Spring 2003 Volume 13 Number 2

OMIC DIGEST

Ophthalmic Mutual Insurance Company

Ophthalmic Risk Management Digest

When FDA Leaves Doctors To Their Own Devices

By Kimberly Wittchow, JD

Ms. Wittchow is a staff attorney with OMIC's Risk Management/Legal Department.

With the constant development of new devices in the global health care marketplace, ophthalmologists in the U.S. are privy to various treatment alternatives, many of which are tested and employed by their peers around the world long before they are approved for use in the U.S. What are the liability risks and risk management issues that arise if American doctors opt to use devices not yet approved by the Food and Drug Administration (FDA)?

Off-label use—the practice of using an FDA-approved drug or device for a purpose that the FDA has not approved—was explored in "Medicolegal Implications of Using Off-label Drugs and Devices," (*OMIC Digest*, Winter 1996). The FDA states that doctors, in the exercise of their best judgment, may use approved drugs or devices off-label if they are well informed about the product, base its use on firm scientific rationale and sound medical evidence, and maintain records of its use and effects.

A related, riskier issue—the use of *unapproved* devices—was recently brought to OMIC's attention by an insured who inquired about the soft tissue filler, Restylane, an injectable, gel-like substance containing hyaluronic acid that is currently used throughout Europe and Canada for lip augmentation and facial contouring. The FDA has received the results of US clinical trials of Restylane and is expected to approve it this summer (2003).

Compared to the FDA position on off-label use, the appropriateness of unapproved use is less clear. To understand the liability risks of using a device not approved by the FDA, it is necessary to understand the FDA device approval process. The Food, Drug and Cosmetic Act (FDCA) states that if a device is labeled, promoted or used in the US, it will be regulated by the FDA and is subject to pre-marketing and post-marketing

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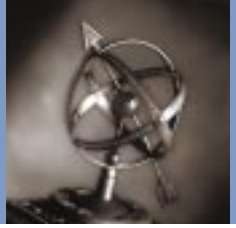

Eye on OMIC

OMIC

The Ophthalmic Risk Management Digest is published quarterly by the Ophthalmic Mutual Insurance Company, a Risk Retention Group sponsored by the American Academy of Ophthalmology, for policyholders and others affiliated with OMIC. Non-OMIC insureds may subscribe to the Digest for $20 per year for AAO members and $35 per year for all others by contacting OMIC's Risk Management Department.

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Record Growth and Strong Financials at Year-end 2002

Adverse loss experience, weak underwriting results, and inadequate capitalization continue to plague the medical malpractice insurance industry. Since January, two physician-owned carriers have been placed into state receivership and several others have had their financial strength rating downgraded by A.M. Best. Carriers that aggressively expanded into new territories during the soft market of the 1990s have pulled back to their core market and are selling off their book of business in unprofitable areas.

Fortunately, OMIC's 15-year history of responsible fiscal management, conservative underwriting, and better-than-average loss experience has put us in a better position to withstand this economic downturn. OMIC's competitive position in relation to many multispecialty carriers has generated considerable interest among ophthalmologists exploring insurance alternatives as evidenced by our 24% growth rate and 96% retention rate. OMIC now insures 3,020 ophthalmologists, up from 2,432 at year-end 2001.

OMIC's year-end 2002 operating and financial results compare quite favorably to other physician-sponsored liability carriers. Direct written premiums increased 37.1% to $27.8 million. After-tax net income at year-end 2002 was $912,000 compared to $890,000 the previous year. Admitted assets grew 18.5% to $87.9 million. OMIC's favorable results are reflective of our continued emphasis on conservative underwriting, proactive risk management, and aggressive claims posture.

During 2002, OMIC returned approximately $71,000 in surplus contributions, bringing to $5.37 million the total amount of surplus returned to policyholders over the past eight years. In light of market conditions, we did not declare a policyholder dividend this year; however, the Board will annually evaluate OMIC's ability to return premium dollars to policyholders in the form of dividends and will resume doing so when market conditions improve. Over the past eleven years, OMIC has returned nearly $2.5 million in dividends.

