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Ophthalmic Risk Management Digest
OMIC DIGEST

Entities at Risk for Professional Liability Claims, Too

By Betsy Kelley
OMIC Vice President of Product Management

Throughout OMIC's history, the number of insured professional entities has steadily increased. Many new group practices have joined OMIC, and physicians who previously practiced alone have merged their practices with others. Groups now represent 55% of OMIC's overall market share. Even physicians who remain in solo practice more often form limited liability corporations or similar professional entities in an effort to protect their personal assets, attain tax advantages, and achieve other benefits. With more physicians shifting from hospital-based surgery to outpatient procedures, outpatient surgical centers have flourished.

As the number of insured entities has increased, so too has the number of reported claims. Between the company's inception in 1987 and year-end 2000, 96 claims and suits were filed against medical entities (multi-shareholder corporations and partnerships), sole shareholder corporations, and surgery centers (outpatient surgical facilities or OSFs). During the next five years, an additional 208 entity-related claims were reported. Claim frequency increased even further between 2005 and 2010. By the end of 2010, a total of 449 entity claims had been reported during the decade. Cases against medical entities represented nearly 60% of all entity claims and 12% of all claims reported to OMIC between 2001 and 2010. For this same period, solo corporations accounted for 29% of all entity claims and 6% of claims altogether, and surgical centers accounted for 11% and 2%, respectively. (See graphs on page 4.) The increase in the number of insured entities, however, does not alone account for the large increase in entity claims. Simply put, entities are more frequently being named in claims. This article will explore the different causes of actions that expose entities to claims.

Let the Superior Reply

Under the doctrine of *respondeat superior*, a professional entity may be held vicariously liable for the acts and omissions of those who provide services on its behalf. As the "master," the entity is ultimately responsible for the actions of its agents ("servants"), including the entity's owners, employees, and, in some cases, independent contractors. This is a common cause of action against insured entities. Increasingly, claims against physicians alleging medical negligence include their entity as a

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MESSAGE FROM THE CHAIRMAN

My biggest concern as a physician, and one shared by most clinicians, is that a decision made or a procedure performed results in harm to a patient, leading to pain and suffering, and perhaps adversely affecting quality or length of life. Most patients understand and accept the reality that events occur in the practice of medicine that fail to salvage vision or restore function. However, patients do not give consent to procedures expecting that they will result in loss of sight, loss of the eye, or injury. Fortunately, such events are rare. After experiencing an adverse outcome, an honest surgeon will ask himself or herself privately, "Did I do something to cause this? Was this my fault? Did I make a mistake? What if I had done things differently?"

Patients who have been harmed, their friends, and family members ask the same questions. Their assessment and answers to those questions are the basis of medical liability claims. It is left to the courts and juries to determine if the complication results from "malpractice" as defined by the courts. All too often, an acceptable complication that occurs in the normal conduct of medical practice results in a claim, particularly when there

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Eye on OMIC

OMIC

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OMIC Launches Social Network

A recent study of web trends suggests that the ophthalmic community has embraced social media for online marketing and professional collaboration to a greater degree than other medical specialties. In 2010, ophthalmologists were more likely to use online physician directories to reach patients and had higher adoption rates for social networking sites to collaborate with both patients and colleagues. A 2011 survey by the American Academy of Ophthalmology indicates that 50% of Academy members use social networks professionally with participation higher among younger ophthalmologists, who are connected through sites such as Facebook, Twitter, LinkedIn, and the AAO Community. The precursor to these sites, ophthalmic LISTSERVs and email groups, are still used by many ophthalmologists for clinical and administrative advice and dialogue as well.

To facilitate enhanced online interaction and feedback from policyholders and the broader ophthalmic community, OMIC has launched several new social platforms. Visit **OMIC.com** for links to social networking pages on Twitter, Facebook, and LinkedIn. Followers will be alerted to news, updates, and announcements from OMIC, including notification whenever new patient consent documents or loss prevention resources are published. OMIC's **Twitter feed@myOMIC** will link OMIC's Facebook fans and LinkedIn network with associated content. Ophthalmologists who want *only* to be notified when OMIC publishes new patient consent documents (and not other OMIC news) can link to and follow our companion Twitter page@OMICdocs.

