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Ophthalmic Risk Management Digest

OMIC DIGEST

Medical Board Investigations Should Not be Faced Alone

By Ryan Bucsi

Mr. Bucsi is a Senior Litigation Analyst with OMIC's Claims Department.

You would never attempt to represent yourself in a medical malpractice lawsuit and assume responsibility for taking all the necessary depositions, preparing your own trial exhibits, examining witnesses during trial, and convincing a jury that your care and treatment met the standard of care. You know that if you are faced with a malpractice complaint, your first course of action should be to call OMIC's claims department so we can put you in touch with a defense attorney who will represent you throughout the course of litigation.

What you may not know is that OMIC is also here to defend you if you receive a letter of investigation from your state medical board regarding patient care you have rendered. Some insureds have failed to report these letters of investigation until after they have responded on their own. Unfortunately, when there is a significant delay in reporting the investigation to OMIC, the results can be as catastrophic as attempting to defend your own malpractice lawsuit.

For example, an OMIC insured received a letter of investigation from her state board requesting a complete copy of a patient's chart. There was no request or requirement that the insured provide a written description or narrative of the patient's care, just a request for the chart. Without contacting OMIC for advice, the insured not only sent the requested records to the medical board but also a detailed narrative outlining her treatment of the patient. The insured did not hear back from the medical board until a year later when she received a letter notifying her that the board had concluded its investigation and was bringing disciplinary charges against her.

In the year that passed between the request for the patient's chart and the notification of disciplinary action, the state board had been busy retaining experts who testified that the insured's care was indeed below the accepted standard. Based on this expert testimony, the board proposed the following disciplinary action against the insured: a fine in the thousands of dollars, reimbursement of the costs associated with the

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MESSAGE FROM THE CHAIRMAN

As a practicing ophthalmologist, I believe that one of the primary benefits of being an OMIC insured is access to a risk management department that is dedicated to specifically helping ophthalmologists prevent and reduce malpractice losses through proactive intervention. As an OMIC board member, I can truly say that the guidance and advice insureds receive from OMIC's risk management staff is without peer in the insurance industry. And nowhere is OMIC's expertise in ophthalmic loss prevention more apparent than when an insured contacts the risk management hotline.

As the name suggests, questions addressed to the hotline are often of an urgent or emergent nature and the risk management staff makes every effort to answer them without delay. In 1993 when the hotline was introduced, access was primarily via telephone or mail. Today, insureds are just as likely to contact the hotline by fax, email, or through OMIC's web site. The hotline is possibly OMIC's most utilized

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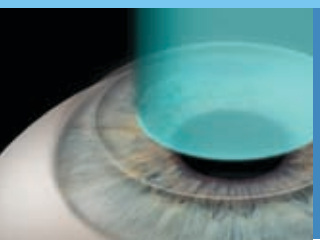

Eye on OMIC

OMIC

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

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

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Broad Regulatory Protection Policy for OMIC Insureds

As a benefit of membership, OMIC purchases a $25,000 Broad Regulatory Protection Policy (BRPP) for each of its professional liability policyholders and qualifying entities. This policy extends 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. Coverage also includes legal expense reimbursement for alleged violations of EMTALA, DEA, and STARK regulations.

Due to the increasing vulnerability of physicians to regulatory investigations, OMIC has arranged several purchasing options for additional coverage to supplement the standard $25,000 policy. Limits of $50,000 or $100,000 may be purchased as a standard BRPP upgrade while limits of $250,000, $500,000, or $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 higher liability limits are purchased.

Policyholders who have provided their email address to OMIC will receive an *E-Bulletin* with a link to the Members Area of OMIC's web site where they can review and download BRPP documents and upgrade forms. Other OMIC policyholders can view this information at www.omic.com/members/mbrsOnlyBRPP.cfm. For additional information on the policy, including frequently asked questions and answers, go to www.omic.com/products/bus_products/BRPP.cfm. Please contact your OMIC underwriter if you wish to have a hard copy of your policy mailed to you.

Message from the Chairman

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policyholder service, logging in 1,500 or more contacts a year. Not only a confidential loss prevention tool for individual insureds, the hotline also provides OMIC with a means to monitor and stay abreast of emerging liability concerns that could adversely impact other insureds as well.

