useful vision in his left eye. During their respective depositions, insured A and the nurse anesthetist both testified that the injury was a result of the retrobulbar block.

Analysis

The defense expert for insured A testified that since the nurse anesthetist had significant experience in administering anesthesia, there was no need for direct supervision of the anesthesia administration. The defense expert for insured B was fully supportive of the insured's care and treatment of the patient, stating that TPA and gas injection was cutting edge and the least invasive approach. The defense expert for the nurse anesthetist testified that everyone except the nurse violated the standard of care. He testified that insured A breached the standard of care by performing cataract surgery on the patient in the first place and opined that a macular pucker, not a cataract, was the cause of the patient's poor vision. The codefendant also retained an expert to testify against insured B. This expert opined that the decision to use a gas bubble injection, rather than a vitrectomy with membrane stripping, fell below the standard of care. This testimony prompted the plaintiff to amend the complaint to include insured B. As to the care provided by the nurse anesthetist, the plaintiff's expert opined that the double perforations represented a considerable departure from the standard of care. An additional criticism was that the nurse failed to recognize this complication, thus delaying a referral to a retinal specialist.

The plaintiff did not retain an expert to testify against insured A or B. Insured A was dismissed from the case, but the group he was part of was not. The codefendant alleged the ostensible agency theory, essentially claiming that the group caused the plaintiff to believe the CRNA was an agent or employee of the group. Since insured A was dismissed and there remained only the allegation of vicarious liability against the group, OMIC attempted to tender the defense to the nurse anesthetist's carrier. The carrier denied OMIC's tender based on the theory that insured A was somehow independently negligent, even though insured A had been dismissed.

OMIC's defense counsel estimated a 90% chance of a defense verdict, since the plaintiff's expert was supportive of insured B, and the only critical testimony would be presented by an expert retained by the codefendant. The plaintiff's demand was for $1 million. The case was mediated prior to trial and the codefendant offered $100,000. No offer was made on behalf of any OMIC insured. The jury returned a defense verdict for OMIC insured B, found against the nurse anesthetist, and awarded the plaintiff $250,000. Since OMIC's offer to tender the defense to the nurse anesthetist's carrier was rejected, it allowed OMIC to pursue a portion of the defense costs. Defense counsel filed a complaint for costs against the codefendant and OMIC received $22,250 reimbursement from the nurse anesthetist's insurance carrier.

Risk Management Principles

As this case demonstrates, ophthalmologists who delegate retrobulbar injections to qualified anesthesia providers are not held liable for the alleged negligence of that provider. The surgeon does, however, need to carefully convey to the anesthetist any information that could impact the anesthetic choice, dosage, or technique, such as unusual anatomical features and co-morbid ocular or medical conditions.

Risk Management Hotline

Interpreters for Deaf Patients

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

Physicians are well aware of the central role clear communication plays in the physician-patient relationship. Patients who are deaf present special challenges to effective interactions. Ophthalmologists often have questions about how to obtain and reimburse interpreters and whether family members can fulfill this role.

Q My deaf patient insists that I provide a translator. Am I required to do so?

A Although the law has been interpreted "by some as creating a requirement that the physician provide and pay for the cost of hearing interpreters for their patients who are hearing disabled," the American Medical Association has noted that there is "no hard and fast requirement for the provision of such services" and that the Americans with Disabilities Act (ADA) "does not mandate the use of interpreters in every instance." The Supreme Court ruled in an education suit, for example, that American Sign Language (ASL) interpreters are not required when lip reading or other accommodations are sufficient. In the medical arena, physicians often rely upon note pads to communicate with deaf patients. At times, such as before major surgery, or when initiating a treatment plan for a complex condition, an interpreter may be necessary.

Q Does the ADA even apply to my practice?

A Yes. Intended to stop discrimination on the basis of disability, the ADA requires those who own, lease, or operate a place of public accommodation, such as a physician's office, to make reasonable accommodations to meet the needs of patients with disabilities, unless "an undue burden or a fundamental alteration would result." Actions, standards, and policies that either intentionally discriminate or have the effect of discrimination against persons with disabilities are prohibited. Moreover, failure to take steps that may be necessary to ensure access, such as providing auxiliary aids and services, could be seen as discriminatory.

Q What steps must my group take to meet the needs of patients with disabilities?

A First, conduct and document an analysis of your overall obligations. Decide what particular aid or service will be provided, based in part upon an analysis of the length and/or complexity of the medical service, treatment, or procedure. A patient's request for a sign language interpreter should be a significant factor in the decision. Determine whether providing such a service would result in an undue burden on the overall practice. Second, assess the patient's needs before providing a particular auxiliary aid or service. Ask the referring physician how he or she usually communicates with the patient. Consult with the patient about his or her needs when the appointment is scheduled and document the discussion. If a patient requests an interpreter, ask staff to acknowledge the request and gather more information about the patient's concerns/ expectations for the visit so the physician can determine the best way to meet them. Document the decision and the assistance provided. For many routine office visits, a notepad may be sufficient to ensure good communication. Office visits before major surgery or for a new, complex treatment plan may require an interpreter. If the physician and patient disagree, reconsider the decision. Finally, maintain a list of qualified sign language and oral interpreters.