OMIC's blog features risk management tips and resources, underwriting and coverage announcements, practice administration advice, information for upcoming seminars and conferences, course materials and forms, case studies, statistics, state and cooperative venture updates, and other relevant OMIC news. Blog entries will automatically be published throughout OMIC's social network. Those who do not use social networking sites can still follow the RSS feed for OMIC's blog by visiting **http://www.omic.com/blog/** and subscribing to the feed through their web browser favorites tab by choosing the RSS link at the bottom of the OMIC blog page and following the subscription instructions.

Message from the Chairman

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is observable physical damage, pain and suffering, or financial loss. Physicians may feel cheated if a settlement is paid out when they are certain that everything was done correctly and within acceptable standards of care. However, one can't escape the reality that a patient lost an eye or vision, suffered a stroke, or passed away in the course of treatment. Even when an adverse outcome is the result of maloccurrence, not malpractice, juries often take the approach that someone has to pay. That "someone" is usually the professional medical liability insurance carrier, which provides protection for physicians both when there is clear evidence of wrongdoing and when there is a settlement in the absence of malpractice. This coverage provides a safety net for patients who have been harmed and protection for the physician's assets.

When a claim comes in to OMIC, investigation and defense of the claim falls to the claims department headed by Mary Kasher, MSN, JD. Insureds are familiar with OMIC's outstanding claims history: average indemnity 18% lower than average ophthalmology indemnity reported by other carriers; 79% of cases closed with no indemnity payment; expense per closed claim 30% below industry average; 85% win rate at trial. This remarkable record reflects Mary's experience and direction and the dedication and skill of senior litigation analysts Ryan Bucsi, Richard Isom, Stacey Meyer, and Randy Morris. This team of claims specialists serves as the intermediary between the attorney and doctor, supervising each claim in their respective geographic jurisdiction and leading each ophthalmologist through the litigation process from beginning to end.

Mary's biggest challenge has been finding outstanding attorneys in each of the 49 states where OMIC insures ophthalmologists and educating them about the specialty so they could knowledgeably and skillfully defend insureds.

Mary's approach to claims defense is shared by the OMIC Board and senior leadership: If a doctor is not negligent, provide the best defense possible, and settle those cases that need to be settled early and fairly.

John W. Shore, MD
Chairman of the Board

Policy Issues

Entity Coverage

By Betsy Kelley
OMIC VP, Product Management

As the lead article illustrates, professional entities face a number of liability exposures. They have direct liability arising from administrative services the entity provides to the practice to facilitate the delivery of health care services. Such functions may include credentialing or supervisory activities, development of practice protocols, and maintenance of the premises. Under the doctrine of vicarious liability, liability for an injury may be assigned to a party who did not cause the injury but who has a legal relationship to the person who did act negligently. For entities, vicarious liability arises from the acts, errors, and omissions ("actions") of the owners, employees, and other health care providers who render services to the practice's patients. Ophthalmologist–owners of the professional entity may be held vicariously liable for direct patient treatment provided by others as well. To protect insureds from these exposures, OMIC extends coverage under two separate insuring agreements.

Coverage C—Professional Entities

Under Coverage Agreement C: Professional Liability Coverage for Professional Entities, coverage is extended to the professional entity for its direct liability arising from direct patient treatment provided by the entity and for its vicarious liability arising from direct patient treatment provided by any person for whose actions it is legally responsible, so long as that person was acting within the scope of his or her licensure, training, and professional liability coverage, if applicable. Coverage also applies under Coverage Agreement C to any person or entity affiliated with the insured professional entity in his, her, or its capacity as a member, officer, director, partner, or shareholder of the entity ("member"). This includes not only vicarious liability coverage for claims arising from direct patient treatment provided by others for whose actions they are legally responsible, but also coverage for claims resulting from professional committee activities the member performs for the insured entity. Professional committee activities include formal accreditation, utilization review, credentialing, quality assurance, peer review, and similar board or committee services. Coverage Agreement C does not cover members for direct liability arising from their own direct patient treatment or vicarious liability for the actions of others arising outside of that member's role as an entity owner. (Ophthalmologists named in the declarations are covered under Coverage Agreement A for these liabilities.)

Vicarious liability coverage provided under Coverage C is conditional. If the claim results from a professional services incident involving direct patient treatment provided by a health care provider not insured under the entity's policy, the provider must maintain professional liability insurance with a carrier acceptable to OMIC during the term of his or her employment, contractual relationship with, or utilization of the facility of, the insured entity. In the event the provider failed to maintain insurance as required, OMIC will not defend the entity or its members or pay damages or other payments resulting from their vicarious liability for the actions of the uninsured provider. This is why we ask you to provide certificates of insurance for all non-OMIC associates at each renewal.

