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Ophthalmic Risk Management Digest

OMIC DIGEST

Using Claims and Incident Reports to Predict the Future

By Paul Weber, JD

Paul Weber is OMIC's Vice President of Risk Management/Legal.

Yogi Berra once said, "Prediction is very hard, especially about the future." Difficult though it may be, an insurance company must continually make predictions about future frequency and severity of claims in order to set aside adequate reserves and charge appropriate premiums to pay for future claims. Using mathematical formulas and financial modeling, actuaries are employed to analyze claims data and assist insurance companies with making loss projections. This article addresses the first and most fundamental step in OMIC's claims data analysis: a review of claims and incident reports made by OMIC insureds.

Over the past five years, OMIC, like other medical malpractice carriers, has witnessed a steep drop in the number of claims reported by its members, from 284 in 2003 to 179 in 2007. At the same time, the number of OMIC insureds increased from 3,200 in 2003 to 3,741 in 2007, resulting in a significant drop in the percentage of OMIC insureds who reported a claim over this four-year period, from 8.9% to 4.8% (see Graph 1). This dramatic downward trend is occurring nationwide, including the five states where OMIC claims activity has been the highest (see Graph 2), and across the spectrum of ophthalmic treatments and procedures, including three that have historically resulted in the most claims (see Graph 3).

Declining claims frequency, along with other rate-setting factors, has allowed OMIC to lower its premiums and return a dividend to policyholders for the last two years. As welcome as this decline in claims frequency is to OMIC and others in the industry, it is also puzzling and not easily explained. According to one claims analyst, "Unless we know what causes it, we can't know what effect it will have and for how long." There are at least five possible reasons cited for the drop in claims frequency:

1. Tort reform in states such as Texas has decreased the amount of non-economic pain and suffering damages that can be awarded to plaintiffs, making it less lucrative for plaintiff attorneys to take a malpractice case.
2. "I'm sorry" legislation passed in about 28 states since 2002 allows physicians to express their sympathy to a patient for a poor outcome without fear that it may be used against them in court.

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MESSAGE FROM THE CHAIRMAN

Many factors influence how a malpractice case is ultimately resolved, but OMIC's governance by ophthalmologists who understand the risks and know what a case is worth and when to settle or go to trial gives us the competitive edge over multispecialty carriers when it comes to defending ophthalmologists. OMIC's claims experience in 2007 was notable for the dismissal or settlement of several potentially large loss cases for amounts well below the reserves set aside to meet the expected value of these cases. To illustrate how "the OMIC factor" was instrumental in bringing about a positive resolution, I shall describe two of last year's cases that presented the potential for large losses.

The first case involved an alleged failure to diagnose an impending CVA in a patient who presented to the ER with vision loss but no accompanying neurological signs. Our insured diagnosed amaurosis fugax, prescribed one aspirin daily, and instructed the patient to contact his primary care physician the next day for a vascular workup. The patient returned to the ER six hours later and was admitted with significant neurological injuries.

When the case was reported, OMIC immediately had it reviewed by a general ophthalmologist, a neuro-ophthalmologist, and a neurologist. All

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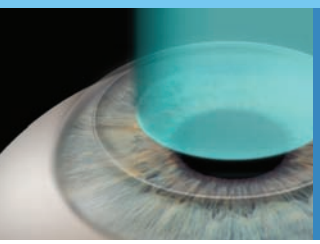

Eye on OMIC

OMIC

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Why Are Dilating Drops in the News?

A medication used routinely by ophthalmologists—dilating drops—was the subject of a recent ruling in the Massachusetts Supreme Court, which in turn occasioned an ASCRS Member Alert. The court opined that if a physician does not warn of the possible side effects of a medication or treatment, he can be held liable not only to his patient but to all those "forseeably put at risk for a failure to warn."

While this case was triggered by a motor vehicle accident, OMIC has also dealt with malpractice allegations involving falls after dilation. Indeed, we recently settled such a case, and were already editing articles on risks related to dilating drops for this issue of the *Digest* (see **Closed Claim Study** and **Risk Management Hotline**) when we were contacted by policyholders in response to the ASCRS Alert. It is important to reiterate OMIC's long-standing recommendations on an ophthalmologist's duty to warn patients about the effects of dilating drops.

