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Ophthalmic Risk Management Digest

OMIC DIGEST

Hidden Costs of Non-Traditional Revenue Sources

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

Long before the national presidential debates focused attention on health care, ophthalmologists were experiencing firsthand the many obstacles to quality, affordable medical services. They have watched as increasingly complex health care delivery systems demand more but pay less. Judging by calls to OMIC's Risk Management Hotline, the poster child for the injustices of this medical pressure cooker is the on-call physician, who at times is forced to provide uncompensated back-up for hospital emergency rooms. Drawing upon the innovative and entrepreneurial spirit that has long characterized ophthalmology, some eye surgeons have responded to financial pressures by offering new health care products, such as diagnostic testing or interpretive centers, cosmetic skin care clinics, and "Medispas." Others promote their ability to serve as independent medical examiners (IME) and expert physician witnesses (EW) in professional liability, workers compensation, and disability litigation and disputes. These business ventures tend to be characterized by a more limited physician-patient relationship, fee-for-service payment, and delegation of care—and even operations—to non-physician staff. Eyes fixed on the financial prize, some physicians ignore or remain unaware of the risks and duties these relationships entail. Whether provided in the trenches of a crowded emergency room or amid the soothing luxury of a Medispa, ophthalmic care poses medical-legal hazards, professional liability insurance coverage issues, and patient safety pitfalls.

ER Call

One of the most frequent reasons OMIC policyholders call our Hotline is for clarification of their ER-call duties. They wonder about hospitals where they have no privileges, other hospitals in a hospital system, patients in other states, and days when they are not on call. Their next question involves outpatient care of patients with or about whom they have had no contact, but who may show up, call for an appointment, or simply have discharge documents containing the physician's name. Depending upon the circumstances, your duties range from none to diagnosis, treatment, and follow-up. The **Table** on page 5 and the **Closed Claim Study** provide brief remarks. See "EMTALA: An Overview" and "EMTALA: On-Call Issues" at www.omic.com for detailed answers.

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MESSAGE FROM THE CHAIRMAN

I have often used this Message to point out the many services OMIC provides to its policyholders, and indeed our profession, that other professional liability carriers cannot. Here is another very recent example of the prompt, specialty-specific advice OMIC is poised to provide. Within days of the 18 June 2008 announcement in the American Academy of Ophthalmology's *Academy Express* that the FDA had approved an injectable triamcinolone acetonide suspension (TA) for ophthalmic use, OMIC began to revise its consent form and anticipate associated medicolegal issues.

Trivaris,™ manufactured by Allergan Inc., is the second approved drug; it joins Alcon's Triesence.™ These drug approvals come just 18 months after ophthalmologists received a "Dear Doctor" letter from Bristol-Myers Squibb advising them that Kenalog™ was not approved for ocular use. In 2006, OMIC policyholders called our confidential Risk Management Hotline to ask if their policy would cover them if they still administered Kenalog.™ OMIC reassured ophthalmologists and assisted them by preparing and distributing a sample consent form to help patients understand that the use of an approved drug in an "off-label" fashion is a legal and often necessary aspect of the practice of medicine.

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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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Coverage for Legal Costs of Regulatory Investigations

Each year, thousands of physicians are investigated for alleged fraudulent billing practices and violations of HIPAA, EMTALA, DEA, and STARK regulations. To protect insureds who incur legal expenses as a result of regulatory investigations, OMIC purchases a $25,000 Broad Regulatory Protection Policy for each of its physician and entity professional liability policyholders as a benefit of membership. OMIC's BRPP 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 provides legal expense reimbursement for alleged violations of EMTALA, DEA, and STARK regulations.

Several purchasing options are available for policyholders who wish additional supplementary coverage. 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 can review and download BRPP policy documents and upgrade forms at www.omic.com/members/mbrsOnlyBRPP.cfm. Please contact your OMIC underwriter if you wish to have a hard copy of your policy mailed to you. Additional BRPP information, including FAQs, is available at www.omic.com/products/bus_products/BRPP.cfm.