Recognizing OMIC's continued profitable operations, commitment to loss reserve adequacy, and strong policyholder retention rate, A.M. Best views our rating outlook as "stable" and reaffirmed our A- (Excellent) rating for 2003.

Business Insurance Serviced by MRMI

In 2002, OMIC transferred the servicing of all sponsored business insurance programs, except professional liability, to Medical Risk Management Insurance, a physician-owned agency specializing in products designed for a medical practice. MRMI now handles all policyholder inquiries concerning coverage quotations, policy issuance, cancellation or nonrenewal notices, certificates of insurance, and direct mail solicitations for the business owners, workers' compensation, fraud & abuse/HIPAA privacy, employment practices, and managed care (directors & officers/errors & omissions) liability programs. The Hartford Insurance Company and NAS Insurance Services continue to underwrite and reinsure the business insurance policies and OMIC continues to oversee them. MRMI can be reached at (800) 610-OMIC (6642).

New Risk Management/Legal Department

In response to increasing legal, regulatory, and compliance requirements, OMIC has established a Risk Management/Legal Department under the direction of Paul Weber, JD, who has been promoted to vice president. Previously in Member Services and Product Sales, Kimberly Wittchow, JD, has joined the new department as staff attorney. Anne Menke, RN, PhD, has been hired as risk manager. She joins OMIC after six years with NORCAL, where she most recently worked as a risk management intervention specialist. Gien Gip will continue as risk management assistant.

In closing, I would like to thank our policyholders whose continued support has helped OMIC grow from a small start-up operation in 1987 to become the largest provider of liability insurance for ophthalmologists in the U.S. with a market share of just under 30%. The next 12 to 18 months will continue to present challenges but I am confident that together we can meet them and emerge stronger.

Timothy J. Padovese
President and CEO

Do You Operate a Surgery Center?

By Betsy Kelley
OMIC Underwriting Manager

Why does OMIC want to know? Quite simply, we want to help protect you, your staff, your facility, and your patients from liability associated with surgical procedures. As is often the case, it took some widely publicized patient deaths following procedures at surgery centers and other outpatient settings to remind physicians and patients alike that there are risks inherent in surgery, regardless of where it is performed.

In order to be licensed and accredited, acute care hospitals must have trained anesthesia and nursing staff, emergency equipment, and procedures in place to treat life-threatening complications when they develop. In the past, outpatient settings and surgery centers often were not subject to the same oversight and as a result, patient safety was compromised. Surgeons performed procedures for which no hospital had credentialed them; sedation was administered without monitoring for cardiopulmonary complications; staff had no training in Basic or Advanced Cardiac Life Support; unlicensed staff were given authority to administer medications, and monitor and discharge patients on their own; and centers had no procedures for handling emergencies or transferring patients. In response to poor patient outcomes, some states passed laws to govern outpatient surgical settings.

Areas of Potential Liability

Outpatient surgery is not just a threat to patient safety. It also creates significant malpractice risks for surgeons, their staff, and the facilities where the surgery takes place. Just like acute care hospitals, surgery centers can be held vicariously liable for the negligent acts or omissions of the surgeons who utilize the facility. Moreover, the center can be held directly liable for its own acts and omissions. Plaintiffs may allege that the surgery center failed to appropriately credential a surgeon or failed to take reasonable or prompt action against a problematic utilizer. Injuries may result if equipment is not properly maintained or calibrated or if conditions are not sufficiently sterile; in such cases, the facility likely will be held accountable. Furthermore, employees who provide professional services or assist utilizers may be a source of exposure.

Definition of a Surgery Center

OMIC's underwriting process is designed to enhance patient safety and reduce liability risk by ensuring that the same standard of care applies to the practice of surgery, regardless of where it takes place. For underwriting and liability purposes, OMIC defines a "surgery center" as: 1) any freestanding surgical or laser refractive facility; 2) any surgical facility (including an in-office surgical suite or in-office laser equipment) utilized by physicians other than the owners and their employees; or 3) any in-office surgical suite used for the performance of surgical procedures other than minor surgical procedures that are routinely done in a physician's office.

