THE DIGEST
OPHTHALMIC MUTUAL INSURANCE COMPANY VOLUME 30 NUMBER 1 2020

Infectious keratitis claims

ANNE M. MENKE, RN, PHD, OMIC Patient Safety Manager

Recently, OMIC made significant payments to settle two claims alleging delay in diagnosis and treatment of acanthamoeba keratitis (AK). Defense experts in these cases noted that AK is rare, difficult to diagnose and treat, and usually leads to poor outcomes. These settlements prompted our Claims Committee to ask Risk Management to review similar lawsuits.

Most ophthalmologists will encounter patients with corneal infections, so all claims in our database related to infectious keratitis were analyzed to see what guidance they provide. This article reports on 55 claims, some of which are not yet resolved, filed by 37 plaintiffs.

Infectious keratitis can be caused by bacterial, fungal, viral, and parasitic organisms. A key allegation in these claims was a delay in identifying the causative organism and prescribing the correct anti-microbial medications. Patient outcomes include significant vision loss, the need for corneal transplants, blindness, and enucleation. Table 1 shows the difference between the initial and final diagnoses, and indicates that patients were often incorrectly diagnosed and treated. Bacterial keratitis (BK) and herpes simplex virus (HSV) were the most common initial diagnoses, accounting for 90% of patients. The final diagnosis was, in descending order of frequency, fungal keratitis (FK), AK, and BK.

TABLE 1. INFECTIOUS KERATITIS: INITIAL VS. FINAL DIAGNOSIS IN 37 CASES

Type of infectious keratitis	Initial	% Initial	Final	% Final
Acanthamoeba (AK)	0	0%	10	27%
Bacterial (BK)	18	49%	7	19%
Fungal (FK)	2	5%	14	38%
Herpes Simples Virus (HSV)	15	41%	3	8%
Multiple	2	5%	3	8%

AK as the final diagnosis

AK was the second most common final diagnosis, but was not the initial diagnosis in any of the 10 confirmed cases, highlighting how difficult it can be to recognize this disease. Two of the confirmed AK cases were initially diagnosed as BK. One of those is still open, the other closed without payment with strong expert support for the defendant who obtained negative cultures for both FK and AK.

The other eight confirmed AK cases were initially treated as HSV. One of those is still open, while two closed without payment. Defense experts noted that one of the defendants immediately referred the patient to an academic corneal practice. In the other case, the signs and symptoms were consistent with HSV and the plaintiff's vision never worsened during the period of treatment. Five of the HSV cases required payments ranging from $27,500 to $750,000 ($307,500 mean).

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MESSAGE FROM THE CHAIR

DANIEL BRICELAND, MD, OMIC Board of Directors

This was supposed to be the year of vision; 2020 began with so much promise for our profession yet we had no idea what was hiding in plain sight. A virus, COVID-19, would force a dramatic, almost complete shut-down of our nation and our practices. Non-urgent care and elective surgeries were cancelled. Our teams were sent home. We were simply waiting it out and in survival mode.

I know many of you felt like I did. How do I keep my practice afloat and my staff employed with my clinic closed down? It was a sinking feeling to think we might not make it through this unprecedented event.

As a leader for both OMIC and the Academy, I am focused on our future, post COVID, and what we can do to mitigate threats to our livelihoods. I am clear-eyed about the challenges we face, but also optimistic that through crisis we will persevere, emerge stronger, accelerate change, and improve care.

The future of eye health is now and OMIC will continue to add resources that reflect our new realties and enhance safety protocols. Regarding medical training

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EYE ON OMIC

OMIC receives 2020 Outstanding Captive of the Year award

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

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OMIC has been chosen Outstanding Captive of the Year for 2020 by the Captive Insurance Companies Association (CICA). A "captive insurer" is generally defined as an insurance company that is wholly owned and controlled by its insureds; its primary purpose is to insure the risks of its owners, and its insureds benefit from the captive insurer's underwriting profits. To date, OMIC has returned more than $90 million in policyholder dividends and helped stabilize the market for ophthalmology professional liability insurance.