Message from the Chairman

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As a result of the limited indications for which Triesence™ and Trivaris™ were approved, much ophthalmic use of these forms of TA will continue to be "off-label." Moreover, now that there are approved formulations of TA, policyholders are calling the Hotline again to ask, "Can I still use Kenalog™?" Why would physicians want to use a drug off-label if it was available in an approved, single dose form? Retina specialists whose patients were being successfully treated with bevacizumab (Avastin™) grappled with this issue when Genentech got approval for another of its own products, ranibizumab (Lucentis™).

The answer then and now is related to the topics addressed elsewhere in this issue of the *Digest*: the cost of health care and the vagaries of reimbursement. Pharmaceutical companies devote years and considerable capital to research and manufacture new drugs. Thus, it is not surprising that freshly approved drugs are generally more expensive than ones already in use. The dilemma for physicians and patients alike, however, is that these drugs may not now—or ever—be included in the formularies of the patient's health insurance plan. If an ophthalmologist feels the medication is indicated but learns that the cost won't be borne by the insurance company or can't be paid by the patient, what should he or she do?

OMIC's board and committee members are ophthalmologists; we know it is our ethical and professional responsibility to put the patient's interests above our own and provide what we feel is the most appropriate care. So our answer to our policyholders remains the same: discuss the situation openly with your patient, use your medical judgment, document your decision-making process, and know that OMIC will support you if your care is challenged. Be sure to call our Hotline to discuss particular concerns, and download the TA consent form and risk management recommendations at www.omic.com.

Our ability to support your care may, however, be jeopardized if you do not properly evaluate and reduce the risks associated with other health care products, such as Medispas, cosmetic skin care, and forensic consulting. While you may gain needed revenue from this type of professional activity, it may come at too high a cost. Indeed, these services raise a number of questions that are addressed in detail in this *Digest*. Some legal issues can only be resolved by contacting your medical board, practice attorney, or the requesting party. Some malpractice claims coverage questions have clear cut answers, others will depend upon your relationship with the patient and the specific allegations. This issue of the *OMIC Digest* will at least help you begin your risk assessment.

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

Policy Issues

Coverage for Non-Traditional Services

By Kimberly Wittchow
OMIC Legal Counsel

This article will review the OMIC professional liability policy coverage of various activities, such as call, forensic consulting, diagnostic and interpretive services, and cosmetic skin care.

OMIC's policy responds to claims that result from injury to a **patient** because of a professional services incident (an act, error, or omission) arising from direct patient treatment. Direct patient treatment is defined as the provision of health care services to a patient, including making diagnoses, providing medical or surgical treatment, prescribing or dispensing drugs or medical supplies or devices, rendering opinions to a patient, giving advice to a patient, or referring a patient to, or consulting about a patient with, another physician or health care provider. The policy responds, therefore, when you are treating an individual within a physician-patient relationship. Of course, there are times when the issue of whether an individual was your patient will arise. As the claim unfolds it will be determined whether such a relationship existed. If one did exist, you may have liability, and OMIC's policy will respond. If no relationship existed, coverage may not be available, but most likely there would also be no corresponding duty to that individual on your part that could give rise to liability.

ER Call

The majority of OMIC insureds take ER call and OMIC's policy is meant to cover it. If you have a duty to a patient, then a physician-patient relationship exists and coverage, within all the terms and conditions of your policy, applies. For more information about your on-call duties, see the lead article and **Closed Claim Study** in this issue.

Forensic Consulting

Forensic consulting takes many forms: providing expert witness testimony and undertaking independent medical exams are the most prevalent. There are several provisions of the policy to reference when determining whether there is coverage for these activities. First, as described above, there must be a physician-patient relationship (see the **Hotline** article). If not, no coverage applies. In addition, OMIC's policy has a specific forensic consulting exclusion. It provides that OMIC will neither defend an insured nor pay damages or supplementary payments because of a Claim that arises out of services performed by the insured as a paid consultant…when such Claim is made by anyone other than the insured's patient. As an example, this means that coverage would be excluded if an employer who hired you for an IME sued you over your determination (claiming you were negligent in your review). However, if the employee, the person being examined by you and thus your patient in a limited capacity, sued you because you missed a diagnosis that should have been apparent during your IME, you would be covered.