One recent example of how early intervention by the OMIC board and staff headed off a potentially broad professional liability concern for insureds was our response to the November 26, 2006 letter to ophthalmologists from the drug manufacturer of Kenalog™. The letter from Bristol-Myers Squibb added to existing prescribing information a recommendation against administering Kenalog™ by intraocular, intraturbinal, subconjunctival, sub-Tenons, retrobulbar, nasal turbinate, and intralesional (about the head) routes. Soon after receiving the letter, insureds were contacting OMIC's hotline to ask, among other things, how this new recommendation might affect their liability, what to tell patients during informed consent, and whether OMIC would cover claims involving "off-label" drug use.

Benefiting from many years of experience responding to similar situations, OMIC was able to quickly revise its informed consent document and risk management recommendation concerning off-label use of Kenalog™ (see this issue's **Risk Management Hotline**). These revisions were communicated to 2,500 insureds in a December blast email and posted on the OMIC web site to an overwhelming response. Since then, there have been more than 1,300 downloads of OMIC's revised risk management recommendation and consent form from the web site.

Personally, I think ophthalmologists are fortunate to have an insurance carrier in which the board and staff collaborate to deliver a program that goes beyond insuring our specialty to one that proactively improves the practice of ophthalmology through such vital services as the risk management hotline. I encourage all OMIC insureds who have not already done so to give us your current email address so we may keep you informed of product alerts and advisories that may have implications for your practice and malpractice coverage. Please send your email address to omic@omic.com.

Policy Issues

Leasing Equipment, Space, or Employees

By Kimberly Wittchow, JD, OMIC Staff Attorney, and Betsy Kelley, OMIC VP of Product Management

It is important to understand how your policy responds when you lease your office equipment, space, or employees to others.

Leased Equipment or Space

If an OMIC insured enters into a lease agreement with another physician or group, allowing the other use of its equipment or space, the arrangement may be treated either like a landlord-tenant relationship or an outpatient surgical facility, depending on the facts of the particular situation.

In general, when an OMIC insured (the lessor) enters into a formal lease agreement to provide space or equipment to other ophthalmologists (the lessee) and the lessor is not providing other health care-related services under the agreement, its liability should, at least theoretically, be limited to that of a landlord or lessor, even though its members are health care providers. This is most clear when leased equipment is used at the lessee's site or when the lessor leases its office space and equipment for use when the lessor's physicians are not themselves occupying the space or using the equipment. The lessor's OMIC policy would not cover any liability arising out of the lessee's use of the equipment or space as this is a general liability exposure.

However, the lessor may be exposed to additional liability risks if the lessee's physicians use the space and/or equipment concurrently with the lessor's physicians or if the lease agreement provides for the lessor to extend services beyond that of a typical landlord/lessor. For instance, the lessor may credential utilizers or operate the equipment on behalf of the lessee. The lessor's liability exposure will depend upon the services the lessor provides and how the situation is perceived by patients.

If there is no formal lease agreement and the outside utilizers are given open access to the owner's space and equipment, the situation is more clear-cut. OMIC would treat the arrangement as an "outpatient surgical facility" (OSF). Subject to underwriting review, compliance with OMIC's OSF requirements, and payment of any applicable premium, coverage may be extended to the OSF for its vicarious liability arising from the professional services rendered at the facility.

An OSF is defined as an ambulatory surgery center, laser refractive center, or surgical facility (including an in-office surgical suite or in-office laser equipment) utilized by physicians other than the owners and their employees. OSFs encounter the same type of increased liability that hospitals do for credentialing the physicians who use the OSF and for conducting peer review. In laser centers in particular, the OSF must properly maintain and calibrate equipment and train users in the operation of the equipment. In addition, employees of the OSF may provide professional support and assistance to the outside utilizers.

For these reasons, when a leasing agreement does not exist, or when the agreement calls for the lessor to perform tasks outside of the landlord/lessor realm, liability is increased and the arrangement must be treated like an OSF in order for the group to be properly underwritten and protected.