Underwriting Review Required

Because of the increased exposure, OMIC performs additional, thorough underwriting review prior to extending professional liability coverage to surgery centers. (Coverage is not "automatic" and applies only if the surgery center is specifically named in the policy declarations.) OMIC reviews a range of issues, including operations, licensure/accreditation, credentialing, peer review, risk management, anesthesia, and emergency protocols as well as prior insurance and claims history. Before extending coverage, reviewers want to be satisfied that physicians who use the facility are properly trained, licensed, credentialed, and insured; that they and the facility are fully equipped and able to promptly and effectively handle emergency situations as well as routine surgeries; and that the center operates in such ways as to limit its exposure.

Eligibility Criteria for Coverage

To qualify for coverage, a surgery center must first meet OMIC's eligibility criteria. Ophthalmologists or ophthalmologist-owned entities must hold at least 50% ownership in the facility, and at least one owner, partner, or shareholder must be insured with OMIC. Ideally, the OMIC-insured owner(s) should hold at least 50% ownership in the facility.

The surgery center should be used primarily for ophthalmic procedures. Other specialists may use the facility, but coverage is not available for surgery centers at which certain high-risk procedures, such as abortions, cardiac surgery, laminectomy, pain management, or surgical weight control, among others, are performed. The surgery center also must meet other OMIC underwriting guidelines.

If approved, the surgery center will be named as an insured under the owner's policy or may be issued a separate policy. The facility may share liability limits with the owner or may maintain separate limits of liability. Premiums are based on the volume and category (ophthalmic, laser refractive, or non-ophthalmic) of procedures performed. The premium may be waived if the facility is used exclusively by the owner-insured and shares liability limits with that insured.

If you operate a surgery center and would like to verify or apply for coverage of the facility, please contact your OMIC underwriting representative at (800) 562-6642.

When FDA Leaves Doctors to Their Own Devices

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regulatory controls to assure safety and effectiveness. Devices are broken down into three classes. Like collagen, Restylane, used for purposes similar to dermal collagen implants, is a Class III device (the most stringent regulatory category). Pre-market Approval (PMA) is the required process of scientific review to ensure the safety and effectiveness of Class III devices. Clinical trials using unapproved medical devices on human subjects are performed under an Investigational Device Exemption (IDE). They must be approved by the FDA and by an Institutional Review Board (IRB) before the study can begin. The IDE allows the device to be used in order to collect the safety and effectiveness data required to support the PMA application to the FDA. Ophthalmologists must be aware that gathering new information on multiple patients for publication purposes, or to obtain approval for a new device or new use of an approved device, probably constitutes research and will require an IDE. However, if the use is based on firm scientific rationale and sound medical evidence, it is probably the practice of medicine, which is theoretically unregulated.

While the FDA approves and regulates the production, sale, and clinical research of medical devices, it does not directly regulate the practice of medicine. OMIC's recent inquiries of FDA staff in the ophthalmic devices division reiterated this position. However, some courts will look for exceptions to a completely "hands off" position. For instance, the Pennsylvania Superior Court held that since the FDA had never approved the use of liquid silicone injections, the trial court erred when it gave a jury the instruction that the FDA has no authority to regulate the practice of medicine. The court noted that this instruction gave the jury the incorrect impression that a physician "can use any drug he wants, irrespective of whether it has been approved or disapproved by the FDA."

Whether the FDA can or will regulate physicians using unapproved devices may be less important than the consequences resulting when a physician uses such a device to treat a patient and the patient files a malpractice lawsuit or disciplinary action with a state licensing board. The crucial question then becomes whether the physician met the standard of care based upon what reasonable physicians in the same specialty would do at the same time under similar circumstances.