Diagnostic/Interpretive Services

Providing diagnostic and interpretive services may also expose you to liability. Again, to determine whether there is coverage, we look at whether direct patient treatment was provided. These services would fit under the definition of direct patient treatment as "consulting about a patient with another physician or health care provider." However, we would also need to consider the telemedicine issue of practicing medicine in multiple states. Your policy specifically excludes defense, damages, or supplementary payment coverage for direct patient treatment when the health care provider does not hold the required license, certification, or accreditation. Thus, you will need to make sure you are properly licensed in the states where the patient is located as well as where you practice.

Cosmetic Skin Care

In the skin care arena, services are often rendered by allied health care professionals under the supervision of either an ophthalmologist within his or her office or, if at a Medispa, an ophthalmologist medical director who may or may not be on-premises. OMIC covers the insured if sued for direct patient treatment provided not only by the insured, but also by an employee acting within the scope of his or her training, licensure, and employment or any other person acting under the supervision, direction, or control of the insured. If these criteria are met, the insured will be covered for the vicarious liability of his or her employees or supervisees. Careful attention should be paid to the scope of practice of the ancillary personnel, to ensure they are practicing within the scope of their licensure. Also, there is a difference between directly supervising staff and being a medical director. The policy specifically excludes coverage for your role as a medical director at any facility, unless that facility is also insured by OMIC under your policy. Many of our insureds have not considered their Medispas a separate entity and have not applied for coverage, leaving themselves as medical directors, their business, and their staff vulnerable to liability suits.

Another consideration is that insureds are only covered for procedures within their coverage class. There are four coverage classes. In the no surgery class, mechanical epilation is specifically permitted. Restricted surgery class 1 additionally covers laser hair removal, injection of Botox or collagen and other fillers, micropigmentation, photorejuvenation, superficial chemical peels limited to the epidermis, and electrical epilation. Less restrictive surgery class 2 also covers thermage. Surgery class 3 has no restrictions except for the general policy exclusions. Refer to your policy or contact your underwriter to determine what specific cosmetic procedures are covered by your coverage class.

Hidden Costs of Non-Traditional Revenue Sources

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Forensic Consultations

During the course of litigation and disputes, insurance companies, employers, employees, plaintiffs, and defendants often need an objective opinion of the nature, cause, and prognosis of eye conditions. In this *Digest*, we will focus on expert witnesses and independent medical examiners in the context of medical malpractice lawsuits. Expert witnesses are hired by either the plaintiff or defense attorney to review medical records and testify under oath whether or not a physician has breached the standard of care. When the opinion of the expert witnesses differ, or the patient has not recently been evaluated, the disputing parties may ask a physician to conduct a single independent examination of the patient as well as a review of medical records; the physician's written report is submitted to the requesting party and generally made available to the opposing party. For more on acting as an EW or IME, see the **Table** on page 5 as well as the **Hotline**. For a discussion of theories of liability, see "Forensic Consulting: From Immunity to Liability," *OMIC Digest,* Summer 2003, Vol. 13, No. 3, at www.omic.com.

Diagnostic Services

Comprehensive ophthalmologists, primary care providers, and optometrists may lack the expertise or (latest) equipment to provide their own patients with visual field testing, fundus photography, IOL (intraocular lens) calculations, OCT (optical coherence tomography), fluorescein angiography, or corneal topography. Rather than request a formal consultation, which involves an examination, testing, interpretation, and treatment recommendations and may result in a transfer of care, these health care providers sometimes prefer to exercise greater control over their patients and send them for "testing only." Our policyholders report being asked to either provide specialized tests or interpret them. At times, these requests come not directly from health care providers but instead from companies that serve as an intermediary between patients and experts. Requests tend to vaunt the benefits for the ophthalmologist. In the case of testing only, the requesting party points out that such tests can be carried out by technical staff, may be billed to the patient's insurance company, and relieve the physician of the risk of misinterpreting the results. Mindful of the cost of the latest version of his or her notoriously expensive ophthalmic equipment and the talent and skill of staff, the physician may feel inclined to say yes. Companies that provide interpretation of tests emphasize this as a way to increase income, and note that the physician can access and report on the tests at his or her convenience using the internet. What is rarely mentioned is that risks persist that must be mitigated. Moreover, whether providing or interpreting diagnostic tests, ophthalmologists have duties to the patients who undergo them.