We first suggested such a practice in 1992, when former OMIC committee member Richard A. Deutsche, MD, advised ophthalmologists to "Discuss Potential Side Effects of Eye Drops" in the AAO's *Argus,* and we provided a sample consent document for dilating drops in 2002.

At the 2007 AAO Annual Meeting, the OMIC Forum on "Medication Safety and Liability" focused attention on two other high-risk medications that play a role in ophthalmic liability: anticoagulants and steroids. Policyholders who were not able to attend the forum may order a complimentary copy of the CD by calling Linda Nakamura at (800) 562-6642, ext. 652. Insureds are also encouraged to consult "Hemorrhage Associated with Ophthalmic Procedures" and our sample consent form for triamcinolone acetonide (Kenalog™), both available at www.omic.com.

Message from the Chairman

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three experts strongly defended the care of our insured. With this level of strength in our medical experts, we made the decision to proceed to trial, even though our defense counsel placed the potential jury verdict at $2,500,000 to $4,000,000. In the months prior to the scheduled trial, we held several discussions with the plaintiff attorney to educate him on the fine points of the ophthalmology involved in this case. After many sessions, we convinced him that our experts could discuss the disease process in such depth that his experts would not be able to respond adequately. Ultimately, the plaintiff's attorney decided not to go up against us at trial and the case was dismissed.

OMIC faced a different challenge in the case of a young child who lost an eye following a severe injury from broken glass penetration. The child was brought to the local ER by her parents and was seen by the ER physician and our insured ophthalmologist. Our insured did not want to risk repair surgery in the ill-equipped ER and recommended transferring the child to a nearby hospital that had the appropriate specialists and equipment. En route to the hospital, the patient experienced an expulsive choroidal hemorrhage; unfortunately, the eye could not be saved by subsequent surgery.

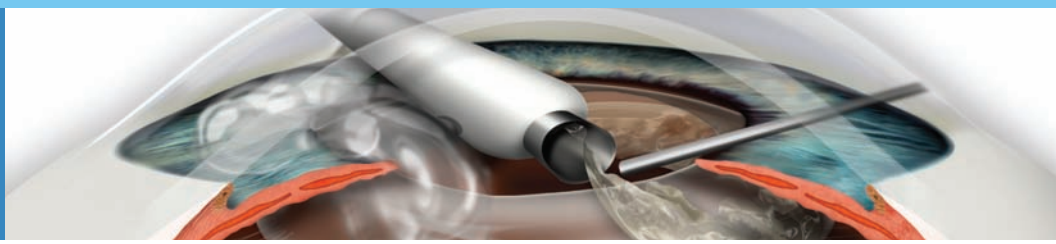
Liability revolved around the accuracy of the ER diagnosis and the decision to transfer the child to another facility. Even though OMIC found excellent experts to testify that the eye was unsalvageable when the child entered the ER, the case was worrisome because of the extreme jury appeal of a small child who had lost an eye. OMIC ran a mock trial survey to quantify risk exposure. The mock jury confirmed our suspicions by coming in with an 80% plaintiff orientation and a suggested verdict in the millions.

Since the indication was that if we took the case to trial, there would be a large plaintiff verdict, and with the plaintiff demanding policy limits to settle, the insured asked that we settle the case to avoid putting his personal assets at risk. After tedious negotiations, including several expert depositions supporting our insured and strengthening our negotiating stance with the plaintiff, the case was reasonably settled well within the insured's policy limits.

In both cases, OMIC's expertise in ophthalmic liability and claims defense enabled us to confidently and knowledgeably present the ophthalmic facts, find the best experts to support our insured, and use advanced litigation technology to assess our risk exposure and bring about the best possible result.

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

Policy Issues



Coverage On-Call

By Kimberly Wittchow, JD
OMIC Legal Counsel

Taking call or arranging for call in your absence is an important part of most physicians' practice. However, this situation gives rise to the following questions: (a) When does my medical malpractice liability insurance cover me for taking call and (b) When is it appropriate for me to take call under these circumstances?