This prestigious award was created to recognize companies that are creative and successful in the way they manage net results, provide exceptional service to its owners, prevail over difficult times or situations, and gain acceptance, recognition, and a positive reputation among agencies, regulators, and colleagues in its industry. CICA also noted the tremendous impact OMIC has had on risk management and patient safety around the world.

To be recognized in such a way among the 3,200 captives operating in the U.S. is truly an honor for our board, employees, and members.

MESSAGE FROM THE CHAIR

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and education, our ophthalmic community implemented new methods of instruction, rethought our approach to assessment, and identified new ways to achieve competencies that are more in line with a modernized world. The Academy just completed a highly successful virtual meeting without skipping a beat. Let's focus on these achievements and strive to improve our systems to meet the challenges of tomorrow.

I would like to take this opportunity to recognize Anne M Menke, RN, PhD, a key employee of OMIC for many years who will be enjoying her well-deserved retirement beginning in 2021.

You've seen Anne's name appear in almost every OMIC Digest published over the past 17 years. You've also perhaps spoken with her on our confidential risk management hotline or at one of the many ophthalmic society meetings where OMIC has presented valuable information to help us protect our patients.

To say Anne has had a significant impact on our practice of ophthalmology would be an understatement. Her influence is evident in many of our most recognized resources for insureds.

Purchase additional cyber coverage

OMIC's policy includes cyber liability protection at a limit up to $100,000 per policy period. We purchase this coverage for our insureds from regulatory/cyber experts, Tokio Marine HCC.

OMIC insureds may purchase higher limits of coverage on the e-MD/Broad Regulatory Protection Plus policy form by contacting Tokio Marine HCC directly. The e-MD/Broad Regulatory Protection Plus coverage also includes expanded coverage benefits and new features.

For information on the unique coverage features offered under the higher limit policy, please contact Dana Pollard Carulli at 877-808-6277 or message her at DPOLLARD@tmhcc.com to purchase additional limits up to $5 million.

OMIC declares 26th dividend

We are pleased to announce that, in addition to the 12.5% COVID credit announced in April and applied to all policies in May, OMIC has declared a 5% 2020 dividend to be applied as a premium credit throughout 2021 to all of our physicians' renewal policies. Together, these equal a 17.5% premium return for our insured ophthalmologists during this very stressful year.

She perfected our "safety net" to prevent retinopathy of prematurity (ROP) and her dedication to patient safety undoubtedly helped save the sight of infants and adult patients in our care.

I would also like to recognize the many years of service of Dr. Steven VL Brown, MD, FACS, who will complete the maximum number of years allowed for OMIC Board and Committee members. He has been an insured ophthalmologist since OMIC's inception in 1987. We view these members as the founders of OMIC. Steve has been a board member since 2003 and past Chair of the Underwriting Committee. He recently served as the Chair of the Nominating Committee, and Vice Chairman of the Board.

Few ophthalmologists have given so much back to our profession as Dr. Brown. I speak for the entire OMIC Board in saying how much his presence will be missed at our great company.

POLICY ISSUES

Ransomware losses on the rise

TOKIO MARINE HCC Featured Article

Increased sophistication of cyber criminals, a growing base of connected devices (aka "the attack surface"), and human vulnerability all contribute to an environment rife with cyber security risk that continues to be exploited by criminal actors.

One of the leading cybercrimes is ransomware which is a malware (malicious software) that 'kidnaps' your practice data and holds it hostage until you pay a ransom. If the ransom is paid, a decryption key is sent to you to decrypt and recover your data (although the key doesn't always work). If the ransom is not paid, your data remains encrypted and unusable. Or, with some ransomware, you must pay the ransom within a certain amount of time otherwise the ransomware deletes your data.

Ransomware typically infects or enters your network when a user opens e-mail attachments containing malware or is lured to a compromised website by an e-mail or pop-up window. Newer variants involve less human interaction. These newer ransomware variants enter your network through "drive-by downloads" which don't require clicking a link or opening an email attachment. Drive-by downloading occurs when a user unknowingly visits an infected website and then malware is downloaded and installed without the user's knowledge. Ransomware can also infect your systems through Remote Desktop Protocol (RDP), Microsoft's desktop software allowing a remote user to access another computer on the network.