Case law has shown that violating the FDCA may be evidence of a breach of the standard of care and consequently result in a determination that malpractice has occurred. A plaintiff attorney could argue that the use of an unapproved device constitutes ***negligence per se*** (*negligence per se* or *legal negligence* is negligence established as a matter of law, usually arising from a statutory violation). If state laws are stricter than the federal FDCA and specifically prohibit the use of unapproved devices, it would be easier for the plaintiff to prove a violation of the law and argue either negligence per se or breach of the standard of care.

In order to provide the best alternative to the patient and stay one step ahead of the market competition, ophthalmologists may be tempted to offer the very latest in products or services. Before deciding whether to use the newest device available, several factors should be considered (see **Questions to Ask Before Using a Non-FDA Approved Device**). The analysis for non-FDA approved devices is based upon the same exercise of professional judgment that should be used in determining whether to use approved or off-label treatment alternatives. Physicians should take special care before using a device for an elective cosmetic procedure. Defense attorneys postulate that juries more closely scrutinize the care of the physician when problems arise in an elective procedure, rather than in an emergency or life-saving procedure. A 2001 OMIC survey found that 73% of ophthalmologists polled believed that elective surgery patients are more likely than other patients to sue their surgeon. Given the higher risk that elective procedures pose, ophthalmologists should consider additional factors in order to make sound decisions to use non-FDA approved devices (see **Additional Questions to Ask Before an Elective Cosmetic Procedure**).

Applying this risk analysis to three different devices shows how fact-dependent the outcome of the analysis can be. First, in the case of Restylane, it appears that its use prior to FDA approval would be difficult to defend in a lawsuit. Even though physicians throughout Europe and Canada have been using Restylane with positive results since the mid-1990s, surgeons in the U.S. will need to gather data based on larger numbers of patients over extended periods of time in order to determine its long-term safety and efficacy. Patient expectations also will have a profound influence on the risk of using Restylane. Web sites already tout Restylane as a method that is "fast and safe and leaves no scars or other traces on the face." Because the efficacy of Restylane is dependant on many variables, such as age, skin type, lifestyle, and muscle activity, patients with unrealistic expectations may be disappointed if they do not achieve the volume, smoothness, or long-lasting effects they anticipated. These factors create an especially risky environment in which to use a non-FDA approved device; prudent physicians would

Questions to Ask Before Using a Non-FDA Approved Device

Has a federal or state regulatory agency specifically banned the use of the device because it was determined to be unsafe?
Is there sound medical evidence supporting the use of this device?
Have peer reviewed articles been published supporting the use of this device?
Can its use be expected to bring good results without a higher complication rate?
If there is an increased risk, do a reasonable number of physicians in this specialty use the device?
Is the use of this device in the best interest of this particular patient?

Additional Questions to Ask Before an Elective Cosmetic Procedure

Does the patient have reasonable expectations?
Has the patient had problems with other treating physicians in the past?
Is he or she set on a certain procedure because of advertisements and recent popularity?
What are the patient's motivations for having this procedure?
Does the patient truly understand what this procedure entails and the possible outcomes?
Does the patient understand that he or she will have to pay out-of-pocket not only for the procedure but also for any enhancement or follow-up?

be well advised not to use Restylane (outside of an approved clinical trial) until it is approved by the FDA. A disappointed patient and plaintiff attorney will not have to look hard for theories of liability or experts to support a lawsuit against an ophthalmologist who injects this "unproven" material.

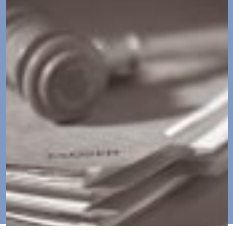
The second device group assessed for use prior to FDA approval is capsular tension rings, Class III devices marketed by Morcher and Ophtec and currently undergoing pre-market approval review with the FDA. These devices are being used in cataract surgery with some regularity and ophthalmologists are sharing their results with their peers. Because these devices are being used therapeutically for medical treatment, some of the patient expectation variables that arise in cosmetic procedures are avoided. Nevertheless, because they are relatively new to the market, ophthalmologists should use them with caution.