OMIC will defend an insured against allegations of vicarious liability for the actions of others based on an apparent partnership between the insured and another health care provider or professional entity, but supplementary payments and damages are excluded from coverage. If you share office space with health care providers who are not owners, employees, or formal independent contractors of your practice, please contact an underwriting representative to request a "Guide to Apparent Partnership."

Coverage E—Premises

Limited office premises liability is insured under Coverage Agreement E. The entity and its members are insured for claims resulting from injury to a patient or property damage to a patient's personal, tangible property caused by a professional services incident resulting solely from premises maintenance performed by the insured or anyone for whom the insured is legally responsible. Premises maintenance refers to the insured's ownership, maintenance, or use of the office premises in which the insured provides direct patient treatment. Premises liability coverage is subject to a maximum limit of $50,000 per claim/$150,000 annual aggregate. Office misadventures that result from negligent supervision or are otherwise related to direct patient treatment are considered professional liability cases and are not subject to this sub-limit. Coverage Agreement E does not constitute and is not meant to replace commercial general liability coverage or other fire and property coverage for the insured's office premises.

Please note that no coverage will extend to an entity, its non-physician employees, or its members in their capacity as members unless the entity is named as an insured on the policy declarations. If your entity is not listed on your declarations and you would like to obtain entity coverage, contact your underwriter at (800) 562-6642, ext. 639, for an application. Similarly, if you form or acquire a new entity, change the name of your entity, or make any other change in your entity affiliation, please notify OMIC as soon as possible to minimize the risk of uninsured liability.

Entities at Risk for Professional Liability Claims, Too

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co-defendant, and on rare occasions, the case may be filed solely against the entity. A savvy plaintiff attorney may include the entity in an effort to find a deeper pocket or an additional limit of liability. Rather than serving as protection from liability, the entity may instead become an additional source of indemnity. While OMIC has often been successful in having the entity dropped or dismissed in court in the absence of negligence on the entity's part, these cases may be costly to defend and indemnity payments are sometimes necessary.

Naming All Potential Plaintiffs

Plaintiff attorneys may start with a primary target but do not initially know all the facts at the beginning of a lawsuit. In the case of alleged negligent surgery, it is common to name the surgery center. An OMIC-insured ophthalmologist performed Descemet's stripping endothelial keratoplasty, without complication, on a patient with Fuchs' dystrophy. When the DSEK failed, the patient underwent penetrating keratoplasty. Claiming complete loss of vision due to alleged negligent corneal transplant, he sued both the surgeon and the outpatient surgical facility. No contention that any OSF employee was negligent or otherwise contributed to the patient's outcome surfaced during discovery. After nearly $15,000 in legal expenses, the OSF was dismissed from the suit. The case proceeded against only the surgeon.

Negligent Acts of Employed Optometrists and Physicians

Optometrists and ophthalmologists have an independent scope of practice regulated by state law and are directly liable for their own care. If they are employees of an entity, however, the entity is not only vicariously liable but also is expected to direct and supervise the care provided. In one practice, a patient with a 25-year history of diabetes was seen by a non-OMIC insured optometrist employed by an OMIC-insured entity. The patient complained of glare at night, problems driving, and a decrease in distance and near visual acuity over the previous several months. The optometrist diagnosed moderate to severe proliferative diabetic retinopathy, narrow angle glaucoma risk OU/neovascular glaucoma OU, and cataracts OU (no surgery indicated).

The patient was instructed to return in two months for a visual field exam with an ophthalmologist. When she did not show for her scheduled appointment ten weeks later, staff consulted the ophthalmologist, who advised offering her the next open appointment, one month later. The patient returned as scheduled, complaining of constant pain and light sensitivity of one week's duration. Her vision was HM OD and LP OS with IOPs of 19 and 76, respectively. The ophthalmologist diagnosed narrow angle glaucoma secondary to neovascular glaucoma, initiated treatment, and arranged for her to be seen emergently by a glaucoma specialist.