Limited Scope Ophthalmologists On-Call

One question that arises is whether an ophthalmologist in a limited coverage class [i.e., Ophthalmology Surgery Class 1 (very limited surgery), Class 2 (limited surgery), or No Surgery] is covered by OMIC for taking call for colleagues who provide a full scope of ophthalmic services, or for a hospital emergency room. Under OMIC's policy, the ophthalmologist is covered for taking such call as long as she only provides those services permitted under her coverage class when she advises and treats patients. If she cannot feasibly and promptly obtain the services of another ophthalmologist to provide care that is outside her scope of coverage, she should consider discussing with an OMIC risk management specialist whether to continue the on-call activity.

OMIC's Risk Management Department provides advice on when to take call in order to help our insureds reduce their liability risk and support overall quality of care. Paul Weber, OMIC Vice President of Legal/Risk Management, notes in "Who's On Call?" (available at www.omic.com) that being "on call" by definition means that a physician is ready and legally able to render medical or surgical care to patients on an urgent or emergent basis. This includes being able to see and treat patients in the office or emergency room and admitting them to a hospital if necessary. Ideally, ophthalmologists who take call for their colleagues or private practice should have a coverage classification sufficient to diagnose and treat patients themselves. By having the full coverage classification of Surgery Class 3 when taking call, an ophthalmologist generally has the ability to not only diagnose the condition but treat it as well, thereby avoiding delays in care. This is especially true when taking ER call, where patients are more likely to present with truly emergent conditions.

The difference between OMIC's policy coverage and risk management recommendations is that the terms and conditions of the policy are binding upon the insured in order for insurance to cover a claim. Risk management recommendations provide useful tools in managing the risks of medical practice and reinforcing the standard of care for our insureds' patients. However, it is not mandatory to implement this risk management advice.

Insureds need to decide for themselves whether they will continue to take call when they are in a limited coverage class. They should do so with the understanding that anything that exceeds the limits of their coverage class must be promptly referred to another physician. Only the insured can decide whether such referral can take place in a timely manner, whereby the patient does not suffer a delay that would contribute to a worsening of the injury or medical condition.

Optometrists On-Call

OMIC offers professional liability insurance to optometrists employed by our ophthalmologist and entity insureds. We have had queries about whether employed optometrists are covered by OMIC's policy for taking call on behalf of their employers or other ophthalmologists. Under the policy, the optometrist is covered for taking call as long as he is acting within the scope of his training, licensure, and employment by the ophthalmologist/entity when he advises and treats patients.

However, in order for the optometrist to be added to an OMIC policy as an insured, his call services must first be analyzed and approved by OMIC's Underwriting Department during the application process. A detailed explanation of the nature and volume of the calls and scope of responsibilities when on call must be provided. An underwriter will assess the liability risk of the optometrist's call. There is a lower risk of liability when an optometrist is screening calls and making referrals only, versus the higher risk of personally examining patients and making independent treatment decisions for an ophthalmologist's patients. The underwriter reviews the protocols in place for handling trauma, surgical complications, emergency call requiring the patient to be seen, and referring or transferring care to a backup ophthalmologist. In order for coverage to be approved, an ophthalmologist must always be available to promptly take patient referrals.

In "Who's On Call?," Paul Weber points out that optometrists' call coverage is more limited than that which can be provided by an ophthalmologist. Due to state laws limiting the optometric scope of practice, as well as differences in training between optometrists and ophthalmologists, optometrists generally should not take call on behalf of ophthalmologists. However, their special training and skill does allow them to handle a number of questions or situations that might arise, so limited call with backup resources and referral/transfer protocols in place may be appropriate.

OMIC Can Help

If you are an optometrist covered by OMIC and your call services have changed since you first applied for coverage, you must notify OMIC's Underwriting Department at (800) 562-6642, ext. 639, so we can assess your liability risk and continue to approve coverage of your practice. Ophthalmologists should contact their underwriter if they have questions about call coverage. For assistance with decision making about when and how to take or assign call, contact OMIC's **Risk Management Hotline** at ext. 641.