The physician who offers tests may be liable for delays in diagnosis caused by malfunctioning equipment and has vicarious liability for training and supervising employed staff. Insurance companies may withhold or challenge payment if the physician is not present in the office during the exam or bills for interpretive services. And patients who are not advised of the limited role the physician plays in the testing may sue the physician for direct liability. To reduce your risks, give patients and referring physicians a copy of the results and a document explaining that: 1) the physician who owns the equipment has an independent practice; 2) the patient is being referred only for a test; 3) the test will be conducted by non-physician staff; and 4) the physician who owns the equipment will not review records, examine or treat the patient, interpret results, or provide recommendations.

Providing a diagnostic interpretation of a test performed elsewhere can be considered a form of telemedicine, since the images and data are usually sent electronically. Radiologists and pathologists have long furnished this type of medical expertise, and retina specialists may be familiar with centers that read fundus photographs of diabetic patients. More recently, some ophthalmologists have begun remote screening of retinopathy of prematurity. Special underwriting requirements apply to ROP, so contact OMIC immediately if you have not yet had a review of your ROP care. For other kinds of diagnostic interpretation services, conduct a due diligence evaluation of the entity requesting it to determine if its medical directors have the requisite knowledge and experience, and how they are obtaining patient referrals. Ask for a copy of the policies, procedures, and protocols to see if the following issues are addressed there: clinical information provided along with the image, image quality, technical issues, turnaround time, and scope of report (e.g., interpretation only, interpretation plus recommendations for additional tests and treatment, etc.). Check state law to determine if you need a license in the state(s) where the images are taken.

Cosmetic Skin Care Clinics Within an Ophthalmology Practice

As the specialty that pioneered Botox for therapeutic purposes, it is hardly surprising that ophthalmology has also championed cosmetic uses of this medication. Oculofacial plastic surgeons frequently offer many such non-therapeutic services to their patients, ranging from skin care products to laser resurfacing procedures, and we receive calls on our Risk Management Hotline from comprehensive ophthalmologists and other subspecialists who are considering adding cosmetic skin care services. OMIC policyholders need to understand their liability risks and contact us for assistance as needed

when assessing these. State medical practice acts do not limit the scope of practice for physicians, so in the event of a malpractice claim, expert witnesses will focus on the standard of care and whether the ophthalmologist has the training, experience, and current competency to provide specific care.

Sometimes, policyholders themselves do not have this expertise but want to hire non-physicians who do; this raises several concerns. First, prescribing a medication and ordering treatment such as laser skin resurfacing almost always falls within a state's definition of medical practice. If non-physician staff provide Botox, collagen fillers, or laser treatment before a patient is evaluated by a physician and/or without a physician order, they may face allegations of practicing without a license, and the physician may face disciplinary action for aiding and abetting the unlicensed practice of medicine. Many states allow only registered nurses to administer Botox and fillers, and perform laser skin treatment. It goes without saying that malpractice lawsuits arising from such care may be difficult to defend. To reduce liability exposure, contact your state medical and nursing boards to determine what is required of you and who can implement your treatment orders. Ensure that you are competent to supervise all care provided by your staff. If registered nurses manage your skin care clinic, review their evaluation of the patient, confirm patient candidacy, order the treatment, and be available to assist if complications occur.

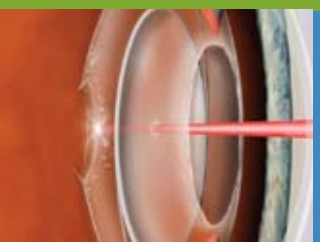
Medispas Not Associated with a Physician's Practice

Although the name evokes images of comfort and pleasure, serving as medical director of a Medispa could lead to headaches, uninsured legal risks, and licensure action. Regardless of the site of service, medical care is governed by the state's medical practice act and scope of practice and pharmacy laws. Call for assistance before getting involved in a Medispa.

IF I AM YOUR DOCTOR, WHAT DO I NEED TO DO?