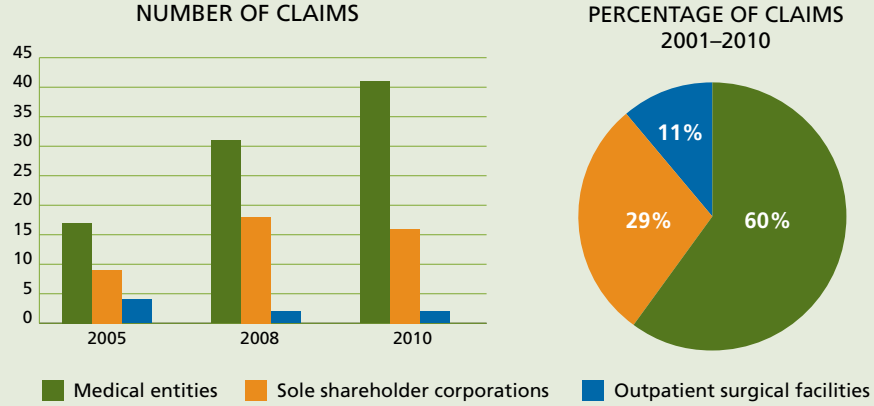
The patient filed suit for delay in treatment and named the optometrist (direct liability) and his employer, the ophthalmologist's sole shareholder corporation (vicarious liability for its employed OD and MD). Defense experts were critical of the OD for not arranging an immediate consultation with an ophthalmologist. They also criticized the ophthalmologist for not having the patient return immediately when she missed the appointment, but he was not named as a defendant. The entity was ultimately dismissed from the suit, and the optometrist reached a settlement of $250,000 with the patient. OMIC paid more than $23,000 defending the corporation.

Former Employed Physician with No Tail Coverage

Entities face increased exposure when health care providers have no direct coverage for their own liability, either because they have chosen to practice without insurance or because, when leaving the practice, they did not purchase "tail" or prior acts coverage for their previous activities. In these situations, the entity may be found legally liable for damages. (See **Policy Issues** for coverage limitations relating to uninsured providers.)

Dr. A (not insured by OMIC), one of several ophthalmologists employed by an OMIC-insured group, saw a patient for complaints of a silver arc of three days' duration. The dilated exam showed a posterior vitreous detachment (PVD). Dr. A advised the patient to return in three months. When she returned two months later, her dilated exam again showed PVD, and she was instructed to return in six months. Instead, she returned in two months. At this exam, Dr. A noted

ENTITY CLAIMS BY ENTITY TYPE



possible Sjogren's. Although Dr. A later testified that he performed a dilated fundus exam at this visit, no fundus exam was documented. Optos images were ordered, which revealed a retinal detachment that Dr. A allegedly missed. When the patient returned a few weeks later complaining of hazy vision, there was questionable optic pallor and the cup-to-disc ratio was 0.1. There is no documentation of a retinal detachment or dilated exam at this visit. Dr. A recommended visual field testing, which was completed the following week and indicated a "possible visual field defect." Plans for carotid Doppler and sedimentation rate were recommended. A few weeks later, the patient was seen at another facility, where the retinal detachment was diagnosed. Because Dr. A did not carry professional liability insurance, the patient also filed suit against the entity for vicarious liability, even though no criticisms of the entity were voiced. The case settled at mediation for $300,000 on behalf of the entity. The uninsured physician also contributed $50,000 towards settlement.

Role of Staff in Lawsuits

The previous cases relate to alleged errors committed by physicians and extended health providers, such as optometrists. Ancillary personnel, such as employed nurses and technicians, are another source of vicarious liability. Although OMIC's policy extends coverage directly to non-physician personnel, such employees are rarely named in medical malpractice complaints. Instead, allegations of employee negligence are generally filed against the employing entity.

A medical entity was sued after a patient suffered a chemical corneal burn caused by an enzyme cleaner. When the patient removed her contact lenses during a pre-surgery check-up, the technician placed them in cleaning solution rather than wetting solution. Upon placing the lens back in her eye, the patient experienced severe burning, swelling, and pain. This case settled for $40,000 against the entity.

In another practice, an insured ophthalmologist discovered, while dictating the operative report for a cataract surgery in which cortex was retained, that the wrong IOL had been implanted. The ophthalmic assistant had incorrectly transcribed A-scan data from another patient's record. The surgeon called the patient the next day and informed him of the error. The patient self-referred to another ophthalmologist, who treated him for complications relating to the retained cortical material. The patient filed a claim against the surgeon and his solo corporation alleging pain, light sensitivity, chronic redness, and the need for additional surgeries. Although these complaints resulted from complications of the initial surgery and were unrelated to the wrong-power IOL, the technical error compromised the case's defensibility. Accordingly, a settlement of $42,500 was made on behalf of the entity.