The final example is cyanoacrylate adhesive, used by ophthalmologists for the medical treatment of corneal perforations. One variant of this product, Dermabond Topical Skin Adhesive (2-octyl cyanoacrylate), was approved by the FDA in 2002 to seal out infection-causing bacteria. Yet cyanoacrylate adhesives have been used in the US for wound repair as an alternative to sutures since the Vietnam War in the mid-1960s. Even before Dermabond's FDA approval, variations of this adhesive had a long and proven track record and near universal acceptance in the ophthalmic community. Because of its widespread peer use and longevity, ophthalmic use of cyanoacrylate adhesive for the treatment of small perforations or leaks would most likely be considered standard medical practice in the community even when applying the most conservative analysis criteria.

After review, if the ophthalmologist decides that there is sound medical evidence and it is in the patient's best interest to use a non-FDA approved device, he or she should conduct and document a thorough and careful informed consent discussion. The patient should be informed of the nature of the technique or device being used, its scientific basis, its benefits, and any possible drawbacks or criticisms from other practitioners. Especially with cosmetic procedures, other options should be discussed, and the patient should be encouraged to seek a second opinion before proceeding.

If the unapproved device in question is used under an IDE, the federal government requires that the physician have a special, detailed informed consent discussion with the patient which addresses its unapproved status. If the device is not being used under an IDE, physicians should consult with legal counsel about whether state law requires them to disclose the device's unapproved status to the patient as part of the informed consent discussion. Regardless of state or federal law, from a risk management perspective, it is always advisable to respect the patient's right to obtain the information needed to make reasoned decisions about his or her own health care. If the physician reasonably believes that the approval status of the device to be used in the patient's treatment will be a factor in the patient's decision to undergo the procedure, this information should be disclosed.

Finally, ophthalmologists should always check with the Underwriting Department of their professional liability carrier to ensure that they will be covered for any off-label or non-FDA approved procedure they are contemplating.



Closed Claim Study

Trauma Cases: Risky to Treat, Difficult to Defend

By Jennifer Takeman, JD

Allegation

Failure to refer trauma patient to ER for neurological exam delayed diagnosis of brain hemorrhage.

Disposition

Defense verdict on behalf of insured ophthalmologist and subsequent treating neurologist.

Case Summary

A 16-year-old male was struck in the right cheek when he pulled a wire hanger serving as a radio antenna from the hood of his car. He complained of pain and immediate blindness in the right eye lasting for approximately 20 minutes before gradually recovering sight. The boy's father called the insured ophthalmologist who came in from home to examine him approximately 80 minutes after the accident. The patient had by then developed a severe headache.

Examination revealed VA 20/25 OD, 20/30 OS. Pupils were four millimeters and reactive to light with positive escape on the right. There was a small puncture wound beneath the right eye. Motility and confrontational visual fields were normal and the right globe was intact with a pressure of 17 mm Hg. Slit lamp examination was entirely within normal limits and direct ophthalmoscopy through an undilated pupil revealed sharp disc margins and positive venous pulsations. The insured did not dilate the right fundus because he wanted to preserve the pupillary reactions for subsequent treaters. He charted a right afferent pupillary defect and " ? scan to r/o bleed."

The insured called a nearby neurologist and advised the office staff that the patient needed to be seen immediately due to an afferent pupillary defect and headache complaints. The neurologist examined the patient less than half an hour later and documented that the exam seemed normal. There was no mention of an afferent pupillary defect. He scheduled the patient for an MRI two days later.

Back at home, the patient blew his nose, immediately complained of an excruciating headache, and became diaphoretic. He was rushed to the ER where a CT scan revealed a large right thalamic and intraventricular hemorrhage. Due to the hemorrhage location, surgery was extremely risky and the prognosis was poor even if the patient survived it. The family rejected surgical intervention and the patient died the next day. The insured ophthalmologist was sued along with the neurologist.