Leased Employees

Ideally, when lessees use equipment leased from an OMIC-insured group, they should provide their own qualified staff to assist them. However, if the lessees do not have anyone qualified to assist and they need the lessor to provide staff trained and skilled in performing procedures on the equipment, then the lessor should formally lease the employee as well as the equipment to the lessee in order for the lessee's policy to respond (assuming the lessee is OMIC insured or has similar policy coverage). In this case, the lessee's policy would extend coverage to the leased employee while that person was rendering services on behalf of the lessee. The lessor's policy would not cover the leased employee for the work he or she did for the outside utilizer. The policy covers non-physician employees only while they are acting within the scope of their employment by and *for the direct benefit of the insured*.

Similarly, if an OMIC insured leases his or her employees to work in another ophthalmologist's office, the employee is not covered under the OMIC insured lessor's policy for such activities. Although it might be part of the employee's job description, he or she will not be working *for the direct benefit of the employer*. Instead, the employee will be working *for the direct benefit of the lessee* and may be covered under the lessee's policy as a leased employee. If the employee is not formally leased to the other ophthalmologist, but instead is simply "loaned," the work by the employee again is not *for the direct benefit of the employer* and therefore is not covered under the employer's policy. And, under OMIC's policy, since the borrower has not formally leased the employee, the employee might not have coverage under the borrower's policy. Employees, therefore, should ensure that they are covered under a lessee's or borrowing ophthalmologist's policy before agreeing to work for them. If not, the employee should obtain his or her own policy with an appropriate carrier.

Medical Board Investigations Should Not Be Faced Alone

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state board investigation, a letter of reprimand, community service, and continuing education.

It was at this point that the insured contacted OMIC for assistance. An attorney was assigned to represent her and experts were retained on her behalf. Unfortunately, the insured had put herself at a great disadvantage by directly responding to the medical board, and no facts that OMIC or defense counsel presented could persuade the board to reverse its decision or reduce the proposed penalties. In the process, the insured's defense coverage limits for this investigation were exhausted. Had the insured contacted OMIC as soon as she received the initial letter of investigation, OMIC would have assigned legal counsel to assist her in writing a response, which could have improved her chances for a more favorable decision from the state board.

OMIC Policy Covers Defense of Medical Board Investigations

Most physicians are not properly trained to respond to medical board inquiries and investigations in a manner that benefits their position. The initial letter from a state medical board may seem like a harmless request for records or information on a patient; however, your initial response is vitally important and may determine whether the board proceeds with an investigation or dismisses the complaint. Significantly, medical board or licensure actions can result in suspension of your medical license, thus making these cases far more risky than a medical malpractice case.

Insureds should treat a notice of medical board investigation the same way they would treat a patient complaint letter or request for information from a plaintiff attorney and contact OMIC before responding. OMIC defense attorneys are experienced in dealing with medical board actions and oftentimes are familiar with the individuals in charge of the investigations. This type of firsthand experience is invaluable when preparing a response to a letter of investigation and may reduce the likelihood that the medical board will pursue the investigation further.

Coverage for state board investigations is included as a part of your OMIC policy: "OMIC shall defend any insured ophthalmologist…against any investigation, disciplinary proceeding, or action for review (hereinafter "investigation") of the insured's practice by any federal, state or local regulatory agency arising from a complaint or report by a patient to such an agency of an injury to that patient resulting from a professional services incident involving direct patient treatment provided by the insured. However, OMIC will have no liability for fines, sanctions, penalties, or other financial awards resulting from the investigation."

Please note that OMIC provides defense coverage only and there is a limit to this coverage: "The most OMIC will pay per insured for the claim expenses for any one such investigation is $25,000. The most OMIC will pay per insured for claim expenses for all such investigations during the policy period or the extended reporting period will be $75,000."

It has been OMIC's experience that meeting or exceeding the $25,000 expense limit is rare. In OMIC's history, only six cases have reached or exceeded the $25,000 coverage limit. In fact, in a review of 46 closed medical board cases, the average expense for these matters was roughly $5,000. The attorneys assigned by OMIC to handle these cases are aware of this limited defense coverage and have negotiated their hourly fees with OMIC accordingly. This gives OMIC insureds the best combination of experience and value as our attorneys will attempt to resolve the matter within policy limits, thus avoiding out-of-pocket defense expenses for the insured.