Slips, Trips, and Other Mishaps

Another area of potential liability is the insured premises. While it may seem that slips, falls, and other office mishaps should be covered under the practice's commercial general liability (CGL) or business owner's policy (BOP), such cases often fall instead under professional liability. Many of these cases center on patient supervision or are related to medical care provided rather than premise defects.

An elderly patient with multiple medical issues was escorted to an uncarpeted exam room and placed on a stool with rollers and no back. While alone in the exam room, she fell off the stool and hit her tailbone. As a precaution, she was sent to a local hospital for examination. X-rays showed no visible damage, but a bone scan taken three months later noted subtle findings of a possible hairline fracture. The patient filed a claim against the ophthalmic entity, which reported the claim to its CGL carrier. That carrier denied coverage, classifying the case as professional liability due to negligent supervision. OMIC settled the case on the entity's behalf for $60,000.

Protocols and Pitfalls

In some instances, the practice's policies and procedures themselves—or the failure of staff to follow them—contribute to liability claims. Breakdown in the phone message system resulted in a $140,000 settlement on behalf of an insured medical entity. A patient with a history of ECCE, laser iridotomy, and pars plana vitrectomy underwent a corneal transplant by Dr. X. The bandage contact lens was removed two months later, and the epithelium was healing. Two weeks later, the patient called the medical exchange on a Saturday morning, complaining of pain and redness in the operated eye. When the call was not returned, he called again that evening and three more times on Sunday. He was finally seen by the on-call physician, who diagnosed endophthalmitis, prescribed Quixin and Cosopt, and advised the patient to return to his corneal specialist the next day. The patient returned as instructed and was referred by Dr. X to the hospital, where the eye was eviscerated. The patient filed suit against the entity only; no physicians were named.

Failure to follow protocols to prevent wrong-eye/wrong-site surgery resulted in a $75,000 payment on behalf of an OSF and $240,000 on behalf of a non-OMIC surgeon. A patient was scheduled for strabismus surgery OD. Preoperatively, the nurse and patient identified the right eye, and all documentation indicated the right eye. In spite of this, the left eye was draped, no "time out" was called, and surgery proceeded on the left eye.

As these cases demonstrate, professional entities face a number of professional liability exposures. This issue's **Risk Management Hotline** discusses ways to reduce some of them.

Closed Claim Study

Two Cases of Entity Liability

By Ryan Bucsi, OMIC Senior Litigation Analyst

CASE 1 ALLEGATION

Post cataract surgery endophthalmitis due to unsterilized surgical instruments.

DISPOSITION

Case settled for $650,000.

CASE 2 ALLEGATION

Failure to assist an elderly patient resulting in a fall and femur fracture.

DISPOSITION

Case settled for $235,000.

Case 1 Summary

An OMIC insured performed an uncomplicated cataract surgery on a patient's left eye. At the completion of surgery, one of the support staff present in the operating room noticed that the instrument tray chemical indicator was white and had not turned dark brown as it should at the completion of the autoclave sterilization process. The patient was not immediately informed of this problem as the consensus was that, while the instruments had not been autoclaved, they had been washed and cleaned and were likely not contaminated. Further, antibiotics had already been prescribed. At the postoperative day one examination, no signs of infection were present, and the sterilization error was explained to the patient. Three days later, during the second postoperative exam, the patient presented with complaints of sudden vision loss and pain OS. Endophthalmitis was diagnosed. A culture revealed the presence of pseudomonas aeruginosa, as did the instruments when they were cleaned in the ultrasonic bath unit without being autoclaved. Despite treatment of the infection with vitrectomy and intraocular antibiotic injections, the patient's vision OS remained light perception only.

Analysis

Defense experts felt the entity's liability was certain as there had been departures from standard medical practice, nursing practice, and internal protocols. A processing technician left a washed, non-sterilized tray of instruments in the autoclave room on a table next to the unit when the tray should have been placed on a cart marked non-sterilized. In the operating room, none of the three OR nurses verified that the indicator on the instrument tray had changed color before setting up the instruments for surgery. As a result of these errors, a $650,000 settlement was negotiated at mediation on behalf of the OMIC insured group.