Analysis

The plaintiff's expert opined that the patient should have been referred directly to the hospital for neurological examination or, failing that, referred once the insured detected an abnormal pupillary reaction. The expert was critical of the insured for not communicating his findings to the neurologist directly. He maintained that the negligence of both doctors resulted in a three-hour delay in diagnosing the hemorrhage.

The defense expert countered that the history relayed by the patient's father when he called the insured suggested a perforated globe, and since the finding of an afferent pupillary defect was indicative only of trauma to the optic nerve, not a brain injury, it was his opinion that referring the patient to the neurologist, not the ER, was appropriate. Further, he explained, it is not unusual to leave details of a patient's condition with office personnel as it is often impossible for physicians to speak directly with one another in a timely manner.

The jury returned a verdict in favor of both the insured ophthalmologist and the neurologist.

Risk Management Principles

The decedent's parents were sympathetic plaintiffs and might have won on that basis alone. Fortunately, the jury listened to the facts and understood that the insured's care and treatment met the standard of care. However, had it not been for the insured's prompt examination of the patient, immediate referral to the neurologist, and thorough documentation of his findings, the jury might easily have found for the plaintiffs. One additional precaution that the insured might have taken would have been to fax a copy of his chart notes to the consulting neurologist, thereby alerting the neurologist to his concern about a possible bleed. In general, a faxed copy of the chart notes, including the referring physician's differential diagnosis and questions for the consultant, will ensure that the consultant has all of the pertinent information to evaluate the patient. In this case, it might even have precluded the insured's involvement in the lawsuit.

Ms. Takeman has defended physicians, nurses, and hospitals in medical malpractice cases. She has worked in hospital risk management and as a claims representative for an insurance company.

Practical Application of HIPAA Privacy Rules (Part 2)

By Kimberly Wittchow, JD
OMIC Staff Attorney

The compliance deadline of April 14, 2003 is behind us, yet many OMIC insureds continue to grapple with certain provisions of the HIPAA Privacy Rules. For this reason, the **Risk Management Hotline** will again tackle a sampling of the latest HIPAA queries. Updated, downloadable documents are available on the OMIC web site (www.omic.com) and the Department of Health and Human Services (HHS) web site (www.hhs.gov/ocr/hipaa). Remember that if you are not a Covered Entity as defined under HIPAA, these federal mandates do not directly apply to you.

Q Can I release information to persons within a patient's circle of care without a written authorization?

A Yes. You must, however, provide the patient with an opportunity to agree or object to this disclosure. If the patient is present, the easiest way to do this is to get the patient's oral permission before sharing protected health information (PHI). If the patient is not present or communication with the patient is impossible, you may in the exercise of professional judgment determine whether the disclosure is in the best interest of the individual and if so, disclose only the information directly relevant to the person's involvement with the patient's care. It is advisable to document these oral agreements or professional judgments to disclose.

Q Can patients request restrictions on the use or disclosure of their protected health information?

A Yes. Patients have the right to ask for restrictions in the use or disclosure of their PHI, but you are under no obligation to agree. However, if you do agree with the restrictions, you must comply with them. You also must accommodate patients' reasonable requests to receive communications of PHI by alternative means, such as sending all communications in a closed envelope rather than on a post card.

Q Is the Notice of Privacy Practices the only policy document my practice needs?

A No. The Rules additionally require that you have written privacy procedures addressing which staff has access to PHI, how PHI will be used, and when PHI may be disclosed. OMIC's *Sample Compliance Plan** is both a template and a guide for creating your own privacy plan. In addition, you must designate a Privacy Officer, train your employees, and take appropriate disciplinary action if you learn of a breach.

Q Are fellow health care providers my Business Associates?

A A Business Associate Agreement is not required when you disclose PHI to another health care provider for treatment of a patient. However, you and another health care provider may be business associates for some other purpose. For example, a hospital might hire you to help train medical students, in which case the hospital would have to obtain an Agreement from you before allowing you access to patient information.

Q Will the government actually enforce the HIPAA Privacy Rules?