The average ransom demand doubled in 2019, from $42K to $84K. Now criminals using the latest strands of ransomware called Maze and DoppelPaymer, are also exporting a copy of the data before encrypting the on-premises copy. This is a concerning development. Why? With a copy of the stolen data, criminals threaten to publish the exported data unless a ransom is paid. This technique significantly increases the pressure to pay the ransom (particularly for those with sensitive client data). It also nullifies the benefit of backups because the victim must pay ransom to prevent publication of its data.

As a healthcare professional, you hold sensitive information including names, addresses, dates of birth, social security numbers, and insurance information that is significant in value. Having a medical record on the dark web, the internet exchange for cyber criminals, is three times as valuable to cybercriminals as other records. Incentivized to earn more, criminals can't resist targeting healthcare providers.

CLAIM EXAMPLE:

A medical group experienced a Ryuk ransomware event that resulted in the shutdown/compromise of their computer system which included multiple desktops and servers, as well as backup systems. The malicious actor made a ransom demand of more than $1.2 million. Attorneys for the insured attempted to negotiate the ransom down, but the hacker wasn't willing to negotiate. Additionally, counsel confirmed that the insured's system could not be restored from the encrypted backup servers. The insured, therefore, paid the $1.2M ransom and was reimbursed up to the policy limit under its Cyber Extortion coverage. After paying the ransom, the insured received the decryption key and was able to regain access to its systems and data.

While cyber insurance is one effective means of mitigating costs, there are several ways to protect yourself and your practice. You need multiple solutions to combat these attacks. Thorough and proactive preparation is important. Following are some tips to reduce risk.

Do you…
1. Require two-factor authentication for all remote access to your network?
2. Have a secure data backup solution in the event of a ransomware attack?
3. Use an effective email spam filter?
4. Fight malware with behavior-based antivirus software?
5. Disable unnecessary remote desktop gateways?
6. Conduct employee phishing training and simulations?

In addition to answering yes to the above questions, your practice should employ the following tools, processes, and technologies to avoid potential data loss:

- Next-generation cloud-enabled endpoint protection, such as CrowdStrike, which is effective against network ransomware variants
- Two-Factor Authentication (2FA) on all remote access to your network, such as Cisco's Duo
- Segregated offsite/backups, such as Datto. Likelihood of paying a ransom is dramatically reduced if there is an intact backup to recover the data.
- Spam filtering and email configuration have been known to block phishing attacks

In conjunction with Tokio Marine HCC – Cyber and Professional Lines Group (also known as NAS Insurance Services, LLC and Professional Indemnity Associates), OMIC offers CyberNET®, the most advanced cyber risk management solution, exclusively for policyholders. For more information, visit OMIC.com/policyholder/benefits.

To purchase additional coverage to supplement the $100K benefit included in your OMIC policy, contact Dana Pollard Carulli at 877-808-6277 or DPOLLARD@tmhcc.com.

Infectious keratitis claims

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Defense experts made the following recommendations:

1. Include AK in the differential when:

- There is a ring-like infiltrate present
- The patient has a non-healing corneal ulcer
- The patient reports significant pain out of proportion to the findings
- Symptoms and findings are bilateral
- Presumed HSV keratitis does not resolve after 10 days of treatment
- A new diagnosis of HSV is made in a contact lens (CL) wearer
- The patient has been treated with steroids since reducing inflammation can alter the appearance

2. Ask carefully about CL wear and cleaning practices, especially about swimming or using a hot tub while wearing CLs, or using water to clean them.

3. Consider early referral to an academic center that will have more advanced diagnostic methods, including the correct culture media as well as confocal microscopy.

4. Consider corneal biopsy, repeat cultures, and confocal microscopy if there is no improvement.

5. Carefully examine corneal dendritic lesions since AK can present with pseudo-dendrites, with elevation at the center of the lesion.

BK as final diagnosis

Eleven of the 18 cases originally diagnosed as BK were determined to be AK (2 cases), FK (8 cases), and HSV (1 case). Only 7 proved to be caused by bacteria. Indemnity payments were made in 5 of these, ranging from $25,000 to $250,000 ($93,400 mean). In one case, the Emergency Department defendant settled for $300,000, while his ophthalmology codefendant paid $42,000. The other two cases were not pursued.