Patient Complaint Often Precedes Malpractice Claim

A patient complaint to the state medical board has all the attributes of a malpractice claim except that the patient is not demanding money from the insured. OMIC's rationale for providing defense coverage for medical board investigations is that these cases are often precursors to impending legal actions. A patient who complains to an investigative entity is most likely unhappy with the insured's care and might later decide to file a medical malpractice claim against the insured.

State medical boards have a duty and a right to investigate patient complaints. Even if the allegations seem frivolous and you do not personally have concerns about your care and treatment of the patient, it is still wise to refer the case to OMIC so an attorney can respond on your behalf. Any OMIC insured is susceptible to these types of complaints; however, the majority of cases historically come from a handful of states, notably Florida, Arizona, and Nevada. OMIC has also defended state board investigations in California, Colorado, Texas, Illinois, Massachusetts, Washington, and Virginia. Regardless of which state you practice in, if you receive a notice of a state board investigation, please contact OMIC immediately.

When OMIC is brought in to defend these investigations early on, it has an excellent history of resolving them without fines or penalties being levied against the insured. Of 46 closed cases involving medical board investigations, 39 were dismissed without any type

of adverse outcome for the insured. In all but two of these 39 cases, OMIC had assigned legal counsel on behalf of the insured. In the two cases that went before the state board without legal representation, the insureds did not report the complaint to OMIC until after they had responded to the initial letter of investigation. In the seven cases with adverse outcomes, the insureds were fined anywhere from $1,000 to $10,000 in addition to the costs of the investigation. They also were required to perform hours of community service and undertake continuing medical education. The complaints in these seven cases pertained to wrong site surgery, wrong surgery performed, or incorrect implantation of intraocular lenses.

It is important to note that once disciplinary action has been taken by a state medical board, it reports the action to the Federation of State Medical Boards and the National Practitioners Data Bank. Furthermore, the physician is required to report any such action to other states where he or she practices or has a medical license. OMIC recommends that insureds consult with their OMIC-appointed attorney regarding reporting requirements of state board actions.

In summary, the same type of caution that is applied to medical malpractice claims and lawsuits should be applied to state medical board investigations. Insureds should contact OMIC's claims department as coverage for such occurrences exists within your OMIC policy. OMIC has experienced defense attorneys to assist insureds in responding to such inquiries. The goal of legal representation is to decrease the likelihood that an investigation will proceed past the initial stages and result in the levying of fines or disciplinary action against the insured.

STATE MEDICAL BOARD ACTIONS

As a matter of public policy, the practice of medicine is a privilege granted by the people of the state acting through their elected representatives. It is not a natural right of individuals. Therefore, each of the 50 states, the District of Columbia, and the U.S. territories has a medical practice act that defines the practice of medicine and delegates the authority to enforce the law to a state medical board. In most states, the board regulates both allopathic and osteopathic physicians; in others, separate boards exist. There are currently 70 state medical boards authorized to regulate physicians.

Some of the functions of a state medical board include licensing physicians, investigating complaints, disciplining those who violate the law, conducting physician evaluations, and facilitating rehabilitation of physicians where appropriate. State laws require that boards assure fairness and due process to any physician under investigation.

Although medical boards sometimes find it necessary to suspend or revoke a license to practice, regulators have found that many problems can be resolved with additional education or training in appropriate areas. In other instances, it may be more appropriate to place a physician on probation or place restrictions on a physician's license to practice. This compromise protects the public while maintaining a valuable community resource in the physician. Probation and restrictions on a medical license may be in place while a physician receives further training or rehabilitation.

If a state medical board determines that a violation has occurred, it may take any of the following actions:

Reprimand or Censure – Physician receives a public admonishment.

Administrative Fine/Monetary Penalty – Physician must pay a civil penalty fee imposed by the board.

Restitution – Physician must reimburse a patient or entity for monies improperly earned.

Probation – Physician's license is monitored for a period of time.

Limitation or Restriction – Physician's license is restricted in some way (e.g., a physician may be prohibited from performing specific procedures or prescribing certain drugs).

Suspension – Physician may not practice for a period of time.