Risk Management Principles

Patients have a right to know when an error has been made. In this case, the patient should have been immediately informed that the instruments used in her surgery may not have been properly sterilized. Immediate disclosure of such information is beneficial to both the patient and the health care provider and maintains trust between them. Advising a patient of complications that might occur and what symptoms to report can lead to earlier, vision-preserving treatment. As a result of this incident, the insured entity developed a protocol to assure that only surgical items that have been appropriately sterilized are used during surgery. One of the nurses in the operating room is now required to show the surgeon the tray of instruments to verify that the chemical indicator has indeed changed color, thus confirming appropriate sterilization.

Case 2 Summary

An elderly patient with macular degeneration was in an examination room with an ophthalmic technician following administration of dilating drops. The technician asked the patient to move from one chair to another. The second chair was on wheels and when the patient placed her weight on it, the chair slid out from under her and she fell. The patient fractured her femur and required surgery with extensive rehabilitation in a skilled nursing facility. She claimed over $100,000 in medical bills related to the injury.

Analysis

Liability was evident as ophthalmic treatment, via administration of dilation drops, and lack of patient supervision contributed to the fall. Defense experts criticized the technician, who, in supervising the patient, did not assess the need for assistance, offer assistance, or immobilize the chair for an elderly patient with impaired vision. The insured entity did facilitate the patient's transfer to the hospital for care and was conscientious in immediately reporting the matter to the OMIC claims department. As a result, a suit was not filed and a settlement of $235,000 was directly negotiated with the patient's attorney.

Risk Management Principles

Observing patients in the waiting room may help identify those who will need assistance maneuvering around the office. Caution should be exercised with elderly patients who have existing visual impairments. Assistance should be provided if it is necessary for an impaired patient to move around the exam room or to another location in the office. At the conclusion of the exam, the patient should be assisted in returning to the waiting room and to the supervision of the family member or caregiver responsible for the patient's transport home.

Risk Management Hotline

Use an Unusual Event to Reduce Entity Liability

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

The malpractice claims presented in this issue of the *Digest* raise concerns about the policies and procedures in effect at solo corporations, group practices, and ambulatory surgery centers. Indeed, inadequacies were identified in coordination of care, follow up of noncompliant patients, credentialing, documentation, use of contact lens solutions, appointment scheduling, telephone screening of ophthalmic problems, and instrument sterilization. How can you take action to identify and rectify such problems? Conduct an "event analysis" as soon as you learn of unusual occurrences; focus your analysis on the impact on the patient and the systems or processes involved.

Q The hospital on-call ophthalmologist just informed me that one of my cataract patients developed endophthalmitis. The patient told her he tried to contact our practice three times and finally went to the ER when no one called back. Should I call the patient?

A Yes. This patient needs to know that you care about the complication and want to learn more about the problems he reported in contacting your office. "I'm so sorry to learn that you have a very serious infection in your eye. How are you feeling today?" When you can, move on to the phone issue. "Dr. Jones tells me that you weren't able to reach our office despite calling three times. Do you feel well enough to tell me more about that?" Keep the focus on the patient: "I can only imagine how upset you must be about not being able to speak with us. Let me assure you that I am going to check with our answering service and find out what happened. May I call you again when I find out?" Notify your partners of the situation, get buy-in on the need to evaluate the system, and identify who will lead the analysis. When you contact the service, remain polite and limit the initial contact to beginning the fact-gathering process. "We're reviewing our call experience this past weekend. Could you please send us a list with details on all the calls you handled for us?" Ask any physicians covering for the practice to provide you with information on calls they took from the service and/or patients. Review the call documentation for clarity, adequacy, response time, and follow up. Consider expanding the analysis: ask all physicians, office staff, and answering service staff for input on questions, problems, or concerns experienced with after-hours calls during the previous six months.

The goal of the analysis is to determine if the problem was with this particular patient and whether the entire process is safe and reliable. You may identify issues such as a physician who yells at the answering service when contacted, lack of clarity on what to do when a physician does not respond, rapid turnover at the service, or malfunctioning equipment. Go back to the physicians in the group with what you have learned and develop an after-hours policy and procedure. Educate all involved parties, then analyze again. Finally, report back to the patient on your findings and your plan; patients appreciate knowing that their poor experience may lead to improved care for other patients.

Q One of my patients was harmed when her contact lenses were cleaned with the wrong solution. Should I fire the assistant who made this mistake?