Defense experts made the following recommendations:

1. Patching and steroids should not be used if the patient wears contact lenses until the organism has been identified and appropriately treated.

2. Treat severe BK with fortified antibiotics.

3. Follow up frequently, even daily, until improvement is noted.

4. Consider early referral to a corneal specialist if no improvement.

5. Treat phone calls from an Emergency Department physician with caution by obtaining a careful history and examination, and consider examining the patient in person.

FK as the final diagnosis

FK was the initial diagnosis in only 2 cases, but the final one in 14. Two of the cases were correctly diagnosed as FK from the start. One with expert support is still open. In the other, a patient with a history of Fuchs' dystrophy developed a fungal interface keratitis after DSAEK, and was treated with anti-fungal medication. He was taken back to surgery 3 weeks later for another DSAEK and repositioning and fixation of his dislocated IOL. There was no intracameral anti-fungal medication available. Rather than refer the patient to another ASC, the defendant used only topical anti-fungal medication. Experts argued that this allowed the fungal infection to worsen after the surgery. The case settled for $450,000.

FK was initially diagnosed as BK in 8 cases. Two of these are still open, and three closed without payment. Defense experts in one case noted that the patient was quickly referred to a retinal specialist to rule out endophthalmitis. Although the experts felt that the retina specialist could have referred the patient to a corneal specialist earlier, the jury returned a defense verdict for all defendants. In the second case, defense experts felt that the defendant had performed a thorough exam at the initial visit, and found no evidence of a fungal infection. When the patient returned with worsening signs, the defendant immediately referred the patient to a corneal specialist. In the third, the plaintiff allowed the statute of limitations to expire.

Three FK cases originally diagnosed as BK closed with indemnity payments ranging from $125,000 to $600,000 (mean $341,667).

Defense experts made the following recommendations:

1. Consider culturing non-healing epithelial defects at the initial visit.

2. Include FK in the differential in patients who wear contact lenses and present with a corneal ulcer.

3. Ask about occupations that could lead to exposure to soil, trauma with organic matter, and recent travel to warm climates.

4. Ensure that the patient stops wearing contact lenses during treatment for FK.

Two FK cases were originally diagnosed as HSV. Both closed without payment. The plaintiff could not find an expert in the first case. Defense experts in the second case felt that the initial diagnosis was reasonable, and that the patient was referred to a corneal specialist in a timely manner.

Patients in two FK cases were diagnosed with both BK and HSV. In one, the medication order for Tobrex was incorrectly entered as Tobradex by the technician. The error was not caught for six weeks, during which time the ulcer worsened considerably due to the steroids. The physicians were dismissed, and the practice settled the case for $750,000. In the second case, experts felt that the ophthalmologist should have cultured the eye at the initial visit, and may have used the wrong medium for the

culture when it was eventually done. This case settled for $75,000.

HSV as the final diagnosis

Only 2 of the 15 patients initially diagnosed with HSV had that as their final diagnosis. Experts supported the care in both cases and they closed without payment. In one, the patient had been exposed to dust during construction work. He did not appear to understand his condition, missed appointments, and did not take his medications as prescribed despite repeat discussions about his infection. He was referred to a corneal specialist after 4 months, and his diagnosis was confirmed.

In the second case, the plaintiff alleged AK despite two negative confocal microscopy exams and confirmation of the HSV diagnosis by five corneal specialists. Defense experts noted that the pain in only one eye with photophobia was consistent with HSV, and appropriately treated with anti-viral medication and steroids. The judge granted a motion of summary judgment and the case was dismissed.

Three patients originally diagnosed with HSV developed another infection in addition to it. One patient had persistent, active HSV when he was also diagnosed with AK. Defense experts supported the care, and the jury rendered a defense verdict. One other was treated for HSV and then developed BK. Experts supported the care is this case as well, and a judge granted a motion for summary judgment. The third patient had both HSV and BK at the time of the corneal transplant. The claim was denied and closed without payment. The ten remaining patients initially diagnosed with HSV had AK (8 cases) and FK (2 cases).