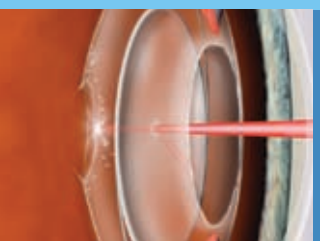
Summary Suspension – Physician's license is suspended immediately based on evidence that the physician's practice presents a threat to public health and safety.

Voluntary Surrender of License – Physician surrenders license to avoid further disciplinary action.

Denial – Physician is not granted a license to practice or license is not renewed.

Revocation – Physician's license is terminated and physician can no longer practice medicine.

To find out more about your state medical board, go to the Federation of State Medical Boards' web site at www.fsmb.org/index.html.



Closed Claim Study

A Medical Board Investigation Handled Perfectly

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Complaint to state medical board of loss of vision following laser treatment for diabetic macular edema.

DISPOSITION

Medical board did not pursue investigation following defense attorney's letter of response.

Case Summary

A patient presented to an OMIC insured's office with a visual acuity of 20/40 in the right eye and 20/60 in the left eye. The physical examination revealed clinically significant diabetic macular edema in both eyes with foveal lipid in the left eye. The ophthalmologist subsequently performed laser treatment on each eye on separate dates. At the follow-up examination, the patient did not exhibit any change in visual acuity or complain of any loss of vision. The diabetic macular edema resolved in the right eye but persisted in the left eye, so the surgeon performed another laser procedure.

The insured's associate evaluated the patient at her follow-up visit two months later. Although the patient had never called to report any visual acuity loss, she now said that she had not been able to see well since the second procedure. Her visual acuity was 20/400 in the right eye and count fingers in the left eye. She was diagnosed with severe diabetic macular edema in both eyes with possible macular ischemia. The associate recommended a repeat fluorescein angiography to assess the perfusion status of the maculae and to evaluate the vascular status of the retina in each eye.

The patient chose not to return to the insured. The insured then advised her in writing that the advanced state of her condition required that she either come in for a follow-up appointment or see another ophthalmologist; he warned that lack of care could further jeopardize her vision. The patient reportedly sought care with another ophthalmologist as advised.

Analysis

The patient filed a complaint with the state medical board alleging that her compromised vision in both eyes was a result of the second laser treatment. The insured and his attorney worked together to craft a response to the medical board complaint and an expert witness was retained to evaluate the care. The physician's letter to the medical board started out by admitting that the laser treatment did indeed cause destruction of the macular retinal tissue responsible for central visual acuity but that it could do so only in the treated eye. Notably, the patient had complained of delayed bilateral visual loss, for which another cause needed to be found.

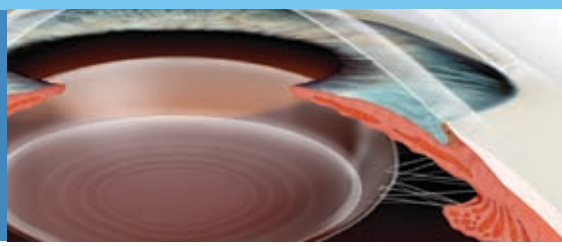
The retained expert supported the physician's care, opining that the procedures were indicated and appropriate for the patient's macular condition and that there was no objective or significant change in her visual acuity immediately following either of the treatments. The expert felt that the most likely cause of the patient's vision loss was her underlying diabetic retinopathy, which had progressed rapidly due to other factors such as duration of her diabetic condition, degree of blood sugar control, underlying vascular disease, compromised renal function, and anemia. This worsening of the patient's diabetic retinopathy may have led to macular ischemia and progressive leakage of fluid and lipid from incompetent diabetic macular blood vessels.

Risk Management Principles

This case exemplifies how a medical board investigation should be handled. Even though the ophthalmologist was confident that he had met the standard of care, he immediately reported the matter to OMIC's claims department. The OMIC litigation specialist for the insured's state promptly referred the case to an attorney, who in turn retained an expert. Within one month of the date of the medical board letter of investigation, the OMIC attorney had worked with the insured to draft a response. Furthermore, the expert signed an affidavit supporting the physician's care; this affidavit was attached to the letter of response. The medical board decided not to pursue the matter and concluded its investigation.

The insured's willingness to cooperate and work with the OMIC-appointed attorney to craft an effective response was a key factor in averting a potentially costly and time-consuming medical board investigation.