A In an April 14, 2003 press release, HHS stated that enforcement will be primarily complaint driven. The Office of Civil Rights (OCR) intends to investigate complaints and ensure that the privacy rights of consumers are protected. OCR may impose civil monetary penalties of $100 per failure to comply. The Department of Justice may prosecute criminal violations with fines ranging from $50,000 to $250,000 and prison terms ranging from one to ten years.

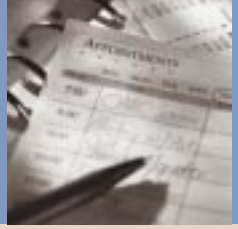
Q Does HIPAA address eye banks?

A Yes. The Privacy Rules permit you to disclose PHI without authorization to eye banks for the purpose of facilitating cadaveric eye donation and transplantation. Furthermore, the procurement or banking of eyes is not considered health care under the Rules and the organizations that perform such activities are not considered health care providers or Covered Entities when conducting these functions.

Q Who are patients' personal representatives and what information can I share with them?

A HIPAA requires that you treat an individual's personal representative as the individual with respect to privacy rights. The scope of the personal representative's authority to act for the individual derives from applicable (generally state) law. Parents have broad authority to act on behalf of their children and legal guardians generally have broad authority to act on behalf of mentally incompetent adults. Conversely, someone with a limited health care power of attorney is that individual's personal representative only with respect to certain health care decisions.

* Contact OMIC for a copy of the *Sample Compliance Plan* or other HIPAA forms and documents.



Calendar of Events

OMIC continues its popular seminar series, *Professional Liability Issues in Ophthalmology*, this summer and fall in conjunction with state, regional and subspecialty societies. CME credit and OMIC's risk management premium discount are available for completing most OMIC-sponsored programs. Cosponsored seminars that qualify for OMIC's maximum risk management discount (10%) are indicated with an asterisk.

In addition to seminars and audioconferences, OMIC is pleased to launch its second online risk management course, *EMTALA and ER-Call Liability*. This course provides an overview of the liability issues related to providing emergency room coverage. OMIC offers another online course, *Ophthalmic Anesthesia Risks*. Insureds interested in earning a 5% risk management premium discount and CME credit can access and complete either course through the OMIC website, http://www.omic.com/resources/risk_man/online_riskmgt.cfm.

August

9 *EMTALA and ER Liability**
Women In Ophthalmology
La Posada de Santa Fe Resort,
Santa Fe, NM
11:20 am–12:20 pm
Register through WIO,
(415) 561-8531

13 *Expert Witness Testimony and the Litigation Process**
Statewide Audioconference
Washington Academy of Eye Physicians and Surgeons
6–7 pm
Register through OMIC,
(800) 562-6642, ext. 24

September

14 *Risk Management Issues for Florida Ophthalmologists**
Florida Society of Ophthalmology
Ritz-Carlton Hotel,
Sarasota, FL
7:30–8:30 am
Register through FSO,
(904) 998-0819

TBA *Risk Management Issues for California Ophthalmologists**
California Academy of Ophthalmology
Statewide Audioconference
Time TBA
Register through OMIC,
(800) 562-6642, ext. 24

TBA *Successfully Maneuvering the Legal Rapids*
Nationwide Audioconference
Time TBA
Register through OMIC,
(800) 562-6642, ext. 24

November

16 *OMIC Mock Litigation*
American Academy of Ophthalmology
Coast Anaheim Hotel,
Anaheim, CA
11 am–2 pm
Register through OMIC,
(800) 562-6642, ext. 24

17 *OMIC Professional Liability and Risk Management Review for Ophthalmology*
American Academy of Ophthalmic Executives
Anaheim Marriott,
Anaheim, CA
9–10 am
Register through AAO,
(415) 561-8500

December

TBA *Risk Management Issues for Louisiana Ophthalmologists**
Louisiana Ophthalmological Association
Statewide Audioconference
Time TBA
Register through OMIC,
(800) 562-6642, ext. 24

This schedule is subject to change. Please call OMIC's Risk Management Department to confirm dates and times.

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