Risk factors in 37 plaintiffs

Infectious keratitis is uncommon in patients with an intact corneal surface. Asking about risk factors helps determine the correct causative organism and guides treatment. All but three of the plaintiffs had one or more risk factors. See a breakdown in Table 2. Failure to explore these factors when taking the history, or to take them into account during the diagnostic process, was a frequent allegation in these claims.

Contact lens wear was the most frequent risk factor. Some plaintiffs who swam while wearing CLs or cleaned them with water were eventually diagnosed with AK, and failure to elicit this history contributed to patient harm and indemnity payments.

TABLE 2. RISK FACTORS

Risk Factors	Number of Plaintiffs
Contact lens wear	17
Recent eye trauma	15
Recent eye surgery	6
No risk factors	3

Defendants were criticized for not asking about the type of CL, wearing schedule, and cleaning process and products. Some cases of fungal keratitis were determined to be caused by contaminated cleaning solutions. Those claims were directed at the manufacturer and are not included in this study.

Experts noted whether patients were advised to stop wearing CLs during treatment, and called attention in their reviews to the few patients who were noncompliant. One patient's noncompliance may have helped persuade the jury to return a defense verdict. Recommendations included giving patients written instructions both to stop wearing CLs and how to wear and clean/disinfect them once it was safe to resume use. The experts also noted that daily disposable lenses may be a better option than reusable lenses for many patients.

The second most frequent risk factor was eye trauma. Defendants were criticized for not learning the exact mechanism of the eye injury. Several patients who developed FK worked as landscapers, but the defendants did not learn of this until the claims were filed. Some defendants were criticized for not initially suspecting an infection and/or prescribing steroids or patching in patients with epithelial defects.

Six plaintiffs developed postoperative infections. One had MRSA after LASIK, and the organism was not sensitive to the antibiotic originally prescribed. There was strong expert support but the defendant wanted to avoid a trial, so the case was settled for $250,000. The other five plaintiffs all developed FK. One case is still open. Two of these FK cases closed without payment. One plaintiff who developed FK after an RK allowed the statute of limitations to expire. Another plaintiff developed FK after cataract surgery; the ophthalmologist received a defense verdict at trial.

Two other FK cases settled. In one, there was no ophthalmologist available to examine a patient with severe pain and vision loss one day after bilateral PRK; the practice settled for $300,000.

The other case, discussed above, involved a patient with known interface fungal keratitis who underwent a repeat DSAEK and IOL repositioning. The ophthalmologist opted to proceed with surgery despite the fact that there was no intracameral anti-fungal medication available. That case settled for $450,000.

This analysis of 37 cases of infectious keratitis shows that correctly diagnosing and treating this condition can be challenging. Ophthalmologists need to obtain detailed histories, regularly reconsider the diagnosis when the condition does not improve as expected, and consider early referral to corneal specialists. Patient behavior and system issues such as referrals, missed appointments, and after-hour calls played a role in these claims, as well.

Additional risk reduction strategies discussed on page 7

CLOSED CLAIM STUDY

Failure to diagnose and treat acanthamoeba

RYAN M. BUCSI, OMIC Claims Vice President

Two claims result in $1.25 million in settlements during 2020.

CLAIM 1

Allegation

Failure to timely diagnose and treat acanthamoeba keratitis resulting in corneal transplants.

Disposition

The case was settled at mediation for $750K.

CLAIM 2

Allegation

Failure to timely diagnose acanthamoeba infection resulting in enucleation OS.

Disposition

The case was settled after months of negotiations for $500K.

The patient in the first claim had been diagnosed with herpes simplex keratitis and was treated with Valtrex and Zirgan before referral to an OMIC-insured corneal specialist for decreasing vision from a central dendritic scar. Upon examination, the insured noted the VA was 20/200 OD, with limited pain, but significant photosensitivity with a central dendritic pattern lesion; there was no epithelial defect. The insured concurred with the initial diagnosis of herpes simplex keratitis and continued Valtrex and Zirgan.