Using Claims and Incident Reports to Predict the Future

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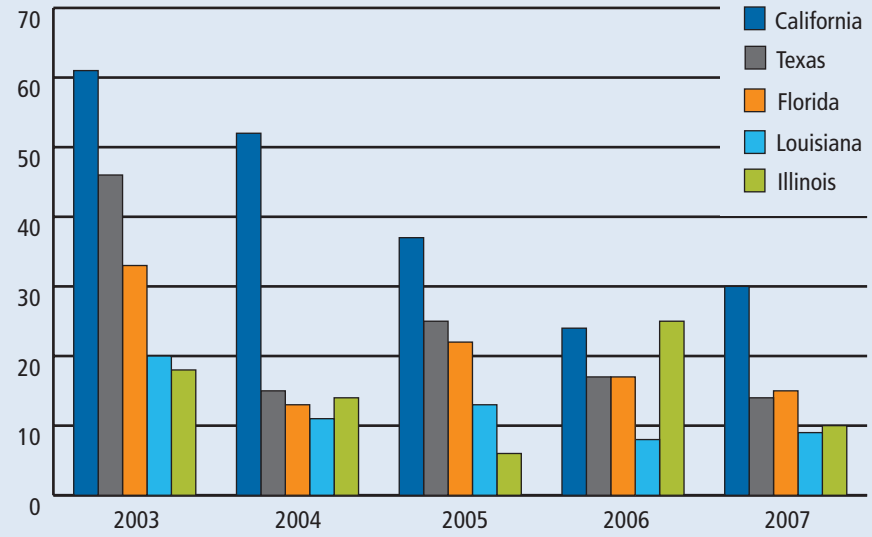
3. Media coverage has brought attention to the trend of physicians discontinuing practice in high risk specialties and high risk states.
4. There has been increased emphasis on the part of hospitals and physicians to implement protocols and standards to reduce medical errors and improve patient safety.
5. Stringent new laws relating to standards and requirements for expert witnesses in medical malpractice litigation have been shown to decrease payments and claims. Rule 16 of the American Academy of Ophthalmology's Code of Ethics mandates and describes acceptable standards of expert witness testimony for its members. Other medical associations are following suit and disciplining unethical experts within their ranks.

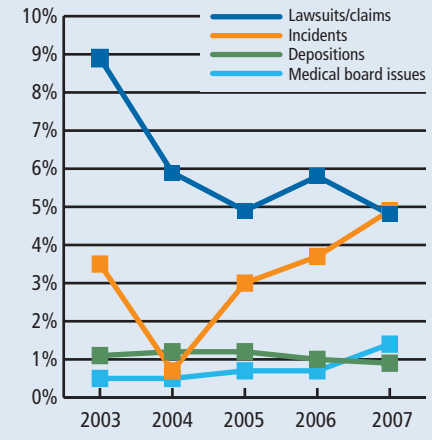
GRAPH 2
NUMBER OF CLAIMS REPORTED TO OMIC BY STATE
Together these five states account for more than 50% of all claims reported to OMIC.



Incident Calls On the Rise

Even before a claim or lawsuit is ever filed, OMIC's Claims Department handles "incidents" (reports of possible claims), state licensing board matters, and assignment of counsel for depositions and other legal assistance to insureds who might potentially be named in a lawsuit. Over the years, providing pre-claims advice and assigning defense counsel to prevent insureds from becoming a party to a claim or being sanctioned by their state licensing board has evolved into one of the many important functions provided by OMIC staff. The data arising from these services is monitored and analyzed to identify and contain any emerging trends.

GRAPH 1
PERCENTAGE OF OMIC INSUREDS REPORTING A CLAIM, INCIDENT, DEPOSITION, OR MEDICAL BOARD ISSUE



While fewer OMIC insureds reported an actual claim in 2007, a record 5% reported an incident to OMIC's Claims Department (see Graph 1). Over time, a small percentage of these incidents will turn into a claim or lawsuit, but even those that do not can become a complex liability matter or risk exposure for the insured, requiring significant care and attention by OMIC claims and risk management staff.

A case in point was the rising incidence of TASS (toxic anterior segment syndrome) in post-cataract surgery patients in 2006. When OMIC began receiving calls from insureds that postoperative inflammation was occurring in ASCs and hospitals where they operated, the origin of the inflammation was still under investigation and there was uncertainty as to where liability might eventually fall. Even though no claims or lawsuits had yet been filed, OMIC took the precaution of assigning defense counsel in order to invoke attorney-client privilege in all communications in the event of an OMIC insured later being named in a suit. We also developed risk management recommendations (see "Endophthalmitis and TASS: Claims Results and Lessons," *Digest*, Spring 2006).