Risk Management Hotline



Responding to "Dear Healthcare Provider" Letters

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

Within the last several months, ophthalmologists have received two "Dear Healthcare Provider" letters from drug manufacturers informing them of "important safety information" about medications they administer regularly. Bristol-Myers Squibb sent the first letter on November 22, 2006 at the urging of the Food and Drug Administration (FDA).[1] Consistent with a prior warning on the prescribing information, the letter again reminded ophthalmologists that Kenalog™ (triamcinolone acetonide) is not approved for intraocular administration. In response to reports of endophthalmitis, eye inflammation, increased intraocular pressure, and visual disturbances including vision loss—all known side effects about which ophthalmologists routinely inform patients—the company added additional prescribing information recommending against administering Kenalog™ by intraocular, intraturbinal, subconjunctival, sub-Tenons, retrobulbar, nasal turbinate, and intralesional (about the head) routes. The second "Dear Healthcare Provider" letter was distributed by Genentech Inc., manufacturer of Avastin™ (bevacizumab) and Lucentis™ (ranibizumab), drugs both widely used for the treatment of age-related macular degeneration (AMD). In its January 24, 2007 letter, the company informed ophthalmologists that the ongoing SAILOR clinical study revealed a higher incidence of stroke in the 0.5-mg Lucentis™ dose group compared with the 0.3-mg dose group (1.2% versus 0.3% respectively; $P = 0.02$).[2] These letters have prompted numerous calls to OMIC's risk management hotline.

Q Can I still administer Kenalog™?

A It is OMIC's opinion that, despite the manufacturer's warning, it remains legal for ophthalmologists to administer Kenalog™ (TA) by the routes mentioned in the letter as part of "the practice of medicine." In the event of a lawsuit, ophthalmologists who are challenged about their use of TA will continue to rely upon expert witnesses, peer-reviewed literature, and well-documented efforts to provide quality care. Moreover, OMIC feels that the ophthalmologist is in the best position to determine how to treat an individual patient and recognizes that "off-label" use of approved medications is a legal and necessary part of the practice of medicine. Accordingly, our professional liability policy provides coverage for such off-label use, including ongoing use of TA.

Q Do I need to tell my patients about the letter?

A Yes. Patients should be informed of TA's off-label status and told that the manufacturer has recommended against ophthalmic use, but that the FDA and attorneys have confirmed that ongoing use is legal as part of the practice of medicine. They should also be advised of the long-standing and widespread use of TA to treat ocular conditions as described in many peer-reviewed articles, and that the National Eye Institute is conducting clinical trials on its use. OMIC has prepared a sample consent form for TA, available at www.omic.com.

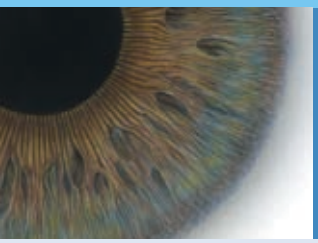
Q The letter from Genentech did not provide any guidance. Am I required to assess a patient's risk of stroke before I administer Lucentis™? Should some patients get the lower dose, even though only the higher dose has been approved by the FDA?

A The label produced when Lucentis™ was approved warns of the theoretical risk of thromboembolic events with intravitreal inhibitors of VEGF,[3] a drug class that also includes Macugen and Avastin. Accordingly, the risk management recommendations that precede OMIC's revised sample consent form advise physicians to consider conditions that increase the risk for such complications. Now that ophthalmologists have been warned of the higher risk of a second stroke in patients with a stroke history, they should specifically elicit and document any history of stroke. The need for a stroke risk consultation with an internist and the dosage amount both depend upon the patient's overall health, extent of AMD, and risk tolerance. Faced with the certainty of visual loss from AMD, some elderly patients may prefer to assume the risk of stroke in order to best preserve their vision. Others may refuse the medication at any dose. Carefully determine and document the patient's clinical findings and preferences, and ensure that patients who refuse the medication understand the consequences of their refusal. Consider giving patients written instructions about how to contact you and a list of eye symptoms that should be immediately reported to you. Patients considered at high risk for stroke should be educated on its symptoms and directed to call 911 or to proceed to the nearest emergency room if they suspect they are having a stroke.