The patient continued to complain of pain during subsequent examinations and an amniotic membrane and later a bandage soft contact lens were placed. The visual acuity improved from 20/400 OD to 20/80 OD. The insured corneal specialist noted a ring infiltrate and epithelial defect and placed another amniotic membrane.

The patient was then referred to an academic corneal specialist, but an appointment was not available for one month. The patient continued to complain of sharp pain, a watery eye, and photophobia. Our insured documented that the patient developed corneal findings absent an amniotic membrane or bandage contact lens and recommended tarsorrhaphy, but the patient opted instead for another bandage soft contact lens.

When the patient eventually saw an academic corneal specialist, confocal microscopy revealed multiple corneal cysts, and the patient was diagnosed with acanthamoeba keratitis. The patient claimed he could not perform his duties as a gastroenterologist due to vision loss following two corneal transplants, pain, light sensitivity, compromised depth perception, and eye strain.

In the second claim, the patient was referred to the OMIC-insured corneal specialist by a comprehensive ophthalmologist with a diagnosis of herpetic keratitis treated with Zirgan, without improvement. During the first examination, the specialist noted the VA OS was 20/50 and diagnosed herpes simplex disciform keratitis with likely surface keratopathy. He prescribed oral acyclovir and prednisolone acetate, and placed a bandage soft contact lens. The VA fluctuated between 20/200 OS and 20/400 OS.

When the patient reported severe pain over a weekend, he was examined by another ophthalmologist who removed the bandage soft contact lens. Two days later, the patient told the corneal specialist that he had less pain; VA was 20/200 OD, and the cornea was improving. The patient was planning to leave the country and was advised to continue artificial tears more frequently while out of the country, and to wear contact lenses for short periods only.

While the patient was abroad he was diagnosed with acanthamoeba keratitis after waking one morning with no vision OS. Eventually, the patient's cornea developed progressive thinning, requiring two corneal transplants. These were unsuccessful and the patient lost all vision in the left eye leading to an enucleation OS.

Analysis

In the first claim, both the plaintiff and the defense experts opined that our insured cornea specialist did not meet the standard of care as acanthamoeba should have been in the differential diagnosis due to the presence of a ring infiltrate. The insured was also criticized for the presumed diagnosis of HSV and the use of steroids for a presumed superficial HSV infection.

In the second claim, the plaintiff's expert opined that the corneal specialist violated the standard of care for not recognizing that the pain, clinical findings of keratitis, a dendrite, lack of improvement with anti-viral therapy, waxing/waning nature of symptoms and persistence of keratitis was not HSV. Our expert opined that the standard of care was breached citing that contact lens wearers with non-resolving corneal issues should be evaluated for acanthamoeba.

Takeaways

Both OMIC-insured cornea specialists were referred patients with the diagnosis of HSV, and they both continued to use this condition as their working diagnosis even though there were symptoms suggestive of acanthamoeba and the patients' conditions did not improve. Under these circumstances, according to both defense and plaintiff experts, acanthamoeba needed to be considered. When treating a contact lens wearing patient with non-resolving corneal issues, especially with a diagnosis of persistent HSV keratitis, acanthamoeba must be considered as the potential significant corneal damage and vision loss can be devastating and costly.

RISK REDUCTION STRATEGIES

Patient and system issues in infectious keratitis cases

ANNE M. MENKE, RN, PHD, OMIC Patient Safety Manager

Most of the criticisms in the infectious keratitis claims discussed in the lead article focused on the physician's diagnostic and treatment decisions, including how frequently to follow up with the patient and when to obtain cultures or refer to a corneal specialist. Our investigation showed that several plaintiffs had not complied with appointments, use of medications, and especially instructions to stop contact lens use. The noncompliance helped secure dismissals and defense verdicts.

System issues played a key role in a few cases. One comprehensive ophthalmologist instructed his staff member to schedule an appointment with a corneal specialist but did not clarify that it was urgent. There was a three-week delay, which experts felt caused a significant deterioration in the patient's condition. The case settled for $600,000.

In another case, a staff member did not inform the ophthalmologist that the patient called with pain and vision loss. The case settled for $490,000.