Q Can I charge the patient for the cost of the interpreter?

A No, the cost of aids cannot be passed onto the patient. However, the patient's employer, health plan, Medicare, or a local hospital may be able to help provide or pay for an ASL interpreter.

For further information on federal rules concerning accommodations for deaf patients and risk management recommendations on how to meet the needs of deaf patients, go to www.omic.com/resources/risk_man/ forms/man_care/InterpretersforDeafPatients.rtf.

New risk management recommendations for meeting the needs of patients with limited English proficiency are also available at www.omic.com/resources/risk_man/forms/man_care/InterpretersforLimitedEnglishProficiencyPatients.rtf.

1. AMA Legal Issues: Americans with Disabilities Act and Hearing Interpreters, http://www.ama-assn.org/ana/pub/category/print/4616.html, accessed 11/21/05.

2. Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, et seq. ADA Title III Technical Assistance Manual,http://www.usdoj.gov/crt/ada/taman3.html, accessed 1/10/06.

Calendar of Events

OMIC continues its popular risk management education programs in 2006. 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 or completing a state or subspecialty society course online (indicated by an asterisk). 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

- *EMTALA and ER-Call Liability* addresses liability issues surrounding on-call emergency room coverage and *EMTALA* statutes. Frequently asked questions on federal and state liability are answered.
- *Ophthalmic Anesthesia Risks* offers an overview of anesthesia risks and provides case studies supporting the issues addressed in the overview.
- *Informed Consent for Ophthalmologists* provides an overview of the informed consent doctrine as it applies to various practice settings.

State and Subspecialty Society Online Courses

A special society-specific edition of *OMIC's Informed Consent for Ophthalmologists* online course is available for physicians in California, Hawaii, Louisiana, Nevada, Oklahoma, and Washington, as well as Women in Ophthalmology members.*

CD Recordings

- *Lessons Learned from Trials and Settlements of 2004* (2005 Nationwide Audioconference) $40
- *Noncompliance and Follow-up Issues* (2005 OMIC Forum) $50
- *Research and Clinical Trials* (2004 Nationwide Audioconference) $40
- *Responding to Unanticipated Outcomes* $25
- *Risks of Telephone Screening and Treatment* $25

Go to www.omic.com/resources/risk_man/seminars.cfm to download CD order forms.

Upcoming Seminars

April

28 *Ophthalmic Anesthesia Liability*
West Virginia/Kentucky Joint Meeting
Griffin Gate Marriott, Lexington, KY
2:00-3:00 pm
Register with West Virginia Academy of Ophthalmology (304) 343-5842 or Kentucky Academy of Eye Physicians and Surgeons (317) 813-3147.

May

5 *Ophthalmic Anesthesia Liability*
American Osteopathic College of Ophthalmology
Hyatt Regency Grand Cypress Hotel, Orlando, FL
Time TBA
Register with AOCCO (800) 455-9404.

6 *Ophthalmic Anesthesia Liability*
Texas Ophthalmological Association Meeting*
George R. Brown Convention Center, Houston, TX
3:30-4:30 pm
Register with TOA (512) 370-1504.

19 *Ophthalmic Anesthesia Liability*
Arizona, Nevada, and New Mexico Tri-State Meeting*
Sedona Hilton, Sedona, AZ
3:00-4:00 pm
Register with your respective state society: Arizona (602) 246-8901; Nevada (303) 832-4900; New Mexico (505) 962-0358.

20 *Ophthalmic Anesthesia Liability*
Missouri Society of Eye Physicians & Surgeons*
St. Louis, MO
1:15-2:15 pm
Register with MOSEPS (847) 680-1666.

June

24 *Ophthalmic Anesthesia Liability*
Virginia Society of Ophthalmology Meeting
Virginia Beach Convention Center, Virginia Beach, VA
Time TBA
Register with the Virginia Society of Ophthalmology (804) 261-9890.

August

9 *Lessons Learned from Settlements and Trials of 2005*
OMIC Nationwide Live Audioconference
OMIC Home Office, San Francisco, CA
2:00-3:00 pm PST
Register with OMIC (415) 202-4652.

20 *Ophthalmic Anesthesia Liability*
Florida Society of Ophthalmology Meeting*
Ritz-Carlton, Naples, FL
7:00-8:00 am
Register with FSO (904) 998-0819.

For further information about OMIC's risk management programs, please contact Linda Nakamura at (800) 562-6642, ext. 652 or lnakamura@omic.com.

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