Medical Board Reports Increasing

OMIC provides defense coverage up to $25,000 for many medical board licensing matters. The number of medical board reports has grown steadily over the past four years; in 2007, over 54 medical board matters were reported to OMIC. (See "A Medical Board Investigation Handled Perfectly," *Digest*, Winter 2007.) This is cause for concern because, with the exception of Florida, there is no apparent reason for the increase. In Florida, the spike in medical board reports is the result of "wrong IOL" or "wrong site" reporting. The Florida state health department mandates that hospitals and ASCs report these events even if the patient is satisfied with the result. Physicians in Florida who are found to have three "wrong"

violations lose their license to practice medicine. It is important to understand that the increase in frequency of medical board reports extends well beyond Florida to many other states where OMIC has large numbers of insureds, including Texas, California, Nevada, Virginia, and Colorado.

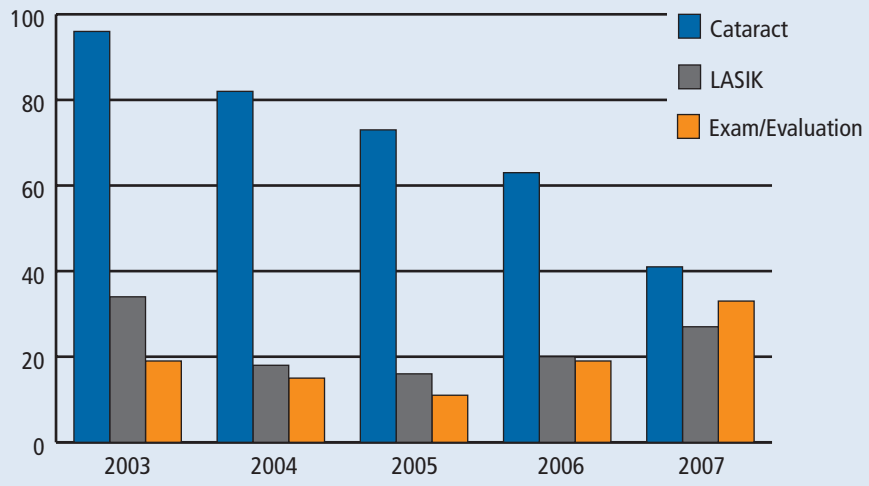
Outside of claims, medical board licensure matters have the greatest potential for adverse consequences. A negative outcome may hurt an ophthalmologist's eligibility for credentialing by hospitals and health care plans for many years. Fortunately, only 1.4% of OMIC insureds reported a medical board licensing matter in 2007.

Pre-Claim Assignment of Defense Counsel

Often when an insured ophthalmologist is deposed in another physician's malpractice case or contacted by a plaintiff or defense attorney to discuss his or her care or the care of a colleague, OMIC assigns legal counsel to the insured. In 2007, 35 such assignments were made. Generally, these cases are not as complex as the TASS incident; however, there is the risk that our insured may be brought in as a party to another physician's malpractice case or, as likely, be manipulated by the plaintiff or defense attorney to give standard of care testimony. Since OMIC insures approximately 35% of the ophthalmologists in private practice in the United States, it is not unusual for a patient who is suing one OMIC insured to be receiving care from another OMIC insured. In such situations, either plaintiff or defense counsel might depose the non-defendant OMIC insured as a "fact witness." Although status as a fact witness should limit the insured's testimony, either side may still try to wheedle an opinion that will favor its case.

When these situations are reported, OMIC's first priority is to minimize any exposure the non-defendant insured might incur from being brought into the lawsuit and help limit the insured's testimony to "facts." Quite often, this is done with the assistance of an OMIC-assigned defense attorney who may accompany the insured to the deposition. OMIC insureds are advised to call the Claims Department when they receive a subpoena for a deposition in a malpractice claim and to avoid "informal" conversations with *any* attorneys. Even if the matter appears innocuous, staff can serve as an excellent sounding board in the unfamiliar arena of malpractice litigation. OMIC has developed and posted on its web site pertinent risk management recommendations for these situations, "Confidentiality and Privacy Issues During the Investigation and Litigation of a Medical Malpractice Incident, Claim, or Lawsuit."