A Termination would be indicated only in exceptional cases. Instead, start by providing comfort to the staff member. Inform her that you would like her help identifying what went wrong so it won't happen again. Call a staff meeting, ask the staff member to explain the incident, and ask other staff to clarify all steps in the process, paying particular attention to ones that could lead to error or harm. Your written team analysis may uncover contributory causes, such as lack of labeling of solutions, similar looking containers, inadequate training, or pressures from an overbooked schedule. Develop a better process to address the causes, write it up, and test it. Modify the procedure as needed.

Q My cataract patient experienced a refractive surprise. When I reviewed the medical record, I found a staff member had made a transcription error that led to implantation of the wrong IOL. Am I expected to review orders on each patient before surgery?

A Not necessarily, but you and your practice need to develop some systematic review process to prevent office-based causes of "wrong IOL." Use this opportunity to develop an office cataract surgery checklist and staff education program. Include the involved staff member, the technician who performs your A-scans, and your surgery scheduler. Have them map out the care process, and highlight steps that could lead to error or harm. Clarify points at which you will be involved, such as when you verify the results of the A-scan and IOL master. Pay particular attention to key information that needs to be transmitted to the ambulatory surgery center, such as allergies and medical and ocular comorbidities that could impact anesthesia or perioperative care. Eliminate as much transcription as possible by, for example, sending a copy of the A-scan and IOL master results along with the preoperative order. Ensure that the refractive target, type and power of IOL, and operative site are specified. Review and approve the final checklist and educational program before it is presented to the entire staff. Monitor outcomes, and adapt the checklist and process as needed.

OMIC risk management staff are here to assist you. Call the confidential Hotline at (800) 562-6642, ext. 641.

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Calendar of Events

OMIC continues its popular risk management courses in 2011. Upon completion of an OMIC online course, CD or MP3 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 (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are listed here and on the OMIC web site, **www.omic.com**.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management programs or to register for online courses.

Upcoming Seminars

July

17 *The Risks and Benefits of Malpractice Litigation;* Georgia Society of Ophthalmology*; The Cloister, Sea Island, GA; 8:15 am. Register with GSO at (404) 299-1700 or **http://www.ga-eyemds.org**.

22 *Malpractice Claims Studies;* Southeast Regional Annual Meeting for Alabama (ALAO)*, Louisiana (LOA)*, Mississippi (MEENTA)*, and Tennessee (TAO)*; Grand Sandestin Hotel & Baytowne Conference Center, Destin, FL; 7:30 am. Register with ALAO at (334) 279-9755 or **www.alabamaeyedoctors.com**.

August

5 *Minimizing the Risk of Wrong Site/Wrong IOL Surgery;* Utah Ophthalmology Society*; Deer Valley Resort, Deer Valley, UT; Time TBA. Register with UOS at **http://www.utaheyemds.org/**.

7 *Malpractice Claims Studies*; Women in Ophthalmology*; Lodge at Sonoma Resort & Spa, Sonoma, CA; 9:30–10:30 am. Register with WIO at **http://www.wioonline.org/index.php/membership/50**.

September

16 *Malpractice Claims Studies;* North Carolina Society of Eye Physicians & Surgeons*; Grove Park Inn Resort, Asheville, NC; Time TBA. Register with NCSEPS at (919) 833-3836 or **ncoph@mcmedsoc.org**.

16 *Malpractice Claims Studies;* Indiana Academy of Ophthalmology*; University Place Conference Center & Hotel, Indianapolis, IN; 3:30–4:30 pm. Register with Kim Williams at (317) 577-3062 or **http://www.indianaeyemds.com/Calendar/**.

23 *Malpractice Claims Studies;* Table Rock Regional Meeting for Arkansas (AOS)*, Kansas (KSEPS)*, Missouri (MoSEPS)*, Oklahoma (OAO)*; Big Cedar Lodge, Ridgedale, MO; Time TBA. Register at **http://www.tablerockroundup.org**.

October

23 *OMIC Forum: The Risks and Benefits of Malpractice Litigation*; Annual Meeting of the American Academy of Ophthalmology; Room Valencia W415abc, Orange County Convention Center, Orlando FL; 2:00–3:30 pm. Register onsite in the presentation room.

24 *Why Take the Risk? How to Create an Effective Risk Management Strategy;* Annual Meeting of the American Academy of Ophthalmology; Room W-105, Orange County Convention Center, Orlando FL; 12:45–1:45 pm. Register onsite in the presentation room.