YOUR ROLE	MD-PT RELATIONSHIP?*	YOUR DUTIES AND OBLIGATIONS
Expert Witness	No, UNLESS you already have a physician-patient relationship	• None to patient • Provide objective, medically sound testimony: do not act as advocate for plaintiff or defendant • Abide by AAO Ethic Rule 16
IME	Yes, but limited in time and scope	• Disclose conflicts and fact that report will be shared with requesting party or parties • Perform evaluation and orally disclose findings to patient • Disclose incidental findings that need follow-up
On-call to ER	Yes, IF all apply: • You have privileges at that hospital • You are on-call that day and you provide telephone or direct patient care for that patient • If you choose to respond, even if not on-call, you have all duties	• Respond to call from ER within 30 minutes • Obtain necessary information on the telephone to determine diagnosis and advise on treatment plan • Come to the ER if the ER physician requests it or you feel you need to • Document details of call • Provide outpatient care if medical staff bylaws require it or you have agreed to • Follow-up on missed appointment
Testing only	Yes	• Maintain equipment • Train and supervise staff • Provide disclaimer on role of MD • Send test result
Interpretation only	Yes	• Obtain medical license(s) in state(s) where image of patient taken AND where results interpreted • Analyze quality of image • Send report of diagnostic interpretation • Provide recommendations for further testing, treatment, and follow-up if required by contract • Include disclaimer that you are not involved in ongoing care
Skin Clinic as part of Ophthalmic Practice	Yes	• Determine candidacy • Order medication or treatment • Obtain informed consent (may at times be delegated) • Develop policies, procedures, and job duties of non-physician staff • Maintain equipment • Train and supervise staff • Follow-up missed appointment
Medispa Director	No, UNLESS no other physician performs duties described for skin clinic, in which case you will most likely be deemed the supervising physician	• Evaluate state law to see if free-standing Medispa is legal • Determine who may administer treatment under state law • Credential physician who will determine candidacy and order treatment • Credential non-physician staff who will administer treatment • Oversee quality of medical care • Ensure maintenance of accurate, secure medical records

* This analysis of the physician-patient relationship applies in most situations. However, courts may find otherwise in particular jurisdictions or sets of facts.



Closed Claim Study

The Duty of an Ophthalmologist Who Is Not On Call

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to properly attend to an alkaline burn and failure to give an adequate consultation to ER physician.

DISPOSITION

Plaintiff voluntarily dismissed case prior to trial.

Case Summary

An OMIC insured received a call from an emergency room physician regarding a patient who had a chemical substance splashed in his left eye while disposing of some garbage at work. The OMIC insured was not on call for this emergency room when he received the call and did not have privileges at the hospital. The insured did not document the conversation and later could only recall being told by the emergency room physician that the call was to alert him that he was being referred a patient the next day. When the patient presented to the insured the following morning, he was diagnosed with an acute chemical abrasion burn OS, secondary cornea edema OS, and chemical abrasion and alteration to the left nose and left ear. A stat appointment was scheduled with a corneal specialist, who noted the patient's eye was alkaline with a pH level of 11. A placental graft was placed OS and eventually the patient's vision returned to near pre-incident levels of acuity.

Analysis

The plaintiff expert contended that the OMIC insured performed an inadequate telephone consultation, failing to advise the ER physician of the importance of testing the pH level of the patient's eye prior to discharge and the need for further irrigation of the eye. The plaintiff attorney alleged that the OMIC insured failed to draw adequate information from the ER physician, including the severity of pain, the condition of the eye, and the effect on the patient's vision, and further maintained that no treatment should have been performed by the ER physician without an exhaustive consult with the insured ophthalmologist.

Although the insured interpreted the call from the ER physician to be a next day referral and not a consultation, it would have been beneficial to his defense had he thoroughly documented the phone call. The insured did testify that his customary practice was to respond to any questions an ER physician might have and that the standard of care in this situation was to cleanse the eye with a saline solution for at least an hour, test the pH level, and perform further cleansing with saline as required. The ER physician admitted during his deposition that he never asked about the need for pH testing to determine the alkaline level of the patient's eye. The ER physician was dismissed from the case prior to the insured.