GRAPH 3
NUMBER OF CLAIMS REPORTED TO OMIC BY PROCEDURE
Together these three procedures account for more than 50% of all claims reported to OMIC.

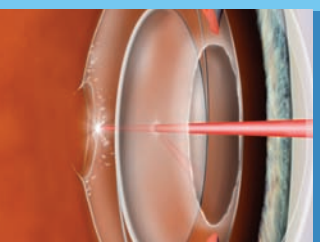


Risk Management Hotline

In 2007, OMIC's confidental **Risk Management Hotline** received calls from over 1,100 insureds and their staff inquiring about all matters of ophthalmic practice and patient care. Sometimes insureds have a question about a medical-legal matter for which there are no specific laws or regulations, or the facts presented fall into a gray area. In such cases, adhering to general risk management principles may be the best approach. These recommendations are developed by staff in collaboration with OMIC board and committee members and are set forth on OMIC's web site.

Conclusion

Over the past 20 years, as OMIC has accumulated more claims and pre-claims reports, it has been able to thoroughly analyze this data for a clearer understanding of the liability exposure of ophthalmologists. Because of our favorable claims experience over the past several years, OMIC has been able to prudently decrease rates and provide a dividend to policyholders. However, OMIC must carefully watch for trends in all areas to make sure rates and reserves are adequately set to cover future losses. OMIC board and management are keenly aware that insurance is a cyclical business and that claims trends could change the insurance market at any time, in which case we would all agree with Yogi that, "This is like déjà vu all over again." By paying close attention to claims trends, OMIC will be prepared when the déjà vu of the insurance cycle happens all over again.



Closed Claim Study

Elderly Patient Falls From Wheelchair Following a Dilated Exam

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to assess fall risk and to warn patient of effects of dilating drops on visual accuity.

DISPOSITION

Case dismissed following patient's death from causes unrelated to injuries sustained in fall.

Case Summary

An elderly patient underwent a dilated examination by an optometrist at an OMIC insured ophthalmology group. She was unaccompanied and used an electric wheelchair. As she was leaving the building following the exam, staff gave her a pair of sunglasses and asked if she required assistance to her car; she declined. Shortly thereafter, some staff members were eating lunch outside the office when they heard a loud crash. They found the patient lying on the steps with her head bent into the stairs. Apparently, she had misjudged the stairs for the wheelchair ramp upon exiting the building.

An ambulance was called, and the patient was admitted to the ICU where a CT scan displayed a small intra-parenchymal contusion. She remained neurologically intact and was not felt to be an appropriate candidate for rehabilitation service at the hospital. Instead, she was discharged nine days later and admitted to a long-term skilled nursing facility where she received care for a rotator cuff tear on her right shoulder. She was subsequently discharged from the skilled nursing facility and was followed by a neurologist. The neurologist noted that her double vision had gradually subsided and that her memory for recent and remote events was unaffected. The patient remained independent in all activities of daily living. She died of an unrelated illness during the investigation of her claims.

Analysis

Staff at the OMIC-insured facility certainly did the right thing by providing sunglasses, offering assistance, and documenting the patient's refusal of it. In retrospect, however, it is clear that the patient was a poor judge of her own need for help. Moreover, the offer of help did not prevent the plaintiff attorney from alleging that more proactive care in the form of a fall risk assessment was required. Indeed, this patient had several risk factors, including her advanced age, wheelchair use, unaccompanied status, and a decline or alteration of vision due to dilating drops.

Furthermore, the wheelchair ramp and stairs leading out of the building were the same color, and it was arguably difficult to distinguish between the two, even with good vision. The lawsuit also alleged a failure to warn since the patient was not told of the risk of a fall or the danger of operating machinery, i.e., driving a motorized wheelchair, while her vision was impaired.

Risk Management Principles

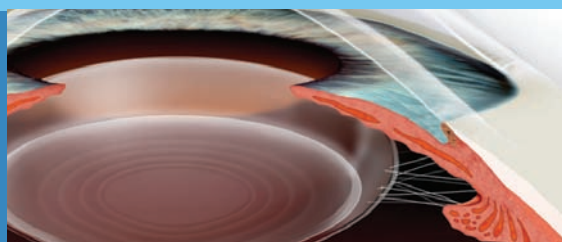
Falls are the most common type of accident in the hospital setting and the fifth leading cause of death among persons over age 65.[1] Ophthalmologists routinely treat elderly individuals with physical limitations, motility impairment, and poor visual acuity. When these same individuals are administered dilating drops, the known side effects—decreased visual acuity, photophobia, lack of accommodation, glare, blurred vision, and decreased contrast threshold and contrast visual acuity—can prove to be much more than they can safely handle.