Another plaintiff continued to worsen despite apparent compliance with treatment. The baffled ophthalmologist eventually learned that his staff member had inadvertently entered a medication order for an antibiotic/steroid combination instead of just the antibiotic. Experts felt the six-week course of steroids led to the need for a corneal transplant. The physician was dismissed, and the claim was settled on behalf of the practice for $750,000.

One patient presented with severe pain and blurry vision a day after bilateral PRK. No physician was available to examine the patient, and experts felt the delay contributed to a poor outcome. The ophthalmologist was dismissed, with a settlement of $300,000 made on behalf of the practice.

In many of the claims, the practice did not have access to the proper diagnostic resources including culture media for acanthamoeba or confocal microscopy. Defendants were criticized for not referring patients earlier to an academic cornea practice.

OMIC has several risk management resources to help address these system issues.

Noncompliance

Our toolkit addresses missed appointments and tracking of test results and referrals. It includes sample letters for missed appointments and forms for refusal of treatment.

Download the toolkit at https://www.omic.com/noncompliance-guidelines-with-sample-missed-appointment-letter/.

Forms when referring patients

Failure to clarify the urgency of a referral or to assist the patient in making an appointment with a sub-specialist can lead to delay in diagnosis and treatment.

Our referral form for the patient gives the urgency of the referral, the reason for it, and who should schedule the appointment. The form sent to the other physician explains the reason for the referral and the input requested.

Download the forms at https://www.omic.com/referral-form-for-patient-and-physician/.

Telephone screening

Staff manage many calls during office hours. Providing them with written guidelines and protocols makes it more likely that the call will be handled safely and properly documented, and that you will be appropriately involved.

Download the guidelines at https://www.omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/.

After-hour calls

Sometimes an ophthalmologist's only involvement in a patient's care is a single phone call from a patient or the Emergency Department. Failure to document the call thoroughly can severely compromise the defense.

Use our after-hour call guide to prompt you to obtain and document the information necessary to safely manage the situation.

Download our form and guide at https://www.omic.com/after-hours-contact-form-and-recommendations/

Assistance from our Risk Management and Claims Departments

OMIC insureds are invited to email us at riskmanagement@omic.com for confidential risk management assistance with difficult patients, consent issues, and unanticipated outcomes.

With your permission, Risk Management staff can contact your Claims representative for additional advice when considering offering a refund and other pre-claims situations.

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ANNOUNCEMENTS

OMIC offers several online courses. Insureds receive a risk management premium discount for participation. Contact Linda Nakamura at 800.562.6642, ext. 652, or lnakamura@omic.com, for questions about OMIC risk management options or learn more at omic.com.

Home Study

For a complete listing of current recordings and computer-based courses available for OMIC insureds, visit omic.com/risk-management/education/online-and-recorded-courses.

Live Seminars

OMIC will conduct live courses again when it is safe to do so. A listing of upcoming courses will be posted at omic.com/calendar.

Online Courses

Bruce Spivey MD Forum 2020: Office-Based Surgery

Claims Are More Than Just Lawsuits

Comanagement

Cyber Security and Electronic Health Record Risks

Duty to Patients: Beginning, Ending, and Obligations

Great Expectations: Liability Risks of Unrealistic Surgical Goals

Identify and Manage Unhappy Patients -Webinar

My Doctor Never Told Me That Would Happen (series of 3 videos on informed consent)

Now What Do I Do?: Information to help you manage a claim or lawsuit

Ophthalmic Anesthesia Malpractice Claims

Pediatric/Strabismus Malpractice Claims Alleging Failure to Diagnose

Prevent Falls in the Ophthalmic Office and OR

Risk Management 101

Risks and Benefits of Malpractice Litigation

Role of Staff in Medical Malpractice Lawsuits

Telemedicine: How to Mitigate Liability Risk

Telephone Screening: Liability Issues and Guidelines

Partnerships

OMIC has partnerships with most ophthalmic societies in the United States.

Members of state, subspecialty, and special interest societies that partner with OMIC receive special discounts when they participate in our risk management program.

Learn more at omic.com/partners.

Alerts and Bulletins

OMIC posts recommendations for responding to recalls and alerts. For a complete archive visit omic.com/risk-management/digests-alerts-and-bulletins.