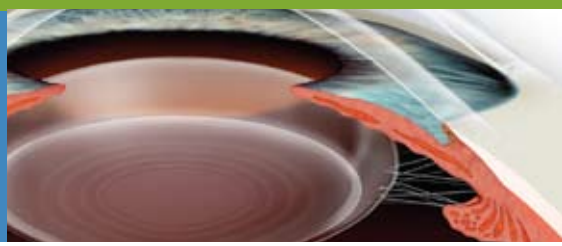
Risk Management Principles

When the insured received the call from the ER physician, he could have informed him that he did not have privileges at the hospital and consequently did not take call there and that the ER physician should consult with the ophthalmologist who *was* on call for the hospital that evening. Even if there was no ophthalmologist on call, it would still be up to the insured whether to assist the ER physician or not. It could be argued that by not specifically refusing to help and agreeing to examine the patient the following day, the insured tacitly agreed to assist the ER physician. Had the insured decided *not* to offer his assistance, and even if no other ophthalmologist was available to help, it would have been entirely appropriate for the insured to tell the ER physician to follow the hospital's back-up plan, such as transferring the patient to another facility if the hospital was unable to provide the necessary care, as required under EMTALA.

Once a decision is made to help, the ophthalmologist may become liable for any harm to the patient resulting from an alleged negligent telephone evaluation or treatment recommendations. At this point, it is vital to thoroughly elicit and document the patient's history and complaints, as well as treatment recommendations and the follow-up plan.

If you will be seeing the patient in your office, ask in writing that the ER fax you the ER record of all patients referred to you for post-ER follow-up. Notify your staff of the type of appointment that should be scheduled. These steps help ensure that your staff schedules the appropriate type of appointment and that you have the information you need to provide continuity of care.

Risk Management Hotline



Services Provided as an Independent Medical Examiner or Expert Witness

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

Forensic consulting can provide physicians with welcome revenue, but it raises many questions for our policyholders when they are asked to serve as an expert witness or to perform an independent medical examination.

Q Is it true that the American Academy of Ophthalmology has issued an opinion about expert witness testimony?

A Yes. The AAO added Rule 16 to its Code of Ethics in order to address concerns raised by its members about the truthfulness and accuracy of expert witness testimony. The Rule clarifies that testimony should be objective, based upon medical knowledge, and free from the influence of nonmedical factors such as solicitation of business, competition, and personal bias. Compensation should reflect the actual time and effort involved, and not be contingent upon the outcome. Physicians are often asked to disclose compensation during their deposition or testimony.[1]

Q Do I establish a physician-patient relationship by providing expert witness testimony or by performing an independent medical exam?

A As an EW, if you do not examine or treat the patient, there is no physician-patient relationship and thus no duty owed to the patient. The situation of an IME is less clear. While some courts have ruled that you do not create a relationship, the American Medical Association recognizes what it terms a "limited" physician-patient relationship.[2] Acknowledging that the patient has not necessarily asked for the evaluation and does not pay for it, and that the examiner will not treat the patient, the AMA nonetheless asserts that professional and ethical standards continue to govern the physician's role in the encounter.

Q What liability risks do I face in an IME?

A Malpractice lawsuits related to independent medical examinations are rare; allegations covered by OMIC's policy include failure to diagnose eye conditions, failure to diagnose and disclose incidental findings, and harm caused by the examination itself (see **Policy Issues**). For a discussion of other theories of liability pertaining to EW and IME, see "Forensic Consulting: From Immunity to Liability," *OMIC Digest,* Summer 2003, Vol. 13, No. 3, at www.omic.com.

Q What duties do I owe the person I examine?

A The AMA explains the duties in its Code of Ethics and opinions. At the start of the visit, address what may be perceived as a conflict of interest by informing the patient who has hired you and will pay your fee. Clarify that your role is limited to conducting an examination and producing a report. State clearly that you will not treat or follow the person and will not discuss the pros and cons of treatment options. Stress that the usual privacy and confidentiality rights are restricted in that your findings will be shared with the company or attorney who hired you. Finally, inform the examinee of what the AMA terms "important health information or abnormalities" that you discover during your examination (for your own protection, document these disclosures and incidental findings). To the extent possible, ensure that the person understands the problem or diagnosis.

Q The person I evaluated during an IME signed a form acknowledging that he would not receive a copy of the report. He now, however, wants a copy of his "medical record." Should I create and provide one?