Fall prevention requires assessment, assistance, supervision, and surveillance. Assistance to and from the office and when getting up from a chair should specifically be offered or supplied to the elderly, handicapped, and/or visually impaired. Thorough evaluation of all of a patient's risk factors as well as an evaluation of the general surroundings should be performed in assessing each patient's risk for an accident following a dilated examination. Utilizing color schemes that maximize the differences between floors, steps, walls, and ramps can decrease the likelihood of a patient fall and injury.

In addition to assessing patients for fall risk, ophthalmologists and/or their staff should also obtain informed consent for dilating drops and offer patients sunglasses. While this case involved a fall, patients and other injured parties have also sued ophthalmologists when patients whose eyes were dilated were involved in motor vehicle accidents after leaving the ophthalmologist's office. See the **Risk Management Hotline** article in this issue as well as OMIC's risk management recommendations and sample consent form at www.omic.com.

1. Rutledge DN, Donaldson NE, Pravikoff DS. "Fall Risk Assessment and Prevention in Healthcare Facilities," *The Online Journal of Clinical Innovations.* Dec. 15, 1998, 1(9):1-33.

Risk Management Hotline



Warn Patients about Side Effects of Dilating Drops

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

Dilating drops are used on countless patients daily during diagnostic examinations and surgical procedures. They are essential in order to obtain an adequate view of the retina and fundus. Indeed, failure to perform a thorough examination of the eye could lead to significant patient harm such as delay in diagnosis or failure to diagnose, as well as surgical complications due to poor visibility. However necessary, drops have also precipitated lawsuits, as discussed in this issue's **Closed Claim Study**. These claims are usually based upon the ophthalmologist's failure to warn of the risks of ambulating and driving following the insertion of dilating drops. While the **Closed Claim Study** discussed fall prevention, this article will focus on driving issues.

Q Do I need to obtain the patient's informed consent before administering dilating drops?

A Having been taught that informed consent is not required for simple procedures whose risks are commonly considered to be remote—drawing a blood sample or taking a chest x-ray are the usual examples—an ophthalmologist might conclude that dilating drops fall into this category. It is important to remember, however, that the legal doctrine of informed consent is based not upon what an ophthalmologist feels should be disclosed but rather upon what a "reasonable person" would want to know prior to undergoing a procedure or taking a new medication. A quick review of the ocular and systemic side effects might lead this hypothetical reasonable person to feel informed consent is needed. Dilating drops cause vision to be blurred for a period of 4 to 8 hours and induce photophobia, lack of accommodation, glare, and decreased contrast threshold and high-contrast visual acuity. For elderly patients whose vision and mobility are already compromised, these visual changes can be dangerous. Dilating drops can also provoke allergic reactions, angle closure attacks, and systemic reactions such as increased blood pressure, arrhythmias, tachycardia, dizziness, and increased sweating. A jury might reasonably conclude that informed consent should be obtained.

Q What specifically do I need to tell the patient? Can I delegate this duty to my staff who administer the drops?

A The patient needs to understand that the drops will cause blurry vision for 4 to 8 hours, and that he or she should wear sunglasses and avoid driving and operating machinery until the effects wear off. Staff may be assigned the task of warning patients and offering sunglasses.

Q Do I need to have the patient sign a consent form?

A Not necessarily. Document the offer of sunglasses (or reminder to wear them) and the warning about side effects, especially the possible impact on walking, driving, and operating machinery. It is helpful to advise new patients as they are making their appointment that their eyes will be dilated. The first time patients' eyes are dilated, ask them to sign a form acknowledging that they have been apprised of the risks (see OMIC's sample consent form at www.omic.com).

Q Do my staff members need to warn the patient each time?

A Yes. To remind them to do so and to expedite the documentation process, you may want to use a chart stamp (see sample following this article and under risk management recommendations for dilating drops at www.omic.com). Consider placing a sign in your waiting room reminding patients whose eyes are dilated not to drive, to wear sunglasses, and to let the staff know if they need assistance walking while their eyes are dilated.