1. Lewis-Hall, Freda, MD, Senior VP for Medical Affairs, Bristol-Myers Squibb Co. Dear Healthcare Provider. 22 Nov. 2006.

2. Barron, Hal, MD. Senior VP Development, Chief Medical Officer, Genentech, Inc. 24 Jan. 2007.

3. The full prescribing information for Lucentis™ is available at http://www.gene.com/gene/products/information/pdf/lucentis-prescribing.pdf.



Calendar of Events

OMIC continues its popular risk management courses throughout 2007. Upon completion of an OMIC online course, audioconference, CD recording, 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 an *additional discount* by attending a qualifying live cosponsored event or completing a state society or subspecialty society course online (indicated by an asterisk). Courses are listed below and 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 *(Reserved for OMIC insureds/No charge)*

- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*

State and Subspecialty Society Online Courses

A society-specific online course on *Ophthalmic Anesthesia Liability* is available for physicians in California, Colorado, Hawaii, Louisiana, Nevada, Oklahoma, Washington, the Contact Lens Association of Ophthalmologists (CLAO), and the American Society of Plastic and Reconstructive Surgeons (ASOPRS).

CD Recordings *(No charge for OMIC insureds)*

- *After-Hours and Emergency Room Calls*
- *Lessons Learned from Trials and Settlements of 2004*
- *Lessons Learned from Trials and Settlements of 2005*
- *Noncompliance and Follow-Up Issues*
- *Research and Clinical Trials*
- *Responding to Unanticipated Outcomes*
- *Risks of Telephone Screening and Treatment*

Download order forms at www.omic.com/resources/risk_man/seminars.cfm.

Seminars and Exhibits

March

31 *Liability Risks of Intravitreal Injections*
American Society of Retina Specialists (ASRS)
Hilton Orange County, Costa Mesa, CA
Time: 4:30–5:15 pm
Register for ASRS at (530) 566-9181 or go to www.asrs.org

April

11 *Documentation of Ophthalmic Care**
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
Seattle, WA
Time: 2–3:15 pm
Register for AAPOS at (415) 561-8505. Complete and turn in attendance form for OMIC seminar.

20 *Documentation of Ophthalmic Care**
Iowa Academy of Ophthalmology (IAO)
Des Moines, IA
Time: Afternoon
Register with the IAO at (847) 680-1666 or email eyeorg@aol.com

28 *Documentation of Ophthalmic Care**
Texas Ophthalmological Association (TOA)
Dallas, TX
Time: 2:15–3:15 pm
Register with the TOA at (512) 370-1504 or go to www.txeyenet.org/2007

30 *Recognizing Medicolegal Risks in the Selection of Patients Who Undergo Refractive Surgery*
American Society of Cataract and Refractive Surgery
San Diego Convention Center
Time: 3–4:30 pm
Register with ASCRS at (866) 878-5588

28–May 1
Academy/OMIC Insurance Center
ASCRS Symposium and ASOA Congress
Booth 2627
San Diego Convention Center

May

11–12
Documentation of Ophthalmic Care
Wisconsin Academy of Ophthalmology (WAO)
The American Club, Kohler, WI
Time: TBA
Register with the WAO at (847) 680-1666

19 *Documentation of Ophthalmic Care**
Missouri Society of Eye Physicians and Surgeons
Kansas City Speedway
Time: TBA
Register with the MoSEPS at (847) 680-1666

20 *Documentation of Ophthalmic Care**
Tri-State Ophthalmological Association (AZ*, NV*, NM)
Las Vegas, NV
Time: 12:30–1:30 pm
Register with the Arizona Ophthalmological Society at (602) 246-8901

June

23 *Documentation of Ophthalmic Care**
Virginia Society of Ophthalmology (VSO)
Williamsburg Lodge
Time: 2–3:30 pm
Register with the VSO at (804) 261-9890 or go to www.vaeyemd.org

24 *Documentation of Ophthalmic Care**
Florida Society of Ophthalmology (FSO)
Rosen Shingle Creek Hotel, Orlando, FL
Time: 7–8 am
Register with the FSO at (904) 998-0819 or go to www.mdeye.org

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

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