A The party that requests the IME usually instructs the ophthalmologist to have the patient acknowledge in writing that both the party paying for the examination, and often the opposing party, will receive a copy of the IME report. Interestingly, in some circumstances and jurisdictions, while the patient still controls which other third parties may have access to the report, he or she may not see or receive a copy of it. In response to Hotline calls, OMIC researched whether the patient is nonetheless entitled to a copy of the medical record. While it seems logical that the examinee would need a copy in order to seek care for any incidental findings, we could not find a clear answer to this question. For that reason, be sure to clarify before agreeing to do an IME whether or not the examinee is entitled to receive a written copy of your findings. Ask if you may provide the patient with a document containing only the "important health information or abnormalities" that the AMA feels you have a duty to disclose. Inform the patient of what you may provide before beginning the exam. Please contact the OMIC Risk Management Hotline if you need further assistance on this issue by calling (800) 562-6642, option 4.

1. See the AAO web site at http://www.aao.org/about/ethics/code_ethics.cfm for more information about the entire Code and Rule 16; accessed on 6/11/08.

2. American Medical Association, Opinion E-10.03. *Physician-Patient Relationship in the Context of Work-Related and Independent Medical Examinations at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.03.HTM; accessed on 6/11/08.

Calendar of Events

OMIC continues its popular risk management programs this summer and fall. Upon completion of an OMIC online course, CD recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society 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 at www.omic.com. CME credit is available for some courses. Please go to www.aao.org to obtain a CME certificate.

Online Courses

(Reserved and free for OMIC insureds)

- *Documentation of Ophthalmic Care*
- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*
- *Responding to Unanticipated Outcomes*

State and Subspecialty Society Online Courses

A society-specific online course, *Documentation of Ophthalmic Care,** is available for physicians in California, Colorado, Hawaii, Iowa, Louisiana, Missouri, Nevada, Oklahoma, Washington, the American Society of Plastic and Reconstructive Surgeons, and Women in Ophthalmology. Contact Linda Nakamura in OMIC's Risk Management Department to register for these online courses.

CD Recordings

(Free to OMIC insureds; $60 for non-insureds)

- *After-Hours and Emergency Room Calls (2006)*
- **NEW!** *Medication Safety and Liability.* Recorded at the AAO Annual Meeting, this OMIC Forum discusses use of anticoagulants and steroids.
- *Lessons Learned from Trials and Settlements of 2006.* Subjects include claims resulting from a "wrong" IOL, hemorrhage during blepharoplasty, and dry eye following co-managed LASIK surgery.
- *Lessons Learned from Trials and Settlements of 2005.* Subjects include follow-up on high-risk postoperative patients, minimizing failure to diagnose allegations with focus on giant cell arteritis, and monitoring patients on steroids for ongoing need, effectiveness, safety, and compliance.
- *Lessons Learned from Trials and Settlements of 2004.* Subjects include informed consent for cataract surgery, traumatic eye injuries, and ASC: Anesthesia provider, monitoring, discharge.
- *Noncompliance and Follow-Up Issues (2005)*
- *Research and Clinical Trials (2004)*
- *Responding to Unanticipated Outcomes (2004).*

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

Upcoming Seminars

July

26 *Now What Do I Do?*
Southeast Regional Meeting—Alabama,* Kentucky, Louisiana,* Mississippi, Tennessee (TAO)*
Grand Sandestin Hotel, Destin, FL
Time: 1:00–2:00 pm
Register with the TAO at (615) 794-1851

August

9 *Now What Do I Do?*
Women in Ophthalmology Renaissance Providence Hotel, Providence, RI
Time: 10:00 a.m.
Register with the WIO at (415) 561-8523

September

TBA *Lessons Learned from Trials and Settlements of 2007*
Audiocourse
Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com
Free to OMIC insureds; $60 for non-OMIC insureds

20 *Now What Do I Do?*
Table Top Regional Meeting—Arkansas, Missouri,* Kansas, Oklahoma*
Big Cedar Lodge, Branson, MO
Time: Afternoon Session
Register with Arkansas Ophthalmological Society at (501) 224-8967

November

9 OMIC Forum: *Preventing Surgical Confusion: Wrong Patient—Wrong Site—Wrong IOL*
AAO Annual Meeting
Georgia World Congress Center, Atlanta, GA
Time: 1:00–3:00 pm
Register onsite during Forum
Contact Linda Nakamura at (800) 562-6642, ext. 652

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 lnakamura@omic.com.

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