Q Some of my patients feel safe driving home, even right after their appointment. Others tell me that no one is available to drive them to the office for their regular retina appointments. Should I refuse to dilate the eye if a patient insists on driving?

A Not necessarily. Use your medical judgment, taking into consideration such factors as the patient's pre-dilation visual acuity and driving ability, driving conditions, the reason for the patient's visit, and how urgently you need to diagnose and/or treat the presenting condition. Involve the patient in the decision-making process and document the discussion. Patients who need to be dilated but will be driving themselves can be offered morning appointments and encouraged to stay in the waiting room until the effects of the drops have worn off. If in doubt, err on the side of patient safety. In general, lawsuits against physicians have been dismissed if the physician warned the patient and documented the warning.

CHART STAMP FOR EASY DOCUMENTATION

Patient screening
Had dilating drops before? No/Yes
Reaction? No/Yes _____
Allergies? No/Yes _____
On heart or blood pressure medication?
No/Yes: _____

Lacrimal duct blocked after administration
By staff _____ By patient _____

Angle-closure glaucoma screening
Patient told has narrow angle No/Yes
Medical record checked No/Yes
Penlight/slit-lamp exam No/Yes_____
Physician consulted No/Yes

Informed consent (staff initial)
Risks, benefits, alternatives discussed_____

Drops given: _____

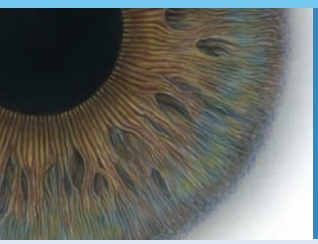
Reaction: None/ _____

Sunglasses: Offered/has _____

Warned not to drive: _____

Needs assistance to car? No/Yes

Assisted to car: _____



Calendar of Events

OMIC will continue its popular risk management programs in 2008. 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 the AAO web site, www.aao.org, to obtain a CME certificate.

Online Courses *(Reserved for OMIC insureds/No charge)*

- *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, the Contact Lens Association of Ophthalmologists, and Women in Ophthalmology. Contact Linda Nakamura in OMIC's Risk Management Department to register for these online courses.

CD Recordings *(No charge for OMIC insureds)*

- *After-Hours and Emergency Room Calls (2006)*
- *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. Free to OMIC insureds; $60 for non-OMIC insureds.
- *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

April

5 *Risk Issues in Adult Strabismus Surgery**
American Assn for Pediatric Ophthalmology & Strabismus
Grand Hyatt Washington, DC
Time: 2:00–3:30 pm
Register with AAPOS at http://www.aapos.org.

5 *Multifocal IOLs as Drivers of Malpractice Lawsuits*
American Society of Cataract & Refractive Surgery
McCormick Place,
West Building, Chicago, IL
Time: 3:30–5:30 pm
Register with ASCRS at (703) 591-0614 or http://www.ascrs.org/Meetings/Annual-Symposium/2008/Registration/index.cfm.

5-8 *OMIC Insurance Center*
ASCRS/ASOA Annual Meeting
Exhibit Booth 1940
McCormick Place,
West Building, Chicago, IL

May

3 *Now What Do I Do?*
Texas Ophthalmological Assn*
Westin Riverwalk, San Antonio
Time: 3:30–5:00 pm
Register with the TOA at www.txeyenet.org.

18 *Now What Do I Do?*
Tri-State Annual Meeting—Arizona Ophthalmological Society*, New Mexico Academy of Ophthalmology, & Nevada Ophthalmological Society*
Hilton Sedona Resort, AZ
Time: 12:30–1:30 pm
Register with the AOS at (602) 246-6053 or www.azeyemds.org.

June

8 *Now What Do I Do?*
Virginia Society of Ophthalmology*
Sheraton Premiere at Tyson's Corner, Vienna, VA
Time: 9:30–11:30 am
Register with the VSO at (804) 261-9890.

22 *Preventing Surgical Confusions*
Florida Society of Ophthalmology*
The Breakers, Palm Beach, FL
Time: 7:00–8:00 am
Register with the FSO at (904) 998-0819.

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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